

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

Short Title: State Hlth Plan \$/Good Health Initiatives.

(Public)

Sponsors:

Referred to:

February 25, 2009

A BILL TO BE ENTITLED

AN ACT TO APPROPRIATE FUNDS FOR THE STATE HEALTH PLAN FOR TEACHERS  
AND STATE EMPLOYEES AND TO MAKE OTHER CHANGES RELATED TO THE  
STATE HEALTH PLAN.

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

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

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

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

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

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

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

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

The General Assembly of North Carolina enacts:

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

**SECTION 1.(a)** Appropriation for 2008-2009 fiscal year. – There is appropriated  
from the Savings Reserve Account established in G.S. 143C-4-2 to the Health Benefit Reserve  
Fund established in G.S. 135-44.5 the sum of two hundred fifty million dollars (\$250,000,000)  
for the 2008-2009 fiscal year. These funds shall be used to address the shortfall in funds



1 available for the payment of health care and administrative costs under the State Health Plan  
2 for Teachers and State Employees ("Plan") for the 2008-2009 fiscal year.

3 **SECTION 1.(b)** General Fund appropriation for 2009-2011 fiscal biennium. –  
4 Notwithstanding G.S. 143C-5-2, there is appropriated from the General Fund to the Reserve for  
5 the State Health Plan in the Office of State Budget and Management the sum of one hundred  
6 twenty-eight million four hundred ten thousand two hundred eight dollars (\$128,410,208) for  
7 the 2009-2010 fiscal year and the sum of two hundred sixty-seven million nine hundred four  
8 thousand one hundred fourteen dollars (\$267,904,114) for the 2010-2011 fiscal year. These  
9 funds shall be used to cover health care and administrative costs to the Plan in the 2009-2011  
10 fiscal biennium.

11 **SECTION 1.(c)** Highway Fund appropriation for the 2009-2011 fiscal biennium. –  
12 Notwithstanding G.S. 143C-5-2, there is appropriated from the Highway Fund to the Reserve  
13 for the State Health Plan in the Office of State Budget and Management the sum of five million  
14 nine hundred ninety-two thousand four hundred seventy-six dollars (\$5,992,476) for the  
15 2009-2010 fiscal year and the sum of twelve million five hundred two thousand one hundred  
16 ninety-two dollars (\$12,502,192) for the 2010-2011 fiscal year. These funds shall be used to  
17 cover health care and administrative costs to the Plan in the 2009-2011 fiscal biennium.

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

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

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

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

## 32 **PART TWO: HEALTH BENEFIT CHANGES.**

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

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

- 40 (1) Program development. – The Plan shall develop a Comprehensive Wellness  
41 Initiative that includes a focus on smoking cessation and weight  
42 management and that is designed to be implemented effective July 1, 2010,  
43 for smoking cessation and July 1, 2011, for weight management. Benefit  
44 levels shall be determined by the Plan based upon tobacco use or the  
45 inability of the member to meet national, evidence-based healthy weight  
46 clinical guidelines. For purposes of the Comprehensive Wellness Initiative,  
47 "member" includes all State Health Plan primary subscribers and their  
48 covered dependents. The Plan shall develop a process whereby a Plan  
49 member may appeal the Plan's basis for action it takes due to the member's  
50 failure or refusal to comply with the Plan's smoking cessation or weight  
51 management requirements.

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

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

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

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

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

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

43 (1) The Plan will pay allowable charges for each outpatient prescription drug  
44 less a copayment to be paid by each covered individual equal to the  
45 following amounts: pharmacy charges up to ten dollars (\$10.00) for each  
46 generic prescription, ~~thirty dollars (\$30.00)~~ thirty-five dollars (\$35.00) for  
47 each preferred branded prescription without a generic equivalent, and forty  
48 dollars (\$40.00) for each preferred branded prescription with a generic  
49 equivalent drug, and fifty dollars (\$50.00) fifty-five dollars (\$55.00) for each  
50 nonpreferred branded or generic prescription. For each branded prescription  
51 drug with a generic equivalent drug, the member shall pay the generic

1 co-payment plus the difference between the Plan's gross allowed cost for the  
2 generic prescription and the Plan's cost for the branded prescription drug.

