1999

HOUSE
HEALTH
COMMITTEE

MINUTES

HOUSE COMMITTEE ON HEALTH
1999 SESSION

MEMBER	ASSISTANT	PHONE NO.	OFFICE NO.	SEAT NO.
Rep. Thomas Wright, Chair	Clarestene Stewart	733-5754	528 LOB	5
Rep. Verla Insko, Vice-Chair	Pat Baker	733-5775	1323 LB	70
Rep. Alma Adams	Troy Williams	733-5902	542 LOB	67
Rep. Martha Alexander	Ann Faust	733-7208	2121 LB	32
Rep. Cary Allred	Jean Allred	733-5607	609 LOB	65
Rep. Joni Bowie	Sharon Gaudette	733-5877	538 LOB	53
Rep. Harold Brubaker	Cindy Coley	715-4946	1229 LB	27
Rep. Debbie Clary	Mary Jamison	733-5654	1211 LB	97
Rep. Andrew Dedmon	Donna Abu Harb	733-5732	2213 LB	12
Rep. Theresa Esposito	Judy Lowe	715-3009	418C LOB	28
Rep. Beverly Earle	Ann Raeford	733-5747	535 LOB	95
Rep. Zeno Edwards	Jo Hinton	733-5906	637 LOB	91
Rep. Julia Howard	Gail Stewart	733-5988	1023 LB	51
Rep. Larry Justus	Carolyn Justus	733-5958	640 LOB	13
Rep. Max Melton	Gerry Durant	733-5784	633 LOB	105
Rep. Jean Preston	Sandra Ellis	733-5706	603 LOB	78
Rep. David Redwine	Nancy Brantley	733-5829	635 LOB	19
Rep. William Wainwright	Denise Smith	733-5898	614LOB	8
Rep. Connie Wilson	Paula Covington	733-5903	501 LOB	73
Rep. Larry Womble	Phyllis Cameron	733-5777	537 LOB	56

Hackney

HOUSE COMMITTEE ON HEALTH

REP. THOMAS E. WRIGHT
CHAIR

Rep. Insko
Vice Chair

Rep. Adams

Rep. Alexander

Rep. Bowie

Rep. Brubaker

Rep. Clary

Rep. Dedmon

Rep. Earle

Rep. Edwards

Rep. Esposito

Rep. Howard

Rep. Justus

Rep. Melton

Rep. Preston

Rep. Redwine

Rep. Wainwright

Rep. Wilson

Rep. Womble

REP. BRASWELL

ATTENDANCE

HOUSE COMMITTEE ON HEALTH

(1999-2000 SESSION)

DATES	5/25	6/1,5	6/8	6/9	7/6	7/9									
WRIGHT, THOMAS (CHAIR)	✓	✓	✓	✓	✓	✓									
INSKO, VERLA (VICE CHAIR)	✓	✓	✓	✓	✓	✓									
ADAMS, ALMA			✓	✓											
ALEXANDER, MARTHA	✓		✓	✓	✓	✓									
ALLRED, CARY			✓	✓											
BOWIE, JOANNE	✓		✓	✓		✓									
BRASWELL, JERRY															
BRUBAKER, HAROLD				✓	✓										
CLARY, DEBBIE			✓	✓	✓	✓									
DEDMON, ANDREW															
EARLE, BEVERLY			✓												
EDWARDS, ZENO			✓		✓	✓									
ESPOSITO, THERESA			✓		✓	✓									
HOWARD, JULIA	✓		✓	✓											
JUSTUS, LARRY			✓	✓	✓	✓									
MELTON, MAX	✓	✓	✓	✓	✓										
PRESTON, JEAN															
REDWINE, DAVID				✓	✓	✓									
WAINWRIGHT, WILLIAM															
WILSON, CONNIE		✓	✓												
WOMBLE, LARRY	✓	✓	✓	✓	✓										
(EX-OFFICIO MEMBERS)															
BADDOUR, PHIL															
CUNNINGHAM, PETE															
DEDMON, ANDREW															
EARLE, BEVERLY															
HACKNEY, JOE															

ATTENDANCE

HOUSE COMMITTEE ON HEALTH

1999-2000 SESSION

DATES	2/25	3/2	3/9	3/16	3/30	4/6	4/13	4/20	4/21	4/23	4/26	4/27	5/4		
WRIGHT, THOMAS Chair	✓	✓			✓	✓	✓	✓	✓	✓	✓	✓	✓		
INSKO, VERLA Vice Chair	✓	✓	E		✓	✓	✓	✓	✓	✓	✓	✓	✓		
ADAMS, Alma	✓	✓			✓	✓	✓	✓	✓	✓	✓	✓			
ALEXANDER, Martha		✓			✓	✓	–			✓	✓	✓	✓		
ALLRED, Cary		✓			✓	✓	–	✓	✓	✓	✓	✓			
BOWIE, Joanne	✓	✓	✓	E	✓	✓	✓	✓	✓	✓	✓	✓	✓		
BRUBAKER, Harold		✓					–	✓		✓	✓	✓			
CLARY, Debbie	✓	✓	✓		✓	✓	✓	✓		✓	✓	✓			
DEDMON, Andrew	✓	✓		ing	✓	✓	–	✓		✓	✓	✓	✓		
EARLE, Beverly	✓	✓		i	✓	✓	✓			✓	✓	✓			
EDWARDS, Zeno	✓	✓		X		✓	✓	✓	✓	✓	✓	✓	✓		
ESPOSITO, Theresa	✓	✓	✓	e	✓	NO	✓	✓		✓	✓	✓			
HOWARD, Julia	✓	✓	✓	e	✓	✓	✓	✓			✓	✓			
JUSTUS, Larry	✓	✓	✓	S			✓	✓	✓	✓	✓	✓	✓		
MELTON, Max	✓		✓		✓	✓	✓	✓	✓	✓	✓	✓	✓		
PRESTON, Jean				20	✓	✓	–		–	✓	✓	✓			
REDWINE, David	✓			20	✓	✓	–			✓	✓				
WAINWRIGHT, William		✓			✓	✓	–	✓		✓	✓	✓			
WILSON, Connie		✓	✓		✓	✓	–	✓		✓	✓	✓	✓		
WOMBLE, Larry	✓	✓	✓		✓		✓	✓	✓	✓	✓	✓			
Braswell, Jerry															
Ex Officio Members								–							
SP Baddour, Phil		✓								✓	✓				
Cunningham, Pete		✓			✓		NO		✓	✓	✓	✓			
Dedmon, Andy															
Earle, Beverly															
MS Hackney, Joe						✓									

NORTH CAROLINA GENERAL ASSEMBLY

COMMITTEE SUMMARY REPORT

1999-2000 Biennium HOUSE: HEALTH Valid Through 16-AUG-1999

BILL	INTRODUCER	SHORT TITLE	LATEST ACTION ON BILL	IN DATE	OUT DATE
H 24=	BAKER	MOBILE PHARMACIES	H -RE-REF COM ON HEALTH	02-16-99	
H 36=	BADDOUR	CHIP CLINICS/REPEAL PROHIBITION	H -RE-REF COM ON HEALTH	02-16-99	
H 103=	INSKO	INSURANCE/COVER CONTRACEPTIVES	H -REF TO COM ON HEALTH	02-17-99	
H 254	EDWARDS	HEALTH CARE FACILITY/PATIENT ABUSE	*S -REF TO COM ON JUDICI	03-04-99	04-15-99
H 255	ALEXANDER	VOCATIONAL REHABILITATION CHANGES	R -CH. SL 99-0161	03-04-99	03-09-99
H 697	DEDMON	AREA AUTHORITY MERGER	H -REF TO COM ON HEALTH	03-30-99	
H 736	ROGERS	MANAGED CARE/PATIENT ACCESS	*S -RE-REF COM ON COMMERCE	04-20-99	04-27-99
H 835=	MOORE R	CHIROPRACTIC OWNERSHIP RESTRICTED	H -REF TO COM ON HEALTH	04-01-99	
H 836=	MOORE R	CHIROPRACTIC CLAIMS REVIEW	H -REF TO COM ON HEALTH	04-01-99	
H 905=	ALEXANDER	DENTAL BENEFITS/HEALTH CHOICE	*H -RE-ASSIGNED TO APP-HRES	04-05-99	04-21-99
H 906	ALEXANDER	PHARMACIST PEER REVIEW	R -CH. SL 99-0081	04-05-99	04-13-99
H 996=	WRIGHT	REGULATE SPINAL MANIPULATION	*S -REF TO COM ON HLTHCARE	04-13-99	04-23-99
H1064	DECKER	ABORTION/RIGHT TO KNOW	H -REF TO COM ON HEALTH	04-15-99	
H1083	**ALEXANDER**	**ARTHRITIS EDUC. TASK FORCE**	**H -ASSIGNED TO APP-HRES**	**04-15-99**	**04-23-99**
H1095=	ALLEN	CLINICAL PHARMACIST PRACTITIONER	*R -CH. SL 99-0290	04-15-99	04-26-99
H1118	WRIGHT	LIMIT LIABILITY/DEFIBRILLATORS	*H -RE-REF COM ON RULES	04-15-99	04-27-99
H1138=	MCCOMAS	ORTHOPAEDIC PHYSICIAN ASSISTANTS	H -REF TO COM ON HEALTH	04-15-99	
H1250	WILSON C	CON MODIFICATIONS	H -REF TO COM ON HEALTH	04-15-99	
H1258=	EARLE	HEALTH CARE PERSONNEL REGISTRY CHANG	*R -CH. SL 99-0159	04-15-99	04-27-99
H1282=	NYE	MANAGED CARE/PATIENT ACCESS	H -REF TO COM ON HEALTH	04-15-99	
H1340	TOLSON	RESPIRATORY CARE PRACTICE ACT	*S -REF TO COM ON HLTHCARE	04-26-99	06-23-99
S 26=	PURCELL	CHIP CLINICS/REPEAL PROHIBITION	R -CH. SL 99-0004	02-18-99	03-02-99
S 59=	FOXX	MOBILE PHARMACIES	*R -CH. SL 99-0246	03-02-99	03-11-99
S 90=	FORRESTER	INSURANCE/COVER CONTRACEPTIVES	*R -CH. SL 99-0231	03-10-99	04-07-99
S 160	PERDUE	NURSE REHABILITATION	R -CH. SL 99-0291	04-05-99	06-29-99
S 194	RAND	NURSE LICENSURE COMPACT	*R -CH. SL 99-0245	04-06-99	05-25-99
S 432=	CARPENTER R	HEALTH CARE PERSONNEL REGISTRY CHANG	*H -RE-REF COM ON HEALTH	04-27-99	05-25-99
S 432=	CARPENTER R	HEALTH CARE PERSONNEL REGISTRY CHANG	*H -RE-REF COM ON HEALTH	07-08-99	
S 732=	SOLES	CHIROPRACTIC OWNERSHIP RESTRICTED	*R -CH. SL 99-0430	04-27-99	07-06-99
S 783=	COCHRANE	LONG-TERM CARE FACILITIES/DISCLOSURE	*S -FAILED CONCUR IN COM SUB	04-29-99	07-09-99

NOTES- = AFTER BILL NUMBER SHOWS THAT BILL IS IDENTICAL, AS INTRODUCED, TO ANOTHER BILL.
* AFTER NUMBERS INDICATES THAT TEXT OF BILL WAS ALTERED BY ACTION ON THE BILL.
BOLDED LINE INDICATES BILL INDEXED AS AFFECTING APPROPRIATIONS.

NORTH CAROLINA GENERAL ASSEMBLY

COMMITTEE SUMMARY REPORT

1999-2000 Biennium HOUSE: HEALTH Valid Through 16-AUG-1999

BILL	INTRODUCER	SHORT TITLE	LATEST ACTION ON BILL	IN DATE	OUT DATE
S 793	CLODFELTER	PSYCHOLOGY PRACTICE DEFINITIONS	R -CH. SL 99-0292	04-20-99	06-29-99
S 951	PERDUE	HEALTH CARE WORKERS/ID BADGE	*R -CH. SL 99-0320	04-27-99	06-30-99
S 960	SOLES	REGULATION OF PHARMACIES	H -REF TO COM ON HEALTH	04-29-99	
S 998	ODOM	CANCER ADVISORY BOARD/MEMBER TERMS	R -CH. SL 99-0280	04-27-99	06-22-99

NOTES- = AFTER BILL NUMBER SHOWS THAT BILL IS IDENTICAL, AS INTRODUCED, TO ANOTHER BILL.
* AFTER NUMBERS INDICATES THAT TEXT OF BILL WAS ALTERED BY ACTION ON THE BILL.
BOLDED LINE INDICATES BILL INDEXED AS AFFECTING APPROPRIATIONS.

AGENDA

HOUSE COMMITTEE ON HEALTH

TUESDAY, FEBRUARY 23, 1999

12:00 NOON ROOM 415

OPENING REMARKS

REP. THOMAS E. WRIGHT
CHAIRMAN

INTRODUCTIONS

COMMITTEE MEMBERS

COMMENTS

ADJOURNMENT

MINUTES

COMMITTEE ON HEALTH

TUESDAY, FEBRUARY 23, 1999

12:00 NOON, ROOM 415 LOB

The House Committee on Health met Tuesday, February 23, 1999 at 12:00 noon in Room 415-LOB. A silent roll was taken,(roll list denotes members present).

Chairman Wright called the meeting to order.

Chairman Wright states that this is an organizational meeting and that there are presently four bills before the Health Committee. Also, the members of the Health Committee are asked to introduce themselves by giving their names and the district they represent.

Rep. Esposito is recognized for a question about the legislation that will filter through the Health Committee. Chairman Wright responds to the inquiry and asks if there are any other questions or comments.

Lastly, Chairman Wright recognizes the Pages for the day; Sergeant-At-Arms staff and Research Staff assigned to the Health Committee.

The Chairman adjourns the meeting.

Rep. Thomas E. Wright, Chairman

Vanda Wilson-Wormack, Committee Assistant

AGENDA

HOUSE COMMITTEE ON HEALTH

Tuesday, March 2, 1999
Room 415 LOB
12:00 Noon

OPENING REMARKS

Representative Thomas E. Wright, Chairman
House Committee on Health

BILL TO BE DISCUSSED

HB-36 CHIP Clinics/Repeal Prohibition
Rep. Baddour

COMMENTS

ADJOURNMENT

MINUTES

COMMITTEE ON HEALTH

TUESDAY, MARCH 2, 1999

12:00 NOON, ROOM 415 LOB

The House Committee on Health met Tuesday, March 2, 1999 at 12:00 noon in Room 415-LOB. A silent roll was taken,(roll list denotes members present).

Chairman Wright called the meeting to order.

Chairman Wright recognized the Page and Sergeant-At-Arms staff.

HB-36-CHILDRENS HEALTH INSURANCE

Chairman Wright recognized Rep. Baddour to explain HB-36. Before taking questions or comments, Chairman Wright recognized Dr. Jane Foy, President of the North Carolina Pediatric Society, to speak on the bill. John Rust, Director of Governmental Relations of the North Carolina Family Policy Council also spoke on the bill.

Rep. Adams asks John Rust to explain further his opposition for this bill. Mr. Rust concerns were the cost-effectiveness of the clinics and Parental Consents of this service. Rep. Wilson asked if Parental Consent is apart of the North Carolina statutes. Rep. Baddour responds. Marilyn Aicee is recognized from the audience of Health Professionals to respond. Rep. Wilson follows-up. Rep. Baddour responds.

Rep. Womble is recognized and directs his question to the staff and the bill sponsor about cost-effectiveness of this program. Rep. Baddour responded. Rep. Womble follows-up with a question to the Chair, Bill Sponsor and Dr. Foy. Rep. Baddour responded. Rep. Womble follows-up with a comment.

Rep. Justus is recognized for a question. The Chair directs the inquiry to staff. The staff replied. Rep. Justus follows-up with another question. Staff responds. Rep. Justus follows-up with a question about the CHIPS Program. Rep. Baddour responds. Rep. Justus comments. Marilyn Aicee is recognized to respond. Rep. Clary is recognized for a comment on the bill.

Chairman Wright states that SB-26 is the identical bill to HB-36 and the Bill Sponsor has agreed to allow SB-26 to be heard.

Rep. Insko moved that HB-36 be withdrawn from today's calendar and SB-26 (Identical Bill) be place on the calendar.

Rep. Allred is recognized for a question on the bill. Rep. Baddour responds. Rep. Allred follows-up with a question. Rep. Baddour responds. Rep. Allred follows-up with a comment.

Rep. Earle moved for a favorable report, unfavorable as to the original bill.

The Chair asked if there is further discussion on the motion. The I's have the majority vote on the motion.

Chairman Wright adjourns the meeting.

Rep. Thomas E. Wright, Chairman

Vanda Wilson-Wormack, Committee Assistant

Identical Bill

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 1999

S 1

SENATE BILL 26*

Short Title: CHIP Clinics/Repeal Prohibition. (Public)

Sponsors: Senators Purcell; Albertson, Ballance, Carter, Dannelly, Garwood, Hagan, Kerr, Kinnaird, Lee, Lucas, Martin of Guilford, Metcalf, Perdue, Phillips, Plyler, Robinson, Shaw of Cumberland, Soles, Warren, Weinstein, and Wellons.

Referred to: Health Care.

February 4, 1999

A BILL TO BE ENTITLED

AN ACT TO REPEAL THE PROHIBITION ON REIMBURSEMENT FOR SERVICES PROVIDED BY SCHOOL-BASED HEALTH CLINICS UNDER THE CHILDREN'S HEALTH INSURANCE PROGRAM.

The General Assembly of North Carolina enacts:

Section 1. Section 8 of S.L. 1998-1, Extra Session 1998, reads as rewritten:

"Section 8. ~~Except for immunization, no State funds, federal funds, or funds from any other source may be used under the Health Insurance Program for Children established under this act to reimburse medical services performed in school-based health clinic settings.~~ The Executive Administrator and Board of Trustees of the Teachers' and State Employees' Comprehensive Major Medical Plan shall conduct a survey of any claims paid by the Plan's self-insured indemnity program during each of the last three plan years. Any results of the survey shall be used by the Plan in conducting a study of the array of medical services delivered in school-based settings and whether or not such services should be eliminated, curtailed, or expanded. No later than March 31, 1999, the Plan shall make its findings and recommendations pursuant to this study known to the Committee on Employee Hospital and Medical Benefits, the Joint Legislative Health Care Oversight Committee, and the 1999 Session of the General Assembly."

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

EXPLANATION OF HOUSE BILL 36
CHIP Clinics/Repeal Prohibition

TO: House Health Committee
FROM: Linda Attarian, Committee Counsel
DATE: March 1, 1999
SPONSOR: Representative Baddour

Explanation of House Bill 36

House Bill 36 amends Section 8 of S.L. 1998-1, Extra Session, to repeal the prohibition on reimbursement for health care services provided by school-based clinics under the Children's Health Insurance Program. The Children's Health Insurance Program (hereinafter CHIP), called NC Health Choice, was established by the General Assembly during the 1998 Extra Session with the enactment of Senate Bill 2, ratified as Chapter 98-01 of the 1998 Session Laws. Section 8 of that legislation restricted reimbursements for health care services provided at school-based health clinics to immunizations. House Bill 36 repeals this restriction and allows all covered services provided to CHIP enrollees at school-based health clinic to be reimbursed with CHIP funds, effective when the bill becomes law.

House Bill 36 leaves intact the second part of Section 8 of Senate Bill 2 which directed the Executive Administrator and Board of the Teachers' and State Employees' Comprehensive Major Medical Plan (hereinafter State Health Plan) to conduct a survey of any claims paid by the State Health Plan during each of the previous three years (1995-97). The results of the survey are to be used to study the types of services delivered at school-based health clinics. Their findings and recommendations as to whether any of the services should be expanded, curtailed or eliminated must be reported to the Joint Legislative Health Care Oversight Committee and the Committee on Employee Hospital and Medical Benefits no later than March 31, 1999.

Background Information on the Children's Health Insurance Program

Congress created a new child health program by enacting Title XXI of the Social Security Act as a part of the Balanced Budget Act of 1997. Under Title XXI, the State Children's Health Insurance Program, federal funds ($39.6 billion over a 10-year period) became available to states for expanding health insurance coverage for low-income children. Participating states have either expanded Medicaid or adopted a non-Medicaid "state plan" option (or a combination of both) to provide health insurance to children under age 19 in families with incomes up to 200 percent of the federal poverty guidelines ($2,057 per month for a family of 4). Title XXI, like Medicaid, is funded jointly by the federal and state governments. As of January 1, 1999, all but two states (Washington and Wyoming) are participating in the program.

North Carolina's CHIP program is called NC Health Choice. Its health care benefits are based on the State Employee's Health Plan and are administered through Blue Cross/Blue Shield of North Carolina. The federal government pays 74 percent of the program costs up to a maximum allotment of 79.5 million each year. The State is required to make a 26 percent match. No county match is required.

NC Health Choice began enrolling children October 1, 1998. It has been estimated that 71,000 children in North Carolina are eligible for the program. As of January 5, 1999 there were 18,511 children enrolled. As a result of the NC Health Choice outreach efforts, an additional 12,601 children have been enrolled in Medicaid

Background Information on School-based Health Clinics in North Carolina

A school-based health clinic is a health center located on school grounds and staffed by health professionals. Students can receive physical and mental health care services without leaving school. School-based health clinics improve access to health care for children who do not get the health care they need because they live in an area with few health care providers, lack transportation, or cannot take time off from school or their parents can't take time off from work.

The clinics provide primary care services such as physical exams, sports physicals, health and dental screenings, health education, diagnosis and treatment of health problems, and laboratory testing. Preventive services include immunizations, nutrition counseling and weight management, substance abuse prevention, pregnancy and sexually transmitted disease prevention (however, no contraceptives, including condoms may be distributed on school property), and conflict resolution. They also provide counseling and referrals for school performance and behavior problems, substance abuse, family conflict, and depression. In North Carolina, parental permission is required before students may receive services from school-based health clinics.

The General Assembly began funding school-based health centers in 1992, appropriating funding for four centers. Since then, $950,000 is appropriated annually to the Department of Health and Human Services to fund fourteen centers. According to the NC Center for Health Statistics, there are currently 50 school-based health centers in 29 counties. There are three major sources of funding for these clinics. Each source of funds contributes one-third the total budgets. The three sources include state, local and federal grants (e.g. the Maternal and Child Health Block Grant) local donations and in-kind contributions; and third party reimbursements (e.g. Medicaid) and fee-for-service.

Facts about School-Based Health Centers

Students do not get the health care they need because they:

- Live in an area with few health care providers;
- Cannot take time off from school or because their parents cannot take time off from work;
- Lack money and/or transportation;
- Do not know how to get to health care services.

Services* provided by centers include:

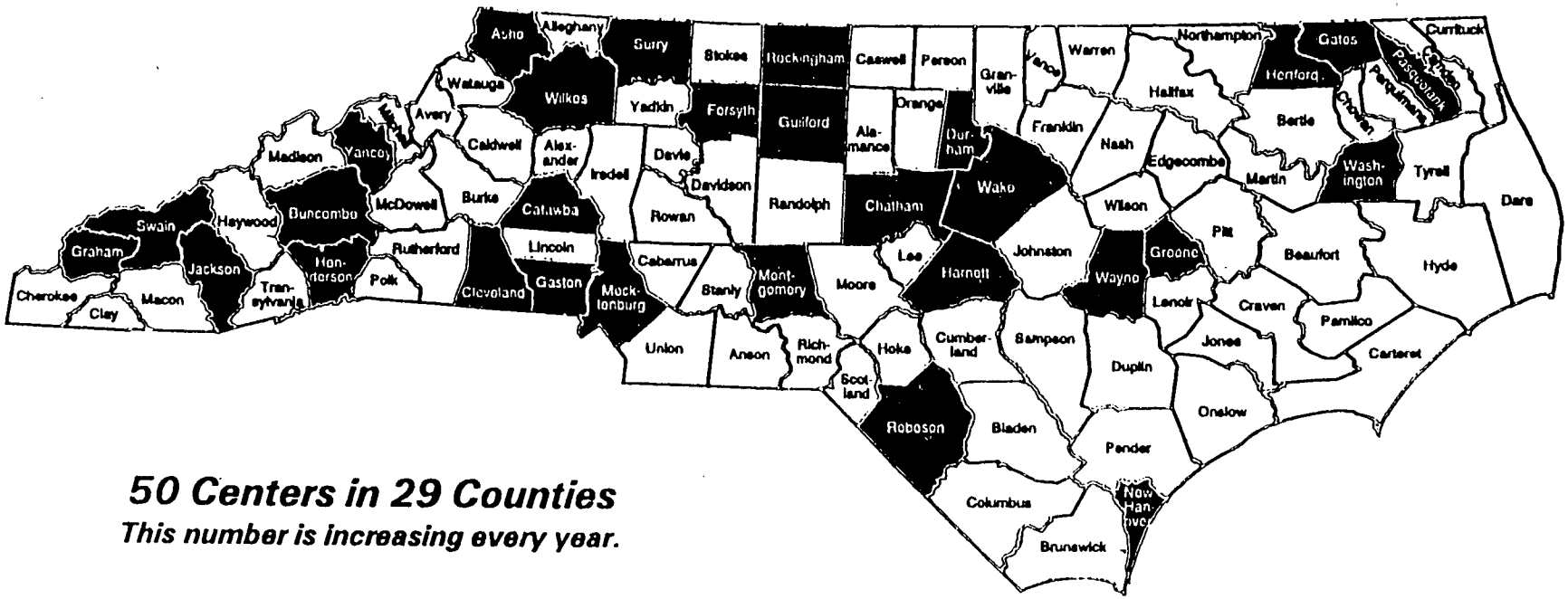
- Prevention and treatment of acute illness and injury;
- Management of chronic illness;
- Immunizations;
- Sports physicals;
- Vision and dental screening;
- Drug and alcohol counseling;
- Nutrition education.

Centers comply with North Carolina law because they:

- Require parental consent for health services.
- Do not distribute contraceptives or condoms.
- Do not perform abortions or refer students for them.

***All services offered at a center, including those related to reproductive health, are chosen by the local community.**

Making the Grade in North Carolina Is Making a Difference



50 Centers in 29 Counties

This number is increasing every year.

Centers Bring Good Health Care to Young People Who Had Little or None Before

State Center for Health Statistics, October 1998

North Carolina School-Based Health Centers

County	Health Center(s)	Medical Sponsor
Ashe	Northwest High School*	Ashe County Health Department
Buncombe	Asheville High School* Asheville Middle School*	Buncombe County Health Department Mission-St. Joseph's Health System
Catawba	Catawba Valley High School*	Catawba County Health Department
Chatham	Horton Middle School*	Chatham County Health Department
Cleveland	Shelby Middle School* Shelby High School Kings Mountain Middle School Kings Mountain High School Burns High School* Crest High School Crest Middle School*	Cleveland County Health Department Cleveland Regional Medical Center
Durham	NC School of Math and Science Hillside High School Wellness Ctr. Southern High School Wellness Ctr. Geo. Watts Elem. Sch. Wellness Ctr.	Lakewood Family Practice Lincoln Community Health Center. Duke University School of Nursing Duke University School of Nursing
Eastern Band of Cherokee Indians	Cherokee Elementary School*	Cherokee Health Delivery
Forsyth	Independence High School*	Bowman-Gray Baptist Medical Center
Gates	Gates County High School*	Gates County Medical Center
Greene	Greene Central High School*	Greene County Health Care
Guilford	Grimsley High School* High Point Central High School*	Guilford County School Health Alliance
Harnett	Wayne Avenue Primary School Harnett Primary School Dunn Middle School	Harnett County Health Department
Henderson	Apple Valley Middle School	Blue Ridge Community Health Services
Hertford	Hertford County Middle School*	Roanoke-Chowan Alliance
Montgomery	East Middle School*	First Health of the Carolinas

County	Health Center(s)	Medical Sponsor
New Hanover	Lakeside High School	Wilmington Health Access for Teens
Pasquotank	Northeastern High School* Elizabeth City Middle School*	Pasquotank County Health Department
Robeson	Purnell Swett High School*	Robeson County Health Department
Rockingham	McMichael High School Morehad High School Reidsville High School Rockingham County High School	Morehead Memorial Hospital
Surry	Gentry Middle School*	Surry County Health Department
Swain, Jackson & Graham	Robbinsville Middle School* Swain County Middle School* Fairview School*	West Care Health System
Washington	Washington Co. Union Middle Sch.	Washington County Hospital
Wayne	Brogden Middle School* Goldsboro Middle School*	WISH, Inc.
Wilkes	Central Wilkes High School* East Wilkes High School* North Wilkes High School* West Wilkes High School* (Mobile van unit)	Wilkes County Health Department
Yancey	East Yancey Middle School* Cane River Middle School*	Yancey County Health Department

North Carolina School-Linked Health Centers

County	Health Center	Medical Sponsor
Eastern Band of Cherokee Indians	Cherokee Teen Center *	Cherokee Health Delivery
Gaston	Advocates for Healthy Citizens, Inc.	Private Family Physician
Mecklenburg	Teen Health Connection	Carolinas Medical Center
New Hanover	Wilmington Health Access to Teens	Grants: RWJ & Duke Hospitals/Health Department
Wake	Wake Teen Medical Services	Wake Medical Center

*Health Centers using School-Health On-line data system

f:\...\ncsbslc.ncf\February, 1999

Basics About Health Check

What is it?

Health Check (Medicaid) is a program funded by the federal, state and county governments of North Carolina. It provides free health insurance to children whose families qualify. More than 600,000 children in North Carolina get health insurance through Health Check.

Who does it serve?

Health Check offers health insurance to children who:

- are less than 21 years of age,
- are residents of North Carolina, and
- have a family that meets the income requirements below.

Child's Age	Qualifying Income Level
Birth through 1 year	at or below 185% FPL*
1 through 5 years	at or below 133% FPL
6 through 18 years	at or below 100% FPL

*FPL means Federal Poverty Level

Individuals 19 or 20 years old may also enroll in Health Check. Contact your county department of social services to find out about eligibility for 19 and 20 year olds.

To find out if a child is eligible for either Health Check or NC Health Choice, an application must be submitted to the local department of social services.

What benefits do enrolled children receive?

Health Check covers all medically necessary services including:

- Well Child Checkups
- Immunizations (shots)
- Sick Visits
- Vision and Hearing Care
- Lab Tests
- Therapies
- Dental Care
- Medicines
- Hospital Care
- Medical Equipment and Supplies
- Counseling
- Surgery

For more specific coverage information, call the CARELINE at 1-800-662-7030.

Each family can choose the doctor or clinic they want to be their child's main health care provider.

How does someone apply?

Applications are in all county departments of social services and health departments. They may also be at other places in a county. Families need to bring in or mail completed applications to their local department of social services along with proof of their income and the child's age. To find out where applications are available, call 1-800-367-2229.

What does it cost?

Families pay no charges for this program.

For more information or to learn how to apply for Health Check or NC Health Choice, contact your county department of social services or call the NC Family Health Resource Line: 1-800-367-222

State of North Carolina • James B. Hunt Jr., Governor
Department of Health and Human Services • H. David Bruton M.D., Secretary

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VISITOR REGISTRATION SHEET

House Committee on Health 3-2-99

VISITORS: PLEASE SIGN BELOW AND RETURN TO COMMITTEE CLERK

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1. Amy Jo Bain	NCMS
2. Eilleene	NCMS.
3. Marcy D Dion	NCMS
4. Adam Searing	NCHAE
5. Lan Pierce	NCPHC
6. Jay Trayanham	NC Pediatric Society
7. Christin Jean	NC Pediatric Society
8. Jennifer Arnold	NC Pediatric Society
9. Carlos Abanses	NC Pediatric Society
10. C. Parker Porter	Bone & Associates
11. Joyce Rogers	AP Assoc/MANEST
12. John Rose	NCFPC
13. Deborah Rowe	NC Public Health Assoc
14. Steve Hicks	Making The South in NC
15. Tom Vaughan	DHHS - DWCH
16. Jan Ramsey	NCSOS
17. Anne Dixon	DC-NOW
18. Kay Michaels	PPOD
19. Tommy Worth	CHS
20. Pat Young	APPCNC/ACLU
21. Katherine Miller	+ Harry Kaplan

VISITOR REGISTRATION SHEET

Health — Name of Committee

3-2-99 — Date

VISITORS: PLEASE SIGN BELOW AND RETURN TO COMMITTEE CLERK.

NAME	FIRM OR AGENCY AND ADDRESS
Buck Sitterson	PCMH
J. Craig Church	PCMH
Robert Paschal	Young, Moore & Henderson, P.A.
Alicia Gregory	Poyner & Spruill
Dave Rock	NC Pediatric Society
M Edgerton	YAIO / DOA
Paula Wolf	Covenant w/ NC's Children
[illegible]	DHHS
Violet Bayour	N.C. State Legislature
[illegible]	Poyner & Spruill
K Wright	BCBSNC
Ashley Westbrook	Governors Office
A. Dennis McBride	DHHS
Jack McGee	March of Dimes
[illegible]	NCSA

VISITOR REGISTRATION SHEET

HEALTH
Name of Committee

3-2-99
Date

VISITORS: PLEASE SIGN BELOW AND RETURN TO COMMITTEE CLERK.

NAME	FIRM OR AGENCY AND ADDRESS
William H Potter Jr	NCCMH NCDS
Christine Bruske	
Christina Medlin	Covenant

AGENDA

HOUSE COMMITTEE ON HEALTH

TUESDAY, MARCH 9, 1999

12:00 NOON ROOM 415-LOB

OPENING REMARKS

Rep. Thomas E. Wright
Chairman

BILLS TO BE DISCUSSED

HB-255 VOCATIONAL REHABILITATION CHANGES/AB

SB-59-MOBILE PHARMACIES

COMMENTS

ADJOURNMENT

MINUTES

HOUSE COMMITTEE HEALTH

TUESDAY, MARCH 9, 1999

12:00 NOON ROOM 415-LOB

The House Committee on Health met on Tuesday, March 9, 1999 at 12:00 Noon in Room 544-LOB. A silent roll was taken, (roll list denotes members present.)

Chairman Wright called the meeting to order.

SB-59 MOBILE PHARMACIES

Senator Fox explained the bill. Rep. Clary asked the bill sponsor a question about section 3 of the bill. Senator Fox responded. Chairman Wright responded to Rep. Clary about a technical amendment that would be sent forth. Chairman Wright read the technical amendment. Rep. Clary responded. Linda Attarian, Staff, responded to Rep. Clary's concern. Senator Fox responded. Rep. Clary commented about a possible amendment to the bill. Linda Attarian commented on the amendment. Chairman Wright read the amendment that amended the bill on page 1, line 18 through page 2, line 1. Linda Attarian commented on the amendment. Rep. Clary made a suggestion about the amendment. Chairman Wright read the amendment sent forth by Rep. Clary that would amend the bill on line 6. Linda Attarian further explained the amendment. Chairman Wright asked Rep. Clary a question about the amendment. Rep. Clary responded. Chairman Wright asked John Young about the impact of this amendment. John Young, Staff, responded. Senator Fox responded.

Rep. Clary moved for adoption of the amendment.

Discussions were heard on the amendment. Rep. Bowie asked Staff a question about the bill. John Young responded. Rep. Bowie followed up with a comment on the bill. Fran Preston from the North Carolina Retail Merchants Association commented on the bill. Rep. Justus asked the bill sponsor a question. Senator Fox responded. Rep. Justus followed up with a question. Senator Fox responded. Rep. Clary commented on the bill. Rep. Wilson commented on the bill.

The question before the Committee was adoption of the amendment. So moved.

Rep. Bowie moved for a favorable report on the proposed committee substitute bill, unfavorable as to the original bill.

A vote was taken. The Ayes had the majority vote.

HB-255-VOCATIONAL REHABILITATION CHANGES/AB

John Young, Staff, explained the bill. Rep. Esposito asked a question about the bill. Jackie Stalnaker, from the Division of Vocational Rehabilitation Services, responded. Rep. Esposito followed up with a question. Jackie Stalnaker responded.

Rep. Wilson moved for a favorable report.

A vote was taken. The Ayes had the majority vote. The bill passed.

Chairman Wright introduced the Pages to the House Health Committee.

The meeting adjourned at 12:45pm.

Rep. Thomas E. Wright, Chairman

Vanda Wilson-Wormack, Committee Asst.

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 1999

H 1

Favor

HOUSE BILL 255

Short Title: Vocational Rehabilitation Changes/AB. (Public)

Sponsors: Representatives Alexander; Mosely and Wainwright.

Referred to: Health.

March 4, 1999

A BILL TO BE ENTITLED

AN ACT TO AMEND THE STATUTES INVOLVING VOCATIONAL REHABILITATION IN ORDER TO COMPLY WITH FEDERAL LAW.

The General Assembly of North Carolina enacts:

Section 1. G.S. 143-545.1(b)(2) reads as rewritten:

"(2) The Secretary of the Department of Health and Human Services shall adopt rules to establish eligibility for services, the nature and scope of services to be provided, standards for community rehabilitation programs and qualified personnel to provide services and conditions, criteria, and procedures under which services may be provided including financial need for services. Rules governing financial need for services shall meet the requirements set in federal law and regulations. ~~The following services shall not be conditioned on the client's or applicant's ability to pay for the cost of those services:~~

~~a. Evaluation of rehabilitation potential, except for those vocational rehabilitation services other than of a diagnostic nature that are provided under an extended evaluation of rehabilitation potential;~~

~~b. Counseling, guidance, and referral services; and~~

~~c. Placement.~~"

Section 2. G.S. 143-548 reads as rewritten:

"**§ 143-548. Vocational Rehabilitation ~~Advisory~~ Council.**

(a) There is established the Vocational Rehabilitation ~~Advisory~~ Council within the Division of Vocational Rehabilitation Services to be composed of ~~15 voting members.~~ not more than 18 appointed members. Appointed members shall be voting members except where prohibited by federal law or regulations. The Director of the Division of Vocational Rehabilitation Services and one vocational rehabilitation counselor who is an employee of the Division shall serve ex officio as nonvoting members. The President Pro Tempore of the Senate shall appoint ~~five~~ six members, the Speaker of the House of Representatives shall appoint ~~five~~ six members, and the Governor shall appoint five or six members. The appointing authorities shall appoint members of the Council after soliciting recommendations from representatives of organizations representing a broad range of individuals with disabilities. Terms of appointment shall be as specified in subsection (d1) of this section. Appointments shall be made as follows:

(1) The ~~five~~ six members appointed by the President Pro Tempore of the Senate shall include one member recommended by the North Carolina Citizens for Business and Industry, one other representing providers of community rehabilitation services, one other who is a vocational rehabilitation counselor, with knowledge of and experience with vocational rehabilitation programs, who is not an employee of the Division, one other representing the Commission on Workforce Preparedness, and two others representing disability advocacy groups representing a cross-section of individuals with physical, cognitive, sensory, and mental disabilities. Of the ~~five~~ six members appointed by the President Pro Tempore of the Senate, three shall be individuals with disabilities;

(2) The ~~five~~ six members appointed by the Speaker of the House of Representatives shall include one member representing the business and industry sector, one other representing labor, one other representing a parent training and information center established pursuant to section 631(c) of the Individuals with Disabilities Education Act, 20 U.S.C. § 1431(c), one other representing the Department of Public Instruction, and two others representing disability advocacy groups representing a cross-section of individuals with physical, cognitive, sensory, and mental disabilities. Of the ~~five~~ six members appointed by the Speaker of the House of Representatives, three shall be individuals with disabilities; and

(3) The five or six members appointed by the Governor shall include one member representing the business and industry sector, one other representing the regional rehabilitation centers for the physically disabled, one other representing the Division's Statewide Independent Living Council, one other representing the ~~Division's~~ State's Client Assistance Program, one other representing the directors of projects carried out under section 121 of the

Rehabilitation Act of 1973, 29 U.S.C. § 741, as amended, if there are any of these projects in the State, and one other current or former applicant for or recipient of vocational rehabilitation services. ~~Three of the members appointed by the Governor shall be individuals with disabilities.~~ If five members are appointed by the Governor, three shall be individuals with disabilities. If six members are appointed by the Governor, four shall be individuals with disabilities.

(b) Repealed by Session Laws 1993, c. 248, s. 1.

(b1) Additional Qualifications. -- In addition to ensuring the qualifications for membership prescribed in subsection (a) of this section, the appointing authorities shall ensure that a majority of Council members are individuals with disabilities and are not employed by the Division of Vocational Rehabilitation Services.

(c) The Council shall elect one of the voting members of the Council as Chair of the Council. The Chair's term shall not exceed a single three-year term.

(d) The Council shall meet at least quarterly and at other times at the call of the Chair. A majority of the voting members of the Council constitutes a quorum.

(d1) Terms of Appointment. --

(1) Length of Term. -- Each member of the Council shall serve for a term of not more than three years, except that:

a. A member appointed to fill a vacancy occurring prior to the expiration of the term for which a predecessor was appointed shall be appointed for the remainder of ~~such~~ that term;

b. The terms of service of the members initially appointed ~~shall be~~ are as specified by the appointing authority for ~~such~~ a fewer number of years as will provide for the expiration of terms on a staggered basis and shall include the members of the existing Council to the extent possible with appropriate adjustments to their terms; ~~and~~

c. The appointing authority shall have the power to remove any member of the Council from office in accordance with the provisions of G.S. ~~143B-16;~~ 143B-16; and

d. A member may continue to serve until a successor for the position is appointed;

(2) Number of Terms. -- No member of the Council other than the representative of the Client Assistance Program and the representative of the directors of projects carried out under section 121 of the Rehabilitation Act of 1973, 29 U.S.C. § 741, as amended, may serve more than two consecutive full terms.

(d2) Vacancies. -- Any vacancy occurring in the membership of the Council shall be filled in the same manner as the original appointment. The vacancy shall not affect the power of the remaining members to execute the duties of the Council.

(d3) Functions of Council. -- The Council ~~shall.~~ shall, after consulting with the Commission on Workforce Preparedness:

(1) Review, analyze, and advise the Division regarding the performance of its responsibilities under Title I of the Rehabilitation Act of 1973, ~~as amended by the Rehabilitation Act Amendments of 1992,~~ Pub. L. No. 93-112, 29 U.S.C. § 720, et seq., as amended, particularly responsibilities relating to:
   a. Eligibility, including order of selection;
   b. The extent, scope, and effectiveness of services provided; and
   c. Functions performed by State agencies that affect or that potentially affect the ability of individuals with disabilities in achieving ~~rehabilitation goals and objectives under the Act;~~ employment outcomes under Title I of the Rehabilitation Act of 1973, Pub. L. No. 93-112, 29 U.S.C. § 720, et seq.;

(1a) In partnership with the Division:
   a. Develop, agree to, and review State goals and priorities in accordance with section 101(a)(15)(C) of the Rehabilitation Act of 1973, 29 U.S.C. § 721(a)(15)(C); and
   b. Evaluate the effectiveness of the vocational rehabilitation program and submit reports of progress to the Commissioner of the Rehabilitation Services Administration of the U.S. Department of Education in accordance with section 101(a)(15)(E) of the Rehabilitation Act of 1973, 29 U.S.C. § 721(a)(15)(E);

(2) Advise the Department of Health and Human Services and the ~~Division, and, at the discretion of the Department,~~ Division regarding activities authorized to be carried out under Title I of the Rehabilitation Act of 1973, Pub. L. No. 93-112, 29 U.S.C. § 720, et seq., as amended and assist in the preparation of applications, the State Plan, ~~the strategic plan and~~ amendments to the plans, reports, needs assessments, and evaluations required by Title I of the ~~Rehabilitation Act of 1973, as amended by the Rehabilitation Act Amendments of 1992;~~ Rehabilitation Act of 1973;

(3) To the extent feasible, conduct a review and analysis of the effectiveness of, and consumer satisfaction with:
   a. ~~The functions performed by~~ Vocational rehabilitation functions and services provided by the Department of Health and Human Services and other State agencies and ~~other~~ public and private entities responsible for ~~performing functions for~~ providing vocational rehabilitation services to individuals with ~~disabilities;~~ disabilities under the

Rehabilitation Act of 1973, Pub. L. No. 93-112, 87 Stat. 355, 29 U.S.C. § 701, et seq.; and

~~b. Vocational rehabilitation services:~~

~~1. Provided, or paid for from funds made available, under the Rehabilitation Act of 1973, as amended by the Rehabilitation Act Amendments of 1992, or through other public or private sources; and~~

~~2. Provided by State agencies and other public and private entities responsible for providing vocational rehabilitation services to individuals with disabilities;~~

c. Employment outcomes achieved by eligible individuals receiving services under Title I of the Rehabilitation Act of 1973, Pub. L. No. 93-112, 29 U.S.C. § 720, et seq., as amended, including the availability of health and other employment benefits in connection with those employment outcomes;

(4) Prepare and submit an annual report to the Governor and the Commissioner of the Rehabilitation Services Administration of the U.S. Department of Education on the status of vocational rehabilitation programs operated within the State and make the report available to the public;

(5) Coordinate activities with the activities of other councils within the State, including the Division's Statewide Independent Living ~~Council,~~ Council established under section 705 of the Rehabilitation Act of 1973, 29 U.S.C. § 742, the advisory panel established under section ~~613(a)(12)~~ 612(a)(21) of the Individuals with Disabilities Education Act, 20 U.S.C. § 1413(a)(12), the State ~~Planning~~ Development Disabilities Council described in section 124 of the Developmental Disabilities Assistance and Bill of Rights Act, 42 U.S.C. § 6024, ~~and~~ the State Mental Health Planning Council established under section ~~1916(c)~~ 1914(a) of the Public Health Service Act, 42 U.S.C. § ~~300x-4(c);~~ 300x-4(e), and the Commission on Workforce Preparedness;

(6) ~~Advise the Department and provide~~ Provide for coordination and the establishment of working relationships between the Department and the Statewide Independent Living Council and centers for independent living within the State; and

(7) Perform such other functions, consistent with the purpose of Title I of the Rehabilitation Act of 1973, ~~as amended by the Rehabilitation Act Amendments of 1992,~~ Pub. L. No. 93-112, 29 U.S.C. § 720, et seq., as amended, as the ~~Governor and the Secretary may refer to it from time to time.~~ Council determines to be appropriate, that are comparable to other functions performed by the Council.

(d4) Resources. --

(1) The Division shall supply all necessary clerical and staff support to the Council pursuant to G.S. 143B-14(a) and ~~(d), and~~ (d). The Council shall prepare, in conjunction with the ~~Council,~~ Division, a plan for the provision of such resources as may be necessary and sufficient to carry out the functions of the Council under this Part. The resource plan shall, to the maximum extent possible, rely on the use of resources in existence during the period of implementation of the plan.

(2) To the extent that there is a disagreement between the Council and the Division in regard to the resources necessary to carry out the functions of the Council as set forth in this Part, the disagreement shall be resolved by the Governor.

(3) While assisting the Council in carrying out its duties, staff and other personnel shall not be assigned duties by the Division or any other agency of the State that would create a conflict of interest.

(d5) Member Conflict of Interest. -- No member of the Council shall cast a vote on any matter that would provide direct financial benefit to the member or otherwise give the appearance of a conflict of interest under State law.

(e) Council members shall be reimbursed for expenses incurred in the performance of their duties in accordance with G.S. 138-5. In addition, Council members may be reimbursed for personal assistance services that are necessary for members to attend Council meetings and perform Council duties. These expenses shall not exceed whichever is lower, the actual cost of the services or the Medicaid rate per day for personal assistance services, in addition to subsistence and travel expenses at the State rate for the attendant."

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

EXPLANATION OF House Bill 255
Vocational Rehabilitation Changes

To: Rep. Thomas Wright
From: John Young, Committee Staff
Date: March 5, 1999
Sponsor: Representative Martha Alexander (at request of DHHS)

Background on HB 255

It is the policy of the State that persons with physical and mental disabilities should be able to participate to the maximum extent of their abilities in the economic, educational, cultural, social and political activities available to all citizens of the State. (G.S. 143-545.1(a)) To implement this policy the Department of Health and Human Services operates a comprehensive program of vocational rehabilitation and independent living that is administered by the Division of Vocational Rehabilitation. The primary funding for those programs in the Division of Vocational Rehabilitation comes from federal sources under authority of the Federal Rehabilitation Act of 1973 with amendments through the Federal Rehabilitation Act Amendments of 1998 as part of the Workforce Investment Act of 1998 (P.L. 105-220). The Division of Vocational Rehabilitation has requested changes in G.S. 143-545.1 and G.S. 143-548 that it believes will conform our statutes to the federal requirements of P.L. 105-220.

Summary of HB 255

HB 255 would make the following statutory changes:

1. ***Section 1***- amends G.S. 143-545.1 to delete the reference to "extended evaluation". Extended evaluation was required under previous federal law to deal with those potential clients in which there was no immediate services available. This category of client is no longer used in the eligibility process under the federal law.
2. ***Section 2***-Amends G.S. 143-548 to make the following changes in the Vocational Rehabilitation Advisory Council;
    a. drops the word "advisory from the name of the Vocational Rehabilitation Advisory Council,
    b. expands the membership from 15 to 17 or 18 by adding one additional member appointed by the President Pro Tempore representing the Commission on Workforce Preparedness, one additional member appointed by the Speaker representing Department of Public Instruction, And one additional member appointed by the Governor representing the directors of projects carried out under sec. 121 of the Rehabilitation Act of 1973 (monies under the Act reserved for native Americans) if there is such projects.
    c. Specifically allocates to the Council certain responsibilities specified under federal statutes.
3. ***Section 3***-Makes the statute effective when it becomes law.

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 1999

S 2

SENATE BILL 59*
Commerce Committee Substitute Adopted 2/24/99

Short Title: Mobile Pharmacies. (Public)

Sponsors:

Referred to:

February 9, 1999

A BILL TO BE ENTITLED

AN ACT TO AMEND THE PHARMACY PRACTICE ACT TO PERMIT CERTAIN NONPROFIT CORPORATIONS TO OPERATE MOBILE PHARMACIES AND TO ALLOW SUCH PHARMACIES TO REGISTER ANNUALLY WITH THE BOARD OF PHARMACY.

The General Assembly of North Carolina enacts:

Section 1. G.S. 90-85.3 is amended by adding a new subsection to read:

"(12) 'Mobile pharmacy' means a mobile unit that is either self-propelled or moveable by another vehicle that is self-propelled and from which prescription drugs are dispensed or compounded. Each mobile unit shall be considered a single pharmacy."

Section 2. G.S. 90-85.21 is amended by adding a new subsection to read:

"(a1) A mobile pharmacy shall register annually with the Board in the manner prescribed in subsection (a) of this section, and the registration shall be renewed annually. A mobile pharmacy shall provide the Board with the address of every location from which prescription drugs will be dispensed by the mobile pharmacy. A mobile pharmacy shall not be required to pay a separate registration fee for each location but shall pay the annual registration fee prescribed in G.S. 90-85.24."

Section 3. This act applies only to mobile pharmacies operated by nonprofit corporations that dispense prescription drugs at no charge to persons whose family income is less than two hundred percent (200%) of the federal poverty level and do not receive reimbursement for the cost of the dispensed prescription drugs from Medicare, Medicaid, a private insurance company, or a governmental unit.

Section 4. This act is effective when it becomes law.

EXPLANATION OF SENATE BILL 59
Mobile Pharmacies

TO: House Health Committee
FROM: Linda Attarian, Committee Counsel
DATE: March 4, 1999
SPONSOR: Senator Foxx

Brief Explanation:

Senate Bill 59, 2nd Edition amends the Pharmacy Practice Act to add the definition of "mobile pharmacy," and require each mobile pharmacy to register annually with the Board of Pharmacy (Board). This bill ensures that mobile pharmacies operated by non-profit corporations that provide prescription drugs at no cost to people with incomes below 200 percent of the federal poverty level are not required to pay a registration fee to the Board for each place drugs are dispensed.

Section by Section Explanation:

Section 1 of the bill defines a "mobile pharmacy" for purposes of the NC Pharmacy Practice Act. This section clarifies that the mobile unit is a single pharmacy. Under current law, a "pharmacy" is defined as "*any* place where prescription drugs are dispensed or compounded". Under the current definition, each location a mobile pharmacy stopped to dispense drugs is interpreted by the Board to be a separate and distinct "pharmacy".

Section 2 amends G.S. 90-85.21 to add a new subsection to provide for the separate registration of mobile pharmacies. Under current law, all pharmacies must register annually with the Board for a fee of $350.00 and renew that registration annually for a fee of $175.00 thereafter. Since the Board has interpreted a mobile pharmacy to be a "series" of pharmacies (equaling the number of stops it made), the Board required a mobile pharmacy to obtain a separate "pharmacy permit" (and pay the $350.00 annual registration fee) for each location the mobile pharmacy might stop at to dispense drugs. Under the bill, mobile pharmacies will be required to provide the Board with the addresses of every location from which the mobile pharmacy intends to dispense drugs, but will only be required to pay one annual registration fee.

Section 3 restricts the application of the act to mobile pharmacies operated by non-profit corporations that dispense prescription drugs at no charge to individuals whose household income is less than twice the federal poverty level ($32,900 for a family of four).

Effective Date: The bill would become effective when it becomes law.

Background Information:

Last year The Watauga County Hunger Coalition received funds from the Kate B. Reynolds Trust to buy a 34-foot recreational vehicle and refurbished it to create a mobile pharmacy. The unit visits rural parts of Ashe, Avery and Watauga Counties to dispense pharmaceuticals to people who cannot afford to buy them. The Grant was based on a demonstrated need for this type of program in these three counties. The "Country Roads Mobile Pharmacy" is staffed by a volunteer licensed pharmacist and a registered nurse, who is an employee of the Coalition. The mobile pharmacy does not stop at people's doors, but stops nine times monthly in each county. Doctors donate most of the medicine that the coalition distributes. The coalition buys the rest. To be eligible for the free medicine, the individual must be a resident of Ashe, Avery or Watauga counties and have a family income of no more than 200 percent of the federal poverty level.

Despite the fact that the mobile pharmacy was one unit, the Board of Pharmacy required the Hunger Coalition to pay the $350.00 annual registration fee to obtain a "pharmacy permit" for each place the mobile unit stopped in these counties. This bill prevents the Board from continuing this action.

AGENDA

HOUSE COMMITTEE ON HEALTH

TUESDAY, MARCH 30, 1999
ROOM 415 LOB
12:00 NOON

OPENING REMARKS

Representative Thomas E. Wright, Chairman
House Committee on Health

BILL TO BE DISCUSSED

SB-90 Insurance/Cover Contraceptives
Sen. Forrester

COMMENTS

ADJOURNMENT

MINUTES

HOUSE COMMITTEE ON HEALTH

TUESDAY, MARCH 30, 1999

12:00 NOON ROOM 415-LOB

The House Committee on Health met on Tuesday, March 30, 1999 at 12:00 Noon in Room 415-LOB. A silent roll was taken, (roll list denotes members present.)

Chairman Wright called the meeting to order.

The Pages were introduced to the Members of the House Health Committee.

SB-90 INSURANCE/ COVER CONTRACEPTIVES

Sen. Forrester explained the bill. Rep. Insko commented on the bill. Rep. Womble asked the bill sponsor a question. Chairman Wright responded. Rep. Womble followed up with a question about the bill. Sen. Forrester responded. Rep. Womble followed up with a question. Sen. Forrester responded. Rep. Womble commented on the bill. Sen. Forrester responded. Rep. Insko responded to Rep. Womble. Rep. Adams asked the bill sponsor a question. Sen. Forrester responded. Rep. Adams followed up with a comment to the bill sponsor. Rep. Wilson asked the bill sponsor a question about the cost to the small employer. Sen. Forrester responded. Rep. Redwine asked a question to the bill sponsor about the cost. Sen. Forrester responded. Rep. Redwine followed up with a question to the bill sponsor about the bill. Senator Forrester responded. Rep. Redwine followed up with a question about how this would affect insurance options for participants. Sen. Forrester responded. Rep. Insko commented on the bill. Rep. Bowie sent forth an amendment to amend the bill on page 1, line 10 and 11, page 3, line 20, and page 4, line 2. Linda Attarian explained the amendment. Rep. Wilson asked the staff a question about the amendment. Rep. Bowie responded. Rep. Esposito asked the bill sponsor a question. Sen. Forrester responded. Rep. Redwine asked Rep. Bowie a question about the religious criteria of the bill. Rep. Bowie responded. Rep. Adams asked Rep. Bowie about the amendment. Rep. Bowie responded. Rep. Wilson asked Rep. Bowie a question about the public funding section of the amendment. Rep. Bowie responded.

A vote was taken. The Amendment was adopted.

Rep. Clary sent forth an amendment that amended the bill on page 3, line 2, line 5, line 41, and page 4, line 2. Rep. Clary explained the amendment. Rep. Esposito asked Rep. Clary a question about the amendment. Rep. Clary responded. Staff responded. Rep. Esposito followed up with a question about the amendment. Rep. Clary responded. Rep. Esposito followed up with a question to the bill sponsor. The bill sponsor responded.

Rep. Redwine asked the bill sponsor a question about the exclusion of certain drugs in the amendment. Sen. Forrester responded. Rep. Redwine followed up with a question to the bill sponsor. Sen. Forrester responded. Rep. Adams commented on the bill. Rep. Clary responded. Rep. Adams followed up with a comment to Sen. Forrester. Sen. Forrester responded. Rep. Wilson asked a question to the bill sponsor. Rep. Clary responded. Linda Attarian responded. Rep. Allred asked the bill sponsor a question. Sen. Forrester responded. Rep. Allred followed up with a question to the bill sponsor. Sen. Forrester responded. Rep. Allred followed up with a question to the bill sponsor. Sen. Forrester responded. Rep. Bowie commented on the amendment. Rep. Wilson asked a question to the bill sponsor. Sen. Forrester responded.

A vote was taken on the amendment. The Amendment was adopted.

Rep. Wilson commented on the bill. Dr. Krine, a family doctor, commented on the bill. Rep. Adams commented on Dr. Krine's comments on the bill.

Rep. Bowie moved to give the bill a favorable report as amended, unfavorable as to the original bill and be re-referred to the Committee on Insurance.

Chairman Wright decided that the committee would vote on this bill at the next meeting.

The meeting adjourned at 12:59pm.

Rep. Thomas E. Wright, Chairman

Vanda Wilson-Wormack, Committee Asst.

NORTH CAROLINA GENERAL ASSEMBLY
AMENDMENT
Senate Bill 90

AMENDMENT NO._____
(to be filled in by
Principal Clerk)

S90-ARM-002 Page 1 of __

Date_____,1998

Comm. Sub. [yes] Second edition
Amends Title []

Representative_____

moves to amend the bill, as amended, on page 3, by rewriting lines 20 and 21, as amended by amendment S90-LB-001A, to read:

"(e) A religious employer may request an entity providing a health benefit plan to provide to the religious employer a health benefit plan that excludes coverage for prescription contraceptive drugs or devices that are contrary to the employer's religious tenets. Upon request, the entity shall provide the requested health benefit plan. An entity providing a health benefit plan requested by a religious employer pursuant to this section shall provide written notice to each person covered under the health benefit plan that prescription contraceptive drugs or devices are excluded from coverage pursuant to this section at the request of the employer. The notice shall appear, in not less than 10-point type, in the health benefit plan, application, and sales brochure for the health benefit plan. Nothing in this subsection authorizes a health benefit plan to exclude coverage for prescription drugs ordered by a health care provider with prescriptive authority for reasons other than contraceptive purposes, or for prescription contraception that is necessary to preserve the life or health of a person covered under the plan. As used in this subsection, the term 'religious employer' means an entity for which all of the following are true:

(1) The entity is organized and operated exclusively for religious purposes and is tax exempt under Section 501(c)(3) of the U.S. Internal Revenue Code.

(2) The inculcation of religious values is the primary purpose of the entity.

(3) The entity employs primarily persons who share the religious tenets of the entity.".

SIGNED _____
Amendment Sponsor

NORTH CAROLINA GENERAL ASSEMBLY
AMENDMENT
Senate Bill 90

AMENDMENT NO. _____
(to be filled in by
Principal Clerk)

S90-ARM-002

SIGNED _____
Committee Chair if Senate Committee Amendment

ADOPTED _____ FAILED _____ TABLED _____

NORTH CAROLINA GENERAL ASSEMBLY
AMENDMENT
Senate Bill 90

AMENDMENT NO._____
(to be filled in by
Principal Clerk)

S90-ARM-003 Page 1 of __

Date_____,1998

Comm. Sub. [yes] Second edition
Amends Title []

Representative_____

moves to amend amendment S90-ALN-001, on page 1, line 9 and 10 by rewriting those lines to read:

"the prescription drug known as 'RU-486', the prescription drug marketed under the name of "Preven", and other prescription drugs marketed or packaged as "Emergency Contraceptive Pills"."

SIGNED _____
Amendment Sponsor

SIGNED _____
Committee Chair if Senate Committee Amendment

ADOPTED _____ FAILED _____ TABLED _____

EXPLANATION OF SENATE BILL 90
Insurance/Cover Contraception

To: Senate Health Care Committee
From: Linda Attarian, Committee Counsel
Date: February 16, 1999
Sponsor: Senator James Forrester

Brief Explanation:

Senate Bill 90 provides for equitable insurance coverage for prescription contraception. The proposed legislation requires health benefit plans that provide coverage for general prescription drugs, devices and outpatient services to provide coverage for FDA-approved prescription contraceptive drugs, devices and outpatient contraceptive services. The legislation does not require a health benefit plan to provide coverage for over-the-counter contraceptives.

Section by Section Explanation:

Whereas Clauses:

This section sets out the factual findings that provide a basis for why the legislation is proposed.

Section 1: General Provisions:

Section 1 of the bill amends Article 3 of Chapter 58, (titled "General Regulations of Insurance"), to add a new section (G.S. 58-3-174) to prohibit health benefit plans from excluding or restricting benefits for FDA-approved prescription contraceptive drugs or devices, if the plan provides benefits for other prescription drugs or devices. By including contraceptive devices, this provision ensures that a range of contraceptives will be covered, not just oral contraceptives. These plans must also include coverage for the insertion or removal of the contraceptive and any medically necessary examinations associated with the utilization of the contraceptive.

In addition, health benefit plans may not exclude or restrict benefits for outpatient contraceptive services, if the plan provides benefits for other outpatient services. The same deductibles, copayments, annual limits, and lifetime limits that apply to outpatient services under the policy must also apply to outpatient contraceptive benefits.

Definitions:

"Health benefit plan" and "Insurer": These terms are broadly defined in the bill to include traditional indemnity plans, managed care plans, HMOs and PPOs. Employer's self-insured health plans would be exempt from these requirements. Many employers, particularly larger employers, self-fund health benefit plans for their employees. These self-funded plans are exempt from State regulation because of a federal law, the Employee Retirement Income Security Act (ERISA), governing employee pension and benefit plans.

"Outpatient contraceptive services": Includes services necessary to utilize contraceptive methods to prevent pregnancy.

"Prescribed contraceptive drugs or devices": Includes all FDA-approved prescription contraceptive drugs and devices.

Other Prohibitions:

Section 1 of the bill also prohibits health benefit plans from (1) denying an individual coverage or refusing to renew coverage to an individual to avoid providing contraceptive coverage; (2) providing incentives to encourage individuals to accept less than the minimum protections required under this legislation; (3) penalizing or reducing the reimbursement of healthcare professionals because they prescribe contraceptives or provide contraceptive services; and from (4) providing incentives to health care providers to withhold contraceptive benefits otherwise required under this legislation.

Section 2: Coverage under the "Standard Health Plan". North Carolina law requires insurance companies to offer two types of guaranteed health plans to employers with less than 50 employees. One is a "standard plan" and the other is a "basic plan". Of the two, the standard plan has more benefits. Under this bill, the standard plan must comply with the contraceptive coverage requirement beginning on January 1, 2000.

Section 3: Contains a severability clause.

Section 4: Effective date: The bill is effective when it becomes law and applies to health benefit plans that are delivered, issued, or renewed on or after January 1, 2000.

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(919) 733-2578

TO: House Health Committee

FROM: Linda Attarian, Committee Counsel

RE: S90-ALN-001A

Explanation of Amendment #001A

The amendment changes the bill to provide an exemption from mandatory coverage of contraceptive benefits to qualified religious employers.

To receive the exemption:

1. A religious employer must request it.
2. The "religious employer", for the purposes of this amendment, must meet the following criteria:
    - The inculcation of religious values is the primary purpose of the employer;
    - Most employees share the religious tenets of the employer;
    - The employer receives no public funding and may not be staffed by public employees.
3. Coverage of contraceptive drugs and devices must be contrary to the employer's religious tenets.

The insurer must:

1. Provide written notice to each person covered under the plan that prescription and contraceptive drugs or devices are excluded from coverage at the request of the employer.
2. The notice must be in 10 point type or larger, and must appear in the health benefit plan application and the sales brochure.

Scope of the amendment:

1. The health benefit plan MAY NOT exclude coverage of contraceptive prescription drugs when prescribed for reasons other than contraception.
2. The health benefit plan MAY NOT exclude coverage of contraceptive prescription drugs when prescribed for contraception necessary to preserve the life or health of the insured.

EXPLANATION OF SENATE BILL 90, Second Edition
Insurance/Cover Contraception

To: House Health Committee
From: Linda Attarian, Committee Counsel
Date: March 11, 1999
Sponsor: Senator James Forrester

Brief Explanation:

Senate Bill 90, 2nd Edition, provides for equitable insurance coverage for prescription contraception. The proposed legislation requires health benefit plans that provide coverage for general prescription drugs, devices and outpatient services to provide coverage for FDA-approved prescription contraceptive drugs, devices and outpatient contraceptive services. The legislation does not require a health benefit plan to provide coverage for over-the-counter contraceptives.

Section by Section Explanation:

Section 1: General Provisions:

Section 1 of the bill amends Article 3 of Chapter 58, (titled "General Regulations of Insurance"), to add a new section (G.S. 58-3-174) to require health benefit plans to provide benefits for FDA-approved prescription contraceptive drugs or devices, if the plan provides benefits for other prescription drugs or devices. By including contraceptive devices, this provision ensures that a range of contraceptives will be covered, not just oral contraceptives. These plans must also include coverage for the insertion or removal of the contraceptive and any medically necessary examinations associated with the utilization of the contraceptive.

In addition, health benefit plans shall provide benefits for outpatient contraceptive services, if the plan provides benefits for other outpatient services. With the exception of drugs or devices that are inserted or do not require periodic refilling, he same deductibles, copayments, annual limits, and lifetime limits that apply to outpatient services under the policy must also apply to outpatient contraceptive benefits. With respect to drugs or devices that are inserted or do not require periodic refilling, (e.g., Norplant) health plans may require the total coinsurance to be paid in advance.

Definitions:

"Health benefit plan" and "Insurer": These terms are broadly defined in the bill to include traditional indemnity plans, managed care plans, HMOs and PPOs. Employer's self-insured health plans would be exempt from these requirements. Many employers, particularly larger employers, self-fund health benefit plans for their employees. These self-funded plans are exempt from State regulation

because of a federal law, the Employee Retirement Income Security Act (ERISA), governing employee pension and benefit plans.

"Outpatient contraceptive services": Includes services necessary to utilize contraceptive methods to prevent pregnancy.

"Prescribed contraceptive drugs or devices": Includes all FDA-approved prescription contraceptive drugs and devices.

Other Prohibitions:

Section 1 of the bill also prohibits health benefit plans from (1) denying an individual coverage or refusing to renew coverage to an individual to avoid providing contraceptive coverage; (2) providing incentives to encourage individuals to accept less than the minimum protections required under this legislation; (3) penalizing or reducing the reimbursement of healthcare professionals because they prescribe contraceptives or provide contraceptive services; and from (4) providing incentives to health care providers to withhold contraceptive benefits otherwise required under this legislation.

Section 2: Coverage under the "Standard Health Plan". North Carolina law requires insurance companies to offer two types of guaranteed health plans to employers with less than 50 employees. One is a "standard plan" and the other is a "basic plan". Of the two, the standard plan has more benefits. Under this bill, the standard plan must comply with the contraceptive coverage requirement beginning on January 1, 2000.

Section 3: Contains a severability clause.

Section 4: Effective date: The bill is effective when it becomes law and applies to health benefit plans that are delivered, issued, or renewed on or after January 1, 2000.

Identical Bill

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 1999

H 1

HOUSE BILL 103

Short Title: Insurance/Cover Contraceptives. (Public)

Sponsors: Representatives Insko, Berry, Bowie, Earle; Adams, Alexander, Allred, Baddour, Barefoot, Bonner, Braswell, Bridgeman, Church, Clary, Cole, Easterling, Fox, Goodwin, Gulley, Hackney, Haire, Hill, Howard, Hunter, Jarrell, Jeffus, Luebke, McAllister, McLawhorn, Mosley, Ramsey, Smith, Sutton, Wainwright, Warren, and Yongue.

Referred to: Health, if favorable, Insurance.

February 17, 1999

A BILL TO BE ENTITLED

AN ACT TO ENSURE THAT INSURERS THAT PROVIDE HEALTH INSURANCE COVERAGE FOR PRESCRIPTION DRUGS PROVIDE COVERAGE FOR PRESCRIBED CONTRACEPTIVE DRUGS AND DEVICES AND FOR OUTPATIENT CONTRACEPTIVE SERVICES.

Whereas, there are approximately three million unintended pregnancies each year in the United States; and

Whereas, unintended pregnancies lead to higher rates of infant mortality, low birth weight, and maternal morbidity, and threaten the economic stability of families; and

Whereas, two-thirds of women of childbearing age rely on some form of private employment-related insurance to defray their medical expenses; Now, therefore,

The General Assembly of North Carolina enacts:

Section 1. Effective January 1, 2000, Article 3 of Chapter 58 of the General Statutes is amended by adding the following new section to read:

"**§ 58-3-174. Coverage for prescription contraceptive drugs or devices and for outpatient contraceptive services.**

(a) Every entity providing a health benefit plan that provides coverage for prescription drugs or devices shall not exclude or restrict coverage for prescription contraceptive drugs or devices. Coverage shall include coverage for the insertion or

removal of and any medically necessary examination associated with the use of the prescribed contraceptive drug or device. The same deductibles, coinsurance, and other limitations as apply to prescription drugs or devices covered under the health benefit plan shall apply to coverage for prescribed contraceptive drugs or devices.

(b) Every entity providing a health benefit plan that provides coverage for outpatient services provided by a health care professional shall not exclude or restrict coverage for outpatient contraceptive services. The same deductibles, coinsurance, and other limitations as apply to outpatient services covered under the health benefit plan shall apply to coverage for outpatient contraceptive services.

(c) As used in this section, the term:

(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, to the extent permitted by the Employee Retirement Income Security Act of 1974, as amended, or by any waiver of or other exception to that Act provided under federal law or regulation. 'Health benefit plan' does not mean any plan implemented or administered by the North Carolina Department of Health and Human Services or the United States Department of Health and Human Services, or any successor agency, or its representatives. 'Health benefit plan' also does not mean any of the following kinds of insurance:

a. Accident
b. Credit
c. Disability income
d. Long-term care or nursing home care
e. Medicare supplement
f. Specified disease
g. Dental or vision
h. Coverage issued as a supplement to liability insurance
i. Workers' compensation
j. Medical payments under automobile or homeowners
k. Hospital income or indemnity
l. Insurance under which benefits are payable with or without regard to fault and that is statutorily required to be contained in any liability policy or equivalent self-insurance.

(2) 'Insurer' includes an insurance company subject to this Chapter, a service corporation organized under Article 65 of this Chapter, a health maintenance organization organized under Article 67 of this Chapter, and a multiple employer welfare arrangement subject to Article 49 of this Chapter.

(3) 'Outpatient contraceptive services' means consultations, examinations, procedures, and medical services provided on an outpatient basis and related to the use of contraceptive methods to prevent pregnancy.

(4) 'Prescribed contraceptive drugs or devices' means drugs or devices approved by the United States Food and Drug Administration for use as contraceptives and obtained under a prescription written by a health care provider authorized to prescribe medications under the laws of this State.

(d) A health benefit plan subject to this section shall not:

(1) Deny eligibility or continued eligibility to enroll or to renew coverage under the terms of the health benefit plan, solely for the purpose of avoiding the requirements of this section;

(2) Provide monetary payments or rebates to an individual participant or beneficiary to encourage the individual participant or beneficiary to accept less than the minimum protections available under this section;

(3) Penalize or otherwise reduce or limit the reimbursement of an attending provider because the provider prescribed contraceptive drugs or devices, or provided contraceptive services in accordance with this section; or

(4) Provide incentives, monetary or otherwise, to an attending provider to induce the provider to withhold from an individual participant or beneficiary contraceptive drugs, devices, or services."

Section 2. Effective January 1, 2000, G.S. 58-50-155 reads as rewritten:

"**§ 58-50-155. Standard and basic health care plan coverages.**

(a) Notwithstanding G.S. 58-50-125(c), the standard health plan developed and approved under G.S. 58-50-125 shall provide coverage for ~~mammograms and pap smears at least equal to the coverage required by G.S. 58-51-57.~~

~~(a1) Notwithstanding G.S. 58-50-125(c), the standard health plan developed and approved under G.S. 58-50-125 shall provide coverage for prostate-specific antigen (PSA) tests or equivalent tests for the presence of prostate cancer at least equal to the coverage required by G.S. 58-51-58.~~

~~(a2) Notwithstanding G.S. 58-50-123(c), the standard health plan developed and approved under G.S. 58-50-125 shall provide coverage for reconstructive breast surgery resulting from a mastectomy at least equal to the coverage required by G.S. 58-51-62.~~ all of the following:

(1) Mammograms and pap smears at least equal to the coverage required by G.S. 58-51-57.

(2) Prostate-specific antigen (PSA) tests or equivalent tests for the presence of prostate cancer at least equal to the coverage required by G.S. 58-51-58.

(3) Reconstructive breast surgery resulting from a mastectomy at least equal to the coverage required by G.S. 58-51-62.

(4) Prescribed contraceptive drugs or devices approved by the United States Food and Drug Administration for use as contraceptives, or outpatient contraceptive services at least equal to the coverage required by G.S. 58-3-174.

(b) Notwithstanding G.S. 58-50-125(c), in developing and approving the plans under G.S. 58-50-125, the Committee and Commissioner shall give due consideration to cost-effective and life-saving health care services and to cost-effective health care providers. ~~This section shall be effective after July 10, 1991.~~"

Section 3. If any section or provision of this act is declared unconstitutional or invalid by the courts, it does not affect the validity of this act as a whole or any part other than the part so declared to be unconstitutional or invalid.

Section 4. This act is effective when it becomes law and applies to health benefit plans that are delivered, issued for delivery, or renewed on and after January 1, 2000. For purposes of this act, renewal of a health benefit policy, contract, or plan is presumed to occur on each anniversary of the date on which coverage was first effective on the person or persons covered by the health benefit plan.

VISITOR REGISTRATION SHEET

Health — 3-30-1999

Name of Committee — Date

VISITORS: Please sign below and return to Committee Clerk.

NAME	FIRM OR STATE AGENCY AND ADDRESS
John Bowdish	Zeb Alley P.A.
Shawn Brown	Self
Dr. Ted Kryn	Self
Alicia Gregory	Poyner & Spruill
V. R. Lambeth, MD	N.C. Ob-Gyn Society
Kay Michaels	PPOD
Brenda Summers	NC Equity
Joann Schaefer	NCNA
Tommy Hester	Carolina Medicare Services
Mary Scott	G-W
Joyce Lee	MANST
Harry Kaplan	
J. Thompson	NCSOS
Claire Wachsman	ACLU-NC
C. Porter	Bone & Associates
Roberta Paschal	Young, Moore & Henderson
Perri Morgan	NFIB
Steve Keene	NCMS
Hugh Tilson	NCHA
Lindsay Brown	DMHDDSAS
Lori Ann Harris	LAHA Inc.

VISITOR REGISTRATION SHEET

Health — 3-30-1999

Name of Committee — Date

VISITORS: Please sign below and return to Committee Clerk.

NAME	FIRM OR STATE AGENCY AND ADDRESS
Wing Lo Lam	NCMS
[illegible]	NC GA
John Bason & crew	UNC-TV
Lisa Wilder	UNC-TV
Ken Wright	BCBSNC
[illegible]	NCFBC
Kevin Dothard	Gov's Office
Judy Wickham	Cst. Sen
Lynn Bakewell	Medical Planning & Hosp Services
Ginger Guy	MGNS
Scott Mooney	GP

AGENDA

HOUSE COMMITTEE ON HEALTH

TUESDAY, APRIL 6, 1999
ROOM 415 LOB
12:00 NOON

OPENING REMARKS

Representative Thomas E. Wright, Chairman
House Committee on Health

BILLS TO BE DISCUSSED

HB-254 – Health Care Facility/Patient Abuse
Rep. Edwards

SB-90 (CS) – Insurance/Cover Contraceptives
Sen. Forrester

COMMENTS

ADJOURNMENT

MINUTES

HOUSE COMMITTEE ON HEALTH

TUESDAY, APRIL 6, 1999

12:00 NOON ROOM 415-LOB

The House Committee on Health met on Tuesday, April 6, 1999 at 12:00 Noon in Room 415-LOB. A silent roll was taken, (roll list denotes members present.)

Chairman Wright called the meeting to order.

The House Pages were introduced to the members of the Health Committee.

SB-90 INSURANCE/ COVER CONTRACEPTIVES

Rep. Bowie moved for a favorable report as amended at last week's meeting of the Health Committee.

Rep. Insko sent forth a perfecting amendment to the bill. Rep. Insko explained the amendment. Rep. Bowie commented on the bill.

Rep. Insko moved for adoption of the amendment on page 3, line 20 and 21.

Rep. Adams asked a question about page 3, line 27. Rep. Insko responded. Rep. Adams followed up. Rep. Insko responded. Rep. Redwine asked a question to Rep. Insko. Rep. Insko responded. Rep. Wilson commented on the bill. The Amendment was adopted. Rep. Wilson sent forth an amendment. The amendment was put on hold because of another pending amendment by Rep. Clary. The Committee adopted Rep. Clary amendment. Rep. Wilson explained her amendment and moved for adoption of the amendment. Linda Attarian, Research Staff, further explained the amendment. Rep. Insko opposed the amendment. Rep. Bowie commented and opposed the amendment sent forth by Rep. Wilson. Rep. Adams asked the staff a question. Linda Attarian responded. Rep. Adams followed up with a comment about the amendment. Rep. Wilson asked the Staff a question. Linda Attarian responded. Rep. Allred asked a question to Staff. Rep. Wilson responded. Rep. Bowie is recognized for a comment. Rep. Wilson responded and withdrew her amendment and sent forth another amendment to amend the bill page 1, line 9 and 10. Rep. Insko commented on the bill. Rep. Adams commented on the bill. Rep. Wilson commented on the amendment. Rep. Allred asked a question on the amendment. Rep. Howard asked the bill sponsor to comment on the amendment. Sen. Forrester responded. Rep. Howard followed up with a comment. Rep. Bowie commented on the bill. Rep. Adams commented on the bill.

A vote was taken to adopt the amendment. The amendment did not pass. Rep. Allred asked a question to Chairman Wright. Chairman Wright responded. A representative from the small business community spoke on the bill. Rep. Allred asked a question to the bill sponsor. Sen. Forrester responded. Rep. Redwine commented on the bill.

A vote was taken on the bill. The Ayes had the majority vote.

The meeting adjourned at 12:55pm

Rep. Thomas E. Wright, Chairman

Vanda Wilson-Wormack, Committee Asst.

1999 COMMITTEE REPORT
HOUSE OF REPRESENTATIVES

The following report(s) from standing committee(s) is/are presented:
By Representative(s) **WRIGHT** for the Committee on **HEALTH**.

☒ Committee Substitute for
S.B. 90 A BILL TO BE ENTITLED AN ACT TO ENSURE THAT INSURERS THAT PROVIDE HEALTH INSURANCE COVERAGE FOR PRESCRIPTION DRUGS OR OUTPATIENT SERVICES PROVIDE COVERAGE FOR PRESCRIBED CONTRACEPTIVE DRUGS AND DEVICES OR OUTPATIENT CONTRACEPTIVE SERVICES.

☐ With a favorable report.

☐ With a favorable report and recommendation that the bill be re-referred to the Committee on Appropriations ☐ Finance ☐ ☐.

☐ With a favorable report, as amended.

☐ With a favorable report, as amended, and recommendation that the bill be re-referred to the Committee on Appropriations ☐ Finance ☐ ☐.

☐ With a favorable report as to committee substitute bill (#), ☐ which changes the title, unfavorable as to (original bill) (Committee Substitute Bill #), (and recommendation that the committee substitute bill #) be re-referred to the Committee on .)

☒ With a favorable report as to House committee substitute bill ~~(#), ☐ which changes the title~~, unfavorable as to Senate committee substitute bill.

☐ With an unfavorable report.

☐ With recommendation that the House concur.

☐ With recommendation that the House do not concur.

☐ With recommendation that the House do not concur; request conferees.

☐ With recommendation that the House concur; committee believes bill to be material.

☐ With an unfavorable report, with a Minority Report attached.

☐ Without prejudice.

☐ With an indefinite postponement report.

☐ With an indefinite postponement report, with a Minority Report attached.

☐ With recommendation that it be adopted. (HOUSE RESOLUTION ONLY)

2/24/99

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 1999

S D

SENATE BILL 90
Health Care Committee Substitute Adopted 3/3/99
Proposed House Committee Substitute S90-PCS1652-RM

Short Title: Insurance/Cover Contraceptives. (Public)

Sponsors:

Referred to:

February 15, 1999

A BILL TO BE ENTITLED

AN ACT TO ENSURE THAT INSURERS THAT PROVIDE HEALTH INSURANCE COVERAGE FOR PRESCRIPTION DRUGS OR OUTPATIENT SERVICES PROVIDE COVERAGE FOR PRESCRIBED CONTRACEPTIVE DRUGS AND DEVICES OR OUTPATIENT CONTRACEPTIVE SERVICES.

The General Assembly of North Carolina enacts:

Section 1. Effective January 1, 2000, Article 3 of Chapter 58 of the General Statutes is amended by adding the following new section to read:

"**§ 58-3-174. Coverage for prescription contraceptive drugs or devices and for outpatient contraceptive services; exemption for religious employers.**

(a) Except as provided in subsection (e) of this section, every entity providing a health benefit plan that provides coverage for prescription drugs or devices shall provide coverage for prescription contraceptive drugs or devices. Coverage shall include coverage for the insertion or removal of and any medically necessary examination associated with the use of the prescribed contraceptive drug or device. Except as otherwise provided in this subsection, the same deductibles, coinsurance, and other limitations as apply to prescription drugs or devices covered under the health benefit plan shall apply to coverage for prescribed contraceptive drugs or devices. A health benefit plan may require that the total coinsurance, based on the useful life of the drug or device, be paid in advance for those drugs or devices that are inserted or prescribed and do not have to be refilled on a periodic basis.

