GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2009

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SENATE BILL 287

Select Committee on Employee Hospital and Medical Benefits Committee Substitute Adopted 3/10/09
Third Edition Engrossed 3/24/09
House Committee Substitute Favorable 4/6/09
PROPOSED HOUSE COMMITTEE SUBSTITUTE S287-PCS35288-LN-9

Short Title: State Hlth Plan $/Good Health Initiatives. (Public)

Sponsors:

Referred to:

February 25, 2009

A BILL TO BE ENTITLED

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.

Whereas, the General Assembly must act quickly and prudently to maintain a financially stable State Health Plan to ensure that all members of the Plan have affordable access to medically necessary health benefits and services within available resources; and

Whereas, in order to meet current fiscal obligations the General Assembly must appropriate $250,000,000 for the 2008-2009 fiscal year to cover the current year shortfall in funds; and

Whereas, estimates indicate that a substantially larger appropriation will be necessary to maintain the fiscal integrity of the Plan in the next and ensuing fiscal periods; and

Whereas, in order to ensure continued access to medically necessary health care to Plan members, the Plan must implement measures to contain costs through premium increases, benefit changes, and healthy lifestyle programs that not only reduce costs but improve member health; and

Whereas, the Plan estimates that over 70,000 Plan members use tobacco, resulting in a cost to the Plan of $2,000 per member per year more than the cost of providing coverage for nonusers of tobacco; and

Whereas, over 60% of North Carolina adults are obese or overweight; and

Whereas, obesity is linked to an over 37% increase in health care spending at a cost of $2,445 per member per year; and

Whereas, weight management and cessation of tobacco use have been demonstrated to result in improved member health and substantial savings in health care costs making it fiscally prudent to implement smoking cessation and weight management incentives and initiatives with mechanisms to verify member compliance with smoking cessation and weight management requirements; Now, therefore,

The General Assembly of North Carolina enacts:

PART ONE: APPROPRIATIONS, DEFINITIONS, AND SCOPE.

SECTION 1.(a) Appropriation for 2008-2009 fiscal year. – There is appropriated from the Savings Reserve Account established in G.S. 143C-4-2 to the Health Benefit Reserve Fund established in G.S. 135-44.5 the sum of two hundred fifty million dollars ($250,000,000) for the 2008-2009 fiscal year. These funds shall be used to address the shortfall in funds available for the payment of health care and administrative costs under the State Health Plan for Teachers and State Employees ("Plan") for the 2008-2009 fiscal year.

SECTION 1.(b) General Fund appropriation for 2009-2011 fiscal biennium. – Notwithstanding G.S. 143C-5-2, there is appropriated from the General Fund to the Reserve for the State Health Plan in the Office of State Budget and Management the sum of one hundred forty-eight million seven hundred sixty-nine thousand six hundred sixty-two dollars ($148,769,662) for the 2009-2010 fiscal year and the sum of three hundred twelve million four hundred sixteen thousand two hundred ninety-one dollars ($312,416,291) for the 2010-2011 fiscal year. These funds shall be used to cover health care and administrative costs to the Plan in the 2009-2011 fiscal biennium.

SECTION 1.(c) Highway Fund appropriation for the 2009-2011 fiscal biennium. – Notwithstanding G.S. 143C-5-2, there is appropriated from the Highway Fund to the Reserve for the State Health Plan in the Office of State Budget and Management the sum of six million nine hundred forty-two thousand five hundred eighty-four dollars ($6,942,584) for the 2009-2010 fiscal year and the sum of fourteen million five hundred seventy-nine thousand four hundred twenty-seven dollars ($14,579,427) for the 2010-2011 fiscal year. These funds shall be used to cover health care and administrative costs to the Plan in the 2009-2011 fiscal biennium.

SECTION 1.(d) All other agency funds required to fund the premium increase enacted in this act, other than funds appropriated in subsections (b) and (c) of this section, are appropriated for the 2009-2011 fiscal biennium.

SECTION 1.(e) Definitions. – As used in this act unless the context clearly requires otherwise:

(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.

(4) "Standard plan." – The Plan's PPO option providing for 80/20 in-network coverage after deductibles and co-payments.

SECTION 1.(f) Scope. – In the event of a conflict between the provisions of this act and Article 3A of Chapter 135 of the General Statutes, this act prevails.

PART TWO: HEALTH BENEFIT CHANGES.

SECTION 2.(a) Eliminate PPO Plus Option. – Effective July 1, 2009, the PPO Plus option (90/10 in-network coverage) under the State Health Plan for Teachers and State Employees ("Plan") is eliminated. The Executive Administrator shall provide notice to all members of the Plan that this option will no longer be available as of July 1, 2009. Employees enrolled in the Plan's Plus option shall have the choice of enrolling in the Basic or Standard plan options for the 2009-2010 benefit year.

