

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2009

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SENATE BILL 287
Select Committee on Employee Hospital and Medical Benefits Committee Substitute
Adopted 3/10/09
Third Edition Engrossed 3/24/09
House Committee Substitute Favorable 4/6/09
House Committee Substitute #2 Favorable 4/8/09
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Short Title: State Hlth Plan \$/Good Health Initiatives. (Public)

Sponsors:

Referred to:

February 25, 2009

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

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

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

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

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

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

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

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

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

28 The General Assembly of North Carolina enacts:

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

30 **SECTION 1.(a)** Appropriation for 2008-2009 fiscal year. – There is appropriated
31 from the Savings Reserve Account established in G.S. 143C-4-2 to the Health Benefit Reserve



1 Fund established in G.S. 135-44.5 the sum of two hundred fifty million dollars (\$250,000,000)
2 for the 2008-2009 fiscal year. These funds shall be used to address the shortfall in funds
3 available for the payment of health care and administrative costs under the State Health Plan
4 for Teachers and State Employees ("Plan") for the 2008-2009 fiscal year.

5 **SECTION 1.(b)** General Fund appropriation for 2009-2011 fiscal biennium. –
6 Notwithstanding G.S. 143C-5-2, there is appropriated from the General Fund to the Reserve for
7 the State Health Plan in the Office of State Budget and Management the sum of one hundred
8 forty-eight million seven hundred sixty-nine thousand six hundred sixty-two dollars
9 (\$148,769,662) for the 2009-2010 fiscal year and the sum of three hundred twelve million four
10 hundred sixteen thousand two hundred ninety-one dollars (\$312,416,291) for the 2010-2011
11 fiscal year. These funds shall be used to cover health care and administrative costs to the Plan
12 in the 2009-2011 fiscal biennium.

13 **SECTION 1.(c)** Highway Fund appropriation for the 2009-2011 fiscal biennium. –
14 Notwithstanding G.S. 143C-5-2, there is appropriated from the Highway Fund to the Reserve
15 for the State Health Plan in the Office of State Budget and Management the sum of six million
16 nine hundred forty-two thousand five hundred eighty-four dollars (\$6,942,584) for the
17 2009-2010 fiscal year and the sum of fourteen million five hundred seventy-nine thousand four
18 hundred twenty-seven dollars (\$14,579,427) for the 2010-2011 fiscal year. These funds shall
19 be used to cover health care and administrative costs to the Plan in the 2009-2011 fiscal
20 biennium.

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

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

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

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

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

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

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

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

- 50 (1) The Plan will pay allowable charges for each outpatient prescription drug
51 less a copayment to be paid by each covered individual equal to the

1 following amounts: pharmacy charges up to ten dollars (\$10.00) for each
2 generic prescription, ~~thirty dollars (\$30.00)~~ thirty-five dollars (\$35.00) for
3 each preferred branded prescription ~~without a generic equivalent, and forty~~
4 ~~dollars (\$40.00)~~ for each preferred branded prescription with a generic
5 equivalent drug, and ~~fifty dollars (\$50.00)~~ fifty-five dollars (\$55.00) for each
6 nonpreferred branded ~~or generic~~ prescription. For each branded prescription
7 drug with a generic equivalent drug, the member shall pay the generic
8 co-payment plus the difference between the Plan's gross allowed cost for the
9 generic prescription and the Plan's cost for the branded prescription drug.

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

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

28 The Plan shall impose a co-payment in the amount of twenty-five percent
29 (25%) of the Plan's gross allowed cost of the specialty drug not to exceed
30 one hundred dollars (\$100.00) per prescription per 30-day supply.

