2001

HOUSE
HEALTH

MINUTES

NORTH CAROLINA GENERAL ASSEMBLY

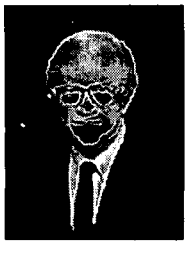
HEALTH
2001 – 2002 SESSION



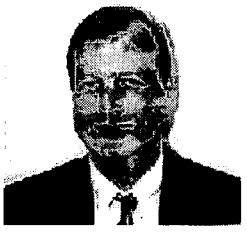
Rep. Wright
Chair



Rep. Edwards
Vice-Chair



Rep. Allred



Rep. Barnhart



Rep. Brubaker



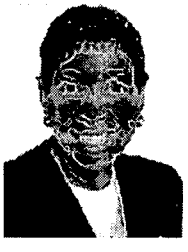
Rep. Buchanan



Rep. Clary



Rep. Crawford



Rep. Earle



Rep. Howard



Rep. Hunter



Rep. Insko



Rep. Justus



Rep. Nye



Rep. Rogers



Rep. Sherrill



Rep. Wainwright

HOUSE HEALTH COMMITTEE
2001 SESSION

MEMBER	ASSISTANT	PHONE	OFFICE	SEAT
Wright, Thomas **Chairman**	Vanda Wilson-Wormack **Committee Assistant**	733-5754	528 LOB	5
Edwards, Zeno **Vice-Chairman**	Jo Hinton	733-5906	637 LOB	3
Allred, Cary	Jean Allread	733-5607	609 LOB	26
Barnhart, Jeff	Melanie McNeely	733-5934	1104 LB	118
Buchanan, Charles	Glenda Jones	733-5824	536 LOB	30
Brubaker, Harold	Cindy Coley	715-4946	1229 LB	39
Clary, Debbie	Elena Askey	733-5624	1211 LB	110
Crawford, James	Linda Winstead	733-5824	1301 LB	24
Earle, Beverly	Ann Raeford	733-5754	535 LOB	95
Howard, Julia	Gail Stewart	733-5904	1023 LB	104
Hunter, Howard	Barbara Phillips	733-2962	613 LOB	68
Insko, Verla	Linda McCrodden	733-5775	1323 LB	70
Justus, Larry	Carolyn Justus	733-5956	640 LOB	13
Nye, Edd	Jo Bobbitt	733-5477	639 LOB	1
Rogers, Gene	Sally Gillis	715-3023	416A LOB	35
Sherrill, Wilma	Rosa Kelley	715-4466	602 LB	37
Wainwright, William	Blinda Edwards	715-3001	420 LOB	8
Linda Attarian Staff Counsel		733-2578		
Dianna Jessup Staff Counsel		733-2578		

ATTENDANCE

House Health Committee

2001 Session

(Name of Committee)

DATES	6-5-01	6-12-01	6-19-01	6-26-01	7-3-01	7/31/01	8/7/01	8/14/01	8-28-01	10/19/01	10/23/01	12/4/01	12/6/01		
Wright, Thomas, **Chairman**	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓		
Edwards, Zeno, **Vice-Chair**	✓	✓		✓	✓	✓	✓	✓	✓	✓		✓	✓		
Allred, Cary	✓							✓			✓				
Barnhart, Jeff	✓	✓				✓	✓	✓	✓	✓	✓		✓		
Buchanan, Charles				✓	✓	✓	✓	✓	✓	✓		✓	✓		
Brubaker, Harold			✓		✓		✓	✓							
Clary, Debbie			✓		✓	✓	✓			✓	✓	✓			
Crawford, James	✓	✓			✓		✓	✓		✓					
Earle, Beverly	✓	✓			✓	✓	✓	✓	✓		✓	✓			
Howard, Julia		✓	✓	✓		✓	✓	✓							
Hunter, Howard															
Insko, Verla	✓	✓	✓		✓	✓	✓	✓	✓		✓		✓		
Justus, Larry	✓		✓		✓	✓	✓	✓		✓		✓	✓		
Nye, Edd	✓		✓	✓	✓	✓	✓	✓	✓	✓		✓	✓		
Rogers, Eugene	✓			✓	✓	✓	✓	✓	✓	✓	✓	✓			
Sherrill, Wilma	✓	✓	✓	✓		✓	✓	✓		✓	✓	✓	✓		
Wainwright, William	✓		✓		✓		✓	✓		✓					
Ex-Officio Members															
Hackney, Joe						✓	✓	✓							
Baddour, Phillip						✓	✓	✓							
Dedmon, Andrew															
Earle, Beverly															
Cunningham, Pete							✓	✓							

(CANCELLED by the Chair)

ATTENDANCE

House Health Committee

2001 Session

(Name of Committee)

DATES	03/13/01	3/20/01	3/27/01	4/3/01	4/5/01	4/10/01	4/12/01	4/17/01 2:00pm	4/19/01	4/24/01 8:00am	4/24/01 12:30pm	5/08/01	5-15-01	5-22-01	5-29-01
Wright, Thomas, **Chairman**	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Edwards, Zeno, **Vice-Chair**	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Allred, Cary	✓	✓	✓	✓	✓	✓	✓	✓	✓				✓	✓	✓
Barnhart, Jeff	✓			✓	✓	✓	✓	✓	✓	✓	✓		✓	✓	
Buchanan, Charles	✓	✓	✓	✓		✓		✓		✓	✓		✓	✓	✓
Brubaker, Harold	✓	✓	✓		✓			✓							
Clary, Debbie		✓	✓	✓	✓	✓		✓	✓	✓	✓	✓	✓		✓
Crawford, James	✓	✓	✓	✓	✓	✓			✓		✓	✓	✓		
Earle, Beverly	✓		✓	✓	✓	✓	✓	✓		✓	✓				✓
Howard, Julia	✓	✓		✓	✓	✓	✓	✓			✓	✓	✓	✓	✓
Hunter, Howard			✓								✓				
Insko, Verla	✓	✓	✓			✓	✓	✓			✓	✓	✓	✓	✓
Justus, Larry	✓	✓			✓	✓			✓		✓		✓	✓	✓
Nye, Edd	✓		✓			✓	✓		✓	✓	✓	✓		✓	✓
Rogers, Eugene	✓	✓	✓	✓	✓	✓		✓	✓		✓			✓	
Sherrill, Wilma	✓	✓	✓	✓	✓	✓		✓	✓	✓	✓	✓	✓		✓
Wainwright, William		✓		✓	✓	✓				✓	✓				
Ex-Officio Members															
Hackney, Joe															
Baddour, Phillip															
Dedmon, Andrew															
Earle, Beverly															
Cunningham, Pete															

AGENDA

HOUSE COMMITTEE ON HEALTH
TUESDAY, MARCH 13, 2001
12:00 NOON, ROOM 415 LOB

OPENING REMARKS

Rep. Thomas E. Wright
Chairman

BILLS TO BE DISCUSSED

HB 162 RATE SETTING/ ADULT DAY CARE. (Rep. Insko)

HB 245 ADULT CARE HOME ASSESSMENT. (Rep. Earle)

HB 329 ADULT DAY CARE TRANSPORTATION. (Rep. Warren)

COMMENTS

ADJOURNMENT

MINUTES

COMMITTEE ON HEALTH

TUESDAY, MARCH 13, 2001

12:00 NOON ROOM 415 LOB

The House Committee on Health met on Tuesday, March 13, 2001 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-162 RATE SETTING/ADULT DAY CARE

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

Theresa Matula, Research Staff, explained the committee substitute. Rep. Insko further explained the committee substitute. Rep. Brubaker asked if the local county commissioner association support this legislation. Rep. Insko responded that the county commissioner association supports the legislation. Rep. Allred asked if the bill had to be re-referred to the appropriations committee. Chairman Wright responded. Rep. Allred followed up with a question about the rate differential. Rep. Insko responded that property taxes, unemployment rates, and other services varied throughout the state. Rep. Allred followed up with a question about the reimbursement rate set at the local level and stated that the bill should go to appropriations. Karen Gottovi, Director of the Division of Aging, commented on Adult Day Care Funding and stated that local planning committees decide how to spend the money. Rep. Wright stated that the bill has gone through a study commission. Rep. Sherrill asked if there was any known opposition to the bill. Rep. Insko responded.

Rep. Sherrill moved for a favorable report, unfavorable to the original bill. So moved.

HB-245 ADULT CARE HOME ASSESSMENT

Rep. Earle explained the bill. Rep. Rogers asked about the incentive of the bill. Rep. Earle responded. Rep. Sherrill asked if the bill was a result of another bill that dealt with grading nursing homes. Rep. Earle responded. Rep. Sherrill followed up with a question about the assessment of other services, such as food, nutritional information, etc.. Rep. Earle responded. Theresa Matula further commented on Rep. Sherrill's inquiry. Rep. Sherrill followed up with a question to Rep. Earle about her opinion on the Department's inclusion of the services in a study and when will the study be completed. Rep. Earle responded. Rep. Justus asked about the appropriations amount in the bill. Rep. Earle responded that the funding would help finance the meetings. Rep. Justus asked about the location of the meetings. Rep. Earle responded.

Rep. Barnhart asked about the local adult care advisory committees and local aging agencies role in this bill. Karen Gottovi, Division of Aging, stated that the Aging Study Commission membership included Area Agency Directors and Supervisors. Rep. Allred asked why is there a section in the bill for Appropriations. Rep. Earle responded.

Rep. Sherrill commented on the appropriated amount in the bill possibly slowing the bill down in the appropriations committee. Rep. Earle responded.

Rep. Justus moved for a favorable report and that the bill be re-referred to the Committee on Appropriations. So moved.

HB-329 ADULT DAY CARE TRANSPORTATION

Rep. Warren explained the bill. Theresa Matula further explained the bill.

Rep. Rogers moved for a favorable report on the bill. So moved.

The meeting adjourned at 12:45pm.

Rep. Thomas E. Wright
Chairman

Vanda Wilson-Wormack
Committee Assistant

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2001

H 1

HOUSE BILL 162*

Short Title:	Rate Setting/Adult Day Care.	(Public)
Sponsors:	Representatives Insko; Earle, Warren, and Alexander.	
Referred to:	Health.	

February 19, 2001

A BILL TO BE ENTITLED

AN ACT TO ALLOW COUNTIES TO ESTABLISH THE RATES FOR REIMBURSEMENT FOR ADULT DAY SERVICES FROM THE HOME AND COMMUNITY CARE BLOCK GRANT FUND.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 143B-181.1(a)(11) reads as rewritten:

"(11) To administer a Home and Community Care Block Grant for older adults, effective July 1, 1992. The Home and Community Care Block Grant shall be comprised of applicable Older Americans Act funds, Social Services Block Grant funding in support of the Respite Care Program (G.S. 143B-181.10), State funds for home and community care services administered by the Division of Aging, portions of the State In-Home and Adult Day Care funds (Chapter 1048, 1981 Session Laws) administered by the Division of Social Services which support services to older adults, and other funds appropriated by the General Assembly as part of the Home and Community Care Block Grant. Notwithstanding G.S. 143B-153 or any other State law to the contrary, counties may establish rates for the reimbursement for adult day services from Home and Community Care Block Grant funds. Funding currently administered by the Division of Social Services to be included in the block grant will be based on the expenditures for older adults at a point in time to be mutually determined by the Divisions of Social Services and Aging. The total amount of Older Americans Act funds to be included in the Home and Community Care Block Grant and the matching rates for the block grant shall be established by the Department of Health and Human Services, Division of Aging. Allocations made to counties in support of older adults shall not be less than resources made available for the period July 1, 1990, through

June 30, 1991, contingent upon availability of current State and federal funding; and".

SECTION 2. G.S. 143B-153(2a) reads as rewritten:

"(2a) The Social Services Commission shall have the power and duty to establish standards and adopt rules and regulations:

a. For social services programs established by federal legislation and by Article 3 of Chapter 108A of the General Statutes;

b. For implementation of Title XX of the Social Security Act, except for Title XX services provided solely through the Division of Mental Health, Developmental Disabilities, and Substance Abuse Services, by promulgating rules and regulations in the following areas:

1. Eligibility for all services established under a Comprehensive Annual Services Plan, as required by federal law;
2. Standards to implement all services established under the Comprehensive Annual Services Plan;
3. Except as otherwise provided in G.S. 143B-181.1, ~~Maximum~~ maximum rates of payment for provision of social services;
4. Fees for services to be paid by recipients of social services;
5. Designation of certain mandated services, from among the services established by the Secretary below, which shall be provided in each county of the State; and
6. Title XX services for the blind, after consultation with the Commission for the Blind.

Provided, that the Secretary is authorized to promulgate all other rules in at least the following areas:

1. Establishment, identification, and definition of all services offered under the Comprehensive Annual Services Plan;
2. Policies governing the allocation, budgeting, and expenditures of funds administered by the Department;
3. Contracting for and purchasing services; and
4. Monitoring for effectiveness and compliance with State and federal law and regulations."

SECTION 3. This act becomes effective July 1, 2001.

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2001

H D

HOUSE BILL 162*
PROPOSED COMMITTEE SUBSTITUTE H162-CSSH-7 [v.2]

3/12/2001 3:58:02 PM

Short Title: Rate Setting/Adult Day Care. (Public)

Sponsors:

Referred to:

February 19, 2001

A BILL TO BE ENTITLED

AN ACT TO ALLOW COUNTIES TO ESTABLISH THE RATES FOR REIMBURSEMENT FOR ADULT DAY CARE FROM THE HOME AND COMMUNITY CARE BLOCK GRANT FUND.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 143B-181.1(a)(11) reads as rewritten:

"(11) To administer a Home and Community Care Block Grant for older adults, effective July 1, 1992. The Home and Community Care Block Grant shall be comprised of applicable Older Americans Act funds, Social Services Block Grant funding in support of the Respite Care Program (G.S. 143B-181.10), State funds for home and community care services administered by the Division of Aging, portions of the State In-Home and Adult Day Care funds (Chapter 1048, 1981 Session Laws) administered by the Division of Social Services which support services to older adults, and other funds appropriated by the General Assembly as part of the Home and Community Care Block Grant. Notwithstanding G.S. 143B-153 or any other State law to the contrary, counties may establish rates for the reimbursement for adult day care from Home and Community Care Block Grant funds. Funding currently administered by the Division of Social Services to be included in the block grant will be based on the expenditures for older adults at a point in time to be mutually determined by the Divisions of Social Services and Aging. The total amount of Older Americans Act funds to be included in the Home and Community Care Block Grant and the matching rates for the block grant shall be established by the Department of Health and Human Services, Division of Aging. Allocations made to counties in support of older adults shall not be

less than resources made available for the period July 1, 1990, through June 30, 1991, contingent upon availability of current State and federal funding; and".

SECTION 2. G.S. 143B-153(2a) reads as rewritten:

"(2a) The Social Services Commission shall have the power and duty to establish standards and adopt rules and regulations:

a. For social services programs established by federal legislation and by Article 3 of Chapter 108A of the General Statutes;

b. For implementation of Title XX of the Social Security Act, except for Title XX services provided solely through the Division of Mental Health, Developmental Disabilities, and Substance Abuse Services, by promulgating rules and regulations in the following areas:

1. Eligibility for all services established under a Comprehensive Annual Services Plan, as required by federal law;
2. Standards to implement all services established under the Comprehensive Annual Services Plan;
3. Except as otherwise provided in G.S. 143B-181.1, ~~Maximum~~ maximum rates of payment for provision of social services;
4. Fees for services to be paid by recipients of social services;
5. Designation of certain mandated services, from among the services established by the Secretary below, which shall be provided in each county of the State; and
6. Title XX services for the blind, after consultation with the Commission for the Blind.

Provided, that the Secretary is authorized to promulgate all other rules in at least the following areas:

1. Establishment, identification, and definition of all services offered under the Comprehensive Annual Services Plan;
2. Policies governing the allocation, budgeting, and expenditures of funds administered by the Department;
3. Contracting for and purchasing services; and
4. Monitoring for effectiveness and compliance with State and federal law and regulations."

SECTION 3. This act becomes effective July 1, 2001.

HOUSE BILL 162:
RATE SETTING/ADULT DAY CARE

BILL ANALYSIS

Committee:	House Health	**Introduced by:**	Representative Insko
Date:	March 13, 2001	**Summary by:**	Theresa Matula
Version:	PCS for 1st Edition H162-CSSH-7[v.2]		Senior Legislative Analyst

SUMMARY: ***House Bill 162 amends G.S. 143B-181.1(a)(11) and G.S. 143B-153(2a) to allow counties to establish the reimbursement rates for adult day care from the Home and Community Care Block Grant (HCCBG) Fund. This act becomes effective July 1, 2001.***

The Proposed Committee Substitute for House Bill 162, H162-CSSH-7[v.2], changes ADULT DAY SERVICES to ADULT DAY CARE in the title and makes a conforming change to the amendment of G.S. 143B-181.1(a)(11). Adult day care is the standard reference in the General Statutes.

CURRENT LAW:

- G.S. 143B-181.1(a)(11) gives the Division of Aging responsibility for administering the Home and Community Care Block Grant (HCCBG) Fund.
- G.S. 143B-153(2a) grants the Social Services Commission general rule making authority for all social services programs and implementation of Title XX of the Social Security Act.

BILL ANALYSIS:

Section 1 of House Bill 162 amends G.S. 143B-181.1(a)(11) to allow counties to establish reimbursement rates for adult day services from Home and Community Care Block Grant funds. Section 2 is a conforming amendment to G.S. 143B-153(2a). Section 3 establishes the effective date of this act as July 1, 2001.

BACKGROUND:

House Bill 162 is a recommendation from the North Carolina Study Commission on Aging based on presentations to the Commission on two occasions. House Bill 162 would allow counties to establish the rates for reimbursement for adult day services from the Home and Community Care Block Grant Fund.

The Social Services Commission sets rates for adult day services provided through both the Home and Community Care Block Grant (HCCBG) and State Adult Day Care Fund (SADCF). This has been the situation since 1992 in order to coordinate HCCBG adult day services rates with SADCF rates. Currently, counties adhere to the adult day services rates set by the Social Services Commission. The only variance is that the HCCBG rate also allows for an administrative cost in addition to the daily rate. Adult day care and adult day health care are currently the only HCCBG services with rates set by the State.

2001 COMMITTEE REPORT
HOUSE OF REPRESENTATIVES

The following report(s) from standing committee(s) is/are presented:
By Representative(s) **Thomas E. Wright** (Chair/Chairs) for the Committee on **Health**.

☐ Committee Substitute for
H.B. 162 A BILL TO BE ENTITLED AN ACT TO ALLOW COUNTIES TO ESTABLISH THE RATES FOR REIMBURSEMENT FOR ADULT DAY SERVICES FROM THE HOME AND COMMUNITY CARE BLOCK GRANT FUND.

☐ 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)

3/13/01

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2001

HOUSE BILL 245*

Short Title:	Adult Care Home Assessment.	(Public)
Sponsors:	Representatives Earle; Insko, Warren, Alexander, Luebke, Weiss, and Wainwright.	
Referred to:	Health.	

February 26, 2001

A BILL TO BE ENTITLED

AN ACT TO DIRECT THE DEPARTMENT OF HEALTH AND HUMAN SERVICES TO DEVELOP AN INSTRUMENT FOR ASSESSING THE QUALITY OF CARE PROVIDED BY ADULT CARE HOMES.

Whereas, the number of persons who are considering residency in adult care homes is increasing; and

Whereas, when choosing among available adult care homes, persons who need the care and services provided by these facilities often do not know how to evaluate and compare the physical plant, care, and services provided, and costs associated with residency; and

Whereas, an evaluation method for adult care homes would enable consumers of adult care home services to determine the extent to which quality of care and physical plant standards have been met by the facility before deciding whether to reside there; Now, therefore,

The General Assembly of North Carolina enacts:

SECTION 1. The Department of Health and Human Services shall develop an assessment instrument that will enable residents of adult care homes, and their families, to determine the extent to which the facility provides quality care. The assessment shall be conducted by the State or local government. The instrument shall address discreet areas of care, services, and physical plant amenities and conditions. The Department shall consult with industry representatives, advocacy and research organizations, and consumers in developing the assessment instrument.

SECTION 2. The Department of Health and Human Services shall report on the development of the assessment instrument to the North Carolina Study Commission on Aging on or before November 1, 2001. The report shall include a recommendation on whether the assessment should be conducted by the State or by local government. The Department may conduct a pilot test of the assessment in selected adult care homes

that have agreed to participate. If a pilot test is conducted, the Department shall report the results of the pilot test to the North Carolina Study Commission on Aging not later than April 1, 2002.

SECTION 3. There is appropriated from the General Fund to the Department of Health and Human Services the sum of one hundred fifty thousand dollars ($150,000) for the 2001-2002 fiscal year. These funds shall be used to implement this act.

SECTION 4. This act becomes effective July 1, 2001.

HOUSE BILL 245:
Adult Care Home Assessment

BILL ANALYSIS

Committee:	House Health	**Introduced by:**	Representative Earle
Date:	March 9, 2001	**Summary by:**	Theresa Matula
Version:	1st Edition		Senior Legislative Analyst

SUMMARY: ***House Bill 245 directs the Department of Health and Human Services to develop an assessment instrument that will enable residents of adult care homes, and their families, to determine the extent to which the facility provides quality care. The act becomes effective July 1, 2001***

BILL ANALYSIS:

Section 1 of House Bill 245 directs the Department of Health and Human Services to develop an assessment instrument to enable residents of adult care homes, and their families, to determine the extent to which the facility provides quality care.

The assessment instrument shall address:

- Discreet areas of care,
- Services,
- Physical plant amenities and conditions.

Section 2 requires the Department to report by November 1, 2001, to the North Carolina Study Commission on Aging regarding the development of the assessment instrument. The report shall include a recommendation on whether the assessment should be conducted by the State or local government. The Department may conduct a pilot test of the instrument and report the results to the Study Commission on Aging not later than April 1, 2002.

Section 3 appropriates one hundred fifty thousand dollars ($150,000) for 2001-2002 from the General Fund to the Department of Health and Human Services for the development of the instrument.

Section 4 establishes the effective date as July 1, 2001.

BACKGROUND:

House Bill 245 is a recommendation from the North Carolina Study Commission on Aging. In response to the Studies Act of 1999, S.L. 1999-395, Section 2.1 4. (b) (HB 163), the Legislative Research Commission referred the issue of biannual inspection and grading of adult care homes to the North Carolina Study Commission on Aging. The Commission studied this issue in 1999 and 2000.

In 1999, North Carolina's percentage of older adults climbed to 12.8%. This percentage is projected to increase to 21.4% in 2025, which will rank North Carolina as having the 11th highest older adult population nationally. The Study Commission on Aging found that the increasing number of older adults as potential adult care home residents necessitates the need for the development of an assessment instrument for adult care homes. It is intended that this assessment instrument will aid consumers in the evaluation and comparison of physical plant, care, services provided, and costs associated with residency in adult care homes.

2001 COMMITTEE REPORT
HOUSE OF REPRESENTATIVES

The following report(s) from standing committee(s) is/are presented:
By Representative(s) **Thomas Wright** (Chair/Chairs) for the Committee on **Health**.

☐ Committee Substitute for
H.B. 245 A BILL TO BE ENTITLED AN ACT TO DIRECT THE DEPARTMENT OF HEALTH AND HUMAN SERVICES TO DEVELOP AN INSTRUMENT FOR ASSESSING THE QUALITY OF CARE PROVIDED BY ADULT CARE HOMES.

☐ 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)

2/15/01

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2001

HOUSE BILL 329

Short Title:	Adult Day Care Transportation.	(Public)
Sponsors:	Representatives Warren; Earle, Insko, Baddour, Wainwright, and Cox.	
Referred to:	Health.	

March 1, 2001

A BILL TO BE ENTITLED

AN ACT PERTAINING TO TRANSPORTATION SERVICES OFFERED BY ADULT DAY CARE PROGRAMS.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 131D-6(b) reads as rewritten:

"(b) As used in this section 'adult day care program' means the provision of group care and supervision in a place other than their usual place of abode on a less than 24-hour basis to adults who may be physically or mentally disabled. The Department of Health and Human Services shall annually inspect and certify all adult day care programs, under rules adopted by the Social Services Commission. The Social Services Commission shall adopt rules to protect the health, safety, and welfare of persons in adult day care programs. These rules shall include minimum standards relating to management of the program, staffing requirements, building requirements, fire safety, sanitation, nutrition, and program activities. Adult day care programs are not required to provide transportation to participants, however, those programs that choose to provide transportation shall comply with rules adopted by the Commission for the health and safety of participants during transport.

The Department of Health and Human Services shall enforce the rules of the Social Services Commission."

SECTION 2. This act becomes effective October 1, 2001.

HOUSE BILL 329:
Adult Day Care Transportation

BILL ANALYSIS

Committee:	House Health	**Introduced by:**	Representative Warren
Date:	March 9, 2001	**Summary by:**	Theresa Matula
Version:	1st Edition		Senior Legislative Analyst

SUMMARY: ***House Bill 329 amends G.S. 131D-6(b) so that adult day care programs may provide, but are not required to provide transportation to participants. Those programs that elect to provide transportation services to participants must comply with the rules adopted by the Social Services Commission. This act becomes effective October 1, 2001.***

CURRENT LAW:

As outlined in G.S. 131D-6 (a), the adult day care program enables individuals "who would otherwise need full-time care away from their own residences to remain in their residences as long as possible and to enjoy as much independence as possible. " G.S. 131D-6 (b) defines an adult day care program as "the provision of group care and supervision in a place other than their usual place of abode on a less than 24-hour basis to adults who may be physically or mentally disabled." The Social Services Commission is charged with adopting rules to protect the health, safety, and welfare of persons in adult day care programs. The Commission has adopted rules concerning the transportation of adult day care clients.

Adult Day Care Program Transportation Rules

With regard to adult day care programs, 10 NCAC 42E.1103 states:

(a) The day care program shall provide transportation in keeping with the needs of participants....

Adult Day Health Care Program Transportation Rules

For adult day health care programs, 10 NCAC 42Z.0804 states:

(a) When the day health program provides transportation in keeping with the needs of participants...

A discrepancy may exist among the intent of the transportation rules and the interpretation by various parties. As such, House Bill 329 will provide clarification.

BILL ANALYSIS:

House Bill 329 amends G.S. 131D-6(b) adding language to state that adult day care programs are not required to provide transportation to participants. However, those programs that choose to provide transportation shall comply with rules adopted by the Social Services Commission.

BACKGROUND:

House Bill 329 is a recommendation from the North Carolina Study Commission on Aging in recognition of the role that adult day care plays as a community-based program providing activities to foster the social, physical, and emotional well-being of older adults who may otherwise need full-time care away from their own residences. Adult day services providers and advocates presented information to the Commission on two occasions regarding transportation costs to and from adult day and adult day health centers. They explained that costs have increased dramatically; in rare cases the transportation costs for some participants are greater than the cost of attending the center.

The Division of Aging's survey of adult day services providers, revealed that the median cost of transportation each way is $4.81; the current reimbursement rate each way is $1.50. The median cost of a round trip is $9.62; the current reimbursement rate for a round trip is $3.00. The difference is absorbed by the provider through available revenues. For non-profit providers, these revenues could include local government funding, United Way and other local donations, grants, fundraising efforts, and revenue from clients paying for services rendered.

2001 COMMITTEE REPORT
HOUSE OF REPRESENTATIVES

The following report(s) from standing committee(s) is/are presented:
By Representative(s) **Thomas Wright** (Chair/Chairs) for the Committee on **Health**.

☐ Committee Substitute for
H.B. 329 A BILL TO BE ENTITLED AN ACT PERTAINING TO TRANSPORTATION SERVICES OFFERED BY ADULT DAY CARE 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)

2/15/01

VISITOR REGISTRATION SHEET

HOUSE HEALTH COMMITTEE — 3/13/01

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Jan Mosley	Division of Aging
Lynne Berry	Div. of Aging
Mary Cogan	Div of Aging
[illegible]	
Crissy Porter	Bone & Associates
Helen Lipina	Meck. Co.
Sharon Hirsch	NC Social Services Consortium
MARY BETHEL	DIVISION OF AGING
GEOFF SANTOLIQUIDO	DIV. OF S.S.
Karen Gottovi	Div. of Aging
Joe Rubera	AHHC

VISITOR REGISTRATION SHEET

HOUSE HEALTH COMMITTEE — 3-13-01

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
DAVID BARNES	Poyner + Spruill
Steve Mitchell	Novartis

AGENDA

HOUSE COMMITTEE ON HEALTH
TUESDAY, MARCH 20, 2001
12:00 NOON, ROOM 415 LOB

OPENING REMARKS

Rep. Thomas E. Wright
Chairman

BILLS TO BE DISCUSSED

HB 109 REIMBURSEMENT FOR MARRIAGE/FAMILY THERAPISTS.
(Rep. Alexander)

HB 204 NC HEALTH CHOICE/ NO WAITING PERIOD.
(Rep. Nesbitt)

COMMENTS

ADJOURNMENT

MINUTES

COMMITTEE ON HEALTH

TUESDAY, MARCH 20, 2001

12:00 NOON, ROOM 415 LOB

The House Committee on Health met on Tuesday, March 20, 2001 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-109 REIMBURSEMENT FOR MARRIAGE/FAMILY THERAPISTS.

Rep. Alexander explained the bill. Dianna Jessup commented on the actuarial note of the bill. Rep. Larry Justus asked about the reimbursement portion of the bill. Rep. Alexander responded. Rep. Larry Justus followed up with a question about marriage/family therapist payments. Rep. Alexander responded. Rep. Larry Justus followed up with another question about the reimbursement of marriage/family therapists and the possible cost to the State Employee Health Plan. Sam Byrd, Fiscal Staff, responded to the concern that Rep. Justus had about the cost to the plan. Rep. Sherrill commented on the bill and asked if this service is in policies in the private sector. Pam Richey, NC Association of Marriage/Family Therapists commented on what private policies offer. Rep. Sherrill followed up with a question about what private policies offer. Pam Richey responded.

Rep. Crawford moved for a favorable report. So moved.

HB-204 NC HEALTH CHOICE/NO WAITING PERIOD

Rep. Wainwright moved for adoption of an amendment to the bill on page 2, line 1, by deleting the word application and substituting the word enrollment. So moved. Rep. Nesbitt explained the bill. Rep. Allred asked about the lack of money available to insure children already enrolled in the plan and where will the money come from. Rep. Nesbitt responded that the state would not save money, but the employees would. Rep. Allred asked if the money from the federal government come on a three to one basis or is it a set amount of money allocated to North Carolina. Rep. Nesbitt responded that it was not an entitlement program, but a set limit. Rep. Allred further commented on the bill. Rep. Nesbitt responded. Rep. Justus asked if there was a fiscal note on the bill. Rep. Wright responded that the bill would go to appropriations. Rep. Nesbitt further commented that there would be no further cost to the bill because the program is capped. Rep. Justus followed up with a question about the number of children currently in the CHIPS Program and the number of additional children covered under the bill. Linda Attarian stated that the fiscal research staff had determined the average monthly enrollment. Rep. Justus commented on the bill. Rep. Nesbitt responded. Rep. Howard asked about the type

of plan coverage. Sam Byrd, fiscal staff, responded. Linda Attarian, staff counsel, further responded. Rep. Nesbitt further responded to Rep. Howard's inquiry.

Rep. Buchanan moved for a favorable report to the committee substitute bill, unfavorable to the original bill and that the bill be re-referred to the Committee on Appropriations.

Rep. Edwards commented on the CHIPS Program verses the Medicaid program. Rep. Allred commented on the bill about a possible sliding scale for families on the program. Linda Attarian further commented on the bill about coverage. Rep. Justus asked about the percentage of state employees that use this plan verses the general public. Sam Byrd responded. June Milbourne, NC Health Choice, commented on Rep. Justus's inquiry about obtaining information. Rep. Justus responded. Rep. Allred asked if members of the plan had to be citizens. Rep. Wright responded that the recipient had to be a citizen.

The motion passed.

The meeting adjourned at 12:50pm.

Rep. Thomas E. Wright, Chairman

VandaWilson-Wormack, Committee Asst.

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2001

H 1

HOUSE BILL 109

Short Title:	Reimbursement for Marriage/Family Therapists.	(Public)
Sponsors:	Representatives Alexander; Earle, Easterling, Fox, Goodwin, Hackney, Hall, Hill, Insko, Jarrell, Luebke, Preston, Underhill, Wainwright, Weiss, Wright, and Yongue.	
Referred to:	Rules, Calendar, and Operations of the House.	

February 14, 2001

A BILL TO BE ENTITLED

AN ACT TO AUTHORIZE REIMBURSEMENT FOR LICENSED MARRIAGE AND FAMILY THERAPISTS UNDER THE STATE HEALTH PLAN FOR THE TREATMENT OF MENTAL HEALTH AND CHEMICAL DEPENDENCY.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 135-40.7B reads as rewritten:

"**§ 135-40.7B. Special provisions for chemical dependency and mental health benefits.**

(a) Except as otherwise provided in this section, benefits for the treatment of mental illness and chemical dependency are covered by the Plan and shall be subject to the same deductibles, durational limits, and coinsurance factors as are benefits for physical illness generally.

