NORTH CAROLINA GENERAL ASSEMBLY

LEGISLATIVE RESEARCH COMMISSION

STATE LEGISLATIVE BUILDING
RALEIGH, NC 27601

April 21, 2014

TO THE MEMBERS OF THE LEGISLATIVE RESEARCH COMMISSION:

Attached for your consideration is the report to the 2014 Regular Session of the 2013 General Assembly. This report was prepared by the Legislative Research Commission's Committee on Health Care Provider Practice Sustainability and Training/Additional Transparency in Health Care, pursuant to G.S. 120-30.17(1).

Senator Ralph Hise

Representative Mark Hollo

Co-Chairs
Committee on Health Care Provider Practice Sustainability and Training/Additional Transparency in Health Care
Legislative Research Commission

This page intentionally left blank

LEGISLATIVE RESEARCH COMMISSION

COMMITTEE ON HEALTH CARE PROVIDER PRACTICE SUSTAINABILITY AND TRAINING/ADDITIONAL TRANSPARENCY IN HEALTH CARE

NORTH CAROLINA GENERAL ASSEMBLY

REPORT TO THE
2014 SESSION
of the
2013 GENERAL ASSEMBLY
OF NORTH CAROLINA

APRIL, 2014

A LIMITED NUMBER OF COPIES OF THIS REPORT ARE AVAILABLE FOR DISTRIBUTION THROUGH THE LEGISLATIVE LIBRARY

ROOM 500
LEGISLATIVE OFFICE BUILDING
RALEIGH, NORTH CAROLINA 27603-5925
TELEPHONE: (919) 733-9390

TABLE OF CONTENTS

This page intentionally left blank

TRANSMITTAL LETTER

April 21, 2014

TO THE MEMBERS OF THE 2014 REGULAR SESSION
OF THE 2013 GENERAL ASSEMBLY

The Legislative Research Commission herewith submits to you for your consideration its report and recommendations to the 2014 Regular Session of the 2013 General Assembly. The report was prepared by the Legislative Research Commission's Committee on Health Care Provider Practice Sustainability and Training/Additional Transparency in Health Care, pursuant to G.S. 120-30.17(1).

Respectfully submitted,

Senator Thomas M. Apodaca

Representative Timothy K. Moore

Co-Chairs
Legislative Research Commission

This page intentionally left blank

LEGISLATIVE RESEARCH COMMISSION MEMBERSHIP

2013 – 2014

Senator Thomas M. Apodaca
Co-Chair

Senator Phil Berger, Ex Officio
Senator Dan Blue
Senator Harry Brown
Senator Martin L. Nesbitt, Jr.

Representative Timothy K. Moore
Co-Chair

Representative Thom Tillis, Ex Officio
Representative John M. Blust
Representative Justin P. Burr
Representative Becky Carney
Representative Mike D. Hager

PREFACE

The Legislative Research Commission, established by Article 6B of Chapter 120 of the General Statutes, is the general purpose study group in the Legislative Branch of State Government. The Commission is co-chaired by the President Pro Tempore of the Senate and the Speaker of the House of Representatives and has five additional members appointed from each house of the General Assembly. Among the Commission's duties is that of making or causing to be made, upon the direction of the General Assembly, "such studies of and investigation into governmental agencies and institutions and matters of public policy as will aid the General Assembly in performing its duties in the most efficient and effective manner" (G.S. 120-30.17(1)).

The Legislative Research Commission authorized the study of the Committee on Health Care Provider Practice Sustainability and Training/Additional Transparency in Health Care, under authority of G.S. 120-30.17(1). The Committee was chaired by Senator Ralph Hise and Representative Mark Hollo, Co-Chairs of the Committee. The full membership of the Committee is listed under Committee Membership. A committee notebook containing the committee minutes and all information presented to the committee will be filed in the Legislative Library by the end of the 2013-2014 biennium.

COMMITTEE PROCEEDINGS

The Legislative Research Commission's Committee on Health Care Provider Practice Sustainability and Training/Additional Transparency in Health Care met 3 times after the 2013 Regular Session. The Committee's Charge can be found here. The following is a brief summary of the Committee's proceedings. Detailed minutes and information from each Committee meeting are available in the Legislative Library.

December 16, 2013

Chairman Hise and Chairman Hollo welcomed the members to the Committee and reviewed the Committee's charge.

