February 24, 2009

S 287. STATE HLTH PLAN $/GOOD HEALTH INITIATIVES. Filed 2/24/09. TO APPROPRIATE FUNDS FOR THE STATE HEALTH PLAN FOR TEACHERS AND STATE EMPLOYEES AND TO MAKE OTHER CHANGES RELATED TO THE STATE HEALTH PLAN.

Appropriations. Appropriates $250 million for 2008-09 from the Savings Reserve Account established in GS 143C-4-2 to the Health Benefit Reserve Fund established in GS 135-44.5 to address the shortfall in funds available for the payment of hospital and medical benefits and administrative costs under the State Health Plan for Teachers and State Employees (Plan) for the 2008-09 fiscal year.

The following appropriations are effective July 1, 2009.

Appropriates $108,432,425 for 2009-10 and $224,768,067 for 2010-11 from the General Fund to the Reserve for the State Health Plan in the Office of State Budget and Management (Plan Reserve) to be used to cover health care and administrative costs to the Plan in the 2009-11 fiscal biennium.

Appropriates $5,060,180 for 2009-10 and $10,489,176 for 2010-11 from the Highway Fund to the Plan Reserve to be used to cover health care and administrative costs to the Plan in the 2009-11 fiscal biennium, despite the provisions of GS 143C-5-2 (regarding the order of appropriations bills).

Provides that all other agency funds required to fund the premium increase enacted in this proposed act are appropriated for the 2009-11 fiscal biennium.

Definitions. Includes the following definitions for terms as used in the proposed act: (1) *Plan*-the State Health Plan for Teachers and State Employees, (2) *Basic Plan*-the Plan's PPO option providing for 70/30 in network coverage after deductibles and co-payments, (3) *Smoking* or *Smoking cessation*-includes cessation of the use of all tobacco products and (4) *Standard Plan*-the Plan's PPO option providing for 80/20 in-network coverage after deductibles and co-payments.

Scope. Directs that should there be a conflict between the provisions of this proposed act and those of GS Chapter 135, Article 3A (regarding other benefits for teachers, state employees, retired state employees, and child health), the provisions of this proposed act are to prevail.

Health Benefit Changes. Eliminates the PPO Plus option that provides 90/10 in-network coverage under the Plan, effective July 1, 2009. Directs the Executive Administrator to notify all Plan members that this option will no longer be available as of July 1, 2009. Provides that members enrolled in the PPO Plus option are to have the choice of enrolling in the Basic (70/30 in-network coverage) or Standard (80/20 in-network coverage) plan options for the 2009-10 benefit year.

Directs the Plan to develop a Comprehensive Wellness Initiative (Wellness Initiative) that includes a focus on smoking cessation, to be implemented effective July 1, 2010, and weight management, to be implemented effective July 1, 2011. Authorizes the Plan to determine benefit levels based upon the member's tobacco use or the member's inability to meet national, evidence-based healthy weight clinical guidelines. For purposes of the Wellness Initiative, *member* includes all Plan primary subscribers and their covered dependents. Directs the Plan to develop an appeal process for members failing or refusing to comply with the Plan's smoking cessation or weight management requirements.

Requires all members of the Plan who do not have Medicare as their primary coverage to enroll in the Basic Plan under the Plan's PPO unless the subscriber can attest that the subscriber or any qualifying dependent does not smoke or otherwise use tobacco products. Provides for an assessment of tobacco product use annually at the time of Plan enrollment. Subscribers who attest that neither they nor their family members use tobacco or whose medical provider certifies in writing that the member is participating in a smoking cessation program may choose to enroll in the Basic plan option or the Standard plan option. Effective July 1, 2010.

Requires all members of the Plan who do not have Medicare as their primary coverage to enroll in the Basic Plan under the Plan's PPO unless the subscriber attests that the subscriber's weight and height is within a range determined by the Plan based on evidence-based healthy weight clinical guidelines. Provides that if the subscriber's medical provider certifies in writing that the member has a medical condition that prevents the attainment of the specified weight range

and that the subscriber is actively participating in a Plan-approved weight management program, the member will have the option to enroll in the Basic or Standard plan. Effective July 1, 2011.

Directs the Executive Administrator to inform Plan members of the healthy lifestyle initiatives, requirements for compliance, and consequences of noncompliance no later than October 1, 2009. Also directs the Executive Administrator to provide education and training to assist members with compliance with the healthy lifestyle initiatives. Permits the Executive Administrator to implement incentive initiatives to encourage members in compliance efforts.

Directs the Executive Administrator to make recommendations to the Committee on Employee Hospital and Medical Benefits for additional sanctions that may be imposed upon a finding that a member intentionally made a false statement on a Plan document.