(b) Every entity providing a health benefit plan that provides coverage for outpatient services provided by a health care professional shall provide coverage for outpatient contraceptive services. The same deductibles, coinsurance, and other limitations as apply to outpatient services covered under the health benefit plan shall apply to coverage for outpatient contraceptive services.

(c) As used in this section, the term:

(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, to the extent permitted by the Employee Retirement Income Security Act of 1974, as amended, or by any waiver of or other exception to that Act provided under federal law or regulation. 'Health benefit plan' does not mean any plan implemented or administered by the North Carolina Department of Health and Human Services or the United States Department of Health and Human Services, or any successor agency, or its representatives. 'Health benefit plan' also does not mean any of the following kinds of insurance:

a. Accident.
b. Credit.
c. Disability income.
d. Long-term care or nursing home care.
e. Medicare supplement.
f. Specified disease.
g. Dental or vision.
h. Coverage issued as a supplement to liability insurance.
i. Workers' compensation.
j. Medical payments under automobile or homeowners.
k. Hospital income or indemnity.
l. Insurance under which benefits are payable with or without regard to fault and that is statutorily required to be contained in any liability policy or equivalent self-insurance.

(2) 'Insurer' includes an insurance company subject to this Chapter, a service corporation organized under Article 65 of this Chapter, a health maintenance organization organized under Article 67 of this Chapter, and a multiple employer welfare arrangement subject to Article 49 of this Chapter.

(3) 'Outpatient contraceptive services' means consultations, examinations, procedures, and medical services provided on an outpatient basis and related to the use of contraceptive methods to prevent pregnancy.

(4) 'Prescribed contraceptive drugs or devices' means drugs or devices that prevent pregnancy and that are approved by the United States Food and Drug Administration for use as contraceptives and obtained under a prescription written by a health care provider authorized to prescribe medications under the laws of this State. Prescription drugs or devices required to be covered under this section shall not include the prescription drug known as 'RU-486', and the prescription drug marketed under the name 'Preven'.

(d) A health benefit plan subject to this section shall not do any of the following:

(1) Deny eligibility or continued eligibility to enroll or to renew coverage under the terms of the health benefit plan, solely for the purpose of avoiding the requirements of this section.

(2) Provide monetary payments or rebates to an individual participant or beneficiary to encourage the individual participant or beneficiary to accept less than the minimum protections available under this section.

(3) Penalize or otherwise reduce or limit the reimbursement of an attending provider because the provider prescribed contraceptive drugs or devices, or provided contraceptive services in accordance with this section.

(4) Provide incentives, monetary or otherwise, to an attending provider to induce the provider to withhold from an individual participant or beneficiary contraceptive drugs, devices, or services.

(e) A religious employer may request an entity providing a health benefit plan to provide to the religious employer a health benefit plan that excludes coverage for prescription contraceptive drugs or devices that are contrary to the employer's religious tenets. Upon request, the entity shall provide the requested health benefit plan. An entity providing a health benefit plan requested by a religious employer pursuant to this section shall provide written notice to each person covered under the health benefit plan that prescription contraceptive drugs or devices are excluded from coverage pursuant to this section at the request of the employer. The notice shall appear, in not less than 10-point type, in the health benefit plan, application, and sales brochure for the health benefit plan. Nothing in this subsection authorizes a health benefit plan to exclude coverage for prescription drugs ordered by a health care provider with prescriptive authority for reasons other than contraceptive purposes, or for prescription contraception that is necessary to preserve the life or health of a person covered under the plan. As used in this subsection, the term 'religious employer' means an entity for which all of the following are true:

(1) The entity is organized and operated exclusively for religious purposes and is tax exempt under section 501(c)(3) of the U.S. Internal Revenue Code.

(2) The inculcation of religious values is the primary purpose of the entity.

(3) The entity employs primarily persons who share the religious tenets of the entity."

Section 2. Effective January 1, 2000, G.S. 58-50-155 reads as rewritten:

"**§ 58-50-155. Standard and basic health care plan coverages.**

(a) Notwithstanding G.S. 58-50-125(c), the standard health plan developed and approved under G.S. 58-50-125 shall provide coverage for ~~mammograms and pap smears at least equal to the coverage required by G.S. 58-51-57.~~

~~(a1) Notwithstanding G.S. 58-50-125(c), the standard health plan developed and approved under G.S. 58-50-125 shall provide coverage for prostate-specific antigen (PSA) tests or equivalent tests for the presence of prostate cancer at least equal to the coverage required by G.S. 58-51-58.~~

~~(a2) Notwithstanding G.S. 58-50-123(c), the standard health plan developed and approved under G.S. 58-50-125 shall provide coverage for reconstructive breast surgery resulting from a mastectomy at least equal to the coverage required by G.S. 58-51-62.~~ all of the following:

(1) Mammograms and pap smears at least equal to the coverage required by G.S. 58-51-57.

(2) Prostate-specific antigen (PSA) tests or equivalent tests for the presence of prostate cancer at least equal to the coverage required by G.S. 58-51-58.

(3) Reconstructive breast surgery resulting from a mastectomy at least equal to the coverage required by G.S. 58-51-62.

(4) Prescribed contraceptive drugs or devices that prevent pregnancy and that are approved by the United States Food and Drug Administration for use as contraceptives, or outpatient contraceptive services at least equal to the coverage required by G.S. 58-3-174, if the plan covers prescription drugs or devices, or outpatient services, as applicable. The same exceptions and exclusions as are provided under G.S. 58-3-174 apply to standard plans developed and approved under G.S. 58-50-125.

(b) Notwithstanding G.S. 58-50-125(c), in developing and approving the plans under G.S. 58-50-125, the Committee and Commissioner shall give due consideration to cost-effective and life-saving health care services and to cost-effective health care providers. ~~This section shall be effective after July 10, 1991.~~"

Section 3. If any section or provision of this act is declared unconstitutional or invalid by the courts, it does not affect the validity of this act as a whole or any part other than the part so declared to be unconstitutional or invalid.

Section 4. This act is effective when it becomes law and applies to health benefit plans that are delivered, issued for delivery, or renewed on and after January 1, 2000. For purposes of this act, renewal of a health benefit policy, contract, or plan is presumed to occur on each anniversary of the date on which coverage was first effective on the person or persons covered by the health benefit plan.

AGENDA

HOUSE COMMITTEE ON HEALTH

TUESDAY, APRIL 13, 1999
ROOM 415 LOB
12:00 NOON

OPENING REMARKS

Representative Thomas E. Wright, Chairman
House Committee on Health

BILLS TO BE DISCUSSED

HB-254—HEALTH CARE FACILITY/PATIENT ABUSE
REP. EDWARDS
HB-697—AREA AUTHORITY MERGER
REP. DEDMON
HB-905—DENTAL BENEFITS/HEALTH CHOICE
REP. ALEXANDER
HB-906—PHARMACIST PEER REVIEW
REP. ALEXANDER

COMMENTS

ADJOURNMENT

MINUTES

HOUSE COMMITTEE ON HEALTH

TUESDAY, APRIL 13, 1999

12:00 NOON ROOM 415 LOB

The House Committee on Health met on Tuesday, April 13, 1999 at 12:00 noon in Room 415-LOB. A silent roll was taken, (roll list denotes members present.)

Chairman Wright called the meeting to order.

The Pages were introduced to the members of the Committee.

HB-254-HEALTH CARE FACILITY/ PATIENT ABUSE

Rep. Insko moved for adoption of the proposed committee substitute. So moved.

Rep. Edwards, the bill sponsor, deferred the explanation of the committee substitute John Williams, Deputy General Counsel for the Department of Crime Control and Public Safety. Rep. Womble asked a question to the bill sponsor about the present laws of North Carolina that pertained to the issue of Health Care Facility and Patient Abuse. John Williams responded. Rep. Womble followed up. John Williams responded. Rep. Womble followed up with a question about page 2, line 5. John Williams responded. Rep. Womble followed up with another question. John Williams responded. Rep. Womble asked the bill sponsor a question. Rep. Edwards responded. Rep. Adams asked John Williams a question about the bill on page 2, line 11 and 12. John Williams responded. Rep. Adams followed up with a question. John Williams responded. Rep. Adams followed up. John Williams responded. Rep. Adams followed up with a question to the bill sponsor. Rep. Edwards responded. Rep. Bowie asked John Williams about page 2, line 6 of the bill. John Williams responded. Rep. Bowie followed up. John Young, Research Staff, responded. Rep. Bowie commented. John Young responded. Rep. Insko asked a question to John Williams. John Williams responded. Rep. Insko asked Staff for further comment. John Young responded by referring to page 2, line 32 for further explanation. Rep. Insko followed up with a question to John Young. Rep. Insko commented. John Williams commented. Rep. Insko commented on the bill on page 2, line 16 and line 24. John Williams commented on the bill. Rep. Clary asked Chairman Wright a question about the bill . Chairman Wright responded. Rep. Justus asked John Williams a question about the abuse claims. John Williams responded. Rep. Justus followed up. John Young responded. Rep. Justus followed up with a question about the inspection of the facilities. John Young responded. Rep. Justus commented on the bill.

Rep. Justus moved for a favorable report, unfavorable as to the original bill and was re-referred to the Committee on Judiciary III.

Pat Yancey, a representative of the long-term care industry, is recognized from the audience for a comment on the bill.

A vote was taken. The Ayes had the majority vote.

HB-254-HEALTH CARE FACILITIES/ PATIENT ABUSE passed and was re-referred to the committee on Judiciary III.

HB-906 PHARMACIST PEER REVIEW

Rep. Alexander explained the bill. David Marley, Executive Director of the North Carolina Pharmacy Recovery network, further explained the bill. John Young, Staff, further explained the bill. Rep. Womble asked David Marley a question about the bill. David Marley responded. John Young further commented on the bill. Rep. Womble followed up with a question. David Marley responded. Rep. Womble followed up with a question. Rep. Alexander responded. Rep. Womble followed up with a question. David Marley responded. Rep. Womble followed up. David Marley responded. John Young commented. Rep. Edwards commented on the bill.

Rep. Insko moved for a favorable report.

A vote was taken. The Ayes had the Majority vote.

The meeting adjourned at 12:55pm.

Rep. Thomas E. Wright, Chairman

Vanda Wilson-Wormack, Committee Asst.

1999 COMMITTEE REPORT
HOUSE OF REPRESENTATIVES

The following report(s) from standing committee(s) is/are presented:
By Representative(s) **THOMAS WRIGHT** for the Committee on **HEALTH**.

☐ Committee Substitute for
H.B. 254 A BILL TO BE ENTITLED AN ACT TO PROVIDE THAT THE ABUSE OR NEGLECT OF A PATIENT AT A HEALTH CARE FACILITY OR A RESIDENTIAL CARE FACILITY THAT DOES NOT RESULT IN SERIOUS BODILY INJURY OR DEATH IS A MISDEMEANOR.

☐ With a favorable report.

☐ With a favorable report and recommendation that the bill be re-referred to the Committee on Appropriations ☐ Finance ☐ ☐.

☐ With a favorable report, as amended.

☐ With a favorable report, as amended, and recommendation that the bill be re-referred to the Committee on Appropriations ☐ Finance ☐ ☐.

☒ With a favorable report as to committee substitute bill, unfavorable as to the original bill, and a recommendation that the committee substitute bill be re-referred to the Committee on JUDICIARY III.

☐ With a favorable report as to House committee substitute bill (#), ☐ which changes the title, unfavorable as to Senate committee substitute bill.

☐ With an unfavorable report.

☐ With recommendation that the House concur.

☐ With recommendation that the House do not concur.

☐ With recommendation that the House do not concur; request conferees.

☐ With recommendation that the House concur; committee believes bill to be material.

☐ With an unfavorable report, with a Minority Report attached.

☐ Without prejudice.

☐ With an indefinite postponement report.

☐ With an indefinite postponement report, with a Minority Report attached.

☐ With recommendation that it be adopted. (HOUSE RESOLUTION ONLY)

2/24/99

file

1999 COMMITTEE REPORT
HOUSE OF REPRESENTATIVES

The following report(s) from standing committee(s) is/are presented:
By Representative(s) **THOMAS WRIGHT** for the Committee on **HEALTH**.

☐ Committee Substitute for
H.B. 906 A BILL TO BE ENTITLED AN ACT AUTHORIZING THE NORTH CAROLINA BOARD OF PHARMACY TO ENTER INTO AGREEMENTS WITH PHARMACIST PEER REVIEW ORGANIZATIONS FOR IMPAIRED PHARMACISTS.

☒ With a favorable report.

☐ With a favorable report and recommendation that the bill be re-referred to the Committee on Appropriations ☐ Finance ☐ ☐.

☐ With a favorable report, as amended.

☐ With a favorable report, as amended, and recommendation that the bill be re-referred to the Committee on Appropriations ☐ Finance ☐ ☐.

☐ With a favorable report as to committee substitute bill (#), ☐ which changes the title, unfavorable as to (original bill) (Committee Substitute Bill #), (and recommendation that the committee substitute bill #) be re-referred to the Committee on .)

☐ With a favorable report as to House committee substitute bill (#), ☐ which changes the title, unfavorable as to Senate committee substitute bill.

☐ With an unfavorable report.

☐ With recommendation that the House concur.

☐ With recommendation that the House do not concur.

☐ With recommendation that the House do not concur; request conferees.

☐ With recommendation that the House concur; committee believes bill to be material.

☐ With an unfavorable report, with a Minority Report attached.

☐ Without prejudice.

☐ With an indefinite postponement report.

☐ With an indefinite postponement report, with a Minority Report attached.

☐ With recommendation that it be adopted. (HOUSE RESOLUTION ONLY)

2/24/99

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 1999

H

HOUSE BILL 906

Short Title: Pharmacist Peer Review. (Public)

Sponsors: Representatives Alexander, Gardner; Brown, Cansler, Church, Earle, Hiatt, Sherrill, Wainwright, and G. Wilson.

Referred to: Health.

April 5, 1999

A BILL TO BE ENTITLED

AN ACT AUTHORIZING THE NORTH CAROLINA BOARD OF PHARMACY TO ENTER INTO AGREEMENTS WITH PHARMACIST PEER REVIEW ORGANIZATIONS FOR IMPAIRED PHARMACISTS.

The General Assembly of North Carolina enacts:

Section 1. Article 4A of Chapter 90 of the General Statutes is amended by adding the following new section:

"**§ 90-85.41. Board agreements with special peer review organizations for impaired pharmacists.**

(a) The North Carolina Board of Pharmacy may, under rules adopted by the Board in compliance with Chapter 150B of the General Statutes, enter into agreements with special impaired pharmacist peer review organizations. Peer review activities to be covered by such agreements shall include investigation, review and evaluation of records, reports, complaints, litigation, and other information about the practices and practice patterns of pharmacists licensed by the Board, as such matters may relate to impaired pharmacists. Special impaired pharmacist peer review organizations may include a statewide supervisory committee and various regional and local components or subgroups.

(b) Agreements authorized under this section shall include provisions for the impaired pharmacist peer review organizations to receive relevant information from the Board and other sources, conduct any investigation, review, and evaluation in an expeditious manner, provide assurance of confidentiality of nonpublic information and of the peer review process, make reports of investigations and evaluations to the

Board, and to do other related activities for operating and promoting a coordinated and effective peer review process. The agreements shall include provisions assuring basic due process for pharmacists that become involved.

(c) The impaired pharmacist peer review organizations that enter into agreements with the Board shall establish and maintain a program for impaired pharmacists licensed by the Board for the purpose of identifying, reviewing, and evaluating the ability of those pharmacists to function as pharmacists, and to provide programs for treatment and rehabilitation. The Board may provide funds for the administration of these impaired pharmacist peer review programs. The Board shall adopt rules to apply to the operation of impaired pharmacist peer review programs, with provisions for: (i) definitions of impairment; (ii) guidelines for program elements; (iii) procedures for receipt and use of information of suspected impairment; (iv) procedures for intervention and referral; (v) arrangements for monitoring treatment, rehabilitation, posttreatment support, and performance; (vi) reports of individual cases to the Board; (vii) periodic reporting of statistical information; and (viii) assurance of confidentiality of nonpublic information and of the peer review process.

(d) Upon investigation and review of a pharmacist licensed by the Board, or upon receipt of a complaint or other information, an impaired pharmacist peer review organization that enters into a peer review agreement with the Board shall report immediately to the Board detailed information about any pharmacist licensed by the Board, if:

(1) The pharmacist constitutes an imminent danger to the public or himself or herself.

(2) The pharmacist refuses to cooperate with the program, refuses to submit to treatment, or is still impaired after treatment and exhibits professional incompetence.

(3) It reasonably appears that there are other grounds for disciplinary action.

(e) Any confidential patient information and other nonpublic information acquired, created, or used in good faith by an impaired pharmacist peer review organization pursuant to this section shall remain confidential and shall not be subject to discovery or subpoena in a civil case. No person participating in good faith in an impaired pharmacist peer review program developed under this section shall be required in a civil case to disclose any information (including opinions, recommendations, or evaluations) acquired or developed solely in the course of participating in the program.

(f) Impaired pharmacist peer review activities conducted in good faith pursuant to any program developed under this section shall not be grounds for civil action under the laws of this State, and the activities are deemed to be State directed and sanctioned and shall constitute "State action" for the purposes of application of antitrust laws."

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

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 1999

H D

HOUSE BILL 254
Proposed Committee Substitute H254-PCS1182-RY

Short Title: Health Care Facility/Patient Abuse/AB. (Public)

Sponsors:

Referred to:

March 4, 1999

A BILL TO BE ENTITLED

AN ACT TO PROVIDE THAT THE ABUSE OR NEGLECT OF A PATIENT AT A HEALTH CARE FACILITY OR A RESIDENTIAL CARE FACILITY THAT DOES NOT RESULT IN SERIOUS BODILY INJURY OR DEATH IS A MISDEMEANOR.

The General Assembly of North Carolina enacts:

Section 1. G.S. 14-32.2 reads as rewritten:

"**§ 14-32.2. Patient abuse and neglect; punishments.**

(a) It shall be unlawful for any person to physically abuse a patient of a health care facility or a resident of a residential care facility, when the abuse ~~is the result of an intentional or culpable negligent act or omission which causes serious bodily injury or death.~~ results in death or bodily injury.

(b) Unless the conduct is prohibited by some other provision of law providing for greater punishment,

(1) ~~Any person who violates~~ A violation of subsection (a) above is ~~guilty of~~ a Class C felony where intentional conduct proximately causes the death of the patient or resident;

(2) ~~Any person who violates~~ A violation of subsection (a) above is ~~guilty of~~ a Class E felony where culpably negligent conduct proximately causes the death of the patient or resident;

(3) ~~Any person who violates~~ A violation of subsection (a) above is ~~guilty of~~ a Class F felony where such conduct proximately causes serious bodily injury to the patient or resident.

(4) A violation of subsection (a) is a Class A1 misdemeanor where such conduct evinces a pattern of conduct and the conduct proximately causes bodily injury to a patient or resident.

(c) 'Health Care Facility' shall include hospitals, skilled nursing facilities, intermediate care facilities, intermediate care facilities for the mentally retarded, psychiatric facilities, rehabilitation facilities, kidney disease treatment centers, home health agencies, ambulatory surgical facilities, and any other health care related facility whether publicly or privately owned.

(c1) 'Residential Care Facility' shall include adult care homes and any other residential care related facility whether publicly or privately owned.

(d) 'Person' shall include any natural person, association, corporation, partnership, or other individual or entity.

(e) 'Culpably negligent' shall mean conduct of a willful, gross and flagrant character, evincing reckless disregard of human life.

(e1) 'Abuse' means the willful or culpably negligent infliction of physical injury or the willful or culpably negligent violation of any law or rule of a State agency designed for the health, welfare, or comfort of a patient or resident.

(f) Any defense which may arise under G.S. 90-321(h) or G.S. 90-322(d) pursuant to compliance with Article 23 of Chapter 90 shall be fully applicable to any prosecution initiated under this section.

(g) Criminal process for a violation of this section may be issued only upon the request of a District Attorney.

(h) The provisions of this section shall not supersede any other applicable statutory or common law offenses."

Section 2. This act becomes effective December 1, 1999, and applies to offenses committed on or after that date.

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 1999

H

HOUSE BILL 254

Short Title: Health Care Facility/Patient Abuse/AB. (Public)

Sponsors: Representatives Edwards; Milton and Mosley.

Referred to: Health, if favorable, Judiciary III.

March 4, 1999

A BILL TO BE ENTITLED

AN ACT TO PROVIDE THAT THE ABUSE OR NEGLECT OF A PATIENT AT A HEALTH CARE FACILITY OR A RESIDENTIAL CARE FACILITY THAT DOES NOT RESULT IN SERIOUS BODILY INJURY OR DEATH IS A MISDEMEANOR.

The General Assembly of North Carolina enacts:

Section 1. G.S. 14-32.2 reads as rewritten:

"**§ 14-32.2. Patient abuse and neglect; punishments.**

(a) It shall be unlawful for any ~~person~~ natural person, association, corporation, partnership, or other individual or entity to physically abuse a patient of a health care facility or a resident of a residential care facility, when the abuse is the result of an intentional or culpable negligent act or omission which causes serious bodily injury or death.

(b) Unless the conduct is prohibited by some other provision of law providing for greater punishment,

(1) ~~Any person who violates~~ A violation of subsection (a) above is ~~guilty of~~ a Class C felony where intentional conduct proximately causes the death of the patient or resident;

(2) ~~Any person who violates~~ A violation of subsection (a) above is ~~guilty of~~ a Class E felony where culpably negligent conduct proximately causes the death of the patient or resident;

(3) ~~Any person who violates~~ A violation of subsection (a) above is ~~guilty of~~ a Class F felony where such conduct proximately causes serious bodily injury to the patient or resident.

(b1) Any natural person, association, corporation, partnership, or other individual or entity who abuses or neglects a patient of a health care facility or a resident of a residential care facility that does not result in serious bodily injury or death is guilty of a Class A1 misdemeanor.

(c) 'Health Care Facility' shall include hospitals, skilled nursing facilities, intermediate care facilities, intermediate care facilities for the mentally retarded, psychiatric facilities, rehabilitation facilities, kidney disease treatment centers, home health agencies, ambulatory surgical facilities, and any other health care related facility whether publicly or privately owned.

'Residential Care Facility' shall include adult care homes and any other residential care related facility whether publicly or privately owned.

~~(d) "Person" shall include any natural person, association, corporation, partnership, or other individual or entity.~~

(e) 'Culpably negligent' shall mean conduct of a willful, gross and flagrant character, evincing reckless disregard of human life.

(e1) 'Abuse' means the willful or grossly negligent infliction of physical pain, injury or mental anguish, unreasonable confinement, or the willful or grossly negligent deprivation of services which are necessary to maintain mental or physical health.

(e2) 'Neglect' means the willful violation of any law or rule of a State agency designed to protect the health, welfare, or comfort of the patient or resident.

(f) Any defense which may arise under G.S. 90-321(h) or G.S. 90-322(d) pursuant to compliance with Article 23 of Chapter 90 shall be fully applicable to any prosecution initiated under this section.

(g) Criminal process for a violation of this section may be issued only upon the request of a District Attorney.

(h) The provisions of this section shall not supersede any other applicable statutory or common law offenses."

Section 2. This act becomes effective December 1, 1999, and applies to offenses committed on or after that date.

HOUSE BILL 254:
Health Care Facility/Patient Abuse

BILL ANALYSIS

Committee:	House Health Committee	**Introduced by:**	Edwards/Milton/Mosley
Date:	April 5, 1999	**Summary by:**	John Young
Version:	2		Committee Staff

SUMMARY: ***The bill would add a new penalty to the existing statutory punishments for abuse and neglect in a health care facility or a residential care facility. The provisions of the bill would be effective December 1, 1999.***

CURRENT LAW: G.S. 14-32.2 prohibits physical abuse of a patient in a health care facility or a resident in a residential care facility if the abuse results from an intentional or culpably negligent act or omission that causes serious bodily injury or death. The act establishes three levels of punishment:

1. Class C felony where intentional conduct proximately causes the death of the patient or resident; (The presumptive minimum sentence for an offender with no prior record is 58-73 months of active incarceration)
2. Class E felony where culpably negligent conduct proximately causes the death of the patient or resident; (The presumptive minimum sentence for an offender with no prior record is 20-25 months of active incarceration and/or community punishment)
3. Class F felony where such conduct proximately causes serious bodily injury to the patient or resident. (The presumptive minimum sentence for an offender with no prior record is 13-16 months of active incarceration and/or intermediate punishment and /or community punnishment.

The act states that defenses arising under G.S. 90-321(h) or 90-322(d) (protecting the withholding, discontinuing or extraordinary medical procedures to prolong life under specified circumstances) apply.

Only a district attorney can request the issuance of criminal process under the act.

BILL ANALYSIS: House bill 254 would make the following changes to G.S. 14.32.2 which makes it a crime to physically abuse a patient in a health care facility or a residential care facility:

1. Makes a number of technical and wording changes to G.S. 14-32.2;
2. Deletes the requirement that the abuse require intent or culpable negligence or omission.
3. Adds definition of "abuse" as the willful or grossly negligent infliction of physical pain, injury, or mental anguish, unreasonable confinment, or the willful or grossly negligent deprivation of servicws which are necessary to maintain mental or physical health;
4. Adds a new penalty for violation of the act. If the conduct shows a pattern of conduct and the conduct proximately causes bodily injury, the violation is a Class A1 misdemeanor. A Class A1 misdemeanor with no prior record is 1-60 days of active/immediate/community service.

HOUSE BILL 254:
Health Care Facility/Patient Abuse

BILL ANALYSIS

Committee: House Health Committee
Date: April 5, 1999
Version: 1

Introduced by: Edwards/Milton/Mosley
Summary by: John Young
Committee Staff

*SUMMARY: **Provides that the abuse or neglect of a patient in a health care facility or resident of a residenial care facility that does not result in serious bodily injury or death is a misdemeanor.***

CURRENT LAW: G.S. 14-32.2 prohibits physical abuse of a patient in a health care facility or a resident in a residential care facility if the abuse results from an intentional or culpably negligent act or omission that causes serious bodily injury or death. The act establishes three levels of punishment:

1. Class C felony where intentional conduct proximately causes the death of the patient or resident;

   (The presumptive minimum sentence for an offender with no prior record is 58-73 months of active incarceration)

2. Class E felony where culpably negligent conduct proximately causes the death of the patient or resident;

   (The presumptive minimum sentence for an offender with no prior record is 20-25 months of active incarceration and/or community punishment)

3. Class F felony where such conduct proximately causes serious bodily injury to the patient or resident.

   (The presumptive minimum sentence for an offender with no prior record is 13-16 months of active incarceration and/or intermediate punishment and /or community punnishment.

BILL ANALYSIS: While the current statute makes it a crime to physically abuse a patient in a health care facility or a resident in a residential care facility, House Bill 254 would add a new provision that abuse and neglect of a patient in a health care facility or a resident in a residential care facility that **does not result is serious bodily injury or death** is a Class A1 misdemeanor. A Class A1 misdemeanor with no prior record is 1-60 days of active/intermediate/community punishment. The bill also does the following:

1. Makes a number of technical wording changes to G.S. 14-32.2;
2. Adds definition of "abuse" as the willful or grossly negligent infliction of physical pain, injury, or mental anguish, unreasonable confinment, or the willful or grossly negligent deprivation of servicws which are necessary to maintain mental or physical health;
3. Adds definition of "neglect" as the willful violation of any law or state agency rule designed to protect the health, welfare or confort of a patient or resident;

4. Makes corporations, associations, and partnerships subject to the provisions of G.S. 14-32-2. As well as persons.

The act states that defenses arising under G.S. 90-321(h) or 90-322(d) (protecting the withholding r discontinuing or extraordinary medical procedures to prolong life under specified circumstances) apply.

Only a district attorney can request the issuance of criminal process under the act.

The provisions are effective December 1, 1999.

VISITOR REGISTRATION SHEET

Health
Name of Committee

4/13/99
Date

VISITORS: PLEASE SIGN BELOW AND RETURN TO COMMITTEE CLERK.

NAME	FIRM OR AGENCY AND ADDRESS
Jonathan Williams	CCPS
Peyton McAngus	SJL
Jonny Cooper	NCALA
Howard KRAMER	N.C. Bd of Nursing
Tanya Taylor	
[illegible]	AP
Patrick Daymond	Legislative Intern
David Marley	Pharmacist Review Network
Joann Schon	NC Nurses Association
Stacy Flannery	NCHCFA
Will Jones	AHHC
Sandy Sands	WCSR
Cindy Sousa	NCACC
Hugh Tilson	NCHA
Lisa Wilder + Crew	UNC TV
Lori Wilson	NCACC

VISITOR REGISTRATION SHEET

Health — 4/13/99
Name of Committee — Date

VISITORS: PLEASE SIGN BELOW AND RETURN TO COMMITTEE CLERK.

NAME	FIRM OR AGENCY AND ADDRESS
Debbie Brown	DMH DDSAS
Deborah Waters	DHHS
Carla Moore	DHHS
Elizabeth Pegram	student - Meredith College
Joyce Peters	MAMSI
Jonathan Simmons	NC Council of Community Programs
MT Burnette	GACPD
Ellen DePue	Novartis
Tommy Wirth	Carolina HealthCare System
Jesse Goodman	DHHS
Amy Jo Bain	NC Medical Society
Steve Allen	V
Patricia A. Yancey	FOR/SCSL
Fran Preston	NCRMA
Amy Fullbright	Hunton & Wms.

VISITOR REGISTRATION SHEET

Health
Name of Committee

4/13/99
Date

VISITORS: PLEASE SIGN BELOW AND RETURN TO COMMITTEE CLERK.

NAME	FIRM OR AGENCY AND ADDRESS
Alan Miles	Barley & Digon LLP

AGENDA

HOUSE COMMITTEE ON HEALTH

TUESDAY, April 20, 1999
ROOM 415 LOB
12:00 NOON

OPENING REMARKS

Representative Thomas E. Wright, Chairman
House Committee on Health

BILLS TO BE DISCUSSED

HB-905—DENTAL BENEFITS/ HEALTH CHOICE
HB-996—REGULATE SPINAL MANIPULATION
HB-1083- ARTHRITIS EDUCATION TASK FORCE
HB-1095- CLINICAL PHARMACIST PRACTITIONER

COMMENTS

ADJOURNMENT

MINUTES

HOUSE COMMITTEE ON HEALTH

TUESDAY, APRIL 20, 1999

12:00 NOON ROOM 415-LOB

The House Committee on Health met on Tuesday, April 20, 1999 at n12:00 Noon in Room 415-LOB. A silent roll was taken, (roll list denotes members present.)

Chairman Wright called the meeting to order.

The House Pages were introduced to the members of the Health Committee.

HB-905 DENTAL BENEFITS/ HEALTH CHOICE

Rep. Edwards moved for adoption of the proposed committee substitute. So moved.

Rep. Edwards explained the committee substitute.

Rep. Allred moved for a favorable report on the proposed committee substitute.

Rep. Edwards sent forth an amendment that amended the bill on page 1, line 12 and 13. A vote was taken and the amendment passed. Rep. Howard asked if there was a fiscal note on this bill. Linda Attarian responded. Rep. Justus asked a question to the bill sponsor about other states that may be involved in this type of legislation. Rep. Edwards responded. Dr. Steve Kline from the Department of Health and Human Services responded. Rep. Justus followed up with a comment. Rep. Howard commented on the bill. Linda Attarian responded. Rep. Howard followed up with a question to staff. John Young responded. Rep. Melton asked a question to the staff. William Potter from the North Carolina Dental Society responded.

A vote was taken.

HB-905, the committee substitute was given a favorable report, unfavorable as to the original bill.

HB-996-REGULATE SPINAL MANIPULATION

Rep. Wright explained the bill. Vice-Chairman Insko recognized Rep. Womble for a question. Rep. Womble asked the bill sponsor a question about the bill. Rep. Wright responded. Rep. Womble followed up with a question to the bill sponsor about other disciplinary actions of the bill. Rep. Wright responded. Rep. Womble followed up with a question to the bill sponsor. Rep. Wright responded.

Rep. Allred asked the bill sponsor a question about the bill. Rep. Wright responded. Rep. Edwards sent forth an amendment that amended the bill on line 22. So moved. Rep. Wainwright asked Rep. Edwards a question about the amendment. Rep. Edwards responded. Rep. Wainwright followed up with a question to Rep. Edwards. John Young responded. Rep. Allred asked a question to the bill sponsor. Rep. Bowie responded. Rep. Allred followed up with a question. John Young responded. Rep. Wright made a comment about the amendment. Dave Horn from the medical society responded to the bill. Dr. Straud, a chiropractor from High Pointe, North Carolina commented on the bill. William Potter, a representative of the physical therapy society, commented on the amendment. Rep. Wainwright commented on the bill. Rep. Wright responded. Dave Horne from the medical society responded.

A vote was taken. Rep. Wright called for a division. A hand vote was taken. The amendment passed 8 to 6. Rep. Wainwright commented on the bill. Rep. Wright deferred to staff to explain the bill a amended. Rep. Bowie responded to the comment made by John Young. Stance Kulon from the Board of Chiropractic Examiners made a comment on the bill. Rep. Bowie asked a question to the bill sponsor. Vice-Chairman Insko responded. Rep. Allred requested to withdraw his vote for the amendment.

Chairman Wright adjourned the meeting at 12:50pm.

Rep. Thomas E. Wright, Chairman

Vanda Wilson-Wormack, Committee Asst.

file

1999 COMMITTEE REPORT
HOUSE OF REPRESENTATIVES

The following report(s) from standing committee(s) is/are presented:
By Representative(s) **THOMAS WRIGHT** for the Committee on **HEALTH.**

☐ Committee Substitute for
H.B. 905 A BILL TO BE ENTITLED AN ACT TO REQUIRE THAT ADDITIONAL DENTAL BENEFITS BE PROVIDED UNDER THE HEALTH INSURANCE PROGRAM FOR CHILDREN.

☐ With a favorable report.

☐ With a favorable report and recommendation that the bill be re-referred to the Committee on Appropriations ☐ Finance ☐ ☐.

☐ With a favorable report, as amended.

☐ With a favorable report, as amended, and recommendation that the bill be re-referred to the Committee on Appropriations ☐ Finance ☐ ☐.

☒ With a favorable report as to committee substitute bill , unfavorable as to the original bill.

☐ With a favorable report as to House committee substitute bill (#), ☐ which changes the title, unfavorable as to Senate committee substitute bill.

☐ With an unfavorable report.

☐ With recommendation that the House concur.

☐ With recommendation that the House do not concur.

☐ With recommendation that the House do not concur; request conferees.

☐ With recommendation that the House concur; committee believes bill to be material.

☐ With an unfavorable report, with a Minority Report attached.

☐ Without prejudice.

☐ With an indefinite postponement report.

☐ With an indefinite postponement report, with a Minority Report attached.

☐ With recommendation that it be adopted. (HOUSE RESOLUTION ONLY)

2/24/99

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 1999

H D

HOUSE BILL 905*
Proposed Committee Substitute H905-PCS2299-RM

Short Title: Dental Benefits/Health Choice. (Public)

Sponsors:

Referred to:

April 5, 1999

A BILL TO BE ENTITLED

AN ACT TO REQUIRE THAT ADDITIONAL DENTAL BENEFITS BE PROVIDED UNDER THE HEALTH INSURANCE PROGRAM FOR CHILDREN.

The General Assembly of North Carolina enacts:

Section 1. G.S. 108A-70.21(b)(1) reads as rewritten:

"(1) Dental: Oral examinations, teeth cleaning, and scaling twice during a 12-month period, full mouth X rays once every 60 months, supplemental bitewing X rays showing the back of the teeth once during a 12-month period, fluoride applications ~~once~~ twice during a 12-month period, sealants, simple extractions, therapeutic pulpotomies, prefabricated stainless steel crowns, and routine fillings of amalgam or other tooth-colored filling material to restore diseased teeth. No benefits are to be provided for services under this subsection that are not performed by or upon the direction of a dentist, doctor, or other professional provider approved by the Plan nor for services and materials that do not meet the standards accepted by the American Dental Association."

Section 2. This act becomes effective July 1, 1999.

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 1999

H 1

HOUSE BILL 905*

Short Title: Dental Benefits/Health Choice. (Public)

Sponsors: Representatives Alexander; Adams, Brown, Cansler, Church, Clary, Earle, Hiatt, Luebke, Mosley, Russell, Sherrill, Wainwright, and G. Wilson.

Referred to: Health.

April 5, 1999

A BILL TO BE ENTITLED

AN ACT TO REQUIRE THAT ADDITIONAL DENTAL BENEFITS BE PROVIDED UNDER THE HEALTH INSURANCE PROGRAM FOR CHILDREN.

The General Assembly of North Carolina enacts:

Section 1. G.S. 108A-70.21(b)(1) reads as rewritten:

"(1) Dental: Oral examinations, teeth cleaning, and scaling twice during a 12-month period, full mouth X rays once every 60 months, supplemental bitewing X rays showing the back of the teeth once during a 12-month period, fluoride applications ~~once~~ twice during a 12-month period, sealants for an unlimited number of teeth, simple extractions, therapeudic pulpotomies excluding final restorations, prefabricated stainless steel crowns, and routine fillings of amalgam or other tooth-colored filling material to restore diseased teeth. No benefits are to be provided for services under this subsection that are not performed by or upon the direction of a dentist, doctor, or other professional provider approved by the Plan nor for services and materials that do not meet the standards accepted by the American Dental Association."

Section 2. This act becomes effective July 1, 1999.

PROPOSED COMMITTEE SUBSTITUTE FOR HOUSE BILL 905: Dental Benefits/ Health Choice

BILL ANALYSIS

Committee:	House Health Committee	**Introduced by:**	Rep. Alexander
Date:	April 18, 1999	**Summary by:**	Linda Attarian
Version:	Proposed Committee Sub		Committee Counsel

SUMMARY: ***This legislation will expand the preventive dental benefits currently offered under the State Children's Health Insurance Program – NC Health Choice. The additional benefits will include: topical floride treatments allowed twice a year rather than once per year, dental sealants on the surfaces of permanent teeth, simple extractions, and stainless steel crowns and pulpotomies for badly broken down primary teeth that need to remain in the child's mouth as a preventative measure. The benefits would become covered on July 1, 1999.***

CURRENT LAW: The following dental services are currently provided: Oral examinations, teeth cleaning, and scaling twice during a 12-month period, full mouth X-rays once every 60 months, supplemental bitewing X-rays showing the back of the teeth once during a 12-month period, flouride applications once during a 12-month period, and routine fillings of amalgam or other tooth-colored filling material to restore diseased teeth. (See G.S. 108A-70.21(b)(1). The reimbursement for dental services is at 100 percent the "usual and customary cost".

BILL ANALYSIS: The proposed legislation would amend G.S. 108A-70.21(b)(1) by adding the following dental services:

1) topical floride treatments allowed twice a year (with each teeth cleaning) rather than once per year;

2) dental sealants on the surfaces of permanent teeth;

3) simple extractions;

4) and stainless steel crowns and pulpotomies for badly broken down primary teeth that need to remain in the child's mouth as a preventative measure.

Fiscal Impact: An acturail note has been requested, but is not yet available.

Section 2: Effective date: July 1, 1999.

BACKGROUND: NC Health Choice.

Congress created a new child health insurance program by enacting Title XXI of the Social Security Act as a part of the Balanced Budget Act of 1997. Under Title XXI, the State Children's Health Insurance Program, federal funds ($39.6 billion over a 10-year period) became available to states for expanding health insurance coverage for chidren of low-income families. Participating states have either expanded their Medicaid eligibility or adopted a non-Medicaid "state plan" option, or developed a combination of both to provide health insurance to children under age 19 in families with incomes up to 200 percent of the federal poverty guidelines ($2,783 per month for a family of 4). Title XXI, like

Medicaid, is funded jointly by federal and state governments. North Carolina's CHIP program is called "NC Health Choice". Its health care benefits are based on the State Employee's Health Plan and are administered through Blue Cross/Blue Shield of North Carolina. The federal government pays 74 percent of the program costs up to a maximum allotment of $79.5 million each year. The State pays 26 percent of the program costs. No county match is required.

NC Health Choice began enrolling children October 1, 1998. It has been estimated that 71,000 children in North Carolina are eligible for the program. As of this month, there were 32,039 children enrolled. As a result of the NC Health Choice outreach efforts, approximately 20,000 children have been enrolled in Medicaid.

VISITOR REGISTRATION SHEET

Health — Name of Committee

4/20/99 — Date

VISITORS: PLEASE SIGN BELOW AND RETURN TO COMMITTEE CLERK.

NAME	FIRM OR AGENCY AND ADDRESS
June Holland, PT	Wake Medical Center, New Bern Ave, Raleigh NC
Steve Tilley, MPT	Duke Univ. - Medical Center, Durham, NC
Ben F. Massey, Jr	N.C. Board of Physical Therapy Examiners
Colleen Kane PT	Springmoor Physical Therapy
[illegible], MBA, PT	North Carolina Physical Therapy Assoc. NCPTA President
Jerry Strickland	North Carolina Physical Therapy Association
Jeff Lipe	Bayer
D. Boz Strand Jr	NCCA
Christine McCara	"
Vance C. Kimbrell	NCCA
Steve Cline	DHHS - Epi/Dental
Glenn Wells	DHHS / Public Health
Pam Seamans	NC Social Services Consortium
Adam Searing	NCHAC
Matt Roman, PT	NCPTA
Fran Preston	NCRMA

VISITOR REGISTRATION SHEET

HEALTH — 4-20-99

Name of Committee — Date

VISITORS: PLEASE SIGN BELOW AND RETURN TO COMMITTEE CLERK.

NAME	FIRM OR AGENCY AND ADDRESS
Jan Geyer PhD PT	NCPTA, Duke University
Leslie Brown	DMH DDSAS
Katherine Miller	Harry Kaplan
Alicia Gregory	Poyner & Spruill
Jack Hawke	
Mari Senter	NCSA
Joyce Peters	NAMSE
Dave Hamm	Smith Anderson
Ann Case	NCRMA
Mike Mann	SSC
Evelyn Lawhorne	UNC-CH
Mac Mansfield	Poyner & Spruill

AGENDA

HOUSE COMMITTEE ON HEALTH
Wednesday, April 21, 1999
ROOM 415 LOB

OPENING REMARKS

Representative Thomas E. Wright
Chairman

BILLS TO BE DISCUSSED

HB—996—REGULATE SPINAL MANIPULATION

COMMENTS

ADJOURNMENT

MINUTES

HOUSE COMMITTEE ON HEALTH

WEDNESDAY, APRIL 21, 1999

ROOM 415-LOB

The House Committee on Health met on Wednesday, April 21, 1999 in Room 415-LOB. A silent roll was taken, (roll list denotes members present.)

Vice-Chairman Insko called the meeting to order.

HB-996 REGULATE SPINAL MANIPULATION

Rep. Allred withdrew his motion on the amendment. So moved.

Rep. Wright recognized Dr. John Webster, a chiropractor, to further explain the purpose of the bill. Rep. Insko appointed a sub-committee to further discuss the bill. The sub-committee consisted of Rep. Brubaker, Rep. Dedmon and Rep. Wright. Rep. Insko returned the seat to Chairman Wright. Rep. Howard asked Chairman Wright a question. Vice-Chairman Insko responded. Rep. Bowie commented to Vice Chairman Insko about the sub-committee. Vice-Chairman Insko responded. Rep. Edwards commented. Rep. Esposito commented. Vice Chairman Insko responded. Chairman Wright responded to the concerns of the committee.

The meeting adjourned.

Rep. Thomas E. Wright, Chairman

Vanda Wilson-Wormack, Committee Asst.

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 1999

H

HOUSE BILL 996*

Short Title: Regulate Spinal Manipulation. (Public)

Sponsors: Representatives Wright; and Wainwright.

Referred to: Health.

April 13, 1999

A BILL TO BE ENTITLED

AN ACT TO REQUIRE HEALTH CARE PROVIDERS PERFORMING SPINAL MANIPULATION TO ATTAIN MINIMUM HOURS OF CLASSROOM INSTRUCTION AND SUPERVISED CLINICAL TRAINING.

The General Assembly of North Carolina enacts:

Section 1. Chapter 90 of the General Statutes is amended by adding a new Article to read:

"ARTICLE 8A.

"Spinal Manipulation.

"**§ 90-157.10. Definitions.**

The following definitions apply in this Article:

(1) Spinal manipulation or spinal adjustment. -- A method of skillful treatment whereby a health care provider uses directed, brief, and sudden impulsion or leverage to move a joint of the patient's spine beyond its normal passive range of motion but without exceeding the limits of anatomical integrity. The term does not include the orthopaedic reduction of fractures and dislocations or joint mobilization in which no sudden impulsion or leverage is used and the patient's joint is not moved beyond its normal passive range of motion.

(2) Health care provider. -- A person holding a license issued under this Chapter.

"**§ 90-157.11. Instruction and training required to perform spinal manipulation.**

HOUSE BILL 996:
Regulate Spinal Manipulation

BILL ANALYSIS

Committee: House Health Committee
Date: April 20, 1999
Version: 1

Introduced by: Wright & Wainwright
Summary by: John Young
Committee Staff

SUMMARY: ***This bill would create a new article 8A of Chapter 90 to define "spinal mnipulation" and to restrict health care providers licensed in Chapter 90 from performing or authorizing spinal manipulation unless the health care provider has received certain prescribed classroom instruction and supervised clinical training.***

CURRENT LAW: Article 8 of Chapter 90 regulates the practice of chiropractic. "Chiropractic is defined as the sciece of adjusting the cause of disease by realigning the spine, releasing pressure on nerves radiating from the spine to all parts of the body, and allowing the nerves to carry thir full quota of health current (nerve energy) from the brain to all parts of the body. The act is administered by a board of seven members, six of whom are practicing doctors of chiopractic. Chapter 90 also covers the following professionals: (1)physicians; (2) dentists; (3) mouth hygienists; (4) pharmacists; (5) substance abuse professionals; (6) optometritists; (7) osteopathy; (8) nurses; (9) midwives; (10) veterinarians; (11) podiatrists; (12) enbalmers and funeral directors; (13) dental hygienists; (14) dispensing opticians; (15) physical therapists; (16) psychologists; (17) marriage and family therapists; (18) nursing home administrators; (19) licensed professional counselors; (20) dietetics/ nutrition; (21) accupuncturists; (22) pastorial counselors; (23) industrial hygienists; and (24) athletic trainers.

BILL ANALYSIS: House Bill 996 would create a new article 8A in Chapter 90 to do the following:

1. Define "spinal manipulation or spinal adjustment" as a method of skillful treatment whereby a health care provider uses directed, brief, and sudden impulsion or leverage to move a joint of the patient's spine beyond its normal passive range of motion but without exceeding the limits of anatomical integrity. It excludes orthopedic reduction of fractures and dislocations and joint mobilization.
2. Define "health care professional" as a person holding a license ussued under Chapter 90.
3. Restrict health care professionals licensed under Chapter 90 from performing or authorizing spinal manipulation or adjustment unless the health care provider has received a minimum of 500 hours of classroom instruction and 700 hours of supervised clinical training.
4. Rrovide that violation of the above requirements will be grounds for suspending, revoking or refusing to renew the health care provider's license.

VISITOR REGISTRATION SHEET

Health
Name of Committee

4/21/99
Date

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Gary Flannery	NCHCFA
Jan Ramquist	NCANA
Lee Wilson	NCSALTC
Joanne Schon	NC Nurses Association
Otis Carter	Carter & Assoc.
Dan Jones	Smith Anderson
R. Armstrong	NCCA
C M Caron	"
V Kinlaw	"
Roger Bone	"
Jack Hawke	"

VISITOR REGISTRATION SHEET

Health
Name of Committee

4/21/99
Date

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Mari Lunn	NCSA
	gpmi
alicia Gregory	Poyner & Spruill
Amy Jo Baum	NC Medical Society

AGENDA

HOUSE COMMITTEE ON HEALTH
FRIDAY, APRIL 23, 1999
10:00am-12:00 NOON
415 LOB

OPENING REMARKS

REP. THOMAS E. WRIGHT
CHAIRMAN

BILLS TO BE DISCUSSED

HB--1083--ARTHRITIS EDUCATION TASK FORCE
REP. ALEXANDER

HB--1095--CLINICAL PHARMACIST PRACTITIONER
REP. ALLEN

HB--1138--ORTHOPEDIC PHYSICIAN ASSISTANT
REP. MCCOMAS

HB--736---OPTOMETRY LICENSING LAW TECHNICAL CHANGE
REP. ROGERS

HB--1258--HEALTH CARE PERSONNEL REGISTRY CHANGE
REP. EARLE

HB--1118--LIMIT LIABILITY/DEFIBRILLATORS
REP. WRIGHT

COMMENTS

ADJOURNMENT

MINUTES

HOUSE COMMITTEE ON HEALTH

FRIDAY, APRIL 23, 1999

10:00AM ROOM 415-LOB

The House Committee on Health met on Friday, April 23, 1999 at 10:00am in Room 415-LOB. A silent roll was taken, (roll list denotes members present.)

Chairman Wright called the meeting to order.

The Pages for the House Health Committee were introduced to the Members of the Committee.

HB-1095-CLINICAL PHARMACIST PRACTITIONER

Rep. Insko moved for adoption of the proposed committee substitute. So moved.

Chairman Wright moved to amend the committee substitute on page 2, line 16-22 and page 2, line 39. Rep. Bowie asked Chairman Wright to explain the second amendment. Rep. Bowie asked the staff a question about the purpose of the amendments. Rep. Adams asked Chairman Wright a question about the amendments. Chairman Wright responded. Rep. Womble asked a question about page 2, line 17-22. Linda Attarian, Staff, responded. Rep. Womble followed up with a question on the amendment. Linda Attarian responded. Rep. Womble followed up with a question. Chairman Wright responded. A vote was taken. The amendment passed.

Rep. Allen explained the bill. Payton Maynard, a representative of family physicians, commented on the bill. Rep. Bowie commented on the bill and made a motion on the bill. Rep. Edwards commented on the bill.

Rep. Bowie moved for a favorable report as to the committee substitute as amended, unfavorable as to the original bill and be re-referred to the committee on finance.

Rep. Justus asked a question about the fee amount in the bill. Chairman Wright responded. A vote was taken. The bill passed.

HB-1083 ARTHRITIS EDUCATION TASK FORCE

Rep. Alexander explained the bill. Rep. Adams commented on the bill.

Rep. Adams moved for a favorable report on the bill and be re-referred to the committee on Appropriations.

Rep. Womble commented on the importance of the diversity of the Arthritis Board. Rep. Alexander responded.

A vote was taken on the motion. The bill passed.

The Sub-Committee on HB-996-Spinal Manipulation was recognized to give their report to the Health Committee.

Rep. Womble moved for adoption of the proposed committee substitute. So moved.

Rep. Wright explained the committee substitute. Rep. Edwards asked a question to the bill sponsor about the physical therapist under the present changes. Rep. Wright responded. Rep. Alexander asked the bill sponsor and staff a question about physical therapist scope of practice. John Young, Staff, responded. Rep. Alexander followed up with a question to John Young. John Young responded. Rep. Bowie asked if representatives from the physical therapist arena would like to speak. Steve Keen, a representative from the North Carolina Medical Society, commented on the bill. Rep. Bowie followed up with a comment. Rep. Adams commented on the bill. Rep.Wright responded. Rep. Bowie responded to Rep. Wright comments and asked a question to the bill sponsor. Rep. Wright responded. Rep. Justus asked a question about spinal manipulation as it relates to physical therapist. Rep. Wright responded. Rep. Justus followed up with a comment. Rep. Preston asked a question to the bill sponsor about the training of physical therapist. Rep. Wright responded. Rep. Preston followed up with a question about the availability of physical therapist if the bill passed. Rep. Wright responded. Rep. Bowie commented on the bill. Rep. Insko asked a question about physical therapist hours of training. Evelyn Hawthorne, from the University of North Carolina, responded to Rep. Insko question. Rep. Womble asked a question about the bill. Rep. Wright responded. Rep. Womble followed up with a question. Rep. Wright responded. Rep. Womble followed up with a question to the bill sponsor. Rep. Wright responded. Rep. Womble sent forth an amendment to change the effective date. Rep. Alexander sent forth an amendment on page 2, line 5. Rep. Wright responded to the committee about the amendment. Rep. Alexander followed up with a comment. Rep. Preston commented on the bill. Rep. Wilson spoke in favor of Rep. Alexander's amendment. Dr. Shawn Taylor spoke on the amendment. Rep. Preston asked Dr. Taylor a question about spinal manipulation. Dr. Taylor responded. Rep. Preston followed up with a question to Dr. Taylor. Dr. Taylor responded. Rep. Bowie commented on the bill. Rep. Esposito asked a question to the Sub-Committee. Rep. Wright responded. Rep. Esposito followed up with a question to the Medical Society. Steve Keen from the medical society, responded to Rep. Esposito. Rep. Esposito followed up with a question to Steve Keen. Rep. Esposito commented on the bill. A vote was taken. The amendment sent forth by Rep. Alexander failed.

Rep. Insko sent forth an amendment that amended the bill on page 2, line 21. So moved. Rep. Insko explained the amendment. Rep. Cunningham asked a question about the amendment. Rep. Insko responded. Rep. Cunningham followed up with a question about the amendment. Rep. Insko responded. Rep. Esposito asked Rep. Insko a question about the amendment. Rep. Esposito followed up with a comment about the amendment. Evelyn Hawthorne, from the University of Chapel Hill responded about the amendment. Rep. Bowie commented on the bill. Rep. Womble commented on the bill. Rep. Wright responded. Rep. Womble followed up with a comment. Rep. Wilson commented on the bill. Rep. Wainwright asked a question to the bill sponsor about the difference between spinal manipulation and spinal mobilization. Rep. Wright responded. Rep. Justus asked a question about the amendment. Rep. Wright responded. Rep. Justus followed up with a question to Rep. Insko. Rep. Insko responded. Rep. Justus followed up with a comment. Rep. Baddour asked the bill sponsor a question. Rep. Wright responded. Rep. Insko commented on the bill. Dave Horne, from the medical society responded on the bill.

A roll call vote was taken. The amendment failed 8 to 11.

Rep. Earle moved for a favorable report of the committee substitute, unfavorable as to the original bill.

Rep. Bowie commented on the bill. Rep. Wilson commented on the bill. Rep. Edwards commented on the bill. Rep. Wright responded. A roll call vote was taken. The Committee Substitute passed 12 to 8.

The meeting adjourned at 11:55am.

Rep. Thomas E. Wright, Chairman

Vanda Wilson-Wormack, Committee Asst.

1999 COMMITTEE REPORT
HOUSE OF REPRESENTATIVES

The following report(s) from standing committee(s) is/are presented:
By Representative **THOMAS E. WRIGHT** for the Committee on **HEALTH**.

☐ Committee Substitute for
H.B. 1095 A BILL TO BE ENTITLED AN ACT AUTHORIZING THE LICENSURE OF CLINICAL PHARMACIST PRACTITIONERS.

☐ With a favorable report.

☐ With a favorable report and recommendation that the bill be re-referred to the Committee on Appropriations ☐ Finance ☐ ☐.

☐ With a favorable report, as amended.

☐ With a favorable report, as amended, and recommendation that the bill be re-referred to the Committee on Appropriations ☐ Finance ☐ ☐.

☒ With a favorable report as to committee substitute bill, ☒ which changes the title, unfavorable as to the original bill, and recommendation that the committee substitute bill be re-referred to the Committee on FINANCE.)

☐ With a favorable report as to House committee substitute bill (#), ☐ which changes the title, unfavorable as to Senate committee substitute bill.

☐ With an unfavorable report.

☐ With recommendation that the House concur.

☐ With recommendation that the House do not concur.

☐ With recommendation that the House do not concur; request conferees.

☐ With recommendation that the House concur; committee believes bill to be material.

☐ With an unfavorable report, with a Minority Report attached.

☐ Without prejudice.

☐ With an indefinite postponement report.

☐ With an indefinite postponement report, with a Minority Report attached.

☐ With recommendation that it be adopted. (HOUSE RESOLUTION ONLY)

2/24/99

1999 COMMITTEE REPORT
HOUSE OF REPRESENTATIVES

The following report(s) from standing committee(s) is/are presented:
By Representative(s) **THOMAS E. WRIGHT** for the Committee on **HEALTH**.

☐ Committee Substitute for
H.B. 1083 A BILL TO BE ENTITLED AN ACT TO ESTABLISH THE ARTHRITIS EDUCATION TASK FORCE AND TO APPROPRIATE FUNDS THEREFOR.

☐ With a favorable report.

☒ With a favorable report and recommendation that the bill be re-referred to the Committee on Appropriations ☒ Finance ☐ ☐.

☐ With a favorable report, as amended.

☐ With a favorable report, as amended, and recommendation that the bill be re-referred to the Committee on Appropriations ☐ Finance ☐ ☐.

☐ With a favorable report as to committee substitute bill (#), ☐ which changes the title, unfavorable as to (original bill) (Committee Substitute Bill #), (and recommendation that the committee substitute bill #) be re-referred to the Committee on .)

☐ With a favorable report as to House committee substitute bill (#), ☐ which changes the title, unfavorable as to Senate committee substitute bill.

☐ With an unfavorable report.

☐ With recommendation that the House concur.

☐ With recommendation that the House do not concur.

☐ With recommendation that the House do not concur; request conferees.

☐ With recommendation that the House concur; committee believes bill to be material.

☐ With an unfavorable report, with a Minority Report attached.

☐ Without prejudice.

☐ With an indefinite postponement report.

☐ With an indefinite postponement report, with a Minority Report attached.

☐ With recommendation that it be adopted. (HOUSE RESOLUTION ONLY)

2/24/99

1999 COMMITTEE REPORT
HOUSE OF REPRESENTATIVES

The following report(s) from standing committee(s) is/are presented:
By Representative(s) **THOMAS E. WRIGHT** for the Committee on **HEALTH.**

☐ Committee Substitute for
H.B. 996 A BILL TO BE ENTITLED AN ACT TO REQUIRE HEALTH CARE PROVIDERS PERFORMING SPINAL MANIPULATION TO ATTAIN MINIMUM HOURS OF CLASSROOM INSTRUCTION AND SUPERVISED CLINICAL TRAINING.

☐ With a favorable report.

☐ With a favorable report and recommendation that the bill be re-referred to the Committee on Appropriations ☐ Finance ☐ ☐.

☐ With a favorable report, as amended.

☐ With a favorable report, as amended, and recommendation that the bill be re-referred to the Committee on Appropriations ☐ Finance ☐ ☐.

☒ With a favorable report as to the committee substitute bill, unfavorable as to the original bill.

☐ With a favorable report as to House committee substitute bill (#), ☐ which changes the title, unfavorable as to Senate committee substitute bill.

☐ With an unfavorable report.

☐ With recommendation that the House concur.

☐ With recommendation that the House do not concur.

☐ With recommendation that the House do not concur; request conferees.

☐ With recommendation that the House concur; committee believes bill to be material.

☐ With an unfavorable report, with a Minority Report attached.

☐ Without prejudice.

☐ With an indefinite postponement report.

☐ With an indefinite postponement report, with a Minority Report attached.

☐ With recommendation that it be adopted. (HOUSE RESOLUTION ONLY)

2/24/99

NORTH CAROLINA GENERAL ASSEMBLY
AMENDMENT
House Bill 1095

AMENDMENT NO._____
(to be filled in by
Principal Clerk)

H1095-ARM-001

Page 1 of __

Date_____,1998

Comm. Sub. [yes]
Amends Title []

Representative _____

moves to amend the bill on page 2, lines 16-22, by deleting those lines and renumbering the remaining sections accordingly; and

on page 2, line 39 rewriting that line to read:
" (a) Any pharmacist who is approved under the provisions of G.S. 90-18(c)(3a) to"; and

on page 4, line 36, by deleting the words "A licensed" and replacing those words with "An approved".

SIGNED _____
Amendment Sponsor

SIGNED _____
Committee Chair if Senate Committee Amendment

ADOPTED _____ FAILED _____ TABLED _____

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 1999

H D

HOUSE BILL 1095
Corrected Copy 4/19/99
Proposed Committee Substitute H1095-PCS8118-RM

Short Title: Clinical Pharmacist Practitioner. (Public)

Sponsors:

Referred to:

April 15, 1999

A BILL TO BE ENTITLED

AN ACT AUTHORIZING THE NORTH CAROLINA MEDICAL BOARD AND THE BOARD OF PHARMACY TO ADOPT REGULATIONS TO APPROVE CLINICAL PHARMACIST PRACTITIONERS TO PRACTICE DRUG THERAPY MANAGEMENT PURSUANT TO A DRUG THERAPY MANAGEMENT AGREEMENT.

The General Assembly of North Carolina enacts:

Section 1. G.S. 90-6 reads as rewritten:

"**§ 90-6. Regulations governing applicants for license, examinations, etc.; appointment of subcommittee.**

(a) The North Carolina Medical Board is empowered to prescribe such regulations as it may deem proper, governing applicants for license, admission to examinations, the conduct of applicants during examinations, and the conduct of examinations proper.

(b) The North Carolina Medical Board shall appoint and maintain a subcommittee to work jointly with a subcommittee of the Board of Nursing to develop rules and regulations to govern the performance of medical acts by registered nurses, including the determination of reasonable fees to accompany an application for approval not to exceed one hundred dollars ($100.00) and for renewal of approval not to exceed fifty dollars ($50.00). The fee for reactivation of an inactive incomplete application shall be five dollars ($5.00). Rules and regulations developed by this subcommittee from time to time shall govern the performance of medical acts by registered nurses and

shall become effective when adopted by both the North Carolina Medical Board and the Board of Nursing. The North Carolina Medical Board shall have responsibility for securing compliance with these regulations.

(c) The North Carolina Medical Board shall appoint and maintain a subcommittee of four licensed physicians to work jointly with a subcommittee of the North Carolina Board of Pharmacy to develop rules and regulations to govern the performance of medical acts by clinical pharmacist practitioners, including the determination of reasonable fees to accompany an application for approval not to exceed one hundred dollars ($100.00) and for renewal of approval not to exceed fifty dollars ($50.00). The fee for reactivation of an inactive incomplete application shall be five dollars ($5.00). Rules and regulations developed by this subcommittee from time to time shall govern the performance of medical acts by clinical pharmacist practitioners and shall become effective when adopted by both the North Carolina Medical Board and the North Carolina Board of Pharmacy. The North Carolina Medical Board shall have responsibility for securing compliance with these regulations."

Section 2. G.S. 90-11 reads as rewritten:

"**§ 90-11. Qualifications of applicant for license.**

Every applicant for a license to practice medicine or to perform medical acts, tasks, and functions as a physician assistant or as a clinical pharmacist practitioner in the State shall satisfy the North Carolina Medical Board that the applicant is of good moral character and meets the other qualifications for the issuance of a license before any such license is granted by the Board to the applicant."

Section 3. G.S. 90-18(c) is amended by adding a new subdivision to read:

"(3a) The provision of drug therapy management by a licensed pharmacist engaged in the practice of pharmacy pursuant to an agreement that is physician, pharmacist, patient, and disease specific when performed in accordance with rules and regulations developed by a joint subcommittee of the North Carolina Medical Board and the North Carolina Board of Pharmacy and approved by both Boards. Drug therapy management shall be defined as the implementation of predetermined drug therapy which includes: (i) diagnosis and product selection by the patient's physician; (ii) modification of prescribed drug dosages, dosage forms, and dosage schedules; and (iii) ordering tests; all pursuant to an agreement that is physician, pharmacist, patient, and disease specific."

Section 4. Article 1 of Chapter 90 of the General Statutes is amended by adding a new section to read:

"**§ 90-18.3. Limitations on clinical pharmacist practitioners.**

(a) Any person who is licensed under the provisions of G.S. 90-18(c)(3a) to perform medical acts, tasks, and functions may use the title 'clinical pharmacist practitioner'. Any other person who uses the title in any form or holds himself or herself out to be a clinical pharmacist practitioner or to be so licensed shall be deemed to be in violation of this Article.

(b) Clinical pharmacist practitioners are authorized to implement predetermined drug therapy, which includes diagnosis and product selection by the patient's physician, modify prescribed drug dosages, dosage forms, and dosage schedules, and to order laboratory tests pursuant to a drug therapy management agreement that is physician, pharmacist, patient, and disease specific under the following conditions:

(1) The North Carolina Medical Board and North Carolina Board of Pharmacy have adopted regulations developed by a joint subcommittee governing the approval of individual clinical pharmacist practitioners to practice drug therapy management with such limitations that the Board determines to be in the best interest of patient health and safety.

(2) The clinical pharmacist practitioner has current approval from both Boards.

(3) The North Carolina Medical Board has assigned an identification number to the clinical pharmacist practitioner which is shown on written prescriptions written by the clinical pharmacist practitioner.

(4) The drug therapy management agreement prohibits the substitution of a chemically dissimilar drug product by the pharmacist for the product prescribed by the physician without the explicit consent of the physician and includes a policy for periodic review by the physician of the drugs modified pursuant to the agreement or changed with the consent of the physician.

(c) Clinical pharmacist practitioners in hospitals and other health facilities that have an established pharmacy and therapeutics committee or similar group that determines the prescription drug formulary or other list of drugs to be utilized in the facility and determines procedures to be followed when considering a drug for inclusion on the formulary and procedures to acquire a nonformulary drug for a patient may order medications and tests under the following conditions:

(1) The North Carolina Medical Board and North Carolina Board of Pharmacy have adopted regulations governing the approval of individual clinical pharmacist practitioners to order medications and tests with such limitations as the Boards determine to be in the best interest of patient health and safety.

(2) The clinical pharmacist practitioner has current approval from both Boards.

(3) The supervising physician has provided to the clinical pharmacist practitioner written instructions for ordering, changing, or substituting drugs, or ordering tests with provision for review of the order by the physician within a reasonable time, as determined by the Boards, after the medication or tests are ordered.

(4) The hospital or health facility has adopted a written policy, approved by the medical staff after consultation with nursing administrators, concerning the ordering of medications and tests, including procedures for verification of the clinical pharmacist

practitioner's orders by nurses and other facility employees and such other procedures that are in the best interest of patient health and safety.

(5) Any drug therapy order written by a clinical pharmacist practitioner or order for medications or tests shall be deemed to have been authorized by the physician approved by the Boards as the supervisor of the clinical pharmacist practitioner and the supervising physician shall be responsible for authorizing the prescription order.

(d) Any registered nurse or licensed practical nurse who receives a drug therapy order from a clinical pharmacist practitioner for medications or tests is authorized to perform that order in the same manner as if the order was received from a licensed physician."

Section 5. G.S. 90-85.3 is amended by adding a new subsection to read:

"(b1) 'Clinical Pharmacist Practitioner' means a licensed pharmacist who meets the guidelines and criteria for such title established by the joint subcommittee of the North Carolina Medical Board and the North Carolina Board of Pharmacy and is authorized to enter into drug therapy management agreements with physicians in accordance with the provisions of G.S. 90-18.3."

Section 6. G.S. 90-85.3(r) reads as rewritten:

"(r) 'Practice of pharmacy' means the responsibility for: interpreting and evaluating drug orders, including prescription orders; compounding, dispensing and labeling prescription drugs and devices; properly and safely storing drugs and devices; maintaining proper records; and controlling pharmacy goods and services. A pharmacist may advise and educate patients and health care providers concerning therapeutic values, content, uses and significant problems of drugs and devices; assess, record and report adverse drug and device reactions; take and record patient histories relating to drug and device therapy; monitor, record and report drug therapy and device usage; perform drug utilization reviews; and participate in drug and drug source selection and device and device source selection as provided in G.S. 90-85.27 through G.S. 90-85.31. A pharmacist who has received special training may be authorized and permitted to administer drugs pursuant to a specific prescription order in accordance with rules and regulations adopted by each of the Boards of Pharmacy, the Board of Nursing, and the North Carolina Medical Board. Such rules and regulations shall be designed to ensure the safety and health of the patients for whom such drugs are administered. A licensed clinical pharmacist practitioner may collaborate with physicians in determining the appropriate health care for a patient, subject to the provisions of G.S. 90-18.3."

Section 7. Article 4A of Chapter 90 of the General Statutes is amended by adding a new section to read:

"**§ 90-85.26A. Clinical pharmacist practitioners subcommittee.**

The Board of Pharmacy shall appoint and maintain a subcommittee of the Board consisting of four licensed pharmacists to work jointly with the subcommittee of the North Carolina Medical Board to develop rules and regulations to govern the

provision of drug therapy management by clinical pharmacist practitioners and to determine reasonable fees to accompany an application for approval or renewal of such approval as provided in G.S. 90-6. The rules developed by this subcommittee shall govern the performance of acts by clinical pharmacist practitioners and shall become effective when they have been adopted by both Boards."

Section 8. This act is effective when it becomes law.

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 1999

H 2

HOUSE BILL 1095
Corrected Copy 4/19/99

Short Title: Clinical Pharmacist Practitioner. (Public)

Sponsors: Representatives Allen; and Cansler.

Referred to: Health, if favorable, Finance.

April 15, 1999

A BILL TO BE ENTITLED

AN ACT AUTHORIZING THE LICENSURE OF CLINICAL PHARMACIST PRACTITIONERS.

The General Assembly of North Carolina enacts:

Section 1. G.S. 90-6 reads as rewritten:

"**§ 90-6. Regulations governing applicants for license, examinations, etc.; appointment of subcommittee.**

(a) The North Carolina Medical Board is empowered to prescribe such regulations as it may deem proper, governing applicants for license, admission to examinations, the conduct of applicants during examinations, and the conduct of examinations proper.

(b) The North Carolina Medical Board shall appoint and maintain a subcommittee to work jointly with a subcommittee of the Board of Nursing to develop rules and regulations to govern the performance of medical acts by registered nurses, including the determination of reasonable fees to accompany an application for approval not to exceed one hundred dollars ($100.00) and for renewal of approval not to exceed fifty dollars ($50.00). The fee for reactivation of an inactive incomplete application shall be five dollars ($5.00). Rules and regulations developed by this subcommittee from time to time shall govern the performance of medical acts by registered nurses and shall become effective when adopted by both the North Carolina Medical Board and the Board of Nursing. The North Carolina Medical Board shall have responsibility for securing compliance with these regulations.

(c) The North Carolina Medical Board shall appoint and maintain a subcommittee of four licensed physicians to work jointly with a subcommittee of the North Carolina Board of Pharmacy to develop rules and regulations to govern the performance of medical acts by licensed pharmacists, including the determination of reasonable fees to accompany an application for approval not to exceed one hundred dollars ($100.00) and for renewal of approval not to exceed fifty dollars ($50.00). The fee for reactivation of an inactive incomplete application shall be five dollars ($5.00). Rules and regulations developed by this subcommittee from time to time shall govern the performance of medical acts by licensed pharmacists and shall become effective when adopted by both the North Carolina Medical Board and the North Carolina Board of Pharmacy. The North Carolina Medical Board shall have responsibility for securing compliance with these regulations."

Section 2. G.S. 90-18(c) is amended by adding a new subdivision to read:

"(3a) The provision of drug therapy management by a licensed pharmacist engaged in the practice of pharmacy pursuant to an agreement that is physician, pharmacist, patient, and disease specific when performed in accordance with rules and regulations developed by a joint subcommittee of the North Carolina Medical Board and the North Carolina Board of Pharmacy and approved by both Boards."

Section 3. Article 1 of Chapter 90 of the General Statutes is amended by adding a new section to read:

"**§ 90-18.3. Limitations on clinical pharmacist practitioners.**

(a) Any person who is licensed under the provisions of G.S. 90-18(c)(3a) to perform medical acts, tasks, and functions may use the title 'clinical pharmacist practitioner'. Any other person who uses the title in any form or holds himself or herself out to be a clinical pharmacist practitioner or to be so licensed shall be deemed to be in violation of this Article.

(b) Clinical pharmacist practitioners are authorized to implement predetermined drug therapy, modify prescribed drug dosages, dosage forms and dosage schedules, and to order laboratory tests pursuant to a drug therapy management agreement that is physician, pharmacist, patient, and disease specific under the following conditions:

(1) The North Carolina Medical Board and Board of Pharmacy have adopted regulations developed by a joint subcommittee governing the approval of individual clinical pharmacist practitioners to practice drug therapy management with such limitations that the Board determines to be in the best interest of patient health and safety.

(2) The clinical pharmacist practitioner has current approval from both Boards.

(3) The North Carolina Medical Board has assigned an identification number to the clinical pharmacist practitioner which is shown on written prescriptions written by the clinical pharmacist practitioner.

(4) The drug therapy management agreement prohibits the substitution of a chemically dissimilar drug product by the pharmacist for the product prescribed by the physician without the consent of the physician and includes a policy for periodic review by the physician of the drugs modified pursuant to the agreement or changed with the consent of the physician.

(c) Clinical pharmacist practitioners in hospitals and other health facilities that have an established pharmacy and therapeutics committee or similar group that determines the prescription drug formulary or other list of drugs to be utilized in the facility and determines procedures to be followed when considering a drug for inclusion on the formulary and procedures to acquire a nonformulary drug for a patient may order medications and tests under the following conditions:

(1) The North Carolina Medical Board and Board of Pharmacy have adopted regulations governing the approval of individual clinical pharmacist practitioners to order medications and tests with such limitations as the Boards determine to be in the best interest of patient health and safety.

(2) The clinical pharmacist practitioner has current approval from both Boards.

(3) The supervising physician has provided to the clinical pharmacist practitioner written instructions for ordering, changing, or substituting drugs, or ordering tests with provision for review of the order by the physician within a reasonable time, as determined by the Boards after the medication or tests are ordered.

(4) The hospital or health facility has adopted a written policy, approved by the medical staff after consultation with nursing administrators, concerning the ordering of medications and tests, including procedures for verification of the clinical pharmacist practitioner's orders by nurses and other facility employees and such other procedures that are in the best interest of patient health and safety.

(d) Any drug therapy order written by a clinical pharmacist practitioner or order for medications or tests shall be deemed to have been authorized by the physician approved by the Boards as the supervisor of the clinical pharmacist practitioner, and the supervising physician shall be responsible for authorizing the prescription order."

(e) Any registered nurse or licensed practical nurse who receives a drug therapy order from a clinical pharmacist practitioner for medications or tests is authorized to perform that order in the same manner as if the order was received from a licensed physician."

Section 4. G.S. 90-85.3 is amended by adding a new subsection to read:

"(b1) 'Clinical Pharmacist Practitioner' means a licensed pharmacist who meets the guidelines and criteria for such title established by the joint subcommittees of the North Carolina Medical Board and the North Carolina Board of Pharmacy and is

authorized to enter into drug therapy management agreements with physicians in accordance with the provisions of G.S. 90-18.3."

Section 5. G.S. 90-85.3(r) reads as rewritten:

"(r) 'Practice of pharmacy' means the responsibility for: interpreting and evaluating drug orders, including prescription orders; compounding, dispensing and labeling prescription drugs and devices; properly and safely storing drugs and devices; maintaining proper records; and controlling pharmacy goods and services. A pharmacist may advise and educate patients and health care providers concerning therapeutic values, content, uses and significant problems of drugs and devices; assess, record and report adverse drug and device reactions; take and record patient histories relating to drug and device therapy; monitor, record and report drug therapy and device usage; perform drug utilization reviews; and participate in drug and drug source selection and device and device source selection as provided in G.S. 90-85.27 through G.S. 90-85.31. A pharmacist who has received special training may be authorized and permitted to administer drugs pursuant to a specific prescription order in accordance with rules and regulations adopted by each of the Boards of Pharmacy, the Board of Nursing, and the North Carolina Medical Board. Such rules and regulations shall be designed to ensure the safety and health of the patients for whom such drugs are administered. A licensed clinical pharmacist practitioner may collaborate with physicians in determining the appropriate health care for a patient, subject to the provisions of G.S. 90-18.3."

Section 6. Article 4A of Chapter 90 of the General Statutes is amended by adding a new section to read:

"**§ 90-85.26A. Clinical pharmacist practitioners subcommittee.**

The Board of Pharmacy shall appoint and maintain a subcommittee of the Board consisting of four licensed pharmacists to work jointly with the subcommittee of the Board of Medical Examiners to develop rules and regulations to govern the provision of drug therapy management by clinical pharmacist practitioners and to determine reasonable fees to accompany an application for approval or renewal of such approval as provided in G.S. 90-6. The rules developed by this subcommittee shall govern the performance of acts by licensed pharmacists and shall become effective when they have been adopted by both Boards."

Section 7. This act is effective when it becomes law.

HOUSE BILL 1095:
Clinical Pharmacist Practitioner

BILL ANALYSIS

Committee:	House Health Committee	**Introduced by:**	Rep. Gorden Allen
Date:	April 18, 1999	**Summary by:**	Linda Attarian
Version:	Proposed Committee Substitute		Committee Counsel

SUMMARY: ***House Bill 1095 (PCS) would allow collaborative practice agreements between physicians and pharmacists, and would create a new area of practice for licensed pharmacists approved to practice as "clinical pharmacist practitioners" under rules to be adopted by the NC Medical Board and the Board of Pharmacy. The bill would authorize clinical pharmacist practitioners to enter into drug therapy management agreements with physicians and perform medical tasks in accordance with law. The bill would establish the law for the conditions and limitations of the practice of clinical pharmacist practitioners.***

CURRENT LAW:

Under current law [G.S. 90-85.3(r)] a licensed pharmacist's scope of practice is limited to: "interpreting and evaluating drug orders, including prescription orders; compounding, dispensing and labeling prescription drugs and devices; properly and safely storing drugs and devices; maintaining proper records; and controlling pharmacy goods and services". A pharmacist may also advise and educate patients and health care providers concerning drugs and devices. A pharmacist who has received special training may be authorized and permitted to administer drugs pursuant to a specific prescription order.

If enacted, a "clinical pharmacist practitioner" will be authorized to perform the tasks that fall within a physician's scope of practice, and would otherwise be prohibited from performing. These tasks include: implementation predetermined drug therapy, modification of prescribed drug dosages, dosage forms, and dosage schedules, and ordering laboratory tests. However, even if the bill is enacted, clinical pharmacist practitioner may perform these tasks only when pursuant to a drug therapy management agreement that is physician, pharmacist, patient and disease specific.

BILL ANALYSIS:

Section 1. Requires the NC Medical Board to appoint and maintain a subcommittee to work jointly with a subcommittee of the NC Board of Pharmacy to develop rules governing the performance of the clinical pharmacist practitioner. These Boards will retain the oversight of the collaborative agreements.

Section 2 –3. Conforming amendments to the Medical Practice Act.

Section 4. Outlines the scope of practice limitations of clinical pharmacist practitioners, including the tasks and functions that the clinical pharmacist practitioner will be authorized to perform and the conditions underwhich such tasks and functions may be performed.

Sections 4 –5: Conforming amendments to the Pharmacy Practice Act.

Section 6: Requires the NC Board of Pharmacy to appoint and maintain a subcommittee to work jointly with a subcommittee of the NC Medical Board to develop rules governing the performance of the clinical pharmacist practitioner.

Section 7. Effective when the bill becomes law.

BACKGROUND: According to the North Carolina Pharmaceutical Association, 24 states allow some form of collaborative agreement between physicians and pharmacists.

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 1999

H 1

HOUSE BILL 1083

Short Title: Arthritis Educ. Task Force. (Public)

Sponsors: Representatives Alexander; and Adams.

Referred to: Health, if favorable, Appropriations.

April 15, 1999

A BILL TO BE ENTITLED

AN ACT TO ESTABLISH THE ARTHRITIS EDUCATION TASK FORCE AND TO APPROPRIATE FUNDS THEREFOR.

The General Assembly of North Carolina enacts:

Section 1.(a) There is established in the Department of Health and Human Services, Division of Community Health, the Arthritis Education Task Force. The Task Force shall have 18 members, as follows:

(1) From the Department of Health and Human Services:
  a. The Director of the Division of Community Health, or a designee thereof;
  b. The Director of the Division of Medical Assistance, or a designee thereof; and
  c. The Director of the Division of Aging, or a designee thereof;

(2) Appointed by the President Pro Tempore of the Senate:
  a. One member of the Senate;
  b. A local health director;
  c. A certified health educator;
  d. A representative of the North Carolina Association of Area Agencies on Aging; and
  e. A person with arthritis;

(3) Appointed by the Speaker of the House of Representatives:
  a. One member of the House of Representatives;
  b. A pharmacist;
  c. A licensed dietitian/nutritionist;

d. A registered nurse; and
e. A person with arthritis;

(4) Appointed by the Governor:
a. A practicing rheumatologist;
b. A practicing physical therapist;
c. A rheumatologist specializing in research of the disease;
d. A representative of a North Carolina Chapter of the Arthritis Foundation; and
e. A representative from the Governor's Council on Physical Fitness and Health.

Section 1.(b) The Governor shall appoint the Chair of the Task Force. The Vice-Chair shall be selected by the Task Force from among its membership. Each appointing authority shall assure insofar as possible that its appointees reflect the composition of the North Carolina population with regard to ethnic, racial, age, gender, and religious composition.

Section 1.(c) The General Assembly and the Governor shall make their appointments to the Task Force not later than 30 days after the adjournment of the 1999 General Assembly, Regular Session 1999. Vacancies on the Task Force shall be filled by the original appointing authority using the criteria set out in this section for the original appointment.

Section 1.(d) The Task Force shall meet at least quarterly or more frequently at the call of the Chair.

Section 1.(e) The Task Force may establish committees for the purpose of making special studies pursuant to its duties and may appoint non-Task Force members to serve on each committee as resource persons. Resource persons shall be voting members of the committees and shall receive subsistence and travel expenses in accordance with G.S. 138-5 and G.S. 138-6. Committees may meet with the frequency needed to accomplish the purposes of this section.

Section 1.(f) Members of the Task Force shall receive per diem and necessary travel and subsistence expenses in accordance with G.S. 120-3.1, 138-5, and 138-6, as applicable.

Section 1.(g) A majority of the Task Force shall constitute a quorum.