Erin Fraher, PhD, MPP, Director of the Program on Health Workforce Research and Policy for the Cecil G. Sheps Center for Health Services Research and Assistant Professor in the Departments of Family Medicine and Surgery at the University of North Carolina at Chapel Hill, addressed the status of the health care provider supply in North Carolina. Dr. Fraher discussed concerns about the sustainability of the current system and the geographic distribution of the health workforce in North Carolina. Dr. Fraher explained that there are a variety of factors that contribute to the distribution problems. Dr. Fraher also gave the Committee information about the various counties in North Carolina that qualify as mental health professional shortage areas as well as information about concerns over the supply of dentist and general surgeons. She explained that the health system is currently under transformation designed to lower costs, increase quality and improve the patient experience. This transformation will also require a workforce that has more educational opportunities that allow for upgrading their skills and becoming more acquainted with new models of care. She suggested that the existing healthcare workforce will need to be equipped with the ability to shift to more community-based settings. Dr. Fraher added that North Carolina is in a good position for workforce planning due to our strong Areas Health Education Centers (AHEC)s and Office of Rural Health and Community Care, the community college and university system, as well as the capacity for data collection and analysis available in North Carolina through the SHEP Center.

Denise Thomas, Fiscal Research, provided the Committee with an overview of current state spending on physician recruitment and retention efforts. This includes the health care provider recruitment and retention programs administered by the Department of Health and Human Services Office of Rural Health and Community Care. A total of 30 loan repayment contracts were awarded to primary care physicians and 5 loan repayment contracts were awarded to psychiatrists during the period from July to December of Fiscal Year 2013-2014. The North Carolina Loan Repayment Budget for Fiscal Year 2013-2014 is $4,685,440. Ms. Thomas also reviewed some of the past key legislative actions in this area.

Chris Collins, MSW, Acting Director of the North Carolina Department of Health and Human Services Office of Rural Health and Community Care, spoke to the Committee about the Department's efforts regarding physician retention and recruitment. He explained the variety of educational programs that begin at the high school level and continue through the university level. Mr. Collins also explained the details involved in Graduate Medical Education and Residency programs. He explained the relationships the Department has with primary care and psychiatric residency programs; the University of North Carolina and East Carolina University Schools of Dentistry; and the nine AHECs. Mr. Collins also discussed the health professional shortage areas: 86 counties have a primary care shortage, 82 counties have a dental shortage, and 62 have a mental health provider shortage. According to Mr. Collins, the Department recruits primary care physicians, nurse practitioners, physician assistants, dentists, dental hygienists, and psychiatrists to practice in the rural and underserved areas across the state. A total of 168 providers were recruited in fiscal year 2013. Finally, Mr. Collins also discussed opportunities for further recruitment and retention of health care providers.

Dr. Erin Fraher again addressed the Committee. She spoke on the status of residency training in North Carolina, including projected future needs for the State. She discussed the creation of a governance board to oversee funding for residency expansion. Dr. Fraher discussed North Carolina's increasing reliance upon importing physicians trained outside of the State. Physicians who complete a North Carolina AHEC residency are more likely to stay in North Carolina to practice.

Dr. Elizabeth Baxley, Senior Associate Dean for Academic Affairs, Brody School of Medicine at East Carolina University, spoke to the Committee about physician recruitment and retention from the perspective of the Brody School. She detailed the mission of the Brody School, which includes increasing the supply of primary care physicians, and provided the Committee with data illustrating how the Brody School works towards that mission. Brody graduates the highest percentage of students in the nation who choose careers in Family Medicine.

Dr. Warren Newton, Vice Dean, UNC School of Medicine, and Director, North Carolina Area Health Education Center (AHEC) at UNC, spoke to the Committee about building a foundation of primary care for North Carolina. He explained that the location where a physician completes his or her residency is a predictor of retention within that state. He also discussed the University of North Carolina's perspective on recruitment and retention of health care providers.

Melanie Phelps, Deputy General Counsel, North Carolina Medical Society, gave the Committee information on the private efforts of the North Carolina Medical Society to address medically underserved areas in the state through the Community Practitioner Program.

The agenda next turned to telemedicine and the Committee heard from Dr. Robin Cummings, Deputy Secretary for Health Services, North Carolina Department of Health and Human Services. Dr. Cummings updated the Committee on the implementation of

the Statewide Telepsychiatry Program as directed by Session Law 2013-360. The Statewide Telepsychiatry Program builds upon East Carolina University's Center for Telepsychiatry and e-Behavioral Health and the Duke Endowment/Albemarle Hospital Foundation Telepsychiatry Project.

The final speaker was Dr. Peter Kragel, Director of the Telemedicine Center at East Carolina University. He explained the North Carolina Medical Board's policy statement on telemedicine and issues involving the Centers for Medicare and Medicaid Services surrounding telemedicine.

January 21, 2014

Erin Fraher, PhD, MPP, Director of the Program on Health Workforce Research and Policy for the Cecil G. Sheps Center for Health Services Research and Assistant Professor in the Departments of Family Medicine and Surgery at the University of North Carolina at Chapel Hill, addressed the supply and distribution of optometrists in North Carolina. Twelve counties have no optometrists and supply in western and northeastern counties is low.