Amends GS 135-45.6(b) to make adjustments to the co-payments and other allowable charges for prescription drugs. Sets the co-payment for each preferred branded prescription *without* a generic equivalent at $35 (was, $30 for each preferred branded prescription and $40 for each preferred branded prescription with a generic equivalent) and sets the co-payment for each non-preferred branded prescription at $55 (was, $50 for each non-preferred branded or generic prescription). Provides that for each preferred branded prescription drug *with* a generic equivalent, the member is to pay the generic co-payment plus the difference between the Plan's cost for the generic prescription and the Plan's cost for the branded prescription drug. Continues the co-payment for a generic prescription at $10. Effective July 1, 2009.

Requires the Plan to impose a co-payment of 25% of the Plan's cost for specialty medications (those that exceed a $500 cost to the Plan) but restricts the co-payment from exceeding $100 per prescription for a 30-day supply. Additionally, permits the Plan to not cover drugs that have therapeutic over-the-counter equivalents. Effective July 1, 2009.

Restricts prescriptions covered by the co-payment provisions to no more than a 30-day supply (was, 34-day supply). Allows the Plan to adopt utilization management procedures for certain drugs and amends the list of treatments for which the Plan may not provide prescription coverage. Effective July 1, 2009.

Amends GS 135-45.8 to add routine eye examinations to the list of non-covered expenses for which benefits will not be paid, beginning January 1, 2010. Effective July 1, 2009.

Deductible and co-payment changes. Makes increases to deductibles, coinsurance, and co-payments under the Basic and Standard PPO plans as indicated, effective July 1, 2009.

Deductible, Coinsurance, or Co-payment	**Basic Plan**	**Standard ¶ 70/3**
In-network annual deductible for member only (*the aggregate maximum deductible*	$800	$600¶*for employee*
Out-of-network annual deductible member only (*the aggregate maximum*	$1,600	$1,200¶*deductible*
In-network coinsurance maximum member only (*the aggregate coinsurance*	$3,250	$2,750¶*maximum*
Out-of-network coinsurance maximum member only (*the aggregate coinsurance*	$6,500	$5,500¶*maximum*
In-network primary care co-payment	$30	$25
In-network specialist co-payment	$70	$60
In-network inpatient co-payment	$250	$200
In-network urgent care co-payment	n/a	$75

Increases include the increase to prescription drug co-pays as required in the proposed amendments to GS 135-45.6(b). Provides that except as otherwise provided in this proposed act, out-of-network co-payments remain the same as applied in the 2008-09 benefit year.

Increases premium rates for contributory coverage under GS 135-44.6 to 7.3% for 2009-10 and provides for an additional 7.3% increase over the premium rate for contributory coverage for the 2010-11 fiscal year. Directs the Plan to implement a maintenance medication retail pharmacy network initiative to reduce pharmaceutical costs to the Plan and to members with respect to refills of long-term maintenance drugs. Provides that this subsection does not apply to medications taken for acute conditions or specialty medications. Effective July 1, 2009.

Eligibility clarification. Amends GS 135-45.1(10) (regarding dependent child clarifications) to clarify that *dependent child* includes a stepchild whose primary residence is with the member and GS 135-45.2(d) (regarding eligibility of full time students) to clarify the conditions under which

coverage of a dependent child may be extended beyond the child's 19th birthday. Includes references to compliance with federal law in GS 135-43.3(b) and GS 135-45.4(b) regarding waiting periods.

Requires that the Executive Administrator provide for an audit of dependent eligibility under the Plan to determine whether all dependents currently covered are eligible for coverage. Requires disenrollment of an identified ineligible dependent within 10 days of sending written notice to the employee, with the effective date of disenrollment and basis for ineligibility included in the notice. Allows the Executive Administrator to waive requirements to collect from the member reimbursement for claims paid for the ineligible covered individual.

Amend GS 135-45.12 to provide that cessation of coverage occurs upon the earlier of specified dates, including the last day of the month in which a covered individual is found to be ineligible. Amends GS 135-45.3 to require that when an eligible or enrolled member applies to enroll the member's eligible dependent or spouse, the member must provide information as required by the Plan to verify the dependent's eligibility for coverage.

NC Health Choice Changes. Establishes the effective date for coverage of over-the-counter medication authorized for the NC Health Choice Program as July 1, 2010, or the date the Department of Health and Human Services (DHHS) assumes full responsibility for administration, processing, and payment of claims under the NC Health Choice Program, whichever is later. Applies the right of subrogation under GS 108A-57 (related to programs of public assistance) to the Plan for payments made by the Plan under the NC Health Choice Program. This right of subrogation expires on July 1, 2010, or the date DHHS assumes full responsibility for administration, processing, and payment of claims under the NC Health Choice Program, whichever is later. Makes a conforming change to GS 108A-57.