SECTION 2.(b) Prescription drug co-payments. – G.S. 135-45.6(b) reads as rewritten:

"(b) Prescription Drugs. – The Plan's allowable charges for prescription legend drugs to be used outside of a hospital or skilled nursing facility shall be as determined by the Plan's Executive Administrator and Board of Trustees, which determinations are not subject to appeal under Article 3 of Chapter 150B of the General Statutes. Co-payments and other allowable charges or coverage for prescription drugs shall be as follows:

(1) 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, ~~thirty dollars ($30.00)~~ thirty-five dollars ($35.00) for each preferred branded prescription without a generic equivalent, ~~and forty dollars ($40.00) for each preferred branded prescription with a generic equivalent drug,~~ and ~~fifty dollars ($50.00)~~ fifty-five dollars ($55.00) for each nonpreferred branded ~~or generic~~ prescription. For each branded prescription drug with a generic equivalent drug, the member shall pay the generic co-payment plus the difference between the Plan's gross allowed cost for the generic prescription and the Plan's cost for the branded prescription drug.

(2) The Plan shall provide coverage of nonacute specialty medications, excluding cancer medications, under the Plan's pharmacy benefit through a specialty pharmacy vendor under contract with the Plan. The Plan may transfer coverage of specified specialty disease medications covered under the Plan's medical benefit to the contracted specialty pharmacy vendor, provided that the Plan shall continue to allow any retail pharmacy to dispense any specialty drug at the same price as determined by the specialty drug vendor. Specialty medications are covered biotech medications and other medications designated and classified by the Plan as specialty medications that are significantly more expensive than alternative drugs or therapies. Medications classified by the Plan as specialty medications shall meet all of the following conditions:

a. Have unique uses for the treatment of complex diseases.
b. Require special dosing or administration.
c. Require special handling.
d. Are typically prescribed by a specialist provider.
e. Exceed four hundred dollars ($400.00) cost to the Plan per prescription.

The Plan shall impose a co-payment in the amount of twenty-five percent (25%) of the Plan's gross allowed cost of the specialty drug not to exceed one hundred dollars ($100.00) per prescription per 30-day supply.

(3) The Plan may exclude coverage of drugs that have therapeutic equivalents, as defined by the U.S. Food and Drug Administration, that are available over the counter. Before excluding coverage under this subdivision, the Plan shall consult with the Plan's Pharmacy and Therapeutics Committee.

~~These co-paymentsapply to all optional alternative plans available under the Plan.~~

(4) 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~~30-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 sexual 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.~~ The Plan may adopt utilization management procedures for certain drugs, but in no event shall the Plan provide coverage for sexual dysfunction or hair growth drugs or nonmedically necessary drugs used for cosmetic purposes. 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. The Plan's Pharmacy Benefit Manager, or any pharmacy or vendor participating in the Plan shall charge the Plan for any prescription legend drug dispensed under the Plan's pharmacy benefit based upon the original National Drug Code (NDC) as established by the manufacturer of the prescription legend drug and published by the United States Food and Drug Administration.

Copayments authorized under this subsection apply to all optional alternative plans available under the Plan."

SECTION 2.(c) Routine eye examinations not covered. – Effective January 1, 2010, G.S. 135-45.8(13) reads as rewritten:

"**§ 135-45.8. General limitations and exclusions.**

The following shall in no event be considered covered expenses nor will benefits described in G.S. 135-45.6 through G.S. 135-45.11 be payable for:

…

(13) Charges for routine eye examinations, eyeglasses or other corrective lenses (except for cataract lenses certified as medically necessary for aphakia persons) and hearing aids or examinations for the prescription or fitting thereof."

SECTION 2.(d) Deductible and co-payment changes. – Effective July 1, 2009, the Executive Administrator shall make the following changes to deductibles, coinsurance maximums, and co-payments under the Basic and Standard PPO Plans:

(1) Basic plan (70/30):

a. Increase the in-network annual deductible to eight hundred dollars ($800.00) for member-only coverage and to one thousand six hundred dollars ($1,600) for the out-of-network annual deductible for member-only coverage.