Dr. Steve Eyler, O.D., and Dr. Hall Herring, O.D., then addressed the Committee regarding North Carolina's lack of an optometry school. The doctors expressed concern that North Carolina students seeking to become optometrists have to be trained in other states. Previously contract spots were allotted for North Carolina students through a grant program to off-set out-of-state tuition. This program has been discontinued. The doctors presented statistics demonstrating a decline in the number of North Carolina students enrolled in optometry programs since the elimination of the tuition off set grant program. The doctors requested the reinstatement of the tuition offset grant program.

Dr. Fraher addressed the Committee again with information about the trends in the supply and distribution of health care providers throughout North Carolina. She explained the NC Health Professions Data System based at the Cecil G. Sheps Center for Health Services Research. She then discussed the supply of advanced practice clinicians (Nurse Practitioners, Physician Assistants, and Certified Nurse Midwives) and pharmacists. She also discussed the supply of other allied health professionals as well.

David Vanderweide, Fiscal Research Division, walked the Committee through Senate Bill 561 of the 2013 Sessoin: Chiropractic Co-Pay Parity. He explained the current co-pays under the State Health Plan and went through the actuarial note associated with SB 561.

The Committee then heard from the following Doctors of Chiropractic: Dr. Joe Siragusa, Executive Director, NC Chiropractic Association; Dr. Joel M. Stevans; Dr. Eugene A. Lewis; Dr. Shawn Phelan, Principal Investigator Chiropractic Study. These gentlemen spoke to the Committee in favor of prohibiting health plans from requiring consumers to pay higher co-pays for chiropractic visits than for visits to primary care providers for a comparable condition. The presentation explained that, in certain instances, the co-pay

required by the insurance company is higher than the actual office visit charge and thus, patients are required to pay entirely out of pocket. Health problems associated with low back pain are prevalent and a common reason for individuals to seek medical care. The presenters indicated that chiropractic care could help ease the patient load on primary care providers and in a cost effective manner. Dr. Phelan also presented his analysis of claims through the State Health Plan involving uncomplicated low back pain; the discrepancies in cost when a patient saw a chiropractic doctor versus a medical doctor; and potential savings to the State Health Plan by implementing chiropractor co-pay equity.

Harry Kaplan, Lobbyist, North Carolina Association of Health Plans, spoke regarding chiropractic co-pays. He explained that chiropractic care is more specialized and limited than primary healthcare and that health plans should be free to charge a co-pay that is appropriate to that plan.

Dr. Brian Caveny, Vice President and Medical Director, Blue Cross and Blue Shield of North Carolina, also addressed the matter of chiropractic co-pays. He stressed the importance of a medical home for patients, including those with chronic back pain, and that chiropractic care is treated as a specialty alongside other specialists in muscular/skeletal care. He explained that in 2006-2007 the State Health Plan was required to treat chiropractic care in a way similar to that proposed under Senate Bill 561 and that the increase in utilization lead to an increase in costs.

The last topic on the agenda was fee transparency in primary health care. Dr. Tom White, President-Elect, North Carolina Family Physicians, spoke about some of the obstacles to transparency in the area of family medicine as well as some of the opportunities and solutions for this area of health care. Harry Kaplan again addressed the Committee on behalf of the North Carolina Association of Health Plans to stress that health plans are in favor of transparency to promote consumer education. He explained some of the ways in which health plans attempt to educate the consumers in this regard. There are considerations to be taken into account when further requirements for transparency are enacted.

April 21, 2014

The Committee reviewed its report to the Legislative Research Commission and the accompanying legislation. The Committee voted to approve the report and legislation.

FINDINGS AND RECOMMENDATIONS

FINDING #1: THERE IS A NEED FOR MORE HEALTH CARE PROVIDERS IN NORTH CAROLINA, PARTICULARLY IN RURAL AND UNDERSERVED LOCATIONS.

The Committee heard various presentations on the shortage of health care providers in the State of North Carolina and the need for an expansion of residency options and clinical practice sites throughout the state. The presentations at the December 16, 2013, meeting highlighted the importance of residency and clinical site training opportunities in rural and underserved areas. According to the NC Department of Health and Human Services Office of Rural Health and Community Care, there are 86 counties with a primary care health professional shortage area (HPSA) designation, 82 counties with a dental HPSA and 62 counties with a mental health HPSA designation. The HPSA designation is based upon federal guidelines that make the area eligible for federal funding and services.

A variety of presentations to the Committee touched upon the need for a mix of health care professionals to address the issue of health care shortages throughout North Carolina. According to the Cecil G. Sheps Center, 34% of individuals employed in the health care field in North Carolina work in the allied health professions. Allied health includes all health professions except for physicians, nurses, chiropractors, dentists, optometrists, pharmacists, podiatrists, nurse aides, orderlies and attendants. Registered and Licensed Nurses make up about 29% of the health work force. Physicians account for 5% of the health work force. In addition to North Carolina's shortage in physicians, especially primary care and general surgeons as noted, North Carolina also has a growing need for other health professionals.

FINDING #2: NORTH CAROLINA HAS SEVERAL RETENTION AND RECRUITMENT PROGRAMS.