Salary-Related Contributions. Effective for the 2009-11 fiscal biennium, required employer salary-related contributions for employees whose salaries are paid from department, office, institution, or agency receipts are to be paid from the same source as the source of the employees' salary. Provides for employee salaries paid in part by appropriations. Applies these requirements to payments paid on behalf of the employee for hospital-medical benefits, longevity pay, unemployment compensation, accumulated leave, workers' compensation, severance pay, separation allowances, and applicable disability income benefits. Provides for retiree employee hospital-medical benefits.

Effective July 1, 2009, sets the state employer contribution rates budgeted for retirement and related benefits as a percentage of covered salaries for the 2009-10 fiscal year according to state employee category, with all rates including 4.5% for hospital and medical benefits. Effective July 1, 2010, sets the same state employer contribution rate percentages as the previous fiscal year for 2010-11.

Effective July 1, 2009, provides for the maximum annual employer contributions, payable monthly, by the state for each covered employee or retiree for the 2009-10 fiscal year to the Plan as (1) $3,396 for Medicare-eligible employees and retirees and (2) $4,460 for non-Medicare-eligible employees and retirees.

Effective July 1, 2010, provides for the maximum annual employer contributions, payable monthly, by the state for each covered employee or retiree for the 2010-11 fiscal year to the Plan as (1) $3,644 for Medicare-eligible employees and retirees and (2) $4,786 for non-Medicare-eligible employees and retirees.

Miscellaneous Changes. Amends GS 135-44.4 to add to the powers and duties of the Executive Administrator and the Board of Trustees that (1) the Plan and its pharmacy benefit manger may implement and administer pharmacy and medical utilization management programs and programs to detect and address utilization abuse of benefits and (2) the Plan may restrict coverage for transplant and bariatric medical procedures to certain in-network providers that are designated by the Plan's claims processing contractor.

Amends GS 135-44.1 to clarify that a majority (was, six) of Board of Trustee members in office constitutes a quorum.

Amends GS 135-45.9(b) to add that state psychiatric hospitals accredited by the Joint Commission on the Accreditation of Healthcare Organizations are covered for mental illness and chemical dependency treatment.

S 287. STATE HLTH PLAN $/GOOD HEALTH INITIATIVES. Filed 2/24/09. Senate committee substitute makes the following changes to 1st edition.

Appropriates $116,656,658 for 2009-10 (was, $108,432,425) and $242,460,864 for 2010-11 (was, $224,768,067) from the General Fund to the Reserve for the State Health Plan in the Office of State Budget and Management (Plan Reserve) to be used to cover health care and administrative costs to the Plan in the 2009-11 fiscal biennium.

Appropriates $5,443,977 for 2009-10 (was, $5,060,180) and $11,314,840 for 2010-11 (was, $10,489,176) from the Highway Fund to the Plan Reserve to be used to cover health care and administrative costs to the State Health Plan (Plan) in the 2009-11 fiscal biennium.

Requires all members of the Plan who do not have Medicare as their primary coverage to enroll in the Basic Plan under the Plan's PPO unless the subscriber attests that the subscriber's weight and height *ratio* (was, height and weight) is within a range determined by the Plan based on evidence-based healthy weight clinical guidelines. Provides that if the subscriber's *physician* (was, medical provider) certifies in writing that the member has a medical condition that prevents the attainment of the specified weight range and that the subscriber is actively participating in a Plan-approved weight management program, the member will have the option to enroll in the Basic or Standard plan.

Amends GS 135-45.6(b) to provide that for each branded prescription drug (was, *preferred* branded prescription drug) with a generic equivalent, the member is to pay the generic co-payment plus the difference between the Plan's *gross allowed* cost (was, cost) for the generic prescription and the Plan's cost for the branded prescription drug.

Requires the Plan to impose a co-payment of 25% of the Plan's *gross allowed* cost (was, cost) for specialty medications that exceed a $400 cost (was, $500) to the Plan, but continues to restrict the co-payment for specialty medications from exceeding $100 per prescription for a 30-day supply.

Requires the Plan's Pharmacy Benefit Manager, or any pharmacy participating in the Plan to charge the Plan for any prescription legend drug dispensed under the Plan's pharmacy benefit based on the original National Drug Code as established by the manufacturer and published by the US Food and Drug Administration. Co-payments for drugs purchased under the maintenance Medication Retail Pharmacy Network Initiative are to be as provided in GS 135-45.11(c).

