GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2001

S **2**

SENATE BILL 822

Insurance and Consumer Protection Committee Substitute Adopted 9/21/01

Short Title: State Self-Funded Health Care Plan. (Public)

Sponsors:

Referred to:

April 3, 2001

A BILL TO BE ENTITLED

AN ACT TO AUTHORIZE THE EXECUTIVE ADMINISTRATOR AND BOARD OF TRUSTEES OF THE TEACHERS' AND STATE EMPLOYEES' COMPREHENSIVE MAJOR MEDICAL PLAN TO ADOPT ARRANGEMENTS FOR OPTIONAL HOSPITAL AND MEDICAL BENEFITS PROGRAMS AS ALTERNATIVES TO THOSE CURRENTLY AVAILABLE; TO TRANSFER ADMINISTRATION OF THE LONG-TERM CARE BENEFITS OF THE PLAN TO THE STATE TREASURER; TO PROVIDE THAT THE TERMS OF CONTRACTS BETWEEN HOSPITALS, HOSPITAL AUTHORITIES, PHYSICIANS OR OTHER MEDICAL PROVIDERS, OR A PHARMACY BENEFIT MANAGER AND THE PLAN ARE CONFIDENTIAL; TO CLARIFY THE AMOUNT OF REIMBURSEMENT ALLOWED FOR PRIVATE DUTY NURSING SERVICES AND ELIGIBILITY FOR CONTINUATION OF COVERAGE FOR TERMINATED EMPLOYEES AND THEIR FAMILIES UNDER THE PLAN; TO PROVIDE FOR REIMBURSEMENT UNDER THE STATE HEALTH PLAN FOR SERVICES PERFORMED BY A CLINICAL PHARMACIST PRACTITIONER; AND TO PROVIDE FOR COMPETITIVE SELECTION OF CERTAIN SUPPLEMENTAL INSURANCE PRODUCTS FOR RETIRED STATE EMPLOYEES.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 135-39.5B reads as rewritten:

"**§ 135-39.5B. Prepaid plans.**

(a) The Executive Administrator and Board of Trustees may, after consultation with the Committee on Employee Hospital and Medical Benefits, provide for optional prepaid hospital and medical benefits plans on a fully insured basis. Benefits offered under such optional plans shall be comparable to those offered under the Plan. The amounts of State funds contributed for such optional plans shall not be more than the amounts contributed for each person eligible under G.S. 135-40.2 on a noncontributory Employee Only basis, with the person selecting an optional plan paying any excess, if

necessary. The amount of State funds contributed to such optional plans shall also not exceed the amount of an optional plan's cost for Employee Only coverage. The Executive Administrator and Board of Trustees are authorized to assess and collect fees from participating optional plans provided by this section for administrative purposes and for risk management purposes. Such fees may be based upon the enrollees' risk factors and the number and types of contracts enrolled by each participating optional plan, and may be collected by the Plan in a manner prescribed by the Executive Administrator and Board of Trustees. In no instance shall benefits be paid under Part 3 of this Article for persons enrolled in an optional prepaid hospital and medical benefit plan authorized under this section on and after the effective date of enrollment in the optional prepaid plan, except in cases of continuous hospital confinement approved by the Executive Administrator.

(b) The Executive Administrator and Board of Trustees may, after consulting with the Committee on Employee Hospital and Medical Benefits, adopt arrangements for optional hospital and medical benefits programs, including one or more underwritten by the State and including programs that operate in rural areas of the State, other than the one specified in subsection (a) of this section. The amounts of State funds contributed for such optional plans shall not be more than the amounts contributed for each person eligible under G.S. 135-40.2 on a noncontributory Employee Only basis, with the person selecting an optional plan paying any excess, if necessary. The amount of State funds contributed to such optional plans shall also not exceed the amount of an optional plan's cost for Employee Only coverage. In no instance shall benefits be paid under Part 3 of this Article for persons enrolled in an optional prepaid hospital and medical benefit plan authorized under this section on and after the effective date of enrollment in the optional prepaid plan, except in cases of continuous hospital confinement approved by the Executive Administrator."

