GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2009

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HOUSE BILL 1274

Committee Substitute Favorable 5/13/09
Third Edition Engrossed 5/14/09
Senate Select Committee on Employee Hospital and Medical Benefits Committee Substitute Adopted 7/30/09
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Short Title: State Health Plan Blue Ribbon Task Force. (Public)

Sponsors:

Referred to:

April 9, 2009

A BILL TO BE ENTITLED

AN ACT MAKING TECHNICAL AND OTHER CHANGES PERTAINING TO THE STATE HEALTH PLAN BLUE RIBBON TASK FORCE AND TO THE STATE HEALTH PLAN FOR TEACHERS AND STATE EMPLOYEES.

The General Assembly of North Carolina enacts:

SECTION 1. Section 7(b) of S.L. 2009-16 reads as rewritten:

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

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

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

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

(4) The chair of the Board of ~~Directors~~ Trustees of the State Health ~~Plan.~~Plan or the chair's designee.

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

SECTION 2. Effective December 31, 2010, Part 7 of S.L. 2009-16, as amended by Section 1 of this act, is repealed.

SECTION 3.(a) G.S. 135-45.2(j) reads as rewritten:

"(j) No person shall be eligible for coverage as an employee or retired employee or as a dependent of an employee or retired employee upon a finding by the Executive Administrator or Board of Trustees or by a court of competent jurisdiction that the employee or dependent knowingly and willfully made or caused to be made a false statement or false representation of

a material fact in a claim for reimbursement of medical services under the ~~Plan.~~Plan or in any representation or attestation to the Plan.

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

SECTION 3.(b) The last paragraph of Section 2(b) of S.L. 2009-16 reads as rewritten:

"The Executive Administrator shall report to the Committee on Employee Hospital and Medical Benefits recommendations the Plan may have for additional sanctions that may be imposed when the Executive Administrator finds that a member intentionally makes a false statement on a Plan document. The five-year cessation of coverage requirement of G.S. 135-45.2(j) does not apply to the smoking cessation and weight management provisions of this subsection."

SECTION 3.(c) G.S. 135-44.6 reads as rewritten:

"**§ 135-44.6. Premiums set.**

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

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

(c) Repealed by Session Laws 2008-107, s. 10.13(a), effective July 1, 2008.

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

(e) The total amount of premiums due the Plan from charter schools as employing units, including amounts withheld from the compensation of Plan members, that is not remitted to the Plan by the fifteenth day of the month following the due date of remittance shall be assessed interest of one and one-half percent (1 1/2%) of the amount due the Plan, per month or fraction thereof, beginning with the sixteenth day of the month following the due date of the remittance. The interest authorized by this section shall be assessed until the premium payment plus the accrued interest amount is remitted to the Plan. The remittance of premium payments under this

section shall be presumed to have been made if the remittance is postmarked in the United States mail on a date not later than the fifteenth day of the month following the due date of the remittance.

(f) Premium rates established or adjusted pursuant to this section shall not become effective except by an act of the General Assembly."

SECTION 3.(d) G.S. 135-45.2(d)(1), as amended by Section 3(b) of S.L. 2009-16, reads as rewritten:

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

SECTION 3.(e) G.S. 135-45.6(b)(4), as amended by Section 2(c) of S.L. 2009-16, reads as rewritten:

"(4) ~~Allowable charges shall not be greater than the lesser of copayments provided under this subsection or a pharmacy's usual and customary charge to the general public for a particular prescription.~~ A Plan member shall pay the lesser of copayments provided under this subsection or a pharmacy's cash price to the general public for a particular prescription. The Plan's pharmacy benefit manager may remove from the pharmacy network any pharmacy that charges an amount in violation of this subdivision. Prescriptions shall be for no more than a 30-day supply for the purposes of the copayments paid by each covered individual. By accepting the copayments and any remaining allowable charges provided by this subsection, pharmacies shall not balance bill an individual covered by the Plan. A prescription legend drug is defined as an article the label of which, under the Federal Food, Drug, and Cosmetic Act, is required to bear the legend: "Caution: Federal Law Prohibits Dispensing Without Prescription." Such articles may not be sold to or purchased by the public without a prescription order. Benefits are provided for insulin even though a prescription is not required. The Plan may adopt utilization management procedures for certain drugs, but in no event shall the Plan provide coverage for sexual dysfunction or hair growth drugs or nonmedically necessary drugs used for cosmetic purposes. Any formulary used by the Plan's Executive Administrator and pharmacy benefit manager shall be an open formulary. Plan members shall not be assessed more than two thousand five hundred dollars ($2,500) per person per fiscal year in copayments required by this subsection. The Plan's Pharmacy Benefit Manager, or any pharmacy or vendor participating in the Plan shall charge the Plan for any prescription legend drug dispensed under the Plan's pharmacy benefit based upon the original National Drug Code (NDC) as established by the manufacturer of the prescription legend drug and published by the United States Food and Drug Administration.

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

SECTION 4. Section 3(e) of this act becomes effective October 1, 2009 and applies to prescription drugs purchased on and after that date. The remainder of this act is effective when it becomes law and applies to Plan years beginning July 1, 2009.