The aggregate maximum annual deductible for employee-child and employee-family coverage shall be three times the member-only annual deductibles.

b. Increase the in-network coinsurance maximum to three thousand two hundred fifty dollars ($3,250) for member-only coverage and to six thousand five hundred dollars ($6,500) for member-only out-of-network maximum coinsurance. The aggregate maximum coinsurance for employee-child and employee-family coverage shall be three times the member-only coinsurance maximums.

c. Increase the in-network primary care co-payment to thirty dollars ($30.00) per covered individual. This co-payment applies to chiropractic services.

d. Increase the in-network specialist co-payment to seventy dollars ($70.00) per covered individual. This co-payment does not apply to chiropractic services.
e. Increase the in-network and out-of-network inpatient co-payment to two hundred fifty dollars ($250.00) per covered individual.
f. Increase prescription drug co-pays as required under G.S. 135-45.6(b) as enacted by this act.
g. The in-network co-payment for physical therapy, occupational therapy, and speech therapy shall be thirty dollars ($30.00) per therapy type per covered individual.
h. Except as otherwise provided in this act, co-payments and coinsurance for coverage not otherwise listed in this subdivision shall remain as applicable in the 2008-2009 benefit year.

(2) Standard plan (80/20):
a. Increase the in-network annual deductible to six hundred dollars ($600.00) for member-only coverage and to one thousand two hundred dollars ($1,200) for the member-only out-of-network annual deductible.
The aggregate maximum annual deductible for employee-child and employee-family coverage shall be three times the member-only annual deductibles.
b. Increase the in-network coinsurance maximum to two thousand seven hundred fifty dollars ($2,750) for member-only coverage and to five thousand five hundred dollars ($5,500) for member-only out-of-network maximum coinsurance. The aggregate maximum coinsurance for employee-child and employee-family coverage shall be three times the member-only coinsurance maximums.
c. Increase the in-network urgent care co-payment to seventy-five dollars ($75.00) per covered individual.
d. Increase the in-network primary care co-payment to twenty-five dollars ($25.00) per covered individual. This co-payment applies to chiropractic services.
e. Increase the in-network specialist co-payment to sixty dollars ($60.00) per covered individual. This co-payment does not apply to chiropractic services.
f. Increase the in-network and out-of-network inpatient co-payment to two hundred dollars ($200.00) per covered individual.
g. Increase prescription drug co-pays as required under G.S. 135-45.6(b) as enacted by this act.
h. The in-network co-payment for physical therapy, occupational therapy, and speech therapy shall be twenty-five dollars ($25.00) per therapy type per covered individual.
i. Except as otherwise provided in this act, co-payments and coinsurance for coverage not otherwise listed in this subdivision shall remain as applicable in the 2008-2009 benefit year.

SECTION 2.(e) Limitation on authority to change benefits. – G.S. 135-45(g) reads as rewritten:

"(g) The Executive Administrator and Board of Trustees shall not change the Plan's comprehensive health benefit coverage, co-payments, deductibles, out-of-pocket expenditures, and lifetime maximums in effect on ~~July 1, 2008,~~ July 1, 2009, or a later act of the General Assembly, that would result in a net increased cost to the Plan or in a reduction in benefits to

Plan members as a whole unless and until the proposed changes are directed to be made in an act of the General Assembly."

SECTION 2.(f) Premium increases. – Premium rates for contributory coverage established in accordance with G.S. 135-44.6 shall be increased to ten and percent (10.0%) for contributory coverage for the 2009-2010 fiscal year and shall be increased by an additional ten percent (10.0%) over the premium rate for contributory coverage for the 2010-2011 fiscal year.

SECTION 2.(g) Pharmacy benefit savings. – The Plan shall direct its pharmacy benefit manager (PBM), within the terms of the Plan's PBM contract, to achieve the sum of eighteen million dollars ($18,000,000) in savings in pharmacy benefit costs in the 2009-2010 fiscal year, and the sum of twenty million dollars ($20,000,000) in savings in pharmacy benefit costs in the 2010-2011 fiscal year through reduced reimbursements paid to pharmacies for prescription drugs. If the savings achieved in each six-month period of the fiscal year do not exceed one hundred-five percent (105%) of the savings amount specified in this section for that fiscal year, there shall be no further adjustment to reimbursements paid to pharmacies for that six-month period. If the total savings achieved, by fiscal year, exceeds one hundred five percent (105%) of the specified savings amount in each six month period of the fiscal year, the Plan shall adjust pharmacy reimbursement reductions accordingly. The Plan shall review savings achieved twice annually to ensure compliance with this section. The Plan shall calculate the savings to be achieved based on Plan enrollment and estimated cost and utilization trends incorporated in the Plan's Financial Projections as of March 20, 2009. The total savings by fiscal year achieved in this section may be increased or decreased without adjustment based on a change in total enrollment provided that the rate of savings achieved on a per member per month basis remains constant. Not later than 60 days immediately following each six-month period, the Plan shall report the amount of savings achieved and any adjustments made for that period to the Committee on Employee Hospital and Medical Benefits.