Section 1.(h) The Task Force may use funds allocated to it to establish one full-time limited position and for other expenditures needed to assist the Task Force in carrying out its duties.

Section 1.(i) In coordination with the National Arthritis Action Plan led by the Centers for Disease Control and Prevention (CDC), the North Carolina Arthritis Education Task Force has the following duties:

(1) To undertake a statistical and qualitative examination of the occurrence, progression, and impact of arthritis including identification of subpopulations at highest risk for developing arthritis, and establish a profile of the arthritis burden in North Carolina.

(2) To raise public awareness of the causes and nature of arthritis, personal risk factors, value of prevention and early detection, and options for diagnosing and treating the disease.

(3) To organize and implement a statewide program for the implementation of the arthritis self-help course, a cost-effective strategy for controlling the pain and cost of arthritis.

(4) To identify, examine limitations of, and recommend to the Governor and the General Assembly changes to existing laws, regulations, programs, services, and policies to enhance arthritis prevention, diagnosis, and treatment for the people of North Carolina.

(5) To determine and recommend to the Governor and the General Assembly the funding and strategies needed to enact new or to modify existing laws, regulations, programs, services, and policies to enhance arthritis prevention, diagnosis, and treatment for the people of North Carolina.

(6) To develop a statewide comprehensive Arthritis Action Plan, and strategies for implementing the Plan and for promoting the Plan to the general public, State and local officials, various public and private organizations and associations, businesses and industries, agencies, potential funding sources, and other community resources in conjunction with the National Arthritis Action Plan as established by the Arthritis Foundation and the U.S. Centers for Disease Control and Prevention (CDC).

(7) To identify strategies to facilitate specific commitments to help implement the Plan from the entities listed in subdivision (6) above.

(8) To facilitate coordination of and communication among State and local agencies and organizations regarding current or future involvement in achieving the aims of the National or North Carolina Arthritis Action Plan.

(9) To receive and consider reports and testimony from individuals, local health departments, community-based organizations, voluntary health organizations, and other public and private organizations statewide, to learn more about their contributions to arthritis diagnosis, prevention, and treatment, and their ideas for improving arthritis prevention, diagnosis, and treatment in North Carolina.

Section 1.(j) The Task Force shall submit a progress report to the Joint Legislative Health Care Oversight Committee, the Governor, and the Fiscal Research Division not later than April 1, 2000. The progress report shall address:

(1) Progress being made in fulfilling the duties of the Task Force and in developing the North Carolina Arthritis Action Plan;

(2) The anticipated time frame for completion of the North Carolina Arthritis Action Plan; and

(3) Recommended strategies or actions to reduce the occurrence of and burdens suffered from arthritis by citizens of this State.

Section 1.(k) The Task Force shall submit its final report to the 2001 General Assembly, the Governor, and the Fiscal Research Division not later than October 1, 2001. Upon submission of its final report the Task Force shall expire.

Section 2. There is appropriated from the General Fund to the Department of Health and Human Services, Division of Community Health, the sum of two hundred fifty thousand dollars ($250,000) for the 1999-2000 fiscal year and the sum of two hundred fifty thousand dollars ($250,000) for the 2000-2001 fiscal year. These funds shall be allocated for the Arthritis Education Task Force created under this act.

Section 3. This act becomes effective July 1, 1999.

HOUSE BILL 1083:
Arthritis Education Task Force

BILL ANALYSIS

Committee: House Health Committee
Date: April 20, 1999
Version: 1

Introduced by: Alexander
Summary by: John Young
Committee Staff

SUMMARY: ***This bill would establish an Arthritis Task Force within the Department of Health and Human Services, Division of Community Health. The Task Force would be composed of 18 members. There would be appropriated to DHHS $250,000 for fy 1999-2000 and $250,000 for fy 2000-2001.***

BILL ANALYSIS: **Section 1.(a)** establishes an 18 person Task Force. The President Pro Tempore of the Senate, the Speaker of the House of Representatives, and the Governor shall appoint five members each from listed categories. There are three designated appointees from the Department of Health and Human Services.

Section 1(b) requires that the Governor shall appoint the Chair. The Vice Chair shall be from the membership of the Task Force. The appointing authoritues shall, as much as possible, reflect the composition of North Carolina population in appointing the membership.

Section 1(c) provides the time frame for appointing the Task Force and the process for filling vacancies.

Section 1(d) requires the Task Force to meet at least quarterly.

Section 1(e) allows the establishment of committees who shall be voting members of the committees and allows for reimbursemen of committee members.

Section 1(f) provides for reimbursement of the Task Force.

Section 1(g) provides that a majority of the Task Force is a quorum for meetings.

Section 1(h) authorizes the hiring of staff.

Section 1(i) defines nine duties of the Task Force.

Section 1(j) requires a progress to the Joint Legislative Health Care Oversight Committee, the Governor, and Fiscal Research no later than April 1, 2000 and defines three elements to be contained in the report.

Section 1(k) requires the Task Force to submit a final Report to the 2001 General Assembly, the Governor and the Fiscal Research Division no later than October 1, 2001. Upon submission of the report, the Task Force shall expire.

Section 2 appropriates $250,000 for each year of the biennium to be allocated to the Arthritis Eduction Task Force.

Section 3 makes the act effective July 1, 1999

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 1999

H D

HOUSE BILL 996*
Proposed Committee Substitute H996-PCS3377-RY

Short Title: Regulate Spinal Manipulation. (Public)

Sponsors:

Referred to:

April 13, 1999

A BILL TO BE ENTITLED

AN ACT TO REQUIRE HEALTH CARE PROVIDERS PERFORMING SPINAL MANIPULATION TO ATTAIN MINIMUM HOURS OF CLASSROOM INSTRUCTION AND SUPERVISED CLINICAL TRAINING.

The General Assembly of North Carolina enacts:

Section 1. Chapter 90 of the General Statutes is amended by adding a new Article to read:

"ARTICLE 8A.

"Spinal Manipulation.

"**§ 90-157.10. Definitions.**

The following definitions apply in this Article:

(1) Health care provider. -- Any person holding a license issued under this Chapter except a physician licensed under Article 1 of Chapter 90 or a doctor of osteopathy licensed under Article 7 of Chapter 90.

(2) Spinal manipulation or spinal adjustment. -- A method of skillful treatment whereby a health care provider uses directed, brief, and sudden impulsion or leverage to move a joint of the patient's spine beyond its normal passive range of motion but without exceeding the limits of anatomical integrity. The term does not include the orthopaedic reduction of fractures and dislocations or joint mobilization in which no sudden impulsion or leverage is used and

the patient's joint is not moved beyond its normal passive range of motion.

"**§ 90-157.11. Instruction and training required to perform spinal manipulation.**

No health care provider shall perform a spinal manipulation or adjustment or permit, direct, or authorize any person under the provider's direct supervision to perform a spinal manipulation or adjustment unless he or she has received a minimum of 500 hours of classroom instruction in spinal manipulation or spinal adjustment and a minimum of 700 hours of supervised clinical training in spinal manipulation or adjustment from an accredited university, medical school, or chiropractic college.

"**§ 90-157.12. Sanctions.**

Violation of G.S. 90-157.11 shall be grounds for the offending health care provider's licensing board to suspend, revoke, or refuse to renew the health care provider's license or to take any other disciplinary action authorized by law."

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

ROLL CALL VOTE

8 YES 11 NO = _____(TOTAL)

HB# 996
SB# ____

HOUSE STANDING COMMITTEE ON HEALTH_

House Subcommittee on HEALTH (Committee Substitute) (AMENDMENT)

YES	NO	MEMBER (last name)	YES	NO	MEMBER (last name)
___	X	WRIGHT			
X	___	INSKO	___	___	
___	X	ADAMS	___	___	
X	___	ALEXANDER	___	___	
___	___	ALLRED	___	___	
X	___	BOWIE	___	___	
___	X	BRUBAKER	___	___	
___	___	CLARY (-)	___	___	
___	X	DEDMON	___	___	
___	X	EARLE	___	___	
X	___	EDWARDS	___	___	
X	___	ESPOSITO	___	___	
___	___	HOWARD	___	___	
___	X	JUSTUS	___	___	
___	X	MELTON	___	___	
X	___	PRESTON	___	___	
___	X	REDWINE	___	___	
___	X	WAINWRIGHT	___	___	
X	___	WILSON	___	___	
X	___	WOMBLE	___	___	
___	___		___	___	
___	___		___	___	
___	___		Ex officio Members		
___	___	HACKNEY	___	___	Speaker Pro Tem
___	X	BADDOUR	___	___	Majority Leader
___	___	EARLE	___	___	Majority Whip
___	X	CUNNINGHAM	___	___	
___	___	DEDMON	___	___	

ROLL CALL VOTE

12 YES 8 NO = 20 (TOTAL)

HB# 996
SB# ____

HOUSE STANDING COMMITTEE ON HEALTH

House Subcommittee on Health (Committee Substitute) (Regulate Spinal Manipulation)

YES	NO	MEMBER (last name)	YES	NO	MEMBER (last name)
X		WRIGHT			
	X	INSKO			
X		ADAMS			
	X	ALEXANDER			
		ALLRED			
	X	BOWIE			
X		BRUBAKER			
	X	CLARY			
X		DEDMON			
X		EARLE			
	X	EDWARDS			
	X	ESPOSITO			
		HOWARD			
X		JUSTUS			
X		MELTON			
	X	PRESTON			
X		REDWINE			
X		WAINWRIGHT			
	X	WILSON			
X		WOMBLE			
			Ex officio Members		
		HACKNEY			Speaker Pro Tem
X		BADDOUR			Majority Leader
		EARLE			Majority Whip
X		CUNNINGHAM			
		DEDMON			

VISITOR REGISTRATION SHEET

HEALTH 4/23/90

~~THE HOUSE APPROPRIATIONS SUBCOMMITTEE ON HUMAN RESOURCES~~

VISITORS: PLEASE SIGN BELOW AND RETURN TO COMMITTEE CLERK

	NAME	FIRM OR AGENCY
1.	Dan Garrett	NCAP
2.	John Bowdish	NCAP
3.	Zeb Alley	NCAP
4.	[illegible]	NCALICT
5.	John McMillan	MF+C
6.	[illegible]	NCMS
7.	Mary Greene	OSBM
8.	Scott Harmack	NCAYL
9.	Lynette Rivenbark	AHA
10.	Patrick Daymond	Legislative Intern
11.	[illegible]	NCHCAN
22.	Mark Black	NCCA
23.	Rudolph E. [illegible]	Am. Heart Assn.
24.	Evelyn Hawthorne	UNC-CH
25.	[illegible]	NC Board of [illegible]
26.	[illegible]	Charter Behavioral Systems
27.	C M Caw[illegible]	NCCA
28.	[illegible]	NCCA
29.	Roslyn Savitt	NC Child Care Coalition
30.	[illegible]	Poyner & Spruill
31.	Peggy Maynard	[illegible]
	Marie Smith	NCSA

VISITOR REGISTRATION SHEET

THE HOUSE APPROPRIATIONS SUBCOMMITTEE ON HUMAN RESOURCES

VISITORS: PLEASE SIGN BELOW AND RETURN TO COMMITTEE CLERK

	NAME	FIRM OR AGENCY
1.	Roslyn Lovett	NCACC
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AGENDA

HOUSE COMMITTEE ON HEALTH
MONDAY, APRIL 26, 1999
3:00 PM- 5:00 PM
415-LOB

OPENING REMARKS

REP. THOMAS E. WRIGHT
CHAIRMAN

BILLS TO BE DISCUSSED

HB-736-----OPTOMETRY LICENSING LAW TECHNICAL CHANGE
REP. ROGERS

HB-1118----LIMIT LIABILITY/DEFIBRILLATORS
REP. WRIGHT

HB-1138----ORTHOPEDIC PHYSICIAN ASSISTANT
REP. MCCOMAS

HB-1064----ABORTION/ RIGHT TO KNOW
REP. DECKER

HB-1258----HEALTH CARE PERSONNEL REGISTRY CHANGE
REP. EARLE

COMMENTS

ADJOURNMENT

MINUTES

HOUSE COMMITTEE ON HEALTH

MONDAY, APRIL 26, 1999

3:00PM-5:00PM ROOM 415-LOB

The House Committee on Health met on Monday, April 26, 1999 at 3:00 P.M. in Room 415-LOB. A silent roll was taken, (roll list denotes members present.)\

Chairman Wright called the meeting to order.

HB-736 OPTOMETRY LICENSING LAW TECHNICAL CHANGE

Rep. Womble moved for adoption of the proposed committee substitute. So moved.

Rep. Redwine is recognized for a question. The Chairman responded. Rep. Nye stated that Linda Attarian would explain the bill. Rep. Womble asked the bill sponsor a question. Chairman Wright responded. Linda Attarian, research staff, responded to Rep. Womble inquiry. Rep. Womble followed up with a question. Chairman Wright responded. Rep. Edwards asked the bill sponsor a question about two other managed care bills. Rep. Nye responded. Rep. Edwards followed up with a question to the bill sponsor about crop payments. Rep. Nye responded. Rep. Wainwright deferred to staff to explain a section of the bill. Chairman Wright asked the bill sponsor if he could respond to Rep. Wainwright inquiry. Rep. Nye responded. Rep. Wainwright followed up with a question to the bill sponsor. Rep. Alexander asked the bill sponsor a question about the administrative fees on page 6, section D. Rep. Nye responded. Rep. Alexander followed up. Rep. Esposito asked the Chairman a question about the bill. Chairman Wright responded. Rep. Redwine asked the bill sponsor about section 4 of the bill. Rep. Nye responded. Rep. Redwine followed up with a comment. Rep. Nye responded. Rep. Redwine followed up with a comment. Rep. Nye responded. Rep. Redwine followed up with a question about the cost from the HMO's. Rep. Nye responded that it would give patient's rights and access that they do not have at this time. Rep. Cunningham commented. Rep. Womble asked the bill sponsor a question about page 6, section D of the bill about the administrative fees. Rep. Nye responded. Rep. Womble followed up. Rep. Nye responded. Rep. Womble followed up with a question about the 5.5 percent percentage. Rep. Nye responded. Rep. Womble asked the bill sponsor about the arrival percentage of 5.5. Rep. Nye responded by stating that 5.5 percent was the average amount given with Medicaid being at 1.7 percent and the high in access of 12 %. Rep. Wilson asked the bill sponsor a question about the managed care industry position on this issue. Rep. Nye responded. Harry Kaplan, of Kaiser Permanente, commented on the bill on page 2, line 25. Rep. Wilson followed up with a question to Chairman Wright about a

motion on the bill. Chairman Wright responded. Rep. Wilson commented on the bill and recommended that a sub-committee be appointed to study the bill further. Rep. Adams asked the bill sponsor a question about HMO's input in this bill. Rep. Nye responded. Rep. Adams followed up with a question to the bill sponsor. Rep. Nye responded. Rep. Justus asked a question to Harry Kaplan about the HMO's in North Carolina. Harry Kaplan responded. Rep. Justus followed up with a comment to Chairman Wright about the appointment of a sub-committee on the bill and the crossover deadline. Rep. Nye responded to Harry Kaplan comments. Rep. Allred commented on the bill. Rep. Cunningham commented on the bill. Mike Clark, an optometrist, commented on the bill. Rep. Womble asked Mike Clark a question about the bill on page 4, section D, line 22-23. Mike Clark responded. Rep. Womble commented that he agrees with Rep. Cunningham and a couple of others that the bill is complex and representatives from the HMO industry should be in attendance to thoroughly discuss the bill. Rep. Bowie commented that the bill is a very complex bill. Rep. Wainwright asked a question to Harry Kaplan about rural accessibility to a HMO provider. Harry Kaplan responded. Rep. Wainwright followed up with a question to Harry Kaplan about patient access and patient choice. Harry Kaplan responded. Rep. Redwine asked the bill sponsor a question about Page 6; section D. Rep. Edwards asked a question to the bill sponsor about page 4, line 33. Rep. Nye responded. Rep. Clary asked Mike Clark a question about accessibility to a HMO provider. Mike Clark responded. Rep. Adams asked Mike Clark a question about the fee. Mike responded. Rep. Adams followed up with a question to Mike Clark. Mike Clark responded. Rep. Adams followed up with a question to the bill sponsor. Rep. Nye responded. Rep. Adams followed up with a question to the bill sponsor. The bill sponsor deferred the question to staff. Linda Attarian, research staff, responded. Rep. Adams followed up with a question to Linda Attarian. Rep. Wainwright asked Harry Kaplan a question. Harry Kaplan responded. Rep. Wainwright followed up with a question to Harry Kaplan about additional cost. Harry Kaplan responded.

Rep. Wainwright moved for a favorable report.

Rep. Insko asked the bill sponsor about the release of a health care provider from a panel. Harry Kaplan, Kaiser Permanente, responded. Rep. Insko followed up with a question about the administrative fee. Harry Kaplan responded. Rep. Redwine commented on the bill. Rep. Womble asked the bill sponsor a question about if the bill was moving toward a Patient's Bill of Rights and his concern about section D. Rep. Nye responded.

The meeting adjourned at 4:55 P.M.

Rep. Thomas E. Wright, Chairman

Vanda Wilson-Wormack, Committee Asst.

VISITOR REGISTRATION SHEET

HEALTH — 4/26/99

Name of Committee — Date

VISITORS: PLEASE SIGN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
CROWLEY	NC PUB RTD
Scott Mooneyham	AP
Kim Nilsen	Fayetteville Observer Times
Lynette Bivenbach	Am. Heart Assoc.
Amy Jo Baum	NC Medical Society
Jane Romaine	NCSOS
[illegible] Clark	NC SOS
DAVID ANDERSON	NC SOS
Alina Gregory	Bryan & Sprill
Jaime Combs	Raleigh WNO
Susan Hill	Raleigh Women's Health Organization
Dave Burton	n/a
ELIZABETH WICKHAM	Raleigh.
Nancy Lischwe	Apex
Carmen Carpenter	Raleigh
John Kurtz	NC Family Policy Council
[illegible] Cooper	NCATL
[illegible]	
[illegible]	NC Equity
[illegible]	NC Community Action Assoc
C M Caron	"
Evelyn Hawthorne	UNC-CH
[illegible] Dewitt Leach	NC SOS
John T. Robinson	NC Board of Optometry
MARY GREENE	OSBM
[illegible] Hoke	DHHS
V L McBride	NCBA
Barbara Hart	NCRTL

VISITOR REGISTRATION SHEET

Health — Name of Committee

4-26-99 — Date

VISITORS: PLEASE SIGN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
[illegible]	Am. Heart Asso.
[illegible]	[illegible]
HUGH TILSON	[illegible]
Lori Ann Harris	L A Harris & Assoc

AGENDA

HOUSE COMMITTEE ON HEALTH
TUESDAY, APRIL 27, 1999
12:00 NOON
415 LOB

OPENING REMARKS

REP. THOMAS E. WRIGHT
CHAIRMAN

BILLS TO BE DISCUSSED

HB-736— MANAGED CARE/ PATIENT ACCESS
REP. ROGERS/ REP. NYE

HB-1118—LIMIT LIABILITY/ DEFIBRILLATORS
REP. WRIGHT

HB-1258—HEALTH CARE PERSONNEL REGISTRY CHANGE
REP. EARLE

HB-1064--ABORTION/ RIGHT TO KNOW
REP. DECKER

COMMENTS

ADJOURNMENT

MINUTES

HOUSE COMMITTEE ON HEALTH

TUESDAY, APRIL 27, 1999

12:00 NOON ROOM 415-LOB

The House Committee on Health met on Tuesday, April 27, 1999 at 12:00 Noon in Room 415-LOB. A silent roll was taken, (roll list denotes members present.)

Chairman Wright called the meeting to order.

The Pages were introduced to the Committee Members.

HB-1118 LIMIT LIABILITY/ DEFIBRILLATORS

Rep. Earle moved for adoption of the committee substitute. So moved.

Vice-Chairman Insko called Rep. Wright to explain the committee substitute.

Rep. Wright moved for a favorable report, unfavorable as to the original bill and be re-referred to the Committee on RULES.

A vote was taken. The Ayes had the majority vote. The motion passed.

HB-1258 HEALTH CARE PERSONNEL REGISTRY CHANGE

Rep. Bowie moved for adoption of the proposed committee substitute. So moved.

Rep. Earle asked Linda Attarian, Staff, to explain the bill. Rep. Bowie asked the bill sponsor a question. Rep. Earle responded. Rep. Bowie followed up with a question to the bill sponsor. Rep. Earle responded. Rep. Bowie followed up with a question to the bill sponsor. Rep. Earle responded. Rep. Bowie followed up with a comment about the registry. Rep. Earle responded. Rep. Bowie commented. Bonnie Kramer, from the Division of Facility Services, responded to Rep. Bowie concerns about the bill. Rep. Womble asked Linda Attarian a question about the bill. Linda Attarian responded. Rep. Womble followed up with a question to Linda Attarian. Linda Attarian responded. Rep. Womble followed up with a question. Linda Attarian responded. Rep. Justus asked a question about page 2, line 8, line 23-paragraph B. Linda Attarian responded.

Rep. Baddour moved for a favorable report to the House proposed committee substitute, unfavorable as to the original bill.

Rep. Bowie asked staff a question. Bonnie Kramer responded about the registry.

A vote was taken on the motion. The Ayes had the majority vote.

HB-736 MANAGED CARE/ PATIENT ACCESS

Rep. Nye explained the amendment to the bill on page 2 about patient access and page 3, line 18, page 5, page 6, page 7

Chairman Wright moved to amend the bill on page 2, line 25-30, page 4, line 1, page 6, line 26 and page 6, line 29-30.

Rep. Baddour asked Chairman Wright about a technical amendment on page 3. The amendment was offered up. Rep. Cunningham asked a question about the administrative fees associated with the bill. Rep. Nye responded. Rep. Cunningham asked Rep. Baddour a question about the amendment. Rep. Baddour responded. Rep. Womble asked a question about the administrative fee change. Rep. Nye responded. Rep. Womble commented on the bill. Rep. Nye responded. Rep. Wainwright asked a question to Chairman Wright. Rep. Edwards commented on the bill. Rep. Baddour commented on the bill. Rep. Wainwright asked Rep. Baddour a question. Rep. Baddour responded. Rep. Adams asked a question about the administrative fee. Linda Attarian responded. Rep. Adams followed up with a question.

Chairman Wright sent forth the amendment. The vote was taken. The amendment passed. Rep. Justus asked a question to the bill sponsor. Rep. Nye responded. Rep. Wainwright moved to amend the bill on page 2, line 31-34. Rep. Wainwright explained the amendment. A vote was taken. The amendment passed.

Rep. Wainwright moved for a favorable report as amended, and be rolled into a committee substitute, unfavorable as to the original bill.

Rep. Womble commented on the administrative fee percentage of the bill.

A vote was taken. The Ayes had the majority vote. The bill passed.

Thomas E. Wright
Rep. Thomas E. Wright, Chairman

Vanda Wilson-Wormack
Vanda Wilson-Wormack, Committee Asst.

file
4-27-99

1999 COMMITTEE REPORT
HOUSE OF REPRESENTATIVES

The following report(s) from standing committee(s) is/are presented:
By Representative **THOMAS E. WRIGHT** for the Committee on **HEALTH**.

☐ Committee Substitute for
H.B. 1118 A BILL TO BE ENTITLED AN ACT TO LIMIT LIABILITY WHEN A PERSON USES AN AUTOMATED EXTERNAL DEFIBRILLATOR TO RENDER EMERGENCY TREATMENT TO SAVE THE LIFE OF A PERSON IN CARDIAC ARREST.

☐ With a favorable report.

☐ With a favorable report and recommendation that the bill be re-referred to the Committee on Appropriations ☐ Finance ☐ ☐.

☐ With a favorable report, as amended.

☐ With a favorable report, as amended, and recommendation that the bill be re-referred to the Committee on Appropriations ☐ Finance ☐ ☐.

☒ With a favorable report as to committee substitute bill, ☒ which changes the title, unfavorable as to the original bill, and recommendation that the committee substitute bill be re-referred to the Committee on RULES.

☐ With a favorable report as to House committee substitute bill (#), ☐ which changes the title, unfavorable as to Senate committee substitute bill.

☐ With an unfavorable report.

☐ With recommendation that the House concur.

☐ With recommendation that the House do not concur.

☐ With recommendation that the House do not concur; request conferees.

☐ With recommendation that the House concur; committee believes bill to be material.

☐ With an unfavorable report, with a Minority Report attached.

☐ Without prejudice.

☐ With an indefinite postponement report.

☐ With an indefinite postponement report, with a Minority Report attached.

☐ With recommendation that it be adopted. (HOUSE RESOLUTION ONLY)

2/24/99

4-27-99

1999 COMMITTEE REPORT
HOUSE OF REPRESENTATIVES

The following report(s) from standing committee(s) is/are presented:
By Representative **THOMAS E. WRIGHT** for the Committee on **HEALTH**.

☐ Committee Substitute for
H.B. 1258 A BILL TO BE ENTITLED AN ACT TO CLARIFY THE FACILITIES THAT ARE INCLUDED IN THE HEALTH CARE PERSONNEL REGISTRY; TO PROVIDE THAT GRIEVANCES PERTAINING TO THE HEALTH CARE PERSONNEL REGISTRY FILED BY STATE EMPLOYEES SHALL BE IN ACCORDANCE WITH STATE PERSONNEL PROCEDURES; AND TO REQUIRE THAT EMPLOYERS AT HEALTH CARE FACILITIES ACCESS THE HEALTH CARE PERSONNEL REGISTRY.

☐ With a favorable report.

☐ With a favorable report and recommendation that the bill be re-referred to the Committee on Appropriations ☐ Finance ☐ ☐.

☐ With a favorable report, as amended.

☐ With a favorable report, as amended, and recommendation that the bill be re-referred to the Committee on Appropriations ☐ Finance ☐ ☐.

☒ With a favorable report as to committee substitute bill, which changes the title, unfavorable as to the original bill.

☐ With a favorable report as to House committee substitute bill (#), ☐ which changes the title, unfavorable as to Senate committee substitute bill.

☐ With an unfavorable report.

☐ With recommendation that the House concur.

☐ With recommendation that the House do not concur.

☐ With recommendation that the House do not concur; request conferees.

☐ With recommendation that the House concur; committee believes bill to be material.

☐ With an unfavorable report, with a Minority Report attached.

☐ Without prejudice.

☐ With an indefinite postponement report.

☐ With an indefinite postponement report, with a Minority Report attached.

☐ With recommendation that it be adopted. (HOUSE RESOLUTION ONLY)

2/24/99

4-27-99

1999 COMMITTEE REPORT
HOUSE OF REPRESENTATIVES

The following report(s) from standing committee(s) is/are presented:
By Representative(s) **THOMAS E. WRIGHT** for the Committee on **HEALTH**.

☒ Committee Substitute for
H.B. 736 A BILL TO BE ENTITLED AN ACT TO MAKE TECHNICAL CHANGES TO THE OPTOMETRY LICENSING LAWS.

☐ With a favorable report.

☐ With a favorable report and recommendation that the bill be re-referred to the Committee on Appropriations ☐ Finance ☐ ☐.

☐ With a favorable report, as amended.

☐ With a favorable report, as amended, and recommendation that the bill be re-referred to the Committee on Appropriations ☐ Finance ☐ ☐.

☒ With a favorable report as to committee substitute bill # 2, ☒ which changes the title, unfavorable as to the committee substitute bill # 1.

☐ With a favorable report as to House committee substitute bill (#), ☐ which changes the title, unfavorable as to Senate committee substitute bill.

☐ With an unfavorable report.

☐ With recommendation that the House concur.

☐ With recommendation that the House do not concur.

☐ With recommendation that the House do not concur; request conferees.

☐ With recommendation that the House concur; committee believes bill to be material.

☐ With an unfavorable report, with a Minority Report attached.

☐ Without prejudice.

☐ With an indefinite postponement report.

☐ With an indefinite postponement report, with a Minority Report attached.

☐ With recommendation that it be adopted. (HOUSE RESOLUTION ONLY)

2/24/99

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 1999

H D

HOUSE BILL 1118
Proposed Committee Substitute H1118-PCS4242-RM

Short Title: Limit Liability/Defibrillators. (Public)

Sponsors:

Referred to:

April 15, 1999

A BILL TO BE ENTITLED

AN ACT TO AUTHORIZE THE LEGISLATIVE RESEARCH COMMISSION TO STUDY THE ISSUE OF LIMITED LIABILITY WHEN A PERSON USES AN AUTOMATED EXTERNAL DEFIBRILLATOR TO RENDER EMERGENCY TREATMENT TO SAVE THE LIFE OF A PERSON IN CARDIAC ARREST.

The General Assembly of North Carolina enacts:

Section 1. The Legislative Research Commission may study the issue of limited liability when a person uses an automated external defibrillator to render emergency treatment to save the life of a person in cardiac arrest.

Section 2. The Commission may report its findings and recommendations to the General Assembly prior to the Regular Session of the 1999-2000 General Assembly.

Section 3. This act becomes effective July 1, 1999.

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 1999

H 1

HOUSE BILL 1118

Short Title: Limit Liability/Defibrillators. (Public)

Sponsors: Representative Wright.

Referred to: Health.

April 15, 1999

A BILL TO BE ENTITLED

AN ACT TO LIMIT LIABILITY WHEN A PERSON USES AN AUTOMATED EXTERNAL DEFIBRILLATOR TO RENDER EMERGENCY TREATMENT TO SAVE THE LIFE OF A PERSON IN CARDIAC ARREST.

The General Assembly of North Carolina enacts:

Section 1. Article 1B of Chapter 90 of the General Statutes is amended by adding a new section to read:

"**§ 90-21.15. Emergency treatment using automated external defibrillator; immunity.**

(a) Intent. -- It is the intent of the General Assembly that, when used in accordance with this section, an automated external defibrillator may be used during an emergency for the purpose of saving the life of another person in cardiac arrest.

(b) Duties. -- In order to ensure public health and safety:

(1) A person or entity that acquires an automated external defibrillator shall ensure that:

a. Expected users of automated external defibrillators receive the American Heart Association training in cardiopulmonary resuscitation (CPR) and automated external defibrillator use, or an equivalent, nationally recognized course in CPR and automated external defibrillator use.

b. The defibrillator is maintained and tested according to the manufacturer's operational guidelines.

c. A licensed physician is involved in the site's program for the purpose of ensuring compliance with requirements under this subsection for training, maintenance, and notification.

d. Any person who renders emergency care or treatment on a person in cardiac arrest by using an automated external defibrillator activates the emergency medical services system as soon as possible and reports any clinical use of the automated external defibrillator to the licensed physician or medical authority under subsubdivision c. of this subdivision.

(2) Any person or entity that acquires an automated external defibrillator shall notify an agent of the local emergency communications or vehicle dispatch center of the existence, location, and type of automated external defibrillator.

(c) Immunity. -- Subject to subsection (e) of this section, any person or entity who in good faith and without compensation renders emergency care or treatment by the use of an automated external defibrillator shall be immune from civil liability for any personal injury as a result of that care or treatment or as a result of any act or failure to act in providing or arranging further medical treatment when that person acts as an ordinary, reasonably prudent person would have acted under the same or similar circumstances. Subject to subsection (f) of this section, the immunity under this subsection applies only if the requirements under subsection (b) of this section have been satisfied.

(d) Scope of Immunity. -- The immunity from civil liability under subsection (c) of this section includes the licensed physician who is involved with automated external defibrillator site placement, the person or entity who provides the CPR and automated external defibrillator site placement, the person or entity who provides the CPR and automated external defibrillator training, and the person or entity responsible for the site where the automated external defibrillator is located.

(e) Liability. -- The immunity from civil liability under subsection (c) of this section does not apply if the personal injury results from the gross negligence or willful or wanton misconduct of the person administering the emergency care.

(f) Duties Not Applicable. -- The requirements under subsection (b) of this section are not a condition of immunity under this section when an individual uses an automated external defibrillator as a volunteer in an emergency setting under G.S. 1-539.10.

(g) Definition. -- As used in this section, 'automated external defibrillator' means a medical device that monitors and defibrillates the heart and that satisfies all of the following criteria:

(1) The device has received approval from the United States Food and Drug Administration of its premarket notification filed pursuant to 21 U.S.C. § 360(k), as amended.

(2) The device is capable of recognizing the presence or absence of ventricular fibrillation or rapid ventricular tachycardia and is

capable of determining, without intervention by an operator, whether defibrillation should be performed.

(3) Upon determining that defibrillation should be performed, the device automatically charges and requests delivery of an electrical impulse to an individual's heart."

Section 2. This act becomes effective October 1, 1999, and applies to causes of action arising on or after that date.

HOUSE BILL 1118:
Limit Liability/Defibrillators

BILL ANALYSIS

Committee:	House Health Care	**Introduced by:**	Rep. Wright
Date:	April 23, 1999	**Summary by:**	Linda Attarian
Version:	First Edition		Committee Counsel

SUMMARY: This bill would:

- ***Establish legislative intent that an "automatic external defibrillator may be used by any person for the purpose of saving the life of another person in cardiac arrest."***
- ***Require training in the use of AED devices by potential users.***
- ***Require AED devices to be maintained and tested to manufacturer's standards.***
- ***Require the involvement of a licensed physician to ensure compliance with the requirements in the bill.***
- ***Create a registry of the location of all such defibrillators, or notification of a local emergency medical authority.***
- ***Allow a "Good Samaritan" exemption from liability for any individual who renders emergency treatment with a defibrillator.***

BILL ANALYSIS:

Section 1. Adds a new section to Article 1B of Chapter 90 to establish the law conditioning the use of automated external defibrillators to protect the public's health and safety and to provide immunity from civil liability to any person or entity who uses an automated external defibrillator in an effort to save a life in the event of a heart attack.

Section 2. If enacted, the bill would become effective October 1, 1999.

BACKGROUND:

Florida was the first state to enact such a broad public access law in April 1997 (Chapter 34 of 1997). As of 3/99, more than 20 states, as listed below, had enacted defibrillator laws or adopted regulations:

AK, AL, AR, CA, CT, DE, FL, GA, HI, IOWA, IL, IN, KS, MA, MN, MS, NJ, NM, NV, NY, OH, RI, TN, UT, VA, WA, WV, and WY.

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 1999

H D

HOUSE BILL 1258*
Proposed Committee Substitute H1258-PCS2325-RM

Short Title: Health Care Personnel Registry Changes. (Public)

Sponsors:

Referred to:

April 15, 1999

A BILL TO BE ENTITLED

AN ACT TO CLARIFY THE FACILITIES THAT ARE INCLUDED IN THE HEALTH CARE PERSONNEL REGISTRY; AND TO REQUIRE THAT EMPLOYERS AT HEALTH CARE FACILITIES ACCESS THE HEALTH CARE PERSONNEL REGISTRY.

The General Assembly of North Carolina enacts:

Section 1. G.S. 131E-256 reads as rewritten:

"**§ 131E-256. Health Care Personnel Registry.**

(a) The Department shall establish and maintain a health care personnel registry containing the names of all health care personnel working in health care facilities in North Carolina who have:

(1) Been subject to findings by the Department of:

a. Neglect or abuse of a resident in a health care facility or a person to whom home care services as defined by G.S. 131E-136 or hospice services as defined by G.S. 131E-201 are being provided.

b. Misappropriation of the property of a resident in a health care facility, as defined in subsection (b) of this section including places where home care services as defined by G.S. 131E-136 or hospice services as defined by G.S. 131E-201 are being provided.

c. Misappropriation of the property of a health care facility.

d. Diversion of drugs belonging to a health care facility or to a patient or client.

e. Fraud against a health care facility or against a patient or client for whom the employee is providing services.

(2) Been accused of any of the acts listed in subdivision (1) of this subsection, but only after the Department has screened the allegation and determined that an investigation is required.

The ~~health care personnel registry~~ Health Care Personnel Registry shall also contain all findings by the Department of neglect of a resident in a nursing facility or abuse of a resident in a nursing facility or misappropriation of the property of a resident in a nursing facility by a nurse aide that are contained in the nurse aide registry under G.S. 131E-255.

(b) For the purpose of this section, the following are considered to be 'health care facilities':

(1) Adult Care Homes as defined in G.S. 131D-2.

(2) Hospitals as defined in G.S. 131E-76.

(3) Home Care Agencies as defined in G.S. 131E-136.

(4) Nursing Pools as defined by G.S. 131E-154.2.

(5) Hospices as defined by G.S. 131E-201.

(6) Nursing Facilities as defined by G.S. 131E-255.

(7) State-Operated Facilities as ~~set forth in G.S. 122C-22.~~ defined in G.S. 122C-3(14)f.

(8) Residential Facilities ~~and Hospitals for the Mentally Ill, Developmentally Disabled, or Substance Abusers licensed pursuant to G.S. 122C-23.~~ as defined in G.S. 122C-3(14)e.

(9) 24-Hour Facilities as defined in G.S. 122C-3(14)g.

(c) For the purpose of this section, the following are considered to be 'health care personnel':

(1) In an adult care home, an adult care personal aide who is any person who either performs or directly supervises others who perform task functions in activities of daily living which are personal functions essential for the health and well-being of residents such as bathing, dressing, personal hygiene, ambulation or locomotion, transferring, toileting, and eating.

(2) A nurse aide.

(3) An in-home aide or an in-home personal care aide who provides hands-on paraprofessional services.

(4) Unlicensed assistant personnel who provide hands-on care, including, but not limited to, habilitative aides and health care technicians.

(d) Health care personnel who wish to contest findings under subdivision (a)(1) of this section are entitled to an administrative hearing as provided by the Administrative Procedure Act, Chapter 150B of the General Statutes. A petition for a contested case shall be filed within 30 days of the mailing of the written notice of the

Department's intent to place its findings about the person in the ~~health care personnel registry.~~ Health Care Personnel Registry.

(d1) Health care personnel who wish to contest the placement of information under subdivision (a)(2) of this section are entitled to an administrative hearing as provided by the Administrative Procedure Act, Chapter 150B of the General Statutes. A petition for a contested case hearing shall be filed within 30 days of the mailing of the written notice of the Department's intent to place information about the person in the ~~health care personnel registry~~ Health Care Personnel Registry under subdivision (a)(2) of this section. Health care personnel who have filed a petition contesting the placement of information in the health care personnel registry under subdivision (a)(2) of this section are deemed to have challenged any findings made by the Department at the conclusion of its investigation.

(d2) Before hiring health care personnel into a health care facility or service, every employer at a health care facility shall access the Health Care Personnel Registry and shall note each incident of access in the appropriate business files.

(e) The Department shall provide an employer or potential employer of any person listed on the ~~health care personnel registry of~~ Health Care Personnel Registry of the nature of the finding or allegation and the status of the investigation.

(f) No person shall be liable for providing any information for the health care personnel registry if the information is provided in good faith. Neither an employer, potential employer, nor the Department shall be liable for using any information from the health care personnel registry if the information is used in good faith for the purpose of screening prospective applicants for employment or reviewing the employment status of an employee.

(g) Upon investigation and documentation, health care facilities shall ensure that the Department is notified of all substantiated allegations against health care personnel which appear to a reasonable person to be related to any act listed in subdivision (a)(1) of this section, and shall promptly report to the Department any resulting disciplinary action, demotion, or termination of employment of health care personnel.

(h) The North Carolina Medical Care Commission shall adopt, amend, and repeal all rules necessary for the implementation of this section."

Section 2. This act becomes effective July 1, 1999.

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 1999

H 1

HOUSE BILL 1258*

Short Title: Health Care Personnel Registry Changes. (Public)

Sponsors: Representatives Earle; Alexander, Braswell, Clary, Moore, Saunders, and C. Wilson.

Referred to: Health.

April 15, 1999

A BILL TO BE ENTITLED

AN ACT TO CLARIFY THE FACILITIES THAT ARE INCLUDED IN THE HEALTH CARE PERSONNEL REGISTRY; TO PROVIDE THAT GRIEVANCES PERTAINING TO THE HEALTH CARE PERSONNEL REGISTRY FILED BY STATE EMPLOYEES SHALL BE IN ACCORDANCE WITH STATE PERSONNEL PROCEDURES; AND TO REQUIRE THAT EMPLOYERS AT HEALTH CARE FACILITIES ACCESS THE HEALTH CARE PERSONNEL REGISTRY.

The General Assembly of North Carolina enacts:

Section 1. G.S. 131E-256 reads as rewritten:

"**§ 131E-256. Health Care Personnel Registry.**

(a) The Department shall establish and maintain a health care personnel registry containing the names of all health care personnel working in health care facilities in North Carolina who have:

(1) Been subject to findings by the Department of:

a. Neglect or abuse of a resident in a health care facility or a person to whom home care services as defined by G.S. 131E-136 or hospice services as defined by G.S. 131E-201 are being provided.

b. Misappropriation of the property of a resident in a health care facility, as defined in subsection (b) of this section including places where home care services as defined by

G.S. 131E-136 or hospice services as defined by G.S. 131E-201 are being provided.

c. Misappropriation of the property of a health care facility.

d. Diversion of drugs belonging to a health care facility or to a patient or client.

e. Fraud against a health care facility or against a patient or client for whom the employee is providing services.

(2) Been accused of any of the acts listed in subdivision (1) of this subsection, but only after the Department has screened the allegation and determined that an investigation is required.

The health care personnel registry shall also contain all findings by the Department of neglect of a resident in a nursing facility or abuse of a resident in a nursing facility or misappropriation of the property of a resident in a nursing facility by a nurse aide that are contained in the nurse aide registry under G.S. 131E-255.

(b) For the purpose of this section, the following are considered to be 'health care facilities':

(1) Adult Care Homes as defined in G.S. 131D-2.

(2) Hospitals as defined in G.S. 131E-76.

(3) Home Care Agencies as defined in G.S. 131E-136.

(4) Nursing Pools as defined by G.S. 131E-154.2.

(5) Hospices as defined by G.S. 131E-201.

(6) Nursing Facilities as defined by G.S. 131E-255.

(7) State-Operated Facilities as ~~set forth in G.S. 122C-22.~~ defined in G.S. 122C-3(14)f.

(8) Residential Facilities ~~and Hospitals for the Mentally Ill, Developmentally Disabled, or Substance Abusers licensed pursuant to G.S. 122C-23.~~ as defined in G.S. 122C-3(14)e.

(9) 24-Hour Facilities as defined in G.S. 122C-3(14)g.

(c) For the purpose of this section, the following are considered to be 'health care personnel':

(1) In an adult care home, an adult care personal aide who is any person who either performs or directly supervises others who perform task functions in activities of daily living which are personal functions essential for the health and well-being of residents such as bathing, dressing, personal hygiene, ambulation or locomotion, transferring, toileting, and eating.

(2) A nurse aide.

(3) An in-home aide or an in-home personal care aide who provides hands-on paraprofessional services.

(4) Unlicensed assistant personnel who provide hands-on care, including, but not limited to, habilitative aides and health care technicians.

(d) Except as otherwise provided in this subsection, health ~~Health~~ care personnel who wish to contest findings under subdivision (a)(1) of this section are entitled to an

administrative hearing as provided by the Administrative Procedure Act, Chapter 150B of the General Statutes. A petition for a contested case shall be filed within 30 days of the mailing of the written notice of the Department's intent to place its findings about the person in the health care personnel registry. Health care personnel who are career State employees as defined by G.S. 126-1.1 who wish to contest findings under subdivision (a)(1) of this section must do so by following the grievance procedures established by Article 8 of Chapter 126 of the General Statutes as administered by the State Personnel Commission.

(d1) Health care personnel who wish to contest the placement of information under subdivision (a)(2) of this section are entitled to an administrative hearing as provided by the Administrative Procedure Act, Chapter 150B of the General Statutes. A petition for a contested case hearing shall be filed within 30 days of the mailing of the written notice of the Department's intent to place information about the person in the health care personnel registry under subdivision (a)(2) of this section. Health care personnel who have filed a petition contesting the placement of information in the health care personnel registry under subdivision (a)(2) of this section are deemed to have challenged any findings made by the Department at the conclusion of its investigation.

(d2) Before hiring health care personnel into a health care facility or service, every employer at a health care facility shall access the Health Care Personnel Registry and shall note each incident of access in the appropriate business files.

(e) The Department shall provide an employer or potential employer of any person listed on the health care personnel registry of the nature of the finding or allegation and the status of the investigation.

(f) No person shall be liable for providing any information for the health care personnel registry if the information is provided in good faith. Neither an employer, potential employer, nor the Department shall be liable for using any information from the health care personnel registry if the information is used in good faith for the purpose of screening prospective applicants for employment or reviewing the employment status of an employee.

(g) Upon investigation and documentation, health care facilities shall ensure that the Department is notified of all allegations against health care personnel which appear to a reasonable person to be related to any act listed in subdivision (a)(1) of this section, and shall promptly report to the Department any resulting disciplinary action, demotion, or termination of employment of health care personnel.

(h) The North Carolina Medical Care Commission shall adopt, amend, and repeal all rules necessary for the implementation of this section."

Section 2. This act becomes effective July 1, 1999.

HOUSE BILL 1258:
Health Care Personnel Registry Changes

BILL ANALYSIS

Committee: House Health Care
Date: April 23, 1999
Version: First Edition

Introduced by: Rep. Earle
Summary by: Linda Attarian
Committee Counsel

SUMMARY: ***Under current law, the Department of Health and Human Services is required to maintain a "Health Care Personnel Registry". The purpose of the Registry is maintain a listing of "health care personnel" (nurse aides, in-home aides, in-home personal care aides, and adult care home personal care aides) working in "health care facilities" (defined to include adult care homes, hospitals, hospices and other residential facilities), who are being investigated for or have been found to have abused, neglected patients or residents they cared for, diverted drugs or misappropriated property that didn't belong to them.***

Upon request, the Department is required by law to provide employers or future employers at health care facilities with access to the information contained in the Registry. The bill would change current law by requiring employers to access the information contained in the Registry prior to hiring the applicant. The bill also makes a few clarifying changes as to the types of health care facilities included in the Registry, and specifies that health care personnel who are career state employees must contest any findings contained in the Registry through the State Employee Personal Act rather than the Administrative Procedures Act.

BILL ANALYSIS: **Section 1.** This section amends G.S. 131E-256, the statute that established the health care personnel registry and provides for its implementation, in three areas:

1. Amends G.S. 131E-256(b) to clarify previous amendments to the subsection made in Section 12.16E, Chap. 212, 1998 Session Laws. The Session Law amendments added residential hospitals, 24-hour facilities and other facilities that are operated by the Department that provide services to the mentally ill, substance abusers, and the developmentally disabled to the list of "health care facilities" subject to the requirements of the statute. This bill amends the citations to clarify which facilities were intended to be added to the list.
2. Amends G.S. 131E-256(d), a provision added to the statute in Section 12.16E, Chap. 212, 1998 Session Laws providing appeal rights to employees wishing to contest the findings about the employee in the health care personnel registry. The bill amends this section to provide that career state employees wishing to contest the findings must do so through the grievance procedures set forth in the State Personnel Act. For the purposes of this subsection, a career state employee is a State employee who is in a permanent position and has been continuously employed by the State in a position subject to the State Personnel Act for the immediate 24 preceding months. (G.S. 126-1.1).
3. Adds a new subsection to G.S. 131E-256 to REQUIRE every employer at a health care facility to access the health care personnel registry BEFORE hiring health care personnel into a health care facility or service. Further requires such employers to document each incident of access to the registry in its business files.

Section 2. This act becomes effective July 1, 1999.

CURRENT LAW: North Carolina law requires health care facilities (defined in the statute) to investigate and document all allegations of resident abuse or neglect, misappropriation of resident or facility property, diversion of drugs belonging to a resident or facility, and fraud against a resident or facility, within five working days of the date the facility becomes aware of the alleged incident. The facility must take whatever steps are necessary to prevent further acts of abuse, neglect, misappropriation of property, drug diversion, or fraud while the investigation is in progress. [NCAC 10-3B.1002].

Upon completion of the investigation, the health care facility is further required to ensure that all allegations which appear reasonably related to any act of resident abuse or neglect, misappropriation of resident or facility property, diversion of drugs belonging to a resident or facility, and fraud against a resident or facility are reported immediately to the Division of Facility Services. The report must include all information relevant to the investigation. [G.S. 131E-246(g)].

The Department of Health and Human Resources (Department) further investigates the substantiated allegations and makes its own independent "findings". As a result of theses efforts, the Department maintains a health care personnel registry containing the names of all health care personnel (as defined in the statute) working in health care facilities in North Carolina who have been the subject of such findings relating to any of the above acts.

A **"finding"** is "a determination by the Department that an allegation of one or more of the above acts has been substantiated". [NCAC 10-3B-1001(4)].

Health care personnel who have been accused of any of the acts listed above will also be placed on the Registry, but only after the Department has screened the allegation and determined that an investigation is required. [G.S. 131E-246(a)(2)].

The Registry also contains all findings by the Department that are contained in the nurse aide registry under G.S. 131E-255.

Health care facilities are defined under current law to include the following:

- Adult Care Homes
- Hospitals
- Home Care Agencies (means a private or public organization, which provides home care services). [G.S. 131-136(2)].
- Nursing Pools (means any firm, corporation, etc., in the business of providing or procuring temporary employment in health care facilities for nursing personnel, including nurses, nursing assistants, nurse aides, orderlies). [G.S. 131E-154.2(4)].
- Hospices
- Nursing Facilities
- State-Operated Facilities
- Residential Facilities and Hospitals for the Mentally Ill, Developmentally Disabled, or Substance Abusers

Health care personnel are defined under current law as: "*An in-home aide or an in-home personal care aide who provides hands-on paraprofessional services*" [See G.S. 131E-256(c)(3)]

- "Hands on care" means any home care service that involves touching the patient in order to implement the patient's plan of care. [See NCAC 3L .0901(11)]
- "In-home aide" means an individual who provides hands-on care to home care clients. [See NCAC 3L .0901(15)]
- "In-home aide services" are hands-on paraprofessional services which assist individuals, their family or both with essential home management tasks, personal care tasks, or supervision of the client's activities, or all of the above, to enable the individual, their family or both, to remain and function effectively at home as long as possible. [See NCAC 3L .0901(17)]
- "Paraprofessional" means an in-home care provider who does not hold a professional license of professional certification and through the nature of their duties assists a professional. [See NCAC 3L .0901(27)]
- "Personal care" includes tasks that range from assistance to an individual with basic personal hygiene, grooming, feeding and ambulation to medical monitoring and other health care related tasks. [See NCAC 3L .0901(29)]

In Home Health Care Personnel not covered under G.S. 131E-256 include:

- In-home maintenance staff that perform duties which do not require "hands-on care";
- Private duty "sitters" or "aides";
- "An individual who engages solely in providing his own services to other individuals"; [See G.S. 131E-136(3)];
- "An individual who engages solely in providing his own services on a temporary basis to health care facilities." [G.S. 131E-14.2(4)]; and
- "Nursing registries if the registry discloses to a client or the client's responsible party, before providing any services, that (I) it is not a licensed home care agency, and (ii) it does not make any representations or guarantees concerning the training, supervision, or competence of the personnel provided." [See G.S. 131E-136(3)]

Use of the registry: The Department must provide an employer or potential employer of any person listed on the health care personnel registry with the nature of the finding or allegation and the status of the investigation, but there is no current requirement that such employers must access the registry prior to hiring the person. [G.S. 131E-246(e)]

Immunity from liability: No person will be liable for providing any information for the health care personnel registry if the information is provided in good faith. [G.S. 131E-246(f)].

Duty to report allegations of "bad acts": health care facilities must notify the Department of all allegations that have been investigated and documented against health care personnel which reasonably relate to any act subject to the registry and any resulting disciplinary action, demotion, or termination. [G.S. 131E-246(g)].

Explanation of how someone can contest the "findings": Health care personnel who wish to contest a finding made by the Department or the placement of information contained in the registry are entitled to an administrative hearing as provided by the Administrative Procedure Act. (APA). [See G.S. 131E-246]. Article 3 of the APA provides that anyone who is aggrieved by an agency action may file a petition for a contested case with the Office of Administrative Hearings (OAH) within 60 days of being notified of the agency action.

Under the Health Care Personnel Registry statute, the petition must be filed within 30 days. Once filed, OAH will assign an Administrative Law Judge (ALJ) to determine if the agency exceeded its authority; acted erroneously; failed to use proper procedure; acted arbitrarily; or failed to act as required by rule or law. The ALJ will make a recommended decision that is not binding on the agency and the agency will make the final decision. Any grievance of a final agency decision goes to superior court. Therefore, if someone wants to contest information in the registry, they can commence a contested case at OAH. An ALJ will hear evidence from both sides and make a recommended decision to the Department. The Department will then decide whether or not to accept the recommendation of the ALJ.

BACKGROUND INFORMATION:

Bonnie Cramer, Division of Facility Services, NC Department of Health and Human Services provided the following background information concerning the Health Care Personnel Registry:

Data Concerning Access to the Registry by Employers:

153,000 calls requesting information on over 197,000 applicants/employees between March of 1998 to March of 1999.

Overview of Current Listings in the Registry:

Currently, the Registry contains 896 substantiated findings involving 669 persons; 271 pending investigations involving 221 persons.

Total Findings (Substantiated Claims) by Category:

Category 01 (Resident Abuse)	696
Category 02 (Resident Neglect)	40
Category 03 (Diversion of Resident Drugs)	6
Category 04 (Diversion of Facility Drugs)	0
Category 05 (Fraud Against Resident)	26
Category 06 (Fraud Against Facility)	50
Category 07 (Misappropriation of Facility Property)	4
Category 08 (Misappropriation of Resident Property)	74

Total Allegations (Pending Claims) by Category:

Category 01 (Resident Abuse)	114
Category 02 (Resident Neglect)	45
Category 03 (Diversion of Resident Drugs)	9

Category 04 (Diversion of Facility Drugs)	0
Category 05 (Fraud Against Resident)	17
Category 06 (Fraud Against Facility)	45
Category 07 (Misappropriation of Facility Property)	2
Category 08 (Misappropriation of Resident Property)	39

Personal Data Contained in the Registry of Health Care Personnel:

Nurse Aide Listing Number
Social Security Number
Date of Birth
Deceased Date

Name
Address
Home Phone
Work Phone

Date Tested
Training Program Attended
Evaluation Program Attended
Expiration Date of Nurse Aide Listing

Last Known Place Worked
Last Known Date Worked

Type of Allegation
Facility Type
Status
Date Entered on Registry

Hearing Date
Hearing Resule
Allegation
Evidence Summary
Rebuttal Statement

NORTH CAROLINA GENERAL ASSEMBLY
AMENDMENT
House Bill 736

AMENDMENT NO._____
(to be filled in by
Principal Clerk)

H736-ARM-001

Date_____,1999

Comm. Sub. [YES]
Amends Title []

moves to amend the bill on page 2, lines 25-30,
by rewriting those lines to read:

"(1) The health plan does not require lospital privileges of providers unless such privileges are necessary for the provider's provision of the full scope of services to the insured.

(2) The plan does not discriminate with respect to participation or indemnification is to any provider acting within"; and

on page 4, line 1, by rewriting that line to read:
"solely related to quality of care, fraud, patient satisfaction, and scope of practice for initial and"; and

on page 6, line 26, by rewriting that line to read:
"health benefit plan provider network, except that the insurer may charge the insured a fifteen percent (15%) administrative fee per service. ~~the out of network benefit levels offered under~~"; and

NORTH CAROLINA GENERAL ASSEMBLY
AMENDMENT
House Bill 736

AMENDMENT NO._____
(to be filled in by
Principal Clerk)

H736-ARM-001 Page 2 of __

on page 6, lines 29-30, by rewriting those lines to read:
"~~without unreasonable delay.~~".

SIGNED _____
Amendment Sponsor

SIGNED _____
Committee Chair if Senate Committee Amendment

ADOPTED _____ FAILED _____ TABLED _____

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 1999

H D

HOUSE BILL 736
Committee Substitute Reported Without Prejudice 4/20/99
Proposed Committee Substitute H736-PCS3382-RN

Short Title: Managed Care/Patient Access. (Public)

Sponsors:

Referred to:

March 30, 1999

A BILL TO BE ENTITLED

AN ACT TO ENSURE PATIENT ACCESS TO QUALITY MANAGED HEALTH CARE.

The General Assembly of North Carolina enacts:

Section 1. Article 3 of Chapter 58 of the General Statutes is amended by adding the following new sections to read:

"**§ 58-3-220. Patient access to quality managed health care.**

(a) Definitions. -- As used in this section and in G.S. 58-3-225, 58-3-230, and 58-3-235:

(1) 'Health benefit plan' or '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, to the extent permitted by the Employee Retirement Income Security Act of 1974, as amended, or by any waiver of or other exception to that Act provided under federal law or regulation. 'Health benefit plan' does not mean any plan implemented or administered by the North Carolina or United States Department of Health and Human Services, or any successor agency, or its representatives, or a managed care plan provided under the Teachers' and State Employees' Comprehensive Major

Medical Plan. 'Health benefit plan' also does not mean any of the following kinds of insurance:

a. Accident.
b. Credit.
c. Disability income.
d. Long-term care or nursing home care.
e. Medicare supplement.
f. Coverage issued as a supplement to liability insurance.
g. Workers' compensation.
h. Medical payments under automobile or homeowners' insurance.
i. Hospital income or indemnity.
j. Insurance under which benefits are payable with or without regard to fault and that is statutorily required to be contained in any liability policy or equivalent self-insurance.

(2) 'Insurer' means an entity that writes a health benefit plan and that is an insurance company subject to this Chapter, a service corporation organized under Article 65 of this Chapter, a health maintenance organization organized under Article 67 of this Chapter, and a multiple employer welfare arrangement subject to Article 49 of this Chapter.

(b) Scope. -- The requirements of this section are in addition to others applicable under this Chapter. If any of the provisions of this section are in conflict with other provisions of this Chapter, this section controls to the extent of the conflict.

(c) Access to Quality Health Care Providers. -- Each plan shall provide reasonable access to health services offered by the insurer. As long as a qualified provider is available and agrees to the terms of the contract, the health benefit plan shall be designed and administered to ensure that it has the number and classes of providers adequate to treat appropriately the number of the plan's insureds in the geographic area or areas covered by the plan and that the plan's insureds have an appropriate choice of primary care providers and other providers. The insurer shall not shift the burden of ensuring access to quality health care as prescribed in this subsection to individual providers.

The Commissioner shall determine what constitutes reasonable access to health services offered by an insurer within a network of providers. When determining what shall constitute reasonable access to health services, the Commissioner shall consider the following factors:

(1) The standard of individual care and access to health care in the community;
(2) The type of condition and severity of health condition of the insured;
(3) The insured's costs and expenses associated with obtaining services in the network as compared to the costs to the insured if the same services could be obtained from any provider;

(4) Waiting times for appointments and number of hours providers are available;

(5) Complaints against the insurers for failure to provide reasonable access to health care.

If the Commissioner determines that a network is not sufficient to provide reasonable access to quality health care, whether in required specifics or in overall effect, the Commissioner shall notify the insurer and, if the Commissioner determines that the insufficiency is part of a pattern of denial of reasonable access, may impose civil penalties pursuant to G.S. 58-2-70.

(d) Access Ensured by Plan Fairness and Due Process. -- Every health benefit plan shall ensure that:

(1) The health plan does not require hospital privileges of providers unless such privileges are necessary for the provider's provision of the full scope of services to the insured.

(2) The plan does not discriminate with respect to participation or indemnification as to any provider acting within the scope of the provider's license or certification solely on the basis of the providers' licenses or classifications.

(3) Not less than 30 days before terminating a provider for cause, the plan shall provide to the provider written notice of the proposed termination, together with specific reasons for the termination.

(4) The terms and conditions of the plan affecting insureds and providers are not modified without 60 days' notification to the insureds and the providers, and there is adequate opportunity for providers to amend these modified terms and conditions, appeal the modified terms and conditions, or terminate the provider's participation.

(5) In addition to meeting the specific requirements prescribed in subsection (c) of this section in developing its network of providers, the insurer shall establish relevant objective criteria solely related to quality of care, fraud, patient satisfaction, and scope of practice for initial and subsequent consideration of providers. These criteria shall be reasonably related to services provided.

Each insurer shall establish mechanisms for soliciting and acting upon applications for provider participation in the plan in a fair and systematic manner. These mechanisms shall, at a minimum, include:

a. Allowing all providers who desire to apply for participation in the plan an opportunity to apply. This does not require the insurer to accept the provider; and

b. Making criteria for provider participation in the plan available to all applicants.

(6) A utilization review or grievance procedure pursuant to G.S. 58-50-61 and G.S. 58-50-62 shall include on the review or grievance panel at least one provider with the same type of license as the provider who is a party to the review or grievance, or, if the provider is a medical doctor, at least one clinical peer of the provider who is a party to the review or grievance.

(e) Insurer Responsibility for Intermediaries. -- For purposes of this section, G.S. 58-3-100, 58-3-191, 58-3-200, 58-3-225, 58-3-230, 58-3-235, 58-67-88, 58-50-62, and 58-67-50, the duties placed on an insurer include a duty to ensure that any intermediary the insurer contracts with to provide health care under the insurer's health benefit plan complies with the requirements of this section to ensure patient access to quality managed health care. As used in this subsection, the term 'intermediary' means an entity that employs or contracts with health care providers for the provision of health care services, and that also contracts with an insurer covering the health care services under a health benefit plan.

"**§ 58-3-225. Provider directories.**

(a) As used in this section, 'updated directory information' means the current participation status of a provider, information known to the insurer indicating that a provider is not currently accepting new patients, and other information included in a printed provider directory.

(b) An insurer that uses a network of contracting health care providers for its health benefit plans shall provide a copy of its current provider directory, including any specialty directory, to all insureds on or before the effective date of initial coverage and shall make these directories available to current and prospective insureds upon request. Updated directory information reflecting the most current information available to the insurer shall be available to insureds by telephone and may also be made available by other media.

(c) Each directory shall include, in addition to the name, address, telephone number, and area of specialty for each health care provider and facility in its provider network, an indication of whether the provider:

(1) May be selected as a primary care provider.

(2) Is or is not currently accepting new patients.

(3) Has any other restrictions that would limit an insured's access to coverage from that provider.

(4) A brief explanation, including costs to the insured, of how an insured may access providers outside of the network.

(5) An explanation of the insured's right to transition coverage.

(6) The consumer complaint telephone number at the Department of Insurance.

The directory shall also include the date of its publication and instructions on how a current or prospective insured can obtain information about changes in the provider network or a provider's ability to accept new patients that may have occurred since the most recent printing of the directory.

(d) The directory shall include all of the types of licensed or certified health care providers with which the insurer contracts directly or with whom the insurer has access through a contract with an intermediary organization. If a contracting provider requests, the names of any allied health care providers who practice and deliver primary care services under the supervision of the contracting provider and whose services are covered by virtue of the carrier's contract with the supervising provider shall be listed as part of the directory listing for the contracting provider.

(e) An insurer may maintain separate directories for specialty services, such as mental health, substance abuse, or centers of excellence, but shall make each of its directories available to current and prospective insureds in accordance with this section.

"**§ 58-3-230. Health plan disclosure requirements.**

At the time of application for and delivery of a health benefit plan, the insurer shall deliver to the applicant and insured a clear and concise description of the coverage provided by the plan. The description shall be printed on a form prescribed by the Commissioner. The description shall include:

(1) Definitions of terms used in the health benefit plan.

(2) A brief description of the principal benefits or coverage provided, including any coverage exclusions or limitations.

(3) A brief description of how coverage determinations are made, including whether factors other than medical necessity and coverage exclusions and limitations are considered.

(4) A brief explanation of insurer and insured payment responsibilities, including how plan allowances, such as 'usual and customary charges,' are developed.

(5) A brief explanation of provider network limitations and requirements, including requirements for the use of subnetworks, when prior authorization or precertification is required, and how tertiary and quaternary care are arranged.

(6) Tax and health plan accreditation status of the insurer.

(7) A statement that the outline is a summary of the health benefit plan and that the health benefit plan should be examined to determine health benefit plan provisions.

(8) A brief explanation, including costs to the insured, of how an insured may access providers outside of the network.

(9) An explanation of the insured's right to transition coverage.

"**§ 58-3-235. Access to eye care providers.**

(a) A health benefit plan offered by an insurer that includes primary eye care benefits and any provider network established by or on behalf of an insurer to provide such benefits shall allow every insured direct access without prior referral to the services of eye care providers for all primary eye benefits provided by the plan and permit any licensed eye care provider who agrees to abide by the terms, conditions, and reimbursement rates, and standards of quality of the health benefit plan to serve as an eye care provider to any person covered by that plan.

(b) Nothing in this section shall be deemed to mandate that an insurer provide any eye care benefits beyond those specified in the health benefit plan.

(c) For purposes of this section:

(1) 'Eye care provider' means a licensed ophthalmologist or licensed optometrist who provides primary eye or vision care services.

(2) 'Primary eye care benefits' means those routine services and materials that are necessary to evaluate the function of the eyes, diagnose, treat, or manage ocular disease or injury, or to fit corrective lenses. This benefit does not include investigational or surgical correction of eye or vision problems."

Section 2. G.S. 58-3-200(d) reads as rewritten:

"(d) Services Outside Provider Networks. -- No insurer shall penalize an insured or subject an insured to additional deductibles, fees, or copayments for health care services covered under the health benefit plan that are obtained outside the insurer's health benefit plan provider network, except that the insurer may charge the insured a fifteen percent (15%) administrative fee per service. ~~the out of network benefit levels offered under the insured's approved health benefit plan unless contracting health care providers able to meet health needs of the insured are reasonably available to the insured without unreasonable delay.~~ The fee paid by an insurer to a provider outside the plan's network shall be at least as much as the fee paid to a provider within the plan's network for the same service minus the amount of the administrative fee."

Section 3. Article 67 of Chapter 58 of the General Statutes is amended by adding a new section to read:

"**§ 58-67-88. Access to transition care.**

(a) Each health benefit plan shall provide transition coverage for a minimum of 90 days or until the insured's reenrollment, whichever is later, to each insured of a participating health care provider who is no longer in the plan network. If an insured's health care provider leaves or is terminated from an insurer's provider network, the insurer shall reimburse for the insured's treatment by that provider for a minimum of 90 days or until the insured's reenrollment, whichever is later or, for an insured who is beyond the first trimester of a pregnancy, until the conclusion of postpartum care. Except in the case of a pregnancy that is beyond the first trimester, this section is complied with if there is a contractual obligation for the insurer and the provider to provide a minimum notice of cancellation or nonrenewal that will allow an insured to receive care for 90 days before the termination of the contract. The period of transition coverage is deemed to commence on the date that the insurer notifies the insured that the insured's provider will no longer participate in the network.

(b) Each insurer shall provide transition coverage to insureds who are newly covered under a new or existing group contract because of an involuntary change in health plans, during which time they may continue to receive reimbursement for care from a provider authorized to treat them under the previous insurer's plan and have access to prescription drugs covered under the formulary of the previous insurer's

plan. Persons eligible for transition coverage are those who are in the second or third trimester of pregnancy or undergoing treatment for a condition or disease that is chronic, degenerative and disabling, or life-threatening. In the case of a member who is beyond the first trimester of a pregnancy at the time of the involuntary plan change, the insurer shall provide for transition coverage until the conclusion of postpartum care. For all other persons eligible, the transition coverage shall be provided for a minimum period of 180 days. Eligibility and the commencement of the transition period shall be determined by the date on which the insured signed the application or enrollment form for the new insurer. Coverage during the transition period is the responsibility of the new insurer.

(c) Coverage of continued services during a transition coverage period may be made contingent upon the provider's agreement to:

(1) Continue to accept reimbursement for services under the same terms that were provided for in the provider's contract that has been or will be terminated.

(2) Comply with the insurer's requirements for quality assurance.

(3) Refer within the insurer's provider network.

(4) Comply with the insurer's established requirements for participating providers and other policies and procedures, such as data submission and obtaining precertification for certain services.

In the case of an insured's involuntary change of health plans, coverage of services from a provider who contracts with the insured's previous insurer shall be based on the new insurer's provider contracts for comparable services. Except as provided in subsection (b) of this section, nothing in this section requires an insurer to cover services that would not be covered if a member had not been in a transition coverage period. An insurer does not have to offer transition coverage if the insurer terminated the provider's contract for reasons relating to quality of care.

(d) Each insurer shall include a clear description of an insured's rights to transition coverage in its evidence of coverage and summary plan description."

Section 4. Nothing in this act requires the appropriation of State funds.

Section 5. This act is effective when it becomes law and applies to health benefit plans delivered, issued for delivery, renewed, extended, or modified on or after January 1, 2000. For purposes of this act, renewal of a health benefit plan is presumed to occur on each anniversary of the date on which coverage was first effective on the person or persons covered by the health benefit plan.

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 1999

H 2

HOUSE BILL 736
Committee Substitute Reported Without Prejudice 4/20/99

Short Title: Optometry Licensing Law Technical Changes. (Local)

Sponsors:

Referred to:

March 30, 1999

A BILL TO BE ENTITLED

AN ACT TO MAKE TECHNICAL CHANGES TO THE OPTOMETRY LICENSING LAWS.

The General Assembly of North Carolina enacts:

Section 1. G.S. 90-115.1(5) is repealed.

Section 2. G.S. 90-116 reads as rewritten:

"**§ 90-116. Board of Examiners in Optometry.**

In order to properly regulate the practice of optometry, there is established a North Carolina State Board of Examiners in Optometry, which shall consist of five regularly graduated optometrists who have been engaged in the practice of optometry in this State for at least five years and two members to represent the public at large.

No public member shall at any time be a health care provider, be related to or be the spouse of a health care provider, or have any pecuniary interest in the profitability of a health care provider. For purposes of this section, the term "health care provider" ~~shall have the same meaning as provided in G.S. 58-47-5(4).~~ means any (i) licensed health care professional and any agent or employee of any health care institution, health care insurer, health care professional school, or a member of any allied health profession or (ii) any person enrolled in a program in preparation for licensing as a health care provider or allied health professional. The Governor shall appoint the two public members not later than July 1, 1981.

The optometric members of the Board shall be appointed by the Governor from a list provided by the North Carolina State Optometric Society. For each vacancy, the society must submit at least three names to the Governor. The society shall establish

procedures for the nomination and election of optometrist members of the Board. These procedures shall be adopted under the rule-making procedures described in Article 2, Chapter 150B of the General Statutes, and notice of the proposed procedures shall be given to all licensed optometrists residing in North Carolina. Such procedures shall not conflict with the provisions of this section. Every optometrist with a current North Carolina license residing in the State shall be eligible to vote in all such elections, and the list of licensed optometrists shall constitute the registration list for elections. Any decision of the society relative to the conduct of such elections may be challenged by civil action in the Wake County Superior Court. A challenge must be filed not later than 30 days after the society has rendered the decision in controversy, and all such cases shall be heard de novo.

All Board members serving on June 30, 1981, shall be eligible to complete their respective terms. No member appointed to a term on or after July 1, 1981, shall serve more than two complete consecutive five-year terms, except that each member shall serve until his successor is chosen and qualifies.

The Governor may remove any member for good cause shown. Any vacancy in the optometrist membership of the Board shall be filled for the period of the unexpired term by the Governor from a list of at least three names submitted by the North Carolina State Optometric Society Executive Council. Any vacancy in the public membership of the Board shall be filled by the Governor for the unexpired term."

Section 3. G.S. 90-119 is repealed.

Section 4. G.S. 90-122 reads as rewritten:

"**§ 90-122. Compensation and expenses of Board.**

Each member of the North Carolina State Board of Examiners in Optometry shall receive as compensation for his services in the performance of his duties under this Article a sum not exceeding fifty dollars ($50.00) for each day actually engaged in the performance of the duties of his office, said per diem to be fixed by said Board, and all legitimate and necessary expenses incurred in attending meetings of the said Board.

~~The secretary-treasurer shall, as compensation for his services, both as secretary-treasurer of the Board and a member thereof, be allowed a reasonable annual salary to be fixed by the Board and shall, in addition thereto, receive all legitimate and necessary expenses incurred by him in attending meetings of the Board and in the discharge of the duties of his office.~~

All per diem allowances and all expenses paid as herein provided shall be paid upon voucher drawn by the ~~secretary-treasurer of the Board who shall likewise draw voucher payable to himself for the salary fixed for him by the Board.~~ Executive Director of the Board in accordance with Board policy.

The Board is authorized and empowered to expend from funds collected hereunder such additional sum or sums as it may determine necessary in the administration and enforcement of this Article, and employ such personnel as it may deem requisite to assist in carrying out the administrative functions required by this Article and by the Board."

Section 5. This act is effective when it becomes law.

PROPOSED COMMITTEE SUBSTITUTE FOR HOUSE BILL 736: Managed Care/Patient Access

BILL ANALYSIS

Committee:	House Health Committee	**Introduced by:**	Rep. Edd Nye
Date:	April 26, 1999	**Summary by:**	Linda Attarian
Version:	First Edition, PCS- Changes Title		Committee Counsel

SUMMARY: ***This Proposed Committee Substitute deletes the entire original bill and substitutes proposed legislation that would expand current North Carolina law regulating managed care organizations. The bill would provide additional consumer and provider protections including: sufficiency of provider networks, provider termination protections, provider discrimination protections, health plan reporting requirements, provider participation on utilization and grievance review panels, direct access to eye care providers, health benefit plan disclosure requirements, health plan transition coverage, and provider directories. The legislation will apply to all health benefit plans including traditional indemnity plans, managed care plans, HMOs and PPOs. Employer's self-insured health plans (including the State Employee's Health Plan) would be exempt from the proposed requirements.***

BILL ANALYSIS:

Section 1. Adds a new section to Article 3 of Chapter 58:

Applicability: Defines *"Health benefit plan" and "Insurer":* These terms are broadly defined to include traditional indemnity plans, managed care plans, HMOs and PPOs. Employer's self-insured health plans would be exempt from these requirements. Many employers, particularly larger employers, self-fund health benefit plans for their employees. These self-funded plans are exempt from State regulation because of a federal law, the Employee Retirement Income Security Act (ERISA), governing employee pension and benefit plans.

Provider networks: Requires insurers to design their networks to meet specific access and sufficiency requirements in terms of numbers and classes of contracted providers within a specified geographic area or areas covered by the health plan, *subject to the availability and willingness of providers to contract with the insurer.*

Commissioner's duty to determine "reasonable access to health services": Provides specific factors the Commissioner must use to determine whether an insurer's network provides reasonable access to health care for its insureds.

Provider protections:

- *Hospital privileges*: insurers would not be able to require providers to obtain hospital privileges in order to contract with the insurer if hospital privileges are not necessary for that provider to perform the covered services to the insured.
- *Discrimination:* insurers would not be able to discriminate between different classes of providers acting within their scope of practice.
- *Notice of termination:* insurers would be required to provide at least 30 days notice and the basis (in writing) for termination to providers.

- *Notice of contract modifications:* insurers would be required to provide at least 60 days notice of any proposed change in the terms and conditions of the health plan to insureds and providers.
- *Objective selection criteria:* insurers would be required to base provider selection criteria on relevant objective criteria solely related to quality of care and scope of practice.
- *Clinical peers:* insurers would be required to include a provider of the same type of license or a clinical peer if the provider is a medical doctor on utilization or grievance panels.

Insurer responsibility of intermediaries: Intermediaries are entities that contracts with the insurer to provide health care services by employing or sub-contracting with health care providers. This section would require insurers to make sure that the intermediaries it contracts with comply with the same laws and regulations regarding access to health care.

Provider directories: This section adds a new G.S. 58-3-225 to regulate the content and availability of an insurer's directory of contracting health care providers.

Health plan disclosure requirements: Adds a new G.S. 58-3-235 that provides for specific disclosure requirements by health benefit plans to applicants and insureds, including:

- Definitions of terms used in the health benefit plan,
- Principal benefits of coverage provided and any coverage exclusions or limitations,
- How coverage determinations are made,
- Insurer and insured payment responsibilities,
- Provider network limitations and requirements,
- Tax and health benefit plan accreditation status of the insurer,
- A description of the insured's rights to transition coverage,
- An explanation of how an insured can access out-of-network providers and any additional costs associated with doing so.
- A statement that these descriptions are summaries and that the health benefit plan itself should be examined to determine health benefit plan benefits.

Direct access to eye care specialists: With the exception of OB/GYN services, current North Carolina law does not provide individuals enrolled in health benefit plans with direct access to providers who are not traditionally considered primary care providers. This section adds a new G.S. 58-3-235 requiring health benefit plans that include primary eye care benefits allow every insured direct access *without prior referral* for primary eyes care ervices to any optometrists and ophthalmologists willing to accept the terms and conditions of the insurer.

Section 2. Amends G.S. 58-3-200(d) to provide for out-of network coverage:

Insured protections: Under current law, insurers are prohibited from penalizing a insured when they seek treatment from a provider outside the insurer's network of contracted physicians *when they can not reasonably obtain the same services from someone within the insurer's network.* This section would amend this provision to provide that insurers may not penalize insureds when they go out of the network for any reason. They would, however be subject to an administrative surcharge of 5.5% or $40.00 (whichever is less) for each service provided by an out-of –network provider.

Provider protections: This section also provides that insurers would not be able to pay the out-of-network provider less than what contracted providers receive for the same service.

Section 3. Transition Coverage: This section adds a new G.S. 58-67-88 to establish a mechanism for transition coverage for health benefit plans offered by HMOs only that are not point-of-service plans. (A point-of-service POS option is a type of plan offered by managed care organizations, including health maintenance organizations that allow people who are willing to pay higher out-of-pocket costs to see out-of-plan providers).

This section requires a minimum of 90 days or until reenrollment (whichever is longer) to each insured for services provided by a health care provider shown as a currently participating provider at the time of enrollment, who will no longer participate in the plan network. If a person becomes newly covered by an HMO because of an involuntary change in health benefit plans, the section requires the new plan to provide 180 days transition coverage.

Section 4. This act does not require an appropriation of State funds.

Section 5. This act is effective when it becomes law and applies to health plans delivered, issued for deliver, renewed, extended or modified on or after January 1, 2000.

VISITOR REGISTRATION SHEET

HEALTH 4-27 , 1999

Name of Committee Date

VISITORS: PLEASE SIGN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Michael Darine	Merck
Amy To Burn	NCMS
Elizabeth P Kandy	Doctor For the Day
Lynette Riverland	Am Heart Assoc
Steve Keene	NCMS
Jerry Cooper	NCALA
Joyce Ramsaur	NCSOS
Edward Eells	Am. Heart assoc.
Tom Parr	UNC
J. Banks	self
G. Conerly	"
J Craig Lamp	PCMH
PA Smith	Self
Andy Cook	Self
Lee Bolton	Self
GILBERT F. SELLERS, OD	OPTOMETRIC HEALTH CARE PRACTIONERS
JOSEPH F. WIGGINS, OD	
J'Ann Rayner, OD	
Vandana Shah	N.C. Atty Gen. Office.
Michelle McPherson	
Debbie Kennedy	Nurse for the day
[illegible]	NCAHP
Joyce Peters	AHEC
Ken Wilson	NCAHTCP
Rush Hyman	DHHS
Starla McKinney	NCDOI
Barbara Morales Burke	NC DOI
[illegible] OD	optometric health care practs

VISITOR REGISTRATION SHEET

Health 4-27 , 1999

Name of Committee Date

VISITORS: PLEASE SIGN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
W C Adams O.D.	Optometric Health Care Practioner
Charles V. Sides II OD	Optometric Health Care Practioner
DAVID ANDERSON, O.D.	NCSOS
MICHAEL CLARK OD	NCSOS
John D Robinson OD	NC Bd of OPTOMETRY
[illegible]	NASW-NC
Bonnie Crane	DHHS-DFS
Alicia Irizarry	Poyner & Spruill
Gary Flannery	NCHCFA
[illegible]	UNC-CH
[illegible]	AHHC
[illegible]	
PAUL MAHONEY	NC ASSN OF HEALTH PLANS
[illegible]	DMHDDSAS
PERRI MORGAN	NFIB
[illegible] Searing	NCHAC
[illegible]	NC Equity
[illegible] Michaels	DPOD
Amy Fullbright	Hunton & Wms
[illegible]	NCSOS
[illegible]	DuPont

AGENDA

HOUSE COMMITTEE ON HEALTH
TUESDAY, MAY 4, 1999
12:00 NOON

OPENING REMARKS

REP. THOMAS E. WRIGHT
CHAIRMAN

BILLS TO BE DISCUSSED

- **HB-1340-RESPIRATORY CARE PRACTICE ACT**
  REP. TOLSON

- **SB-160-NURSE REHABILITATION**
  SENATOR PERDUE

SB-194-NURSE LICENSURE COMPACT
SENATOR RAND

- **SB-951-HEALTH CARE WORKERS/ ID BADGES**
  SENATOR PERDUE

COMMENTS

ADJOURNMENT

MINUTES

HOUSE COMMITTEE ON HEALTH

TUESDAY, MAY 4, 1999

12:00 NOON ROOM 415 LOB

The House Committee on Health met on Tuesday, May 4, 1999 at 12:00 Noon in Room 415-LOB. A silent roll was taken, (roll list denotes members present.)

Chairman Wright called the meeting to order.

The Pages for the Health Committee were introduced to the members.

SB-194-NURSE LICENSURE COMPACT

Senator Rand explained the bill. John Young, Research Staff, further explained the bill. Rep. Justus asked the bill sponsor a question. John Young responded. Senator Rand commented. Rep. Justus followed up with a question to Chairman Wright. Rep. Edwards asked if there was a representative from the Board of Nursing Examiners present. Polly Johnson, Director of the Board of Nursing, commented on the bill. Rep. Insko asked Polly Johnson about the licensure procedures of other states. Polly Johnson responded. Rep. Bowie asked Polly Johnson about the nursing standards before a person enters into a compact. Polly Johnson responded. Senator Rand commented. Rep. Bowie followed up with a comment about the nursing standards to enter into a compact. Polly Johnson responded. Rep. Bowie followed up with a question to Polly Johnson about disciplinary action of the compact. Polly Johnson responded. Senator Rand commented about the disciplinary actions of the compact. Rep. Bowie commented. Chairman Wright asked a question to Polly Johnson. Polly Johnson responded. John Young asked a question to the bill sponsor about the current status of nurses that transfer to this state. Senator Rand responded, along with Polly Johnson. Rep. Justus asked the bill sponsor a question. Senator Rand responded. Polly Johnson commented. Rep. Insko asked the bill sponsor a question about the compact. John Young responded.

Rep. Edwards moved for a favorable report.

