2007-2008

SELECT COMMITTEE ON EMPLOYEE HOSPITAL AND MEDICAL BENEFITS

MINUTES

SELECT COMMITTEE ON EMPLOYEE HOSPITAL AND MEDICAL BENEFITS

CHAIRMAN:	SENATOR TONY RAND
MEMBERS:	SENATOR TOM APODACA
	SENATOR ROBERT ATWATER
	SENATOR DAN CLODFELTER
	SENATOR JANET COWELL
	SENATOR CHARLES DANNELLY
	SENATOR JIM FORRESTER
	SENATOR LINDA GARROU
	SENATOR KAY HAGAN
	SENATOR DAVID HOYLE
	SENATOR RICHARD STEVENS

SELECT COMMITTEE ON EMPLOYEE HOSPITAL AND MEDICAL BENEFITS

2007 SESSION

INDEX

2007-2008 Biennium
Leg. Day: H-113/S-111

Bill	Introducer	Short Title		Latest Action	In Date	Out Date
H0503=	Thomas	STATE HEALTH PLAN/ VARIOUS LOCAL GOVT	*S	Ref To Com On Select Committee on Employee Hospital and Medical Benefits	05-24-07	
H0508=	Tarleton	STATE HEALTH PLAN/ LOCAL GOV. PARTICIP.	*S	Pres. To Gov. 8/2/ 2007	05-24-07	07-31-07
H1181	Frye	SMALL BUSINESS CONTRACTOR ACT.	*S	Pres. To Gov. 8/2/ 2007	05-29-07	07-31-07
H1593	Folwell	STATE HEALTH PLAN/ PLAN YR. CHANGE..	*S	Pres. To Gov. 8/3/ 2007	07-31-07	08-02-07
S0148=	R. C. Soles, Jr.	SUNSET BCH/OCEAN ISLE BCH/STATE HEALTH PLAN.	S	Ref to Select Committee on Employee Hospital and Medical Benefits. If fav, re-ref to Appropriations/ Base Budget	02-14-07	
S0648=	Tom Apodaca	STATE HEALTH PLAN/ TOWN OF BILTMORE FOREST.	S	Ref To Com On Select Committee on Employee Hospital and Medical Benefits	03-12-07	
S0759	Charlie S. Danne	HEALTH INSURANCE/ INFERTILITY COVERAGE.	S	Ref to Select Committee on Employee Hospital and Medical Benefits. If fav, re-ref to Commerce, Small Business and Entrepreneurship	03-14-07	
S1033=	Daniel G. Clodfe	HEALTH BENEFIT PLANS/ STD. INSURANCE CARD.	S	Ref To Com On Select Committee on Employee Hospital and Medical Benefits	03-21-07	
S1108	Julia Boseman	STATE HEALTH PLAN/ DIABETIC TEST STRIPS.	S	Ref To Com On Select Committee on Employee Hospital and Medical Benefits	03-22-07	
S1109	Jean Preston	STATE EMPLOYEES HEALTH PLAN/CHARTER SCHOOL.	S	Ref To Com On Select Committee on Employee Hospital and Medical Benefits	03-22-07	
S1192	Martin L. Nesbit	STATE HEALTH PLAN/ COUNTY PARTICIPATION.	S	Ref To Com On Select Committee on Employee Hospital and Medical Benefits	03-22-07	
S1207	Tony Rand	STATE HEALTH PLAN CHANGES.	S	Ref To Com On Select Committee on Employee	03-26-07	

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Bill	Introducer	Short Title		Latest Action	In Date	Out Date
				Hospital and Medical Benefits		

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MINUTES

SELECT COMMITTEE ON EMPLOYEE HOSPITAL AND MEDICAL BENEFITS

JULY 31, 2007

The Select Committee on Employee Hospital and Medical Benefits met at 6:00 p.m., July 31, 2007 at Senator Rand's Senate Chamber Desk. Six members of the committee were present.

HOUSE COMMITTEE SUBSTITUTE #1 – 508 – STATE HEALTH PLAN/CITY PARTICIPATION

Senator Rand presented the committee with a proposed Senate Committee Substitute for the above bill. Senator Hoyle moved that the committee hear the proposed Senate Committee Substitute.

Senator Rand explained that this bill added the employees or retirees of Mitchell County and the towns of Black Mountain and Tabor City to the State Health Plan. Senator Apodaca moved for a favorable report of the Senate Committee Substitute for House Bill 508.

The committee gave the Senate Committee Substitute for House Bill 508 - State Health Plan/City Participation a favorable report.

Tony Rand

Senator Tony Rand, Chairman

Evelyn Costello

Evelyn Costello, Committee Ass't.

NORTH CAROLINA GENERAL ASSEMBLY
SENATE

SELECT COMMITTEE ON EMPLOYEE HOSPITAL AND MEDICAL BENEFITS
COMMITTEE REPORT
Senator Tony Rand, Chair

Tuesday, July 31, 2007

Senator RAND,
submits the following with recommendations as to passage:

UNFAVORABLE AS TO COMMITTEE SUBSTITUTE BILL NO. 1, BUT FAVORABLE AS TO SENATE COMMITTEE SUBSTITUTE BILL

H.B.(CS #1) **508** State Health Plan/City Particip.

Draft Number:	PCS 70612
Sequential Referral:	None
Recommended Referral:	None
Long Title Amended:	Yes

TOTAL REPORTED: 1

Committee Clerk Comments:

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2007

H D

HOUSE BILL 508

Committee Substitute Favorable 4/19/07

PROPOSED SENATE COMMITTEE SUBSTITUTE H508-PCS70612-LN-57

Short Title: State Health Plan/Local Gov. Particip. (Public)

Sponsors:

Referred to:

March 7, 2007

A BILL TO BE ENTITLED

AN ACT TO AUTHORIZE MITCHELL COUNTY AND THE TOWNS OF BILTMORE FOREST, BLACK CREEK, BLACK MOUNTAIN, BLOWING ROCK, OCEAN ISLE BEACH, SUNSET BEACH, AND TABOR CITY TO ENROLL ITS EMPLOYEES OR RETIREES IN THE TEACHERS' AND STATE EMPLOYEES' COMPREHENSIVE MAJOR MEDICAL PLAN.

The General Assembly of North Carolina enacts:

SECTION 1. Section 31.26(j) of S.L. 2004-124, as amended by Section 29.32 of S.L. 2005-276, reads as rewritten:

"**SECTION 31.26.(j)** This section applies to:

(1) Bladen, Cherokee, Mitchell, Rutherford, Washington, and Wilkes Counties only, and

(2) The ~~Town~~ Towns of Biltmore Forest, Black Creek, Black Mountain, Blowing Rock, Forest ~~City~~ City, Ocean Isle Beach, Sunset Beach, and Tabor City only."

SECTION 2. This act is effective when it becomes law.

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2007

H D

HOUSE BILL 508

Committee Substitute Favorable 4/19/07

PROPOSED SENATE COMMITTEE SUBSTITUTE H508-PCS70612-LN-57

Short Title: State Health Plan/Local Gov. Particip. (Public)

Sponsors:

Referred to:

March 7, 2007

A BILL TO BE ENTITLED

AN ACT TO AUTHORIZE MITCHELL COUNTY AND THE TOWNS OF BILTMORE FOREST, BLACK CREEK, BLACK MOUNTAIN, BLOWING ROCK, OCEAN ISLE BEACH, SUNSET BEACH, AND TABOR CITY TO ENROLL ITS EMPLOYEES OR RETIREES IN THE TEACHERS' AND STATE EMPLOYEES' COMPREHENSIVE MAJOR MEDICAL PLAN.

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SECTION 2. This act is effective when it becomes law.

MINUTES

SELECT COMMITTEE ON EMPLOYEE HOSPITAL AND MEDICAL BENEFITS COMMITTEE

AUGUST 2, 2007

The Committee on Employee Hospital and Medical Benefits met on Thursday, August 2, 2007 at 3:30 p.m. at Senator Tony Rand's Chamber Desk. Nine members of the committee were present.

HOUSE BILL 1593 – STATE HEALTH PLAN/CHANGE TO CALENDAR YEAR

Senator Rand presented the committee with a proposed Senate Committee Substitute for the above bill.

Senator Apodaca moved for the adoption of the proposed Senate Committee Substitute for HB 1593. The committee adopted the Senate Committee Substitute.

Senator Rand explained that this bill would allow the State Health Plan to prepare to change the date of the plan from a fiscal year to a calendar year. During that time the State Health Plan would study cost increases or reductions in contracts providing claims processing of medical and drug claims, provision of provider networks, or other contractual administration, as well as investigating the feasibility of adding a Medigap policy to the plan.

Senator Hoyle moved for the adoption of the Senate Committee Substitute for HB 1593 – STATE HEALTH PLAN/PLAN YR. CHANGE.

The Committee gave the Senate Committee Substitute for HB 1593 a favorable report.

Tony Rand
Senator Ton Rand, Chairman

Evelyn Costello
Evelyn Costello, Committee Ass't.

NORTH CAROLINA GENERAL ASSEMBLY
SENATE

SELECT COMMITTEE ON EMPLOYEE HOSPITAL AND MEDICAL BENEFITS
COMMITTEE REPORT
Senator Tony Rand, Chair

Thursday, August 02, 2007

Senator RAND,
submits the following with recommendations as to passage:

UNFAVORABLE AS TO COMMITTEE SUBSTITUTE BILL NO. 1, BUT FAVORABLE AS TO SENATE COMMITTEE SUBSTITUTE BILL

H.B.(CS #1) **1593** State Health Plan/Change to Calendar Year.

Draft Number:	PCS 60410
Sequential Referral:	None
Recommended Referral:	None
Long Title Amended:	Yes

TOTAL REPORTED: 1

Committee Clerk Comments:

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2007

H D

HOUSE BILL 1593

Committee Substitute Favorable 7/30/07

PROPOSED SENATE COMMITTEE SUBSTITUTE H1593-PCS60410-LN-58

Short Title: State Health Plan/ Plan Yr.Change. (Public)

Sponsors:

Referred to:

April 19, 2007

A BILL TO BE ENTITLED

AN ACT TO DIRECT THE EXECUTIVE ADMINISTRATOR OF THE TEACHERS' AND STATE EMPLOYEES' COMPREHENSIVE MAJOR MEDICAL PLAN TO PREPARE TO CHANGE THE STATE HEALTH PLAN FROM A FISCAL YEAR TO A CALENDAR YEAR.

The General Assembly of North Carolina enacts:

SECTION 1. The Executive Administrator of the Teachers' and State Employees' Comprehensive Major Medical Plan shall evaluate the actuarial, administrative, financial, operational, and plan member impact of converting the Plan's benefit plan year to a calendar year basis from a fiscal year basis. Not later than April 1, 2008, the Executive Administrator shall report his findings and recommendations to the Committee on Employee Hospital and Medical Benefits and the Fiscal Research Division. The report shall include the following information:

(1) An estimate of actuarial impact to the Plan under six-month and 18-month transition plan years respectively, as a means to implement a fiscal year to calendar year transition. Each respective transition plan year scenario estimate shall clearly state the Executive Administrator's assumptions about projected out-of-pocket requirements and limits for plan members for deductibles and co-insurance under each scenario.

(2) A description of potential benefit option changes that may be possible in the event the General Assembly authorizes the Plan to switch its benefit plan year to a calendar year. Each option should be accompanied with an analysis of the change in benefits to plan members and a refined estimate of actuarial impact to the Plan with clearly stated assumptions and supporting data from which any analysis is offered by the Executive Administrator.

(3) A description of any other actuarial, administrative, financial, operational, and plan member impacts including, but not limited to, costs increases or reductions in contracts providing claims processing of medical and drug claims, provision of provider networks, or other contractual administration.

(4) Any specific recommendations or other issues by the Executive Administrator with respect to a possible transition to a calendar year based benefit plan year.

SECTION 2. This act is effective when it becomes law.

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2007

H 2

HOUSE BILL 1593

Committee Substitute Favorable 7/30/07

Short Title: State Health Plan/Change to Calendar Year. (Public)

Sponsors:

Referred to:

April 19, 2007

A BILL TO BE ENTITLED

AN ACT TO ALLOW THE TEACHERS' AND STATE EMPLOYEES' COMPREHENSIVE MAJOR MEDICAL PLAN TO CHANGE ITS PLAN YEAR FROM A FISCAL YEAR TO A CALENDAR YEAR.

The General Assembly of North Carolina enacts:

SECTION 1.(a) G.S. 135-40.1(7b) is repealed.

SECTION 1.(b) G.S. 135-40.1 is amended by recodifying subdivision (13b) as (13c) and adding the following new subdivision to read:

"(13b) Plan Year. – An annual period established by the Executive Administrator and Board of Trustees under G.S. 135-39.5C."

SECTION 1.(c) Article 3 of Chapter 135 of the General Statutes is amended by adding a new section to read:

"**§ 135-39.5C. Plan year.**

(a) The plan year shall be July 1 through June 30 unless changed to a calendar year by the Executive Administrator and Board of Trustees after consultation with the Committee on Employee Hospital and Medical Benefits. If changed, the initial transition plan year after the change may be either six months or 18 months.

(b) The plan year may be changed under this section only if the Plan has sufficient funds available to fund the transition costs without altering premium rates and benefit levels on account of the change."

SECTION 1.(d) Except in G.S. 135-39.6, the Revisor of Statutes shall delete the term "fiscal year" wherever it appears in Parts 1 through 3 of Article 3 of Chapter 135 of the General Statutes and substitute the term "plan year."

SECTION 2. This act is effective when it becomes law.

Committee: **Select Committee- Employee Hospital and Medical Benefits**

NAMES 2007-2008 Session
Sen. Tony Rand-Chair
Sen. Tom Apodaca
Sen. Robert Atwater
Sen. Daniel Clodfelter
Sen. Janet Cowell
Sen. Charles Dannelly
Sen. James Forrester
Sen. Linda Garrou
Sen. Kay Hagan
Sen. David Hoyle
Sen. Richard Stevens

SELECT COMMITTEE ON EMPLOYEE HOSPITAL AND MEDICAL BENEFITS

2008 SESSION

INDEX

July 9, 2008

H.B. (CS #1) 2443	**State Health Plan** Unfavorable as to House Committee Sub. #1 Favorable as to Senate Committee Sub.for House Bill (CS#1) 2443 – State Health Plan.

2007-2008 Biennium
Leg. Day: H-155/S-153

Bill	Introducer	Short Title		Latest Action	In Date	Out Date
H0503=	Thomas	STATE HEALTH PLAN/ VARIOUS LOCAL GOVT	*S	Ref To Com On Select Committee on Employee Hospital and Medical Benefits	05-24-07	
H0508=	Tarleton	STATE HEALTH PLAN/ LOCAL GOV. PARTICIP.	*SR	Ch. SL 2007-405	05-24-07	07-31-07
H1181	Frye	SMALL BUSINESS CONTRACTOR ACT.	*SR	Ch. SL 2007-441	05-29-07	07-31-07
H1593	Folwell	STATE HEALTH PLAN/ PLAN YR. CHANGE..	*SR	Ch. SL 2007-521	07-31-07	08-02-07
H2214=	Church	CHARTER SCHOOL/STATE HEALTH PLAN.	*S	Ref To Com On Select Committee on Employee Hospital and Medical Benefits	07-17-08	
$ H2440	**Michaux**	**STATE HEALTH PLAN/ SHORTFALL FUNDS.**	**S**	**Ref To Com On Select Committee on Employee Hospital and Medical Benefits**	**07-17-08**	
H2443=	Holliman	STATE HEALTH PLAN.	*S	Pres. To Gov. 7/ 15/2008	07-03-08	07-09-08
S0148=	R. C. Soles, Jr.	SUNSET BCH/OCEAN ISLE BCH/STATE HEALTH PLAN.	S	Ref to Select Committee on Employee Hospital and Medical Benefits. If fav, re-ref to Appropriations/ Base Budget	02-14-07	
S0548=	Tom Apodaca	STATE HEALTH PLAN/ TOWN OF BILTMORE FOREST.	S	Ref To Com On Select Committee on Employee Hospital and Medical Benefits	03-12-07	
S0759	Charlie S. Danne	HEALTH INSURANCE/ INFERTILITY COVERAGE.	S	Ref to Select Committee on Employee Hospital and Medical Benefits. If fav, re-ref to Commerce, Small Business and Entrepreneurship	03-14-07	
S1033=	Daniel G. Clodfe	HEALTH BENEFIT PLANS/ STD. INSURANCE CARD.	S	Ref To Com On Select Committee on Employee Hospital and Medical Benefits	03-21-07	
S1108	Julia Boseman	STATE HEALTH PLAN/ DIABETIC TEST STRIPS.	S	Ref To Com On Select Committee on Employee Hospital and Medical Benefits	03-22-07	
S1109	Jean Preston	STATE EMPLOYEES	S	Ref To Com On	03-22-07	

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Bill	Introducer	Short Title		Latest Action	In Date	Out Date
		HEALTH PLAN/CHARTER SCHOOL.		Select Committee on Employee Hospital and Medical Benefits		
S1192	Martin L. Nesbit	STATE HEALTH PLAN/ COUNTY PARTICIPATION.	S	Ref To Com On Select Committee on Employee Hospital and Medical Benefits	03-22-07	
S1207	Tony Rand	STATE HEALTH PLAN CHANGES.	S	Ref To Com On Select Committee on Employee Hospital and Medical Benefits	03-26-07	
S1599	Ed Jones	TOWN OF HOBGOOD/STATE HEALTH PLAN.	S	Ref To Com On Select Committee on Employee Hospital and Medical Benefits	05-15-08	
S1640=	Tom Apodaca	HENDERSONVILLE/STATE HEALTH PLAN.	S	Ref To Com On Select Committee on Employee Hospital and Medical Benefits	05-20-08	
S1785	Clark Jenkins	FUNDS/STATE EMPLOYEE WELLNESS PROGRAM.	S	Ref to Select Committee on Employee Hospital and Medical Benefits. If fav, re-ref to Appropriations/ Base Budget	05-21-08	
S1838=	Jim Jacumin	CHARTER SCHOOL/STATE HEALTH PLAN.	S	Ref To Com On Select Committee on Employee Hospital and Medical Benefits	05-22-08	
S1853=	Tony Rand	STATE HEALTH PLAN.	S	Ref To Com On Select Committee on Employee Hospital and Medical Benefits	05-22-08	
S2028	Andrew C. Brock	STATE HEALTH PLAN/NO ABORTION COVERAGE.	S	Ref To Com On Select Committee on Employee Hospital and Medical Benefits	05-28-08	
S2145	Tony Rand	STATE HEALTH PLAN/ TECHNICAL CORRECTIONS.	S	Ref To Com On Select Committee on Employee Hospital and Medical Benefits	05-29-08	
S2146	Tony Rand	STATE HEALTH PLAN/ CHANGES TO LOCAL GOV'T. ENR.	S	Ref To Com On Select Committee on Employee Hospital and	05-29-08	

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Bill	Introducer	Short Title		Latest Action	In Date	Out Date
S2158=	Tony Rand	STATE HEALTH PLAN/ LOCAL GOVT PARTICIPATION.	S	Medical Benefits Ref To Com On Select Committee on Employee Hospital and Medical Benefits	05-29-08	

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MINUTES

SELECT COMMITTEE ON EMPLOYEE HOSPITAL AND MEDICAL BENEFITS

JULY 9 2008

The Select Committee on Employee Hospital and Medical Benefits met 15 minutes after session at 4:45 p.m. on July 9, 2008 in Room 421 of the LOB. Senator Tony Rand presided. Seven members of the committee were present.

HOUSE COMMITTEE SUBSTITUTE 2443 - STATE HEALTH PLAN

Senator Rand presented the committee with a proposed Senate Committee Substitute for the above bill. Senator Dannelly moved that the committee hear the proposed Senate Committee Substitute. The motion carried.

Senator Rand offered a technical amendment which will be engrossed in the bill. Upon motion of Senator Dannelly, the committee voted to accept the amendment for the committee substitute for the above bill.

Senator Rand introduced Gann Watson of Legislative Drafting to explain the bill. A summary of her explanation is attached to these minutes and marked Exhibit I.

Senator Rand stated that they had intended to change to a calendar year from January to December to coordinate with Medicare and to offer a Medicare Advantage for possible savings to our retirees. Unfortunately, this cannot be done at this time.

Senator Stevens asked what this bill does for the participant and pharmacy coverage.

Mark Trogdon: "Currently the pharmacy coverage would not be allowed to be covered under Medicare Advantage. The initial authorization allows the plan to do this on an optional basis for the medical benefits only. You can offer a pharmacy benefit under Advantage, and the plan will no doubt look at that in the future".

Senator Forrester questioned the fact that there were only 3 members on the State Health Plan Administrative Commission who could hire and fire the Executive Administrator of the State Health Plan.

Senator Garrou moved for a favorable report for the proposed Senate Committee Substitute for House Bill 2443 and the committee voted for a favorable report for this bill.

The meeting adjourned at 4:45 p.m.

Tony Rand
Senator Tony Rand, Chairman

Evelyn Costello
Evelyn Costello, Committee Ass't.

Exhibit I

NC STATE HEALTH PLAN

HOUSE BILL 2443, 3rd edition

TALKING POINTS

I. **Rewrites Chapter 135** to accommodate the change from an indemnity plan to a PPO or other authorized health care coverage arrangement.

95% of the bill is technical in nature (e.g. recodifying sections of the current Law and making conforming changes.)

II. **Plan Structure/Coverage.** The new structure provides the same benefits, copayments, coinsurance, and deductibles as were in effect on July 1, 2008 under both the indemnity plan and the PPO. (p. 14, lines 18-33)

III. **Executive Administrator flexibility/General Assembly oversight:**

"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, that would result in a net increased cost to the Plan or in a reduction in benefits to Plan members unless and until the proposed changes are directed to be made in an Act of the General Assembly." (p.15, line 22)

IV. **Medicare Advantage Plan** for Medicare-eligible Plan members. This optional plan will be an independent insurance product designed to effectuate cost savings to the Plan and provide enhanced benefits to eligible retirees. A plan member that has elected to enroll in the optional Medicare Advantage plan may disenroll from Medicare Advantage and elect to re-enroll in the State Health Plan at the annual enrollment period. Details of the Medicare Advantage Plan are being worked out. (pp. 40, lines 3-21)

V. **State Health Plan Administrative Commission.** This is a 3-member Commission charged with the hiring and removal of the Executive Administrator of the State Health Plan. Members of the Commission are appointed for 2-year terms by the General Assembly. The Commissioner of Insurance serves as Secretary of the Commission. (pp. 12-14)

NORTH CAROLINA GENERAL ASSEMBLY
SENATE

SELECT COMMITTEE ON EMPLOYEE HOSPITAL AND MEDICAL BENEFITS
COMMITTEE REPORT
Senator Tony Rand, Chair

Wednesday, July 09, 2008

Senator RAND,
submits the following with recommendations as to passage:

UNFAVORABLE AS TO COMMITTEE SUBSTITUTE BILL NO. 1, BUT FAVORABLE AS TO SENATE COMMITTEE SUBSTITUTE BILL

With Amendment
H.B.(CS #1) **2443** State Health Plan.

Draft Number:	PCS80635
Sequential Referral:	None
Recommended Referral:	None
Long Title Amended:	Yes

TOTAL REPORTED: 1

Committee Clerk Comments:

GENERAL ASSEMBLY OF NORTH CAROLINA

Session 2007

Legislative Actuarial Note

HEALTH BENEFITS

BILL NUMBER: House Bill 2443 (Second Edition)

SHORT TITLE: State Health Plan.

SPONSOR(S):

SYSTEM OR PROGRAM AFFECTED: Teachers' and State Employees' Comprehensive Major Medical Plan. On and after July 1, 2008 the Plan will be known as the *State Health Plan for Teachers and State Employees* (see Section 28.22A of Session Law 2007-323).

FUNDS AFFECTED: State General Fund, State Highway Fund, other State employer receipts; premium payments for dependents of active employees and retired employees of State agencies and universities, local public schools and local community colleges; premium payments for coverages selected by eligible former employees; premium payments for coverages selected by firefighters, rescue squad workers, members of the National Guard, and certain authorized local governments.

BILL SUMMARY: The proposed committee substitute to House Bill 2443 (H2443-CSLN-75) generally rewrites Article 3 of Chapter 135 to make certain policy, conforming and technical changes to the Article to reflect the elimination of the Indemnity plan benefit option effective July 1, 2008 as enacted in Sections 28.22 and 28.22A of Session Law 2007-323.

From an actuarial and financial perspective, there are two changes included in the proposed committee substitute that are not authorized in current law:

(1) **Authority of the Executive Administrator and Board of Trustees to offer multiple type benefit plans**: Section 3 (c) of the proposed committee substitute establishes the authority of the Plan to offer comprehensive group health benefit coverage through one or more group health plans. The Executive Administrator and Board of Trustees may operate group plans as a preferred provider option, health maintenance, point-of-service, or other organizational arrangement. Furthermore, an act of the General Assembly is required for the Executive Administrator and the Board of Trustees to change at any point in time the Plan's comprehensive benefit coverage, including co-payments, deductibles, out-of-pocket expenditures, and lifetime maximums, under any plan type option authorized.

(2) **Authorize an optional Medicare Advantage program**: Under Section 3 (o) of the proposed committee substitute, the Plan is authorized to offer an insured Medicare Advantage product to Medicare eligible plan members in lieu of other coverage offered under the Plan in conjunction with carve outs for Medicare Parts A & B. Under the proposed authorization Medicare eligible plan members would have an option to select a Medicare Advantage plan offered through an

authorized insurer under contract with the Plan. The authorizing language also requires the Plan to continue to offer the Plan's current outpatient prescription drug coverage to all Medicare eligible plan members regardless of whether they are enrolled in a Medicare Advantage product or continue to remain in other benefit plans offered by the Plan.

ESTIMATED IMPACT ON STATE:

Authority to Offer Multiple Benefit Plans

An act of the General Assembly would be required to offer any change in comprehensive benefits offered through a single or multi plan type offering authorized in the proposed legislation. In addition, House rules, Senate rules, and G.S. 120-114 require any change in health benefits proposed in a bill before the General Assembly to have an actuarial note to estimate financial and actuarial effect to the State. Therefore, it is assumed that any future changes to benefits recommended by the Executive Administrator and Board of Trustees in future proposed legislation before the General Assembly would be considered with the appropriate legislative actuarial note attached.

Optional Medicare Advantage Plan

Aon Consulting, the consulting actuary for the Teachers' and State Employees' Comprehensive Major Medical Plan, estimates that the implementation of a Medicare Advantage plan, implemented effective January 1, 2009, and thereafter on a fiscal year basis, would generate estimated savings of $5.9 million in the 2008-2009 fiscal year, and $11.8 million in the 2009-2010 fiscal year. Aon Consulting estimates in part rely upon a proprietary database and cost projection model in conjunction with other data. Aon Consulting also uses an assumed midpoint enrollment rate of 30,000 Medicare eligible plan members electing to enroll in a future Medicare Advantage plan beginning January 1, 2009.

Hartman & Associates, the consulting actuary for the General Assembly's Fiscal Research Division, estimates that a Medicare Advantage plan would not have a significant financial impact based on the information available from the Plan. Hartman & Associates noted that the yet- to-be determined benefit design and unknown geographic availability of a potential Medicare Advantage product to be offered by the Plan, limits any reliable estimate of actuarial and financial impact to the Plan at this time.

EFFECTIVE DATE: July 1, 2008

ASSUMPTIONS AND METHODOLOGY:

Summary Plan Information

The Plan operates on a self-funded basis funded through premium contributions, investment earnings and other receipts. As of October 1, 2006, the Plan operates an Indemnity plan and an optional Preferred Provider Option (PPO) plan. Effective July 1, 2008, the Plan will no longer operate the Indemnity Plan as a benefit option for plan members. The PPO plan offers three options to plan members that include: (1) a "basic" 70/30 plan that offers higher out-of pocket requirements in return for lower fully contributory dependent premiums; (2) a "standard" 80/20 plan; and (3) a 90/10 "plus" plan with enhanced benefits via lower out-of-pocket requirements as compared to the other PPO plan options. Participation in the plus plan requires employees and retired employees to make a partially contributory premium contribution to participate in this option. The basic and standard plans offer coverage to employees and retired employees on a noncontributory basis. Coverage for dependents under all plans is offered on a fully contributory basis.

Additional assumptions include Medicare benefit "carve-outs," cost containment strategies including prior approval for certain medical services, utilization of the "Blue Options" provider network, case and disease management for selected medical conditions, mental health case management, coordination of benefits with other payers, a prescription drug benefit manager with manufacturer rebates from formularies, and fraud detection, and other authorized actions by the Executive Administrator and Board of Trustees to manage the Plan to maintain and improve the Plan's operation and financial condition where possible. Claim cost trends are expected to increase at a rate of 9% annually according to the Plan's consulting actuary. Investment earnings are based upon a 4.5% return on available cash balances.

Financial Condition

Year-to-date Operating Results [1]

Through May 31, 2008, the Plan has an operating loss of approximately $38.7 million for the 2007-2008 fiscal year. Year-to-date operating losses in the Indemnity plan total $91.8 million versus a projected annual loss of $2.5 million. To date, these losses are partially offset by $53.1 million in operating gains under the PPO plans. The Plan as a result is operating substantially behind its projected annual operating income of $57.9 million for the 2007-2008 fiscal year. Based on actual results through May 2008, the Plan revised its projected income to reflect an estimated $63.9 million loss for the fiscal year, or a reduction of $121.8 million in projected income. The negative results experienced during the 2007-2008 fiscal year are expected to require the Executive Administrator of the Plan to implement additional cost saving programs for the balance of the 2007-2009 biennium.

[1] Summary of Operations (Cash Basis Reporting), For the Period Ending May 2008, 2007-2008 Fiscal Year, Teachers' and State Employees Comprehensive Major Medical Plan.

Financial Projection (Revised June 2008)[2]

Combined Benefit Plan Components (Indemnity and PPO): For the fiscal year beginning July 1, 2007, the Plan is projected to start its operations with a beginning cash balance of $156.7 million. Receipts for the year are estimated to be $2.223 billion from premium collections, $51.8 million from Medicare Part D subsidies and $8.5 million from investment earnings for a total of $2.283 billion in receipts for the year. Claims payments from the Plan are expected to be $1.653 billion in medical claim payments, $548 million in pharmacy claim payments, plus $9.6 million in other cost adjustments for total net claims payments of $2.211 billion. Total disbursements of the Plan are expected to be $2.347 billion after adding total net claims payments plus $136.9 million in administration and claims processing expenses. For the fiscal year beginning July 1, 2007, the Plan is expected to have net operating income loss of approximately $63.9 million for the year. The Plan is also projected to have an available beginning cash balance of $92.8 million for the fiscal year beginning July 1, 2008. The Plan does maintain a claim stabilization reserve for claim cost fluctuations equal to 7.5% of annual claim payments without reserving additional funds for incurred but unreported claims.

Indemnity Plan Component: For the fiscal year beginning July 1, 2007, the Indemnity plan started its operations with a beginning cash balance of $112.8 million. Receipts for the year are estimated to be $686.7 million from premium collections, $47.7 million from Medicare Part D subsidies and $4.1 million from investment earnings for a total of $738.5 million in receipts for the year. Claims payments from the Indemnity Plan are expected to be $545.1 million in medical claim payments, $232 million in pharmacy claim payments, minus $1.3 million in other cost adjustments for total net claims payments of $775.8 million. Total disbursements of the Indemnity plan are expected to be $837.9 million after adding total net claims payments plus $62.1 million in administration and claims processing expenses. For the fiscal year beginning July 1, 2007, the Indemnity plan is expected to have net operating income loss of approximately $99.4 million for the year. The Indemnity plan is projected to have an ending cash balance of $13.4 million for the fiscal year ending June 30, 2008. The Indemnity plan as a benefit plan option will cease to exist on July 1, 2008.

