GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 1993

H **2**

HOUSE BILL 300
Committee Substitute Favorable 5/20/93

Short Title: GPAC-State Employee Health Benefits. (Public)

Sponsors:

Referred to:

February 25, 1993

A BILL TO BE ENTITLED

AN ACT TO IMPLEMENT THE RECOMMENDATIONS OF THE GOVERNMENT PERFORMANCE AUDIT COMMITTEE REGARDING STATE EMPLOYEE HEALTH BENEFITS PROVIDED THROUGH THE TEACHERS' AND STATE EMPLOYEES' COMPREHENSIVE MAJOR MEDICAL PLAN AND RELATED BENEFIT PLANS.

The General Assembly of North Carolina enacts:

Section 1. 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:

(1) Supervising and monitoring of the Claims Processor.
(2) Providing for enrollment of employees in the Plan.
(3) Communicating with employees enrolled under the Plan.
(4) Communicating with health care providers providing services under the Plan.
(5) Making payments at appropriate intervals to the Claims Processor for benefit costs and administrative costs.
(6) Conducting administrative reviews under G.S. 135-39.7.
(7) Annually assessing the performance of the Claims Processor.

(8) Preparing and submitting to the Governor and the General Assembly cost estimates for the health benefits plan, including those required by Article 15 of Chapter 120 of the General Statutes.

(9) Recommending to the Governor and the General Assembly changes or additions to the health benefits program and health care cost containment programs, together with statements of financial and actuarial effects as required by Article 15 of Chapter 120 of the General Statutes.

(10) Working with State employee groups to improve health benefit programs.

(11) Repealed by Session Laws 1985, c. 732, s. 9.

(12) Determining basis of payments to health care providers, including payments in accordance with G.S. 58-50-55.

(13) Requiring bonding of the Claims Processor in the handling of State funds.

(14) Repealed by Session Laws 1985, c. 732, s. 7.

(15) In case of termination of the contract under G.S. 135-39.5A, to select a new Claims Processor, after competitive bidding procedures approved by the Department of Administration.

(16) Notwithstanding the provisions of Part 3 of this Article, to formulate and implement cost-containment measures which are not in direct conflict with that Part.

(17) Implementing pilot programs necessary to evaluate proposed cost containment measures which are not in direct conflict with Part 3 of this Article, and expending funds necessary for the implementation of such programs.

(18) Authorizing coverage for alternative forms of care not otherwise provided by the Plan in individual cases when medically necessary, medically equivalent to services covered by the Plan, and when such alternatives would be less costly than would have been otherwise.

(19) Establishing and operating a hospital and other provider bill audit program and a fraud detection program.

(20) Determining administrative and medical policies that are not in direct conflict with Part 3 of this Article upon the advice of the Claims Processor and upon the advice of the Plan's consulting actuary when Plan costs are involved.

(21) Supervising the payment of claims and all other disbursements under this Article, including the recovery of any disbursements that are not made in accordance with the provisions of this Article.

(22) Implementing and operating a preventative health promotion and education program to reduce the claim costs associated with catastrophic and other illnesses and injuries identified by the Plan.

(23) Establishing and operating managed, individualized care programs for high-risk maternity cases and other high-cost treatment cases for acute and chronic illnesses and injuries identified by the Plan."

Sec. 2. G.S. 135-40.7 reads as rewritten:

"**§ 135-40.7. General limitations and exclusions.**

The following shall in no event be considered covered expenses nor will benefits described in G.S. 135-40.5 through G.S. 135-40.11 be payable for:

(1) Charges for any services rendered to a person prior to the date coverage under this Plan becomes effective with respect to such person.

(2) Charges for care in a nursing home, home for the aged, convalescent home, or in any other facility or location for custodial or domiciliary care or for rest cures.

(3) Charges to the extent paid, or which the individual is entitled to have paid, or to obtain without cost, in accordance with any government laws or regulations except Medicare. If a charge is made to any such person which he or she is legally required to pay, any benefits under this Plan will be computed in accordance with its provisions, taking into account only such charge. "Any government" includes the federal, State, provincial or local government, or any political subdivision thereof, of the United States, Canada or any other country.

(4) Charges for services rendered in connection with any occupational injury or disease arising out of and in the course of employment with any employer, if (i) the employer furnishes, pays for or provides reimbursement for such charges, or (ii) the employer makes a settlement payment for such charges, or (iii) the person incurring such charges waives or fails to assert his or her rights respecting such charges.

(5) Charges for any care, treatment, services or supplies other than those which are certified by a physician who is attending the individual as being required for the medically necessary treatment of the injury or disease.

(6) Charges for any services rendered as a result of injury or sickness due to an act of war, declared or undeclared, which act shall have occurred after the effective date of a person's coverage under the Plan.

