GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 1993

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HOUSE BILL 1563*

Short Title: Medicaid Compliance. (Public)

Sponsors: Representatives Nye; Bowman, McCrary, and Ives.

Referred to: Insurance.

May 25, 1994

A BILL TO BE ENTITLED

AN ACT TO AMEND STATE INSURANCE AND MEDICAID LAWS TO COMPLY WITH THE FEDERAL OMNIBUS BUDGET RECONCILIATION ACT OF 1993 AND GUARANTEE THE CONTINUED AVAILABILITY OF FEDERAL MEDICAID FUNDS FOR THE STATE; AND TO MAKE A CORRESPONDING INSURANCE LAW AMENDMENT.

The General Assembly of North Carolina enacts:

Section 1. Article 51 of Chapter 58 of the General Statutes is amended by adding the following new sections:

"**§ 58-51-115. Coordination of benefits with Medicaid.**

(a) As used in this section and in G.S. 58-51-120 and G.S. 58-51-125:

(1) 'Health benefit plan' means any accident and health insurance policy or certificate; a nonprofit hospital or medical service corporation contract; a health maintenance organization subscriber contract; a plan provided by a multiple employer welfare arrangement; or a plan provided by another benefit arrangement.

(2) 'Health insurer' means any health insurance company subject to Articles 1 through 63 of this Chapter, including a multiple employee welfare arrangement, and any corporation subject to Articles 65 and 67 of this Chapter; and means a group health plan, as defined in section 607(1) of the Employee Retirement Income Security Act of 1974.

(b) No health insurer shall consider the availability or eligibility for medical assistance in this or any other state under 42 U.S.C. § 1396a (section 1902 of the Social Security Act) when considering eligibility for coverage or making payments under its

health benefit plan for eligible enrollees, subscribers, policy holders, or certificate holders.

(c) To the extent that payment for covered services has been made under G.S. 108A-55 for health care items or services furnished to an individual, in any case where a third party has a legal liability to make payments, the Department of Human Resources is considered to have acquired the rights of the individual to payment by any other party for those health care items or services.

"**§ 58-51-120. Coverage of children.**

(a) No health insurer shall deny enrollment of a child under the health benefit plan of the child's parent on any of the following grounds:

(1) The child was born out of wedlock.

(2) The child is not claimed as a dependent on the parent's federal tax return.

(3) The child does not reside with the parent or in the insurer's service area.

(b) If a child has health benefit plan coverage through the health insurer of a noncustodial parent that health insurer shall do all of the following:

(1) Provide such information to the custodial parent as may be necessary for the child to obtain benefits through that coverage.

(2) Permit the custodial parent (or the health care provider, with the custodial parent's approval) to submit claims for covered services without the approval of the noncustodial parent.

(3) Make payments on claims submitted in accordance with subdivision (2) of this subsection directly to the custodial parent, the provider, or the Department of Human Resources.

(c) If a parent is required by a court or administrative order to provide health benefit plan coverage for a child, and the parent is eligible for family health benefit plan coverage, the health insurer:

(1) Must allow the parent to enroll, under the family coverage, a child who is otherwise eligible for the coverage without regard to any enrollment season restrictions.

(2) Must enroll the child under family coverage upon application of the child's other parent or the Department of Human Resources in connection with its administration of the Medical Assistance or Child Support Enforcement Program if the parent is enrolled but fails to make application to obtain coverage for the child.

(3) May not disenroll or eliminate coverage of the child unless the health insurer is provided satisfactory written evidence that:

a. The court or administrative order is no longer in effect; or

b. The child is or will be enrolled in comparable health benefit plan coverage through another health insurer, which coverage will take effect not later than the effective date of disenrollment.

(d) No health insurer may impose requirements on any State agency that has been assigned the rights of an individual eligible for medical assistance under Medicaid and

covered for health benefits from the insurer that are different from requirements applicable to an agent or assignee of any other individual so covered.

"**§ 58-51-125. Adopted child coverage.**

(a) Definitions – As used in this section:

(1) 'Child' means, in connection with any adoption or placement for adoption of the child, an individual who has not attained 18 years of age as of the date of the adoption or placement for adoption.

(2) 'Placement for adoption' means the assumption and retention by a person of a legal obligation for total or partial support of a child in anticipation of the adoption of the child. The child's placement with a person terminates upon the termination of such legal obligations.

(b) Coverage Effective Upon Placement for Adoption – If a health benefit plan provides coverage for dependent children of persons insured by the plan, the plan shall provide benefits to dependent children placed with insureds for adoption under the same terms and conditions that apply to the natural, dependent children of insureds, irrespective of whether the adoption has become final.

(c) Restrictions Based on Preexisting Conditions at Time of Placement for Adoption Prohibited – A health benefit plan may not restrict coverage under the plan of any dependent child adopted by an insured, or placed with an insured for adoption, solely on the basis of any preexisting condition of the child at the time that the child would otherwise become eligible for coverage under the plan, if the adoption or placement for adoption occurs while the insured is eligible for coverage under the plan."

