

**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  
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House Committee Substitute Favorable 4/6/09  
House Committee Substitute #2 Favorable 4/8/09  
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Proposed Conference Committee Substitute S287-PCCS35293-LN-3**

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

Sponsors:

Referred to:

February 25, 2009

1 A BILL TO BE ENTITLED  
2 AN ACT TO APPROPRIATE FUNDS FOR THE STATE HEALTH PLAN FOR TEACHERS  
3 AND STATE EMPLOYEES AND TO MAKE OTHER CHANGES RELATED TO THE  
4 STATE HEALTH PLAN.

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

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

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

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

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

20 Whereas, cessation of tobacco use has been demonstrated to result in improved  
21 member health and substantial savings in health care costs making it fiscally prudent to  
22 implement smoking cessation incentives and initiatives with mechanisms to verify member  
23 compliance with smoking cessation requirements; and

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

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

27 Whereas, weight management and cessation of tobacco use have been demonstrated  
28 to result in improved member health and substantial savings in health care costs making it



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1 fiscally prudent to implement smoking cessation and weight management incentives and  
2 initiatives with mechanisms to verify member compliance with smoking cessation and weight  
3 management requirements; Now, therefore,

4 The General Assembly of North Carolina enacts:

5 **PART ONE: APPROPRIATIONS, DEFINITIONS, AND SCOPE.**

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

12 **SECTION 1.(b)** General Fund Appropriation for 2009-2011 Fiscal Biennium. –  
13 Notwithstanding G.S. 143C-5-2, there is appropriated from the General Fund to the Reserve for  
14 the State Health Plan in the Office of State Budget and Management the sum of one hundred  
15 thirty-two million two hundred fourteen thousand seven hundred fifty-two dollars  
16 (\$132,214,752) for the 2009-2010 fiscal year and the sum of two hundred seventy-six million  
17 one hundred seventy-nine thousand seven hundred nine dollars (\$276,179,709) for the  
18 2010-2011 fiscal year. These funds shall be used to cover health care and administrative costs  
19 to the Plan in the 2009-2011 fiscal biennium.

20 **SECTION 1.(c)** Highway Fund Appropriation for the 2009-2011 Fiscal Biennium.  
21 – Notwithstanding G.S. 143C-5-2, there is appropriated from the Highway Fund to the Reserve  
22 for the State Health Plan in the Office of State Budget and Management the sum of six million  
23 one hundred seventy thousand twenty-two dollars (\$6,170,022) for the 2009-2010 fiscal year  
24 and the sum of twelve million eight hundred eighty-eight thousand three hundred eighty-six  
25 dollars (\$12,888,386) for the 2010-2011 fiscal year. These funds shall be used to cover health  
26 care and administrative costs to the Plan in the 2009-2011 fiscal biennium.

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

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

- 32 (1) "Plan." – The State Health Plan for Teachers and State Employees.
- 33 (2) "Basic Plan." – The Plan's PPO option providing for 70/30 in-network  
34 coverage after deductibles and co-payments.
- 35 (3) "Smoking" or "Smoking cessation." – Includes cessation of the use of all  
36 tobacco products.
- 37 (4) "Standard Plan." – The Plan's PPO option providing for 80/20 in-network  
38 coverage after deductibles and co-payments.

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

41 **PART TWO: HEALTH BENEFIT CHANGES.**

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

48 **SECTION 2.(b)** Implement Comprehensive Wellness Initiative.

- 49 (1) Program development. – The Plan shall develop a Comprehensive Wellness  
50 Initiative that includes a focus on smoking cessation and weight  
51 management and that is designed to be implemented effective July 1, 2010,

1 for smoking cessation and July 1, 2011, for weight management. Benefit  
2 levels shall be determined by the Plan based upon tobacco use or the  
3 inability of the member to meet national, evidence-based healthy weight  
4 clinical guidelines. For purposes of the Comprehensive Wellness Initiative,  
5 "member" includes all State Health Plan primary subscribers and their  
6 covered dependents. The Plan shall develop a process whereby a Plan  
7 member may appeal the Plan's basis for action it takes due to the member's  
8 failure or refusal to comply with the Plan's smoking cessation or weight  
9 management requirements.