(b) Notwithstanding any other provision of this Part, the following necessary services for the care and treatment of chemical dependency and mental illness shall be covered under this section: allowable institutional and professional charges for inpatient care, outpatient care, intensive outpatient program services, partial hospitalization treatment, and residential care and treatment:

(1) For mental illness treatment:
   a. Licensed psychiatric hospitals;
   b. Licensed psychiatric beds in licensed general hospitals;
   c. Licensed residential treatment facilities;
   d. Area Mental Health, Developmental Disabilities, and Substance Abuse Authorities;
   e. Licensed intensive outpatient treatment programs; and
   f. Licensed partial hospitalization programs.

(2) For chemical dependency treatment:

a. Licensed chemical dependency units in licensed psychiatric hospitals;
b. Licensed chemical dependency hospitals;
c. Licensed chemical dependency treatment facilities;
d. Area Mental Health, Developmental Disabilities, and Substance Abuse Authorities;
e. Licensed intensive outpatient treatment programs;
f. Licensed partial hospitalization programs; and
g. Medical detoxification facilities or units.

(c) Notwithstanding any other provisions of this Part, the following providers and no others may provide necessary care and treatment for mental health under this section:

(1) Psychiatrists who have completed a residency in psychiatry approved by the American Council for Graduate Medical Education and who are licensed as medical doctors or doctors of osteopathy in the state in which they perform and services covered by the Plan;
(2) Licensed or certified doctors of psychology;
(3) Certified clinical social workers;
(3a) Licensed professional counselors;
(4) Certified clinical specialists in psychiatric and mental health nursing;
(4a) Nurses working under the employment and direct supervision of such physicians, psychologists, or psychiatrists;
(5) Repealed by Session Laws 1997-512, s. 14.
(6) Psychological associates with a masters degree in psychology under the direct employment and supervision of a licensed psychiatrist or licensed or certified doctor of psychology;
(7), (8) Repealed by Session Laws 1997-512, s. 14.
(9) Certified fee-based practicing pastoral counselors; ~~and~~
(10) Licensed physician assistants under the supervision of a licensed psychiatrist and acting pursuant to G.S. 90-18.1 or the applicable laws and rules of the area in which the physician assistant is licensed or ~~certified.~~certified; and
(11) Licensed marriage and family therapists.

(c1) Notwithstanding any other provisions of this Part, the following providers and no others may provide necessary care and treatment for chemical dependency under this section:

(1) The following providers with appropriate substance abuse training and experience in the field of alcohol and other drug abuse as determined by the mental health case manager, in facilities described in subdivision (b)(2) of this section, in day/night programs or outpatient treatment facilities licensed after July 1, 1984, under Article 2 of Chapter 122C of the General Statutes or in North Carolina area programs in substance abuse services are authorized to provide treatment for chemical dependency under this section:

a. Licensed physicians including, but not limited to, physicians who are certified in substance abuse by the American Society of Addiction Medicine (ASAM);
b. Licensed or certified psychologists;
c. Psychiatrists;
d. Certified substance abuse counselors working under the direct supervision of such physicians, psychologists, or psychiatrists;
e. Psychological associates with a masters degree in psychology working under the direct supervision of such physicians, psychologists, or psychiatrists;
f. Nurses working under the direct supervision of such physicians, psychologists, or psychiatrists;
g. Certified clinical social workers;
h. Certified clinical specialists in psychiatric and mental health nursing;
i. Licensed professional counselors;
j. Certified fee-based practicing pastoral counselors; ~~and~~
k. Substance abuse professionals certified under Article 5C of Chapter 90 of the General ~~Statutes.~~Statutes; and
l. Licensed marriage and family therapists.

(2) The following providers with appropriate substance abuse training and experience in the field of alcohol and other drug abuse as determined by the mental health case manager are authorized to provide treatment for chemical dependency in outpatient practice settings:
a. Licensed physicians who are certified in substance abuse by the American Society of Addiction Medicine (ASAM);
b. Licensed or certified psychologists;
c. Psychiatrists;
d. Certified substance abuse counselors working under the employment and direct supervision of such physicians, psychologists, or psychiatrists;
e. Psychological associates with a masters degree in psychology working under the employment and direct supervision of such physicians, psychologists, or psychiatrists;
f. Nurses working under the employment and direct supervision of such physicians, psychologists, or psychiatrists;
g. Certified clinical social workers;
h. Certified clinical specialists in psychiatric and mental health nursing;
i. Licensed professional counselors;
j. Certified fee-based practicing pastoral counselors;
1. Substance abuse professionals certified under Article 5C of Chapter 90 of the General Statutes; ~~and~~
j1. Licensed marriage and family therapists; and

k. In the absence of meeting one of the criteria above, the Mental Health Case Manager could consider, on a case-by-case basis, a provider who supplies:
   1. Evidence of graduate education in the diagnosis and treatment of chemical dependency, and
   2. Supervised work experience in the diagnosis and treatment of chemical dependency (with supervision by an appropriately credentialed provider), and
   3. Substantive past and current continuing education in the diagnosis and treatment of chemical dependency commensurate with one's profession.

Provided, however, that nothing in this subsection shall prohibit the Plan from requiring the most cost-effective treatment setting to be utilized by the person undergoing necessary care and treatment for chemical dependency.

(d) Benefits provided under this section shall be subject to a case management program for medical necessity and medical appropriateness consisting of (i) precertification of outpatient visits beyond 26 visits each Plan year, (ii) all electroconvulsive treatment, (iii) inpatient utilization review through preadmission and length-of-stay certification for nonemergency admissions to the following levels of care: inpatient units, partial hospitalization programs, residential treatment centers, chemical dependency detoxification and treatment programs, and intensive outpatient programs, (iv) length-of-stay certification of emergency inpatient admissions, and (v) a network of qualified, available providers of inpatient and outpatient psychiatric and chemical dependency treatment. Care which is not both medically necessary and medically appropriate will be noncertified, and benefits will be denied. Where qualified preferred providers of inpatient and outpatient care are reasonably available, use of providers outside of the preferred network shall be subject to a twenty percent (20%) coinsurance rate up to five thousand dollars ($5,000) per fiscal year to be assessed against each covered individual in addition to the general coinsurance percentage and maximum fiscal year amount specified by G.S. 135-40.4 and G.S. 135-40.6.

(e) For the purpose of this section, 'emergency' is the sudden and unexpected onset of a condition manifesting itself by acute symptoms of sufficient severity that, in the absence of an immediate psychiatric or chemical dependency inpatient admission, could imminently result in injury or danger to self or others."

SECTION 2. This act becomes effective October 1, 2001, and applies to claims for payment or reimbursement for services rendered on or after that date.

HOUSE BILL 109:
Reimbursement for Marriage/Family Therapists

BILL ANALYSIS

Committee:	House Health	**Introduced by:**	Rep. Alexander
Date:	March 20, 2001	**Summary by:**	Dianna Jessup
Version:	First Edition		Committee Counsel

SUMMARY: House Bill 109 adds licensed marriage and family therapists to the list of providers that may be reimbursed under the State Health Plan for the necessary care and treatment of mental health and chemical dependency.

CURRENT LAW: North Carolina has made available a Comprehensive Major Medical Plan (the "State Health Plan" or the "Plan") for the benefit of its employees, retired employees, and their dependents. State law specifies who is eligible to be covered and what services are covered. Necessary care and treatment of mental illness and chemical dependency is covered by the Plan, subject to limitations concerning which providers may provide the care and treatment and be reimbursed. Some of the providers who are currently reimbursed for treating mental illness and chemical dependency include psychiatrists, psychologists, psychologist associates, certified clinical social workers, licensed professional counselors, and certified fee-based practicing pastoral counselors.

"Marriage and family therapy" is defined by statute to mean the clinical practice, within the context of marriage and family systems, of the diagnosis and treatment of psychosocial aspects of mental and emotional disorders. Under current law, generally it is unlawful for a person not licensed as a marriage and family therapist by the North Carolina Marriage and Family Therapy Licensure Board to practice marriage or family therapy. In order to become licensed, an applicant must possess a minimum of a master's degree in marriage and family therapy or a degree in an allied health field, have at least 1,500 hours of clinical experience in marriage and family therapy, and pass an examination administered by the Board.

BILL ANALYSIS: House Bill 109 would permit a licensed marriage and family therapist to be reimbursed by the State Health Plan under three circumstances:

- When providing necessary care and treatment for mental health;
- When providing necessary care and treatment for chemical dependency; and
- When providing treatment for chemical dependency in outpatient practice settings, if the therapist has appropriate substance abuse training and experience in the field of alcohol and other drug abuse as determined by the mental health case manager.

According to the North Carolina Association for Marriage and Family Therapy, there are 548 licensed marriage and family therapists. Of these therapists, 166 hold a license as a pastoral counselor, professional counselor, or clinical social worker; 28 are licensed psychologists; and 13 are licensed psychologist associates.

The act would become effective October 1, 2001 and apply to claims for payment or reimbursement for services rendered on or after that date.

H109 – SMSW- 001

North Carolina General Assembly
Legislative Services Office

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MEMORANDUM

TO: Representative Martha Alexander

FROM: Sam Byrd, Fiscal Research Division

DATE: March 12, 2001

SUBJECT: Actuarial Note (House Bill 109)

Re: Licensed Marriage and Family Therapists as Providers of Mental Health and Substance Abuse Services under the State Employee Health Benefit 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. Thomas Wright, House Committee on Health
Principal Clerk, House of Representatives

Attachment(s):
(1) House Bill 109.
(2) Actuarial Note, Hartman & Associates, House Bill 109, March 4, 2001
(3) Actuarial Note, Aon Consulting, House Bill 109, March 6, 2001.

AN EQUAL OPPORTUNITY/AFFIRMATIVE ACTION EMPLOYER

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2001

H 1

HOUSE BILL 109

Short Title:	Reimbursement for Marriage/Family Therapists.	(Public)
Sponsors:	Representatives Alexander; Earle, Easterling, Fox, Goodwin, Hackney, Hall, Hill, Insko, Jarrell, Luebke, Preston, Underhill, Wainwright, Weiss, Wright, and Yongue.	
Referred to:	Rules, Calendar, and Operations of the House.	

February 14, 2001

A BILL TO BE ENTITLED

AN ACT TO AUTHORIZE REIMBURSEMENT FOR LICENSED MARRIAGE AND FAMILY THERAPISTS UNDER THE STATE HEALTH PLAN FOR THE TREATMENT OF MENTAL HEALTH AND CHEMICAL DEPENDENCY.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 135-40.7B reads as rewritten:

"**§ 135-40.7B. Special provisions for chemical dependency and mental health benefits.**

(a) Except as otherwise provided in this section, benefits for the treatment of mental illness and chemical dependency are covered by the Plan and shall be subject to the same deductibles, durational limits, and coinsurance factors as are benefits for physical illness generally.

(b) Notwithstanding any other provision of this Part, the following necessary services for the care and treatment of chemical dependency and mental illness shall be covered under this section: allowable institutional and professional charges for inpatient care, outpatient care, intensive outpatient program services, partial hospitalization treatment, and residential care and treatment:

(1) For mental illness treatment:
   a. Licensed psychiatric hospitals;
   b. Licensed psychiatric beds in licensed general hospitals;
   c. Licensed residential treatment facilities;
   d. Area Mental Health, Developmental Disabilities, and Substance Abuse Authorities;
   e. Licensed intensive outpatient treatment programs; and
   f. Licensed partial hospitalization programs.

(2) For chemical dependency treatment:

a. Licensed chemical dependency units in licensed psychiatric hospitals;
b. Licensed chemical dependency hospitals;
c. Licensed chemical dependency treatment facilities;
d. Area Mental Health, Developmental Disabilities, and Substance Abuse Authorities;
e. Licensed intensive outpatient treatment programs;
f. Licensed partial hospitalization programs; and
g. Medical detoxification facilities or units.

(c) Notwithstanding any other provisions of this Part, the following providers and no others may provide necessary care and treatment for mental health under this section:

(1) Psychiatrists who have completed a residency in psychiatry approved by the American Council for Graduate Medical Education and who are licensed as medical doctors or doctors of osteopathy in the state in which they perform and services covered by the Plan;
(2) Licensed or certified doctors of psychology;
(3) Certified clinical social workers;
(3a) Licensed professional counselors;
(4) Certified clinical specialists in psychiatric and mental health nursing;
(4a) Nurses working under the employment and direct supervision of such physicians, psychologists, or psychiatrists;
(5) Repealed by Session Laws 1997-512, s. 14.
(6) Psychological associates with a masters degree in psychology under the direct employment and supervision of a licensed psychiatrist or licensed or certified doctor of psychology;
(7), (8) Repealed by Session Laws 1997-512, s. 14.
(9) Certified fee-based practicing pastoral counselors; ~~and~~
(10) Licensed physician assistants under the supervision of a licensed psychiatrist and acting pursuant to G.S. 90-18.1 or the applicable laws and rules of the area in which the physician assistant is licensed or ~~certified.~~certified; and
(11) Licensed marriage and family therapists.

(c1) Notwithstanding any other provisions of this Part, the following providers and no others may provide necessary care and treatment for chemical dependency under this section:

(1) The following providers with appropriate substance abuse training and experience in the field of alcohol and other drug abuse as determined by the mental health case manager, in facilities described in subdivision (b)(2) of this section, in day/night programs or outpatient treatment facilities licensed after July 1, 1984, under Article 2 of Chapter 122C of the General Statutes or in North Carolina area programs in substance abuse services are authorized to provide treatment for chemical dependency under this section:

a. Licensed physicians including, but not limited to, physicians who are certified in substance abuse by the American Society of Addiction Medicine (ASAM);
b. Licensed or certified psychologists;
c. Psychiatrists;
d. Certified substance abuse counselors working under the direct supervision of such physicians, psychologists, or psychiatrists;
e. Psychological associates with a masters degree in psychology working under the direct supervision of such physicians, psychologists, or psychiatrists;
f. Nurses working under the direct supervision of such physicians, psychologists, or psychiatrists;
g. Certified clinical social workers;
h. Certified clinical specialists in psychiatric and mental health nursing;
i. Licensed professional counselors;
j. Certified fee-based practicing pastoral counselors; ~~and~~
k. Substance abuse professionals certified under Article 5C of Chapter 90 of the General ~~Statutes.~~Statutes; and
l. Licensed marriage and family therapists.

(2) The following providers with appropriate substance abuse training and experience in the field of alcohol and other drug abuse as determined by the mental health case manager are authorized to provide treatment for chemical dependency in outpatient practice settings:
a. Licensed physicians who are certified in substance abuse by the American Society of Addiction Medicine (ASAM);
b. Licensed or certified psychologists;
c. Psychiatrists;
d. Certified substance abuse counselors working under the employment and direct supervision of such physicians, psychologists, or psychiatrists;
e. Psychological associates with a masters degree in psychology working under the employment and direct supervision of such physicians, psychologists, or psychiatrists;
f. Nurses working under the employment and direct supervision of such physicians, psychologists, or psychiatrists;
g. Certified clinical social workers;
h. Certified clinical specialists in psychiatric and mental health nursing;
i. Licensed professional counselors;
j. Certified fee-based practicing pastoral counselors;
1. Substance abuse professionals certified under Article 5C of Chapter 90 of the General Statutes; ~~and~~
j1. Licensed marriage and family therapists; and

k. In the absence of meeting one of the criteria above, the Mental Health Case Manager could consider, on a case-by-case basis, a provider who supplies:
   1. Evidence of graduate education in the diagnosis and treatment of chemical dependency, and
   2. Supervised work experience in the diagnosis and treatment of chemical dependency (with supervision by an appropriately credentialed provider), and
   3. Substantive past and current continuing education in the diagnosis and treatment of chemical dependency commensurate with one's profession.

Provided, however, that nothing in this subsection shall prohibit the Plan from requiring the most cost-effective treatment setting to be utilized by the person undergoing necessary care and treatment for chemical dependency.

(d) Benefits provided under this section shall be subject to a case management program for medical necessity and medical appropriateness consisting of (i) precertification of outpatient visits beyond 26 visits each Plan year, (ii) all electroconvulsive treatment, (iii) inpatient utilization review through preadmission and length-of-stay certification for nonemergency admissions to the following levels of care: inpatient units, partial hospitalization programs, residential treatment centers, chemical dependency detoxification and treatment programs, and intensive outpatient programs, (iv) length-of-stay certification of emergency inpatient admissions, and (v) a network of qualified, available providers of inpatient and outpatient psychiatric and chemical dependency treatment. Care which is not both medically necessary and medically appropriate will be noncertified, and benefits will be denied. Where qualified preferred providers of inpatient and outpatient care are reasonably available, use of providers outside of the preferred network shall be subject to a twenty percent (20%) coinsurance rate up to five thousand dollars ($5,000) per fiscal year to be assessed against each covered individual in addition to the general coinsurance percentage and maximum fiscal year amount specified by G.S. 135-40.4 and G.S. 135-40.6.

(e) For the purpose of this section, 'emergency' is the sudden and unexpected onset of a condition manifesting itself by acute symptoms of sufficient severity that, in the absence of an immediate psychiatric or chemical dependency inpatient admission, could imminently result in injury or danger to self or others."

SECTION 2. This act becomes effective October 1, 2001, and applies to claims for payment or reimbursement for services rendered on or after that date.

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

March 4, 2001

Mr. Sam Byrd
Fiscal Research Division
North Carolina General Assembly
300 N. Salisbury Street
Raleigh, NC 27603-5925

Re: House Bill 109: An Act to Authorize Reimbursement for Licensed Marriage and Family Therapists Under the State Health Plan for the Treatment of Mental Health and Chemical Dependency

Dear Mr. Byrd:

This bill would modify G.S. 135-40.7B to provide coverage for treatment of mental health and chemical dependency provided by licensed marriage and family therapists in the North Carolina Teachers and State Employees Comprehensive Major Medical Plan. This bill is effective October 1, 2001 and applies to services rendered on or after that date.

This bill adds licensed marriage and family therapists to the list of authorized providers of mental health and chemical dependency treatment under the plan. Based on a review of mental health and chemical dependancy charges for 1998 through 2000 and the number of licensed marriage and family therapists in North Carolina, this bill is not expected to have a significant financial impact on the State Health Plan.

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 109

Licensed Marriage and Family Therapists as Providers of Mental Health and Substance Abuse Services

Prepared by:

Aon Consulting
One Piedmont Center
3565 Piedmont Road, N.E.
Atlanta, Georgia 30363

March 2001

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 109 entitled "An Act to authorize reimbursement for licensed marriage and family therapists under the State Health Plan for the treatment of mental health and chemical dependency".

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

3/6/01
Date

Professional Peer Review by:

D. Michael Jones, A.S.A., M.A.A.A., E.A.
Assistant Vice President

3/6/01
Date

Aon Consulting

LICENSED MARRIAGE AND FAMILY THERAPIST MADE DIRECT PROVIDERS FOR TREATMENT OF MENTAL HEALTH AND CHEMICAL DEPENDENCY

PLAN CHANGE

Currently the North Carolina Teachers' & State Employees' Comprehensive Major Medical Plan (Plan) does not allow licensed marriage and family therapists to provide mental health or chemical dependency benefits.

The proposed change is to expand the available providers for mental health and chemical dependency benefits to include licensed marriage and family therapists. This change would add approximately 340 providers

The proposed act is effective October 1, 2001.

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 $
Adding licensed marriage and family therapists as a provider of MH/SA benefits				Negligible		

Based on projected claims of $1,229,088,552 and $1,372,418,005 for the 2002 and 2003 fiscal years respectively. First year cost assumes an implementation date of October 1, 2001 and a 2 month claims payment lag.

PRICING APPROACH AND COMMENTS

- A report was received from the claims processing contractor that quantified the amount paid by provider for mental health and chemical dependency benefits in calendar years 1998, 1999 and 2000 (approximately $10 million per year). The report also identified the average charges by the major provider categories including: Psychiatric Nurses, Certified Clinical Social Workers, Pastoral Counselors, Licensed Professional Counselors, Psychologists, Psychiatrists and other Physicians. The data clearly indicates that the social workers' and counselors' average charge per service was 10% to 20% less than that of other professional providers.

- The State's Family and Marriage Therapists Licensing Board Director has indicated to Fiscal Research that their charges would be consistent with the group of social workers and counselors listed above and therefore be less than the cost of the services currently being provided under the Plan.

- Aon has assumed that there will be negligible change in overall costs since slight decreases in per-session expense will likely be offset by increases in utilization. This assumption is consistent with the above mentioned reports.

- We have assumed there has been no expansion in the scope of benefits that the Plan currently provides.

2001 COMMITTEE REPORT
HOUSE OF REPRESENTATIVES

The following report(s) from standing committee(s) is/are presented:
By Representative(s) **Thomas E. Wright** (Chair/Chairs) for the Committee on **Health**.

☐ Committee Substitute for
H.B. 109 A BILL TO BE ENTITLED AN ACT TO AUTHORIZE REIMBURSEMENT FOR LICENSED MARRIAGE AND FAMILY THERAPISTS UNDER THE STATE HEALTH PLAN FOR THE TREATMENT OF MENTAL HEALTH AND CHEMICAL DEPENDENCY.

☒ 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)

2/15/01

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2001

H 1

HOUSE BILL 204

Short Title:	NC Health Choice/No Waiting Period.	(Public)
Sponsors:	Representatives Nesbitt; Adams, Barefoot, Insko, Luebke, Walker, and Womble.	
Referred to:	Health.	

February 22, 2001

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.**

As used in this Part, 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 is <u>not covered under any private or employer-sponsored comprehensive health</u>

insurance plan on the date of application. ~~and was not covered under any private or employer sponsored comprehensive health insurance plan for 60 days immediately preceding the date of application. The waiting periods required under this subdivision shall be waived if:~~

~~a. The child has been enrolled in Medicaid and has lost Medicaid eligibility;~~

~~b. The child has lost health care benefits due to cessation of a nonprofit organization program that provides health care benefits to low income children;~~

~~c. The child 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; or~~

~~d. Health insurance benefits available to the family of a special needs child have been terminated due to a long term disability or a substantial reduction in or limitation of lifetime medical benefits or benefit category. As used in this paragraph, "special needs child" has the definition applied in G.S. 108A 70.23(a).~~"

SECTION 2. This act becomes effective July 1, 2001.

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2001

H D

HOUSE BILL 204
PROPOSED COMMITTEE SUBSTITUTE H204-PCS7102-RM-9

Short Title: NC Health Choice/No Waiting Period. (Public)

Sponsors:

Referred to:

February 22, 2001

A BILL TO BE ENTITLED

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(5) 'Program' means The Health Insurance Program for Children established in this Part.

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(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 is not covered under any private or employer-sponsored comprehensive health insurance plan on the date of enrollment. ~~and was not covered under any private or employer-sponsored comprehensive health insurance~~

~~plan for 60 days immediately preceding the date of application. The waiting periods required under this subdivision shall be waived if:~~

~~a. The child has been enrolled in Medicaid and has lost Medicaid eligibility;~~

~~b. The child has lost health care benefits due to cessation of a nonprofit organization program that provides health care benefits to low-income children;~~

~~c. The child 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; or~~

~~d. Health insurance benefits available to the family of a special needs child have been terminated due to a long-term disability or a substantial reduction in or limitation of lifetime medical benefits or benefit category. As used in this paragraph, "special needs child" has the definition applied in G.S. 108A-70.23(a).~~"

SECTION 2. This act becomes effective July 1, 2001.

NORTH CAROLINA GENERAL ASSEMBLY
AMENDMENT
House Bill 204

AMENDMENT NO. 1
(to be filled in by
Principal Clerk)

H204-ALN-1 [v.0]

Date March 20 ,2001

Comm. Sub. [NO]
Amends Title [NO]
First Edition

Representative ~~Nesbitt~~ WAINWRIGHT

moves to amend the bill on page 2, line 1,
by deleting "application." and substituting "enrollment.".

SIGNED _____
Amendment Sponsor

SIGNED _____
Committee Chair if Senate Committee Amendment

ADOPTED ✓ FAILED _____ TABLED _____

HOUSE BILL 204:
NC Health Choice/No Waiting Period

BILL ANALYSIS

Committee:	House Health	**Introduced by:**	Rep. Nesbitt
Date:	March 18, 2001	**Summary by:**	Linda Attarian
Version:	Introduced		Committee Counsel

SUMMARY: ***House Bill 204, if enacted, will amend the definition of "uninsured" under the North Carolina Health Insurance Program for Children (NC Health Choice) to delete the current 60-day look-back period. The current definition requires the applicant to have been uninsured for at least 60 days prior to applying for the program, with certain specified exceptions. The proposed definition would require the applicant to be uninsured on the date of application. The act, if enacted, is effective on July 1, 2001.***

CURRENT LAW: Title XXI of the Balanced Budget Act created the State Children's Health Insurance Program (CHIP) and provides enhanced federal funding to provide health insurance coverage to targeted children from low-income families. All states have implemented programs in accordance with the federal law. For more information about the federal CHIP program and descriptions of all the state programs, the National Conference of State Legislatures' web site (www.ncsl.org) and the Health Care Financing Administration's web site (www.hcfa.gov) are excellent resources.

The federal law that is particularly relevant to House Bill 204, is that under Title XXI, states must adopt procedures to ensure that their plans don't substitute for employer-sponsored coverage. There are two types of substitution: 1) Employee-based substitution or "opt-out" is when individuals choose a government-subsidized program instead of selecting employer-sponsored coverage; 2) Employer-based substitution or "push-out" is when employers reduce or eliminate health insurance coverage to workers and their families or increase employee and/or individual costs. Most states believe that "opt-out" is the greater concern and have designed their programs to limit substitution by focusing on "opt-out".

The three mechanisms North Carolina has implemented to limit "opt-out" include:

- **Cost-Sharing:** *Families above 150% will pay copayments as follows: $6 for each prescription and $5 for each physician visit, dental and optometry visit except for preventive services, $5 for outpatient hospital visits, and $20 co-payment for unnecessary emergency room use. Families who have been exempted from cost-sharing as members of federally recognized Native American Tribes will not be subject to copayments and a $0 copayment will be printed on their health insurance card.*

- **Enrollment Fee:** *Before they can be enrolled, a family enrollment fee of $50 for one child or $100 for two or more children must be paid to the County DSS for those families who fall between 150% and 200% of the federal poverty level. Upon presentation of proof of membership in a federally recognized Native American tribe, this requirement shall be waived*

- **A Period of Uninsurance**: *To be eligible for benefits, the child must be uninsured. Under current law, "uninsured" means the applicant is and was not covered under any private or employer-sponsored creditable health insurance plan for 60 days immediately preceding the date of application. The waiting period will be waived if:*

  A. The child has been enrolled in Medicaid and has lost Medicaid eligibility

B. The child has lost health care benefits due to cessation of a nonprofit organization program that provides health care benefits to low-income children

C. The child 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 or

D. *Health insurance benefits available to the family of a special needs child have been terminated due to a long-term disability or a substantial reduction in or limitation of lifetime medical benefits or benefit category. As used in this paragraph, `special needs child' has the definition applied in G.S. 108A-70.23. (**Note:** this criteria for a waiver from the 60-day look-back period was added to G.S. 108A-70.18(8) in Section 11.8(a) of S.L. 2000-67).*

BILL ANALYSIS: Section 1 amends the definition of "uninsured". The proposed definition does not include a 60-day look-back period to insure that the applicant doesn't drop private insurance to become eligible for the program. The applicant would simple need to show that he or she is uninsured at the time of application.

Section 2 makes the bill effective July 1, 2001.

BACKGROUND:

Other State CHIP Plans With No Waiting Periods: Of the 33 states that have state-only CHIP plans, 28 require the applicant to have been uninsured for various periods of time prior to application. Five states and Puerto Rico do not have such a requirement:

Massachusetts: This state will be monitoring the enrollment practices relating to employer-sponsored health insurance. If it is determined that crowd out is occurring the State will implement a 3-month period of no insurance coverage or HCFA and the State will collaborate on an alternative corrective action.

Florida: The KidCare Program requires that children be uninsured at the time of application. The State will study the impact of the Healthy Kids Program on crowd out. It the study shows and increase, the State will implement a crowd-pout policy.

Idaho: If the private coverage does not meet HIPPA standards, a child who meets all eligibility criteria is enrolled in SCHIP. The state believes that its low cap on eligibility is a deterrent to crowd out.

Oklahoma: If a high incidence of individuals are dropping private coverage to access Title XXI benefits, the State will implement a corrective action plan.

Pennsylvania simply requires that children be totally uninsured or ineligible for Medicaid to be eligible for PA CHIP. Pennsylvania conducts an annual analysis of crowd-out by asking potential enrollees questions regarding previous insurance coverage. If the data indicate that 12% of the enrolled children are crowd-out children, the State will prepare an analysis to examine possible eligibility criteria options that may include, but not be limited to, implementing a waiting period prior to coverage by SCHIP and

denying coverage to children whose families have access to employer-based coverage in which the employer pays at least 50% of the cost of premiums.

New York: According to NCSL, NY has no waiting period but is monitoring the status. New York collected data regarding crowd-out over a 9-month period. It was required impose a required period of uninsurance if crowd-out occurred in 8% or more of enrollees. Only 6.5% of population indicated crowd-out, no waiting period was imposed.

South Dakota: According to South Dakota's plan evaluation (submitted 3/31/00), crowd out was being monitored, but no waiting periods existed.

Basic Elements of the North Carolina Title XXI Plan: (NC Health Choice for Children)

- The plan will cover uninsured children whose family incomes do not exceed 200% of the federal poverty level.
- Eligible children will be in a non-entitlement program, which means that the amount of funds available to serve them will determine how many can be served.
- The benefits package will be that provided through the North Carolina Teachers' and State Employees' Comprehensive Major Medical Plan (TSECMMP) but in addition includes preventive and maintenance dental, vision and hearing benefits. Benefits for special needs children will be provided as follows: the TSECMMP will administer and process claims for children's acute medical care and other care of special needs children. Benefits for special needs children shall be as provided under the Medical Assistance Program except that no services for long-term care shall be provided for special needs children and except that services for respite care for special needs children shall be provided only under emergency circumstances.
- Families above 150% will pay copayments as follows: $6 for each prescription; $5 each physician visit, clinic visit, dental and optometry visit except for preventive services, $5 for outpatient hospital visits, and a $20 co-payment for unnecessary emergency room use.
- There will be an annual enrollment fee for those above 150% of the federal poverty level of $50 per child and $100 maximum for two or more children.
- Applicants will have to have been uninsured for six months from the date the program becomes effective. Six months after the program becomes effective, applicants must have been uninsured for 60 days prior to application.
- Existing administrative structures and delivery systems will be used.
- Extensive outreach campaigns will be conducted to ensure that eligible children are enrolled and that their health care needs are met. Payment for their care should reduce cost shifting to other payers and improve health outcomes by rendering primary and preventive care in a timely manner, thus reducing the need for costly emergency room and acute care services.

- Allow enrollees whose income increases above 200% FPL to 225% FPL to buy-in to the program for one year at full cost.

For further information about NC Health Choice for Children, see NC Division of Medical Assistant's website http://www.dhhs.state.nc.us/dma/.

2001 COMMITTEE REPORT
HOUSE OF REPRESENTATIVES

The following report(s) from standing committee(s) is/are presented:
By Representative(s) **Thomas E. Wright** (Chair/Chairs) for the Committee on **Health**.

☐ Committee Substitute for
H.B. 204 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).

☐ 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 Appropriations.

☐ 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)

2/15/01

NORTH CAROLINA
child ADVOCACY Institute

March 19, 2001

To: Representative Martin Nesbitt

Fr: Tom Vitaglione Tom V.
Senior Fellow

Re: HB 204: NC Health Choice/ No Waiting Period

Thank you for submitting this bill to provide equity for working families who can no longer pay increasing premiums for private or employer-based coverage. As you know, those families are currently "punished" for having made a decision to insure their children. The elimination of the waiting period removes a critical barrier.

Your bill is timely, for federal regulations scheduled to take effect April 11, 2001, will allow states for the first time to submit state plans that do not require "substitution prevention strategies" for children in families with incomes below 200% of the federal poverty guidelines. (66 FR 2490 Sec. 457.805) States will be required only to monitor the issue of substitution.

This rule has been eased because substitution has not proven to be a big issue nationwide. In fact, the Sheps Center at UNC has done a study of Health Choice and found a miniscule 0.2%- 0.7% substitution rate.

We would like to recommend a change to the last word in (8) on the first page of the bill. We recommend that the word "application" be changed to "enrollment". Local departments of social services have 45 days to process applications. The current wording would require a child to be uninsured during that processing period. The proposed wording would allow families to drop current coverage on the day they are informed that the child has been enrolled in Health Choice.

Thanks again for this bill and for your advocacy on behalf of vulnerable children. It we can be of any assistance to you in this regard, please feel free to contact me at 834-6623 Ex. 235, or tomv@intrex.net.