SECTION 2.(h) Required disclosure. – The Plan's pharmacy benefit manager (PBM) shall 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. This information and the corresponding information of the amount the Plan is charged or will be charged by the PBM for each prescription shall be available to the Committee on Employee Hospital and Medical Benefits.

PART THREE: ELIGIBILITY CLARIFICATION.

SECTION 3.(a) Dependent child clarifications. – G.S. 135-45.1(10) reads as rewritten:

"(10) Dependent child. – A natural, legally adopted, or foster child or children of the employee and or spouse, unmarried, up to the first of the month following his or her 19th birthday, whether or not the child is living with the employee, as long as the employee is legally responsible for such child's maintenance and support. Dependent child also includes a stepchild of the member who is married to the stepchild's natural parent. To be eligible, the stepchild must have his or her primary residence with the member. Dependent child shall also include any child under age 19 who has reached his or her 18th birthday, provided the employee was legally responsible for such child's maintenance and support on his or her 18th birthday. Dependent children of firefighters, rescue squad workers, and members of the national guard are subject to the same terms and conditions as are other dependent children covered by this subdivision. Eligibility of dependent children is subject to the requirements of G.S. 135-45.2(d). The Plan may require documentation from the member confirming a child's eligibility to be covered as the member's dependent."

SECTION 3.(b) Eligibility of full-time students. – G.S. 135-45.2(d) reads as rewritten:

"(d) A foster child is covered as a dependent child (i) if living in a regular parent-child relationship with the expectation that the employee will continue to rear the child into adulthood, (ii) if at the time of enrollment, or at the time a foster child relationship is established, whichever occurs first, the employee applies for coverage for such child and submits evidence of a bona fide foster child relationship, identifying the foster child by name and setting forth all relevant aspects of the relationship, (iii) if the claims processor accepts the foster child as a participant through a separate written document identifying the foster child by name and specifically recognizing the foster child relationship, and (iv) if at the time a claim is incurred, the foster child relationship, as identified by the employee, continues to exist. Children placed in a home by a welfare agency which obtains control of, and provides for maintenance of the child, are not eligible participants.

Coverage of a dependent child may be extended beyond the 19th birthday under the following conditions:

(1) If the dependent is a full-time student, ~~aged 19 years and one month~~ through the end of the month following the student's 26th ~~birthday,~~birthday. As used in this section, a full-time student is a student who is pursuing a course of study that represents at least the normal workload of a full-time student at a school or college accredited by the state of jurisdiction. In accordance with applicable federal law, coverage of a full-time student that loses full-time status due to illness may be extended for one year from the effective date of the loss of full-time status provided that the student was enrolled at the time of the onset of the illness.

(2) The dependent is physically or mentally incapacitated to the extent that he or she is incapable of earning a living and (i) such handicap developed or began to develop before the dependent's 19th birthday, or (ii) such handicap developed or began to develop before the dependent's 26th birthday if the dependent was covered by the Plan in accordance with G.S. 135-45.2(5)a."

SECTION 3.(c) Waiting periods subject to federal law. – G.S. 135-45.3(b) reads as rewritten:

"(b) ~~"Newly~~ Except as otherwise required by applicable federal law, newly acquired dependents (spouse/child) enrolled within 30 days of becoming an eligible dependent will not be subject to the 12-month waiting period for preexisting conditions. A dependent can become qualified due to marriage, adoption, entering a foster child relationship, due to the divorce of a dependent child or the death of the spouse of a dependent child, and at the beginning of each legislative session (applies only to enrolled legislators). Effective date for newly acquired dependents if application was made within the 30 days can be the first day of the following month. Effective date for an adopted child can be date of adoption, or date of placement in the adoptive parents' home, or the first of the month following the date of adoption or placement. Firefighters, rescue squad workers, and members of the national guard, and their eligible dependents, are subject to the same terms and conditions as are new employees and their dependents covered by this subdivision. Enrollments in these circumstances must occur within 30 days of eligibility to enroll."

SECTION 3.(d) G.S. 135-45.4(b)(5) reads as rewritten:

"(5) To administer the 12-month waiting period for preexisting conditions under this that Article, the Plan must give credit against the 12-month period for the time a person was covered under a previous plan if the previous plan's coverage was continuous to a date not more than 63 days before the effective date of coverage. As used in this subdivision, a "previous plan" means any policy, certificate, contract, or any other arrangement provided by any

accident and health insurer, any hospital or medical service corporation, any health maintenance organization, any preferred provider organization, any multiple employer welfare arrangement, any self-insured health benefit arrangement, any governmental health benefit or health care plan or program, or any other health benefit arrangement. Waiting periods for preexisting conditions administered under this Article are subject to applicable federal law."