PPO Plans Component: For the fiscal year beginning July 1, 2007, the consolidated PPO plans started operations with a beginning cash balance of $43.9 million. Receipts for the year are estimated to be $1.537 billion from premium collections, $4.1 million from Medicare Part D subsidies and $4.4 million from investment earnings for a total of $1.546 billion in receipts for the year. Claims payments from the Plan are expected to be $1.108 million in medical claim payments, $316 million in pharmacy claim payments, plus $10.9 million in other cost adjustments for total net claims payments of $1.435 billion. Total disbursements of the Plan are expected to be $1.510 billion after adding total net claims payments plus $74.8 million in administration and claims processing expenses. For the fiscal year beginning July 1, 2007, the PPO plans are expected to have net operating income of approximately $35.6 million for the year. The PPO plans are also projected to have an available beginning cash balance of $79.5 million for the fiscal year beginning July 1, 2008.

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[2] Aon Consulting, Consulting Actuary for the Teachers' and State Employees' Comprehensive Major Medical Plan, June 2008.

Enrollment Data as of December 31, 2007

I. No. of Participants	Indemnity Plan	PPO Options	Total	Percent of Total
Actives				
Employees	68,745	253,572	322,317	50.0%
Dependents	21,031	135,744	156,775	24.3%
Sub-total	89,776	389,316	479,092	74.4%
Retired				
Employees	85,753	55,948	141,701	22.0%
Dependents	7,859	11,611	19,470	3.0%
Sub-total	93,612	67,559	161,171	25.0%
Former Employees with Continuation Coverage				
Employees	682	1,022	1,704	0.3%
Dependents	226	616	842	0.1%
Sub-total	908	1,638	2,546	0.4%
Firefighters, Rescue Squad & National Guard				
Employees	3	-	3	0.0%
Dependents	-	-	-	0.0%
Sub-total	3	-	3	0.0%
Local Governments				
Employees	16	1,082	1,098	0.2%
Dependents	-	459	459	0.1%
Sub-total	16	1,541	1,557	0.2%
Total	184,315	460,054	644,369	
Percent of Total	28.6%	71.4%	100.0%	100.0%

II. Retiree Enrollment by Category	Indemnity Plan	PPO Options	Total
Non-Medicare Eligible	25,859	34,711	60,570
Medicare Eligible	67,753	32,848	100,601
Total	93,612	67,559	161,171

Percent by Category (Retiree)	Indemnity Plan	PPO Options	Total
Non-Medicare Eligible	27.6%	51.4%	37.6%
Medicare Eligible	72.4%	48.6%	62.4%
Total	100.0%	100.0%	100.0%

Enrollment Data Continued

III. Enrollment by Age	Indemnity Plan	PPO Options	Total
29 & Under	25,706	147,450	173,156
30 to 44	23,965	105,402	129,367
45 to 54	28,204	89,488	117,692
55 to 64	40,880	82,975	123,855
65 & Over	65,560	34,739	100,299
Total	184,315	460,054	644,369

Percent Enrollment by Age	Indemnity Plan	PPO Options	Total
29 & Under	13.9%	32.1%	26.9%
30 to 44	13.0%	22.9%	20.1%
45 to 54	15.3%	19.5%	18.3%
55 to 64	22.2%	18.0%	19.2%
65 & Over	35.6%	7.6%	15.6%
Total	100.0%	100.0%	100.0%

IV. Enrollment by Sex	Indemnity Plan	PPO Options	Total
Female	117,283	284,899	402,182
Male	67,032	175,155	242,187
Total	184,315	460,054	644,369

Percent Enrollment by Sex	Indemnity Plan	PPO Options	Percent of Total
Female	63.6%	61.9%	62.4%
Male	36.4%	38.1%	37.6%
Total	100.0%	100.0%	100.0%

SOURCES OF DATA:
-Actuarial Note, Hartman & Associates, House Proposed Committee Substitute to House Bill 2443 (H2443-CSLN-75), June 24, 2008, original of which is on file in the General Assembly's Fiscal Research Division.

-Actuarial Note, Aon Consulting, House Proposed Committee Substitute to House Bill 2443 (H2443-CSLN-75), June 25, 2008, original of which is on file with the Teachers' and State Employees' Comprehensive Major Medical Plan and the General Assembly's Fiscal Research Division.

TECHNICAL CONSIDERATIONS: None

FISCAL RESEARCH DIVISION: (919) 733-4910

PREPARED BY: Mark Trogdon

APPROVED BY:

Lynn Muchmore, Director
Fiscal Research Division

DATE: July 1, 2008

Signed Copy Located in the NCGA Principal Clerk's Offices

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2007

H D

HOUSE BILL 2443*

Committee Substitute Favorable 6/30/08

PROPOSED SENATE COMMITTEE SUBSTITUTE H2443-PCS80635-LN-79

Short Title: State Health Plan. (Public)

Sponsors:

Referred to:

May 26, 2008

A BILL TO BE ENTITLED

AN ACT TO REWRITE GENERAL STATUTE PROVISIONS PERTAINING TO HEALTH AND LONG-TERM CARE BENEFITS FOR TEACHERS, STATE EMPLOYEES, RETIRED STATE EMPLOYEES, AND THEIR ELIGIBLE DEPENDENTS.

The General Assembly of North Carolina enacts:

SECTION 1.(a) Effective July 1, 2008, Article 3 of Chapter 135 of the General Statutes is recodified as Article 3A of Chapter 135 of the General Statutes.

SECTION 1.(b) Effective July 1, 2008, the title of Article 3A of Chapter 135 of the General Statutes, as enacted by this act, reads as rewritten:

"~~Other Teacher, Employee Benefits; Child Health Benefits.~~

Other Benefits for Teachers, State Employees, Retired State Employees, and Child Health."

SECTION 1.(c) Effective July 1, 2008, Part 1 of Article 3A of Chapter 135 of the General Statutes, as enacted by this act, is recodified as Part 1A of Article 3A of Chapter 135 of the General Statutes.

SECTION 1.(d) Effective July 1, 2008, G.S. 135-37, as amended by Section 28.22A of S.L. 2007-323, is recodified as G.S. 135-37.1 under Part 1A of Article 3A of Chapter 135 of the General Statutes, as enacted by this act, and as recodified, reads as rewritten:

"**§ 135-37.1. Confidentiality of information and medical records; provider contracts.**

(a) Any information as herein described in this section which is in the possession of the Executive Administrator and the Board of Trustees of the State Health Plan for Teachers and State Employees or its Claims Processor under the Plan or the Predecessor Plan shall be confidential and shall be exempt from the provisions of Chapter 132 of the General Statutes or any other provision requiring information and records held by State

agencies to be made public or accessible to the public. This section shall apply to all information concerning individuals, including the fact of coverage or noncoverage, whether or not a claim has been filed, medical information, whether or not a claim has been paid, and any other information or materials concerning a plan participant. Provided, however, such information may be released to the State Auditor, or to the Attorney General, or to the persons designated under G.S. 135-39.3 in furtherance of their statutory duties and responsibilities, or to such persons or organizations as may be designated and approved by the Executive Administrator and Board of Trustees of the Plan, but any information so released shall remain confidential as stated above and any party obtaining such information shall assume the same level of responsibility for maintaining such confidentiality as that of the Executive Administrator and Board of Trustees of the State Health Plan for Teachers and State Employees.

(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 plans or programs,~~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. Provided, however, nothing in this subsection shall be deemed 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, 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 plans or programs~~ optional alternative comprehensive health benefit plans, and programs available under the optional alternative plans, as authorized under G.S. 135-40 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 on its progress in negotiating the preferred provider contracts.~~Benefits."

SECTION 1.(e) Effective July 1, 2008, G.S. 135-38 is recodified as G.S. 135-37.2 under Part 1A of Article 3A of Chapter 135 of the General Statutes, as enacted by this act, and as recodified, reads as rewritten:

"**§ 135-37.2. Committee on Employee Hospital and Medical Benefits.**

(a) The Committee on Employee Hospital and Medical Benefits shall consist of 12 members as follows:

(1) The President Pro Tempore of the Senate or a designee thereof;
~~(2a)~~(2)The Speaker of the House of Representatives or a designee thereof;
~~(3a)~~(3)Five members of the Senate appointed by the President Pro Tempore of the Senate; and
~~(4a)~~(4)Five members of the House of Representatives appointed by the Speaker.

(b) The President Pro Tempore of the Senate and the Speaker of the House of Representatives, or their designees, shall remain on the Committee for the duration of their terms in those offices. Terms of the other Committee members are for two ~~years and begin on January 15 of each odd-numbered year, except the terms of the initial members, which begin on appointment and expire January 14, 1997.~~years. Members may complete a term of service on the Committee even if they do not seek reelection or are not reelected to the General Assembly, but resignation or removal from service in the General Assembly constitutes resignation or removal from service on the Committee. Members shall serve until their successors are appointed.

(c) The Committee shall review programs of hospital, medical and related care provided by ~~Part 3 and~~ Part 3A and Part 5 of this Article and programs of long-term care benefits provided by ~~Part 4~~Part 4A of this Article as recommended by the Executive Administrator and Board of Trustees of the Plan. The Executive Administrator and the Board of Trustees shall provide the Committee with any information or assistance requested by the Committee in performing its duties under this Article. The Committee shall meet not less than once each quarter to review the actions of the Executive Administrator and Board of Trustees. At each meeting, the Executive Administrator shall report to the Committee on any administrative and medical policies which have been issued as rules ~~and regulations~~ in accordance with ~~G.S. 135-39.8,~~G.S. 135-38.11 and on any benefit denials, resulting from the policies, which have been appealed to the Board of Trustees.

(d) The time members spend on Committee business shall be considered official legislative business for purposes of G.S. 120-3."

SECTION 1.(f) G.S. 135-38.1, as amended by Section 28.22A(o) of S.L. 2007-323, is recodified under Part 1A of Article 3A of Chapter 135 of the General Statutes, as enacted by this act.

SECTION 2.(a) Effective July 1, 2008, Part 2 of Article 3A of Chapter 135 of the General Statutes, as enacted by this act, is recodified as Part 2A of Article 3A of Chapter 135 of the General Statutes.

SECTION 2.(b) Effective July 1, 2008, G.S. 135-39.3, as amended by S.L. 2007-323(o), is recodified as G.S. 135-37.3 under Part 2A of Article 3A of Chapter 135 of the General Statutes, as enacted by this act, and as recodified, reads as rewritten:

"**§ 135-37.3. Oversight team.**

(a) The Committee on Employee Hospital and Medical Benefits may use employees of the Legislative Services Office and may employ contractual services as approved by the Legislative Services Commission to monitor the Executive Administrator and Board of Trustees, the Claims Processor, and the State Health Plan for Teachers and State Employees. The Director of the Budget may use employees of

the Office of State Budget and Management to monitor the Executive Administrator and Board of Trustees, the Claims Processor, and the State Health Plan for Teachers and State Employees. ~~Such assistance~~ Employees authorized by the Legislative Services Commission and the Director of the Budget to provide assistance to the Committee on Employee Hospital and Medical Benefits and to the Director of the Budget shall comprise an oversight team.

(b) The oversight team shall, jointly or individually, have access to all records of the Board of Trustees, the Executive Administrator, the Claims Processor, and the ~~Comprehensive Major Medical~~ Plan. ~~They~~ The oversight team shall, jointly or individually, be entitled to attend all meetings of the Board of Trustees.

(c) The oversight team shall report to the Committee on Employee Hospital and Medical Benefits when requested by the Committee."

SECTION 2.(c) G.S. 135-39.9 is recodified as G.S. 135-37.4 under Part 2A of Article 3A of Chapter 135 of the General Statutes, as enacted by this act, and as recodified, reads as rewritten:

"**§ 135-37.4. Reports to the General Assembly.**

~~(a)~~ The Executive Administrator and Board of Trustees shall report to the General Assembly at such times and in such forms as shall be ~~provided~~ designated by the Committee on Employee Hospital and Medical Benefits."

SECTION 2.(d) G.S. 135-39.11 is recodified as G.S. 135-37.5 under Part 2A of this Article, as enacted by this act, and as recodified, reads as rewritten:

"**§ 135-37.5. ~~Contract disputes.~~Contract disputes not contested case under the Administrative Procedure Act, Chapter 150B of the General Statutes.**

A dispute involving the performance, terms, or conditions of a contract between the Plan and an entity under contract with the Plan is not a contested case under Article 3 of Chapter 150B of the General Statutes."

SECTION 2.(e) G.S. 135-39, as amended by Section 28.22A(o) of S.L. 2007-323, is recodified as G.S. 135-38.2 under Part 2A of Article 3A of Chapter 135 of the General Statutes, as enacted by this act, and as recodified, reads as rewritten:

"**§ 135-38.2. Board of Trustees established.**

(a) There is ~~hereby~~ established the Board of Trustees of the State Health Plan for Teachers and State Employees ("Board").

~~(a1)~~(b)The Board shall consist of nine members.

~~(b)~~(c) Three members shall be appointed by the Governor. ~~Of the initial members, one shall serve a term to expire June 30, 1983, and two shall serve terms to expire June 30, 1984. Subsequent terms~~Terms shall be for two years. Vacancies shall be filled by the Governor. Of the members appointed by the Governor, one shall be either:

(1) An employee of a State department, agency, or institution;
(2) A teacher employed by a North Carolina public school system;
(3) A retired employee of a State department, agency, or institution; or
(4) A retired teacher from a North Carolina public school system.

~~(c)~~(d) Three members shall be appointed by the General Assembly upon the recommendation of the Speaker of the House of Representatives in accordance with G.S. 120-121. ~~Of the initial members, two shall serve terms expiring June 30, 1983, and~~

~~one shall serve a term expiring June 30, 1984.~~Terms shall be for two years. Vacancies shall be filled in accordance with G.S. 120-122.

~~(d)~~(e) Three members shall be appointed by the General Assembly upon the recommendation of the President Pro Tempore of the Senate in accordance with G.S. 120-121. ~~Of the initial members, two shall serve terms expiring June 30, 1983, and one shall serve a term expiring June 30, 1984.~~Terms shall be for two years. Vacancies shall be filled in accordance with G.S. 120-122.

~~(e)~~(f) ~~The Governor shall have the power to remove any member appointed by him under subsection (b). The General Assembly may remove any member appointed under subsections (c) or (d).~~Each appointing authority may remove any member appointed by that appointing authority.

~~(f)~~(g) The members of the Board of Trustees shall receive one hundred dollars ($100.00) per day, except employees eligible to enroll in the Plan, whenever the full Board of Trustees holds a public session, and travel allowances under G.S. 138-6 when traveling to and from meetings of the Board of Trustees or hearings under ~~G.S. 135-39.7,~~G.S. 135-38.10, but shall not receive any subsistence allowance or per diem under G.S. 138-5, except when holding a meeting or hearing where this section does not provide for payment of one hundred dollars ($100.00) per day.

(h) No member of the Board of Trustees may serve more than three consecutive two-year terms.

(i) Meetings of the Board of Trustees may be called by the Executive Administrator, the ~~Chairman,~~Chair, or by any three members."

SECTION 2.(f) G.S. 135-39.2 is recodified as G.S. 135-38.3 under Part 2A of Article 3A of Chapter 135 of the General Statutes, as enacted by this act, and as recodified, reads as rewritten:

"**§ 135-38.3. Officers, quorum, meetings.**

(a) The Board of Trustees shall elect from its own membership such officers as it sees fit.

(b) Six 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.

(c) Meetings may be called by the ~~Chairman,~~Chair, or at the written request of three members."

SECTION 2.(g) G.S. 135-39.1, as amended by Section 28.22A(o) of S.L. 2007-323, is recodified as G.S. 135-38.4 under Part 2A of Article 3A of Chapter 135 of the General Statutes, as enacted by this act.

SECTION 2.(h) G.S. 135-39.4A, as amended by Section 28.22A of S.L. 2007-323, is recodified as G.S. 135-38.5 under Part 2A of Article 3A of Chapter 135 of the General Statutes as enacted by this act, and as recodified, reads as rewritten:

"**§ 135-38.5. Executive Administrator.**

(a) The Plan shall have an Executive Administrator and a Deputy Executive Administrator. The Executive Administrator and the Deputy Executive Administrator positions are exempt from the provisions of Chapter 126 of the General Statutes as provided in G.S. 126-5(c1).

(b) The Executive Administrator shall be appointed by the Commissioner of Insurance. The term of employment and salary of the Executive Administrator shall be set by the Commissioner of Insurance upon the advice of an executive committee of the Committee on Employee Hospital and Medical Benefits.

The Executive Administrator may be removed from office by the Commissioner of Insurance, upon the advice of an executive committee of the Committee on Employee Hospital and Medical Benefits, and any vacancy in the office of Executive Administrator may be filled by the Commissioner of Insurance with the term of employment and salary set upon the advice of an executive committee of the Committee on Employee Hospital and Medical Benefits.

~~(f)~~(c) The Executive Administrator shall appoint the Deputy Executive Administrator and may employ such clerical and professional staff, and such other assistance as may be necessary to assist the Executive Administrator and the Board of Trustees in carrying out their duties and responsibilities under this Article. The Executive Administrator may designate managerial, professional, or policy-making positions as exempt from the State Personnel Act. The Executive Administrator may also negotiate, renegotiate and execute contracts with third parties in the performance of ~~his~~ the Executive Administrator's duties and responsibilities under this Article; provided any contract negotiations, renegotiations and execution with a Claims Processor, with ~~an optional hospital and medical benefit plan or program authorized under G.S. 135-40,~~ an optional alternative comprehensive health benefit plan, or program thereunder, authorized under G.S. 135-39.12, with a preferred provider of institutional or professional hospital and medical care, or with a pharmacy benefit manager shall be done only after consultation with the Committee on Employee Hospital and Medical Benefits.

~~(g)~~(d) The Executive Administrator shall be responsible for:

(1) Cost management programs;
(2) Education and illness prevention programs;
(3) Training programs for Health Benefit Representatives;
(4) Membership functions;
(5) Long-range planning;
(6) Provider and participant relations; and
(7) Communications.

Managed care practices used by the Executive Administrator in cost management programs are subject to the requirements of G.S. 58-3-191, 58-3-221, 58-3-223, 58-3-235, 58-3-240, 58-3-245, 58-3-250, 58-3-265, 58-67-88, and 58-50-30.

~~(h)~~(e) The Executive Administrator shall make reports and recommendations on the Plan to the President of the Senate, the Speaker of the House of Representatives and the Committee on Employee Hospital and Medical Benefits."

SECTION 2.(i) G.S. 135-39.10, as amended by Section 28.22A(d),(o) of S.L. 2007-323, is recodified as G.S. 135-38.6 under Part 2A of Article 3A of Chapter 135 of the General Statutes, as enacted by this act.

SECTION 2.(j) G.S. 135-39.5 is recodified as G.S. 135-38.7 under Part 2A of Article 3A of Chapter 135 of the General Statutes, as enacted by this act, and as recodified, reads as rewritten:

"**§ 135-38.7. 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:

(1) Supervising and monitoring of the Claims Processor.

(2) Providing for enrollment of employees in the Plan.

(3) Communicating with employees enrolled under the Plan.

(4) Communicating with health care providers providing services under the Plan.

(5) Making payments at appropriate intervals to the Claims Processor for benefit costs and administrative costs.

(6) Conducting administrative reviews under ~~G.S. 135-39.7.~~G.S. 135-38.10.

(7) Annually assessing the performance of the Claims Processor.

(8) Preparing and submitting to the Governor and the General Assembly cost estimates for the ~~health benefits plan,~~ Plan, including those required by Article 15 of Chapter 120 of the General Statutes.

(9) Recommending to the Governor and the General Assembly changes or additions to the health benefits ~~program~~ programs and health care cost containment ~~programs,~~ programs offered under the Plan, together with statements of financial and actuarial effects as required by Article 15 of Chapter 120 of the General Statutes.

(10) Working with State employee groups to improve health benefit programs.

(11) Repealed by Session Laws 1985, c. 732, s. 9.

(12) Determining basis of payments to health care providers, including payments in accordance with G.S. 58-50-56. ~~The Comprehensive Major Medical Plan and optional plans and programs adopted pursuant to G.S. 135-39.5B shall comply with G.S. 58-3-225.~~

(13) Requiring bonding of the Claims Processor in the handling of State funds.

(14) Repealed by Session Laws 1985, c. 732, s. 7.

(15) In case of termination of the contract under ~~G.S. 135-39.5A,~~ subdivision (29) of this section, to select a new Claims Processor, after ~~competitive~~ bidding procedures approved by the Department of Administration.

(16) Notwithstanding the provisions of ~~Part 3~~ Part 3A of this Article, to formulate and implement cost-containment measures which are not in direct conflict with that Part.

(17) Implementing pilot programs necessary to evaluate proposed cost containment measures which are not in direct conflict with ~~Part 3~~ Part 3A of this Article, and expending funds necessary for the implementation of ~~such~~ the pilot programs.

(18) Authorizing coverage for alternative forms of care not otherwise provided by the Plan in individual cases when medically necessary, medically equivalent to services covered by the Plan, and when such alternatives would be less costly than would have been otherwise.

(19) Establishing and operating a hospital and other provider bill audit program and a fraud detection program.

(20) Determining administrative and medical policies that are not in direct conflict with ~~Part 3~~ Part 3A of this Article ~~upon the advice of~~ after consultation with the Claims Processor and ~~upon the advice of~~ the Plan's consulting actuary when Plan costs are involved.

(21) Supervising the payment of claims and all other disbursements under this Article, including the recovery of any disbursements that are not made in accordance with the provisions of this Article.

(22) Implementing and administering a program of long-term care benefits pursuant to ~~Part 4~~ Part 4A of this Article.

(23) Implementing and administering a program of child health insurance benefits pursuant to Part 5 of this Article.

(24) Implementing and administering a case management and disease management ~~program.~~program and a wellness program.

(25) Implementing and administering a pharmacy benefit management program through a third-party contract awarded after receiving competitive quotes.

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

(27) The Executive Administrator may establish pilot programs to measure potential cost savings and improvements in patient care available through local, provider-driven medical management.

(28) It is the intent of the General Assembly that active employees and retired employees covered under the Plan and its successor Plan shall have several opportunities in each fiscal year to attend presentations conducted by Plan management staff providing detailed information about benefits, limitations, premiums, co-payments, and other pertinent Plan matters. To this end, beginning in 2007 and annually

thereafter, the Plan's management staff shall conduct multiple presentations each year to Plan members and association groups representing active and retired employees across all geographic regions of the State. Regional meetings shall be held in locations that afford reasonably convenient access to Plan members. The presentations shall be designed not only to present information about the Plan but also to hear and respond to Plan members' questions and concerns.

(29) The Executive Administrator and Board of Trustees may terminate the contract with the Claims Processor ~~as provided in the request for proposal.~~in accordance with the terms of the contract.

(30) The prompt pay requirements of G.S. 58-3-225 apply to the Plan."

SECTION 2.(k) G.S. 135-39.5A is recodified as G.S. 135-38.7(29), as enacted by this act.

SECTION 2.(l) G.S. 135-39.6 is recodified as G.S. 135-38.8 under Part 2A of Article 3A of Chapter 135 of the General Statutes, as enacted by this act, and as recodified reads as rewritten:

"**§ 135-38.8. ~~Special~~ Health benefit trust funds created.**

(a) There are hereby established two ~~special~~ health benefit trust funds, to be known as the Public Employee Health Benefit Fund and the Health Benefit Reserve Fund for the payment of hospital and medical benefits. As used in this section, the term "health benefit trust funds" refers to the fund type described under G.S. 143C-1-3(a)(10).

All premiums, fees, charges, rebates, refunds or any other receipts including, but not limited to, earnings on investments, occurring or arising in connection with health benefits programs established by this Article, shall be deposited into the Public Employee Health Benefit Fund. Disbursements from the Fund shall include any and all amounts required to pay the benefits and administrative costs of such programs as may be determined by the Executive Administrator and Board of Trustees.

Any unencumbered balance in excess of prepaid premiums or charges in the Public Employee Health Benefit Fund at the end of each fiscal year shall be used first, to provide an actuarially determined Health Benefit Reserve Fund for incurred but unpresented claims, second, to reduce the premiums required in providing the benefits of the health benefits programs, and third to improve the plan, as may be provided by the General Assembly. The balance in the Health Benefits Reserve Fund may be transferred from time to time to the Public Employee Health Benefit Fund to provide for any deficiency occurring therein.

The Public Employee Health Benefit Fund and the Health Benefit Reserve Fund shall be deposited with the State Treasurer and invested as provided in G.S. 147-69.2 and 147-69.3.

(b) Disbursement from the Public Employee Health Benefit Fund may be made by warrant drawn on the State Treasurer by the Executive Administrator, or the Executive Administrator and Board of Trustees may by contract authorize the Claims Processors to draw the warrant.

(c) Separate and apart from the ~~special~~ health benefit trust funds authorized by subsections (a) and (b) of this section, there shall be a Public Employee Long-Term Care Benefit Fund if the long-term care benefits provided by Part 4 of this Article are administered on a self-insured basis.

(d) Separate and apart from the special funds authorized by subsections (a), (b), and (c) of this section, there shall be a Child Health Insurance Fund. All premium receipts or any other receipts, including earnings on investments, occurring or arising in connection with acute medical care benefits provided under the Health Insurance Program for Children shall be deposited into the Child Health Insurance Fund. Disbursements from the Child Health Insurance Fund shall include any and all amounts required to pay the benefits and administrative costs of the Health Insurance Program for Children as may be determined by the Executive Administrator and Board of Trustees."

SECTION 2.(m) G.S. 135-39.6A, as amended by Section 11 of S.L. 2007-345, and as further amended by Section 28.22A(m),(o) of S.L. 2007-323, is recodified as G.S. 135-38.9 under Part 2A of Article 3 of Chapter 135 of the General Statutes, as enacted by this act, and as recodified, reads as rewritten:

"**§ 135-38.9. Premiums set.**

(a) The Executive Administrator and Board of Trustees shall, from time to time, establish premium rates for the Plan except as they may be established by the General Assembly in the Current Operations Appropriations Act, and establish ~~regulations~~ rules for payment of the premiums. Premium rates shall be established for coverages where Medicare is the primary payer of health benefits separate and apart from the rates established for coverages where Medicare is not the primary payer of health benefits. The amount of State funds contributed for optional coverage for employees and retirees on a partially contributory basis shall not be more than the Plan's total noncontributory premium for Employee Only coverage, with the person selecting the coverage paying the balance of the partially contributory premium not paid by the Plan. The amount of State funds contributed shall not exceed the Plan's cost for Employee Only coverage. The Executive Administrator and Board of Trustees shall not impose a partially contributory premium until after it has consulted on the premium and the optional coverage design with the Committee on Employee Hospital and Medical Benefits.

(b) The Executive Administrator and Board of Trustees shall establish separate premium rates for the long-term care benefits provided by ~~Part 4~~Part 4A of this Article if the benefits are administered on a self-insured basis.

(c) The Executive Administrator and Board of Trustees shall establish premium rates for benefits provided under Part 5 of this Article. The Department of Health and Human Services shall, from State and federal appropriations and from any other funds made available for the Health Insurance Program for Children established under Part 8 of Article 2 of Chapter 108A of the General Statutes, make payments to the State Health Plan for Teachers and State Employees as determined by the Plan for its administration, claims processing, and other services authorized to provide coverage for acute medical care for children eligible for benefits provided under Part 5 of this Article.

(d) In setting premiums for ~~firemen,~~firefighters, rescue squad workers, and members of the national guard, and their eligible dependents, the Executive Administrator and Board of Trustees shall establish rates separate from those affecting other members of the Plan. These separate premium rates shall include rate factors for incurred but unreported claim costs, for the effects of adverse selection from voluntary participation in the Plan, and for any other actuarially determined measures needed to protect the financial integrity of the Plan for the benefit of its served employees, retired employees, and their eligible dependents.

(e) The total amount of premiums due the Plan from charter schools as employing units, including amounts withheld from the compensation of Plan members, that is not remitted to the Plan by the fifteenth day of the month following the due date of remittance shall be assessed interest of one and one-half percent (1 ½%) of the amount due the Plan, per month or fraction thereof, beginning with the sixteenth day of the month following the due date of the remittance. The interest authorized by this section shall be assessed until the premium payment plus the accrued interest amount is remitted to the Plan. The remittance of premium payments under this section shall be presumed to have been made if the remittance is postmarked in the United States mail on a date not later than the fifteenth day of the month following the due date of the remittance."

SECTION 2.(n) G.S. 135-39.7 is recodified as G.S. 135-38.10 under Part 2A of Article 3A of Chapter 135 of the General Statutes as enacted by this act, and as recodified, reads as rewritten:

"**§ 135-38.10. Administrative review.**

(a) If, after exhaustion of internal appeal handling as outlined in the contract with the Claims Processors any person is aggrieved, the Claims Processors shall bring the matter to the attention of the Executive Administrator and Board of Trustees, which shall promptly decide whether the subject matter of the appeal is a determination subject to external review under Part 4 of Article 50 of Chapter 58 of the General Statutes. The Executive Administrator and Board of Trustees shall inform the aggrieved person and the aggrieved person's provider of the decision and shall provide the aggrieved person notice of the aggrieved person's right to appeal that decision as provided in this subsection. If the Executive Administrator and Board of Trustees decide that the subject matter of the appeal is not a determination subject to external review, then the Executive Administrator and Board of Trustees may make a binding decision on the matter in accordance with procedures established by the Executive Administrator and Board of Trustees. The Executive Administrator and Board of Trustees shall provide a written summary of the decisions made pursuant to this section to all employing units, all health benefit representatives, the oversight team provided for in ~~G.S. 135-39.3,~~G.S. 135-37.3, all relevant health care providers affected by a decision, and to any other parties requesting a written summary and approved by the Executive Administrator and Board of Trustees to receive a summary immediately following the issuance of a decision. A decision by the Executive Administrator and Board of Trustees that a matter raised on internal appeal is a determination subject to external review as provided in subsection (b) of this section may be contested by the aggrieved person under Chapter 150B of the

General Statutes. The person contesting the decision may proceed with external review pending a decision in the contested case under Chapter 150B of the General Statutes.

(b) The Executive Administrator and Board of Trustees shall adopt and implement utilization review and internal grievance procedures that are substantially equivalent to those required under G.S. 58-50-61 and G.S. 58-50-62. External review of determinations shall be conducted in accordance with Part 4 of Article 50 of Chapter 58 of the General Statutes. As used in this section, "determination" is a decision by the Executive Administrator and Board of Trustees, ~~the Plan's designated utilization review organization, or a self-funded health maintenance organization~~ or the Plan's designated utilization review organization administrated by or under contract with the Plan that an admission, availability of care, continued stay, or other health care service has been reviewed and, based upon information provided, does not meet the Plan's requirements for medical necessity, appropriateness, health care setting, or level of care or effectiveness, and the requested service is therefore denied, reduced, or terminated.

(c) The Board of Trustees shall make the final agency decision in all cases contested pursuant to Chapter 150B of the General Statutes. The Executive Administrator shall execute the Board's final agency decisions. For purposes of G.S. 150B-44, the Board of Trustees is an agency that is a board or commission."