Cc: Paula Wolf
Jonathan Sher
Beth Melcher

311 East Edenton Street • Raleigh, North Carolina 27601-1017
VOICE 919-834-6623 • FAX 919-829-7299 • E-MAIL nccai@intrex.net • WEB PAGE http://www.ncchild.org

VISITOR REGISTRATION SHEET

Health — Name of Committee

3-20-01 — Date

VISITORS:. PLEASE SIGN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Paula L. Hoyt	Covenant w/NC's Children
Jeid Calhoun	NCAE
Jon Carter	Jordan Price
HARRY LONG	N.C. ASSOC. OF MARRIAGE & FAMILY THERAPY
Pam Richey	NC Association of Marriage & Family Therapy
Mickey Fanny	Rep Baddour
JOE LIBERA	AHHC
J. CRAIG QUICK	UHS
Margaret Washington	UCLH
Brian Francis	Meck County
John Bourdeau	Alley Associates
Charlotte Craver	Udell Options, Inc
Jimmy Blayne	Staff
Paul Dallas	
Allen Grossman	US Federal Courts

AGENDA

HOUSE COMMITTEE ON HEALTH
TUESDAY, MARCH 27, 2001
12:00 NOON, ROOM 415 LOB

OPENING REMARKS

Rep. Thomas E. Wright
Chairman

BILLS TO BE DISCUSSED

HB-216 MEDICAID WAIVER/ADULT DAY HEALTH SERVICES.
(Rep. Warren)

SB-118 TELEMEDICINE BY INTERNET/PHONE/INJUNCTION.
(Sen. Forrester)

COMMENTS

ADJOURNMENT

MINUTES

HOUSE COMMITTEE ON HEALTH
TUESDAY, MARCH 27, 2001
12:00 NOON, ROOM 415-LOB

The House Committee on Health met on Tuesday, March 27, 2001 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-216 MEDICAID DRAFT PLAN AMEND/ADULT DAY HEALTH.

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

Rep. Warren explained the bill.

Rep. Brubaker moved for a favorable report to the committee substitute bill, unfavorable to the original bill.

Rep. Sherrill asked about the cost of the bill. Rep. Warren responded. Rep. Sherrill followed up with a question about other state models and is there a federal match to the bill. Daphne Lyons, Division of Medical Assistance, commented on other state models and federal government's role. Rep. Sherrill followed up with a question about the cost to local governments. Daphne Lyons responded. Rep. Wright further commented on the bill. Rep. Insko asked about the services under the current program. Daphne Lyons responded. Rep. Insko further commented on the bill.

A vote was taken on the motion made by Rep. Brubaker. So moved.

SB-118 TELEMEDICINE BY INTERNET/PHONE/INJUNCTION.

Sen. Forrester explained the bill. Linda Attarian explained the technical amendment to the bill on page 2, line 3.

Rep. Sherrill moved for adoption of the amendment. So moved.

Andy Watry, of the NC Medical Board, further commented on the bill. Rep. Clary further commented on the bill about the right of a person to freely utilize the internet. Andy Watry responded. Rep. Allred asked about the license procedure of medical physicians. Andy Watry responded that the NC Medical Board adopted a Position Statement that addresses the issue. Linda Attarain, Staff, commented on the bill. Andy Watry further commented on the bill. Rep. Sherrill asked if this applied to acupuncturist. Andy Watry responded. Rep. Sherrill asked Sen. Purcell if the bill was constitutional. Sen. Purcell

responded that Gerry Cohen, Bill Drafting, stated that the bill was constitutional. Rep. Edwards commented on the sales of prescription drugs.

Rep. Buchanan moved for a favorable report to the proposed committee substitute, unfavorable to the original bill. So moved.

The meeting adjourned at 12:50pm.

Thomas E. Wright, Chairman

Vanda Wilson-Wormack, Committee Asst.

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2001

S 2

SENATE BILL 118

Health Care Committee Substitute Adopted 3/8/01

Short Title: Telemedicine by Internet/Phone/Injunction. (Public)

Sponsors:

Referred to:

February 12, 2001

A BILL TO BE ENTITLED

AN ACT AUTHORIZING THE NORTH CAROLINA MEDICAL BOARD TO REQUIRE ANY PERSON TREATING A PATIENT BY USE OF THE INTERNET OR A TOLL-FREE TELEPHONE NUMBER TO OBTAIN A LICENSE IN THIS STATE AND TO PERMIT THE MEDICAL BOARD TO BRING AN ACTION FOR INJUNCTIVE RELIEF AGAINST NONRESIDENTS IN THE DISTRICT WHERE THE BOARD RESIDES.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 90-14.12 reads as rewritten:

"**§ 90-14.12. Injunctions.**

The Board may appear in its own name in the superior courts in an action for injunctive relief to prevent violation of this Article and the superior courts shall have power to grant such injunctions regardless of whether criminal prosecution has been or may be instituted as a result of such violations. Actions under this section shall be commenced in the superior court district or set of districts as defined in G.S. 7A-41.1 in which the respondent resides or has his principal place of business or in which the alleged acts ~~occurred.~~occurred, or in the case of an action against a nonresident, in the district where the Board resides."

SECTION 2. G.S. 90-18 reads as rewritten:

"**§ 90-18. Practicing without license; practicing defined; penalties.**

(a) No person shall practice medicine or surgery, or any of the branches thereof, nor in any case prescribe for the cure of diseases unless the person shall have been first licensed and registered so to do in the manner provided in this Article, and if any person shall practice medicine or surgery without being duly licensed and registered, as provided in this Article, the person shall not be allowed to maintain any action to collect any fee for such services. The person so practicing without license shall be guilty of a Class 1 misdemeanor.

(b) Any person shall be regarded as practicing medicine or surgery within the meaning of this Article who shall diagnose or attempt to diagnose, treat or attempt to

treat, operate or attempt to operate on, or prescribe for or administer to, or profess to treat any human ailment, physical or mental, or any physical injury to or deformity of another person. A person who resides in any state or foreign country and who, by use of any electronic or other mediums, performs any of the acts described in this ~~subsection~~subsection, including prescribing medication by use of the Internet or a toll-free telephone number, shall be regarded as practicing medicine or surgery and shall be subject to the provisions of this Article and appropriate regulation by the North Carolina Medical Board.

(c) The following shall not constitute practicing medicine or surgery as defined in subsection (b) of this section:

(1) The administration of domestic or family remedies in cases of emergency.

(2) The practice of dentistry by any legally licensed dentist engaged in the practice of dentistry and dental surgery.

(3) The practice of pharmacy by any legally licensed pharmacist engaged in the practice of pharmacy.

(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 rules 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: (i) the implementation of predetermined drug therapy which includes diagnosis and product selection by the patient's physician; (ii) modification of prescribed drug dosages, dosage forms, and dosage schedules; and (iii) ordering tests; (i), (ii), and (iii) shall be pursuant to an agreement that is physician, pharmacist, patient, and disease specific.

(4) The practice of medicine and surgery by any surgeon or physician of the United States army, navy, or public health service in the discharge of his official duties.

(5) The treatment of the sick or suffering by mental or spiritual means without the use of any drugs or other material means.

(6) The practice of optometry by any legally licensed optometrist engaged in the practice of optometry.

(7) The practice of midwifery as defined in G.S. 90-178.2.

(8) The practice of chiropody by any legally licensed chiropodist when engaged in the practice of chiropody, and without the use of any drug.

(9) The practice of osteopathy by any legally licensed osteopath when engaged in the practice of osteopathy as defined by law, and especially G.S. 90-129.

(10) The practice of chiropractic by any legally licensed chiropractor when engaged in the practice of chiropractic as defined by law, and without the use of any drug or surgery.

(11) The practice of medicine or surgery by any nonregistered reputable physician or surgeon who comes into this State, either in person or by use of any electronic or other mediums, on an irregular basis, to consult with a resident registered physician or to consult with personnel at a medical school about educational or medical training. This proviso shall not apply to physicians resident in a neighboring state and regularly practicing in this State.

(12) Any person practicing radiology as hereinafter defined shall be deemed to be engaged in the practice of medicine within the meaning of this Article. "Radiology" shall be defined as, that method of medical practice in which demonstration and examination of the normal and abnormal structures, parts or functions of the human body are made by use of X ray. Any person shall be regarded as engaged in the practice of radiology who makes or offers to make, for a consideration, a demonstration or examination of a human being or a part or parts of a human body by means of fluoroscopic exhibition or by the shadow imagery registered with photographic materials and the use of X rays; or holds himself out to diagnose or able to make or makes any interpretation or explanation by word of mouth, writing or otherwise of the meaning of such fluoroscopic or registered shadow imagery of any part of the human body by use of X rays; or who treats any disease or condition of the human body by the application of X rays or radium. Nothing in this subdivision shall prevent the practice of radiology by any person licensed under the provisions of Articles 2, 7, 8, and 12A of this Chapter.

(13) The performance of any medical acts, tasks, and functions by a licensed physician assistant at the direction or under the supervision of a physician in accordance with rules adopted by the Board. This subdivision shall not limit or prevent any physician from delegating to a qualified person any acts, tasks, and functions that are otherwise permitted by law or established by custom. The Board shall authorize physician assistants licensed in this State or another state to perform specific medical acts, tasks, and functions during a disaster.

(14) The practice of nursing by a registered nurse engaged in the practice of nursing and the performance of acts otherwise constituting medical practice by a registered nurse when performed in accordance with rules and regulations developed by a joint subcommittee of the North Carolina Medical Board and the Board of Nursing and adopted by both boards.

(15) The practice of dietetics/nutrition by a licensed dietitian/nutritionist under the provisions of Article 25 of this Chapter.

(16) The practice of acupuncture by a licensed acupuncturist in accordance with the provisions of Article 30 of this Chapter.

(17) The use of an automated external defibrillator as provided in G.S. 90-21.15.

(18) The practice of medicine by any nonregistered physician residing in another state or foreign country who is contacted by one of the physician's regular patients for treatment by use of the Internet or a toll-free telephone number while the physician's patient is temporarily in this State."

SECTION 3. This act becomes effective December 1, 2001, and applies to offenses committed and causes of action arising on or after that date.

SENATE BILL 118:
Telemedicine by Internet/Phone/Injunction.

BILL ANALYSIS

Committee:	House Health	**Introduced by:**	Sen. Forrester, Purcell
Date:	March 27, 2001	**Summary by:**	Dianna Jessup
Version:	Second Edition		Committee Counsel

SUMMARY: ***Senate Bill 118 would prohibit a person from prescribing medication to patients by use of the Internet or a toll-free telephone number unless that person is licensed and registered to practice medicine in North Carolina. The bill would except nonresident physicians treating their regular patients who are temporarily in this State from this prohibition. The bill also would permit the North Carolina Medical Board to bring an action in Wake County to enjoin nonresidents from engaging in the practice of medicine in North Carolina.***

CURRENT LAW: Current law requires persons engaged in the "practice of medicine" to be licensed and registered to practice medicine by the North Carolina Medical Board. The "practice of medicine" includes diagnosing, treating, operating on, prescribing for, or professing to treat any human ailment. Further, persons residing in any state that, by use of any electronic or other mediums, performs any of these acts are regarded to be "practicing medicine." Exceptions to this broad definition are set forth in statute.

Under current law, the Board may bring an action seeking injunctive relief to prevent a person from engaging in the practice of medicine without a license. Currently, the Board must bring the injunctive action either where the person resides or has his principal place of business or where the acts occurred.

BILL ANALYSIS: Senate Bill 118 addresses the instance where a person, without any face-to-face consultation, prescribes medication to patients over the Internet or by use of a toll-free telephone number by specifically prohibiting the practice. The prohibition would not apply to a physician residing in another state or foreign country who is contacted by a regular patient for treatment by use of the Internet or a toll-free telephone number while the patient is temporarily in North Carolina. (See Section 2)

The bill also changes the injunction statute by adding that in the case of an action against a nonresident, the Board may bring an action seeking injunctive relief in the "district where the Board resides," i.e. Wake County. (See Section 1)

The second edition substantively differs from the first in the following respects:

- Adds the change to the injunction statute (Section 1)
- Deletes "treatment" from the original prohibition (was "treat or prescribe medication", now "prescribe medication")
- Changes the effective date to December 1, 2001 and makes it applicable to offenses committed or causes of action arising on or after that date
- Adds "or foreign country" on page 2, line 3 and page 4, line 8

The act would become effective December 1, 2001 and would apply to offenses committed and causes of action arising on or after that date.

S118-SMSW-002

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2001

S D

SENATE BILL 118

Health Care Committee Substitute Adopted 3/8/01

PROPOSED HOUSE COMMITTEE SUBSTITUTE S118-PCS8591-SW-13

Short Title: Medical Treatment by Internet/Toll-Free Number. (Public)

Sponsors:

Referred to:

February 12, 2001

A BILL TO BE ENTITLED

AN ACT AUTHORIZING THE NORTH CAROLINA MEDICAL BOARD TO REQUIRE ANY PERSON TREATING A PATIENT BY USE OF THE INTERNET OR A TOLL-FREE TELEPHONE NUMBER TO OBTAIN A LICENSE IN THIS STATE AND TO PERMIT THE MEDICAL BOARD TO BRING AN ACTION FOR INJUNCTIVE RELIEF AGAINST NONRESIDENTS IN THE DISTRICT WHERE THE BOARD RESIDES.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 90-14.12 reads as rewritten:

"**§ 90-14.12. Injunctions.**

The Board may appear in its own name in the superior courts in an action for injunctive relief to prevent violation of this Article and the superior courts shall have power to grant such injunctions regardless of whether criminal prosecution has been or may be instituted as a result of such violations. Actions under this section shall be commenced in the superior court district or set of districts as defined in G.S. 7A-41.1 in which the respondent resides or has his principal place of business or in which the alleged acts ~~occurred.~~occurred, or in the case of an action against a nonresident, in the district where the Board resides."

SECTION 2. G.S. 90-18 reads as rewritten:

"**§ 90-18. Practicing without license; practicing defined; penalties.**

(a) No person shall practice medicine or surgery, or any of the branches thereof, nor in any case prescribe for the cure of diseases unless the person shall have been first licensed and registered so to do in the manner provided in this Article, and if any person shall practice medicine or surgery without being duly licensed and registered, as provided in this Article, the person shall not be allowed to maintain any action to collect any fee for such services. The person so practicing without license shall be guilty of a Class 1 misdemeanor.

(b) Any person shall be regarded as practicing medicine or surgery within the meaning of this Article who shall diagnose or attempt to diagnose, treat or attempt to treat, operate or attempt to operate on, or prescribe for or administer to, or profess to treat any human ailment, physical or mental, or any physical injury to or deformity of another person. A person who resides in any state or foreign country and who, by use of any electronic or other mediums, performs any of the acts described in this ~~subsections~~subsection, including prescribing medication by use of the Internet or a toll-free telephone number, shall be regarded as practicing medicine or surgery and shall be subject to the provisions of this Article and appropriate regulation by the North Carolina Medical Board.

(c) The following shall not constitute practicing medicine or surgery as defined in subsection (b) of this section:

(1) The administration of domestic or family remedies in cases of emergency.

(2) The practice of dentistry by any legally licensed dentist engaged in the practice of dentistry and dental surgery.

(3) The practice of pharmacy by any legally licensed pharmacist engaged in the practice of pharmacy.

(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 rules 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: (i) the implementation of predetermined drug therapy which includes diagnosis and product selection by the patient's physician; (ii) modification of prescribed drug dosages, dosage forms, and dosage schedules; and (iii) ordering tests; (i), (ii), and (iii) shall be pursuant to an agreement that is physician, pharmacist, patient, and disease specific.

(4) The practice of medicine and surgery by any surgeon or physician of the United States army, navy, or public health service in the discharge of his official duties.

(5) The treatment of the sick or suffering by mental or spiritual means without the use of any drugs or other material means.

(6) The practice of optometry by any legally licensed optometrist engaged in the practice of optometry.

(7) The practice of midwifery as defined in G.S. 90-178.2.

(8) The practice of chiropody by any legally licensed chiropodist when engaged in the practice of chiropody, and without the use of any drug.

(9) The practice of osteopathy by any legally licensed osteopath when engaged in the practice of osteopathy as defined by law, and especially G.S. 90-129.

(10) The practice of chiropractic by any legally licensed chiropractor when engaged in the practice of chiropractic as defined by law, and without the use of any drug or surgery.

(11) The practice of medicine or surgery by any nonregistered reputable physician or surgeon who comes into this State, either in person or by use of any electronic or other mediums, on an irregular basis, to consult with a resident registered physician or to consult with personnel at a medical school about educational or medical training. This proviso shall not apply to physicians resident in a neighboring state and regularly practicing in this State.

(12) Any person practicing radiology as hereinafter defined shall be deemed to be engaged in the practice of medicine within the meaning of this Article. "Radiology" shall be defined as, that method of medical practice in which demonstration and examination of the normal and abnormal structures, parts or functions of the human body are made by use of X ray. Any person shall be regarded as engaged in the practice of radiology who makes or offers to make, for a consideration, a demonstration or examination of a human being or a part or parts of a human body by means of fluoroscopic exhibition or by the shadow imagery registered with photographic materials and the use of X rays; or holds himself out to diagnose or able to make or makes any interpretation or explanation by word of mouth, writing or otherwise of the meaning of such fluoroscopic or registered shadow imagery of any part of the human body by use of X rays; or who treats any disease or condition of the human body by the application of X rays or radium. Nothing in this subdivision shall prevent the practice of radiology by any person licensed under the provisions of Articles 2, 7, 8, and 12A of this Chapter.

(13) The performance of any medical acts, tasks, and functions by a licensed physician assistant at the direction or under the supervision of a physician in accordance with rules adopted by the Board. This subdivision shall not limit or prevent any physician from delegating to a qualified person any acts, tasks, and functions that are otherwise permitted by law or established by custom. The Board shall authorize physician assistants licensed in this State or another state to perform specific medical acts, tasks, and functions during a disaster.

(14) The practice of nursing by a registered nurse engaged in the practice of nursing and the performance of acts otherwise constituting medical practice by a registered nurse when performed in accordance with rules and regulations developed by a joint subcommittee of the North Carolina Medical Board and the Board of Nursing and adopted by both boards.

(15) The practice of dietetics/nutrition by a licensed dietitian/nutritionist under the provisions of Article 25 of this Chapter.

(16) The practice of acupuncture by a licensed acupuncturist in accordance with the provisions of Article 30 of this Chapter.

(17) The use of an automated external defibrillator as provided in G.S. 90-21.15.

(18) The practice of medicine by any nonregistered physician residing in another state or foreign country who is contacted by one of the physician's regular patients for treatment by use of the Internet or a toll-free telephone number while the physician's patient is temporarily in this State."

SECTION 3. This act becomes effective December 1, 2001, and applies to offenses committed and causes of action arising on or after that date.

NORTH CAROLINA GENERAL ASSEMBLY
AMENDMENT
Senate Bill 118

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

S118-ASW-4 [v.1]

Date _____,2001

Comm. Sub. [NO]
Amends Title [NO]
Second Edition

Representative

1 moves to amend the bill
2 on page 2, line 3, by rewriting the line to read "another person. A person who resides
3 in any state or foreign country and who, by use of".

SIGNED _____
Amendment Sponsor

SIGNED _____
Committee Chair if Senate Committee Amendment

ADOPTED _____ FAILED _____ TABLED _____

2001 COMMITTEE REPORT
HOUSE OF REPRESENTATIVES

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

☒ Committee Substitute for
S.B. 118 A BILL TO BE ENTITLED AN ACT AUTHORIZING THE NORTH CAROLINA MEDICAL BOARD TO REQUIRE ANY PERSON TREATING A PATIENT BY USE OF THE INTERNET OR A TOLL-FREE TELEPHONE NUMBER TO OBTAIN A LICENSE IN THIS STATE AND TO PERMIT THE MEDICAL BOARD TO BRING AN ACTION FOR INJUNCTIVE RELIEF AGAINST NONRESIDENTS IN THE DISTRICT WHERE THE BOARD RESIDES.

☐ 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 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)

2/15/01

CONTACT WITH PATIENTS BEFORE PRESCRIBING

It is the position of the North Carolina Medical Board that prescribing drugs to an individual the prescriber has not personally examined is inappropriate except as noted in the paragraph below. Before prescribing a drug, a physician should make an informed medical judgment based on the circumstances of the situation and on his or her training and experience . Ordinarily, this will require that the physician personally perform an appropriate history and physical examination, make a diagnosis, and formulate a therapeutic plan, a part of which might be a prescription. This process must be documented appropriately.

Prescribing for a patient whom the physician has not personally examined may be suitable under certain circumstances. These may include admission orders for a newly hospitalized patient, prescribing for a patient of another physician for whom the prescriber is taking call, or continuing medication on a short-term basis for a new patient prior to the patient's first appointment. Established patients may not require a new history and physical examination for each new prescription, depending on good medical practice.

It is the position of the Board that prescribing drugs to individuals the physician has never met based solely on answers to a set of questions, as is common in Internet or toll-free telephone prescribing, is inappropriate and unprofessional.

(Adopted 11/99, 2/01)

Return to Position Statements Table of Contents.

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2001

HOUSE BILL 216

Short Title:	Medicaid Waiver/Adult Day Health Services.	(Public)
Sponsors:	Representatives Warren; Earle, Insko, Alexander, Jeffus, and Luebke.	
Referred to:	Health.	

February 22, 2001

A BILL TO BE ENTITLED

AN ACT TO DIRECT THE DEPARTMENT OF HEALTH AND HUMAN SERVICES TO APPLY FOR A MEDICAID WAIVER TO PROVIDE MEDICAID COVERAGE TO ADULT DAY HEALTH SERVICES CLIENTS.

The General Assembly of North Carolina enacts:

SECTION 1. The Department of Health and Human Services shall apply to the United States Health Care Financing Administration for a waiver to provide Medicaid coverage for eligible clients of adult day health services. If the waiver is granted, the Department shall not implement the waiver unless the implementation is approved and enacted by the General Assembly and funds are appropriated for that purpose. The Department shall report the status of the waiver to the Senate Appropriations Committee on Human Resources and the House of Representatives Appropriations Subcommittee on Health and Human Services on October 1, 2001, and March 1, 2002. The report shall include the estimated amount of funds needed to implement the waiver. Nothing in this act obligates the General Assembly to appropriate funds to implement a Medicaid waiver granted by the federal government for the purposes stated in this act.

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

PCS H216-CSSH-11 [V.1]:
Medicaid Draft Plan Amend/Adult Day Health

BILL ANALYSIS

Committee:	House Health	**Introduced by:**	Representative Warren
Date:	March 23, 2001	**Summary by:**	Theresa Matula
Version:	PCS for 1st Edition H216 PCS H216-CSSH-11[v.1]		Legislative Analyst

SUMMARY: ***The Proposed Committee Substitute for House Bill 216, PCS H216-CSSH-11[v.1], directs the Department of Health and Human Services to submit a draft Medicaid State Plan amendment to provide coverage for adult day health care services. The act is effective when it becomes law. (The PCS changes the language from Medicaid Waiver to a draft Medicaid State Plan amendment.)***

BILL ANALYSIS:

Section 1: PCS H216-CSSH-11[v.1] requires the Department of Health and Human Services to submit to the United States Health Care Financing Administration (HCFA) a draft Medicaid State Plan amendment to provide coverage for adult day health care services. The Department is required to request comment from HCFA on the amendment and whether it would be approved as submitted.

On October 1, 2001, and March 1, 2002, the Department shall report to the Senate Appropriations Committee on Human Resources and the House of Representatives Appropriations Subcommittee on Health and Human Services regarding the:

- status of the draft State Plan amendment, and the
- estimated amount of funds needed to implement a State Plan amendment, if the draft amendment receives a favorable reply.

This bill does not obligate the General Assembly to appropriate funds to implement a State Plan amendment.

Section 2: The act is effective when it becomes law.

BACKGROUND:

House Bill 216 is a recommendation from the North Carolina Study Commission on Aging. The Commission addressed the issue of Medicaid coverage for adult day health clients on two occasions. The Commission heard from the Division of Aging, the Division of Medical Assistance, adult day care providers, and the North Carolina Adult Day Services Association. Through these presentations the Commission learned that other states have been able to include coverage in their regular Medicaid program for services similar, or identical, to adult day health care services.

Initially it was thought that a Waiver would accomplish the goal of Medicaid coverage for eligible adult day health services. Upon further review, it was determined that a Medicaid State Plan amendment would be required.

Continued....

In the past, North Carolina Medicaid State Plan amendments to cover adult day health care services have been denied by the United States Health Care Financing Administration (HCFA). It is possible that changes resulting from the Supreme Court's decision in Olmstead v. L. C., 119 S.Ct. 2176 (1999), may provide a more favorable opportunity for approval by HCFA. In the Olmstead decision, the Court challenges us to develop more opportunities for individuals with disabilities through more accessible systems of cost-effective community-based services. A *draft* State Plan amendment allows the State to explore the option of Medicaid coverage for adult day health care services without making a funding commitment at this time.

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2001

H D

HOUSE BILL 216*
PROPOSED COMMITTEE SUBSTITUTE H216-CSSH-11 [v.1]

3/23/2001 10:26:10 AM

Short Title: Medicaid Draft Plan Amend/Adult Day Health. (Public)

Sponsors:

Referred to:

February 22, 2001

A BILL TO BE ENTITLED

AN ACT TO DIRECT THE DEPARTMENT OF HEALTH AND HUMAN SERVICES TO SUBMIT A DRAFT PLAN AMENDMENT TO PROVIDE MEDICAID COVERAGE TO ADULT DAY HEALTH CARE SERVICES.

The General Assembly of North Carolina enacts:

SECTION 1. The Department of Health and Human Services shall submit to the United States Health Care Financing Administration a draft Medicaid State Plan amendment to provide coverage for adult day health care services. The Department shall request comment from the Health Care Financing Administration on the amendment and whether it would be approved as submitted. The Department shall report the status of the draft State Plan amendment to the Senate Appropriations Committee on Human Resources and the House of Representatives Appropriations Subcommittee on Health and Human Services on October 1, 2001, and March 1, 2002. The report shall include comment from the Health Care Financing Administration on the draft State Plan amendment. If the draft amendment receives a favorable reply from the Health Care Financing Administration, the report shall also include the estimated amount of funds needed to implement a State Plan amendment. Nothing in this act obligates the General Assembly to appropriate funds to implement a Medicaid State Plan amendment.

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

2001 COMMITTEE REPORT
HOUSE OF REPRESENTATIVES

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

☐ Committee Substitute for
H.B. 216 A BILL TO BE ENTITLED AN ACT TO DIRECT THE DEPARTMENT OF HEALTH AND HUMAN SERVICES TO APPLY FOR A MEDICAID WAIVER TO PROVIDE MEDICAID COVERAGE TO ADULT DAY HEALTH SERVICES CLIENTS.

☐ 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)

2/15/01

VISITOR REGISTRATION SHEET

Health — Name of Committee

3-27-01 — Date

VISITORS:. PLEASE SIGN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Matt Campbell	Western Alamance High School
Jamie Avant	Western Alamance High School
Beth Stringfellow	Western Alamance High School
Nikki Clifton	Western Alamance High School
Laura Beth Payne	Western Alamance High School
Michael Edwards	Western Alamance High school
BRYAN BROTHERS	WESTERN ALAMANCE HIGH SCHOOL
David Smerker	Western Alamance High School
Kristin Foust	Western Alamance High School
Ashlee Wilson	Western Alamance High School
Jessica Prevatt	Western Alamance High School
Ernie Flack	Western Alamance High School
Matt Petersen	Western Alamance High School WA
Rod Mullen	P.O Box 460 Haw River NC 27258
ED ALEXANDER	1627 WYCLIFF CT. BURLINGTON NC 27215 KIWANIS ESCORT FOR H.S. GROUP
Daphne Lyon	DMA - DHHS
JOE LIBERA	AHIC
Fred Johnson	NC ADAS - 919-872-7933
Shane Parham	Western Alamance High
ANDY WATRY	NC MED BOARD
Watson Savage	Bailey & Dixon
Patricia A. Young	APPCNC / Carolina Center for Hospice & End of Life Care
Cindy Ellen	NCRMA

AGENDA

HOUSE COMMITTEE ON HEALTH
TUESDAY, APRIL 3, 2001
12:00 NOON, ROOM 415 LOB

OPENING REMARKS

Rep. Thomas E. Wright
Chairman

BILLS TO BE DISCUSSED

HB-226 ALLOW PHARMACY BOARD TO ACQUIRE PROPERTY.
(Rep. Culpepper)

HB-437 DELIVERY OF DEVICES/MEDICAL EQUIPMENT.
(Rep. Tolson)

HB-453 REGULATION OF EMERGENCY MEDICAL SERVICES.
(Rep. Wright)

COMMENTS

ADJOURNMENT

MINUTES

COMMITTEE ON HEALTH

TUESDAY, APRIL 3, 2001

12:00 NOON ROOM 415 LOB

The House Committee on Health met on Tuesday, April 3, 2001 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-437 DELIVERY OF DEVICES/ MEDICAL EQUIPMENT-(Rep. Tolson)

Rep. Tolson explained the bill.

Rep. Howard moved for a favorable report.

Rep. Edwards asked about the definition of devices. Andy Ellen of the NC Retail Merchants Association defined the term "devices" for Rep. Edwards. Dianna Jessup further explained the definition of the term "devices." Rep. Allred asked about the purchase of permits or licenses from the State Board. Rep. Tolson responded. Rep. Allred asked followed up with a question about the cost of the license or permit. Rep. Tolson responded that the cost would be $300.00 Rep. Allred expressed his concern about the license fee and the possibility of it being unconstitutional. Rep. Tolson responded.

Chairman Wright called the question before the committee. So moved.

HB-226 ALLOW PHARMACY BOARD TO ACQUIRE PROPERTY. (Rep. Culpepper)

Rep. Culpepper explained the bill to the committee.

Rep. Barnhart moved for a favorable report to the original bill.

Rep. Rogers asked if insurance was considered in the bill. Dianna Jessup responded that the bill would allow the Board to purchase insurance.

Chairman Wright called the question before the committee. So moved.

HB-453 REGULATION OF EMERGENCY MEDICAL SERVICES.(Rep. Wright)

Vice Chairman Edwards introduced Rep. Wright to explain the bill. Rep. Wright explained the bill. Drexdall Pratt, Chief of the Office of Emergency Medical Services, further explained on the bill.

Rep. Wright moved to adopt the Proposed Committee Substitute to HB-453. So moved.

Rep. Sherrill asked about additional staff to the department. Rep. Wright responded. Drexdall Pratt further commented on the bill. Rep. Howard asked about the technical changes to the bill. Rep. Wright responded. Rep. Allred asked about the volunteer firefighters in his district opposition to the bill. Drexdall Pratt responded. Regina Woodard of the American Heart Association spoke in support of the bill. A vote was not taken on the PCS.

Chairman Wright adjourned the meeting at 12:50pm.

Rep. Thomas Wright, Chairman

Vanda Wilson-Wormack, Committee Assistant

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2001

HOUSE BILL 226

Short Title:	Allow Pharmacy Bd. to Acquire Property.	(Public)
Sponsors:	Representatives Culpepper; and Alexander.	
Referred to:	Health.	

February 26, 2001

A BILL TO BE ENTITLED

AN ACT AUTHORIZING THE NORTH CAROLINA BOARD OF PHARMACY TO ACQUIRE REAL PROPERTY AND TO PURCHASE EQUIPMENT AND LIABILITY INSURANCE.

The General Assembly of North Carolina enacts:

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

"**§ 90-85.11A. Acquisition of real property; equipment; liability insurance.**

(a) The Board shall have the power to acquire, hold, rent, encumber, alienate, and otherwise deal with real property in the same manner as a private person or corporation, subject only to approval of the Governor and the Council of State as to the acquisition, rental, encumbering, leasing, and sale of real property. Collateral pledged by the Board for an encumbrance is limited to the assets, income, and revenues of the Board.

(b) The Board may purchase, rent, or lease equipment and supplies and purchase liability insurance or other insurance to cover the activities of the Board, its operations, or its employees."

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

HOUSE BILL 226:
Allow Pharmacy Bd. to Acquire Property

BILL ANALYSIS

Committee:	House Health	**Introduced by:**	Rep. Culpepper
Date:	April 3, 2001	**Summary by:**	Dianna Jessup
Version:	First Edition		Committee Counsel

SUMMARY: ***House Bill 226 would permit the North Carolina Board of Pharmacy to acquire, hold, rent, encumber, alienate, and otherwise deal with real property and to purchase or lease equipment and supplies and purchase liability or other insurance.***

CURRENT LAW: The North Carolina Board of Pharmacy is responsible for enforcing the provisions of the Pharmacy Practice Act and the laws pertaining to the distribution and use of drugs. The Board of Pharmacy is self-funded through fees.

The Department of Administration is responsible for purchasing or leasing space for all State agencies, including Boards. Generally, under the insurance statutes, State agencies may not purchase insurance without statutory authorization. Once authorized, all insurance is effected and placed by the Department of Insurance and paid for by the State agency.

Last session, the General Assembly raised the State Tort Claims limit to $500,000, the first $150,000 of which must be paid by the State agency who employed the employee at the time the claim arose.

BILL ANALYSIS: House Bill 226 would permit the Board of Pharmacy to purchase or lease real property, equipment, and supplies and to purchase insurance. Purchases and rental of real property will be subject to the approval of the Governor and the Council of State.