SECTION 3.(e) Eligibility audit. – The Executive Administrator shall provide for an audit of dependent eligibility under the Plan. The audit shall be designed to determine whether all dependents currently covered under the Plan are eligible for coverage under current law. Upon identification of an individual who is enrolled as a dependent but not eligible, the Plan shall disenroll the ineligible dependent effective within 10 days of sending written termination notice to the employee. The notice shall state the date upon which disenrollment will become effective and the basis on which the determination of dependent ineligibility is made. Notwithstanding any other provision of law, the Executive Administrator may waive requirements to collect from the member reimbursement for claims paid for the ineligible covered individual.

SECTION 3.(f) Cessation of coverage of ineligible individuals. – G.S. 135-45.12 is amended by adding the following new subdivision to read:

"(8) The last day of the month in which a covered individual is found to be ineligible for coverage."

SECTION 3.(g) Documentation of dependent eligibility. – G.S. 135-45.3 is amended by adding the following new subsection to read:

"(c) When an eligible or enrolled member applies to enroll the member's eligible dependent child or spouse, the member shall provide the documentation required by the Plan to verify the dependent's eligibility for coverage."

PART FOUR: NC HEALTH CHOICE CHANGES.

SECTION 4.(a) Over-the-counter medications. – Coverage of over-the-counter medication authorized under G.S. 108A-70.21(d) for the NC Health Choice Program shall become effective on the later of July 1, 2010, or the date upon which the Department of Health and Human Services assumes full responsibility for administration and processing of claims under the NC Health Choice Program.

SECTION 4.(b) Subrogation. – For the period authorized under subsection (a) of this section, the right of subrogation under G.S. 108A-57 applies to the State Health Plan for payments made by the Plan under the NC Health Choice Program. This subsection expires on the later of July 1, 2010, or the date upon which the Department of Health and Human Services assumes full responsibility for administration, processing, and payment of claims under the NC Health Choice Program.

SECTION 4.(c) DHHS Subrogation under NC Health Choice. – G.S. 108A-57 is amended by adding the following new subsection to read:

"(c) This section applies to the administration of and claims payments made by the Department of Health and Human Services under the NC Health Choice Program established under Part 8 of this Article."

SECTION 4.(d) G.S. 108A-70.21(g) reads as rewritten:

"(g) Purchase of Extended Coverage. – An enrollee in the Program who loses eligibility due to an increase in family income above two hundred ~~fifty percent (250%)~~percent (200%) of the federal poverty level and up to and including two hundred ~~seventy-five percent (275%)~~ twenty-five percent (225%) of the federal poverty level may purchase at full premium cost continued coverage under the Program for a period not to exceed one year beginning on the date the enrollee becomes ineligible under the income requirements for the Program. The benefits, copayments, and other conditions of enrollment under the Program applicable to

extended coverage purchased under this subsection shall be the same as those applicable to an NC Kids' Care enrollee whose family income equals two hundred ~~fifty percent (250%)~~ percent (200%) of the federal poverty level."

PART FIVE: OTHER CHANGES.

SECTION 5.(a) G.S. 135-45.4(b)(2) reads as rewritten:

"(2) Employees not enrolling or not adding dependents when first eligible may enroll later on the first of any following month, but will be subject to a twelve-month waiting period for preexisting conditions except as provided in subdivision (a)(3) of this section. The waiting period under this subdivision is subject to applicable federal law."

SECTION 5.(b) Utilization management functions. – G.S. 135-44.4 is amended by adding the following new subdivisions to read:

"(13a) The Plan and its pharmacy benefit manager may implement and administer pharmacy and medical utilization management programs and programs to detect and address utilization abuse of benefits.

…

(29) For transplant and bariatric medical procedures, the Plan may restrict coverage to certain in-network providers that are designated by the Plan's claims processing contractor."

SECTION 5.(c) G.S. 135-44.1(b) reads as rewritten:

"(b) ~~Six~~ A majority of the members of the Board of Trustees in office shall constitute a quorum. Decisions of the Board of Trustees shall be made by a majority vote of the Trustees present, except as otherwise provided in this Part."

SECTION 5.(d) G.S. 135-45.9(b) reads as rewritten:

"(b) Notwithstanding any other provision of this Part, the following necessary services for the care and treatment of chemical dependency and mental illness shall be covered as provided in this section: allowable institutional and professional charges for inpatient care, outpatient care, intensive outpatient program services, partial hospitalization treatment, and residential care and treatment:

(1) For mental illness treatment:
  a. Licensed psychiatric ~~hospitals;~~ hospitals or State psychiatric hospitals accredited by the Joint Commission on the Accreditation of Healthcare Organizations;
  b. Licensed psychiatric beds in licensed general hospitals;
  c. Licensed residential treatment facilities that have 24-hour on-site care provided by a registered nurse who is physically located at the facility at all times and that hold current accreditation by a national accrediting body approved by the Plan's mental health case manager;
  d. Area Mental Health, Developmental Disabilities, and Substance Abuse Authorities or County Programs in accordance with G.S. 122C-141;
  e. Licensed intensive outpatient treatment programs; and
  f. Licensed partial hospitalization programs.