SECTION 2.(o) G.S. 135-39.8 is recodified as G.S. 135-38.11 under Part 2A of Article 3A of Chapter 135 of the General Statutes as enacted by this act, and as recodified, reads as rewritten:

"**§ 135-38.11. ~~Rules and regulations.~~Rules.**

The Executive Administrator and Board of Trustees may ~~issue~~ adopt rules ~~and regulations~~ to implement Parts ~~2, 3, 4, and 5~~ 2A, 3A, 4A, and 5A of this Article. The Executive Administrator and Board of Trustees shall provide to all employing units, all health benefit representatives, the oversight team provided for in ~~G.S. 135-39.3,~~G.S. 135-37.3, all relevant health care providers affected by a ~~rule or regulation,~~rule, and to any other persons requesting a written description and approved by the Executive Administrator and Board of Trustees written notice and an opportunity to comment not later than 30 days prior to adopting, amending, or rescinding a ~~rule or regulation,~~rule, unless immediate adoption of the rule ~~or regulation~~ without notice is necessary in order to fully effectuate the purpose of the ~~rule or regulation.~~ rule. Rules ~~and regulations~~ of the Board of Trustees shall remain in effect until amended or repealed by the Executive Administrator and Board of Trustees. The Executive Administrator and Board of Trustees shall provide a written description of the rules ~~and regulations issued~~ adopted under this section to all employing units, all health benefit representatives, the oversight team provided for in ~~G.S. 135-39.3,~~G.S. 135-37.3, all relevant health care providers affected by a ~~rule or regulation,~~rule, and to any other persons requesting a written description and approved by the Executive Administrator and Board of Trustees on a timely basis. Rules adopted by the Executive Administrator and Board of Trustees to implement this Article are not subject to Article 2A of Chapter 150B of the General Statutes."

SECTION 2.1. Effective when this act becomes law, Part 2A of Article 3A of Chapter 135 of the General Statutes, as enacted by this act, is amended by adding a new section to read:

"**§ 135.38.5A. State Health Plan Administrative Commission. – Creation; membership; appointments, terms, and vacancies; officers; meetings and quorum; compensation.**

(a) The State Health Plan Administrative Commission (hereinafter "Commission") is created. It is composed of three members appointed by the General Assembly as follows:

(1) In 2008 and quadrennially thereafter, two members appointed for two-year terms by the General Assembly upon the recommendation of the Speaker of the House of Representatives in accordance with G.S. 120-121, and in 2010 and quadrennially thereafter, one member appointed for a two-year term by the General Assembly upon the recommendation of the Speaker of the House of Representatives in accordance with G.S. 120-121.

(2) In 2008 and quadrennially thereafter, one member appointed for a two-year term by the General Assembly upon the recommendation of the President Pro Tempore of the Senate in accordance with G.S. 120-121, and in 2010 and quadrennially thereafter, two members appointed for two-year terms by the General Assembly upon the recommendation of the President Pro Tempore of the Senate in accordance with G.S. 120-121.

(b) Terms of office shall commence July 1 and end June 30, except that the terms of the initial members shall commence upon appointment and expire June 30, 2010.

(c) The Commissioner of Insurance or his designee serves as secretary of the Commission.

(d) Vacancies in appointments made by the General Assembly shall be filled in accordance with G.S. 120-122.

(e) The Governor may remove any member of the Commission from office after a hearing for nonfeasance, misfeasance, or malfeasance. The General Assembly may remove any member of the Commission.

(f) The Commission shall elect from its membership a chair and a vice-chair to serve terms coterminous with the terms of the members.

(g) The Commission meets at the call of the chair or upon written request of at least two members.

(h) The Commission shall be located administratively within the Department of Insurance but shall exercise all of its prescribed statutory powers independently of the Commissioner of Insurance.

(i) A majority of the Commission shall constitute a quorum for the transaction of business.

(j) Members of the Commission shall receive travel allowances under G.S. 138-6 when traveling to and from meetings of the Commission, but shall not receive any subsistence allowance or per diem under G.S. 138-5."

SECTION 2.2. Effective the later of 10 days after this act becoming law or the appointment of at least two members of the State Health Plan Administrative Commission as established by Section 3.1 of this act, G.S. 135-38.5(b), as recodified and rewritten by Section 2(h) of this act, reads as rewritten:

"(b) The Executive Administrator shall be appointed by the ~~Commissioner of Insurance.~~ State Health Plan Administrative Commission. The term of employment and salary of the Executive Administrator shall be set by the ~~Commissioner of Insurance~~ State Health Plan Administrative Commission upon the advice of an executive committee of the Committee on Employee Hospital and Medical Benefits.

The Executive Administrator may be removed from office by the ~~Commissioner of Insurance,~~ State Health Plan Administrative Commission, upon the advice of an executive committee of the Committee on Employee Hospital and Medical Benefits, and any vacancy in the office of Executive Administrator may be filled by the ~~Commissioner of Insurance~~ State Health Plan Administrative Commission with the term of employment and salary set upon the advice of an executive committee of the Committee on Employee Hospital and Medical Benefits."

SECTION 3.(a) Effective July 1, 2008, Part 3 of Article 3A of Chapter 135 of the General Statutes, as enacted by this act, is recodified as Part 3A of Article 3A of Chapter 135 of the General Statutes.

SECTION 3.(b) Effective July 1, 2008, G.S. 135-40 is repealed.

SECTION 3.(c) Part 3A of Article 3A of Chapter 135 of the General Statutes, as enacted by this act, is amended by adding the following new section to read:

"**§ 135-39.12. Undertaking.**

(a) The State of North Carolina undertakes to make available a State Health Plan (hereinafter called the "Plan") exclusively for the benefit of eligible employees, eligible retired employees, and certain of their eligible dependents, which will pay benefits in accordance with the terms of this Article. The Plan shall have all the powers and privileges of a corporation and shall be known as the State Health Plan for Teachers and State Employees. The Executive Administrator and Board of Trustees shall carry out their duties and responsibilities as fiduciaries for the Plan. The Plan shall administer one or more group health plans that are comprehensive in coverage and shall provide eligible employees and retired employees coverage on a noncontributory basis under at least one of the group plans with benefits equal to that specified in subsection (g) of this section. The Executive Administrator and Board of Trustees may operate group plans as a preferred provider option, or health maintenance, point-of-service, or other organizational arrangement and may offer the plans to employees and retirees on a noncontributory or partially contributory basis. Plans offered on a partially contributory basis must provide benefits that are additional to that specified in subsection (g) of this section and may not be offered unless approved in an act of the General Assembly.

(b) Individuals eligible for coverage under G.S. 135-39.14 on a fully or partially contributory basis are eligible to participate in any plan authorized under this section.

(c) The State of North Carolina deems it to be in the public interest for North Carolina firefighters, rescue squad workers, and members of the national guard, and certain of their dependents, who are not eligible for any other type of comprehensive

group health insurance or other comprehensive group health benefits, and who have been without any form of group health insurance or other comprehensive group health benefit coverage for at least six consecutive months, to be given the opportunity to participate in the benefits provided by the State Health Plan for Teachers and State Employees. Coverage under the Plan shall be voluntary for eligible firefighters, rescue squad workers, and members of the national guard who elect participation in the Plan for themselves and their eligible dependents.

(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. 135-39.13 through G.S. 135-39.27 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. 135-39.13 through G.S. 135-39.27 and the request for proposals must be modified for inclusion in the contract because of State law, such modification shall be made.

(e) Payroll deduction shall be available for coverage under this Part for subscribers able to meet the Plan's requirements for payroll deduction.

(f) Notwithstanding any other provisions of the Plan, the Executive Administrator and Board of Trustees are specifically authorized to use all appropriate means to secure tax qualification of the Plan under any applicable provisions of the Internal Revenue Code of 1954 as amended. The Executive Administrator and Board of Trustees shall furthermore comply with all applicable provisions of the Internal Revenue Code as amended, to the extent that this compliance is not prohibited by this Article.

(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, that would result in a net increased cost to the Plan or in a reduction in benefits to Plan members unless and until the proposed changes are directed to be made in an act of the General Assembly."

SECTION 3.(d) G.S. 135-40.1 is repealed.

SECTION 3.(e) Part 3A of Article 3A of Chapter 135 of the General Statutes, as enacted by this act, is amended by adding the following new section to read:

"**§ 135-39.13. General Definitions.**

As used in this Article unless the context clearly requires otherwise, the following definitions apply:

(1) Allowed amount. – The charge that the Plan or its claims proessors determines is reasonable for covered services provided to a Plan member. This amount may be established in accordance with an agreement between the provider and the Plan or its claims processor. In the case of providers that have not entered into an agreement with the Plan or its claims processor, the allowed amount will be the lesser of the provider's actual charge or a reasonable charge established by

the Plan or its claims processor using a methodology that is applied to comparable providers for similar services under a similar health benefit plan.

(2) Benefit period. – The period of time during which charges for covered services provided to a Plan member must be incurred in order to be eligible for payment by the Plan.

(3) Chemical dependency. – The pathological use or abuse of alcohol or other drugs in a manner or to a degree that produces an impairment in personal, social, or occupational functioning and which may, but need not, include a pattern of tolerance and withdrawal.

(4) Claims Processor. – One or more administrators, third-party administrators, or other parties contracting with the Plan to administer Plan benefits.

(5) Clinical trials. – Patient research studies designed to evaluate new treatments, including prescription drugs. Coverage for clinical trials shall be as provided in G.S. 135-39.20.

(6) Comprehensive health benefit plan. – Health care coverage that consists of inpatient and outpatient hospital and medical benefits, as well as other outpatient medical services, prescription drugs, medical supplies, and equipment that are generally available in the health insurance market.

(7) Covered service; benefit; allowable expense. – Any medically necessary, reasonable, and customary items of service, including prescription drugs, and medical supplies included in the Plan.

(8) Deductible. – The dollar amount that must be incurred for certain covered services in a benefit period before benefits are payable by the Plan.

The deductible applies separately to each covered individual in each fiscal year, subject to an aggregate maximum per employee and child, employee and spouse, or employee and family coverage contract in any fiscal year.

If two or more family members are injured in the same accident, only one deductible is required for charges related to that accident during the benefit period.

(9) Dependent. – An eligible Plan member other than the subscriber.

(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 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. 135-39.14(d).

(11) Employee or State employee. – Any permanent full-time or permanent part-time regular employee (designated as half-time or more) of an employing unit.

(12) Employing Unit. – A North Carolina School System; Community College; State Department, Agency, or Institution; Administrative Office of the Courts; or Association or Examining Board whose employees are eligible for membership in a State-Supported Retirement System. An employing unit also shall mean a charter school in accordance with Part 6A of Chapter 115C of the General Statutes whose board of directors elects to become a participating employer in the Plan under G.S. 135-39.17. Bona fide fire departments, rescue or emergency medical service squads, and national guard units are deemed to be employing units for the purpose of providing benefits under this Article.

(13) Experimental/Investigational. – Experimental/Investigational Medical Procedures. – The use of a service, supply, drug, or device not recognized as standard medical care for the condition, disease, illness, or injury being treated as determined by the Executive Administrator and Board of Trustees upon the advice of the Claims Processor.

(14) Firefighter. – Eligible firefighters as defined by G.S. 58-86-25 who belong to a bona fide fire department as defined by G.S. 58-86-25 and who are not eligible for any type of comprehensive group health insurance or other comprehensive group health benefit coverage and who have been without any form of group health insurance or other comprehensive group health benefit coverage for at least six months. Firefighter shall also include members of the North Carolina Firemen and Rescue Squad Workers' Pension Fund who are in receipt of a monthly pension, who are not eligible for any type of comprehensive group health insurance or other comprehensive group health benefit coverage, and who have been without any form of group health insurance or other comprehensive group health benefit coverage for at least six months. Comprehensive group health insurance and other benefit coverage consists of inpatient and outpatient hospital and medical benefits, as well as other outpatient medical services, prescription drugs, medical supplies, and equipment that are generally available in the health insurance market. For purposes of this subdivision, comprehensive group health insurance and other benefit coverage includes Medicare benefits, CHAMPUS benefits, and other Uniformed Services benefits. North Carolina fire departments or their respective governing bodies shall certify the eligibility of their

firefighters to the Plan for their participation in its benefits prior to enrollment.

(15) Health Benefits Representative. – The employee designated by the employing unit to administer the Plan for the unit and its employees. The HBR is responsible for enrolling new employees, reporting changes, explaining benefits, reconciling group statements, and remitting group fees. The State Retirement System is the Health Benefits Representative for retired State employees.

(16) Medical necessity or medically necessary. – Covered services or supplies that are:

a. Provided for the diagnosis, treatment, cure, or relief of a health condition, illness, injury, or disease; and, except for clinical trials covered under the Plan, not for experimental, investigational, or cosmetic purposes.

b. Necessary for and appropriate to the diagnosis, treatment, cure, or relief of a health condition, illness, injury, disease, or its symptoms.

c. Within generally accepted standards of medical care in the community.

d. Not solely for the convenience of the Plan member, the Plan member's family, or the provider.

For medically necessary services, the Plan or its representative may compare the cost-effectiveness of alternative services or supplies when determining which of the services or supplies will be covered and in what setting medically necessary services are eligible for coverage.

(17) National guard members. – Members of the North Carolina army and air national guard who are not eligible for any type of comprehensive group health insurance or other comprehensive group health benefit coverage and who have been without any form of group health insurance or other comprehensive group health benefit coverage for at least six months. Members of the North Carolina army and air national guard include those who are actively serving in the national guard as well as former members of the national guard who have completed 20 or more years of service in the national guard but have not attained the minimum age to begin receipt of a uniformed service military retirement benefit. Comprehensive group health insurance and other benefit coverage consists of inpatient and outpatient hospital and medical benefits, as well as other outpatient medical services, prescription drugs, medical supplies, and equipment that are generally available in the health insurance market. Comprehensive group health insurance and other benefit coverage includes Medicare benefits, Civilian Health and Medical Program of the Uniformed Services (CHAMPUS) benefits, and other Uniformed Services benefits. North Carolina national guard units shall certify the eligibility of their

members to the Plan for their participation in its benefits prior to enrollment.

(18) Optional alternative comprehensive benefit plans. – Comprehensive benefit plans administered by the Plan that differ in coverage, deductibles, coinsurance from the Standard Plan providing for 80/20 coinsurance, and that are alternative choices for coverage at the option of the Plan member.

(19) Plan or State Health Plan. – The North Carolina State Health Plan for Teachers and State Employees. Unless otherwise expressly provided, "Plan" includes all comprehensive health benefit plans offered under the Plan.

(20) Plan member. – A subscriber or dependent who is eligible and currently enrolled in the Plan and for whom a premium is paid.

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

(22) Predecessor plan. – The Hospital and Medical Benefits for the Teachers' and State Employees' Retirement System of the State of North Carolina and the North Carolina Teachers' and State Employees' Comprehensive Major Medical Plan.

(23) Rescue squad workers. – Eligible rescue squad workers as defined by the provisions of G.S. 58-86-30 who belong to a rescue or emergency medical services squad as defined by the same statute and who are not eligible for any type of comprehensive group health insurance or other comprehensive group health benefit coverage and who have been without any form of group health insurance or other comprehensive group health benefit coverage for at least six months. Rescue squad workers shall also include members of the North Carolina Firemen and Rescue Squad Workers' Pension Fund who are in receipt of a monthly pension, who are not eligible for any type of comprehensive group health insurance or other comprehensive group health benefit coverage, and who have been without any form of group health insurance or other comprehensive group health benefit coverage for at least six months. Comprehensive group health insurance and other benefit coverage consists of inpatient and outpatient hospital and medical benefits, as well as other outpatient medical services, prescription drugs, medical supplies, and equipment that are generally available in the health insurance market. For purposes of this subdivision, comprehensive group health insurance and other benefit coverage includes Medicare benefits, CHAMPUS benefits, and other Uniformed Services benefits. North Carolina rescue or emergency medical services squads or their respective governing bodies shall certify the eligibility of their rescue squad workers to the Plan for their participation in its benefits prior to enrollment.

(24) Retired employee (retiree). – Retired teachers, State employees, and members of the General Assembly who are receiving monthly retirement benefits from any retirement system supported in whole or in part by contributions of the State of North Carolina, so long as the retiree is enrolled.

(25) Subscriber. – A Plan member who is not a dependent.

(26) Surviving spouse. – The spouse of a deceased Plan member who is eligible for Plan enrollment."

SECTION 3.(f) G.S. 135-40.2, as amended by Section 28.22A of S.L. 2007-323, is recodified as G.S. 135-39.14 under Part 3A of Article 3A of Chapter 135 of the General Statutes, as enacted by this act, and as recodified, reads as rewritten:

"**§ 135-39.14. Eligibility.**

(a) Noncontributory Coverage. – The following persons are eligible for coverage under the Plan, on a noncontributory basis, subject to the provisions of ~~G.S. 135-40.3~~G.S. 135-39.16:

(1) All permanent full-time employees of an employing unit who meet the following conditions:

a. Paid from general or special State funds, or

b. Paid from non-State funds and in a group for which his or her employing unit has agreed to provide coverage.

Employees of State agencies, departments, institutions, boards, and commissions not otherwise covered by the Plan who are employed in permanent job positions on a recurring basis and who work 30 or more hours per week for nine or more months per calendar year are covered by the provisions of this subdivision.

~~(1a)~~(2) Permanent hourly employees as defined in G.S. 126-5(c4) who work at least one-half of the workdays of each pay period.

~~(2)~~(3) Retired teachers, State employees, members of the General Assembly, and retired State law enforcement officers who retired under the Law Enforcement Officers' Retirement System prior to January 1, 1985. Except as otherwise provided in this subdivision, on and after January 1, 1988, a retiring employee or retiree must have completed at least five years of contributory retirement service with an employing unit prior to retirement from any State-supported retirement system in order to be eligible for group benefits under this Part as a retired employee or retiree. For employees first hired on and after October 1, 2006, and members of the General Assembly first taking office on and after February 1, 2007, future coverage as retired employees and retired members of the General Assembly is subject to a requirement that the future retiree have 20 or more years of retirement service credit in order to be covered by the provisions of this subdivision.

~~(2a)~~(4) Surviving spouses of:

a. Deceased retired employees, provided the death of the former plan member occurred prior to October 1, 1986; and

b. Deceased teachers, State employees, and members of the General Assembly who are receiving a survivor's alternate benefit under any of the State-supported retirement programs, provided the death of the former plan member occurred prior to October 1, 1986.

~~(3a)~~(5) Employees of the General Assembly, not otherwise covered by this section, as determined by the Legislative Services Commission, except for legislative interns and pages.

~~(4)~~(6) Members of the General Assembly.

~~(5)~~(7) Notwithstanding the provisions of subsection (e) of this section, employees on official leave of absence while completing a full-time program in school administration in an approved program as a Principal Fellow in accordance with Article 5C of Chapter 116 of the General Statutes.

~~(6)~~(8) Notwithstanding the provisions of G.S. ~~135-40.11,~~G.S. 135-39.24 employees formerly covered by the provisions of this section, other than retired employees, who have been employed for 12 or more months by an employing unit and whose jobs are eliminated because of a reduction, in total or in part, in the funds used to support the job or its responsibilities, provided the employees were covered by the Plan at the time of separation from service resulting from a job elimination. Employees covered by this subsection shall be covered for a period of up to 12 months following a separation from service because of a job elimination.

~~(7)~~(9) Any member enrolled pursuant to subdivision (1) or ~~(1a)~~(2) of this subsection who is on approved leave of absence with pay or receiving workers' compensation.

~~(8)~~(10) Employees on approved Family and Medical Leave.

~~(a2)~~(b) Partially Contributory. – The following persons are eligible for coverage under the Plan on a partially contributory basis subject to the provisions of G.S. 135-39.16:

(1) A school employee in a job-sharing position as defined in ~~G.S. 130-40.3.~~G.S. 135-39.16. If these employees elect to participate in the Plan, the employing unit shall pay fifty percent (50%) of the Plan's total noncontributory premiums. Individual employees shall pay the balance of the total noncontributory premiums not paid by the employing unit.

(2) ~~(a3)~~ Subject to the provisions of ~~G.S. 135-40.3,~~ G.S. 135-39.16, employees and members of the General Assembly with 10 but less than 20 years of retirement service credit ~~shall be eligible for coverage under the Plan on a partially contributory basis,~~ provided the employees were first hired on or after October 1, 2006, and the members first took office on or after February 1, 2007. For such future retirees, the State shall pay fifty percent (50%) of the Plan's total

noncontributory premiums. Individual retirees shall pay the balance of the total noncontributory premiums not paid by the State.

~~(a4) The Executive Administrator and Board of Trustees may in addition to noncontributory coverage offer optional coverage on a partially contributory basis and may set premium rates for the optional coverage on a partially contributory basis. The amount of State funds contributed for optional coverage on a partially contributory basis shall not be more than the Plan's total noncontributory premium for Employee Only coverage, with the person selecting the coverage paying the balance of the partially contributory premium not paid by the Plan. The amount of State funds contributed shall not exceed the Plan's cost for Employee Only coverage. The Executive Administrator and Board of Trustees shall not impose a partially contributory premium until after it has consulted on the premium and the optional coverage design with the Committee on Employee Hospital and Medical Benefits.~~

~~(b)~~(c) Fully Contributory. – The following person shall be eligible for coverage under the Plan, on a fully contributory basis, subject to the provisions of ~~G.S. 135-40.3:~~G.S. 135-39.16:

~~(2)~~(1) Former members of the General Assembly who enroll before October 1, 1986.

~~(2a)~~(2) For enrollments after September 30, 1986, former members of the General Assembly if covered under the Plan at termination of membership in the General Assembly. To be eligible for coverage as a former member of the General Assembly, application must be made within 30 days of the end of the term of office. Only members of the General Assembly covered by the Plan at the end of the term of office are eligible. If application is not made within the specified time period, the member forfeits eligibility.

(3) Surviving spouses of deceased former members of the General Assembly who enroll before October 1, 1986.

~~(3a)~~(4) Employees of the General Assembly, not otherwise covered by this section, as determined by the Legislative Services Commission, except for legislative interns and pages.

~~(3b)~~(5) For enrollments after September 30, 1986, surviving spouses of deceased former members of the General Assembly, if covered under the Plan at the time of death of the former member of the General Assembly.

~~(4)~~(6) All permanent part-time employees (designated as half-time or more) of an employing unit who meets the conditions outlined in subdivision (a)(1)a above, and who are not covered by the provisions of ~~G.S. 135-40.2(a)(1);~~G.S. 135-39.14(a)(1).

~~(5)~~(7) The spouses and eligible dependent children of enrolled teachers, State employees, retirees, former members of the General Assembly, former employees covered by the provisions of ~~G.S. 135-40.2(a)(6);~~G.S. 135-39.14(a)(8), Disability Income Plan beneficiaries, enrolled continuation members, and members of the

General Assembly. Spouses of surviving dependents are not eligible, nor are dependent children if they were not covered at the time of the member's death. Surviving spouses may cover their dependent children provided the children were enrolled at the time of the member's death or enroll within ~~30~~ 90 days of the member's death.

~~(6)~~(8) Blind persons licensed by the State to operate vending facilities under contract with the Department of Health and Human Services, Division of Services for the Blind and its successors, who are:

a. Operating such a vending facility;

b. Former operators of such a vending facility whose service as an operator would have made these operators eligible for an early or service retirement allowance under Article 1 of this Chapter had they been members of the Retirement System; and

c. Former operators of such a vending facility who attain five or more years of service as operators and who become eligible for and receive a disability benefit under the Social Security Act upon cessation of service as an operator.

Spouses, dependent children, surviving spouses, and surviving dependent children of such members are not eligible for coverage.

~~(8)~~(9) Surviving spouses of deceased retirees and surviving spouses of deceased teachers, State employees, and members of the General Assembly provided the death of the former Plan member occurred after September 30, 1986, and the surviving spouse was covered under the Plan at the time of death.

(10) Any eligible dependent child of the deceased retiree, teacher, State employee, member of the General Assembly, former member of the General Assembly, or Disability Income Plan beneficiary, provided the child was covered at the time of death of the retiree, teacher, State employee, member of the General Assembly, former member of the General Assembly, or Disability Income Plan beneficiary, (or was in posse at the time and is covered at birth under this Part), or was covered under the Plan on September 30, 1986. An eligible surviving dependent child can remain covered until age 19, or age 26 if a full-time student, or indefinitely if certified as incapacitated under ~~G.S. 135-40.1(3)b.~~G.S. 135-39.13(5)b.

~~(11a)~~(11) Retired teachers, State employees, and members of the General Assembly with less than 10 years of retirement service credit, provided the teachers and State employees were first hired on or after October 1, 2006, and the members first took office on or after February 1, 2007.

(12) Notwithstanding the provisions of ~~G.S. 135-40.11,~~G.S. 135-39.23 former employees covered by the provisions of ~~G.S. 135-40.2(a)(6),~~G.S. 135-39.14 and their spouses and eligible dependent children who were covered by the Plan at the time of the former employees' separation from service pursuant to

~~G.S. 135-40.2(a)(6),~~ G.S. 135-39.14, following expiration of the former employees' coverage provided by ~~G.S. 135-40.2(a)(6).~~ G.S. 135-39.14. Election of coverage under this subdivision shall be made within 90 days after the termination of coverage provided under ~~G.S. 135-40.2(a)(6).~~G.S. 135-39.14.

(13) ~~Firemen,~~Firefighters, rescue squad workers, and members of the national guard, their eligible spouses, and eligible dependent children.

(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, 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.

(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. 135-39.14(5)a.

~~(c)~~(e) No person shall be eligible for coverage as a dependent if eligible as an employee or retired employee, except when a spouse is eligible on a fully contributory basis. In addition, no person shall be eligible for coverage as a dependent of more than one employee or retired employee at the same time.

~~(d)~~(f) Former employees who are receiving disability retirement benefits or disability income benefits pursuant to Article 6 of Chapter 135 of the General Statutes, provided the former employee has at least five years of retirement membership service, shall be eligible for the benefit provisions of this Plan, as set forth in this Part, on a noncontributory basis. Such coverage shall terminate as of the end of the month in which such former employee is no longer eligible for disability retirement benefits or disability income benefits pursuant to Article 6 of this Chapter.

~~(e)~~(g) Employees on official leave of absence without pay may elect to continue this group coverage at group cost provided that they pay the full employee and employer contribution through the employing unit during the leave period.

~~(f)~~(h) For the support of the benefits made available to any member vested at the time of retirement, their spouses or surviving spouses, and the surviving spouses of employees who are receiving a survivor's alternate benefit under G.S. 135-5(m) of those associations listed in G.S. 135-27(a), licensing and examining boards under G.S. 135-1.1, the North Carolina State Art Society, Inc., and the North Carolina Symphony Society, Inc., each association, organization or board shall pay to the Plan the full cost of providing these benefits under this section as determined by the Board of Trustees of the State Health Plan for Teachers and State Employees. In addition, each association, organization or board shall pay to the Plan an amount equal to the cost of the benefits provided under this section to presently retired members of each association, organization or board since such benefits became available at no cost to the retired member. This subsection applies only to those individuals employed prior to July 1, 1983, as provided in G.S. 135-27(d).

~~(g)~~(i) An eligible surviving spouse and any eligible surviving dependent child of a deceased retiree, teacher, State employee, member of the General Assembly, former member of the General Assembly, or Disability Income Plan beneficiary shall be eligible for group benefits under this section without waiting periods for preexisting conditions provided coverage is elected within 90 days after the death of the former plan member. Coverage may be elected at a later time, but will be subject to the 12-month waiting period for preexisting conditions and will be effective the first day of the month following receipt of the application.

~~(h)~~(j) No person shall be eligible for coverage as an employee or retired employee or as a dependent of an employee or retired employee upon a finding by the Executive Administrator or Board of Trustees or by a court of competent jurisdiction that the employee or dependent knowingly and willfully made or caused to be made a false statement or false representation of a material fact in a claim for reimbursement of medical services under the Plan. The Executive Administrator and Board of Trustees may make an exception to the provisions of this subsection when persons subject to this subsection have had a cessation of coverage for a period of five years and have made a full and complete restitution to the Plan for all fraudulent claim amounts. Nothing in this subsection shall be construed to obligate the Executive Administrator and Board of Trustees to make an exception as allowed for under this subsection.

~~(i)~~(k) Any employee receiving benefits pursuant to Article 6 of this Chapter when the employee has less than five years of retirement membership service, or an employee on leave without pay due to illness or injury for up to 12 months, is entitled to continued coverage under the Plan for the employee and any eligible dependents by paying one hundred percent (100%) of the cost."

SECTION 3.(g) Part 3A of Article 3A of Chapter 135 of the General Statutes is amended by adding the following new section to read:

"**§ 135-39.15. Enrollment.**

(a) Except as otherwise required by applicable federal law, new employees must be given the opportunity to enroll or decline enrollment for themselves and their dependents within 30 days from the date of employment or from first becoming eligible on a noncontributory basis. Coverage may become effective on the first day of the month following date of entry on payroll or on the first day of the following month. New employees not enrolling themselves and their dependents within 30 days, or not adding dependents when first eligible as provided herein may enroll on the first day of any month but will be subject to a 12-month waiting period for preexisting health conditions, except for employees who elect to change their coverage in accordance with rules established by the Executive Administrator and Board of Trustees for optional or alternative plans available under the Plan. Children born to covered employees having coverage type (2) or (3), as outlined in G.S. 135-40.3(d) shall be automatically covered at the time of birth without any waiting period for preexisting health conditions. Children born to covered employees having coverage type (1) shall be automatically covered at birth without any waiting period for preexisting health conditions so long as the claims processor receives notification within 30 days of the date of birth that the employee desires to change from coverage (1) to coverage type (2) or (3), provided that the employee pays any additional premium required by the coverage type selected retroactive to the first day of the month in which the child was born.

(b) 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.(h) G.S. 135-40.3, as amended by Section 28.22A of S.L. 2007-323, is recodified as G.S. 135-39.16 under Part 3A of Article 3A of Chapter 135 of the General Statutes, as enacted by this act, and as recodified, reads as rewritten:

"**§ 135-39.16. Effective dates of coverage.**

(a) Employees and Retired Employees. –

(1) Employees and retired employees covered under the Predecessor Plan will continue to be covered, subject to the terms hereof.

(2) New employees may apply for coverage to be effective on the first day of the month following employment, or on a like date the following month if the employee has enrolled.

(3) Employees not enrolling or adding dependents when first eligible in accordance with ~~G.S. 135-40.1(7)~~G.S. 135-39.15 may enroll later on

the first of any following month but will be subject to a 12-month waiting period for a preexisting health condition, except employees who elect to change their coverage in accordance with rules adopted by the Executive Administrator and Board of Trustees for optional ~~prepaid hospital and medical benefit plans.~~alternative plans offered under the Plan.

(4) Members of the General Assembly, beginning with the 1985 Session, shall become first eligible with the convening of each Session of the General Assembly, regardless of a Member's service during previous Sessions. Members and their dependents enrolled when first eligible after the convening of each Session of the General Assembly will not be subject to any waiting periods for preexisting health conditions. Members of the 1983 Session of the General Assembly, not already enrolled, shall be eligible to enroll themselves and their dependents on or before October 1, 1983, without being subject to any waiting periods for preexisting health conditions.

(b) Waiting Periods and Preexisting Conditions. –

(1) New employees and dependents enrolling when first eligible are subject to no waiting period for preexisting conditions under the Plan.

(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.

(3) Retiring employees and dependents enrolled when first eligible after an employee's retirement are subject to no waiting period for preexisting conditions under the Plan. Retiring employees not enrolled or not adding dependents when first eligible after an employee's retirement may enroll later on the first of any following month, but will be subject to a 12-month waiting period for preexisting conditions except as provided in subdivision (a)(3) of this section.