In light of the provision requiring State agencies to pay the first $150,000 of a claim, the Pharmacy Board if authorized to purchase insurance could purchase insurance to cover that amount. If the Board is authorized to purchase insurance and purchases insurance in an amount at least equal to the limits of the State Tort Claims Act (which is currently $500,000), the Board's insurance coverage will be in lieu of the State's obligation to pay a claim under the State Tort Claims Act.

BACKGROUND: At least four other boards have the authority to purchase or lease real property and equipment, including the Board of General Contractors, the North Carolina Medical Board, the Board of CPA Examiners, and the N.C. State Bar. The North Carolina Veterinary Medical Board has been authorized to purchase liability insurance.

The act would become effective when it becomes law.

2001 COMMITTEE REPORT
HOUSE OF REPRESENTATIVES

The following report(s) from standing committee(s) is/are presented:
By Representative(s) **Thomas Wright** (Chair/Chairs) for the Committee on **Health**.

☐ Committee Substitute for
H.B. 226 A BILL TO BE ENTITLED AN ACT AUTHORIZING THE NORTH CAROLINA BOARD OF PHARMACY TO ACQUIRE REAL PROPERTY AND TO PURCHASE EQUIPMENT AND LIABILITY INSURANCE.

☒ 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)

2/15/01

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2001

HOUSE BILL 437

Short Title:	Delivery of Devices/Medical Equipment.	(Public)
Sponsors:	Representatives Tolson; Barbee, Cox, and Goodwin.	
Referred to:	Health.	

March 1, 2001

A BILL TO BE ENTITLED

AN ACT TO CLARIFY THAT ANY PLACE, WHETHER LOCATED IN THIS STATE OR OUT-OF-STATE, DELIVERING OR DISPENSING DEVICES OR MEDICAL EQUIPMENT TO A USER IN THIS STATE SHALL COMPLY WITH THE REGISTRATION REQUIREMENTS OF THE BOARD OF PHARMACY.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 90-85.22 reads as rewritten:

"**§ 90-85.22. Device and medical equipment permits.**

(a) Devices. – Each ~~place~~place, whether located in this State or out-of-state, where devices are dispensed or delivered to the user in this State shall register annually with the Board on a form provided by the Board and obtain a device permit. A business that has a current pharmacy permit does not have to register and obtain a device permit. Records of devices dispensed in pharmacies or other places shall be kept in accordance with rules adopted by the Board.

(b) Medical Equipment. – Each ~~place~~place, whether located in this State or out-of-state, that delivers medical equipment to the user of the equipment in this State shall register annually with the Board on a form provided by the Board and obtain a medical equipment permit. A business that has a current pharmacy permit or a current device permit does not have to register and obtain a medical equipment permit. Medical equipment shall be delivered only in accordance with requirements established by rules adopted by the Board."

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

HOUSE BILL 437:
Delivery of Medical Devices/Medical Equipment

BILL ANALYSIS

Committee:	House Health	**Introduced by:**	Rep. Tolson
Date:	April 3, 2001	**Summary by:**	Dianna Jessup
Version:	First Edition		Committee Counsel

SUMMARY: ***House Bill 437 specifies that any business engaging in dispensing devices or medical equipment, whether the business is located in North Carolina or not, must register with the Board of Pharmacy and obtain a permit if the devises or equipment are delivered to a user in this State.***

CURRENT LAW: The Board of Pharmacy regulates the dispensing and delivery of devices and medical equipment. The terms "devices" and "medical equipment" are defined in statute, and include implements, apparatus, mobility and diagnostic equipment, and respiratory care equipment.

Current law provides that places where devices are dispensed and that deliver medical equipment to the user of the equipment must register with the Board of Pharmacy and obtain a permit, but it does not specifically provide that this statute applies to out of state companies that deliver devices and medical equipment to users in North Carolina. Another section of the statutes specifically requires out-of-state pharmacies that ship, mail, or delivery a dispensed legend drug into this State to register annually with the Board.

The fee for registration to dispense devices, deliver medical equipment, or both is $300 per year. A permit applicant must meet certain requirements set forth in the rules adopted by the Board, including demonstrating that the applicant has adequate qualified personnel to properly render device and medical equipment services in a manner prescribed by law, that the applicant's services are available 24 hours, seven days per week when essential to the maintenance of life or when the lack of such services might reasonably cause harm, and that the applicant implements and maintains a written procedure for handling complaints and problems.

BILL ANALYSIS: If enacted, any business, regardless of location, that dispenses devices in this State or delivers devices or medical equipment to a user in this State must register with the Board and obtain a permit.

BACKGROUND: While the language in the current statute is general in application, the Board of Pharmacy has taken the position that it needs specific authorization in statute in order to regulate out-of-state suppliers of devices and medical equipment.

The act would become effective when it becomes law.

2001 COMMITTEE REPORT
HOUSE OF REPRESENTATIVES

The following report(s) from standing committee(s) is/are presented:
By Representative(s) **Thomas Wright** (Chair/Chairs) for the Committee on **Health.**

☐ Committee Substitute for
H.B. 437 A BILL TO BE ENTITLED AN ACT TO CLARIFY THAT ANY PLACE, WHETHER LOCATED IN THIS STATE OR OUT-OF-STATE, DELIVERING OR DISPENSING DEVICES OR MEDICAL EQUIPMENT TO A USER IN THIS STATE SHALL COMPLY WITH THE REGISTRATION REQUIREMENTS OF THE BOARD OF PHARMACY.

☐ 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)

2/15/01

VISITOR REGISTRATION SHEET

HOUSE HEALTH COMMITTEE — 4/3/01

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Gordon A Joyner	NCARREMS PO Box 1914 Goldsboro NC 27533
Dreydel Pratt	NCOEMS
Lynda McDaniel	NCDFS
Ed Browning	NC OEMS
Mike Eddinger	NCOEMS
David Ferrell	Hofer Caldwell & Ferrell PA
Greg Mears	NC OEMS
Sam Spicer	NC HJCA
Eddie Caldwell	NCCEP
Steve Mitchell	Novartis
Ann Ellen Mills	Nurse of Day

VISITOR REGISTRATION SHEET

HOUSE HEALTH COMMITTEE — April 3, 2001

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Joanne Schoen	NC nurses Association
Peter Mangone	MD of Blue Ridge Bone Joint, Asheville, NC
Regina E. Woodard	American Heart Association
Dr. Al Wentzy	Northampton Co. Gov't
Cindy Ell	NCRMA
Warren Savage	Bailey + Dixon
Steve Wilt	DHHS
Chris Hoke	—
Jane Koene	NCMS

AGENDA

HOUSE COMMITTEE ON HEALTH
THURSDAY, APRIL 5, 2001
12:00 NOON, ROOM 415 LOB

OPENING REMARKS

Rep. Thomas E. Wright
Chairman

BILLS TO BE DISCUSSED

- **HB- 736 LONG TERM CARE/POST STAFFING.(Rep. Earle)**

  HB-896 DATABASE/CONTROLLED SUBSTANCES.(Rep. Hensley)

  HB-936 ENTERAL SEDATION/DENTIST PERMITS.(Rep. Wright)

- **HB-950 RAISE AIDS DRUG ASSISTANCE PROGRAM INCOME LIMIT. (Rep. Wright)**

- **HB-958 COST REPORTS-SPECIAL CARE UNITS. (Rep. Cansler, Insko & Clary)**

COMMENTS

ADJOURNMENT

MINUTES

HOUSE COMMITTEE ON HEALTH

THURSDAY, APRIL 5, 2001

12:00 NOON, ROOM 415 LOB

The House Committee on Health met on Thursday, April 5, 2001 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-958 COST REPORTS-SPECIAL CARE UNITS.(Rep. Cansler, Insko & Clary)

Rep. Cansler explained the bill. Rep. Clary further commented on the bill.

Rep. Allred moved for a favorable report. So moved.

HB-736 LONG-TERM CARE/POST STAFFING. (Rep. Earle)

Rep. Earle explained the bill to the committee.

Rep. Earle sent forth an amendment to the bill and moved for adoption. So moved.

Rep. Clary moved to roll the bill into a committee substitute, unfavorable to the original bill. So moved.

HB-896 DATABASE/CONTROLLED SUBSTANCE.(Rep. Hensley)

Rep. Hensley explained the bill. Rep. Brubaker asked if other states participated in this type of database management. Rep. Hensley responded.

Rep. Brubaker moved for a favorable report.

Rep. Rogers asked how would this database obtained the information. Rep. Hensley responded that the pharmacist would enter the information into the database system. Rep. Rogers asked if the pharmacies had been contacted. Rep. Hensley responded. Randolph Cloud of the NC Association of Behavioral Health Care stated that he supported the bill. Rep. Sherrill asked about other states with similar legislation. Rep. Hensley responded that other states do have similar legislation, but the statutory schemes are different. Rep. Sherrill followed up with a question about the smaller pharmacies that do not have a system in place to transfer information and would this cost the State of North Carolina money. Rep. Hensley responded that there would be fees collected and not a fiscal impact

on the general budget. Rep. Hensley also responded that pharmacies that do not have a computer system would be able to use the records to send the information. John Womble with the Control Substance Regulatory Branch in the Division of Mental Health stated that there was an universal form that could be used for those pharmacies that do not have a computer system to transfer the information. Rep. Sherrill followed up with a question about having the language in the bill to allow for the universal forms. John Womble responded. Linda Attarian, staff, further explained the bill to the committee. Rep. Allred asked about the penalty if there isn't compliance. Linda Attarian responded. Rep. Hensley also responded. Rep. Allred commented on the bill. Rep. Edwards commented on the importance of the database. Rep. Justus asked a question about line 18, section 221. Rep. Hensley responded. Linda Attarian further responded.

Rep. Crawford sent forth an amendment for adoption.

Rep. Justus asked about the penalties for a Class I misdemeanor. Rep. Hensley responded.

Rep. Justus sent forth a perfecting amendment to include penalty fees in the Class I misdemeanor.

Andy Ellen of the Retail Merchants Association stated that he had some concerns about the bill, especially the privacy regulations.

Chairman Wright called the question.

Rep. Sherrill asked about the access of information to physicians. John Womble responded that a physician could check the database upon release of the patient. Chairman Wright stated that he would temporally displace the bill and move to the next bill on the calendar.

HB-950 RAISE AIDS DRUG ASSISTANCE PROGRAM INCOME LIMIT.(Rep. Wright)

Rep. Wright explained the bill and moved that the bill be given a favorable report and re-referred to the Committee on Appropriations.

Rep. Earle expressed concern about the 250% poverty level that is set in the bill. Rep. Wright responded. Rep. Clary stated that she had an objection to the 250% poverty level set in the bill. Rep. Wright responded. Rep. Clary followed up with a statement about the shortage of money in the budget. Rep. Sherrill asked Rep. Clary if she would prepare an amendment. Rep. Clary responded. Rep. Wainwright asked about the income level of persons who are at 250% poverty level. Dianna Jessup, Staff, responded that the income level at 250% poverty level is based at $24, 000.

Rep. Clary moved to vote without prejudice and re-refer the bill to appropriations. So moved.

HB-896 DATABASE/CONTROLLED SUBSTANCES.(Rep. Hensley)

Chairman Wright placed HB-896 backed on the agenda. Rep. Hensley stated that a perfecting amendment was ready. Linda Attarian, Staff, explained the perfecting amendment. Rep. Wainwright asked about the penalty fees. Linda Attarian, Staff, responded. Rep. Wainwright followed up with a question about setting a cap on the fees. Chairman Wright responded that this bill would be taken up at the next Health meeting.

The meeting adjourned at 12:50pm.

Rep. Thomas E. Wright, Chairman Vanda Wilson-Wormack, Committee Assistant

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2001

H 1

HOUSE BILL 950

Short Title:	Raise ADAP Income Limit.	(Public)
Sponsors:	Representative Wright.	
Referred to:	Health.	

April 3, 2001

A BILL TO BE ENTITLED

AN ACT TO RAISE THE ELIGIBILITY CAP FOR PARTICIPATION IN THE AIDS DRUG ASSISTANCE PROGRAM TO TWO HUNDRED FIFTY PERCENT OF THE FEDERAL POVERTY LEVEL.

The General Assembly of North Carolina enacts:

SECTION 1. For the 2001-2003 fiscal biennium, HIV-positive individuals with incomes at or below two hundred fifty percent (250%) of the federal poverty level are eligible for participation in the AIDS Drug Assistance Program (ADAP). All individuals who are eligible for participation in ADAP shall be served by the Department of Health and Human Services.

SECTION 2. This act becomes effective July 1, 2001.

HOUSE BILL 950:
Raise ADAP Income Limit

BILL ANALYSIS

Committee:	House Health	**Introduced by:**	Rep. Wright
Date:	April 10, 2001	**Summary by:**	Dianna Jessup
Version:	First Edition		Committee Counsel

SUMMARY: ***House Bill 950 would raise the eligibility income limit for participation in the Aids Drug Assistance Program from 125% of poverty to 250% of poverty and requires the Department of Health and Human Services to serve all those who are eligible for participation. The act becomes effective July 1, 2001.***

CURRENT LAW: The Aids Drug Assistance Program (ADAP) provides assistance to low-income, uninsured, HIV-positive individuals for purchasing medications. Currently, HIV-positive individuals with incomes at or below 125% of the federal poverty level ($10,737 per year) are eligible. The Program is funded using a combination of State and federal funds. Last biennium, a total of $13.3 million of State funds were allocated to the program.

During the last biennium, the Department of Health and Human Services was directed to study the estimated participation rates and costs if eligibility for participation in ADAP were raised to 200% of poverty or to 250% of poverty and report its results by May 15, 2000. The Department in that report projected a cost of $17.8 million to raise the eligibility level to 250% of poverty.

BILL ANALYSIS: If enacted, additional persons, i.e. those persons earning income between 125% and 250% of poverty ($24,475 per year), would be entitled to assistance under the ADAP.

2001 COMMITTEE REPORT
HOUSE OF REPRESENTATIVES

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

☐ Committee Substitute for
H.B. 950 A BILL TO BE ENTITLED AN ACT TO RAISE THE ELIGIBILITY CAP FOR PARTICIPATION IN THE AIDS DRUG ASSISTANCE PROGRAM TO TWO HUNDRED FIFTY PERCENT OF THE FEDERAL POVERTY LEVEL.

☐ 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 and be re-referred to the Committee on Appropriations.

☐ With an indefinite postponement report.

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

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

2/15/01

H 1

HOUSE BILL 958

Short Title:	Cost Reports - Special Care Units.	(Public)
Sponsors:	Representatives Cansler, Insko, and Clary (Primary Sponsors).	
Referred to:	Health.	

April 3, 2001

A BILL TO BE ENTITLED

AN ACT TO REQUIRE COST REPORTS SPECIFIC TO ADULT CARE HOME SPECIAL CARE UNITS AND TO DIRECT THE DEPARTMENT OF HEALTH AND HUMAN SERVICES TO DEVELOP A DESIGNATED REIMBURSEMENT SYSTEM FOR RESIDENTS IN SPECIAL CARE UNITS.

Whereas, the number of individuals diagnosed with Alzheimer's disease or related dementia and mental health disabilities is increasing; and

Whereas, family members must often seek out-of-home care for these individuals in special care units; and

Whereas, separate licensure and operational policies are required for special care units that advertise themselves as such; and

Whereas, current reimbursement systems do not adequately address the total cost of care being provided for persons diagnosed with Alzheimer's disease or related dementia or mental health disabilities in licensed adult care home special care units, and this inadequacy creates a barrier to access for the public assistance population; Now, therefore,

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 131D-4.2 reads as rewritten:

"**§ 131D-4.2. Adult care homes; family care homes; annual cost reports; exemptions; enforcement.**

(a) Except for family care homes, adult care homes with a licensed capacity of seven to twenty beds, which are licensed pursuant to this Chapter, to Chapter 122C of the General Statutes, and to Chapter 131E of the General Statutes, shall submit audited reports of actual costs to the Department at least every two years in accordance with rules adopted by the Department under G.S. 143B-10. For years in which an audited report of actual costs is not required, an annual cost report shall be submitted to the Department in accordance with rules adopted by the Department under G.S. 143B-10. Adult care homes that have special care units shall include in reports required under this

subsection cost reports specific to the special care unit and shall not average special care costs with other costs of the adult care home.

(b) Except for family care homes, adult care homes with a licensed capacity of twenty-one beds or more, which are licensed pursuant to this Chapter, to Chapter 122C of the General Statutes, and to Chapter 131E of the General Statutes, shall submit annual audited reports of actual costs to the Department of Health and Human Services, in accordance with rules adopted by the Department under G.S. 143B-10. Adult care homes that have special care units shall include in the reports required under this subsection cost reports specific to the special care unit and shall not average special care costs with other costs of the adult care home.

(d) Facilities that do not receive State/County Special Assistance or Medicaid personal care are exempt from the reporting requirements of this section.

(e) Except as otherwise provided in this subsection, the annual reporting period for facilities licensed pursuant to this Chapter or Chapter 131E of the General Statutes shall be October 1 through September 30, with the annual report due by the following December 31, unless the Department determines there is good cause for delay. The annual report for combination facilities and free-standing adult care home facilities owned and operated by a hospital shall be due 15 days after the hospital's Medicare cost report is due. The annual report for combination facilities not owned and operated by a hospital shall be due 15 days after the nursing facility's Medicaid cost report is due. The annual reporting period for facilities licensed pursuant to Chapter 122C of the General Statutes shall be July 1 through June 30, with the annual report due by the following December 31, unless the Department determines there is good cause for delay. Under this subsection, good cause is an action that is uncontrollable by the provider. If the Department finds good cause for delay, it may extend the deadline for filing a report for up to an additional 30 days.

(f) The Department shall have the authority to conduct audits and review audits submitted pursuant to subsections (a), (b), and (c) above.

(g) The Department shall suspend admissions to facilities that fail to submit annual reports by December 31, or by the date established by the Department when good cause for delay is found pursuant to G.S. 131D-4.2(e). Suspension of admissions shall remain in effect until reports are submitted or licenses are suspended or revoked under subdivision (2) of this subsection. The Department may take either or both of the following actions to enforce compliance by a facility with this section, or to punish noncompliance:

(1) Seek a court order to enforce compliance;

(2) Suspend or revoke the facility's license, subject to the provisions of Chapter 150B of the General Statutes.

(h) The report documentation shall be used to adjust the adult care home rate annually, an adjustment that is in addition to the annual standard adjustment for inflation as determined by the Office of State Budget, Planning and Management. Rates for family care homes shall be based on market rate data. The Secretary of Health and Human Services shall adopt rules for the rate-setting methodology and audited cost reports in accordance with G.S. 143B-10."

SECTION 2. Based upon the data obtained from cost reports, the Department of Health and Human Services shall develop a designated reimbursement system for residents residing in special care units in adult care homes taking into account the costs determined and funding available from both State/County Special Assistance and Medicaid payments. The Department shall not implement the designated reimbursement system until the General Assembly has reviewed the system pursuant to Section 3 of this act.

SECTION 3. Not later than May 1, 2002, the Department of Health and Human Services shall report to the General Assembly on the development of cost reports and designated reimbursement systems required under this act. The Department shall provide a copy of the report to the House of Representatives and Senate appropriations committees on health and human services and to the Fiscal Research Division of the Legislative Services Office.

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

HOUSE BILL 958:
Cost Reports - Special Care Units

BILL ANALYSIS

Committee:	House Health	**Introduced by:**	Reps. Cansler, Insko, Clary
Date:	April 5, 2001	**Summary by:**	Dianna Jessup
Version:	First Edition		Committee Counsel

SUMMARY: ***House Bill 958 would require an adult care home that has a special care unit to include in its cost reports those costs specific to the special care unit. Based on this data, the Department of Health and Human Services (DHHS) would develop a designated reimbursement system for residents residing in special care units in adult care homes, but would not implement this reimbursement system until after the General Assembly reviews it. Not later than May 1,2001, DHHS would report to the General Assembly on its development of the cost reports and designated reimbursement system. The act would become effective when it becomes law.***

CURRENT LAW: Certain adult care homes must submit cost reports to the Department of Health and Human Services. Adult care homes with a licensed capacity of seven to twenty beds must submit audited reports at least every two years, and in those years in which an audited cost report is not required, an annual cost report must be submitted. Adult care homes with a licensed capacity of twenty-one beds or more must submit audited cost reports annually. The cost reports are used to adjust the adult care home reimbursement rate on an annual basis.

BILL ANALYSIS: Section 1 amends the adult care home cost reporting statute to require both audited and unaudited cost reports for the adult care homes with a licensed capacity of seven to twenty beds and over twenty beds to include the costs specific to any special care unit in the adult care home. Section 2 directs the Department of Health and Human Services to develop a designated reimbursement system for residents residing in special care units, but the Department would not implement this system until it has been reviewed by the General Assembly. Section 3 requires the Department to report to the General Assembly not later than May 1, 2002, on the development of cost reports and designated reimbursement systems required under this act and to submit that report to the House and Senate appropriations committees on health and human services.

BACKGROUND: The term "special care unit" means a wing or hallway within an adult care home, or a program provided by an adult care home, that is designated especially for residents with Alzheimer's disease or other dementias, a mental health disability, or other special needs disease or condition as determined by the Medical Care Commission. Concern has been raised that facilities are not being appropriately reimbursed for the care provided in special care units.

2001 COMMITTEE REPORT
HOUSE OF REPRESENTATIVES

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

☐ Committee Substitute for
H.B. 958 A BILL TO BE ENTITLED AN ACT TO REQUIRE COST REPORTS SPECIFIC TO ADULT CARE HOME SPECIAL CARE UNITS AND TO DIRECT THE DEPARTMENT OF HEALTH AND HUMAN SERVICES TO DEVELOP A DESIGNATED REIMBURSEMENT SYSTEM FOR RESIDENTS IN SPECIAL CARE UNITS.

☒ 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)

2/15/01

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2001

HOUSE BILL 736

Short Title:	Long-Term Care/Post Staffing.	(Public)
Sponsors:	Representatives Earle; Alexander, Barefoot, Bell, Bonner, Luebke, Rogers, Wainwright, Warren, Weiss, and Yongue.	
Referred to:	Health.	

March 22, 2001

A BILL TO BE ENTITLED

AN ACT TO REQUIRE THAT LONG-TERM CARE FACILITIES POST INFORMATION ABOUT STAFFING LEVELS.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 131D-4.3(a) reads as rewritten:

"(a) Pursuant to G.S. 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) Repealed by Session Laws 2000-111, s. 1.

(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;

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. Each facility shall post in a conspicuous place information about staffing that enables residents and their families to ascertain each day the number of direct care staff and supervisors that are on duty for each shift for that day."

SECTION 2. Part A of Article 6 of Chapter 131E of the General Statutes is amended by adding the following new section to read:

"**§ 131E-114.1. Posting of information indicating number of staff on duty.**

Every nursing home subject to licensure under this Part shall post in a conspicuous place in the nursing home information about staffing that enables residents and their families to readily ascertain each day the number of direct care staff and supervisors that are on duty for each shift for that day."

SECTION 3. This act becomes effective October 1, 2001.

HOUSE BILL 736:
Long-Term Care/Post Staffing

BILL ANALYSIS

Committee:	House Health	**Introduced by:**	Rep. Earle
Date:	April 5, 2001	**Summary by:**	Dianna Jessup
Version:	First Edition		Committee Counsel

SUMMARY: ***House Bill 736 would require adult care homes and nursing homes to post staffing information in a conspicuous place so that residents and their families can determine the numbers and level of staff on duty for each shift each day.***

CURRENT LAW: Though current law requires certain levels of staffing for adult care homes and nursing homes, one could not determine how many people are on duty at an adult care home or nursing home without asking someone. No similar posting requirements were discovered in State statutes or rules.

BILL ANALYSIS: Under the bill, adult care homes and nursing homes would be required to post information concerning the number of direct care staff and supervisors that are on duty for each shift for each day. The information must be posted in a conspicuous place.

The act would become effective October 1, 2001.

2001 COMMITTEE REPORT
HOUSE OF REPRESENTATIVES

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

☐ Committee Substitute for
H.B. 736 A BILL TO BE ENTITLED AN ACT TO REQUIRE THAT LONG-TERM CARE FACILITIES POST INFORMATION ABOUT STAFFING LEVELS.

☐ 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)

2/15/01

VISITOR REGISTRATION SHEET

Health — Name of Committee

4/5/01 — Date

VISITORS:. PLEASE SIGN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
W Cherry	Bone & Assoc
Ken Melton	Allen Associates
Bennie Holton	DHHS
Linda McDaniel	DFS
Dan Barnes	DFS
Gary Bryan	DHHS - Controller's office
Lisa Peterby	NCDS
Joanne Schoen Stevens	nc nurses association
Craig Souza	NCHCFA
Jerry Cooper	NCALA
Stacy Flannery	NCHCFA
George Ingwig	Johnson & Johnson
John Wurtle	DMH/DD/SAS
Wendell S. Cloud	Randolph Cloud & Associates
Anna Bridges	Randolph Cloud + Ass.
Clayton Yeates	DHHS
Clyde Hoke	
Roger Bone	Bone & Assoc NCALTCF
Cindy Avant	NCLMA
Ann Edmondson	NCLMA

AGENDA

HOUSE COMMITTEE ON HEALTH
TUESDAY, APRIL 10, 2001
12:00 NOON, ROOM 415 LOB

OPENING REMARKS

Rep. Thomas E. Wright
Chairman

BILLS TO BE DISCUSSED

HB- 275 INFANT HOMICIDE PREVENTION ACT-(Rep. Haire)

HB-452 EMERGENCY MEDICAL SERVICES ACT UPDATE (Rep. Wright)

HB-453 REGULATION OF EMERGENCY MEDICAL SERVICES (Rep. Wright)

COMMENTS

ADJOURNMENT

MINUTES

COMMITTEE ON HEALTH

TUESDAY, APRIL 10, 2001

The House Committee on Health met on Tuesday, April 10, 2001 at 12:00 Noon in Room 415 LOB . A silent roll was taken, (roll list denotes members present).

Vice-Chairman Edwards called the meeting to order.

HB-452 EMERGENCY MEDICAL SERVICES ACT UPDATE. (Rep. Wright)
HB-453 REGULATION OF EMERGENCY MEDICAL SERVICES.(Rep. Wright)

Drexdall Pratt, Chief of the Office of Emergency Medical Services, explained HB-452 and HB-453 to the Committee. Rep. Barnhart asked if all interested parties participated in updating the Act. Drexdall Pratt responded that all interested parties participated in the process. Rep. Allred asked about concerns that the volunteer fire departments and Chiefs. Drexdall Pratt responded. Rep. Allred followed up with a comment about the concerns of the volunteer fire departments. Drexdall Pratt responded. Rep. Allred followed up with a question about the fiscal impact of the bill. Dianna Jessup, Staff, responded that a fiscal note has been requested from Jim Johnson (Fiscal Research Director).

Rep. Buchanan moved for adoption of the proposed committee substitute for HB-452. So moved.

Rep. Sherrill asked if the number of members on the Commission expanded. Rep. Wright responded. Rep. Sherrill asked if the travel of the members come out of the Human Resources Budget. Rep. Wright responded. Rep. Insko asked about line 15 on page 8. Drexdall Pratt responded about the County's responsibility. Rep. Insko followed up with a question about local EMS Services. Drexdall Pratt responded. Rep. Sherrill asked about the new EMS Disciplinary Committee. Drexdall Pratt responded that currently disciplinary action is handled by the State EMS office, the Medical Care Commission and the Medical Board. Rep. Rogers asked about page 3, paragraph 4. Drexdall Pratt responded. Dianna Jessup, Staff, further explained the section. Rep. Howard asked if the bill would cause local governments any additional money. Rep. Wright responded. Rep. Howard asked if the County Commissioner Association signed on to the bill. Rep. Wright responded.

Rep. Buchanan moved for a favorable report to the committee substitute bill, unfavorable to the original bill and reporting of the bill would be delayed for a fiscal note. So moved.

HB-453 REGULATION OF EMERGENCY MEDICAL SERVICES.

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

Rep. Wright explained the bill. Drexdall Pratt further explained the bill. Dianna Jessup, Staff, commented on the bill.

Rep. Wainwright moved for a favorable report for the proposed committee substitute, unfavorable to the original bill. So moved.

Rep. Wright stated that a fiscal note would accompany the report and the bill.

HB-275 INFANT HOMICIDE PREVENTION ACT.

Rep. Haire explained the bill. Tom Bennett, Executive Director of the NC Child Fatality Task Force, urged members to support the bill. Rep. Haire further commented on the bill. Rep. Nye asked if there were changes to the bill that would make it a better bill. Rep. Haire responded. Rep. Allred asked if parents could reclaim the child. Rep. Haire responded. Rep. Edwards asked about the language on page 2, lines C & D. Rep. Haire responded. Rep. Sherrill commented on the bill.

Rep. Sherrill moved for a favorable report of the bill.

Rep. Earle further commented on the bill and urged support of the bill. Rep. Howard asked about the age of the baby. Rep. Haire responded. Tom Bennett responded to Rep. Howard's inquiry. Rep. Rogers asked about how the information would be disseminated. Rep. Edwards commented on amending the bill.

Chairman Wright adjourned the meeting at 12:55pm.

Rep. Thomas Wright,
Chairman

Vanda Wilson-Wormack
Committee Assistant

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2001

H 1

HOUSE BILL 452

Short Title:	Emergency Medical Services Act Update-AB.	(Public)
Sponsors:	Representatives Wright; and Wainwright.	
Referred to:	Health.	

March 1, 2001

A BILL TO BE ENTITLED

AN ACT TO REVISE AND UPDATE THE EMERGENCY MEDICAL SERVICES ACT OF 1973.

The General Assembly of North Carolina enacts:

SECTION 1. Article 56 of Chapter 143 reads as rewritten:

"Article 56.

"Emergency Medical Services Act of 1973.

"**§ 143-507. Establishment of emergency medical services program.**

(a) There is ~~hereby~~ established a comprehensive emergency medical services program in the Department of Health and Human Services. All responsibility for this program shall be vested in the Secretary of the Department of Health and Human Services and other ~~such~~ officers, boards, and commissions specified by law or regulation.

(b) This Article is to enable and assist providers of emergency medical services in the delivery of ~~adequate~~ emergency medical services for all the people of North Carolina and the provision of medical care during a disaster.

(c) Emergency medical services referred to in this Article include all services rendered in responding to improve the health and wellness of the community and to address the individual's need for ~~immediate~~ emergency medical care in order to prevent loss of life or further aggravation of physiological or psychological illness or injury. The Statewide Emergency Medical Services System ~~medical care is further described as~~ also includes first aid by members of the community; public knowledge and easy access into the system; prompt emergency medical dispatch of well designed, equipped, and staffed ambulances; effective care by ~~trained attendants~~ credentialed personnel with appropriate disposition at the scene of the emergency ~~and while in transit~~; communications with the treatment center while at the scene and while in transit; routing and referral to the appropriate treatment facility; ~~immediate~~ definitive care at the emergency treatment facility; injury prevention initiatives; wellness initiatives within

the community and the public health system; and follow-up lifesaving and restorative care.

"§ 143-508. Department of Health and Human Services to establish program; rules and regulations of North Carolina Medical Care Commission.

(a) The State Department of Health and Human Services shall establish and maintain a program for the improvement and upgrading of emergency medical services throughout the State. The Department shall consolidate all State functions relating to emergency medical services, both regulatory and developmental, under the auspices of this program.

(b) The North Carolina Medical Care Commission ~~is authorized and directed to adopt~~ shall adopt, amend, and rescind rules ~~and regulations~~ to carry out the purpose of this Article and ~~Article 26~~ Articles 7 and 7A of Chapter ~~130~~ 131E of the General Statutes ~~of North Carolina~~ regardless of other provisions of rule or law. ~~Such~~ These rules ~~and regulations~~ shall be adopted with the advice of the Emergency Medical Services Advisory Council. The Department of Health and Human Services shall enforce all rules adopted by the Commission.

(c) The North Carolina Medical Care Commission may adopt rules with regard to emergency medical services, not inconsistent with the laws of this State, that may be required by the federal government for grants-in-aid for emergency medical services and licensure which may be made available to the State by the federal government. This section is to be liberally construed in order that the State and its citizens may benefit from such grants-in-aid.

(d) The North Carolina Medical Care Commission shall adopt rules to do all of the following:

(1) Establish standards and criteria for the credentialing of emergency medical services agencies to carry out the purpose of Article 7 of Chapter 131E of the General Statutes of North Carolina.

(2) Establish standards and criteria for the credentialing of trauma centers to carry out the purpose of Article 7A of Chapter 131E of the General Statutes of North Carolina.

(3) Establish standards and criteria for the education and credentialing of emergency medical services personnel to carry out the purpose of Article 7 of Chapter 131E of the General Statutes of North Carolina.

(4) Establish standards and criteria for the credentialing of EMS educational institutions to carry out the purpose of Article 7 of Chapter 131E of the General Statutes of North Carolina.

(5) Establish standards and criteria for data collection as part of the statewide emergency medical services information system to carry out the purpose of G.S. 143-509(5).

(6) Define the scope of practice of credentialed emergency medical services personnel.

(7) Define the practice settings of credentialed emergency medical services personnel.

(8) Establish standards for vehicles and equipment used within the emergency medical services system.