Increases premium rates for contributory coverage under GS 135-44.6 to 7.8% (was, 7.3%) for 2009-10 and provides for an additional 7.8% (was, 7.3%) increase over the premium rate for contributory coverage for the 2010-11 fiscal year.

The first edition directed the Plan to implement a maintenance medication retail pharmacy network initiative to reduce pharmaceutical costs to the Plan and to members with respect to refills of long-term maintenance drugs. The Senate committee substitute codifies that provision as a new subsection (c) to GS 135-45.11 and amends the provision to require the Plan to establish a network of retail pharmacies that agree to participate in the maintenance retail network under the Plan's contract terms, (was, the Plan *may* establish a network), and to direct the Plan to offer all retail pharmacies an opportunity to join the network. Clarifies that for each three-month supply of a maintenance medication that a member obtains from a participating pharmacy or by mail order, the member will be responsible for not more than two and one-half tomes the monthly co-payment for a 30-day supply. Permits the Plan to impose an increased co-payment for the purchase of *less* than a three-month supply of a maintenance medication from a maintenance network pharmacy or by mail. Provides that under the increased co-payment, the member is responsible for 50% of the Plan's allowed gross cost for each 30-day supply of the maintenance medication purchased from a network pharmacy or by mail.

Amends GS 135-45.2(d) (regarding eligibility of full time students) to clarify that coverage of a dependent child who is a full-time student may be extended through the end of the month following the student's 26thbirthday.

Increases the in-network *and* out-of network (was, increased the in-network) inpatient co-payment to $250 per covered individual under the 70/30 (Basic plan) and to $200 per covered individual under the 80/20 (Standard plan). Also provides that under the Basic and Standard

plans, co-payments and coinsurance (was, out-of-network co-payments) for coverage not otherwise listed remain the same as in the 2008-09 benefit year. Makes the in-network *and* out-of-network specialist co-payment $60 per covered individual under the Standard plan (was, $60 in-network specialist co-payment).

Amends GS 108A-70.21(g) regarding enrollees in the NC Health Choice Program (Program) to provide that an enrollee who loses the enrollee's eligibility because of an increase in family income above 200% (was, 250%) and up to 225% (was, 275%) of the federal poverty level may purchase continued coverage under the Program for a period of up to one year. Provides that the conditions of enrollment under the Program that are applicable to extended coverage purchased under this subsection are to be the same as those applicable to a NC Kids' Care enrollee whose family income equals 200% (was, 250%) of the federal poverty level. Applies to applications for extended coverage made on or after July 1, 2008.

Amends the state's employer contribution rates budgeted for retirement and related benefits as a percentage of covered salaries for the 2009-10 and the 2010-11 fiscal years.

Provides for the maximum annual employer contributions effective July 1, 2009, payable monthly, by the state for each covered employee or retiree for the 2009-10 fiscal year to the Plan as (1) $3,413 (was, $3,396) for Medicare-eligible employees and retirees and (2) $4,482 (was, $4,460) for non-Medicare-eligible employees and retirees.

Provides for the maximum annual employer contributions effective July 1, 2010, payable monthly, by the state for each covered employee or retiree for the 2010-11 fiscal year to the Plan as (1) $3,680 (was, $3,644) for Medicare-eligible employees and retirees and (2) $4,834 (was, $4,786) for non-Medicare-eligible employees and retirees.

Amends Section 28.22A(k) of SL 2007-323 to provide that subsection (j) (providing that the Plan is not to limit visits for covered services for physical therapy, occupational therapy, and speech therapy) expires June 30, 2011 (was, June 30, 2009).

Makes additional technical and organizational changes.