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

35 ~~These co-payments apply to all optional alternative plans available under the Plan.~~

36 (4) Allowable charges shall not be greater than a pharmacy's usual and
37 customary charge to the general public for a particular prescription.
38 Prescriptions shall be for no more than a ~~34 day~~ 30-day supply for the
39 purposes of the copayments paid by each covered individual. By accepting
40 the copayments and any remaining allowable charges provided by this
41 subsection, pharmacies shall not balance bill an individual covered by the
42 Plan. A prescription legend drug is defined as an article the label of which,
43 under the Federal Food, Drug, and Cosmetic Act, is required to bear the
44 legend: "Caution: Federal Law Prohibits Dispensing Without Prescription."
45 Such articles may not be sold to or purchased by the public without a
46 prescription order. Benefits are provided for insulin even though a
47 prescription is not required. ~~The Plan may use a pharmacy benefit manager~~
48 ~~to help manage the Plan's outpatient prescription drug coverage. In~~
49 ~~managing the Plan's outpatient prescription drug benefits, the Plan and its~~
50 ~~pharmacy benefit manager shall not provide coverage for sexual~~
51 ~~dysfunction, growth hormone, antiwrinkle, weight loss, and hair growth~~

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

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

20 **SECTION 2.(c)** Routine eye examinations not covered. – Effective January 1,
21 2010, G.S. 135-45.8(13) reads as rewritten:

22 "**§ 135-45.8. General limitations and exclusions.**

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

25 ...

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

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

33 (1) Basic plan (70/30):

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

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

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

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

- 1 d. Increase the in-network specialist co-payment to seventy dollars
 2 (\$70.00) per covered individual. This co-payment does not apply to
 3 chiropractic services.
- 4 e. Increase the in-network and out-of-network inpatient co-payment to
 5 two hundred fifty dollars (\$250.00) per covered individual.
- 6 f. Increase prescription drug co-pays as required under
 7 G.S. 135-45.6(b) as enacted by this act.
- 8 g. The in-network co-payment for physical therapy, occupational
 9 therapy, and speech therapy shall be thirty dollars (\$30.00) per
 10 therapy type per covered individual.
- 11 h. Except as otherwise provided in this act, co-payments and
 12 coinsurance for coverage not otherwise listed in this subdivision shall
 13 remain as applicable in the 2008-2009 benefit year.
- 14 (2) Standard plan (80/20):
- 15 a. Increase the in-network annual deductible to six hundred dollars
 16 (\$600.00) for member-only coverage and to one thousand two
 17 hundred dollars (\$1,200) for the member-only out-of-network annual
 18 deductible.
 19 The aggregate maximum annual deductible for employee-child and
 20 employee-family coverage shall be three times the member-only
 21 annual deductibles.
- 22 b. Increase the in-network coinsurance maximum to two thousand
 23 seven hundred fifty dollars (\$2,750) for member-only coverage and
 24 to five thousand five hundred dollars (\$5,500) for member-only
 25 out-of-network maximum coinsurance. The aggregate maximum
 26 coinsurance for employee-child and employee-family coverage shall
 27 be three times the member-only coinsurance maximums.
- 28 c. Increase the in-network urgent care co-payment to seventy-five
 29 dollars (\$75.00) per covered individual.
- 30 d. Increase the in-network primary care co-payment to twenty-five
 31 dollars (\$25.00) per covered individual. This co-payment applies to
 32 chiropractic services.
- 33 e. Increase the in-network specialist co-payment to sixty dollars
 34 (\$60.00) per covered individual. This co-payment does not apply to
 35 chiropractic services.
- 36 f. Increase the in-network and out-of-network inpatient co-payment to
 37 two hundred dollars (\$200.00) per covered individual.
- 38 g. Increase prescription drug co-pays as required under
 39 G.S. 135-45.6(b) as enacted by this act.
- 40 h. The in-network co-payment for physical therapy, occupational
 41 therapy, and speech therapy shall be twenty-five dollars (\$25.00) per
 42 therapy type per covered individual.
- 43 i. Except as otherwise provided in this act, co-payments and
 44 coinsurance for coverage not otherwise listed in this subdivision shall
 45 remain as applicable in the 2008-2009 benefit year.

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

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

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

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

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

26 **SECTION 2.(h)** Required disclosure. – The Plan's pharmacy benefit manager
27 (PBM) shall disclose to the Plan the amount actually paid or to be paid to the pharmacy for
28 each prescription, including the drug name, dose, and quantity. This information and the
29 corresponding information of the amount the Plan is charged or will be charged by the PBM for
30 each prescription shall be available to the Committee on Employee Hospital and Medical
31 Benefits.