(9) Establish standards for a statewide EMS communications system.

(10) Establish standards and criteria for the denial, suspension, or revocation of emergency medical services credentials for emergency medical services agencies, educational institutions, and personnel including the establishment of fines for credentialing violations.

(11) Establish standards and criteria for the education and credentialing of persons trained to administer lifesaving treatment to a person who suffers a severe adverse reaction to insect stings.

~~All rules and regulations not inconsistent with the provisions of this Article heretofore adopted by the State Board of Health or the Commission for Health Services shall remain in full force and effect until repealed or superseded by action of the North Carolina Medical Care Commission.~~

"§ 143-509. Powers and duties of Secretary.

The Secretary of the Department of Health and Human Services has full responsibilities for supervision and direction of the emergency medical services program and, to that end, ~~shall:~~shall accomplish all of the following:

(1) After consulting with the Emergency Medical Services Advisory Council and with ~~such~~ any local governments ~~as~~ that may be involved, seek the establishment of a statewide, ~~regional and local~~ emergency medical services ~~operations;~~ system, integrated with other health care providers and networks including, but not limited to, public health, community health monitoring activities, and special needs populations.

(2) Repealed by Session Laws 1989, c. 74.

(3) ~~Encourage and assist in the development of appropriately located comprehensive emergency treatment centers;~~ Establish and maintain a comprehensive statewide trauma system in accordance with the provisions of Article 7A of Chapter 131E of the General Statutes of North Carolina and the rules of the North Carolina Medical Care Commission.

(4) ~~Encourage and assist in the development of~~ Establish and maintain a statewide emergency medical services communications system including designation of EMS radio frequencies and coordination of EMS radio communications networks within FCC rules and regulations. ~~which will enable transport vehicles to communicate with treatment facilities;~~

(5) Establish and maintain a ~~State~~ statewide emergency medical services ~~records system;~~ information that provides information linkage between various public safety services and other health care providers.

(6) ~~Inspect ambulances, issue permits for operation of ambulance vehicles, train and license ambulance~~ Credential emergency medical services providers, vehicles, EMS educational institutions, and personnel after documenting that the requirements of the North Carolina Medical Care

Commission are met. ~~and shall be responsible for the enforcement of all other quality control provisions of the Ambulance Act of 1967, Article 26 of Chapter 130 of the General Statutes of North Carolina;~~

~~(7) Designate emergency medical services radio frequencies and coordinate emergency medical services radio communications networks within FCC rules and regulations; and~~

~~(8) Promote the development of an air ambulance support system to supplement ground vehicle operations.~~

(9) Promote a means of training individuals to administer life-saving treatment to persons who suffer a severe adverse reaction to insect stings. Individuals, upon successful completion of this training program, may be approved by the North Carolina Medical ~~Board~~ Care Commission to administer epinephrine to these persons, in the absence of the availability of physicians or other practitioners who are authorized to administer the treatment. This training may also be offered as part of the emergency medical ~~technician~~ services training program.

(10) Establish and maintain a collaborative effort with other community resources and agencies to educate the public regarding EMS systems and issues.

(11) Collaborate with community agencies and other health care providers to integrate the principles of injury prevention into the statewide EMS system to improve community health.

(12) Establish and maintain a means of medical direction and control for the statewide EMS system.

"§ 143-510. North Carolina Emergency Medical Services Advisory Council.

(a) There is ~~hereby~~ created an Emergency Medical Services Advisory Council ~~composed of 21 members~~ to consult with the Secretary of the Department of Health and Human Services in the administration of this Article. ~~The Secretary of the Department of Health and Human Services shall appoint 17 members with at least one member representing each of the following categories:~~

~~(1) Physicians licensed to practice medicine versed in treatment of trauma and suddenly occurring illnesses;~~

~~(2) Emergency room nurses;~~

~~(3) Hospitals;~~

~~(4) Providers of ambulance service (including rescue squads);~~

~~(5) Local government; and~~

~~(6) The general public.~~

~~The President Pro Tempore of the Senate shall appoint two members from the Senate, and the Speaker of the House of Representatives shall appoint two members from the House of Representatives.~~

~~(b) Members appointed by the Secretary of the Department of Health and Human Services shall hold office for a term of four years beginning July 1, 1973, and quadrennially thereafter, except the terms of the members first taking office shall expire,~~

~~as designated at the time of appointment, six at the end of the second year, six at the end of the third year, and five at the end of the fourth year. Members appointed by the President Pro Tempore and the Speaker shall serve for two years coinciding with the term for which they were elected to the General Assembly. Vacancies shall be filled by the office making the initial appointment and for the remainder of the unexpired term only.~~

~~(c) The Council shall meet at least once each quarter and at the call of the Secretary of the Department of Health and Human Services. The Council shall elect its chairman annually.~~

~~(d) Council members who are not members of the General Assembly or State employees or officers shall receive per diem, travel, and subsistence as provided by G.S. 138-5 while engaged in Council business or attending Council meetings. Council members who are members of the General Assembly shall receive travel and subsistence allowances as provided by G.S. 120-3.1. Council members who are State employees or officers shall receive travel and subsistence as provided by G.S. 138-6.~~

The North Carolina Emergency Medical Services Advisory Council shall consist of 21 members appointed by the Secretary of the Department of Health and Human Services to serve four-year terms. Three of the members shall represent the North Carolina Medical Society, and include one licensed pediatrician, surgeon, and public health physician. Three members shall represent the North Carolina College of Emergency Physicians, two of whom shall be current local EMS Medical Directors. Two members shall represent the North Carolina Committee on Trauma. One member each shall represent the North Carolina Association of Rescue and Emergency Medical Services, the North Carolina Association of EMS Administrators, the North Carolina Hospital Association, the North Carolina Nurses Association, and the North Carolina Association of County Commissioners. The remaining eight members shall be appointed so as to fairly represent the general public, credentialed and practicing EMS personnel, EMS educators, local public health officials, and other EMS interest groups in North Carolina.

(b) The initial membership of the Council shall be the current 21 members of the North Carolina Emergency Medical Services Advisory Council. These persons shall serve as members of the Council for a period equal to the remainder of their current terms. Upon the expiration of these terms, the Secretary shall make appointments as hereinabove provided. The two Council members appointed by the General Assembly upon the recommendation of the President Pro Tempore of the Senate and the two Council members appointed by the General Assembly upon the recommendation of the Speaker of the House of Representatives shall not be reappointed at the end of their current terms on the Council.

(c) Any appointment to fill a vacancy on the Council created by the resignation, dismissal, death, or disability of a member shall be for the balance of the unexpired term. Vacancies on the Council among the membership nominated by a society, association, or foundation as provided in subsection (a) of this section shall be filled by appointment of the Secretary upon consideration of a nomination by the Executive Committee or other authorized agent of the society, association, or foundation until the

next meeting of the society, association, or foundation at which time the society, association, or foundation shall nominate a member to fill the vacancy for the unexpired term.

(d) The members of the Council shall receive per diem and necessary travel and subsistence expenses in accordance with the provisions of G.S. 138-5.

(e) A majority of the Council shall constitute a quorum for the transaction of business. All clerical and other services required by the Council shall be supplied by the Department of Health and Human Services, Division of Facility Services, Office of Emergency Medical Services.

"**§ 143-511. Powers and duties of the Council.**

The Emergency Medical Services Advisory Council ~~shall~~ may advise the Secretary of the Department of Health and Human Services on personnel and policy issues regarding the statewide Emergency Medical Services program, including all rules proposed to be adopted by the North Carolina Medical Care Commission.

~~(1) Advise the Secretary of the Department of Health and Human Services on recommendation to the commission or commissions as to designation of multicounty emergency medical services regions;~~

~~(2) Give their advice as to all rules and regulations proposed to be adopted by the commission or commissions; and~~

~~(3) Advise the Secretary on all other matters pertaining to this Article.~~

"**§ 143-512. Regional demonstration plans.**

The Secretary of the Department of Health and Human Services ~~is authorized to~~ may develop and implement, in conjunction with ~~such~~ any local sponsors ~~as~~ that may agree to participate, regional emergency medical services systems in order to demonstrate the desirability of comprehensive regional emergency medical services systems and to determine the optimum characteristics of such plans. The Secretary may make special grants-in-aid to participants.

"**§ 143-513. Regional emergency medical services councils.**

The Secretary of the Department of Health and Human Services may establish emergency medical services regional councils to implement and coordinate emergency medical services programs within regions.

~~"§ 143-514. Training programs; utilization of emergency services personnel.~~

~~The Department of Health and Human Services in cooperation with educational institutions shall develop training programs for emergency medical service personnel. Upon successful completion of such training programs and other programs approved by the North Carolina Medical Board, emergency medical services personnel may, in the course of their emergency medical services duties, perform such acts, tasks and functions as they have been trained to perform and as provided in rules and regulations of such Board, regardless of other provisions of law.~~

"**§ 143-515. Establishment of regions.**

The Secretary is authorized to establish an appropriate number of multicounty emergency medical services regions.

"**§ 143-516. Single State agency.**

The Department of Health and Human Services is hereby designated as the single agency for North Carolina for the purposes of all federal emergency medical services legislation as has or may be hereafter enacted to assist in development of emergency medical services plans and programs.

"**§ 143-517. Ambulance support; free enterprise.**

Each county shall ensure that emergency medical services are provided to its citizens. Nothing in this Article affects the power of local governments to finance ambulance operations or to support rescue squads. Nothing in this Article shall be construed to allow infringement on the private practice of medicine or the lawful operation of health care facilities.

"**§ 143-518. Confidentiality of patient information.**

(a) Medical records compiled and maintained by the Department or EMS providers in connection with dispatch, response, treatment, or transport of individual patients or in connection with the statewide trauma system pursuant to Article 7 of Chapter 131E of the General Statutes may contain identifiable data which will allow linkage to other health care-based data systems for the purposes of quality management, peer review, and public health initiatives.

This data shall be strictly confidential and shall not be released or made public except under any of the following conditions:

(1) Release is made of specific medical or epidemiological information for statistical purposes in a way that no person can be identified.

(2) Release is made of all or part of the medical record with the written consent of the person or persons identified or their guardians.

(3) Release is made to health care personnel providing medical care to the patient.

(4) Release is made pursuant to subpoena or court order. Upon request of the person identified in the record, the record shall be reviewed in camera. In the trial, the trial judge may, during the taking of testimony concerning such information, exclude from the courtroom all persons except the officers of the court, the parties, and those engaged in the trial of the case.

(5) Release is made for the purposes of bona fide research purposes. The North Carolina Medical Care Commission shall adopt rules to establish standards and criteria providing for the use of the information for research purposes.

(b) Charges, accounts, credit histories, and other personal financial records compiled and maintained by the Department or EMS providers in connection with the admission, treatment, and discharge of individual patients are strictly confidential and shall not be released.

"**§§ ~~143-518~~ 143-519 through 143-520:** Reserved for future codification purposes."

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

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2001

H D

HOUSE BILL 452
PROPOSED COMMITTEE SUBSTITUTE H452-CSRM-17 [v.4]

4/10/2001 10:38:19 AM

Short Title: Emergency Medical Services Act Update-AB. (Public)

Sponsors:

Referred to:

March 1, 2001

A BILL TO BE ENTITLED

AN ACT TO REVISE AND UPDATE THE EMERGENCY MEDICAL SERVICES ACT OF 1973.

The General Assembly of North Carolina enacts:

SECTION 1. Article 56 of Chapter 143 reads as rewritten:

"Article 56.

"Emergency Medical Services Act of 1973.

"§ 143-507. Establishment of emergency medical services program.

(a) There is ~~hereby~~ established a comprehensive emergency medical services program in the Department of Health and Human Services. All responsibility for this program shall be vested in the Secretary of the Department of Health and Human Services and other ~~such~~ officers, boards, and commissions specified by law or regulation.

(b) This Article is to enable and assist providers of emergency medical services in the delivery of ~~adequate emergency medical~~ these services for all the people of North Carolina and the provision of medical care during a disaster.

(c) Emergency medical services referred to in this Article include ~~all~~ services rendered by emergency medical services personnel as defined in G.S. 131E-155(7) in responding to improve the health and wellness of the community and to address the individual's need for ~~immediate~~ emergency medical care in order to prevent loss of life or further aggravation of physiological or psychological illness or injury. The Statewide Emergency Medical Services System ~~medical care is further described as~~ also includes first aid by members of the community; public knowledge and easy access into the system; prompt emergency medical dispatch of well designed, equipped, and staffed ambulances; effective care by ~~trained attendants~~ credentialed personnel with appropriate disposition at the scene of the emergency ~~and while in transit~~; communications with the treatment center while at the scene and while in transit; routing and referral to the appropriate treatment facility; ~~immediate definitive care~~ emergency medical services at the emergency treatment facility; injury prevention initiatives; wellness initiatives

within the community and the public health system; and follow-up lifesaving and restorative care.

"§ 143-508. Department of Health and Human Services to establish program; rules and regulations of North Carolina Medical Care Commission.

(a) The State Department of Health and Human Services shall establish and maintain a program for the improvement and upgrading of emergency medical services throughout the State. The Department shall consolidate all State functions relating to emergency medical services, both regulatory and developmental, under the auspices of this program.

(b) The North Carolina Medical Care Commission ~~is authorized and directed to adopt~~ shall adopt, amend, and rescind rules ~~and regulations~~ to carry out the purpose of this Article and ~~Article 26~~ Articles 7 and 7A of Chapter ~~130~~ 131E of the General Statutes ~~of North Carolina~~ regardless of other provisions of rule or law. ~~Such~~ These rules ~~and regulations~~ shall be adopted with the advice of the Emergency Medical Services Advisory Council. The Department of Health and Human Services shall enforce all rules adopted by the Commission. Nothing in this Chapter shall be construed to authorize the North Carolina Medical Care Commission to establish or modify the scope of practice of emergency medical personnel.

(c) The North Carolina Medical Care Commission may adopt rules with regard to emergency medical services, not inconsistent with the laws of this State, that may be required by the federal government for grants-in-aid for emergency medical services and licensure which may be made available to the State by the federal government. This section is to be liberally construed in order that the State and its citizens may benefit from such grants-in-aid.

(d) The North Carolina Medical Care Commission shall adopt rules to do all of the following:

(1) Establish standards and criteria for the credentialing of emergency medical services agencies to carry out the purpose of Article 7 of Chapter 131E of the General Statutes of North Carolina.

(2) Establish standards and criteria for the credentialing of trauma centers to carry out the purpose of Article 7A of Chapter 131E of the General Statutes of North Carolina.

(3) Establish standards and criteria for the education and credentialing of emergency medical services personnel to carry out the purpose of Article 7 of Chapter 131E of the General Statutes of North Carolina.

(4) Establish standards and criteria for the credentialing of EMS educational institutions to carry out the purpose of Article 7 of Chapter 131E of the General Statutes of North Carolina.

(5) Establish standards and criteria for data collection as part of the statewide emergency medical services information system to carry out the purpose of G.S. 143-509(5).

(6) Implement the scope of practice of credentialed emergency medical services personnel as determined by the North Carolina Medical Board.

(7) Define the practice settings of credentialed emergency medical services personnel.

(8) Establish standards for vehicles and equipment used within the emergency medical services system.

(9) Establish standards for a statewide EMS communications system.

(10) Establish standards and criteria for the denial, suspension, or revocation of emergency medical services credentials for emergency medical services agencies, educational institutions, and personnel including the establishment of fines for credentialing violations.

(11) Establish standards and criteria for the education and credentialing of persons trained to administer lifesaving treatment to a person who suffers a severe adverse reaction to insect stings.

(12) Establish standards for the voluntary submission of hospital emergency medical care data consistent with Article 11A of Chapter 131E of the General Statutes.

~~All rules and regulations not inconsistent with the provisions of this Article heretofore adopted by the State Board of Health or the Commission for Health Services shall remain in full force and effect until repealed or superseded by action of the North Carolina Medical Care Commission.~~

"§ 143-509. Powers and duties of Secretary.

The Secretary of the Department of Health and Human Services has full responsibilities for supervision and direction of the emergency medical services program and, to that end, ~~shall:~~shall accomplish all of the following:

(1) After consulting with the Emergency Medical Services Advisory Council and with ~~such~~ any local governments ~~as~~ that may be involved, seek the establishment of a statewide, ~~regional and local~~ emergency medical services ~~operations;~~ system, integrated with other health care providers and networks including, but not limited to, public health, community health monitoring activities, and special needs populations.

(2) Repealed by Session Laws 1989, c. 74.

(3) ~~Encourage and assist in the development of appropriately located comprehensive emergency treatment centers;~~ Establish and maintain a comprehensive statewide trauma system in accordance with the provisions of Article 7A of Chapter 131E of the General Statutes of North Carolina and the rules of the North Carolina Medical Care Commission.

(4) ~~Encourage and assist in the development of~~ Establish and maintain a statewide emergency medical services communications system including designation of EMS radio frequencies and coordination of EMS radio communications networks within FCC rules and

regulations. ~~which will enable transport vehicles to communicate with treatment facilities;~~

(5) Establish and maintain a ~~State~~ statewide emergency medical services ~~records system;~~ information that provides information linkage between various public safety services and other health care providers.

(6) ~~Inspect ambulances, issue permits for operation of ambulance vehicles, train and license ambulance~~ Credential emergency medical services providers, vehicles, EMS educational institutions, and personnel after documenting that the requirements of the North Carolina Medical Care Commission are met. ~~and shall be responsible for the enforcement of all other quality control provisions of the Ambulance Act of 1967, Article 26 of Chapter 130 of the General Statutes of North Carolina;~~

~~(7) Designate emergency medical services radio frequencies and coordinate emergency medical services radio communications networks within FCC rules and regulations; and~~

~~(8) Promote the development of an air ambulance support system to supplement ground vehicle operations.~~

(9) Promote a means of training individuals to administer life-saving treatment to persons who suffer a severe adverse reaction to insect stings. Individuals, upon successful completion of this training program, may be approved by the North Carolina Medical ~~Board~~ Care Commission to administer epinephrine to these persons, in the absence of the availability of physicians or other practitioners who are authorized to administer the treatment. This training may also be offered as part of the emergency medical ~~technician~~ services training program.

(10) Establish and maintain a collaborative effort with other community resources and agencies to educate the public regarding EMS systems and issues.

(11) Collaborate with community agencies and other health care providers to integrate the principles of injury prevention into the statewide EMS system to improve community health.

(12) Establish and maintain a means of medical direction and control for the statewide EMS system.

"§ 143-510. North Carolina Emergency Medical Services Advisory Council.

(a) There is ~~hereby~~ created an Emergency Medical Services Advisory Council ~~composed of 21 members~~ to consult with the Secretary of the Department of Health and Human Services in the administration of this Article. ~~The Secretary of the Department of Health and Human Services shall appoint 17 members with at least one member representing each of the following categories:~~

~~(1) Physicians licensed to practice medicine versed in treatment of trauma and suddenly occurring illnesses,~~

~~(2) Emergency room nurses,~~

~~(3) Hospitals,~~
~~(4) Providers of ambulance service (including rescue squads),~~
~~(5) Local government, and~~
~~(6) The general public.~~

~~The President Pro Tempore of the Senate shall appoint two members from the Senate, and the Speaker of the House of Representatives shall appoint two members from the House of Representatives.~~

~~(b) Members appointed by the Secretary of the Department of Health and Human Services shall hold office for a term of four years beginning July 1, 1973, and quadrennially thereafter, except the terms of the members first taking office shall expire, as designated at the time of appointment, six at the end of the second year, six at the end of the third year, and five at the end of the fourth year. Members appointed by the President Pro Tempore and the Speaker shall serve for two years coinciding with the term for which they were elected to the General Assembly. Vacancies shall be filled by the office making the initial appointment and for the remainder of the unexpired term only.~~

~~(c) The Council shall meet at least once each quarter and at the call of the Secretary of the Department of Health and Human Services. The Council shall elect its chairman annually.~~

~~(d) Council members who are not members of the General Assembly or State employees or officers shall receive per diem, travel, and subsistence as provided by G.S. 138-5 while engaged in Council business or attending Council meetings. Council members who are members of the General Assembly shall receive travel and subsistence allowances as provided by G.S. 120-3.1. Council members who are State employees or officers shall receive travel and subsistence as provided by G.S. 138-6.~~

The North Carolina Emergency Medical Services Advisory Council shall consist of 25 members.

(1) Twenty-one of the members shall be appointed by the Secretary of the Department of Health and Human Services as follows:

a. Three (3) of the members shall represent the North Carolina Medical Society, and include one licensed pediatrician, surgeon, and public health physician.

b. Three (3) members shall represent the North Carolina College of Emergency Physicians, two of whom shall be current local EMS Medical Directors.

c. One (1) member shall represent the North Carolina Chapter of the American College of Surgeons Committee on Trauma.

d. One (1) member shall represent the North Carolina Association of Rescue and Emergency Medical Services.

e. One (1) member shall represent the North Carolina Association of EMS Administrators.

f. One (1) member shall represent the North Carolina Hospital Association.

g. One (1) member shall represent the North Carolina Nurses Association.
h. One (1) member shall represent the North Carolina Association of County Commissioners.
i. One (1) member shall represent the North Carolina Medical Board.
j. One (1) member shall represent the American Heart Association, North Carolina Council.
k. One (1) member shall represent the American Red Cross.
l. The remaining six (6) members shall be appointed so as to fairly represent the general public, credentialed and practicing EMS personnel, EMS educators, local public health officials, and other EMS interest groups in North Carolina.

(2) Two members shall be appointed by the General Assembly upon the recommendation of the Speaker of the House of Representatives .

(3) Two members shall be appointed by the General Assembly upon the recommendation of the President Pro Tempore of the Senate.

The membership of the Council shall, to the extent possible, reflect the gender and racial makeup of the population of the State.

(b) Five of the members appointed by the Secretary of the Department of Health and Human Services pursuant to subsection (a) of this section shall serve initial terms of one year. Five of the members appointed by the Secretary of the Department of Health and Human Services pursuant to subsection (a) of this section shall serve initial terms of two years. Five of the members appointed by the Secretary of the Department of Health and Human Services pursuant to subsection (a) of this section shall serve initial terms of three years. Six of the members appointed by the Secretary of the Department of Health and Human Services pursuant to subsection (a) of this section shall serve initial terms of four years. One of the Council members appointed by the General Assembly upon the recommendation of the President Pro Tempore of the Senate and one of the Council members appointed by the General Assembly upon the recommendation of the Speaker of the House of Representatives shall serve initial terms of two years. One of the Council 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 serve initial terms of four years. Thereafter all terms shall be four years.

(c) Any appointment to fill a vacancy on the Council created by the resignation, dismissal, death, or disability of a member shall be for the balance of the unexpired term. Vacancies on the Council among the membership nominated by a society, association, or foundation as provided in subsection (a) of this section shall be filled by appointment of the Secretary upon consideration of a nomination by the Executive Committee or other authorized agent of the society, association, or foundation until the next meeting of the society, association, or foundation at which time the society,

association, or foundation shall nominate a member to fill the vacancy for the unexpired term.

(d) The members of the Council shall receive per diem and necessary travel and subsistence expenses in accordance with the provisions of G.S. 138-5.

(e) A majority of the Council shall constitute a quorum for the transaction of business. All clerical and other services required by the Council shall be supplied by the Department of Health and Human Services, Division of Facility Services, Office of Emergency Medical Services.

"§ 143-511. Powers and duties of the Council.

The Emergency Medical Services Advisory Council ~~shall~~ may advise the Secretary of the Department of Health and Human Services on personnel and policy issues regarding the statewide Emergency Medical Services program, including all rules proposed to be adopted by the North Carolina Medical Care Commission.

~~(1) Advise the Secretary of the Department of Health and Human Services on recommendation to the commission or commissions as to designation of multicounty emergency medical services regions,~~

~~(2) Give their advice as to all rules and regulations proposed to be adopted by the commission or commissions, and~~

~~(3) Advise the Secretary on all other matters pertaining to this Article.~~

"§ 143-512. Regional demonstration plans.

The Secretary of the Department of Health and Human Services ~~is authorized to~~ may develop and implement, in conjunction with ~~such~~ any local sponsors ~~as~~ that may agree to participate, regional emergency medical services systems in order to demonstrate the desirability of comprehensive regional emergency medical services systems and to determine the optimum characteristics of such plans. The Secretary may make special grants-in-aid to participants.

"§ 143-513. Regional emergency medical services councils.

The Secretary of the Department of Health and Human Services may establish emergency medical services regional councils to implement and coordinate emergency medical services programs within regions.

~~"§ 143-514. Training programs; utilization of emergency services personnel.~~Scope of practice for credentialed emergency medical services personnel.

~~The Department of Health and Human Services in cooperation with educational institutions shall develop training programs for emergency medical service personnel. Upon successful completion of such training programs and other programs approved by the North Carolina Medical Board, emergency medical services personnel may, in the course of their emergency medical services duties, perform such acts, tasks and functions as they have been trained to perform and as provided in rules and regulations of such Board, regardless of other provisions of law.~~

The North Carolina Medical Board shall determine the scope of practice for credentialed emergency medical services personnel regardless of other provisions of law by establishing the medical skills and medications that may be used by credentialed emergency medical services personnel at each level of patient care. No provision of Article 56 of Chapter 143 or Article 7

of Chapter 131E shall be interpreted to require the North Carolina Medical Board to include any service within the scope of practice of any Emergency Medical Service provider, unless the North Carolina Medical Board determines that the emergency medical service personnel in question have the experience and training necessary to ensure the service can be provided in a safe manner."

"§ 143-515. Establishment of regions.

The Secretary ~~is authorized to~~ may establish an appropriate number of multicounty emergency medical services regions.

"§ 143-516. Single State agency.

The Department of Health and Human Services is hereby designated as the single agency for North Carolina for the purposes of all federal emergency medical services legislation as has or may be hereafter enacted to assist in development of emergency medical services plans and programs.

"§ 143-517. Ambulance support; free enterprise.

Each county shall ensure that emergency medical services are provided to its citizens. Nothing in this Article affects the power of local governments to finance ambulance operations or to support rescue squads. Nothing in this Article shall be construed to allow infringement on the private practice of medicine or the lawful operation of health care facilities.

"§ 143-518. Confidentiality of patient information.

(a) Medical records compiled and maintained by the Department or EMS providers in connection with dispatch, response, treatment, or transport of individual patients or in connection with the statewide trauma system pursuant to Article 7 of Chapter 131E of the General Statutes may contain identifiable data which will allow linkage to other health care-based data systems for the purposes of quality management, peer review, and public health initiatives.

These medical records and data shall be strictly confidential and shall not be considered public records within the meaning of G.S. 132-1, and shall not be released or made public except under any of the following conditions:

(1) Release is made of specific medical or epidemiological information for statistical purposes in a way that no person can be identified.

(2) Release is made of all or part of the medical record with the written consent of the person or persons identified or their guardians.

(3) Release is made to health care personnel providing medical care to the patient.

(4) Release is made pursuant to subpoena or court order. Upon request of the person identified in the record, the record shall be reviewed in camera. In the trial, the trial judge may, during the taking of testimony concerning such information, exclude from the courtroom all persons except the officers of the court, the parties, and those engaged in the trial of the case.

(5) Release is made to a Medical Review Committee as defined in G.S. 131E –95 or in G.S. 90-21.11(d).

(6) Release is made for use in a health research project under rules adopted by the North Carolina Medical Care Commission. The Commission shall adopt rules that allow release of information when an institutional review board, as defined by the Commission, has determined:

(i) Is of sufficient scientific importance to outweigh the intrusion into the privacy of the patient that would result from the disclosure;

(ii) Is impracticable without the use or disclosure of identifying health information;

(iii) Contains safeguards to protect the information from redisclosure;

(iv) Contains safeguards against identifying, directly or indirectly, any patient in any report of the research project; and

(v) Contains procedures to remove or destroy at the earliest opportunity, consistent with the purposes of the project, information that would enable the patient to be identified, unless an institutional review board authorizes retention of identifying information for purposes of another research project.

(7) Release is made to a Statewide Data Processor, as defined in Article 11A of G.S. 131E, in which case the data is deemed to have been submitted pursuant to that Article.

Disclosure for a purpose listed in this paragraph may not be used for the purpose of marketing or sales.

(b) Charges, accounts, credit histories, and other personal financial records compiled and maintained by the Department or EMS providers in connection with the admission, treatment, and discharge of individual patients are strictly confidential and shall not be released.

"**§ 143-519. Emergency Medical Services Disciplinary Committee.**

(a) There is created an Emergency Medical Services Disciplinary Committee which shall review and made recommendations to the Department regarding all disciplinary matters relating to credentialing of emergency medical services personnel.

(b) The Emergency Medical Services Disciplinary Committee shall consist of five members appointed by the Secretary of the Department of Health and Human Services to serve four year terms. Two of the members shall be currently practicing local EMS physician medical directors. One member each shall be a current physician member of the North Carolina Medical Board, a current EMS administrator, and a currently practicing and credentialed emergency medical technician-paramedic.

(c) In order to stagger the terms of the membership of the Committee, the initial appointment for one of the local EMS physician medical directors and the currently practicing and credentialed emergency medical technician-paramedic shall be for a

three- year term. The other three initial appointments and all future appointments shall be for four-year terms.

(d) Any appointment to fill a vacancy on the Committee created by a resignation, dismissal, death, or disability of a member shall be for the balance of the unexpired term.

(e) A majority of the Committee shall constitute a quorum for the transaction of business. The Department of Health and Human Services, Division of Facilities Services, Office of Emergency Medial Services shall supply all clerical and other services required by the Committee."

"~~§§ 143-518 143-519 through~~§ 143-520: Reserved for future codification purposes."

"**SECTION 2.** In addition to the temporary rulemaking authority contained in G.S. 150B-21-1, the Secretary of the Department of Health and Human Services may adopt temporary rules to implement Articles 7 and 7A of Chapter 131E and Article 56 of Chapter 143 of the General Statutes. The Secretary's authority to adopt temporary rules pursuant to this section shall expire on the date that permanent rules adopted by the Medical Care Commission to implement Articles 7 and 7A of Chapter 131E and Article 56 of Chapter 143 of the General Statutes as enacted by this act become effective.

SECTION 3. This act becomes effective January 1, 2002."

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2001

H D

HOUSE BILL 452
PROPOSED COMMITTEE SUBSTITUTE H452-PCS6237-RM-17

Short Title: Emergency Medical Services Act Update-AB. (Public)

Sponsors:

Referred to:

March 1, 2001

A BILL TO BE ENTITLED

AN ACT TO REVISE AND UPDATE THE EMERGENCY MEDICAL SERVICES ACT OF 1973.

The General Assembly of North Carolina enacts:

SECTION 1. Article 56 of Chapter 143 reads as rewritten:

"Article 56.

"Emergency Medical Services Act of 1973.

"**§ 143-507. Establishment of emergency medical services program.**

(a) There is ~~hereby~~ established a comprehensive emergency medical services program in the Department of Health and Human Services. All responsibility for this program shall be vested in the Secretary of the Department of Health and Human Services and other ~~such~~ officers, boards, and commissions specified by law or regulation.

(b) This Article is to enable and assist providers of emergency medical services in the delivery of ~~adequate emergency medical~~ these services for all the people of North Carolina and the provision of medical care during a disaster.

(c) Emergency medical services referred to in this Article include ~~all~~ services rendered by emergency medical services personnel as defined in G.S. 131E-155(7) in responding to improve the health and wellness of the community and to address the individual's need for ~~immediate~~emergency medical care in order to prevent loss of life or further aggravation of physiological or psychological illness or injury. The Statewide Emergency Medical Services System ~~medical care is further described as~~ also includes first aid by members of the community; public knowledge and easy access into the system; prompt emergency medical dispatch of well designed, equipped, and staffed ambulances; effective care by ~~trained attendants~~ credentialed personnel with appropriate disposition at the scene of the emergency ~~and while in transit~~; communications with the treatment center while at the scene and while in transit; routing and referral to the appropriate treatment facility; ~~immediate definitive care~~ emergency medical services at the emergency treatment facility; injury prevention initiatives; wellness initiatives

within the community and the public health system; and follow-up lifesaving and restorative care.

"**§ 143-508. Department of Health and Human Services to establish program; rules and regulations of North Carolina Medical Care Commission.**

(a) The State Department of Health and Human Services shall establish and maintain a program for the improvement and upgrading of emergency medical services throughout the State. The Department shall consolidate all State functions relating to emergency medical services, both regulatory and developmental, under the auspices of this program.

(b) The North Carolina Medical Care Commission ~~is authorized and directed to adopt~~shall adopt, amend, and rescind rules ~~and regulations~~ to carry out the purpose of this Article and ~~Article 26~~ Articles 7 and 7A of Chapter ~~130~~131E of the General Statutes ~~of North Carolina~~ regardless of other provisions of rule or law. ~~Such~~ These rules ~~and regulations~~ shall be adopted with the advice of the Emergency Medical Services Advisory Council. The Department of Health and Human Services shall enforce all rules adopted by the Commission. Nothing in this Chapter shall be construed to authorize the North Carolina Medical Care Commission to establish or modify the scope of practice of emergency medical personnel.