(4) Employees and dependents enrolling or reenrolling within 12 months after a termination of enrollment or employment that were not enrolled at the time of this previous termination, regardless of the employing units involved, shall not be considered as newly-eligible employees or dependents for the purposes of waiting periods and preexisting conditions. Employees and dependents transferring from optional ~~plans in accordance with G.S. 135-39.5B;~~ alternative plans available under the Plan; employees and dependents immediately returning to service from an employing unit's approved periods of leave without pay for illness, injury, educational improvement, workers' compensation, parental duties, or for military reasons; employees and dependents immediately returning to service from a reduction in an employing unit's work force; retiring employees and dependents reenrolled in accordance with

~~G.S. 135-40.3(b)(3);~~G.S.135-39.16(b)(3): formerly-enrolled dependents reenrolling as eligible employees; formerly-enrolled employees reenrolling as eligible dependents; and employees and dependents reenrolled without waiting periods and preexisting conditions under specific rules ~~and regulations~~ adopted by the Executive Administrator and Board of Trustees in the best interests of the Plan shall not be considered reenrollments for the purpose of this subdivision. Furthermore, employees accepting permanent, full-time appointments who had previously worked in a part-time or temporary position and their qualified dependents shall not be covered by waiting periods and preexisting conditions under this division provided enrollment as a permanent, full-time employee is made when the employee and his dependents are first eligible to enroll.

(5) To administer the 12-month waiting period for preexisting conditions under this Article, the Plan must give credit against the 12-month period for the time that 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.

(c) Dependents of Employees and Retired Employees. –

(1) Dependents of employees and retired employees who have family coverage under the Predecessor Plan will continue to be covered subject to the terms hereof.

(2) Employees who have dependents may apply for family coverage at the time they enroll as provided in subdivisions (a)(2) and (a)(3) of this section and such dependents will be covered under the Plan beginning the same date as such employees.

(3) Employees and retired employees may change from ~~individual or parent/child(ren) coverage to parent/child(ren) or family coverage or add dependents to existing family or parent/child(ren) coverage upon acquiring a dependent~~ one category of coverage to a different category of coverage without a waiting period for preexisting conditions, ~~and~~ and, as applicable, dependents will be covered under the Plan the first of the month or the first of the second month following the dependent's eligibility for coverage, provided written application is submitted to the Health Benefits Representative within 30 days of becoming eligible.

(4) Employees or retired employees who wish to change ~~from family coverage to parent/child(ren) or individual or from parent/child(ren) to individual coverage~~ to employee only coverage shall give written notice to their Health Benefits Representative within 30 days after any change in the status of dependents, (resulting from death, divorce, etc.) that requires a change in contract ~~type.~~category. The effective date will be the first of the month following the dependent's ineligibility event. If notification was not made within the 30 days following the dependent's ineligibility event, the dependent will be retroactively removed the first of the month following the dependent's ineligibility event, and the coverage ~~type~~ category change will be the first of the month following written notification, except in cases of death, in which case the coverage ~~type~~ category change will be made retroactive to the first of the month following the death.

(5) Employees not adding dependents when first eligible may enroll later on the first of any following month, but dependents will be subject to a 12-month waiting period for preexisting health conditions except as provided in subdivision (a)(3) of this section.

(6) Employees or retired employees who wish to change to employee only coverage ~~from family to parent/child(ren) or individual coverage or from parent/child(ren) to individual coverage,~~ even though their dependents continue to be eligible, shall give written notification to their Health Benefits Representative. ~~Effective~~ Except as otherwise required by applicable federal law, the date of this ~~type~~ category change will be the first of the month following written notification or any first of the month thereafter as desired by the employee.

(7) The effective date for newborns or adopted children will be date of birth, date of adoption, or placement with adoptive parent provided member is currently covered under ~~a family or parent/child(ren) coverage.~~ employee and family or employee and child coverage. If the member wishes to add a newborn or adopted child and is currently enrolled ~~on individual~~ in employee only coverage, the member must submit application for coverage and a coverage type change within 30 days of the child's birth or date of adoption or placement. Effective date for the coverage ~~type~~ category change is the first of the month in which the child is born, adopted, or placed. Adopted children may also be covered the first of the month following placement or adoption.

(d) ~~Types~~ Categories of Coverage Available. – There are ~~three~~ four ~~types~~ categories of coverage which an employee or retiree may elect.

(1) Employee Only. – Covers enrolled employees only. Maternity benefits are provided to employee only.

(2) Employee and ~~Child(ren).~~Child. – Covers enrolled employee and all eligible dependent children. Maternity benefits are provided to the employee only.

(3) Employee and Family. – Covers employee and spouse, and all eligible dependent children. Maternity benefits are provided to employee or enrolled spouse.

(4) Employee and spouse. Covers employee and spouse only. Maternity benefits are provided to the employee or the employee's enrolled spouse.

(e) Notwithstanding any other provision of this section, no coverage under the Plan shall become effective prior to the payment of premiums required by the Plan.

(f) ~~Firemen,~~Firefighters, rescue squad workers, and members of the national guard are subject to the same terms and conditions of this section as are employees. Eligible dependents of ~~firemen,~~firefighters, rescue squad workers, and members of the national guard are subject to the same terms and conditions of this section as are dependents of employees.

(g) Different categories of coverage may be offered for optional alternative plans or programs.

(h) If any provision of this section is in conflict with applicable federal law, federal law shall control to the extent of the conflict."

SECTION 3.(i) G.S. 135-40.3A is recodified as G.S. 135-39.17 under Part 3A of Article 3A of Chapter 135 of the General Statutes, as enacted by this act.

SECTION 3.(j) G.S. 135-40.5, as amended by Section 28.22 of S.L. 2007-323, and as further amended by Section 22.28A of S.L. 2007-323, is recodified as G.S. 135-39.18 under Part 3A of Article 3A of Chapter 135 of the General Statues, as enacted by this act, and as recodified, reads as rewritten:

"**§ 135-39.18. Benefits not subject to deductible or coinsurance.**

~~(c) Preadmission Testing. The Plan will pay one hundred percent (100%) of reasonable and customary charges for diagnostic, laboratory and x-ray examinations performed on an outpatient basis.~~

~~(f)~~(a) Immunizations. – The Plan will pay one hundred percent (100%) of allowable medical charges for immunizations for the prevention of contagious diseases as generally accepted medical practices would dictate when directed by ~~an attending physician.~~a credentialed provider as determined by the claims processor.

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

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) for each preferred branded prescription, and forty dollars ($40.00) for each preferred branded prescription with a generic equivalent drug, and fifty dollars ($50.00) for each nonpreferred branded or generic prescription. These co-payments apply to ~~the Plan's optional programs.~~all optional alternative plans available under the Plan.

Allowable charges shall not be greater than a pharmacy's usual and customary charge to the general public for a particular prescription. Prescriptions shall be for no more than a 34-day supply for the purposes of the copayments paid by each covered individual. By accepting the copayments and any remaining allowable charges provided by this subsection, pharmacies shall not balance bill an individual covered by the Plan. A prescription legend drug is defined as an article the label of which, under the Federal Food, Drug, and Cosmetic Act, is required to bear the legend: "Caution: Federal Law Prohibits Dispensing Without Prescription." Such articles may not be sold to or purchased by the public without a prescription order. Benefits are provided for insulin even though a prescription is not required. The Plan may use a pharmacy benefit manager to help manage the Plan's outpatient prescription drug coverage. In managing the Plan's outpatient prescription drug benefits, the Plan and its pharmacy benefit manager shall not provide coverage for ~~erectile~~ 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. Any formulary used by the Plan's Executive Administrator and pharmacy benefit manager shall be an open formulary. Plan members shall not be assessed more than two thousand five hundred dollars ($2,500) per person per fiscal year in copayments required by this subsection.

SECTION 3.(k) G.S. 135-40.6A is repealed.

SECTION 3.(l) Part 3A of Article 3A of Chapter 135 of the General Statutes is amended by adding the following new section to read:

"**§ 135-39.19. Prior approval procedures.**

The Executive Administrator and Board of Trustees may establish procedures to require prior medical approval and may implement the procedures after consultation with the Committee on Employee Hospital and Medical Benefits."

SECTION 3.(m) Effective July 1, 2008, G.S. 135-40.7, as amended by Section 28.22A(j) of S.L. 2007-323, is recodified as G.S. 135-39.20 under Part 3A of Article 3A of Chapter 135 of the General Statutes, as enacted by this act, and, as recodified, reads as rewritten:

"**§ 135-39.20. General limitations and exclusions.**

The following shall in no event be considered covered expenses nor will benefits described in ~~G.S. 135-40.5 through G.S. 135-40.11~~G.S. 135-39.18 through G.S. 135-39.23 be payable for:

(1) Charges for any services rendered to a person prior to the date coverage under this Plan becomes effective with respect to such person.

(2) Charges for care in a nursing home, adult care home, convalescent home, or in any other facility or location for custodial or for rest cures.

(3) Charges to the extent paid, or which the individual is entitled to have paid, or to obtain without cost, in accordance with any government laws or regulations except Medicare. If a charge is made to any such

person which he or she is legally required to pay, any benefits under this Plan will be computed in accordance with its provisions, taking into account only such charge. "Any government" includes the federal, State, provincial or local government, or any political subdivision thereof, of the United States, Canada or any other country.

(4) Charges for services rendered in connection with any occupational injury or disease arising out of and in the course of employment with any employer, if (i) the employer furnishes, pays for or provides reimbursement for such charges, or (ii) the employer makes a settlement payment for such charges, or (iii) the person incurring such charges waives or fails to assert his or her rights respecting such charges.

(5) Charges for any care, treatment, services or supplies other than those which are certified by a physician who is attending the individual as being required for the medically necessary treatment of the injury or disease and are deemed medically necessary and appropriate for the treatment of the injury or disease by the Executive Administrator and Board of Trustees upon the advice of the Claims Processor. This subdivision shall not be construed, however, to require certification by an attending physician for a service provided by an advanced practice registered nurse acting within the nurse's lawful scope of ~~practice, subject to the limitations of G.S. 135-40.6(10).~~practice.

(6) Charges for any services rendered as a result of injury or sickness due to an act of war, declared or undeclared, which act shall have occurred after the effective date of a person's coverage under the Plan.

(7) Charges for personal services such as barber services, guest meals, radio and TV rentals, etc.

(8) Charges for any services with respect to which there is no legal obligation to pay. For the purposes of this item, any charge which exceeds the charge that would have been made if a person were not covered under this Plan shall, to the extent of such excess, be treated as a charge for which there is no legal obligation to pay; and any charge made by any person for anything which is normally or customarily furnished by such person without payment from the recipient or user thereof shall also be treated as a charge for which there is no legal obligation to pay.

(9) Charges during a continuous hospital confinement which commenced prior to the effective date of the person's coverage under this Plan.

(10) Charges in excess of either ~~the usual, customary and reasonable charge for~~ the allowed amount or the reasonable amount, or the fair and reasonable value of the services or supply which gives rise to the expense; provided that in each instance the extent that a particular charge is usual, customary and reasonable or fair and reasonable shall be measured and determined by comparing the charge with charges

made for similar things to individuals of similar age, sex, income and medical condition in the locality concerned, and the result of such determination shall constitute the maximum allowable as covered medical expenses unless the Claims Processor finds that considerations of fairness and equity in a particular set of circumstances require that greater or lesser charges be considered as covered medical expenses in that set of circumstances.

(11) Charges for or in connection with any dental work or dental treatment except to the extent that such work or treatment is specifically provided for under the Plan. Excluded is payment for surgical benefits for tooth replacement, such as crowns, bridges or dentures; orthodontic care; filling of teeth; extraction of teeth (whether or not impacted); root canal therapy; removal of root tips from teeth; treatment for tooth decay; inflammation of gingiva, or surgical procedures on diseased gingiva or other periodontal surgery; repositioning soft tissue, reshaping bone, and removal of bony projections from the ridges preparatory to fitting of dentures; removal of cysts incidental to removal of root tips from teeth and extraction of teeth; or other dental procedures involving teeth and their bones or tissue supporting structure.

(12) Charges incurred for any medical observations or diagnostic study when no disease or injury is revealed, unless proof satisfactory to the Claims Processor is furnished that (i) the claim is in order in all other respects, (ii) the covered individual had a definite symptomatic condition of disease or injury other than hypochondria, and (iii) the medical observation and diagnostic studies concerned were not undertaken as a matter of routine physical examination or health ~~checkup as provided in G.S. 135-40.6(8)s.~~checkup.

(13) Charges for 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.

(14) Charges for cosmetic surgery or treatment except that charges for cosmetic surgery or treatment required for correction of damage caused by accidental injury sustained by the covered individual while coverage under this plan is in force on his or her account or to correct congenital deformities or anomalies shall not be excluded if they otherwise qualify as covered medical expenses. Reconstructive breast surgery following mastectomy, as those terms are defined in G.S. 58-51-62, is not "cosmetic surgery or treatment" for purposes of this section.

(15) Admissions for diagnostic tests or procedures which could be, and generally are, performed on an outpatient basis and inpatient services or supplies which are not consistent with the diagnosis, for which admitted.

(16) Costs denied by the Claims Processor as part of its overall program of claim review and cost containment.

~~(16a)~~(17) Charges in excess of negotiated rates allowed for preferred providers of institutional and professional medical care and ~~services in accordance with the provisions of G.S. 135-40.4,~~ services, when such preferred providers are reasonably available to provide institutional and professional medical care.

~~(17)~~(18) If a covered service becomes excluded from coverage under the Plan, the Executive Administrator and Claims Processor may, in the event of exceptional situations creating undue hardships or adverse medical conditions, allow persons enrolled in the Plan to remain covered by the Plan's previous coverage for up to three months after the effective date of the change in coverage, provided the persons so enrolled had been undergoing a continuous plan of specific treatment initiated within three months prior to the effective date of the change in coverage.

~~(18)~~(19) Charges for services unless a claim is filed within 18 months from the date of service.

~~(19)~~(20) Any service, treatment, facility, equipment, drug, supply, or procedure that is experimental or investigational as defined ~~in G.S. 135-40.1(7a).~~ by the Plan. Clinical trial phases III and IV are covered by the Plan as is clinical trial phase II when approved by the Plan. Regardless of the type of trial phases covered by the Plan, all covered trials must involve the treatment of life-threatening medical conditions, must be clearly superior to available noninvestigational treatment alternatives, and must have clinical and preclinical data that shows the trials will be at least as effective as noninvestigational alternatives. Trials must also involve determinations by treating physicians, relevant scientific data, and opinions of experts in relevant fields of medicine. Covered trials must be approved by the National Institutes of Health, a National Institutes of Health cooperative group or center, the U.S. Food and Drug Administration, the U.S. Department of Defense, or the U.S. Department of Veterans Affairs. The Plan may also cover clinical trials sponsored by other entities. Trials must also be approved by applicable qualified institutional review boards. All covered trials must be conducted in and by facilities and personnel that maintain a high level of expertise because of their training, experience, and volume of patients. To be covered by the Plan, patients participating in clinical trials must meet substantially all protocol requirements of the trials and exercise informed consent in the trials. Only medically necessary costs of health care services involved in treatments provided to patients for the purpose of the trials are covered by the Plan to the extent that such costs are not customarily funded by national agencies, commercial manufacturers,

distributors, or other such providers. Clinical trial costs not covered by the Plan include, but are not limited to, the costs of services that are not health care services and costs associated with managing research in the trials. The Plan shall not exclude benefits for covered clinical trials if the proposed treatment is the only appropriate protocol for the condition being treated.

~~(20)~~(21) Complications arising from noncovered ~~services known at the time the noncovered services were provided.~~services.

~~(21)~~(22) Charges related to a noncovered service, even if the charges would have been covered if rendered in connection with a covered service.

~~(22)~~(23) Charges for services covered by the long-term care benefit provisions of ~~Part 4~~Part 4A of this Article.

~~(23)~~(24) Charges disallowed by the Plan's pharmacy benefits manager."

SECTION 3.(n) G.S. 135-40.7B, as amended by Section 28.22(f) of S.L. 2007-323, and as further amended by Section 28.22A(o) of S.L. 2007-323, is recodified as G.S. 135-39.21 under Part 3A of Article 3A of Chapter 135 of the General Statutes, as enacted by this act, and as recodified, reads as rewritten:

"**§ 135-39.21. Special provisions for chemical dependency and mental health benefits.**

(a) Except as otherwise provided in this section, benefits for the treatment of mental illness and chemical dependency are covered by the Plan and shall be subject to the same deductibles, durational limits, and coinsurance factors as are benefits for physical illness generally.

(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 ~~under~~ 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;
   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;~~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;

b. Licensed chemical dependency hospitals;
c. Licensed chemical dependency treatment facilities;
d. Area Mental Health, Developmental Disabilities, and Substance Abuse ~~Authorities;~~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.

(c) Notwithstanding any other provisions of this Part, the following providers and no others may provide necessary care and treatment for mental health under this section:

(1) Psychiatrists who have completed a residency in psychiatry approved by the American Council for Graduate Medical Education and who are licensed as medical doctors or doctors of osteopathy in the state in which they perform and services covered by the Plan;
(2) Licensed ~~or certified~~ doctors of psychology;
(3) ~~Certified clinical~~Clinical social workers licensed or certified by the North Carolina Social Work Certification and Licensure Board under Chapter 90B of the General Statutes.~~and licensed clinical social workers;~~
~~(3a)~~(4)Licensed professional counselors;
~~(4)~~(5) Certified clinical specialists in psychiatric and mental health ~~nursing;~~ nursing in accordance with Article 9A of Chapter 90 of the General Statutes;
~~(4a)~~(6)Nurses working under the employment and direct supervision of such physicians, psychologists, or psychiatrists;
~~(6)~~(7) Licensed psychological associates;
~~(9)~~(8) Certified fee-based practicing pastoral ~~counselors;~~counselors in accordance with Article 26 of Chapter 90 of the General Statutes;
~~(10)~~(9) Licensed physician assistants under the supervision of a licensed psychiatrist and acting pursuant to G.S. 90-18.1 or the applicable laws and rules of the area in which the physician assistant is licensed or certified; and
~~(11)~~(10)Licensed marriage and family therapists.
(11) Physicians licensed under Chapter 90 of the General Statutes and certified professionals with training and experience in the care and treatment for mental health and working under the direct supervision of such physicians.

~~(c1)~~(d) Notwithstanding any other provisions of this Part, the following providers and no others may provide necessary care and treatment for chemical dependency under this section:

(1) The following providers with appropriate substance abuse training and experience in the field of alcohol and other drug abuse as determined by the mental health case manager, in facilities described in

subdivision (b)(2) of this section, in day/night programs or outpatient treatment facilities licensed after July 1, 1984, under Article 2 of Chapter 122C of the General Statutes or in North Carolina area programs in substance abuse services are authorized to provide treatment for chemical dependency under this section:

a. Licensed physicians including, but not limited to, physicians who are certified in substance abuse by the American Society of Addiction Medicine (ASAM);
b. Licensed ~~or certified~~ psychologists;
c. Psychiatrists;
d. Certified substance abuse counselors working under the direct supervision of such physicians, psychologists, or psychiatrists;
e. Licensed psychological associates;
f. Nurses working under the direct supervision of such physicians, psychologists, or psychiatrists;
g. ~~Certified clinical social workers and licensed clinical social workers;~~Clinical social workers licensed or certified by the North Carolina Social Work Certification and Licensure Board under Chapter 90B of the General Statutes;
h. Certified clinical specialists in psychiatric and mental health ~~nursing;~~nursing in accordance with Article 9A of Chapter 90 of the General Statutes;
i. Licensed professional counselors;
j. Certified fee-based practicing pastoral ~~counselors;~~counselors in accordance with Article 26 of Chapter 90 of the General Statutes;
k. Substance abuse professionals certified under Article 5C of Chapter 90 of the General Statutes; and
l. Licensed marriage and family and therapists.

(2) The following providers with appropriate substance abuse training and experience in the field of alcohol and other drug abuse as determined by the mental health case manager are authorized to provide treatment for chemical dependency in outpatient practice settings:

a. Licensed physicians including, but not limited to, physicians who are certified in substance abuse by the American Society of Addiction Medicine (ASAM);
b. Licensed ~~or certified~~ psychologists;
c. Psychiatrists;
d. Certified substance abuse counselors working under the direct supervision of such physicians, psychologists, or psychiatrists;
e. Licensed psychological associates;
f. Nurses working under the direct supervision of such physicians, psychologists, or psychiatrists;

g. ~~Certified clinical social workers and licensed clinical social workers;~~ Clinical social workers licensed or certified by the North Carolina Social Work Certification and Licensure Board under Chapter 90B of the General Statutes.

h. Certified clinical specialists in psychiatric and mental health ~~nursing;~~ nursing in accordance with Article 9A of Chapter 90 of the General Statutes;

i. Licensed professional counselors;

j. Certified fee-based practicing pastoral ~~counselors;~~counselors in accordance with Article 26 of Chapter 90 of the General Statutes;

~~j1.~~(k) Licensed marriage and family and therapists;

1. Substance abuse professionals certified under Article 5C of Chapter 90 of the General Statutes;and

~~k.~~(m) In the absence of meeting one of the criteria above, the Mental Health Case Manager could consider, on a case-by-case basis, a provider who supplies:

1. Evidence of graduate education in the diagnosis and treatment of chemical dependency, and
2. Supervised work experience in the diagnosis and treatment of chemical dependency (with supervision by an appropriately credentialed provider), and
3. Substantive past and current continuing education in the diagnosis and treatment of chemical dependency commensurate with one's profession.

(3) Physicians licensed under Chapter 90 of the General Statutes and certified professionals with training and experience in the care and treatment for chemical dependency and working under the direct supervision of such physicians.

Provided, however, that nothing in this subsection shall prohibit the Plan from requiring the most cost-effective treatment setting to be utilized by the person undergoing necessary care and treatment for chemical dependency.

~~(d)~~(e) Benefits provided under this section shall be subject to a case management program for medical necessity and medical appropriateness consisting of (i) precertification of outpatient visits beyond 26 visits each Plan year, (ii) all electroconvulsive treatment, (iii) inpatient utilization review through preadmission and length-of-stay certification for nonemergency admissions to the following levels of care: inpatient units, partial hospitalization programs, residential treatment centers, chemical dependency detoxification and treatment programs, and intensive outpatient programs, (iv) length-of-stay certification of emergency inpatient admissions, and (v) a network of qualified, available providers of inpatient and outpatient psychiatric and chemical dependency

treatment. Care which is not both medically necessary and medically appropriate will be noncertified, and benefits will be denied. ~~Where qualified preferred providers of inpatient and outpatient care are reasonably available, use of providers outside of the preferred network shall be subject to a twenty percent (20%) coinsurance rate up to five thousand dollars ($5,000) per fiscal year to be assessed against each covered individual in addition to the general coinsurance percentage and maximum fiscal year amount specified by G.S. 135-40.4 and G.S. 135-40.6.~~

~~(e)~~(f) For the purpose of this section, "emergency" is the sudden and unexpected onset of a condition manifesting itself by acute symptoms of sufficient severity that, in the absence of an immediate psychiatric or chemical dependency inpatient admission, could imminently result in injury or danger to self or others.

~~(f)~~(g) ~~For purposes of~~As used in this section, the word "Plan" includes all optional and alternative plans, and programs available under the optional or alternative plans, ~~or plans~~ in effect under the State Health Plan and its successor Plans."

SECTION 3.(o) G.S. 135-40.10 is recodified as G.S. 135-39.22 under Part 3A of Article 3A of Chapter 135 of the General Statutes, as enacted by this act, and, as recodified, reads as rewritten:

"**§ 135-39.22. Persons eligible for ~~Medicare.~~Medicare; optional participation in other Medicare products.**

(a) Benefits payable for covered expenses under this Plan in ~~G.S. 135-40.5~~G.S. 135-39.18 through ~~G.S. 135-40.9~~G.S. 135-39.22 will be reduced by any benefits payable for the same covered expenses under Medicare, so that Medicare will be the primary carrier except where compliance with federal law specifies otherwise.

(b) For those participants eligible for Medicare, the ~~State's plan~~Plan will be administered on a "carve out" basis. The provisions of the ~~plan~~ Plan are applied to the charges not paid by Medicare (Parts A & B). In other words, those charges not paid by Medicare would be subject to the deductible and coinsurance of the Plan just as if the charges not paid by Medicare were the total bill.

(c) For those individuals eligible for Part A (at no cost to them), benefits under this program will be reduced by the amounts to which the covered individuals would be entitled to under Parts A and B of Medicare, even if they choose not to enroll for Part B.

(d) Notwithstanding the foregoing provisions of this section or any other provisions of the Plan, the Executive Administrator and Board of Trustees may enter into negotiations with the ~~Health Care Financing Administration,~~ Centers for Medicare and Medicaid Services, U.S. Department of Health and Human Services, in order to secure a more favorable coordination of the Plan's benefits with those provided by Medicare, including but not limited to, measures by which the Plan would provide Medicare benefits for all of its Medicare-eligible members in return for adequate payments from the federal government in providing such benefits. Should such negotiations result in an agreement favorable to the Plan and its Medicare-eligible members, the Executive Administrator and Board of Trustees may, after consultation

with the Committee on Employee Hospital and Medical Benefits, implement such an agreement which shall supersede all other provisions of the Plan to the contrary related to its payment of claims for Medicare-eligible members.

(e) Notwithstanding subsections (a), (b), and (c) of this section, the Plan may offer an optional Medicare Advantage plan to a Medicare eligible Plan member. A Medicare Advantage plan offered by the Plan shall be an insured product offered through a private insurance carrier authorized by the Centers for Medicare and Medicaid Services to offer Medicare Advantage plans. A Medicare Advantage plan offered by the Plan shall not be a self-funded benefit plan underwritten by the State of North Carolina. Prescription drug benefits shall not be included in the benefits offered under a Medicare Advantage insurance product but shall continue to be provided by the Plan as authorized under G.S. 135-39.18

An eligible Plan member may choose to enroll in a Medicare Advantage plan in lieu of any other benefit coverage plan offered under the Plan to Medicare eligible Plan members. A Medicare eligible Plan member must be enrolled in Medicare Part B to participate in an optional Medicare Advantage plan. A non-Medicare eligible dependent of a Medicare Advantage eligible Plan member may enroll on a fully contributory basis in benefit plans offered under the Plan to non-Medicare eligible Plan members. If an enrolled Plan member decides not to re-enroll in an optional Medicare Advantage plan during the Plan's annual enrollment period, the Plan member may at that time re-enroll in other benefit coverage offered by the Plan in accordance with the provisions of subsections (a), (b), and (c) of this section."

SECTION 3.(p) Part 3A of Article 3A of Chapter 135 of the General Statutes, as enacted by this act, is amended by adding the following new section to read:

"**§ 135-39.23. Cost-savings initiatives and incentive programs authorized.**

(a) Cost-Saving Initiatives. – Coverage of Over-the-Counter Medications. – The Executive Administrator and Board of Trustees may authorize coverage for over-the-counter medications as recommended by the Plan's pharmacy and therapeutics committee. In approving for coverage one or more over-the-counter medications, the Executive Administrator and Board of Trustees shall ensure that each recommended over-the-counter medication has been analyzed to ensure medical effectiveness and Plan member safety. The analysis shall also address the financial impact on the Plan. The Executive Administrator and Board of Trustees may impose a co-payment to be paid by each covered individual for each packaged over-the-counter medication. The Executive Administrator and Board of Trustees may adopt policies establishing limits on the amount of coverage available for over-the-counter medications for each covered individual over a 12-month period. Prior to implementing policy and co-payment changes authorized under this section, the Executive Administrator and Board of Trustees shall submit the proposed policies and co-payments to the Committee on Employee Hospital and Medical Benefits for its review.

(b) Incentive Programs. – For the purposes of helping Plan members to achieve and maintain a healthy lifestyle without impairing patient care, and to increase cost effectiveness in Plan coverage, the Executive Administrator and Board of Trustees may adopt programs offering incentives to Plan members to encourage changes in member

behavior or lifestyle designed to improve member health and promote cost-efficiency in the Plan. Participation in one or more incentive programs is voluntary on the part of the Plan member. Before adopting an incentive program, the Executive Administrator and Board of Trustees shall conduct an impact analysis on the proposed incentive program to determine (i) whether the program is likely to result in significant member satisfaction, (ii) that it will not adversely affect quality of care, and (iii) whether it is likely to result in significant cost savings to the Plan. The impact analysis may be conducted by a committee of the Plan, in conjunction with the Plan's consulting actuary, provided that the Plan's medical director participates in the analysis. An approved incentive plan may provide for a waiver of deductibles, co-payments, and coinsurance required under this Article in order to determine the effectiveness of the incentive program in promoting the health of members and increasing cost-effectiveness to the Plan. The Executive Administrator and Board of Trustees shall, before implementing incentive programs authorized under this section, submit the proposed programs to the Committee on Employee Hospital and Medical Benefits for review."

SECTION 3.(q) G.S. 135-40.11 is recodified as G.S. 135-39.24 under Part 3A of Article 3A of Chapter 135 of the General Statutes, as enacted by this act, and as recodified, reads as rewritten:

"**§ 135-39.24. Cessation of coverage.**

(a) Coverage under this Plan of an employee and his or her surviving spouse or eligible dependent children or of a retired employee and his or her surviving spouse or eligible dependent children shall cease on the earliest of the following dates:

(1) The last day of the month in which an employee or retired employee dies. Provided such surviving spouse or eligible dependent children were covered under the Plan at the time of death of the former employee or retired employee, or were covered on September 30, 1986, any such surviving spouse or eligible dependent children may then elect to continue coverage under the Plan by submitting written application to the Claims Processor and by paying the cost for such coverage when due at the applicable fees. Such coverage shall cease on the last day of the month in which such surviving spouse or eligible dependent children die, except as provided by this Article.

(2) The last day of the month in which an employee's employment with the State is terminated as provided in subsection (c) of this section.

(3) The last day of the month in which a divorce becomes final.

(4) The last day of the month in which an employee or retired employee requests cancellation of coverage.

(5) The last day of the month in which a covered individual enters active military service.

(6) The last day of the month in which a covered individual is found to have knowingly and willfully made or caused to be made a false statement or false representation of a material fact in a claim for reimbursement of medical services under the Plan. The Executive Administrator and Board of Trustees may make an exception to the

provisions of this subdivision when persons subject to this subdivision have had a cessation of coverage for a period of five years and have made a full and complete restitution to the Plan for all fraudulent claim amounts. Nothing in this subdivision shall be construed to obligate the Executive Administrator and Board of Trustees to make an exception as allowed for under this subdivision.

(7) The last day of the month in which an employee who is Medicare-eligible selects Medicare to be the primary payer of medical benefits. Coverage for a Medicare-eligible spouse of an employee shall also cease the last day of the month in which Medicare is selected to be the primary payer of medical benefits for the Medicare-eligible spouse. Such members are eligible to apply for conversion coverage.

(b) Coverage under this Plan as a dependent child ceases when the child ceases to be a dependent child as defined by ~~G.S. 135-40.1(3)~~G.S. 135-39.13 except, coverage may continue under this Plan for a period of not more than 36 months after loss of dependent status on a fully contributory basis provided the dependent child was covered under the Plan at the time of loss of dependent status.

~~(b1)~~(c) Coverage under the Plan as a surviving dependent child whether covered as a dependent of a surviving spouse, or as an individual member (no living parent), ceases when the child ceases to be a dependent child as defined by ~~G.S. 135-40.1(3),~~G.S. 135-39.13, except coverage may continue under the Plan on a fully contributory basis for a period of not more than 36 months after loss of dependent status.