Denise Thomas with Fiscal Research explained that health care provider recruitment and retention programs, including loan repayment, are administered by the Department of Human Services Office of Rural Health and Community Care. To be eligible for these programs, an individual must be a licensed primary care medical, dental, mental health or behavioral health care provider. These loan repayment programs are provided to individuals in exchange for working in rural and underserved areas. In Fiscal Year 2013-2014, from the months of July to December, 35 loan repayment contracts have been awarded to primary care physicians and psychiatrists.

The North Carolina Department of Health and Human Services Office of Rural Health and Community Care shared their efforts to recruit and retain health care professionals. Additionally, the Division of Mental Health/Developmental Disabilities/Substance Abuse

has a tuition-assistance contract with the University of North Carolina School of Nursing for the Psychiatric Mental Health Nurse Practitioner Program. The National Health Services Corp offers tax free scholarships to medicals students and in Fiscal Year 2013, 7 scholars in North Carolina were selected.

There are also a variety of private assistance programs. Melanie Phelps with the North Carolina Medical Society gave a presentation on one such private effort to address the rural and underserved areas in North Carolina. Currently there are twenty-one medical doctors, five doctors of osteopathy, ten physician assistants, and seven family nurse practitioners participating in this Community Practitioner Program.

FINDING #3: IN ADDITION TO RECRUITMENT/RETENTION PROGRAMS, THE LOCATION OF A HEALTH PROFESSIONAL'S TRAINING AND EDUCATION OFTEN INFLUENCES WHERE THE PROFESSIONAL CHOOSES TO PRACTICE.

The location of a health care professional's training often influences where that professional ultimately chooses to practice. For example, Dr. Warren Newton, Director, North Carolina Area Health Education Centers (AHEC), presented information that indicates that 46% of physicians who complete a North Carolina AHEC residency stay in North Carolina to practice as compared with only 31% of physicians who complete a non-AHEC residency and stay in North Carolina. These AHEC residents are also more likely to practice in the rural areas.

Additionally, 42% of physicians who have a residency in North Carolina are retained in this state. However, as presented by the Cecil G. Sheps Center, North Carolina is behind the national average of residents per 10,000 population. The national average is 3.6 residents per 10,000 population whereas in North Carolina, there are 3.1 residents per 10,000 population.

RECOMMENDATION #1: SUPPORT THE EXPANSION OF RESIDENCY OPTIONS AND CLINICAL PRACTICE SITES THROUGH THE STATE.

As several presenters highlighted, much of the medical education debate has occurred at a national level. In this regard, the Committee on Health Care Provider Practice Sustainability and Training/Additional Transparency in Health Care encourages the General Assembly to expanded residency opportunities and participate in federal programs that benefit the state and could lead to increased retention of health care professionals in North Carolina. On a state level, the Committee on Health Care Provider Practice Sustainability and Training/Additional Transparency in Health Care recommends continued support by the General Assembly of programs that assist in recruiting and retaining health care professionals and expansion of residency options and clinical practice sites throughout the state for all areas of heath care training.

RECOMMENDATION #2: STUDY BETTER UTILIZATION BY THE NORTH CAROLINA DEPARTMENT OF HEALTH AND SERVICES OF WORKFORCE DATA AVAILABLE FROM THE CECIL G. SHEPS CENTER.

The Cecil G. Sheps Center made four presentations to the Committee on a variety of subjects relating to health services research and health workforce data. The North Carolina Health Professions Data System (HPDS) is based at the Cecil G. Sheps Center for Health Services Research at the University of North Carolina – Chapel Hill with a statewide mission. The wealth of information housed in the HPDS is useful to the North Carolina Department of Health and Human Services. The Committee on Health Care Provider Practice Sustainability and Training/Additional Transparency in Health Care recommends further study the information available from the Cecil G. Sheps Center and the HPDS and its use, or potential use, by the North Carolina Department of Health and Human Services. This study should consider funding needs and funding sources for increased and expanded study of the health care workforce in North Carolina utilizing the HPDS and explore ways in which the North Carolina Department of Health and Humans Services may take a more active role in monitoring the healthcare workforce supply in the state.

RECOMMENDATION #3: STUDY THE TUITION COSTS FOR HEALTHCARE-RELATED PROGRAMS IN THE STATE AND THE ASSISTANCE PROGRAMS AVAILABLE TO SUPPLEMENT THOSE TUITION COSTS AND CONTINUE TO SUPPORT STATE-ASSISTED FINANCIAL AID.

The Committee on Health Care Provider Practice Sustainability and Training/Additional Transparency in Health Care recommends further study of the tuition costs for all healthcare-related education programs in the state and the assistance programs available to supplement the costs. This study should include assistance available to students on the front-end, such as scholarships and loans, as well as assistance available to students after completion of their education. The Committee on Health Care Provider Practice Sustainability and Training/Additional Transparency in Health Care recommends the General Assembly continue to support state-assisted financial aid in a manner that results in effective retention of health care providers within North Carolina and which prioritizes funding for highly needed occupations in underserved areas.