SECTION 2. G.S. 135-39.5 is amended by adding a new subdivision to read:

"(27) The Executive Administrator may establish a pilot program in a county with at least 10,000 Plan enrollees to measure potential cost savings and improvements in patient care available through local, provider-driven medical management."

SECTION 3. G.S. 135-39.5 reads as rewritten:

"**§ 135-39.5. Powers and duties of the Executive Administrator and Board of Trustees.**

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

…

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

…."

SECTION 3.1. Part 4 of Article 3 of Chapter 135 of the General Statutes is repealed.

SECTION 3.2. G.S. 135-39.6A(b) is repealed.

SECTION 3.3. Chapter 135 of the General Statutes is amended by adding a new Article to read:

"Article 7.

"Long-Term Care Plan.

"**§ 135-120. Short title and purpose.**

(a) This Article shall be known and may be cited as the "Long-Term Care Plan of North Carolina".

(b) The purpose of the Article is to attract and hold qualified employees and officials of the State of North Carolina and its political subdivisions by making available an optional program of long-term care benefits for the benefit of its qualified employees, retired employees, and their dependents which will pay benefits in accordance with the terms hereof and rules and regulations promulgated by the State Treasurer pursuant to this Article. Retired employees of the Local Governmental Employees' Retirement System pursuant to Article 3 of Chapter 128 of the General Statutes and their dependents are also eligible to be qualified for the benefits provided by this Article.

"**§ 135-121. Administration.**

(a) The provisions of this Article shall be administered by the Department of State Treasurer.

(b) The Long-Term Care Plan shall have the powers and privileges of a corporation and shall be known as the "Long-Term Care Plan of North Carolina" and by this name all of its business shall be transacted.

(c) The Department of State Treasurer shall have full power and authority to adopt rules and regulations for the administration of the Plan, provided they are not inconsistent with the provisions of this Article. The Department of State Treasurer may appoint those agents, contractors, employees, and committees as they deem advisable to carry out the terms and conditions of the Plan. The Department of State Treasurer may employ clerical and professional staff and such other assistance as may be necessary to assist the Department of State Treasurer in carrying out its duties and responsibilities under this Article. The benefits provided by this Article may be offered by the Plan on a self-insured basis, in which case a third-party claims processor shall be chosen through competitive bids in accordance with State law, or through a contract of insurance, in which case a carrier licensed to do business in North Carolina shall be selected on a competitive bid basis in accordance with State law.

(d) The Department of State Treasurer shall be charged with a fiduciary responsibility for managing all aspects of the Plan, including the receipt, maintenance, investment, and disposition of all Plan assets.

(e) The benefits authorized by this Article are available only to qualified employees and retired employees who voluntarily elect to provide such benefits for

themselves and their qualified dependents. Payroll deductions shall be available from employee salary and disability benefit payments and from retired employee retirement benefit payments for fully contributory premium amounts.

(f) The State Treasurer shall ensure insofar as possible that the long-term care benefits provided by this Part shall be tax-qualified under federal law.

(g) The administrative costs of the Plan to the Department of State Treasurer may be charged to participants or deducted from participants' accounts in accordance with nondiscriminatory procedures established by the Department of State Treasurer.

(h) Except as otherwise provided in this Article, "employee", as used in this Article, shall mean the term as defined in G.S. 135-40.1(5).

"**§ 135-122. Right to alter, amend, or repeal.**

The General Assembly reserves the right to alter, amend, or repeal this Article."

SECTION 4. G.S. 135-40.4, as amended by S.L. 2001-253, reads as rewritten:

"**§ 135-40.4. Benefits in general.**

(a) In the event a covered person, as a result of accidental bodily injury, disease or pregnancy, incurs covered expenses, the Plan will pay benefits up to the amounts described in G.S. 135-40.5 through G.S. 135-40.9.