3 (2) The Plan shall provide coverage of nonacute specialty medications under the  
4 Plan's pharmacy benefit through a specialty pharmacy vendor under contract  
5 with the Plan. The Plan may transfer coverage of specified specialty disease  
6 medications covered under the Plan's medical benefit to the contracted  
7 specialty pharmacy vendor. Specialty medications are covered biotech  
8 medications and other medications designated and classified by the Plan as  
9 specialty medications that are typically significantly more expensive than  
10 alternative drugs or therapies. Medications classified by the Plan as specialty  
11 medications generally have unique uses for the treatment of complex  
12 diseases, require special dosing or administration, require special handling,  
13 are typically prescribed by a specialist provider, and exceed four hundred  
14 dollars (\$400.00) cost to the Plan per prescription. The Plan shall impose a  
15 co-payment in the amount of Plan per prescription. The Plan shall impose a  
16 co-payment in the amount of twenty-five percent (25%) of the Plan's gross  
17 allowed cost of the specialty drug not to exceed one hundred dollars  
18 (\$100.00) per prescription per 30-day supply.

19 (3) The Plan may exclude coverage of drugs that have therapeutic equivalents  
20 that are available over the counter. Before excluding coverage under this  
21 subdivision, the Plan shall consult with the Plan's Pharmacy and  
22 Therapeutics Committee.

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

24 (4) Allowable charges shall not be greater than a pharmacy's usual and  
25 customary charge to the general public for a particular prescription.  
26 Prescriptions shall be for no more than a ~~34-day~~30-day supply for the  
27 purposes of the copayments paid by each covered individual. By accepting  
28 the copayments and any remaining allowable charges provided by this  
29 subsection, pharmacies shall not balance bill an individual covered by the  
30 Plan. A prescription legend drug is defined as an article the label of which,  
31 under the Federal Food, Drug, and Cosmetic Act, is required to bear the  
32 legend: "Caution: Federal Law Prohibits Dispensing Without Prescription."  
33 Such articles may not be sold to or purchased by the public without a  
34 prescription order. Benefits are provided for insulin even though a  
35 prescription is not required. ~~The Plan may use a pharmacy benefit manager~~  
36 ~~to help manage the Plan's outpatient prescription drug coverage. In~~  
37 ~~managing the Plan's outpatient prescription drug benefits, the Plan and its~~  
38 ~~pharmacy benefit manager shall not provide coverage for sexual~~  
39 ~~dysfunction, growth hormone, antiwrinkle, weight loss, and hair growth~~  
40 ~~drugs unless such coverage is medically necessary to the health of the~~  
41 ~~member. The Plan and its pharmacy benefit manager shall not provide~~  
42 ~~coverage for growth hormone and weight loss drugs and antifungal drugs for~~  
43 ~~the treatment of nail fungus and botulinum toxin without approval in~~  
44 ~~advance by the pharmacy benefit manager. The Plan may adopt utilization~~  
45 ~~management procedures for certain drugs, but in no event shall the Plan~~  
46 ~~provide coverage for sexual dysfunction or hair growth drugs or~~  
47 ~~nonmedically necessary drugs used for cosmetic purposes. Any formulary~~  
48 ~~used by the Plan's Executive Administrator and pharmacy benefit manager~~  
49 ~~shall be an open formulary. Plan members shall not be assessed more than~~  
50 ~~two thousand five hundred dollars (\$2,500) per person per fiscal year in~~  
51 ~~copayments required by this subsection. The Plan's Pharmacy Benefit~~

1           Manager, or any pharmacy or vendor participating in the Plan shall charge  
2           the Plan for any prescription legend drug dispensed under the Plan's  
3           pharmacy benefit based upon the original National Drug Code (NDC) as  
4           established by the manufacturer of the prescription legend drug and  
5           published by the United States Food and Drug Administration.

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

8           **SECTION 2.(d)** Routine eye examinations not covered. – Effective January 1,  
9           2010, G.S. 135-45.8(13) reads as rewritten:

10          **"§ 135-45.8. General limitations and exclusions.**

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

13                 ...

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

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

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

- 22                     a. Increase the in-network annual deductible to eight hundred dollars  
23                     (\$800.00) for member-only coverage and to one thousand six  
24                     hundred dollars (\$1,600) for the out-of-network annual deductible for  
25                     member-only coverage.