10 (2) Smoking cessation. – Effective July 1, 2010, all members of the Plan who do  
11 not have Medicare as their primary coverage shall be enrolled in the Basic  
12 Plan under the Plan's PPO unless the subscriber can attest that the subscriber  
13 or any qualifying dependent does not smoke or otherwise use tobacco  
14 products. The Plan shall develop a mechanism for verifying that the member  
15 does not smoke or use other tobacco products. Tobacco use will be  
16 reassessed annually at the time of Plan enrollment. All subscribers who have  
17 attested that neither they nor their dependents use tobacco, or whose  
18 physician certifies in writing that the member is participating in a smoking  
19 cessation program, shall have the choice of remaining in the Basic Plan  
20 option or enrolling in the Standard Plan option. For purposes of the smoking  
21 cessation initiative, "member" includes all members covered under the Plan.  
22 As used in this section, "smoking cessation program" means active  
23 participation in a Plan-approved cessation program to include counseling or  
24 use of tobacco cessation medications.

25 (3) Weight management. – Effective July 1, 2011, all members of the Plan who  
26 do not have Medicare as their primary coverage shall be enrolled in the  
27 Basic Plan under the Plan's PPO Plan unless the subscriber attests that the  
28 weight and height ratio of the member is within a range determined by the  
29 Plan based on evidence-based healthy weight clinical guidelines, or unless  
30 the member's physician certifies in writing that the member has a medical  
31 condition that prevents the attainment of the specified weight range or that  
32 the member is actively participating in a Plan-approved weight management  
33 program. In either case, the member shall have the option to enroll in the  
34 Basic or Standard Plan.

35 Not later than October 1, 2009, the Executive Administrator shall inform Plan  
36 members of the healthy lifestyle initiatives, requirements for compliance, and consequences of  
37 noncompliance. The Executive Administrator shall provide to members education and training  
38 to assist members in complying with healthy lifestyle initiatives. The Executive Administrator  
39 may implement incentive initiatives to further encourage member achievement in smoking  
40 cessation, weight management, and other integrated health management programs.

41 The Executive Administrator shall report to the Committee on Employee Hospital  
42 and Medical Benefits recommendations the Plan may have for additional sanctions that may be  
43 imposed when the Executive Administrator finds that a member intentionally makes a false  
44 statement on a Plan document.

45 **SECTION 2.(c)** Prescription Drug Co-Payments. – G.S. 135-45.6(b) reads as  
46 rewritten:

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

- 1           (1)    The Plan will pay allowable charges for each outpatient prescription drug  
2           less a copayment to be paid by each covered individual equal to the  
3           following amounts: pharmacy charges up to ten dollars (\$10.00) for each  
4           generic prescription, ~~thirty dollars (\$30.00)~~ thirty-five dollars (\$35.00) for  
5           each preferred branded prescription without a generic equivalent, and forty  
6           dollars (\$40.00) for each preferred branded prescription with a generic  
7           equivalent drug, and fifty dollars (\$50.00) fifty-five dollars (\$55.00) for each  
8           nonpreferred branded or generic prescription. For each branded prescription  
9           drug with a generic equivalent drug, the member shall pay the generic  
10          co-payment plus the difference between the Plan's gross allowed cost for the  
11          generic prescription and the Plan's cost for the branded prescription drug.
- 12          (2)    The Plan shall provide coverage of nonacute specialty medications,  
13          excluding cancer medications, under the Plan's pharmacy benefit through a  
14          specialty pharmacy vendor under contract with the Plan. The Plan may  
15          transfer coverage of specified specialty disease medications covered under  
16          the Plan's medical benefit to the contracted specialty pharmacy vendor.  
17          Specialty medications are covered biotech medications and other  
18          medications designated and classified by the Plan as specialty medications  
19          that are significantly more expensive than alternative drugs or therapies.  
20          Medications classified by the Plan as specialty medications shall meet all of  
21          the following conditions:
- 22               a.       Have unique uses for the treatment of complex diseases.  
23               b.       Require special dosing or administration.  
24               c.       Require special handling.  
25               d.       Are typically prescribed by a specialist provider.  
26               e.       Exceed four hundred dollars (\$400.00) cost to the Plan per  
27               prescription.
- 28          The Plan shall impose a co-payment in the amount of twenty-five percent  
29          (25%) of the Plan's gross allowed cost of the specialty drug not to exceed  
30          one hundred dollars (\$100.00) per prescription per 30-day supply.
- 31          (3)    The Plan may exclude coverage of drugs that have therapeutic equivalents,  
32          as defined by the U.S. Food and Drug Administration, that are available over  
33          the counter. Before excluding coverage under this subdivision, the Plan shall  
34          consult with the Plan's Pharmacy and Therapeutics Committee.
- 35          ~~These co-payments apply to all optional alternative plans available under the Plan.~~
- 36          (4)    Allowable charges shall not be greater than a pharmacy's usual and  
37          customary charge to the general public for a particular prescription.  
38          Prescriptions shall be for no more than a ~~34-day~~ 30-day supply for the  
39          purposes of the copayments paid by each covered individual. By accepting  
40          the copayments and any remaining allowable charges provided by this  
41          subsection, pharmacies shall not balance bill an individual covered by the  
42          Plan. A prescription legend drug is defined as an article the label of which,  
43          under the Federal Food, Drug, and Cosmetic Act, is required to bear the  
44          legend: "Caution: Federal Law Prohibits Dispensing Without Prescription."  
45          Such articles may not be sold to or purchased by the public without a  
46          prescription order. Benefits are provided for insulin even though a  
47          prescription is not required. ~~The Plan may use a pharmacy benefit manager~~  
48          ~~to help manage the Plan's outpatient prescription drug coverage. In~~  
49          ~~managing the Plan's outpatient prescription drug benefits, the Plan and its~~  
50          ~~pharmacy benefit manager shall not provide coverage for sexual~~  
51          ~~dysfunction, growth hormone, antiwrinkle, weight loss, and hair growth~~