The Plan is divided into two parts. The first part includes certain benefits which are not subject to a deductible or coinsurance. The second part is a comprehensive plan and includes those benefits which are subject to both a three hundred fifty dollar ($350.00) deductible for each covered individual to an aggregate maximum of one thousand fifty dollars ($1,050) per employee and child(ren) or employee and family coverage contract and coinsurance of 80%/20%. There is a limit on out-of-pocket expenses under the second part.

Notwithstanding the provisions of this Article, the Executive Administrator and Board of Trustees of the Teachers' and State Employees' Comprehensive Major Medical Plan may contract with providers of institutional and professional medical care and services to established preferred provider networks. The terms of any contract, including reimbursement rates, between hospitals, hospital authorities, doctors or other medical providers, or a pharmacy benefit manager and the Plan shall be confidential and not a public record under Chapter 132 of the General Statutes. Provided, however, nothing in this subsection shall be deemed to prevent or restrict the release of any information made confidential under this subsection to the State Auditor, the Attorney General, the Director of the State Budget, the Plan's Executive Administrator, and the Joint Legislative Health Care Oversight Committee solely and exclusively for their use in the furtherance of their duties and responsibilities. The design, adoption, and implementation of ~~such~~ the preferred provider contracts and networks are not subject to the requirements of Chapter 143 of the General Statutes, provided that for any hospital preferred provider network all hospitals will have an opportunity to contract with the Plan if they meet the contract requirements. The Executive Administrator and Board of Trustees shall, under the provisions of G.S. 135-39.5(12), pursue such preferred

provider contracts on a timely basis and shall make reports as requested to the President of the Senate, the President Pro Tempore of the Senate, the Speaker of the House of Representatives, and the Committee on Employee Hospital and Medical Benefits on its progress in negotiating ~~such~~ the preferred provider contracts. The Executive Administrator and Board of Trustees shall implement a refined diagnostic-related grouping or diagnostic-related grouping-based reimbursement system for hospitals as soon as practicable, but no later than January 1, 1995.

(b) As used in this section the term "preferred provider contracts or networks" includes, but is not limited to, a refined diagnostic-related grouping or diagnostic-related grouping-based system of reimbursement for hospitals."

SECTION 5. G.S. 135-40.6(8)b. reads as rewritten:

"b. Private Duty Nursing: Services of licensed nurses (not immediate relatives or members of the participant's household or private duty nursing used in lieu of or as a substitute for hospital staff nurses) ordered by the attending doctor for a condition requiring skilled nursing services. Private Duty Nursing ordered must be approved in advance by the Claims Processor as medically necessary. Allowances for Private Duty Nursing shall not exceed the lesser of the Plan's usual, customary and reasonable allowances or ninety percent (90%) of the daily semiprivate rate at skilled nursing facilities as determined by the Plan."

SECTION 5.1. G.S. 135-40.6, as amended by S.L. 2001-253, is amended by adding a new subdivision to read:

"(12) Coverage for services of Clinical Pharmacist Practitioners. – Notwithstanding any other provision of this section or the Plan, benefits shall be payable for services performed by a Clinical Pharmacist Practitioner subject to the following limitations:

a. The service performed is within the Clinical Pharmacist Practitioner's limitations pursuant to G.S. 90-18.4.

b. The Plan currently provides reimbursement for identical services provided by other health care providers.

c. The reimbursement shall be at the discretion of the Executive Administrator regarding services covered and compensation.

d. The reimbursement is made to the Clinical Pharmacist Practitioner.

e. Nothing in this subdivision authorizes payment to more than one provider for the same service."

SECTION 6. G.S. 135-40.1(2), as amended by S.L. 2001-253, reads as rewritten:

"(2) Deductible. – Deductible shall mean an amount of covered expenses during a fiscal year which must be incurred after which benefits

(subject to the deductible) becomes payable. The deductible for an employee, retired employee and/or his or her dependents shall be three hundred fifty dollars ($350.00) for each fiscal ~~year.~~ year, unless an employee or retired employee, and his or her dependents for which Medicare is not the primary payer of health benefits selects the optional benefit plan, then the deductible shall be five hundred dollars ($500.00) for each fiscal year.