(2) For chemical dependency treatment:
  a. Licensed chemical dependency units in licensed psychiatric ~~hospitals;~~ hospitals or in State psychiatric hospitals accredited by the Joint Commission on the Accreditation of Healthcare Organizations;
  b. Licensed chemical dependency hospitals;
  c. Licensed chemical dependency treatment facilities;

d. Area Mental Health, Developmental Disabilities, and Substance Abuse Authorities or County Programs in accordance with G.S. 122C-141;
e. Licensed intensive outpatient treatment programs;
f. Licensed partial hospitalization programs; and
g. Medical detoxification facilities or units."

SECTION 5.(e) Section 28.22A(k) of S.L. 2007-323 reads as rewritten:

"**SECTION 28.22A.(k)** Subsection (j) of this section expires ~~June 30, 2009.~~ June 30, 2011."

SECTION 5.(f) G.S. 135-43(b) reads as rewritten:

"(b) Notwithstanding the provisions of this Article, the Executive Administrator and Board of Trustees of the State Health Plan for Teachers and State Employees may contract with providers of institutional and professional medical care and services to establish preferred provider networks.

~~The terms pertaining to reimbursement rates or other terms of consideration of any contract between hospitals, hospital authorities, doctors, or other medical providers, or a pharmacy benefit manager and the Plan, or contracts pertaining to the provision of any medical benefit offered under the Plan, including its optional alternative comprehensive benefit plans, and programs available under the optional alternative plans, shall not be a public record under Chapter 132 of the General Statutes for a period of 30 months after the date of the expiration of the contract.~~ 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 the terms in those contracts that contain trade secrets or proprietary or competitive information are not a public record under Chapter 132 of the General Statutes and any such proprietary or competitive information and trade secrets contained in the contract shall be redacted by the Plan prior to making it available to the public. ~~Provided, however, nothing in this subsection shall be deemed to~~This subsection shall not be construed to prevent or restrict the release of any information made not a public record under this subsection to the State Auditor, the Attorney General, the Director of the State Budget, the Plan's Executive Administrator, ~~the Department of Health and Human Services solely for the purpose of implementing the transition of NC Health Choice from the Plan to the Department of Health and Human Services,~~ and the Committee on Employee Hospital and Medical Benefits solely and exclusively for their use in the furtherance of their duties and ~~responsibilities.~~responsibilities, and to the Department of Health and Human Services solely for the purpose of implementing the transition of NC Health Choice from the Plan to the Department of Health and Human Services. The design, adoption, and implementation of the preferred provider contracts, networks, and optional alternative comprehensive health benefit plans, and programs available under the optional alternative plans, as authorized under G.S. 135-45 are not subject to the requirements of Chapter 143 of the General Statutes. The Executive Administrator and Board of Trustees 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."

SECTION 5.(g) Calendar year change. – Effective January 1, 2011, G.S. 135-45.1(21) reads as rewritten:

"(21) Plan year. – The period beginning ~~July 1~~ January 1 and ending on ~~June 30~~ December 31 of the succeeding calendar year."

SECTION 5.(h) Calendar year conforming changes. – The following adjustments to the pertinent dollar amounts and percentages enacted in this act shall be made to account for the change from a Plan year to a calendar year enacted in subsection (g) of this section:

(1) The amounts for annual deductibles and annual co-insurance maximums in effect on July 1, 2009 shall be fifty percent (50%) of the annual amount for the six-month plan year beginning July 1, 2010 through December 31, 2010.

(2) The total annual amount of the pharmacy co-payments assessed per plan member shall not exceed one thousand two hundred fifty dollars ($1,250) for the six-month plan year beginning July 1, 2010 through December 31, 2010.

(3) Effective January 1, 2011, Plan benefits, co-payments, deductibles, out-of-pocket expenditures, and lifetime maximums shall be as enacted effective July 1, 2009.

SECTION 5.(i) G.S. 135-44.4 is amended by adding the following new subdivision to read:

"**§ 135-44.4. 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:

…

(29) The Executive Administrator shall 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, to review the Claims Processing Contractor's administrative costs and services to the Plan by the Claim's Processing Contractor."