March 24, 2009

S 287. STATE HLTH PLAN $/GOOD HEALTH INITIATIVES. Filed 2/24/09. Senate amendment number one makes the following changes to 2nd edition. Amends the General Fund appropriation to the Reserve for the State Health Plan to provide $128,410,208 for 2009-10 and $267,904,114 for 2010-11. Amends the Highway Fund appropriation to the Reserve for the State Health Plan to appropriate $5,992,476 for 2009-10 and $12,502,192 for 2010-11. Changes from "medical provider" to "physician" the person who must certify in writing a member's participation in a smoking cessation program. Exempts members from the application of the weight management provision if either the member has a medical condition that prevents the attainment of the specified weight range or (was, "and") that member is actively participating in an approved weight management plan. Amends the provision applying to non-acute "specialty medications" [GS 135-45.6(b)] to define that term as covered biotech medications and other medications designated and classified by the Plan as specialty medications that are typically significantly more expensive than alternative drugs or therapies and that generally have unique uses for the treatment of complex diseases, require special dosing or administration, require special handling, are typically prescribed by a specialist provider, and exceed $400 cost to the Plan per prescription. Removes from language amending GS 135-45.6(b) reference to the Plan's Maintenance Medication Retail Pharmacy Network Initiative under GS 135-45.11(c). Rewrites language adding new subsection (c) of GS 135-45.11 to replace the proposed maintenance medication retail pharmacy network initiative with language requiring the Plan to direct its pharmacy benefits manager to achieve $18 million in savings in pharmacy benefits for 2009-10 and $20 million for 2010-11 through reduced reimbursements paid to pharmacies for prescription drugs. Deletes the increase in out-of-network specialist co-payments. Raises the successive annual increases in premium rates for contributory coverage under GS 135-44.6 from 7.8% to 8.6%. Increases the maximum annual employer contribution by the state for each covered employee or retiree (set out in the 2nd edition) by $25 for Medicare-eligible employees and retirees and $33 for non-Medicare employees and retirees effective July 1, 2009. Raises the proposed increases to employee contributions for these same categories by $55 and $71 respectively effective July 1, 2010. Amends a whereas clause.

Senate amendment number two adds language amending GS 135-43(b) to provide that the terms of a contract between the Plan and its third party administrator or between the Plan and its pharmacy benefit manager are a public record except that contract terms containing trade secrets or proprietary or competitive information are not a public record.

April 6, 2009

S 287. STATE HLTH PLAN $/GOOD HEALTH INITIATIVES. Filed 2/24/09. House committee substitute makes the following changes to 3rd edition. Increases the proposed appropriation from the General Fund to the Reserve for the State Health Plan (Plan) in the Office of State Budget Management (OSBM) to $134,810,947 (was, $128,410,208) for 2009-10 and $281,838,088 (was, $267,904,114) for 2010-11. Increases the proposed appropriation from the Highway Fund to the Reserve for the Plan in OSBM to $6,291,178 (was, $5,992,476) for 2009-10 and $13,152,444 (was, $12,502,192) for 2010-11.

Amends proposed GS 135-45.6(b)(2) to specify that cancer medications are excluded from the requirement that the Plan provide coverage of nonacute specialty medications under the Plan's pharmacy benefit through a contracted specialty pharmacy vendor. Provides that the Plan is required to continue to allow any retail pharmacy to dispense any specialty drug at the same price as determined by the specialty drug vendor if the Plan transfers coverage of specified specialty disease medications to the contracted specialty pharmacy vendor. Adds to the conditions qualifying medications as a specialty medication that the medication (1) requires special handling and (2) is typically prescribed by a specialist provider. Makes organizational changes.

Clarifies that for the Basic plan (70/30) (1) the increased $30 co-payment for in-network primary care, *not* the increased $70 co-payment for in-network specialists, applies to chiropractic services and (2) the in-network co-payment for physical therapy, occupational therapy, and speech therapy is $30 per individual therapy type per covered individual. Clarifies that for the Standard plan (80/20) (1) the increased $25 co-payment for in-network primary care, *not* the increased $60 co-payment for in-network specialists, applies to chiropractic services and (2) the in-network co-payment for physical therapy, occupational therapy, and speech therapy is $25 per individual therapy type per covered individual.

Increases the proposed increased premium rates for contributory coverage to 9.1% (was, 8.6%) and an additional 9.1% (was, 8.6%) over the premium rate for contributory coverage for 2010-11.

Requires that the Plan's pharmacy benefit manager (PBM) disclose to the Plan the amount actually paid or to be paid to the pharmacy for each prescription, including the drug name, dose, and quantity. Makes this information and information containing the corresponding amounts charged by the PBM to the Plan available to the Committee on Employee Hospital and Medical Benefits.

Effective January 1, 2011, amends GS 135-45.1(21) to define *Plan year* as the period beginning January 1 (was, July 1) and ending on December 31 (was, June 30) of the succeeding calendar year.

April 8, 2009

S 287. STATE HLTH PLAN $/GOOD HEALTH INITIATIVES. Filed 2/24/09. House committee substitute makes the following changes to 4th edition. Increases the appropriation from the General Fund to the Reserve for the State Health Plan (Plan) in the Office of State Budget and Management (OSBM) to $148,769,662 (was, $134,810,947) for 2009-10 and to $312,416,291 (was, $281,838,088) for 2010-11. Increases the appropriation from the Highway Fund to the Reserve for the State Health Plan in OSBM to $6,942,584 (was, $6,291,178) for 2009-10 and to $14,579,427 (was, $13,152,444) for 2010-11.

Makes a clarifying change to proposed GS 135-45.6(b)(3).