The deductible applies separately to each covered individual in each fiscal year, subject to an aggregate maximum of one thousand fifty dollars ($1,050) per employee and child(ren) or employee and family coverage contract in any fiscal ~~year.~~ year, except if an employee or retired employee, and his or her dependents for which Medicare is not the primary payer of health benefits selects the optional benefit plan, then the aggregate maximum deductible is one thousand five hundred dollars ($1,500) per employee and child(ren) or employee and family coverage contract in any fiscal year. If two or more family members are injured in the same accident only one deductible is required for charges related to that accident during the benefit period."

SECTION 7. G.S. 135-40.4(a), as amended by S.L. 2001-253, and as amended by Section 4 of this act, reads as rewritten:

"(a) In the event a covered person, as a result of accidental bodily injury, disease or pregnancy, incurs covered expenses, the Plan will pay benefits up to the amounts described in G.S. 135-40.5 through G.S. 135-40.9.

The Plan is divided into two parts. The first part includes certain benefits which are not subject to a deductible or coinsurance. The second part is a comprehensive plan and includes those benefits ~~which are subject to both a three hundred fifty dollar ($350.00) deductible for each covered individual to an aggregate maximum of one thousand fifty dollars ($1,050) per employee and child(ren) or employee and family coverage contract and coinsurance of 80%/20%.~~ that are subject to both a deductible for each covered individual to an aggregate maximum deductible per employee and child(ren) or employee and family coverage contract, and coinsurance, as established in this Part. The following cost-sharing requirements apply to an optional benefit plan made available under the Plan:

(1) $500.00 annual deductible in accordance with G.S. 135-40.6.

(2) $1,500 annual aggregate maximum deductible for employee and child(ren) or employee and family in accordance with G.S. 135-40.6.

(3) 70%/30% coinsurance in accordance with G.S. 135-40.6 and G.S. 135-40.8.

(4) $6,000 aggregate annual coinsurance maximum in accordance with G.S. 135-40.6 and G.S. 135-40.8.

(5) $25.00 copayment for home, office, or skilled nursing facility visit in accordance with G.S. G.S. 135-40.8.

(6) $50.00 annual outpatient prescription drug deductible in accordance with G.S. 135-40.5.

Persons eligible are covered under the comprehensive plan unless the employee or retired employee, and his or her dependents for which Medicare is not the primary payer of health benefits selects coverage under the optional benefit plan. There is a limit on out-of-pocket expenses under the second part.

Notwithstanding the provisions of this Article, the Executive Administrator and Board of Trustees of the Teachers' and State Employees' Comprehensive Major Medical Plan may contract with providers of institutional and professional medical care and services to established preferred provider networks. The terms of any contract, including reimbursement rates, between hospitals, hospital authorities, doctors or other medical providers, or a pharmacy benefit manager and the Plan shall be confidential and not a public record under Chapter 132 of the General Statutes. Provided, however, nothing in this subsection shall be deemed to prevent or restrict the release of any information made confidential under this subsection to the State Auditor, the Attorney General, the Director of the State Budget, the Plan's Executive Administrator, and the Joint Legislative Health Care Oversight Committee solely and exclusively for their use in the furtherance of their duties and responsibilities. The design, adoption, and implementation of such preferred provider contracts and networks are not subject to the requirements of Chapter 143 of the General Statutes, provided that for any hospital preferred provider network all hospitals will have an opportunity to contract with the Plan if they meet the contract requirements. The Executive Administrator and Board of Trustees shall, under the provisions of G.S. 135-39.5(12), pursue such preferred provider contracts on a timely basis and shall make reports as requested to the President of the Senate, the President Pro Tempore of the Senate, the Speaker of the House of Representatives, and the Committee on Employee Hospital and Medical Benefits on its progress in negotiating such preferred provider contracts. The Executive Administrator and Board of Trustees shall implement a refined diagnostic-related grouping or diagnostic-related grouping-based reimbursement system for hospitals as soon as practicable, but no later than January 1, 1995."