Rep. Alexander asked the bill sponsor a question. Senator Rand responded. Rep. Insko asked a question to the bill sponsor. Sen. Rand responded.

A vote was taken. The Ayes had the majority vote.

SB-194 Nurse Licensure Compact was given a favorable report.

Rep. Thomas E. Wright, Chairman

Vanda Wilson-Wormack, Committee Asst.

file

1999 COMMITTEE REPORT
HOUSE OF REPRESENTATIVES

The following report(s) from standing committee(s) is/are presented:
By Representative(s) **THOMAS E. WRIGHT** for the Committee on **HEALTH**.

☐ Committee Substitute for
S.B. 194 A BILL TO BE ENTITLED AN ACT TO CREATE THE NURSE LICENSURE COMPACT.

☐ With a favorable report.

☒ With a favorable report and recommendation that the bill be re-referred to the Committee on Appropriations ☐ Finance ☐ JUDICIARY II ☒.

☐ With a favorable report, as amended.

☐ With a favorable report, as amended, and recommendation that the bill be re-referred to the Committee on Appropriations ☐ Finance ☐ ☐.

☐ With a favorable report as to committee substitute bill (#), ☐ which changes the title, unfavorable as to (original bill) (Committee Substitute Bill #), (and recommendation that the committee substitute bill #) be re-referred to the Committee on .)

☐ With a favorable report as to House committee substitute bill (#), ☐ which changes the title, unfavorable as to Senate committee substitute bill.

☐ With an unfavorable report.

☐ With recommendation that the House concur.

☐ With recommendation that the House do not concur.

☐ With recommendation that the House do not concur; request conferees.

☐ With recommendation that the House concur; committee believes bill to be material.

☐ With an unfavorable report, with a Minority Report attached.

☐ Without prejudice.

☐ With an indefinite postponement report.

☐ With an indefinite postponement report, with a Minority Report attached.

☐ With recommendation that it be adopted. (HOUSE RESOLUTION ONLY)

5/25/99

AGENDA

HOUSE COMMITTEE ON HEALTH
TUESDAY, MAY 25, 1999
12:00 NOON-ROOM 415

OPENING REMARKS

REP. THOMAS E. WRIGHT
CHAIRMAN

BILLS TO BE DISCUSSED

√SB-432-HEALTH CARE PERSONNEL REGISTRY-(SEN. CARPENTER)

SB-951-HEALTH CARE WORKERS/ID BADGE-(SEN. PERDUE)

SB-998-CANCER ADVISORY BOARD/ MEMBER TERM-(SEN. ODOM)

COMMENTS

ADJOURNMENT

MINUTES

HOUSE COMMITTEE ON HEALTH

TUESDAY, MAY 25, 1999

12:00 NOON ROOM 415 LOB

The House Committee on Health met on Tuesday, May 25, 1999 at 12:00 Noon in Room 415l-LOB. A silent roll was taken. (roll list denotes members present.)

Chairman Wright called the meeting to order.

The Pages were introduced to the Health Committee Members.

SB-432- HEALTH CARE PERSONNEL REGISTRY

Sen. Carpenter explained the bill. Jessie Goodman, Chief of the Personnel Registry of Facility Services, expounded on the bill.

Rep. Bowie moved for a favorable report.

Rep. Womble asked a question about page 2, line 26, item 9. Linda Attarian, Research Attorney responded and deferred the question to Jessie Goodman. Jessie Goodman responded. Rep. Womble followed-up with a question to Jessie Goodman. Jessie Goodman responded. Rep. Womble asked Chairman Wright about the bill. Chairman Wright responded. Rep. Howard asked a question to the bill sponsor. The bill sponsor responded.

A vote was taken. The Ayes had the majority vote.

SB-Health Care Personnel Registry received a favorable report.

Rep. Womble asked Chairman Wright about the Health Gap in North Carolina. Chairman Wright responded.

Chairman Wright adjourned the meeting at 12:25pm.

Rep. Thomas E. Wright, Chairman

Vanda Wilson-Wormack, Committee Asst.

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1999 COMMITTEE REPORT
HOUSE OF REPRESENTATIVES

The following report(s) from standing committee(s) is/are presented:
By Representative(s) **THOMAS E. WRIGHT** for the Committee on **HEALTH**.

☐ Committee Substitute for
S.B. 432 A BILL TO BE ENTITLED AN ACT TO CLARIFY THE FACILITIES THAT ARE INCLUDED IN THE HEALTH CARE PERSONNEL REGISTRY; AND TO REQUIRE THAT EMPLOYERS AT HEALTH CARE FACILITIES ACCESS THE HEALTH CARE PERSONNEL REGISTRY.

☒ With a favorable report.

☐ With a favorable report and recommendation that the bill be re-referred to the Committee on Appropriations ☐ Finance ☐ ☐.

☐ With a favorable report, as amended.

☐ With a favorable report, as amended, and recommendation that the bill be re-referred to the Committee on Appropriations ☐ Finance ☐ ☐.

☐ With a favorable report as to committee substitute bill (#), ☐ which changes the title, unfavorable as to (original bill) (Committee Substitute Bill #), (and recommendation that the committee substitute bill #) be re-referred to the Committee on .)

☐ With a favorable report as to House committee substitute bill (#), ☐ which changes the title, unfavorable as to Senate committee substitute bill.

☐ With an unfavorable report.

☐ With recommendation that the House concur.

☐ With recommendation that the House do not concur.

☐ With recommendation that the House do not concur; request conferees.

☐ With recommendation that the House concur; committee believes bill to be material.

☐ With an unfavorable report, with a Minority Report attached.

☐ Without prejudice.

☐ With an indefinite postponement report.

☐ With an indefinite postponement report, with a Minority Report attached.

☐ With recommendation that it be adopted. (HOUSE RESOLUTION ONLY)

5/25/99

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 1999

S 2

SENATE BILL 432
Children & Human Resources Committee Substitute Adopted 4/26/99

Short Title: Health Care Personnel Registry Changes. (Public)

Sponsors:

Referred to:

March 22, 1999

A BILL TO BE ENTITLED

AN ACT TO CLARIFY THE FACILITIES THAT ARE INCLUDED IN THE HEALTH CARE PERSONNEL REGISTRY; AND TO REQUIRE THAT EMPLOYERS AT HEALTH CARE FACILITIES ACCESS THE HEALTH CARE PERSONNEL REGISTRY.

The General Assembly of North Carolina enacts:

Section 1. G.S. 131E-256 reads as rewritten:

"**§ 131E-256. Health Care Personnel Registry.**

(a) The Department shall establish and maintain a health care personnel registry containing the names of all health care personnel working in health care facilities in North Carolina who have:

(1) Been subject to findings by the Department of:

a. Neglect or abuse of a resident in a health care facility or a person to whom home care services as defined by G.S. 131E-136 or hospice services as defined by G.S. 131E-201 are being provided.

b. Misappropriation of the property of a resident in a health care facility, as defined in subsection (b) of this section including places where home care services as defined by G.S. 131E-136 or hospice services as defined by G.S. 131E-201 are being provided.

c. Misappropriation of the property of a health care facility.

d. Diversion of drugs belonging to a health care facility or to a patient or client.

e. Fraud against a health care facility or against a patient or client for whom the employee is providing services.

(2) Been accused of any of the acts listed in subdivision (1) of this subsection, but only after the Department has screened the allegation and determined that an investigation is required.

The ~~health care personnel registry~~ Health Care Personnel Registry shall also contain all findings by the Department of neglect of a resident in a nursing facility or abuse of a resident in a nursing facility or misappropriation of the property of a resident in a nursing facility by a nurse aide that are contained in the nurse aide registry under G.S. 131E-255.

(b) For the purpose of this section, the following are considered to be 'health care facilities':

(1) Adult Care Homes as defined in G.S. 131D-2.

(2) Hospitals as defined in G.S. 131E-76.

(3) Home Care Agencies as defined in G.S. 131E-136.

(4) Nursing Pools as defined by G.S. 131E-154.2.

(5) Hospices as defined by G.S. 131E-201.

(6) Nursing Facilities as defined by G.S. 131E-255.

(7) State-Operated Facilities as ~~set forth in G.S. 122C-22.~~ defined in G.S. 122C-3(14)f.

(8) Residential Facilities ~~and Hospitals for the Mentally Ill, Developmentally Disabled, or Substance Abusers licensed pursuant to G.S. 122C-23.~~ as defined in G.S. 122C-3(14)e.

(9) 24-Hour Facilities as defined in G.S. 122C-3(14)g.

(c) For the purpose of this section, the following are considered to be 'health care personnel':

(1) In an adult care home, an adult care personal aide who is any person who either performs or directly supervises others who perform task functions in activities of daily living which are personal functions essential for the health and well-being of residents such as bathing, dressing, personal hygiene, ambulation or locomotion, transferring, toileting, and eating.

(2) A nurse aide.

(3) An in-home aide or an in-home personal care aide who provides hands-on paraprofessional services.

(4) Unlicensed assistant personnel who provide hands-on care, including, but not limited to, habilitative aides and health care technicians.

(d) Health care personnel who wish to contest findings under subdivision (a)(1) of this section are entitled to an administrative hearing as provided by the Administrative Procedure Act, Chapter 150B of the General Statutes. A petition for a contested case shall be filed within 30 days of the mailing of the written notice of the

Department's intent to place its findings about the person in the ~~health care personnel registry.~~ Health Care Personnel Registry.

(d1) Health care personnel who wish to contest the placement of information under subdivision (a)(2) of this section are entitled to an administrative hearing as provided by the Administrative Procedure Act, Chapter 150B of the General Statutes. A petition for a contested case hearing shall be filed within 30 days of the mailing of the written notice of the Department's intent to place information about the person in the ~~health care personnel registry~~ Health Care Personnel Registry under subdivision (a)(2) of this section. Health care personnel who have filed a petition contesting the placement of information in the health care personnel registry under subdivision (a)(2) of this section are deemed to have challenged any findings made by the Department at the conclusion of its investigation.

(d2) Before hiring health care personnel into a health care facility or service, every employer at a health care facility shall access the Health Care Personnel Registry and shall note each incident of access in the appropriate business files.

(e) The Department shall provide an employer or potential employer of any person listed on the ~~health care personnel registry of~~ Health Care Personnel Registry of the nature of the finding or allegation and the status of the investigation.

(f) No person shall be liable for providing any information for the health care personnel registry if the information is provided in good faith. Neither an employer, potential employer, nor the Department shall be liable for using any information from the health care personnel registry if the information is used in good faith for the purpose of screening prospective applicants for employment or reviewing the employment status of an employee.

(g) Upon investigation and documentation, health care facilities shall ensure that the Department is notified of all substantiated allegations against health care personnel which appear to a reasonable person to be related to any act listed in subdivision (a)(1) of this section, and shall promptly report to the Department any resulting disciplinary action, demotion, or termination of employment of health care personnel.

(h) The North Carolina Medical Care Commission shall adopt, amend, and repeal all rules necessary for the implementation of this section."

Section 2. This act becomes effective July 1, 1999.

Cancelled

AGENDA

HOUSE COMMITTEE ON HEALTH
TUESDAY, JUNE 8, 1999
12:00 NOON-ROOM 415

OPENING REMARKS

REP. THOMAS E. WRIGHT
CHAIRMAN

BILLS TO BE DISCUSSED

SB-793-PSYCHOLOGY PRACTICE DEFINITIONS--(SEN. CLODFELTER)

SB-951-HEALTH CARE WORKERS/ID BADGES—(SEN. PERDUE)

SB-960-REGULATION OF PHARMACIES—(SEN. R. SOLES)

SB-998-CANCER ADVISORY BOARD/MEMBER TERM—(SEN. ODOM)

COMMENTS

ADJOURNMENT

MINUTES

HOUSE COMMITTEE ON HEALTH

TUESDAY, JUNE 8, 1999

12:00 NOON ROOM 415

The House Committee on Health was cancelled on Tuesday, June 8, 1999 at 12:00 Noon in Room 415-LOB.

AGENDA

HOUSE COMMITTEE ON HEALTH
TUESDAY, JUNE 15, 1999
12:00 NOON, ROOM 415

OPENING REMARKS

REP. THOMAS E. WRIGHT
CHAIRMAN

BILLS TO BE DISCUSSED

SB-793-PSYCHOLOGY PRACTICE DEFINITIONS-(SEN. CLODFELTER)

SB-951-HEALTH CARE WORKERS/ID BADGES-(SEN. PERDUE)

SB-960-REGULATION OF PHARMACIES-(SEN. SOLES)

SB-998-CANCER ADVISORY BOARD/MEMBER TERM-(SEN. ODOM)

COMMENTS

ADJOURNMENT

MINUTES

HOUSE COMMITTEE ON HEALTH

TUESDAY, JUNE 15, 1999

12:00 NOON ROOM 415

The House Committee on Health was cancelled on Tuesday, June 15, 1999 at 12:00 Noon in Room 415-LOB.

AGENDA

HOUSE COMMITTEE ON HEALTH
TUESDAY, JUNE 22, 1999
ROOM 415 LOB
12:00 NOON

OPENING REMARKS

REP. THOMAS E. WRIGHT
CHAIRMAN

BILLS TO BE DISCUSSED

SB-960-REGULATION OF PHARMACIES (SEN. SOLES)

✓SB-998-CANCER ADVISORY BOARD (SEN. ODOM)

HB-1064- ABORTION RIGHT TO KNOW (REP. DECKER)

✓HB-1340-RESPIRATORY CARE PRACTICE ACT (REP. TOLSON)

COMMENTS

ADJOURNMENT

MINUTES

HOUSE COMMITTEE ON HEALTH

TUESDAY, JUNE 22, 1999

12:00 NOON ROOM 415 LOB

The House Committee on Health met on Tuesday, June 22, 1999 at 12:00 Noon in Room 415- LOB. A silent roll was taken, (roll list denotes members present.)

Chairman Wright called the meeting to order.

Chairman Wright introduced the Pages for the Health Committee.

SB-998 CANCER ADVISORY BOARD

Sen. Odom explained the bill.

Rep. Justus moved for a favorable report.

A vote was taken. The Ayes had the majority vote.

SB-998 Cancer Advisory Board was given a favorable report.

HB-1340 RESPIRATORY CARE PRACTICE ACT

Rep. Insko moved for adoption of the proposed amendment. So moved.

Rep. Tolson explained the bill. Rick Lennard, a clinical instructor with several of the North Carolina Community Colleges, commented on the bill. Rep. Tolson commented on the bill.

Rep. Wilson moved for a favorable report, and to have the amendments to the bill rolled up into a proposed committee substitute bill, unfavorable to the original bill.

Rep. Bowie asked the bill sponsor a question about third party reimbursements. Rep. Tolson responded. Rep. Insko asked a question to the Rick Lennard about licensure. Rick Lennard responded. Rep. Insko followed up with a question about temporary and provisional licensing. Rick Lennard responded. Rep. Alexander asked the bill sponsor a question. Rep. Tolson responded. Rep. Justus asked the Chairman Wright if this bill would go to finance. Chairman Wright responded.

A vote was taken. The Ayes had the majority vote.

HB-1340 Respiratory Care Practice Act, the Proposed Committee Substitute, was given a favorable report and re-referred to the Committee on Finance.

HB-1064 ABORTION/ RIGHT TO KNOW

Rep. Decker explained the bill. Rep. Womble asked Chairman Wright about the explanation of the bill. Chairman Wright responded. Rep. Adams asked a question to the bill sponsor about the informational material. Rep. Decker responded. Rep. Adams followed up with a question to the bill sponsor. Rep. Decker responded. Rep. Bowie asked the bill sponsor a question about liability. Rep. Decker responded to the liability issue. Rep. Bowie followed up with a question. Rep. Decker responded. Rep. Insko asked the bill sponsor a question. Rep. Decker responded. Rep. Melton asked the bill sponsor a question. Rep. Decker responded. Rep. Adams asked the bill sponsor a question. The bill sponsor deferred the question to staff. Linda Attarian, Research Staff, responded. Rep. Womble asked a question to the bill sponsor about the opposing forces of the bill. Rep. Decker responded. Rep. Womble followed up with a question about the names of the organizations or groups that may be opposed to the bill. Rep. Decker responded. Rep. Womble followed up with a question to the bill sponsor about the materials given to the patients. Rep. Decker responded. Rep. Womble followed up with a question to the bill sponsor. Rep. Decker responded.

Chairman Wright adjourned the meeting at 12:59 P.M.

Rep. Thomas E. Wright, Chairman

Vanda Wilson-Wormack, Committee Asst.

1999 COMMITTEE REPORT
HOUSE OF REPRESENTATIVES

The following report(s) from standing committee(s) is/are presented:
By Representative(s) **THOMAS E. WRIGHT** for the Committee on **HEALTH**.

☐ Committee Substitute for
S.B. 998 A BILL TO BE ENTITLED AN ACT TO PROVIDE THAT MEMBERS APPOINTED TO THE CANCER CONTROL ADVISORY COMMITTEE FOR INITIAL TWO-YEAR TERMS MAY EACH BE REAPPOINTED FOR ONE ADDITIONAL FOUR-YEAR TERM.

☒ With a favorable report.

☐ With a favorable report and recommendation that the bill be re-referred to the Committee on Appropriations ☐ Finance ☐ ☐.

☐ With a favorable report, as amended.

☐ With a favorable report, as amended, and recommendation that the bill be re-referred to the Committee on Appropriations ☐ Finance ☐ ☐.

☐ With a favorable report as to committee substitute bill (#), ☐ which changes the title, unfavorable as to (original bill) (Committee Substitute Bill #), (and recommendation that the committee substitute bill #) be re-referred to the Committee on .)

☐ With a favorable report as to House committee substitute bill (#), ☐ which changes the title, unfavorable as to Senate committee substitute bill.

☐ With an unfavorable report.

☐ With recommendation that the House concur.

☐ With recommendation that the House do not concur.

☐ With recommendation that the House do not concur; request conferees.

☐ With recommendation that the House concur; committee believes bill to be material.

☐ With an unfavorable report, with a Minority Report attached.

☐ Without prejudice.

☐ With an indefinite postponement report.

☐ With an indefinite postponement report, with a Minority Report attached.

☐ With recommendation that it be adopted. (HOUSE RESOLUTION ONLY)

2/24/99

file

1999 COMMITTEE REPORT
HOUSE OF REPRESENTATIVES

The following report(s) from standing committee(s) is/are presented:
By Representative(s) **THOMAS E. WRIGHT** for the Committee on **HEALTH**.

☐ Committee Substitute for
H.B. 1340 A BILL TO BE ENTITLED AN ACT TO ESTABLISH THE RESPIRATORY CARE PRACTICE ACT.

☐ With a favorable report.

☐ With a favorable report and recommendation that the bill be re-referred to the Committee on Appropriations ☐ Finance ☐ ☐.

☐ With a favorable report, as amended.

☐ With a favorable report, as amended, and recommendation that the bill be re-referred to the Committee on Appropriations ☐ Finance ☐ ☐.

☒ With a favorable report as to the committee substitute bill, unfavorable as to the original bill and recommendation that the committee substitute bill be re-referred to the Committee on finance.

☐ With a favorable report as to House committee substitute bill (#), ☐ which changes the title, unfavorable as to Senate committee substitute bill.

☐ With an unfavorable report.

☐ With recommendation that the House concur.

☐ With recommendation that the House do not concur.

☐ With recommendation that the House do not concur; request conferees.

☐ With recommendation that the House concur; committee believes bill to be material.

☐ With an unfavorable report, with a Minority Report attached.

☐ Without prejudice.

☐ With an indefinite postponement report.

☐ With an indefinite postponement report, with a Minority Report attached.

☐ With recommendation that it be adopted. (HOUSE RESOLUTION ONLY)

06/23/99

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 1999

S 1

SENATE BILL 998

Short Title: Cancer Advisory Board/Member Terms. (Public)

Sponsors: Senator Odom.

Referred to: Children & Human Resources.

April 15, 1999

A BILL TO BE ENTITLED

AN ACT TO PROVIDE THAT MEMBERS APPOINTED TO THE CANCER CONTROL ADVISORY COMMITTEE FOR INITIAL TWO-YEAR TERMS MAY EACH BE REAPPOINTED FOR ONE ADDITIONAL FOUR-YEAR TERM.

The General Assembly of North Carolina enacts:

Section 1. Notwithstanding G.S. 130A-33.50(b), members of the Advisory Committee on Cancer Coordination and Control appointed in 1993 to serve initial two-year terms may be reappointed for one additional four-year term commencing upon the expiration of the current terms of those members.

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

NORTH CAROLINA GENERAL ASSEMBLY
AMENDMENT
House Bill 1340

AMENDMENT NO._____
(to be filled in by
Principal Clerk)

H1340-ARM-001

Page 1 of __

Date_____,1999

Comm. Sub. []
Amends Title []

Representative Tolson

moves to amend the bill on page 3, line 1-4, by rewriting those lines to read:

"f. Nontraditional cardiopulmonary support techniques in appropriately identified environments and under the training and practice guidelines established by the appropriate professional associations.; and

further amends the bill on page 3, line 22, by deleting the word "eight" and substituting the word "nine"; and

further amends the bill on page 3, lines 28-29, by rewriting those lines to read:

(3) One member shall represent the NCHA.".

SIGNED _____
Amendment Sponsor

SIGNED _____
Committee Chair if Senate Committee Amendment

ADOPTED _____ FAILED _____ TABLED _____

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 1999

H D

HOUSE BILL 1340
Proposed Committee Substitute H1340-PCS4272-RM

Short Title: Respiratory Care Practice Act. (Public)

Sponsors:

Referred to:

April 26, 1999

A BILL TO BE ENTITLED

AN ACT TO ESTABLISH THE RESPIRATORY CARE PRACTICE ACT.

The General Assembly of North Carolina enacts:

Section 1. Chapter 90 of the General Statutes is amended by adding a new Article to read:

"ARTICLE 37.

"Respiratory Care Practice Act.

"**§ 90-646. Short title.**

This Article may be cited as the 'Respiratory Care Practice Act'.

"**§ 90-647. Purpose.**

The General Assembly finds that the practice of respiratory care in the State of North Carolina affects the public health, safety, and welfare and that the mandatory licensure of persons who engage in respiratory care is necessary to ensure a minimum standard of competency. It is the purpose and intent of this Article to protect the public from the unqualified practice of respiratory care and from unprofessional conduct by persons licensed pursuant to this Article.

"**§ 90-648. Definitions.**

The following definitions apply in this Article:

(1) Board. -- The North Carolina Respiratory Care Board.

(2) Diagnostic testing. -- Cardiopulmonary procedures and tests performed on the written order of a physician licensed under Article 1 of this Chapter that provide information to the physician to formulate a diagnosis of the patient's condition. The tests and

procedures may include pulmonary function testing, electrocardiograph testing, cardiac stress testing, and sleep related testing.

(3) Direct supervision. -- The authority and responsibility to direct the performance of activities as established by policies and procedures for safe and appropriate completion of services.

(4) Individual. -- A human being.

(5) License. -- A certificate issued by the Board recognizing the person named therein as having met the requirements to practice respiratory care as defined in this Article.

(6) Licensee. -- A person who has been issued a license under this Article.

(7) Medical director. -- An appointed physician who is licensed under Article 1 of this Chapter and a member of the entity's medical staff, and who is granted the authority and responsibility for assuring and establishing policies and procedures and that the provision of such is provided to the quality, safety, and appropriateness standards as recognized within the defined scope of practice for the entity.

(8) Person. -- An individual, corporation, partnership, association, unit of government, or other legal entity.

(9) Physician. -- A doctor of medicine licensed by the State of North Carolina in accordance with Article 1 of this Chapter.

(10) Practice of respiratory care. -- As defined by the written order of a physician licensed under Article 1 of this Chapter, the observing and monitoring of signs and symptoms, general behavior, and general physical response to respiratory care treatment and diagnostic testing, including the determination of whether such signs, symptoms, reactions, behavior, or general response exhibit abnormal characteristics, and the performance of diagnostic testing and therapeutic application of:

a. Medical gases, humidity, and aerosols including the maintenance of associated apparatus, except for the purpose of anesthesia.

b. Pharmacologic agents related to respiratory care procedures, including those agents necessary to perform hemodynamic monitoring.

c. Mechanical or physiological ventilatory support.

d. Cardiopulmonary resuscitation and maintenance of natural airways, the insertion and maintenance of artificial airways under the direct supervision of a recognized medical director in a health care environment which identifies these services within the scope of practice by the facility's governing board.

e. Hyperbaric oxygen therapy.
f. Nontraditional cardiopulmonary support techniques in appropriately identified environments and under the training and practice guidelines established by the appropriate professional associations.

The term also means the interpretation and implementation of a physician's written or verbal order pertaining to the acts described in this subdivision.

(11) Respiratory care. -- As defined by the written order of a physician licensed under Article 1 of Chapter 90, the treatment, management, diagnostic testing, and care of patients with deficiencies and abnormalities associated with the cardiopulmonary system.

(12) Respiratory care practitioner. -- A person who has been licensed by the Board to engage in the practice of respiratory care.

(13) Support activities. -- Procedures that do not require formal academic training, including the delivery, setup, and maintenance of apparatus. The term also includes giving instructions on the use, fitting, and application of apparatus, but does not include therapeutic evaluation and assessment.

"**§ 90-649. North Carolina Respiratory Care Board; creation.**

(a) The North Carolina Respiratory Care Board is created. The Board shall consist of nine members as follows:

(1) Two members shall be respiratory care practitioners.
(2) Three members shall be physicians licensed to practice in North Carolina, and whose primary practice is Pulmonology, Anesthesiology, Critical Care Medicine, or whose specialty is Cardiothoracic Disorders.
(3) One member shall represent the NCHA.
(4) One member shall represent the North Carolina Association of Medical Equipment Services.
(5) Two members shall represent the public at large.

(b) Members of the Board shall be citizens of the United States and residents of this State. The respiratory care practitioner members shall have practiced respiratory care for at least five years and shall be licensed under this Article. The public members shall not be: (i) a respiratory care practitioner, (ii) an agent or employee of a person engaged in the profession of respiratory care, (iii) a health care professional licensed under this Chapter or a person enrolled in a program to become a licensed health care professional, (iv) an agent or employee of a health care institution, a health care insurer, or a health care professional school, (v) a member of an allied health profession or a person enrolled in a program to become a member of an allied health profession, or (vi) a spouse of an individual who may not serve as a public member of the Board.

"**§ 90-650. Appointments and removal of Board members; terms and compensation.**

(a) The members of the Board shall be appointed as follows:

(1) The Governor shall appoint the public members described in G.S. 90-649(a)(5).

(2) The General Assembly, upon the recommendation of the Speaker of the House of Representatives, shall appoint one of the respiratory care practitioner members described in G.S. 90-649(a)(1) and one of the physician members described in G.S. 90-649(a)(2) in accordance with G.S. 120-121.

(3) The General Assembly, upon the recommendation of the President Pro Tempore of the Senate, shall appoint one of the respiratory care practitioner members described in G.S. 90-649(a)(1) and one of the physician members described in G.S. 90-649(a)(2) in accordance with G.S. 120-121.

(4) The North Carolina Medical Society shall appoint one of the physician members described in G.S. 90-649(a)(2).

(5) The North Carolina Hospital Association shall appoint the member described in G.S. 90-649(a)(3).

(6) The North Carolina Association of Medical Equipment Services shall appoint the member described in G.S. 90-649(a)(4).

(b) Members of the Board shall take office on the first day of July immediately following the expired term of that office and shall serve for a term of three years and until their successors are appointed and qualified. No member shall serve on the Board for more than two consecutive terms.

(c) The Governor may remove members of the Board, after notice and an opportunity for hearing, for incompetence, neglect of duty, unprofessional conduct, conviction of any felony, failure to meet the qualifications of this Article, or committing any act prohibited by this Article.

(d) Any vacancy shall be filled by the authority originally filling that position, except that any vacancy in appointments by the General Assembly shall be filled in accordance with G.S. 120-122. Appointees to fill vacancies shall serve the remainder of the unexpired term and until their successors have been duly appointed and qualified.

(e) Members of the Board shall receive no compensation for their services but shall be entitled to travel, per diem, and other expenses authorized by G.S. 93B-5.

(f) Individual members shall be immune from civil liability arising from activities performed within the scope of their official duties.

"**§ 90-651. Election of officers; meetings of the Board.**

(a) The Board shall elect a chair and a vice-chair who shall hold office according to rules adopted pursuant to this Article, except that all officers shall be elected annually by the Board for one-year terms and shall serve until their successors are elected and qualified.

(b) The Board shall hold at least two regular meetings each year as provided by rules adopted pursuant to this Article. The Board may hold additional meetings

upon the call of the chair or any two Board members. A majority of the Board membership shall constitute a quorum.

"**§ 90-652. Powers and duties of the Board.**

The Board shall have the power and duty to:

(1) Determine the qualifications and fitness of applicants for licensure, renewal of licensure, and reciprocal licensure.

(2) Establish and adopt rules necessary to conduct its business, carry out its duties, and administer this Article.

(3) Adopt and publish a code of ethics.

(4) Deny, issue, suspend, revoke, and renew licenses in accordance with this Article.

(5) Conduct investigations, subpoena individuals and records, and do all other things necessary and proper to discipline persons licensed under this Article and to enforce this Article.

(6) Employ professional, clerical, investigative, or special personnel necessary to carry out the provisions of this Article and purchase or rent office space, equipment, and supplies.

(7) Adopt a seal by which it shall authenticate its proceedings, official records, and licenses.

(8) Conduct administrative hearings in accordance with Article 3A of Chapter 150B of the General Statutes.

(9) Establish certain reasonable fees as authorized by this Article for applications for examination, licensure, provisional licensure, renewal of licensure, and other services provided by the Board.

(10) Submit an annual report to the North Carolina Medical Board, the North Carolina Hospital Association, the North Carolina Society of Respiratory Care, the Governor, and the General Assembly of all the Board's official actions during the preceding year, together with any recommendations and findings regarding improvements of the practice of respiratory care.

(11) Publish and make available upon request the licensure standards prescribed under this Article and all rules adopted pursuant to this Article.

(12) Request and receive the assistance of State educational institutions or other State agencies.

(13) Establish and approve continuing education requirements for persons seeking licensure under this Article.

"**§ 90-653. Licensure requirements; examination.**

(a) Each applicant for licensure under this Article shall meet the following requirements:

(1) Submit a completed application as required by the Board.

(2) Submit any fees required by the Board.

(3) Submit to the Board written evidence, verified by oath, that the applicant has successfully completed the minimal requirements of a

respiratory care education program as approved by the Commission for Accreditation of Allied Health Educational Programs.

(4) Submit to the Board written evidence, verified by oath, that the applicant has successfully completed the minimal requirements for Basic Cardiac Life Support as recognized by the American Heart Association.

(5) Pass the entry-level examination given by the National Board for Respiratory Care, Inc.

(b) At least three times each year, the Board shall cause the examination required in subdivision (5) of subsection (a) of this section to be given to applicants at a time and place to be announced by the Board. Any applicant who fails to pass the first examination may take additional examinations in accordance with rules adopted pursuant to this Article.

"**§ 90-654. Exemption from certain requirements.**

(a) The Board may issue a license to an applicant who, as of October 1, 1999, has passed the entry-level examination given by the National Board for Respiratory Care, Inc. An applicant applying for licensure under this subsection shall submit his or her application to the Board before October 1, 2001.

(b) The Board may grant a temporary license to an applicant who, as of October 1, 1999, does not meet the qualifications of G.S. 90-653 but, through written evidence verified by oath, demonstrates that he or she is performing the duties of a respiratory care practitioner within the State. The temporary license is valid until October 1, 2000, within which time the applicant shall be required to complete the requirements of G.S. 90-653(a)(5). A license granted under this subsection shall contain an endorsement indicating that the license is temporary and shall state the date the license was granted and the date it expires.

"**§ 90-655. Licensure by reciprocity.**

The Board may grant, upon application and the payment of proper fees, a license to a person who, at the time of application holds a valid license, certificate, or registration as a respiratory care practitioner issued by another state or a political territory or jurisdiction acceptable to the Board if, in the Board's determination, the requirements for that license, certificate, or registration are substantially the same as the requirements for licensure under this Article.

"**§ 90-656. Provisional license.**

The Board may grant a provisional license for a period not exceeding 12 months to any applicant who has successfully completed the education requirements under G.S. 90-653(a)(3) and has made application to take the examination required under G.S. 90-653(a)(5). A provisional license allows the individual to practice respiratory care under the supervision of a respiratory care practitioner and in accordance with rules adopted pursuant to this Article. A license granted under this section shall contain an endorsement indicating that the license is provisional and stating the terms and conditions of its use by the licensee and shall state the date the license was granted and the date it expires.

"**§ 90-657. Notification of applicant following evaluation of application.**

After evaluation of the application and of any other evidence required from the applicant by the Board, the Board shall notify each applicant that the application and evidence submitted are satisfactory and accepted or unsatisfactory and rejected. If the application and evidence is rejected, the notice shall state the reasons for the rejection.

"**§ 90-658. License as property of the Board; display requirement; renewal; inactive status.**

(a) A license issued by the Board is the property of the Board and shall be surrendered by the licensee to the Board on demand.

(b) The licensee shall display the license in the manner prescribed by the Board.

(c) The licensee shall inform the Board of any change of the licensee's address.

(d) The license shall be renewed by the Board annually upon the payment of a renewal fee if, at the time of application for renewal, the applicant is not in violation of this Article and has fulfilled the current requirements regarding continuing education as established by rules adopted pursuant to this Article.

(e) The Board shall notify a licensee at least 30 days in advance of the expiration of his or her license. Each licensee is responsible for renewing his or her license before the expiration date. Licenses that are not renewed automatically lapse.

(f) The Board may provide for the late renewal of an automatically lapsed license upon the payment of a late fee. No late fee renewal may be granted more than five years after a license expires.

(g) In accordance with rules adopted pursuant to this Article, a licensee may request that his or her license be declared inactive and may thereafter apply for active status.

"**§ 90-659. Suspension, revocation, and refusal to renew a license.**

(a) The Board shall take the necessary actions to deny or refuse to renew a license, suspend or revoke a license, or to impose probationary conditions on a licensee or applicant if the licensee or applicant:

(1) Has engaged in any of the following conduct:
   a. Employed fraud, deceit, or misrepresentation in obtaining or attempting to obtain a license or the renewal of a license.
   b. Committed an act of malpractice, gross negligence, or incompetence in the practice of respiratory care.
   c. Practiced respiratory care without a license.
   d. Engaged in health care practices that are determined to be hazardous to public health, safety, or welfare.

(2) Was convicted of or entered a plea of guilty or nolo contendere to any crime involving moral turpitude.

(3) Was adjudicated insane or incompetent, until proof of recovery from the condition can be established.

(4) Engaged in any act or practice that violates any of the provisions of this Article or any rule adopted pursuant to this Article, or aided, abetted, or assisted any person in such a violation.

(b) Denial, refusal to renew, suspension, or revocation of a license, or imposition of probationary conditions upon a licensee may be ordered by the Board after a hearing held in accordance with Article 3A of Chapter 150B of the General Statutes and rules adopted pursuant to this Article. An application may be made to the Board for reinstatement of a revoked license if the revocation has been in effect for at least one year.

"§ 90-660. Expenses; fees.

(a) All salaries, compensation, and expenses incurred or allowed for carrying out the purposes of this Article shall be paid by the Board exclusively out of the fees received by the Board as authorized by this Article or funds received from other sources. In no case shall any salary, expense, or other obligations of the Board be charged against the State.

(b) All monies received by the Board pursuant to this Article shall be deposited in an account for the Board and shall be used for the administration and implementation of this Article. The Board shall establish fees in amounts to cover the cost of services rendered for the following purposes:

(1) For an initial application, a fee not to exceed twenty-five dollars ($25.00).

(2) For examination or reexamination, a fee not to exceed one hundred fifty dollars ($150.00).

(3) For issuance of any license, a fee not to exceed one hundred dollars ($100.00).

(4) For the renewal of any license, a fee not to exceed fifty dollars ($50.00).

(5) For the late renewal of any license, an additional late fee not to exceed fifty dollars ($50.00).

(6) For a license with a provisional or temporary endorsement, a fee not to exceed thirty-five dollars ($35.00).

(7) For copies of rules adopted pursuant to this Article and licensure standards, charges not exceeding the actual cost of printing and mailing.

"§ 90-661. Requirement of license.

After October 1, 2000, it shall be unlawful for any person who is not currently licensed under this Article to:

(1) Engage in the practice of respiratory care.

(2) Use the title 'respiratory care practitioner'.

(3) Use the letters 'RCP', 'RTT', 'RT', or any facsimile or combination in any words, letters, abbreviations, or insignia.

(4) Imply orally or in writing or indicate in any way that the person is a respiratory care practitioner or is otherwise licensed under this Article.

(5) Employ or solicit for employment unlicensed persons to practice respiratory care.

"§ 90-662. Violation a misdemeanor.

Any person who violates any provision of this Article shall be guilty of a Class 1 misdemeanor.

"**§ 90-663. Injunctions.**

The Board may apply to the superior court for an order enjoining violations of this Article, and upon a showing by the Board that any person has violated or is about to violate this Article, the court may grant an injunction or restraining order or take other appropriate action.

"**§ 90-664. Persons and practices not affected.**

The requirements of this Article shall not apply to:

(1) Any person registered, certified, credentialed, or licensed to engage in another profession or occupation or any person working under the supervision of a person registered, certified, credentialed, or licensed to engage in another profession or occupation in this State who is performing work incidental to the practice of that profession or occupation and does not represent himself or herself as a respiratory care practitioner.

(2) A student or trainee working under the direct supervision of a respiratory care practitioner while fulfilling an experience requirement or pursuing a course of study to meet requirements for licensure in accordance with rules adopted pursuant to this Article.

(3) A respiratory care practitioner serving in the armed forces or the Public Health Service of the United States or employed by the Veterans Administration when performing duties associated with that service or employment.

(4) A person aiding in the practice of respiratory care, in accordance with rules adopted pursuant to this Article, if the person works under the direct supervision of a respiratory care practitioner or on the order of or under the direct supervision of a physician licensed under Article 1 of this Chapter and performs only support activities as defined in G.S. 90-648(12).

"**§ 90-665. Third-party reimbursement.**

Nothing in this Article shall be construed to require direct third-party reimbursements to persons licensed under this Article."

Section 2. G.S. 120-123 is amended by adding a new subdivision to read:

"(70) The North Carolina Respiratory Care Board as created by Article 37 of Chapter 90 of the General Statutes."

Section 3. The initial appointments to the North Carolina Respiratory Care Board, created in G.S. 90-649, as enacted in Section 1 of this act, shall be appointed no later than October 1, 1999. Notwithstanding the provisions of G.S. 90-649(b), as enacted in Section 1 of this act, the initial members of the North Carolina Respiratory Care Board who are appointed pursuant to G.S. 90-649(a)(1) shall be licensed under Article 37 of Chapter 90 of the General Statutes, as enacted in Section 1 of this act, no later than June 30, 2000, and, until October 1, 2004, must have

passed the entry-level examination administered by the National Board for Respiratory Care, Inc. Notwithstanding the provisions of G.S. 90-650(b), as enacted in Section 1 of this act, of the initial appointments to the North Carolina Respiratory Care Board, one of the members appointed by the General Assembly, upon the recommendation of the Speaker of the House of Representatives, and one of the members appointed by the General Assembly, upon the recommendation of the President Pro Tempore of the Senate, shall be appointed for three-year terms; one of the members appointed by the General Assembly, upon the recommendation of the Speaker of the House of Representatives, and one of the members appointed by the General Assembly, upon the recommendation of the President Pro Tempore of the Senate, shall be appointed for two-year terms; the public member appointed by the Governor shall be appointed for a one-year term; the physician member appointed by the North Carolina Medical Society shall be appointed for a one-year term; and the members appointed by the North Carolina Hospital Association and the North Carolina Association of Medical Equipment Services shall be appointed for one-year terms.

Section 4. This act is effective when it becomes law.

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 1999

HOUSE BILL 1340

Short Title: Respiratory Care Practice Act. (Public)

Sponsors: Representatives Tolson; Barefoot, Clary, Hardaway, and Kiser.

Referred to: Health, if favorable, Finance.

April 26, 1999

A BILL TO BE ENTITLED

AN ACT TO ESTABLISH THE RESPIRATORY CARE PRACTICE ACT.

The General Assembly of North Carolina enacts:

Section 1. Chapter 90 of the General Statutes is amended by adding a new Article to read:

"ARTICLE 37.

"Respiratory Care Practice Act.

"§ 90-646. Short title.

This Article may be cited as the 'Respiratory Care Practice Act'.

"§ 90-647. Purpose.

The General Assembly finds that the practice of respiratory care in the State of North Carolina affects the public health, safety, and welfare and that the mandatory licensure of persons who engage in respiratory care is necessary to ensure a minimum standard of competency. It is the purpose and intent of this Article to protect the public from the unqualified practice of respiratory care and from unprofessional conduct by persons licensed pursuant to this Article.

"§ 90-648. Definitions.

The following definitions apply in this Article:

(1) Board. -- The North Carolina Respiratory Care Board.

(2) Diagnostic testing. -- Cardiopulmonary procedures and tests performed on the written order of a physician licensed under Article 1 of this Chapter that provide information to the physician to formulate a diagnosis of the patient's condition. The tests and procedures may include pulmonary function testing,

electrocardiograph testing, cardiac stress testing, and sleep related testing.

(3) Direct supervision. -- The authority and responsibility to direct the performance of activities as established by policies and procedures for safe and appropriate completion of services.

(4) Individual. -- A human being.

(5) License. -- A certificate issued by the Board recognizing the person named therein as having met the requirements to practice respiratory care as defined in this Article.

(6) Licensee. -- A person who has been issued a license under this Article.

(7) Medical director. -- An appointed physician who is licensed under Article 1 of this Chapter and a member of the entity's medical staff, and who is granted the authority and responsibility for assuring and establishing policies and procedures and that the provision of such is provided to the quality, safety, and appropriateness standards as recognized within the defined scope of practice for the entity.

(8) Person. -- An individual, corporation, partnership, association, unit of government, or other legal entity.

(9) Physician. -- A doctor of medicine licensed by the State of North Carolina in accordance with Article 1 of this Chapter.

(10) Practice of respiratory care. -- As defined by the written order of a physician licensed under Article 1 of this Chapter, the observing and monitoring of signs and symptoms, general behavior, and general physical response to respiratory care treatment and diagnostic testing, including the determination of whether such signs, symptoms, reactions, behavior, or general response exhibit abnormal characteristics, and the performance of diagnostic testing and therapeutic application of:

a. Medical gases, humidity, and aerosols including the maintenance of associated apparatus, except for the purpose of anesthesia.

b. Pharmacologic agents related to respiratory care procedures, including those agents necessary to perform hemodynamic monitoring.

c. Mechanical or physiological ventilatory support.

d. Cardiopulmonary resuscitation and maintenance of natural airways, the insertion and maintenance of artificial airways under the direct supervision of a recognized medical director in a health care environment which identifies these services within the scope of practice by the facility's governing board.

e. Hyperbaric oxygen therapy.

f. Extracorporeal membrane oxygenation in appropriately identified environments and under the training and practice guidelines established by the Extracorporeal Life Support Organization.

The term also means the interpretation and implementation of a physician's written or verbal order pertaining to the acts described in this subdivision.

(11) Respiratory care. -- As defined by the written order of a physician licensed under Article 1 of Chapter 90, the treatment, management, diagnostic testing, and care of patients with deficiencies and abnormalities associated with the cardiopulmonary system.

(12) Respiratory care practitioner. -- A person who has been licensed by the Board to engage in the practice of respiratory care.

(13) Support activities. -- Procedures that do not require formal academic training, including the delivery, setup, and maintenance of apparatus. The term also includes giving instructions on the use, fitting, and application of apparatus, but does not include therapeutic evaluation and assessment.

"§ 90-649. North Carolina Respiratory Care Board; creation.

(a) The North Carolina Respiratory Care Board is created. The Board shall consist of eight members as follows:

(1) Two members shall be respiratory care practitioners.

(2) Three members shall be physicians licensed to practice in North Carolina, and whose primary practice is Pulmonology, Anesthesiology, Critical Care Medicine, or whose specialty is Cardiothoracic Disorders.

(3) One member shall represent the North Carolina Hospital Association.

(4) One member shall represent the North Carolina Association of Medical Equipment Services.

(5) Two members shall represent the public at large.

(b) Members of the Board shall be citizens of the United States and residents of this State. The respiratory care practitioner members shall have practiced respiratory care for at least five years and shall be licensed under this Article. The public members shall not be: (i) a respiratory care practitioner, (ii) an agent or employee of a person engaged in the profession of respiratory care, (iii) a health care professional licensed under this Chapter or a person enrolled in a program to become a licensed health care professional, (iv) an agent or employee of a health care institution, a health care insurer, or a health care professional school, (v) a member of an allied health profession or a person enrolled in a program to become a member of an allied health profession, or (vi) a spouse of an individual who may not serve as a public member of the Board.

"§ 90-650. Appointments and removal of Board members; terms and compensation.

(a) The members of the Board shall be appointed as follows:

(1) The Governor shall appoint the public members described in G.S. 90-649(a)(5).

(2) The General Assembly, upon the recommendation of the Speaker of the House of Representatives, shall appoint one of the respiratory care practitioner members described in G.S. 90-649(a)(1) and one of the physician members described in G.S. 90-649(a)(2) in accordance with G.S. 120-121.

(3) The General Assembly, upon the recommendation of the President Pro Tempore of the Senate, shall appoint one of the respiratory care practitioner members described in G.S. 90-649(a)(1) and one of the physician members described in G.S. 90-649(a)(2) in accordance with G.S. 120-121.

(4) The North Carolina Medical Society shall appoint one of the physician members described in G.S. 90-649(a)(2).

(5) The North Carolina Hospital Association shall appoint the member described in G.S. 90-649(a)(3).

(6) The North Carolina Association of Medical Equipment Services shall appoint the member described in G.S. 90-649(a)(4).

(b) Members of the Board shall take office on the first day of July immediately following the expired term of that office and shall serve for a term of three years and until their successors are appointed and qualified. No member shall serve on the Board for more than two consecutive terms.

(c) The Governor may remove members of the Board, after notice and an opportunity for hearing, for incompetence, neglect of duty, unprofessional conduct, conviction of any felony, failure to meet the qualifications of this Article, or committing any act prohibited by this Article.

(d) Any vacancy shall be filled by the authority originally filling that position, except that any vacancy in appointments by the General Assembly shall be filled in accordance with G.S. 120-122. Appointees to fill vacancies shall serve the remainder of the unexpired term and until their successors have been duly appointed and qualified.

(e) Members of the Board shall receive no compensation for their services but shall be entitled to travel, per diem, and other expenses authorized by G.S. 93B-5.

(f) Individual members shall be immune from civil liability arising from activities performed within the scope of their official duties.

"**§ 90-651. Election of officers; meetings of the Board.**

(a) The Board shall elect a chair and a vice-chair who shall hold office according to rules adopted pursuant to this Article, except that all officers shall be elected annually by the Board for one-year terms and shall serve until their successors are elected and qualified.

(b) The Board shall hold at least two regular meetings each year as provided by rules adopted pursuant to this Article. The Board may hold additional meetings

upon the call of the chair or any two Board members. A majority of the Board membership shall constitute a quorum.

"**§ 90-652. Powers and duties of the Board.**

The Board shall have the power and duty to:

(1) Determine the qualifications and fitness of applicants for licensure, renewal of licensure, and reciprocal licensure.

(2) Establish and adopt rules necessary to conduct its business, carry out its duties, and administer this Article.

(3) Adopt and publish a code of ethics.

(4) Deny, issue, suspend, revoke, and renew licenses in accordance with this Article.

(5) Conduct investigations, subpoena individuals and records, and do all other things necessary and proper to discipline persons licensed under this Article and to enforce this Article.

(6) Employ professional, clerical, investigative, or special personnel necessary to carry out the provisions of this Article and purchase or rent office space, equipment, and supplies.

(7) Adopt a seal by which it shall authenticate its proceedings, official records, and licenses.

(8) Conduct administrative hearings in accordance with Article 3A of Chapter 150B of the General Statutes.

(9) Establish certain reasonable fees as authorized by this Article for applications for examination, licensure, provisional licensure, renewal of licensure, and other services provided by the Board.

(10) Submit an annual report to the North Carolina Medical Board, the North Carolina Hospital Association, the North Carolina Society of Respiratory Care, the Governor, and the General Assembly of all the Board's official actions during the preceding year, together with any recommendations and findings regarding improvements of the practice of respiratory care.

(11) Publish and make available upon request the licensure standards prescribed under this Article and all rules adopted pursuant to this Article.

(12) Request and receive the assistance of State educational institutions or other State agencies.

(13) Establish and approve continuing education requirements for persons seeking licensure under this Article.

"**§ 90-653. Licensure requirements; examination.**

(a) Each applicant for licensure under this Article shall meet the following requirements:

(1) Submit a completed application as required by the Board.

(2) Submit any fees required by the Board.

(3) Submit to the Board written evidence, verified by oath, that the applicant has successfully completed the minimal requirements of a

respiratory care education program as approved by the Commission for Accreditation of Allied Health Educational Programs.

(4) Submit to the Board written evidence, verified by oath, that the applicant has successfully completed the minimal requirements for Basic Cardiac Life Support as recognized by the American Heart Association.

(5) Pass the entry-level examination given by the National Board for Respiratory Care, Inc.

(b) At least three times each year, the Board shall cause the examination required in subdivision (5) of subsection (a) of this section to be given to applicants at a time and place to be announced by the Board. Any applicant who fails to pass the first examination may take additional examinations in accordance with rules adopted pursuant to this Article.

"§ 90-654. Exemption from certain requirements.

(a) The Board may issue a license to an applicant who, as of October 1, 1999, has passed the entry-level examination given by the National Board for Respiratory Care, Inc. An applicant applying for licensure under this subsection shall submit his or her application to the Board before October 1, 2001.

(b) The Board may grant a temporary license to an applicant who, as of October 1, 1999, does not meet the qualifications of G.S. 90-653 but, through written evidence verified by oath, demonstrates that he or she is performing the duties of a respiratory care practitioner within the State. The temporary license is valid until October 1, 2000, within which time the applicant shall be required to complete the requirements of G.S. 90-653(a)(5). A license granted under this subsection shall contain an endorsement indicating that the license is temporary and shall state the date the license was granted and the date it expires.

"§ 90-655. Licensure by reciprocity.

The Board may grant, upon application and the payment of proper fees, a license to a person who, at the time of application holds a valid license, certificate, or registration as a respiratory care practitioner issued by another state or a political territory or jurisdiction acceptable to the Board if, in the Board's determination, the requirements for that license, certificate, or registration are substantially the same as the requirements for licensure under this Article.

"§ 90-656. Provisional license.

The Board may grant a provisional license for a period not exceeding 12 months to any applicant who has successfully completed the education requirements under G.S. 90-653(a)(3) and has made application to take the examination required under G.S. 90-653(a)(5). A provisional license allows the individual to practice respiratory care under the supervision of a respiratory care practitioner and in accordance with rules adopted pursuant to this Article. A license granted under this section shall contain an endorsement indicating that the license is provisional and stating the terms and conditions of its use by the licensee and shall state the date the license was granted and the date it expires.

"**§ 90-657. Notification of applicant following evaluation of application.**

After evaluation of the application and of any other evidence required from the applicant by the Board, the Board shall notify each applicant that the application and evidence submitted are satisfactory and accepted or unsatisfactory and rejected. If the application and evidence is rejected, the notice shall state the reasons for the rejection.

"**§ 90-658. License as property of the Board; display requirement; renewal; inactive status.**

(a) A license issued by the Board is the property of the Board and shall be surrendered by the licensee to the Board on demand.

(b) The licensee shall display the license in the manner prescribed by the Board.

(c) The licensee shall inform the Board of any change of the licensee's address.

(d) The license shall be renewed by the Board annually upon the payment of a renewal fee if, at the time of application for renewal, the applicant is not in violation of this Article and has fulfilled the current requirements regarding continuing education as established by rules adopted pursuant to this Article.

(e) The Board shall notify a licensee at least 30 days in advance of the expiration of his or her license. Each licensee is responsible for renewing his or her license before the expiration date. Licenses that are not renewed automatically lapse.

(f) The Board may provide for the late renewal of an automatically lapsed license upon the payment of a late fee. No late fee renewal may be granted more than five years after a license expires.

(g) In accordance with rules adopted pursuant to this Article, a licensee may request that his or her license be declared inactive and may thereafter apply for active status.

"**§ 90-659. Suspension, revocation, and refusal to renew a license.**

(a) The Board shall take the necessary actions to deny or refuse to renew a license, suspend or revoke a license, or to impose probationary conditions on a licensee or applicant if the licensee or applicant:

(1) Has engaged in any of the following conduct:
   a. Employed fraud, deceit, or misrepresentation in obtaining or attempting to obtain a license or the renewal of a license.
   b. Committed an act of malpractice, gross negligence, or incompetence in the practice of respiratory care.
   c. Practiced respiratory care without a license.
   d. Engaged in health care practices that are determined to be hazardous to public health, safety, or welfare.

(2) Was convicted of or entered a plea of guilty or nolo contendere to any crime involving moral turpitude.

(3) Was adjudicated insane or incompetent, until proof of recovery from the condition can be established.

(4) Engaged in any act or practice that violates any of the provisions of this Article or any rule adopted pursuant to this Article, or aided, abetted, or assisted any person in such a violation.

(b) Denial, refusal to renew, suspension, or revocation of a license, or imposition of probationary conditions upon a licensee may be ordered by the Board after a hearing held in accordance with Article 3A of Chapter 150B of the General Statutes and rules adopted pursuant to this Article. An application may be made to the Board for reinstatement of a revoked license if the revocation has been in effect for at least one year.

"§ 90-660. Expenses; fees.

(a) All salaries, compensation, and expenses incurred or allowed for carrying out the purposes of this Article shall be paid by the Board exclusively out of the fees received by the Board as authorized by this Article or funds received from other sources. In no case shall any salary, expense, or other obligations of the Board be charged against the State.

(b) All monies received by the Board pursuant to this Article shall be deposited in an account for the Board and shall be used for the administration and implementation of this Article. The Board shall establish fees in amounts to cover the cost of services rendered for the following purposes:

(1) For an initial application, a fee not to exceed twenty-five dollars ($25.00).

(2) For examination or reexamination, a fee not to exceed one hundred fifty dollars ($150.00).

(3) For issuance of any license, a fee not to exceed one hundred dollars ($100.00).

(4) For the renewal of any license, a fee not to exceed fifty dollars ($50.00).

(5) For the late renewal of any license, an additional late fee not to exceed fifty dollars ($50.00).

(6) For a license with a provisional or temporary endorsement, a fee not to exceed thirty-five dollars ($35.00).

(7) For copies of rules adopted pursuant to this Article and licensure standards, charges not exceeding the actual cost of printing and mailing.

"§ 90-661. Requirement of license.

After October 1, 2000, it shall be unlawful for any person who is not currently licensed under this Article to:

(1) Engage in the practice of respiratory care.

(2) Use the title 'respiratory care practitioner'.

(3) Use the letters 'RCP', 'RTT', 'RT', or any facsimile or combination in any words, letters, abbreviations, or insignia.

(4) Imply orally or in writing or indicate in any way that the person is a respiratory care practitioner or is otherwise licensed under this Article.

(5) Employ or solicit for employment unlicensed persons to practice respiratory care.

"§ 90-662. Violation a misdemeanor.

Any person who violates any provision of this Article shall be guilty of a Class 1 misdemeanor.

"**§ 90-663. Injunctions.**

The Board may apply to the superior court for an order enjoining violations of this Article, and upon a showing by the Board that any person has violated or is about to violate this Article, the court may grant an injunction or restraining order or take other appropriate action.

"**§ 90-664. Persons and practices not affected.**

The requirements of this Article shall not apply to:

(1) Any person registered, certified, credentialed, or licensed to engage in another profession or occupation or any person working under the supervision of a person registered, certified, credentialed, or licensed to engage in another profession or occupation in this State who is performing work incidental to the practice of that profession or occupation and does not represent himself or herself as a respiratory care practitioner.

(2) A student or trainee working under the direct supervision of a respiratory care practitioner while fulfilling an experience requirement or pursuing a course of study to meet requirements for licensure in accordance with rules adopted pursuant to this Article.

(3) A respiratory care practitioner serving in the armed forces or the Public Health Service of the United States or employed by the Veterans Administration when performing duties associated with that service or employment.

(4) A person aiding in the practice of respiratory care, in accordance with rules adopted pursuant to this Article, if the person works under the direct supervision of a respiratory care practitioner or on the order of or under the direct supervision of a physician licensed under Article 1 of this Chapter and performs only support activities as defined in G.S. 90-648(12).

"**§ 90-665. Third-party reimbursement.**

Nothing in this Article shall be construed to require direct third-party reimbursements to persons licensed under this Article."

Section 2. G.S. 120-123 is amended by adding a new subdivision to read:

"(70) The North Carolina Respiratory Care Board as created by Article 37 of Chapter 90 of the General Statutes."

Section 3. The initial appointments to the North Carolina Respiratory Care Board, created in G.S. 90-649, as enacted in Section 1 of this act, shall be appointed no later than October 1, 1999. Notwithstanding the provisions of G.S. 90-649(b), as enacted in Section 1 of this act, the initial members of the North Carolina Respiratory Care Board who are appointed pursuant to G.S. 90-649(a)(1) shall be licensed under Article 37 of Chapter 90 of the General Statutes, as enacted in Section 1 of this act, no later than June 30, 2000, and, until October 1, 2004, must have

passed the entry-level examination administered by the National Board for Respiratory Care, Inc. Notwithstanding the provisions of G.S. 90-650(b), as enacted in Section 1 of this act, of the initial appointments to the North Carolina Respiratory Care Board, one of the members appointed by the General Assembly, upon the recommendation of the Speaker of the House of Representatives, and one of the members appointed by the General Assembly, upon the recommendation of the President Pro Tempore of the Senate, shall be appointed for three-year terms; one of the members appointed by the General Assembly, upon the recommendation of the Speaker of the House of Representatives, and one of the members appointed by the General Assembly, upon the recommendation of the President Pro Tempore of the Senate, shall be appointed for two-year terms; the public member appointed by the Governor shall be appointed for a one-year term; the physician member appointed by the North Carolina Medical Society shall be appointed for a one-year term; and the members appointed by the North Carolina Hospital Association and the North Carolina Association of Medical Equipment Services shall be appointed for one-year terms.

Section 4. This act is effective when it becomes law.

HOUSE BILL 1340:
Respiratory Care Practice Act

BILL ANALYSIS

Committee:	House Health	**Introduced by:**	Rep. Tolson
Date:	June 21, 1999	**Summary by:**	Linda Attarian
Version:	First		Committee Counsel

SUMMARY: House Bill 1340 would create a new occupational licensure board and require the mandatory licensure of persons engaged in the practice of respiratory care as defined in the Act.

CURRENT LAW: North Carolina does not regulate respiratory care practitioners.

BILL ANALYSIS:

Section 1. Creates the "Respiratory Care Practice Act". The following is a brief summary of the provisions:

G.S. 90-648: Definitions.

- Defines "practice of respiratory care" (procedures that may only be performed by a licensed respiratory care practitioner) and "support activities" (prodedures that do not require licensure).

G.S. 90-649. NC Respiratory Care Board; creation.

- Creates an eight member Board and defines the criteria for the selection of members.

G.S. 90-650. Appointments and removal of Board members; terms and compensation.

- Provides for the appointments, terms, removal, vacancy, compensation, and personal liability of Board members.

G.S. 90-651. Election of Officers; meetings of the Board.

- Provides for the election of officers, quorum requirements, and the required number of Board meetings per year.

G.S. 90-653. Licensure requirements; examination.

- Provides the following minimal standards that must be met to receive a license to practice respiratory care:
  1. Completion of a respiratory care education program as approved by the Commission for Accreditation for Accreditation of Allied Health Educational Programs of the American Medical Association.
  2. Completion of the American Heart Association's Basic Cardiac Life Support program.
  3. Passage of the entry-level examination given by the National Board of Respiratory Care, Inc. (applicants may take the exam more than once).

G.S. 90-654. Exemptions from certain requirements.

- Provides that an applicant who passes the entry-level exam given by the National Board of Respiratory Care, Inc. prior to October 1,1999 is exempt from the other requirements.

- An applicant who is currently practicing as a respiratory care practitioner but who has not passed the national exam may be issued a "temporary license" which will be valid until October 1, 2000. The applicant may receive full licensure when he or she passes the national exam prior to October 1, 2000.

G.S. 90-655. License by reciprocity.

- Provides that the Board is authorized to grant North Carolina licensure to an applicant holding a valid out-of-state license, certificate, or registration as a respiratory care practitioner if the Board determines the out-of-state requirements are substantially the same as the requirements under this Article.

G.S. 90-656. Provisional license.

- Provides that the Board is authorized to grant an applicant a provisional license for a period of one year if the applicant has completed the minimum educational requirements and has applied to take the national exam. The provisional license allows the applicant to practice under the supervision of a licensed respiratory care practitioner.

G.S. 90-657. Notification of applicant following evaluation of application.

- Provides notification requirements.

G.S. 90-658. License as property of the Board; display requirement; renewal; inactive status.

- Provides various requirements concerning the license itself.

G.S. 90-659. Suspension, revocation, and refusal to renew a license.

- Provides the circumstances under which the Board may suspend, revoke, or refuse to renew a license.
- Provides a licensee who is subject to possible liscensure suspension, revokation or refusal of renewal the right to an administrative hearing pursuant to Article 3A of Chapter 150B.

G.S. 90-660. Expenses; fees.

- Establishes the fee structure to cover the costs of the Board's services.

G.S. 90-661. Requirement of license.

- Sets forth the unlawful actions for any person who is not currently licensed under the Article.

G.S. 90-662. Violations a misdemeanor.

- Provides that anyone violating this Article is guilty of a Class 1 misdemeanor.

G.S. 90-663. Injunctions.

- Authorizes the Board to obtain a court order enjoining violations of the Act.

G.S. 90-664. Persons and practices not affected.

- Provides that the following practicing members of the respiratory care profession are exempt from licensure requirements.

1. A health care practitioner or any person working under the supervision of such practitioner who is performing services authorized by their scope of practice and who does not hold themselves out to be a respiratory care practitioner.
2. A student in a respiratory care education program, working under direct supervision of a respiratory care practitioner while fulfilling requirements of the course of study.
3. Persons serving in the armed forces or the Public Health Service of the United States or employed by the Veteran's Administration when performing duties associated with that service or employment.
4. Persons aiding in the practice of respiratory care who perform support activities which do not require formal academic training, if these persons work under the supervision of a respiratory care practitioner or physician.

G.S. 90-665. Third-party reimbursement.

- Provides that this Article does authorize respiratory care practitioners to bill directly for third-party reimbursement.

Section 2. Amends G.S. 120-123 to prohibit members of the NC General Assembly from being appointed to the Board.

Section 3. Provides that the initial Board members shall be appointed no later than October 1, 1999 and, not withstanding G.S. 90-649, these initial members must obtain licensure under this Article no later than October 1, 2000. Further, until October 1, 2004, the initial board members must have passed the entry-level National Board for Respiratory Care, Inc. exam.

Provides also that two the initial Board members appointed by the General Assembly shall serve two-year terms instead of three-year terms as provided for in G.S. 90-650.

Also, the initial public member appointed by the Governor, the initial physician member appointed by the NC Medical Society, and the initial members appointed by the NC Hospital Association and the NC Association of Medical Equipment Services shall all be appointed for one-year terms instead of three-year terms as provided for in G.S. 90-650.

Section 4. This Act is effective when it becomes law.

VISITOR REGISTRATION SHEET

Health Committee — 6-22-99

Name of Committee — Date

VISITORS: PLEASE SIGN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Loretta Thompson	NC RTL Greensboro
Bailey Fowler	student from S.C.
Kerry Stevens	Respiratory Care Student - Robeson Comm. Coll.
Angie Bobo	Respiratory Care Student - Robeson Comm. College
Connie Jonat	Respiratory Care Student Robeson Comm College.
Roberta Forbes	Gov's Office
Ashley Barnes	SBE
Alan Miles	Bailey & Dixon LLP
[illegible]	JP Assoc/MAMSI
[illegible]	NC AHP
Jacob Kline	ACLU
[illegible]	[illegible]
[illegible] Summers	NC Equity
Beth Ann Knudsen	Women's Forum
Michelle L. Rucker	Rep. Rucker's L.A.
Karen Bley	Planned Parenthood
[illegible] Michaels	PPOD
[illegible]	DHHS/Public Health
John Boardish	Zeb Alley P.A.
[illegible] Henderson	CALAK
Guy Rohling	CVS/PHARMACY
Andy Ell[illegible]	NCRMA
Linwood Mercer	Mercer & Associates
R. Alan Leonard	NC Respiratory Care Society
Ronnie Moore	N.C. Democratic Party
John Rust[illegible]	NCFPC
Marie Smith	Glaxo-Wellcome
Leto Copeley	NC Ass. of Women Attorneys

VISITOR REGISTRATION SHEET

Health Committee — 6-22-99

Name of Committee — Date

VISITORS: PLEASE SIGN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Ben Murray	NCNA
joanne Schaad	NCNA
Betty Wickham	LifeTree, Inc
DAVID HARDIN	CATHOLIC DIOCESE OF RALEIGH
Nancy Lischwe	Lifetree Inc.
John Bacon + crew	CNC-TV

AGENDA

HOUSE COMMITTEE ON HEALTH
TUESDAY, JUNE 29, 1999
ROOM 415 LOB
12:00 NOON

OPENING REMARKS

REP. THOMAS E. WRIGHT
CHAIRMAN

BILLS TO BE DISCUSSED

SB-160 NURSE REHABILITATION-(SEN. PERDUE)

SB-951-HEALTH CARE WORKERS/ ID BADGES-(SEN. PERDUE)

SB-793-PSCHOLOGY PRACTICE DEFINITIONS-(REP. BADDOUR)

COMMENTS

ADJOURNMENT

MINUTES

HOUSE COMMITTEE ON HEALTH

TUESDAY, JUNE 29, 1999

12:00 NOON ROOM 415-LOB

The House Committee on Health met on Tuesday, June 29, 1999 at 12:00 Noon in Room 415-LOB. A silent roll was taken, (roll list denotes members present.)

Chairman Wright called the meeting to order.

The House Pages were introduced to the members of the Health Committee.

SB-793-PSCHOLOGY PRACTICE DEFINITIONS

Rep. Baddour explained the bill. Rep. Womble asked the bill sponsor about the origination of the bill and the opposing forces of the bill. Rep. Baddour responded.

Rep. Insko moved for a favorable report.

A vote was taken and the Ayes had a majority vote.

SB-793-Psychology Practice Definitions was given a favorable report.

SB-160- NURSE REHABILITATION

Sen. Perdue explained the bill. Rep. Bowie is recognized for a comment about the bill.

Rep. Bowie moved for a favorable report.

Rep. Melton asked the chair a question. The Chair responded. Rep. Alexander asked the bill sponsor a question about the volunteer participation of the nurses. Sen. Perdue responded. Howard Kramer, Board of Nursing, made a comment about the bill.

A vote was taken. The Ayes had the majority vote.

SB-160- Nurse Rehabilitation was given a favorable report.

SB-951 HEALTH CARE WORKERS/ ID BADGES

Sen. Perdue explained the bill. Rep. Womble asked the bill sponsor a question about the cost associated with the bill. Sen. Perdue responded. Rep. Womble followed up with a question about the design of the badge. Sen. Perdue responded. Rep. Womble followed up with a question about the rationale of the bill. Sen. Perdue responded.

Rep. Womble moved for a favorable report.

Rep. Adams is recognized for a comment on the bill. Rep. Redwine asked the bill sponsor a question about the bill on page 2. Sen. Perdue responded and referred the question to Cindy Barker of the North Carolina Nurses Association. Rep. Redwine followed-up with a comment. John Young, Research Staff, explained the bill further. Michael Krowlan, Counsel for the Board of Nursing, responded. Rep. Redwine followed-up with a comment. John Young is recognized for a question to Michael Krowlan. Rep. Redwine responded. Sen. Perdue commented on the bill. Rep. Bowie responded and asked if a representative from the Medical Society respond. Steve King from the Medical Society responded. Rep. Insko asked a question to Steve King of the Medical Society. Steve King responded.

Rep. Womble moved to withdraw the motion to give SB-951 a favorable report and offered that the House proposed committee substitute be adopted. So moved.

Rep. Womble moved for a favorable report to the House proposed committee substitute.

Rep. Esposito is recognized for a question. Cindy Barker responded. A vote was taken. The Ayes had the majority vote.

House Proposed Committee Substitute for SB-951 was given a favorable report.

The meeting adjourn at 12:54 P.M.

Rep. Thomas E. Wright, Chairman

Vanda Wilson-Wormack, Committee Asst.

1999 COMMITTEE REPORT
HOUSE OF REPRESENTATIVES

The following report(s) from standing committee(s) is/are presented:
By Representative(s) **THOMAS E. WRIGHT** for the Committee on **HEALTH**.

☐ Committee Substitute for
S.B. 160 A BILL TO BE ENTITLED AN ACT AUTHORIZING THE NORTH CAROLINA BOARD OF NURSING TO ESTABLISH PROGRAMS TO AID THE REHABILITATION AND MONITORING OF NURSES WHO EXPERIENCE CERTAIN ADDICTIONS AND DISABILITIES.

☒ With a favorable report.

☐ With a favorable report and recommendation that the bill be re-referred to the Committee on Appropriations ☐ Finance ☐ ☐.

☐ With a favorable report, as amended.

☐ With a favorable report, as amended, and recommendation that the bill be re-referred to the Committee on Appropriations ☐ Finance ☐ ☐.

☐ With a favorable report as to committee substitute bill (#), ☐ which changes the title, unfavorable as to (original bill) (Committee Substitute Bill #), (and recommendation that the committee substitute bill #) be re-referred to the Committee on .)

☐ With a favorable report as to House committee substitute bill (#), ☐ which changes the title, unfavorable as to Senate committee substitute bill.

☐ With an unfavorable report.

☐ With recommendation that the House concur.

☐ With recommendation that the House do not concur.

☐ With recommendation that the House do not concur; request conferees.

☐ With recommendation that the House concur; committee believes bill to be material.

☐ With an unfavorable report, with a Minority Report attached.

☐ Without prejudice.

☐ With an indefinite postponement report.

☐ With an indefinite postponement report, with a Minority Report attached.

☐ With recommendation that it be adopted. (HOUSE RESOLUTION ONLY)

06/29/99

1999 COMMITTEE REPORT
HOUSE OF REPRESENTATIVES

The following report(s) from standing committee(s) is/are presented:
By Representative(s) **THOMAS E. WRIGHT** for the Committee on **HEALTH**.

☐ Committee Substitute for
S.B. 793 A BILL TO BE ENTITLED AN ACT AMENDING THE PSYCHOLOGY PRACTICE ACT TO INCLUDE WITHIN THE SCOPE OF PRACTICE THE DIAGNOSIS AND TREATMENT OF NEUROPSYCHOLOGICAL ASPECTS OF PHYSICAL ILLNESS, ACCIDENT, INJURY, OR DISABILITY AND TO DEFINE THE TERM NEUROPSYCHOLOGICAL.

☒ With a favorable report.

☐ With a favorable report and recommendation that the bill be re-referred to the Committee on Appropriations ☐ Finance ☐ ☐.

☐ With a favorable report, as amended.

☐ With a favorable report, as amended, and recommendation that the bill be re-referred to the Committee on Appropriations ☐ Finance ☐ ☐.

☐ With a favorable report as to committee substitute bill (#), ☐ which changes the title, unfavorable as to (original bill) (Committee Substitute Bill #), (and recommendation that the committee substitute bill #) be re-referred to the Committee on .)

☐ With a favorable report as to House committee substitute bill (#), ☐ which changes the title, unfavorable as to Senate committee substitute bill.

☐ With an unfavorable report.

☐ With recommendation that the House concur.

☐ With recommendation that the House do not concur.

☐ With recommendation that the House do not concur; request conferees.

☐ With recommendation that the House concur; committee believes bill to be material.

☐ With an unfavorable report, with a Minority Report attached.

☐ Without prejudice.

☐ With an indefinite postponement report.

☐ With an indefinite postponement report, with a Minority Report attached.

☐ With recommendation that it be adopted. (HOUSE RESOLUTION ONLY)

06/29/99

file 2

1999 COMMITTEE REPORT
HOUSE OF REPRESENTATIVES

The following report(s) from standing committee(s) is/are presented:
By Representative(s) **THOMAS E. WRIGHT** for the Committee on **HEALTH**.

☐ Committee Substitute for
S.B. 951 A BILL TO BE ENTITLED AN ACT TO PROTECT PATIENT'S RIGHTS BY REQUIRING NAME BADGES OR OTHER IDENTIFICATION FOR HEALTH CARE PRACTITIONERS.

☐ With a favorable report.

☐ With a favorable report and recommendation that the bill be re-referred to the Committee on Appropriations ☐ Finance ☐ ☐.

☐ With a favorable report, as amended.

☐ With a favorable report, as amended, and recommendation that the bill be re-referred to the Committee on Appropriations ☐ Finance ☐ ☐.

☐ With a favorable report as to committee substitute bill (#), ☐ which changes the title, unfavorable as to (original bill) (Committee Substitute Bill #), (and recommendation that the committee substitute bill #) be re-referred to the Committee on .)

☒ With a favorable report as to House committee substitute bill, unfavorable as to Senate committee substitute bill.

☐ With an unfavorable report.

☐ With recommendation that the House concur.

☐ With recommendation that the House do not concur.

☐ With recommendation that the House do not concur; request conferees.

☐ With recommendation that the House concur; committee believes bill to be material.

☐ With an unfavorable report, with a Minority Report attached.

☐ Without prejudice.

☐ With an indefinite postponement report.

☐ With an indefinite postponement report, with a Minority Report attached.

☐ With recommendation that it be adopted. (HOUSE RESOLUTION ONLY)

06/30/99

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 1999

S 1

SENATE BILL 160

Short Title: Nurse Rehabilitation. (Public)

Sponsors: Senators Perdue; Carpenter, Carter, Clodfelter, Cochrane, Cooper, Dannelly, Forrester, Garrou, Garwood, Hagan, Hoyle, Kerr, Lucas, Martin of Guilford, Metcalf, Miller, Plyler, Purcell, Rand, Reeves, Shaw of Cumberland, Soles, and Warren.

Referred to: Health Care.

February 22, 1999

A BILL TO BE ENTITLED

AN ACT AUTHORIZING THE NORTH CAROLINA BOARD OF NURSING TO ESTABLISH PROGRAMS TO AID THE REHABILITATION AND MONITORING OF NURSES WHO EXPERIENCE CERTAIN ADDICTIONS AND DISABILITIES.

The General Assembly of North Carolina enacts:

Section 1. G.S. 90-171.23(b) is amended by adding a new subdivision to read:

"(18) Establish programs for aiding in the recovery and rehabilitation of nurses who experience chemical addiction or abuse or mental or physical disabilities and programs for monitoring such nurses for safe practice."

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

EXPLANATION OF SENATE BILL 160
Nurse Rehabilitation

TO: **Representative Thomas Wright, Chair**
House Health Committee
FROM: **John Young, Committee Staff**
DATE: **May 3, 1999**
SPONSOR: **Senator Beverly Perdue**

Background

Article 9 of Chapter 90 defines the practice of nursing and establishes the process for licensing of nurses. G.S. 90-171.37 gives the Board of Nursing certain powers to revoke, suspend or deny a license if the Board determines that an applicant or licensee has "a mental or physical disability or uses any drug to a degree that interferes with his or her fitness to practice.

A number of professions in North Carolina including medicine, pharmacy, dentistry and law have programs sanctioned by the various licensing boards that attempt to rehabilitate rather than take traditional disciplinary actions against its drug-dependent licensees. In 1994, the Board of Nursing established a voluntary pilot program to rehabilitate nurses whose competency could be impaired because of use of alcohol and/or drugs called the Alternative Program for Chemical Dependency.

Background Information on the Alternative Program for Chemical Dependency

Criteria for participation in the Alternative Program for Chemical Dependency include:

1. Nurse acknowledges actions which violate the Nursing Practice Act;
2. Nurse acknowledges a chemical dependency problem;
3. Nurse voluntarily requests to participate in the Program;
4. Nurse has no previous history of disciplinary action by the Board.

If an individual signs the contract with the Program to participate in the Program, the license is held in abeyance a minimum of three months. Following the time interval, the nurse may petition to return to nursing practice.

While the nurse is on the Program, the nurse is monitored in various ways including various required reports and random urine drug screenings. The nurse must notify the Board if the nurse takes medication, including prescription drugs and certain other over-the-counter medications. Monitoring continues for a minimum of three years from the date the nurse returns to licensed nursing practice.

Summary of Senate Bill 160

Although the Board of Nursing may have implicit authority to conduct the Program for Chemical Dependency, SB 160 adds a new power to the Board that gives the Board explicit authority to establish programs to aid and monitor nurses experiencing chemical addiction or disabilities.

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 1999

S 1

SENATE BILL 793

Short Title: Psychology Practice Definitions. (Public)

Sponsors: Senator Clodfelter.

Referred to: Health Care.

April 8, 1999

A BILL TO BE ENTITLED

AN ACT AMENDING THE PSYCHOLOGY PRACTICE ACT TO INCLUDE WITHIN THE SCOPE OF PRACTICE THE DIAGNOSIS AND TREATMENT OF NEUROPSYCHOLOGICAL ASPECTS OF PHYSICAL ILLNESS, ACCIDENT, INJURY, OR DISABILITY AND TO DEFINE THE TERM NEUROPSYCHOLOGICAL.

The General Assembly of North Carolina enacts:

Section 1. G.S. 90-270.2 is rewritten to add the following new subsection to read:

"(7a) Neuropsychological. -- Pertaining to the study of brain-behavior relationships, including the diagnosis, including etiology and prognosis, and treatment of the emotional, behavioral, and cognitive effects of cerebral dysfunction through psychological and behavioral techniques and methods."

Section 2. G.S. 90-270.2(8) reads as rewritten:

"(8) Practice of psychology. -- The observation, description, evaluation, interpretation, or modification of human behavior by the application of psychological principles, methods, and procedures for the purpose of preventing or eliminating symptomatic, maladaptive, or undesired behavior or of enhancing interpersonal relationships, work and life adjustment, personal effectiveness, behavioral health, or mental health. The practice of psychology includes, but is not limited to: psychological testing and the evaluation or assessment of personal characteristics such as

intelligence, personality, abilities, interests, aptitudes, and neuropsychological functioning; counseling, psychoanalysis, psychotherapy, hypnosis, biofeedback, and behavior analysis and therapy; ~~diagnosis~~ diagnosis, including etiology and prognosis, and treatment of mental and emotional disorder or disability, alcoholism and substance abuse, disorders of habit or conduct, as well as of the psychological and neuropsychological aspects of physical illness, accident, injury, or disability; and psychoeducational evaluation, therapy, remediation, and consultation. Psychological services may be rendered to individuals, families, groups, and the public. The practice of psychology shall be construed within the meaning of this definition without regard to whether payment is received for services rendered."

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

SENATE BILL 793:
Psychology Practice Definitions

BILL ANALYSIS

Committee:	House Health Committee	**Introduced by:**	Clodfelter
Date:	June 8, 1999	**Summary by:**	John Young
Version:	1		Committee Staff

SUMMARY: ***This bill amends the Psychology Practice Act to include within its scope of practice the diagnosis (including etiology and prognosis) and treatment of neuropsychological aspects of physical illness, accident, injury, or disability and to define the term "neuropsychology".***

CURRENT LAW: Article 18A of Chapter regulates the practice of psychology and was first passed by the General Assembly in 1967. This act establishes the North Carolina Psychology Board that consist of seven members appointed by the Governor . . The Board is composed of three licensed psychologists, two licensed psychological associates and two members of the public. The act defines the practice of psychology and who must be licensed to practice and who is exempt .

BILL ANALYSIS: Senate Bill 793 amends the "definitions" section of the Psychology Practice Act to:

1. Add a definition of "neuropsychological"; and
2. Clarify that within the scope of practice of psychology is diagnosis, including etiology and prognosis, and treatment of neuropsychological aspects of physical illness, accident, injury, or disability. This would confirm that diagnosis includes determinations of cause and prognosis

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 1999

S 2

SENATE BILL 951
Health Care Committee Substitute Adopted 4/21/99

Short Title: Health Care Workers/ID Badge. (Public)

Sponsors:

Referred to:

April 14, 1999

A BILL TO BE ENTITLED

AN ACT TO PROTECT PATIENTS' RIGHTS BY REQUIRING NAME BADGES OR OTHER IDENTIFICATION FOR HEALTH CARE PRACTITIONERS.

The General Assembly of North Carolina enacts:

Section 1. Chapter 90 of the General Statutes is amended by adding the following new Article to read:

"ARTICLE 37.

"Health Care Practitioner Identification.

"**§ 90-640. Identification badges required.**

(a) For purposes of this section, 'health care practitioner' means an individual who is licensed, certified, or registered to engage in the practice of medicine, nursing, dentistry, pharmacy, or any related occupation involving the direct provision of health care to patients.

(b) When providing health care to a patient, a health care practitioner shall wear a badge or other form of identification displaying in readily visible type the individual's name and the license, certification, or registration held by the practitioner. If the identity of the individual's license, certification, or registration is commonly expressed by an abbreviation rather than by full title, that abbreviation may be used on the badge or other identification.

(c) The badge or other form of identification is not required to be worn if the patient is being seen in the health care practitioner's office and, the name and license of the practitioner can be readily determined by the patient from a posted license, a sign in the office, a brochure provided to patients, or otherwise.

(d) Each licensing board or other regulatory authority for health care practitioners may adopt rules for exemptions from wearing a badge or other form of identification, or for allowing use of the practitioner's first name only, when necessary for the health care practitioner's safety or for therapeutic concerns.

(e) Violation of this section is a ground for disciplinary action against the health care practitioner by the practitioner's licensing board or other regulatory authority."