1 ~~drugs unless such coverage is medically necessary to the health of the~~  
 2 ~~member. The Plan and its pharmacy benefit manager shall not provide~~  
 3 ~~coverage for growth hormone and weight loss drugs and antifungal drugs for~~  
 4 ~~the treatment of nail fungus and botulinum toxin without approval in~~  
 5 ~~advance by the pharmacy benefit manager. The Plan may adopt utilization~~  
 6 ~~management procedures for certain drugs, but in no event shall the Plan~~  
 7 ~~provide coverage for sexual dysfunction or hair growth drugs or~~  
 8 ~~nonmedically necessary drugs used for cosmetic purposes.~~ Any formulary  
 9 used by the Plan's Executive Administrator and pharmacy benefit manager  
 10 shall be an open formulary. Plan members shall not be assessed more than  
 11 two thousand five hundred dollars (\$2,500) per person per fiscal year in  
 12 copayments required by this subsection. The Plan's Pharmacy Benefit  
 13 Manager, or any pharmacy or vendor participating in the Plan shall charge  
 14 the Plan for any prescription legend drug dispensed under the Plan's  
 15 pharmacy benefit based upon the original National Drug Code (NDC) as  
 16 established by the manufacturer of the prescription legend drug and  
 17 published by the United States Food and Drug Administration.

18 Co-payments and other allowable charges under this subsection shall be the lesser of the  
 19 Plan's discounted cost of the drug or the co-payment amount or allowable charge and apply to  
 20 all optional alternative plans available under the Plan."

21 **SECTION 2.(d)** Routine Eye Examinations Not Covered. – Effective January 1,  
 22 2010, G.S. 135-45.8(13) reads as rewritten:

23 **"§ 135-45.8. General limitations and exclusions.**

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

26 ...

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

31 **SECTION 2.(e)** Deductible and Co-Payment Changes. – Effective July 1, 2009,  
 32 the Executive Administrator shall make the following changes to deductibles, coinsurance  
 33 maximums, and co-payments under the Basic and Standard PPO Plans:

- 34 (1) Basic plan (70/30):

- 35 a. Increase the in-network annual deductible to eight hundred dollars  
 36 (\$800.00) for member-only coverage and to one thousand six  
 37 hundred dollars (\$1,600) for the out-of-network annual deductible for  
 38 member-only coverage.

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

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

- 48 c. Increase the in-network primary care co-payment to thirty dollars  
 49 (\$30.00) per covered individual.