FINDING #4: NORTH CAROLINA'S RATIO OF OPTOMETRISTS PER 10,000 POPULATION IS LESS THAN THE NATIONAL AVERAGE.

Data from the Cecil G. Sheps Center shows that North Carolina's ratio of optometrists per 10,000 population is below the national average and has consistently been below the national average since 1979. Most recent data shows that the North Carolina average is 1.09 optometrists per 10,000 population, while the national average is 1.17 per 10,000. There are twelve counties in North Carolina without a single optometrist. However, there is a relatively even proportion of optometrists in the State's rural and urban counties, though there has been some decline in the rural areas over the past ten years.

FINDING #5: NORTH CAROLINA OFFERS OPTOMETRY STUDENTS FORGIVABLE EDUCATION LOANS FOR SERVICE, BUT DOES NOT HAVE A SCHOOL OF OPTOMETRY.

The Forgivable Loans for Service Program allows optometry students to receive an annual loan of $14,000. The Program generally allows students to repay a year of the loan with a year of service in a qualified position in North Carolina. The Forgivable Loans for Service Program does allow loan funds to be used for tuition at schools located outside of North Carolina. According to information provided by the Fiscal Research Division to the Committee at the January 21, 2014, for fiscal year 2012-2013, ten optometry students received an award under this program.

It is important to note that the Forgivable Education Loans for Service Program allows optometry students to utilize the loan resources at out-of-state educational institutions as there is no optometry school located in North Carolina. The Association of Schools and Colleges reports that 115 North Carolina resident students were enrolled in its twenty reporting schools for fiscal year 2011-2012. The Fiscal Research Division reports that the number of North Carolina resident optometry students for the 2012-2013 school year is about 100.

RECOMMENDATION #4: SUPPORT THE ENACTMENT OF LEGISLATION TO STUDY THE NEED FOR AN OPTOMETRY SCHOOL IN NORTH CAROLINA.

The lack of educational opportunities for students wishing to study optometry in the state of North Carolina may lead to residents attending out-of-state institutions and not returning to North Carolina to practice optometry after graduation. In order to increase the potential for optometry students to stay and practice in North Carolina, the Committee on Health Care Provider Practice Sustainability and Training/Additional Transparency in Health Care recommends the enactment of legislation **2013-MGz-132** by the General Assembly, which would require the Board of Governors of The University of North Carolina to evaluate the feasibility of opening an optometry school at one or more of the following locations: The University of North Carolina - Chapel Hill; East Carolina University; Elizabeth City State University; Fayetteville State University; NC A & T State University; North Carolina Central University; and Winston-Salem State University. The bill requires the Board of Governors to report their findings to the Joint Legislative Oversight Committee on Health and Human Services and Fiscal research Division by December 1, 2014.

Independent colleges and universities could also play an important role in providing educational opportunities for students wishing to purse a degree in optometry. This recommended legislation would also encourage the North Carolina Independent Colleges and Universities, Inc. to examine of the feasibility of establishing an affiliated school of optometry. The North Carolina Independent Colleges and Universities, Inc. is

encouraged to submit the report to the Joint Legislative Oversight Committee on Health and Human Services and Fiscal research Division by December 1, 2014.

FINDING #6: CHIROPRACTIC CARE IS SUBJECT TO A HIGHER CO-PAYMENT THAN PRIMARY CARE UNDER MOST HEALTH INSURANCE BENEFIT PLANS.

During the meeting on January 21, 2014, the Committee heard from a variety of speakers on the subject of chiropractic care coverage by health insurance benefit plans. Under most insurance plans, co-payment responsibilities of the plan member are divided up into various categories. Most often, primary care is associated with the lowest co-payment requirement, while specialty care carries a higher co-payment amount. Chiropractic care is frequently categorized as specialist co-pay. However, some insurance plans do place chiropractic care in a category of its own, but one that still carries a higher co-payment than primary care. For example, as explained by David Vanderweide, Fiscal Research Division, the State Health Plan's co-payment requirement for chiropractic care falls in between that for primary care (with the lowest co-payment) and that for specialty care (with the highest co-payment).

FINDING #7: HIGHER CO-PAYMENTS MAY SERVE AS A DISINCENTIVE TO SEEK CARE.

As the costs of health care increase, a patient may find cost to be a barrier to seeking healthcare services. As such, a higher co-payment to obtain chiropractic services may prevent individuals from seeking chiropractic care. Health care is frequently provided by Doctors of Chiropractic who are licensed by the State of North Carolina for the care of back pain and neck pain, as well as other conditions. Information presented by Joel Stevans, DC and Post-Doctoral Fellow at the School of Health and Rehabilitation Sciences at the University of Pittsburgh, provided data to the Committee indicating that 80% of individuals will experience back pain in their lifetime. This back pain leads to 90 billion dollars annually in direct medical costs and 50 billion dollars annually in absentee, disability, and lost productivity costs. Dr. Stevens cited a randomized controlled trial indicating that patients' access to chiropractic care is sensitive to cost-sharing expenses.