32 **PART THREE: ELIGIBILITY CLARIFICATION.**

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

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

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

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

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

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

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

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

32 "~~Newly~~ Except as otherwise required by applicable federal law, newly acquired
33 dependents (spouse/child) enrolled within 30 days of becoming an eligible dependent will not
34 be subject to the 12-month waiting period for preexisting conditions. A dependent can become
35 qualified due to marriage, adoption, entering a foster child relationship, due to the divorce of a
36 dependent child or the death of the spouse of a dependent child, and at the beginning of each
37 legislative session (applies only to enrolled legislators). Effective date for newly acquired
38 dependents if application was made within the 30 days can be the first day of the following
39 month. Effective date for an adopted child can be date of adoption, or date of placement in the
40 adoptive parents' home, or the first of the month following the date of adoption or placement.
41 Firefighters, rescue squad workers, and members of the national guard, and their eligible
42 dependents, are subject to the same terms and conditions as are new employees and their
43 dependents covered by this subdivision. Enrollments in these circumstances must occur within
44 30 days of eligibility to enroll."

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

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

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

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

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

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

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

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

27 **PART FOUR: NC HEALTH CHOICE CHANGES.**

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

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

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

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

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

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

1 extended coverage purchased under this subsection shall be the same as those applicable to an
2 NC Kids' Care enrollee whose family income equals two hundred ~~twenty-five percent (25%)~~-percent
3 (200%) of the federal poverty level."

4 **PART FIVE: OTHER CHANGES.**

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

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

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

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

16 ...

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

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

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

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

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

30 (1) For mental illness treatment:

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

44 (2) For chemical dependency treatment:

- 45 a. ~~Licensed chemical dependency units in licensed psychiatric~~
46 ~~hospitals;~~ hospitals or in State psychiatric hospitals accredited by the
47 Joint Commission on the Accreditation of Healthcare Organizations;
- 48 b. Licensed chemical dependency hospitals;
- 49 c. Licensed chemical dependency treatment facilities;

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

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

8 "**SECTION 28.22A.(k)** Subsection (j) of this section expires ~~June 30, 2009.~~ June 30,
9 2011."

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

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

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

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

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

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

- 1 (1) The amounts for annual deductibles and annual co-insurance maximums in
2 effect on July 1, 2009 shall be fifty percent (50%) of the annual amount for
3 the six-month plan year beginning July 1, 2010 through December 31, 2010.
- 4 (2) The total annual amount of the pharmacy co-payments assessed per plan
5 member shall not exceed one thousand two hundred fifty dollars (\$1,250) for
6 the six-month plan year beginning July 1, 2010 through December 31, 2010.
- 7 (3) Effective January 1, 2011, Plan benefits, co-payments, deductibles,
8 out-of-pocket expenditures, and lifetime maximums shall be as enacted
9 effective July 1, 2009.

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

12 "**§ 135-44.4. Powers and duties of the Executive Administrator and Board of Trustees.**

13 The Executive Administrator and Board of Trustees of the Teachers' and State Employees'
14 Comprehensive Major Medical Plan shall have the following powers and duties:

15 ...

- 16 (29) The Executive Administrator shall ensure provisions in contracts between
17 the Plan and the Plan's Claims Processing Contractor that call for the Plan to
18 contract with an independent auditor, selected by the Plan, to review the
19 Claims Processing Contractor's administrative costs and services to the Plan
20 by the Claim's Processing Contractor."

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

22 "(d) The Plan benefits shall be provided under contracts between the Plan and the claims
23 processors selected by the Plan. The Executive Administrator may contract with a pharmacy
24 benefits manager to administer pharmacy benefits under the Plan. Such contracts shall include
25 the applicable provisions of G.S. 135-45.1 through G.S. 135-45.15 and the description of the
26 Plan in the request for proposal, and shall be administered by the respective claims processor or
27 Pharmacy Benefits Manager, which will determine benefits and other questions arising
28 thereunder. The contracts necessarily will conform to applicable State law. If any of the
29 provisions of G.S. 135-45.1 through G.S. 135-45.15 and the request for proposals must be
30 modified for inclusion in the contract because of State law, such modification shall be made.
31 The Executive Administrator shall ensure that the terms of the contract between the Plan and
32 the Plan's Claims Processing Contractor, the Pharmacy Benefit Manager, and the Disease
33 Management Contractor require the contractor to provide the following:

- 34 (1) Detailed billing by each entity showing itemized cost information, including
35 individual administrative services provided;
- 36 (2) Transactional data; and
- 37 (3) The cost to the Plan for each administrative function performed by the
38 contractor."