SECTION 5.(j) G.S. 135-45(d) reads as rewritten:

"(d) The Plan benefits shall be provided under contracts between the Plan and the claims processors selected by the Plan. The Executive Administrator may contract with a pharmacy benefits manager to administer pharmacy benefits under the Plan. Such contracts shall include the applicable provisions of G.S. 135-45.1 through G.S. 135-45.15 and the description of the Plan in the request for proposal, and shall be administered by the respective claims processor or Pharmacy Benefits Manager, which will determine benefits and other questions arising thereunder. The contracts necessarily will conform to applicable State law. If any of the provisions of G.S. 135-45.1 through G.S. 135-45.15 and the request for proposals must be modified for inclusion in the contract because of State law, such modification shall be made. The Executive Administrator shall 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 the following:

(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."

SECTION 5.(k) G.S. 135-44.4 is amended by adding the following new subdivision to read:

"(29) The Plan shall 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. The Plan shall report the results of the review to the Committee on Employee Hospital and Medical Benefits and the State Health Plan Blue Ribbon Task Force at least semiannually."

SECTION 5.(l) The Executive Administrator shall 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. The Executive Administrator shall report to the

Committee on Employee Hospital and Medical Benefits and the State Health Plan Blue Ribbon Task Force on the specialist co-payment.

PART SIX: SALARY-RELATED CONTRIBUTIONS.

SECTION 6.(a) Effective for the 2009-2011 fiscal biennium, required employer salary-related contributions for employees whose salaries are paid from department, office, institution, or agency receipts shall be paid from the same source as the source of the employees' salary. If an employee's salary is paid in part from the General Fund or Highway Fund and in part from department, office, institution, or agency receipts, required employer salary-related contributions may be paid from the General Fund or Highway Fund only to the extent of the proportionate part paid from the General Fund or Highway Fund in support of the salary of the employee, and the remainder of the employer's requirements shall be paid from the source that supplies the remainder of the employee's salary. The requirements of this section as to source of payment are also applicable to payments 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.

Notwithstanding any other provision of law, an employing unit that is subject to Part 3A of Article 3A of Chapter 135 of the General Statutes and that hires or has hired as an employee a retiree that is in receipt of monthly retirement benefits from any retirement system supported in whole or in part by contributions of the State shall enroll the retiree in the active group and pay the cost for the hospital-medical benefits if that retiree is employed in a position that would require the employer to pay hospital-medical benefits if the individual had not been retired.

SECTION 6.(b) Effective July 1, 2009, the State's employer contribution rates budgeted for retirement and related benefits as percentage of covered salaries for the 2009-2010 fiscal year are: (i) eight and fifty-four hundredths percent (8.54%) – Teachers and State Employees; (ii) thirteen and fifty-four hundredths percent (13.54%) – State Law Enforcement Officers; (iii) eleven and eighty-six hundredths percent (11.86%) – University Employees' Optional Retirement System; (iv) eleven and eighty-six hundredths percent (11.86%) – Community College Optional Retirement Program; (v) seventeen and seventy-one hundredths percent (17.71%) – Consolidated Judicial Retirement System; and (vi) four and fifty hundredths percent (4.50%) – Legislative Retirement System. Each of the foregoing contribution rates includes four and fifty hundredths percent (4.50%) for hospital and medical benefits. The rate for Teachers and State Employees, State Law Enforcement Officers, Community College Optional Retirement Program, and for the University Employees' Optional Retirement Program includes fifty-two hundredths percent (0.52%) for the Disability Income Plan. The rates for Teachers and State Employees and State Law Enforcement Officers include sixteen-hundredths percent (0.16%) for the Death Benefits Plan. The rate for State Law Enforcement Officers includes five percent (5%) for Supplemental Retirement Income.

SECTION 6.(c) Effective July 1, 2010, the State's employer contribution rates budgeted for retirement and related benefits as percentage of covered salaries for the 2010-2011 fiscal year are: (i) eight and ninety-four hundredths percent (8.94%) – Teachers and State Employees; (ii) thirteen and ninety-four hundredths percent (13.94%) – State Law Enforcement Officers; (iii) twelve and twenty-six hundredths percent (12.26%) – University Employees' Optional Retirement System; (iv) twelve and twenty-six hundredths percent (12.26%) – Community College Optional Retirement Program; (v) eighteen and eleven hundredths percent (18.11%) – Consolidated Judicial Retirement System; and (vi) four and ninety hundredths percent (4.90%) – Legislative Retirement System. Each of the foregoing contribution rates includes four and ninety hundredths percent (4.90%) for hospital and medical benefits. The rate for Teachers and State Employees, State Law Enforcement Officers, Community College Optional Retirement Program, and for the University Employees' Optional Retirement Program

includes fifty-two hundredths percent (0.52%) for the Disability Income Plan. The rates for Teachers and State Employees and State Law Enforcement Officers include sixteen-hundredths percent (0.16%) for the Death Benefits Plan. The rate for State Law Enforcement Officers includes five percent (5%) for Supplemental Retirement Income.