- 50 d. Increase the in-network specialist co-payment to seventy dollars  
 51 (\$70.00) per covered individual, except that for mental health and

1 substance abuse services, chiropractic services, and physical therapy,  
2 occupational therapy, and speech therapy services, the in-network  
3 specialist co-payment shall be fifty-five dollars (\$55.00) per covered  
4 individual.

5 e. Increase the in-network and out-of-network inpatient co-payment to  
6 two hundred fifty dollars (\$250.00) per covered individual.

7 f. Increase prescription drug co-pays as required under  
8 G.S. 135-45.6(b) as enacted by this act.

9 g. Except as otherwise provided in this act, co-payments and  
10 coinsurance for coverage not otherwise listed in this subdivision shall  
11 remain as applicable in the 2008-2009 benefit year.

12 (2) Standard Plan (80/20):

13 a. Increase the in-network annual deductible to six hundred dollars  
14 (\$600.00) for member-only coverage and to one thousand two  
15 hundred dollars (\$1,200) for the member-only out-of-network annual  
16 deductible.

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

20 b. Increase the in-network coinsurance maximum to two thousand  
21 seven hundred fifty dollars (\$2,750) for member-only coverage and  
22 to five thousand five hundred dollars (\$5,500) for member-only  
23 out-of-network maximum coinsurance. The aggregate maximum  
24 coinsurance for employee-child and employee-family coverage shall  
25 be three times the member-only coinsurance maximums.

26 c. Increase the in-network urgent care co-payment to seventy-five  
27 dollars (\$75.00) per covered individual.

28 d. Increase the in-network primary care co-payment to twenty-five  
29 dollars (\$25.00) per covered individual.

30 e. Increase the in-network specialist co-payment to sixty dollars  
31 (\$60.00) per covered individual, except that for mental health and  
32 substance abuse services, chiropractic services, and physical therapy,  
33 occupational therapy, and speech therapy services, the in-network  
34 specialist co-payment shall be forty-five dollars (\$45.00) per covered  
35 individual.

36 f. Increase the in-network and out-of-network inpatient co-payment to  
37 two hundred dollars (\$200.00) per covered individual.

38 g. Increase prescription drug co-pays as required under  
39 G.S. 135-45.6(b) as enacted by this act.

40 h. Except as otherwise provided in this act, co-payments and  
41 coinsurance for coverage not otherwise listed in this subdivision shall  
42 remain as applicable in the 2008-2009 benefit year.

43 **SECTION 2.(f)** Limitation on Authority to Change Benefits. – G.S. 135-45(g)

44 reads as rewritten:

45 "(g) The Executive Administrator and Board of Trustees shall not change the Plan's  
46 comprehensive health benefit coverage, co-payments, deductibles, out-of-pocket expenditures,  
47 and lifetime maximums in effect on ~~July 1, 2008~~, July 1, 2009, or a later act of the General  
48 Assembly, that would result in a net increased cost to the Plan or in a reduction in benefits to  
49 Plan members as a whole unless and until the proposed changes are directed to be made in an  
50 act of the General Assembly."

1           **SECTION 2.(g)** Premium Increases. – Premium rates for contributory coverage  
2 established in accordance with G.S. 135-44.6 shall be increased to eight and nine-tenths percent  
3 (8.9%) for contributory coverage for the 2009-2010 fiscal year and shall be increased by an  
4 additional eight and nine-tenths percent (8.9%) over the premium rate for contributory  
5 coverage for the 2010-2011 fiscal year.

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

25 **PART THREE: ELIGIBILITY CLARIFICATION.**

26           **SECTION 3.(a)** Dependent Child Clarifications. – G.S. 135-45.1(10) reads as  
27 rewritten:

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

44           **SECTION 3.(b)** Eligibility of Full-Time Students. – G.S. 135-45.2(d) reads as  
45 rewritten:

46           "(d) A foster child is covered as a dependent child (i) if living in a regular parent-child  
47 relationship with the expectation that the employee will continue to rear the child into  
48 adulthood, (ii) if at the time of enrollment, or at the time a foster child relationship is  
49 established, whichever occurs first, the employee applies for coverage for such child and  
50 submits evidence of a bona fide foster child relationship, identifying the foster child by name  
51 and setting forth all relevant aspects of the relationship, (iii) if the claims processor accepts the

1 foster child as a participant through a separate written document identifying the foster child by  
2 name and specifically recognizing the foster child relationship, and (iv) if at the time a claim is  
3 incurred, the foster child relationship, as identified by the employee, continues to exist.  
4 Children placed in a home by a welfare agency which obtains control of, and provides for  
5 maintenance of the child, are not eligible participants.