Section 2. G.S. 90-171.43 reads as rewritten:

"**§ 90-171.43. License required.**

~~No person shall practice or offer to practice as or use any card, title or abbreviation to indicate that such person is a registered nurse or licensed practical nurse unless that person is currently licensed as provided by this Article.~~ No person shall practice or offer to practice as a registered nurse or licensed practical nurse, or use the word 'nurse' as a title for herself or himself, or use an abbreviation to indicate that the person is a registered nurse or licensed practical nurse, unless the person is currently licensed as a registered nurse or licensed practical nurse as provided by this Article. If the word 'nurse' is part of a longer title, such as 'nurse's aide', a person who is entitled to use that title shall use the entire title and may not abbreviate the title to 'nurse'. This Article shall not, however, be construed to prohibit or limit the following:

(1) The performance by any person of any act for which that person holds a license issued pursuant to North Carolina law;

(2) The clinical practice by students enrolled in approved nursing programs, continuing education programs, or refresher courses under the supervision of qualified faculty;

(3) The performance of nursing performed by persons who hold a temporary license issued pursuant to G.S. 90-171.33;

(4) The delegation to any person, including a member of the patient's family, by a ~~physician licensed to practice medicine in North Carolina, a licensed dentist or~~ registered nurse of those patient-care services which are routine, repetitive, limited in scope that do not require the professional judgment of a registered nurse or licensed practical nurse;

(5) Assistance by any person in the case of emergency.

Any person permitted to practice nursing without a license as provided in subdivision (2) or (3) of this section shall be held to the same standard of care as any licensed nurse."

Section 3. This act becomes effective October 1, 1999, but from October 1, 1999, to October 1, 2001, all health care practitioners are required to wear name badges only. Effective October 1, 2001, all health care practitioners shall be in full compliance with this act.

SENATE BILL 951:
Health Care Workers/ID Badges

BILL ANALYSIS

Committee:	House Health Committee	**Introduced by:**	Perdue
Date:	May 3, 1999	**Summary by:**	John Young
Version:	2 (2nd version only changed effective dates)		Committee Staff

SUMMARY: ***Requires (with certain exemptions) that a physician, nurse, dentist or pharmacist shall wear a badge or other form of identification displaying the individuial's name and the license, certification or registration held by the proactitioner. The act regulating the practice of nursing is also amended to specify that no one may use the word "nurse" as a title unless the person is currently licensed. The act is effective October 1, 1999, but from October 1,1999 to October 1, 2001 all health care practitioners are required to wear name badges only.***

CURRENT LAW: Senate Bill would add a new Article 37 to Chapter 90 of the General statutes and amend the Nurse Practice Act to redefine who may use the word "nurse".

BILL ANALYSIS: Senate Bill 951 would do the following:

1. Add a new Article 37 to GS Chapter 90 with the following provisions;
   a. define "health care practitioner" to mean an individual who is licensed, certified, or registered to practice medicine, nursing, dentistry, pharmacy or any related occupation involving the direct provision of health care to patients,
   b. Such health care practitioners, when providing care to patients, must wear a badge in readily visible type, the individual's name and the license, certification, or registration the practitioner holds,
   c. The badge need not be worn if the patient is being seen in the practitioner's office and the name and license can readily be determined by the patient from a posted license, a sign ,etc.
   d. Authorizes licensing boards and other rgulatory authorities for practitioners to adopt rules for exemption from wearing badges when necessary for practitioner's safety or for therapeutic
   e. Violation of this section is a ground for disciplinary action against a proactitioner by the board.

2. Amend G.S. 90-171.43 (requiring license for the practice of nursing) to do the following:
   a. No one may use the word "nurse" as a title unless the person is currently licensed as a registered nurse or licensed practical nurse.
   b. If the word "nurse" is part of a larger title such as "nurse aide", a person who is entitled to use that

title is to use the entire title and may not abbreviate it to "nurse".

C. G.S. 90-171.43 requires the licensure of nurses but exempts certain functions from these licensing provisions. One of these is the delegation to any person, including the members of a person' family, by a physician licensed to practice medicine in North Carolina, a licensed dentist, or a registered nurse , patient care services that do not require the professional judgement of a registered nurse. The bill would remove this delegation from the physician and dentist but leave this with the nurse.

VISITOR REGISTRATION SHEET

Health — June 29, 1999

Name of Committee — Date

VISITORS: PLEASE SIGN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Dr. P.E. Logue	Duke Medical Center - Durham
Sally Cameron	NC Psychological Assoc.
joanne Schoen	nc nurses Assoc.
[illegible]	NC PA
Howard KRAMER	N.C. Bd. of Nursing
Beth Melcher	NAMI NC
Sandra Kang	NCAPP
Judy Border	NC Nurses Association
Will Eliggator	MHA/NC
Tommy Worth	Carolina Healthcare System
Dr. D.A. Harshaw	First Baptist Church
Katherine [illegible]	
[illegible]	
MICHAEL CROWELL	NC PSYCH ASSN; NC NURSES ASSN
[illegible]	NC [illegible]
Mary Ann Kelly	NCATL
[illegible]	[illegible]
Stan [illegible]	NCMS
[illegible]	NCMS
[illegible]	AHHC
Stacy Flannery	NCHCFA
Jon Wilson	NCALTCF

AGENDA

HOUSE COMMITTEE ON HEALTH
TUESDAY, JULY 6, 1999
12:00 NOON, ROOM 415 LOB

OPENING REMARKS

REP. THOMAS E. WRIGHT
CHAIRMAN

BILLS TO BE DISCUSSED

HB-836-CHIROPRACTIC CLAIMS REVIEW-(REP. MOORE)

SB-732-CHIROPRACTIC OWNERSHIP RESTRICTED-(SEN. SOLES)

COMMENTS

ADJOURNMENT

MINUTES

HOUSE COMMITTEE ON HEALTH

TUESDAY, JULY 6, 1999

12:00 NOON, ROOM 415 LOB

The House Committee on Health met on Tuesday, July 6, 1999 at 12:00 Noon in Room 415-LOB. A silent roll was taken, (roll list denotes members present).

Chairman Wright called the meeting to order.

The Pages for the Committee on Health was introduced to the Health Committee.

SB-732 CHIROPRACTIC OWNERSHIP RESTRICTED

Senator Soles was introduced to explain the bill.

Rep. Justus is recognized and moved for a favorable report on the bill.

Rep. Edwards is recognized and makes a comment on the bill. Rep. Esposito is recognized for a question to the bill sponsor about the effective date of the bill. Sen. Soles responds. Rep. Womble is recognized for a question about the cost. Sen. Soles responds. Rep. Womble follows-up with another question. Sen. Soles responds. Rep. Womble commented that he supported the bill and requested more information about the cost. Chairman Wright asked if there were further questions or comments on the motion.

The vote was taken. The Ayes had the majority vote.

SB-732-Chiropractic Ownership Restricted was given a favorable report.

The meeting adjourned at 12:35 PM.

Rep. Thomas E. Wright, Chairman

Vanda Wilson-Wormack, Committee Asst.

file
2

1999 COMMITTEE REPORT
HOUSE OF REPRESENTATIVES

The following report(s) from standing committee(s) is/are presented:
By Representative(s) **THOMAS E. WRIGHT** for the Committee on **HEALTH.**

☒ Committee Substitute for
S.B. 732 A BILL TO BE ENTITLED AN ACT AUTHORIZING THE NORTH CAROLINA BOARD OF CHIROPRACTIC EXAMINERS TO ASSESS LICENSEES CERTAIN COSTS AND LIMITING THE OWNERSHIP OF CHIROPRACTIC PRACTICES TO PERSONS LICENSED AS CHIROPRACTORS.

☒ With a favorable report.

☐ With a favorable report and recommendation that the bill be re-referred to the Committee on Appropriations ☐ Finance ☐ ☐.

☐ With a favorable report, as amended.

☐ With a favorable report, as amended, and recommendation that the bill be re-referred to the Committee on Appropriations ☐ Finance ☐ ☐.

☐ With a favorable report as to committee substitute bill (#), ☐ which changes the title, unfavorable as to (original bill) (Committee Substitute Bill #), (and recommendation that the committee substitute bill #) be re-referred to the Committee on .)

☐ With a favorable report as to House committee substitute bill (#), ☐ which changes the title, unfavorable as to Senate committee substitute bill.

☐ With an unfavorable report.

☐ With recommendation that the House concur.

☐ With recommendation that the House do not concur.

☐ With recommendation that the House do not concur; request conferees.

☐ With recommendation that the House concur; committee believes bill to be material.

☐ With an unfavorable report, with a Minority Report attached.

☐ Without prejudice.

☐ With an indefinite postponement report.

☐ With an indefinite postponement report, with a Minority Report attached.

☐ With recommendation that it be adopted. (HOUSE RESOLUTION ONLY)

07/06/99

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 1999

S 2

SENATE BILL 732
Commerce Committee Substitute Adopted 4/21/99

Short Title: Chiropractic Ownership Restricted. (Public)

Sponsors:

Referred to:

April 1, 1999

A BILL TO BE ENTITLED

AN ACT AUTHORIZING THE NORTH CAROLINA BOARD OF CHIROPRACTIC EXAMINERS TO ASSESS LICENSEES CERTAIN COSTS AND LIMITING THE OWNERSHIP OF CHIROPRACTIC PRACTICES TO PERSONS LICENSED AS CHIROPRACTORS.

The General Assembly of North Carolina enacts:

Section 1. G.S. 90-154 is amended by adding a new subsection to read:

"(c) If a licensee is found guilty in a contested case arising under subsection (b) of this section, the Board may assess the licensee the reasonable cost of the hearing held to make such a determination if the Board finds that the licensee's defense at the hearing was dilatory or not asserted in good faith."

Section 2. Article 8 of Chapter 90 of the General Statutes is amended by adding a new section to read:

"**§ 90-157.3. Ownership of chiropractic practices limited.**

(a) Each partner in a partnership that is engaged in the practice of chiropractic shall be licensed under this Article.

(b) Each general partner in a limited partnership that is engaged in the practice of chiropractic and each limited partner who takes part in the control of the practice shall be licensed under this Article.

(c) The provisions of Chapter 55B of the General Statutes shall apply to all business corporations organized under Chapter 55 of the General Statutes and engaged in the practice of chiropractic."

Section 3. Section 1 of this act is effective when it becomes law. Section 2 of this act becomes effective January 1, 2000.

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 1999

S 2

SENATE BILL 732
Commerce Committee Substitute Adopted 4/21/99

Short Title: Chiropractic Ownership Restricted. (Public)

Sponsors:

Referred to:

April 1, 1999

A BILL TO BE ENTITLED

AN ACT AUTHORIZING THE NORTH CAROLINA BOARD OF CHIROPRACTIC EXAMINERS TO ASSESS LICENSEES CERTAIN COSTS AND LIMITING THE OWNERSHIP OF CHIROPRACTIC PRACTICES TO PERSONS LICENSED AS CHIROPRACTORS.

The General Assembly of North Carolina enacts:

Section 1. G.S. 90-154 is amended by adding a new subsection to read:

"(c) If a licensee is found guilty in a contested case arising under subsection (b) of this section, the Board may assess the licensee the reasonable cost of the hearing held to make such a determination if the Board finds that the licensee's defense at the hearing was dilatory or not asserted in good faith."

Section 2. Article 8 of Chapter 90 of the General Statutes is amended by adding a new section to read:

"**§ 90-157.3. Ownership of chiropractic practices limited.**

(a) Each partner in a partnership that is engaged in the practice of chiropractic shall be licensed under this Article.

(b) Each general partner in a limited partnership that is engaged in the practice of chiropractic and each limited partner who takes part in the control of the practice shall be licensed under this Article.

(c) The provisions of Chapter 55B of the General Statutes shall apply to all business corporations organized under Chapter 55 of the General Statutes and engaged in the practice of chiropractic."

Section 3. Section 1 of this act is effective when it becomes law. Section 2 of this act becomes effective January 1, 2000.

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 1999

S 1

SENATE BILL 732

Short Title: Chiropractic Ownership Restricted. (Public)

Sponsors: Senator Soles.

Referred to: Commerce.

April 1, 1999

A BILL TO BE ENTITLED

AN ACT AUTHORIZING THE NORTH CAROLINA BOARD OF CHIROPRACTIC EXAMINERS TO ASSESS LICENSEES CERTAIN COSTS AND LIMITING THE OWNERSHIP OF CHIROPRACTIC PRACTICES TO PERSONS LICENSED AS CHIROPRACTORS.

The General Assembly of North Carolina enacts:

Section 1. G.S. 90-154 is amended by adding a new subsection to read:

"(c) If a licensee is found guilty in a contested case arising under subsection (b) of this section, the Board may assess the licensee the reasonable cost of the hearing held to make such a determination if the Board finds that the licensee's defense at the hearing was dilatory or not asserted in good faith."

Section 2. Article 8 of Chapter 90 of the General Statutes is amended by adding a new section to read:

"**§ 90-157.3. Ownership of chiropractic practices limited.**

(a) Each partner in a partnership that is engaged in the practice of chiropractic shall be licensed under this Article.

(b) Each general partner in a limited partnership that is engaged in the practice of chiropractic and each limited partner who takes part in the control of the practice shall be licensed under this Article.

(c) The provisions of Chapter 55B of the General Statutes shall apply to all business corporations organized under Chapter 55 of the General Statutes and engaged in the practice of chiropractic.

(d) A chiropractic physician may form a professional corporation or limited liability company with another health care provider who is licensed under Chapter 90 of the General Statutes."

Section 3. Section 1 of this act is effective when it becomes law. Section 2 of this act becomes effective January 1, 2000.

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 1999

H 1

HOUSE BILL 836

Short Title: Chiropractic Claims Review. (Public)

Sponsors: Representative Moore.

Referred to: Health.

April 1, 1999

A BILL TO BE ENTITLED

AN ACT REQUIRING THAT THE REVIEW OF CERTAIN MEDICAL CLAIMS BE CONDUCTED BY PERSONS LICENSED TO PRACTICE CHIROPRACTIC IN THIS STATE.

The General Assembly of North Carolina enacts:

Section 1. Article 8 of Chapter 90 of the General Statutes is amended by adding a new section to read:

"**§ 90-153.1. Practice of chiropractic includes claims review.**

Any person who reviews the clinical records, narratives, reports, or billing statements of a chiropractic physician who has treated a resident of this State for the purpose of determining whether any service or treatment rendered by such chiropractic physician was necessary, and who undertakes such review at the request of or for the benefit of any insurer, claims adjuster, managed care entity, or health benefits plan shall be deemed to be engaged in the practice of chiropractic and shall be subject to the provisions of this Article."

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

HOUSE BILL 836:
Chiopractic Claims Review

BILL ANALYSIS

Committee:	House Health Committee	**Introduced by:**	Moore
Date:	April 23, 1999	**Summary by:**	John Young
Version:	1		Committee Staff

SUMMARY: ***House Bill 836 would define that the review of certain medical claims is the practice of chiropractic and makes such reviewer subject to the provisions of the Chiropractor Practice Act.***

CURRENT LAW: Article 8 of Chapter 90 regulates the practice of chiropractic. "Chiropractic is defined as the science of adjusting the cause of disease by realigning the spine, releasing pressure on nerves radiating from the spine to all parts of the body, and allowing the nerves to carry thir full quota of health current (nerve energy) from the brain to all parts of the body. The act is administered by a board of seven members, six of whom are practicing doctors of chiopractic.

BILL ANALYSIS: House Bill 836 would add a new G.S. 90-153.1 to the provisions governing the practice of chiropractic to provide that any person who reviews the clinical records, narratives, reports, or billing statements of a chiropractic physician to conduct a claims review on behalf of any insurer, claims adjuster, managed care entity, or health benefits plan shall be deemed to be engaged in the practice of chiropractic and subject to the provisions governing chiropractic practice.

SENATE BILL 732:
Chiropractic Ownership Restricted

BILL ANALYSIS

Committee:	House Health Committee	**Introduced by:**	Senator Soles
Date:	July 6, 1999	**Summary by:**	John Young
Version:	Second Edition		Esther Manheimer

BILL ANALYSIS:

Licensee Found Guilty Must Pay Reasonable Cost of Hearing.
Section 1. Amends G.S. 90-154 by adding a new subsection. G.S. 90-154 is the section that pertains to grounds for professional discipline. The proposed subsection would allow the State Board of Chiropractic Examiners to assess a licensee found guilty in a contested case hearing the reasonable cost of the hearing if the Board finds that the licensee's defense at the hearing was (1) dilatory (intended to cause delay) or (2) not asserted in good faith.

Certain Persons to be Licensed, Professional Corporation Act to Apply, Chiropractic Physicians to form Professional Corporations with other Licensed Health Care Providers.
Section 2. Amends Article 8 of Chapter 90 by adding a new section. This section would require that the following persons obtain a license authorizing them to practice chiropractic in North Carolina:

1. Each partner in a partnership that is engaged in the practice of chiropractic.
2. Each general partner in a limited partnership that is engaged in the practice of chiropractic and each limited partner who takes part in the control of the practice.

In addition, this section would require the Professional Corporation Act to apply to corporations that are formed under the Business Corporation Act and engage in the practice of chiropractic.

Section 1 of this act is effective when it becomes law. Section 2 becomes effective January 1, 2000.

S732-SMSK-001

SUMMARY OF SB 732: CHIROPRACTIC OWNERSHIP RESTRICTED

I. The main purpose of SB 732 is to close loopholes in the existing law and make certain that chiropractic clinics located in North Carolina are owned and operated by chiropractors licensed in North Carolina. The Professional Corporations Act already restricts ownership of a chiropractic P.C. to licensed chiropractors; SB 732 would extend that restriction to partnerships and ordinary business corporations as well.

The Board of Chiropractic Examiners developed SB 732 after becoming aware that several chiropractic clinics located in North Carolina were owned or controlled by lay persons from outside the State who viewed the clinics merely as investments. Although these investors hired licensed chiropractors to deliver patient services, key business decisions were made by the investors. Consequently, advertising and billing practices that violated State law could not be policed effectively by the Board of Examiners, whose jurisdiction is limited to the chiropractor-employee.

It is the understanding of the Board that most other health care professions in North Carolina already have comparable ownership restrictions in place.

II. The secondary purpose of SB 732, unrelated to the ownership issue, is to enable the Board of Chiropractic Examiners to tax the actual costs of a formal disciplinary hearing upon a respondent physician if he is found guilty and is also found to have interposed dilatory or bad faith defenses.

In the Board's experience, a few doctors have failed to respond in any manner to the Board's attempts to settle disciplinary grievances informally, forcing the Board to convene formal hearings. At hearing, the physician asserts no defense on the merits, and it becomes clear that the case could and should have been resolved informally. In such circumstances, the proposed legislation would permit the Board to recover from the respondent its actual costs, which typically include overnight accommodations for Board members, per diems, and court reporting fees.

The Board believes that having this statute on the books would serve as a deterrent to unnecessary hearings. The General Assembly has already seen fit to enact a similar provision for the Nursing Board.

VISITOR REGISTRATION SHEET

House Committee on Health — 7/6/99
Name of Committee — Date

VISITORS: PLEASE SIGN BELOW AND RETURN TO COMMITTEE CLERK.

NAME	FIRM OR AGENCY AND ADDRESS
Jack Hawke	NCCA
Mike Mann	NCCA
Otis Carter	Carter & Associates
Amy DeBaun	NCMS
Ron Mennuti	Poyner & Spruill
HUGH WILSON	NCHA
G. PEYTON MAYNARD	GPM Co.
John Rusin	NCFPC
Steve Keen	NCMS
John Cyrus	N.C. State Grange
Joe Rainey	Poyner & Spruill
Will Ivy	AHHC

AGENDA

HOUSE COMMITTEE ON HEALTH
FRIDAY, JULY 9, 1999
9:00 A.M., ROOM 415 LOB

OPENING REMARKS

REP. THOMAS E. WRIGHT
CHAIRMAN

BILLS TO BE DISCUSSED

SB-783-LONG-TERM CARE FACILITIES/ DISCLOSURE-(SEN. COCHRANE)

COMMENTS

ADJOURNMENT

MINUTES

HOUSE COMMITTEE ON HEALTH

FRIDAY, JULY 9, 1999

9:00A.M., ROOM 415 LOB

The House Committee on Health met on Friday, July 9, 1999 at 9:00am in Room 415-LOB. A silent roll was taken, (roll list denotes members present.)

Chairman Wright called the meeting to order.

The Pages for the House Committee on Health was introduced to the Health Committee.

SB-783-LONG-TERM CARE FACILITIES/ DISCLOSURE

Rep. Justus moved for adoption of the proposed committee substitute. So moved.

Vice-Chairman Insko recognized Rep. Wright to explain the committee substitute. Vice-Chairman asked the committee if there were any questions or comments on the proposed committee substitute bill. Rep. Redwine is recognized for a question about the affect of this bill on small town pharmacies. Rep. Wright deferred the question to staff and Linda Attarian responded. Rep. Redwine followed-up with a question about In-State Practitioners vs. Out-of-State Practitioners. John Young , General Research, responded. Rep. Redwine followed-up. Rep. Wright responds. Rep. Bowie is recognized for a question by the Vice-Chairman. Rep. Bowie comments about the bill on page four. Vice-Chairman re-frames the question of Rep. Bowie about how can laws be passed in North Carolina that could control a pharmacists in another state. Linda Attarian, Research Staff, responded. Rep. Bowie follows-up. The Vice-Chairman recognized Alan Miles, Counsel to the Board of Pharmacy. Alan Miles comments.

Rep. Bowie follows-up and sent forth an amendment that deletes section five of the bill.

Rep. Redwine is recognized for a question about the bill. Alan Miles responded. Rep. Redwine followed-up. Alan Miles responded. Rep. Esposito is recognized for a question. Alan Miles responded and directed the question to David Work, Director of the Board of Pharmacy. Mr. Work is recognized by Vice-Chairman Insko for a comment. Rep. Esposito followed-up. David Work responded. Rep. Bowie comments and deferred her concern to Marvin Musselwhite of Merck Medco. for a comment on the issue. Rep. Bowie would like to make an amendment to section five of the bill. Rep. Edwards is recognized for a question. David Work responded. Rep. Redwine asked a question to

Marvin Musselwhite. Mr. Musselwhite responded. Rep. Redwine followed-up. Mr. Musselwhite responded. Rep. Clary spoke in favor of the amendment. Rep. Justus asked Mr. Musselwhite a question. Mr. Musselwhite responded. Rep. Justus followed-up. Mr. Musselwhite responded. Rep. Wright is recognized and opposed the amendment. Vice-Chairman Insko states that the amendment is properly before the committee for a vote.

The vote was taken by show of hands at the request of Vice-Chairman Insko. The amendment failed, 3-5.

Vice-Chairman Insko asked for further discussion on the bill.

Rep. Justus asked the Chairman if there would be any more Health Committee meetings held this session. Rep. Wright responded.

Rep. Wright moved for a favorable report, unfavorable as to the original bill.

The Ayes had the majority vote.

The meeting adjourned at 11:15am.

Rep. Thomas E. Wright, Chairman

Vanda Wilson-Wormack, Committee Asst.

1999 COMMITTEE REPORT
HOUSE OF REPRESENTATIVES

The following report(s) from standing committee(s) is/are presented:
By Representative(s) **THOMAS E. WRIGHT** for the Committee on **HEALTH.**

☒ Committee Substitute for
S.B. 783 A BILL TO BE ENTITLED AN ACT TO REQUIRE THAT NURSING HOMES PROVIDING SPECIAL CARE FOR PERSONS WITH ALZHEIMER'S DISEASE OR OTHER DEMENTIAS DISCLOSE CERTAIN INFORMATION.

☐ With a favorable report.

☐ With a favorable report and recommendation that the bill be re-referred to the Committee on Appropriations ☐ Finance ☐ ☐.

☐ With a favorable report, as amended.

☐ With a favorable report, as amended, and recommendation that the bill be re-referred to the Committee on Appropriations ☐ Finance ☐ ☐.

☐ With a favorable report as to committee substitute bill, ☐ which changes the title, unfavorable as to Committee Substitute Bill, .)

☒ With a favorable report as to House committee substitute bill, unfavorable as to Senate committee substitute bill.

☐ With an unfavorable report.

☐ With recommendation that the House concur.

☐ With recommendation that the House do not concur.

☐ With recommendation that the House do not concur; request conferees.

☐ With recommendation that the House concur; committee believes bill to be material.

☐ With an unfavorable report, with a Minority Report attached.

☐ Without prejudice.

☐ With an indefinite postponement report.

☐ With an indefinite postponement report, with a Minority Report attached.

☐ With recommendation that it be adopted. (HOUSE RESOLUTION ONLY)

07/09/99

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 1999

S D

SENATE BILL 783
Health Care Committee Substitute Adopted 4/28/99
Proposed House Committee Substitute S783-PCS8624-RN

Short Title: Long-Term Care Facilities/Disclosure. (Public)

Sponsors:

Referred to:

April 7, 1999

A BILL TO BE ENTITLED

AN ACT TO REQUIRE THAT NURSING HOMES PROVIDING SPECIAL CARE FOR PERSONS WITH ALZHEIMER'S DISEASE OR OTHER DEMENTIAS DISCLOSE CERTAIN INFORMATION, TO ALLOW CERTAIN INDIVIDUALS EXCLUDED FROM MEMBERSHIP IN THE TEACHERS' AND STATE EMPLOYEES' COMPREHENSIVE MAJOR MEDICAL PLAN TO APPLY FOR REINSTATEMENT IN THE PLAN, AND TO REQUIRE OUT-OF-STATE PHARMACIES TO FILL VALID PRESCRIPTIONS WRITTEN BY NORTH CAROLINA PRACTITIONERS.

The General Assembly of North Carolina enacts:

Section 1. Part A of Article 6 of Chapter 131E of the General Statutes is amended by adding the following new section to read:

"**§ 131E-113. Special care units; disclosure of information required.**

(a) A nursing home or combination home licensed under this Part that provides special care for persons with Alzheimer's disease or other dementias in a special care unit shall make the following disclosures pertaining to the special care provided that distinguishes the special care unit as being especially designed for residents with Alzheimer's disease or other dementias. The disclosure shall be made annually, in writing, to all of the following:

(1) The Department, as part of its licensing procedures.

(2) Each person seeking placement within a special care unit, or the person's authorized representative, prior to entering into an agreement with the person to provide special care.

(b) Information that must be disclosed in writing shall include, but is not limited to, all of the following:

(1) A statement of the overall philosophy and mission of the licensed facility and how it reflects the special needs of residents with dementia.

(2) The process and criteria for placement, transfer, or discharge to or from the special care unit.

(3) The process used for assessment and establishment of the plan of care and its implementation, as required under State and federal law.

(4) Typical staffing patterns and how the patterns reflect the resident's need for increased care and supervision.

(5) Dementia-specific staff training.

(6) Physical environment features designed specifically for the special care unit.

(7) Alzheimer's disease and other dementia-specific programming.

(8) Opportunities for family involvement.

(9) Additional costs or fees to the resident for special care.

(c) As part of its license renewal procedures and inspections, the Department shall examine for accuracy the written disclosures made by each licensed facility subject to this section.

(d) Nothing in this section shall be construed as prohibiting a nursing home or combination home that does not offer a special care unit from admitting a person with Alzheimer's disease or other dementias. The disclosures required by this section apply only to a nursing home or combination home that advertises, markets, or otherwise promotes itself as providing a special care unit for persons with Alzheimer's disease or other dementias.

(e) As used in this section, the term 'special care unit' means a wing or hallway within a nursing home, or a program provided by a nursing home, that is designated especially for residents with Alzheimer's disease or other dementias, or other special needs disease or condition, as determined by the Medical Care Commission, which may include mental disabilities."

Section 2. G.S. 135-40.2(h) reads as rewritten:

"(h) No person shall be eligible for coverage as an employee or retired employee or as a dependent of an employee or retired employee upon a finding by the Executive Administrator or Board of Trustees or by a court of competent jurisdiction that the employee or dependent knowingly and willfully made or caused to be made a false statement or false representation of a material fact in a claim for reimbursement of medical services under the Plan. Persons subject to this subsection shall have a cessation of coverage for a period of five years and are eligible to apply

for reinstatement of coverage after the five-year period upon a full and complete restitution to the Plan."

Section 3. G.S. 135-40.11(a)(6) reads as rewritten:

"(6) The last day of the month in which a covered individual is found to have knowingly and willfully made or caused to be made a false statement or false representation of a material fact in a claim for reimbursement of medical services under the Plan. Persons subject to this subdivision shall have a cessation of coverage for a period of five years and are eligible to apply for reinstatement of coverage after the five-year period upon a full and complete restitution to the Plan."

Section 4. G.S. 135-39.5 is amended by adding a new subdivision to read:

"(24) Implementing and administering policies, including requirements for a five-year cessation of coverage, full restitution to the Plan, and other relevant factors, governing reinstatement to the Plan of persons whose coverage was terminated pursuant to G.S. 135-40.2(h) and G.S. 135-40.11(a)(6)."

Section 5. G.S. 90-85.21A reads as rewritten:

"**§ 90-85.21A. Applicability to out-of-state operations.**

(a) Any pharmacy operating outside the State which ships, mails, or delivers in any manner a dispensed legend drug into this State shall annually register with the Board on a form provided by the Board.

(b) Any pharmacy subject to this section shall at all times maintain a valid unexpired license, permit, or registration necessary to conduct such pharmacy in compliance with the laws of the state in which such pharmacy is located. No pharmacy operating outside the State may ship, mail, or deliver in any manner a dispensed legend drug into this State unless such drug is lawfully dispensed by a licensed pharmacist in the state where the pharmacy is located.

(c) The Board shall be entitled to charge and collect not more than two hundred fifty dollars ($250.00) for original registration of a pharmacy under this section, and for renewal thereof, not more than one hundred twenty-five dollars ($125.00).

(d) The Board may deny a nonresident pharmacy registration upon a determination that the pharmacy has a record of being formally disciplined in its home state for violations that relate to the compounding or dispensing of legend drugs and presents a threat to the public health and safety.

(e) Except as otherwise provided in this subsection, the Board may adopt rules to protect the public health and safety that are necessary to implement this section. Notwithstanding G.S. 90-85.6, the Board shall not adopt rules pertaining to the shipment, mailing, or other manner of delivery of dispensed legend drugs by pharmacies required to register under this section that are more restrictive than federal statutes or regulations governing the delivery of prescription medications by mail or common carrier. A pharmacy required to register under this section shall comply with rules adopted pursuant to this section.

(e1) A pharmacy subject to this section that receives a valid prescription from a practitioner in this State who is authorized to prescribe prescription drugs shall dispense or arrange for the dispensing of the prescription.

(f) The Board may deny, revoke, or suspend a nonresident pharmacy registration for failure to comply with any requirement of this section."

Section 6. Section 1 of this act becomes effective January 1, 2000. The remainder of this act is effective when it becomes law.

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 1999

S 2

SENATE BILL 783
Health Care Committee Substitute Adopted 4/28/99

Short Title: Long-Term Care Facilities/Disclosure. (Public)

Sponsors:

Referred to:

April 7, 1999

A BILL TO BE ENTITLED

AN ACT TO REQUIRE THAT NURSING HOMES PROVIDING SPECIAL CARE FOR PERSONS WITH ALZHEIMER'S DISEASE OR OTHER DEMENTIAS DISCLOSE CERTAIN INFORMATION.

The General Assembly of North Carolina enacts:

Section 1. Part A of Article 6 of Chapter 131E of the General Statutes is amended by adding the following new section to read:

"§ 131E-112. Special care units; disclosure of information required.

(a) A nursing home or combination home licensed under this Part that provides special care for persons with Alzheimer's disease or other dementias in a special care unit shall make the following disclosures pertaining to the special care provided that distinguishes the special care unit as being especially designed for residents with Alzheimer's disease or other dementias. The disclosure shall be made annually, in writing, to all of the following:

(1) The Department, as part of its licensing procedures.

(2) Each person seeking placement within a special care unit, or the person's authorized representative, prior to entering into an agreement with the person to provide special care.

(b) Information that must be disclosed in writing shall include, but is not limited to, all of the following:

(1) A statement of the overall philosophy and mission of the licensed facility and how it reflects the special needs of residents with dementia.

(2) The process and criteria for placement, transfer, or discharge to or from the special care unit.

(3) The process used for assessment and establishment of the plan of care and its implementation, as required under State and federal law.

(4) Typical staffing patterns and how the patterns reflect the resident's need for increased care and supervision.

(5) Dementia-specific staff training.

(6) Physical environment features designed specifically for the special care unit.

(7) Alzheimer's disease and other dementia-specific programming.

(8) Opportunities for family involvement.

(9) Additional costs or fees to the resident for special care.

(c) As part of its license renewal procedures and inspections, the Department shall examine for accuracy the written disclosures made by each licensed facility subject to this section.

(d) Nothing in this section shall be construed as prohibiting a nursing home or combination home that does not offer a special care unit from admitting a person with Alzheimer's disease or other dementias. The disclosures required by this section apply only to a nursing home or combination home that advertises, markets, or otherwise promotes itself as providing a special care unit for persons with Alzheimer's disease or other dementias.

(e) As used in this section, the term 'special care unit' means a wing or hallway within a nursing home, or a program provided by a nursing home, that is designated especially for residents with Alzheimer's disease or other dementias, or other special needs disease or condition, as determined by the Medical Care Commission, which may include mental disabilities."

Section 2. This act becomes effective January 1, 2000.

§90-85.21A. Applicability to out-of-state operations.

(a) Any pharmacy operating outside the State which ships, mails, or delivers in any manner a dispensed legend drug into this State shall annually register with the Board on a form provided by the Board.

(b) Any pharmacy subject to this section shall at all times maintain a valid unexpired license, permit, or registration necessary to conduct such pharmacy in compliance with the laws of the state in which such pharmacy is located. No pharmacy operating outside the State may ship, mail, or deliver in any manner a dispensed legend drug into this State unless such drug is lawfully dispensed by a licensed pharmacist in the state where the pharmacy is located.

(c) The Board shall be entitled to charge and collect not more than two hundred fifty dollars ($250.00) for original registration of a pharmacy under this section, and for renewal thereof, not more than one hundred twenty-five dollars ($125.00)

(d) The Board may deny a nonresident pharmacy registration upon a determination that the pharmacy has a record of being formally disciplined in its home state for violations that relate to the compounding or dispensing of legend drugs and presents a threat to the public health and safety.

(e) Except as otherwise provided in this subsection, the Board may adopt rules to protect the public health and safety that are necessary to implement this section. Notwithstanding G.S. 90-85.6 the Board shall not adopt rules pertaining to the shipment, mailing, or other manner of delivery of dispensed legend drugs by pharmacies required to register under this section that are more restrictive than federal statutes or regulations governing the delivery of prescription medications by mail or common carrier. A pharmacy required to register under this section shall comply with rules adopted pursuant to this section.

(f) Any pharmacy subject to this section which receives a valid prescription from a practitioner in this State who is authorized to prescribe prescription drugs shall dispense or arrange for the dispensing of the prescription.

(g) The Board may deny, revoke, or suspend a nonresident pharmacy registration for failure to comply with any requirement of this section.

SENATE BILL 783:
Long-Term Care Facilities Disclosure

BILL ANALYSIS

Committee: House Health Committee
Date: July 7, 1999
Version: 2

Introduced by: Cochrane
Summary by: John Young
Committee Staff

SUMMARY: ***Section 1 of SB 783 would require that nursing homes offering special care to persons with Alzheimer's disease or related dementia disclose in writing certain information about the distinguishing characteristics of the special program to the Department of Health and Human Services and to the person seaking placement or to the person's authorized representative. Sections 2-4 would allow a person to reapply to the Board of Trustees of the State health Plan to regain coverage under the Plan after they have been deemed ineligible for coverage for committing fraud against the plan. Section 5 would require out-of-state pharmacies regulated by the NC Board of Pharmacy to fill all prescriptions written by any North Carolina practitioner authorized in this State to prescribe prescription drugs. Section 1 of the act would become effective January 1, 2000. The remainder of the act is effective when it becomes law.***

SECTION 1

BACKGROUND: As of 1998, an estimated 127,000 older persons have some form of dementia, with about 65,600 experiencing a moderate or severe cognitive impairment, such as Alzheimer's disease that affects their memory and ability to reason. Even though only about 5 % of older adults reside in institutions, almost half of all elderly people will live in a nursing home or adult care facility at some point in their lives.

BILL ANALYSIS: The provisions of SB 783 cover nursing homes which are health care facilities that provide nursing care for patients who need continuing medical supervision for chronic medical conditions or for patients who need remedial or convalescent care, but are not acutely ill on admission and do not need general hospital care.

SB 783 does the following:

- Defines a "special care unit" as a wing or hallway within a nursing home or a program provided by a nursing home that is designated especially for residents with Alzheimer's disease or other denentias.
- Requires that the Medical Care Commission develop rules for compliance with the disclosure requirements as part of the rules governing special care units in nursing homes.
- Requires nursing homes providing special care for Alzheimer's disease or other dementias to disclose anniually in writing to DHHS as part of the licensing procedure and to each person seeking placement or receiving services the following information:
  1. a statement of the overall philosophy and mission and how it reflects the special needs of resident;
  2. process and criteria for placement, transfer or discharge;

3. process used for assessment and establishment of the plan of care and its implementation;
4. typical staffing patterns and how these patterns reflect the patient's need for increased care;
5. dementia-specific staff training;
6. physical environmental features designed specifically for the special care unit;
7. dementia-specific programming;
8. opportunities for family involvement; and
9. additional costs or fees to the resident for special care.

SECTIONS 2-4

CURRENT LAW: If at any time a person is found to have knowingly and willfully made a false statement or a false representation of a material fact in a claim for reimbursement under the State Employee's Health Plan, their coverage will be terminated and the person will no longer be eligible for reinstatement of coverage under the Plan.

BILL ANALYSIS: Sections 2 through 4 of the bill allow a person to reapply to the Board of Trustees of the State Health Plan to regain coverage under the Plan after they have been deemed ineligible for coverage under the Plan for committing fraud against the Plan. To apply for reinstatement, the person must have been off the Plan for 5 years, must have made full restitution, and must comply with any relevant factors the Board establishes for reinstatement.

SECTION 5

BACKGROUND: Other states do not necessarily recognize the validity of prescriptions written by certain NC health care providers, namely, optometrists, physician assistants, and nurse practitioners because these practitioners do not have the same prescriptive authority in such states as they do under North Carolina law. Pharmacies in such states will not fill prescriptions written by these providers, even though the prescription was written in North Carolina to a patient residing in North Carolina. The proposed provision is intended to allow such out-of-state pharmacies to defend a decision to fill a prescription written by a North Carolina provider by stating that they were actin pursuant to a statutory requirement in North Carolina.

BILL ANALYSIS: G.S. 90-85.21, titled Applicability to Out-of-State Operations, authorizes the Board of Pharmacy to regulate out-of-state pharmacies that ship, mail, or deliver prescription drugs into this State. The PCS would amend G.S. 90-85.21 to require out-of-state pharmacies regulated by the NC Board of Pharmacy to fill all prescriptions written by any North Carolina practitioner authorized in this State to prescribe prescription drugs.

NORTH CAROLINA GENERAL ASSEMBLY

LEGISLATIVE FISCAL NOTE

BILL NUMBER: SB 783 Committee Substitute

SHORT TITLE: Long Term Care Facilities - Disclosure

SPONSOR(S):

FISCAL IMPACT

Yes ( ) **No (X)** **No Estimate Available ( )**

	FY 1999-00	FY 2000-01	FY 2001-02	FY 2002-03	FY 2003-04
REVENUES					
EXPENDITURES	none				
POSITIONS:					

PRINCIPAL DEPARTMENT(S) & PROGRAM(S) AFFECTED: Department of Health and Human Services

EFFECTIVE DATE: January 1 2000

BILL SUMMARY:

April 28, 1999

S 783. LONG-TERM CARE FACILITIES/DISCLOSURE. Intro. 4/7/99. Senate committee substitute makes the following changes to 1st edition. Enacts new GS 131E-112 to provide that a nursing home or combination home that provides special care for persons with Alzheimer's disease or other dementias in a special care unit shall make certain disclosures to DHHS and each person seeking placement in the unit, or that person's representative, including: (1) a statement of its philosophy and mission; (2) criteria for placement and transfer to the special unit; (3) staffing patterns; (4) dementia-specific staff training; and (5) Alzheimer's disease and other dementia-specific programming. Special care unit is defined as a wing or hallway within a nursing home, or a program provided by a nursing home, that is designated especially for residents with Alzheimer's disease or other dementias, or other special needs disease or condition, as determined by the Medical Care Comm'n. Effective Jan. 1, 2000.

ASSUMPTIONS AND METHODOLOGY: Diclosure provisions and requirements in Section 1, subsection (a)(1) would occur within the routine licensing process of these facilities and would not incur any additional costs upon the Department.

TECHNICAL CONSIDERATIONS: none

FISCAL RESEARCH DIVISION 733-4910

PREPARED BY:

DATE: July 10, 1999

VISITOR REGISTRATION SHEET

Health
Name of Committee

July 9, 1999
Date

VISITORS: PLEASE SIGN BELOW AND RETURN TO COMMITTEE CLERK.

NAME	FIRM OR AGENCY AND ADDRESS
Stacy Flannery	NCHCFA
Lynda McDaniel	DHHS/DFS
[illegible]	NCAA
[illegible]	NC[illegible]
Jill [illegible]	Ombudsman Assoc
Pam [illegible]	" "
Kristie Russ	" "
Tom Cruise	Hollywood
J Ramquist	NCSOS
Karen Gottovi	Div. of Aging
George Reed	NC Council of Churches
David Work	NC Board of Pharmacy
Alan Miles	[illegible] & Dixon LLP
[illegible] Burnette	GACPD
[illegible] Bain	NCMS
[illegible] B. Watson	[illegible]

VISITOR REGISTRATION SHEET

Health — Name of Committee

7-9-99 — Date

VISITORS: PLEASE SIGN BELOW AND RETURN TO COMMITTEE CLERK.

NAME	FIRM OR AGENCY AND ADDRESS
Hugh Tilson	NCHA
Steve Keene	NCMS

2000

HOUSE
HEALTH
COMMITTEE

MINUTES

HOUSE COMMITTEE ON HEALTH
2000 SESSION

MEMBER	ASSISTANT	PHONE NO.	OFFICE NO.	SEAT NO.
Rep. Thomas Wright, Chair	Clarestene Stewart Vanda Wilson-Wormack	733-5754	528 LOB	5
Rep. Verla Insko, Vice-Chair	Pat Baker	733-5775	1323 LB	70
Rep. Alma Adams		733-5902	542 LOB	67
Rep. Martha Alexander	Ann Faust	733-7208	2121 LOB	32
Rep. Cary Allred	Jean Allred	733-5607	609 LOB	65
Rep. Joni Bowie	Sharon Gaudette	733-5877	538 LOB	53
Rep. Harold Brubaker	Cindy Coley	715-4946	1229 LOB	27
Rep. Debbie Clary	Mary Jamison	733-5654	1211 LOB	97
Rep. Andrew Dedmon	Donna Abu Harb	733-5732	2213 LOB	12
Rep. Theresa Esposito	Judy Lowe	715-3009	418C LOB	28
Rep. Beverly Earle	Ann Raeford	733-5747	535 LOB	95
Rep. Zeno Edwards	Jo Hinton	733-5906	637 LOB	91
Rep. Julia Howard	Gail Stewart	733-5988	1023 LOB	51
Rep. Larry Justus	Carolyn Justus	733-5958	640 LOB	13
Rep. Max Melton	Gerry Durant	733-5784	633 LOB	105
Rep. Jean Preston	Sandra Ellis	733-5706	603 LOB	78
Rep. David Redwine	Nancy Brantley	733-5829	635 LOB	19
Rep. William Wainwright	Blinda Edwards	733-5898	614 LOB	8
Rep. Connie Wilson	Paula Covington	733-5903	501 LOB	73
Rep. Larry Womble	Phyllis Cameron	733-5777	537 LOB	56

HOUSE COMMITTEE ON HEALTH

 Rep. Thomas Wright CHAIRMAN	 Rep. Verla Insko VICE CHAIR	 Rep. Adams	 Rep. Alexander	 Rep. Bowie
 Rep. Brubaker	 Rep. Clary	 Rep. Dedmon	 Rep. Earle	 Rep. Edwards
 Rep. Esposito	Picture is Unavailable Rep. Ford	 Rep. Howard	 Rep. Justus	 Rep. Melton
 Rep. Preston	 Rep. Redwine	 Rep. Wainwright	 Rep. Wilson	 Rep. Womble

ATTENDANCE

HOUSE COMMITTEE ON HEALTH

(Name of Committee)

DATES	6/20	6/22	6/27	9/11										
WRIGHT, THOMAS (CHAIR)	✓	✓	✓	✓										
INSKO, VERLA (VICE CHAIR)	✓	✓	✓	✓										
ADAMS, ALMA	✓	✓		✓										
ALEXANDER, MARTHA	✓	✓	✓											
ALLRED, CARY				✓										
BOWIE, JOANNE	✓	✓	✓	✓										
BRUBAKER, HAROLD				✓										
CLARY, DEBBIE			✓											
DEDMON, ANDREW	✓		✓	✓										
EARLE, BEVERLY	✓	✓												
EDWARDS, ZENO	✓	✓	✓	✓										
ESPOSITO, THERESA	✓		✓	✓										
HOWARD, JULIA				✓										
JUSTUS, LARRY	✓	✓	✓	✓										
MELTON, MAX	✓	✓	✓	✓										
PRESTON, JEAN			✓	✓										
REDWINE, DAVID				✓										
WAINWRIGHT, WILLIAM	✓													
WILSON, CONNIE	✓		✓	✓										
WOMBLE, LARRY	✓		✓	✓										
(EX-OFFICIO MEMBERS)														
BADDOUR, PHIL														
CUNNINGHAM, PETE	✓			✓										
DEDMON, ANDREW														
EARLE, BEVERLY														
HACKNEY, JOE														
Ford, Jimmie	✓	✓	✓											

NORTH CAROLINA GENERAL ASSEMBLY

COMMITTEE SUMMARY REPORT

1999-2000 Biennium HOUSE: HEALTH Valid Through 12-SEP-2000

BILL	INTRODUCER	SHORT TITLE	LATEST ACTION ON BILL	IN DATE	OUT DATE
H 24=	BAKER	MOBILE PHARMACIES	H -RE-REF COM ON HEALTH	02-16-99	
H 36=	BADDOUR	CHIP CLINICS/REPEAL PROHIBITION	H -RE-REF COM ON HEALTH	02-16-99	
H 103=	INSKO	INSURANCE/COVER CONTRACEPTIVES	H -REF TO COM ON HEALTH	02-17-99	
H 254	EDWARDS	HEALTH CARE FACILITY/PATIENT ABUSE	*S -REF TO COM ON JUDICI	03-04-99	04-15-99
H 255	ALEXANDER	VOCATIONAL REHABILITATION CHANGES	R -CH. SL 99-0161	03-04-99	03-09-99
H 697	DEDMON	AREA AUTHORITY MERGER	H -REF TO COM ON HEALTH	03-30-99	
H 736	ROGERS	MANAGED CARE/PATIENT ACCESS	*S -RE-REF COM ON COMMERCE	04-20-99	04-27-99
H 835=	MOORE R	CHIROPRACTIC OWNERSHIP RESTRICTED	H -REF TO COM ON HEALTH	04-01-99	
H 836=	MOORE R	CHIROPRACTIC CLAIMS REVIEW	H -REF TO COM ON HEALTH	04-01-99	
H 905=	ALEXANDER	DENTAL BENEFITS/HEALTH CHOICE	*HF-POSTPONED INDEFINITELY	04-05-99	04-21-99
H 906	ALEXANDER	PHARMACIST PEER REVIEW	R -CH. SL 99-0081	04-05-99	04-13-99
H 996=	WRIGHT	REGULATE SPINAL MANIPULATION	*S -REF TO COM ON HLTHCARE	04-13-99	04-23-99
H1064	DECKER	ABORTION/RIGHT TO KNOW	HF-POSTPONED INDEFINITELY	04-15-99	
H1083	**ALEXANDER**	**ARTHRITIS EDUC. TASK FORCE**	**HF-POSTPONED INDEFINITELY**	**04-15-99**	**04-23-99**
H1095=	ALLEN	CLINICAL PHARMACIST PRACTITIONER	*R -CH. SL 99-0290	04-15-99	04-26-99
H1118	WRIGHT	LIMIT LIABILITY/DEFIBRILLATORS	*HF-POSTPONED INDEFINITELY	04-15-99	04-27-99
H1123=	MOSLEY	STATE HEALTH PLAN AMENDMENTS	H -RE-REF COM ON HEALTH	00-07-05	
H1138=	MCCOMAS	ORTHOPAEDIC PHYSICIAN ASSISTANTS	H -REF TO COM ON HEALTH	04-15-99	
H1250	WILSON C	CON MODIFICATIONS	H -REF TO COM ON HEALTH	04-15-99	
H1258=	EARLE	HEALTH CARE PERSONNEL REGISTRY CHANG	*R -CH. SL 99-0159	04-15-99	04-27-99
H1282=	NYE	MANAGED CARE/PATIENT ACCESS	H -REF TO COM ON HEALTH	04-15-99	
H1340	TOLSON	RESPIRATORY CARE PRACTICE ACT	*R -CH. SL 00-0162	04-26-99	06-23-99
H1396	**INSKO**	**HEALTH CARE FUNDAMENTAL RIGHT**	**H -RE-REF COM ON HEALTH**	**00-05-23**	
H1510=	WRIGHT	HEALTH CARE REGISTRY REPORTS	H -REF TO COM ON HEALTH	00-05-11	
H1572=	EARLE	LONG-TERM CARE RESIDENTS/IMMUN	H -REF TO COM ON HEALTH	00-05-17	
H1628=	WARREN EDITH	MEDICAL CARE COMMN/RULES	H -REF TO COM ON HEALTH	00-05-18	
H1636=	WRIGHT	LIMIT LIABILITY/DEFIBRILLATOR	H -REF TO COM ON HEALTH	00-05-18	
H1831	NESBITT	NC HEALTH CHOICE/NO WAITING PERIOD	H -RE-REF COM ON HEALTH	00-05-31	
H1838	CULPEPPER	STATE HEALTH PLAN AMENDMENTS	*S -RE-REF COM ON APPROPR	00-05-30	00-06-27
H1855	WRIGHT	STATE HEALTH PLAN CHANGES	*R -CH. SL 00-0141	00-05-30	00-06-20

NOTES- = AFTER BILL NUMBER SHOWS THAT BILL IS IDENTICAL, AS INTRODUCED, TO ANOTHER BILL.
* AFTER NUMBERS INDICATES THAT TEXT OF BILL WAS ALTERED BY ACTION ON THE BILL.
BOLDED LINE INDICATES BILL INDEXED AS AFFECTING APPROPRIATIONS.

NORTH CAROLINA GENERAL ASSEMBLY

COMMITTEE SUMMARY REPORT

1999-2000 Biennium HOUSE: HEALTH Valid Through 12-SEP-2000

BILL	INTRODUCER	SHORT TITLE	LATEST ACTION ON BILL	IN DATE	OUT DATE
S 26=	PURCELL	CHIP CLINICS/REPEAL PROHIBITION	R -CH. SL 99-0004	02-18-99	03-02-99
S 59=	FOXX	MOBILE PHARMACIES	*R -CH. SL 99-0246	03-02-99	03-11-99
S 90=	FORRESTER	INSURANCE/COVER CONTRACEPTIVES	*R -CH. SL 99-0231	03-10-99	04-07-99
S 160	PERDUE	NURSE REHABILITATION	R -CH. SL 99-0291	04-05-99	06-29-99
S 194	RAND	NURSE LICENSURE COMPACT	*R -CH. SL 99-0245	04-06-99	05-25-99
S 432=	CARPENTER R	MISCELLANEOUS HEALTH PLAN CHANGES	*R -CH. SL 00-0184	04-27-99	05-25-99
S 432=	CARPENTER R	MISCELLANEOUS HEALTH PLAN CHANGES	*R -CH. SL 00-0184	07-08-99	00-07-11
S 732=	SOLES	CHIROPRACTIC OWNERSHIP RESTRICTED	*R -CH. SL 99-0430	04-27-99	07-06-99
S 783=	COCHRANE	LONG-TERM CARE FACILITIES/DISCLOSURE	*S -FAILED CONCUR IN COM SUB	04-29-99	07-09-99
S 793	CLODFELTER	PSYCHOLOGY PRACTICE DEFINITIONS	R -CH. SL 99-0292	04-20-99	06-29-99
S 951	PERDUE	HEALTH CARE WORKERS/ID BADGE	*R -CH. SL 99-0320	04-27-99	06-30-99
S 960	SOLES	REGULATION OF PHARMACIES	H -REF TO COM ON HEALTH	04-29-99	
S 998	ODOM	CANCER ADVISORY BOARD/MEMBER TERMS	R -CH. SL 99-0280	04-27-99	06-22-99
S1179=	RAND	HEALTH CARE REGISTRY REPORTS	*R -CH. SL 00-0055	00-06-06	00-06-20
S1215=	DANNELLY	MEDICAL CARE COMMN/RULES	*R -CH. SL 00-0111	00-06-14	00-06-27
S1234=	PURCELL	LONG-TERM CARE RESIDENTS/IMMUN	*R -CH. SL 00-0112	00-06-07	00-06-22
S1269=	WARREN E	LIMIT LIABILITY/DEFIBRILLATOR	*R -CH. SL 00-0113	00-06-19	00-06-22

NOTES- = AFTER BILL NUMBER SHOWS THAT BILL IS IDENTICAL, AS INTRODUCED, TO ANOTHER BILL.
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BOLDED LINE INDICATES BILL INDEXED AS AFFECTING APPROPRIATIONS.

AGENDA

HOUSE COMMITTEE ON HEALTH
TUESDAY, June 20, 2000
12:00 NOON
415 LOB

OPENING REMARKS

REP. THOMAS E. WRIGHT
CHAIRMAN

BILLS TO BE DISCUSSED

✓ HB-1855 State Health Plan Changes
Rep. Wright

HB-1396 Health Care Fundamental Right
Rep. Insko, Rep. Alexander & Rep. Wright

✓ SB-1179 Health Care Registry Reports
Sen. Rand

SB-1234 Long Term Care Residents/ Immunizations
Sen. Purcell

COMMENTS

ADJOURNMENT

MINUTES

COMMITTEE ON HEALTH

TUESDAY, JUNE 20, 2000

12:00 NOON ROOM 415-LOB

The House Committee on Health met on Tuesday, June 20, 2000 at 12:00 Noon in Room 415-LOB. A silent roll was taken, (roll list denotes members present).

Chairman Wright called the meeting to order.

SB-1179 HEALTH CARE REGISTRY REPORTS

Vice-Chairman Verla Insko recognized Rep. Wright to explain the bill. Rep. Wright explained the bill. John Young, Research Division Staff, further explained the bill.

Rep. Justus moved for a favorable report. So moved.

HB-1855 STATE HEALTH PLAN CHANGES

Rep. Womble moved for adoption of the proposed committee substitute. So moved.

Rep. Wright explained the bill. Sam Byrd, Fiscal Research Division Staff, further explained the bill. Jack Walker of the State Employee Health Plan spoke on the bill. Carlos Artiz, CVS Pharmacy, spoke on the bill. Rep. Bowie asked Carlos Artiz about the formula for purchasing generic drugs. Rep. Justus asked about CVS Pharmacy's relationship with other pharmacies. Carlos Artiz responded. Rep. Justus asked if CVS represent the independent pharmacy. Carlos Artiz responded. Mark Gregory with Kerr Drug commented on the bill. Dana Cope with the State Employees Association commented on the bill. Rep. Edwards asked about other states purchasing costs. Sam Byrd responded. Rep. Edwards followed up with a question about life-style drugs. Sam Byrd responded. Rep. Edwards asked if the Pharmacy Benefit Manager would be a state employee. Sam Byrd responded that it would be a private contractor. Rep. Womble asked about the increase of outpatient prescriptions and what categories of drugs are involved. Sam Byrd responded. Rep. Womble followed up with a question. Sam Byrd responded. Rep. Wilson asked a question about the bill. Sam Byrd responded. Rep. Wright responded on the bill. Rep. Justus asked about the advertisement of drugs. Sam Byrd responded. Rep. Adams asked a question about the bill. Rep. Wright responded. Rep. Wright commented on the bill.

Rep. Womble moved for a favorable report, unfavorable as to the original bill.

HB-1396 HEALTH CARE FUNDAMENTAL RIGHT
(Discussion Only)

Rep. Wright introduced Rep. Insko to explain the bill. Dr. Levine, UNC School of Public Health, commented on the bill. Rep. Insko commented on the bill. Rep. Justus asked if there were other states involved in universal coverage. Rep. Insko responded. John Hammin, with the state employee health plan, explained the cost of family health insurance as percent of income by plan. Rep. Insko asked Dr. Carol Kirshembuam to comment on the bill. Gretchen Lothen commented on the bill.

The meeting adjourned at 12:55pm.

Rep. Thomas E. Wright, Chairman

Vanda Wilson-Wormack,Committee Asst.

2000 COMMITTEE REPORT
HOUSE OF REPRESENTATIVES

The following report(s) from standing committee(s) is/are presented:
By Representative(s) **Thomas E. Wright** for the Committee on **Health**.

☐ Committee Substitute for
S.B. 1179 A BILL TO BE ENTITLED AN ACT PERTAINING TO REPORTING REQUIREMENTS FOR THE HEALTH CARE PERSONNEL REGISTRY; IMPOSING PENALTIES FOR VIOLATIONS OF LICENSING AND OTHER REQUIREMENTS FOR CERTAIN MENTAL HEALTH FACILITIES; AND AUTHORIZING THE ADOPTION OF CERTAIN TEMPORARY AND PERMANENT RULES TO IMPLEMENT REQUIREMENTS FOR CERTAIN MENTAL HEALTH FACILITIES.

☒ With a favorable report.

☐ With a favorable report and recommendation that the bill be re-referred to the Committee on Appropriations ☐ Finance ☐ ☐.

☐ With a favorable report, as amended.

☐ With a favorable report, as amended, and recommendation that the bill be re-referred to the Committee on Appropriations ☐ Finance ☐ ☐.

☐ With a favorable report as to committee substitute bill (#), ☐ which changes the title, unfavorable as to (original bill) (Committee Substitute Bill #), (and recommendation that the committee substitute bill #) be re-referred to the Committee on .)

☐ With a favorable report as to House committee substitute bill (#), ☐ which changes the title, unfavorable as to the original bill.

☐ With an unfavorable report.

☐ With recommendation that the House concur.

☐ With recommendation that the House do not concur.

☐ With recommendation that the House do not concur; request conferees.

☐ With recommendation that the House concur; committee believes bill to be material.

☐ With an unfavorable report, with a Minority Report attached.

☐ Without prejudice.

☐ With an indefinite postponement report.

☐ With an indefinite postponement report, with a Minority Report attached.

☐ With recommendation that it be adopted. (HOUSE RESOLUTION ONLY)

5/25/00

2000 COMMITTEE REPORT
HOUSE OF REPRESENTATIVES

The following report(s) from standing committee(s) is/are presented:
By Representative(s) **Thomas E. Wright** for the Committee on **Health**.

☐ Committee Substitute for
H.B. 1855 A BILL TO BE ENTITLED AN ACT PERTAINING TO PRESCRIPTION DRUG COSTS UNDER THE TEACHERS' AND STATE EMPLOYEES' COMPREHENSIVE MAJOR MEDICAL PLAN.

☐ With a favorable report.

☐ With a favorable report and recommendation that the bill be re-referred to the Committee on Appropriations ☐ Finance ☐ ☐.

☐ With a favorable report, as amended.

☐ With a favorable report, as amended, and recommendation that the bill be re-referred to the Committee on Appropriations ☐ Finance ☐ ☐.

☐ With a favorable report as to committee substitute bill (#), ☐ which changes the title, unfavorable as to (original bill) (Committee Substitute Bill #), (and recommendation that the committee substitute bill #) be re-referred to the Committee on .)

☒ With a favorable report as to House committee substitute bill (# 1855), ☒ which changes the title, unfavorable as to the original bill.

☐ With an unfavorable report.

☐ With recommendation that the House concur.

☐ With recommendation that the House do not concur.

☐ With recommendation that the House do not concur; request conferees.

☐ With recommendation that the House concur; committee believes bill to be material.

☐ With an unfavorable report, with a Minority Report attached.

☐ Without prejudice.

☐ With an indefinite postponement report.

☐ With an indefinite postponement report, with a Minority Report attached.

☐ With recommendation that it be adopted. (HOUSE RESOLUTION ONLY)

6/26/00

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 1999

H D

HOUSE BILL 1855
Proposed Committee Substitute H1855-PCSA255

Short Title: State Health Plan Changes. (Public)

Sponsors:

Referred to:

May 30, 2000

A BILL TO BE ENTITLED

AN ACT PERTAINING TO PRESCRIPTION DRUG, RETIREE PREMIUMS, AND CHRONIC CONDITION CLAIM COSTS UNDER THE TEACHERS' AND STATE EMPLOYEES' COMPREHENSIVE MAJOR MEDICAL PLAN.

The General Assembly of North Carolina enacts:

Section 1. G.S. 135-40.5(g) 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 ninety percent (90%) of the average wholesale ~~price.~~ price for branded prescriptions and forty percent (40%) of the average wholesale price for generic prescriptions. A dispensing fee of ~~six dollars ($6.00)~~ four dollars ($4.00) per prescription shall also be an allowable charge for qualified providers. 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, fifteen dollars ($15.00) for each branded prescription, and twenty dollars ($20.00) for each branded prescription with a generic equivalent ~~drug.~~ drug, and twenty-five dollars ($25.00) for each branded or generic prescription not on a formulary used by the 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. Any formulary used by the manager shall be an open formulary. A manager may implement dispensing limits, manufacturer rebates, generic substitutions, concurrent reviews for compliance with appropriate clinical protocols, cost-effective protocols, and contraindications, and prospective reviews for drugs requiring prior approval. A manager shall be required to maintain continuous and open communications with physicians, pharmacies, and members of the Plan regarding the safest and most efficacious use of outpatient prescription drugs."

Section 2. G.S. 135-39.4A(f) reads as rewritten:

"(f) The Executive Administrator may employ such clerical and professional staff, and such other assistance as may be necessary to assist the Executive Administrator and the Board of Trustees in carrying out their duties and responsibilities under this Article. The Executive Administrator may also negotiate, renegotiate and execute contracts with third parties in the performance of his duties and responsibilities under this Article; provided any contract negotiations, renegotiations and execution with a Claims Processor or with an optional prepaid hospital and medical benefit plan or with a preferred provider of institutional or professional hospital and medical care or with a pharmacy benefit manager shall be done only after consultation with the Committee on Employee Hospital and Medical Benefits."

Section 3. Effective January 1, 2001, G.S. 135-39.5 is amended by adding subdivisions to read:

"(24) Implementing and administering a case management and disease management program.

(25) Implementing and administering a pharmacy benefit management program through a third-party contract awarded after competitive bid."

Section 4. Effective January 1, 2001, G.S. 135-40.6A(b) is amended by adding a subdivision to read:

"(10) Outpatient prescription drugs requiring prospective review under the Plan's pharmacy benefit management program."

Section 5. G.S. 135-40.7 is amended by adding a subdivision to read:

"(23) Charges disallowed by the Plan's pharmacy benefits manager."

Section 6.(a) G.S. 135-40.2(a) reads as rewritten:

"(a) The following persons are eligible for coverage under the Plan, on a noncontributory basis, subject to the provisions of G.S. 135-40.3:

. . .

(2) Retired teachers, State employees, members of the General Assembly, and retired State law enforcement officers who retired

under the Law Enforcement Officers' Retirement System prior to January 1, 1985. ~~For employees first hired on and after October 1, 1995, and members of the General Assembly first taking office on and after October 1, 1995, future coverage as retired employees and retired members of the General Assembly is subject to a requirement that the future retiree have 20 or more years of retirement service credit in order to be covered by the provisions of this subdivision.~~"

Section 6.(b) G.S. 135-40.2(a1) and G.S. 135-40.2(b)(11) are repealed.

Section 7. This act becomes effective August 1, 2000, unless otherwise stated.

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 1999

HOUSE BILL 1855

Short Title: State Health Plan Changes. (Public)

Sponsors: Representatives Wright; Hurley and Wainwright.

Referred to: Health.

May 30, 2000

A BILL TO BE ENTITLED

AN ACT PERTAINING TO PRESCRIPTION DRUG COSTS UNDER THE TEACHERS' AND STATE EMPLOYEES' COMPREHENSIVE MAJOR MEDICAL PLAN.

The General Assembly of North Carolina enacts:

Section 1. G.S. 135-40.5(g) reads as rewritten:

"**§ 135-40.5. Benefits not subject to deductible or coinsurance.**

. . .

(g) Prescription Drugs. -- The Plan's allowable charges for prescription legend drugs to be used outside of a hospital or skilled nursing facility are ~~ninety percent (90%) of the average wholesale price. A dispensing fee of six dollars ($6.00) per prescription shall also be an allowable charge for qualified providers.~~ determined by a third-party pharmacy benefit manager under contract with the Plan. 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, fifteen dollars ($15.00) for each branded prescription, and twenty dollars ($20.00) for each branded prescription with a generic equivalent drug. ~~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."

Section 2. G.S. 135-39.5 is amended by adding the following new subdivision to read:

"(24) Implementing and administering a case management and disease management program."

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

NORTH CAROLINA GENERAL ASSEMBLY
LEGISLATIVE ACTUARIAL NOTE

BILL NUMBER: HB 1855 - Proposed House Committee Substitute

SHORT TITLE: State Health Plan Changes

SPONSOR(S): Rep. Wright

SYSTEM OR PROGRAM AFFECTED: Teachers' and State Employees' Comprehensive Major Medical Plan.

FUNDS AFFECTED: State General Fund, State Highway Fund, other State employer receipts, premium payments for dependents by active and retired teachers and State employees, and premium payments for coverages selected by eligible former teachers and State employees.

BILL SUMMARY: The Proposed House Committee Substitute for HB 1855 changes the Plan's outpatient prescription benefit, authorizes the Plan to use case management and disease management programs, and allows non-contributory health plan premiums for all retired employees not just those employed prior to October 1, 1995. The proposed changes are listed below by section.

Section 1: Rewrites G.S. 135-40.5(g) to provide the following changes to the Plan's outpatient prescription benefit: reduce the Plan's reimbursement of allowable charges for generic prescription drugs to 40% of Average Wholesale Price (AWP) from the current reimbursement level of 90% of AWP; reduce the dispensing fee paid per prescription to qualified providers for branded and generic prescription drugs to $4.00 per script from the current dispensing fee of $6.00 per script; and, require that allowable charges from providers shall not be greater than a pharmacy's usual and customary charge to the general public for a particular prescription.

Effective January 1, 2001, the Plan is authorized by the legislation to use a pharmacy benefit manager to help manage the Plan's outpatient prescription drug coverage. Any formulary used by the pharmacy benefit manager for the purpose of manufacturer rebates or utilization controls shall be an open formulary. Also, a fourth tier copayment of $25.00 is added for each branded or generic prescription drug not on a formulary used by the Plan.

A pharmacy benefit manager under contract with the Plan may implement dispensing limits, therapeutic and generic substitutions, concurrent reviews for compliance with appropriate clinical protocols, cost effective protocols, contraindications, and prospective reviews for drugs requiring prior approval. A pharmacy benefit manager under contract with the Plan shall be required to maintain continuous and open communications with physicians, pharmacies, and members of the Plan regarding the safest and most efficacious use of outpatient prescription drugs.

Section 2: Rewrites G.S. 135-39.4A(f) to require the Plan's Executive Administrator to consult with the Committee on Employee Hospital and Medical Benefits before executing a contract with a pharmacy benefit manager.

Section 3: Amends G.S. 135-39.5 to authorize the Plan's Executive Administrator and Board of Trustees to implement and administer a case management program for high cost cases, a disease management program for chronic cases and a pharmacy benefit manager. The contract with the pharmacy benefit manager shall be executed only after competitive bid. This section goes into effect January 1, 2001.

Section 4: Amends G.S. 135-40.6A(b) to require prior approval for prescriptions requiring prospective review by the Plan's pharmacy benefit manager. This section goes into effect January 1, 2001.

Section 5: Amends G.S. 135-40.7 to provide an exclusion from pharmacy benefits for charges excluded by the Plan's pharmacy benefit manager.

Section 6: Rewrites G.S. 135-40.2(a) to provide for non-contributory health plan premiums for all retired employees not just those employed prior to October 1, 1995.

EFFECTIVE DATE: The Act is effective August 1, 2000 unless otherwise stated.

ESTIMATED IMPACT ON STATE: Based upon information supplied by the Teachers' and State Employees' Comprehensive Major Medical, the consulting actuary for the Plan, Aon Consulting, estimates an overall reduction in claims costs to the Plan's indemnity program to be $38.4 million for 2000-2001 and $67.2 million for 2001-2002. Based upon claims information and assumptions supplied by the Plan, the consulting actuary for the General Assembly's Fiscal Research Division, Hartman & Associates, estimates a net reduction in claims costs to the Plan's indemnity program to be $28.9 million for 2000-2001 and $46.7 million for 2001-2002. A combined estimate from the two actuaries on the additional savings to the Plan's indemnity program is $33.7 million for 2000-2001 and $57.0 million for 2001-2002.

ASSUMPTIONS AND METHODOLOGY: The Comprehensive Major Medical Plan for Teachers and State Employees is divided into two programs. From October, 1982, through June, 1986, the Plan had only a self-funded indemnity type of program which covered all employees, retired employees, eligible dependents of employees and retired employees, and eligible former employees and their eligible dependents authorized to continue coverage past a termination of employment other than for retirement or disability purposes. A prepaid program of coverage by health maintenance organizations (HMOs) was offered in July, 1986, as an alternative to the Plan's self-insured indemnity program. The benefits of the self-insured indemnity type of program are spelled out in Part 3 of Article 3 of Chapter 135 of the North Carolina General Statutes (i.e., $250 annual deductible, 20% coinsurance up to $1,000 annually, etc. paid by the program's members). HMOs are required to offer

benefits that are comparable to those provided by the self-insured indemnity program. Employer-paid non-contributory premiums are only authorized for the indemnity program's coverage for employees and retired employees. Whenever employees and office holders first employed or taking office on and after October 1, 1995 become eligible for health benefits as retired employees, the amount of premium paid by the State for individual coverage will be based upon the retiree's amount of retirement service credit at the time of retirement. Only retired employees with 20 or more years of service credit at retirement will be eligible for non-contributory health benefit premiums. Retirees with 10 or more years of service credit at retirement will be eligible for 50% partially contributory health benefit premiums. Retired employees with 5 or more year of service credit at retirement will be eligible to continue their health benefits on a fully contributory basis. All other types of premium in the indemnity program are fully contributory. Premiums paid by employers to HMOs are limited to like amounts paid to the indemnity program with employees and retired employees paying any HMO amounts above the indemnity program's non-contributory rates. Both types of coverage continue to be available in the Plan with nine HMOs currently covering about 25% of the Plan's total population in about 66 of the State's 100 counties. The Plan's employees and retired employees select the type of program that they wish for themselves and their dependents during the months of August and September of each year for coverage beginning in October. The demographics of the Plan as of December 31, 1999, include:

	Self-Insured Indemnity Program	Alternative HMOs	Plan Total
Number of Participants			
Active Employees	203,482	70,681	274,163
Active Employee Dependents	110,453	44,369	154,822
Retired Employees	96,217	5,712	101,929
Retired Employee Dependents	16,374	1,165	17,539
Former Employees & Dependents with Continued Coverage	2,891	323	3,706
Total Enrollments	429,417	122,742	552,159
Number of Contracts			
Employee Only	230,456	54,059	284,515
Employee & Child(ren)	31,626	14,644	46,270
Employee & Family	39,670	8,182	47,852
Total Contracts	301,752	76,885	378,637
Percentage of Enrollment by Age			
29 & Under	26.7%	41.6%	30.0%
30-44	20.1	27.3	21.7
45-54	21.1	19.6	20.8
55-64	14.9	8.7	13.5
65 & Over	17.2	2.7	14.0
Percentage of Enrollment by Sex			
Male	39.4%	37.8%	39.0%
Female	60.6	62.2	61.0

Assumptions for the Self-Insured Indemnity Program: For the fiscal year beginning July 1, 1999, the self-insured program started its operations with a beginning cash balance of $234.1 million. Receipts for the year are estimated to be $763 million from premium collections, $15 million from investment earnings, and $15 million in risk adjustment and administrative fees from HMOs, for a total of $793 million in receipts for the year. Disbursements from the self-insured program are expected to be $820 million in claim payments and $24 million in administration and claims processing expenses for a total of $844 million for the year beginning July 1, 1999. For the fiscal year beginning July 1, 2000, the self-insured indemnity program is expected to have an operating cash balance of over $183 million with a net operating loss of approximately $120 million for the 2000-2001 fiscal year. For the fiscal year beginning July 1, 2001, the self-insured indemnity program is expected to have an operating cash balance of only $63 million. The self-insured indemnity program is consequently assumed to be unable to carry out its operations for the 2001-2003 biennium without increases in its current premium rates or a reduction in existing benefits or both. This assumption is further predicated upon the fact that the program's cost containment strategies (hospital DRG reimbursements, pre-admission hospital testing, pre-admission hospital inpatient certification with length-of-stay approval, hospital bill audits, required second surgical opinions, mental health case management, coordination of benefits with other payers, Medicare benefit "carve-outs", cost reduction contracts with participating physicians and other providers, prescription drug manufacturer rebates from voluntary formularies, and fraud detection) are maintained and improved where possible. Current non-contributory premium rates are $143.10 monthly for employees whose primary payer of health benefits is Medicare and $[illegible].98 per month for employees whose primary payer of health benefits is not Medicare. Fully contributory premium amounts for employee and child(ren) contracts are $89.06 monthly for children whose primary payer of health benefits is Medicare and $117.16 monthly for other covered children, and $213.60 per month for family contracts whose dependents have Medicare as the primary payer of health benefits and $281.04 per month for other family contract dependents. Claim cost trends are expected to increase 13% plus annually. Total enrollment in the program is expected to increase about 3-4% annually over the next two years due to enrollment losses from alternative HMOs. The number of enrolled active employees is expected to show a 4-5% increase annually over the next two years, whereas the growth in the number of retired employees is assumed to be 4% per year. The program is expected to increase by 1-2% per year the number of active employee dependents and enrolled retiree dependents. Investment earnings are based upon a 5-6% monthly return on available cash balances. The self-insured indemnity program maintains a claim stabilization reserve for claim cost fluctuations equal to 7.5% of annual claim payments without reserving additional funds for incurred but unreported claims.

Assumptions for Indemnity Plan's Outpatient Prescription Drug Program:

There are two primary components to be implemented under the Plan's outpatient prescription drug program as proposed in the legislation: 1) A reduction in the rate of reimbursement for allowable charges for generic drugs, a reduced dispensing fee for brand and generic outpatient prescription drugs, and a $25 copayment for non-formulary drugs; and 2) the

installation of a pharmacy benefit manager to administer outpatient pharmacy claims under an open formulary with drug utilization review.

The assumptions used to estimate the reduction in allowable charges for prescription drugs include: reducing the Plan's reimbursement of allowable charges for generic prescription drugs to 40% of AWP from the current reimbursement level of 90% of AWP; lowering the dispensing fee paid per prescription to qualified providers for branded and generic prescription drugs to $4.00 per script from the current dispensing fee of $6.00 per script; and, requiring that allowable charges from providers shall not be greater than a pharmacy's usual and customary charge to the general public for a particular prescription. In addition, upon implementation of a pharmacy benefit manager, it assumed that a mail order service will not be implemented by the Plan under its contract with a pharmacy benefit manager.

The assumptions used to estimate claims cost reductions from the implementation of drug utilization review by a pharmacy benefit manager under contract with the Plan are as follows per the Executive Administrator of the Plan: Limit coverage for erectile dysfunction drugs to one tablet or suppository or injection per week; require the dispensing of growth hormones to be subject to prior approval; eliminate coverage of weight loss drugs except for medical conditions involving morbid obesity subject to prior approval for medical necessity; and require infertility treatments to be subject to prior approval and disallow coverage of infertility treatments for artificial means of conception. In addition, the Plan may utilize the following claims management options provided by a pharmacy benefit manager: dispensing limits, therapeutic and generic substitutions, concurrent reviews for compliance with appropriate clinical protocols, cost effective protocols, contraindications, and prospective reviews for drugs requiring prior approval.

Reduction in Allowable Charges -- Based upon information supplied by the Teachers' and State Employees' Comprehensive Major Medical, the consulting actuary for the Plan, Aon Consulting, estimates a reduction in claims costs from reducing the rate of reimbursement for allowable charges for generic drugs, a reduced dispensing fee for brand and generic outpatient prescription drugs, and a $25 copayment for non-formulary drugs to be $31.5 million for 2000-2001 and $46.7 million for 2001-2002. Based upon claims information and assumptions supplied by the Plan, the consulting actuary for the General Assembly's Fiscal Research Division, Hartman & Associates, estimates a net reduction in claims costs to the Plan's indemnity program to be $23.5 million for 2000-2001 and $31.3 million for 2001-2002. A combined estimate from the two actuaries on the additional savings to the Plan's indemnity program is $27.5 million for 2000-2001 and $39.0 million for 2001-2002.

Drug Utilization Review Savings -- Based upon information supplied by the Teachers' and State Employees' Comprehensive Major Medical, the consulting actuary for the Plan, Aon Consulting, estimates a net reduction in claims costs from reducing the rate of reimbursement for allowable charges for generic drugs and a reduced dispensing fee for brand and generic outpatient prescription drugs to be $2.9 million for 2000-2001 and $11.0 million for 2001-2002. Based upon claims information and assumptions supplied by the Plan, the consulting actuary for the General Assembly's Fiscal Research

Division, Hartman & Associates, estimates a net reduction in claims costs to the Plan's indemnity program to be $3.0 million for 2000-2001 and $8.8 million for 2001-2002. A combined estimate from the two actuaries on the additional savings to the Plan's indemnity program is $2.95 million for 2000-2001 and $9.9 million for 2001-2002.

Increases in the indemnity program's per capita claim costs for outpatient prescription drugs have been 20.9% for 1998-99, 19.0% for 1997-98, 14.5% for 1996-97, 17.0% for 1995-96, 13.0% for 1994-95 and 13.0% for 1993-94.

Assumptions for Implementing Case Management and Disease Management Programs by the Indemnity Plan:

The Plan's Executive Administrator and Board of Trustees are authorized under the legislation to implement and administer a case management program for high cost cases, and a disease management program for chronic cases. Per the Executive Administrator of the Plan, it is assumed that case management and disease management will be implemented on a voluntary participation basis by Plan members.

Case Management and Disease Management Savings -- Based upon information supplied by the Teachers' and State Employees' Comprehensive Major Medical, the consulting actuary for the Plan, Aon Consulting, estimates a reduction in claims costs to the Plan's indemnity program from case management and disease management programs to be $4.0 million for 2000-2001 and $9.5 million for 2001-2002. Based upon claims information and assumptions supplied by the Plan, the consulting actuary for the General Assembly's Fiscal Research Division, Hartman & Associates, estimates a net reduction in claims costs to the Plan's indemnity program to be $2.5 million for 2000-2001 and $6.6 million for 2001-2002. A combined estimate from the two actuaries on the additional savings to the Plan's indemnity program is $3.25 million for 2000-2001 and $8.1 million for 2001-2002.

Assumptions for Implementing Non-Contributory Retiree Health Premiums by the Indemnity Plan:

The legislation provides for non-contributory health plan premiums for all retired employees not just those employed prior to October 1, 1995. No additional costs or savings were projected due to the elimination of contributory premium requirements for certain retirees. The financial impact of this change is assumed to be negligible.

SOURCES OF DATA:

-Actuarial Note, Hartman & Associates, Proposed Committee Substitute for House Bill 1855, June 16, 1999, original of which is on file in the General Assembly's Fiscal Research Division.
-Actuarial Note, Aon Consulting, Proposed Committee Substitute for House Bill 1855, June 16, 2000, original of which is on file with the Comprehensive Major Medical Plan for Teachers and State Employees and the General Assembly's Fiscal Research Division.

TECHNICAL CONSIDERATIONS: None

FISCAL RESEARCH DIVISION -- 733-4910
PREPARED BY: Mark Trogdon
APPROVED BY: James D. Johnson
DATE: June 19, 2000

NORTH CAROLINA TEACHERS' & STATE EMPLOYEES' COMPREHENSIVE MAJOR MEDICAL PLAN

• • •

House Bill 1855
(Proposed Committee Substitute H1855-CS-01)

Add Outpatient Prescription Drug PBM, Disease and Case Management Programs and Retiree Premiums

Prepared by:

Aon Consulting
One Piedmont Center
3565 Piedmont Road, N.E.
Atlanta, Georgia 30363

June 2000

Aon Consulting

ACTUARIAL STATEMENT

The State of North Carolina Teachers' and State Employees' Comprehensive Major Medical Plan (Plan) has requested that Aon Consulting prepare an Actuarial Note in response to House Bill 1855 (as amended) entitled "An Act pertaining to prescription drug, retiree premiums, and chronic condition claim costs under the Teachers' and State Employees' Comprehensive Major Medical Plan."

The Actuarial Note was prepared according to generally accepted actuarial principles and practices, in compliance with General Statute 120-114. As required by statute, the Note includes an explanatory statement of the proposed change(s) and, to the extent possible, an estimate of the financial and actuarial effect of the proposed change(s) on the Plan. The Actuarial Note makes no comment or opinion with regard to the merits of the measure for which the Note is prepared; however, any identified technical or mechanical defects have been noted.

We have reviewed the input and results of our analysis for reasonableness, and relied upon the data and information provided by the Plan and their Claims Processing Contractor.

Kenneth C. Vieira, F.S.A., M.A.A.A., E.A.
Senior Vice President

6/19/00
Date

Professional Peer Review by:

Fred W. Munzenmaier, F.S.A., M.A.A.A., E.A.
Senior Vice President

6/19/00
Date

Aon Consulting

ADD OUTPATIENT PRESCRIPTION DRUG PBM, DISEASE AND CASE MANAGEMENT PROGRAMS AND RETIREE PREMIUMS

PLAN CHANGES

The Plan current covers outpatient prescription drugs at an allowable charge of 90% of the Average Wholesale Price (AWP) plus a $6 dispensing fee. The Plan will pay allowable charges less a copayment to be paid by each member equal to the following amounts: $10 for generics, $15 for brand-name prescriptions, and $20 for brand names when a generic equivalent is available. By accepting the copayments and any remaining allowable charges provided by this subsection, pharmacies shall not balance bill a member covered by the Plan.