SECTION 8. G.S. 135-40.5(g), as amended by S.L. 2001-253, reads as rewritten:

"(g) Prescription Drugs. – The Plan's allowable charges for prescription legend drugs to be used outside of a hospital or skilled nursing facility are to be determined by the Plan's Executive Administrator and Board of Trustees. The Plan will pay allowable charges for each outpatient prescription drug less a copayment to be paid by each covered individual equal to the following amounts: pharmacy charges up to ten dollars ($10.00) for each generic prescription, twenty-five dollars ($25.00) for each branded prescription, and thirty-five dollars ($35.00) for each branded prescription with a generic equivalent drug, and forty dollars ($40.00) for each branded or generic

prescription not on a formulary used by the ~~Plan.~~ Plan, and less a fifty-dollar ($50.00) deductible for each covered individual per fiscal year if an employee or retired employee, and his or her dependents for which Medicare is not the primary payer of health benefits selects the optional benefit plan. Allowable charges shall not be greater than a pharmacy's usual and customary charge to the general public for a particular prescription. Prescriptions shall be for no more than a 34-day supply for the purposes of the copayments paid by each covered individual. By accepting the copayments and any remaining allowable charges provided by this subsection, pharmacies shall not balance bill an individual covered by the Plan. A prescription legend drug is defined as an article the label of which, under the Federal Food, Drug, and Cosmetic Act, is required to bear the legend: "Caution: Federal Law Prohibits Dispensing Without Prescription." Such articles may not be sold to or purchased by the public without a prescription order. Benefits are provided for insulin even though a prescription is not required. The Plan may use a pharmacy benefit manager to help manage the Plan's outpatient prescription drug coverage. In managing the Plan's outpatient prescription drug benefits, the Plan and its pharmacy benefit manager shall not provide coverage for ~~erectile dysfunction,~~ growth hormone, antiwrinkle, weight loss, and hair growth drugs unless such coverage is medically necessary to the health of the member. The Plan and its pharmacy benefit manager shall not provide coverage for growth hormone and weight loss drugs and antifungal drugs for the treatment of nail fungus and botulinium toxin without approval in advance by the pharmacy benefit manager. The Plan and its pharmacy benefit manager may provide up to three dosages per month of medication for erectile dysfunction. Any formulary used by the Plan's Executive Administrator and pharmacy benefit manager shall be an open formulary. Plan members shall not be assessed more than two thousand five hundred dollars ($2,500) per person per fiscal year in copayments required by this subsection."

SECTION 9. The first paragraph of G.S. 135-40.6, as amended by S.L. 2001-253, reads as rewritten:

"The benefits provided in this section are subject to a deductible of three hundred fifty dollars ($350.00) per covered individual to an aggregate maximum of one thousand fifty dollars ($1,050) per employee and child(ren) or employee and family coverage contract per fiscal year and are payable on the basis of eighty percent (80%) by the Plan and twenty percent (20%) by the covered individual up to a maximum of one thousand five hundred dollars ($1,500) out-of-pocket per fiscal ~~year.~~year, unless an employee or retired employee, and his or her dependents for which Medicare is not the primary payer of health benefits selects the optional benefit plan, in which case the benefits provided in this section are subject to a deductible of five hundred dollars ($500.00) per covered individual to an aggregate maximum of one thousand five hundred dollars ($1,500) per employee and child(ren) or employee and family coverage contract per fiscal year and payable on the basis of seventy percent (70%) by the Plan and thirty percent (30%) by the covered individual up to a maximum of two thousand dollars ($2,000) out-of-pocket per fiscal year. The aggregate maximum out-of-pocket required of individuals covered

by this section shall not be more than four thousand five hundred dollars ($4,500) per employee and child(ren) or employee and family coverage contract per fiscal ~~year.~~year, unless an employee or retired employee, and his or her dependents for which Medicare is not the primary payer of health benefits selects the optional benefit plan, in which case the aggregate maximum out-of-pocket required of individuals covered by this section shall not be more than six thousand dollars ($6,000) per employee and child(ren) or employee and family coverage contract per fiscal year."