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

- 8 (1) If the dependent is a full-time student, ~~aged 19 years and one month~~ through  
9 the end of the month following the student's 26th ~~birthday~~, birthday. As used  
10 in this section, a full-time student is a student who is pursuing a course of  
11 study that represents at least the normal workload of a full-time student at a  
12 school or college accredited by the state of jurisdiction. In accordance with  
13 applicable federal law, coverage of a full-time student that loses full-time  
14 status due to illness may be extended for one year from the effective date of  
15 the loss of full-time status provided that the student was enrolled at the time  
16 of the onset of the illness.  
17 (2) The dependent is physically or mentally incapacitated to the extent that he or  
18 she is incapable of earning a living and (i) such handicap developed or began  
19 to develop before the dependent's 19th birthday, or (ii) such handicap  
20 developed or began to develop before the dependent's 26th birthday if the  
21 dependent was covered by the Plan in accordance with G.S. 135-45.2(5)a."

22 **SECTION 3.(c)** Waiting Periods Subject to Federal Law. – G.S. 135-45.3(b) reads  
23 as rewritten:

24 "(b) ~~Newly~~ Except as otherwise required by applicable federal law, newly acquired  
25 dependents (spouse/child) enrolled within 30 days of becoming an eligible dependent will not  
26 be subject to the 12-month waiting period for preexisting conditions. A dependent can become  
27 qualified due to marriage, adoption, entering a foster child relationship, due to the divorce of a  
28 dependent child or the death of the spouse of a dependent child, and at the beginning of each  
29 legislative session (applies only to enrolled legislators). Effective date for newly acquired  
30 dependents if application was made within the 30 days can be the first day of the following  
31 month. Effective date for an adopted child can be date of adoption, or date of placement in the  
32 adoptive parents' home, or the first of the month following the date of adoption or placement.  
33 Firefighters, rescue squad workers, and members of the national guard, and their eligible  
34 dependents, are subject to the same terms and conditions as are new employees and their  
35 dependents covered by this subdivision. Enrollments in these circumstances must occur within  
36 30 days of eligibility to enroll."

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

- 38 "(5) To administer the 12-month waiting period for preexisting conditions under  
39 this that Article, the Plan must give credit against the 12-month period for  
40 the time a person was covered under a previous plan if the previous plan's  
41 coverage was continuous to a date not more than 63 days before the effective  
42 date of coverage. As used in this subdivision, a "previous plan" means any  
43 policy, certificate, contract, or any other arrangement provided by any  
44 accident and health insurer, any hospital or medical service corporation, any  
45 health maintenance organization, any preferred provider organization, any  
46 multiple employer welfare arrangement, any self-insured health benefit  
47 arrangement, any governmental health benefit or health care plan or  
48 program, or any other health benefit arrangement. Waiting periods for  
49 preexisting conditions administered under this Article are subject to  
50 applicable federal law."



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

11           **SECTION 3.(f)** Cessation of Coverage of Ineligible Individuals. – G.S. 135-45.12  
12 is amended by adding the following new subdivision to read:

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

15           **SECTION 3.(g)** Documentation of Dependent Eligibility. – G.S. 135-45.3 is  
16 amended by adding the following new subsection to read:

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

#### 20 **PART FOUR: NC HEALTH CHOICE CHANGES.**

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

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

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

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

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

38           "(g) Purchase of Extended Coverage. – An enrollee in the Program who loses eligibility  
39 due to an increase in family income above two hundred ~~twenty-five percent (25%)~~ percent (200%) of  
40 the federal poverty level and up to and including two hundred ~~seventy-five percent (75%)~~  
41 twenty-five percent (225%) of the federal poverty level may purchase at full premium cost  
42 continued coverage under the Program for a period not to exceed one year beginning on the  
43 date the enrollee becomes ineligible under the income requirements for the Program. The  
44 benefits, copayments, and other conditions of enrollment under the Program applicable to  
45 extended coverage purchased under this subsection shall be the same as those applicable to an  
46 NC Kids' Care enrollee whose family income equals two hundred ~~twenty-five percent (25%)~~ percent  
47 (200%) of the federal poverty level."

