

**GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2011**

**SESSION LAW 2011-96
HOUSE BILL 578**

AN ACT (1) TO ALLOW THE STATE HEALTH PLAN FOR TEACHERS AND STATE EMPLOYEES TO PROVIDE THE BASIC PLAN PREMIUM-FREE USING AVAILABLE CASH BALANCE RESERVES, (2) TO DELAY IMPLEMENTATION OF CERTAIN CHANGES TO THE STATE HEALTH PLAN UNTIL SEPTEMBER 2011, (3) TO COMPLY WITH THE FEDERAL AFFORDABLE CARE ACT, (4) TO CLARIFY THE STATE HEALTH PLAN'S SUBROGATION RIGHTS, (5) TO GRANT THE STATE TREASURER IMMEDIATE ACCESS TO CONFIDENTIAL STATE HEALTH PLAN DOCUMENTS TO PLAN FOR THE TRANSFER, AND (6) TO CLARIFY THE BOARD COMPOSITION AND STAGGER INITIAL APPOINTMENTS.

The General Assembly of North Carolina enacts:

SECTION 1.(a) Notwithstanding Section 1.2(a) of Senate Bill 323 of the 2011 Regular Session, if the State Health Plan for Teachers and State Employees has sufficient available cash balance reserves to do so, the State Health Plan may offer the Basic Plan premium-free to employees during fiscal year 2011-2012.

SECTION 1.(b) Notwithstanding Section 1.2(a) of Senate Bill 323 of the 2011 Regular Session, the State Health Plan for Teachers and State Employees is directed to find savings through wellness programs, Medicare Advantage plans, alternative plan designs, or other resources and, if those found savings and any available cash balance reserves allow the State Health Plan to do so, the State Health Plan may offer a premium-free plan option to employees during fiscal year 2012-2013.

SECTION 2. Delayed implementation of certain changes. – (a) Section 1.11 of Senate Bill 323 of the 2011 Regular Session reads as rewritten:

"**SECTION 1.11.** Except as otherwise provided, Part I of this act becomes effective ~~July 1, 2011~~ September 1, 2011. Sections 1.1, 1.7, 1.8, and 1.10(c) become effective July 1, 2011."

SECTION 2.(b) Section 1.4 of Senate Bill 323 is repealed.

SECTION 2.(c) Effective September 1, 2011, G.S. 135-45(g) reads as rewritten:

"(g) The Executive Administrator and Board of Trustees shall not change the Plan's comprehensive health benefit coverage, co-payments, deductibles, out-of-pocket expenditures, and lifetime maximums in effect on ~~July 1, 2009~~ September 1, 2011, that would result in a net increased cost to the Plan or in a reduction in benefits to Plan members unless and until the proposed changes are directed to be made in an act of the General Assembly."

SECTION 2.(d) When revising the General Statutes as directed by Senate Bill 323 of the 2011 Regular Session, the Revisor of Statutes shall make the following changes to what appears in Senate Bill 323:

- (1) In Section 1.7(c), notwithstanding Section 1.11, as amended by this act, the deletion of the word "noncontributory" and replacement with the words "partially contributory" in G.S. 135-45.3(a) shall be made effective September 1, 2011, rather than July 1, 2011. The remainder of the changes in Section 1.7(c) shall remain effective July 1, 2011, as provided in Section 1.11 of Senate Bill 323 of the 2011 Regular Session, as amended by Section 2(a) of this act.
- (2) In Section 2.10, within the changes to G.S. 135-48.43 the designation of a second subsection "(d)" shall instead be "(e)" and the following subsection's designation as "(e)" shall instead be "(f)".
- (3) In Section 2.10, the reservation of "§ 135.48.36" shall instead be a reservation of "§ 135-48.36".



SECTION 2.(e) Credits toward deductibles and coinsurance maximums that Plan members earn for services incurred during the months of July and August of 2011 shall be carried forward and applied toward meeting the new deductibles and coinsurance maximums for the period beginning September 1, 2011. If a Plan member fully meets his or her deductible or coinsurance maximum during the months of July and August of 2011, then that Plan member shall receive credit for the amount of the deductible or coinsurance maximum that the Plan member met during that time, but shall then be subject to meeting any additional amounts required by the new deductible and coinsurance maximums effective September 1, 2011.