(c) The North Carolina Medical Care Commission may adopt rules with regard to emergency medical services, not inconsistent with the laws of this State, that may be required by the federal government for grants-in-aid for emergency medical services and licensure which may be made available to the State by the federal government. This section is to be liberally construed in order that the State and its citizens may benefit from such grants-in-aid.

(d) The North Carolina Medical Care Commission shall adopt rules to do all of the following:

(1) Establish standards and criteria for the credentialing of emergency medical services agencies to carry out the purpose of Article 7 of Chapter 131E of the General Statutes.

(2) Establish standards and criteria for the credentialing of trauma centers to carry out the purpose of Article 7A of Chapter 131E of the General Statutes.

(3) Establish standards and criteria for the education and credentialing of emergency medical services personnel to carry out the purpose of Article 7 of Chapter 131E of the General Statutes.

(4) Establish standards and criteria for the credentialing of EMS educational institutions to carry out the purpose of Article 7 of Chapter 131E of the General Statutes.

(5) Establish standards and criteria for data collection as part of the statewide emergency medical services information system to carry out the purpose of G.S. 143-509(5).

(6) Implement the scope of practice of credentialed emergency medical services personnel as determined by the North Carolina Medical Board.

(7) Define the practice settings of credentialed emergency medical services personnel.

(8) Establish standards for vehicles and equipment used within the emergency medical services system.

(9) Establish standards for a statewide EMS communications system.

(10) Establish standards and criteria for the denial, suspension, or revocation of emergency medical services credentials for emergency medical services agencies, educational institutions, and personnel including the establishment of fines for credentialing violations.

(11) Establish standards and criteria for the education and credentialing of persons trained to administer lifesaving treatment to a person who suffers a severe adverse reaction to insect stings.

(12) Establish standards for the voluntary submission of hospital emergency medical care data consistent with Article 11A of Chapter 131E of the General Statutes.

~~All rules and regulations not inconsistent with the provisions of this Article heretofore adopted by the State Board of Health or the Commission for Health Services shall remain in full force and effect until repealed or superseded by action of the North Carolina Medical Care Commission.~~

"§ 143-509. Powers and duties of Secretary.

The Secretary of the Department of Health and Human Services has full responsibilities for supervision and direction of the emergency medical services program and, to that end, ~~shall:~~shall accomplish all of the following:

(1) After consulting with the Emergency Medical Services Advisory Council and with ~~such~~ any local governments ~~as~~ that may be involved, seek the establishment of a statewide, ~~regional and local~~ emergency medical services ~~operations;~~ system, integrated with other health care providers and networks including, but not limited to, public health, community health monitoring activities, and special needs populations.

(2) Repealed by Session Laws 1989, c. 74.

(3) ~~Encourage and assist in the development of appropriately located comprehensive emergency treatment centers;~~Establish and maintain a comprehensive statewide trauma system in accordance with the provisions of Article 7A of Chapter 131E of the General Statutes and the rules of the North Carolina Medical Care Commission.

(4) ~~Encourage and assist in the development of~~ Establish and maintain a statewide emergency medical services communications system including designation of EMS radio frequencies and coordination of EMS radio communications networks within FCC rules and

regulations. ~~which will enable transport vehicles to communicate with treatment facilities;~~

(5) Establish and maintain a ~~State~~ statewide emergency medical services ~~records system;~~information system that provides information linkage between various public safety services and other health care providers.

(6) ~~Inspect ambulances, issue permits for operation of ambulance vehicles, train and license ambulance~~ Credential emergency medical services providers, vehicles, EMS educational institutions, and personnel after documenting that the requirements of the North Carolina Medical Care Commission are met. ~~and shall be responsible for the enforcement of all other quality control provisions of the Ambulance Act of 1967, Article 26 of Chapter 130 of the General Statutes of North Carolina;~~

~~(7) Designate emergency medical services radio frequencies and coordinate emergency medical services radio communications networks within FCC rules and regulations; and~~

~~(8) Promote the development of an air ambulance support system to supplement ground vehicle operations.~~

(9) Promote a means of training individuals to administer life-saving treatment to persons who suffer a severe adverse reaction to insect stings. Individuals, upon successful completion of this training program, may be approved by the North Carolina Medical ~~Board~~ Care Commission to administer epinephrine to these persons, in the absence of the availability of physicians or other practitioners who are authorized to administer the treatment. This training may also be offered as part of the emergency medical ~~technician~~ services training program.

(10) Establish and maintain a collaborative effort with other community resources and agencies to educate the public regarding EMS systems and issues.

(11) Collaborate with community agencies and other health care providers to integrate the principles of injury prevention into the statewide EMS system to improve community health.

(12) Establish and maintain a means of medical direction and control for the statewide EMS system.

"**§ 143-510. North Carolina Emergency Medical Services Advisory Council.**

(a) There is ~~hereby~~ created ~~an~~ the North Carolina Emergency Medical Services Advisory Council ~~composed of 21 members~~ to consult with the Secretary of the Department of Health and Human Services in the administration of this Article. ~~The Secretary of the Department of Health and Human Services shall appoint 17 members with at least one member representing each of the following categories:~~

~~(1) Physicians licensed to practice medicine versed in treatment of trauma and suddenly occurring illnesses,~~

~~(2) Emergency room nurses,~~

~~(3) Hospitals,~~
~~(4) Providers of ambulance service (including rescue squads),~~
~~(5) Local government, and~~
~~(6) The general public.~~

~~The President Pro Tempore of the Senate shall appoint two members from the Senate, and the Speaker of the House of Representatives shall appoint two members from the House of Representatives.~~

~~(b) Members appointed by the Secretary of the Department of Health and Human Services shall hold office for a term of four years beginning July 1, 1973, and quadrennially thereafter, except the terms of the members first taking office shall expire, as designated at the time of appointment, six at the end of the second year, six at the end of the third year, and five at the end of the fourth year. Members appointed by the President Pro Tempore and the Speaker shall serve for two years coinciding with the term for which they were elected to the General Assembly. Vacancies shall be filled by the office making the initial appointment and for the remainder of the unexpired term only.~~

~~(c) The Council shall meet at least once each quarter and at the call of the Secretary of the Department of Health and Human Services. The Council shall elect its chairman annually.~~

~~(d) Council members who are not members of the General Assembly or State employees or officers shall receive per diem, travel, and subsistence as provided by G.S. 138-5 while engaged in Council business or attending Council meetings. Council members who are members of the General Assembly shall receive travel and subsistence allowances as provided by G.S. 120-3.1. Council members who are State employees or officers shall receive travel and subsistence as provided by G.S. 138-6.~~

The North Carolina Emergency Medical Services Advisory Council shall consist of 25 members.

(1) Twenty-one of the members shall be appointed by the Secretary of the Department of Health and Human Services as follows:

a. Three of the members shall represent the North Carolina Medical Society, and include one licensed pediatrician, surgeon, and public health physician.

b. Three members shall represent the North Carolina College of Emergency Physicians, two of whom shall be current local EMS Medical Directors.

c. One member shall represent the North Carolina Chapter of the American College of Surgeons Committee on Trauma.

d. One member shall represent the North Carolina Association of Rescue and Emergency Medical Services.

e. One member shall represent the North Carolina Association of EMS Administrators.

f. One member shall represent the North Carolina Hospital Association.

g. One member shall represent the North Carolina Nurses Association.
h. One member shall represent the North Carolina Association of County Commissioners.
i. One member shall represent the North Carolina Medical Board.
j. One member shall represent the American Heart Association, North Carolina Council.
k. One member shall represent the American Red Cross.
l. The remaining six members shall be appointed so as to fairly represent the general public, credentialed and practicing EMS personnel, EMS educators, local public health officials, and other EMS interest groups in North Carolina.

(2) Two members shall be appointed by the General Assembly upon the recommendation of the Speaker of the House of Representatives.

(3) Two members shall be appointed by the General Assembly upon the recommendation of the President Pro Tempore of the Senate.

The membership of the Council shall, to the extent possible, reflect the gender and racial makeup of the population of the State.

(b) The members of the council appointed pursuant to subsection (a) of this section shall serve initial terms as follows:

(1) The members appointed by the Secretary of the Department of Health and Human Services shall serve initial terms as follows:
a. Five members shall serve initial terms of one year;
b. Five members shall serve initial terms of two years;
c. Five members shall serve initial terms of three years; and
d. Six members shall serve initial terms of four years.

(2) The members appointed by the General Assembly upon the recommendation of the President Pro Tempore of the Senate shall serve initial terms as follows:
a. One member shall serve an initial term of two years; and
b. One member shall serve an initial term of four years.

(3) The members appointed by the General Assembly upon the recommendation of the Speaker of the House of the Representatives shall serve initial terms as follows:
a. One member shall serve an initial term of two years; and
b. One member shall serve an initial term of four years.

Thereafter, all terms shall be four years.

(c) Any appointment to fill a vacancy on the Council created by the resignation, dismissal, death, or disability of a member shall be for the balance of the unexpired term. Vacancies on the Council among the membership nominated by a society, association, or foundation as provided in subsection (a) of this section shall be filled by appointment of the Secretary upon consideration of a nomination by the Executive Committee or other authorized agent of the society, association, or foundation until the

next meeting of the society, association, or foundation at which time the society, association, or foundation shall nominate a member to fill the vacancy for the unexpired term.

(d) The members of the Council shall receive per diem and necessary travel and subsistence expenses in accordance with the provisions of G.S. 138-5.

(e) A majority of the Council shall constitute a quorum for the transaction of business. All clerical and other services required by the Council shall be supplied by the Department of Health and Human Services, Division of Facility Services, Office of Emergency Medical Services.

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The North Carolina Emergency Medical Services Advisory Council ~~shall~~may advise the Secretary of the Department of Health and Human Services on personnel and policy issues regarding the statewide Emergency Medical Services program, including all rules proposed to be adopted by the North Carolina Medical Care Commission.

~~(1) Advise the Secretary of the Department of Health and Human Services on recommendation to the commission or commissions as to designation of multicounty emergency medical services regions,~~

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"**§ 143-512. Regional demonstration plans.**

The Secretary of the Department of Health and Human Services ~~is authorized to~~ may develop and implement, in conjunction with ~~such~~ any local sponsors ~~as~~ that may agree to participate, regional emergency medical services systems in order to demonstrate the desirability of comprehensive regional emergency medical services systems and to determine the optimum characteristics of such plans. The Secretary may make special grants-in-aid to participants.

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The Secretary of the Department of Health and Human Services may establish emergency medical services regional councils to implement and coordinate emergency medical services programs within regions.

"**§ 143-514. ~~Training programs; utilization of emergency services personnel.~~Scope of practice for credentialed emergency medical services personnel.**

~~The Department of Health and Human Services in cooperation with educational institutions shall develop training programs for emergency medical service personnel. Upon successful completion of such training programs and other programs approved by the North Carolina Medical Board, emergency medical services personnel may, in the course of their emergency medical services duties, perform such acts, tasks and functions as they have been trained to perform and as provided in rules and regulations of such Board, regardless of other provisions of law.~~

The North Carolina Medical Board shall determine the scope of practice for credentialed emergency medical services personnel regardless of other provisions of law by establishing the medical skills and medications that may be used by credentialed

emergency medical services personnel at each level of patient care. No provision of Article 56 of Chapter 143 or Article 7 of Chapter 131E of the General Statutes shall be interpreted to require the North Carolina Medical Board to include any service within the scope of practice of any Emergency Medical Services provider, unless the North Carolina Medical Board determines that the emergency medical service personnel in question have the experience and training necessary to ensure the service can be provided in a safe manner.

"§ 143-515. Establishment of regions.

The Secretary ~~is authorized to~~ may establish an appropriate number of multicounty emergency medical services regions.

"§ 143-516. Single State agency.

The Department of Health and Human Services is hereby designated as the single agency for North Carolina for the purposes of all federal emergency medical services legislation as has or may be hereafter enacted to assist in development of emergency medical services plans and programs.

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Each county shall ensure that emergency medical services are provided to its citizens. Nothing in this Article affects the power of local governments to finance ambulance operations or to support rescue squads. Nothing in this Article shall be construed to allow infringement on the private practice of medicine or the lawful operation of health care facilities.

"§ 143-518. Confidentiality of patient information.

(a) Medical records compiled and maintained by the Department or EMS providers in connection with dispatch, response, treatment, or transport of individual patients or in connection with the statewide trauma system pursuant to Article 7 of Chapter 131E of the General Statutes may contain identifiable data which will allow linkage to other health care-based data systems for the purposes of quality management, peer review, and public health initiatives.

These medical records and data shall be strictly confidential and shall not be considered public records within the meaning of G.S. 132-1 and shall not be released or made public except under any of the following conditions:

(1) Release is made of specific medical or epidemiological information for statistical purposes in a way that no person can be identified.

(2) Release is made of all or part of the medical record with the written consent of the person or persons identified or their guardians.

(3) Release is made to health care personnel providing medical care to the patient.

(4) Release is made pursuant to subpoena or court order. Upon request of the person identified in the record, the record shall be reviewed in camera. In the trial, the trial judge may, during the taking of testimony concerning such information, exclude from the courtroom all persons except the officers of the court, the parties, and those engaged in the trial of the case.

(5) Release is made to a Medical Review Committee as defined in G.S. 131E-95 or in G.S. 90-21.22A.

(6) Release is made for use in a health research project under rules adopted by the North Carolina Medical Care Commission. The Commission shall adopt rules that allow release of information when an institutional review board, as defined by the Commission, has determined:

a. Is of sufficient scientific importance to outweigh the intrusion into the privacy of the patient that would result from the disclosure;

b. Is impracticable without the use or disclosure of identifying health information;

c. Contains safeguards to protect the information from redisclosure;

d. Contains safeguards against identifying, directly or indirectly, any patient in any report of the research project; and

e. Contains procedures to remove or destroy at the earliest opportunity, consistent with the purposes of the project, information that would enable the patient to be identified, unless an institutional review board authorizes retention of identifying information for purposes of another research project.

(7) Release is made to a statewide data processor, as defined in Article 11A of G.S. 131E of the General Statutes, in which case the data is deemed to have been submitted pursuant to that Article.

Disclosure for a purpose listed in this subsection may not be used for the purpose of marketing or sales.

(b) Charges, accounts, credit histories, and other personal financial records compiled and maintained by the Department or EMS providers in connection with the admission, treatment, and discharge of individual patients are strictly confidential and shall not be released.

"**§ 143-519. Emergency Medical Services Disciplinary Committee.**

(a) There is created an Emergency Medical Services Disciplinary Committee which shall review and make recommendations to the Department regarding all disciplinary matters relating to credentialing of emergency medical services personnel.

(b) The Emergency Medical Services Disciplinary Committee shall consist of five members appointed by the Secretary of the Department of Health and Human Services to serve four-year terms. Two of the members shall be currently practicing local EMS physician medical directors. One member each shall be a current physician member of the North Carolina Medical Board, a current EMS administrator, and a currently practicing and credentialed emergency medical technician-paramedic.

(c) In order to stagger the terms of the membership of the Committee, the initial appointment for one of the local EMS physician medical directors and the currently

practicing and credentialed emergency medical technician-paramedic shall be for a three-year term. The other three initial appointments and all future appointments shall be for four-year terms.

(d) Any appointment to fill a vacancy on the Committee created by a resignation, dismissal, death, or disability of a member shall be for the balance of the unexpired term.

(e) A majority of the Committee shall constitute a quorum for the transaction of business. The Department of Health and Human Services, Division of Facilities Services, Office of Emergency Medical Services shall supply all clerical and other services required by the Committee.

"~~§§ 143-518 through 143-520:~~§ 143-520: Reserved for future codification purposes."

SECTION 2. In addition to the temporary rule-making authority contained in G.S. 150B-21.1, the Secretary of the Department of Health and Human Services may adopt temporary rules to implement Articles 7 and 7A of Chapter 131E and Article 56 of Chapter 143 of the General Statutes. The Secretary's authority to adopt temporary rules pursuant to this section shall expire on the date that permanent rules adopted by the Medical Care Commission to implement Articles 7 and 7A of Chapter 131E and Article 56 of Chapter 143 of the General Statutes, as enacted by this act, become effective.

SECTION 3. This act becomes effective January 1, 2002.

HOUSE BILL 452:
Emergency Medical Service Update-AB

BILL ANALYSIS

Committee:	House Health Committee	**Introduced by:**	Rep. Wright
Date:	April 10, 2001	**Summary by:**	Linda Attarian
Version:	H453-CSRM-17		Committee Counsel

SUMMARY: ***The Proposed Committee Substitute of H453, if enacted, would update the Emergency Medical Services Act of 1973 to expand and consolidate rule-making authority to NC Medical Care Commission, including the authority to implement scope of practice and practice setting of EMS personnel as determined by the NC Medical Board. The PCS amends the Act to encourage the integration of Emergency Medical Services (EMS) with public and community health and structures the membership of the State EMS Advisory Council to be more representative of the current profession. The act will become effective on January 1, 2002.***

CURRENT LAW:

G.S. 143, Article 56, entitled the *Emergency Medical Services Act of 1973*, was passed to establish and better define standards for a comprehensive statewide EMS system. It addresses the role and responsibilities of the Department of Health and Human Services, Office of Emergency Medical Services, and State EMS Advisory Council.

BILL ANALYSIS: **Section 1** amends the Emergency Medical Services (EMS) Act of 1973 to:

- Update the statute and conform it to the present-day and future needs of the State EMS system;
- Consolidate the rule making authority under the Act to the NC Medical Care Commission by moving some authority that was vested with the NC Medical Board and to require the Board to adopt additional rules to implement the Act as updated;
- Update the powers and duties of the Secretary of Health and Human Services to conform with the expanded scope of service delivery, for example, the PCS requires the Secretary to expand EMS services to include a system that is integrated with other health care providers and networks including public health, community health monitoring activities, and special needs populations;
- Restructure the membership of the State EMS Advisory Council to be more representative of the profession;
- Clarify that county governments are responsible for ensuring that EMS services are available to its citizens;
- Clarify that the NC Medical Board retains the authority to establish the scope of practice for credentialed EMS personnel, but that the NC Medical Care Commission has the rule making authority over EMS personnel; and
- Protect the confidentiality of identifiable patient information that is collected and maintained by the Department in connection with EMS or with the statewide trauma system.

Section 2 authorizes the Department to adopt temporary rules to implement the act.

Section 3 makes the act effective on January 1, 2002.

NORTH CAROLINA GENERAL ASSEMBLY

LEGISLATIVE FISCAL NOTE

BILL NUMBER: HB 452 (House PCS6237-RM-17)

SHORT TITLE: Emergency Medical Services Act Update-AB

SPONSOR(S): Representative Wright

FISCAL IMPACT

Yes ( ) **No (X)** **No Estimate Available ( )**

	FY 2001-02	FY 2002-03	FY 2003-04	FY 2004-05	FY 2005-06
REVENUES					
EXPENDITURES					
POSITIONS:					

PRINCIPAL DEPARTMENT(S) & PROGRAM(S) AFFECTED:

Department of Health and Human Services
Division of Facility Services

EFFECTIVE DATE: When it becomes law

BILL SUMMARY: The proposed legislation updates the Emergency Medical Services Act by amending GS Chapter 143, Article 56, the Emergency Medical Services Act of 1973. Expands scope of activities of statewide Emergency Medical Services System to include injury prevention initiatives and wellness initiatives within the community and the public health system. Authorizes NC Medical Care Commission to adopt rules for emergency medical services (EMS) that are required for federal grants-in-aid and licensure. Requires Commission to adopt rules (1) regarding the credentialing of EMS agencies, personnel, and educational institutions; (2) regarding the credentialing of trauma centers; (3) regarding EMS data collection; (4) defining the scope of practice and practice settings of credentialed EMS personnel; (5) establishing standards for EMS vehicles and equipment and a statewide EMS communications system; (6) regarding the education and credentialing of persons trained to administer lifesaving treatment to persons who suffer severe adverse reactions to insect stings. Creates additional related duties for Secretary of Health and Human Services. Rewrites GS 143-510, which created the NC Emergency Medical Services Advisory

Council. Increases the size of the Council from 21 to 25 members. Specifies membership categories. Authorizes Council to advise Secretary on personnel and policy issues in the statewide EMS program. Requires each county to ensure that emergency medical services are provided in the county. Provides that medical records compiled or maintained by Department of Health and Human Services or EMS providers in connection with dispatch, response, treatment, or transport of patients or in connection with statewide trauma system may contain identifiable data allowing linkage to other health data systems for purposes of quality management, peer review, and public health initiatives. Makes such records confidential and specifies the only circumstances under which it may be released or made public. Makes financial information related to individual patients strictly confidential. Makes additional conforming and technical changes.

ASSUMPTIONS AND METHODOLOGY:

The proposed legislation updates existing law for Emergency Medical Services, but it does not significantly enlarge the responsibilities of the Department of Health and Human Services to the point where additional staff or funding is necessary. The proposed legislation does increase the membership of the Emergency Medical Services Advisory Council from 21 members to 25 members, but the increased membership is not expected to significantly increase the cost of operating the Council and any additional cost (up to $200 per year) can be covered within the existing budget for the Office of Emergency Medical Services.

TECHNICAL CONSIDERATIONS:

FISCAL RESEARCH DIVISION 733-4910

PREPARED BY: L. Carol Shaw

APPROVED BY: James D. Johnson



DATE: April 16, 2001

2001 COMMITTEE REPORT
HOUSE OF REPRESENTATIVES

The following report(s) from standing committee(s) is/are presented:
By Representative(s) **Wright** (Chair/Chairs) for the Committee on **Health**.

☐ Committee Substitute for
H.B. 452 A BILL TO BE ENTITLED AN ACT TO REVISE AND UPDATE THE EMERGENCY MEDICAL SERVICES ACT OF 1973.

☐ 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)

2/15/01

HOUSE BILL 453

Short Title:	Regulation of Emergency Medical Services-AB.	(Public)
Sponsors:	Representative Wright.	
Referred to:	Health.	

March 1, 2001

A BILL TO BE ENTITLED

AN ACT TO PROVIDE FOR THE REGULATION OF EMERGENCY MEDICAL SERVICES.

The General Assembly of North Carolina enacts:

SECTION 1. Article 7 of Chapter 131E of the General Statutes reads as rewritten:

"Article 7.

"Regulation of ~~Ambulance~~ Emergency Medical Services.

"**§ 131E-155. Definitions.**

As used in this Article, unless otherwise specified:

(1) "Ambulance" means any privately or publicly owned motor vehicle, aircraft, or vessel that is specially designed, constructed, or modified and equipped and is intended to be used for and is maintained or operated for the transportation of patients on the streets or highways, waterways or airways of this State ~~of persons who are sick, injured, wounded, or otherwise incapacitated or helpless~~.

(2) Repealed by Session Laws 1997-443, s. 11A.129C.

(3) "~~Ambulance~~ EMS provider" means ~~an individual,~~ a firm, corporation or association who engages or professes to engage in the business or service of providing out-of-hospital care for ~~transporting~~ patients ~~in an ambulance~~.

(4) "Commission" means the North Carolina Medical Care Commission.

(5) "Emergency medical dispatcher" means an emergency telecommunicator who has completed an educational program approved by the Department and has been credentialed as an emergency medical dispatcher by the Department.

(6) "Emergency medical services" means all services rendered in responding to improve the health and wellness of the community and

to address the individual's need for emergency medical care in order to prevent loss of life or further aggravation of physiological or psychological illness or injury.

(7) "Emergency medical services-nurse practitioner" means a nurse who is licensed by the North Carolina Board of Nursing and approved to perform medical acts by the North Carolina Medical Board and the North Carolina Board of Nursing and approved by the Office of Emergency Medical Services to issue instructions to ALS professionals in accordance with protocols approved by the sponsor hospital and under the direction of the medical director.

(8) "Emergency medical services-physician assistant" means a physician assistant who has been licensed by the North Carolina Medical Board and approved by the Office of Emergency Medical Services to issue instructions to ALS professionals in accordance with protocols approved by the sponsor hospital and under the direction of the medical director.

~~(5)~~(9) "Emergency medical technician" means an individual who has completed an educational program in emergency medical care approved by the Department and has been ~~certified~~ credentialed as an emergency medical technician by the Department.

(10) "Emergency medical technician-defibrillation" means an individual who has completed an educational program in emergency medical care approved by the Department and has been credentialed as an emergency medical technician-defibrillation by the Department.

(11) "Emergency medical technician-intermediate" means an individual who has completed an educational program in emergency medical care approved by the Department and has been credentialed as an emergency medical technician-intermediate by the Department.

(12) "Emergency medical technician-paramedic" means an individual who has completed an educational program in emergency medical care approved by the Department and has been credentialed as an emergency medical technician-paramedic by the Department.

~~(5a)~~(13) "Medical responder" means an individual who has completed an educational program in emergency medical care and first aid approved by the Department and has been ~~certified~~ credentialed as a medical responder by the Department.

(14) "Mobile intensive care nurse" means an individual who has completed an educational program in emergency medical care approved by the Department and has been credentialed as a mobile intensive care nurse by the Department.

~~(6)~~(15) "Patient" means an individual who is sick, injured, wounded, or otherwise incapacitated or helpless such that the need for some medical assistance might be anticipated. ~~while being transported to or from a medical facility.~~

~~(7)~~(16) "Practical examination" means a test where an applicant for ~~certification or recertification~~ credentialing as an emergency medical technician, ~~or~~ medical responder, emergency medical technician-defibrillation, emergency medical technician-intermediate, or emergency medical technician-paramedic demonstrates the ability to perform specified emergency medical care skills.

"§ 131E-155.1. ~~Ambulance~~ EMS Provider License required.

(a) No ~~person,~~ firm, corporation, or association shall furnish, operate, conduct, maintain, advertise, or otherwise engage in or profess to be engaged in the business or service of ~~treating~~ providing out-of-hospital treatment for patients or transporting patients upon the streets or highways, waterways, or airways in North Carolina unless a valid ~~Ambulance~~ EMS Provider License has been issued by the Department.

(b) Before an ~~Ambulance~~ EMS Provider License may be issued, the ~~person,~~ firm, corporation, or association seeking the license shall apply to the Department for this license. Application shall be made upon forms and according to procedures established by the Department. Prior to issuing an original or renewal ~~Ambulance~~ EMS Provider License, the Department shall determine that the applicant meets all requirements for this license as set forth in this Article and in the rules adopted under this Article. ~~Ambulance~~ EMS Provider Licenses shall be valid for a period specified by the Department, provided that the period shall be a minimum of four years unless action is taken under subsection (d) of this section.

(c) The Commission shall adopt rules setting forth the qualifications required for obtaining or renewing an ~~Ambulance~~ EMS Provider License.

(d) The Department may deny, suspend, amend, or revoke an ~~Ambulance~~ EMS Provider License in any case ~~in which~~ where the Department finds that there has been a substantial failure to comply with the provisions of this Article or the rules adopted under this Article. The Department's decision to deny, suspend, amend, or revoke an ~~Ambulance~~ EMS Provider License may be appealed by the applicant or licensee pursuant to the provisions of Article 3 of Chapter 150B of the General Statutes, the Administrative Procedure Act.

(e) Operating as an ~~ambulance~~ EMS provider without a valid ~~Ambulance~~ EMS Provider License is a Class 3 misdemeanor. Each day's operation as an ~~ambulance~~ EMS provider without a license is a separate offense.

"§ 131E-156. Permit required to operate ambulance.

(a) No person, firm, corporation, or association, either as owner, agent, provider, or otherwise, shall furnish, operate, conduct, maintain, advertise, or otherwise engage in or profess to be engaged in the business or service of transporting patients upon the streets or highways, waterways or airways in North Carolina unless a valid permit from the Department has been issued for each ambulance used in the business or service.

(b) Before a permit may be issued for a vehicle to be operated as an ambulance, the ~~ambulance~~ EMS provider ~~must~~ shall apply to the Department for an ambulance permit. Application shall be made upon forms and according to procedures established by the Department. Prior to issuing an original or renewal permit for an ambulance, the Department shall determine that the vehicle for which the permit is issued meets all

requirements as to equipment, design, supplies and sanitation as set forth in this Article and in the rules of the Commission and that the ~~ambulance~~ EMS provider has the ~~certified~~ credentialed personnel necessary to operate the ambulance in accordance with this Article. Permits issued for ambulances shall be valid for a period specified by the Department, not to exceed ~~one year.~~four years.

(c) Duly authorized representatives of the Department may issue temporary permits for vehicles not meeting required standards for a period not to exceed 60 days, when it determines the public interest will be served.

(d) When a permit has been issued for an ambulance as specified by this Article, the vehicle and records relating to the maintenance and operation of the vehicle shall be open to inspection by duly authorized representatives of the Department at all reasonable times.

"§ 131E-157. Standards for equipment; inspection of equipment and supplies required for ambulances.

(a) The Commission shall adopt rules specifying equipment, sanitation, supply and design requirements for ambulances.

(b) The Department shall inspect each ambulance for compliance with the requirements set forth by the Commission and this Article when it deems an inspection is necessary. The Department shall maintain a record of the inspection.

(c) Upon a determination, based upon an inspection, that an ambulance fails to meet the requirements of this Article or rules adopted under this Article, the Department may suspend or revoke the permit for the ambulance concerned until these requirements are met.

"§ 131E-158. ~~Certified~~ Credentialed personnel required.

(a) Every ambulance when transporting a patient shall be occupied at a minimum by all of the following:

(1) At least one emergency medical technician who shall be responsible for the medical aspects of the mission prior to arrival at the medical facility, assuming no other individual ~~of~~ with higher ~~certification or license~~ credentials is ~~available; and~~available.

(2) One medical responder who is responsible for the operation of the vehicle and rendering assistance to the emergency medical technician.

An ambulance owned and operated by a licensed health care facility that is used solely to transport sick or infirm patients with known nonemergency medical conditions between facilities or between a residence and a facility for scheduled medical appointments is exempt from the requirements of this subsection.

(b) The Commission shall adopt rules setting forth exemptions to the requirements stated in (a) of this section applicable to situations where exemptions are considered by the Commission to be in the public interest.

"§ 131E-159. Credentialing Requirements ~~for certification~~.

(a) An individual seeking ~~certification~~ credentials as an emergency medical ~~technician or~~ technician, emergency medical technician-defibrillation, emergency medical technician-intermediate, emergency medical technician-paramedic, mobile intensive care nurse, emergency medical services-physician assistant, or emergency

medical services-nurse practitioner medical responder shall apply to the Department using forms prescribed by that agency. The Department's representatives shall examine the applicant ~~for emergency medical technician by written and practical examination and the applicant for medical responder~~ by either ~~written and~~ written, practical, or written and practical examination. The Department shall issue ~~a certificate~~ appropriate credentials to the applicant who meets all the requirements set forth in this Article and the rules adopted for this Article and who successfully completes the examinations required for ~~certification~~ credentialing. Emergency medical ~~technician and~~ technician, medical ~~responder~~ responder, emergency medical dispatcher, emergency medical technician-defibrillation, emergency medical technician-intermediate, emergency medical technician-paramedic, mobile intensive care nurse, emergency medical services-physician assistant, and emergency medical services-nurse practitioner ~~certificates~~ credentials shall be valid for a period not to exceed four years and may be renewed ~~after reexamination~~ if the holder meets the requirements set forth in the rules of the Commission. The Department is authorized to revoke or suspend ~~a certificate~~ these credentials at any time it determines that the holder no longer meets the qualifications prescribed. ~~for emergency medical technicians or for medical responders.~~

(b) The Commission shall adopt rules setting forth the qualifications required for ~~certification~~ credentialing of medical ~~responders and~~ responders, emergency medical ~~technicians.~~technicians, emergency medical technician-defibrillation, emergency medical technician-intermediate, emergency medical technician-paramedic, emergency medical dispatcher, mobile intensive care nurse, emergency medical services-physician assistant, and emergency medical services-nurse practitioner.

~~(b1)~~(c) An individual currently ~~certified~~ credentialed as an emergency medical ~~technician~~ technician, emergency medical technician-defibrillation, emergency medical technician-intermediate, and emergency medical technician-paramedic by the National Registry of Emergency Medical Technicians or by another state where the ~~education/certification~~ education/credentialing requirements have been approved for legal recognition by the Department of Health and Human Services, in accordance with rules promulgated by the Medical Care Commission, and who is either currently residing in North Carolina or affiliated with a permitted ~~ambulance~~ EMS provider offering service within North Carolina, may be eligible for ~~certification~~ credentialing as an emergency medical technician without examination. This ~~certification~~ credentialing shall be valid for a period not to exceed the length of the emergency medical technician-defibrillation, emergency medical technician-intermediate, and emergency medical technician-paramedic applicant's original ~~certification~~ credentialing or four years, whichever is less.

~~(b2)~~(d) An individual currently credentialed as an emergency medical dispatcher by a national credentialing agency, or by another state where the education/credentialing requirements have been approved for legal recognition by the Department of Health and Human Services, in accordance with rules issued by the Medical Care Commission, and who is either currently residing in North Carolina or affiliated with an emergency medical dispatcher program approved by the Department of Health and Human Services offering service within North Carolina, may be eligible for credentialing as an

emergency medical dispatcher without examination. This credentialing shall be valid for a period not to exceed the length of the applicant's original credentialing or four years, whichever is less.