#### 48 **PART FIVE: OTHER CHANGES.**

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

50           "(2) Employees not enrolling or not adding dependents when first eligible may  
51 enroll later on the first of any following month, but will be subject to a

1 twelve-month waiting period for preexisting conditions except as provided  
 2 in subdivision (a)(3) of this section. The waiting period under this  
 3 subdivision is subject to applicable federal law."

4 **SECTION 5.(b)** Powers and Duties of Executive Administrator. – G.S. 135-44.4 is  
 5 amended by adding the following new subdivisions to read:

6 "(13a) The Plan and its pharmacy benefit manager may implement and administer  
 7 pharmacy and medical utilization management programs and programs to  
 8 detect and address utilization abuse of benefits.

9 ...

10 (29) For transplant and bariatric medical procedures, the Plan may restrict  
 11 coverage to certain in-network providers that are designated by the Plan's  
 12 Claims Processing Contractor.

13 (30) The Executive Administrator shall ensure provisions in contracts between  
 14 the Plan and the Plan's Claims Processing Contractor that call for the Plan to  
 15 contract with an independent auditor, selected by the Plan, to review the  
 16 Claims Processing Contractor's administrative costs and services to the Plan  
 17 by the Claim's Processing Contractor.

18 (31) The Plan shall conduct a monthly review of Plan costs as compared to the  
 19 same month in the immediately preceding year and a comparison of  
 20 projected costs and savings to actual costs and savings. The Plan shall report  
 21 the results of the review to the Committee on Employee Hospital and  
 22 Medical Benefits and the State Health Plan Blue Ribbon Task Force at least  
 23 semiannually."

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

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

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

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

34 (1) For mental illness treatment:

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

48 (2) For chemical dependency treatment:

- 49 a. Licensed chemical dependency units in licensed psychiatric  
 50 ~~hospitals;~~ hospitals or in State psychiatric hospitals accredited by the  
 51 Joint Commission on the Accreditation of Healthcare Organizations;

- 1 b. Licensed chemical dependency hospitals;  
2 c. Licensed chemical dependency treatment facilities;  
3 d. Area Mental Health, Developmental Disabilities, and Substance  
4 Abuse Authorities or County Programs in accordance with  
5 G.S. 122C-141;  
6 e. Licensed intensive outpatient treatment programs;  
7 f. Licensed partial hospitalization programs; and  
8 g. Medical detoxification facilities or units."

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

10 "**SECTION 28.22A.(k)** Subsection (j) of this section expires ~~June 30, 2009~~. June 30,  
11 2011."

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

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

17 ~~The terms pertaining to reimbursement rates or other terms of consideration of any contract~~  
18 ~~between hospitals, hospital authorities, doctors, or other medical providers, or a pharmacy~~  
19 ~~benefit manager and the Plan, or contracts pertaining to the provision of any medical benefit~~  
20 ~~offered under the Plan, including its optional alternative comprehensive benefit plans, and~~  
21 ~~programs available under the optional alternative plans, shall not be a public record under~~  
22 ~~Chapter 132 of the General Statutes for a period of 30 months after the date of the expiration of~~  
23 ~~the contract. The terms of a contract between the Plan and its third party administrator or~~  
24 ~~between the Plan and its pharmacy benefit manager are a public record except that the terms in~~  
25 ~~those contracts that contain trade secrets or proprietary or competitive information are not a~~  
26 ~~public record under Chapter 132 of the General Statutes, and any such proprietary or~~  
27 ~~competitive information and trade secrets contained in the contract shall be redacted by the~~  
28 ~~Plan prior to making it available to the public. Provided, however, nothing in this subsection~~  
29 ~~shall be deemed to~~This subsection shall not be construed to prevent or restrict the release of any  
30 information made not a public record under this subsection to the State Auditor, the Attorney  
31 General, the Director of the State Budget, the Plan's Executive Administrator, the Department  
32 of Health and Human Services solely for the purpose of implementing the transition of NC  
33 Health Choice from the Plan to the Department of Health and Human Services, and the  
34 Committee on Employee Hospital and Medical Benefits solely and exclusively for their use in  
35 the furtherance of their duties and responsibilities, and to the Department of  
36 Health and Human Services solely for the purpose of implementing the transition of NC Health  
37 Choice from the Plan to the Department of Health and Human Services. The design, adoption,  
38 and implementation of the preferred provider contracts, networks, and optional alternative  
39 comprehensive health benefit plans, and programs available under the optional alternative  
40 plans, as authorized under G.S. 135-45 are not subject to the requirements of Article 3 of  
41 Chapter 143 of the General Statutes. The Executive Administrator and Board of Trustees shall  
42 make reports as requested to the President of the Senate, the President Pro Tempore of the  
43 Senate, the Speaker of the House of Representatives, and the Committee on Employee Hospital  
44 and Medical Benefits."