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

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

- 35                     c. Increase the in-network primary care co-payment to thirty dollars  
36                     (\$30.00) per covered individual.

- 37                     d. Increase the in-network specialist co-payment to seventy dollars  
38                     (\$70.00) per covered individual.

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

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

- 43                     g. 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                 (2) Standard plan (80/20):

- 47                     a. Increase the in-network annual deductible to six hundred dollars  
48                     (\$600.00) for member-only coverage and to one thousand two  
49                     hundred dollars (\$1,200) for the member-only out-of-network annual  
50                     deductible.

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

- 4 b. Increase the in-network coinsurance maximum to two thousand  
5 seven hundred fifty dollars (\$2,750) for member-only coverage and  
6 to five thousand five hundred dollars (\$5,500) for member-only  
7 out-of-network maximum coinsurance. The aggregate maximum  
8 coinsurance for employee-child and employee-family coverage shall  
9 be three times the member-only coinsurance maximums.
- 10 c. Increase the in-network urgent care co-payment to seventy-five  
11 dollars (\$75.00) per covered individual.
- 12 d. Increase the in-network primary care co-payment to twenty-five  
13 dollars (\$25.00) per covered individual.
- 14 e. Increase the in-network specialist co-payment to sixty dollars  
15 (\$60.00) per covered individual.
- 16 f. Increase the in-network and out-of-network inpatient co-payment to  
17 two hundred dollars (\$200.00) per covered individual.
- 18 g. Increase prescription drug co-pays as required under  
19 G.S. 135-45.6(b) as enacted by this act.
- 20 h. Except as otherwise provided in this act, co-payments and  
21 coinsurance for coverage not otherwise listed in this subdivision shall  
22 remain as applicable in the 2008-2009 benefit year.

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

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

31 **SECTION 2.(g)** Premium increases. – Premium rates for contributory coverage  
32 established in accordance with G.S. 135-44.6 shall be increased to eight and six-tenths percent  
33 (8.6%) for contributory coverage for the 2009-2010 fiscal year and shall be increased by an  
34 additional eight and six-tenths percent (8.6%) over the premium rate for contributory coverage  
35 for the 2010-2011 fiscal year.

36 **SECTION 2.(h)** Pharmacy benefit savings. – The Plan shall direct its pharmacy  
37 benefit manager (PBM), within the terms of the Plan's PBM contract, to achieve the sum of  
38 eighteen million dollars (\$18,000,000) in savings in pharmacy benefit costs in the 2009-2010  
39 fiscal year, and the sum of twenty million dollars (\$20,000,000) in savings in pharmacy benefit  
40 costs in the 2010-2011 fiscal year through reduced reimbursements paid to pharmacies for  
41 prescription drugs. If the savings achieved in each six-month period of the fiscal year do not  
42 exceed one hundred-five percent (105%) of the savings amount specified in this section for that  
43 fiscal year, there shall be no further adjustment to reimbursements paid to pharmacies for that  
44 six-month period. If the total savings achieved, by fiscal year, exceeds one hundred five  
45 percent (105%) of the specified savings amount in each six month period of the fiscal year, the  
46 Plan shall adjust pharmacy reimbursement reductions accordingly. The Plan shall review  
47 savings achieved twice annually to ensure compliance with this section. The Plan shall  
48 calculate the savings to be achieved based on Plan enrollment and estimated cost and utilization  
49 trends incorporated in the Plan's Financial Projections as of March 20, 2009. The total savings  
50 by fiscal year achieved in this section may be increased or decreased without adjustment based  
51 on a change in total enrollment provided that the rate of savings achieved on a per member per

1 month basis remains constant. Not later than 60 days immediately following each six-month  
2 period, the Plan shall report the amount of savings achieved and any adjustments made for that  
3 period to the Committee on Employee Hospital and Medical Benefits."