~~(c)~~(d) Termination of employment shall mean termination for any reason, including layoff and leave of absence, except as provided in subdivisions (a)(1) and (2) of this section, but shall not, for purposes of this Plan, include retirement upon which the employee is granted an immediate service or disability pension under and pursuant to a State-supported Retirement System.

(1) In the event of termination for any reason other than death, coverage under the Plan for an employee and his or her eligible spouse or dependent children, provided the eligible spouse or dependent children were covered under the Plan at termination of employment may be continued for a period of not more than 18 months following termination of employment on a fully contributory basis. Employees who were covered under the Plan at termination of employment may be continued for a period of not more than 18 months or 29 months if determined to be disabled under the Social Security Act, Title II, OASDI or Title XVI, SSI.

~~(3)~~(2) In the event of approved leave of absence without pay, other than for active duty in the armed forces of the United States, coverage under this Plan for an employee and his or her dependents may be continued during the period of such leave of absence by the employee's paying one hundred percent (100%) of the cost.

~~(4)~~(3) If employment is terminated in the second half of a calendar month and the covered individual has made the required contribution for any coverage in the following month, that coverage will be continued to the end of the calendar month following the month in which employment was terminated.

~~(5)~~(4) Employees paid for less than 12 months in a year, who are terminated at the end of the work year and who have made contributions for the non-work months, will continue to be covered to the end of the period for which they have made contributions, with the understanding that if they are not employed by another State-covered employer under this Plan at the beginning of the next work year, the employee will refund to the ex-employer the amount of the employer's cost paid for them during the non-paycheck months.

~~(6)~~(5) Any employee receiving benefits pursuant to Article 6 of this Chapter when the employee has less than five years of retirement membership service, or an employee on leave of absence without pay due to illness or injury for up to 12 months, is entitled to continued coverage under the Plan for the employee and any eligible dependents by the employee's paying one hundred percent (100%) of the cost.

~~(d) No benefits will be paid by this Plan for any expenses incurred or treatment received after cessation of coverage as provided in subsections (a) or (b) of this section, except that in the event of hospital confinement at that time, hospitalization benefits as described in G.S. 135-40.6 will continue to the extent provided therein.~~

~~(e)~~(d) A legally divorced spouse and any eligible dependent children of a covered employee or retired employee may continue coverage under this Plan for a period of not more than 36 months following the first of the month after a divorce becomes final on a fully contributory basis, provided the former spouse and any eligible dependent children were covered under the Plan at the time a divorce became final.

~~(f)~~(e) A legally separated spouse of a covered employee or retired employee may continue coverage under this Plan for a period not to exceed 36 months from the separation date on a fully contributory basis, provided the separated spouse was covered under the Plan at the time of separation and provided the covered employee's or retired employee's actions result in the loss of coverage for the separated spouse. Eligible dependent children may also continue coverage if covered under the Plan at time of separation, provided the employee's or retired employee's actions result in the loss of coverage for the dependent children.

~~(g)~~(f) Whenever this section gives a right to continuation coverage, such coverage must be elected ~~no later than a date set by the Executive Administrator and Board of Trustees.~~within the time allowed by applicable federal law.

~~(h)~~(g) Continuation coverage under this Plan shall not be continued past the occurrence of any one of the following events:

(1) The termination of the Plan.

(2) Failure of a Plan member to pay monthly in advance any required premiums.

(3) A person becomes a covered employee or a dependent of a covered employee under any group health plan and that group health plan has no restrictions or limitations on benefits.

(4) A person becomes eligible for Medicare benefits on or after the effective date of the continuation coverage.

(5) The person was determined to be no longer disabled, provided the 18-month coverage was extended to 29 months due to having been determined to be disabled under the Social Security Act, Title II, OASDI or Title XVI, SSI.

(6) The person reaches the maximum applicable continuation period of 18, 29, or 36 months.

~~(i)~~(h) Notice requirements concerning continuation coverage shall be developed by the Executive Administrator and Board of Trustees.

~~(j)~~(i) The spouse and any eligible dependent children of a covered employee may continue coverage under the Plan on a fully contributory basis for a period not to exceed 36 months from the date the employee becomes eligible for Medicare benefits which results in a loss of coverage under the Plan, provided that the spouse and eligible dependent children were covered under the Plan at the time the employee became eligible for Medicare benefits which results in a loss of coverage under the Plan."

SECTION 3.(r) G.S. 135-40.12 is recodified as G.S. 135-39.25 under Part 3A of Article 3A of Chapter 135 of the General Statutes, as enacted by this act.

SECTION 3.(s) G.S. 135-40.13 is recodified as G.S. 135-39.26 under Part 3A of Article 3A of Chapter 135 of the General Statutes, as enacted by this act.

SECTION 3.(t) G.S. 135-40.13A is recodified as G.S. 135-39.27 under Part 3A of Article 3A of Chapter 135 of the General Statutes, as enacted by this act.

SECTION 3.(u) G.S. 135-40.14 is recodified as G.S. 135-39.28 under Part 3A of Article 3A of Chapter 135 of the General Statutes, as enacted by this act.

SECTION 3.(v) Effective July 1, 2008, the State Health Plan for Teachers and State Employees shall not limit the number of visits for covered services for physical therapy, occupational therapy, and speech therapy. This subsection expires July 1, 2009. Sections 28.22A(j) and (k) of S.L. 2007-323 are repealed.

SECTION 4.(a) Parts 4 and 5 of Article 3 of Chapter 135 of the General Statutes are recodified as Parts 4A and 5A, respectively, under Article 3A of Chapter 135 of the General Statutes, as enacted by this act.

SECTION 4.(b) G.S. 135-41, as amended by Section 28.22A(o) of S.L. 2007-323, is recodified under Part 4A of Article 3A of Chapter 135 of the General Statutes, as enacted by this act.

SECTION 4.(c) G.S. 135-41(b), as recodified by this act, and as amended by Section 28.22A(o) of S.L. 2007-323, reads as rewritten:

"(b) The long-term care benefits provided by this Part shall be made available through the State Health Plan for Teachers and State Employees pursuant to Article 2A and 3A of this Chapter (hereinafter called the "Plan") and administered by the Plan's Executive Administrator and Board of Trustees. In administering the benefits provided by this Part, the Executive Administrator and Board of Trustees shall have the same

type of powers and duties that are provided under ~~Part 3~~Part 3A of this Article for hospital and medical benefits. The benefits provided by this Part may be offered by the Plan on a self-insured basis, in which case a third-party claims processor shall be chosen through competitive ~~bids in accordance with State law;~~bids, or through a contract of insurance, in which case a carrier licensed to do business in North Carolina shall be selected on a competitive bid basis in accordance with State law."

SECTION 4.(d) G.S. 135-41.1 is recodified under Part 4A of Article 3A of Chapter 135 of the General Statutes, as enacted by this act.

SECTION 4.(e) The lead paragraph of G.S. 135-41.1, as recodified by this act under Part 4A of this Article, reads as rewritten:

"**§ 135-41.1. Long-term care benefits.**

Long-term care benefits provided by this Part are subject to elimination periods, coinsurance provisions, and other limitations separate and apart from those provided for in ~~Part 3~~ Part 3A of this Article. No limitation on out-of-pocket expenses are provided for the benefits covered by this section. Long-term care benefits are as follows:"

SECTION 5.(a) Effective July 1, 2008, G.S. 150B-1(d)(7), as amended by Section 28.22A(o) of S.L. 2007-323, reads as rewritten:

"(7) The State Health Plan for Teachers and State Employees in administering the provisions of ~~Parts 2, 3, 4, and 5 of Article 3~~ Article 3A of Chapter 135 of the General Statutes."

SECTION 5.(b) G.S. 150B-44 reads as rewritten:

"**§ 150B-44. Right to judicial intervention when decision unreasonably delayed.**

Unreasonable delay on the part of any agency or administrative law judge in taking any required action shall be justification for any person whose rights, duties, or privileges are adversely affected by such delay to seek a court order compelling action by the agency or administrative law judge. An agency that is subject to Article 3 of this Chapter and is not a board or commission has 60 days from the day it receives the official record in a contested case from the Office of Administrative Hearings to make a final decision in the case. This time limit may be extended by the parties or, for good cause shown, by the agency for an additional period of up to 60 days. An agency that is subject to Article 3 of this Chapter and is a board or commission has 60 days from the day it receives the official record in a contested case from the Office of Administrative Hearings or 60 days after its next regularly scheduled meeting, whichever is longer, to make a final decision in the case. This time limit may be extended by the parties or, for good cause shown, by the agency for an additional period of up to 60 days. If an agency subject to Article 3 of this Chapter has not made a final decision within these time limits, the agency is considered to have adopted the administrative law judge's decision as the agency's final decision. Failure of an agency subject to Article 3A of this Chapter to make a final decision within 120 days of the close of the contested case hearing is justification for a person whose rights, duties, or privileges are adversely affected by the delay to seek a court order compelling action by the agency or, if the case was heard by an administrative law judge, by the administrative law judge. The Board of Trustees of the North Carolina State Health Plan for Teachers and State Employees is a "board" for purposes of this section."

SECTION 6. Section 31.24 of S.L. 2004-124 is repealed.

SECTION 7. This act becomes effective July 1, 2008.

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2007

H 2

HOUSE BILL 2443*
Committee Substitute Favorable 6/30/08

Short Title: State Health Plan. (Public)

Sponsors:

Referred to:

May 26, 2008

A BILL TO BE ENTITLED

AN ACT TO REWRITE GENERAL STATUTE PROVISIONS PERTAINING TO HEALTH AND LONG-TERM CARE BENEFITS FOR TEACHERS, STATE EMPLOYEES, RETIRED STATE EMPLOYEES, AND THEIR ELIGIBLE DEPENDENTS, AND PERTAINING TO THE NORTH CAROLINA HEALTH CHOICE PROGRAM.

The General Assembly of North Carolina enacts:

SECTION 1.(a) Effective July 1, 2008, Article 3 of Chapter 135 of the General Statutes is recodified as Article 3A of Chapter 135 of the General Statutes.

SECTION 1.(b) Effective July 1, 2008, the title of Article 3A of Chapter 135 of the General Statutes, as enacted by this act, reads as rewritten:

"~~Other Teacher, Employee Benefits; Child Health Benefits.~~

Other Benefits for Teachers, State Employees, Retired State Employees, and Child Health."

SECTION 1.(c) Effective July 1, 2008, Part 1 of Article 3A of Chapter 135 of the General Statutes, as enacted by this act, is recodified as Part 1A of Article 3A of Chapter 135 of the General Statutes.

SECTION 1.(d) Effective July 1, 2008, G.S. 135-37, as amended by Section 28.22A of S.L. 2007-323, is recodified as G.S. 135-37.1 under Part 1A of Article 3A of Chapter 135 of the General Statutes, as enacted by this act, and as recodified, reads as rewritten:

"**§ 135-37.1. Confidentiality of information and medical records; provider contracts.**

(a) Any information as herein described in this section which is in the possession of the Executive Administrator and the Board of Trustees of the State Health Plan for Teachers and State Employees or its Claims Processor under the Plan or the Predecessor Plan shall be confidential and shall be exempt from the provisions of Chapter 132 of the General Statutes or any other provision requiring information and records held by State agencies to be made public or accessible to the public. This section shall apply to all

information concerning individuals, including the fact of coverage or noncoverage, whether or not a claim has been filed, medical information, whether or not a claim has been paid, and any other information or materials concerning a plan participant. Provided, however, such information may be released to the State Auditor, or to the Attorney General, or to the persons designated under G.S. 135-39.3 in furtherance of their statutory duties and responsibilities, or to such persons or organizations as may be designated and approved by the Executive Administrator and Board of Trustees of the Plan, but any information so released shall remain confidential as stated above and any party obtaining such information shall assume the same level of responsibility for maintaining such confidentiality as that of the Executive Administrator and Board of Trustees of the State Health Plan for Teachers and State Employees.

(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 plans or programs,~~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. Provided, however, nothing in this subsection shall be deemed 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, and the Committee on Employee Hospital and Medical Benefits solely and exclusively for their use in the furtherance of their duties and responsibilities. The design, adoption, and implementation of the preferred provider contracts, networks, and ~~optional plans or programs~~ optional alternative comprehensive health benefit plans, and programs available under the optional alternative plans, as authorized under G.S. 135-40 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 on its progress in negotiating the preferred provider contracts.~~Benefits."

SECTION 1.(e) Effective July 1, 2008, G.S. 135-38 is recodified as G.S. 135-37.2 under Part 1A of Article 3A of Chapter 135 of the General Statutes, as enacted by this act, and as recodified, reads as rewritten:

"**§ 135-37.2. Committee on Employee Hospital and Medical Benefits.**

(a) The Committee on Employee Hospital and Medical Benefits shall consist of 12 members as follows:

(1) The President Pro Tempore of the Senate or a designee thereof;

~~(2a)~~(2)The Speaker of the House of Representatives or a designee thereof;

~~(3a)~~(3)Five members of the Senate appointed by the President Pro Tempore of the Senate; and

~~(4a)~~(4)Five members of the House of Representatives appointed by the Speaker.

(b) The President Pro Tempore of the Senate and the Speaker of the House of Representatives, or their designees, shall remain on the Committee for the duration of their terms in those offices. Terms of the other Committee members are for two ~~years and begin on January 15 of each odd-numbered year, except the terms of the initial members, which begin on appointment and expire January 14, 1997.~~years. Members may complete a term of service on the Committee even if they do not seek reelection or are not reelected to the General Assembly, but resignation or removal from service in the General Assembly constitutes resignation or removal from service on the Committee. Members shall serve until their successors are appointed.

(c) The Committee shall review programs of hospital, medical and related care provided by ~~Part 3 and~~ Part 3A and Part 5 of this Article and programs of long-term care benefits provided by ~~Part 4~~Part 4A of this Article as recommended by the Executive Administrator and Board of Trustees of the Plan. The Executive Administrator and the Board of Trustees shall provide the Committee with any information or assistance requested by the Committee in performing its duties under this Article. The Committee shall meet not less than once each quarter to review the actions of the Executive Administrator and Board of Trustees. At each meeting, the Executive Administrator shall report to the Committee on any administrative and medical policies which have been issued as rules ~~and regulations~~ in accordance with ~~G.S. 135-39.8,~~G.S. 135-38.11 and on any benefit denials, resulting from the policies, which have been appealed to the Board of Trustees.

(d) The time members spend on Committee business shall be considered official legislative business for purposes of G.S. 120-3."

SECTION 1.(f) G.S. 135-38.1, as amended by Section 28.22A(o) of S.L. 2007-323, is recodified under Part 1A of Article 3A of Chapter 135 of the General Statutes, as enacted by this act.

SECTION 2.(a) Effective July 1, 2008, Part 2 of Article 3A of Chapter 135 of the General Statutes, as enacted by this act, is recodified as Part 2A of Article 3A of Chapter 135 of the General Statutes.

SECTION 2.(b) Effective July 1, 2008, G.S. 135-39.3, as amended by S.L. 2007-323(o), is recodified as G.S. 135-37.3 under Part 2A of Article 3A of Chapter 135 of the General Statutes, as enacted by this act, and as recodified, reads as rewritten:

"**§ 135-37.3. Oversight team.**

(a) The Committee on Employee Hospital and Medical Benefits may use employees of the Legislative Services Office and may employ contractual services as approved by the Legislative Services Commission to monitor the Executive Administrator and Board of Trustees, the Claims Processor, and the State Health Plan for Teachers and State Employees. The Director of the Budget may use employees of the Office of State Budget and Management to monitor the Executive Administrator and Board of Trustees, the Claims Processor, and the State Health Plan for Teachers and

State Employees. ~~Such assistance~~ Employees authorized by the Legislative Services Commission and the Director of the Budget to provide assistance to the Committee on Employee Hospital and Medical Benefits and to the Director of the Budget shall comprise an oversight team.

(b) The oversight team shall, jointly or individually, have access to all records of the Board of Trustees, the Executive Administrator, the Claims Processor, and the ~~Comprehensive Major Medical~~ Plan. ~~They~~ The oversight team shall, jointly or individually, be entitled to attend all meetings of the Board of Trustees.

(c) The oversight team shall report to the Committee on Employee Hospital and Medical Benefits when requested by the Committee."

SECTION 2.(c) G.S. 135-39.9 is recodified as G.S. 135-37.4 under Part 2A of Article 3A of Chapter 135 of the General Statutes, as enacted by this act, and as recodified, reads as rewritten:

"**§ 135-37.4. Reports to the General Assembly.**

~~(a)~~ The Executive Administrator and Board of Trustees shall report to the General Assembly at such times and in such forms as shall be ~~provided~~ designated by the Committee on Employee Hospital and Medical Benefits."

SECTION 2.(d) G.S. 135-39.11 is recodified as G.S. 135-37.5 under Part 2A of this Article, as enacted by this act, and as recodified, reads as rewritten:

"**§ 135-37.5. ~~Contract disputes.~~Contract disputes not contested case under the Administrative Procedure Act, Chapter 150B of the General Statutes.**

A dispute involving the performance, terms, or conditions of a contract between the Plan and an entity under contract with the Plan is not a contested case under Article 3 of Chapter 150B of the General Statutes."

SECTION 2.(e) G.S. 135-39, as amended by Section 28.22A(o) of S.L. 2007-323, is recodified as G.S. 135-38.2 under Part 2A of Article 3A of Chapter 135 of the General Statutes, as enacted by this act, and as recodified, reads as rewritten:

"**§ 135-38.2. Board of Trustees established.**

(a) There is ~~hereby~~ established the Board of Trustees of the State Health Plan for Teachers and State Employees ("Board").

~~(a1)~~(b)The Board shall consist of nine members.

~~(b)~~(c) Three members shall be appointed by the Governor. ~~Of the initial members, one shall serve a term to expire June 30, 1983, and two shall serve terms to expire June 30, 1984. Subsequent terms~~Terms shall be for two years. Vacancies shall be filled by the Governor. Of the members appointed by the Governor, one shall be either:

(1) An employee of a State department, agency, or institution;
(2) A teacher employed by a North Carolina public school system;
(3) A retired employee of a State department, agency, or institution; or
(4) A retired teacher from a North Carolina public school system.

~~(c)~~(d) Three members shall be appointed by the General Assembly upon the recommendation of the Speaker of the House of Representatives in accordance with G.S. 120-121. ~~Of the initial members, two shall serve terms expiring June 30, 1983, and one shall serve a term expiring June 30, 1984.~~Terms shall be for two years. Vacancies shall be filled in accordance with G.S. 120-122.

~~(d)~~(e) Three members shall be appointed by the General Assembly upon the recommendation of the President Pro Tempore of the Senate in accordance with G.S. 120-121. ~~Of the initial members, two shall serve terms expiring June 30, 1983, and one shall serve a term expiring June 30, 1984.~~Terms shall be for two years. Vacancies shall be filled in accordance with G.S. 120-122.

~~(e)~~(f) ~~The Governor shall have the power to remove any member appointed by him under subsection (b). The General Assembly may remove any member appointed under subsections (c) or (d).~~Each appointing authority may remove any member appointed by that appointing authority.

~~(f)~~(g) The members of the Board of Trustees shall receive one hundred dollars ($100.00) per day, except employees eligible to enroll in the Plan, whenever the full Board of Trustees holds a public session, and travel allowances under G.S. 138-6 when traveling to and from meetings of the Board of Trustees or hearings under ~~G.S. 135-39.7,~~G.S. 135-38.10, but shall not receive any subsistence allowance or per diem under G.S. 138-5, except when holding a meeting or hearing where this section does not provide for payment of one hundred dollars ($100.00) per day.

(h) No member of the Board of Trustees may serve more than three consecutive two-year terms.

(i) Meetings of the Board of Trustees may be called by the Executive Administrator, the ~~Chairman,~~Chair, or by any three members."

SECTION 2.(f) G.S. 135-39.2 is recodified as G.S. 135-38.3 under Part 2A of Article 3A of Chapter 135 of the General Statutes, as enacted by this act, and as recodified, reads as rewritten:

"**§ 135-38.3. Officers, quorum, meetings.**

(a) The Board of Trustees shall elect from its own membership such officers as it sees fit.

(b) Six 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.

(c) Meetings may be called by the ~~Chairman,~~Chair, or at the written request of three members."

SECTION 2.(g) G.S. 135-39.1, as amended by Section 28.22A(o) of S.L. 2007-323, is recodified as G.S. 135-38.4 under Part 2A of Article 3A of Chapter 135 of the General Statutes, as enacted by this act.

SECTION 2.(h) G.S. 135-39.4A, as amended by Section 28.22A of S.L. 2007-323, is recodified as G.S. 135-38.5 under Part 2A of Article 3A of Chapter 135 of the General Statutes as enacted by this act, and as recodified, reads as rewritten:

"**§ 135-38.5. Executive Administrator.**

(a) The Plan shall have an Executive Administrator and a Deputy Executive Administrator. The Executive Administrator and the Deputy Executive Administrator positions are exempt from the provisions of Chapter 126 of the General Statutes as provided in G.S. 126-5(c1).

(b) The Executive Administrator shall be appointed by the Commissioner of Insurance. The term of employment and salary of the Executive Administrator shall be

set by the Commissioner of Insurance upon the advice of an executive committee of the Committee on Employee Hospital and Medical Benefits.

The Executive Administrator may be removed from office by the Commissioner of Insurance, upon the advice of an executive committee of the Committee on Employee Hospital and Medical Benefits, and any vacancy in the office of Executive Administrator may be filled by the Commissioner of Insurance with the term of employment and salary set upon the advice of an executive committee of the Committee on Employee Hospital and Medical Benefits.

~~(f)~~(c) The Executive Administrator shall appoint the Deputy Executive Administrator and may employ such clerical and professional staff, and such other assistance as may be necessary to assist the Executive Administrator and the Board of Trustees in carrying out their duties and responsibilities under this Article. The Executive Administrator may designate managerial, professional, or policy-making positions as exempt from the State Personnel Act. The Executive Administrator may also negotiate, renegotiate and execute contracts with third parties in the performance of ~~his~~ the Executive Administrator's duties and responsibilities under this Article; provided any contract negotiations, renegotiations and execution with a Claims Processor, with ~~an optional hospital and medical benefit plan or program authorized under G.S. 135-40,~~ an optional alternative comprehensive health benefit plan, or program thereunder, authorized under G.S. 135-39.12, with a preferred provider of institutional or professional hospital and medical care, or with a pharmacy benefit manager shall be done only after consultation with the Committee on Employee Hospital and Medical Benefits.

~~(g)~~(d) The Executive Administrator shall be responsible for:

(1) Cost management programs;
(2) Education and illness prevention programs;
(3) Training programs for Health Benefit Representatives;
(4) Membership functions;
(5) Long-range planning;
(6) Provider and participant relations; and
(7) Communications.

Managed care practices used by the Executive Administrator in cost management programs are subject to the requirements of G.S. 58-3-191, 58-3-221, 58-3-223, 58-3-235, 58-3-240, 58-3-245, 58-3-250, 58-3-265, 58-67-88, and 58-50-30.

~~(h)~~(e) The Executive Administrator shall make reports and recommendations on the Plan to the President of the Senate, the Speaker of the House of Representatives and the Committee on Employee Hospital and Medical Benefits."

SECTION 2.(i) G.S. 135-39.10, as amended by Section 28.22A(d),(o) of S.L. 2007-323, is recodified as G.S. 135-38.6 under Part 2A of Article 3A of Chapter 135 of the General Statutes, as enacted by this act.

SECTION 2.(j) G.S. 135-39.5 is recodified as G.S. 135-38.7 under Part 2A of Article 3A of Chapter 135 of the General Statutes, as enacted by this act, and as recodified, reads as rewritten:

"§ 135-38.7. **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:

(1) Supervising and monitoring of the Claims Processor.

(2) Providing for enrollment of employees in the Plan.

(3) Communicating with employees enrolled under the Plan.

(4) Communicating with health care providers providing services under the Plan.

(5) Making payments at appropriate intervals to the Claims Processor for benefit costs and administrative costs.

(6) Conducting administrative reviews under ~~G.S. 135-39.7.~~G.S. 135-38.10.

(7) Annually assessing the performance of the Claims Processor.

(8) Preparing and submitting to the Governor and the General Assembly cost estimates for the ~~health benefits plan,~~ Plan, including those required by Article 15 of Chapter 120 of the General Statutes.

(9) Recommending to the Governor and the General Assembly changes or additions to the health benefits ~~program~~ programs and health care cost containment ~~programs,~~ programs offered under the Plan, together with statements of financial and actuarial effects as required by Article 15 of Chapter 120 of the General Statutes.

(10) Working with State employee groups to improve health benefit programs.

(11) Repealed by Session Laws 1985, c. 732, s. 9.

(12) Determining basis of payments to health care providers, including payments in accordance with G.S. 58-50-56. ~~The Comprehensive Major Medical Plan and optional plans and programs adopted pursuant to G.S. 135-39.5B shall comply with G.S. 58-3-225.~~

(13) Requiring bonding of the Claims Processor in the handling of State funds.

(14) Repealed by Session Laws 1985, c. 732, s. 7.

(15) In case of termination of the contract under ~~G.S. 135-39.5A,~~ subdivision (29) of this section, to select a new Claims Processor, after ~~competitive~~ bidding procedures approved by the Department of Administration.

(16) Notwithstanding the provisions of ~~Part 3~~ Part 3A of this Article, to formulate and implement cost-containment measures which are not in direct conflict with that Part.

(17) Implementing pilot programs necessary to evaluate proposed cost containment measures which are not in direct conflict with ~~Part 3~~ Part 3A of this Article, and expending funds necessary for the implementation of ~~such~~ the pilot programs.

(18) Authorizing coverage for alternative forms of care not otherwise provided by the Plan in individual cases when medically necessary, medically equivalent to services covered by the Plan, and when such alternatives would be less costly than would have been otherwise.

(19) Establishing and operating a hospital and other provider bill audit program and a fraud detection program.

(20) Determining administrative and medical policies that are not in direct conflict with ~~Part 3~~ Part 3A of this Article ~~upon the advice of~~ after consultation with the Claims Processor and ~~upon the advice of~~ the Plan's consulting actuary when Plan costs are involved.

(21) Supervising the payment of claims and all other disbursements under this Article, including the recovery of any disbursements that are not made in accordance with the provisions of this Article.

(22) Implementing and administering a program of long-term care benefits pursuant to ~~Part 4~~ Part 4A of this Article.

(23) Implementing and administering a program of child health insurance benefits pursuant to Part 5 of this Article.

(24) Implementing and administering a case management and disease management ~~program.~~program and a wellness program.

(25) Implementing and administering a pharmacy benefit management program through a third-party contract awarded after receiving competitive quotes.

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

(27) The Executive Administrator may establish pilot programs to measure potential cost savings and improvements in patient care available through local, provider-driven medical management.

(28) It is the intent of the General Assembly that active employees and retired employees covered under the Plan and its successor Plan shall have several opportunities in each fiscal year to attend presentations conducted by Plan management staff providing detailed information about benefits, limitations, premiums, co-payments, and other pertinent Plan matters. To this end, beginning in 2007 and annually thereafter, the Plan's management staff shall conduct multiple presentations each year to Plan members and association groups representing active and retired employees across all geographic regions of the State. Regional meetings shall be held in locations that

afford reasonably convenient access to Plan members. The presentations shall be designed not only to present information about the Plan but also to hear and respond to Plan members' questions and concerns.

(29) The Executive Administrator and Board of Trustees may terminate the contract with the Claims Processor ~~as provided in the request for proposal.~~in accordance with the terms of the contract.

(30) The prompt pay requirements of G.S. 58-3-225 apply to the Plan."

SECTION 2.(k) G.S. 135-39.5A is recodified as G.S. 135-38.7(29), as enacted by this act.

SECTION 2.(l) G.S. 135-39.6 is recodified as G.S. 135-38.8 under Part 2A of Article 3A of Chapter 135 of the General Statutes, as enacted by this act, and as recodified reads as rewritten:

"**§ 135-38.8. ~~Special~~ Health benefit trust funds created.**

(a) There are hereby established two ~~special~~ health benefit trust funds, to be known as the Public Employee Health Benefit Fund and the Health Benefit Reserve Fund for the payment of hospital and medical benefits. As used in this section, the term "health benefit trust funds" refers to the fund type described under G.S. 143C-1-3(a)(10).

All premiums, fees, charges, rebates, refunds or any other receipts including, but not limited to, earnings on investments, occurring or arising in connection with health benefits programs established by this Article, shall be deposited into the Public Employee Health Benefit Fund. Disbursements from the Fund shall include any and all amounts required to pay the benefits and administrative costs of such programs as may be determined by the Executive Administrator and Board of Trustees.

Any unencumbered balance in excess of prepaid premiums or charges in the Public Employee Health Benefit Fund at the end of each fiscal year shall be used first, to provide an actuarially determined Health Benefit Reserve Fund for incurred but unpresented claims, second, to reduce the premiums required in providing the benefits of the health benefits programs, and third to improve the plan, as may be provided by the General Assembly. The balance in the Health Benefits Reserve Fund may be transferred from time to time to the Public Employee Health Benefit Fund to provide for any deficiency occurring therein.

The Public Employee Health Benefit Fund and the Health Benefit Reserve Fund shall be deposited with the State Treasurer and invested as provided in G.S. 147-69.2 and 147-69.3.

(b) Disbursement from the Public Employee Health Benefit Fund may be made by warrant drawn on the State Treasurer by the Executive Administrator, or the Executive Administrator and Board of Trustees may by contract authorize the Claims Processors to draw the warrant.

(c) Separate and apart from the ~~special~~ health benefit trust funds authorized by subsections (a) and (b) of this section, there shall be a Public Employee Long-Term Care Benefit Fund if the long-term care benefits provided by Part 4 of this Article are administered on a self-insured basis.

(d) Separate and apart from the special funds authorized by subsections (a), (b), and (c) of this section, there shall be a Child Health Insurance Fund. All premium receipts or any other receipts, including earnings on investments, occurring or arising in connection with acute medical care benefits provided under the Health Insurance Program for Children shall be deposited into the Child Health Insurance Fund. Disbursements from the Child Health Insurance Fund shall include any and all amounts required to pay the benefits and administrative costs of the Health Insurance Program for Children as may be determined by the Executive Administrator and Board of Trustees."

SECTION 2.(m) G.S. 135-39.6A, as amended by Section 11 of S.L. 2007-345, and as further amended by Section 28.22A(m),(o) of S.L. 2007-323, is recodified as G.S. 135-38.9 under Part 2A of Article 3 of Chapter 135 of the General Statutes, as enacted by this act, and as recodified, reads as rewritten:

"**§ 135-38.9. Premiums set.**

(a) The Executive Administrator and Board of Trustees shall, from time to time, establish premium rates for the Plan except as they may be established by the General Assembly in the Current Operations Appropriations Act, and establish ~~regulations~~ rules for payment of the premiums. Premium rates shall be established for coverages where Medicare is the primary payer of health benefits separate and apart from the rates established for coverages where Medicare is not the primary payer of health benefits. The amount of State funds contributed for optional coverage for employees and retirees on a partially contributory basis shall not be more than the Plan's total noncontributory premium for Employee Only coverage, with the person selecting the coverage paying the balance of the partially contributory premium not paid by the Plan. The amount of State funds contributed shall not exceed the Plan's cost for Employee Only coverage. The Executive Administrator and Board of Trustees shall not impose a partially contributory premium until after it has consulted on the premium and the optional coverage design with the Committee on Employee Hospital and Medical Benefits.

(b) The Executive Administrator and Board of Trustees shall establish separate premium rates for the long-term care benefits provided by ~~Part 4~~Part 4A of this Article if the benefits are administered on a self-insured basis.