Increases the proposed increased premium rates for contributory coverage to 10% (was, 9.1%) and an additional 10% (was, 9.1%) over the premium rate for contributory coverage for 2010-11.

Provides for adjustments to pertinent dollar amounts and percentages to account for the change from a Plan year to a calendar year as follows: (1) the amounts for annual deductibles and annual co-insurance maximums, in effect on July 1, 2009, are to be 50% of the annual amount for a six-month plan year beginning in July 1, 2010, through December 31, 2010, (2) limits the total annual amount of the pharmacy co-payments assessed per plan member to $1,250 for the six-month plan year beginning July 1, 2010, through December 31, 2010, and (3) effective January 1, 2011, Plan benefits, co-payments, deductibles, out-of-pocket expenditures, and lifetime maximums are as enacted effective July 1, 2009.

Establishes the 15 member Blue Ribbon Task Force on the State Health Plan for Teachers and State Employees (Task Force) to review governance of the Plan and to make recommendations that will ensure ongoing financial stability of the Plan, increase and maintain high participation rates for dependent coverage, study and compare coverage and costs of the Plan to other state health plans in the region, and address issues of cost, quality, and access to health coverage. Specifies other issues to be considered. Provides for appointment of members. Requires that the Task Force report on its findings and recommendations, upon the convening of each session of the General Assembly, to the General Assembly, the Governor, and the Committee on Hospital and Medical Benefits (Committee). Directs the Legislative Services Officer to allocate a portion of appropriated funds for each fiscal year for Task Force expenses.

Amends GS 135-44.4 to require the Executive Administrator of the Teachers' and State Employees' Comprehensive Major Medical Plan to ensure provisions in contracts between the Plan and the Plan's Claims Processing Contractor that call for the Plan to contract with an independent auditor, selected by the Plan, include review of the Claims Processing Contractor's administrative costs and services to the Plan by the Claim's Processing Contractor. Requires the Plan to (1) conduct a monthly review of Plan costs as compared to the same month in the immediately preceding year and a comparison of projected costs and savings to actual costs and savings and (2) report the results of the review to the Committee and the Task Force at least semiannually. Amends GS 135-45(d) to require that the Executive Administrator ensure that the terms of the contract between the Plan and the Plan's Claims Processing Contractor, the Pharmacy Benefit Manager, and the Disease Management Contractor require the contractor to provide (1) detailed billing by each entity showing itemized cost information, including individual administrative services provided, (2) transactional data, and (3) the cost to the Plan for each administrative function performed by the contractor.

Requires the Executive Administrator to propose a new in-network specialist co-payment that establishes a midpoint co-payment for office services covering mental health and chemical dependency, chiropractic and physical therapy, occupational therapy, and speech therapy services. Requires the Executive Administrator to report on the specialist co-payment to the Committee and Task Force.

Increases the proposed employer contribution rates for retirement and related benefits as a percentage of covered salaries for 2009-10 and 2010-11 by .1%.

Increases the maximum annual employer contributions effective July 1, 2009, payable monthly, by the state for each covered employee or retiree for the 2009-10 fiscal year to the Plan to (1) $3,483 (was, $3,438) for Medicare-eligible employees and retirees and (2) $4,572 (was, $4,515) for non-Medicare-eligible employees and retirees.

Increases the maximum annual employer contributions effective July 1, 2010, payable monthly, by the state for each covered employee or retiree for the 2010-11 fiscal year to the Plan to (1) $3,828 (was, $3,735) for Medicare-eligible employees and retirees and (2) $5,031 (was, $4,905) for non-Medicare-eligible employees and retirees.

Deletes provision concerning the implementation of a complete wellness initiative.

April 14, 2009

S 287. STATE HLTH PLAN $/GOOD HEALTH INITIATIVES. Filed 2/24/09. House amendments make the following changes to 5th edition.

Amendment #1 amends Section 7(a) to add that the State Health Plan Blue Ribbon Task Force must consider the benefits of implementing a closed prescription drug formulary when conducting its review of the State Health Plan for Teachers and State Employees (Plan) (was, in

considering the issue of governance of the Plan). Also makes organizational and technical changes.