The proposed legislation amends Section 1. G.S. 135-40.5(g) to make the plan allowable equal to 80% of AWP for branded prescriptions and 40% of AWP for generic prescriptions. The legislation also reduces the dispensing fee to $4 per prescription from $6.

A provision is added to contract with a pharmacy benefit manager (PBM). The PBM will be allowed to use a formulary and all non-formulary drugs will be subject to a $25 copay. The maximum copay is limited to usual and reasonable charges since many generic drugs will be less than $25. The PBM will also have drug utilization review to help manage the program's costs.

In addition, the proposed legislation allows for "Implementing and administering a case management and disease management program."

The amendment also requires implementing a drug utilization review program that has physician and patient education and plan participant initiatives as a minimum.

The final provision is to eliminate the service related contribution for all retirees first hired on or after October 1, 1995.

The act is effective August 1, 2000.

PROJECTED COST IMPACT

Implementing PBM Pricing	3.8%	4.0%	4.2%	$31,502	$46,679	$53,944
Disease Management	0.0%	0.1%	0.3%	$503	$1,182	$1,323
Case Management	0.4%	0.7%	1.0%	$3,524	$8,271	$9,263
Drug Utilization Review	0.7%	1.0%	1.3%	$2,865	$11,044	$19,293
Eliminate Service-Based Retiree Premium	0.0%	0.0%	0.0%	$0	$0	$0
Total	4.9%	5.8%	6.8%	$38,394	$67,176	$83,823

Based on projected claims of $1,006,964,999, $1,161,523,674 and $1,323,306,515 for the 2001, 2002 and 2003 fiscal years respectively. First year cost assumes an implementation date of January 1, 2001 and a claims payment lag of 3-months for disease and case management, and August 1, 2000 and a claims payment lag of 1-month for prescription drugs.

Aon Consulting

PRICING APPROACH AND COMMENTS

- A prescription drug report was received by the Claims Processing Contractor (CPC) detailing the program expenditures over the last 4 fiscal years. The report summarized prescription drug utilization for brand, generic and brand name drugs with a generic equivalent. From the information, Aon was able to develop average allowable cost per script by prescription type and apply the PBM pricing structure and dispensing fees. The allowable charge less the member copayments represents the cost to the Plan.

- In the baseline scenario, Aon has assumed that the number of scripts per member will increase 10% per year and the average price per script will increase 7% per year. Membership is level until October 1, 2000, where the elimination of 5 HMO options will return 46,484 plan members into the program. The increased membership is factored into the projected costs.

- Current pricing for prescription drugs is 90% of AWP plus a $6 pharmacy dispensing fee. Under the proposed legislation, the dispensing fee was reduced to $4 and the generic % of AWP was reduced to 40%. It was assumed that the percentage of brand on formulary would be 85% in the expected scenario. The high and low scenarios used 80% and 90% respectively. Due to the variability in formularies, Aon assumed the price structure for the non-formulary brand to be equivalent to the current brand pricing structure.

- 29% of the cost savings are attributed to the $2 reduction in the dispensing fees. 13% of the savings is due to the additional copayment under the non-formulary drugs. The remaining savings (58%) are due to the revised pricing for generics, AWP-60%. The plan has already achieved the 10% discount for brands, but the discount of AWP for generic would be modified.

- Drug Utilization Review (DUR) typically will produce additional cost savings ranging from 3% to 5% of expected prescription drug costs, depending on the number of years since implementation. Aon assumed a first-year impact of 3.5%, with an additional 2% per year thereafter. This results in a mature second year reduction of 5.43% and a third year reduction of 7.32%. This is the reduction currently expected by many PBMs. Again, savings will vary depending on the scope (e.g., physician profiling, therapeutic intervention, etc.) of drug utilization review programs implemented.

- Adding a prescription drug based case management and disease management program may also produce some additional cost savings. Typically, it takes a few years before investment in these programs produce results. For this reason, the initial savings is minimal but savings may increase over time as individuals are targeted for case management and/or disease management. We have estimated initial savings ranging from .2% to .4% for year one. Estimated savings are projected to increase in subsequent years from a low estimate of .4%, to .8% for a mid-estimate, to 1.3% for a high estimate over the three-year period. Savings will vary based on the scope and effectiveness of the disease management programs offered.

- The current provisions have a service related contribution that will impact future retirees only. There are currently no eligible retirees who are impacted by the proposed legislation.

HARTMAN & ASSOCIATES, LLC
ACTUARIAL CONSULTING

MARK V. HARTMAN, FSA, MAAA, MCA, EA

Phone: (336) 731-4038
Fax: (336) 731-2583

668 Link Road
Lexington, NC 27295

June 16, 2000

Mr. Sam Byrd
Fiscal Research Division
North Carolina General Assembly
300 N. Salisbury Street
Raleigh, NC 27603-5925

Re: Proposed Committee Substitute to House Bill 1855: An Act Pertaining to Prescription Drug, Retiree Premiums, and Chronic Condition Claim Costs under the Teachers' and State Employees' Comprehensive Major Medical Plan

Dear Mr. Byrd:

This proposed committee substitute modifies various provisions in the Teachers' and State Employees' Comprehensive Major Medical Plan. These include:

i. G.S. 135 40.5(g) is rewritten to modify the allowable charges for outpatient prescription legend drugs. The current allowable charges are 90% of the average wholesale price (AWP) plus a dispensing fee of $6.00. This would be modified to 40% of AWP for generic drugs and 90% of AWP for brand drugs, plus a dispensing fee of $4.00 per prescription. Allowable charges are further limited to the pharmacy's usual and customary charge to the general public for a particular prescription.

ii. G.S. 135-40.5(g) is modified to introduces a $25.00 copayment for prescriptions not on a formulary used by the plan. Currently, the member pays a copayment of $10.00 for each generic drug, $15.00 for each branded drug, and $20.00 for each branded drug for which there is a generic equivalent.

iii. New subdivisions are added to G.S. 135-39.5 to authorize the implementation of a case management and disease management program and to implement a pharmacy benefit manager (PBM) through a third party contract.

iv. A new subdivision is added to G.S. 135-40.6A(b) covering outpatient prescription drugs requiring prospective review under the PBM program. This would subject such prescriptions to prior approval procedures.

v. G.S. 135-40.2 is amended to eliminate contribution requirements for certain retired employees to be covered under the plan. Currently, employees hired on or after October 1, 1995 and members of the General Assembly first taking office on and after October 1, 1995 may be required to contribute towards the cost of coverage when they retire. Such future retired members are eligible for coverage under the plan on a fully contributory if they have less than 10 years of retirement service credit, a 50% contributory if they have 10 but less than 20 years of retirement service credit, or a noncontributory basis if they have at least 20 years of retirement service credit. This provision would eliminate the service and contribution requirements, allowing all retirees to be eligible on a noncontributory basis.

The provisions listed as items iii and iv, above, are effective January 1, 2001. All other provisions are effective August 1, 2000.

Cost savings were projected in three separate categories. The first component is savings due to a decrease in the plan's cost for prescription drugs. This results from both the reduction in the dispensing fee and the greater discount from AWP for generic drugs, plus the increased copayment for prescriptions not in a plan formulary.

Savings are additionally projected from Drug Utilization Review (DUR) implemented by a PBM. Various parameters for a DUR system are indicated, including an open formulary, concurrent and prospective reviews, generic substitutions, and certain protocols. Cost savings have been projected using comparable industry standards.

Cost savings are also projected for the case management and disease management provision. Projected savings are based on industry standards for such programs applied to high cost cases in the Comprehensive Major Medical Plan. Data was obtained for costly hospital admissions, and a distribution of claims by size was analyzed to identify cases with charges over $50,000. Projected savings were based on these distributions.

The estimated savings resulting from implementation of these provisions are shown below for the next two fiscal years. No costs or savings were projected for the elimination of contributory requirements for certain future retirees. The financial impact of this provision is expected to be negligible.

	Estimated Savings for the Fiscal Year Beginning	
Component	July 1, 2000	July 1, 2001
Allowable Charge Reduction	$23,451,540	$31,273,956
DUR Implementation	2,985,324	8,787,210
Case & Disease management	2,448,099	6,600,783
Total	$28,884,963	$46,661,949

These estimates are based on analysis of prescription drug claims and total claims for the State Employees' Health Benefits Plan for the past five years. The reduction in allowable charges is projected from August 1, 2000, while savings from implementation of a DUR system and case management are projected from January 1, 2001. A one month claim payment lag was incorporated. The projections include annual drug price inflation of approximately 8% and utilization increases of 11.0% for brand drugs and 5.4% for generic drugs. Non-drug claim costs were projected to increase at a 10.0% annual trend.

If you have any questions, let me know.

Sincerely,

Mark Hartman

Mark V. Hartman, FSA, MAAA, MCA, EA
Consulting Actuary

MVH/mt

Cost of Family Health Insurance as
Percent of Income by Plan

				State Plan	WellPath	BCBS	United
1999/2000 Rates					Select	PCP	Health
Annual Family Premium				$3,372.48	$5,007.84	$5,614.32	$6,354.72
	No.			Percent	Percent	Percent	Percent
Job Title	**in Job**	**Grade**	**Salary**	**Income**	**Income**	**Income**	**Income**
Accountant I	2	71	$30,434.00	11	16	18	21
Cardiac Cath Specialist	5	68	$32,543.00	10	15	17	20
Electronic Technician I	2	64	$22,695.00	15	22	25	28
Office Assistant IV	40	59	$20,213.00	17	25	28	31
Medical Records Assistant II	79	57	$18,682.00	18	27	30	34
Cook I	7	52	$16,061.00	21	31	35	40
Hospital Aide	36	51	$16,018.00	21	31	35	40
No. in grades below 64	*162*						
2000/2001 Rates				State Plan	WellPath	BCBS	United
					Select	PCP	Health
Annual Family Premium				$3,372.48	$6,816.72	----------	----------
	No.			Percent	Percent	Percent	Percent
Job Title	**in Job**	**Grade**	**Salary**	**Income**	**Income**	**Income**	**Income**
Accountant I	2	71	$30,434.00	11	22	NA	NA
Cardiac Cath Specialist	5	68	$32,543.00	10	21	NA	NA
Electronic Technician I	2	64	$22,695.00	15	30	NA	NA
Office Assistant IV	40	59	$20,213.00	17	34	NA	NA
Medical Records Assistant II	79	57	$18,682.00	18	36	NA	NA
Cook I	7	52	$16,061.00	21	42	NA	NA
Hospital Aide	36	51	$16,018.00	21	43	NA	NA
No. in grades below 64	*162*						

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 1999

S 2

SENATE BILL 1179
Health Care Committee Substitute Adopted 5/31/00

Short Title: Health Care Registry Reports. (Public)

Sponsors:

Referred to:

May 9, 2000

A BILL TO BE ENTITLED

AN ACT PERTAINING TO REPORTING REQUIREMENTS FOR THE HEALTH CARE PERSONNEL REGISTRY; IMPOSING PENALTIES FOR VIOLATIONS OF LICENSING AND OTHER REQUIREMENTS FOR CERTAIN MENTAL HEALTH FACILITIES; AND AUTHORIZING THE ADOPTION OF CERTAIN TEMPORARY AND PERMANENT RULES TO IMPLEMENT REQUIREMENTS FOR CERTAIN MENTAL HEALTH FACILITIES.

The General Assembly of North Carolina enacts:

Section 1. G.S. 131E-256(g) reads as rewritten:

"(g) ~~Upon investigation and documentation, health~~ Health care facilities shall ensure that the Department is notified of all ~~substantiated~~ allegations against health care ~~personnel~~ personnel, including injuries of unknown source, which appear to ~~a reasonable person to~~ be related to any act listed in subdivision (a)(1) of this ~~section, and shall promptly report to the Department any resulting disciplinary action, demotion, or termination of employment of health care personnel.~~ section. Facilities must have evidence that all alleged acts are investigated and must make every effort to protect residents from harm while the investigation is in progress. The results of all investigations must be reported to the Department within five working days of the initial notification to the Department."

Section 2. Article 15 of Chapter 131E of the General Statutes is amended by adding the following new section to read:

"**§ 131E-256.1. Adverse action on a license; appeal procedures.**

(a) The Department may suspend, cancel, or amend a license when a facility subject to this Article has substantially failed to comply with this Article or rules adopted under this Article.

(b) Administrative action taken by the Department under this section shall be in accordance with Chapter 150B of the General Statutes."

Section 3. G.S. 122C-23 is amended by adding the following new subsection to read:

"(g) The Secretary may suspend the admission of any new clients to a facility licensed under this Article where the conditions of the facility are detrimental to the health or safety of the clients. This suspension shall be for the period determined by the Secretary and shall remain in effect until the Secretary is satisfied that conditions or circumstances merit removal of the suspension. In suspending admissions under this subsection, the Secretary shall consider the following factors:

(1) The degree of sanctions necessary to ensure compliance with this section and rules adopted to implement this subsection, and

(2) The character and degree of impact of the conditions at the facility on the health or safety of its clients.

A facility may contest a suspension of admissions under this subsection in accordance with Chapter 150B of the General Statutes. In contesting the suspension of admissions, the facility must file a petition for a contested case within 20 days after the Department mails notice of suspension of admissions to the licensee."

Section 4. Article 2 of Chapter 122C of the General Statutes is amended by adding the following new section to read:

"**§ 122C-24.1. Penalties; remedies.**

(a) Violations Classified. -- The Department of Health and Human Services shall impose an administrative penalty in accordance with provisions of this Article on any facility licensed under this Article which is found to be in violation of Article 2 or 3 of this Chapter or applicable State and federal laws and regulations. Citations issued for violations shall be classified according to the nature of the violation as follows:

(1) "Type A Violation" means a violation by a facility of the regulations, standards, and requirements set forth in Article 2 or 3 of this Chapter or applicable State or federal laws and regulations governing the licensure or certification of a facility which results in death or serious physical harm, or results in substantial risk that death or serious physical harm will occur. Type A Violations shall be abated or eliminated immediately. The Department shall require an immediate plan of correction for each Type A Violation. The person making the findings shall do the following:

a. Orally and immediately inform the administrator of the facility of the specific findings and what must be done to correct them, and set a date by which the violation must be corrected;

b. Within 10 working days of the investigation, confirm in writing to the administrator the information provided orally under sub-subdivision a. of this subdivision; and

c. Provide a copy of the written confirmation required under sub-subdivision b. of this subdivision to the Department.

The Department shall impose a civil penalty in an amount not less than two hundred fifty dollars ($250.00) nor more than five thousand dollars ($5,000) for each Type A Violation in facilities or programs that serve nine or fewer persons. The Department shall impose a civil penalty in an amount not less than five hundred dollars ($500.00) nor more than ten thousand dollars ($10,000) for each Type A Violation in facilities or programs that serve 10 or more persons.

(2) "Type B Violation" means a violation by a facility of the regulations, standards, and requirements set forth in Article 2 or 3 of this Chapter or applicable State or federal laws and regulations governing the licensure or certification of a facility which present a direct relationship to the health, safety, or welfare of any client or patient, but which does not result in substantial risk that death or serious physical harm will occur. The Department shall require a plan of correction for each Type B Violation and may require the facility to establish a specific plan of correction within a specific time period to address the violation.

(b) Penalties for Failure to Correct Violations Within Time Specified. --

(1) Where a facility has failed to correct a Type A Violation, the Department shall assess the facility a civil penalty in the amount of up to five hundred dollars ($500.00) for each day that the deficiency continues beyond the time specified in the plan of correction approved by the Department or its authorized representative. The Department or its authorized representative shall ensure that the violation has been corrected.

(2) Where a facility has failed to correct a Type B Violation within the time specified for correction by the Department or its authorized representative, the Department shall assess the facility a civil penalty in the amount of up to two hundred dollars ($200.00) for each day that the deficiency continues beyond the date specified for correction without just reason for the failure. The Department or its authorized representative shall ensure that the violation has been corrected.

(3) The Department shall impose a civil penalty which is treble the amount assessed under subdivision (1) of subsection (a) of this section when a facility under the same management, ownership, or control has received a citation and paid a penalty for violating the

same specific provision of a statute or regulation for which it received a citation during the previous 12 months.

(c) Factors to Be Considered in Determining Amount of Initial Penalty. -- In determining the amount of the initial penalty to be imposed under this section, the Department shall consider the following factors:

(1) The gravity of the violation, including the fact that death or serious physical harm to a client or patient has resulted; the severity of the actual or potential harm, and the extent to which the provisions of the applicable statutes or regulations were violated;

(2) The gravity of the violation, including the probability that death or serious physical harm to a client or patient will result; the severity of the potential harm, and the extent to which the provisions of the applicable statutes or regulations were violated;

(3) The gravity of the violation, including the probability that death or serious physical harm to a client or patient may result; the severity of the potential harm, and the extent to which the provisions of the applicable statutes or regulations were violated;

(4) The reasonable diligence exercised by the licensee to comply with G.S. 131E-256 and other applicable State and federal laws and regulations;

(5) Efforts by the licensee to correct violations;

(6) The number and type of previous violations committed by the licensee within the past 36 months;

(7) The amount of assessment necessary to ensure immediate and continued compliance; and

(8) The number of clients or patients put at risk by the violation.

(d) The facts found to support the factors in subsection (c) of this section shall be the basis in determining the amount of the penalty. The Department shall document the findings in written record and shall make the written record available to all affected parties including:

(1) The licensee involved;

(2) The clients or patients affected; and

(3) The family members or guardians of the clients or patients affected.

(e) The Department shall impose a civil penalty on any facility which refuses to allow an authorized representative of the Department to inspect the premises and records of the facility.

(f) Any facility wishing to contest a penalty shall be entitled to an administrative hearing as provided in Chapter 150B of the General Statutes. A petition for a contested case shall be filed within 30 days after the Department mails a notice of penalty to a licensee. At least the following specific issues shall be addressed at the administrative hearing:

(1) The reasonableness of the amount of any civil penalty assessed, and

(2) The degree to which each factor has been evaluated pursuant to subsection (c) of this section to be considered in determining the amount of an initial penalty.

If a civil penalty is found to be unreasonable or if the evaluation of each factor is found to be incomplete, the hearing officer may recommend that the penalty be adjusted accordingly.

(g) Any penalty imposed by the Department of Health and Human Services under this section shall commence on the day the violation began.

(h) The Secretary may bring a civil action in the superior court of the county wherein the violation occurred to recover the amount of the administrative penalty whenever a facility:

(1) Which has not requested an administrative hearing fails to pay the penalty within 60 days after being notified of the penalty, or

(2) Which has requested an administrative hearing fails to pay the penalty within 60 days after receipt of a written copy of the decision as provided in G.S. 150B-36.

(i) In lieu of assessing an administrative penalty, the Secretary may order a facility to provide staff training if:

(1) The penalty would be for the facility's only violation within a 12-month period preceding the current violation and while the facility is under the same management; and

(2) The training is:

a. Specific to the violation;

b. Approved by the Department of Health and Human Services; and

c. Taught by someone approved by the Department and other than the provider.

(j) The clear proceeds of civil penalties provided for in this section shall be remitted to the State Treasurer for deposit in accordance with State law.

(k) In considering renewal of a license, the Department shall not renew a license if outstanding fines and penalties imposed by the Department against the facility or program have not been paid. Fines and penalties for which an appeal is pending are exempt from consideration for nonrenewal under this subsection."

Section 5. G.S. 122C-26 reads as rewritten:

"**§ 122C-26. Powers of the Commission.**

In addition to other powers and duties, the Commission shall exercise the following powers and duties:

(1) Adopt, amend, and repeal rules consistent with the laws of this State and the laws and regulations of the federal government to implement the provisions and purposes of this Article;

(2) Issue declaratory rulings needed to implement the provisions and purposes of this Article;

(3) Adopt rules governing appeals of decisions to approve or deny licensure under this Article; ~~and~~

(4) Adopt rules for the waiver of rules adopted under this ~~Article.~~ Article; and

(5) Adopt rules applicable to facilities licensed under this Article:

a. Establishing personnel requirements of staff employed in facilities;

b. Establishing qualifications of facility administrators or directors;

c. Establishing requirements for death reporting including confidentiality provisions related to death reporting; and

d. Establishing requirements for patient advocates."

Section 6. Notwithstanding G.S. 150B-21.1(a), the Commission for Mental Health, Developmental Disabilities, and Substance Abuse Services shall adopt temporary rules to implement G.S. 122C-26(5).

Section 7. Sections 1 through 4 of this act become effective October 1, 2000. The remainder of this act is effective when it becomes law.

SENATE BILL 1179:
Health Care Registry and Certain Mental Health Reporting

BILL ANALYSIS

Committee: House Health
Date: June 19, 2000
Version: 2

Introduced by: Sen. Rand
Summary by: John Young
Committee Staff

SUMMARY:

Sections 1 and 2 amend the North Carolina Health Care Personnel Registry to standardize reporting requirements such that standards required under State law are the same as those required for nursing homes under federal law.

Sections 3 through 6 impose administrative penalties on licensed MH/DD/SAS facilities (private psychiatric hospitals, group homes and day treatment and outpatient programs, and ICFMR facilities) for certain violations and authorize adoption of rules to implement

Sections 1 through 4 are effective October 1, 2000. The remaining sections are effective upon becoming law.

CURRENT LAW:

Sections 1 and 2-Nursing homes are required by State law and federal regulation to report to the Department of Health and Human Services (DHHS) ALL allegations of patient neglect or abuse, misappropriation of patient or facility property, diversion of patient or facility drugs, and fraud against a patient or facility. **Adult care homes and certain other facilities that provide hands on, paraprofessional personnel care to the elderly or disabled** are subject to State law only, which requires that they report to DHHS such incidents only after an internal investigation has substantiated the allegation. Nursing homes and adult care homes are required by State law to report to DHHS any resulting disciplinary action, demotion, or termination of employment. Penalty provisions exist in current law for nursing homes that fail to make the required reports. No such penalties currently exist for adult care homes and other facilities subject to the health care personnel registry law.

Sections 3 through 6-The current statutes does not permit the Secretary of DHHS or the Mental Health Commission to address certain problem facilities licensed under G.S. 122C short of revoking a license. Those types of facilities licensed under G.S. 122C are 10 private psychiatric hospitals, 3400 mental health group homes, day treatment, and outpatient programs, and 332 intermediate care facilities for the mentally retarded.

BILL ANALYSIS:

Section 1: Requires health care facilities to notify DHHS of **all allegations (not just substantiated)** against health care personnel which appear to be related to a prohibited act (abuse, neglect, misappropriation of property, fraud, diversion of drugs). **Current law requires the notice only after the facility has conducted an investigation and the allegation has been substantiated.** Requires facilities to have evidence that an investigation of the allegation was conducted and must make every effort to

protect residents from harm while the investigation is in progress. Requires facilities to report the results of all investigations to DHHS within five working days of the initial notification. **Current law requires the facility to report promptly to DHHS resulting disciplinary action taken by the facility.**

Section 2-Authorizes DHHS to suspend, cancel, or amend a license when a facility substantially fails to comply with the Registry reporting requirements. Facilities may appeal in accordance with Chapter 150B of the General Statutes.

Section 3-Amends G.S. 123-23 to give the Secretary of DHHS the authority to suspend admissions of new clients where conditions are detrimental to the health and safety of the clients. The suspension shall be for the period determined by the Secretary. Listed are the factors to be considered by the Secretary in suspending admissions.

Section 4-Amends 122C-24.1 to impose civil monetary penalties based upon the size of the facility and the severity of the violation. Type "A" violations are violations which results in death or serious physical harm or results in substantial risk that death or serious physical harm will occur. The penalty may be not less than $250 nor more than $5000 per violation for facilities licensed for 10 beds or more. And up to $10,000 per violation in facilities licensed for 10 or more beds. DHHS may also impose Type "B" violations These are violations of the regulations, standards and requirements governing the licensure or certification of a facility which present a direct relationship to the health, safety, or welfore of any client or patient but which does not result in substantial risk of death or serious physical harm. There is no monetary penalty but DHHS shall require a plan of correction.

Section 5-and 6-Amends 122C-26 to give MH/DD/SAS Commission authority to adopt rules including temporary rules to:

1. set personnel staffing requirements for staff employed in licensed facilities;
2. set qualifications of mental health facility administrators or directors;
3. implement death reporting requirements; and
4. require patient advocates as a condition of licensure.

Section 7-Directs the Secretary to adopt temporary rules for reporting of deaths in State facilities.

BACKGROUND:

Sections 1 and 2 are recommendation from the Joint Legislative Health Care Oversight Committee.

Sections 3 through 7 were requested by the Department of Health and Human Services to address issues within the mental health system to give regulators a broader range of options in dealing with problem facilities.

VISITOR REGISTRATION SHEET

HEALTH — 6/20/00

Name of Committee — Date

VISITORS: PLEASE SIGN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Lynda McDaniel	DHHS/DFS
Jesse Goodman	DHHS/DFS
Jeff Horton	DHHS/DFS
EVELYN TERRY	STATE HEALTH PLAN
Tom Vodaylinne	NC CHILD ADVOCACY INST.
Paul G. Sebo	NC Health Plan
Jack Walker	" " "
Evelyn Terry	" " "
[illegible]	NCAHP
C. C. Dawson	N.C. Ret Sch Personnel
Shannon Vickery	UNC-TV
Susan Morgan	Division of Public Health
Barbara Laymon	" " " "
Wendy Mills	SEANC
Frank Lewis	OSBM
Ron Levine	UNC School of Public Health
Natasha H. Shannon	P.O. Box 176 Saxapahaw NC Mother
ROBERT J. GWYN	750 WEAVER DAIRY RD. CHAPEL HILL 27514
[illegible]	CGPC NC Comm to Defend Health Care
Daniel Young	418 Tinkerbell Rd, Chapel Hill, NC 27514
GEORGE TERWILLIG	JOHNSON & JOHNSON
John Bowdish	PHARMACY ASSOC.
[illegible]	Glaxo Wellcome
Elizabeth Seifert	Glaxo Wellcome
Bill Wilson	NCAE
Stacy Flannery	NCHCFA
[illegible]	AHHC
Joan F. Walsh	NC Committee to Defend Health Care

VISITOR REGISTRATION SHEET

HEALTH — Name of Committee

6-20-00 — Date

VISITORS: PLEASE SIGN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Dick Carlton	Merck & Co.
John E. Hammond	Professor UNC School of Medicine
Dennis Lazof	NC-CDHC 306 Monticello Ave Durham
Ginny Dedek	Mother of sick uninsured child, 1115 Scott King Rd Durham
Bennie Hollen	DHHS
Joanne Schoen	NC Nurses Association
Leigh Hammond	NC Retired Gov't Emp Assn.
Heyden Wright	State Health Plan
Tom Wills	DHHS
Amy [illegible]	NCMS
John McMillan	NFOS PA
Jonathan Koch	NC Committee to Defend Health Care
Stan Goff	Democracy South
Mistique CANO	Democracy South
Molly K. Galvin	Democracy South
Jen Stanley	N.C. Voters for Clean Elections

AGENDA

HOUSE COMMITTEE ON HEALTH
TUESDAY, June 22, 2000
11:00 AM
415 LOB

OPENING REMARKS

REP. THOMAS E. WRIGHT
CHAIRMAN

BILLS TO BE DISCUSSED

SB-1234 Long Term Care Residents/ Immunizations
Sen. Purcell

SB-1269 Limit Liability/ Defibrillator

HB-1838 SEHP Wellness Benefit/ Annual Pap

COMMENTS

ADJOURNMENT

MINUTES

COMMITTEE ON HEALTH

TUESDAY, JUNE 22, 2000

12:00 NOON ROOM 415 LOB

The House Committee on Health met on Tuesday, June 22, 2000 at 12:00 Noon in Room 415 LOB. A silent roll was taken, (roll list denotes members present).

Chairman Wright called the meeting to order.

HB-1838 SEHP WELLNESS BENEFIT/ANNUAL PAP

Rep. Culpepper explained the bill. Rep. Adams commented on the bill. Mark Trogden, fiscal staff, further explained the bill. Rep. Adams asked about the age of women in relation to their annual pap smears. Sam Byrd, fiscal staff, responded. Rep. Edwards also commented on the bill. Rep. Bowie also commented that the bill is a good bill. Rep. Culpepper commented on the cost of the bill. Chairman Wright stated that the bill was for discussion only and would be taken up at a later meeting.

SB-1234 LONG TERM CARE RESIDENTS/ IMMUNIZATIONS

Rep. Earle explained the bill and stated that the bill came out of the Aging Study Commission. John Young, staff, further explained the bill. Rep. Adams asked about the immunization of the residents. Rep. Earle responded. Rep. Adams followed up with a question about the vaccinations. Rep. Earle responded. Rep. Justus asked about the vaccinations and why they weren't being done. Rep. Earle responded that Rep. Insko brought the issue to her attention. Rep. Justus followed up with a comment about the bill. John Young further commented on a small percentage on homes that did not vaccinate and the bill would be a impetus for the homes to vaccinate. Rep. Alexander asked about the coverage for vaccinations. Rep. Earle responded that medicaid/medicare would take care of some of the cost, as well as, health departments. Rep. Edwards asked if homes could require vaccination records before admittance into the adult care homes. John Young responded that it was in the bill page 1, 139-D9. Rep. Bowie commented on the bill and asked why did the word 'require' appear in the bill. Rep. Earle responded that the Aging Study Commission thought that by using the word 'require' that it would send a stronger message to adult care homes. Rep. Insko commented that she would oppose using the term 'require' in the bill. Rep. Bowie further commented on the use of the term 'require' in the bill. John Young further explained the bill by deferring members to page 1, line 11 and 12 of the bill. Rep. Bowie commented on the bill. John Young deferred members to section 5, which requires DHHS to make available educational information pertaining to vaccinations.

Rep. Adams moved for a favorable report. So moved.

SB-1269 LIMIT LIABILITY/ DEFIBRILLATOR

Rep. Insko recognized Rep. Wright to explain the bill. Al Andrews, research staff, further explained the bill. Rep. Womble commented on the bill and asked if there was opposition to the bill. Rep. Wright responded. Rep. Bowie asked if there were AED's located in the General Assembly buildings. Rep. Insko commented on the bill. Lynnette Rivenbark, with the American Heart Association, stated that an AED is located in both legislative buildings. Rep. Justus asked if the AED was user friendly. Rep. Wright responded. Rep. Alexander asked would the organizations be responsible for promotion of the AED and how would they be distributed. Lynette Rivenbark stated that the marketing plan is called Operation Heartbeat, which is the Chain of Survival, in which the third link is the use of the AED.

Rep. Wright sent forth an amendment, which changes the language on line 7 and 8, page 3. Rep. Wright read the amendment. The vote was taken and the amendment passed.

Rep. Womble moved for a favorable report as to the House Committee Substitute bill, unfavorable as to the Senate Committee Substitute Bill. So moved.

The meeting adjourned at 1:00pm

Rep. Thomas E. Wright, Chairman

Vanda Wilson-Wormack, Committee Asst.

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2000 COMMITTEE REPORT
HOUSE OF REPRESENTATIVES

The following report(s) from standing committee(s) is/are presented:
By Representative(s) **Thomas E. Wright** for the Committee on **Health**.

☐ Committee Substitute for
S.B. 1234 A BILL TO BE ENTITLED AN ACT TO REQUIRE THAT ADULT CARE HOMES AND NURSING HOMES ENSURE THAT RESIDENTS AND EMPLOYEES ARE IMMUNIZED AGAINST INFLUENZA VIRUS AND THAT RESIDENTS ARE ALSO IMMUNIZED AGAINST PNEUMOCOCCAL DISEASE.

☒ With a favorable report.

☐ With a favorable report and recommendation that the bill be re-referred to the Committee on Appropriations ☐ Finance ☐ ☐.

☐ With a favorable report, as amended.

☐ With a favorable report, as amended, and recommendation that the bill be re-referred to the Committee on Appropriations ☐ Finance ☐ ☐.

☐ With a favorable report as to committee substitute bill (#), ☐ which changes the title, unfavorable as to (original bill) (Committee Substitute Bill #), (and recommendation that the committee substitute bill #) be re-referred to the Committee on .)

☐ With a favorable report as to House committee substitute bill (#), ☐ which changes the title, unfavorable as to Senate committee substitute bill.

☐ With an unfavorable report.

☐ With recommendation that the House concur.

☐ With recommendation that the House do not concur.

☐ With recommendation that the House do not concur; request conferees.

☐ With recommendation that the House concur; committee believes bill to be material.

☐ With an unfavorable report, with a Minority Report attached.

☐ Without prejudice.

☐ With an indefinite postponement report.

☐ With an indefinite postponement report, with a Minority Report attached.

☐ With recommendation that it be adopted. (HOUSE RESOLUTION ONLY)

5/25/00

2000 COMMITTEE REPORT
HOUSE OF REPRESENTATIVES

The following report(s) from standing committee(s) is/are presented:
By Representative(s) Wright for the Committee on Health

☒ Committee Substitute for
S.B. 1269 A BILL TO BE ENTITLED AN ACT TO LIMIT LIABILITY WHEN A PERSON USES AN AUTOMATED EXTERNAL DEFIBRILLATOR TO RENDER EMERGENCY HEALTH CARE TREATMENT TO ATTEMPT TO SAVE THE LIFE OF A PERSON WHO IS IN OR WHO APPEARS TO BE IN CARDIAC ARREST.

☐ With a favorable report.

☐ With a favorable report and recommendation that the bill be re-referred to the Committee on Appropriations ☐ Finance ☐ ☐.

☐ With a favorable report, as amended.

☐ With a favorable report, as amended, and recommendation that the bill be re-referred to the Committee on Appropriations ☐ Finance ☐ ☐.

☐ With a favorable report as to committee substitute bill (#), ☐ which changes the title, unfavorable as to (original bill) (Committee Substitute Bill #), (and recommendation that the committee substitute bill #) be re-referred to the Committee on .)

☒ With a favorable report as to the House committee substitute bill, unfavorable as to Senate committee substitute bill.

☐ With an unfavorable report.

☐ With recommendation that the House concur.

☐ With recommendation that the House do not concur.

☐ With recommendation that the House do not concur; request conferees.

☐ With recommendation that the House concur; committee believes bill to be material.

☐ With an unfavorable report, with a Minority Report attached.

☐ Without prejudice.

☐ With an indefinite postponement report.

☐ With an indefinite postponement report, with a Minority Report attached.

☐ With recommendation that it be adopted. (HOUSE RESOLUTION ONLY)

5/25/00

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 1999

S 2

SENATE BILL 1234*
Health Care Committee Substitute Adopted 5/31/00

Short Title: Long-Term Care Residents/Immuniz. (Public)

Sponsors:

Referred to:

May 15, 2000

A BILL TO BE ENTITLED

AN ACT TO REQUIRE THAT ADULT CARE HOMES AND NURSING HOMES ENSURE THAT RESIDENTS AND EMPLOYEES ARE IMMUNIZED AGAINST INFLUENZA VIRUS AND THAT RESIDENTS ARE ALSO IMMUNIZED AGAINST PNEUMOCOCCAL DISEASE.

The General Assembly of North Carolina enacts:

Section 1. Effective September 1, 2000, Article 1 of Chapter 131D of the General Statutes is amended by adding the following new section to read:

"**§ 131D-9. Immunization of residents of adult care homes.**

(a) Except as provided in subsection (e) of this section, an adult care home licensed under this Article shall require residents to be immunized against pneumococcal disease.

(b) Upon admission, an adult care home shall notify the resident of the immunization requirements of this section and shall request that the resident agree to be immunized against pneumococcal disease.

(c) An adult care home shall document the immunization against pneumococcal disease for each resident. Upon finding that a resident is lacking the immunization, or if the adult care home is unable to verify that the individual has received the required immunization, the adult care home shall provide or arrange for immunization. The immunization and documentation required shall occur not later than November 30 of each year.

(d) For an individual who becomes a resident of the adult care home after November 30 but before March 30 of the following year, the adult care home shall

determine the individual's status for the immunization required under this section, and if found to be deficient, the adult care home shall provide the immunization.

(e) No individual shall be required to receive vaccine under this section if the vaccine is medically contraindicated, or if the vaccine is against the individual's religious beliefs, or if the individual refuses the vaccine after being fully informed of the health risks of not being immunized.

(f) Notwithstanding any other provision of law to the contrary, the Health Services Commission shall have the authority to adopt rules to implement the immunization requirements of this section."

Section 2. Effective September 1, 2001, G.S. 131D-9, as enacted by Section 1 of this act, reads as rewritten:

"**§ 131D-9. Immunization of employees and residents of adult care homes.**

(a) Except as provided in subsection (e) of this section, an adult care home licensed under this Article shall require residents and employees to be immunized annually against influenza virus and shall require residents to also be immunized against pneumococcal disease.

(b) Upon admission, an adult care home shall notify the resident of the immunization requirements of this section and shall request that the resident agree to be immunized against influenza virus and pneumococcal disease.

(b1) An adult care home shall notify every employee of the immunization requirements of this section and shall request that the employee agree to be immunized against the influenza virus.

(c) An adult care home shall document the annual immunization against influenza virus and the immunization against pneumococcal disease for each ~~resident.~~ resident and each employee, as required under this section. Upon finding that a resident is lacking ~~the immunization,~~ one or both of these immunizations or that an employee has not been immunized against influenza virus, or if the adult care home is unable to verify that the individual has received the required immunization, the adult care home shall provide or arrange for immunization. The immunization and documentation required shall occur not later than November 30 of each year.

(d) For an individual who becomes a resident of or who is newly employed by the adult care home after November 30 but before March 30 of the following year, the adult care home shall determine the individual's status for the ~~immunization~~ immunizations required under this section, and if found to be deficient, the adult care home shall provide the immunization.

(e) No individual shall be required to receive vaccine under this section if the vaccine is medically contraindicated, or if the vaccine is against the individual's religious beliefs, or if the individual refuses the vaccine after being fully informed of the health risks of not being immunized.

(f) Notwithstanding any other provision of law to the contrary, the Health Services Commission shall have the authority to adopt rules to implement the immunization requirements of this section.

(g) As used in this section, 'employee' means an individual who is a part-time or full-time employee of the adult care home."

Section 3. Effective September 1, 2000, Part A of Article 6 of Chapter 131E of the General Statutes is amended by adding the following new section to read:

"**§ 131E-113. Immunization of residents.**

(a) Except as provided in subsection (e) of this section, a nursing home licensed under this Part shall require residents to be immunized against pneumococcal disease.

(b) Upon admission, a nursing home shall notify the resident of the immunization requirements of this section and shall request that the resident agree to be immunized against pneumococcal disease.

(c) A nursing home shall document the immunization against pneumococcal disease for each resident. Upon finding that a resident is lacking the immunization, or if the nursing home is unable to verify that the individual has received the required immunization, the nursing home shall provide or arrange for immunization. The immunization and documentation required shall occur not later than November 30 of each year.

(d) For an individual who becomes a resident of the nursing home after November 30 but before March 30 of the following year, the nursing home shall determine the individual's status for the immunization required under this section, and if found to be deficient, the nursing home shall provide the immunization.

(e) No individual shall be required to receive vaccine under this section if the vaccine is medically contraindicated, or if the vaccine is against the individual's religious beliefs, or if the individual refuses the vaccine after being fully informed of the health risks of not being immunized.

(f) Notwithstanding any other provision of law to the contrary, the Health Services Commission shall have the authority to adopt rules to implement the immunization requirements of this section."

Section 4. Effective September 1, 2001, G.S. 131E-113, as enacted by Section 3 of this act, reads as rewritten:

"**§ 131E-113. Immunization of employees and residents.**

(a) Except as provided in subsection (e) of this section, a nursing home licensed under this Part shall require residents and employees to be immunized against influenza virus and shall require residents to also be immunized against pneumococcal disease.

(b) Upon admission, a nursing home shall notify the resident of the immunization requirements of this section and shall request that the resident agree to be immunized against influenza virus and pneumococcal disease.

(b1) A nursing home shall notify every employee of the immunization requirements of this section and shall request that the employee agree to be immunized against influenza virus.

(c) A nursing home shall document the annual immunization against influenza virus and the immunization against pneumococcal disease for each ~~resident.~~ resident and each employee, as required under this section. Upon finding that a resident is lacking one or both of these immunizations or that an employee has not been immunized against influenza virus, ~~the immunization,~~ or if the nursing home is unable to verify that the individual has received the required immunization, the

nursing home shall provide or arrange for immunization. The immunization and documentation required shall occur not later than November 30 of each year.

(d) For an individual who becomes a resident of or who is newly employed by the nursing home after November 30 but before March 30 of the following year, the nursing home shall determine the individual's status for the ~~immunization~~ immunizations required under this section, and if found to be deficient, the nursing home shall provide the immunization.

(e) No individual shall be required to receive vaccine under this section if the vaccine is medically contraindicated, or if the vaccine is against the individual's religious beliefs, or if the individual refuses the vaccine after being fully informed of the health risks of not being immunized.

(f) Notwithstanding any other provision of law to the contrary, the Health Services Commission shall have the authority to adopt rules to implement the immunization requirements of this section.

(g) As used in this section, 'employee' means an individual who is a part-time or full-time employee of the nursing home."

Section 5. The Department of Health and Human Services shall make available to nursing homes and adult care homes educational and informational materials pertaining to vaccinations required under this act.

Section 6. G.S. 130A-29(c) is amended by adding the following new subdivision to read:

"(9) Implementing immunization requirements for adult care homes as provided in G.S. 131D-9 and for nursing homes as provided in G.S. 131E-113."

Section 7. This act is effective when it becomes law.

SENATE BILL 1234:
Long-Term Care Residents Immunization

BILL ANALYSIS

Committee:	House Health	**Introduced by:**	Sen. Purcell
Date:	June 19, 2000	**Summary by:**	John Young
Version:	3		Committee Staff

SUMMARY:

SB 1234 would require that adult care homes and nursing homes ensure that residents and employees are immunized against influenza virus and that residents are also immunized against pneumococcal disease. Immunization for pneumoccocal disease will be effective September 1, 2000 and immunization for influenza will be effective September 1, 2001.

CURRENT LAW:

The bill would add a new G.S. 131D-3.9 and G.S. 131E-113. There is no current requirement concerning immunization in long-term care facilities.

BILL ANALYSIS:

Section 1. Effective September 1, 2000 residents of adult care homes will be required to be immunized against pneumoccocal disease.

Section 2. Effective September 1, 2001, residents of adult care homes must be immunized annually against influenza and residents must be immunized against pneumoccocal disease.

Section 3. Effective September 1, 2000 residents of nursing homes will be required to be immunized against pneumoccocal disease.

Section 4. Effective September 1, 2001, residents and employees of nursing homes will be required to be immunized annually against influenza, and residents must also be immunized against pneumococcal disease. Also provides that authority to adopt rules for immunization resides with the Commission for Health Services

NOTE: G.S. 131D-9 and 131E-113 provides that no person may be required to receive either vaccine if it is medically countraindicated, if it is against the person's religious beliefs, or if the person refuses the vaccine after being fully informed of the health risks of not being immunized.

Section 5. Requires DHHS to make available to adult care homes and nursing homes edicational and informational materials pertaining to vaccinations.

Section 6. Amends the Commission for Health Services statute to authorize adoption of rules for immunizations.

BACKGROUND:

This bill was recommended by the North Carolina Study Commission on Aging after learning the following facts about influenza and pneumoccocal disease among the elderly:

- Although preventable by safe and effective immunizations, influenza and pneumonia are major public health problems in North Carolina, especially among senior citizens;
- In 1998, there were 2688 deaths attributable to influenza and pneumonia,of those deaths, 2362 were 65 years of age or older which is 87.9% of the total; and
- A significant difference exists between Caucasian and African-American immunization rates and mortality rates.
-

Pneumonia and influenza are the leading causes of death attributable to infection in patients aged 65 and older an in the long-term care setting, pneumonia accounts for 13 % to 48% of infections with mortality rates as high as 44%.

From the evidence presented to the Commission, residents and employees of adult care homes and nursing homes are a special population and more vulnerable to outbreaks of these diseases with increased chances of morbidity and mortality.

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 1999

S 3

SENATE BILL 1269
Judiciary II Committee Substitute Adopted 5/30/00
Third Edition Engrossed 6/14/00

Short Title: Limit Liability/Defibrillator. (Public)

Sponsors:

Referred to:

May 17, 2000

A BILL TO BE ENTITLED

AN ACT TO LIMIT LIABILITY WHEN A PERSON USES AN AUTOMATED EXTERNAL DEFIBRILLATOR TO RENDER EMERGENCY HEALTH CARE TREATMENT TO ATTEMPT TO SAVE THE LIFE OF A PERSON WHO IS IN OR WHO APPEARS TO BE IN CARDIAC ARREST.

The General Assembly of North Carolina enacts:

Section 1. Article 1B of Chapter 90 of the General Statutes is amended by adding a new section to read:

"**§ 90-21.15. Emergency treatment using automated external defibrillator; immunity.**

(a) Intent. -- It is the intent of the General Assembly that, when used in accordance with this section, an automated external defibrillator may be used during an emergency for the purpose of attempting to save the life of another person who is in or who appears to be in cardiac arrest.

(b) Definitions. -- For purposes of this section:

(1) 'Automated external defibrillator' means a device, heart monitor, and defibrillator that meets all of the following requirements:

a. The device has received approval from the United States Food and Drug Administration of its premarket notification filed pursuant to 21 U.S.C. § 360(k), as amended.

b. The device is capable of recognizing the presence or absence of ventricular fibrillation or rapid ventricular

tachycardia and is capable of determining, without intervention by an operator, whether defibrillation should be performed.

c. Upon determining that defibrillation should be performed, the device automatically charges and requests delivery of, or delivers, an electrical impulse to an individual's heart.

(2) 'Person' means an individual, corporation, limited liability company, partnership, association, unit of government, or other legal entity.

(3) 'Training' means a nationally recognized course or training program in cardiopulmonary resuscitation (CPR) and automated external defibrillator use including the programs approved and provided by the:

a. American Heart Association.

b. American Red Cross.

(c) Immunity. -- The use of an automated external defibrillator when used to attempt to save or to save a life shall constitute 'first-aid or emergency health care treatment' under G.S. 90-21.14(a).

(d) The person who provides the cardiopulmonary resuscitation and automated external defibrillator training to a person using an automated external defibrillator, the person responsible for the site where the automated external defibrillator is located when the person has provided for a program of training, and a North Carolina licensed physician writing a prescription without compensation for an automated external defibrillator whether or not required by any federal or state law, shall be immune from civil liability arising from the use of an automated external defibrillator used in accordance with subsection (c) of this section.

(e) The immunity from civil liability otherwise existing under law shall not be diminished by the provisions of this section.

(f) No Purchase, Placement, or Use Requirement. -- Nothing in this section requires the purchase, placement, or use of automated external defibrillators by any person, entity, or agency of State, county, or local government. Nothing in this section applies to a products liability claim against a manufacturer or seller as defined in G.S. 99B-1."

Section 2. G.S. 90-18(c) reads as rewritten:

"(c) The following shall not constitute practicing medicine or surgery as defined in subsection (b) of this section:

. . .

(17) The use of an automated external defibrillator as provided in G.S. 90-21.15."

Section 3. This act becomes effective October 1, 2000, and applies to causes of action arising on or after that date.

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 1999

S D

SENATE BILL 1269
Judiciary II Committee Substitute Adopted 5/30/00
Third Edition Engrossed 6/14/00
Proposed House Committee Substitute S1269-PCS6797-SN002

Short Title: Limit Liability/Defibrillator. (Public)

Sponsors:

Referred to:

May 17, 2000

A BILL TO BE ENTITLED

AN ACT TO LIMIT LIABILITY WHEN A PERSON USES AN AUTOMATED EXTERNAL DEFIBRILLATOR TO RENDER EMERGENCY HEALTH CARE TREATMENT TO ATTEMPT TO SAVE THE LIFE OF A PERSON WHO IS IN OR WHO APPEARS TO BE IN CARDIAC ARREST.

The General Assembly of North Carolina enacts:

Section 1. Article 1B of Chapter 90 of the General Statutes is amended by adding a new section to read:

"**§ 90-21.15. Emergency treatment using automated external defibrillator; immunity.**

(a) It is the intent of the General Assembly that, when used in accordance with this section, an automated external defibrillator may be used during an emergency for the purpose of attempting to save the life of another person who is in or who appears to be in cardiac arrest.

(b) For purposes of this section:

(1) 'Automated external defibrillator' means a device, heart monitor, and defibrillator that meets all of the following requirements:

a. The device has received approval from the United States Food and Drug Administration of its premarket notification filed pursuant to 21 U.S.C. § 360(k), as amended.

b. The device is capable of recognizing the presence or absence of ventricular fibrillation or rapid ventricular

tachycardia and is capable of determining, without intervention by an operator, whether defibrillation should be performed.

c. Upon determining that defibrillation should be performed, the device automatically charges and requests delivery of, or delivers, an electrical impulse to an individual's heart.

(2) 'Person' means an individual, corporation, limited liability company, partnership, association, unit of government, or other legal entity.

(3) 'Training' means a nationally recognized course or training program in cardiopulmonary resuscitation (CPR) and automated external defibrillator use including the programs approved and provided by the:

a. American Heart Association.

b. American Red Cross.

(c) The use of an automated external defibrillator when used to attempt to save or to save a life shall constitute 'first-aid or emergency health care treatment' under G.S. 90-21.14(a).

(d) The person who provides the cardiopulmonary resuscitation and automated external defibrillator training to a person using an automated external defibrillator, the person responsible for the site where the automated external defibrillator is located when the person has provided for a program of training, and a North Carolina licensed physician writing a prescription without compensation for an automated external defibrillator whether or not required by any federal or state law, shall be immune from civil liability arising from the use of an automated external defibrillator used in accordance with subsection (c) of this section.

(e) The immunity from civil liability otherwise existing under law shall not be diminished by the provisions of this section.

(f) Nothing in this section requires the purchase, placement, or use of automated external defibrillators by any person, entity, or agency of State, county, or local government. Nothing in this section applies to a product's liability claim against a manufacturer or seller as defined in G.S. 99B-1.

(g) In order to enhance public health and safety, a seller of an automated external defibrillator shall notify the North Carolina Department of Health and Human Services, Division of Facilities Services, Office of Emergency Medical Services of the existence, location, and type of automated external defibrillator."

Section 2. G.S. 90-18(c) reads as rewritten:

"(c) The following shall not constitute practicing medicine or surgery as defined in subsection (b) of this section:

. . .

(17) The use of an automated external defibrillator as provided in G.S. 90-21.15."

Section 3. This act becomes effective October 1, 2000, and applies to causes of action arising on or after that date.

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 1999

S D

SENATE BILL 1269
Judiciary II Committee Substitute Adopted 5/30/00
Third Edition Engrossed 6/14/00
Proposed Committee Substitute for Senate Bill 1269 S1269-PCSSN-001
WARNING: LINE NUMBERS MAY CHANGE AFTER ADOPTION
20-JUN-00 14:04:01

Short Title: Limit Liability/Defibrillator. (Public)

Sponsors:

Referred to:

May 17, 2000

A BILL TO BE ENTITLED

AN ACT TO LIMIT LIABILITY WHEN A PERSON USES AN AUTOMATED EXTERNAL DEFIBRILLATOR TO RENDER EMERGENCY HEALTH CARE TREATMENT TO ATTEMPT TO SAVE THE LIFE OF A PERSON WHO IS IN OR WHO APPEARS TO BE IN CARDIAC ARREST.

The General Assembly of North Carolina enacts:

Section 1. Article 1B of Chapter 90 of the General Statutes is amended by adding a new section to read:

"§ 90-21.15. Emergency treatment using automated external defibrillator; immunity.

(a) It is the intent of the General Assembly that, when used in accordance with this section, an automated external defibrillator may be used during an emergency for the purpose of attempting to save the life of another person who is in or who appears to be in cardiac arrest.

(b) For purposes of this section:

(1) 'Automated external defibrillator' means a device, heart monitor, and defibrillator that meets all of the following requirements:

a. The device has received approval from the United States Food and Drug Administration of its premarket notification filed pursuant to 21 U.S.C. § 360(k), as amended.

b. The device is capable of recognizing the presence or absence of ventricular fibrillation or rapid ventricular tachycardia and is capable of determining, without intervention by an operator, whether defibrillation should be performed.

c. Upon determining that defibrillation should be performed, the device automatically charges and requests delivery of, or delivers, an electrical impulse to an individual's heart.

(2) 'Person' means an individual, corporation, limited liability company, partnership, association, unit of government, or other legal entity.

(3) 'Training' means a nationally recognized course or training program in cardiopulmonary resuscitation (CPR) and automated external defibrillator use including the programs approved and provided by the:

a. American Heart Association.

b. American Red Cross.

(c) The use of an automated external defibrillator when used to attempt to save or to save a life shall constitute 'first-aid or emergency health care treatment' under G.S. 90-21.14(a).

(d) The person who provides the cardiopulmonary resuscitation and automated external defibrillator training to a person using an automated external defibrillator, the person responsible for the site where the automated external defibrillator is located when the person has provided for a program of training, and a North Carolina licensed physician writing a prescription without compensation for an automated external defibrillator whether or not required by any federal or state law, shall be immune from civil liability arising from the use of an automated external defibrillator used in accordance with subsection (c) of this section.

(e) The immunity from civil liability otherwise existing under law shall not be diminished by the provisions of this section.

(f) Nothing in this section requires the purchase, placement, or use of automated external defibrillators by any person, entity, or agency of State, county, or local government. Nothing in this section applies to a products liability claim against a manufacturer or seller as defined in G.S. 99B-1.

(g) In order to enhance public health and safety, a seller of an automated external defibrillator shall notify an agent of the local emergency communications or vehicle dispatch center of the existence, location, and type of automated external defibrillator."

Section 2. G.S. 90-18(c) reads as rewritten:

"(c) The following shall not constitute practicing medicine or surgery as defined in subsection (b) of this section:

. . .

(17) The use of an automated external defibrillator as provided in G.S. 90-21.15."

Section 3. This act becomes effective October 1, 2000, and applies to causes of action arising on or after that date.

SENATE BILL 1269:
Lmit Liability/Defibrillator

BILL ANALYSIS

Committee:	House Health	**Introduced by:**	Senator Warren
Date:	June 20, 2000	**Summary by:**	Al Andrews
Version:	PCS (S1269-PCSSN-001)		Research Division

SUMMARY: This Proposed Committee Substitute to S1269 third edition engrossed inserts a provision that directs automated external defibrilator (AED) sellers to notify local emergency communcations agents or vehicle dispatch centers of the existence, location, and type of AED available at a particular site. For economy of language, this PCS also removes subsection headings from the bill.

CURRENT LAW: There is no current law expressly providing limited liability from suit to volunteer users of AED's. The Good Samaritan statute, G.S. 90-21.14, provides qualified immunity to volunteers who, render first aid or emergency health care treatment to persons who are unconscious, ill or injured. This protection is qualified because it does not apply when there is gross negligence, wanton conduct, or intentional wrongdoing on the part of the volunteer rendering assistance.

BILL ANALYSIS: S1269 is designed to encourage the placement of AED's throughout the public and private sector in North Carolina and thus enhance the likelihood that a cardiac arrest victim will survive. The bill clarifies that volunteer AED users are provided qualified immunity just like Good Samaritans.

This PCS directs automated external defibrillator (AED) sellers to notify local emergency communcations agents or vehicle dispatch centers of the existence, location, and type of AED available at a particular site. This provision is intended to enhance public health and safety. An emergency dispatcher who has knowledge of an AED's location at the site of a call for emergency assistance can inform the caller of that fact.

For economy of language, this PCS also removes subsection headings from the bill.

BACKGROUND: During the interim, the Legislative Research Commission's Defibrillators – Use and Liability Study Committee met several times to assess the public benefit of limiting a volunteer AED user's liability. After receiving reports, hearing testimony, and viewing demonstrations from many experts and interested parties in the field, the committee recommended an AED limited liability study bill to the LRC. This bill was largely the product of several meetings of a multi-member interested parties working group. The working group's members represented the American Heart Association, the American Red Cross, the North Carolina Medcal Board, the North Carolina Medcal Society, the North Carolina Hospital Association, the North Carolina Academy of Trial Lawyers, and the Durham County Attorney's Office. The Senate version of the bill ran first and was amended there. The seller notification provision this PCS inserts is from the original study bill.

VISITOR REGISTRATION SHEET

HEALTH
Name of Committee

6/22/00
Date

VISITORS: PLEASE SIGN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Jack W. Walker	State Health Plan
EVELYN TERRY	State Health Plan
Jim Blackburn	County Commissioners Assoc
A.C. Zachary	Dearborn Co.
Patty Gay Garey	Hosp. for the Carolinas / Friends of Residents
Joe Hall	AHHC
Alan Miles	Bailey & Dixon LLP
David Ferrell	Hyde, McGuire, Caldwell et al
John Bowdish	Alley Associates
Frank Lewis	OSBM
Sean Mays	D.P.H.
Lyn Wilson	NCAHTC
Stacy Flannery	NCHCFA
Bruce Jagers	NC Area Network (AFSIA)
Glenn Wells	DHHS

AGENDA

HOUSE COMMITTEE ON HEALTH
TUESDAY, June 27, 2000
12:00 NOON
415 LOB

OPENING REMARKS

REP. THOMAS E. WRIGHT
CHAIRMAN

BILLS TO BE DISCUSSED

SB-1215 Medical Care Commn/ Rules
Sen. Dannelly

HB-1831 NC Health Choice/ No Waiting Period
Rep. Nesbitt

HB-1396 Health Care Fundamental Right
Rep. Insko

COMMENTS

ADJOURNMENT

MINUTES

COMMITTEE ON HEALTH

TUESDAY, JUNE 27, 2000

12:00 Noon ROOM 415 LOB

The House Committee on Health met on Tuesday, June 27, 2000 at 12:00 Noon in Room 415 LOB. A silent roll was taken, (roll list denotes members present).

Chairman Wright called the meeting to order.

SB-1215 MEDICAL CARE COMMN/ RULES

Sen. Dannelly explained the bill to the committee as a technical change bill to existing legislation. There were no questions from the committee.

Rep. Alexander moved that SB 1215 receive a favorable report, unfavorable to the original bill.

HB-1838 SEHP WELLNESS BENEFIT/ ANNUAL PAP

Rep. Womble moved for adoption of the proposed committee substitute. So moved.

Vice-Chairman Insko introduced Rep. Wright to explain the bill. Rep. Wright explained the bill. Linda Attarian, Staff Counsel, further explained the bill. Rep. Alexander asked about the number of occurrences according to section 2 of the bill. Linda Attarian responded that there were actuarial notes on section 2 and 3 of the bill. Rep. Wright responded. Rep. Bowie asked if this would be a legal matter. Linda Attarian responded. Rep. Bowie followed up with another question about the legality of the matter. Rep. Wright responded. John Young, Staff, further explained the bill. Rep. Womble asked if there was any opposition to the bill. Rep. Wright responded. Rep. Womble followed up with a question about the compromised language in the bill. Rep. Wright responded. Rep. Womble followed up with a question about the cost of the annual Pap smear. Rep. Wright responded by deferring members to section 1 of the bill for further explanation, as well as, the actuarial note. Rep. Edwards commented on the bill.

Rep. Womble moved for a favorable report, unfavorable to the original bill.

HB 1396 HEALTH CARE FUNDAMENTAL RIGHT

Rep. Womble moved for adoption of the proposed house committee substitute.

Rep. Insko explained the bill and deferred members to the handout about the uninsured citizens of this state and the country. Rep. Bowie asked if there was a fiscal note on the proposed bill. Rep. Insko responded that there was no plan in place and the bill would require the state to put a plan together. Rep. Bowie followed up with a question about the state plan as it relates to universal healthcare. Rep. Insko responded. Rep. Bowie commented on the bill. Rep. Insko responded. Rep. Wright further commented on the bill. Rep. Edwards made a comment about the bill. Rep. Justus asked Rep. Insko about the number of people who do not have access to medical care. Rep. Insko responded. Rep. Justus commented on the bill. Rep. Preston further commented on the bill. Rep. Insko responded. Rep. Wright commented on the bill and asked if Dr. Kirshimbaum wanted to comment on the bill. Dr. Kirshimbaum commented on the bill.

The meeting adjourned at 12:55pm.

Rep. Thomas Wright, Chairman

Vanda Wilson-Wormack, Committee Asst.

2000 COMMITTEE REPORT
HOUSE OF REPRESENTATIVES

The following report(s) from standing committee(s) is/are presented:
By Representative(s) **Thomas E. Wright** for the Committee on **Health**.

☒ Committee Substitute for
S.B. 1215 A BILL TO BE ENTITLED AN ACT TO MAKE CONFORMING CHANGES TO THE GENERAL STATUTES PERTAINING TO MEDICAL CARE COMMISSION AUTHORITY TO ADOPT RULES REGULATING ADULT CARE HOMES AND SOCIAL SERVICES COMMISSION AUTHORITY TO ADOPT RULES PERTAINING TO PUBLIC ASSISTANCE PROGRAMS.

☒ With a favorable report.

☐ With a favorable report and recommendation that the bill be re-referred to the Committee on Appropriations ☐ Finance ☐ ☐.

☐ With a favorable report, as amended.

☐ With a favorable report, as amended, and recommendation that the bill be re-referred to the Committee on Appropriations ☐ Finance ☐ ☐.

☐ With a favorable report as to committee substitute bill (#), ☐ which changes the title, unfavorable as to (original bill) (Committee Substitute Bill #), (and recommendation that the committee substitute bill #) be re-referred to the Committee on .)

☐ With a favorable report as to House committee substitute bill (#), ☐ which changes the title, unfavorable as to Senate committee substitute bill.

☐ With an unfavorable report.

☐ With recommendation that the House concur.

☐ With recommendation that the House do not concur.

☐ With recommendation that the House do not concur; request conferees.

☐ With recommendation that the House concur; committee believes bill to be material.

☐ With an unfavorable report, with a Minority Report attached.

☐ Without prejudice.

☐ With an indefinite postponement report.

☐ With an indefinite postponement report, with a Minority Report attached.

☐ With recommendation that it be adopted. (HOUSE RESOLUTION ONLY)

5/25/00

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 1999

S 2

SENATE BILL 1215*
Health Care Committee Substitute Adopted 6/7/00

Short Title: Medical Care Commn./Rules. (Public)

Sponsors:

Referred to:

May 11, 2000

A BILL TO BE ENTITLED

AN ACT TO MAKE CONFORMING CHANGES TO THE GENERAL STATUTES PERTAINING TO MEDICAL CARE COMMISSION AUTHORITY TO ADOPT RULES REGULATING ADULT CARE HOMES AND SOCIAL SERVICES COMMISSION AUTHORITY TO ADOPT RULES PERTAINING TO PUBLIC ASSISTANCE PROGRAMS.

The General Assembly of North Carolina enacts:

Section 1. G.S. 131D-4.3(a) reads as rewritten:

"(a) Pursuant to G.S. ~~143B-153, the Social Services~~ 143B-165, the North Carolina Medical Care Commission shall adopt rules to ensure at a minimum, but shall not be limited to, the provision of the following by adult care homes:

~~(1) Client assessment and independent case management;~~

(2) A minimum of 75 hours of training for personal care aides performing heavy care tasks and a minimum of 40 hours of training for all personal care aides. The training for aides providing heavy care tasks shall be comparable to State-approved Certified Nurse Aide I training. For those aides meeting the 40-hour requirement, at least 20 hours shall be classroom training to include at a minimum:

a. Basic nursing skills;

b. Personal care skills;

c. Cognitive, behavioral, and social care;

d. Basic restorative services; and

e. Residents' rights.

A minimum of 20 hours of training shall be provided for aides in family care homes that do not have heavy care residents. Persons who either pass a competency examination developed by the Department of Health and Human Services, have been employed as personal care aides for a period of time as established by the Department, or meet minimum requirements of a combination of training, testing, and experience as established by the Department shall be exempt from the training requirements of this subdivision;

(3) Monitoring and supervision of residents;

(4) Oversight and quality of care as stated in G.S. 131D-4.1; and

(5) Adult care homes shall comply with all of the following staffing requirements:

a. First shift (morning): 0.4 hours of aide duty for each resident (licensed capacity or resident census), or 8.0 hours of aide duty per each 20 residents (licensed capacity or resident census) plus 3.0 hours for all other residents, whichever is greater;

b. Second shift (afternoon): 0.4 hours of aide duty for each resident (licensed capacity or resident census), or 8.0 hours of aide duty per each 20 residents plus 3.0 hours for all other residents (licensed capacity or resident census), whichever is greater;

c. Third shift (evening): 8.0 hours of aide duty per 30 or fewer residents (licensed capacity or resident census).

In addition to these requirements, the facility shall provide staff to meet the needs of the facility's heavy care residents equal to the amount of time reimbursed by Medicaid. As used in this subdivision, the term 'heavy care resident' means an individual residing in an adult care home who is defined 'heavy care' by Medicaid and for which the facility is receiving enhanced Medicaid payments for such needs."

Section 2. G.S. 131D-4.5(5) reads as rewritten:

"**§ 131D-4.5. Rules adopted by Medical Care Commission.**

The Medical Care Commission shall adopt rules as follows:

. . .

(5) Implementing the due process and appeal rights for discharge and transfer of residents in adult care homes afforded by G.S. 131D-21. The rules ~~may provide for procedures comparable to those provided to nursing home residents pursuant to federal law, to Chapter 131E of the General Statutes, and to related rules.~~ shall offer at least the same protections to residents as State and federal rules and regulations governing the transfer or discharge of residents from nursing homes."

Section 3. G.S. 131D-21(17) reads as rewritten:

"**§ 131D-21. Declaration of residents' rights.**

Each facility shall treat its residents in accordance with the provisions of this Article. Every resident shall have the following rights:

. . .

(17) To not be transferred or discharged from a facility except for medical reasons, the residents' own or other residents' welfare, nonpayment for the stay, or when the transfer is mandated under State or federal law. The resident shall be given at least 30 days' advance notice to ensure orderly transfer or discharge, except in the case of jeopardy to the health or safety of the resident or others in the home. The resident has the right to appeal a facility's attempt to transfer or discharge the resident pursuant to rules adopted by the ~~Secretary,~~ Medical Care Commission, and the resident shall be allowed to remain in the facility until resolution of the appeal unless otherwise provided by law. The ~~Secretary~~ Medical Care Commission shall adopt rules pertaining to the transfer and discharge of residents that offer at least the same protections to residents as State and federal rules and regulations governing the transfer or discharge of residents from nursing homes."

Section 4. G.S. 143B-153(2) reads as rewritten:

"(2) The Social Services Commission shall have the power and duty to establish standards and adopt rules and regulations:

a. For the programs of public assistance established by federal legislation and by Article 2 of Chapter 108A of the General Statutes of the State of North Carolina with the exception of the program of medical assistance established by G.S. 108A-25(b);

b. To achieve maximum cooperation with other agencies of the State and with agencies of other states and of the federal government in rendering services to strengthen and maintain family life and to help recipients of public assistance obtain self-support and self-care;

c. For the placement and supervision of dependent juveniles and of delinquent juveniles who are placed in the custody of the Office of Juvenile Justice, and payment of necessary costs of foster home care for needy and homeless children as provided by G.S. 108A-48; ~~and~~

d. For the payment of State funds to private child-placing agencies as defined in G.S. 131D-10.2(4) and residential child care facilities as defined in G.S. 131D-10.2(13) for care and services provided to children who are in the custody or

placement responsibility of a county department of social ~~services.~~ services; and

e. For client assessment and independent case management pertaining to the functions of county departments of social services for public assistance programs authorized under paragraph a. of this subdivision."

Section 5. This act is effective when it becomes law.

SENATE BILL 1215:
Medical Care Commission/Rules

BILL ANALYSIS

Committee:	House Health Committee	**Introduced by:**	Sen. Dannelly
Date:	June 27, 2000	**Summary by:**	John Young
Version:	5		Committee Staff

SUMMARY:

Senate Bill 1215 makes conforming changes to the General statutes pertaining to the Medical Care Commission's authority to adopt rules regulating adult care homes and Social Services Commission authority to adopt rules pertaining to public assistance programs. It also makes it clear that Medical Care Commission rules pertaining to transfer and discharge of adult care home residents shall be as stringent as the temporary rules adopted by the Secretary of DHHS

BILL ANALYSIS and BACKGROUND:

The 1999 General Assembly passed Senate Bill 10, which established new safety requirements for adult care homes pertaining to medication administration, staff training, and standards for supervisors and staffing requirements. This bill amended G.S. 143B-153, G.S. 143B-165 and several provisions in G.S. Chapter 131D to transfer from the Social Services Commission to the Medical Care Commission rule making authority with respect to the licensure, inspection, and operation of adult care homes and personnel requirements for adult care home staff.

Although it was the intent of the bill sponsors to transfer rule-making authority for adult care homes to the Medical Care Commission, Senate Bill 10 failed to do that completely. Therefore Senate Bill 1215 makes some changes to delete temporary rule making authority by the Secretary and to complete the transfer of rule making authority to the Medical Care Commission. The following changes are proposed in SB 1215:

- **Sections 1 and 4**-Section 1 deletes one overlooked reference to the Social Services Commission; and deletes the client assessment and independent case management language from the duties of the Medical Care Commission for adult care homes. Adult care homes do not provide and are not reimbursed to provide independent case management for residents. The Social Services Commission needs to have continuing authority to adopt rules for client assessment and case management needed to determine whether State/County Special Assistance applicants and recipients need adult care home level of care. Therefore Section 4 adds it as a duty of the Social Services Commission.

- **Sections 2 and 3**-delete reference to the Secretary of DHHS having temporary rule making authority with respect to transfer and discharge of residents in adult care homes, thereby leaving sole authority for this function with the Medical Care Commission. In the temporary rules, the Secretary "shall offer at least the same protections to residents as State and federal rules and regulations governing the transfer or discharge of residents from nursing homes". This same requirement would be placed on the Medical Care Commission.

- **Section 4**-makes it clear that the Social Services Commission still has the authority to adopt rules for client assessment and independent case management activities administered by county departments of social services concerning programs of public assistance authorized under paragraph a.of this subdivision. The effect is to give both the Social Services Commission and the Medical Care Commission authority to make rules for State/County Special Assistance clients in adult care homes.

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 1999

H 1

HOUSE BILL 1831

Short Title: NC Health Choice/No Waiting Period. (Public)

Sponsors: Representatives Nesbitt; Blue, Buchanan, Easterling, Sherrill, Wainwright, and Womble.

Referred to: Rules, Calendar, and Operations of the House.

May 30, 2000

A BILL TO BE ENTITLED

AN ACT TO REPEAL THE WAITING PERIOD FOR COVERAGE UNDER THE NORTH CAROLINA HEALTH INSURANCE PROGRAM FOR CHILDREN (NORTH CAROLINA HEALTH CHOICE).

The General Assembly of North Carolina enacts:

Section 1. G.S. 108A-70.18 reads as rewritten:

"**§ 108A-70.18. Definitions.**

Unless the context clearly requires otherwise, the term:

(1) 'Comprehensive health coverage' means creditable health coverage as defined under Title XXI.

(2) 'Family income' has the same meaning as used in determining eligibility for the Medical Assistance Program.

(3) 'FPL' or 'federal poverty level' means the federal poverty guidelines established by the United States Department of Health and Human Services, as revised each April 1.

(4) 'Medical Assistance Program' means the State Medical Assistance Program established under Part 6 of Article 2 of Chapter 108A of the General Statutes.

(5) 'Program' means The Health Insurance Program for Children established in this Part.

(6) 'State Plan' means the State Child Health Plan for the State Children's Health Insurance Program established under Title XXI.

(7) 'Title XXI' means Title XXI of the Social Security Act, as added by Pub. L. 105-33, 111 Stat. 552, codified in scattered sections of 42 U.S.C. (1997).

(8) 'Uninsured' means the applicant for Program benefits ~~was not covered under any private or employer-sponsored comprehensive health insurance plan for the six-month period immediately preceding the date of application for Program benefits. Effective April 1, 1999, 'uninsured' means the applicant is and was not covered under any private or employer-sponsored comprehensive health insurance plan for 60 days immediately preceding~~ is not covered under any private or employer-sponsored comprehensive health insurance plan on the date of application. ~~The waiting periods required under this subdivision shall be waived if the child has been enrolled in Medicaid and has lost Medicaid eligibility, has lost health care benefits due to cessation of a nonprofit organization program that provides health care benefits to low-income children, or has lost employer-sponsored comprehensive health care coverage due to termination of employment, cessation by the employer of employer-sponsored health coverage, or cessation of the employer's business.~~"

Section 2. This act becomes effective July 1, 2000.

HB 1831:
NC Health Choice/No Waiting Period

BILL ANALYSIS

Committee:	House Health	**Introduced by:**	Nesbitt (Primary Sponsor)
Date:	June 27, 2000	**Summary by:**	Linda Attarian
Version:	1		Committee Counsel

SUMMARY: ***HB 1831 would amend the definition of "uninsured" for the purposes of eligibility to receive coverage under the State Children's Health Insurance Program (NC Health Choice). The amended definition repeals the current 60-day "look back" for children who previously had health insurance prior to applying for coverage under NC Health Choice. The act becomes effective July 1, 2000.***

CURRENT LAW: *NC Health Choice Overview:*

North Carolina established the State Children's Health Insurance Program in 1998. The program is called North Carolina Health Choice and it is a private insurance plan for resident children from birth through age 18 with family incomes at or below 200 percent of the federal poverty level (FPL).

The program is run by both the Department of Health and Human Services (DHHS) and the State Employees' Health Plan (SEHP). DHHS handles program administration, while SEHP is responsible for claims processing. The health benefit package is the North Carolina Teacher's and State Employees' Comprehensive Major Medical Plan (TSECMMP) supplemented with Medicaid-equivalent benefits for special needs children, and dental, optical, and hearing services.

A child is not eligible for coverage if, during the prior two months, the child had health insurance coverage. The state will waive the waiting period if the person lost Medicaid coverage or employer-sponsored coverage due to termination of employment, cessation by employer of employer-sponsored coverage, or cessation of employer's business.

If an enrollee looses coverage under the program due to an increase in income, above 200 percent of the FPL up to 225 percent of the FPL, the enrollee may purchase coverage at full premium cost for one year from the date coverage is lost.

Families above 150 percent of the FPL are required to pay enrollment fees and copayments. The annual enrollment fee is $50 per child with a maximum of $100 per year. Copayments are also charged according to the following schedule:

$5 per provider visit
$5 per outpatient hospital visit
$6 per prescription drugs (outpatient)
$20 per ER visit--nonemergency

Further, the health insurance program includes a tax credit for certain families that pay for dependent health insurance coverage for their children.

The General Assembly passed three amendments to the state's CHIP plan in 1999. One requires that in order to be eligible, children must be uninsured for 60 days prior to application (the waiting period previously was six months). Another allows school-based health centers to participate in the plan and deliver clinic services, and the third change amends the dental package to include sealants, simple extractions and stainless steel crowns.

BACKGROUND:

Preventing private insurance "crowd-out": (*Excerpted from "Insuring More Kids: Options for Lawmakers", NCSL, 1999 update).*

"Crowd Out" refers to replacing private sector insurance coverage with a public program. Under Title XXI of the Social Security Act, the federal law that created the State Children's Health Insurance Program, states must adopt procedures to ensure that their plans don't substitute for employer-sponsored coverage. Crowd out occurs either when individuals drop their employer coverage to participate in a public program, or when individuals drop health coverage benefits for employees, assuming they can get government assistance. Title XXI law disqualifies children who currently have insurance.

Other states impose waiting period for children who recently had employer coverage. For example, MinnesotaCare excludes applicants who had health insurance coverage in the previous four months. MinnesotaCare also excludes applicants if they had access to employer-subsidized coverage during the previous 18 months, when the employer pays at least 50 percent of the coverage. California CHIP plan proposes a three-month "look back" for children under a group plan, but no restriction for children who were previously insured under a non-group policy. The California legislation also allows extending the waiting period to six months if the three-month period is too short to deter crowd out. Florida's Healthy Kids Program initially had a six-month "look back" requirement, which was dropped in response to concerns that it was too punitive and defeated the purpose of making sure children received needed health care services.

NORTH CAROLINA GENERAL ASSEMBLY
LEGISLATIVE ACTUARIAL NOTE

BILL NUMBER: HB 1831 (First Edition)

SHORT TITLE: NC Health Choice/No Waiting Period

SPONSOR(S): Representative Martin Nesbitt

SYSTEM OR PROGRAM AFFECTED: NC Health Choice Program as administered by the Teachers' and State Employees' Comprehensive Major Medical Plan.

FUNDS AFFECTED: Special Receipt Fund for administering the NC Health Choice Program..

BILL SUMMARY: HB 1831 rewrites the definition for "Uninsured" under the NC Health Choice program to mean an applicant that is not covered under any private or employer-sponsored comprehensive health insurance plan on the date of application. The effect of the proposed change is to eliminate the current 60-day waiting period for an applicant to have been uninsured before becoming eligible to participate under NC Health Choice.

EFFECTIVE DATE: The act is effective July 1, 2000.

ESTIMATED IMPACT ON STATE: Based upon information supplied by the Teachers' and State Employees' Comprehensive Major Medical Plan, the consulting actuary for the Plan, Aon Consulting, estimates the administrative impact to be negligible. Based upon claims information and assumptions supplied by the Plan, the consulting actuary for the General Assembly's Fiscal Research Division, Hartman & Associates, estimates a negligible impact on the Plan's administrative costs under the proposed legislation.

ASSUMPTIONS AND METHODOLOGY: The Comprehensive Major Medical Plan for Teachers and State Employees is divided into two programs. From October, 1982, through June, 1986, the Plan had only a self-funded indemnity type of program which covered all employees, retired employees, eligible dependents of employees and retired employees, and eligible former employees and their eligible dependents authorized to continue coverage past a termination of employment other than for retirement or disability purposes. A prepaid program of coverage by health maintenance organizations (HMOs) was offered in July, 1986, as an alternative to the Plan's self-insured indemnity program. The benefits of the self-insured indemnity type of program are spelled out in Part 3 of Article 3 of Chapter 135 of the North Carolina General Statutes (i.e., $250 annual deductible, 20% coinsurance up to $1,000 annually, etc. paid by the program's members). HMOs are required to offer benefits that are comparable to those provided by the self-insured indemnity program. Employer-paid non-contributory premiums are only authorized for the indemnity program's coverage for employees and retired employees. Whenever employees and office holders first employed or taking office on and after October 1, 1995 become eligible for health benefits as retired employees, the amount of premium paid by the State for individual coverage

will be based upon the retiree's amount of retirement service credit at the time of retirement. Only retired employees with 20 or more years of service credit at retirement will be eligible for non-contributory health benefit premiums. Retirees with 10 or more years of service credit at retirement will be eligible for 50% partially contributory health benefit premiums. Retired employees with 5 or more year of service credit at retirement will be eligible to continue their health benefits on a fully contributory basis. All other types of premium in the indemnity program are fully contributory. Premiums paid by employers to HMOs are limited to like amounts paid to the indemnity program with employees and retired employees paying any HMO amounts above the indemnity program's non-contributory rates. Both types of coverage continue to be available in the Plan with nine HMOs currently covering about 25% of the Plan's total population in about 66 of the State's 100 counties. The Plan's employees and retired employees select the type of program that they wish for themselves and their dependents during the months of August and September of each year for coverage beginning in October. The demographics of the Plan as of December 31, 1999, include:

	Self-Insured Indemnity Program	Alternative HMOs	Plan Total
Number of Participants			
Active Employees	203,482	70,681	274,163
Active Employee Dependents	110,453	44,369	154,822
Retired Employees	96,217	5,712	101,929
Retired Employee Dependents	16,374	1,165	17,539
Former Employees & Dependents with Continued Coverage	2,891	323	3,706
Total Enrollments	429,417	122,742	552,159
Number of Contracts			
Employee Only	230,456	54,059	284,515
Employee & Child(ren)	31,626	14,644	46,270
Employee & Family	39,670	8,182	47,852
Total Contracts	301,752	76,885	378,637
Percentage of Enrollment by Age			
29 & Under	26.7%	41.6%	30.0%
30-44	20.1	27.3	21.7
45-54	21.1	19.6	20.8
55-64	14.9	8.7	13.5
65 & Over	17.2	2.7	14.0
Percentage of Enrollment by Sex			
Male	39.4%	37.8%	39.0%
Female	60.6	62.2	61.0

Assumptions for the Self-Insured Indemnity Program: For the fiscal year beginning July 1, 1999, the self-insured program started its operations with a beginning cash balance of $234.1 million. Receipts for the year are estimated to be $763 million from premium collections, $15 million from investment earnings, and $15 million in risk adjustment and administrative fees from HMOs, for a total of $793 million in receipts for the year.

Disbursements from the self-insured program are expected to be $820 million in claim payments and $24 million in administration and claims processing expenses for a total of $844 million for the year beginning July 1, 1999. For the fiscal year beginning July 1, 2000, the self-insured indemnity program is expected to have an operating cash balance of over $183 million with a net operating loss of approximately $120 million for the 2000-2001 fiscal year. For the fiscal year beginning July 1, 2001, the self-insured indemnity program is expected to have an operating cash balance of only $63 million. The self-insured indemnity program is consequently assumed to be unable to carry out its operations for the 2001-2003 biennium without increases in its current premium rates or a reduction in existing benefits or both. This assumption is further predicated upon the fact that the program's cost containment strategies (hospital DRG reimbursements, pre-admission hospital testing, pre-admission hospital inpatient certification with length-of-stay approval, hospital bill audits, required second surgical opinions, mental health case management, coordination of benefits with other payers, Medicare benefit "carve-outs", cost reduction contracts with participating physicians and other providers, prescription drug manufacturer rebates from voluntary formularies, and fraud detection) are maintained and improved where possible. Current non-contributory premium rates are $143.10 monthly for employees whose primary payer of health benefits is Medicare and $187.98 per month for employees whose primary payer of health benefits is not Medicare. Fully contributory premium amounts for employee and child(ren) contracts are $89.06 monthly for children whose primary payer of health benefits is Medicare and $117.16 monthly for other covered children, and $213.60 per month for family contracts whose dependents have Medicare as the primary payer of health benefits and $281.04 per month for other family contract dependents. Claim cost trends are expected to increase 13% plus annually. Total enrollment in the program is expected to increase about 3-4% annually over the next two years due to enrollment losses from alternative HMOs. The number of enrolled active employees is expected to show a 4-5% increase annually over the next two years, whereas the growth in the number of retired employees is assumed to be 4% per year. The program is expected to increase by 1-2% per year the number of active employee dependents and enrolled retiree dependents. Investment earnings are based upon a 5-6% monthly return on available cash balances. The self-insured indemnity program maintains a claim stabilization reserve for claim cost fluctuations equal to 7.5% of annual claim payments without reserving additional funds for incurred but unreported claims.