SECTION 6.(d) Effective July 1, 2009, the maximum annual employer contributions, payable monthly, by the State for each covered employee or retiree for the 2009-2010 fiscal year to the State Health Plan for Teachers and State Employees are: (i) Medicare-eligible employees and retirees – three thousand four hundred eighty-three dollars ($3,483) and (ii) non-Medicare-eligible employees and retirees – four thousand five hundred seventy-two dollars ($4,572).

SECTION 6.(e) Effective July 1, 2010, the maximum annual employer contributions, payable monthly, by the State for each covered employee or retiree for the 2010-2011 fiscal year to the State Health Plan for Teachers and State Employees are: (i) Medicare-eligible employees and retirees – three thousand eight hundred twenty-eight dollars ($3,828) and (ii) non-Medicare-eligible employees and retirees – five thousand thirty-one dollars ($5,031).

PART SEVEN: STATE HEALTH PLAN BLUE RIBBON TASK FORCE.

SECTION 7.(a) State Health Plan Blue Ribbon Task Force. – There is established the Blue Ribbon Task Force on the State Health Plan for Teachers and State Employees (Task Force). The purpose of the Task Force is to review the governance of the State Health Plan for Teachers and State Employees (Plan) and to make recommendations for changes that will ensure the ongoing financial stability of the Plan, increase and maintain high participation rates for dependent coverage under the Plan, study and compare coverage and costs of the Plan to coverage and costs of other State health plans in the region, and address issues of cost, quality, and access to health care coverage under the Plan. In considering the issue of governance the Task Force shall review the feasibility of transferring the ongoing day-to-day oversight of the Plan to an independent Board or to a State agency. In considering benefits and costs the Task Force shall study tiered premium rates for member-only coverage for employees and future retirees based on income or ability to pay, and should also study ways to increase participation in dependent coverage including supplements from the State or other methods for reducing dependent premiums. The Task Force shall also consider weight management and smoking cessation initiatives to determine the feasibility of implementing the initiatives for the purpose of improving Plan member health and reducing health care costs to the Plan and the Plan member.

SECTION 7.(b) The Task Force shall consist of 15 members, appointed as follows:

(1) Six members by the General Assembly upon the recommendation of the Speaker of the House of Representatives, four of whom shall be members of the House of Representatives, one shall be a public schoolteacher, and one shall be a State or local government retiree other than a retired public schoolteacher. Of the four legislators appointed to the Task Force, one shall be a member of the minority party.

(2) 6 members by the General Assembly upon the recommendation of the President Pro Tempore of the Senate, four of whom shall be members of the Senate, one shall be a State employee who is not a public schoolteacher, and one shall be a retired State public school employee. Of the four legislators appointed to the Task Force, one shall be a member of the minority party.

(3) One member by the Governor with expertise in the business of health insurance or in administering health care services other than an insurance company or third-party administrator or contractor of the Plan

(4) The chair of the Board of Directors of the State Health Plan.

(5) The Commissioner of Insurance or the Commissioner's designee.

SECTION 7.(c) The cochairs of the Task Force shall convene the first meeting as soon as possible after appointments have been made. The Task Force may engage the services of a consultant to provide independent analysis of Plan costs and recommendations on how to strengthen the Plan's financial stability, benefit structure and coverage, and the most effective and efficient location for Plan administration.

SECTION 7.(d) Upon the convening of each session of the General Assembly, the Task Force shall report its findings and recommendations to the General Assembly, the Governor, and the Committee on Employee Hospital and Medical Benefits.

SECTION 7.(e) A majority of the Task Force members shall constitute a quorum for the transaction of business. The Speaker of the House of Representatives and the President Pro Tempore of the Senate shall each appoint one Task Force member as chair. Appointments shall be made as soon as possible after this act becomes law. Task Force members shall receive no compensation for their service but shall be paid per diem, subsistence, and travel expenses in accordance with G.S. 120-3.1, G.S. 138-5, and G.S. 138-6, as applicable.

SECTION 7.(f) The Legislative Services Officer shall allocate from a portion of the funds appropriated to the General Assembly for each fiscal year for expenses of the Task Force.

PART EIGHT: EFFECTIVE DATE.

SECTION 8. Sections 1(b), 1(c), 1(d), 2(c) through (e), 2(g), and 2(h) of this act become effective July 1, 2009. Section 4(d) of this act applies to applications for the purchase of extended coverage made on and after July 1, 2008. The remainder of this act is effective when it becomes law.