Amendment #2 creates new Section 5(m) to require the Director of the Fiscal Research Division (Director) of the Legislative Services Office to prepare a Request for Proposal (RFP) for an independent audit of claims paid by the Plan to determine whether savings to the Plan and Plan members could be achieved if claim payments and processing were more efficiently and effectively administered. Provides that the audit encompasses Plan years beginning in 2005, or earlier, through 2008 and must look at claims administration and payment under the former Indemnity Plan as compared to the present PPO Plan. Specifies issues that the contracting entity must identify and make recommendations about while conducting the audit. States that it is the intent of the General Assembly that identified savings that are realized through enactment of the General Assembly and overpayments identified by the audit or the Plan be allocated by the General Assembly to minimize benefit reductions and maintain affordable contributions, deductibles, and co-payments and to maintain fiscal integrity of the Plan. Requires that the Director offer the RFP by July 1, 2009. Allows the Director to include in the RFP any other matters that the Director believes will produce an audit report that is the most timely and useful to the General Assembly in addressing Plan issues.

Amendment #4 amends GS 135-45.6 to prohibit co-payments and other allowable charges or coverage for prescription drugs from being greater than the actual cost of the prescription drug to the patient.

April 22, 2009

S 287. STATE HEALTH PLAN$/GOOD HEALTH INITIATIVES. Filed 2/24/09. Conference report recommends the following changes to 6th edition to reconcile matters in controversy.

Appropriations. Decreases the proposed appropriation from the General Fund to the Reserve for the State Health Plan (Plan) in the Office of State Budget Management (OSBM) to $132,214,752 (was, $148,769,662) for 2009-10 and $276,179,709 (was, $312,416,291) for 2010-11. Decreases the proposed appropriation from the Highway Fund to the Reserve for the Plan in OSBM to $6,170,022 (was, $6,942,584) for 2009-10 and $12,888,386 (was, $14,579,427) for 2010-11.

Health Benefit Changes. Directs the Plan to develop a Comprehensive Wellness Initiative (Wellness Initiative) that includes a focus on smoking cessation, to be implemented effective July 1, 2010, and weight management, to be implemented effective July 1, 2011. Authorizes the Plan to determine benefit levels based upon the member's tobacco use or the member's inability to meet national, evidence-based healthy weight clinical guidelines. For purposes of the Wellness Initiative, *member* includes all Plan primary subscribers and their covered dependents. Directs the Plan to develop an appeal process for members failing or refusing to comply with the Plan's smoking cessation or weight management requirements.

Requires all members of the Plan who do not have Medicare as their primary coverage to enroll in the Basic Plan under the Plan's PPO unless the subscriber can attest that the subscriber or any qualifying dependent does not smoke or otherwise use tobacco products. Requires the Plan to develop a mechanism for verifying that the member does not smoke or use other tobacco products. Provides for an assessment of tobacco product use annually at the time of Plan enrollment. Subscribers who attest that neither they nor their dependents use tobacco or whose medical provider certifies in writing that the member is participating in a smoking cessation program may choose to enroll in the Basic Plan option or the Standard Plan option. Effective July 1, 2010.

Requires all members of the Plan who do not have Medicare as their primary coverage to enroll in the Basic Plan under the Plan's PPO unless the subscriber attests that the subscriber's weight and height is within a range determined by the Plan based on evidence-based healthy weight clinical guidelines. Provides that if the subscriber's medical provider certifies in writing that the member has a medical condition that prevents the attainment of the specified weight range or that the subscriber is actively participating in a Plan-approved weight management program, the member will have the option to enroll in the Basic or Standard plan. Effective July 1, 2011.

Directs the Executive Administrator to inform Plan members of the healthy lifestyle initiatives, requirements for compliance, and consequences of noncompliance by October 1, 2009. Also directs the Executive Administrator to provide education and training to assist members with compliance with the healthy lifestyle initiatives. Permits the Executive Administrator to implement incentive initiatives to encourage member achievement in smoking cessation, weight management, and other integrated health management programs.

Directs the Executive Administrator to make recommendations to the Committee on Employee Hospital and Medical Benefits (Committee) for additional sanctions that may be imposed upon a finding that a member intentionally made a false statement on a Plan document.

Deletes, in GS 135-45.6(b), proposed language that prohibited co-payments and other allowable charges or coverage for prescription drugs from being greater than the actual cost of the prescription drug to the patient. Deletes in proposed GS 135-45.6(b)(2) that the Plan may transfer coverage of specified specialty disease medications to the contracted specialty pharmacy vendor, provided the Plan continues to allow any retail pharmacy to dispense any specialty drug at the same price as determined by the specialty drug vendor. Adds that co-payments and other allowable charges under this subsection must be the lesser of the Plan's discounted cost of the drug or the co-payment amount or allowable charge *and* apply to all optional alternative plans available under the Plan.

Deletes for both for the Basic Plan and Standard Plan (1) that the increased in-network primary care co-payment applies to chiropractic services and (2) the specific co-payment amount for physical therapy, occupational therapy, and speech therapy. Instead, creates an exception to the increased in-network specialist co-payment for mental health and substance abuse services, chiropractic services, and physical therapy, occupational therapy, and speech therapy services and sets the co-payments for these services as $55 under the Basic Plan and $45 under the Standard Plan.