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

- 41 "(29) The Plan shall conduct a monthly review of Plan costs as compared to the
42 same month in the immediately preceding year and a comparison of
43 projected costs and savings to actual costs and savings. The Plan shall report
44 the results of the review to the Committee on Employee Hospital and
45 Medical Benefits and the State Health Plan Blue Ribbon Task Force at least
46 semiannually."

47 **SECTION 5.(l)** The Executive Administrator shall propose a new in-network
48 specialist co-payment that establishes a midpoint co-payment for office services covering
49 mental health and chemical dependency, chiropractic and physical therapy, occupational
50 therapy, and speech therapy services. The Executive Administrator shall report to the

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

3 **SECTION 5.(m)** The Director of the Fiscal Research Division of the Legislative
4 Services Office shall prepare a Request for Proposal (RFP) for an independent audit of claims
5 paid by the State Health Plan for Teachers and State Employees. The purpose of the audit is to
6 determine whether savings to the Plan and to Plan members could be achieved if claims
7 payments and processing were more efficiently and effectively administered. The audit shall
8 encompass Plan years beginning in 2005, or earlier, through 2008 and shall look at claims
9 administration and payment under the former Indemnity Plan as compared to the present PPO
10 Plan. In conducting the audit the contracting entity shall identify and make recommendations
11 on all of the following:

- 12 (1) Estimated or actual savings that could be achieved if changes recommended
13 by the Auditor were enacted by the General Assembly, and how those
14 savings should be allocated to the benefit of Plan members.
- 15 (2) The Governance structure of the Plan and whether it should be under the
16 supervision and oversight of the Governor or a State agency.
- 17 (3) The extent to which the failure or inability to share confidential or otherwise
18 protected information with the Board of Directors and the General Assembly
19 contributes to financial weaknesses in the Plan, and how such data sharing
20 should be strengthened.
- 21 (4) The role of the Board of Directors of the Plan and whether the role should be
22 strengthened or otherwise changed.
- 23 (5) Past, present and potential areas of over-payments, over-utilization, under-
24 utilization, or abuse that contributes to increasing costs of Plan benefits,
25 including deductibles, co-payments, dependent premiums, and co-insurance
26 maximums.
- 27 (6) Safeguards to ensure the prompt reporting of claims data and trends to the
28 actuaries under contract with the Plan and the General Assembly.
- 29 (7) Any other matters the contracting entity believes would be useful in helping
30 to strengthen the financial integrity of the Plan and Plan benefits.

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

36 The Director of the Fiscal Research Division shall offer the RFP not later than July 1, 2009.
37 In addition to the requirements of this section, the Director of Fiscal Research may include in
38 the RFP any other matters that in the Director's opinion will produce an audit report in a
39 manner that is most timely and useful to the General Assembly in addressing State Health Plan
40 issues.

41 **PART SIX: SALARY-RELATED CONTRIBUTIONS.**

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

1 hospital-medical benefits, longevity pay, unemployment compensation, accumulated leave,
2 workers' compensation, severance pay, separation allowances, and applicable disability income
3 benefits.

4 Notwithstanding any other provision of law, an employing unit that is subject to Part
5 3A of Article 3A of Chapter 135 of the General Statutes and that hires or has hired as an
6 employee a retiree that is in receipt of monthly retirement benefits from any retirement system
7 supported in whole or in part by contributions of the State shall enroll the retiree in the active
8 group and pay the cost for the hospital-medical benefits if that retiree is employed in a position
9 that would require the employer to pay hospital-medical benefits if the individual had not been
10 retired.