~~(c)~~(e) Duly authorized representatives of the Department may issue temporary ~~certificates~~ credentials with or without examination upon finding that this action will be in the public interest. Temporary ~~certificates~~ credentials shall be valid for a period not exceeding 90 days.

"§ 131E-160. Exemptions.

~~The~~All of the following vehicles are exempt from the provisions of this Article:

(1) Privately owned vehicles not ~~regularly~~ used in the business of transporting ~~patients;~~patients.

(2) A vehicle rendering service as an ambulance in case of a major catastrophe or emergency, when the permitted ambulances based in the locality of the catastrophe or emergency are insufficient to render the services ~~required;~~required.

(3) Any ambulance based outside this State, except that an ambulance which receives a patient within this State for transportation to a location within this State shall comply with the provisions of this ~~Article;~~Article.

(4) Ambulances owned and operated by an agency of the United States ~~government; and~~government.

(5) Vehicles owned and operated by rescue squads chartered by the State of North Carolina as nonprofit corporations or associations which are not regularly used to transport sick, injured, wounded or otherwise incapacitated or helpless persons except as a part of rescue operations.

"§ 131E-161. Violation declared misdemeanor.

It shall be the responsibility of the ~~ambulance~~ EMS provider to ensure that the ambulance operation complies with the provisions of this Article and all rules adopted for this Article. Upon the violation of any part of this Article or any rule adopted under authority of this Article, the Department shall have the power to revoke or suspend the permits of all vehicles owned or operated by the violator. The operation of an ambulance without a valid permit or after a permit has been suspended or revoked or without ~~an emergency medical technician and medical responder aboard~~ appropriate credentialed staffing as required by G.S. 131E-158, shall constitute a Class 1 misdemeanor."

SECTION 2. Article 7A of Chapter 131E reads as rewritten:

"Article 7A.

"Statewide Trauma System Act of 1993.

"§ 131E-162. Statewide trauma system.

The Department shall establish and maintain a program for the development of a statewide trauma system. The Department shall consolidate all State functions relating to trauma systems, both regulatory and developmental, under the auspices of this program.

The Commission shall adopt rules to carry out the purpose of this Article. These rules shall be adopted with the advice of the State Emergency Medical Services Advisory Council and shall include the operation of a statewide trauma registry, statewide educational requirements fundamental to the implementation of the trauma ~~system,~~ system. ~~and~~ The rules adopted by the Commission shall establish guidelines for monitoring and evaluating the system including standards and criteria for the denial, suspension, voluntary withdrawal, or revocation of credentials for trauma center designation. The rules adopted by the Commission shall avoid duplication of reporting and minimize the cost to hospitals or other persons reporting under this act. The Office of Emergency Medical Services shall be the agency responsible for monitoring system development, ensuring compliance with rules, and overseeing system effectiveness.

With respect to collection of data and educational requirements regarding trauma, rules adopted by the Medical Care Commission shall limit the authority of the Department to hospitals and ~~prehospital~~ Emergency Medical Services providers. Nothing in this Article shall be interpreted so as to grant the Department authority to require private physicians, schools, or universities, except those ~~voluntarily~~ participating in the trauma system, to provide information or data or to conduct educational programs regarding trauma.

"**§§ 131E-163, 131E-164:** Reserved for future codification purposes."

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

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2001

H D

HOUSE BILL 453
PROPOSED COMMITTEE SUBSTITUTE H453-CSRM-18 [v.2]

4/9/2001 6:58:16 PM

Short Title: Regulation of Emergency Medical Services.-AB. (Public)

Sponsors:

Referred to:

March 1, 2001

A BILL TO BE ENTITLED

AN ACT TO PROVIDE FOR THE REGULATION OF EMERGENCY MEDICAL SERVICES.

The General Assembly of North Carolina enacts:

SECTION 1. Article 7 of Chapter 131E of the General Statutes reads as rewritten:

"Article 7.

"Regulation of ~~Ambulance~~ Emergency Medical Services.

"**§ 131E-155. Definitions.**

As used in this Article, unless otherwise specified:

(1) "Ambulance" means any privately or publicly owned motor vehicle, aircraft, or vessel that is specially designed, constructed, or modified and equipped and is intended to be used for and is maintained or operated for the transportation of patients on the streets or highways, waterways or airways of this State ~~of persons who are sick, injured, wounded, or otherwise incapacitated or helpless~~.

(2) Repealed by Session Laws 1997-443, s. 11A.129C.

(3) "~~Ambulance~~ EMS provider" means ~~an individual,~~ a firm, corporation or association ~~who~~ which engages in or professes to ~~engage in the business or service of transporting patients in an ambulance.~~provide emergency medical services.

(4) "Commission" means the North Carolina Medical Care Commission.

(5) "Emergency medical dispatcher" means an emergency telecommunicator who has completed an educational program approved by the Department and has been credentialed as an emergency medical dispatcher by the Department.

(6) "Emergency medical services" means all services rendered in responding to improve the health and wellness of the community and to address the individual's need for emergency medical care within the

scope of practice as defined by the North Carolina Medical Board in accordance with G.S. 143-514 in order to prevent loss of life or further aggravation of physiological or psychological illness or injury.

(7) "Emergency medical services personnel" means all the personnel defined in subdivisions (8), (9), (10), (11), (12), (13), (14), (15), and (16) of this section.

(8) "Emergency medical services-nurse practitioner" means a registered nurse who is licensed to practice nursing in North Carolina and approved to perform medical acts by the North Carolina Medical Board and the North Carolina Board of Nursing and credentialed by the Office of Emergency Medical Services to issue instructions to ALS professionals in accordance with protocols approved by the sponsor hospital and under the direction of the medical director.

(9) "Emergency medical services-physician assistant" means a physician assistant who has been licensed by the North Carolina Medical Board and approved by the Office of Emergency Medical Services to issue instructions to ALS professionals in accordance with protocols approved by the sponsor hospital and under the direction of the medical director.

~~(5)~~(10) "Emergency medical technician" means an individual who has completed an educational program in emergency medical care approved by the Department and has been ~~certified~~ credentialed as an emergency medical technician by the Department.

(11) "Emergency medical technician-defibrillation" means an individual who has completed an educational program in emergency medical care approved by the Department and has been credentialed as an emergency medical technician-defibrillation by the Department.

(12) "Emergency medical technician-intermediate" means an individual who has completed an educational program in emergency medical care approved by the Department and has been credentialed as an emergency medical technician-intermediate by the Department.

(13) "Emergency medical technician-paramedic" means an individual who has completed an educational program in emergency medical care approved by the Department and has been credentialed as an emergency medical technician-paramedic by the Department.

~~(5a)~~(14) "Medical responder" means an individual who has completed an educational program in emergency medical care and first aid approved by the Department and has been ~~certified~~ credentialed as a medical responder by the Department.

(15) "Mobile intensive care nurse" means a registered nurse who is licensed to practice nursing in North Carolina and who has completed an educational program in emergency medical care approved by the

Department and has been credentialed as a mobile intensive care nurse by the Department.

~~(6)~~(16) "Patient" means an individual who is sick, injured, wounded, or otherwise incapacitated or helpless such that the need for some medical assistance might be anticipated. ~~while being transported to or from a medical facility.~~

~~(7)~~(17) "Practical examination" means a test where an applicant for ~~certification or recertification~~ credentialing as an emergency medical technician, ~~or~~ medical responder, emergency medical technician-defibrillation, emergency medical technician-intermediate, or emergency medical technician-paramedic demonstrates the ability to perform specified emergency medical care skills.

"§ 131E-155.1. ~~Ambulance~~ EMS Provider License required.

(a) No ~~person,~~ firm, corporation, or association shall furnish, operate, conduct, maintain, advertise, or otherwise engage in or profess to ~~be engaged in the business or service of treating~~ provide emergency medical services or ~~transporting~~ transport patients upon the streets or highways, waterways, or airways in North Carolina unless a valid ~~Ambulance~~ EMS Provider License has been issued by the Department.

(b) Before an ~~Ambulance~~ EMS Provider License may be issued, the ~~person,~~ firm, corporation, or association seeking the license shall apply to the Department for this license. Application shall be made upon forms and according to procedures established by the Department. Prior to issuing an original or renewal ~~Ambulance~~ EMS Provider License, the Department shall determine that the applicant meets all requirements for this license as set forth in this Article and in the rules adopted under this Article. ~~Ambulance~~ EMS Provider Licenses shall be valid for a period specified by the Department, provided that the period shall be a minimum of four years unless action is taken under subsection (d) of this section.

(c) The Commission shall adopt rules setting forth the qualifications required for obtaining or renewing an ~~Ambulance~~ EMS Provider License.

(d) The Department may deny, suspend, amend, or revoke an ~~Ambulance~~ EMS Provider License in any case ~~in which~~ where the Department finds that there has been a substantial failure to comply with the provisions of this Article or the rules adopted under this Article. The Department's decision to deny, suspend, amend, or revoke an ~~Ambulance~~ EMS Provider License may be appealed by the applicant or licensee pursuant to the provisions of Article 3 of Chapter 150B of the General Statutes, the Administrative Procedure Act.

(e) Operating as an ~~ambulance~~ EMS provider without a valid ~~Ambulance~~ EMS Provider License is a Class 3 misdemeanor. Each day's operation as an ~~ambulance~~ EMS provider without a license is a separate offense.

"§ 131E-156. Permit required to operate ambulance.

(a) No person, firm, corporation, or association, either as owner, agent, provider, or otherwise, shall furnish, operate, conduct, maintain, advertise, or otherwise engage in or profess to be engaged in the business or service of transporting patients upon the

streets or highways, waterways or airways in North Carolina unless a valid permit from the Department has been issued for each ambulance used in the business or service.

(b) Before a permit may be issued for a vehicle to be operated as an ambulance, the ~~ambulance~~ EMS provider ~~must~~ shall apply to the Department for an ambulance permit. Application shall be made upon forms and according to procedures established by the Department. Prior to issuing an original or renewal permit for an ambulance, the Department shall determine that the vehicle for which the permit is issued meets all requirements as to equipment, design, supplies and sanitation as set forth in this Article and in the rules of the Commission and that the ~~ambulance~~ EMS provider has the ~~certified~~ credentialed personnel necessary to operate the ambulance in accordance with this Article. Permits issued for ambulances shall be valid for a period specified by the Department, not to exceed ~~one year.~~ four years.

(c) Duly authorized representatives of the Department may issue temporary permits for vehicles not meeting required standards for a period not to exceed 60 days, when it determines the public interest will be served.

(d) When a permit has been issued for an ambulance as specified by this Article, the vehicle and records relating to the maintenance and operation of the vehicle shall be open to inspection by duly authorized representatives of the Department at all reasonable times.

"§ 131E-157. Standards for equipment; inspection of equipment and supplies required for ambulances.

(a) The Commission shall adopt rules specifying equipment, sanitation, supply and design requirements for ambulances.

(b) The Department shall inspect each ambulance for compliance with the requirements set forth by the Commission and this Article when it deems an inspection is necessary. The Department shall maintain a record of the inspection.

(c) Upon a determination, based upon an inspection, that an ambulance fails to meet the requirements of this Article or rules adopted under this Article, the Department may ~~suspend~~ deny, suspend, or revoke the permit for the ambulance concerned until these requirements are met.

"§ 131E-158. ~~Certified~~ Credentialed personnel required.

(a) Every ambulance when transporting a patient shall be occupied at a minimum by all of the following:

(1) At least one emergency medical technician who shall be responsible for the medical aspects of the mission prior to arrival at the medical facility, assuming no other individual ~~of~~ with higher ~~certification or license~~ credentials is ~~available; and~~ available.

(2) One medical responder who is responsible for the operation of the vehicle and rendering assistance to the emergency medical technician.

An ambulance owned and operated by a licensed health care facility that is used solely to transport sick or infirm patients with known nonemergency medical conditions between facilities or between a residence and a facility for scheduled medical appointments is exempt from the requirements of this subsection.

(b) The Commission shall adopt rules setting forth exemptions to the requirements stated in (a) of this section applicable to situations where exemptions are considered by the Commission to be in the public interest.

"§ 131E-159. Credentialing Requirements ~~for certification~~.

(a) An individual seeking ~~certification~~ credentials as an emergency medical ~~technician or~~ technician, emergency medical technician-defibrillation, emergency medical technician-intermediate, emergency medical technician-paramedic, mobile intensive care nurse, emergency medical services-physician assistant, or emergency medical services-nurse practitioner medical responder shall apply to the Department using forms prescribed by that agency. The Department's representatives shall examine the applicant ~~for emergency medical technician by written and practical examination and the applicant for medical responder~~ by either ~~written and~~ written, practical, or written and practical examination. The Department shall issue ~~a certificate~~ appropriate credentials to the applicant who meets all the requirements set forth in this Article and the rules adopted for this Article and who successfully completes the examinations required for ~~certification~~ credentialing. Emergency medical ~~technician and~~ technician, medical ~~responder~~ responder, emergency medical dispatcher, emergency medical technician-defibrillation, emergency medical technician-intermediate, emergency medical technician-paramedic, mobile intensive care nurse, emergency medical services-physician assistant, and emergency medical services-nurse practitioner ~~certificates~~ credentials shall be valid for a period not to exceed four years and may be renewed ~~after reexamination~~ if the holder meets the requirements set forth in the rules of the Commission. The Department is authorized to revoke or suspend ~~a certificate~~ these credentials at any time it determines that the holder no longer meets the qualifications prescribed. ~~for emergency medical technicians or for medical responders.~~

(b) The Commission shall adopt rules setting forth the qualifications required for ~~certification~~ credentialing of medical ~~responders and~~ responders, emergency medical ~~technicians.~~technicians, emergency medical technician-defibrillation, emergency medical technician-intermediate, emergency medical technician-paramedic, emergency medical dispatcher, mobile intensive care nurse, emergency medical services-physician assistant, and emergency medical services-nurse practitioner.

~~(b1)~~(c) An individual currently ~~certified~~ credentialed as an emergency medical ~~technician~~ technician, emergency medical technician-defibrillation, emergency medical technician-intermediate, and emergency medical technician-paramedic by the National Registry of Emergency Medical Technicians or by another state where the ~~education/certification~~ education/credentialing requirements have been approved for legal recognition by the Department of Health and Human Services, in accordance with rules promulgated by the Medical Care Commission, and who is either currently residing in North Carolina or affiliated with a permitted ~~ambulance~~ EMS provider offering service within North Carolina, may be eligible for ~~certification~~ credentialing as an emergency medical technician without examination. This ~~certification~~ credentialing shall be valid for a period not to exceed the length of the emergency medical technician-defibrillation, emergency medical technician-intermediate, and emergency medical

technician-paramedic applicant's original ~~certification~~ credentialing or four years, whichever is less.

~~(b2)~~(d) An individual currently credentialed as an emergency medical dispatcher by a national credentialing agency, or by another state where the education/credentialing requirements have been approved for legal recognition by the Department of Health and Human Services, in accordance with rules issued by the Medical Care Commission, and who is either currently residing in North Carolina or affiliated with an emergency medical dispatcher program approved by the Department of Health and Human Services offering service within North Carolina, may be eligible for credentialing as an emergency medical dispatcher without examination. This credentialing shall be valid for a period not to exceed the length of the applicant's original credentialing or four years, whichever is less.

~~(c)~~(e) Duly authorized representatives of the Department may issue temporary ~~certificates~~ credentials with or without examination upon finding that this action will be in the public interest. Temporary ~~certificates~~ credentials shall be valid for a period not exceeding 90 days.

(f) The Department may deny, suspend, amend, or revoke the credentials of a medical responder, emergency medical technician, emergency medical technician-defibrillation, emergency medical technician-intermediate, emergency medical technician-paramedic, emergency medical dispatcher, emergency medical services-physician assistant, emergency medical services-nurse practitioner, or mobile intensive care nurse in any case in which the Department finds that there has been a substantial failure to comply with the provisions of this Article or the rules issued under this Article. Prior to implementation of any of the above disciplinary actions, the Department shall consider the recommendations of the EMS Disciplinary Committee pursuant to G.S. 143-519. The Department's decision to deny, suspend, amend, or revoke credentials may be appealed by the applicant or credentialed personnel pursuant to the provisions of Article 3 of Chapter 150B of the General Statutes, the Administrative Procedure Act.

"§ 131E-160. Exemptions.

~~The~~All of the following vehicles are exempt from the provisions of this Article:

(1) Privately owned vehicles not ~~regularly~~ used in the business of transporting ~~patients;~~patients.

(2) A vehicle rendering service as an ambulance in case of a major catastrophe or emergency, when the permitted ambulances based in the locality of the catastrophe or emergency are insufficient to render the services ~~required;~~required.

(3) Any ambulance based outside this State, except that an ambulance which receives a patient within this State for transportation to a location within this State shall comply with the provisions of this ~~Article;~~Article.

(4) Ambulances owned and operated by an agency of the United States ~~government; and~~government.

(5) Vehicles owned and operated by rescue squads chartered by the State of North Carolina as nonprofit corporations or associations which are not regularly used to transport sick, injured, wounded or otherwise incapacitated or helpless persons except as a part of rescue operations.

"§ 131E-161. Violation declared misdemeanor.

It shall be the responsibility of the ~~ambulance~~ EMS provider to ensure that the ambulance operation complies with the provisions of this Article and all rules adopted for this Article. Upon the violation of any part of this Article or any rule adopted under authority of this Article, the Department shall have the power to ~~revoke~~ deny, revoke, or suspend the permits of all vehicles owned or operated by the violator. The operation of an ambulance without a valid permit or after a permit has been ~~suspended~~ denied, suspended, or revoked or without ~~an emergency medical technician and medical responder aboard~~ appropriate credentialed staffing as required by G.S. 131E-158, shall constitute a Class 1 misdemeanor."

SECTION 2. Article 7A of Chapter 131E reads as rewritten:

"Article 7A.

"Statewide Trauma System Act of 1993.

"§ 131E-162. Statewide trauma system.

The Department shall establish and maintain a program for the development of a statewide trauma system. The Department shall consolidate all State functions relating to trauma systems, both regulatory and developmental, under the auspices of this program.

The Commission shall adopt rules to carry out the purpose of this Article. These rules shall be adopted with the advice of the State Emergency Medical Services Advisory Council and shall include the operation of a statewide trauma registry, statewide educational requirements fundamental to the implementation of the trauma ~~system,~~ system. ~~and~~ The rules adopted by the Commission shall establish guidelines for monitoring and evaluating the system including standards and criteria for the denial, suspension, voluntary withdrawal, or revocation of credentials for trauma center designation. The rules adopted by the Commission shall avoid duplication of reporting and minimize the cost to hospitals or other persons reporting under this act. The Office of Emergency Medical Services shall be the agency responsible for monitoring system development, ensuring compliance with rules, and overseeing system effectiveness.

With respect to collection of data and educational requirements regarding trauma, rules adopted by the Medical Care Commission shall limit the authority of the Department to hospitals and ~~prehospital~~ Emergency Medical Services providers. Nothing in this Article shall be interpreted so as to grant the Department authority to require private physicians, schools, or universities, except those ~~voluntarily~~ participating in the trauma system, to provide information or data or to conduct educational programs regarding trauma.

"§§ 131E-163, 131E-164: Reserved for future codification purposes."

"SECTION 3. In addition to the temporary rulemaking authority contained in G.S. 150B-21-1, the Secretary of the Department of Health and Human Services may

adopt temporary rules to implement Articles 7 and 7A of Chapter 131E and Article 56 of Chapter 143 of the General Statutes. The Secretary's authority to adopt temporary rules pursuant to this section shall expire on the date that permanent rules adopted by the Medical Care Commission to implement Articles 7 and 7A of Chapter 131E and Article 56 of Chapter 143 of the General Statutes as enacted by this act become effective.

SECTION 4. This act becomes effective January 1, 2002."

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2001

H D

HOUSE BILL 453
PROPOSED COMMITTEE SUBSTITUTE H453-PCS7186-RM-18

Short Title: Regulation of Emergency Medical Services-AB. (Public)

Sponsors:

Referred to:

March 1, 2001

A BILL TO BE ENTITLED

AN ACT TO PROVIDE FOR THE REGULATION OF EMERGENCY MEDICAL SERVICES.

The General Assembly of North Carolina enacts:

SECTION 1. Article 7 of Chapter 131E of the General Statutes reads as rewritten:

"Article 7.

"Regulation of ~~Ambulance~~ Emergency Medical Services.

"§ 131E-155. Definitions.

As used in this Article, unless otherwise specified:

(1) "Ambulance" means any privately or publicly owned motor vehicle, aircraft, or vessel that is specially designed, constructed, or modified and equipped and is intended to be used for and is maintained or operated for the transportation of patients on the streets or highways, waterways or airways of this State ~~of persons who are sick, injured, wounded, or otherwise incapacitated or helpless~~.

(2) Repealed by Session Laws 1997-443, s. 11A.129C.

(3) "~~Ambulance~~ EMS provider" means ~~an individual,~~ a firm, corporation or association ~~who~~ which engages in or professes to ~~engage in the business or service of transporting patients in an ambulance.~~ provide emergency medical services.

(4) "Commission" means the North Carolina Medical Care Commission.

(5) "Emergency medical dispatcher" means an emergency telecommunicator who has completed an educational program approved by the Department and has been credentialed as an emergency medical dispatcher by the Department.

(6) "Emergency medical services" means services rendered by emergency medical services personnel in responding to improve the health and wellness of the community and to address the individual's need for

emergency medical care within the scope of practice as defined by the North Carolina Medical Board in accordance with G.S. 143-514 in order to prevent loss of life or further aggravation of physiological or psychological illness or injury.

(7) "Emergency medical services personnel" means all the personnel defined in subdivisions (8), (9), (10), (11), (12), (13), (14), and (15) of this section.

(8) "Emergency medical services-nurse practitioner" means a registered nurse who is licensed to practice nursing in North Carolina and approved to perform medical acts by the North Carolina Medical Board and the North Carolina Board of Nursing and credentialed by the Office of Emergency Medical Services to issue instructions to ALS professionals in accordance with protocols approved by the sponsor hospital and under the direction of the medical director.

(9) "Emergency medical services-physician assistant" means a physician assistant who has been licensed by the North Carolina Medical Board and approved by the Office of Emergency Medical Services to issue instructions to ALS professionals in accordance with protocols approved by the sponsor hospital and under the direction of the medical director.

~~(5)~~(10) "Emergency medical technician" means an individual who has completed an educational program in emergency medical care approved by the Department and has been ~~certified~~ credentialed as an emergency medical technician by the Department.

(11) "Emergency medical technician-defibrillation" means an individual who has completed an educational program in emergency medical care approved by the Department and has been credentialed as an emergency medical technician-defibrillation by the Department.

(12) "Emergency medical technician-intermediate" means an individual who has completed an educational program in emergency medical care approved by the Department and has been credentialed as an emergency medical technician-intermediate by the Department.

(13) "Emergency medical technician-paramedic" means an individual who has completed an educational program in emergency medical care approved by the Department and has been credentialed as an emergency medical technician-paramedic by the Department.

~~(5a)~~(14) "Medical responder" means an individual who has completed an educational program in emergency medical care and first aid approved by the Department and has been ~~certified~~ credentialed as a medical responder by the Department.

(15) "Mobile intensive care nurse" means a registered nurse who is licensed to practice nursing in North Carolina and who has completed an educational program in emergency medical care approved by the

Department and has been credentialed as a mobile intensive care nurse by the Department.

~~(6)~~(16) "Patient" means an individual who is sick, injured, wounded, or otherwise incapacitated or helpless such that the need for some medical assistance might be ~~anticipated while being transported to or from a medical facility.~~ anticipated.

~~(7)~~(17) "Practical examination" means a test where an applicant for ~~certification or recertification~~ credentialing as an emergency medical ~~technician or~~ technician, medical ~~responder~~ responder, emergency medical technician-defibrillation, emergency medical technician-intermediate, or emergency medical technician-paramedic demonstrates the ability to perform specified emergency medical care skills.

"§ 131E-155.1. ~~Ambulance~~ EMS Provider License required.

(a) No ~~person,~~ firm, corporation, or association shall furnish, operate, conduct, maintain, advertise, or otherwise engage in or profess to ~~be engaged in the business or service of treating~~ provide emergency medical services or ~~transporting~~ transport patients upon the streets or highways, waterways, or airways in North Carolina unless a valid ~~Ambulance~~ EMS Provider License has been issued by the Department.

(b) Before an ~~Ambulance~~ EMS Provider License may be issued, the ~~person,~~ firm, corporation, or association seeking the license shall apply to the Department for this license. Application shall be made upon forms and according to procedures established by the Department. Prior to issuing an original or renewal ~~Ambulance~~ EMS Provider License, the Department shall determine that the applicant meets all requirements for this license as set forth in this Article and in the rules adopted under this Article. ~~Ambulance~~ EMS Provider Licenses shall be valid for a period specified by the Department, provided that the period shall be a minimum of four years unless action is taken under subsection (d) of this section.

(c) The Commission shall adopt rules setting forth the qualifications required for obtaining or renewing an ~~Ambulance~~ EMS Provider License.

(d) The Department may deny, suspend, amend, or revoke an ~~Ambulance~~ EMS Provider License in any case ~~in which~~ where the Department finds that there has been a substantial failure to comply with the provisions of this Article or the rules adopted under this Article. The Department's decision to deny, suspend, amend, or revoke an ~~Ambulance~~ EMS Provider License may be appealed by the applicant or licensee pursuant to the provisions of Article 3 of Chapter 150B of the General Statutes, the Administrative Procedure Act.

(e) Operating as an ~~ambulance~~ EMS provider without a valid ~~Ambulance~~ EMS Provider License is a Class 3 misdemeanor. Each day's operation as an ~~ambulance~~ EMS provider without a license is a separate offense.

"§ 131E-156. Permit required to operate ambulance.

(a) No person, firm, corporation, or association, either as owner, agent, provider, or otherwise, shall furnish, operate, conduct, maintain, advertise, or otherwise engage in

or profess to be engaged in the business or service of transporting patients upon the streets or highways, waterways or airways in North Carolina unless a valid permit from the Department has been issued for each ambulance used in the business or service.

(b) Before a permit may be issued for a vehicle to be operated as an ambulance, the ~~ambulance~~ EMS provider ~~must~~ shall apply to the Department for an ambulance permit. Application shall be made upon forms and according to procedures established by the Department. Prior to issuing an original or renewal permit for an ambulance, the Department shall determine that the vehicle for which the permit is issued meets all requirements as to equipment, design, supplies and sanitation as set forth in this Article and in the rules of the Commission and that the ~~ambulance~~ EMS provider has the ~~certified~~ credentialed personnel necessary to operate the ambulance in accordance with this Article. Permits issued for ambulances shall be valid for a period specified by the Department, not to exceed ~~one year.~~ four years.

(c) Duly authorized representatives of the Department may issue temporary permits for vehicles not meeting required standards for a period not to exceed 60 days, when it determines the public interest will be served.

(d) When a permit has been issued for an ambulance as specified by this Article, the vehicle and records relating to the maintenance and operation of the vehicle shall be open to inspection by duly authorized representatives of the Department at all reasonable times.

"§ 131E-157. Standards for equipment; inspection of equipment and supplies required for ambulances.

(a) The Commission shall adopt rules specifying equipment, sanitation, supply and design requirements for ambulances.

(b) The Department shall inspect each ambulance for compliance with the requirements set forth by the Commission and this Article when it deems an inspection is necessary. The Department shall maintain a record of the inspection.

(c) Upon a determination, based upon an inspection, that an ambulance fails to meet the requirements of this Article or rules adopted under this Article, the Department may ~~suspend~~ deny, suspend, or revoke the permit for the ambulance concerned until these requirements are met.

"§ 131E-158. ~~Certified~~ Credentialed personnel required.

(a) Every ambulance when transporting a patient shall be occupied at a minimum by all of the following:

(1) At least one emergency medical technician who shall be responsible for the medical aspects of the mission prior to arrival at the medical facility, assuming no other individual ~~of~~ with higher ~~certification or license~~ credentials is ~~available; and~~ available.

(2) One medical responder who is responsible for the operation of the vehicle and rendering assistance to the emergency medical technician.

An ambulance owned and operated by a licensed health care facility that is used solely to transport sick or infirm patients with known nonemergency medical conditions

between facilities or between a residence and a facility for scheduled medical appointments is exempt from the requirements of this subsection.

(b) The Commission shall adopt rules setting forth exemptions to the requirements stated in (a) of this section applicable to situations where exemptions are considered by the Commission to be in the public interest.

"§ 131E-159. ~~Requirements for certification.~~ Credentialing requirements.

(a) An individual seeking ~~certification~~ credentials as an emergency medical ~~technician or~~ technician, emergency medical technician-defibrillation, emergency medical technician-intermediate, emergency medical technician-paramedic, mobile intensive care nurse, emergency medical services-physician assistant, or emergency medical services-nurse practitioner medical responder shall apply to the Department using forms prescribed by that agency. The Department's representatives shall examine the applicant ~~for emergency medical technician by written and practical examination and the applicant for medical responder~~ by either ~~written and practical~~ written, practical, or written and practical examination. The Department shall issue ~~a certificate~~ appropriate credentials to the applicant who meets all the requirements set forth in this Article and the rules adopted for this Article and who successfully completes the examinations required for ~~certification~~ credentialing. Emergency medical ~~technician and~~ technician, medical ~~responder~~ responder, emergency medical dispatcher, emergency medical technician-defibrillation, emergency medical technician-intermediate, emergency medical technician-paramedic, mobile intensive care nurse, emergency medical services-physician assistant, and emergency medical services-nurse practitioner ~~certificates~~ credentials shall be valid for a period not to exceed four years and may be renewed ~~after reexamination~~ if the holder meets the requirements set forth in the rules of the Commission. The Department is authorized to revoke or suspend ~~a certificate~~ these credentials at any time it determines that the holder no longer meets the qualifications ~~prescribed~~ prescribed. ~~for emergency medical technicians or for medical responders.~~

(b) The Commission shall adopt rules setting forth the qualifications required for ~~certification~~ credentialing of medical ~~responders and~~ responders, emergency medical ~~technicians.~~ technicians, emergency medical technician-defibrillation, emergency medical technician-intermediate, emergency medical technician-paramedic, emergency medical dispatcher, mobile intensive care nurse, emergency medical services-physician assistant, and emergency medical services-nurse practitioner.

~~(b1)~~(c) An individual currently ~~certified~~ credentialed as an emergency medical ~~technician~~ technician, emergency medical technician-defibrillation, emergency medical technician-intermediate, and emergency medical technician-paramedic by the National Registry of Emergency Medical Technicians or by another state where the ~~education/certification~~ education/credentialing requirements have been approved for legal recognition by the Department of Health and Human Services, in accordance with rules promulgated by the Medical Care Commission, and who is either currently residing in North Carolina or affiliated with a permitted ~~ambulance~~ EMS provider offering service within North Carolina, may be eligible for ~~certification~~ credentialing as

an emergency medical technician without examination. This ~~certification~~ credentialing shall be valid for a period not to exceed the length of the emergency medical technician-defibrillation, emergency medical technician-intermediate, and emergency medical technician-paramedic applicant's original ~~certification~~ credentialing or four years, whichever is less.

(d) An individual currently credentialed as an emergency medical dispatcher by a national credentialing agency, or by another state where the education/credentialing requirements have been approved for legal recognition by the Department of Health and Human Services, in accordance with rules issued by the Medical Care Commission, and who is either currently residing in North Carolina or affiliated with an emergency medical dispatcher program approved by the Department of Health and Human Services offering service within North Carolina, may be eligible for credentialing as an emergency medical dispatcher without examination. This credentialing shall be valid for a period not to exceed the length of the applicant's original credentialing or four years, whichever is less.

~~(c)~~(e) Duly authorized representatives of the Department may issue temporary ~~certificates~~ credentials with or without examination upon finding that this action will be in the public interest. Temporary ~~certificates~~ credentials shall be valid for a period not exceeding 90 days.

(f) The Department may deny, suspend, amend, or revoke the credentials of a medical responder, emergency medical technician, emergency medical technician-defibrillation, emergency medical technician-intermediate, emergency medical technician-paramedic, emergency medical dispatcher, emergency medical services-physician assistant, emergency medical services-nurse practitioner, or mobile intensive care nurse in any case in which the Department finds that there has been a substantial failure to comply with the provisions of this Article or the rules issued under this Article. Prior to implementation of any of the above disciplinary actions, the Department shall consider the recommendations of the EMS Disciplinary Committee pursuant to G.S. 143-519. The Department's decision to deny, suspend, amend, or revoke credentials may be appealed by the applicant or credentialed personnel pursuant to the provisions of Article 3 of Chapter 150B of the General Statutes, the Administrative Procedure Act.

"§ 131E-160. Exemptions.

~~The~~ All of the following vehicles are exempt from the provisions of this Article:

(1) Privately owned vehicles not ~~regularly~~ used in the business of transporting ~~patients;~~ patients.

(2) A vehicle rendering service as an ambulance in case of a major catastrophe or emergency, when the permitted ambulances based in the locality of the catastrophe or emergency are insufficient to render the services ~~required;~~ required.

(3) Any ambulance based outside this State, except that an ambulance which receives a patient within this State for transportation to a

location within this State shall comply with the provisions of this ~~Article;~~ Article.