SECTION 3. Affordable Care Act compliance. – (a) G.S. 135-45.1(10), as amended by Section 1.7(a) of Senate Bill 323 of the 2011 Regular Session, reads as rewritten:

"(10) **Dependent child.** – Subject to the eligibility requirements of G.S. 135-45.2(d), any of the ~~following:~~ following up to the first month following the dependent child's 26th birthday:

- a. A natural or legally adopted child or children of the ~~employee up to the first of the month following the child's 26th birthday,~~ employee, whether or not the child is living with the employee.
- b. A foster child or children of the ~~employee up to the first month following the child's 19th birthday,~~ employee, whether or not the child is living with the employee, as long as the employee is legally responsible for the child's maintenance and support.
- c. A child for which an employee is a court-appointed guardian, as long as the employee is legally responsible for the child's maintenance and support.
- d. A stepchild ~~who primarily resides with~~ of a member who is married to the stepchild's natural parent.
- e. ~~Any child under age 19 who has reached his or her 18th birthday, provided the employee was legally responsible for the child's maintenance and support on his or her 18th birthday.~~

Dependent children of firefighters, rescue squad workers, and members of the National Guard are subject to the same terms and conditions as are other dependent children covered by this subdivision."

SECTION 3.(b) G.S. 135-45.2(d), as amended by Section 1.7(b) of Senate Bill 323 of the 2011 Regular Session, reads as rewritten:

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

A dependent child shall not be eligible for coverage under the Plan if the dependent child is eligible for employer based health care outside of the State Health Plan for Teachers and State ~~Employees.~~ Employees, other than a parent's plan. Coverage of a dependent child may be extended beyond the 26th birthday if the dependent is physically or mentally incapacitated to the extent that he or she is incapable of earning a living and (i) such handicap developed or began to develop before the dependent's 19th birthday, or (ii) such handicap developed or began to develop before the dependent's 26th birthday if the dependent was covered by the Plan in accordance with G.S. 135-45.2(c)(7)."

SECTION 3.(c) G.S. 135-45.3, as amended by Section 1.7(c) of Senate Bill 323 of the 2011 Regular Session, as modified by Section 2(d)(1) of this act, reads as rewritten:

"§ 135-45.3. Enrollment.

(a) Except as otherwise required by applicable federal law, new employees must be given the opportunity to enroll or decline enrollment for themselves and their dependents within 30 days from the date of employment or from first becoming eligible on a noncontributory basis. Coverage may become effective on the first day of the month following

date of entry on payroll or on the first day of the following month. New employees age 19 and older not enrolling themselves and their dependents age 19 and older within 30 days, or not adding dependents when first eligible as provided herein may enroll on the first day of any month but will be subject to a 12-month waiting period for preexisting health conditions, except for employees who elect to change their coverage in accordance with rules established by the Executive Administrator and Board of Trustees for optional or alternative plans available under the Plan. Children born to covered employees having coverage type (2) or (3), as outlined in G.S. 135-45.4(d) shall be automatically covered at the time of birth without any waiting period for preexisting health conditions. Children born to covered employees having coverage type (1) shall be automatically covered at birth without any waiting period for preexisting health conditions so long as the claims processor receives notification within 30 days of the date of birth that the employee desires to change from coverage (1) to coverage type (2) or (3), provided that the employee pays any additional premium required by the coverage type selected retroactive to the first day of the month in which the child was born.

...
(c) Eligible employees younger than age 19 and dependents younger than age 19 may be enrolled at any time and shall not be subject to any waiting period for a preexisting condition.

...."
SECTION 3.(d) G.S. 135-45.4, as amended by Section 1.7(d) of Senate Bill 323 of the 2011 Regular Session, reads as rewritten:

"§ 135-45.4. Effective dates of coverage.

(a) Employees and Retired Employees. –

...
(3) Employees age 19 and older not enrolling or adding dependents age 19 and older when first eligible in accordance with G.S. 135-45.3 may enroll later on the first of any following month but will be subject to a 12-month waiting period for a preexisting health condition, except employees who elect to change their coverage in accordance with rules adopted by the Executive Administrator and Board of Trustees for optional alternative plans offered under the Plan.