RECOMMENDATION #5: SUPPORT THE ENACTMENT OF CHIROPRACTOR CO-PAY PARITY.

The Committee on Health Care Provider Practice Sustainability and Training/Additional Transparency in Health Care recommends the enactment of legislation 2013-MGz-133 by the General Assembly, which would prohibit a health benefit plan from requiring a member to pay an office co-payment for services performed by a licensed chiropractor that is higher than the office co-payment for services performed by a licensed primary care physician for a comparable medically necessary treatment or condition.

FINDING #8: SESSION LAW 2013-473 CREATED THE HEALTH CARE COST REDUCTION AND TRANSPARENCY ACT OF 2013.

The Health Care Cost Reduction and Transparency Act of 2013 requires hospitals to report on pricing for the 100 most common inpatient diagnostic related groups (DRG's) in each hospital. The law contains similar reporting requirements for hospital outpatient departments and ambulatory surgical facilities (ASCs) for the 20 most common surgical procedures and the 20 most common imaging procedures performed in each setting. The North Carolina Department of Health and Human Services must publish this information reported by the hospitals and ASC's on its internet website available to the public. The Medical Care Commission is charged with adopting rules identifying the DRG's, surgical procedures and imaging procedures on which the facilities will report. In addition, non-profit hospitals and ASC's must provide public access to their financial assistance policies and annual financial assistance costs.

FINDING #9: TRANSPARENCY IN HEALTH CARE COSTS IS POSSIBLE IN OTHER AREAS.

At the January 21, 2014, meeting, the North Carolina Academy of Family Physicians presented a variety of obstacles and opportunities for transparency in the practice of family medicine, including the difficulty of estimating a total service cost without prior evaluation of a patient. Dr. Thomas White said that cost transparency is important; however quality transparency is also necessary. Costs associated with primary care services may vary based upon a patient's insurance plan, or lack thereof. Dr. White ran through some examples of providers and provider practices that have adopted innovative practice models that assist with transparency. Harry Kaplan with the North Carolina Association of Health Plans agreed that there has been significant movement in the State to improve quality and reduce health care costs in the primary care field. He stated that health plans are in favor of more transparency to assist consumers in making informed medical decisions. Both presenters indicated that the topic is complex and that they would be interested in further discussions and being part of the solution. There is no direct and obvious path as to which additional health care providers should be subject to the Health Care Cost Reduction and Transparency Act and this topic needs further study.

RECOMMENDATION #6: SUPPORT THE ENACTMENT OF LEGISLATION TO REQUIRE THE NORTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES TO STUDY EXPANSION OF HEALTHCARE TRANSPARENCY REQUIREMENTS.

The Committee on Health Care Provider Practice Sustainability and Training/Additional Transparency in Health Care recommends the enactment of legislation 2013-MGz-134 by the General Assembly, which would require the North Carolina Department of Health and Human Services to study and identify specific categories of healthcare providers to which the requirements of the Health Care Cost Reduction and Transparency Act of 2013 should be expanded. Further, the legislation requires the Department to study and recommend what data should be collected for the purpose of transparency from each

category of identified healthcare providers; what exemptions from the Act each category of healthcare providers should receive; and when each category of healthcare providers should become subject to the Act's requirements. The bill would require the Department to report to the Joint Legislative Oversight Committee on Health and Human Services with recommendations December 1, 2014.

Appendix A

COMMITTEE MEMBERSHIP

2013-2014

President Pro Tempore of the Senate Appointments:

Senator Ralph Hise, Co-Chair

Senator David Curtis
Senator Eugene McLaurin
Senator Jeffery Tarte
Senator Tommy Tucker

Speaker of the House of Representatives Appointments:

Representative Mark Hollo, Co-Chair

Representative Jim Fulghum
Representative Verla Insko
Representative Bert Jones
Representative Susan Martin

COMMITTEE CHARGE

The following is an excerpt from the October 29, 2013, LRC letter from Senator Phil Berger, President Pro Tempore of the Senate, and Representative Thom Tillis, Speaker of the House of Representatives:

…

Health Care Provider Practice Sustainability and Training/Additional Transparency in Health Care - The LRC Study Committee on Health Care Provider Practice Sustainability and Training/Additional Transparency in Health Care shall study ways to enhance health care provider recruitment, retention and distribution in order to increase access to medical care and make recommendations on the following:

(1) A comprehensive assessment of the State's current and projected supply and distribution of health care providers. The assessment shall identify the health care provider specialties that are currently most needed in this State and those that are expected to be in greater need in the future.