4 **PART THREE: ELIGIBILITY CLARIFICATION.**

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

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

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

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

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

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

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

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

3           "(b) ~~"Newly~~ Except as otherwise required by applicable federal law, newly acquired  
4 dependents (spouse/child) enrolled within 30 days of becoming an eligible dependent will not  
5 be subject to the 12-month waiting period for preexisting conditions. A dependent can become  
6 qualified due to marriage, adoption, entering a foster child relationship, due to the divorce of a  
7 dependent child or the death of the spouse of a dependent child, and at the beginning of each  
8 legislative session (applies only to enrolled legislators). Effective date for newly acquired  
9 dependents if application was made within the 30 days can be the first day of the following  
10 month. Effective date for an adopted child can be date of adoption, or date of placement in the  
11 adoptive parents' home, or the first of the month following the date of adoption or placement.  
12 Firefighters, rescue squad workers, and members of the national guard, and their eligible  
13 dependents, are subject to the same terms and conditions as are new employees and their  
14 dependents covered by this subdivision. Enrollments in these circumstances must occur within  
15 30 days of eligibility to enroll."

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

17           "(5) To administer the 12-month waiting period for preexisting conditions under  
18 this that Article, the Plan must give credit against the 12-month period for  
19 the time a person was covered under a previous plan if the previous plan's  
20 coverage was continuous to a date not more than 63 days before the effective  
21 date of coverage. As used in this subdivision, a "previous plan" means any  
22 policy, certificate, contract, or any other arrangement provided by any  
23 accident and health insurer, any hospital or medical service corporation, any  
24 health maintenance organization, any preferred provider organization, any  
25 multiple employer welfare arrangement, any self-insured health benefit  
26 arrangement, any governmental health benefit or health care plan or  
27 program, or any other health benefit arrangement. Waiting periods for  
28 preexisting conditions administered under this Article are subject to  
29 applicable federal law."

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

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

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

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

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

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

50           **SECTION 4.(a)** Over-the-counter medications. – Coverage of over-the-counter  
51 medication authorized under G.S. 108A-70.21(d) for the NC Health Choice Program shall



1 become effective on the later of July 1, 2010, or the date upon which the Department of Health  
2 and Human Services assumes full responsibility for administration and processing of claims  
3 under the NC Health Choice Program.

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

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

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

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

16 "(g) Purchase of Extended Coverage. – An enrollee in the Program who loses eligibility  
17 due to an increase in family income above two hundred ~~fifty percent (250%)~~ percent (200%) of  
18 the federal poverty level and up to and including two hundred ~~seventy five percent (275%)~~  
19 twenty-five percent (225%) of the federal poverty level may purchase at full premium cost  
20 continued coverage under the Program for a period not to exceed one year beginning on the  
21 date the enrollee becomes ineligible under the income requirements for the Program. The  
22 benefits, copayments, and other conditions of enrollment under the Program applicable to  
23 extended coverage purchased under this subsection shall be the same as those applicable to an  
24 NC Kids' Care enrollee whose family income equals two hundred ~~fifty percent (250%)~~ percent  
25 (200%) of the federal poverty level."

26 **PART FIVE: OTHER CHANGES.**

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

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

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

35 "(13a) The Plan and its pharmacy benefit manager may implement and administer  
36 pharmacy and medical utilization management programs and programs to  
37 detect and address utilization abuse of benefits.

38 ...

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

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

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

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

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

- 1 (1) For mental illness treatment:
- 2 a. Licensed psychiatric ~~hospitals;~~
- 3 hospitals or State psychiatric hospitals accredited by the Joint
- 4 Commission on the Accreditation of Healthcare Organizations;
- 5 b. Licensed psychiatric beds in licensed general hospitals;
- 6 c. Licensed residential treatment facilities that have 24-hour on-site
- 7 care provided by a registered nurse who is physically located at the
- 8 facility at all times and that hold current accreditation by a national
- 9 accrediting body approved by the Plan's mental health case manager;
- 10 d. Area Mental Health, Developmental Disabilities, and Substance
- 11 Abuse Authorities or County Programs in accordance with
- 12 G.S. 122C-141;
- 13 e. Licensed intensive outpatient treatment programs; and
- 14 f. Licensed partial hospitalization programs.
- 15 (2) For chemical dependency treatment:
- 16 a. Licensed chemical dependency units in licensed psychiatric
- 17 ~~hospitals;~~ hospitals or in State psychiatric hospitals accredited by the
- 18 Joint Commission on the Accreditation of Healthcare Organizations;
- 19 b. Licensed chemical dependency hospitals;
- 20 c. Licensed chemical dependency treatment facilities;
- 21 d. Area Mental Health, Developmental Disabilities, and Substance
- 22 Abuse Authorities or County Programs in accordance with
- 23 G.S. 122C-141;
- 24 e. Licensed intensive outpatient treatment programs;
- 25 f. Licensed partial hospitalization programs; and
- 26 g. Medical detoxification facilities or units."