SECTION 10. G.S. 135-40.8(a), as amended by S.L. 2001-253, reads as rewritten:

"(a) ~~For~~ Except if an employee or retired employee, and his or her dependents for which Medicare is not the primary payer of benefits selects the optional benefit plan, for the balance of any fiscal year after each eligible employee, retired employee, or dependent satisfies the cash deductible, the Plan pays eighty percent (80%) of the eligible expenses outlined in G.S. 135-40.6. The remaining twenty percent (20%) is paid by the covered individual until one thousand five hundred dollars ($1,500) per covered individual up to an aggregate of four thousand five hundred dollars ($4,500) per employee and child(ren) or employee and family coverage contract per fiscal year in excess of the deductible has been paid out of pocket. The Plan then pays one hundred percent (100%) of the remaining covered expenses. If the optional benefit plan is selected, then for the balance of any fiscal year after each eligible employee, retired employee, and his or her dependents for which Medicare is not the primary payer of health benefits satisfies the cash deductible, the Plan pays seventy percent (70%) of the eligible expenses outlined in G.S. 135-40.6. The remaining thirty percent (30%) is paid by the covered individual until two thousand dollars ($2,000) per covered individual up to an aggregate of six thousand dollars ($6,000) per employee and child(ren) or employee and family coverage contract per fiscal year in excess of the deductible has been paid out of pocket. The Plan then pays one hundred percent (100%) of the remaining covered expenses."

SECTION 11. G.S. 135-40.8(c3), as enacted by S.L. 2001-253, reads as rewritten:

"(c3) Notwithstanding any other provision of this Article, the Plan does not pay for the first fifteen dollars ~~($15.00)~~ ($15.00), or twenty-five dollars ($25.00) if an employee or retired employee, and his or her dependents for which Medicare is not the primary payer of health benefits selects the optional benefit plan, of allowable charges for each home, office, or skilled nursing facility visit under the provisions of G.S. 135-40.6(7)a. and b., G.S. 135-40.6(4), G.S. 135-40.6(8)e.(IV therapy), i., j., k., n., r., and s., and G.S. 135-40.5(e). The copayment assessed by this subsection shall be assessed only once per person per provider per day and shall not apply to laboratory, pathology, and radiology services. The exclusion made under this subsection shall not count toward the deductible nor toward the maximum amount of coinsurance out-of-pocket costs."

SECTION 12. G.S. 135-40.2(b)(12) reads as rewritten:

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

SECTION 13. Article 31 of Chapter 58 of the General Statutes is amended by adding a new section to read:

"**§ 58-31-61. Competitive selection of retirement benefit payment deduction supplemental insurance products paid for by retired State employees.**

(a) Duties of the Board of Trustees. – The Board of Trustees of the Teachers' and State Employees' Retirement System shall:

(1) Review insurance products currently offered through retirement benefit payment deduction to retired State employees to determine if those products meet the needs and desires of the retired employees.

(2) Select the types of insurance products that reflect the needs and desires of retired State employees.

(3) Competitively select the best insurance products of the types determined by the Department of State Treasurer and the Board of Trustees to reflect the needs and desires of the retired employees.

As used in this section, "insurance product" includes a prepaid legal services plan registered under G.S. 84-23.1.

(b) Conflicts of Interest. – The Board of Trustees shall be autonomous in its selection of insurance products and insurance companies and no member of the Board of Trustees having a conflict of interest in the selection of insurance products or insurance companies shall participate in the discussion or selection of the insurance products or insurance companies. Any decision rendered pursuant to this section by the Board of Trustees where the autonomy of Board of Trustees or a conflict of interest is questioned shall be subject to appeal to the State Treasurer's Office pursuant to the Administrative Procedure Act.