Decreases the proposed increased premium rates for contributory coverage to 8.9% (was, 10%) for 2009-10 and an additional 8.9% (was, 10%) over the premium rate for contributory coverage for 2010-11.

Deletes the proposed requirement that the Plan's pharmacy benefit manager (PBM) disclose to the Plan the amount actually paid or to be paid to the pharmacy for each prescription, including the drug name, dose, and quantity. Made this information and information containing the corresponding amounts charged by the PBM to the Plan available to the Committee.

Other Changes.

Deletes the amendment to GS 135-45.1(21), which defined *Plan year* as the period beginning January 1 and ending on December 31 of the succeeding calendar year. Also deletes conforming changes that were needed to implement the change from a Plan year to a calendar year.

Deletes the requirement that the Executive Administrator propose a new in-network specialist co-payment that establishes a midpoint co-payment for office services covering mental health and chemical dependency, chiropractic and physical therapy, occupational therapy, and speech therapy services.

Modifies Section 5 of the act to require that the Executive Administrator (was, the Director of the Fiscal Research Division of the Legislative Services Office prepared the RFP) include in the development of its Request for Proposal (RFP) for an independent audit of the Plan, an audit of claims paid by the Plan to determine whether savings to the Plan and Plan members could be achieved if claim payments and processing were more efficiently and effectively administered. Requires the Executive Administrator to consult with the Fiscal Research Division staff and the Director of the Program Evaluation Division of the General Assembly to ensure that the issues set forth in the previous edition of the bill are addressed by the independent audit. Adds that the independent audit must address any other matters that *the Executive Administrator*, *Fiscal Research Division Staff*, *the Director of the Program Evaluation Division or* the contracting entity believe would be useful in helping to strengthen the financial integrity of the Plan and Plan benefits. Requires that the Executive Administrator provide the RFP to the Division of Purchase and Contract by July 1, 2009 (was, the Director of the Fiscal Research Division offer the RFP by July 1, 2009). Requires a copy of the audit report be provided to the Committee.

Salary-Related Contributions. Decreases the maximum annual employer contributions effective July 1, 2009, payable monthly, by the state for each covered employee or retiree for the 2009-10 fiscal year to the Plan to (1) $3,447 (was, $3,483) for Medicare-eligible employees and retirees and (2) $4,527 (was, $4,572) for non-Medicare-eligible employees and retirees.

Decreases the maximum annual employer contributions effective July 1, 2010, payable monthly, by the state for each covered employee or retiree for the 2010-11 fiscal year to the Plan to (1) $3,753 (was, $3,828) for Medicare-eligible employees and retirees and (2) $4,929 (was, $5,031) for non-Medicare-eligible employees and retirees.

State Health Plan Blue Ribbon Task Force. Deletes that the State Health Plan Blue Ribbon Task Force (Task Force) must consider in its review of the Plan whether it is feasible to implement weight management and smoking cessation initiatives. Adds that the Task Force must consider (1) whether it is advisable to move the Plan to a calendar year, the costs involved in the move, and the benefits that accrue to the Plan and members as a result of moving to a calendar year and (2) any other matters the Task Force considers relevant to its purpose. Modifies the composition of the Task Force by reducing the members of the Senate and the House of Representatives appointed to the Task Force to three members from each chamber and adding that the Speaker of the House and the President Pro Tempore may each recommend for appointment one member at-large.

Makes various technical changes throughout.

Adds a whereas clause that states that the cessation of tobacco use has been demonstrated to result in improved member health and substantial savings in health care costs making it fiscally prudent to implement smoking cessation incentives and initiatives with mechanisms to verify member compliance with smoking cessation requirements.

April 23, 2009

SL 2009-16 (S 287). STATE HEALTH PLAN$/GOOD HEALTH INITIATIVES. *AN ACT TO APPROPRIATE FUNDS FOR THE STATE HEALTH PLAN FOR TEACHERS AND STATE EMPLOYEES AND TO MAKE OTHER CHANGES RELATED TO THE STATE HEALTH PLAN.* Summarized in *Daily Bulletin* 2/24/09, 3/10/09, 3/24/09, 4/6/09, 4/8/09, 4/14/09, and 4/22/09. Enacted April 23, 2009. Sections 1(b)–(d), 2(c), 2(f), and 2(h) are effective July 1, 2009. Section 4(d) applies to applications for the purchase of extended coverage made on and after July 1, 2008. The remainder is effective April 23, 2009.