Assumptions for Administrative Effects on the Indemnity Plan : The additional administrative expenses assumed to be experienced by the Plan are estimated to be negligible.

SOURCES OF DATA:

-Actuarial Note, Hartman & Associates, House Bill 1831, June 26, 2000, original of which is on file in the General Assembly's Fiscal Research Division.

-Actuarial Note, Aon Consulting, House Bill 1831 (First Edition), June 12, 2000, original of which is on file with the Comprehensive Major Medical Plan for Teachers and State Employees and the General Assembly's Fiscal Research Division.

TECHNICAL CONSIDERATIONS: None

FISCAL RESEARCH DIVISION
733-4910
PREPARED BY: Mark Trogdon
APPROVED BY: James D. Johnson
DATE: June 26, 2000

HARTMAN & ASSOCIATES, LLC

ACTUARIAL CONSULTING

MARK V. HARTMAN, FSA, MAAA, MCA, EA

Phone: (336) 731-4038
Fax: (336) 731-2583

668 Link Road
Lexington, NC 27295

June 26, 2000

Mr. Mark Trogdon
Fiscal Research Division
North Carolina General Assembly
300 N. Salisbury Street
Raleigh, NC 27603-5925

Re: House Bill 1831: An Act to Repeal the Waiting Period for Coverage Under the North Carolina Health Insurance Program for Children

Dear Mr. Trogdon:

This bill would rewrite G.S. 108A-70.18 to eliminate the waiting period for coverage under the North Carolina Health Insurance Program for Children (North Carolina Health Choice).

North Carolina Health Choice covers certain uninsured children. Currently, the definition of uninsured requires that the applicant was not covered under any private or employer-sponsored health insurance plan for 60 days immediately preceding the date of application for NC Health Choice. This bill would eliminate the 60-day period and only require that the applicant is not covered under any private or employer-sponsored health insurance plan on the date of application. This act becomes effective July 1, 2000.

The Teachers' and State Employees' Comprehensive Major Medical Plan serves as the administrator for NC Health Choice. The financial impact on the Plan is the additional administrative costs, if any. This bill is not expected to increase the administrative costs, so the financial impact of this act on the Plan is expected to be negligible.

If you have any questions, let me know.

Sincerely,

Mark Hartman

Mark V. Hartman, FSA, MAAA, MCA, EA
Consulting Actuary

MVH/mt

NORTH CAROLINA
HEALTH INSURANCE PROGRAM FOR CHILDREN
(NORTH CAROLINA HEALTHY CHOICE)

• • •

House Bill 1831
(First Edition)

Eliminate Waiting Period

Prepared by:

Aon Consulting
One Piedmont Center
3565 Piedmont Road, N.E.
Atlanta, Georgia 30363

June 2000

Aon Consulting

ACTUARIAL STATEMENT

The State of North Carolina Health Insurance Program for Children (North Carolina Health Choice) (the "Plan") has requested that Aon Consulting prepare an Actuarial Note in response to House Bill 1831 (first edition) entitled "An Act to repeal the waiting period for coverage under the North Carolina Health Insurance Program (North Carolina Healthy Choice)".

The Actuarial Note was prepared according to generally accepted actuarial principles and practices, in compliance with General Statute 120-114, and within the confidentiality requirements of General Statute 120-129 through 120-134. As required by statute, the Note includes an explanatory statement of the proposed change(s) and, to the extent possible, an estimate of the financial and actuarial effect of the proposed change(s) on the Plan. The Actuarial Note makes no comment or opinion with regard to the merits of the measure for which the Note is prepared; however, any identified technical or mechanical defects have been noted.

We have reviewed the input and results of our analysis for reasonableness, and relied upon the data and information provided by the Plan and their Claims Processing Contractor.

Kenneth C. Vieira, F.S.A., M.A.A.A., E.A.
Senior Vice President

6/12/05
Date

Professional Peer Review by:

Fred W. Munzenmaier, F.S.A., M.A.A.A., E.A.
Senior Vice President

6/12/00
Date

Aon Consulting

ELIMINATE WAITING PERIOD

PLAN CHANGES

Elimination of Waiting Period

The Plan currently requires that applicants have not been insured under any private or employer-sponsored comprehensive health insurance plan for a period of no less than 60 days before applying for enrollment. The proposed legislation will eliminate the 60-day waiting period and require that applicants be uninsured at the time of application.

The act will be implemented July 1, 2000.

PROJECTED COST IMPACT

	% Increase			Based on "Midpoint" Increase (in 000's)		
Plan Design Change	Low	Mid	High	First Year Cost $	Second Year Cost $	Total Biennium Cost $
Eliminate Waiting Period	Negligible					

Based on projected claims of $93,363,241 and $102,699,565 for the 2000 and 2001 fiscal years respectively. First year cost assumes an implementation date of July 1, 2000 and a 2 month claims payment lag.

PRICING APPROACH AND COMMENTS

- The average increase in overall monthly enrollment for the program over the 6-month period ending April 2000 was identified from data provided by the Claims Processing Contractor (CPC) to be 1,212. The anticipated cost of eliminating the waiting period is the cost of benefits for the new entrants during what would have been their 60-day waiting period, above the received premiums. This amount would be negligible.

- In addition, another group of potential applicants will emerge – those who were otherwise eligible but were previously uninsured for less than 60-days. Since this group is potentially larger than the first, we would expect minimal or actual reductions to the overall plan adverse selection.

- We have assumed that there will be no adverse selection impact due to this proposed Plan change. Since the additional applicants will have been insured more recently, there may in fact be a slight improvement in adverse selection. Aon has assumed that the per-capita cost of benefits for both groups will equal that of the currently enrolled members.

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 1999

H D

HOUSE BILL 1396
Proposed Committee Substitute H1396-PCS2445-RM001

Short Title: Health Care Fundamental Right. (Public)

Sponsors:

Referred to:

April 29, 1999

A BILL TO BE ENTITLED

AN ACT TO AMEND THE CONSTITUTION OF NORTH CAROLINA TO RECOGNIZE THE RIGHT TO HEALTH CARE.

The General Assembly of North Carolina enacts:

Section 1. Article I of the Constitution is amended by adding a new section to read:

"**Sec. 38. Health care.**

(1) Basic rights. Health care is an essential safeguard of human life and there is an obligation for the State to ensure that every resident is able to exercise this fundamental right. No later than May 31, 2004, the General Assembly shall provide by law a plan that enables every resident in the State to access appropriate health care on a regular basis.

(2) No money damages. Nothing in this section shall be construed as creating a claim for money damages against the State, a county, a municipality, or any of the agencies, instrumentalities, or employees thereof. The General Assembly may provide for other remedies to ensure adequate enforcement of this section."

Section 2. The amendment set out in Section 1 of this act shall be submitted to the qualified voters of the State at the general election in November 2000, which election shall be conducted under the laws then governing elections in the State. Ballots, voting systems, or both may be used in accordance with Chapter 163 of the General Statutes. The question to be used in the voting systems and ballots shall be:

"[ ] FOR [ ] AGAINST

Constitutional amendment providing that health care is a fundamental right."

Section 3. If a majority of the votes cast on the question are in favor of the amendment set out in Section 1 of this act, the State Board of Elections shall certify the amendment to the Secretary of State. The amendment becomes effective upon this certification. The Secretary of State shall enroll the amendment so certified among the permanent records of that office.

Section 4. There is appropriated from the General Fund to the State Board of Elections for the 2000-2001 fiscal year the sum of twenty thousand dollars ($20,000) to implement this act..

Section 5. This act is effective when it becomes law.

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 1999

H 1

HOUSE BILL 1396

Short Title: Health Care Fundamental Right. (Public)

Sponsors: Representatives Insko; Alexander, Wright (Primary Sponsors) and Luebke.

Referred to: Rules, Calendar and Operations of the House.

April 29, 1999

A BILL TO BE ENTITLED

AN ACT TO AMEND THE CONSTITUTION OF NORTH CAROLINA TO RECOGNIZE THE RIGHT TO HEALTH CARE.

The General Assembly of North Carolina enacts:

Section 1. Article I of the Constitution is amended by adding a new section to read:

"**Sec. 37. Health care.** Health care is an essential safeguard of human life and dignity, and there is an obligation for the State to ensure that every resident is able to realize this fundamental right. No later than May 31, 2004, the General Assembly shall provide by law a plan for universal health insurance that permits everyone in the State to obtain decent health care on a regular basis."

Section 2. The amendment set out in Section 1 of this act shall be submitted to the qualified voters of the State at the general election in November 2000, which election shall be conducted under the laws then governing elections in the State. Ballots, voting systems, or both may be used in accordance with Chapter 163 of the General Statutes. The question to be used in the voting systems and ballots shall be:

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upon this certification. The Secretary of State shall enroll the amendment so certified among the permanent records of that office.

Section 4. There is appropriated from the General Fund to the State Board of Elections for the 2000-2001 fiscal year the sum of twenty thousand dollars ($20,000) to implement this act.

Section 5. This act is effective when it becomes law.

INFORMATION FOR HOUSE BILL 1396
HEALTH CARE FUNDAMENTAL RIGHT

I. Information on North Carolina
II. Information on the United States
III. Information on global uninsured levels

I. North Carolina Uninsured

- Under the current health care system in North Carolina, the numbers of uninsured have been increasing slowly. Ten years ago, in 1988, the number of uninsured North Carolinians was 919,603. This number has grown to 1,129,481 uninsured in 1999. (Source: CPS, 1988/99, 1998/99. Numbers calculated using two-year averages.)

- The number of people covered by Medicaid has increased over the years, from about 600,000 in 1988 to about 1,100,000 in 1999. Nevertheless, these increases have not been sufficient to cover the ever-growing number of uninsured North Carolinians. (Source: Table I. North Carolina Medicaid State Fiscal Years 1979-1988. A History of Medicaid Eligibles. CPS, 1988/89, 1998/99. Medicaid eligibles are based on SFY data.)

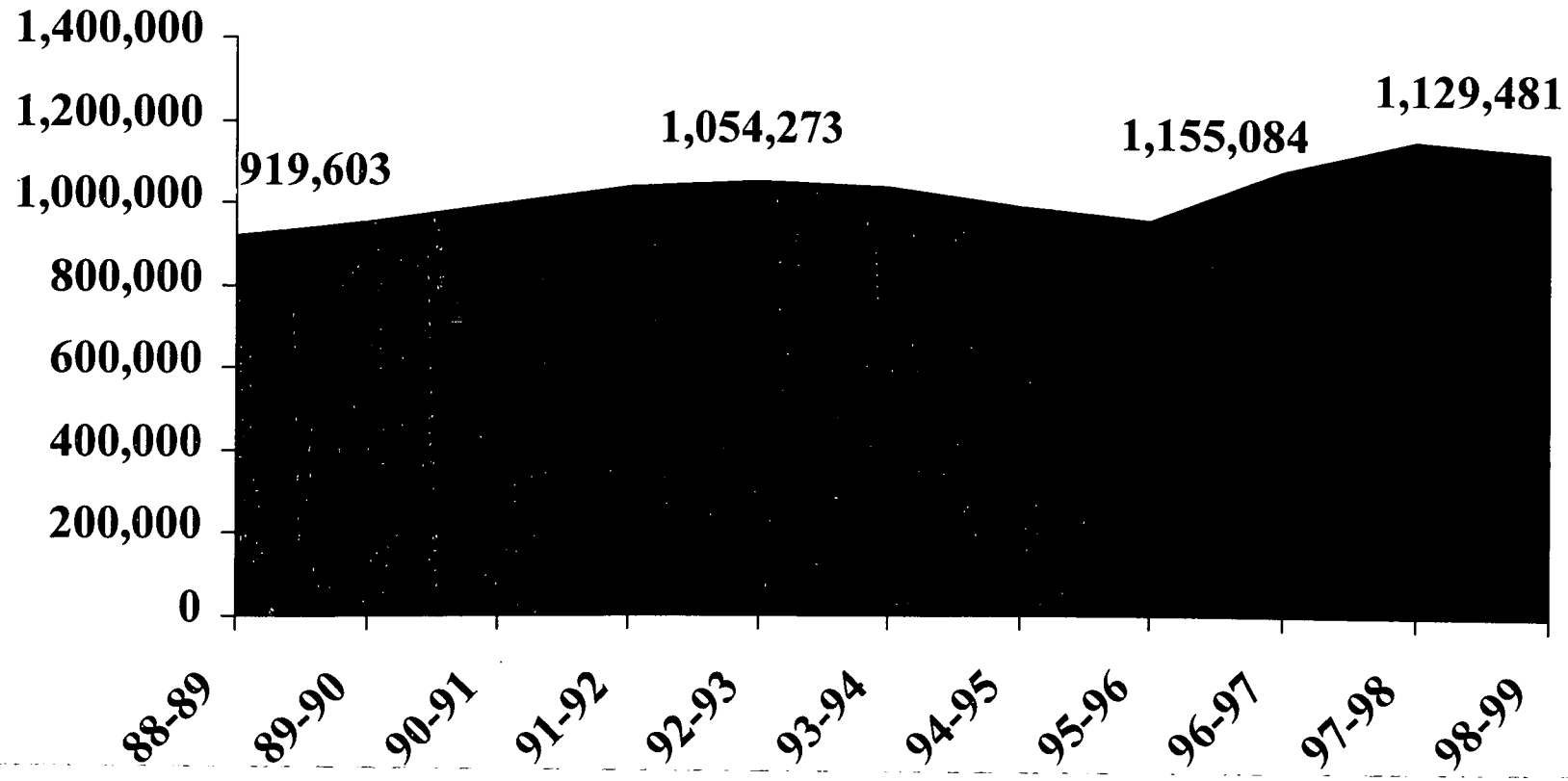
- There has been a slight decrease since 1988 in the percentage of uninsured who are poor. For those who are at or below the poverty level, uninsured levels have dropped from 30.5% in 1988 to 30.2% in 1998; for those between 100-199% of the poverty level, uninsured levels have dropped from 29.4% to 29.0%; and for those between 200-299% of the poverty level, uninsured levels have dropped from 29.2% to 27.1%. (Source: CPS, 1988/89, 1998/99.)

- For 1998-1999, the risk of being uninsured was roughly 25% for those citizens below 400% of the poverty level. (Source: CPS, 1997-1999.)

- Of those North Carolinians without health insurance in 1998, 22% had no connection to the workforce, 11% had someone in their families working part time, and 67% had someone in their families working full time. (Source: CPS, 1998.)

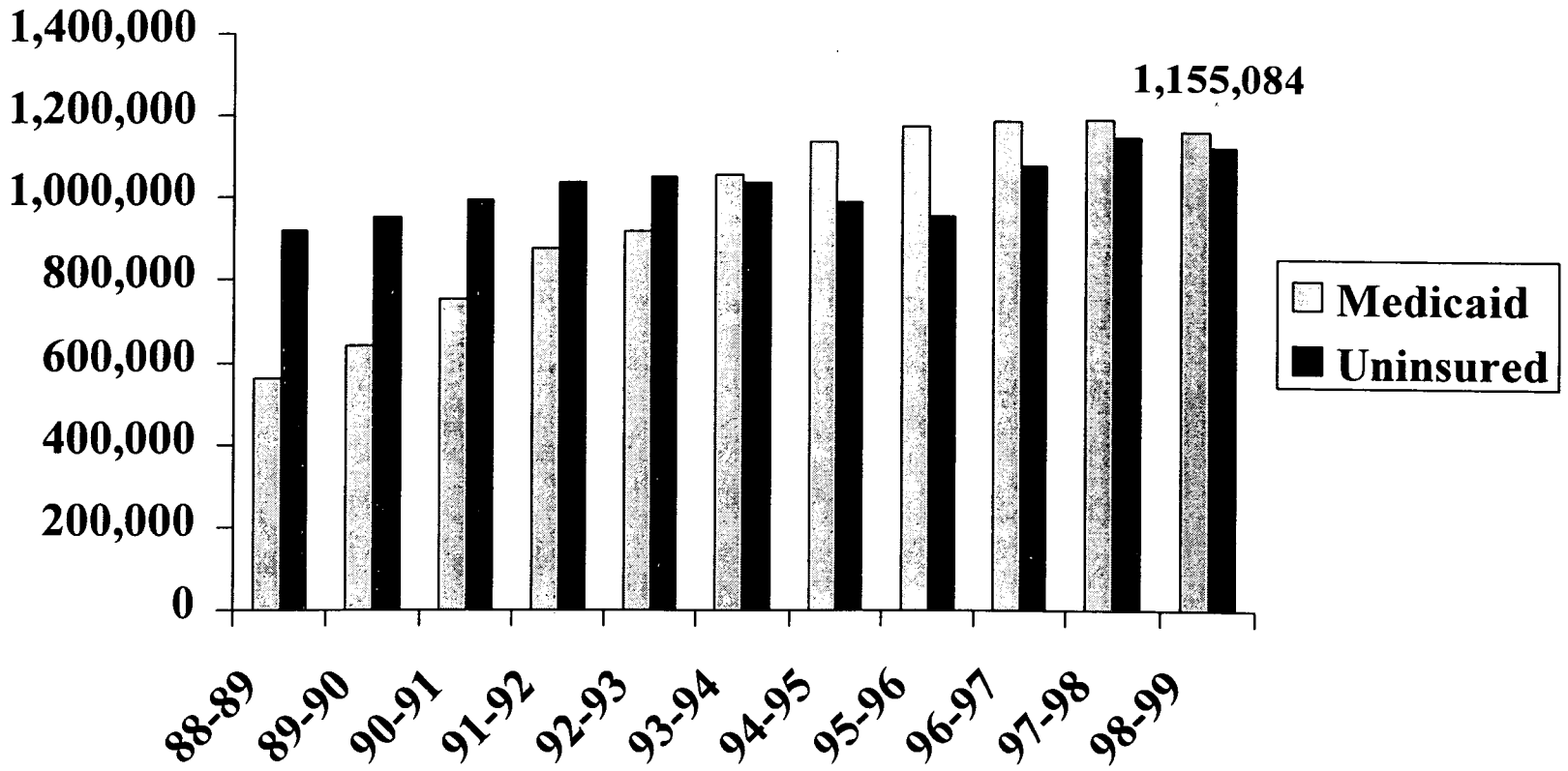
- A study done over the past ten years has shown that while uninsured levels have risen across the board, people working in small companies are more at-risk than those working in larger companies, or even those who are unemployed. For those citizens working in companies of 10 or fewer employees, the uninsured level has risen from 20.4% in 1988 to 28.7% in 1998; for those citizens who were unemployed, the uninsured level has dropped from 16.6% to 14.4%; for those citizens working for companies of 1000 or more employees, the uninsured level has risen from 0% to 8.62%. (Source: CPS, 1988/89, 1998/99.)

Numbers of Uninsured Is Increasing Slowly



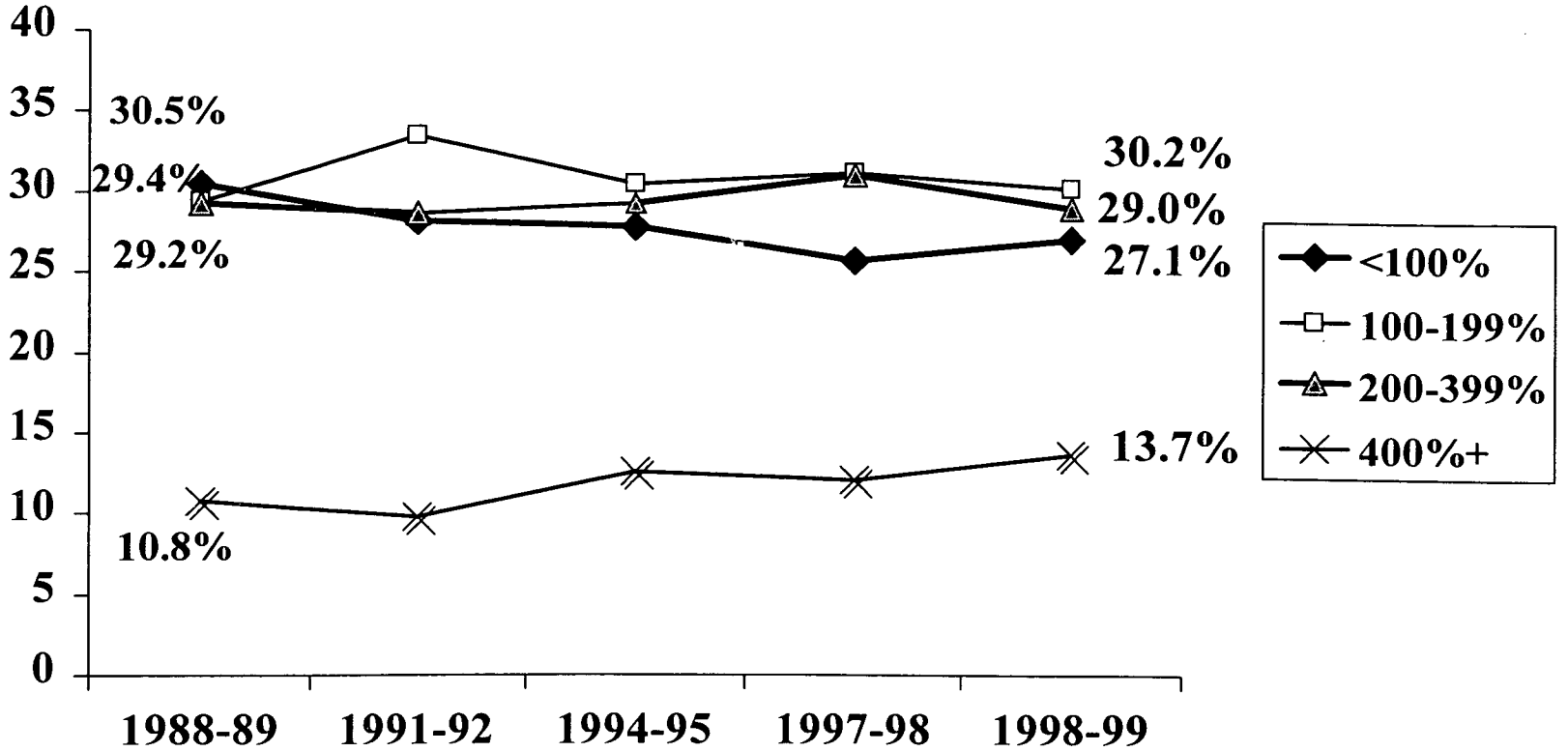
(Source: CPS, 1988/89, 1991/92, 1994/95, 1997/98. Uninsured are calculated using two-year averages.)

Numbers of Uninsured Continue to Rise Despite Medicaid Increases



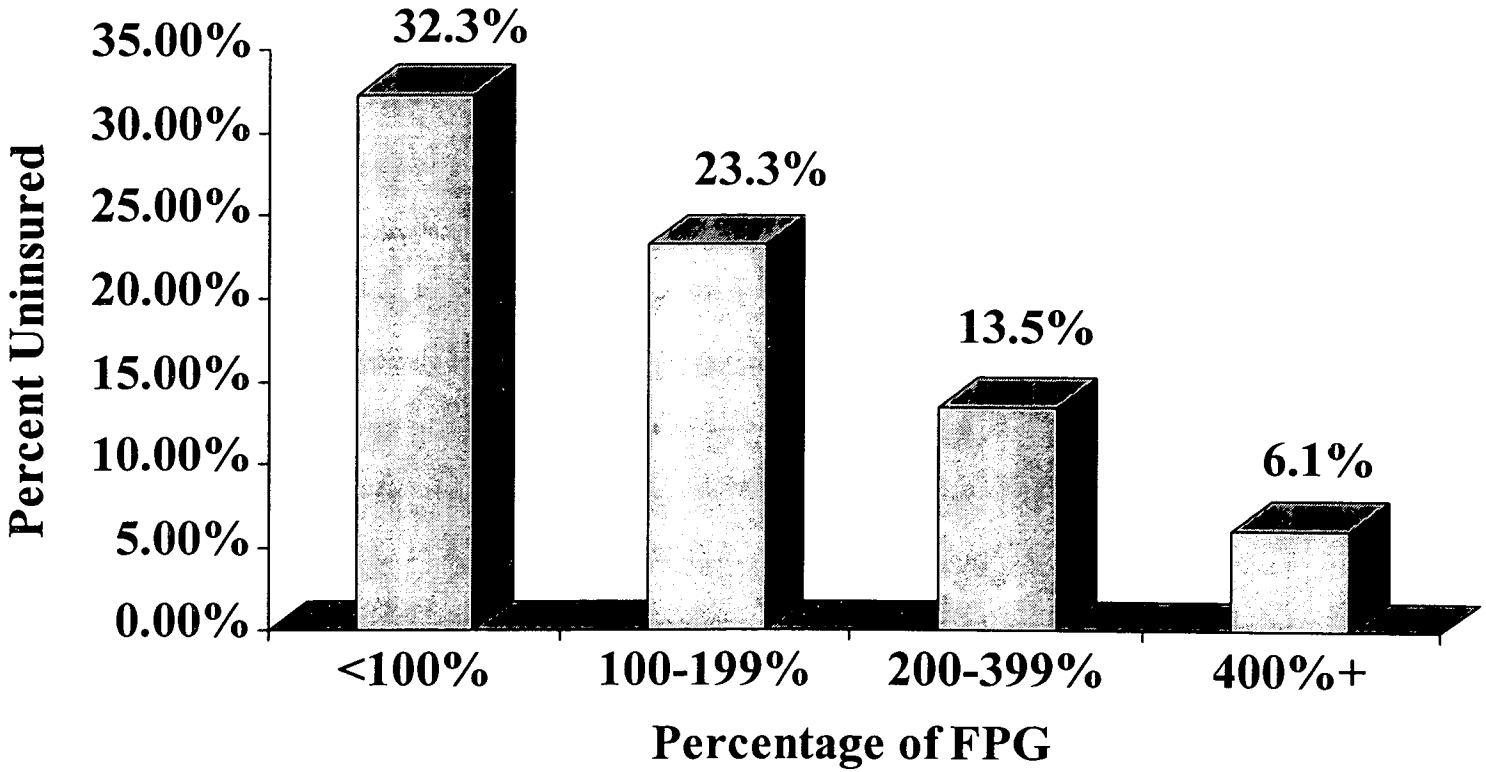
(Source: Table I. North Carolina Medicaid State Fiscal Years 1979-1988. A History of Medicaid Eligibles. CPS, 1988/89 1991/92, 1994/95, 1997/98. Medicaid eligibles are based on SFY data. Uninsured are calculated using two-year averages.)

Slight Decrease in Percentage of Uninsured Who are Poor (1988-1999)



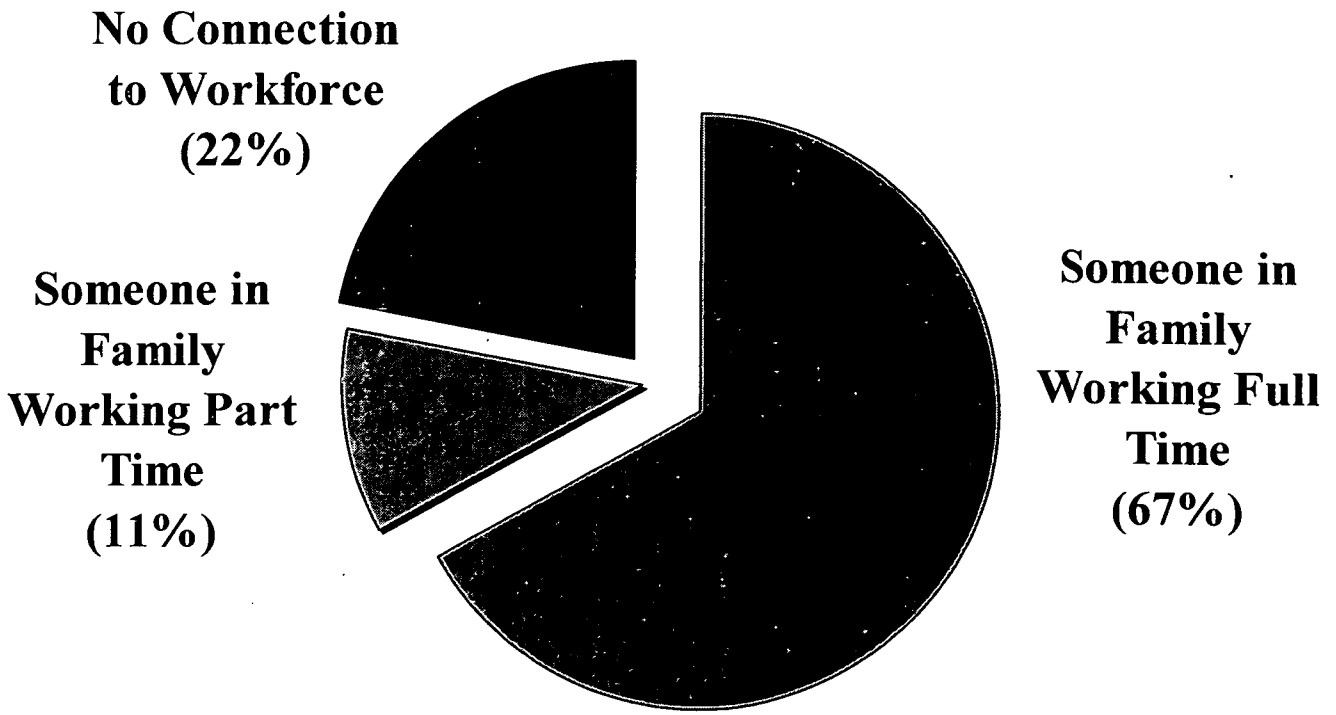
(Source: CPS, 1998/89, 1991/92, 1994/95, 1997/98. CPS data calculated using two-year averages.)

Risk of Being Uninsured by Income (1998-1999)



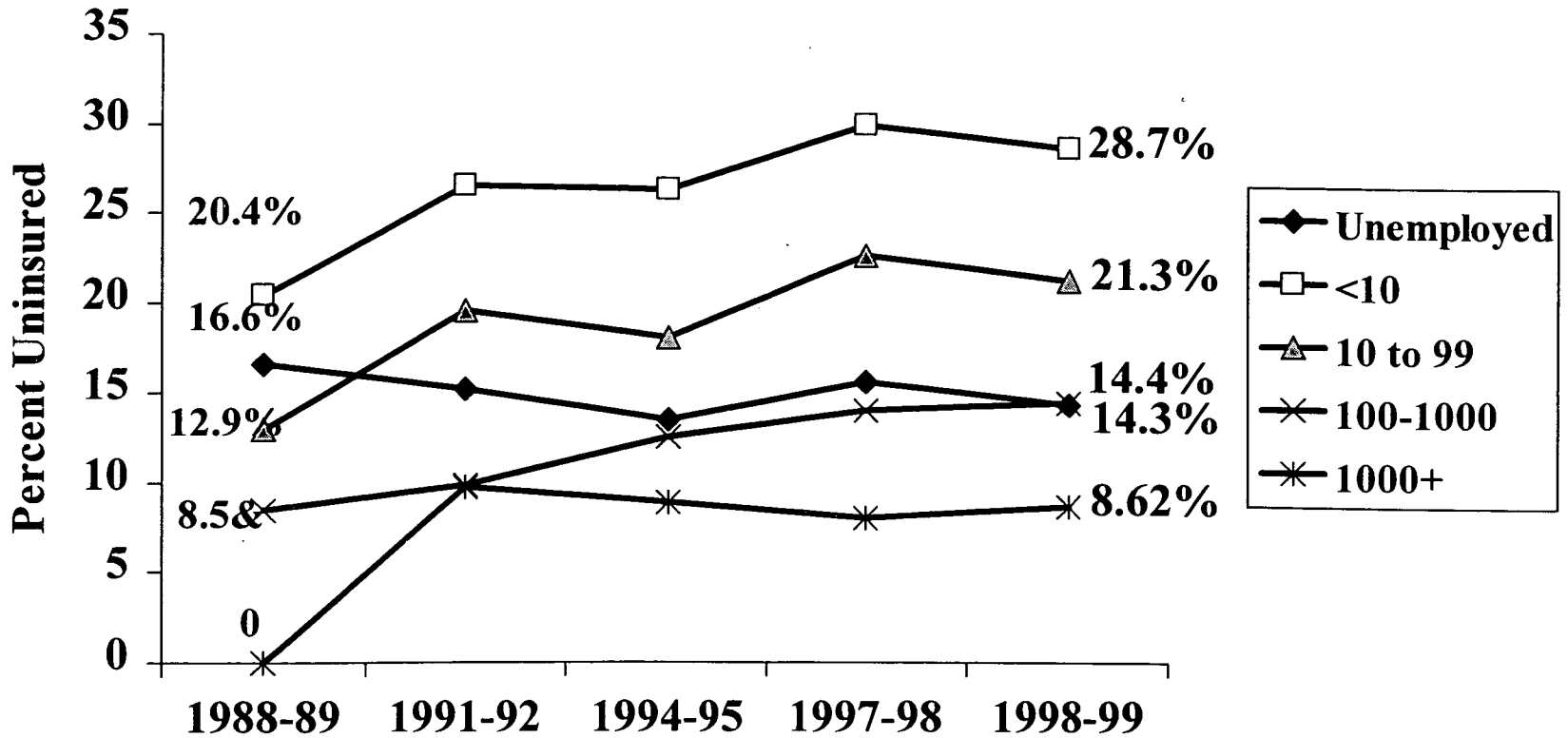
(Source: CPS, 1997, 1998, 1999)

Uninsured Connection to the Workforce (1998)



(source: CPS, 1998. Children, including full-time students under age 26, are classified according to the work status of their parents. Families that have at least one adult member working full-time are classified in the full-time category. A family is classified in the part-time category if at least one adult member is working part-time and there are no adult full-time workers. Families with no working members are included in the "no connection to the workforce" category.)

Risk of Being Uninsured by Size of Employer (or Unemployed)



(Source: CPS, 1988/89, 1991/92, 1994/95, 1997/98. CPS data calculated using two-year averages.)

II. United States Uninsured

- In the United States as a whole, 16.3% of the population was uninsured in 1998, increasing from 15.6% in 1996 and 16.1% in 1997. (Source: U.S. Census Bureau, 1998.)

- The following table lists the ten states with the lowest and the highest uninsured rates and compares those rates to those of North Carolina:

RANK	STATE	% UNINSURED
1	Nebraska	9.0%
2/3	Iowa/Minnesota	9.3%
4	Vermont	9.9%
5/6	Hawaii/Rhode Island	10.0%
7/8	Kansas/Massachusetts	10.3%
9	Ohio	10.4%
10/11	Missouri/Pennsylvania	10.5%
28	***North Carolina***	***15.0%***
41	Oklahoma	18.3%
42	Arkansas	18.7%
43	Louisiana	19.0%
44	Montana	19.6%
45	Mississippi	20.0%
46	New Mexico	21.1%
47	Nevada	21.2%
48	California	22.1%
49	Arizona	24.2%
50	Texas	24.5%

(Source: U.S. Census Bureau, 1998.)

- Several other states in America have begun to take action in this issue of health coverage. Washington, Oregon, Vermont, Maryland, Massachusetts, and New York all have initiatives or

laws providing for more universal coverage. (Source: Ad Hoc Committee to Defend Health Care, 2000.)

- Washington's Initiative 725, Oregon's Health Care for All plan, and Vermont's House Bill 678 provide for universal health care coverage. These three plans all create a health care board which would oversee a health care trust and implement the universal health care plans for the states.

III. Global Uninsured

The World Health Organization (WHO) recently released "The World Health Report 2000 – Health Systems: Improving Performance," which analyzed the health care systems of all 191 member nations.

- Overall, the United States was ranked 24th in health levels, based on the average life expectancy of our citizens. (Source: World Health Report 2000, Annex Table 1.)

- Regarding the efficiency of each plan in translating dollars into health care, the United States ranked number 72 – below Yugoslavia, Iran, China, Bosnia and Herzegovina, and most of South America. Regarding the effectiveness of each health system, or the overall health of the people in relation to the amount of money spent on health care, the US ranked number 37. (Source: WHO, Annex Table 10.)

- The United States was ranked number 1 in terms of the level of responsiveness of health care providers. This ranking was based on seven elements of responsiveness: dignity, autonomy, confidentiality, prompt attention, quality of basic amenities, access to social support networks during care, and choice of care provider. (Source: WHO, Annex Table 6.)

Annex Table 1 Health system attainment and performance in all Member States, ranked by eight measures, estimates for 1997

Afghanistan	168	182	181-182	172-173	103-104	183	184	150	173
Albania	102	129	136	117	173-174	86	149	64	55
Algeria	84	110	90-91	50-52	74-75	99	114	45	81
Andorra	10	25	28	39-42	33-34	17	23	7	4
Angola	165	178	177	188	103-104	181	164	165	181
Antigua and Barbuda	48	58	47-48	39-42	116-120	71	43	123	86
Argentina	39	60	40	3-38	89-95	49	34	71	75
Armenia	41	63	92	111-112	181	81	102	56	104
Australia	2	17	12-13	3-38	26-29	12	17	39	32
Austria	17	8	12-13	3-38	12-15	10	6	15	9
Azerbaijan	65	99	130-131	125	116-120	103	162	60	109
Bahamas	109	67	18	3-38	138-139	64	22	137	94
Bahrain	61	72	43-44	3-38	61	58	48	30	42
Bangladesh	140	125	178	181	51-52	131	144	103	88
Barbados	53	36	39	3-38	107	38	36	87	46
Belarus	83	46	76-79	45-47	84-86	53	74	116	72
Belgium	16	26	16-17	3-38	3-5	13	15	28	21
Belize	94	95	105-107	90	146	104	88	34	69
Benin	157	132	175-176	160	140-141	143	171	136	97
Bhutan	138	158	163	137-138	89-95	144	135	73	124
Bolivia	133	118	151-153	178	68	117	101	142	126
Bosnia and Herzegovina	56	79	108-110	124	82-83	79	105	70	90
Botswana	187	146	76-79	111-112	89-95	168	85	188	169
Brazil	111	108	130-131	84-85	189	125	54	78	125
Brunei Darussalam	59	42	24	3-38	89-95	37	32	76	40
Bulgaria	60	53	161	2	170	74	96	92	102
Burkina Faso	178	137	174	164	173-174	159	173	162	132
Burundi	179	154	171	168	114	161	186	171	143
Cambodia	148	150	137-138	137-138	183	166	140	157	174
Cameroon	156	160	156	183	182	163	131	172	164
Canada	12	18	7-8	3-38	17-19	7	10	35	30
Cape Verde	118	123	154	134-135	89-95	126	150	55	113
Central African Republic	175	189	183	191	166	190	178	164	189
Chad	161	175	181-182	185	58-60	177	175	161	178
Chile	32	1	45	103	168	33	44	23	33
China	81	101	88-89	105-106	188	132	139	61	144
Colombia	74	44	82	93-94	1	41	49	51	22
Comoros	146	143	157-160	153-155	79-81	137	165	141	118
Congo	150	142	137-138	151	162	155	122	167	166
Cook Islands	67	92	65	89	45-47	88	61	95	107
Costa Rica	40	45	68	86-87	64-65	45	50	25	36
Côte d'Ivoire	155	181	157-160	153-155	116-120	157	153	133	137
Croatia	38	33	76-79	83	108-111	36	56	57	43
Cuba	33	41	115-117	98-100	23-25	40	118	36	39
Cyprus	25	31	11	44	131-133	28	39	22	24
Czech Republic	35	19	47-48	45-47	71-72	30	40	81	48
Democratic People's Republic of Korea	137	145	139	130-131	179	149	172	153	167
Democratic Republic of the Congo	174	174	142	169-170	169	179	188	185	188
Denmark	28	21	4	3-38	3-5	20	8	65	34
Djibouti	166	169	170	140	3-5	170	163	163	157
Dominica	26	35	84-86	77-78	99-100	42	70	59	35
Dominican Republic	79	97	95	72	154	66	92	42	51
Ecuador	93	133	76-79	182	88	107	97	96	111
Egypt	115	141	102	59	125-127	110	115	43	63
El Salvador	87	115	128	128-129	176	122	83	37	115
Equatorial Guinea	152	151	143	118	134	152	129	174	171
Eritrea	169	167	186	169-170	108-111	176	187	148	158
Estonia	69	43	66	69	145	48	60	115	77
Ethiopia	182	176	179	179-180	138-139	186	189	169	180
Fiji	106	71	57-58	73-74	54-55	78	87	124	96
Finland	20	27	19	3-38	8-11	22	18	44	31
France	3	12	16-17	3-38	26-29	6	4	4	1
Gabon	144	136	118-119	101-102	84-86	141	95	143	139
Gambia	143	155	165-167	157	149	153	158	109	146
Georgia	44	61	165-167	141	105-106	76	125	84	114
Germany	22	20	5	3-38	6-7	14	3	41	25
Ghana	149	149	132-135	146	74-75	139	166	158	135
Greece	7	6	36	3-38	41	23	30	11	14
Grenada	49	82	63-64	84-85	147	68	67	49	85
Guatemala	129	106	115-117	159	157	113	130	99	78
Guinea	167	166	168-169	130-131	76-78	172	159	160	161
Guinea-Bissau	170	177	184	174	122-123	180	156	156	176
Guyana	98	126	114	105-106	45-47	116	109	104	128
Haiti	153	152	157-160	172-173	163	145	155	139	138
Honduras	92	119	129	163	178	129	100	48	131

Hungary	62	40	62	58	105-106	43	59	105	66
Iceland	19	24	15	3-38	12-15	16	14	27	15
India	134	153	108-110	127	42-44	121	133	118	112
Indonesia	103	156	63-64	70	73	106	154	90	92
Iran, Islamic Republic of	96	113	100	93-94	112-113	114	94	58	93
Iraq	126	130	103-104	114	56-57	124	117	75	103
Ireland	27	13	25	3-38	6-7	25	25	32	19
Israel	23	7	20-21	3-38	38-40	24	19	40	28
Italy	6	14	22-23	3-38	45-47	11	11	3	2
Jamaica	36	87	105-107	73-74	115	69	89	8	53
Japan	1	3	6	3-38	8-11	1	13	9	10
Jordan	101	83	84-86	53-57	49-50	84	98	100	83
Kazakhstan	122	52	90-91	60-61	167	62	112	135	64
Kenya	162	135	144	142	79-81	142	152	178	140
Kiribati	125	121	120-121	122	16	123	103	144	142
Kuwait	68	54	29	3-38	30-32	46	41	68	45
Kyrgyzstan	123	122	124	96	171	135	146	134	151
Lao People's Democratic Republic	147	147	145-147	143-144	159	154	157	155	165
Latvia	82	56	69-72	53-57	164-165	67	77	121	105
Lebanon	95	88	55	79-81	101-102	93	46	97	91
Lesotho	171	164	145-147	148-149	89-95	173	123	186	183
Liberia	181	191	175-176	176	84-86	187	181	176	186
Libyan Arab Jamahiriya	107	102	57-58	76	12-15	97	84	94	87
Lithuania	63	48	80-81	45-47	131-133	52	71	93	73
Luxembourg	18	22	3	3-38	2	5	5	31	16
Madagascar	172	168	168-169	179-180	116-120	167	190	173	159
Malawi	189	187	162	152	89-95	182	161	187	185
Malaysia	89	49	31	62	122-123	55	93	86	49
Maldives	130	134	98-99	101-102	51-52	128	76	147	147
Mali	183	180	187-188	187	150-151	178	179	170	163
Malta	21	38	43-44	3-38	42-44	31	37	2	5
Marshall Islands	121	120	98-99	134-135	20-22	119	80	140	141
Mauritania	158	163	165-167	123	153	169	141	151	162
Mau[illegible]	78	77	56	3-38	124	90	69	113	84
M[illegible]	55	65	53-54	108-109	144	51	55	63	61
Micronesia, Federated States of	104	112	112	128-129	23-25	111	81	110	123
Monaco	9	30	14	3-38	42-44	18	12	12	13
Mongolia	131	148	46	91	97	136	145	138	145
Morocco	110	111	151-153	67-68	125-127	94	99	17	29
Mozambique	180	190	189-190	175	38-40	185	160	168	184
Myanmar	139	162	151-153	158	190	175	136	129	190
Namibia	136	173	113	156	125-127	165	66	189	168
Nauru	136	51	42	39-42	17-19	75	42	166	98
Nepal	142	161	185	166-167	186	160	170	98	150
Netherlands	13	15	9	3-38	20-22	8	9	19	17
New Zealand	31	16	22-23	3-38	23-25	26	20	80	41
Nicaragua	117	96	140	139	164-165	101	104	74	71
Niger	190	184	189-190	184	160-161	188	185	177	170
Nigeria	163	188	149	177	180	184	176	175	187
Niue	85	100	126	145	35-36	102	127	108	121
Norway	15	4	7-8	3-38	8-11	3	16	18	11
Oman	72	59	83	49	56-57	59	62	1	8
Pakistan	124	183	120-121	115	62-63	133	142	85	122
Palau	112	66	52	39-42	30-32	63	47	125	82
Panama	47	93	59	88	76-78	70	53	67	95
Papua New Guinea	145	157	150	119	71-72	150	137	146	148
Paraguay	71	57	97	133	177	73	91	52	57
Peru	105	103	172	161	184	115	78	119	129
Philippines	113	50	49	48	128-130	54	124	126	60
Poland	45	5	50	65	150-151	34	58	89	50
Portugal	29	34	38	53-57	58-60	32	28	13	12
Qatar	66	55	26-27	3-38	70	47	27	53	44
Republic of Korea	51	37	35	43	53	35	31	107	58
Republic of Moldova	88	64	123	107	148	91	108	106	101
Romania	80	78	73-74	67-68	79-81	72	107	111	99
Russian Federation	91	69	69-72	86-87	185	100	75	127	130
Rwanda	185	185	145-147	143-144	58-60	171	177	181	172
Saint Kitts and Nevis	86	91	53-54	3-38	136-137	98	51	122	100
Saint [illegible]cia	54	86	84-86	62	66-67	87	86	54	68
Sai[illegible]nt and the Grenadines	43	89	103-104	98-100	99-100	92	90	38	74
Sam[illegible]	97	81	80-81	98-100	33-34	82	121	131	119
San Marino	11	9	32	3-38	30-32	21	21	5	3
Sao Tome and Principe	132	139	148	126	66-67	138	167	117	133
Saudi Arabia	58	70	67	50-52	37	61	63	10	26
Senegal	151	105	118-119	104	87	118	143	132	59
Seychelles	108	73	75	75	64-65	83	52	83	56
Sierra Leone	191	186	173	186	191	191	183	183	191

Singapore	30	29	20-21	3-38	101-102	27	38	14	6
Slovakia	42	39	60	63-64	96	39	45	88	62
Slovenia	34	23	37	53-57	82-83	29	29	62	38
Solomon Islands	127	117	132-135	120	17-19	108	134	20	80
Somalia	173	179	191	190	136-137	189	191	154	179
South Africa	160	128	73-74	147	142-143	151	57	182	175
Spain	5	11	34	3-38	26-29	19	24	6	7
Sri Lanka	76	80	101	77-78	76-78	80	138	66	76
Sudan	154	159	164	148-149	160-161	148	169	149	134
Suriname	77	94	87	79-81	172	105	72	77	110
Swaziland	164	140	108-110	110	156	164	116	184	177
Sweden	4	28	10	3-38	12-15	4	7	21	23
Switzerland	8	10	2	3-38	38-40	2	2	26	20
Syrian Arab Republic	114	107	69-72	79-81	142-143	112	119	91	108
Tajikistan	120	124	125	136	112-113	127	126	145	154
Thailand	99	74	33	50-52	128-130	57	64	102	47
The former Yugoslav Republic of Macedonia	64	85	111	95	116-120	89	106	69	89
Togo	159	170	155	162	152	156	180	159	152
Tonga	75	84	61	97	108-111	85	73	114	116
Trinidad and Tobago	57	75	141	108-109	69	56	65	79	67
Tunisia	90	114	94	60-61	108-111	77	79	46	52
Turkey	73	109	93	66	49-50	96	82	33	70
Turkmenistan	128	131	88-89	113	121	130	128	152	153
Tuvalu	119	116	132-135	153-155	26-29	120	151	128	136
Uganda	186	138	187-188	165	128-130	162	168	179	149
Ukraine	70	47	96	63-64	140-141	60	111	101	79
United Arab Emirates	50	62	30	1	20-22	44	35	16	27
United Kingdom	14	2	26-27	3-38	8-11	9	26	24	18
United Republic of Tanzania	176	172	157-160	150	48	158	174	180	156
United States of America	24	32	1	3-38	54-55	15	1	72	37
Uruguay	37	68	41	53-57	35-36	50	33	50	65
Uzbekistan	100	144	105-107	71	131-133	109	120	112	117
Vanuatu	135	127	127	132	62-63	134	132	120	127
Venezuela, Bolivarian Republic of	52	76	69-72	92	98	65	68	29	54
Viet Nam	116	104	51	121	187	140	147	130	160
Yemen	141	165	180	189	135	146	182	82	120
Yugoslavia	46	90	115-117	116	158	95	113	47	106
Zambia	188	171	132-135	171	155	174	148	190	182
Zimbabwe	184	98	122	166-167	175	147	110	191	155

Source: Annex Tables 5-10.

Annex Table [illegible] Health system performance in all Member States, WHO [illegible]xes, estimates for 1997

1	1 - 5	Oman	0.992	0.975 - 1.000	1	1 - 5	France	0.994	0.982 - 1.000
2	1 - 4	Malta	0.989	0.968 - 1.000	2	1 - 5	Italy	0.991	0.978 - 1.000
3	2 - 7	Italy	0.976	0.957 - 0.994	3	1 - 6	San Marino	0.988	0.973 - 1.000
4	2 - 7	France	0.974	0.953 - 0.994	4	2 - 7	Andorra	0.982	0.966 - 0.997
5	2 - 7	San Marino	0.971	0.949 - 0.988	5	3 - 7	Malta	0.978	0.965 - 0.993
6	3 - 8	Spain	0.968	0.948 - 0.989	6	2 - 11	Singapore	0.973	0.947 - 0.998
7	4 - 9	Andorra	0.964	0.942 - 0.980	7	4 - 8	Spain	0.972	0.959 - 0.985
8	3 - 12	Jamaica	0.956	0.928 - 0.986	8	4 - 14	Oman	0.961	0.938 - 0.985
9	7 - 11	Japan	0.945	0.926 - 0.963	9	7 - 12	Austria	0.959	0.946 - 0.972
10	8 - 15	Saudi Arabia	0.936	0.915 - 0.959	10	8 - 11	Japan	0.957	0.948 - 0.965
11	9 - 13	Greece	0.936	0.920 - 0.951	11	8 - 12	Norway	0.955	0.947 - 0.964
12	9 - 16	Monaco	0.930	0.908 - 0.948	12	10 - 15	Portugal	0.945	0.931 - 0.958
13	10 - 15	Portugal	0.929	0.911 - 0.945	13	10 - 16	Monaco	0.943	0.929 - 0.957
14	10 - 15	Singapore	0.929	0.909 - 0.942	14	13 - 19	Greece	0.933	0.921 - 0.945
15	13 - 17	Austria	0.914	0.896 - 0.931	15	12 - 20	Iceland	0.932	0.917 - 0.948
16	13 - 23	United Arab Emirates	0.907	0.883 - 0.932	16	14 - 21	Luxembourg	0.928	0.914 - 0.942
17	14 - 22	Morocco	0.906	0.886 - 0.925	17	14 - 21	Netherlands	0.928	0.914 - 0.942
18	16 - 23	Norway	0.897	0.878 - 0.914	18	16 - 21	United Kingdom	0.925	0.913 - 0.937
19	17 - 24	Netherlands	0.893	0.875 - 0.911	19	14 - 22	Ireland	0.924	0.909 - 0.939
20	15 - 31	Solomon Islands	0.892	0.863 - 0.920	20	17 - 24	Switzerland	0.916	0.903 - 0.930
21	18 - 26	Sweden	0.890	0.870 - 0.907	21	18 - 24	Belgium	0.915	0.903 - 0.926
22	19 - 28	Cyprus	0.885	0.865 - 0.898	22	14 - 29	Colombia	0.910	0.881 - 0.939
23	19 - 30	Chile	0.884	0.864 - 0.903	23	20 - 26	Sweden	0.908	0.893 - 0.921
24	21 - 28	United Kingdom	0.883	0.866 - 0.900	24	16 - 30	Cyprus	0.906	0.879 - 0.932
25	18 - 32	Costa Rica	0.882	0.859 - 0.898	25	22 - 27	Germany	0.902	0.890 - 0.914
26	21 - 31	Switzerland	0.879	0.860 - 0.891	26	22 - 32	Saudi Arabia	0.894	0.872 - 0.916
27	21 - 31	Iceland	0.879	0.861 - 0.897	27	23 - 33	United Arab Emirates	0.886	0.861 - 0.911
28	23 - 30	Belgium	0.878	0.860 - 0.894	28	26 - 32	Israel	0.884	0.870 - 0.897
29	23 - 33	Venezuela, Bolivarian Republic of	0.873	0.853 - 0.891	29	18 - 39	Morocco	0.882	0.834 - 0.925
30	23 - 37	Bahrain	0.867	0.843 - 0.890	30	27 - 32	Canada	0.881	0.868 - 0.894
31	28 - 35	Luxembourg	0.864	0.847 - 0.881	31	27 - 33	Finland	0.881	0.866 - 0.895
32	29 - 38	Ireland	0.859	0.840 - 0.870	32	28 - 34	Australia	0.876	0.861 - 0.891
33	27 - 40	Turkey	0.858	0.835 - 0.878	33	22 - 43	Chile	0.870	0.816 - 0.918
34	25 - 48	Belize	0.853	0.821 - 0.884	34	32 - 36	Denmark	0.862	0.848 - 0.874
35	33 - 40	Canada	0.849	0.832 - 0.864	35	31 - 41	Dominica	0.854	0.824 - 0.883
36	32 - 42	Cuba	0.849	0.830 - 0.866	36	33 - 40	Costa Rica	0.849	0.825 - 0.871
37	30 - 49	El Salvador	0.846	0.817 - 0.873	37	35 - 44	United States of America	0.838	0.817 - 0.859
38	28 - 52	Saint Vincent and the Grenadines	0.845	0.812 - 0.876	38	34 - 46	Slovenia	0.838	0.813 - 0.859
39	35 - 43	Australia	0.844	0.826 - 0.861	39	36 - 44	Cuba	0.834	0.816 - 0.852
40	36 - 44	Israel	0.841	0.825 - 0.858	40	36 - 48	Brunei Darussalam	0.829	0.808 - 0.849
41	39 - 47	Germany	0.836	0.819 - 0.852	41	38 - 45	New Zealand	0.827	0.815 - 0.840
42	33 - 54	Dominican Republic	0.834	0.806 - 0.863	42	37 - 48	Bahrain	0.824	0.804 - 0.845
43	37 - 53	Egypt	0.829	0.811 - 0.849	43	39 - 53	Croatia	0.812	0.782 - 0.837
44	41 - 50	Finland	0.829	0.812 - 0.844	44	41 - 51	Qatar	0.812	0.793 - 0.831
45	38 - 55	Algeria	0.829	0.808 - 0.850	45	41 - 52	Kuwait	0.810	0.790 - 0.830
46	41 - 55	Tunisia	0.824	0.803 - 0.844	46	41 - 53	Barbados	0.808	0.779 - 0.834
47	38 - 58	Yugoslavia	0.824	0.798 - 0.848	47	36 - 59	Thailand	0.807	0.759 - 0.852
48	40 - 61	Honduras	0.820	0.793 - 0.844	48	43 - 54	Czech Republic	0.805	0.781 - 0.825
49	37 - 63	Grenada	0.819	0.789 - 0.850	49	42 - 55	Malaysia	0.802	0.772 - 0.830
50	42 - 59	Uruguay	0.819	0.794 - 0.842	50	45 - 59	Poland	0.793	0.762 - 0.819

51	41 - 64	Colombia	0.814	0.787 - 0.843	51	38 - 67	[redacted]ominican Republic	0.789	0.735 - 0.845
52	42 - 6[redacted]	Paraguay	0.813	0.785 - 0.842	52	41 - 67	[redacted]nisia	0.785	0.741 - 0.832
53	43 - 64	Qatar	0.813	0.786 - 0.839	53	47 - 62	Jamaica	0.782	0.754 - 0.809
54	43 - 69	Saint Lucia	0.809	0.781 - 0.837	54	50 - 64	Venezuela, Bolivarian Republic of	0.775	0.745 - 0.803
55	41 - 70	Cape Verde	0.808	0.776 - 0.842	55	41 - 75	Albania	0.774	0.709 - 0.834
56	47 - 64	Armenia	0.806	0.785 - 0.823	56	51 - 63	Seychelles	0.773	0.747 - 0.797
57	51 - 61	Croatia	0.805	0.789 - 0.821	57	47 - 77	Paraguay	0.761	0.714 - 0.806
58	48 - 65	Iran, Islamic Republic of	0.805	0.783 - 0.827	58	55 - 67	Republic of Korea	0.759	0.740 - 0.776
59	45 - 73	Dominica	0.804	0.774 - 0.833	59	50 - 78	Senegal	0.756	0.711 - 0.800
60	49 - 67	Azerbaijan	0.803	0.781 - 0.820	60	53 - 73	Philippines	0.755	0.720 - 0.789
61	52 - 65	China	0.800	0.782 - 0.813	61	52 - 74	Mexico	0.755	0.719 - 0.789
62	55 - 66	Slovenia	0.797	0.781 - 0.813	62	54 - 73	Slovakia	0.754	0.721 - 0.781
63	56 - 73	Mexico	0.789	0.771 - 0.808	63	49 - 81	Egypt	0.752	0.707 - 0.798
64	55 - 76	Albania	0.789	0.766 - 0.808	64	50 - 80	Kazakhstan	0.752	0.699 - 0.802
65	61 - 72	Denmark	0.785	0.769 - 0.801	65	55 - 80	Uruguay	0.745	0.702 - 0.782
66	57 - 80	Sri Lanka	0.783	0.761 - 0.807	66	59 - 74	Hungary	0.743	0.713 - 0.768
67	57 - 80	Panama	0.783	0.759 - 0.807	67	53 - 81	Trinidad and Tobago	0.742	0.695 - 0.784
68	56 - 83	Kuwait	0.782	0.753 - 0.808	68	59 - 75	Saint Lucia	0.740	0.717 - 0.765
69	61 - 78	The former Yugoslav Republic of Macedonia	0.781	0.761 - 0.796	69	58 - 81	Belize	0.736	0.697 - 0.772
70	59 - 83	Bosnia and Herzegovina	0.780	0.754 - 0.803	70	60 - 81	Turkey	0.734	0.698 - 0.764
71	65 - 76	Argentina	0.779	0.762 - 0.794	71	58 - 83	Nicaragua	0.733	0.696 - 0.770
72	67 - 78	United States of America	0.774	0.758 - 0.789	72	64 - 84	Belarus	0.723	0.691 - 0.750
73	61 - 86	Bhutan	0.773	0.748 - 0.797	73	65 - 82	Lithuania	0.722	0.690 - 0.750
74	63 - 84	Nicaragua	0.772	0.750 - 0.793	74	63 - 83	Saint Vincent and the Grenadines	0.722	0.686 - 0.754
75	65 - 84	Iraq	0.770	0.752 - 0.791	75	66 - 81	Argentina	0.722	0.695 - 0.747
76	67 - 85	Brunei Darussalam	0.768	0.749 - 0.787	76	68 - 84	Sri Lanka	0.716	0.692 - 0.740
77	61 - 88	Suriname	0.768	0.740 - 0.798	77	68 - 85	Estonia	0.714	0.684 - 0.741
78	66 - 88	Brazil	0.767	0.745 - 0.787	78	57 - 99	Guatemala	0.713	0.642 - 0.774
79	70 - 84	Trinidad and Tobago	0.767	0.750 - 0.780	79	70 - 88	Ukraine	0.708	0.674 - 0.734
80	72 - 83	New Zealand	0.766	0.750 - 0.780	80	68 - 93	Solomon Islands	0.705	0.664 - 0.739
81	73 - 83	Czech Republic	0.765	0.749 - 0.779	81	70 - 92	Algeria	0.701	0.669 - 0.730
82	66 - 91	Yemen	0.761	0.733 - 0.789	82	75 - 88	Palau	0.700	0.679 - 0.719
83	72 - 88	Seychelles	0.759	0.739 - 0.778	83	75 - 88	Jordan	0.698	0.675 - 0.720
84	73 - 91	Georgia	0.758	0.736 - 0.776	84	75 - 91	Mauritius	0.691	0.665 - 0.719
85	73 - 89	Pakistan	0.757	0.738 - 0.777	85	74 - 96	Grenada	0.689	0.652 - 0.723
86	75 - 92	Malaysia	0.751	0.731 - 0.771	86	76 - 93	Antigua and Barbuda	0.688	0.657 - 0.718
87	77 - 92	Barbados	0.749	0.730 - 0.770	87	79 - 96	Libyan Arab Jamahiriya	0.683	0.655 - 0.707
88	85 - 92	Slovakia	0.742	0.729 - 0.757	88	69 - 111	Bangladesh	0.675	0.618 - 0.732
89	84 - 94	Poland	0.742	0.723 - 0.758	89	83 - 107	The former Yugoslav Republic of Mace	0.664	0.630 - 0.695
90	79 - 98	Indonesia	0.741	0.715 - 0.766	90	84 - 106	Bosnia and Herzegovina	0.664	0.632 - 0.694
91	85 - 99	Syrian Arab Republic	0.733	0.712 - 0.755	91	85 - 104	Lebanon	0.664	0.638 - 0.688
92	89 - 96	Bulgaria	0.733	0.717 - 0.747	92	85 - 107	Indonesia	0.660	0.632 - 0.689
93	89 - 103	Lithuania	0.724	0.705 - 0.742	93	83 - 110	Iran, Islamic Republic of	0.659	0.620 - 0.693
94	89 - 104	Libyan Arab Jamahiriya	0.723	0.699 - 0.746	94	87 - 108	Bahamas	0.657	0.625 - 0.687
95	89 - 105	Cook Islands	0.722	0.696 - 0.746	95	87 - 107	Panama	0.656	0.627 - 0.686
96	89 - 104	Ecuador	0.721	0.700 - 0.742	96	90 - 106	Fiji	0.653	0.630 - 0.674
97	91 - 105	Lebanon	0.719	0.697 - 0.740	97	78 - 123	Benin	0.647	0.573 - 0.710
98	93 - 107	Nepal	0.714	0.691 - 0.736	98	94 - 107	Nauru	0.647	0.630 - 0.664
99	93 - 107	Guatemala	0.714	0.691 - 0.735	99	92 - 110	Romania	0.645	0.624 - 0.666
100	94 - 107	Jordan	0.711	0.689 - 0.732	100	90 - 113	Saint Kitts and Nevis	0.643	0.611 - 0.678
101	97 - 104	Ukraine	0.711	0.695 - 0.726	101	92 - 114	Republic of Moldova	0.639	0.600 - 0.672
102	93 - 111	Thailand	0.710	0.682 - 0.736	102	94 - 113	Bulgaria	0.639	0.617 - 0.660
103	93 - 109	Bangladesh	0.709	0.684 - 0.735	103	91 - 117	Iraq	0.637	0.597 - 0.669
104	92 - 115	Guyana	0.704	0.672 - 0.738	104	86 - 126	Armenia	0.630	0.566 - 0.682
105	101 - 111	Hungary	0.698	0.682 - 0.714	105	94 - 118	Latvia	0.630	0.589 - 0.665
106	102 - 111	Republic of Moldova	0.696	0.680 - 0.710	106	94 - 120	Yugoslavia	0.629	0.586 - 0.664

107	100 - 113	Republic of Korea	0.694	0.674 - 0.711	107	95 - 121	Cook Islands	0.628	0.583 - 0.664
108	93 - [redacted]	Niue	0.693	0.650 - 0.731	108	94 - 120	[redacted]rian Arab Republic	0.628	0.589 - 0.661
109	103 - 116	Gambia	0.687	0.671 - 0.704	109	93 - 122	Azerbaijan	0.626	0.582 - 0.665
110	100 - 121	Micronesia, Federated States of	0.684	0.656 - 0.717	110	91 - 123	Suriname	0.623	0.571 - 0.671
111	107 - 117	Romania	0.682	0.668 - 0.696	111	88 - 125	Ecuador	0.619	0.565 - 0.684
112	107 - 119	Uzbekistan	0.681	0.662 - 0.700	112	105 - 118	India	0.617	0.599 - 0.638
113	105 - 120	Mauritius	0.679	0.657 - 0.702	113	95 - 127	Cape Verde	0.617	0.561 - 0.664
114	105 - 121	Tonga	0.677	0.651 - 0.704	114	103 - 121	Georgia	0.615	0.583 - 0.642
115	107 - 119	Estonia	0.677	0.657 - 0.694	115	94 - 130	El Salvador	0.608	0.544 - 0.667
116	109 - 119	Belarus	0.676	0.657 - 0.692	116	106 - 121	Tonga	0.607	0.582 - 0.632
117	109 - 121	Sao Tome and Principe	0.671	0.651 - 0.691	117	92 - 134	Uzbekistan	0.599	0.532 - 0.668
118	112 - 120	India	0.670	0.654 - 0.683	118	86 - 139	Comoros	0.592	0.509 - 0.689
119	111 - 123	Peru	0.665	0.643 - 0.686	119	114 - 126	Samoa	0.589	0.564 - 0.612
120	108 - 123	Vanuatu	0.665	0.639 - 0.689	120	92 - 140	Yemen	0.587	0.497 - 0.672
121	115 - 125	Latvia	0.655	0.631 - 0.677	121	114 - 129	Niue	0.584	0.549 - 0.614
122	114 - 127	Saint Kitts and Nevis	0.650	0.621 - 0.679	122	109 - 132	Pakistan	0.583	0.541 - 0.626
123	115 - 131	Antigua and Barbuda	0.641	0.606 - 0.678	123	114 - 131	Micronesia, Federated States of	0.579	0.543 - 0.610
124	120 - 133	Fiji	0.632	0.600 - 0.662	124	111 - 136	Bhutan	0.575	0.520 - 0.618
125	121 - 131	Palau	0.632	0.606 - 0.656	125	111 - 136	Brazil	0.573	0.526 - 0.619
126	122 - 131	Philippines	0.630	0.608 - 0.653	126	112 - 135	Bolivia	0.571	0.526 - 0.615
127	124 - 131	Russian Federation	0.623	0.606 - 0.638	127	118 - 138	Vanuatu	0.559	0.512 - 0.594
128	123 - 134	Tuvalu	0.618	0.594 - 0.644	128	119 - 140	Guyana	0.554	0.504 - 0.593
129	124 - 137	Myanmar	0.612	0.584 - 0.641	129	122 - 138	Peru	0.547	0.517 - 0.577
130	125 - 136	Viet Nam	0.611	0.587 - 0.634	130	126 - 136	Russian Federation	0.544	0.527 - 0.563
131	127 - 139	Samoa	0.602	0.579 - 0.626	131	115 - 145	Honduras	0.544	0.471 - 0.611
132	128 - 138	Senegal	0.601	0.584 - 0.620	132	114 - 147	Burkina Faso	0.543	0.472 - 0.611
133	129 - 139	Côte d'Ivoire	0.598	0.580 - 0.617	133	124 - 144	Sao Tome and Principe	0.535	0.482 - 0.575
134	128 - 140	Kyrgyzstan	0.598	0.575 - 0.620	134	119 - 151	Sudan	0.524	0.447 - 0.594
135	129 - 138	Kazakhstan	0.598	0.581 - 0.615	135	118 - 150	Ghana	0.522	0.452 - 0.596
136	129 - 139	Benin	0.596	0.576 - 0.616	136	130 - 145	Tuvalu	0.518	0.481 - 0.551
137	127 - 142	Bahamas	0.593	0.564 - 0.624	137	124 - 149	Côte d'Ivoire	0.517	0.463 - 0.572
138	132 - 144	Mongolia	0.581	0.555 - 0.607	138	120 - 152	Haiti	0.517	0.439 - 0.595
139	134 - 143	Haiti	0.580	0.561 - 0.599	139	129 - 149	Gabon	0.511	0.456 - 0.553
140	131 - 144	Marshall Islands	0.579	0.549 - 0.609	140	130 - 148	Kenya	0.505	0.461 - 0.549
141	137 - 145	Comoros	0.570	0.550 - 0.590	141	133 - 147	Marshall Islands	0.504	0.469 - 0.534
142	137 - 145	Bolivia	0.567	0.544 - 0.590	142	135 - 150	Kiribati	0.495	0.455 - 0.529
143	139 - 146	Gabon	0.559	0.538 - 0.579	143	125 - 157	Burundi	0.494	0.411 - 0.572
144	138 - 148	Kiribati	0.554	0.525 - 0.581	144	125 - 162	China	0.485	0.375 - 0.567
145	140 - 148	Tajikistan	0.551	0.523 - 0.580	145	134 - 154	Mongolia	0.483	0.429 - 0.531
146	141 - 149	Papua New Guinea	0.546	0.520 - 0.572	146	135 - 154	Gambia	0.482	0.427 - 0.533
147	144 - 154	Maldives	0.524	0.496 - 0.555	147	138 - 154	Maldives	0.477	0.430 - 0.516
148	146 - 153	Eritrea	0.521	0.504 - 0.538	148	137 - 159	Papua New Guinea	0.467	0.400 - 0.522
149	146 - 154	Sudan	0.519	0.496 - 0.543	149	136 - 158	Uganda	0.464	0.404 - 0.526
150	146 - 155	Afghanistan	0.517	0.488 - 0.547	150	138 - 159	Nepal	0.457	0.400 - 0.516
151	147 - 153	Mauritania	0.517	0.501 - 0.533	151	143 - 157	Kyrgyzstan	0.455	0.410 - 0.490
152	145 - 158	Turkmenistan	0.513	0.479 - 0.546	152	142 - 158	Togo	0.449	0.398 - 0.501
153	147 - 156	Democratic People's Republic of Korea	0.510	0.485 - 0.536	153	143 - 161	Turkmenistan	0.443	0.390 - 0.490
154	148 - 157	Somalia	0.506	0.480 - 0.530	154	147 - 163	Tajikistan	0.428	0.381 - 0.470
155	152 - 160	Lao People's Democratic Republic	0.489	0.466 - 0.510	155	143 - 167	Zimbabwe	0.427	0.352 - 0.497
156	154 - 162	Guinea-Bissau	0.481	0.462 - 0.499	156	145 - 166	United Republic of Tanzania	0.422	0.368 - 0.479
157	153 - 162	Cambodia	0.481	0.460 - 0.501	157	149 - 168	Djibouti	0.414	0.355 - 0.459
158	153 - 162	Ghana	0.479	0.457 - 0.500	158	152 - 170	Eritrea	0.399	0.339 - 0.446
159	155 - 164	Togo	0.472	0.452 - 0.492	159	149 - 170	Madagascar	0.397	0.329 - 0.463
160	157 - 164	Guinea	0.469	0.455 - 0.483	160	155 - 166	Viet Nam	0.393	0.366 - 0.420
161	156 - 165	Chad	0.465	0.444 - 0.487	161	155 - 170	Guinea	0.385	0.334 - 0.425
162	157 - 166	Burkina Faso	0.463	0.441 - 0.483	162	154 - 172	Mauritania	0.384	0.328 - 0.431

163	158 - 167	Djibouti	0.457	0.434 - 0.479	163	156 - 176	Mali	0.361	0.284 - 0.429
164	160 - [redacted]	Central African Republic	0.454	0.436 - 0.470	164	150 - 181	[redacted]meroon	0.357	0.246 - 0.458
165	159 - 167	Angola	0.453	0.433 - 0.473	165	157 - 178	Lao People's Democratic Republic	0.356	0.298 - 0.410
166	162 - 168	Nauru	0.444	0.424 - 0.464	166	160 - 176	Congo	0.354	0.302 - 0.401
167	164 - 170	Congo	0.433	0.411 - 0.454	167	157 - 180	Democratic People's Republic of Korea	0.353	0.278 - 0.414
168	164 - 172	Mozambique	0.424	0.399 - 0.450	168	158 - 180	Namibia	0.340	0.268 - 0.413
169	167 - 171	Ethiopia	0.418	0.400 - 0.435	169	164 - 179	Botswana	0.338	0.288 - 0.373
170	168 - 172	Mali	0.410	0.393 - 0.426	170	158 - 180	Niger	0.337	0.266 - 0.416
171	168 - 174	Burundi	0.403	0.374 - 0.435	171	163 - 180	Equatorial Guinea	0.337	0.277 - 0.384
172	169 - 174	Cameroon	0.399	0.375 - 0.421	172	161 - 182	Rwanda	0.327	0.268 - 0.389
173	170 - 174	Madagascar	0.394	0.378 - 0.410	173	164 - 181	Afghanistan	0.325	0.262 - 0.376
174	172 - 175	Equatorial Guinea	0.377	0.355 - 0.400	174	161 - 184	Cambodia	0.322	0.234 - 0.392
175	174 - 176	Nigeria	0.353	0.331 - 0.375	175	164 - 182	South Africa	0.319	0.251 - 0.374
176	175 - 178	Liberia	0.337	0.318 - 0.355	176	164 - 183	Guinea-Bissau	0.314	0.239 - 0.375
177	176 - 178	Niger	0.323	0.306 - 0.340	177	166 - 184	Swaziland	0.305	0.234 - 0.369
178	176 - 178	Kenya	0.320	0.298 - 0.343	178	167 - 183	Chad	0.303	0.231 - 0.363
179	179 - 180	Uganda	0.280	0.264 - 0.295	179	167 - 186	Somalia	0.286	0.199 - 0.369
180	179 - 180	United Republic of Tanzania	0.279	0.260 - 0.298	180	173 - 185	Ethiopia	0.276	0.215 - 0.326
181	181 - 185	Rwanda	0.240	0.214 - 0.265	181	172 - 186	Angola	0.275	0.198 - 0.343
182	181 - 185	South Africa	0.232	0.209 - 0.251	182	170 - 186	Zambia	0.269	0.204 - 0.339
183	181 - 185	Sierra Leone	0.230	0.213 - 0.247	183	174 - 186	Lesotho	0.266	0.205 - 0.319
184	181 - 186	Swaziland	0.229	0.205 - 0.255	184	170 - 187	Mozambique	0.260	0.186 - 0.339
185	182 - 187	Democratic Republic of the Congo	0.217	0.198 - 0.235	185	171 - 188	Malawi	0.251	0.174 - 0.332
186	183 - 188	Lesotho	0.211	0.187 - 0.236	186	180 - 189	Liberia	0.200	0.117 - 0.282
187	186 - 188	Malawi	0.196	0.181 - 0.211	187	183 - 189	Nigeria	0.176	0.094 - 0.251
188	187 - 189	Botswana	0.183	0.172 - 0.194	188	185 - 189	Democratic Republic of the Congo	0.171	0.100 - 0.232
189	185 - 189	Namibia	0.183	0.152 - 0.214	189	179 - 190	Central African Republic	0.156	0.000 - 0.306
190	190	Zambia	0.112	0.095 - 0.129	190	175 - 191	Myanmar	0.138	0.000 - 0.311
191	191	Zimbabwe	0.080	0.057 - 0.103	191	190 - 191	Sierra Leone	0.000	0.000 - 0.079

Annex Table 6 Responsiveness of health systems, level and distribution in all Member States, WHO indexes, estimates for 1999 [a]

1	United States of America	8.10	7.32 - 8.96
2	Switzerland	7.44	6.79 - 8.13
3	Luxembourg	7.37	6.73 - 8.06
4	Denmark	7.12	6.55 - 7.73
5	Germany	7.10	6.52 - 7.72
6	Japan	7.00	6.43 - 7.61
7-8	Canada	6.98	6.44 - 7.54
7-8	Norway	6.98	6.40 - 7.60
9	Netherlands	6.92	6.38 - 7.49
10	Sweden	6.90	6.35 - 7.47
11	Cyprus	6.88	6.76 - 7.00
12-13	Australia	6.86	6.34 - 7.40
12-13	Austria	6.86	6.31 - 7.45
14	Monaco	6.85	6.32 - 7.44
15	Iceland	6.84	6.31 - 7.42
16-17	Belgium	6.82	6.29 - 7.39
16-17	France	6.82	6.27 - 7.42
18	Bahamas	6.77	6.28 - 7.29
19	Finland	6.76	6.26 - 7.29
20-21	Israel	6.70	6.22 - 7.22
20-21	Singapore	6.70	6.16 - 7.25
22-23	Italy	6.65	6.13 - 7.20
22-23	New Zealand	6.65	6.18 - 7.15
24	Brunei Darussalam	6.59	6.11 - 7.07
25	Ireland	6.52	6.03 - 7.02
26-27	Qatar	6.51	6.02 - 7.00
26-27	United Kingdom	6.51	6.01 - 7.05
28	Andorra	6.44	5.97 - 6.93
29	Kuwait	6.34	5.84 - 6.82
30	United Arab Emirates	6.33	6.24 - 6.41
31	Malaysia	6.32	6.21 - 6.42
32	San Marino	6.30	5.84 - 6.79
33	Thailand	6.23	6.11 - 6.35
34	Spain	6.18	5.74 - 6.63
35	Republic of Korea	6.12	5.99 - 6.24
36	Greece	6.05	5.63 - 6.48
37	Slovenia	6.04	5.62 - 6.48
38	Portugal	6.00	5.58 - 6.44
39	Barbados	5.98	5.57 - 6.41
40	Argentina	5.93	5.53 - 6.34
41	Uruguay	5.87	5.47 - 6.28
42	Nauru	5.83	5.41 - 6.25
43-44	Bahrain	5.82	5.38 - 6.24
43-44	Malta	5.82	5.42 - 6.24
45	Chile	5.81	5.41 - 6.21
46	Mongolia	5.79	5.67 - 5.92
47-48	Antigua and Barbuda	5.78	5.37 - 6.17
47-48	Czech Republic	5.78	5.38 - 6.19
49	Philippines	5.75	5.64 - 5.87
50	Poland	5.73	5.61 - 5.85
51	Viet Nam	5.70	5.59 - 5.81
52	Palau	5.69	5.27 - 6.09
53-54	Mexico	5.66	5.25 - 6.07
53-54	Saint Kitts and Nevis	5.66	5.26 - 6.06
55	Lebanon	5.61	5.20 - 6.01
56	Mauritius	5.57	5.15 - 5.96
57-58	Fiji	5.53	5.10 - 5.93
57-58	Libyan Arab Jamahiriya	5.53	5.10 - 5.93
59	Panama	5.52	5.11 - 5.90
60	Slovakia	5.51	5.37 - 5.66
61	Tonga	5.49	5.07 - 5.89
62	Hungary	5.47	5.36 - 5.59
63-64	Grenada	5.46	5.04 - 5.85
63-64	Indonesia	5.46	5.35 - 5.57
65	Cook Islands	5.45	5.05 - 5.85
66	Estonia	5.44	5.04 - 5.84
67	Saudi Arabia	5.40	4.97 - 5.78
68	Costa Rica	5.39	4.99 - 5.77
69-72	Latvia	5.37	4.97 - 5.77
69-72	Russian Federation	5.37	4.97 - 5.76
69-72	Syrian Arab Republic	5.37	4.94 - 5.76
69-72	Venezuela, Bolivarian Republic of	5.37	4.98 - 5.75
73-74	Romania	5.35	4.96 - 5.76
73-74	South Africa	5.35	5.21 - 5.49
75	Seychelles	5.34	4.94 - 5.73
76-79	Belarus	5.32	4.92 - 5.72
76-79	Botswana	5.32	5.15 - 5.49
76-79	Croatia	5.32	4.93 - 5.71
76-79	Ecuador	5.32	5.15 - 5.49
80-81	Lithuania	5.31	4.90 - 5.71
1	United Arab Emirates	1.000	1.000 - 1.000
2	Bulgaria	0.996	0.994 - 0.997
3-38	Argentina	0.995	0.992 - 0.997
3-38	Australia	0.995	0.993 - 0.997
3-38	Austria	0.995	0.993 - 0.997
3-38	Bahamas	0.995	0.992 - 0.997
3-38	Bahrain	0.995	0.992 - 0.997
3-38	Barbados	0.995	0.993 - 0.997
3-38	Belgium	0.995	0.993 - 0.997
3-38	Brunei Darrusalam	0.995	0.993 - 0.997
3-38	Canada	0.995	0.993 - 0.997
3-38	Denmark	0.995	0.993 - 0.997
3-38	Finland	0.995	0.993 - 0.997
3-38	France	0.995	0.993 - 0.997
3-38	Germany	0.995	0.993 - 0.997
3-38	Greece	0.995	0.993 - 0.997
3-38	Iceland	0.995	0.993 - 0.997
3-38	Ireland	0.995	0.993 - 0.997
3-38	Israel	0.995	0.993 - 0.997
3-38	Italy	0.995	0.993 - 0.997
3-38	Japan	0.995	0.993 - 0.997
3-38	Kuwait	0.995	0.993 - 0.997
3-38	Luxembourg	0.995	0.993 - 0.997
3-38	Malta	0.995	0.993 - 0.997
3-38	Mauritius	0.995	0.992 - 0.997
3-38	Monaco	0.995	0.993 - 0.997
3-38	Netherlands	0.995	0.993 - 0.997
3-38	New Zealand	0.995	0.993 - 0.997
3-38	Norway	0.995	0.993 - 0.997
3-38	Qatar	0.995	0.993 - 0.997
3-38	Saint Kitts and Nevis	0.995	0.993 - 0.997
3-38	San Marino	0.995	0.993 - 0.997
3-38	Singapore	0.995	0.993 - 0.997
3-38	Spain	0.995	0.992 - 0.997
3-38	Sweden	0.995	0.993 - 0.997
3-38	Switzerland	0.995	0.993 - 0.997
3-38	United Kingdom	0.995	0.993 - 0.997
3-38	United States of America	0.995	0.993 - 0.997
39-42	Andorra	0.994	0.992 - 0.996
39-42	Antigua and Barbuda	0.994	0.992 - 0.996
39-42	Nauru	0.994	0.992 - 0.996
39-42	Palau	0.994	0.992 - 0.996
43	Republic of Korea	0.992	0.990 - 0.994
44	Cyprus	0.991	0.988 - 0.994
45-47	Belarus	0.987	0.984 - 0.990
45-47	Czech Republic	0.987	0.984 - 0.990
45-47	Lithuania	0.987	0.984 - 0.990
48	Philippines	0.986	0.982 - 0.987
49	Oman	0.983	0.979 - 0.987
50-52	Algeria	0.982	0.977 - 0.985
50-52	Saudi Arabia	0.982	0.978 - 0.986
50-52	Thailand	0.982	0.973 - 0.990
53-57	Jordan	0.981	0.976 - 0.985
53-57	Latvia	0.981	0.977 - 0.985
53-57	Portugal	0.981	0.977 - 0.985
53-57	Slovenia	0.981	0.977 - 0.985
53-57	Uruguay	0.981	0.977 - 0.985
58	Hungary	0.980	0.976 - 0.985
59	Egypt	0.979	0.968 - 0.988
60-61	Kazakhstan	0.976	0.972 - 0.981
60-61	Tunisia	0.976	0.971 - 0.981
62	Malaysia	0.975	0.965 - 0.983
63-64	Slovakia	0.973	0.968 - 0.978
63-64	Ukraine	0.973	0.968 - 0.978
65	Poland	0.970	0.964 - 0.976
66	Turkey	0.969	0.964 - 0.974
67-68	Morocco	0.967	0.960 - 0.973
67-68	Romania	0.967	0.961 - 0.972
69	Estonia	0.963	0.957 - 0.968
70	Indonesia	0.961	0.948 - 0.973
71	Uzbekistan	0.960	0.953 - 0.965
72	Dominican Republic	0.959	0.952 - 0.966
73-74	Fiji	0.956	0.950 - 0.962
73-74	Jamaica	0.956	0.950 - 0.962
75	Seychelles	0.955	0.948 - 0.961
76	Libyan Arab Jamahiriya	0.953	0.947 - 0.960
77-78	Dominica	0.949	0.942 - 0.955
77-78	Sri Lanka	0.949	0.941-0.956
79-81	Lebanon	0.947	0.940 - 0.954
79-81	Suriname	0.947	0.940 - 0.953