...
(b) **Waiting Periods and Preexisting Conditions.** –

...
(2) Employees age 19 and older not enrolling or not adding dependents age 19 and older when first eligible may enroll later on the first of any following month, but will be subject to a twelve-month waiting period for preexisting conditions except as provided in subdivision (a)(3) of this section. The waiting period under this subdivision is subject to applicable federal law.

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

...."

SECTION 3.(e) This section becomes effective July 1, 2011.

SECTION 4. Subrogation by Plan. – G.S. 135-45.14(g) reads as rewritten:

"(g) **Right of Recovery.** – Whenever payments have been made by the Plan or its Claims Processor with respect to covered services in a total amount which is, at any time, in excess of the maximum amount of payment necessary at that time to satisfy the intent of this provision,

irrespective of to whom paid, the Plan or its Claims Processor shall have the right to recover such payments, to the extent of such excess, from among one or more of the following, as the Plan or its Claims Processor shall determine: any persons to or for or with respect to whom such payments were made, any insurance companies, or any other organizations."

SECTION 5. Treasurer's access to records. – Notwithstanding G.S. 135-43, the Department of the State Treasurer shall have immediate access to all records, including confidential records, of the State Health Plan for Teachers and State Employees in order to plan for the January 1, 2012, transfer of the State Health Plan to the Department of State Treasurer. The Department of the State Treasurer shall assume the same level of responsibility for maintaining the confidentiality of the records as the Executive Administrator and Board of Trustees of the State Health Plan for Teachers and State Employees.

SECTION 6. Governance adjustments. – (a) Effective January 1, 2012, G.S. 135-48.20, as enacted by and amended by Senate Bill 323 of the 2011 Regular Session, reads as rewritten:

"§ 135-48.20. Board of Trustees established.

...
(i) In making appointments, the appointing authorities shall ensure that one of the appointees under subsection (e) of this section, one of the appointees under subsection (f) of this section, and one of the appointees under subsection (g) of this section, and one of the appointees under subsection (h) of this section are one of the following:

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

~~Each~~ In making appointments to the Board under this section, each appointing authority shall consult with all other appointing authorities prior to making its own appointments to ensure that the Board's composition reflects a diversity of employees, teachers, retired employees, and retired teachers. Board includes members of each of the groups listed in subdivisions (1) through (4) of this subsection.

(j) In making appointments, ~~except for the appointees under subsection (i) of this section,~~ the appointing authorities shall appoint individuals from the following areas of expertise:

- (1) Actuarial science.
- (2) Health economics.
- (3) Health benefits and administration.
- (4) Health law and policy.

In making appointments to the Board under this section, each appointing authority shall consult with all other appointing authorities prior to making its own appointments to ensure that each of the areas of expertise ~~required by listed in subdivisions (1) through (4) of this subsection~~ is represented by at least one member of the Board. ~~Each appointing authority shall consider the expertise of the other members of the Board and make appointments so that the Board's composition reflects a diversity of expertise.~~

...."
SECTION 6.(b) Section 2.13(b) of Senate Bill 323 of the 2011 Regular Session is repealed.

SECTION 6.(c) Notwithstanding the two-year term limitation in G.S. 135-48.20(m), as enacted by Senate Bill 323 of the 2011 Regular Session, the terms of appointees under G.S. 135-48.20 shall be as follows and shall begin January 1, 2012:

- (1) Two and one-half years. – Appointees under G.S. 135-48.20(i).
- (2) Three and one-half years. – Appointees not under G.S. 135-48.20(i).

SECTION 7. Except as otherwise provided, this act is effective when it becomes law. No section of this act, however, becomes effective unless Senate Bill 323 of the 2011 Regular Session becomes law.

In the General Assembly read three times and ratified this the 19th day of May, 2011.

s/ Walter H. Dalton
President of the Senate

s/ Thom Tillis
Speaker of the House of Representatives

s/ Beverly E. Perdue
Governor

Approved 10:57 a.m. this 26th day of May, 2011