45 **SECTION 5.(g)** The Executive Administrator of the Plan shall include in the  
46 development of its Request for Proposal (RFP) for an independent audit of the Plan, an audit of  
47 claims paid by the State Health Plan for Teachers and State Employees. One purpose of the  
48 audit is to determine whether savings to the Plan and to Plan members could be achieved if  
49 claims payments and processing were more efficiently and effectively administered. The audit  
50 shall encompass Plan years beginning in 2005, or earlier, through 2008 and shall look at claims  
51 administration and payment under the former Indemnity Plan as compared to the present PPO

1 Plan. In developing the RFP, the Executive Administrator shall consult with the Fiscal  
2 Research Division staff and the Director of the Program Evaluation Division of the General  
3 Assembly to ensure that all of the following are addressed by the independent audit.

- 4 (1) Estimated or actual savings that could be achieved if changes recommended  
5 by the independent auditor were enacted by the General Assembly, and how  
6 those savings should be allocated to the benefit of Plan members.
- 7 (2) The governance structure of the Plan and whether it should be under the  
8 supervision and oversight of the Governor or a State agency.
- 9 (3) The extent to which the failure or inability to share confidential or otherwise  
10 protected information with the Board of Directors and the General Assembly  
11 contributes to financial weaknesses in the Plan, and how such data sharing  
12 should be strengthened.
- 13 (4) The role of the Board of Directors of the Plan and whether the role should be  
14 strengthened or otherwise changed.
- 15 (5) Past, present, and potential areas of overpayments, overutilization,  
16 underutilization, or abuse that contributes to increasing costs of Plan  
17 benefits, including deductibles, co-payments, dependent premiums, and  
18 co-insurance maximums.
- 19 (6) Safeguards to ensure the prompt reporting of claims data and trends to the  
20 actuaries under contract with the Plan and the General Assembly.
- 21 (7) Any other matters the Executive Administrator, Fiscal Research Division  
22 Staff, the Director of the Program Evaluation Division, or the contracting  
23 entity believe would be useful in helping to strengthen the financial integrity  
24 of the Plan and Plan benefits.

25 It is the intent of the General Assembly that savings identified by the independent  
26 audit and realized through enactment by the General Assembly, and overpayments identified by  
27 the audit or by the Plan, will be allocated by the General Assembly to minimize benefit  
28 reductions and maintain affordable contributions, deductibles, and co-payments by Plan  
29 members and to maintain the fiscal integrity of the Plan itself.

30 The Executive Administrator shall provide the RFP developed in accordance with  
31 this section to the Division of Purchase and Contract not later than July 1, 2009. A copy of the  
32 audit report submitted to the Plan by the contracting entity shall be provided to the Committee  
33 on Employee Hospital and Medical Benefits.

34 **SECTION 5.(h)** G.S. 135-45(d) reads as rewritten:

35 "(d) The Plan benefits shall be provided under contracts between the Plan and the claims  
36 processors selected by the Plan. The Executive Administrator may contract with a pharmacy  
37 benefits manager to administer pharmacy benefits under the Plan. Such contracts shall include  
38 the applicable provisions of G.S. 135-45.1 through G.S. 135-45.15 and the description of the  
39 Plan in the request for proposal, and shall be administered by the respective claims processor or  
40 Pharmacy Benefits Manager, which will determine benefits and other questions arising  
41 thereunder. The contracts necessarily will conform to applicable State law. If any of the  
42 provisions of G.S. 135-45.1 through G.S. 135-45.15 and the request for proposals must be  
43 modified for inclusion in the contract because of State law, such modification shall be made.  
44 The Executive Administrator shall ensure that the terms of the contract between the Plan and  
45 the Plan's Claims Processing Contractor, the Pharmacy Benefit Manager, and the Disease  
46 Management Contractor require the contractor to provide the following:

- 47 (1) Detailed billing by each entity showing itemized cost information, including  
48 individual administrative services provided;
- 49 (2) Transactional data; and
- 50 (3) The cost to the Plan for each administrative function performed by the  
51 contractor."