(c) The Executive Administrator and Board of Trustees shall establish premium rates for benefits provided under Part 5 of this Article. The Department of Health and Human Services shall, from State and federal appropriations and from any other funds made available for the Health Insurance Program for Children established under Part 8 of Article 2 of Chapter 108A of the General Statutes, make payments to the State Health Plan for Teachers and State Employees as determined by the Plan for its administration, claims processing, and other services authorized to provide coverage for acute medical care for children eligible for benefits provided under Part 5 of this Article.

(d) In setting premiums for ~~firemen,~~firefighters, rescue squad workers, and members of the national guard, and their eligible dependents, the Executive Administrator and Board of Trustees shall establish rates separate from those affecting other members of the Plan. These separate premium rates shall include rate factors for incurred but unreported claim costs, for the effects of adverse selection from voluntary

participation in the Plan, and for any other actuarially determined measures needed to protect the financial integrity of the Plan for the benefit of its served employees, retired employees, and their eligible dependents.

(e) The total amount of premiums due the Plan from charter schools as employing units, including amounts withheld from the compensation of Plan members, that is not remitted to the Plan by the fifteenth day of the month following the due date of remittance shall be assessed interest of one and one-half percent (1 ½%) of the amount due the Plan, per month or fraction thereof, beginning with the sixteenth day of the month following the due date of the remittance. The interest authorized by this section shall be assessed until the premium payment plus the accrued interest amount is remitted to the Plan. The remittance of premium payments under this section shall be presumed to have been made if the remittance is postmarked in the United States mail on a date not later than the fifteenth day of the month following the due date of the remittance."

SECTION 2.(n) G.S. 135-39.7 is recodified as G.S. 135-38.10 under Part 2A of Article 3A of Chapter 135 of the General Statutes as enacted by this act, and as recodified, reads as rewritten:

"**§ 135-38.10. Administrative review.**

(a) If, after exhaustion of internal appeal handling as outlined in the contract with the Claims Processors any person is aggrieved, the Claims Processors shall bring the matter to the attention of the Executive Administrator and Board of Trustees, which shall promptly decide whether the subject matter of the appeal is a determination subject to external review under Part 4 of Article 50 of Chapter 58 of the General Statutes. The Executive Administrator and Board of Trustees shall inform the aggrieved person and the aggrieved person's provider of the decision and shall provide the aggrieved person notice of the aggrieved person's right to appeal that decision as provided in this subsection. If the Executive Administrator and Board of Trustees decide that the subject matter of the appeal is not a determination subject to external review, then the Executive Administrator and Board of Trustees may make a binding decision on the matter in accordance with procedures established by the Executive Administrator and Board of Trustees. The Executive Administrator and Board of Trustees shall provide a written summary of the decisions made pursuant to this section to all employing units, all health benefit representatives, the oversight team provided for in ~~G.S. 135-39.3,~~G.S. 135-37.3, all relevant health care providers affected by a decision, and to any other parties requesting a written summary and approved by the Executive Administrator and Board of Trustees to receive a summary immediately following the issuance of a decision. A decision by the Executive Administrator and Board of Trustees that a matter raised on internal appeal is a determination subject to external review as provided in subsection (b) of this section may be contested by the aggrieved person under Chapter 150B of the General Statutes. The person contesting the decision may proceed with external review pending a decision in the contested case under Chapter 150B of the General Statutes.

(b) The Executive Administrator and Board of Trustees shall adopt and implement utilization review and internal grievance procedures that are substantially equivalent to those required under G.S. 58-50-61 and G.S. 58-50-62. External review of

determinations shall be conducted in accordance with Part 4 of Article 50 of Chapter 58 of the General Statutes. As used in this section, "determination" is a decision by the Executive Administrator and Board of Trustees, ~~the Plan's designated utilization review organization, or a self-funded health maintenance organization~~ or the Plan's designated utilization review organization administrated by or under contract with the Plan that an admission, availability of care, continued stay, or other health care service has been reviewed and, based upon information provided, does not meet the Plan's requirements for medical necessity, appropriateness, health care setting, or level of care or effectiveness, and the requested service is therefore denied, reduced, or terminated.

(c) The Board of Trustees shall make the final agency decision in all cases contested pursuant to Chapter 150B of the General Statutes. The Executive Administrator shall execute the Board's final agency decisions. For purposes of G.S. 150B-44, the Board of Trustees is an agency that is a board or commission."

SECTION 2.(o) G.S. 135-39.8 is recodified as G.S. 135-38.11 under Part 2A of Article 3A of Chapter 135 of the General Statutes as enacted by this act, and as recodified, reads as rewritten:

"**§ 135-38.11. ~~Rules and regulations.~~Rules.**

The Executive Administrator and Board of Trustees may ~~issue~~ adopt rules ~~and regulations~~ to implement Parts ~~2, 3, 4, and 5~~ 2A, 3A, 4A, and 5A of this Article. The Executive Administrator and Board of Trustees shall provide to all employing units, all health benefit representatives, the oversight team provided for in ~~G.S. 135-39.3,~~G.S. 135-37.3, all relevant health care providers affected by a ~~rule or regulation,~~rule, and to any other persons requesting a written description and approved by the Executive Administrator and Board of Trustees written notice and an opportunity to comment not later than 30 days prior to adopting, amending, or rescinding a ~~rule or regulation,~~rule, unless immediate adoption of the rule ~~or regulation~~ without notice is necessary in order to fully effectuate the purpose of the ~~rule or regulation.~~ rule. Rules ~~and regulations~~ of the Board of Trustees shall remain in effect until amended or repealed by the Executive Administrator and Board of Trustees. The Executive Administrator and Board of Trustees shall provide a written description of the rules ~~and regulations issued~~ adopted under this section to all employing units, all health benefit representatives, the oversight team provided for in ~~G.S. 135-39.3,~~G.S. 135-37.3, all relevant health care providers affected by a ~~rule or regulation,~~rule, and to any other persons requesting a written description and approved by the Executive Administrator and Board of Trustees on a timely basis. Rules adopted by the Executive Administrator and Board of Trustees to implement this Article are not subject to Article 2A of Chapter 150B of the General Statutes."

SECTION 3.(a) Effective July 1, 2008, Part 3 of Article 3A of Chapter 135 of the General Statutes, as enacted by this act, is recodified as Part 3A of Article 3A of Chapter 135 of the General Statutes.

SECTION 3.(b) Effective July 1, 2008, G.S. 135-40 is repealed.

SECTION 3.(c) Part 3A of Article 3A of Chapter 135 of the General Statutes, as enacted by this act, is amended by adding the following new section to read:

"**§ 135-39.12. Undertaking.**

(a) The State of North Carolina undertakes to make available a State Health Plan (hereinafter called the "Plan") exclusively for the benefit of eligible employees, eligible retired employees, and certain of their eligible dependents, which will pay benefits in accordance with the terms of this Article. The Plan shall have all the powers and privileges of a corporation and shall be known as the State Health Plan for Teachers and State Employees. The Executive Administrator and Board of Trustees shall carry out their duties and responsibilities as fiduciaries for the Plan. The Plan shall administer one or more group health plans that are comprehensive in coverage and shall provide eligible employees and retired employees coverage on a noncontributory basis under at least one of the group plans with benefits equal to that specified in subsection (g) of this section. The Executive Administrator and Board of Trustees may operate group plans as a preferred provider option, or health maintenance, point-of-service, or other organizational arrangement and may offer the plans to employees and retirees on a noncontributory or partially contributory basis. Plans offered on a partially contributory basis must provide benefits that are additional to that specified in subsection (g) of this section and may not be offered unless approved in an act of the General Assembly.

(b) Individuals eligible for coverage under G.S. 135-39.14 on a fully or partially contributory basis are eligible to participate in any plan authorized under this section.

(c) The State of North Carolina deems it to be in the public interest for North Carolina firefighters, rescue squad workers, and members of the national guard, and certain of their dependents, who are not eligible for any other type of comprehensive group health insurance or other comprehensive group health benefits, and who have been without any form of group health insurance or other comprehensive group health benefit coverage for at least six consecutive months, to be given the opportunity to participate in the benefits provided by the State Health Plan for Teachers and State Employees. Coverage under the Plan shall be voluntary for eligible firefighters, rescue squad workers, and members of the national guard who elect participation in the Plan for themselves and their eligible dependents.

(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. 135-39.13 through G.S. 135-39.27 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. 135-39.13 through G.S. 135-39.27 and the request for proposals must be modified for inclusion in the contract because of State law, such modification shall be made.

(e) Payroll deduction shall be available for coverage under this Part for subscribers able to meet the Plan's requirements for payroll deduction.

(f) Notwithstanding any other provisions of the Plan, the Executive Administrator and Board of Trustees are specifically authorized to use all appropriate means to secure tax qualification of the Plan under any applicable provisions of the Internal Revenue Code of 1954 as amended. The Executive Administrator and Board of

Trustees shall furthermore comply with all applicable provisions of the Internal Revenue Code as amended, to the extent that this compliance is not prohibited by this Article.

(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, that would result in a net increased cost to the Plan or in a reduction in benefits to Plan members unless and until the proposed changes are directed to be made in an act of the General Assembly."

SECTION 3.(d) G.S. 135-40.1 is repealed.

SECTION 3.(e) Part 3A of Article 3A of Chapter 135 of the General Statutes, as enacted by this act, is amended by adding the following new section to read:

"**§ 135-39.13. General Definitions.**

As used in this Article unless the context clearly requires otherwise, the following definitions apply:

(1) Allowed amount. – The charge that the Plan or its claims proessors determines is reasonable for covered services provided to a Plan member. This amount may be established in accordance with an agreement between the provider and the Plan or its claims processor. In the case of providers that have not entered into an agreement with the Plan or its claims processor, the allowed amount will be the lesser of the provider's actual charge or a reasonable charge established by the Plan or its claims processor using a methodology that is applied to comparable providers for similar services under a similar health benefit plan.

(2) Benefit period. – The period of time during which charges for covered services provided to a Plan member must be incurred in order to be eligible for payment by the Plan.

(3) Chemical dependency. – The pathological use or abuse of alcohol or other drugs in a manner or to a degree that produces an impairment in personal, social, or occupational functioning and which may, but need not, include a pattern of tolerance and withdrawal.

(4) Claims Processor. – One or more administrators, third-party administrators, or other parties contracting with the Plan to administer Plan benefits.

(5) Clinical trials. – Patient research studies designed to evaluate new treatments, including prescription drugs. Coverage for clinical trials shall be as provided in G.S. 135-39.20.

(6) Comprehensive health benefit plan. – Health care coverage that consists of inpatient and outpatient hospital and medical benefits, as well as other outpatient medical services, prescription drugs, medical supplies, and equipment that are generally available in the health insurance market.

(7) Covered service; benefit; allowable expense. – Any medically necessary, reasonable, and customary items of service, including prescription drugs, and medical supplies included in the Plan.

(8) Deductible. – The dollar amount that must be incurred for certain covered services in a benefit period before benefits are payable by the Plan.

The deductible applies separately to each covered individual in each fiscal year, subject to an aggregate maximum per employee and child, employee and spouse, or employee and family coverage contract in any fiscal year.

If two or more family members are injured in the same accident, only one deductible is required for charges related to that accident during the benefit period.

(9) Dependent. – An eligible Plan member other than the subscriber.

(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 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. 135-39.14(d).

(11) Employee or State employee. – Any permanent full-time or permanent part-time regular employee (designated as half-time or more) of an employing unit.

(12) Employing Unit. – A North Carolina School System; Community College; State Department, Agency, or Institution; Administrative Office of the Courts; or Association or Examining Board whose employees are eligible for membership in a State-Supported Retirement System. An employing unit also shall mean a charter school in accordance with Part 6A of Chapter 115C of the General Statutes whose board of directors elects to become a participating employer in the Plan under G.S. 135-39.17. Bona fide fire departments, rescue or emergency medical service squads, and national guard units are deemed to be employing units for the purpose of providing benefits under this Article.

(13) Experimental/Investigational. – Experimental/Investigational Medical Procedures. – The use of a service, supply, drug, or device not recognized as standard medical care for the condition, disease, illness,

or injury being treated as determined by the Executive Administrator and Board of Trustees upon the advice of the Claims Processor.

(14) Firefighter. – Eligible firefighters as defined by G.S. 58-86-25 who belong to a bona fide fire department as defined by G.S. 58-86-25 and who are not eligible for any type of comprehensive group health insurance or other comprehensive group health benefit coverage and who have been without any form of group health insurance or other comprehensive group health benefit coverage for at least six months. Firefighter shall also include members of the North Carolina Firemen and Rescue Squad Workers' Pension Fund who are in receipt of a monthly pension, who are not eligible for any type of comprehensive group health insurance or other comprehensive group health benefit coverage, and who have been without any form of group health insurance or other comprehensive group health benefit coverage for at least six months. Comprehensive group health insurance and other benefit coverage consists of inpatient and outpatient hospital and medical benefits, as well as other outpatient medical services, prescription drugs, medical supplies, and equipment that are generally available in the health insurance market. For purposes of this subdivision, comprehensive group health insurance and other benefit coverage includes Medicare benefits, CHAMPUS benefits, and other Uniformed Services benefits. North Carolina fire departments or their respective governing bodies shall certify the eligibility of their firefighters to the Plan for their participation in its benefits prior to enrollment.

(15) Health Benefits Representative. – The employee designated by the employing unit to administer the Plan for the unit and its employees. The HBR is responsible for enrolling new employees, reporting changes, explaining benefits, reconciling group statements, and remitting group fees. The State Retirement System is the Health Benefits Representative for retired State employees.

(16) Medical necessity or medically necessary. – Covered services or supplies that are:

a. Provided for the diagnosis, treatment, cure, or relief of a health condition, illness, injury, or disease; and, except for clinical trials covered under the Plan, not for experimental, investigational, or cosmetic purposes.

b. Necessary for and appropriate to the diagnosis, treatment, cure, or relief of a health condition, illness, injury, disease, or its symptoms.

c. Within generally accepted standards of medical care in the community.

d. Not solely for the convenience of the Plan member, the Plan member's family, or the provider.

For medically necessary services, the Plan or its representative may compare the cost-effectiveness of alternative services or supplies when determining which of the services or supplies will be covered and in what setting medically necessary services are eligible for coverage.

(17) National guard members. – Members of the North Carolina army and air national guard who are not eligible for any type of comprehensive group health insurance or other comprehensive group health benefit coverage and who have been without any form of group health insurance or other comprehensive group health benefit coverage for at least six months. Members of the North Carolina army and air national guard include those who are actively serving in the national guard as well as former members of the national guard who have completed 20 or more years of service in the national guard but have not attained the minimum age to begin receipt of a uniformed service military retirement benefit. Comprehensive group health insurance and other benefit coverage consists of inpatient and outpatient hospital and medical benefits, as well as other outpatient medical services, prescription drugs, medical supplies, and equipment that are generally available in the health insurance market. Comprehensive group health insurance and other benefit coverage includes Medicare benefits, Civilian Health and Medical Program of the Uniformed Services (CHAMPUS) benefits, and other Uniformed Services benefits. North Carolina national guard units shall certify the eligibility of their members to the Plan for their participation in its benefits prior to enrollment.

(18) Optional alternative comprehensive benefit plans. – Comprehensive benefit plans administered by the Plan that differ in coverage, deductibles, coinsurance from the Standard Plan providing for 80/20 coinsurance, and that are alternative choices for coverage at the option of the Plan member.

(19) Plan or State Health Plan. – The North Carolina State Health Plan for Teachers and State Employees. Unless otherwise expressly provided, "Plan" includes all comprehensive health benefit plans offered under the Plan.

(20) Plan member. – A subscriber or dependent who is eligible and currently enrolled in the Plan and for whom a premium is paid.

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

(22) Predecessor plan. – The Hospital and Medical Benefits for the Teachers' and State Employees' Retirement System of the State of North Carolina and the North Carolina Teachers' and State Employees' Comprehensive Major Medical Plan.

(23) Rescue squad workers. – Eligible rescue squad workers as defined by the provisions of G.S. 58-86-30 who belong to a rescue or emergency

medical services squad as defined by the same statute and who are not eligible for any type of comprehensive group health insurance or other comprehensive group health benefit coverage and who have been without any form of group health insurance or other comprehensive group health benefit coverage for at least six months. Rescue squad workers shall also include members of the North Carolina Firemen and Rescue Squad Workers' Pension Fund who are in receipt of a monthly pension, who are not eligible for any type of comprehensive group health insurance or other comprehensive group health benefit coverage, and who have been without any form of group health insurance or other comprehensive group health benefit coverage for at least six months. Comprehensive group health insurance and other benefit coverage consists of inpatient and outpatient hospital and medical benefits, as well as other outpatient medical services, prescription drugs, medical supplies, and equipment that are generally available in the health insurance market. For purposes of this subdivision, comprehensive group health insurance and other benefit coverage includes Medicare benefits, CHAMPUS benefits, and other Uniformed Services benefits. North Carolina rescue or emergency medical services squads or their respective governing bodies shall certify the eligibility of their rescue squad workers to the Plan for their participation in its benefits prior to enrollment.

(24) Retired employee (retiree). – Retired teachers, State employees, and members of the General Assembly who are receiving monthly retirement benefits from any retirement system supported in whole or in part by contributions of the State of North Carolina, so long as the retiree is enrolled.

(25) Subscriber. – A Plan member who is not a dependent.

(26) Surviving spouse. – The spouse of a deceased Plan member who is eligible for Plan enrollment."

SECTION 3.(f) G.S. 135-40.2, as amended by Section 28.22A of S.L. 2007-323, is recodified as G.S. 135-39.14 under Part 3A of Article 3A of Chapter 135 of the General Statutes, as enacted by this act, and as recodified, reads as rewritten:

"**§ 135-39.14. Eligibility.**

(a) Noncontributory Coverage. – The following persons are eligible for coverage under the Plan, on a noncontributory basis, subject to the provisions of ~~G.S. 135-40.3~~G.S. 135-39.16:

(1) All permanent full-time employees of an employing unit who meet the following conditions:

a. Paid from general or special State funds, or

b. Paid from non-State funds and in a group for which his or her employing unit has agreed to provide coverage.

Employees of State agencies, departments, institutions, boards, and commissions not otherwise covered by the Plan who are employed in

permanent job positions on a recurring basis and who work 30 or more hours per week for nine or more months per calendar year are covered by the provisions of this subdivision.

~~(1a)~~(2) Permanent hourly employees as defined in G.S. 126-5(c4) who work at least one-half of the workdays of each pay period.

~~(2)~~(3) Retired teachers, State employees, members of the General Assembly, and retired State law enforcement officers who retired under the Law Enforcement Officers' Retirement System prior to January 1, 1985. Except as otherwise provided in this subdivision, on and after January 1, 1988, a retiring employee or retiree must have completed at least five years of contributory retirement service with an employing unit prior to retirement from any State-supported retirement system in order to be eligible for group benefits under this Part as a retired employee or retiree. For employees first hired on and after October 1, 2006, and members of the General Assembly first taking office on and after February 1, 2007, future coverage as retired employees and retired members of the General Assembly is subject to a requirement that the future retiree have 20 or more years of retirement service credit in order to be covered by the provisions of this subdivision.

~~(2a)~~(4) Surviving spouses of:

a. Deceased retired employees, provided the death of the former plan member occurred prior to October 1, 1986; and

b. Deceased teachers, State employees, and members of the General Assembly who are receiving a survivor's alternate benefit under any of the State-supported retirement programs, provided the death of the former plan member occurred prior to October 1, 1986.

~~(3a)~~(5) Employees of the General Assembly, not otherwise covered by this section, as determined by the Legislative Services Commission, except for legislative interns and pages.

~~(4)~~(6) Members of the General Assembly.

~~(5)~~(7) Notwithstanding the provisions of subsection (e) of this section, employees on official leave of absence while completing a full-time program in school administration in an approved program as a Principal Fellow in accordance with Article 5C of Chapter 116 of the General Statutes.

~~(6)~~(8) Notwithstanding the provisions of G.S. ~~135-40.11,~~G.S. 135-39.24 employees formerly covered by the provisions of this section, other than retired employees, who have been employed for 12 or more months by an employing unit and whose jobs are eliminated because of a reduction, in total or in part, in the funds used to support the job or its responsibilities, provided the employees were covered by the Plan at the time of separation from service resulting from a job elimination. Employees covered by this subsection shall be covered for a period of

up to 12 months following a separation from service because of a job elimination.

~~(7)~~(9) Any member enrolled pursuant to subdivision (1) or ~~(1a)~~(2) of this subsection who is on approved leave of absence with pay or receiving workers' compensation.

~~(8)~~(10)Employees on approved Family and Medical Leave.

~~(a2)~~(b) Partially Contributory. – The following persons are eligible for coverage under the Plan on a partially contributory basis subject to the provisions of G.S. 135-39.16:

(1) A school employee in a job-sharing position as defined in ~~G.S. 130-40.3.~~G.S. 135-39.16. If these employees elect to participate in the Plan, the employing unit shall pay fifty percent (50%) of the Plan's total noncontributory premiums. Individual employees shall pay the balance of the total noncontributory premiums not paid by the employing unit.

(2) ~~(a3)~~ Subject to the provisions of ~~G.S. 135-40.3,~~ G.S. 135-39.16, employees and members of the General Assembly with 10 but less than 20 years of retirement service credit ~~shall be eligible for coverage under the Plan on a partially contributory basis,~~ provided the employees were first hired on or after October 1, 2006, and the members first took office on or after February 1, 2007. For such future retirees, the State shall pay fifty percent (50%) of the Plan's total noncontributory premiums. Individual retirees shall pay the balance of the total noncontributory premiums not paid by the State.

~~(a4) The Executive Administrator and Board of Trustees may in addition to noncontributory coverage offer optional coverage on a partially contributory basis and may set premium rates for the optional coverage on a partially contributory basis. The amount of State funds contributed for optional coverage on a partially contributory basis shall not be more than the Plan's total noncontributory premium for Employee Only coverage, with the person selecting the coverage paying the balance of the partially contributory premium not paid by the Plan. The amount of State funds contributed shall not exceed the Plan's cost for Employee Only coverage. The Executive Administrator and Board of Trustees shall not impose a partially contributory premium until after it has consulted on the premium and the optional coverage design with the Committee on Employee Hospital and Medical Benefits.~~

~~(b)~~(c) Fully Contributory. – The following person shall be eligible for coverage under the Plan, on a fully contributory basis, subject to the provisions of ~~G.S. 135-40.3:~~G.S. 135-39.16:

~~(2)~~(1) Former members of the General Assembly who enroll before October 1, 1986.

~~(2a)~~(2)For enrollments after September 30, 1986, former members of the General Assembly if covered under the Plan at termination of membership in the General Assembly. To be eligible for coverage as a former member of the General Assembly, application must be made

within 30 days of the end of the term of office. Only members of the General Assembly covered by the Plan at the end of the term of office are eligible. If application is not made within the specified time period, the member forfeits eligibility.

(3) Surviving spouses of deceased former members of the General Assembly who enroll before October 1, 1986.

~~(3a)~~(4) Employees of the General Assembly, not otherwise covered by this section, as determined by the Legislative Services Commission, except for legislative interns and pages.

~~(3b)~~(5) For enrollments after September 30, 1986, surviving spouses of deceased former members of the General Assembly, if covered under the Plan at the time of death of the former member of the General Assembly.

~~(4)~~(6) All permanent part-time employees (designated as half-time or more) of an employing unit who meets the conditions outlined in subdivision (a)(1)a above, and who are not covered by the provisions of ~~G.S. 135-40.2(a)(1).~~G.S. 135-39.14(a)(1).

~~(5)~~(7) The spouses and eligible dependent children of enrolled teachers, State employees, retirees, former members of the General Assembly, former employees covered by the provisions of ~~G.S. 135-40.2(a)(6),~~G.S. 135-39.14(a)(8), Disability Income Plan beneficiaries, enrolled continuation members, and members of the General Assembly. Spouses of surviving dependents are not eligible, nor are dependent children if they were not covered at the time of the member's death. Surviving spouses may cover their dependent children provided the children were enrolled at the time of the member's death or enroll within ~~30~~ 90 days of the member's death.

~~(6)~~(8) Blind persons licensed by the State to operate vending facilities under contract with the Department of Health and Human Services, Division of Services for the Blind and its successors, who are:

a. Operating such a vending facility;

b. Former operators of such a vending facility whose service as an operator would have made these operators eligible for an early or service retirement allowance under Article 1 of this Chapter had they been members of the Retirement System; and

c. Former operators of such a vending facility who attain five or more years of service as operators and who become eligible for and receive a disability benefit under the Social Security Act upon cessation of service as an operator.

Spouses, dependent children, surviving spouses, and surviving dependent children of such members are not eligible for coverage.

~~(8)~~(9) Surviving spouses of deceased retirees and surviving spouses of deceased teachers, State employees, and members of the General Assembly provided the death of the former Plan member occurred

after September 30, 1986, and the surviving spouse was covered under the Plan at the time of death.

(10) Any eligible dependent child of the deceased retiree, teacher, State employee, member of the General Assembly, former member of the General Assembly, or Disability Income Plan beneficiary, provided the child was covered at the time of death of the retiree, teacher, State employee, member of the General Assembly, former member of the General Assembly, or Disability Income Plan beneficiary, (or was in posse at the time and is covered at birth under this Part), or was covered under the Plan on September 30, 1986. An eligible surviving dependent child can remain covered until age 19, or age 26 if a full-time student, or indefinitely if certified as incapacitated under ~~G.S. 135-40.1(3)b.~~G.S. 135-39.13(5)b.

~~(11a)~~(11) Retired teachers, State employees, and members of the General Assembly with less than 10 years of retirement service credit, provided the teachers and State employees were first hired on or after October 1, 2006, and the members first took office on or after February 1, 2007.

(12) Notwithstanding the provisions of ~~G.S. 135-40.11,~~G.S. 135-39.23 former employees covered by the provisions of ~~G.S. 135-40.2(a)(6),~~G.S. 135-39.14 and their spouses and eligible dependent children who were covered by the Plan at the time of the former employees' separation from service pursuant to ~~G.S. 135-40.2(a)(6),~~ G.S. 135-39.14, following expiration of the former employees' coverage provided by ~~G.S. 135-40.2(a)(6).~~ G.S. 135-39.14. Election of coverage under this subdivision shall be made within 90 days after the termination of coverage provided under ~~G.S. 135-40.2(a)(6).~~G.S. 135-39.14.

(13) ~~Firemen,~~Firefighters, rescue squad workers, and members of the national guard, their eligible spouses, and eligible dependent children.

(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, between the ages of 19 and 26, 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.

(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. 135-39.14(5)a.

~~(e)~~(e) No person shall be eligible for coverage as a dependent if eligible as an employee or retired employee, except when a spouse is eligible on a fully contributory basis. In addition, no person shall be eligible for coverage as a dependent of more than one employee or retired employee at the same time.

~~(d)~~(f) Former employees who are receiving disability retirement benefits or disability income benefits pursuant to Article 6 of Chapter 135 of the General Statutes, provided the former employee has at least five years of retirement membership service, shall be eligible for the benefit provisions of this Plan, as set forth in this Part, on a noncontributory basis. Such coverage shall terminate as of the end of the month in which such former employee is no longer eligible for disability retirement benefits or disability income benefits pursuant to Article 6 of this Chapter.

~~(e)~~(g) Employees on official leave of absence without pay may elect to continue this group coverage at group cost provided that they pay the full employee and employer contribution through the employing unit during the leave period.

~~(f)~~(h) For the support of the benefits made available to any member vested at the time of retirement, their spouses or surviving spouses, and the surviving spouses of employees who are receiving a survivor's alternate benefit under G.S. 135-5(m) of those associations listed in G.S. 135-27(a), licensing and examining boards under G.S. 135-1.1, the North Carolina State Art Society, Inc., and the North Carolina Symphony Society, Inc., each association, organization or board shall pay to the Plan the full cost of providing these benefits under this section as determined by the Board of Trustees of the State Health Plan for Teachers and State Employees. In addition, each association, organization or board shall pay to the Plan an amount equal to the cost of the benefits provided under this section to presently retired members of each association, organization or board since such benefits became available at no cost to the retired member. This subsection applies only to those individuals employed prior to July 1, 1983, as provided in G.S. 135-27(d).

~~(g)~~(i) An eligible surviving spouse and any eligible surviving dependent child of a deceased retiree, teacher, State employee, member of the General Assembly, former member of the General Assembly, or Disability Income Plan beneficiary shall be eligible for group benefits under this section without waiting periods for preexisting conditions provided coverage is elected within 90 days after the death of the former plan member. Coverage may be elected at a later time, but will be subject to the 12-month

waiting period for preexisting conditions and will be effective the first day of the month following receipt of the application.

~~(h)~~(j) No person shall be eligible for coverage as an employee or retired employee or as a dependent of an employee or retired employee upon a finding by the Executive Administrator or Board of Trustees or by a court of competent jurisdiction that the employee or dependent knowingly and willfully made or caused to be made a false statement or false representation of a material fact in a claim for reimbursement of medical services under the Plan. The Executive Administrator and Board of Trustees may make an exception to the provisions of this subsection when persons subject to this subsection have had a cessation of coverage for a period of five years and have made a full and complete restitution to the Plan for all fraudulent claim amounts. Nothing in this subsection shall be construed to obligate the Executive Administrator and Board of Trustees to make an exception as allowed for under this subsection.

~~(i)~~(k) Any employee receiving benefits pursuant to Article 6 of this Chapter when the employee has less than five years of retirement membership service, or an employee on leave without pay due to illness or injury for up to 12 months, is entitled to continued coverage under the Plan for the employee and any eligible dependents by paying one hundred percent (100%) of the cost."

SECTION 3.(g) Part 3A of Article 3A of Chapter 135 of the General Statutes is amended by adding the following new section to read:

"**§ 135-39.15. Enrollment.**

(a) Except as otherwise required by applicable federal law, new employees must be given the opportunity to enroll or decline enrollment for themselves and their dependents within 30 days from the date of employment or from first becoming eligible on a noncontributory basis. Coverage may become effective on the first day of the month following date of entry on payroll or on the first day of the following month. New employees not enrolling themselves and their dependents within 30 days, or not adding dependents when first eligible as provided herein may enroll on the first day of any month but will be subject to a 12-month waiting period for preexisting health conditions, except for employees who elect to change their coverage in accordance with rules established by the Executive Administrator and Board of Trustees for optional or alternative plans available under the Plan. Children born to covered employees having coverage type (2) or (3), as outlined in G.S. 135-40.3(d) shall be automatically covered at the time of birth without any waiting period for preexisting health conditions. Children born to covered employees having coverage type (1) shall be automatically covered at birth without any waiting period for preexisting health conditions so long as the claims processor receives notification within 30 days of the date of birth that the employee desires to change from coverage (1) to coverage type (2) or (3), provided that the employee pays any additional premium required by the coverage type selected retroactive to the first day of the month in which the child was born.

(b) 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.(h) G.S. 135-40.3, as amended by Section 28.22A of S.L. 2007-323, is recodified as G.S. 135-39.16 under Part 3A of Article 3A of Chapter 135 of the General Statutes, as enacted by this act, and as recodified, reads as rewritten:

"**§ 135-39.16. Effective dates of coverage.**

(a) Employees and Retired Employees. –

(1) Employees and retired employees covered under the Predecessor Plan will continue to be covered, subject to the terms hereof.

(2) New employees may apply for coverage to be effective on the first day of the month following employment, or on a like date the following month if the employee has enrolled.