(c) Retirement Benefit Payment Deduction Slots. – The company or companies selected by the Board of Trustees shall be permitted to sell through retirement benefit payment deduction only the products specifically approved by the Board of Trustees. The assignment by the Board of Trustees of a retirement benefit payment deduction slot shall be for a period of not less than two years unless the insurance company shall be in violation of the terms of the written agreement specified in this subsection. The insurance company awarded a retirement benefit payment deduction slot shall, pursuant to a written agreement setting out the rights and duties of the insurance company, be afforded an adequate opportunity to solicit retired State employees by making such

retired employees aware that a representative of the company will be available at a specified time and at a location convenient to the retired employees.

Notwithstanding any other provision of the General Statutes, once a retired employee has selected an insurance product for retirement benefit payment deduction, that product may not be removed from retirement benefit payment deduction for that employee without his or her specific written consent.

When retirement benefit payment deduction is no longer available, the insurance company may not terminate life insurance products purchased under the retirement benefit payment deduction plan without the retiree's specific written consent solely because the premium is no longer deducted from retirement benefit payments.

(d) Procedure for Selection of Insurance Product Proposals. – All insurance product proposals shall be sealed. The Board of Trustees shall open all proposals in public and record them in the minutes of the Board of Trustees, at which time the proposals become public records open to public inspection.

After the public opening, the Board of Trustees shall review the proposals, examining the cost and quality of the products, the reputation and capabilities of the insurance companies submitting the proposals, and other appropriate criteria. The Board of Trustees shall determine which proposal, if any, would meet the needs and desires of the retired employees and shall award a retirement benefit payment deduction slot to the company submitting the proposal that meets those needs and desires. The Board of Trustees may reject any or all proposals.

A company may seek to modify or withdraw a proposal only after the public opening and only on the basis that the proposal contains an unintentional clerical error as opposed to an error in judgment. A company seeking to modify or withdraw a proposal shall submit to the Board of Trustees a written request, with facts and evidence in support of its position, prior to the award of the retirement benefit payment deduction slot, but not later than two days after the public opening of the proposals. The Board of Trustees shall promptly review the request, examine the nature of the error, and determine whether to permit or deny the request.

(e) Committee of the Board. – The Board may designate a committee consisting of not less than five members of the Board to carry out the duties of the full Board set forth in this section. If a committee is designated to carry out the full Board's duties, it shall comply with all the provisions of this section and its determination on the award of retirement benefit payment deduction slots to companies submitting proposals shall constitute a recommendation to the full Board rather than a final decision on the award. The full Board shall either adopt or reject each of the recommendations offered by the committee. Board adoption of a recommendation of the committee constitutes an award of a retirement benefit payment deduction slot for purposes of this section.

(f) Criminal Penalty. – It shall be a Class 3 misdemeanor for any member of the Board of Trustees having a conflict of interest in the selection of insurance products or insurance companies to attempt to influence the Board of Trustees in the selection of insurance products or insurance companies knowing or having reason to know that the

member has a conflict of interest in the selection of insurance products or insurance companies, or for anyone to open a sealed insurance product proposal or disclose or exhibit the contents of a sealed insurance product proposal, prior to the public opening of the proposal. The Commissioner of Insurance shall have the authority to investigate complaints alleging acts subject to the criminal penalty and shall report the Commissioner's findings to the Attorney General of North Carolina.

(g) The Department of State Treasurer may employ clerical and professional staff and such other assistance as may be necessary to assist the Department of State Treasurer in carrying out its duties and responsibilities under this section. The administrative costs to the Department of State Treasurer of carrying out its duties and responsibilities under this section may be charged to participants or deducted from participants' accounts in accordance with nondiscriminatory procedures established by the Department of State Treasurer."

SECTION 14. Sections 3, 3.1, 3.2, and 3.3 of this act become effective July 31, 2002. Sections 6 through 13 of this act become effective January 1, 2002. The remainder of this act is effective when it becomes law.