(2) A comprehensive review of all existing State programs that are designed to recruit and retain health care providers, including an examination of program focused on recruiting new and partially retired health care providers.

(3) A comprehensive review of the current and future role and availability of physician extenders as a partial solution for increasing the availability of medical care in this State, particularly in rural and medically underserved areas. The term "physician extender" includes physicians' assistants and registered nurses licensed to practice in this state.

(4) A review of programs and strategies used in other states that are designed to recruit and retain health care providers, including an examination of programs and strategies focused on recruiting new and partially retired health care providers.

(5) A review of programs and strategies for recruiting and retaining health care providers, including consultation related to the State's existing administrative and regulatory burdens that discourage health care providers from practicing in the State.

(6) An examination of the cost and benefits of requiring health care providers to quote to a patient their out of pocket expenditures before a service or procedure is performed and potential impacts that this requirement may have on quality of care and health outcomes.

(7) An examination of whether primary care providers are best equipped to provide such quotes.

(8) A comprehensive review of all existing State programs that are designed to improve access to health care provider care using telemedicine, including the name of the program, a description of the program, and details on program performance.

(9) Identification of programs and strategies employed in other states that are designed to improve access to health care provider care using telemedicine.

(10) Any other issues pertinent to this study.

…

STATUTORY AUTHORITY

N O R T H C A R O L I N A G E N E R A L S T A T U T E S
ARTICLE 6B.

Legislative Research Commission.

§ 120-30.17. Powers and duties.

The Legislative Research Commission has the following powers and duties:

(1) Pursuant to the direction of the General Assembly or either house thereof, or of the chairmen, to make or cause to be made such studies of and investigations into governmental agencies and institutions and matters of public policy as will aid the General Assembly in performing its duties in the most efficient and effective manner.

(2) To report to the General Assembly the results of the studies made. The reports may be accompanied by the recommendations of the Commission and bills suggested to effectuate the recommendations.

(3), (4) Repealed by Session Laws 1969, c. 1184, s. 8.

(5), (6) Repealed by Session Laws 1981, c. 688, s. 2.

(7) To obtain information and data from all State officers, agents, agencies and departments, while in discharge of its duty, pursuant to the provisions of G.S. 120-19 as if it were a committee of the General Assembly.

(8) To call witnesses and compel testimony relevant to any matter properly before the Commission or any of its committees. The provisions of G.S. 120-19.1 through G.S. 120-19.4 shall apply to the proceedings of the Commission and its committees as if each were a joint committee of the General Assembly. In addition to the other signatures required for the issuance of a subpoena under this subsection, the subpoena shall also be signed by the members of the Commission or of its committee who vote for the issuance of the subpoena.

(9) For studies authorized to be made by the Legislative Research Commission, to request another State agency, board, commission or committee to conduct the study if the Legislative Research Commission determines that the other body is a more appropriate vehicle with which to conduct the study. If the other body agrees, and no legislation specifically provides otherwise, that body shall conduct the study as if the original authorization had assigned the study to that body and shall report to the General Assembly at the same time other studies to be conducted by the Legislative Research Commission are to be reported. The other agency shall conduct the transferred study within the funds already assigned to it.

LEGISLATIVE PROPOSALS

LEGISLATIVE PROPOSAL 1:

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2013

S **D**

BILL DRAFT 2013-MGz-132 [v.10] (02/11)

(THIS IS A DRAFT AND IS NOT READY FOR INTRODUCTION)
4/10/2014 11:20:32 AM

Short Title:	Study Establishment of New Optometry Schools.	(Public)
Sponsors:	Senator (Primary Sponsor).	
Referred to:		

A BILL TO BE ENTITLED

AN ACT REQUIRING THE BOARD OF GOVERNORS OF THE UNIVERSITY OF NORTH CAROLINA, AND ENCOURAGING THE NORTH CAROLINA INDEPENDENT COLLEGES AND UNIVERSITIES, INC., TO STUDY AND REPORT TO THE JOINT LEGISLATIVE OVERSIGHT COMMITTEE ON HEALTH AND HUMAN SERVICES ON THE FEASIBILITY OF ESTABLISHING AN AFFILIATED SCHOOL OF OPTOMETRY, AS RECOMMENDED BY THE LEGISLATIVE RESEARCH COMMISSION STUDY COMMITTEE ON HEALTH CARE PROVIDER PRACTICE SUSTAINABILITY AND TRAINING/ADDITIONAL TRANSPARENCY IN HEALTH CARE.

The General Assembly of North Carolina enacts:

SECTION 1.(a) By December 1, 2014, The Board of Governors of The University of North Carolina shall evaluate and report to the Joint Legislative Oversight Committee on Health and Human Services and the Fiscal Research Division on the feasibility of establishing a school of optometry at one or more of the following constituent institutions:

(1) The University of North Carolina at Chapel Hill
(2) East Carolina University
(3) Elizabeth City State University
(4) Fayetteville State University
(5) North Carolina Agricultural and Technical State University
(6) North Carolina Central University

(7) Winston-Salem State University

SECTION 1.(b) The report shall include at least all of the following:

(1) A breakdown of any projected capital, operational, or other expenditures necessary for establishing and operating a school of optometry affiliated with the institution.