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

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

29 2011."

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

31 "(b) Notwithstanding the provisions of this Article, the Executive Administrator and

32 Board of Trustees of the State Health Plan for Teachers and State Employees may contract with

33 providers of institutional and professional medical care and services to establish preferred

34 provider networks.

35 ~~The terms pertaining to reimbursement rates or other terms of consideration of any contract~~

36 ~~between hospitals, hospital authorities, doctors, or other medical providers, or a pharmacy~~

37 ~~benefit manager and the Plan, or contracts pertaining to the provision of any medical benefit~~

38 ~~offered under the Plan, including its optional alternative comprehensive benefit plans, and~~

39 ~~programs available under the optional alternative plans, shall not be a public record under~~

40 ~~Chapter 132 of the General Statutes for a period of 30 months after the date of the expiration of~~

41 ~~the contract. The terms of a contract between the Plan and its third party administrator or~~

42 between the Plan and its pharmacy benefit manager are a public record except that the terms in

43 those contracts that contain trade secrets or proprietary or competitive information are not a

44 public record under Chapter 132 of the General Statutes and any such proprietary or

45 competitive information and trade secrets contained in the contract shall be redacted by the

46 Plan prior to making it available to the public. ~~Provided, however, nothing in this subsection~~

47 shall be deemed to ~~This subsection shall not be construed to prevent or restrict the release of any~~

48 information made not a public record under this subsection to the State Auditor, the Attorney

49 General, the Director of the State Budget, the Plan's Executive Administrator, ~~the Department~~

50 ~~of Health and Human Services solely for the purpose of implementing the transition of NC~~

51 ~~Health Choice from the Plan to the Department of Health and Human Services, and the~~

1 Committee on Employee Hospital and Medical Benefits solely and exclusively for their use in  
2 the furtherance of their duties and ~~responsibilities~~responsibilities, and to the Department of  
3 Health and Human Services solely for the purpose of implementing the transition of NC Health  
4 Choice from the Plan to the Department of Health and Human Services. The design, adoption,  
5 and implementation of the preferred provider contracts, networks, and optional alternative  
6 comprehensive health benefit plans, and programs available under the optional alternative  
7 plans, as authorized under G.S. 135-45 are not subject to the requirements of Chapter 143 of  
8 the General Statutes. The Executive Administrator and Board of Trustees shall make reports as  
9 requested to the President of the Senate, the President Pro Tempore of the Senate, the Speaker  
10 of the House of Representatives, and the Committee on Employee Hospital and Medical  
11 Benefits."

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

13 **SECTION 6.(a)** Effective for the 2009-2011 fiscal biennium, required employer  
14 salary-related contributions for employees whose salaries are paid from department, office,  
15 institution, or agency receipts shall be paid from the same source as the source of the  
16 employees' salary. If an employee's salary is paid in part from the General Fund or Highway  
17 Fund and in part from department, office, institution, or agency receipts, required employer  
18 salary-related contributions may be paid from the General Fund or Highway Fund only to the  
19 extent of the proportionate part paid from the General Fund or Highway Fund in support of the  
20 salary of the employee, and the remainder of the employer's requirements shall be paid from the  
21 source that supplies the remainder of the employee's salary. The requirements of this section as  
22 to source of payment are also applicable to payments on behalf of the employee for  
23 hospital-medical benefits, longevity pay, unemployment compensation, accumulated leave,  
24 workers' compensation, severance pay, separation allowances, and applicable disability income  
25 benefits.

26 Notwithstanding any other provision of law, an employing unit that is subject to Part  
27 3A of Article 3A of Chapter 135 of the General Statutes and that hires or has hired as an  
28 employee a retiree that is in receipt of monthly retirement benefits from any retirement system  
29 supported in whole or in part by contributions of the State shall enroll the retiree in the active  
30 group and pay the cost for the hospital-medical benefits if that retiree is employed in a position  
31 that would require the employer to pay hospital-medical benefits if the individual had not been  
32 retired.