(3) Employees not enrolling or adding dependents when first eligible in accordance with ~~G.S. 135-40.1(7)~~G.S. 135-39.15 may enroll later on the first of any following month but will be subject to a 12-month waiting period for a preexisting health condition, except employees who elect to change their coverage in accordance with rules adopted by the Executive Administrator and Board of Trustees for optional ~~prepaid hospital and medical benefit plans.~~alternative plans offered under the Plan.

(4) Members of the General Assembly, beginning with the 1985 Session, shall become first eligible with the convening of each Session of the General Assembly, regardless of a Member's service during previous Sessions. Members and their dependents enrolled when first eligible after the convening of each Session of the General Assembly will not be subject to any waiting periods for preexisting health conditions. Members of the 1983 Session of the General Assembly, not already enrolled, shall be eligible to enroll themselves and their dependents on or before October 1, 1983, without being subject to any waiting periods for preexisting health conditions.

(b) Waiting Periods and Preexisting Conditions. –

(1) New employees and dependents enrolling when first eligible are subject to no waiting period for preexisting conditions under the Plan.

(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.

(3) Retiring employees and dependents enrolled when first eligible after an employee's retirement are subject to no waiting period for preexisting conditions under the Plan. Retiring employees not enrolled or not adding dependents when first eligible after an employee's retirement may enroll later on the first of any following month, but will be subject to a 12-month waiting period for preexisting conditions except as provided in subdivision (a)(3) of this section.

(4) Employees and dependents enrolling or reenrolling within 12 months after a termination of enrollment or employment that were not enrolled at the time of this previous termination, regardless of the employing units involved, shall not be considered as newly-eligible employees or dependents for the purposes of waiting periods and preexisting conditions. Employees and dependents transferring from optional ~~plans in accordance with G.S. 135-39.5B;~~ alternative plans available under the Plan; employees and dependents immediately returning to service from an employing unit's approved periods of leave without pay for illness, injury, educational improvement, workers' compensation, parental duties, or for military reasons; employees and dependents immediately returning to service from a reduction in an employing unit's work force; retiring employees and dependents reenrolled in accordance with ~~G.S. 135-40.3(b)(3);~~G.S.135-39.16(b)(3); formerly-enrolled dependents reenrolling as eligible employees; formerly-enrolled employees reenrolling as eligible dependents; and employees and dependents reenrolled without waiting periods and preexisting conditions under specific rules ~~and regulations~~ adopted by the Executive Administrator and Board of Trustees in the best interests of the Plan shall not be considered reenrollments for the purpose of this subdivision. Furthermore, employees accepting permanent, full-time appointments who had previously worked in a part-time or temporary position and their qualified dependents shall not be covered by waiting periods and preexisting conditions under this division provided enrollment as a permanent, full-time employee is made when the employee and his dependents are first eligible to enroll.

(5) To administer the 12-month waiting period for preexisting conditions under this Article, the Plan must give credit against the 12-month period for the time that 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.

(c) Dependents of Employees and Retired Employees. –

(1) Dependents of employees and retired employees who have family coverage under the Predecessor Plan will continue to be covered subject to the terms hereof.

(2) Employees who have dependents may apply for family coverage at the time they enroll as provided in subdivisions (a)(2) and (a)(3) of this section and such dependents will be covered under the Plan beginning the same date as such employees.

(3) Employees and retired employees may change from ~~individual or parent/child(ren) coverage to parent/child(ren) or family coverage or add dependents to existing family or parent/child(ren) coverage upon acquiring a dependent~~ one category of coverage to a different category of coverage without a waiting period for preexisting conditions, ~~and~~ and, as applicable, dependents will be covered under the Plan the first of the month or the first of the second month following the dependent's eligibility for coverage, provided written application is submitted to the Health Benefits Representative within 30 days of becoming eligible.

(4) Employees or retired employees who wish to change ~~from family coverage to parent/child(ren) or individual or from parent/child(ren) to individual coverage~~ to employee only coverage shall give written notice to their Health Benefits Representative within 30 days after any change in the status of dependents, (resulting from death, divorce, etc.) that requires a change in contract ~~type.~~category. The effective date will be the first of the month following the dependent's ineligibility event. If notification was not made within the 30 days following the dependent's ineligibility event, the dependent will be retroactively removed the first of the month following the dependent's ineligibility event, and the coverage ~~type~~ category change will be the first of the month following written notification, except in cases of death, in which case the coverage ~~type~~ category change will be made retroactive to the first of the month following the death.

(5) Employees not adding dependents when first eligible may enroll later on the first of any following month, but dependents will be subject to a 12-month waiting period for preexisting health conditions except as provided in subdivision (a)(3) of this section.

(6) Employees or retired employees who wish to change to employee only coverage ~~from family to parent/child(ren) or individual coverage or from parent/child(ren) to individual coverage,~~ even though their dependents continue to be eligible, shall give written notification to their Health Benefits Representative. ~~Effective~~ Except as otherwise required by applicable federal law, the date of this ~~type~~ category

change will be the first of the month following written notification or any first of the month thereafter as desired by the employee.

(7) The effective date for newborns or adopted children will be date of birth, date of adoption, or placement with adoptive parent provided member is currently covered under ~~a family or parent/child(ren) coverage.~~ employee and family or employee and child coverage. If the member wishes to add a newborn or adopted child and is currently enrolled ~~on individual~~ in employee only coverage, the member must submit application for coverage and a coverage type change within 30 days of the child's birth or date of adoption or placement. Effective date for the coverage ~~type~~ category change is the first of the month in which the child is born, adopted, or placed. Adopted children may also be covered the first of the month following placement or adoption.

(d) ~~Types~~ Categories of Coverage Available. – There are ~~three~~ four ~~types~~ categories of coverage which an employee or retiree may elect.

(1) Employee Only. – Covers enrolled employees only. Maternity benefits are provided to employee only.

(2) Employee and ~~Child(ren).~~Child. – Covers enrolled employee and all eligible dependent children. Maternity benefits are provided to the employee only.

(3) Employee and Family. – Covers employee and spouse, and all eligible dependent children. Maternity benefits are provided to employee or enrolled spouse.

(4) Employee and spouse. Covers employee and spouse only. Maternity benefits are provided to the employee or the employee's enrolled spouse.

(e) Notwithstanding any other provision of this section, no coverage under the Plan shall become effective prior to the payment of premiums required by the Plan.

(f) ~~Firemen,~~Firefighters, rescue squad workers, and members of the national guard are subject to the same terms and conditions of this section as are employees. Eligible dependents of ~~firemen,~~firefighters, rescue squad workers, and members of the national guard are subject to the same terms and conditions of this section as are dependents of employees.

(g) Different categories of coverage may be offered for optional alternative plans or programs.

(h) If any provision of this section is in conflict with applicable federal law, federal law shall control to the extent of the conflict."

SECTION 3.(i) G.S. 135-40.3A is recodified as G.S. 135-39.17 under Part 3A of Article 3A of Chapter 135 of the General Statutes, as enacted by this act.

SECTION 3.(j) G.S. 135-40.5, as amended by Section 28.22 of S.L. 2007-323, and as further amended by Section 22.28A of S.L. 2007-323, is recodified as G.S. 135-39.18 under Part 3A of Article 3A of Chapter 135 of the General Statues, as enacted by this act, and as recodified, reads as rewritten:

"**§ 135-39.18. Benefits not subject to deductible or coinsurance.**

~~(e) Preadmission Testing. The Plan will pay one hundred percent (100%) of reasonable and customary charges for diagnostic, laboratory and x-ray examinations performed on an outpatient basis.~~

~~(f)~~(a) Immunizations. – The Plan will pay one hundred percent (100%) of allowable medical charges for immunizations for the prevention of contagious diseases as generally accepted medical practices would dictate when directed by ~~an attending physician.~~a credentialed provider as determined by the claims processor.

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

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) for each preferred branded prescription, and forty dollars ($40.00) for each preferred branded prescription with a generic equivalent drug, and fifty dollars ($50.00) for each nonpreferred branded or generic prescription. These co-payments apply to ~~the Plan's optional programs.~~all optional alternative plans available under the Plan.

Allowable charges shall not be greater than a pharmacy's usual and customary charge to the general public for a particular prescription. Prescriptions shall be for no more than a 34-day supply for the purposes of the copayments paid by each covered individual. By accepting the copayments and any remaining allowable charges provided by this subsection, pharmacies shall not balance bill an individual covered by the Plan. A prescription legend drug is defined as an article the label of which, under the Federal Food, Drug, and Cosmetic Act, is required to bear the legend: "Caution: Federal Law Prohibits Dispensing Without Prescription." Such articles may not be sold to or purchased by the public without a prescription order. Benefits are provided for insulin even though a prescription is not required. The Plan may use a pharmacy benefit manager to help manage the Plan's outpatient prescription drug coverage. In managing the Plan's outpatient prescription drug benefits, the Plan and its pharmacy benefit manager shall not provide coverage for ~~erectile~~ 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. Any formulary used by the Plan's Executive Administrator and pharmacy benefit manager shall be an open formulary. Plan members shall not be assessed more than two thousand five hundred dollars ($2,500) per person per fiscal year in copayments required by this subsection.

SECTION 3.(k) G.S. 135-40.6A is repealed.

SECTION 3.(l) Part 3A of Article 3A of Chapter 135 of the General Statutes is amended by adding the following new section to read:

"**§ 135-39.19. Prior approval procedures.**

The Executive Administrator and Board of Trustees may establish procedures to require prior medical approval and may implement the procedures after consultation with the Committee on Employee Hospital and Medical Benefits."

SECTION 3.(m) Effective July 1, 2008, G.S. 135-40.7, as amended by Section 28.22A(j) of S.L. 2007-323, is recodified as G.S. 135-39.20 under Part 3A of Article 3A of Chapter 135 of the General Statutes, as enacted by this act, and, as recodified, reads as rewritten:

"**§ 135-39.20. General limitations and exclusions.**

The following shall in no event be considered covered expenses nor will benefits described in ~~G.S. 135-40.5 through G.S. 135-40.11~~G.S. 135-39.18 through G.S. 135-39.23 be payable for:

(1) Charges for any services rendered to a person prior to the date coverage under this Plan becomes effective with respect to such person.

(2) Charges for care in a nursing home, adult care home, convalescent home, or in any other facility or location for custodial or for rest cures.

(3) Charges to the extent paid, or which the individual is entitled to have paid, or to obtain without cost, in accordance with any government laws or regulations except Medicare. If a charge is made to any such person which he or she is legally required to pay, any benefits under this Plan will be computed in accordance with its provisions, taking into account only such charge. "Any government" includes the federal, State, provincial or local government, or any political subdivision thereof, of the United States, Canada or any other country.

(4) Charges for services rendered in connection with any occupational injury or disease arising out of and in the course of employment with any employer, if (i) the employer furnishes, pays for or provides reimbursement for such charges, or (ii) the employer makes a settlement payment for such charges, or (iii) the person incurring such charges waives or fails to assert his or her rights respecting such charges.

(5) Charges for any care, treatment, services or supplies other than those which are certified by a physician who is attending the individual as being required for the medically necessary treatment of the injury or disease and are deemed medically necessary and appropriate for the treatment of the injury or disease by the Executive Administrator and Board of Trustees upon the advice of the Claims Processor. This subdivision shall not be construed, however, to require certification by an attending physician for a service provided by an advanced practice registered nurse acting within the nurse's lawful scope of ~~practice, subject to the limitations of G.S. 135-40.6(10).~~practice.

(6) Charges for any services rendered as a result of injury or sickness due to an act of war, declared or undeclared, which act shall have occurred after the effective date of a person's coverage under the Plan.

(7) Charges for personal services such as barber services, guest meals, radio and TV rentals, etc.

(8) Charges for any services with respect to which there is no legal obligation to pay. For the purposes of this item, any charge which exceeds the charge that would have been made if a person were not covered under this Plan shall, to the extent of such excess, be treated as a charge for which there is no legal obligation to pay; and any charge made by any person for anything which is normally or customarily furnished by such person without payment from the recipient or user thereof shall also be treated as a charge for which there is no legal obligation to pay.

(9) Charges during a continuous hospital confinement which commenced prior to the effective date of the person's coverage under this Plan.

(10) Charges in excess of either ~~the usual, customary and reasonable charge for~~ the allowed amount or the reasonable amount, or the fair and reasonable value of the services or supply which gives rise to the expense; provided that in each instance the extent that a particular charge is usual, customary and reasonable or fair and reasonable shall be measured and determined by comparing the charge with charges made for similar things to individuals of similar age, sex, income and medical condition in the locality concerned, and the result of such determination shall constitute the maximum allowable as covered medical expenses unless the Claims Processor finds that considerations of fairness and equity in a particular set of circumstances require that greater or lesser charges be considered as covered medical expenses in that set of circumstances.

(11) Charges for or in connection with any dental work or dental treatment except to the extent that such work or treatment is specifically provided for under the Plan. Excluded is payment for surgical benefits for tooth replacement, such as crowns, bridges or dentures; orthodontic care; filling of teeth; extraction of teeth (whether or not impacted); root canal therapy; removal of root tips from teeth; treatment for tooth decay, inflammation of gingiva, or surgical procedures on diseased gingiva or other periodontal surgery; repositioning soft tissue, reshaping bone, and removal of bony projections from the ridges preparatory to fitting of dentures; removal of cysts incidental to removal of root tips from teeth and extraction of teeth; or other dental procedures involving teeth and their bones or tissue supporting structure.

(12) Charges incurred for any medical observations or diagnostic study when no disease or injury is revealed, unless proof satisfactory to the Claims Processor is furnished that (i) the claim is in order in all other respects, (ii) the covered individual had a definite symptomatic condition of disease or injury other than hypochondria, and (iii) the

medical observation and diagnostic studies concerned were not undertaken as a matter of routine physical examination or health ~~checkup as provided in G.S. 135-40.6(8)s.~~checkup.

(13) Charges for 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.

(14) Charges for cosmetic surgery or treatment except that charges for cosmetic surgery or treatment required for correction of damage caused by accidental injury sustained by the covered individual while coverage under this plan is in force on his or her account or to correct congenital deformities or anomalies shall not be excluded if they otherwise qualify as covered medical expenses. Reconstructive breast surgery following mastectomy, as those terms are defined in G.S. 58-51-62, is not "cosmetic surgery or treatment" for purposes of this section.

(15) Admissions for diagnostic tests or procedures which could be, and generally are, performed on an outpatient basis and inpatient services or supplies which are not consistent with the diagnosis, for which admitted.

(16) Costs denied by the Claims Processor as part of its overall program of claim review and cost containment.

~~(16a)~~(17) Charges in excess of negotiated rates allowed for preferred providers of institutional and professional medical care and ~~services in accordance with the provisions of G.S. 135-40.4,~~ services, when such preferred providers are reasonably available to provide institutional and professional medical care.

~~(17)~~(18) If a covered service becomes excluded from coverage under the Plan, the Executive Administrator and Claims Processor may, in the event of exceptional situations creating undue hardships or adverse medical conditions, allow persons enrolled in the Plan to remain covered by the Plan's previous coverage for up to three months after the effective date of the change in coverage, provided the persons so enrolled had been undergoing a continuous plan of specific treatment initiated within three months prior to the effective date of the change in coverage.

~~(18)~~(19) Charges for services unless a claim is filed within 18 months from the date of service.

~~(19)~~(20) Any service, treatment, facility, equipment, drug, supply, or procedure that is experimental or investigational as defined ~~in G.S. 135-40.1(7a).~~by the Plan. Clinical trial phases III and IV are covered by the Plan as is clinical trial phase II when approved by the Plan. Regardless of the type of trial phases covered by the Plan, all covered trials must involve the treatment of life-threatening medical conditions, must be clearly superior to available noninvestigational

treatment alternatives, and must have clinical and preclinical data that shows the trials will be at least as effective as noninvestigational alternatives. Trials must also involve determinations by treating physicians, relevant scientific data, and opinions of experts in relevant fields of medicine. Covered trials must be approved by the National Institutes of Health, a National Institutes of Health cooperative group or center, the U.S. Food and Drug Administration, the U.S. Department of Defense, or the U.S. Department of Veterans Affairs. The Plan may also cover clinical trials sponsored by other entities. Trials must also be approved by applicable qualified institutional review boards. All covered trials must be conducted in and by facilities and personnel that maintain a high level of expertise because of their training, experience, and volume of patients. To be covered by the Plan, patients participating in clinical trials must meet substantially all protocol requirements of the trials and exercise informed consent in the trials. Only medically necessary costs of health care services involved in treatments provided to patients for the purpose of the trials are covered by the Plan to the extent that such costs are not customarily funded by national agencies, commercial manufacturers, distributors, or other such providers. Clinical trial costs not covered by the Plan include, but are not limited to, the costs of services that are not health care services and costs associated with managing research in the trials. The Plan shall not exclude benefits for covered clinical trials if the proposed treatment is the only appropriate protocol for the condition being treated.

~~(20)~~(21) Complications arising from noncovered ~~services known at the time the noncovered services were provided.~~services.

~~(21)~~(22) Charges related to a noncovered service, even if the charges would have been covered if rendered in connection with a covered service.

~~(22)~~(23) Charges for services covered by the long-term care benefit provisions of ~~Part 4~~Part 4A of this Article.

~~(23)~~(24) Charges disallowed by the Plan's pharmacy benefits manager."

SECTION 3.(n) G.S. 135-40.7B, as amended by Section 28.22(f) of S.L. 2007-323, and as further amended by Section 28.22A(o) of S.L. 2007-323, is recodified as G.S. 135-39.21 under Part 3A of Article 3A of Chapter 135 of the General Statutes, as enacted by this act, and as recodified, reads as rewritten:

"**§ 135-39.21. Special provisions for chemical dependency and mental health benefits.**

(a) Except as otherwise provided in this section, benefits for the treatment of mental illness and chemical dependency are covered by the Plan and shall be subject to the same deductibles, durational limits, and coinsurance factors as are benefits for physical illness generally.

(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 ~~under~~ 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;
  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;~~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;
  b. Licensed chemical dependency hospitals;
  c. Licensed chemical dependency treatment facilities;
  d. Area Mental Health, Developmental Disabilities, and Substance Abuse ~~Authorities;~~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.

(c) Notwithstanding any other provisions of this Part, the following providers and no others may provide necessary care and treatment for mental health under this section:

(1) Psychiatrists who have completed a residency in psychiatry approved by the American Council for Graduate Medical Education and who are licensed as medical doctors or doctors of osteopathy in the state in which they perform and services covered by the Plan;
(2) Licensed ~~or certified~~ doctors of psychology;
(3) ~~Certified clinical~~Clinical social workers licensed or certified by the North Carolina Social Work Certification and Licensure Board under Chapter 90B of the General Statutes.~~and licensed clinical social workers;~~
~~(3a)~~(4)Licensed professional counselors;
~~(4)~~(5) Certified clinical specialists in psychiatric and mental health ~~nursing;~~ nursing in accordance with Article 9A of Chapter 90 of the General Statutes;

~~(4a)~~(6)Nurses working under the employment and direct supervision of such physicians, psychologists, or psychiatrists;

~~(6)~~(7) Licensed psychological associates;

~~(9)~~(8) Certified fee-based practicing pastoral ~~counselors;~~counselors in accordance with Article 26 of Chapter 90 of the General Statutes;

~~(10)~~(9) Licensed physician assistants under the supervision of a licensed psychiatrist and acting pursuant to G.S. 90-18.1 or the applicable laws and rules of the area in which the physician assistant is licensed or certified; and

~~(11)~~(10)Licensed marriage and family therapists.

(11) Physicians licensed under Chapter 90 of the General Statutes and certified professionals with training and experience in the care and treatment for mental health and working under the direct supervision of such physicians.

~~(c1)~~(d) Notwithstanding any other provisions of this Part, the following providers and no others may provide necessary care and treatment for chemical dependency under this section:

(1) The following providers with appropriate substance abuse training and experience in the field of alcohol and other drug abuse as determined by the mental health case manager, in facilities described in subdivision (b)(2) of this section, in day/night programs or outpatient treatment facilities licensed after July 1, 1984, under Article 2 of Chapter 122C of the General Statutes or in North Carolina area programs in substance abuse services are authorized to provide treatment for chemical dependency under this section:

a. Licensed physicians including, but not limited to, physicians who are certified in substance abuse by the American Society of Addiction Medicine (ASAM);

b. Licensed ~~or certified~~ psychologists;

c. Psychiatrists;

d. Certified substance abuse counselors working under the direct supervision of such physicians, psychologists, or psychiatrists;

e. Licensed psychological associates;

f. Nurses working under the direct supervision of such physicians, psychologists, or psychiatrists;

g. ~~Certified clinical social workers and licensed clinical social workers;~~Clinical social workers licensed or certified by the North Carolina Social Work Certification and Licensure Board under Chapter 90B of the General Statutes;

h. Certified clinical specialists in psychiatric and mental health ~~nursing;~~nursing in accordance with Article 9A of Chapter 90 of the General Statutes;

i. Licensed professional counselors;

j. Certified fee-based practicing pastoral ~~counselors;~~counselors in accordance with Article 26 of Chapter 90 of the General Statutes;
k. Substance abuse professionals certified under Article 5C of Chapter 90 of the General Statutes; and
l. Licensed marriage and family and therapists.

(2) The following providers with appropriate substance abuse training and experience in the field of alcohol and other drug abuse as determined by the mental health case manager are authorized to provide treatment for chemical dependency in outpatient practice settings:
a. Licensed physicians including, but not limited to, physicians who are certified in substance abuse by the American Society of Addiction Medicine (ASAM);
b. Licensed ~~or certified~~ psychologists;
c. Psychiatrists;
d. Certified substance abuse counselors working under the direct supervision of such physicians, psychologists, or psychiatrists;
e. Licensed psychological associates;
f. Nurses working under the direct supervision of such physicians, psychologists, or psychiatrists;
g. ~~Certified clinical social workers and licensed clinical social workers;~~ Clinical social workers licensed or certified by the North Carolina Social Work Certification and Licensure Board under Chapter 90B of the General Statutes.
h. Certified clinical specialists in psychiatric and mental health ~~nursing;~~ nursing in accordance with Article 9A of Chapter 90 of the General Statutes;
i. Licensed professional counselors;
j. Certified fee-based practicing pastoral ~~counselors;~~counselors in accordance with Article 26 of Chapter 90 of the General Statutes;
~~j1.~~(k) Licensed marriage and family and therapists;
1. Substance abuse professionals certified under Article 5C of Chapter 90 of the General Statutes;and
~~k.~~(m) In the absence of meeting one of the criteria above, the Mental Health Case Manager could consider, on a case-by-case basis, a provider who supplies:
1. Evidence of graduate education in the diagnosis and treatment of chemical dependency, and
2. Supervised work experience in the diagnosis and treatment of chemical dependency (with supervision by an appropriately credentialed provider), and

3. Substantive past and current continuing education in the diagnosis and treatment of chemical dependency commensurate with one's profession.

(3) Physicians licensed under Chapter 90 of the General Statutes and certified professionals with training and experience in the care and treatment for chemical dependency and working under the direct supervision of such physicians.

Provided, however, that nothing in this subsection shall prohibit the Plan from requiring the most cost-effective treatment setting to be utilized by the person undergoing necessary care and treatment for chemical dependency.

~~(d)~~(e) Benefits provided under this section shall be subject to a case management program for medical necessity and medical appropriateness consisting of (i) precertification of outpatient visits beyond 26 visits each Plan year, (ii) all electroconvulsive treatment, (iii) inpatient utilization review through preadmission and length-of-stay certification for nonemergency admissions to the following levels of care: inpatient units, partial hospitalization programs, residential treatment centers, chemical dependency detoxification and treatment programs, and intensive outpatient programs, (iv) length-of-stay certification of emergency inpatient admissions, and (v) a network of qualified, available providers of inpatient and outpatient psychiatric and chemical dependency treatment. Care which is not both medically necessary and medically appropriate will be noncertified, and benefits will be denied. ~~Where qualified preferred providers of inpatient and outpatient care are reasonably available, use of providers outside of the preferred network shall be subject to a twenty percent (20%) coinsurance rate up to five thousand dollars ($5,000) per fiscal year to be assessed against each covered individual in addition to the general coinsurance percentage and maximum fiscal year amount specified by G.S. 135-40.4 and G.S. 135-40.6.~~

~~(e)~~(f) For the purpose of this section, "emergency" is the sudden and unexpected onset of a condition manifesting itself by acute symptoms of sufficient severity that, in the absence of an immediate psychiatric or chemical dependency inpatient admission, could imminently result in injury or danger to self or others.

~~(f)~~(g) ~~For purposes of~~As used in this section, the word "Plan" includes all optional and alternative plans, and programs available under the optional or alternative plans, ~~or plans~~ in effect under the State Health Plan and its successor Plans."

SECTION 3.(o) G.S. 135-40.10 is recodified as G.S. 135-39.22 under Part 3A of Article 3A of Chapter 135 of the General Statutes, as enacted by this act, and, as recodified, reads as rewritten:

"**§ 135-39.22. Persons eligible for ~~Medicare.~~Medicare; optional participation in other Medicare products.**

(a) Benefits payable for covered expenses under this Plan in ~~G.S. 135-40.5~~G.S. 135-39.18 through ~~G.S. 135-40.9~~G.S. 135-39.22 will be reduced by any benefits payable for the same covered expenses under Medicare, so that Medicare will be the primary carrier except where compliance with federal law specifies otherwise.

(b) For those participants eligible for Medicare, the ~~State's plan~~Plan will be administered on a "carve out" basis. The provisions of the ~~plan~~ Plan are applied to the charges not paid by Medicare (Parts A & B). In other words, those charges not paid by Medicare would be subject to the deductible and coinsurance of the Plan just as if the charges not paid by Medicare were the total bill.

(c) For those individuals eligible for Part A (at no cost to them), benefits under this program will be reduced by the amounts to which the covered individuals would be entitled to under Parts A and B of Medicare, even if they choose not to enroll for Part B.

(d) Notwithstanding the foregoing provisions of this section or any other provisions of the Plan, the Executive Administrator and Board of Trustees may enter into negotiations with the ~~Health Care Financing Administration,~~ Centers for Medicare and Medicaid Services, U.S. Department of Health and Human Services, in order to secure a more favorable coordination of the Plan's benefits with those provided by Medicare, including but not limited to, measures by which the Plan would provide Medicare benefits for all of its Medicare-eligible members in return for adequate payments from the federal government in providing such benefits. Should such negotiations result in an agreement favorable to the Plan and its Medicare-eligible members, the Executive Administrator and Board of Trustees may, after consultation with the Committee on Employee Hospital and Medical Benefits, implement such an agreement which shall supersede all other provisions of the Plan to the contrary related to its payment of claims for Medicare-eligible members.

(e) Notwithstanding subsections (a), (b), and (c) of this section, the Plan may offer an optional Medicare Advantage plan to a Medicare eligible Plan member. A Medicare Advantage plan offered by the Plan shall be an insured product offered through a private insurance carrier authorized by the Centers for Medicare and Medicaid Services to offer Medicare Advantage plans. A Medicare Advantage plan offered by the Plan shall not be a self-funded benefit plan underwritten by the State of North Carolina. Prescription drug benefits shall not be included in the benefits offered under a Medicare Advantage insurance product but shall continue to be provided by the Plan as authorized under G.S. 135-39.18

An eligible Plan member may choose to enroll in a Medicare Advantage plan in lieu of any other benefit coverage plan offered under the Plan to Medicare eligible Plan members. A Medicare eligible Plan member must be enrolled in Medicare Part B to participate in an optional Medicare Advantage plan. A non-Medicare eligible dependent of a Medicare Advantage eligible Plan member may enroll on a fully contributory basis in benefit plans offered under the Plan to non-Medicare eligible Plan members. If an enrolled Plan member decides not to re-enroll in an optional Medicare Advantage plan during the Plan's annual enrollment period, the Plan member may at that time re-enroll

in other benefit coverage offered by the Plan in accordance with the provisions of subsections (a), (b), and (c) of this section."

SECTION 3.(p) Part 3A of Article 3A of Chapter 135 of the General Statutes, as enacted by this act, is amended by adding the following new section to read:

"**§ 135-39.23. Cost-savings initiatives and incentive programs authorized.**

(a) Cost-Saving Initiatives. – Coverage of Over-the-Counter Medications. – The Executive Administrator and Board of Trustees may authorize coverage for over-the-counter medications as recommended by the Plan's pharmacy and therapeutics committee. In approving for coverage one or more over-the-counter medications, the Executive Administrator and Board of Trustees shall ensure that each recommended over-the-counter medication has been analyzed to ensure medical effectiveness and Plan member safety. The analysis shall also address the financial impact on the Plan. The Executive Administrator and Board of Trustees may impose a co-payment to be paid by each covered individual for each packaged over-the-counter medication. The Executive Administrator and Board of Trustees may adopt policies establishing limits on the amount of coverage available for over-the-counter medications for each covered individual over a 12-month period. Prior to implementing policy and co-payment changes authorized under this section, the Executive Administrator and Board of Trustees shall submit the proposed policies and co-payments to the Committee on Employee Hospital and Medical Benefits for its review.

(b) Incentive Programs. – For the purposes of helping Plan members to achieve and maintain a healthy lifestyle without impairing patient care, and to increase cost effectiveness in Plan coverage, the Executive Administrator and Board of Trustees may adopt programs offering incentives to Plan members to encourage changes in member behavior or lifestyle designed to improve member health and promote cost-efficiency in the Plan. Participation in one or more incentive programs is voluntary on the part of the Plan member. Before adopting an incentive program, the Executive Administrator and Board of Trustees shall conduct an impact analysis on the proposed incentive program to determine (i) whether the program is likely to result in significant member satisfaction, (ii) that it will not adversely affect quality of care, and (iii) whether it is likely to result in significant cost savings to the Plan. The impact analysis may be conducted by a committee of the Plan, in conjunction with the Plan's consulting actuary, provided that the Plan's medical director participates in the analysis. An approved incentive plan may provide for a waiver of deductibles, co-payments, and coinsurance required under this Article in order to determine the effectiveness of the incentive program in promoting the health of members and increasing cost-effectiveness to the Plan. The Executive Administrator and Board of Trustees shall, before implementing incentive programs authorized under this section, submit the proposed programs to the Committee on Employee Hospital and Medical Benefits for review."

SECTION 3.(q) G.S. 135-40.11 is recodified as G.S. 135-39.24 under Part 3A of Article 3A of Chapter 135 of the General Statutes, as enacted by this act, and as recodified, reads as rewritten:

"**§ 135-39.24. Cessation of coverage.**

(a) Coverage under this Plan of an employee and his or her surviving spouse or eligible dependent children or of a retired employee and his or her surviving spouse or eligible dependent children shall cease on the earliest of the following dates:

(1) The last day of the month in which an employee or retired employee dies. Provided such surviving spouse or eligible dependent children were covered under the Plan at the time of death of the former employee or retired employee, or were covered on September 30, 1986, any such surviving spouse or eligible dependent children may then elect to continue coverage under the Plan by submitting written application to the Claims Processor and by paying the cost for such coverage when due at the applicable fees. Such coverage shall cease on the last day of the month in which such surviving spouse or eligible dependent children die, except as provided by this Article.

(2) The last day of the month in which an employee's employment with the State is terminated as provided in subsection (c) of this section.

(3) The last day of the month in which a divorce becomes final.

(4) The last day of the month in which an employee or retired employee requests cancellation of coverage.

(5) The last day of the month in which a covered individual enters active military service.