**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

1 percent (0.16%) for the Death Benefits Plan. The rate for State Law Enforcement Officers  
2 includes five percent (5%) for Supplemental Retirement Income.

3 **SECTION 6.(d)** Effective July 1, 2009, the maximum annual employer  
4 contributions, payable monthly, by the State for each covered employee or retiree for the  
5 2009-2010 fiscal year to the State Health Plan for Teachers and State Employees are: (i)  
6 Medicare-eligible employees and retirees – three thousand four hundred forty-seven dollars  
7 (\$3,447) and (ii) non-Medicare-eligible employees and retirees – four thousand five hundred  
8 twenty-seven dollars (\$4,527).

9 **SECTION 6.(e)** Effective July 1, 2010, the maximum annual employer  
10 contributions, payable monthly, by the State for each covered employee or retiree for the  
11 2010-2011 fiscal year to the State Health Plan for Teachers and State Employees are: (i)  
12 Medicare-eligible employees and retirees – three thousand seven hundred fifty-three dollars  
13 (\$3,753) and (ii) non-Medicare-eligible employees and retirees – four thousand nine hundred  
14 twenty-nine dollars (\$4,929).

15 **PART SEVEN: STATE HEALTH PLAN BLUE RIBBON TASK FORCE.**

16 **SECTION 7.(a)** State Health Plan Blue Ribbon Task Force. – There is established  
17 the Blue Ribbon Task Force on the State Health Plan for Teachers and State Employees (Task  
18 Force). The purpose of the Task Force is to review the governance of the State Health Plan for  
19 Teachers and State Employees (Plan) and to make recommendations for changes that will  
20 ensure the ongoing financial stability of the Plan, increase and maintain high participation rates  
21 for dependent coverage under the Plan, study and compare coverage and costs of the Plan to  
22 coverage and costs of other State health plans in the region, and address issues of cost, quality,  
23 and access to health care coverage under the Plan. In conducting its review of the Plan the Task  
24 Force shall consider all of the following:

- 25 (1) The feasibility of transferring the ongoing day-to-day oversight of the Plan  
26 to an independent board or to a State agency.
- 27 (2) Tiered premium rates for member-only coverage for employees and future  
28 retirees based on income or ability to pay.
- 29 (3) Ways to increase participation in dependent coverage including supplements  
30 from the State or other methods for reducing dependent premiums.
- 31 (4) The benefits of implementing a closed prescription drug formulary.
- 32 (5) Whether it is advisable to move the Plan to a calendar year, the costs  
33 involved in the move, and the benefits that accrue to the Plan and the  
34 members as a result of moving to a calendar year.
- 35 (6) Any other matters the Task Force considers relevant to its purpose.

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

- 38 (1) Six members by the General Assembly upon the recommendation of the  
39 Speaker of the House of Representatives, three of whom shall be members  
40 of the House of Representatives, one shall be a public schoolteacher, one  
41 shall be a State or covered local government retiree other than a retired  
42 public schoolteacher, and one at-large. Of the three legislators appointed to  
43 the Task Force, one shall be a member of the minority party.
- 44 (2) Six members by the General Assembly upon the recommendation of the  
45 President Pro Tempore of the Senate, three of whom shall be members of the  
46 Senate, one shall be a State employee who is not a public schoolteacher, one  
47 shall be a retired State public school employee, and one at-large. Of the three  
48 legislators appointed to the Task Force, one shall be a member of the  
49 minority party.

- 1 (3) One member by the Governor with expertise in the business of health  
2 insurance or in administering health care services other than an insurance  
3 company or third-party administrator or contractor of the Plan.  
4 (4) The chair of the Board of Directors of the State Health Plan.  
5 (5) The Commissioner of Insurance or the Commissioner's designee.

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

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

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

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

23 **PART EIGHT: EFFECTIVE DATE.**

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