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

27 **SECTION 6.(c)** Effective July 1, 2010, the State's employer contribution rates
28 budgeted for retirement and related benefits as percentage of covered salaries for the 2010-2011
29 fiscal year are: (i) eight and ninety-four hundredths percent (8.94%) – Teachers and State
30 Employees; (ii) thirteen and ninety-four hundredths percent (13.94%) – State Law Enforcement
31 Officers; (iii) twelve and twenty-six hundredths percent (12.26%) – University Employees'
32 Optional Retirement System; (iv) twelve and twenty-six hundredths percent (12.26%) –
33 Community College Optional Retirement Program; (v) eighteen and eleven hundredths percent
34 (18.11%) – Consolidated Judicial Retirement System; and (vi) four and ninety hundredths
35 percent (4.90%) – Legislative Retirement System. Each of the foregoing contribution rates
36 includes four and ninety hundredths percent (4.90%) for hospital and medical benefits. The
37 rate for Teachers and State Employees, State Law Enforcement Officers, Community College
38 Optional Retirement Program, and for the University Employees' Optional Retirement Program
39 includes fifty-two hundredths percent (0.52%) for the Disability Income Plan. The rates for
40 Teachers and State Employees and State Law Enforcement Officers include sixteen-hundredths
41 percent (0.16%) for the Death Benefits Plan. The rate for State Law Enforcement Officers
42 includes five percent (5%) for Supplemental Retirement Income.

43 **SECTION 6.(d)** Effective July 1, 2009, the maximum annual employer
44 contributions, payable monthly, by the State for each covered employee or retiree for the
45 2009-2010 fiscal year to the State Health Plan for Teachers and State Employees are: (i)
46 Medicare-eligible employees and retirees – three thousand four hundred eighty-three dollars
47 (\$3,483) and (ii) non-Medicare-eligible employees and retirees – four thousand five hundred
48 seventy-two dollars (\$4,572).

49 **SECTION 6.(e)** Effective July 1, 2010, the maximum annual employer
50 contributions, payable monthly, by the State for each covered employee or retiree for the
51 2010-2011 fiscal year to the State Health Plan for Teachers and State Employees are: (i)

1 Medicare-eligible employees and retirees – three thousand eight hundred twenty-eight dollars
2 (\$3,828) and (ii) non-Medicare-eligible employees and retirees – five thousand thirty-one
3 dollars (\$5,031).

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

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

- 14 (1) The feasibility of transferring the ongoing day-to-day oversight of the Plan
15 to an independent Board or to a State agency.
- 16 (2) Tiered premium rates for member-only coverage for employees and future
17 retirees based on income or ability to pay.
- 18 (3) Ways to increase participation in dependent coverage including supplements
19 from the State or other methods for reducing dependent premiums.
- 20 (4) Weight management and smoking cessation initiatives to determine the
21 feasibility of implementing the initiatives for the purpose of improving Plan
22 member health and reducing health care costs to the Plan and Plan members.
- 23 (5) The benefits of implementing a closed prescription drug formulary.

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

- 26 (1) Six members by the General Assembly upon the recommendation of the
27 Speaker of the House of Representatives, four of whom shall be members of
28 the House of Representatives, one shall be a public schoolteacher, and one
29 shall be a State or local government retiree other than a retired public
30 schoolteacher. Of the four legislators appointed to the Task Force, one shall
31 be a member of the minority party.
- 32 (2) 6 members by the General Assembly upon the recommendation of the
33 President Pro Tempore of the Senate, four of whom shall be members of the
34 Senate, one shall be a State employee who is not a public schoolteacher, and
35 one shall be a retired State public school employee. Of the four legislators
36 appointed to the Task Force, one shall be a member of the minority party.
- 37 (3) One member by the Governor with expertise in the business of health
38 insurance or in administering health care services other than an insurance
39 company or third-party administrator or contractor of the Plan
- 40 (4) The chair of the Board of Directors of the State Health Plan.
- 41 (5) The Commissioner of Insurance or the Commissioner's designee.

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

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

50 **SECTION 7.(e)** A majority of the Task Force members shall constitute a quorum
51 for the transaction of business. The Speaker of the House of Representatives and the President

1 Pro Tempore of the Senate shall each appoint one Task Force member as chair. Appointments
2 shall be made as soon as possible after this act becomes law. Task Force members shall receive
3 no compensation for their service but shall be paid per diem, subsistence, and travel expenses
4 in accordance with G.S. 120-3.1, G.S. 138-5, and G.S. 138-6, as applicable.

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

8 **PART EIGHT: EFFECTIVE DATE.**

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