80-81	Samoa	5.31	4.88 - 5.72
82	Colombia	5.30	4.92 - 5.68
83	Oman	5.27	4.85 - 5.65
84-86	Dominica	5.25	4.86 - 5.64
84-86	Jordan	5.25	4.83 - 5.63
[illegible]6	Saint Lucia	5.25	4.84 - 5.63
[illegible]7	Suriname	5.23	4.82 - 5.62
88-89	China	5.20	4.79 - 5.58
88-89	Turkmenistan	5.20	4.78 - 5.59
90-91	Algeria	5.19	4.77 - 5.57
90-91	Kazakhstan	5.19	4.80 - 5.58
92	Armenia	5.18	4.77 - 5.57
93	Turkey	5.16	4.74 - 5.53
94	Tunisia	5.15	4.75 - 5.52
95	Dominican Republic	5.14	4.74 - 5.51
96	Ukraine	5.13	4.72 - 5.52
97	Paraguay	5.12	4.74 - 5.50
98-99	Maldives	5.11	4.69 - 5.49
98-99	Marshall Islands	5.11	4.70 - 5.52
100	Iran, Islamic Republic of	5.10	4.71 - 5.48
101	Sri Lanka	5.08	4.69 - 5.47
102	Egypt	5.06	4.94 - 5.17
103-104	Iraq	5.05	4.63 - 5.43
103-104	Saint Vincent and the Grenadines	5.05	4.66 - 5.43
105-107	Belize	5.03	4.63 - 5.40
105-107	Jamaica	5.03	4.65 - 5.41
105-107	Uzbekistan	5.03	4.62 - 5.42
108-110	Bosnia and Herzegovina	5.02	4.64 - 5.40
108-110	India	5.02	4.61 - 5.41
108-110	Swaziland	5.02	4.61 - 5.40
111	The former Yugoslav Republic of Macedonia	5.01	4.62 - 5.40
112	Micronesia, Federated States of	5.00	4.60 - 5.38
113	Namibia	4.99	4.62 - 5.37
114	Guyana	4.98	4.58 - 5.36
115-117	Cuba	4.97	4.57 - 5.36
115-117	Guatemala	4.97	4.81 - 5.12
115-117	Yugoslavia	4.97	4.59 - 5.36
118-119	Gabon	4.96	4.57 - 5.32
118-119	Senegal	4.96	4.83 - 5.09
[illegible]1	Kiribati	4.95	4.54 - 5.35
[illegible]1	Pakistan	4.95	4.54 - 5.32
122	Zimbabwe	4.94	4.82 - 5.05
123	Republic of Moldova	4.92	4.54 - 5.30
124	Kyrgyzstan	4.91	4.51 - 5.29
125	Tajikistan	4.90	4.49 - 5.29
126	Niue	4.87	4.48 - 5.25
127	Vanuatu	4.85	4.46 - 5.22
128	El Salvador	4.84	4.47 - 5.22
129	Honduras	4.82	4.45 - 5.19
130-131	Azerbaijan	4.81	4.43 - 5.19
130-131	Brazil	4.81	4.68 - 4.94
132-135	Ghana	4.80	4.69 - 4.92
132-135	Solomon Islands	4.80	4.40 - 5.18
132-135	Tuvalu	4.80	4.40 - 5.18
132-135	Zambia	4.80	4.40 - 5.18
136	Albania	4.79	4.39 - 5.17
137-138	Cambodia	4.77	4.37 - 5.15
137-138	Congo	4.77	4.39 - 5.15
139	Democratic People's Republic of Korea	4.76	4.36 - 5.14
140	Nicaragua	4.75	4.36 - 5.11
141	Trinidad and Tobago	4.73	4.60 - 4.86
142	Democratic Republic of the Congo	4.72	4.34 - 5.10
143	Equatorial Guinea	4.71	4.33 - 5.07
144	Kenya	4.67	4.28 - 5.05
145-147	Lao People's Democratic Republic	4.62	4.23 - 5.00
145-147	Lesotho	4.62	4.23 - 4.99
145-147	Rwanda	4.62	4.22 - 5.01
148	Sao Tome and Principe	4.61	4.21 - 4.99
149	Nigeria	4.60	4.22 - 4.98
150	Papua New Guinea	4.59	4.18 - 4.96
151-153	Bolivia	4.58	4.46 - 4.70
151-153	Morocco	4.58	4.20 - 4.94
151-153	Myanmar	4.58	4.21 - 4.95
[illegible]4	Cape Verde	4.56	4.17 - 4.92
[illegible]5	Togo	4.54	4.16 - 4.91
156	Cameroon	4.50	4.13 - 4.87
157-160	Comoros	4.46	4.06 - 4.83
157-160	Côte d'Ivoire	4.46	4.08 - 4.83
157-160	Haiti	4.46	4.10 - 4.84
157-160	United Republic of Tanzania	4.46	4.06 - 4.84
161	Bulgaria	4.43	4.30 - 4.57
162	Malawi	4.42	4.03 - 4.80
163	Bhutan	4.35	3.96 - 4.72
164	Sudan	4.34	3.96 - 4.71
165-167	Gambia	4.33	3.95 - 4.70
79-81	Syrian Arab Republic	0.947	0.940 - 0.954
82	Saint Lucia	0.946	0.938 - 0.953
83	Croatia	0.945	0.939 - 0.952
84-85	Brazil	0.944	0.942 - 0.968
84-85	Grenada	0.944	0.937 - 0.951
86-87	Costa Rica	0.943	0.936 - 0.950
86-87	Russian Federation	0.943	0.936 - 0.950
88	Panama	0.939	0.932 - 0.946
89	Cook Islands	0.938	0.929 - 0.946
90	Belize	0.937	0.929 - 0.944
91	Mongolia	0.934	0.916 - 0.952
92	Venezuela, Bolivarian Republic of	0.933	0.925 - 0.941
93-94	Colombia	0.931	0.923 - 0.939
93-94	Iran, Islamic Republic of	0.931	0.923 - 0.939
95	The former Yugoslav Republic of Macedor	0.926	0.915 - 0.935
96	Kyrgyzstan	0.925	0.915 - 0.933
97	Tonga	0.921	0.910 - 0.932
98-100	Cuba	0.920	0.909 - 0.930
98-100	Saint Vincent and the Grenadines	0.920	0.911 - 0.929
98-100	Samoa	0.920	0.908 - 0.930
101-102	Gabon	0.919	0.909 - 0.928
101-102	Maldives	0.919	0.909 - 0.928
103	Chile	0.918	0.902 - 0.933
104	Senegal	0.914	0.889 - 0.928
105-106	China	0.911	0.899 - 0.922
105-106	Guyana	0.911	0.900 - 0.921
107	Republic of Moldova	0.910	0.899 - 0.919
108-109	Mexico	0.909	0.888 - 0.924
108-109	Trinidad and Tobago	0.909	0.894 - 0.925
110	Swaziland	0.908	0.897 - 0.918
111-112	Armenia	0.905	0.891 - 0.917
111-112	Botswana	0.905	0.877-0.932
113	Turkmenistan	0.899	0.886 - 0.912
114	Iraq	0.898	0.883 - 0.912
115	Pakistan	0.897	0.883 - 0.909
116	Yugoslavia	0.895	0.882 - 0.907
117	Albania	0.894	0.878 - 0.910
118	Equatorial Guinea	0.892	0.877 - 0.906
119	Papua New Guinea	0.891	0.875 - 0.906
120	Solomon Islands	0.890	0.875 - 0.903
121	Viet Nam	0.884	0.870 - 0.900
122	Kiribati	0.883	0.864 - 0.901
123	Mauritania	0.882	0.840 - 0.919
124	Bosnia and Herzegovina	0.881	0.866 - 0.895
125	Azerbaijan	0.878	0.863 - 0.893
126	Sao Tome and Principe	0.877	0.857 - 0.895
127	India	0.876	0.856 - 0.895
128-129	El Salvador	0.874	0.854 - 0.892
128-129	Micronesia, Federated States of	0.874	0.858 - 0.889
130-131	Democratic People's Republic of Korea	0.873	0.852 - 0.892
130-131	Guinea	0.873	0.842 - 0.902
132	Vanuatu	0.872	0.854 - 0.887
133	Paraguay	0.871	0.848 - 0.892
134-135	Cape Verde	0.866	0.847 - 0.882
134-135	Marshall Islands	0.866	0.848 - 0.882
136	Tajikistan	0.864	0.845 - 0.881
137-138	Bhutan	0.861	0.840 - 0.881
137-138	Cambodia	0.861	0.836 - 0.884
139	Nicaragua	0.860	0.840 - 0.878
140	Djibouti	0.858	0.834 - 0.880
141	Georgia	0.855	0.835 - 0.874
142	Kenya	0.852	0.830 - 0.871
143-144	Lao People's Democratic Republic	0.850	0.778 - 0.912
143-144	Rwanda	0.850	0.824 - 0.875
145	Niue	0.848	0.824 - 0.871
146	Ghana	0.847	0.811 - 0.882
147	South Africa	0.844	0.811 - 0.869
148-149	Lesotho	0.842	0.818 - 0.863
148-149	Sudan	0.842	0.818 - 0.863
150	United Republic of Tanzania	0.836	0.808 - 0.862
151	Congo	0.834	0.780 - 0.881
152	Malawi	0.831	0.804 - 0.855
153-155	Comoros	0.830	0.801 - 0.856
153-155	Côte d'Ivoire	0.830	0.804 - 0.857
153-155	Tuvalu	0.830	0.804 - 0.856
156	Namibia	0.828	0.802 - 0.854
157	Gambia	0.825	0.797 - 0.850
158	Myanmar	0.822	0.785 - 0.856
159	Guatemala	0.812	0.787 - 0.837
160	Benin	0.811	0.776 - 0.843
161	Peru	0.808	0.793 - 0.850
162	Togo	0.803	0.771 - 0.835
163	Honduras	0.800	0.757 - 0.841
164	Burkina Faso	0.799	0.751 - 0.847
165	Uganda	0.796	0.751 - 0.818

165-167	Georgia	4.33	4.18 - 4.48
165-167	Mauritania	*4.33*	*3.97 - 4.69*
168-169	Guinea	*4.29*	*3.92 - 4.64*
168-169	Madagascar	*4.29*	*3.92 - 4.65*
170	Djibouti	*4.28*	*3.87 - 4.66*
171	Burundi	*4.25*	*3.86 - 4.64*
172	Peru	4.24	4.12 - 4.36
173	Sierra Leone	*4.23*	*3.86 - 4.61*
174	Burkina Faso	4.18	4.06 - 4.31
175-176	Benin	*4.14*	*3.75 - 4.50*
175-176	Liberia	*4.14*	*3.77 - 4.50*
177	Angola	*4.10*	*3.74 - 4.46*
178	Bangladesh	4.07	3.94 - 4.20
179	Ethiopia	*4.00*	*3.62 - 4.38*
180	Yemen	*3.98*	*3.61 - 4.35*
181-182	Afghanistan	*3.96*	*3.57 - 4.33*
181-182	Chad	*3.96*	*3.59 - 4.31*
183	Central African Republic	*3.94*	*3.57 - 4.30*
184	Guinea-Bissau	*3.89*	*3.52 - 4.26*
185	Nepal	3.83	3.69 - 3.98
186	Eritrea	*3.75*	*3.36 - 4.13*
187-188	Mali	*3.74*	*3.36 - 4.13*
187-188	Uganda	3.74	3.61 - 3.87
189-190	Mozambique	*3.73*	*3.34 - 4.12*
189-190	Niger	*3.73*	*3.35 - 4.12*
191	Somalia	*3.69*	*3.31 - 4.07*

166-167	Nepal	0.792	0.757 - 0.825
166-167	Zimbabwe	0.792	0.747 - 0.814
168	Burundi	*0.790*	*0.750 - 0.825*
169-170	Democratic Republic of the Congo	*0.783*	*0.743 - 0.817*
169-170	Eritrea	*0.783*	*0.743 - 0.822*
171	Zambia	*0.781*	*0.739 - 0.816*
172-173	Afghanistan	*0.776*	*0.729 - 0.819*
172-173	Haiti	*0.776*	*0.726 - 0.823*
174	Guinea-Bissau	*0.762*	*0.703 - 0.818*
175	Mozambique	*0.758*	*0.703 - 0.810*
176	Liberia	*0.753*	*0.680 - 0.822*
177	Nigeria	*0.746*	*0.696 - 0.792*
178	Bolivia	0.745	0.723 - 0.768
179-180	Ethiopia	*0.733*	*0.665 - 0.797*
179-180	Madagascar	*0.733*	*0.665 - 0.798*
181	Bangladesh	0.728	0.699 - 0.756
182	Ecuador	0.723	0.709 - 0.821
183	Cameroon	*0.710*	*0.564 - 0.827*
184	Niger	*0.690*	*0.591 - 0.781*
185	Chad	*0.688*	*0.573 - 0.792*
186	Sierra Leone	*0.686*	*0.595 - 0.771*
187	Mali	*0.685*	*0.601 - 0.763*
188	Angola	*0.683*	*0.549 - 0.797*
189	Yemen	*0.673*	*0.489 - 0.820*
190	Somalia	*0.621*	*0.440 - 0.772*
191	Central African Republic	*0.414*	*0.006 - 0.733*

*Figures in italics are based on estimates.

VISITOR REGISTRATION SHEET

Health
Name of Committee

6-27-00
Date

VISITORS: PLEASE SIGN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Patricia A. Yancey	Friends of Residents in Long Term Care/Hospice
Lynn Duncan	NCAHP
VL McBride	NCDA
Bobby Bryan	RRC
Bill Wilson	NCAE
	DHHS
Lynda McDaniel	DHHS/DFS
Alex Mercer Schmidt	Raymond Smith
Cynthia Reichenbach MD	Physician & President of NC committee to Defend Health Care
Dennis LAZOF	Citizen, Supporter of HB 1396
Christina Sim	Intern, Rep. Insko
Ed Regan	N.C. Assoc. of County Commissioners
Daniel Gorlay, MD	Member NC Committee to Defend Health Care - supporter of 1396
Arnold R. Post	Citizen in support of HB 1396
Lacy Rubsell	CJPC
Jim Stanley	UNC - Chapel Hill
Alex Reeves	Sen. Garrou's office
Harbour Partesotti	Intern Division of Aging
Amy Jo Bain	NCMS
William H. Potter, JR	NCDS & NCPTA
BRENT BOND, MD	WAKE FOREST UNIVERSITY MEDICAL CENTER
Sonya Williams	UNC-TV

AGENDA

HOUSE COMMITTEE ON HEALTH
WEDNESDAY, July 5, 2000
12:00 Noon
415 LOB

OPENING REMARKS

REP. THOMAS E. WRIGHT
CHAIRMAN

BILLS TO BE DISCUSSED

HB-1831 NC HEALTH CHOICE/ NO WAITING PERIOD
SB-432 HEALTH CARE PERSONNEL REGISTRY

COMMENTS

ADJOURNMENT

Vanda Wilson-Womak (Rep. Wright)

From: Vanda Wilson-Womak (Rep. Wright)
Sent: Wednesday, July 05, 2000 11:08 AM
To: @House/Health/LAs
Cc: Vanda Wilson-Womak (Rep. Wright)
Subject: CANCELLATION OF THE HOUSE HEALTH COMMITTEE

Importance: High

CANCELLATION NOTICE

The House Health Committee meeting scheduled for Wednesday, July 5, 2000 at 12:00 Noon in Room 415 LOB has been cancelled.

If you have any further questions, please contact Vanda Wilson-Wormack, Committee Assistant, at 733-5754.

AGENDA

HOUSE COMMITTEE ON HEALTH
TUESDAY, JULY 11, 2000
ROOM 415 LOB
9:00AM

OPENING REMARKS

REP. THOMAS E. WRIGHT
CHAIRMAN

BILLS TO BE DISCUSSED

SB-432 HEALTH CARE PERSONNEL REGISTRY

SB-960 REGULATION OF PHARMACIES

COMMENTS

ADJOURNMENT

MINUTES

COMMITTEE ON HEALTH

TUESDAY, JULY 11, 2000

9:00AM ROOM 544 LOB

The House Committee on Health met on Tuesday, July 11, 2000 at 9:00am in Room 544 LOB. A silent roll was taken, (roll list denotes members present).

Chairman Wright called the meeting to order.

SB-432 HEALTH CARE PERSONNEL REGISTRY

Rep. Womble moved for adoption of the proposed committee substitute. So moved.

Rep. Wright explained the bill. Rep. Bowie asked for clarity on section 1 of the bill. Rep. Wright responded. Linda Attarian, Staff Counsel, further explained the bill by sections. John Young gave an explanation of section 7 of the bill. Rep. Justus asked staff about the nursing and adult care homes' section of the bill. John Young responded. Rep. Justus followed up with a question about the certificate of need as it relates to nursing homes. John Young responded. Rep. Wilson asked about section 5 of the bill. Rep. Wright responded. Rep. Wilson requested that a representative from the medical society and optometry board comment on the bill. Steve Keen of the North Carolina Medical Society commented on the bill. Rep. Womble commented on the bill. Rep. Bowie asked a question about the broad language of the bill and if the language could be more specific. Rep. Wright responded. Rep. Esposito asked if the bill would provide immunity. Rep. Insko responded.

Rep. Womble moved for a favorable report, unfavorable to the original bill.

Discussion continued. Rep. Redwine asked about changing the title of the bill. Rep. Insko responded. Rep. Redwine asked about the coverage of prostate screening under the state plan. Rep. Insko responded.

Rep. Bowie sent forth an amendment. Rep. Insko read the amendment. Steve Keen of the NC Medical Society, stated that he agreed with the changed language of the bill. The vote was taken and the amendment passed.

SB 960 REGULATION OF PHARMACIES

Rep. Womble moved for adoption of the proposed committee substitute. So moved.

Rep. Womble asked for clarification as it related to the proposed committee substitute versus the original bill. Linda Attarian responded. Rep. Edwards asked if the bill would

require different requirements of the pharmacy board than other boards. Rep. Wright responded. Rep. Womble asked about the number of members on the board. Rep. Insko responded. Rep. Womble asked if the bill would address diversity. Rep. Wright deferred members to page 8, line 33 of the bill. Rep. Redwine asked a question about page 5, line 13 of the bill. Rep. Wright responded. Linda Attarian further explained the section to the committee about pharmacist work hours and the lawsuit. Rep. Wright responded. Alan Miles, Counsel to the Board of Pharmacy, responded. Rep. Wilson asked if there were other comments from other organizations. Fran Preston of the NC Retail Merchants Association, commented on the bill. Rep. Howard followed up with a question about the regulation of pharmacies. Rep. Wright responded. Rep. Howard stated that she would like an amendment to the language. Rep. Bowie asked if the bill would affect out-of-state pharmacies. Rep. Wright responded. Linda Attarian responded. Alan Miles, with the Board of Pharmacy, commented on the bill. Rep. Redwine further commented on the bill. Steve Keen of the NC Medical Society, commented on the bill.

Rep. Howard sent forth an amendment. Vice-Chairman Insko read it and Rep. Howard asked Andy Ellen of the NC Retail Merchants Association, to further comment on the bill. Rep. Wright responded. Rep. Wilson asked if the language of the original bill was agreed to before the lawsuit. Alan Miles responded. Rep. Wilson followed up with another question about the regulation of small and large pharmacies. Andy Ellen responded. Rep. Wilson followed up with a question to the Board of Pharmacy about a possible agreement with the medical society. Alan Miles responded. Rep. Wilson followed up with a comment about the amendment. Rep. Edwards commented on the term limits of the board. Rep. Bowie stated that she had an amendment to offer. Rep. Wright stated that he opposed the amendment sent forth by Rep. Howard. Rep. Clary urged support for the amendment sent forth by Rep. Howard. Alan Miles responded. Rep. Clary followed up with a question about the fees. Alan Miles responded. Hugh Tilson with the NC Hospital Association commented on the bill. Rep. Howard commented and called the question.

The vote was taken by show of hands requested by Rep. Adams. The amendment failed 7-7.

Rep. Bowie sent forth an amendment and moved for adoption of the amendment.

Discussion continued. Rep. Redwine asked a question about the amendment. Steve Keen of the NC Medical Society, commented on the amendment. Rep. Redwine followed up with a question about the lawsuit. Steve Keen responded. Alan Miles commented on the bill. Hugh Tilson further commented on the amendment. Rep. Esposito commented on the amendment and how it would affect the public health pharmacy. Rep. Adams commented on the amendment. Linda Attarian responded. Rep. Wright commented on the amendment and suggested to discuss the issue at the next meeting. Rep. Edwards commented on the bill. Discussion continued.

Rep. Bowie sent forth a perfecting change to the amendment. John Bowdish of the Pharmacy Association, commented on the bill. Linda Attarian responded. Rep. Bowie

read the perfecting amendment. Rep. Wright asked the committee to defer action on the bill until further discussion.

The meeting adjourned at 10:35am.

Rep. Thomas Wright, Chairman

Vanda Wilson-Wormack, Committee Asst.

My Copy

2000 COMMITTEE REPORT
HOUSE OF REPRESENTATIVES

The following report(s) from standing committee(s) is/are presented:
By Representative(s) **Thomas E. Wright** for the Committee on **Health**.

☒ Committee Substitute for
S.B. 432 A BILL TO BE ENTITLED AN ACT TO CLARIFY THE FACILITIES THAT ARE INCLUDED IN THE HEALTH CARE PERSONNEL REGISTRY; AND TO REQUIRE THAT EMPLOYERS AT HEALTH CARE FACILITIES ACCESS THE HEALTH CARE PERSONNEL REGISTRY.

☐ With a favorable report.

☐ With a favorable report and recommendation that the bill be re-referred to the Committee on Appropriations ☐ Finance ☐ ☐.

☐ With a favorable report, as amended.

☐ With a favorable report, as amended, and recommendation that the bill be re-referred to the Committee on Appropriations ☐ Finance ☐ ☐.

☐ With a favorable report as to committee substitute bill (#), ☐ which changes the title, unfavorable as to (original bill) (Committee Substitute Bill #), (and recommendation that the committee substitute bill #) be re-referred to the Committee on .)

☒ With a favorable report as to the House committee substitute bill, ☒ which changes the title, unfavorable as to the Senate committee substitute bill.

☐ With an unfavorable report.

☐ With recommendation that the House concur.

☐ With recommendation that the House do not concur.

☐ With recommendation that the House do not concur; request conferees.

☐ With recommendation that the House concur; committee believes bill to be material.

☐ With an unfavorable report, with a Minority Report attached.

☐ Without prejudice.

☐ With an indefinite postponement report.

☐ With an indefinite postponement report, with a Minority Report attached.

☐ With recommendation that it be adopted. (HOUSE RESOLUTION ONLY)

5/25/00

My Copy

2000 COMMITTEE REPORT
HOUSE OF REPRESENTATIVES

The following report(s) from standing committee(s) is/are presented:
By Representative(s) **Thomas E. Wright** for the Committee on **Health**.

☐ Committee Substitute for
H.B. 1838 A BILL TO BE ENTITLED AN ACT TO PROVIDE THAT THE TEACHERS' AND STATE EMPLOYEES' COMPREHENSIVE MAJOR MEDICAL PLAN SHALL COVER THE COST OF ONE ANNUAL PAP SMEAR FOR ANY COVERED FEMALE UNDER THE PLAN'S WELLNESS BENEFIT.

☐ With a favorable report.

☐ With a favorable report and recommendation that the bill be re-referred to the Committee on Appropriations ☐ Finance ☐ ☐.

☐ With a favorable report, as amended.

☐ With a favorable report, as amended, and recommendation that the bill be re-referred to the Committee on Appropriations ☐ Finance ☐ ☐.

☒ With a favorable report as to the committee substitute bill, ☒ which changes the title, unfavorable as to the original bill.

☐ With a favorable report as to House committee substitute bill (#), ☐ which changes the title, unfavorable as to Senate committee substitute bill.

☐ With an unfavorable report.

☐ With recommendation that the House concur.

☐ With recommendation that the House do not concur.

☐ With recommendation that the House do not concur; request conferees.

☐ With recommendation that the House concur; committee believes bill to be material.

☐ With an unfavorable report, with a Minority Report attached.

☐ Without prejudice.

☐ With an indefinite postponement report.

☐ With an indefinite postponement report, with a Minority Report attached.

☐ With recommendation that it be adopted. (HOUSE RESOLUTION ONLY)

5/25/00

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 1999

H D

HOUSE BILL 1838
Proposed Committee Substitute H1838-PCS5110-RM002

Short Title: State Health Plan Amend's. (Public)

Sponsors:

Referred to:

May 30, 2000

A BILL TO BE ENTITLED

AN ACT TO PROVIDE THAT THE TEACHERS' AND STATE EMPLOYEES' COMPREHENSIVE MAJOR MEDICAL PLAN SHALL COVER THE COST OF ONE ANNUAL PAP SMEAR FOR ANY COVERED FEMALE UNDER THE PLAN'S WELLNESS BENEFIT AND TO ALLOW INDIVIDUALS EXCLUDED FROM MEMBERSHIP IN THE TEACHERS' AND STATE EMPLOYEES' COMPREHENSIVE MAJOR MEDICAL PLAN FOR FILING FRAUDULENT CLAIMS TO BE CONSIDERED FOR REINSTATEMENT IN THE PLAN.

The General Assembly of North Carolina enacts:

Section 1. G.S. 135-40.5(e) reads as rewritten:

"(e) Routine Diagnostic Examinations. -- The Plan will pay one hundred percent (100%) of allowable charges for routine diagnostic examinations and tests, including ~~Pap smears,~~ breast, colon, rectal, and prostate exams, X rays, mammograms, blood and blood pressure checks, urine tests, tuberculosis tests, and general health checkups that are medically necessary for the maintenance and improvement of individual health but no more often than once every three years for covered individuals to age 40 years, once every two years for covered individuals to age 50 years, and once a year for covered individuals age 50 years and older, unless a more frequent occurrence is warranted by a medical condition when such charges are incurred in a medically supervised facility. Routine diagnostic examinations and tests covered under this subsection also include one Pap smear per year for any covered female. Provided, however, that charges for such examinations and tests are not covered by the Plan when they are incurred to obtain or continue employment, to secure

insurance coverage, to comply with legal proceedings, to attend schools or camps, to meet travel requirements, to participate in athletic and related activities, or to comply with governmental licensing requirements. The maximum amount payable under this subsection for a covered individual is one hundred fifty dollars ($150.00) per fiscal year."

Section 2. G.S. 135-40.2(h) reads as rewritten:

"(h) No person shall be eligible for coverage as an employee or retired employee or as a dependent of an employee or retired employee upon a finding by the Executive Administrator or Board of Trustees or by a court of competent jurisdiction that the employee or dependent knowingly and willfully made or caused to be made a false statement or false representation of a material fact in a claim for reimbursement of medical services under the Plan. The Executive Administrator and Board of Trustees may make an exception to the provisions of this subsection when persons subject to this subsection have had a cessation of coverage for a period of five years and have made a full and complete restitution to the Plan for all fraudulent claim amounts. Nothing in this subsection shall be construed to obligate the Executive Administrator and Board of Trustees to make an exception as allowed for under this subsection."

Section 3. G.S. 135-40.11(a)(6) reads as rewritten:

"(6) The last day of the month in which a covered individual is found to have knowingly and willfully made or caused to be made a false statement or false representation of a material fact in a claim for reimbursement of medical services under the Plan. The Executive Administrator and Board of Trustees may make an exception to the provisions of this subdivision when persons subject to this subdivision have had a cessation of coverage for a period of five years and have made a full and complete restitution to the Plan for all fraudulent claim amounts. Nothing in this subdivision shall be construed to obligate the Executive Administrator and Board of Trustees to make an exception as allowed for under this subdivision."

Section 4. This act becomes effective July 1, 2000.

PROPOSED COMMITTEE SUB. FOR HOUSE BILL 1838 STATE HEALTH PLAN AMENDMENTS:

BILL ANALYSIS

Committee:	House Health	**Introduced by:**	
Date:	June 27, 2000	**Summary by:**	Linda Attarian and John Young
Version:	2		Committee Counsel

SUMMARY: ***Section 1 provides that SEHP shall cover the cost of one annual Pap smear for any covered female under the Plan's wellness benefit. Sections 2 and 3 allows a person to reapply to the Board of Trustees of the SEHP to regain coverage under the Plan after they have been deemed ineligible for coverage for committing fraud against the Plan. Acceptance for coverage would be at the discretion of the Executive Administrator and the Board of Trustees.. The act becomes effective July 1, 2000.***

CURRENT LAW: **Section 1**-Currently, under G.S. 135-40.5(e), charges for Pap smears are covered at 100% as part of routine diagnostic examinations. However, the frequency is limited to once every three years for individuals under age 40, once every two years t ages 40-49, and annually at ages 50 and older.

Sections 2 and 3-Currently, under G.S. 135-40.2(h) if at any time a person is found to have knowingly and willfully made a false statement or a false representation of a material fact in a claim for reimbursement under the State Employee's Health Plan, their coverage will be terminated and the person will no longer be eligible for reinstatement of coverage under the Plan..

BILL ANALYSIS: **Section 1**-Rewrites G.S. 135-40.5(e), "Routine Diagnostic Examinations", to allow coverage for an annual Pap smear for any covered female without regard to age under the Plan's $150 annual wellness benefit. The proposed change affects covered females age 50 and under since the current wellness benefit allows for an annual Pap smear for females age 50 and over. A combined estimate from the two actuaries on the additional cost to the Plan's indemnity program is $526,519 for 2000-2001 and $633,611 for 2001-2002.

Section 2 and 3- Would allow a person to reapply to the Board of Trustees of the State Health Plan to regain coverage under the Plan after they have been deemed ineligible for coverage under the Plan for committing fraud against the Plan. To reapply for reinstatement, the person must have been off the Plan for 5 years, must have made full restitution, and must comply with any relevant factors the Board establishes for restitution. Acceptance for coverage would be at the discretion of the Executive Director and the Board of Trustees.

NORTH CAROLINA GENERAL ASSEMBLY
LEGISLATIVE ACTUARIAL NOTE

BILL NUMBER: HB 1838

SHORT TITLE: SEHP Wellness Benefit/Annual Pap

SPONSOR(S): Rep. Culpepper

SYSTEM OR PROGRAM AFFECTED: Teachers' and State Employees' Comprehensive Major Medical Plan.

FUNDS AFFECTED: State General Fund, State Highway Fund, other State employer receipts, premium payments for dependents by active and retired teachers and State employees, and premium payments for coverages selected by eligible former teachers and State employees.

BILL SUMMARY: Rewrites G.S. 135-40.5(e), "Routine Diagnostic Examinations", to allow coverage for an annual Pap smear for any covered female without regard to age under the Plan's $150.00 annual wellness benefit. The proposed change affects covered females age 50 and under since the current wellness benefit allows for an annual Pap smear for females age 50 and over.

EFFECTIVE DATE: July 1, 2000

ESTIMATED IMPACT ON STATE: Based upon information supplied by the Teachers' and State Employees' Comprehensive Major Medical, the consulting actuary for the Plan, Aon Consulting, estimates the additional cost to the Plan's indemnity program to be $136,000 for 2000-2001 and $203,000 for 2001-2002. Based upon claims information supplied by the Plan, the consulting actuary for the General Assembly's Fiscal Research Division, Hartman & Associates, estimates the additional cost to the Plan's indemnity program to be $1,189,038 for 2000-2001 and $1,470,222 for 2001-2002. A combined estimate from the two actuaries on the additional cost to the Plan's indemnity program is $526,519 for 2000-2001 and $633,611 for 2001-2002.

ASSUMPTIONS AND METHODOLOGY: The Comprehensive Major Medical Plan for Teachers and State Employees is divided into two programs. From October, 1982, through June, 1986, the Plan had only a self-funded indemnity type of program which covered all employees, retired employees, eligible dependents of employees and retired employees, and eligible former employees and their eligible dependents authorized to continue coverage past a termination of employment other than for retirement or disability purposes. A prepaid program of coverage by health maintenance organizations (HMOs) was offered in July, 1986, as an alternative to the Plan's self-insured indemnity program. The benefits of the self-insured indemnity type of program are spelled out in Part 3 of Article 3 of Chapter 135 of the North Carolina General Statutes (i.e., $250 annual deductible, 20% coinsurance up to $1,000

annually, etc. paid by the program's members). HMOs are required to offer benefits that are comparable to those provided by the self-insured indemnity program. Employer-paid non-contributory premiums are only authorized for the indemnity program's coverage for employees and retired employees. Whenever employees and office holders first employed or taking office on and after October 1, 1995 become eligible for health benefits as retired employees, the amount of premium paid by the State for individual coverage will be based upon the retiree's amount of retirement service credit at the time of retirement. Only retired employees with 20 or more years of service credit at retirement will be eligible for non-contributory health benefit premiums. Retirees with 10 or more years of service credit at retirement will be eligible for 50% partially contributory health benefit premiums. Retired employees with 5 or more year of service credit at retirement will be eligible to continue their health benefits on a fully contributory basis. All other types of premium in the indemnity program are fully contributory. Premiums paid by employers to HMOs are limited to like amounts paid to the indemnity program with employees and retired employees paying any HMO amounts above the indemnity program's non-contributory rates. Both types of coverage continue to be available in the Plan with nine HMOs currently covering about 25% of the Plan's total population in about 66 of the State's 100 counties. The Plan's employees and retired employees select the type of program that they wish for themselves and their dependents during the months of August and September of each year for coverage beginning in October. The demographics of the Plan as of December 31, 1999, include:

	Self-Insured Indemnity Program	Alternative HMOs	Plan Total
Number of Participants			
Active Employees	203,482	70,681	274,163
Active Employee Dependents	110,453	44,369	154,822
Retired Employees	96,217	5,712	101,929
Retired Employee Dependents	16,374	1,165	17,539
Former Employees & Dependents with Continued Coverage	2,891	323	3,706
Total Enrollments	429,417	122,742	552,159
Number of Contracts			
Employee Only	230,456	54,059	284,515
Employee & Child(ren)	31,626	14,644	46,270
Employee & Family	39,670	8,182	47,852
Total Contracts	301,752	76,885	378,637
Percentage of Enrollment by Age			
29 & Under	26.7%	41.6%	30.0%
30-44	20.1	27.3	21.7
45-54	21.1	19.6	20.8
55-64	14.9	8.7	13.5
65 & Over	17.2	2.7	14.0
Percentage of Enrollment by Sex			
Male	39.4%	37.8%	39.0%
Female	60.6	62.2	61.0

Assumptions for the Self-Insured Indemnity Program: For the fiscal year beginning July 1, 1999, the self-insured program started its operations with a beginning cash balance of $234.1 million. Receipts for the year are estimated to be $763 million from premium collections, $15 million from investment earnings, and $15 million in risk adjustment and administrative fees from HMOs, for a total of $793 million in receipts for the year. Disbursements from the self-insured program are expected to be $820 million in claim payments and $24 million in administration and claims processing expenses for a total of $844 million for the year beginning July 1, 1999. For the fiscal year beginning July 1, 2000, the self-insured indemnity program is expected to have an operating cash balance of over $183 million with a net operating loss of approximately $120 million for the 2000-2001 fiscal year. For the fiscal year beginning July 1, 2001, the self-insured indemnity program is expected to have an operating cash balance of only $63 million. The self-insured indemnity program is consequently assumed to be unable to carry out its operations for the 2001-2003 biennium without increases in its current premium rates or a reduction in existing benefits or both. This assumption is further predicated upon the fact that the program's cost containment strategies (hospital DRG reimbursements, pre-admission hospital testing, pre-admission hospital inpatient certification with length-of-stay approval, hospital bill audits, required second surgical opinions, mental health case management, coordination of benefits with other payers, Medicare benefit "carve-outs", cost reduction contracts with participating physicians and other providers, prescription drug manufacturer rebates from voluntary formularies, and fraud detection) are maintained and improved where possible. Current non-contributory premium rates are $143.10 monthly for employees whose primary payer of health benefits is Medicare and $187.98 per month for employees whose primary payer of health benefits is not Medicare. Fully contributory premium amounts for employee and child(ren) contracts are $89.06 monthly for children whose primary payer of health benefits is Medicare and $117.16 monthly for other covered children, and $213.60 per month for family contracts whose dependents have Medicare as the primary payer of health benefits and $281.04 per month for other family contract dependents. Claim cost trends are expected to increase 13% plus annually. Total enrollment in the program is expected to increase about 3-4% annually over the next two years due to enrollment losses from alternative HMOs. The number of enrolled active employees is expected to show a 4-5% increase annually over the next two years, whereas the growth in the number of retired employees is assumed to be 4% per year. The program is expected to increase by 1-2% per year the number of active employee dependents and enrolled retiree dependents. Investment earnings are based upon a 5-6% monthly return on available cash balances. The self-insured indemnity program maintains a claim stabilization reserve for claim cost fluctuations equal to 7.5% of annual claim payments without reserving additional funds for incurred but unreported claims.

Assumptions for Indemnity Plan's Pap Smear Claims:

The estimate by the Plan's consulting actuary assumes an overall utilization rate of 40% by female participants under the proposed enhanced Pap Smear benefit. The Plan's consulting actuary assumes an average amount paid per Pap Smear procedure to be $19.33 based on the historical claims data reviewed and an annual 12% growth trend in claims costs. The consulting

actuary for the General Assembly's Fiscal Research Division, Hartman & Associates, based on claims data supplied by the Plan, assumes and overall utilization rate of 90% by affected female participants under the proposed enhanced Pap Smear benefit. Hartman & Associates also assumes an average amount paid per Pap Smear procedure to be $19.77 based on the historical claims data reviewed and an annual 12% growth trend in claims costs.

SOURCES OF DATA:

-Actuarial Note, Hartman & Associates, House Bill 1838, June 19, 1999, original of which is on file in the General Assembly's Fiscal Research Division.

-Actuarial Note, Aon Consulting, House Bill 1838, June 12, 2000, original of which is on file with the Comprehensive Major Medical Plan for Teachers and State Employees and the General Assembly's Fiscal Research Division.

TECHNICAL CONSIDERATIONS: None

FISCAL RESEARCH DIVISION
733-4910
PREPARED BY: Mark Trogdon
APPROVED BY: James D. Johnson
DATE: June 22, 2000

HARTMAN & ASSOCIATES, LLC

ACTUARIAL CONSULTING

MARK V. HARTMAN, FSA, MAAA, MCA, EA

Phone: (336) 731-4038
Fax: (336) 731-2583

668 Link Road
Lexington, NC 27295

June 19, 2000

Mr. Mark Trogdon
Fiscal Research Division
North Carolina General Assembly
300 N. Salisbury Street
Raleigh, NC 27603-5925

Re: House Bill 1838: An Act to Provide Coverage for the Cost of One Annual Pap Smear for any Female Covered Under the SEHP

Dear Mr. Trogdon:

This bill would rewrite G.S. 135-40.5(e) to provided coverage for one Pap smear per year for any covered female under the Teachers' and State Employees' Comprehensive Major Medical Plan. Coverage is provided under the wellness benefit as part of routine diagnostic examinations and is not subject to the deductible and coinsurance provisions of the plan. This act becomes effective July 1, 2000.

Currently, charges for Pap smears are covered at 100% as part of routine diagnostic examinations. However, the frequency is limited to once every three years for individuals under age 40, once every two years at ages 40 through 49, and annually at ages 50 and older.

The estimated cost of this act is shown below:

Estimated Cost	
Fiscal Year Beginning July 1, 2000	Fiscal Year Beginning July 1, 2001
$1,189,038	$1,470,222

These estimates are based on an analysis of Pap smears covered under the plan's wellness benefit over the past three years. Projections assume a 12% annual claim cost trend, a 60-day claim payment lag, 3% administrative expense, and a 7.5% claim fluctuation reserve. Increased payments have also been limited by the plan's overall wellness benefit limit of $150 per year.

If you have any questions, let me know.

Sincerely,

Mark Hartman

Mark V. Hartman, FSA, MAAA, MCA, EA
Consulting Actuary

MVH/jj

NORTH CAROLINA TEACHERS' & STATE EMPLOYEES' COMPREHENSIVE MAJOR MEDICAL PLAN

• • •

House Bill 1838

SEHP Wellness Benefit/Annual Pap

Prepared by:

Aon Consulting
One Piedmont Center
3565 Piedmont Road, N.E.
Atlanta, Georgia 30363

June 2000

Aon Consulting

ACTUARIAL STATEMENT

The State of North Carolina Teachers' and State Employees' Comprehensive Major Medical Plan (Plan) has requested that Aon Consulting prepare an Actuarial Note in response to House Bill 1838 entitled "An Act to provide that the Teachers' and State Employees' Comprehensive Major Medical Plan shall cover the cost of one annual PAP Smear for any covered female under the plan's wellness benefit".

The Actuarial Note was prepared according to generally accepted actuarial principles and practices, in compliance with General Statute 120-114, and within the confidentiality requirements of General Statute 120-129 through 120-134. As required by statute, the Note includes an explanatory statement of the proposed change(s) and, to the extent possible, an estimate of the financial and actuarial effect of the proposed change(s) on the Plan. The Actuarial Note makes no comment or opinion with regard to the merits of the measure for which the Note is prepared; however, any identified technical or mechanical defects have been noted.

We have reviewed the input and results of our analysis for reasonableness, and relied upon the data and information provided by the Plan and their Claims Processing Contractor.

Kenneth C. Vieira, F.S.A., M.A.A.A., E.A.
Senior Vice President

6/12/05
Date

Professional Peer Review by:

Fred W. Munzenmaier, F.S.A., M.A.A.A., E.A.
Senior Vice President

6/12/05
Date

Aon Consulting

ADDITION OF ANNUAL PAP SMEAR TO MEDICAL PLAN WELLNESS BENEFIT

PLAN CHANGE

The draft bill proposes that the North Carolina Teachers' & State Employees' Comprehensive Major Medical Plan (Plan) be amended to cover the cost of one annual PAP Smear for any covered female under the plan's wellness benefit.

Currently the plan pays 100% of allowable charges ($150 fiscal year maximum) for certain routine examinations and tests that are medically necessary for the maintenance and improvement of individual health. These wellness benefits are limited to once every three years for covered individuals under age 40, once every two years for individuals age 40 to 49 and once every year for individuals age 50 and over.

PAP Smear expenses are an allowable charge under the current wellness benefits, subject to the age related utilization limits. **It is proposed that the plan's wellness benefits be amended to cover one PAP Smear per year, regardless of age.**

The proposed act is effective July 1, 2000.

PROJECTED COST IMPACT

	% Increase			Based on "Midpoint" Increase (in 000's)		
Plan Design Change	Low	Mid	High	First Year Cost $	Second Year Cost $	Third Year Cost $
Include annual PAP Smear as allowable charge under plan's wellness benefit.	<0.01%	<0.01%	<0.01%	$136	$203	$228

First year cost assumes an implementation date of July 1, 2000 and a 3 month claims payment lag. An annual trend of 12% has been assumed.

PRICING APPROACH

- There are currently 212,000 (approx.) female plan participants eligible for the enhanced PAP Smear benefit. Claims data shows that utilization increases from age 20 through age 59, reducing slightly after age 60. The average utilization rate for all age groups was approximately 30% during the past three experience periods reviewed. The average amount paid per procedure was calculated from the historical claims records and assumed to be $19.33.

- Increased benefit utilization would be expected with the enhanced benefit and we have projected that utilization would increase from 30% to 40% in the affected age group. However, the benefit increase will only impact female participants under age 50. Annual PAP Smears are already available for participant age 50+. The age 50+ accounts for 38% of the projected utilization. Factoring in that the proposed change does not impact all female participants, and the rather low cost per service, this change will have minimal cost impact.

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 1999

H 1

HOUSE BILL 1207

Short Title: Eligibility for State Health Benefits. (Public)

Sponsors: Representatives Culpepper; Mosley and Hurley.

Referred to: Judiciary IV.

April 15, 1999

A BILL TO BE ENTITLED

AN ACT TO ALLOW INDIVIDUALS EXCLUDED FROM MEMBERSHIP IN THE TEACHERS' AND STATE EMPLOYEES' COMPREHENSIVE MAJOR MEDICAL PLAN FOR FILING FRAUDULENT CLAIMS TO BE REINSTATED IN THE PLAN.

The General Assembly of North Carolina enacts:

Section 1. G.S. 135-40.2(h) reads as rewritten:

"(h) No person shall be eligible for coverage as an employee or retired employee or as a dependent of an employee or retired employee upon a finding by the Executive Administrator or Board of Trustees or by a court of competent jurisdiction that the employee or dependent knowingly and willfully made or caused to be made a false statement or false representation of a material fact in a claim for reimbursement of medical services under the Plan. Persons subject to this subsection shall have a cessation of coverage for a period of five years and are eligible for benefits after the five-year period upon a full and complete restitution to the Plan for all fraudulent claim amounts."

Section 2. G.S. 135-40.11(a)(6) reads as rewritten:

"(6) The last day of the month in which a covered individual is found to have knowingly and willfully made or caused to be made a false statement or false representation of a material fact in a claim for reimbursement of medical services under the Plan. Persons subject to this subdivision shall have a cessation of coverage for a period of five years and are eligible for benefits after the five-year period

North Carolina General Assembly
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MEMORANDUM

TO: Representative Bill Culpepper

FROM: Sam Byrd, Fiscal Research Division

DATE: April 20, 1999

SUBJECT: Actuarial Note (House Bill 1207)

Re: Fraudulent Claim Filers Allowed Back in the Teachers' & State Employees' Comprehensive Major Medical Plan.

In accordance with North Carolina General Statute 120-114 and applicable Rules of the North Carolina Senate and House of Representatives, attached is a certified copy of an original actuarial note on the above subject as prepared by the General Assembly's Consulting Actuary. A certified copy of an original actuarial note on the same subject from the Plan Administrator's Consulting Actuary is also attached for your review.

cc: Rep. Phil Baddour, Committee on Judiciary IV
Principal Clerk, House of Representatives

Attachment(s):
(1) House Bill 1207.
(2) Actuarial Note, Proposed Draft Legislation, Hartman & Associates, March 26, 1999.
(3) Actuarial Note, Proposed Draft Legislation, Aon Consulting, March 29, 1999.

HARTMAN & ASSOCIATES, LLC
ACTUARIAL CONSULTING

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668 Link Road
Lexington, NC 27295

ACTUARIAL NOTE

March 26, 1999

Mr. Sam Byrd
Fiscal Research Division
North Carolina General Assembly
300 N. Salisbury Street
Raleigh, NC 27603-5925

Re: Proposed Legislation to Allow Individuals Excluded from the Teachers' and State Employees' Comprehensive Major Medical Plan for Filing Fraudulent Claims to be Reinstated in the Plan

Dear Mr. Byrd:

This proposal would amend G.S. 135-40.2(h) and G.S. 135-40.11(a)(6) to provide a means of reinstatement for individuals who have knowingly and willfully made fraudulent claims in the Teachers' and State Employees' Comprehensive Major Medical Plan.

Currently, coverage for an employee or retired employee and their dependents will cease if they are found to have made or caused to be made a fraudulent claim. This proposal provides that after a five year period without coverage and upon full and complete restitution to the Plan for all fraudulent claim amounts, these individuals would be reinstated in the plan and again be eligible for benefits. This act would become effective when it becomes law.

The reinstatement provision may allow adverse selection by the fraudulent claim filers at the time of reinstatement. However, data provided by the Plan indicates that only six employees have ben excluded from coverage since enactment of this provision in 1989. Given this low frequency of exclusion, the financial impact of the reinstatement provided by this legislation is expected to be negligible.

If you have any questions, let me know.

Sincerely,

Mark Hartman

Mark V. Hartman, FSA, MAAA, MCA, EA
Consulting Actuary

MVH/jj

NORTH CAROLINA TEACHERS' & STATE EMPLOYEES' COMPREHENSIVE MAJOR MEDICAL PLAN

•••

Draft Bill

Eligibility for Plan Members Filing Fraudulent Claims

ACTUARIAL NOTE
True & Exact Copy of Original
Certified By: _____ Date: 4-20-99
Legislative Fiscal Research

Prepared by:

Aon Consulting
One Piedmont Center
3565 Piedmont Road, N.E.
Atlanta, Georgia 30363

March 1999

ACTUARIAL STATEMENT

The State of North Carolina Teachers' and State Employees' Comprehensive Major Medical Plan (Plan) has requested that Aon Consulting prepare an Actuarial Note in response to the Draft Bill to be entitled "An Act to allow individuals excluded from membership in the Teachers' and State Employees' Comprehensive Major Medical Plan for filing fraudulent claims to be reinstated in the Plan".

The Actuarial Note was prepared according to generally accepted actuarial principles and practices, in compliance with General Statute 120-114, and applicable Rules of the North Carolina Senate and House of Representatives. As required by statute, the Note includes an explanatory statement of the proposed change(s) and, to the extent possible, an estimate of the financial and actuarial effect of the proposed change(s) on the Plan. The Actuarial Note makes no comment or opinion with regard to the merits of the measure for which the Note is prepared; however, any identified technical or mechanical defects have been noted.

We have reviewed the input and results of our analysis for reasonableness, and relied upon the data and information provided by the Plan and their Claims Processing Contractor.

Kenneth C. Vieira, F.S.A., M.A.A.A., E.A.
Vice President

3/29/99
Date

Professional Peer Review by:

Fred W. Munzenmaier, F.S.A., M.A.A.A., E.A.
Senior Vice President

March 29, 1999
Date

Aon Consulting

Eligibility for State Health Benefits

PLAN CHANGE

Section 1, General Statutes 135-40.2 (h), will be amended to read:

"(h) No person shall be eligible for coverage as an employee or retired employee or as a dependent of an employee or retired employee upon a finding by the Executive Administrator or Board of Trustees or by a court of competent jurisdiction that the employee or dependent knowingly and willfully made or caused to be made a false statement or false representation of a material fact in a claim for reimbursement of medical services under the Plan. Persons subject to this subsection shall have a cessation of coverage for a period of five years and are eligible for benefits after the five year period upon a full and complete restitution to the Plan for all fraudulent claim amounts.

Section 2. General Statute 135-40.11(a) (6) reads as rewritten:

"(6) The last day of the month in which a covered individual is found to have knowingly and willfully made or caused to be made a false statement or false representation of a material fact in a claim for reimbursement of medical services under the Plan. Persons subject to this subdivision shall have a cessation of coverage for a period of five years and are eligible for benefits after the five year period upon a full and complete restitution to the Plan for all fraudulent claim amounts."

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

PROJECTED COST IMPACT

	% Increase			Based on "Midpoint" Increase (in 000's)		
Plan Design Change	Low	Mid	High	First Year Cost $	Second Year Cost $	Third Year Cost $
New Benefit Eligibility for Plan Members Filing Fraudulent Claims Under the Teachers' and State Employees Comprehensive Major Medical Plan	Negligible					

PRICING APPROACH

- The number of members excluded from the Plan for filing fraudulent claims is expected to be less than 100 members. To be reinstated in the Plan will be like individual insurance, making it highly probable that claims per enrolled member will be substantially higher than those of the current Plan members and that "adverse selection" will exist.

- Due to the possibility of "adverse selection" and a select group of enrollees, a claims factor should be added to the current premium rate to ensure that the Plan will not be providing a subsidy. Claims factors for these types of risk typically range from 150-200% of expected Plan costs, with some instances being as high as 300%.

NORTH CAROLINA GENERAL ASSEMBLY
LEGISLATIVE ACTUARIAL NOTE

BILL NUMBER: House Bill 1207

SHORT TITLE: Eligibility for State Health Benefits.

SPONSOR(S): Rep. Bill Culpepper.

SYSTEM OR PROGRAM AFFECTED: Teachers' and State Employees' Comprehensive Major Medical Plan.

FUNDS AFFECTED: State General Fund, State Highway Fund, other State employer receipts, premium payments for dependents by active and retired teachers and State employees, and premium payments for coverages selected by eligible former teachers and State employees.

BILL SUMMARY: The bill allows former Plan members who have been excluded from coverage for filing fraudulent claims to be reinstated in the Plan upon a cessation of coverage for five years and upon full and complete restitution to the Plan for all fraudulent claims amounts.

EFFECTIVE DATE: When it becomes law.

ESTIMATED IMPACT ON STATE: Based upon information supplied by the Teachers' and State Employees' Comprehensive Major Medical Plan, the consulting actuary for the Plan, Aon Consulting, and the consulting actuary for the General Assembly's Fiscal Research Division, Hartman & Associates, estimate that the bill will not materially increase the cost to the Plan's indemnity program. The only concern expressed by both actuaries was the likelihood of adverse selection against the Plan by fraudulent filers at the time of reinstatement since they would have been out of the Plan for at least five years.

ASSUMPTIONS AND METHODOLOGY: The Comprehensive Major Medical Plan for Teachers and State Employees is divided into two programs. From October, 1982, through June, 1986, the Plan had only a self-funded indemnity type of program which covered all employees, retired employees, eligible dependents of employees and retired employees, and eligible former employees and their eligible dependents authorized to continue coverage past a termination of employment other than for retirement or disability purposes. A prepaid program of coverage by health maintenance organizations (HMOs) was offered in July, 1986, as an alternative to the Plan's self-insured indemnity program. The benefits of the self-insured indemnity type of program are spelled out in Part 3 of Article 3 of Chapter 135 of the North Carolina General Statutes (i.e., $250 annual deductible, 20% coinsurance up to $1,000 annually, etc. paid by the program's members). HMOs are required to offer benefits that are comparable to those provided by the self-insured indemnity program. Employer-paid non-contributory premiums are only authorized for the indemnity program's coverage for employees and retired employees.

Whenever employees and office holders first employed or taking office on and after October 1, 1995 become eligible for health benefits as retired employees, the amount of premium paid by the State for individual coverage will be based upon the retiree's amount of retirement service credit at the time of retirement. Only retired employees with 20 or more years of service credit at retirement will be eligible for non-contributory health benefit premiums. Retirees with 10 or more years of service credit at retirement will be eligible for 50% partially contributory health benefit premiums. Retired employees with 5 or more year of service credit at retirement will be eligible to continue their health benefits on a fully contributory basis. All other types of premium in the indemnity program are fully contributory. Premiums paid by employers to HMOs are limited to like amounts paid to the indemnity program with employees and retired employees paying any HMO amounts above the indemnity program's non-contributory rates. Both types of coverage continue to be available in the Plan with nine HMOs currently covering about 25% of the Plan's total population in 66 of the State's 100 counties. The Plan's employees and retired employees select the type of program that they wish for themselves and their dependents during the months of August and September of each year for coverage beginning in October. The demographics of the Plan as of December 31, 1998, include:

	Self-Insured Indemnity Program	Alternative HMOs	Plan Total
Number of Participants			
Active Employees	192,800	74,400	267,200
Active Employee Dependents	107,400	52,200	159,600
Retired Employees	91,600	6,700	98,300
Retired Employee Dependents	15,600	1,300	16,900
Former Employees & Dependents with Continued Coverage	2,700	700	3,400
Total Enrollments	410,100	135,300	545,400
Number of Contracts			
Employee Only	217,400	55,100	272,500
Employee & Child(ren)	30,600	16,500	47,100
Employee & Family	38,400	9,900	48,300
Total Contracts	286,400	81,500	367,900
Percentage of Enrollment by Age			
29 & Under	27.0%	44.3%	31.3%
30-44	20.2	26.5	21.7
45-54	20.8	18.5	20.2
55-64	14.6	8.0	13.0
65 & Over	17.4	2.7	13.8
Percentage of Enrollment by Sex			
Male	39.5%	39.2%	39.5%
Female	60.5	60.8	60.5

Assumptions for the Self-Insured Indemnity Program: For the fiscal year beginning July 1, 1998, the self-insured program started its operations with a beginning cash balance of $334.1 million. Receipts for the year are estimated to be $590 million from premium collections, $20 million from investment earnings, and $15 million in risk adjustment and administrative fees from HMOs, for a total of $625 million in receipts for the year.

Disbursements from the self-insured program are expected to be $720 million in claim payments and $19 million in administration and claims processing expenses for a total of $739 million for the year beginning July 1, 1998. For the fiscal year beginning July 1, 1999, the self-insured indemnity program is expected to have an operating cash balance of over $220 million with a net operating loss of $185 million for the 1999-2000 fiscal year. For the fiscal year beginning July 1, 2000, the self-insured indemnity program is expected to have an operating cash balance of $35 million with a net operating loss of $270 million for the 2000-2001 fiscal year. The self-insured indemnity program is consequently assumed to be unable to carry out its operations for the 1999-2001 biennium without increases in its current premium rates or a reduction in existing benefits or both. This assumption is further predicated upon the fact that the program's cost containment strategies (hospital DRG reimbursements, pre-admission hospital testing, pre-admission hospital inpatient certification with length-of-stay approval, hospital bill audits, required second surgical opinions, mental health case management, coordination of benefits with other payers, Medicare benefit carve-outs, cost reduction contracts with participating physicians and other providers, prescription drug manufacturer rebates from voluntary formularies, and fraud detection) are maintained and improved where possible. Current non-contributory premium rates are $110.08 monthly for employees whose primary payer of health benefits is Medicare and $144.60 per month for employees whose primary payer of health benefits is not Medicare. Fully contributory premium amounts for employee and child(ren) contracts are $68.50 monthly for children whose primary payer of health benefits is Medicare and $90.12 monthly for other covered children, and $164.30 per month for family contracts whose dependents have Medicare as the primary payer of health benefits and $216.18 per month for other family contract dependents. Claim cost trends are expected to increase 8-10% annually. Total enrollment in the program is expected to decrease about one percent (1%) annually due to competition from alternative HMOs. The number of enrolled active employees is expected to show a 1-2% loss annually, whereas the growth in the number of retired employees is assumed to be 4% per year. The program is expected to lose about 2-3% of its number of active employee dependents each year, whereas the number of enrolled retiree dependents is assumed to grow 1-2% from year to year. Investment earnings are based upon a 5-6% monthly return on available cash balances. The self-insured indemnity program maintains a claim stabilization reserve for claim cost fluctuations equal to 7.5% of annual claim payments without reserving additional funds for incurred but unreported claims.

Assumptions for Indemnity Plan's Fraudulent Claim Filers: Based upon information provided by the Plan, only about six Plan members have been excluded from coverage for filing fraudulent claims. A large majority of these claims involved reimbursement to Plan members for outpatient prescription drugs. Since the time that such claims were determined to be fraudulent, the Plan has taken steps to try to prevent the possibility of future occurrences of fraudulent claims involving outptient prescription drugs.

SOURCES OF DATA:

-Actuarial Note, Hartman & Associates, Proposed Draft Legislation, March 26, 1999, original of which is on file in the General Assembly's Fiscal Research Division.

-Actuarial Note, Aon Consulting, Proposed Draft Legislation, March 29, 1999, original of which is on file with the Comprehensive Major Medical Plan for

Teachers and State Employees and the General Assembly's Fiscal Research Division.

TECHNICAL CONSIDERATIONS: None.

FISCAL RESEARCH DIVISION
733-4910
PREPARED BY: Sam Byrd

APPROVED BY: Tom Covington

DATE:
Tuesday, April 20, 1999

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 1999

S 2

SENATE BILL 960
Health Care Committee Substitute Adopted 4/28/99
Proposed House Committee Substitute
S960-PCSRM-003

Short Title: (Public)

Sponsors:

Referred to:

April 15, 1999

A BILL TO BE ENTITLED

AN ACT TO INCREASE THE MEMBERSHIP OF THE BOARD OF PHARMACY BY TWO MEMBERS.

The General Assembly of North Carolina enacts:

Section 1. G.S. 90-85.21 reads as rewritten:

"§ 90-85.21. Pharmacy ~~permit.~~ permit; Board regulation of pharmacies.

(a) In accordance with Board regulations, each pharmacy in North Carolina shall annually register with the Board on a form provided by the Board. The application shall identify the pharmacist-manager of the pharmacy and all pharmacist personnel employed in the pharmacy. All pharmacist-managers shall notify the Board of any change in pharmacist personnel within 30 days of such change.

(b) Each physician who dispenses prescription drugs, for a fee or other charge, shall annually register with the Board on the form provided by the Board, and with the licensing board having jurisdiction over the physician. Such dispensing shall comply in all respects with the relevant laws and regulations that apply to pharmacists governing the distribution of drugs, including packaging, labeling, and record keeping. Authority and

responsibility for disciplining physicians who fail to comply with the provisions of this subsection are vested in the licensing board having jurisdiction over the physician. The form provided by the Board under this subsection shall be as follows:

Application For Registration
With The Pharmacy Board
As A Dispensing Physician

1. Name and Address of Dispensing Physician

2. Affix Dispensing Label Here

3. Physician's North Carolina License Number .....

4. Are you currently practicing in a professional association registered with the North Carolina Medical Board? .....Yes .....No. If yes, enter the name and registration number of the professional corporation:
.....
.....

5. I certify that the information is correct and complete.
....
Signature Date

(c) To protect the public health and safety, the Board may adopt rules regulating pharmacies that are consistent with the laws of this State. In adopting such rules the Board shall consider:

(1) The maintenance of the quality, quantity, integrity, safety, and efficacy of drugs or devices distributed, dispensed, or administered;

(2) The maintenance of the integrity of, and public confidence in, the profession and the delivery of quality pharmaceutical services to the citizens of North Carolina; and

(3) Any other factors related to public health, safety, and welfare."

Section 2. G.S. 90-85.3 reads as rewritten:

"**§ 90-85.3. Definitions.**

(a) "Administer" means the direct application of a drug to the body of a patient by injection, inhalation, ingestion or other means.

(b) "Board" means the North Carolina Board of Pharmacy.

(b1) **(Effective July 1, 2000)** "Clinical pharmacist practitioner" means a licensed pharmacist who meets the guidelines and criteria for such title established by the joint subcommittee of the North Carolina Medical Board and the North Carolina Board of Pharmacy and is authorized to enter into drug therapy management agreements with physicians in accordance with the provisions of G.S. 90-18.3.

(c) "Compounding" means taking two or more ingredients and combining them into a dosage form of a drug, exclusive of compounding by a drug manufacturer, distributor, or packer.

(d) "Deliver" means the actual, constructive or attempted transfer of a drug, a device, or medical equipment from one person to another.

(e) "Device" means an instrument, apparatus, implement, machine, contrivance, implant, in vitro reagent or other similar or related article including any component part or accessory, whose label or labeling bears the statement "Caution: federal law requires dispensing by or on the order of a physician." The term does not include:

(1) Devices used in the normal course of treating patients by health care facilities and agencies licensed under Chapter 131E or Article 2 of Chapter 122C of the General Statutes;

(2) Devices used or provided in the treatment of patients by medical doctors, dentists, physical therapists, occupational therapists, speech pathologists, optometrists, chiropractors, podiatrists, and nurses licensed under Chapter 90 of the General Statutes, provided they do not dispense devices used to administer or dispense drugs.

(f) "Dispense" means preparing and packaging a prescription drug or device in a container and labeling the container with information required by State and federal law. Filling or refilling drug containers with prescription drugs for subsequent use by a patient is "dispensing". Providing quantities of unit dose prescription drugs for subsequent administration is "dispensing".

(g) "Drug" means:

(1) Any article recognized as a drug in the United States Pharmacopeia, or in any other drug compendium or any supplement thereto, or an article recognized as a drug by the United States Food and Drug Administration;
(2) Any article, other than food or devices, intended for use in the diagnosis, cure, mitigation, treatment or prevention of disease in man or other animals;
(3) Any article, other than food or devices, intended to affect the structure or any function of the body of man or other animals; and
(4) Any article intended for use as a component of any articles specified in clause (1), (2) or (3) of this subsection.

(h) "Emancipated minor" means any person under the age of 18 who is or has been married or who is or has been a parent; or whose parents or guardians have surrendered their rights to the minor's services and earnings as well as their right to custody and control of the minor's person; or who has been emancipated by an appropriate court order.

(i) "Health care provider" means any licensed health care professional; any agent or employee of any health care institution, health care insurer, health care professional school; or a member of any allied health profession.

(j) "Label" means a display of written, printed or graphic matter upon the immediate or outside container of any drug.

(k) "Labeling" means preparing and affixing a label to any drug container, exclusive of labeling by a manufacturer, packer or distributor of a nonprescription drug or a commercially packaged prescription drug or device.

(l) "License" means a license to practice pharmacy including a renewal license issued by the Board.

(11) "Medical equipment" means any of the following items that are intended for use by the consumer in the consumer's place of residence:
(1) A device.
(2) Ambulation assistance equipment.
(3) Mobility equipment.
(4) Rehabilitation seating.
(5) Oxygen and respiratory care equipment.
(6) Rehabilitation environmental control equipment.
(7) Diagnostic equipment.

(8) A bed prescribed by a physician to treat or alleviate a medical condition.

The term "medical equipment" does not include (i) medical equipment used or dispensed in the normal course of treating patients by or on behalf of home care agencies, hospitals, and nursing facilities licensed under Chapter 131E of the General Statutes or hospitals or agencies licensed under Article 2 of Chapter 122C of the General Statutes; (ii) medical equipment used or dispensed by professionals licensed under Chapters 90 or 93D of the General Statutes, provided the professional is practicing within the scope of that professional's practice act; (iii) upper and lower extremity prosthetics and related orthotics; or (iv) canes, crutches, walkers, and bathtub grab bars.

(12) "Mobile pharmacy" means a pharmacy that meets all of the following conditions:

(1) Is either self-propelled or moveable by another vehicle that is self-propelled.

(2) Is operated by a nonprofit corporation.

(3) Dispenses prescription drugs at no charge or at a reduced charge to persons whose family income is less than two hundred percent (200%) of the federal poverty level and who do not receive reimbursement for the cost of the dispensed prescription drugs from Medicare, Medicaid, a private insurance company, or a governmental unit.

(13) "Multi-store retail community pharmacist" means a pharmacist licensed under this Article and employed by a corporation or other legal entity, which owns five or more retail pharmacies operating in the State of North Carolina.

(m) "Permit" means a permit to operate a pharmacy, deliver medical equipment, or dispense devices, including a renewal license issued by the Board.

(n) "Person" means an individual, corporation, partnership, association, unit of government, or other legal entity.

(o) "Person in loco parentis" means the person who has assumed parental responsibilities for a child.

(p) "Pharmacist" means a person licensed under this Article to practice pharmacy.

(q) "Pharmacy" means any place where prescription drugs are dispensed or compounded.

(r) **(Effective until July 1, 2000)** "Practice of pharmacy" means the responsibility for: interpreting and evaluating drug orders, including prescription orders; compounding, dispensing and labeling prescription drugs and devices; properly and safely

storing drugs and devices; maintaining proper records; and controlling pharmacy goods and services. A pharmacist may advise and educate patients and health care providers concerning therapeutic values, content, uses and significant problems of drugs and devices; assess, record and report adverse drug and device reactions; take and record patient histories relating to drug and device therapy; monitor, record and report drug therapy and device usage; perform drug utilization reviews; and participate in drug and drug source selection and device and device source selection as provided in G.S. 90-85.27 through G.S. 90-85.31. A pharmacist who has received special training may be authorized and permitted to administer drugs pursuant to a specific prescription order in accordance with rules and regulations adopted by each of the Boards of Pharmacy, the Board of Nursing, and the North Carolina Medical Board. Such rules and regulations shall be designed to ensure the safety and health of the patients for whom such drugs are administered.

(r) **(Effective July 1, 2000)** "Practice of pharmacy" means the responsibility for: interpreting and evaluating drug orders, including prescription orders; compounding, dispensing and labeling prescription drugs and devices; properly and safely storing drugs and devices; maintaining proper records; and controlling pharmacy goods and services. A pharmacist may advise and educate patients and health care providers concerning therapeutic values, content, uses and significant problems of drugs and devices; assess, record and report adverse drug and device reactions; take and record patient histories relating to drug and device therapy; monitor, record and report drug therapy and device usage; perform drug utilization reviews; and participate in drug and drug source selection and device and device source selection as provided in G.S. 90-85.27 through G.S. 90-85.31. A pharmacist who has received special training may be authorized and permitted to administer drugs pursuant to a specific prescription order in accordance with rules adopted by each of the Boards of Pharmacy, the Board of Nursing, and the North Carolina Medical Board. The rules shall be designed to ensure the safety and health of the patients for whom such drugs are administered. An approved clinical pharmacist practitioner may collaborate with physicians in determining the appropriate health care for a patient, subject to the provisions of G.S. 90-18.3.

(s) "Prescription drug" means a drug that under federal law is required, prior to being dispensed or delivered, to be labeled with the following statement:

"Caution: Federal law prohibits dispensing without prescription."

(t) "Prescription order" means a written or verbal order for a prescription drug, prescription device, or pharmaceutical service from a person authorized by law to prescribe such drug, device, or service. A prescription order includes an order entered in a chart or other medical record of a patient.

(t1) "Public health pharmacist" means a pharmacist licensed under the Article and employed in a local health department.

(u) "Unit dose medication system" means a system in which each dose of medication is individually packaged in a properly sealed and properly labeled container."

Section 3. G.S. 90.85.6 reads as rewritten:

"§ **90-85.6. Board of Pharmacy; creation; membership; qualification of members.**

(a) Creation. -- The responsibility for enforcing the provisions of this Article and the laws pertaining to the distribution and use of drugs is vested in the Board. The Board shall adopt reasonable rules for the performance of its duties. The Board shall have all of the duties, powers and authorities specifically granted by and necessary for the enforcement of this Article, as well as any other duties, powers and authorities that may be granted from time to time by other appropriate statutes. The Board may establish a program for the purpose of aiding in the recovery and rehabilitation of pharmacists who have become addicted to controlled substances or alcohol, and the Board may use money collected as fees to fund such a program.

(b) Membership. -- The Board shall consist of ~~six~~ eight members, one of whom shall be a representative of the public, and the remainder of whom shall be pharmacists.

(c) Qualifications. -- The public member of the Board shall not be a health care provider or the spouse of a health care provider. He shall not be enrolled in a program to prepare him to be a health care provider. The public member of the Board shall be a resident of this State at the time of his appointment and while serving as a Board member. The pharmacist members of the Board shall be residents of this State at the time of their appointment and while serving as Board members." Section 4. G.S. 90-85.7 reads as rewritten:

"§ **90-85.7. Board of Pharmacy; selection; vacancies; commission; term; per diem; removal.**

(a) The Board of Pharmacy shall consist of ~~six~~ eight persons. ~~Five~~ Seven of the members shall be licensed as pharmacists within

this ~~State~~ State. ~~and shall be elected and commissioned by the Governor as hereinafter provided. Pharmacist~~ Five of the pharmacist members shall be chosen in an election held as hereinafter provided in which every person licensed to practice pharmacy in North Carolina and residing in North Carolina shall be entitled to vote. Two of the pharmacist members shall be appointed as provided in subsection (a2).

(a1) Each of the five elected pharmacist ~~member~~ members of said Board shall be elected for a term of five years and until ~~his~~ a successor shall be elected and shall qualify. Members chosen by election under this section shall be elected upon the expiration of the respective terms of the members of the present Board of Pharmacy. No pharmacist shall be nominated for membership on said Board, or shall be elected to membership on said Board, unless, at the time of such nomination, and at the time of such election, ~~he~~ the pharmacist is licensed to practice pharmacy in North Carolina. In case of death, resignation or removal from the State of any pharmacist member of said Board, the pharmacist members of the Board shall elect in ~~his~~ that member's place a pharmacist who meets the criteria set forth in this section to fill the unexpired term.

(a2) Two pharmacist members of the Board shall be appointed as follows: one member shall be a multi-store retail community pharmacist and shall be appointed by the General Assembly upon the recommendation of the President Pro Tempore of the Senate and one member shall be a public health pharmacist and shall be appointed by the General Assembly upon the recommendation of the Speaker of the House of Representatives.

(a3) One member of the Board shall be a person who is not a pharmacist and who represents the interest of the public at large. The Governor shall appoint this member.

(a4) ~~All Board members serving on June 30, 1989, shall be eligible to complete their respective terms.~~ Each appointing authority shall assure insofar as possible that appointees reflect the gender, geographic, and racial diversity of the State. No member appointed or elected to a term on or after July 1, 1989, shall serve more than two complete consecutive five-year terms. The Governor may remove any member appointed by him for good cause shown and may appoint persons to fill unexpired terms of members appointed by him.

It shall be the duty of a member of the Board of Pharmacy, within 10 days after receipt of notification of his appointment and commission, to appear before the clerk of the superior court of the county in which he resides and take and subscribe an oath

to properly and faithfully discharge the duties of his office according to law.

(b) All nominations and elections of the elected pharmacist members of the Board shall be conducted by the Board of Pharmacy, which is hereby constituted a Board of Pharmacy Elections. Every pharmacist with a current North Carolina license residing in this State shall be eligible to vote in all elections. The list of pharmacists shall constitute the registration list for elections. The Board of Pharmacy Elections is authorized to make rules and regulations relative to the conduct of these elections, provided such rules and regulations are not in conflict with the provisions of this section and provided that notice shall be given to all pharmacists residing in North Carolina. All such rules and regulations shall be adopted subject to the procedures of Chapter 150B of the General Statutes of North Carolina. From any decision of the Board of Pharmacy Elections relative to the conduct of such elections, appeal may be taken to the courts in the manner otherwise provided by Chapter 150B of the General Statutes.

(c) All rules, regulations, and bylaws of the North Carolina Board of Pharmacy so far as they are not inconsistent with the provisions of this Article, shall continue in effect.

(d) Notwithstanding G.S. 93B-5, Board members shall receive as compensation for their services per diem not to exceed one hundred dollars ($100.00) for each day during which they are engaged in the official business of the Board."

Section 5. G.S. 90.85.9 reads as rewritten:

"**§90-85.9. Meetings.**

The Board shall meet at least twice annually for the purpose of administering examinations and conducting other business. ~~Four~~ Five Board members constitute a quorum. The Board shall keep a record of its proceedings, a register of all licensed persons, and a register of all persons to whom permits have been issued. The Board shall report, in writing, annually to the Governor and the presiding officer of each house of the General Assembly.

Section 6. This act is effective when it becomes law.

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 1999

S 2

SENATE BILL 432
Children & Human Resources Committee Substitute Adopted 4/26/99

Short Title: Health Care Personnel Registry Changes. (Public)

Sponsors:

Referred to:

March 22, 1999

A BILL TO BE ENTITLED

AN ACT TO CLARIFY THE FACILITIES THAT ARE INCLUDED IN THE HEALTH CARE PERSONNEL REGISTRY; AND TO REQUIRE THAT EMPLOYERS AT HEALTH CARE FACILITIES ACCESS THE HEALTH CARE PERSONNEL REGISTRY.

The General Assembly of North Carolina enacts:

Section 1. G.S. 131E-256 reads as rewritten:

"**§ 131E-256. Health Care Personnel Registry.**

(a) The Department shall establish and maintain a health care personnel registry containing the names of all health care personnel working in health care facilities in North Carolina who have:

(1) Been subject to findings by the Department of:

a. Neglect or abuse of a resident in a health care facility or a person to whom home care services as defined by G.S. 131E-136 or hospice services as defined by G.S. 131E-201 are being provided.

b. Misappropriation of the property of a resident in a health care facility, as defined in subsection (b) of this section including places where home care services as defined by G.S. 131E-136 or hospice services as defined by G.S. 131E-201 are being provided.

c. Misappropriation of the property of a health care facility.

d. Diversion of drugs belonging to a health care facility or to a patient or client.

e. Fraud against a health care facility or against a patient or client for whom the employee is providing services.

(2) Been accused of any of the acts listed in subdivision (1) of this subsection, but only after the Department has screened the allegation and determined that an investigation is required.

The ~~health care personnel registry~~ Health Care Personnel Registry shall also contain all findings by the Department of neglect of a resident in a nursing facility or abuse of a resident in a nursing facility or misappropriation of the property of a resident in a nursing facility by a nurse aide that are contained in the nurse aide registry under G.S. 131E-255.

(b) For the purpose of this section, the following are considered to be 'health care facilities':

(1) Adult Care Homes as defined in G.S. 131D-2.

(2) Hospitals as defined in G.S. 131E-76.

(3) Home Care Agencies as defined in G.S. 131E-136.

(4) Nursing Pools as defined by G.S. 131E-154.2.

(5) Hospices as defined by G.S. 131E-201.

(6) Nursing Facilities as defined by G.S. 131E-255.

(7) State-Operated Facilities as ~~set forth in G.S. 122C-22.~~ defined in G.S. 122C-3(14)f.

(8) Residential Facilities ~~and Hospitals for the Mentally Ill, Developmentally Disabled, or Substance Abusers licensed pursuant to G.S. 122C-23.~~ as defined in G.S. 122C-3(14)e.

(9) 24-Hour Facilities as defined in G.S. 122C-3(14)g.

(c) For the purpose of this section, the following are considered to be 'health care personnel':

(1) In an adult care home, an adult care personal aide who is any person who either performs or directly supervises others who perform task functions in activities of daily living which are personal functions essential for the health and well-being of residents such as bathing, dressing, personal hygiene, ambulation or locomotion, transferring, toileting, and eating.

(2) A nurse aide.

(3) An in-home aide or an in-home personal care aide who provides hands-on paraprofessional services.

(4) Unlicensed assistant personnel who provide hands-on care, including, but not limited to, habilitative aides and health care technicians.

(d) Health care personnel who wish to contest findings under subdivision (a)(1) of this section are entitled to an administrative hearing as provided by the Administrative Procedure Act, Chapter 150B of the General Statutes. A petition for a contested case shall be filed within 30 days of the mailing of the written notice of the

Department's intent to place its findings about the person in the ~~health care personnel registry.~~ Health Care Personnel Registry.

(d1) Health care personnel who wish to contest the placement of information under subdivision (a)(2) of this section are entitled to an administrative hearing as provided by the Administrative Procedure Act, Chapter 150B of the General Statutes. A petition for a contested case hearing shall be filed within 30 days of the mailing of the written notice of the Department's intent to place information about the person in the ~~health care personnel registry~~ Health Care Personnel Registry under subdivision (a)(2) of this section. Health care personnel who have filed a petition contesting the placement of information in the health care personnel registry under subdivision (a)(2) of this section are deemed to have challenged any findings made by the Department at the conclusion of its investigation.

(d2) Before hiring health care personnel into a health care facility or service, every employer at a health care facility shall access the Health Care Personnel Registry and shall note each incident of access in the appropriate business files.

(e) The Department shall provide an employer or potential employer of any person listed on the ~~health care personnel registry of~~ Health Care Personnel Registry of the nature of the finding or allegation and the status of the investigation.

(f) No person shall be liable for providing any information for the health care personnel registry if the information is provided in good faith. Neither an employer, potential employer, nor the Department shall be liable for using any information from the health care personnel registry if the information is used in good faith for the purpose of screening prospective applicants for employment or reviewing the employment status of an employee.

(g) Upon investigation and documentation, health care facilities shall ensure that the Department is notified of all substantiated allegations against health care personnel which appear to a reasonable person to be related to any act listed in subdivision (a)(1) of this section, and shall promptly report to the Department any resulting disciplinary action, demotion, or termination of employment of health care personnel.

(h) The North Carolina Medical Care Commission shall adopt, amend, and repeal all rules necessary for the implementation of this section."

Section 2. This act becomes effective July 1, 1999.

VISITOR REGISTRATION SHEET

HEALTH
Name of Committee

7/11/00
Date

VISITORS: PLEASE SIGN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Leah M Killian	Moore Van Allen
[illegible]	NC Dept of Insurance
[illegible]	NCMS
Lisa Tofil	CMS
Frank Lewis	OSBM
[illegible]	Moore & Van Allen
[illegible]	NCMHP
[illegible]	[illegible]/Marsh
[illegible]	GlaxoWellcome
[illegible]	NCAHP
Lynnette Rivenbark	ANA
Lori Ann Harris	LA Harris & Assoc.
[illegible]	NCFDC
Linda Upchurch	Student Pharmacy Pharm
Gene Klepac	NC Med Soc
Cressy Porter	Boine & Associates
David Averell	Hyatt McNamara Caldwell et al
Eddie Caldwell	HMCCC&A
John Bowdish	Alley Associates
Deborah Johnson	NCSPA
Kristen Johnson	Chapel Hill
[illegible]	[illegible]
[illegible]	[illegible]
[illegible]	Poyner & Spruill
[illegible]	Merck
Melissa Barry Murphy	Pfizer
John Rainey	Poyner & Spruill