(7) Charges for personal services such as barber services, guest meals, radio and TV rentals, etc.

(8) Charges for any services with respect to which there is no legal obligation to pay. For the purposes of this item, any charge which exceeds the charge that would have been made if a person were not covered under this Plan shall, to the extent of such excess, be treated as a charge for which there is no legal obligation to pay; and any charge made by any person for anything which is normally or customarily furnished by such person without payment from the recipient or user

thereof shall also be treated as a charge for which there is no legal obligation to pay.

(9) Charges during a continuous hospital confinement which commenced prior to the effective date of the person's coverage under this Plan.

(10) Charges in excess of either the usual, customary and reasonable charge for or the fair and reasonable value of the services or supply which gives rise to the expense; provided that in each instance the extent that a particular charge is usual, customary and reasonable or fair and reasonable shall be measured and determined by comparing the charge with charges made for similar things to individuals of similar age, sex, income and medical condition in the locality concerned, and the result of such determination shall constitute the maximum allowable as covered medical expenses unless the Claims Processor finds that considerations of fairness and equity in a particular set of circumstances require that greater or lesser charges be considered as covered medical expenses in that set of circumstances.

(11) Charges for or in connection with any dental work or dental treatment except to the extent that such work or treatment is specifically provided for under the Plan. Excluded is payment for surgical benefits for tooth replacement, such as crowns, bridges or dentures; orthodontic care; filling of teeth; extraction of teeth (whether or not impacted); root canal therapy; removal of root tips from teeth; treatment for tooth decay, inflammation of gingiva, or surgical procedures on diseased gingiva or other periodontal surgery; repositioning soft tissue, reshaping bone, and removal of bony projections from the ridges preparatory to fitting of dentures; removal of cysts incidental to removal of root tips from teeth and extraction of teeth; or other dental procedures involving teeth and their bones or tissue supporting structure.

(12) Charges incurred for any medical observations or diagnostic study when no disease or injury is revealed, unless proof satisfactory to the Claims Processor is furnished that (i) the claim is in order in all other respects, (ii) the covered individual had a definite symptomatic condition of disease or injury other than hypochondria, and (iii) the medical observation and diagnostic studies concerned were not undertaken as a matter of routine physical examination or health checkup as provided in G.S. 135-40.6(8)s.

(13) Charges for eyeglasses or other corrective lenses (except for cataract lenses certified as medically necessary for aphakia persons) and hearing aids or examinations for the prescription or fitting thereof.

(14) Charges for cosmetic surgery or treatment except that charges for cosmetic surgery or treatment required for correction of damage caused by accidental injury sustained by the covered individual while coverage under this plan is in force on his or her account or to correct

congenital deformities or anomalies shall not be excluded if they otherwise qualify as covered medical expenses.

(15) Admissions for diagnostic tests or procedures which could be, and generally are, performed on an outpatient basis and inpatient services or supplies which are not consistent with the diagnosis, for which admitted.

(16) Costs denied by the Claims Processor as part of its overall program of claim review and cost containment.

(16a) Charges in excess of negotiated rates allowed for preferred providers of institutional and professional medical care and services in accordance with the provisions of G.S. 135-40.4, when such preferred providers are reasonably available to provide institutional and professional medical care.

(16b) Charges incurred but not approved by the Plan under managed, individualized care programs established by the Executive Administrator and Board of Trustees.

(17) If a covered service becomes excluded from coverage under the Plan, the Executive Administrator and Claims Processor may, in the event of exceptional situations creating undue hardships or adverse medical conditions, allow persons enrolled in the Plan to remain covered by the Plan's previous coverage for up to three months after the effective date of the change in coverage, provided the persons so enrolled had been undergoing a continuous plan of specific treatment initiated within three months prior to the effective date of the change in coverage.

(18) Charges for services unless a claim is filed within 18 months from the date of service."

Sec. 3. G.S. 135-40.8(d) reads as rewritten:

"(d) Where a network of qualified preferred providers of ~~inpatient and outpatient hospital care~~ institutional and professional medical care and services is reasonably available for use by those individuals covered by the Plan, use of providers outside of the preferred network shall be subject to a twenty percent (20%) coinsurance rate up to five thousand dollars ($5,000) per fiscal year per covered individual in addition to the general coinsurance percentage and maximum fiscal year amount specified by G.S. 135-40.4 and G.S. 135-40.6."

Sec. 4. The Plan shall report its plans for expansion of preferred providers, and establishing and operating managed, individualized care programs for high-risk maternity cases and other high-cost treatment cases for acute and chronic illnesses identified by the Plan to the Joint Legislative Committee on Governmental Operations by March 1, 1994.

Sec. 5. This act becomes effective January 1, 1994.