(2) A breakdown of all funds available to assist the institution with these expenses.

(3) A projected number of applicants for the affiliated school of optometry.

SECTION 2. The North Carolina Independent Colleges and Universities, Inc. is encouraged to examine and report by December 1, 2014, to the Joint Legislative Oversight Committee on Health and Human Services and the Fiscal Research Division on the feasibility of establishing an affiliated school of optometry. The report should include at least all of the following:

(1) A breakdown of any projected capital, operational, or other expenditures necessary for establishing and operating a school of optometry affiliated with the institution.

(2) A breakdown of all funds available to assist the institution with these expenses.

(3) A projected number of applicants for the affiliated school of optometry.

SECTION 3. This act is effective when it becomes law.

Appendix D

LEGISLATIVE PROPOSAL 2

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2013

S **D**

BILL DRAFT 2013-MGz-133 [v.4] (02/11)

(THIS IS A DRAFT AND IS NOT READY FOR INTRODUCTION)
3/14/2014 12:55:18 PM

Short Title:	Establish Chiropractor Co-Pay Parity.	(Public)
Sponsors:	Senator Hise (Primary Sponsor).	
Referred to:		

A BILL TO BE ENTITLED

AN ACT TO REENACT A LAW CONCERNING HEALTH BENEFIT PLAN CO-PAYMENTS FOR SERVICES PERFORMED BY CHIROPRACTORS, AS RECOMMENDED BY THE LEGISLATIVE RESEARCH COMMISSION STUDY COMMITTEE ON HEALTH CARE PROVIDER PRACTICE SUSTAINABILITY AND TRAINING/ADDITIONAL TRANSPARENCY IN HEALTH CARE.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 58-50-30(a3) reads as rewritten:

"(a3) Whenever any health benefit plan, subscriber contract, or policy of insurance issued by a health maintenance organization, hospital or medical service corporation, or insurer governed by Articles 1 through 67 of this Chapter provides coverage for medically necessary treatment, the insurer shall not impose any limitation on treatment or levels of coverage if performed by a duly licensed chiropractor acting within the scope of the chiropractor's practice as defined in G.S. 90-151 unless a comparable limitation is imposed on the medically necessary treatment if performed or authorized by any other duly licensed physician. An insurer shall not impose upon an insured as a limitation on treatment or level of coverage a copayment amount for services performed by a duly licensed chiropractor that is higher than the copayment amount imposed upon the insured for services performed by a duly licensed primary care physician for a comparable, medically necessary treatment or condition."

SECTION 2. This act becomes effective January 1, 2015, and applies to insurance policies issued, renewed, or amended on or after that date.

Appendix D
LEGISLATIVE PROPOSAL 3

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2013

S **D**

BILL DRAFT 2013-MGz-134 [v.5] (02/11)

(THIS IS A DRAFT AND IS NOT READY FOR INTRODUCTION)
4/7/2014 4:03:00 PM

Short Title:	Study Expansion of Healthcare Transparency.	(Public)
Sponsors:	Senator (Primary Sponsor).	
Referred to:		

A BILL TO BE ENTITLED

AN ACT REQUIRING THE DEPARTMENT OF HEALTH AND HUMAN SERVICES TO STUDY AND REPORT TO THE JOINT LEGISLATIVE OVERSIGHT COMMITTEE ON HEALTH AND HUMAN SERVICES ITS RECOMMENDATIONS FOR EXTENDING HEALTHCARE TRANSPARENCY REQUIREMENTS TO ADDITIONAL HEALTHCARE PROVIDERS, AS RECOMMENDED BY THE LEGISLATIVE RESEARCH COMMISSION STUDY COMMITTEE ON HEALTH CARE PROVIDER PRACTICE SUSTAINABILITY AND TRAINING/ADDITIONAL TRANSPARENCY IN HEALTH CARE.

The General Assembly of North Carolina enacts:

SECTION 1. By December 1, 2014, the Department of Health and Human Services shall study and submit a written report to the Joint Legislative Oversight Committee on Health and Human Services summarizing its recommendations for extending North Carolina's Health Care Cost Reduction and Transparency Act of 2013 to additional healthcare providers. The report shall identify all of the following:

(1) Recommended categories of additional healthcare providers that should be subject to the requirements of the Act.

(2) Recommended data to be collected for the purpose of transparency from each category of identified healthcare providers.

(3) Recommended exemptions, if any, from certain requirements of the Act for each category of identified healthcare providers.

(4) Recommended effective dates for the applicability of the Act to each category of identified healthcare providers.

SECTION 2. This act is effective when it becomes law.