33 **SECTION 6.(b)** Effective July 1, 2009, the State's employer contribution rates  
34 budgeted for retirement and related benefits as percentage of covered salaries for the 2009-2010  
35 fiscal year are: (i) eight and forty-four hundredths percent (8.44%) – Teachers and State  
36 Employees; (ii) thirteen and forty-four hundredths percent (13.44%) – State Law Enforcement  
37 Officers; (iii) eleven and seventy-six hundredths percent (11.76%) – University Employees'  
38 Optional Retirement System; (iv) eleven and seventy-six hundredths percent (11.76%) –  
39 Community College Optional Retirement Program; (v) seventeen and sixty-one hundredths  
40 percent (17.61%) – Consolidated Judicial Retirement System; and (vi) four and forty  
41 hundredths percent (4.40%) – Legislative Retirement System. Each of the foregoing  
42 contribution rates includes four and forty hundredths percent (4.40%) for hospital and medical  
43 benefits. The rate for Teachers and State Employees, State Law Enforcement Officers,  
44 Community College Optional Retirement Program, and for the University Employees' Optional  
45 Retirement Program includes fifty-two hundredths percent (0.52%) for the Disability Income  
46 Plan. The rates for Teachers and State Employees and State Law Enforcement Officers include  
47 sixteen-hundredths percent (0.16%) for the Death Benefits Plan. The rate for State Law  
48 Enforcement Officers includes five percent (5%) for Supplemental Retirement Income.

49 **SECTION 6.(c)** Effective July 1, 2010, the State's employer contribution rates  
50 budgeted for retirement and related benefits as percentage of covered salaries for the 2010-2011  
51 fiscal year are: (i) eight and eighty-four hundredths percent (8.84%) – Teachers and State

1 Employees; (ii) thirteen and eighty-four hundredths percent (13.84%) – State Law Enforcement  
2 Officers; (iii) twelve and sixteen hundredths percent (12.16%) – University Employees'  
3 Optional Retirement System; (iv) twelve and sixteen hundredths percent (12.16%) –  
4 Community College Optional Retirement Program; (v) eighteen and one hundredths percent  
5 (18.01%) – Consolidated Judicial Retirement System; and (vi) four and eighty hundredths  
6 percent (4.80%) – Legislative Retirement System. Each of the foregoing contribution rates  
7 includes four and eighty hundredths percent (4.80%) for hospital and medical benefits. The  
8 rate for Teachers and State Employees, State Law Enforcement Officers, Community College  
9 Optional Retirement Program, and for the University Employees' Optional Retirement Program  
10 includes fifty-two hundredths percent (0.52%) for the Disability Income Plan. The rates for  
11 Teachers and State Employees and State Law Enforcement Officers include sixteen-hundredths  
12 percent (0.16%) for the Death Benefits Plan. The rate for State Law Enforcement Officers  
13 includes five percent (5%) for Supplemental Retirement Income.

14 **SECTION 6.(d)** Effective July 1, 2009, the maximum annual employer  
15 contributions, payable monthly, by the State for each covered employee or retiree for the  
16 2009-2010 fiscal year to the State Health Plan for Teachers and State Employees are: (i)  
17 Medicare-eligible employees and retirees – three thousand four hundred thirty-eight dollars  
18 (\$3,438) and (ii) non-Medicare-eligible employees and retirees – four thousand five hundred  
19 fifteen dollars (\$4,515).

20 **SECTION 6.(e)** Effective July 1, 2010, the maximum annual employer  
21 contributions, payable monthly, by the State for each covered employee or retiree for the  
22 2010-2011 fiscal year to the State Health Plan for Teachers and State Employees are: (i)  
23 Medicare-eligible employees and retirees – three thousand seven hundred thirty-five dollars  
24 (\$3,735) and (ii) non-Medicare-eligible employees and retirees – four thousand nine hundred  
25 five dollars (\$4,905).

26 **PART SEVEN: EFFECTIVE DATE.**

27 **SECTION 7.** Sections 1(b), 1(c), 1(d), 2(c) through (e), 2(g), and 2(h) of this act  
28 become effective July 1, 2009. Section 4(d) of this act applies to applications for the purchase  
29 of extended coverage made on and after July 1, 2008. The remainder of this act is effective  
30 when it becomes law.