Sec. 2. G.S. 58-51-30 reads as rewritten:

"**§ 58-51-30. Policies to cover newborn infants and ~~adopted~~ foster children.**

(a) Every ~~policy of insurance and every hospital service or medical service plan as defined in Articles 65 and 66 of this Chapter, and any health care plan operated by a health maintenance organization as defined in Article 67 of this Chapter (regardless of whether any of such policies or plans shall be defined as individual, family, group, blanket, franchise, industrial or otherwise)~~ health benefit plan, as defined in G.S. 58-51-115(a)(1), that provides benefits ~~on account of~~ for any sickness, illness, or disability of any minor child or that provides benefits ~~on account of~~ for any medical treatment or service ~~authorized or permitted to be~~ furnished by a ~~hospital under the laws of this State~~ health care provider or institution to any minor child shall provide the benefits for those occurrences beginning with the moment of the child's birth if the birth occurs while the ~~policy, subscriber contract, or evidence of coverage with such a~~ plan is in force. ~~Adoptive~~ Foster children shall be treated the same as newborn infants and eligible for coverage on the same basis upon placement in the ~~adoptive home, regardless of whether a final decree of adoption has been entered; provided that a petition for adoption has been duly filed and is pursued to a final decree of adoption.~~ foster home.

(b) Benefits in such ~~insurance policies, plans, or evidence of coverage~~ plans shall be the same for congenital defects or anomalies as are provided for most sicknesses or illnesses suffered by minor children ~~which~~ that are covered by the ~~policies, plans, or evidence of coverage.~~ plans. Benefits for congenital defects or anomalies shall

specifically include, but not be limited to, all necessary treatment and care needed by individuals born with cleft lip or cleft palate.

(c) No ~~policy or~~ plan ~~subscriber contract or evidence of coverage~~ shall be approved by the Commissioner ~~of Insurance pursuant to the provisions of this Article or the provisions of Articles 65, 66, and 67 of~~ under this Chapter that does not comply with ~~the provisions of~~ this section.

(d) ~~The provisions of this section apply both~~ This section applies to insurers governed by ~~the provisions of~~ Articles 1 through ~~64~~ 63 of this Chapter and to corporations governed by ~~the provisions of~~ Articles 65, 66, and 67 of this Chapter.

(e) This section and G.S. 58-51-125 shall be construed in **pari materia**."

Sec. 3. Part 6 of Article 2 of Chapter 108A of the General Statutes is amended by adding the following new sections:

"**§ 108A-69. Employer obligations.**

(a) As used in this section and in G.S. 108A-70:

(1) 'Health benefit plan' means an accident and health insurance policy or certificate; a nonprofit hospital or medical service corporation contract; a health maintenance organization subscriber contract; a plan provided by a multiple employer welfare arrangement; or a plan provided by another benefit arrangement.

(2) 'Health insurer' means any health insurance company subject to Articles 1 through 63 of Chapter 58 of the General Statutes, including a multiple employee welfare arrangement, and any corporation subject to Articles 65 and 67 of Chapter 58 of the General Statutes; and means a group health plan, as defined in section 607(1) of the Employee Retirement Income Security Act of 1974.

(b) If a parent is required by a court or administrative order to provide health benefit plan coverage for a child, which coverage is available through that parent's employer and the employer is doing business in this State, the employer:

(1) Must allow the parent to enroll, under family coverage, the child if the child would be otherwise eligible for coverage without regard to any enrollment season restrictions;

(2) Must enroll the child under family coverage upon application of the child's other parent or the Department of Human Resources in connection with its administration of the Medical Assistance or Child Support Enforcement Program if the parent is enrolled but fails to make application to obtain coverage for the child.

(3) May not disenroll or eliminate coverage of the child unless:

a. The employer is provided satisfactory written evidence that:

1. The court or administrative order is no longer in effect; or

2. The child is or will be enrolled in comparable health benefit plan coverage through another employer or health insurer, which coverage will take effect not later than the effective date of disenrollment; or

b. The employer has eliminated family health benefit plan coverage for all of its employees.

(4) Must withhold from the employee's compensation the employee's share, if any, of premiums for health benefit plan coverage, not to exceed the maximum amount permitted to be withheld under section 303(b) of the federal Consumer Credit Protection Act, as amended; and must pay this amount to the health insurer.

"**§ 108A-70. Recoupment of amounts spent on child medical care.**

The Department may garnish the wages, salary, or other employment income of, and the Secretary of Revenue shall withhold amounts from State tax refunds to, any person who:

(1) Is required by court or administrative order to provide health benefit plan coverage for the cost of health care services to a child eligible for medical assistance under Medicaid; and

(2) Has received payment from a third party for the costs of such services; but

(3) Has not used such payments to reimburse, as appropriate, either the other parent or guardian of the child or the provider of the services;

to the extent necessary to reimburse the Department for expenditures for such costs under this Part; provided, however, claims for current and past due child support shall take priority over any such claims for the costs of such services."

Sec. 4. If any section or provision of this act is declared unconstitutional or invalid by the courts, it does not affect the validity of the act as a whole or any part other than the part so declared to be unconstitutional or invalid.

Sec. 5. This act becomes effective October 1, 1994, and applies to each health benefit plan, as defined in this act, that is delivered, that is issued for delivery, or, on the next anniversary date of a health benefit plan policy or contract, that is renewed or continued in this State or covering persons residing in this State, on and after October 1, 1994.