(6) The last day of the month in which a covered individual is found to have knowingly and willfully made or caused to be made a false statement or false representation of a material fact in a claim for reimbursement of medical services under the Plan. The Executive Administrator and Board of Trustees may make an exception to the provisions of this subdivision when persons subject to this subdivision have had a cessation of coverage for a period of five years and have made a full and complete restitution to the Plan for all fraudulent claim amounts. Nothing in this subdivision shall be construed to obligate the Executive Administrator and Board of Trustees to make an exception as allowed for under this subdivision.

(7) The last day of the month in which an employee who is Medicare-eligible selects Medicare to be the primary payer of medical benefits. Coverage for a Medicare-eligible spouse of an employee shall also cease the last day of the month in which Medicare is selected to be the primary payer of medical benefits for the Medicare-eligible spouse. Such members are eligible to apply for conversion coverage.

(b) Coverage under this Plan as a dependent child ceases when the child ceases to be a dependent child as defined by ~~G.S. 135-40.1(3)~~G.S. 135-39.13 except, coverage may continue under this Plan for a period of not more than 36 months after loss of dependent status on a fully contributory basis provided the dependent child was covered under the Plan at the time of loss of dependent status.

~~(b1)~~(c) Coverage under the Plan as a surviving dependent child whether covered as a dependent of a surviving spouse, or as an individual member (no living parent),

ceases when the child ceases to be a dependent child as defined by ~~G.S. 135-40.1(3),~~G.S. 135-39.13, except coverage may continue under the Plan on a fully contributory basis for a period of not more than 36 months after loss of dependent status.

~~(c)~~(d) Termination of employment shall mean termination for any reason, including layoff and leave of absence, except as provided in subdivisions (a)(1) and (2) of this section, but shall not, for purposes of this Plan, include retirement upon which the employee is granted an immediate service or disability pension under and pursuant to a State-supported Retirement System.

(1) In the event of termination for any reason other than death, coverage under the Plan for an employee and his or her eligible spouse or dependent children, provided the eligible spouse or dependent children were covered under the Plan at termination of employment may be continued for a period of not more than 18 months following termination of employment on a fully contributory basis. Employees who were covered under the Plan at termination of employment may be continued for a period of not more than 18 months or 29 months if determined to be disabled under the Social Security Act, Title II, OASDI or Title XVI, SSI.

~~(3)~~(2) In the event of approved leave of absence without pay, other than for active duty in the armed forces of the United States, coverage under this Plan for an employee and his or her dependents may be continued during the period of such leave of absence by the employee's paying one hundred percent (100%) of the cost.

~~(4)~~(3) If employment is terminated in the second half of a calendar month and the covered individual has made the required contribution for any coverage in the following month, that coverage will be continued to the end of the calendar month following the month in which employment was terminated.

~~(5)~~(4) Employees paid for less than 12 months in a year, who are terminated at the end of the work year and who have made contributions for the non-work months, will continue to be covered to the end of the period for which they have made contributions, with the understanding that if they are not employed by another State-covered employer under this Plan at the beginning of the next work year, the employee will refund to the ex-employer the amount of the employer's cost paid for them during the non-paycheck months.

~~(6)~~(5) Any employee receiving benefits pursuant to Article 6 of this Chapter when the employee has less than five years of retirement membership service, or an employee on leave of absence without pay due to illness or injury for up to 12 months, is entitled to continued coverage under the Plan for the employee and any eligible dependents by the employee's paying one hundred percent (100%) of the cost.

~~(d) No benefits will be paid by this Plan for any expenses incurred or treatment received after cessation of coverage as provided in subsections (a) or (b) of this section, except that in the event of hospital confinement at that time, hospitalization benefits as described in G.S. 135-40.6 will continue to the extent provided therein.~~

~~(e)~~(d) A legally divorced spouse and any eligible dependent children of a covered employee or retired employee may continue coverage under this Plan for a period of not more than 36 months following the first of the month after a divorce becomes final on a fully contributory basis, provided the former spouse and any eligible dependent children were covered under the Plan at the time a divorce became final.

~~(f)~~(e) A legally separated spouse of a covered employee or retired employee may continue coverage under this Plan for a period not to exceed 36 months from the separation date on a fully contributory basis, provided the separated spouse was covered under the Plan at the time of separation and provided the covered employee's or retired employee's actions result in the loss of coverage for the separated spouse. Eligible dependent children may also continue coverage if covered under the Plan at time of separation, provided the employee's or retired employee's actions result in the loss of coverage for the dependent children.

~~(g)~~(f) Whenever this section gives a right to continuation coverage, such coverage must be elected ~~no later than a date set by the Executive Administrator and Board of Trustees.~~within the time allowed by applicable federal law.

~~(h)~~(g) Continuation coverage under this Plan shall not be continued past the occurrence of any one of the following events:

(1) The termination of the Plan.

(2) Failure of a Plan member to pay monthly in advance any required premiums.

(3) A person becomes a covered employee or a dependent of a covered employee under any group health plan and that group health plan has no restrictions or limitations on benefits.

(4) A person becomes eligible for Medicare benefits on or after the effective date of the continuation coverage.

(5) The person was determined to be no longer disabled, provided the 18-month coverage was extended to 29 months due to having been determined to be disabled under the Social Security Act, Title II, OASDI or Title XVI, SSI.

(6) The person reaches the maximum applicable continuation period of 18, 29, or 36 months.

~~(i)~~(h) Notice requirements concerning continuation coverage shall be developed by the Executive Administrator and Board of Trustees.

~~(j)~~(i) The spouse and any eligible dependent children of a covered employee may continue coverage under the Plan on a fully contributory basis for a period not to exceed 36 months from the date the employee becomes eligible for Medicare benefits which results in a loss of coverage under the Plan, provided that the spouse and eligible dependent children were covered under the Plan at the time the employee became eligible for Medicare benefits which results in a loss of coverage under the Plan."

SECTION 3.(r) G.S. 135-40.12 is recodified as G.S. 135-39.25 under Part 3A of Article 3A of Chapter 135 of the General Statutes, as enacted by this act.

SECTION 3.(s) G.S. 135-40.13 is recodified as G.S. 135-39.26 under Part 3A of Article 3A of Chapter 135 of the General Statutes, as enacted by this act.

SECTION 3.(t) G.S. 135-40.13A is recodified as G.S. 135-39.27 under Part 3A of Article 3A of Chapter 135 of the General Statutes, as enacted by this act.

SECTION 3.(u) G.S. 135-40.14 is recodified as G.S. 135-39.28 under Part 3A of Article 3A of Chapter 135 of the General Statutes, as enacted by this act.

SECTION 3.(v) Effective July 1, 2008, the State Health Plan for Teachers and State Employees shall not limit the number of visits for covered services for physical therapy, occupational therapy, and speech therapy. This subsection expires July 1, 2009. Sections 28.22A(j) and (k) of S.L. 2007-323 are repealed.

SECTION 4.(a) Parts 4 and 5 of Article 3 of Chapter 135 of the General Statutes are recodified as Parts 4A and 5A, respectively, under Article 3A of Chapter 135 of the General Statutes, as enacted by this act.

SECTION 4.(b) G.S. 135-41, as amended by Section 28.22A(o) of S.L. 2007-323, is recodified under Part 4A of Article 3A of Chapter 135 of the General Statutes, as enacted by this act.

SECTION 4.(c) G.S. 135-41(b), as recodified by this act, and as amended by Section 28.22A(o) of S.L. 2007-323, reads as rewritten:

"(b) The long-term care benefits provided by this Part shall be made available through the State Health Plan for Teachers and State Employees pursuant to Article 2A and 3A of this Chapter (hereinafter called the "Plan") and administered by the Plan's Executive Administrator and Board of Trustees. In administering the benefits provided by this Part, the Executive Administrator and Board of Trustees shall have the same type of powers and duties that are provided under ~~Part 3~~Part 3A of this Article for hospital and medical benefits. The benefits provided by this Part may be offered by the Plan on a self-insured basis, in which case a third-party claims processor shall be chosen through competitive ~~bids in accordance with State law,~~bids, or through a contract of insurance, in which case a carrier licensed to do business in North Carolina shall be selected on a competitive bid basis in accordance with State law."

SECTION 4.(d) G.S. 135-41.1 is recodified under Part 4A of Article 3A of Chapter 135 of the General Statutes, as enacted by this act.

SECTION 4.(e) The lead paragraph of G.S. 135-41.1, as recodified by this act under Part 4A of this Article, reads as rewritten:

"**§ 135-41.1. Long-term care benefits.**

Long-term care benefits provided by this Part are subject to elimination periods, coinsurance provisions, and other limitations separate and apart from those provided for in ~~Part 3~~Part 3A of this Article. No limitation on out-of-pocket expenses are provided for the benefits covered by this section. Long-term care benefits are as follows:"

SECTION 5.(a) Effective July 1, 2008, Part 5 of Chapter 135 of the General Statutes is recodified under Article 3A of Chapter 135 of the General Statutes, as enacted by this act.

SECTION 5.(b) G.S. 135-42 reads as rewritten:

"§ 135-42. ~~Undertaking.~~Administration and processing of Program claims.

(a) The State of North Carolina undertakes to make available a health insurance program for ~~children (hereinafter called the "Program")~~ children (Program), which shall be called North Carolina Health Choice for Children. The Program shall ~~to~~ provide comprehensive acute medical care to low-income, uninsured children who are residents of this State and who meet the eligibility requirements established for the Program under Part 8 of Article 2 of Chapter 108A of the General Statutes. ~~The Executive Administrator and Board of Trustees of the State Health Plan for Teachers and State Employees (hereinafter called the "Plan") shall administer the Program under this Part and shall carry out their duties and responsibilities in accordance with Parts 2 and 3 of this Article and with applicable provisions of Part 8 of Article 2 of Chapter 108A. The Plan's self-insured indemnity program shall not incur any financial obligations for the Program in excess of the amount of funds that the Plan's self-insured indemnity program receives for the Program.~~ Except as provided in this Part, the Program shall be administered by the Department of Health and Human Services in accordance with Part 8 of Article 2 of Chapter 108A of the General Statutes and as required under applicable federal law.

(a1) Notwithstanding any other provision of law, the Secretary of the Department of Health and Human Services shall delegate the responsibility for the administration and processing of claims for benefits provided under the Program to the Executive Administrator and Board of Trustees of the State Health Plan for Teachers and State Employees (hereinafter called the "Plan") until such date, but not later than July 1, 2010, the Secretary determines that the Department is prepared to assume some or all of these responsibilities. In administering the processing of claims for benefits, the Executive Administrator and Board of Trustees shall have the same type of powers and duties as provided for these purposes under the Predecessor Plan. For the purposes of this Part, "Predecessor Plan" means the "North Carolina Teachers' and State Employees' Comprehensive Major Medical Plan in effect prior to July 1, 2008." The claims payments shall be made against accounts maintained by the Department of Health and Human Services. The Executive Administrator and Board of Trustees shall establish premium rates for benefits provided under this Part. The Department of Health and Human Services shall, from State and federal appropriations and from any other funds made available for the Program, make payments to the Plan as determined by the Plan for its administration, claims processing, and other services delegated by the Secretary to provide coverage for acute medical care for children eligible for benefits provided under the Program. The Plan shall not incur any financial obligations for the Program in excess of the amount of funds that the Plan receives for the Program.

(b) The benefits provided under the Program shall be equivalent to the Teachers' and State Employees' Comprehensive Major Medical Plan (hereafter "Predecessor Plan") in effect through June 30, 2008, and as provided under Part 8 of Article 2 of Chapter 108A of the General Statutes. ~~and made available through the Plan pursuant to Articles 2 and 3 of this Chapter and as provided under G.S. 108A-70.21(b) and administered by the Plan's Executive Administrator and Board of Trustees.~~ To the extent there is a conflict between the provisions of Part 8 of Article 2 of Chapter 108A

and ~~Part 3 of this Article~~ the Predecessor Plan pertaining to eligibility, fees, deductibles, copayments, and lifetime maximum benefits, and other cost-sharing charges, the provisions of Part 8 of Article 2 of Chapter 108A shall control. In administering the benefits provided by this Part, the Executive Administrator and Board of Trustees shall have the same type of powers and duties that are provided under ~~Part 3 of this Article~~ the Predecessor Plan for hospital and medical benefits.

(c) The benefits authorized by this Part are available only to children who are residents of this State and who meet the eligibility requirements established for the Program under Part 8 of Article 2 of Chapter 108A of the General Statutes."

SECTION 5.(c) Part 5 of Article 3 of Chapter 135 of the General Statutes is amended by adding the following new sections to read:

"**§ 135-43. Child health insurance fund.**

There is established a Child Health Insurance Fund. All premium receipts or any other receipts, including earnings on investments, occurring or arising in connection with acute medical care benefits provided under the Program shall be deposited into the Child Health Insurance Fund. Disbursements from the Child Health Insurance Fund shall include any and all amounts required to pay the benefits and administrative costs of the Health Insurance Program for Children.

"**§ 135-44. Data reporting.**

The Executive Administrator and Board of Trustees of the State Health Plan for Teachers and State Employees shall provide to the Department:

(1) Data as necessary and in sufficient detail to meet federal reporting requirements under Title XXI; and

(2) Data showing cost-sharing paid by Program enrollees to assist the Department in monitoring and ensuring that enrollees do not exceed the Program's cost of sharing limitations.

(3) Data as necessary and in sufficient detail to meet the data collections and reporting requirements pursuant to G.S. 108A -70.27."

SECTION 5.(d) G.S. 108A-70.18 reads as rewritten:

"**§ 108A-70.18. Definitions.**

As used in this Part, unless the context clearly requires otherwise, the term:

(1) "Comprehensive health coverage" means creditable health coverage as defined under Title XXI.

(2) "Family income" has the same meaning as used in determining eligibility for the Medical Assistance Program.

(3) "FPL" or "federal poverty level" means the federal poverty guidelines established by the United States Department of Health and Human Services, as revised each April 1.

(4) "Medical Assistance Program" means the State Medical Assistance Program established under Part 6 of Article 2 of Chapter 108A of the General Statutes.

(4a) "Predecessor Plan" means the North Carolina Teachers' and State Employees' Comprehensive Major Medical Plan in effect prior to July 1, 2008.

(5) "Program" means The Health Insurance Program for Children established in this Part.
(6) "State Plan" means the State Child Health Plan for the State Children's Health Insurance Program established under Title XXI.
(7) "Title XXI" means Title XXI of the Social Security Act, as added by Pub. L. 105-33, 111 Stat. 552, codified in scattered sections of 42 U.S.C. (1997).
(8) "Uninsured" means the applicant for Program benefits is not covered under any private or employer-sponsored comprehensive health insurance plan on the date of enrollment."

SECTION 5.(e) G.S. 108A-70.20 reads as rewritten:

"**§ 108A-70.20. Program established.**

The Health Insurance Program for Children is established. The Program shall be known as North Carolina Health Choice for Children, and it shall be administered by the Department of Health and Human Services in accordance with this Part and as required under Title XXI and related federal rules and regulations. Administration of Program benefits and claims processing shall be as provided under Part 5 of Article 3 of Chapter 135 of the General Statutes."

SECTION 5.(f) Effective July 1, 2008, G.S. 108A-70.21 reads as rewritten:

"**§ 108A-70.21. Program eligibility; benefits; enrollment fee and other cost-sharing; coverage from private plans; purchase of extended coverage.**

(a) Eligibility. – The Department may enroll eligible children based on availability of funds. Following are eligibility and other requirements for participation in the Program:

(1) Children must:
a. Be between the ages of 6 through 18;
b. Be ineligible for Medicaid, Medicare, or other federal government-sponsored health insurance;
c. Be uninsured;
d. Be in a family whose family income is above one hundred percent (100%) through two hundred percent (200%) of the federal poverty level;
e. Be a resident of this State and eligible under federal law; and
f. Have paid the Program enrollment fee required under this Part.

(2) Proof of family income and residency and declaration of uninsured status shall be provided by the applicant at the time of application for Program coverage. The family member who is legally responsible for the children enrolled in the Program has a duty to report any change in the enrollee's status within 60 days of the change of status.

(3) If a responsible parent is under a court order to provide or maintain health insurance for a child and has failed to comply with the court order, then the child is deemed uninsured for purposes of determining eligibility for Program benefits if at the time of application the

custodial parent shows proof of agreement to notify and cooperate with the child support enforcement agency in enforcing the order.

If health insurance other than under the Program is provided to the child after enrollment and prior to the expiration of the eligibility period for which the child is enrolled in the Program, then the child is deemed to be insured and ineligible for continued coverage under the Program. The custodial parent has a duty to notify the Department within 10 days of receipt of the other health insurance, and the Department, upon receipt of notice, shall disenroll the child from the Program. As used in this paragraph, the term "responsible parent" means a person who is under a court order to pay child support.

(4) Except as otherwise provided in this section, enrollment shall be continuous for one year. At the end of each year, applicants may reapply for Program benefits.

(b) Benefits. – Except as otherwise provided for eligibility, fees, deductibles, copayments, and other cost-sharing charges, health benefits coverage provided to children eligible under the Program shall be equivalent to coverage provided for dependents under the ~~State Health Plan for Teachers and State Employees, including optional prepaid plans.~~Predecessor Plan.

In addition to the benefits provided under the ~~Plan,~~Predecessor Plan, the following services and supplies are covered under the Health Insurance Program for Children established under this Part:

(1) Dental: Oral examinations, teeth cleaning, and scaling twice during a 12-month period, full mouth X-rays once every 60 months, supplemental bitewing X-rays showing the back of the teeth once during a 12-month period, fluoride applications twice during a 12-month period, fluoride varnish, sealants, simple extractions, therapeutic pulpotomies, prefabricated stainless steel crowns, and routine fillings of amalgam or other tooth-colored filling material to restore diseased teeth. No benefits are to be provided for services and materials under this subsection that ~~are not performed by or upon the direction of a dentist, doctor, or other professional provider approved by the Plan nor for services and materials that~~ do not meet the standards accepted by the American Dental Association.

(2) Vision: Scheduled routine eye examinations once every 12 months, eyeglass lenses or contact lenses once every 12 months, routine replacement of eyeglass frames once every 24 months, and optical supplies and solutions when needed. Optical services, supplies, and solutions must be obtained from licensed or certified ophthalmologists, optometrists, or optical dispensing laboratories. Eyeglass lenses are limited to single vision, bifocal, trifocal, or other complex lenses necessary for a Plan enrollee's visual welfare. Coverage for oversized lenses and frames, designer frames, photosensitive lenses, tinted contact lenses, blended lenses, progressive multifocal lenses, coated

lenses, and laminated lenses is limited to the coverage for single vision, bifocal, trifocal, or other complex lenses provided by this subsection. Eyeglass frames are limited to those made of zylonite, metal, or a combination of zylonite and metal. All visual aids covered by this subsection require ~~prior approval of the Plan. Upon prior approval by the Plan,~~ prior approval. Upon prior approval refractions may be covered more often than once every 12 months.

(3) Hearing: Auditory diagnostic testing services and hearing aids and accessories when provided by a licensed or certified audiologist, otolaryngologist, or other approved hearing aid ~~specialist approved by the Plan. Prior approval of the Plan~~ specialist. Prior approval is required for hearing aids, accessories, earmolds, repairs, loaners, and rental aids.

(4) Over-the-counter medications: Selected over-the-counter medications provided the medication is covered under the State Medical Assistance Plan. Coverage shall be subject to the same policies and approvals as required under the Medicaid program.

~~Effective January 1, 2006, the~~ The Department shall provide services to children enrolled in the NC Health Choice Program through Community Care of North Carolina and shall pay Community Care of North Carolina providers for these services as allowed under Medicaid.

(b1) Payments. – Prescription drug providers shall accept as payment in full, for outpatient prescriptions filled, amounts allowable for prescription drugs under Medicaid. For all other providers, ~~effective no later than January 1, 2006,~~ services provided to children enrolled in the Program shall be provided at rates equivalent to one hundred ~~fifteen percent (115%)~~ percent (100%) of Medicaid rates, less any co-payments assessed to enrollees under this Part. ~~Effective July 1, 2006, services provided to these children shall be provided at rates equivalent to one hundred percent (100%) of Medicaid rates, less any co-payments assessed to enrollees under this Part. Effective until rates equivalent to one hundred fifteen percent (115%) of Medicaid rates become effective, providers of services to Program enrollees shall accept as payment in full for services rendered the maximum allowable charges under the State Health Plan for Teachers and State Employees for services less any co-payments assessed to enrollees under this Part.~~

(c) Annual Enrollment Fee. – There shall be no enrollment fee for Program coverage for enrollees whose family income is at or below one hundred fifty percent (150%) of the federal poverty level. The enrollment fee for Program coverage for enrollees whose family income is above one hundred fifty percent (150%) of the federal poverty level shall be fifty dollars ($50.00) per year per child with a maximum annual enrollment fee of one hundred dollars ($100.00) for two or more children. The enrollment fee shall be collected by the county department of social services and retained to cover the cost of determining eligibility for services under the Program. County departments of social services shall establish procedures for the collection of enrollment fees.

(d) Cost-Sharing. – There shall be no deductibles, copayments, or other cost-sharing charges for families covered under the Program whose family income is at or below one hundred fifty percent (150%) of the federal poverty level, except that fees for outpatient prescription drugs are applicable and shall be one dollar ($1.00) for each outpatient generic prescription ~~drug and~~drug, for each outpatient brand-name prescription drug for which there is no generic substitution ~~available.~~available, and for each covered over-the-counter medication. The fee for each outpatient brand-name prescription drug for which there is a generic substitution available is three dollars ($3.00). Families covered under the Program whose family income is above one hundred fifty percent (150%) of the federal poverty level shall be responsible for copayments to providers as follows:

(1) Five dollars ($5.00) per child for each visit to a provider, except that there shall be no copayment required for well-baby, well-child, or age-appropriate immunization services;

(2) Five dollars ($5.00) per child for each outpatient hospital visit;

(3) A one dollar ($1.00) fee for each outpatient generic prescription ~~drug and~~drug, for each outpatient brand-name prescription drug for which there is no generic substitution ~~available.~~available, and for each covered over-the-counter medication. The fee for each outpatient brand-name prescription drug for which there is a generic substitution available is ten dollars ($10.00).

(4) Twenty dollars ($20.00) for each emergency room visit unless:

a. The child is admitted to the hospital, or

b. No other reasonable care was available as determined by the ~~Claims Processing Contractor of the State Health Plan for Teachers and State Employees.~~Department.

Copayments required under this subsection for prescription drugs apply only to prescription drugs prescribed on an outpatient basis.

(e) Cost-Sharing Limitations. ~~The total annual aggregate cost-sharing, including fees, with respect to all children in a family receiving Program benefits under this Part shall not exceed five percent (5%) of the family's income for the year involved. To assist the Department in monitoring and ensuring that the limitations of this subsection are not exceeded, the Executive Administrator and Board of Trustees of the State Health Plan for Teachers and State Employees shall provide data to the Department showing cost-sharing paid by Program enrollees.~~ The Department shall establish maximum annual cost-sharing limits per individual or family, provided that the total annual aggregate cost-sharing, including enrollment fees, with respect to all children in a family receiving benefits under this section shall not exceed five percent (5%) of the family's income for the year involved.

(f) Coverage From Private Plans. – The Department shall, from funds available for the Program, pay the cost for dependent coverage provided under a private insurance plan for persons eligible for coverage under the Program if all of the following conditions are met:

(1) The person eligible for Program coverage requests to obtain dependent coverage from a private insurer in lieu of coverage under the Program and shows proof that coverage under the private plan selected meets the requirements of this subsection;

(2) The dependent coverage under the private plan is actuarially equivalent to the coverage provided under the Program and the private plan does not engage in the exclusive enrollment of children with favorable health care risks;

(3) The cost of dependent coverage under the private plan is the same as or less than the cost of coverage under the Program; and

(4) The total annual aggregate cost-sharing, including fees, paid by the enrollee under the private plan for all dependents covered by the plan, do not exceed five percent (5%) of the enrollee's family income for the year involved.

The Department may reimburse an enrollee for private coverage under this subsection upon a showing of proof that the dependent coverage is in effect for the period for which the enrollee is eligible for the Program.

(g) Purchase of Extended Coverage. – An enrollee in the Program who loses eligibility due to an increase in family income above two hundred percent (200%) of the federal poverty level and up to and including two hundred 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 same benefits, copayments, and other conditions of enrollment under the Program shall apply to extended coverage purchased under this subsection.

(h) No State Funds for Voluntary Participation. – No State or federal funds shall be used to cover, subsidize, or otherwise offset the cost of coverage obtained under subsection (f) of this section.

(i) No Lifetime Maximum Benefit Limit. – Benefits provided to an enrollee in the Program shall not be subject to a maximum lifetime limit."

SECTION 5.(g) G.S. 108A-70.22 is repealed.

SECTION 5.(h) G.S. 108A-70.23 reads as rewritten:

"**§ 108A-70.23. Services for children with special needs established; definition; eligibility; services; limitation; recommendations; no entitlement.**

(a) [Special Needs Services Authorized. –] The Department shall, from federal funds received and State funds appropriated for the Program, pay for services for children with special needs as authorized under this section. As used in this section, the term "children with special needs" or "special needs child" means children who have been diagnosed as having one or more of the following conditions which in the opinion of the diagnosing physician (i) is likely to continue indefinitely, (ii) interferes with daily routine, and (iii) require extensive medical intervention and extensive family management:

(1) Birth defect, including genetic, congenital, or acquired disorders;

(2) Developmental disability as defined under G.S. 122C-3;

(3) Mental or behavioral disorder; or
(4) Chronic and complex illnesses.

(b) Eligibility for Services. – In order to be eligible for services under this section a special needs child must be enrolled in the Program.

(c) Services Provided. – The services authorized to be provided to children eligible under this section are as follows:

(1) The same level of services as provided for special needs children under the Medical Assistance Program as authorized in the Current Operations Appropriations Act except that:
a. No services for long-term care shall be provided under this section;
b. Services for respite care shall be provided only under emergency circumstances; and
c. The Department may limit services for special needs children after consultation with the Commission on Children with Special Health Care Needs.

(2) Only those services eligible under this section that are not covered or otherwise provided under ~~Part 5 of Article 3 of Chapter 135 of the General Statutes.~~the Predecessor Plan.

(d) Limitation. – Funds may be expended for services under this section only if the special needs child is enrolled in the Program, the services provided under this section are not provided under ~~Part 5 of Article 3 of Chapter 135 of the General Statutes,~~ the Predecessor Plan and the child meets the definition of a special needs child under this section.

(e) Case Management Services. – The Department shall develop procedures for the provision of case management services by the Department to eligible special needs children. Case management services shall be developed to ensure to the maximum extent possible that services are provided in the most efficient and effective manner considering the special needs of the child. The cost of providing case management services for children with special needs shall be paid from funds available for services under this section.

(f) Recommendations by Commission on Children With Special Health Care Needs. – In implementing this section the Department shall consider the recommendations of the Commission on Children With Special Health Care Needs established under ~~Article 71~~Article 72 of Chapter 143 of the General Statutes. The Department, in consultation with the Commission on Children With Special Health Care Needs shall develop procedures for providing respite care services under emergency circumstances.

(g) No Entitlement. – Nothing in this section shall be construed as entitling any person to services under this section."

SECTION 5.(i) G.S. 108A-70.24 is repealed.

SECTION 5.(j) G.S. 108A-27(c) reads as rewritten:

"**§ 108A-70.27. Data collection; reporting.**

...

(c) ~~The Executive Administrator and Board of Trustees of the North Carolina Teachers' and State Employees' Major Medical Plan ("Plan") shall provide to the Department data required under this section that are collected by the Plan. Data shall be reported by the Plan in sufficient detail to meet federal reporting requirements under Title XXI. The Plan~~The Department shall report periodically to the Joint Legislative Health Care Oversight Committee claims processing data for the Program and any other information the Plan or the Committee deems appropriate and relevant to assist the Committee in its review of the Program."

SECTION 5.(k) Effective July 1, 2009, G.S. 108A-70.21(b)(1), as amended by subsection (g) of this section, reads as rewritten:

"**§ 108A-70.21. Program eligibility; benefits; enrollment fee and other cost-sharing; coverage from private plans; purchase of extended coverage.**

...

(b) Benefits. – Except as otherwise provided for eligibility, fees, deductibles, copayments, and other cost-sharing charges, health benefits coverage provided to children eligible under the Program shall be equivalent to coverage provided for dependents under the Predecessor Plan.

In addition to the benefits provided under the Predecessor Plan, dental services and supplies as follows:

(1) ~~Dental:~~ Oral examinations, teeth cleaning, and ~~scaling~~ topical fluoride treatments twice during a 12-month period, full mouth X-rays once every 60 months, supplemental bitewing X-rays showing the back of the teeth once during a 12-month period, ~~fluoride applications twice during a 12-month period, fluoride varnish, sealants, simple extractions,~~sealants, extractions, other than impacted teeth or wisdom teeth, therapeutic pulpotomies, space maintainers, root canal therapy for permanent anterior teeth and permanent first molars, prefabricated stainless steel crowns, and routine fillings of amalgam or other tooth-colored filling material to restore diseased teeth.

(1a) Orthognathic surgery to correct functionally impairing malocclusions when orthodontics was approved and initiated while the child was covered by Medicaid and the need for orthognathic surgery was documented in the orthodontic treatment plan.

No benefits are to be provided for services and materials under this subsection that do not meet the standards accepted by the American Dental Association."

SECTION 5.(l) Subsections (a) through (c) and subsections (e) through (k) of this section become effective July 1, 2008. Effective July 1, 2010, G.S. 135-42, as amended by subsection (b) of this section, is repealed. The remainder of this section is effective when this act becomes law.

SECTION 5.(m) Notwithstanding subsection (l) of this section, if Section 10.13 of House Bill 2436, 2007 General Assembly, 2008 Regular Session, is enacted effective July 1, 2008, then this section is repealed.

SECTION 6.(a) Effective July 1, 2008, G.S. 150B-1(d)(7), as amended by Section 28.22A(o) of S.L. 2007-323, reads as rewritten:

"(7) The State Health Plan for Teachers and State Employees in administering the provisions of ~~Parts 2, 3, 4, and 5 of Article 3~~ Article 3A of Chapter 135 of the General Statutes."

SECTION 6.(b) G.S. 150B-44 reads as rewritten:

"**§ 150B-44. Right to judicial intervention when decision unreasonably delayed.**

Unreasonable delay on the part of any agency or administrative law judge in taking any required action shall be justification for any person whose rights, duties, or privileges are adversely affected by such delay to seek a court order compelling action by the agency or administrative law judge. An agency that is subject to Article 3 of this Chapter and is not a board or commission has 60 days from the day it receives the official record in a contested case from the Office of Administrative Hearings to make a final decision in the case. This time limit may be extended by the parties or, for good cause shown, by the agency for an additional period of up to 60 days. An agency that is subject to Article 3 of this Chapter and is a board or commission has 60 days from the day it receives the official record in a contested case from the Office of Administrative Hearings or 60 days after its next regularly scheduled meeting, whichever is longer, to make a final decision in the case. This time limit may be extended by the parties or, for good cause shown, by the agency for an additional period of up to 60 days. If an agency subject to Article 3 of this Chapter has not made a final decision within these time limits, the agency is considered to have adopted the administrative law judge's decision as the agency's final decision. Failure of an agency subject to Article 3A of this Chapter to make a final decision within 120 days of the close of the contested case hearing is justification for a person whose rights, duties, or privileges are adversely affected by the delay to seek a court order compelling action by the agency or, if the case was heard by an administrative law judge, by the administrative law judge. The Board of Trustees of the North Carolina State Health Plan for Teachers and State Employees is a "board" for purposes of this section."

SECTION 7. Section 31.24 of S.L. 2004-124 is repealed.

SECTION 8. This act becomes effective July 1, 2008.

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JULY 9, 2008

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