(4) Ambulances owned and operated by an agency of the United States ~~government; and~~ government.

(5) Vehicles owned and operated by rescue squads chartered by the State of North Carolina as nonprofit corporations or associations which are not regularly used to transport sick, injured, wounded or otherwise incapacitated or helpless persons except as a part of rescue operations.

"**§ 131E-161. Violation declared misdemeanor.**

It shall be the responsibility of the ~~ambulance~~ EMS provider to ensure that the ambulance operation complies with the provisions of this Article and all rules adopted for this Article. Upon the violation of any part of this Article or any rule adopted under authority of this Article, the Department shall have the power to ~~revoke~~ deny, revoke, or suspend the permits of all vehicles owned or operated by the violator. The operation of an ambulance without a valid permit or after a permit has been ~~suspended~~ denied, suspended, or revoked or without ~~an emergency medical technician and medical responder aboard~~ appropriate credentialed staffing as required by G.S. 131E-158, shall constitute a Class 1 misdemeanor."

SECTION 2. Article 7A of Chapter 131E reads as rewritten:

"Article 7A.

"Statewide Trauma System Act of 1993.

"**§ 131E-162. Statewide trauma system.**

The Department shall establish and maintain a program for the development of a statewide trauma system. The Department shall consolidate all State functions relating to trauma systems, both regulatory and developmental, under the auspices of this program.

The Commission shall adopt rules to carry out the purpose of this Article. These rules shall be adopted with the advice of the State Emergency Medical Services Advisory Council and shall include the operation of a statewide trauma registry, statewide educational requirements fundamental to the implementation of the trauma ~~system,~~ system. ~~and~~ The rules adopted by the Commission shall establish guidelines for monitoring and evaluating the system including standards and criteria for the denial, suspension, voluntary withdrawal, or revocation of credentials for trauma center designation. The rules adopted by the Commission shall avoid duplication of reporting and minimize the cost to hospitals or other persons reporting under this act. The Office of Emergency Medical Services shall be the agency responsible for monitoring system development, ensuring compliance with rules, and overseeing system effectiveness.

With respect to collection of data and educational requirements regarding trauma, rules adopted by the Medical Care Commission shall limit the authority of the Department to hospitals and ~~prehospital~~ Emergency Medical Services providers. Nothing in this Article shall be interpreted so as to grant the Department authority to require private physicians, schools, or universities, except those ~~voluntarily~~ participating

in the trauma system, to provide information or data or to conduct educational programs regarding trauma.

"**§§ 131E-163, 131E-164:** Reserved for future codification purposes."

SECTION 3. In addition to the temporary rule-making authority contained in G.S. 150B-21.1, the Secretary of the Department of Health and Human Services may adopt temporary rules to implement Articles 7 and 7A of Chapter 131E and Article 56 of Chapter 143 of the General Statutes. The Secretary's authority to adopt temporary rules pursuant to this section shall expire on the date that permanent rules adopted by the Medical Care Commission to implement Articles 7 and 7A of Chapter 131E and Article 56 of Chapter 143 of the General Statutes, as enacted by this act, become effective.

SECTION 4. This act becomes effective January 1, 2002.

HOUSE BILL 453:
Regulation of Emergency Medical Services

BILL ANALYSIS

Committee:	House Health	**Introduced by:**	Rep. Wright
Date:	April 3, 2001	**Summary by:**	Linda Attarian
Version:	H453-CSRM-18		Committee Counsel

SUMMARY: ***The Proposed Committee Substitute for House Bill 453, if enacted, would amend the current law regulating ambulance services to expand the scope of the statute beyond that of the transport of patients to a medical facility by an ambulance service, to include all services provided by a variety of emergency services personnel in responding to an individual's need for emergency care and in responding to improve the community's health and wellness. Any entity engaged in the business providing a continuum of out-of-hospital care for patients would be covered under the Article. The bill also proposes to require the Medical Care Commission to adopt rules to establish standards and criteria for the denial, suspension, voluntary withdrawal, or revocation of credentials for trauma center designation. The act is effective when it becomes law.***

CURRENT LAW: The General Assembly first adopted laws to regulate ambulance services in 1967. In 1995, the General Assembly enacted legislation to require the Medical Care Commission (Commission) to adopt rules setting forth the qualifications required for a person or entity to obtain an Ambulance Provider License from the Department of Health and Human Services (Department) to engage in the business or service of treating or transporting patients "upon the streets or highways, waterways, or airways" in North Carolina. That same legislation authorized the Department to deny, suspend, amend or revoke a provider's license in any case the Department finds that there has been a substantial failure to comply with the provisions of the article or the rules adopted by the Commission.

The Commission sets forth the requirements for equipment, sanitation, supply, and design for ambulances. When necessary, the Department inspects each ambulance for compliance with these specifications.

No person or entity may operate any vehicle as an ambulance without first obtaining an operating permit for that vehicle. The Department may issue the permit upon receipt of an application and after the Department determines that the vehicle meets all the necessary ambulance requirements.

Every ambulance must be staffed by at least one certified "emergency medical technician" (EMT) who is responsible for the medical aspects of the mission and one certified "medical responder" (MR) who is responsible for the operation of the ambulance and who assists the emergency medical technician. There are exceptions to this general requirement.

The Department certifies EMTs and MRs. The certification process is based on the applicant's qualifications and performance on written and practical examinations.

Anyone violating the law is subject to having his or her license revoked and the operation of an ambulance without a valid permit constitutes a Class 1 misdemeanor.

The following ambulances are exempt from the requirements set forth in the Article:

(1) Privately owned vehicles not regularly used in the business of transporting patients;

(2) A vehicle rendering service as an ambulance in case of a major catastrophe or emergency,

(3) Any ambulance based outside this State;

(4) Ambulances owned and operated by an agency of the United States government; and

(5) Vehicles owned and operated by rescue squads as a part of rescue operations.

BILL ANALYSIS: Aside from making numerous technical and conforming amendments, **Section 1** amends Article 7 of Chapter 131E of the General Statutes to reflect the current state of emergency medicine and the provision of emergency services. This area of health care services has evolved into a comprehensive system of community support and emergency services since the current law was enacted.

Section 1 amends the statutes to provide regulatory oversight to the continuum of emergency services provided outside the hospital setting. The proposed amendments include:

- Several new definitions are added to G.S. 131E-155 to account for the various types of personnel that are typically involved in the provision of emergency services. These personnel include:
  1. Emergency medical dispatcher (See 131E-155 (5));
  2. Emergency medical services-nurse practitioner (See 131E-155(8));
  3. Emergency medical services-physician assistant (See 131E-155(9);
  4. Emergency medical technician-defibrillation (See 131E-155(11));
  5. Emergency medical technician-intermediate (See 131E-155(12));
  6. Emergency medical technician-paramedic (See 131E-155(14); and
  7. Mobile intensive care nurse (See 131E-155(15).
- The PCS changes and expands the scope of the Article by deleting, in the title of the Article, the reference to "Ambulance Services" and replacing that term with "Emergency Medical Services" (EMS). The term EMS is defined in the PCS to mean "*all services rendered in responding to improve the health and wellness of the community and to address the individual's need for emergency medical care within the scope of practice as defined by the NC Medical Board in order to prevent loss of life or aggravation of physiological or psychological illness or injury.*" Thus, if enacted, the PCS would expand the scope of Article 7 to regulate the provision of these services. See G.S. 131E-155(6).
- The current law regulates ambulance providers. An ambulance provider is currently defined as someone or an entity engaged in the ambulance business. This is a fundamental definition that defines and limits the scope of the current law. The PCS proposes to amend the definition by deleting the reference to "ambulance" and replacing it with "EMS". The PCS defines an EMS provider as *an entity (other than a person), which engages providing EMS services.*
- The PCS does not change the current requirement that a permit is required for a vehicle to be used as an ambulance, but the PCS changes the expiration date of the permit from one year to four years from the date of issuance. See G.S. 131E-155(b).
- The PCS changes the initial process by which "EMS" personnel are approved by the Department by deleting references to "certifying" and replacing that term with "credentialing". All other provisions related to this process remain unchanged, except for a new provision that would allow the Department

to credential persons who are currently credentialed in other states or by a national credentialing agency and who are currently residing in North Carolina and seeking NC credentialed status.

Section 2 amends G.S. 131E-162, which requires the Department to establish and maintain a program for the development of a statewide trauma system, to require the Medical Care Commission to adopt rules relating to the standards and criteria for the denial, suspension, voluntary withdrawal, or revocation of credentials for trauma center designation.

Section 3 specifically authorizes the Department of Health and Human Services to adopt temporary rules to implement the act.

Section 4 makes the bill effective on January 1, 2002.

NORTH CAROLINA GENERAL ASSEMBLY

LEGISLATIVE FISCAL NOTE

BILL NUMBER: HB 453 (House PCS7186-RM-18)

SHORT TITLE: Regulation of Emergency Medical Services - AB

SPONSOR(S): Representative Wright

FISCAL IMPACT

Yes ( ) **No (X)** **No Estimate Available ( )**

	FY 2001-02	FY 2002-03	FY 2003-04	FY 2004-05	FY 2005-06
REVENUES					
EXPENDITURES					
POSITIONS:					

PRINCIPAL DEPARTMENT(S) & PROGRAM(S) AFFECTED:

Department of Health and Human Service
Division of Facility Services

EFFECTIVE DATE: When it becomes law

BILL SUMMARY: The proposed legislation provides for the regulation of emergency medical services by amending GS Chapter 131E, Article 7, Regulation of Ambulance Services. Changes title to "Regulation of Emergency Medical Services" and makes provisions of article applicable to all emergency medical services (EMS) provided in NC. Adds new definitions for terms describing various categories of EMS personnel. Increases period for which an ambulance permit is valid to up to four years (currently, up to one year). Requires EMS personnel to be credentialed by Department of Health and Human Services. Authorizes NC Medical Care Commission to adopt rules regarding such credentialing. Amends GS Chapter 131E, Article 7A, the Statewide Trauma System Act, to require Commission to adopt rules regarding credentials for trauma centers. Makes additional technical, updating, and conforming changes.

ASSUMPTIONS AND METHODOLOGY:
The proposed legislation updates existing law for regulating Emergency Medical Services, but it does not significantly enlarge the responsibilities of the Department of Health and Human Services to the point where additional staff or funding is necessary.

TECHNICAL CONSIDERATIONS:

FISCAL RESEARCH DIVISION 733-4910
PREPARED BY: L. Carol Shaw

APPROVED BY: James D. Johnson



DATE: April 16, 2001

2001 COMMITTEE REPORT
HOUSE OF REPRESENTATIVES

The following report(s) from standing committee(s) is/are presented:
By Representative(s) **Wright** (Chair/Chairs) for the Committee on **Health**.

☐ Committee Substitute for
H.B. 453 A BILL TO BE ENTITLED AN ACT TO PROVIDE FOR THE REGULATION OF EMERGENCY MEDICAL 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 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)

2/15/01

VISITOR REGISTRATION SHEET

Health- — 4-10-01

Name of Committee — Date

VISITORS:. PLEASE SIGN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Howard KRAMER	N.C. Bd of NURSING
Glenn Welch	DHHS
HUGH TILSON	NCHA
& Peyton Maynard	GPM Co
Jane Pinsky	NCCAI
TOM VITACCIONE	NC CHILD FATALITY TASK FORCE
Lynell Rivenbark	AHA
Susan M. Safran	AHA
Steve Shone	NC Pediatric Society
Sharon Hirsch	NC Social Services Consortium
Jim Bradley	NC DOI INSURANCE
Rachel O'Dell	Prof Fire Fighters & Paramedics of NC
Nicole Rosenberry	PFAF Action Fund Orange & Durham
Pam Benson	NC Primary Care Assoc.
Gordon A Joyner	NCAREMS PO Box 1914 Goldsboro NC 27533
John Bowdish	Alley Associates
Bennie Hollen	DHHS
Mike Fallinger	DHHS/DFS/EMS
Ed Browning	DHHS/DFS/EMS
Lynda McDaniel	DHHS/DFS
David Anders	Prof. Fire Fighters & Paramedics of NC
Michelle Frazier	NC Bar Assoc.
Alicia Gruenebaum	YAFO
Andy [illegible]	NCRMA
AL DEITCH	DOA/YAFO
Paula A. Wolf	Covenant w/NC's Children
IRISH WILSON	W&D
ANN LORE	DHHS
Evelyn Newsome	UNC Chapel Hill

VISITOR REGISTRATION SHEET

House Health — 4/10/01

Name of Committee — Date

VISITORS:. PLEASE SIGN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
John Rustin	NCFPC
DAMICO	W-Salem Journal
Joe LIBERA	AHHC
Jayne V. Bennett	NCCFTF
Greg Mears	NCOEMS
Sam Spicer	NCHICA
W.N. Hilliard	NCCEP
Dyer	News & Record, Greensboro

AGENDA

HOUSE COMMITTEE ON HEALTH
THURSDAY, APRIL 12, 2001
12:00 NOON, ROOM 415 LOB

OPENING REMARKS

Rep. Thomas E. Wright
Chairman

BILLS TO BE DISCUSSED

HB- 275 INFANT HOMICIDE PREVENTION ACT-(Rep. Haire)

HB-896 DATABASE/CONTROLLED SUBSTANCES-(Rep. Hensley)

HB-936 ENTERAL SEDATION/DENTIST PERMITS.-(Rep. Wright)

COMMENTS

ADJOURNMENT

MINUTES

COMMITTEE ON HEALTH

THURSDAY, APRIL 12, 2001

The House Committee on Health met on Thursday, April 12, 2001 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-936 ENTERAL SEDATION/DENTIST PERMITS

Vice-Chairman Edwards introduced Chairman Wright to explain the bill. Rep. Wright explained the bill. William Potter, of the NC Dental Society, further explained the bill. Rep. Wright further commented on the bill. Rep. Insko asked about the enteral IV and anesthesia. Rep. Edwards responded, along with, William Potter.

Rep. Howard moved for a favorable report to the bill. So moved.

The meeting adjourned at 12:15pm.

Rep. Thomas Wright,
Chairman

Vanda Wilson-Wormack
Committee Assistant

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2001

H 1

HOUSE BILL 936*

Short Title:	Enteral Sedation/Dentist Permits.	(Public)
Sponsors:	Representative Wright.	
Referred to:	Health.	

March 29, 2001

A BILL TO BE ENTITLED

AN ACT AUTHORIZING THE NORTH CAROLINA BOARD OF DENTAL EXAMINERS TO ESTABLISH REGULATORY STANDARDS FOR THE ADMINISTRATION AND MONITORING OF ENTERAL SEDATION FOR OUTPATIENTS IN THE DENTAL SETTING IN ADDITION TO EXISTING STANDARDS FOR GENERAL ANESTHESIA AND PARENTERAL SEDATION.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 90-30.1 reads as rewritten:

"**§ 90-30.1. Standards for general anesthesia and enteral and parenteral sedation; fees authorized.**

The North Carolina Board of Dental Examiners may establish by regulation reasonable education, training, and equipment standards for safe administration and monitoring of general anesthesia and enteral and parenteral sedation for outpatients in the dental setting. Regulatory standards may include a permit process for general anesthesia and enteral and parenteral sedation by dentists. The requirements of any permit process adopted under the authority of this section ~~must~~shall include provisions that will allow a dentist to qualify for continued use of ~~general anesthesia,~~enteral sedation, if he or she is licensed to practice dentistry in North Carolina and shows the Board that he or she has been utilizing ~~general anesthesia~~enteral sedation in a competent manner for the five years preceding ~~July 1, 1988,~~January 1, 2002, and his or her office facilities pass an on-site examination and inspection by qualified representatives of the Board. For purposes of this section, oral premedication administered for minimal sedation (anxiolysis) shall not be included in the definition of enteral sedation. In order to provide the means of regulating general anesthesia and enteral and parenteral sedation, including examination and inspection of dental offices involved, the Board may charge and collect fees established by its rules for each permit application, each

annual permit renewal, and each office inspection in an amount not to exceed the maximum fee amounts set forth in G.S. 90-39."

SECTION 2. This act becomes effective January 1, 2002.

2001 COMMITTEE REPORT
HOUSE OF REPRESENTATIVES

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

☐ Committee Substitute for
H.B. 936 A BILL TO BE ENTITLED AN ACT AUTHORIZING THE NORTH CAROLINA BOARD OF DENTAL EXAMINERS TO ESTABLISH REGULATORY STANDARDS FOR THE ADMINISTRATION AND MONITORING OF ENTERAL SEDATION FOR OUTPATIENTS IN THE DENTAL SETTING IN ADDITION TO EXISTING STANDARDS FOR GENERAL ANESTHESIA AND PARENTERAL SEDATION.

☒ 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)

2/15/01

VISITOR REGISTRATION SHEET

Health
Name of Committee

4-12-01
Date

VISITORS:. PLEASE SIGN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
[illegible]	NCSA
WHPotts Jr	NCDS
J LIBERA	AHHC
[illegible]	NCDS
W Cherry	Bone & Assoc
[illegible]	Prof Fire Fighters & Paramedics of NC
[illegible]	Bone -

AGENDA

HOUSE COMMITTEE ON HEALTH
TUESDAY, APRIL 17, 2001
12:00 NOON, ROOM 415 LOB

OPENING REMARKS

Rep. Thomas E. Wright
Chairman

BILLS TO BE DISCUSSED

HB- 275 INFANT HOMICIDE PREVENTION ACT-(Rep. Haire)

HB-1001- HOSPITAL LICENSURE/ CRITICAL ACCESS HOSPITAL. (Rep. Wright)

HB-1002 HOSPITAL GOVERNING AUTHORITY. (Rep. Wright)

HB-1030 MENTAL HEALTH SVCES/MEDICAID BILLING. (Rep. Clary)

COMMENTS

ADJOURNMENT

MINUTES

COMMITTEE ON HEALTH

TUESDAY, APRIL 17, 2001

12:00 NOON ROOM 415 LOB

The House Committee met on Tuesday, April 17, 2001 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-1001 HOSPITAL LICENSURE/CRITICAL ACCESS HOSPITAL(Rep. Wright)

Vice-Chairman Edwards introduced Rep. Wright to explain the bill. Rep. Wright explained the bill. Hugh Tilson of the NC Hospital Association further commented on the bill. Rep. Edwards asked Hugh Tilson about the Rural Hospital Network. Hugh Tilson responded. Rep. Insko asked about the networking arrangement. Rep. Wright responded.

Rep. Buchanan moved for a favorable report to the bill. So moved.

HB-1002 HOSPITAL GOVERNING AUTHORITY.(Rep. Wright)

Vice Chairman Edwards introduced Rep. Wright to explain the bill. Rep. Wright explained the bill.

Rep. Buchanan moved for a favorable report to the bill. So moved.

HB-275 INFANT HOMICIDE PREVENTION ACT.(Rep. Haire)

Rep. Haire was recognized to explain the bill. Rep. Haire stated that there were several amendments to the bill. Rep. Sherrill moved to amend the bill on page 3, line 9, line 13 and line 20. Rep. Sherrill further explained the amendments. Dianna Jessup further commented on the amendments. Rep. Barnhart asked about the number of children affected. Rep. Haire responded. Rep. Haire followed up with another question about the number of children. Rep. Haire responded.

The question before the committee is the adoption of the amendment. So moved.

Rep. Edwards sent forth an amendment and moved for an adoption. Dianna Jessup, staff, further explained the amendment. Rep. Wright asked if the amendment would affect an off duty emergency services worker. Dianna Jessup responded.

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

Rep. Edwards sent forth a second amendment. Rep. Edwards explained the amendment to the committee and moved for adoption. So moved.

Rep. Barnhart sent forth an amendment.

Rep. Barnhart explained the amendment to the committee and moved for adoption. Rep. Haire responded to the amendment brought forth by Rep. Barnhart. Rep. Sherrill opposed the amendment before the committee. Rep. Barnhart responded. Rep. Clary commented on the amendment. Tom Taglione of the NC Child Fatality Task Force, commented on the amendment. Rep. Clary followed up with a comment about the bill. Tom Taglione responded.

Rep. Clary sent forth a perfecting amendment.

Rep. Edwards asked if the mothers were nursing the abandoned infants. Tom Bennett of the NC Child Fatality Task Force responded. Rep. Sherrill commented on the importance of the bill. Rep. Barnhart stated the original amendment sent forth by him was his original intent for the amendment and opposed the perfecting amendment.

Chairman Wright called the question before the committee to vote on the perfecting amendment sent forth by Rep. Clary. A vote was taken. 6 in the affirmative and 2 opposed. The perfecting amendment was adopted.

Rep. Barnhart was recognized to send forth a second amendment.

Rep. Barnhart explained the amendment to the committee and moved for adoption of the amendment. Rep. Earle asked if the term "infant" was defined. Dianna Jessup responded. Rep. Earle followed up with a comment about the definition for the term "infant". Rep. Haire commented on the amendment and asked the committee to oppose the amendment. Rep. Barnhart responded. Rep. Haire followed up with a comment about the amendment. Rep. Barnhart responded. Rep. Insko commented on the bill.

Chairman Wright called the question before the committee for the adoption of the amendment sent forth by Rep. Barnhart. The amendment failed.

Rep. Earle moved to give the Proposed House Committee Substitute HB-275 a favorable report, unfavorable to the original bill. So moved.

Chairman Wright adjourned the meeting at 12:55pm

Rep. Thomas E. Wright
Chairman

Vanda Wilson-Wormack
Committee Assistant

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2001

H 2

HOUSE BILL 275*
Committee Substitute Favorable 3/21/01

Short Title: Infant Homicide Prevention Act. (Public)

Sponsors:

Referred to:

February 27, 2001

A BILL TO BE ENTITLED

AN ACT TO DECRIMINALIZE ABANDONMENT OF AN INFANT UNDER CERTAIN CIRCUMSTANCES AND TO MODIFY SOME PROCEDURES INVOLVING ABANDONED JUVENILES.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 7B-302(a) reads as rewritten:

"(a) When a report of abuse, neglect, or dependency is received, the director of the department of social services shall make a prompt and thorough investigation in order to ascertain the facts of the case, the extent of the abuse or neglect, and the risk of harm to the juvenile, in order to determine whether protective services should be provided or the complaint filed as a petition. When the report alleges abuse, the director shall immediately, but no later than 24 hours after receipt of the report, initiate the investigation. When the report alleges neglect or dependency, the director shall initiate the investigation within 72 hours following receipt of the report. When the report alleges abandonment, the director shall immediately initiate an investigation, take appropriate steps to assume temporary custody of the juvenile, and take appropriate steps to secure an order for nonsecure custody of the juvenile. The investigation and evaluation shall include a visit to the place where the juvenile resides. When the report alleges abandonment, the investigation shall include a request from the director to law enforcement officials to investigate through the North Carolina Center for Missing Persons and other national and State resources whether the juvenile is a missing child. All information received by the department of social services, including the identity of the reporter, shall be held in strictest confidence by the department."

SECTION 2. G.S. 7B-500 reads as rewritten:

"**§ 7B-500. Taking a juvenile into temporary ~~custody.~~custody; civil and criminal immunity.**

(a) Temporary custody means the taking of physical custody and providing personal care and supervision until a court order for nonsecure custody can be obtained. A juvenile may be taken into temporary custody without a court order by a law

enforcement officer or a department of social services worker if there are reasonable grounds to believe that the juvenile is abused, neglected, or dependent and that the juvenile would be injured or could not be taken into custody if it were first necessary to obtain a court order. If a department of social services worker takes a juvenile into temporary custody under this section, the worker may arrange for the placement, care, supervision, and transportation of the juvenile.

(b) The following individuals shall, without a court order, take into temporary custody an infant under 15 days of age that is voluntarily delivered to the individual by the infant's parent who does not express an intent to return for the infant:

(1) A health care provider, as defined under G.S. 90-21.11, who is on duty or at a hospital or at a local or district health department.

(2) A law enforcement officer who is on duty or at a police station or sheriff's department.

(3) A social services worker who is on duty or at a local department of social services.

(4) An emergency medical technician who is on duty or at a fire station.

(c) An individual who takes an infant into temporary custody under subsection (b) of this section shall perform any act necessary to protect the physical health and well-being of the infant and shall immediately notify the department of social services or a local law enforcement agency. Any individual who takes an infant into temporary custody under subsection (b) of this section may inquire as to the parents' identities and as to any relevant medical history, but the parent is not required to provide this information.

(d) Any adult may, without a court order, take into temporary custody an infant under 15 days of age that is voluntarily delivered to the individual by the infant's parent who does not express an intent to return for the infant. Any individual who takes an infant into temporary custody under this section shall perform any act necessary to protect the physical health and well-being of the infant and shall immediately notify the department of social services or a local law enforcement agency. An individual who takes an infant into temporary custody under this subsection may inquire as to the parents' identities and as to any relevant medical history, but the parent is not required to provide this information.

(e) An individual who takes an infant into temporary custody under subsection (b) or (d) of this section is immune from any civil or criminal liability that might otherwise be incurred or imposed as a result of any omission or action taken pursuant to the requirements of subsection (b), (c), or (d) of this section so long as that individual was acting in good faith. The immunity established by this subsection does not extend to gross negligence, wanton conduct, or intentional wrongdoing that would otherwise be actionable."

SECTION 3. G.S. 7B-1111(a)(7) reads as rewritten:

"(a) The court may terminate the parental rights upon a finding of one or more of the following:

...

(7) The parent has willfully abandoned the juvenile for at least six consecutive months immediately preceding the filing of the petition or ~~motion.~~motion, or the parent has voluntarily abandoned an infant pursuant to G.S. 7B-500 for at least 60 consecutive days immediately preceding the filing of the petition or motion."

SECTION 4. G.S. 14-318.2 is amended by adding a new subsection to read:

"(c) A parent who abandons an infant less than 15 days of age pursuant to G.S. 14-322.3 shall not be prosecuted under this section for any acts or omissions related to the care of that infant."

SECTION 5. G.S. 14-318.4 is amended by adding a new subsection to read:

"(c) Abandonment of an infant less than 15 days of age pursuant to G.S. 14-322.3 may be treated as a mitigating factor in sentencing for a conviction under this section involving that infant."

SECTION 6. Article 40 of Chapter 14 of the General Statutes is amended by adding a new section to read:

"**§ 14-322.3. Abandonment of an infant under 15 days of age.**

When a parent abandons an infant less than 15 days of age by voluntarily delivering the infant as provided in G.S. 7B-500(b) or G.S. 7B-500(d) and does not express an intent to return for the infant, that parent shall not be prosecuted under G.S. 14-322 or G.S. 14-322.1."

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

HB 275:
Infant Homicide Prevention Act.

BILL ANALYSIS

Committee:	House Health	**Introduced by:**	Representative Haire
Date:	April 10, 2001	**Summary by:**	Dianna Jessup
Version:	Second Edition		Committee Counsel

SUMMARY: House Bill 275 decriminalizes the abandonment of an infant less than 15 days old under certain circumstances. The bill requires certain persons and authorizes others to receive the infant. The bill shields a good faith "receiver" of the infant from civil and criminal liability. The bill shortens the required waiting period to terminate parental rights from six months to 60 days in cases of voluntary abandonment of infants less than 15 days old.

BILL ANALYSIS:

Abandoning an Infant Less than 15 Days of Age and Immunity from Prosecution.

Under current law, an abandoned juvenile may be taken into temporary custody by a law enforcement officer or a department of social services worker (G.S. 7B-500). In other words, the parent of a newborn infant who desires to abandon the infant could turn the infant over to an officer or to a department of social services worker. However, the parent is potentially subject to prosecution under the following statutes:

- G.S. 14-318.2 - Misdemeanor Child Abuse
- G.S. 14-318.4 - Felony Child Abuse
- G.S. 14-322 - Misdemeanor to refuse to provide child support
- G.S. 14-322.1 - Felony Abandonment

This bill would allow the parent of an infant less than 15 days of age to turn their child over to one of the following persons:

- A health care provider who is on duty or at a hospital or local health department,
- A law enforcement officer who is on duty or at a police station or sheriff's department,
- A department of social services worker who is on duty or at a local department of social services,
- An emergency medical technician who is on duty or at a fire station, or
- Any adult of suitable discretion who willingly accepts the infant.

In addition, the parent would not be subject to prosecution under G.S. 14-322, misdemeanor to refuse to provide child support, and G.S. 14-322.1, felony abandonment. The abandoning parent would not be subject to prosecution under G.S. 14-318.2, misdemeanor child abuse, for acts or omissions related to the care of the infant. Finally, abandoning parents who also commit felony child abuse could still be prosecuted under G.S. 14-318.4, but abandoning an infant according to the provisions of this bill would be treated as a mitigating factor in the sentencing of a conviction under G.S. 14-318.4.

Taking a Juvenile into Temporary Custody.

The persons listed above **must** take an infant less than 15 of age into temporary custody without a court order when the infant is voluntarily delivered to the individual by the infant's parent and the parent does not express an intent to return for the infant. In addition, any adult **may**, under the same circumstances, take an infant less than 15 days old into temporary custody.

Obligation of the Individual Taking Temporary Custody.

Individuals taking an infant into temporary custody under the provisions of this bill must protect the health and well being of the infant and must immediately inform the department of social services or a local law enforcement agency.

Identity of the Parents.

The individual may inquire as to the parents' identities and medical history, but the parent is not required to provide this information.

Civil and Criminal Immunity.

Individuals taking an infant into temporary custody under the provisions of this bill are immune from civil or criminal liability under the temporary custody provisions of this bill so long as the individual acted in good faith. However, the immunity does not extend to gross negligence, wanton conduct, or intentional wrongdoing that would otherwise be actionable.

Director of DSS to Initiate Investigation Immediately in Cases of Abandonment.

Under current law, when abuse of a juvenile is alleged, the Director of the Division of Social Services (DSS) must initiate an investigation within 24 hours. When neglect or dependency is alleged the Director must initiate the investigation within 72 hours (G.S. 7B-302(a)).

When abandonment is alleged (abandonment is considered a type of neglect), this bill would require the Director to initiate an investigation immediately, to take temporary custody of the juvenile, and to secure an order of nonsecure custody. The Director must also request that law enforcement investigate through the N.C. Center for Missing Persons and other resources as to whether or not the juvenile is a missing child.

Termination of Parental Rights (TPR).

Under current law, a court may terminate parental rights upon various grounds including that the parent has willfully abandoned the child for at least six consecutive months immediately preceding the filing of the TPR petition.

Under this bill, the court may terminate parental rights when a parent voluntarily abandons an infant less than 15 days old for at least 60 consecutive days immediately preceding the filing of the petition.

Effective Date.

This bill is effective when it becomes law.

Esther Manheimer, Staff Attorney, contributed to this summary.

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2001

H D

HOUSE BILL 275*

Committee Substitute Favorable 3/21/01

PROPOSED COMMITTEE SUBSTITUTE H275*-PCS8193-SW-31

Short Title: Infant Homicide Prevention Act. (Public)

Sponsors:

Referred to:

February 27, 2001

A BILL TO BE ENTITLED

AN ACT TO DECRIMINALIZE ABANDONMENT OF AN INFANT UNDER CERTAIN CIRCUMSTANCES AND TO MODIFY SOME PROCEDURES INVOLVING ABANDONED JUVENILES.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 7B-302(a) reads as rewritten:

"(a) When a report of abuse, neglect, or dependency is received, the director of the department of social services shall make a prompt and thorough investigation in order to ascertain the facts of the case, the extent of the abuse or neglect, and the risk of harm to the juvenile, in order to determine whether protective services should be provided or the complaint filed as a petition. When the report alleges abuse, the director shall immediately, but no later than 24 hours after receipt of the report, initiate the investigation. When the report alleges neglect or dependency, the director shall initiate the investigation within 72 hours following receipt of the report. When the report alleges abandonment, the director shall immediately initiate an investigation, take appropriate steps to assume temporary custody of the juvenile, and take appropriate steps to secure an order for nonsecure custody of the juvenile. The investigation and evaluation shall include a visit to the place where the juvenile resides. When the report alleges abandonment, the investigation shall include a request from the director to law enforcement officials to investigate through the North Carolina Center for Missing Persons and other national and State resources whether the juvenile is a missing child. All information received by the department of social services, including the identity of the reporter, shall be held in strictest confidence by the department."

SECTION 2. G.S. 7B-500 reads as rewritten:

"**§ 7B-500. Taking a juvenile into temporary ~~custody.~~custody; civil and criminal immunity.**

(a) Temporary custody means the taking of physical custody and providing personal care and supervision until a court order for nonsecure custody can be obtained.

A juvenile may be taken into temporary custody without a court order by a law enforcement officer or a department of social services worker if there are reasonable grounds to believe that the juvenile is abused, neglected, or dependent and that the juvenile would be injured or could not be taken into custody if it were first necessary to obtain a court order. If a department of social services worker takes a juvenile into temporary custody under this section, the worker may arrange for the placement, care, supervision, and transportation of the juvenile.

(b) The following individuals shall, without a court order, take into temporary custody an infant under seven days of age that is voluntarily delivered to the individual by the infant's parent who does not express an intent to return for the infant:

(1) A health care provider, as defined under G.S. 90-21.11, who is on duty or at a hospital or at a local or district health department.

(2) A law enforcement officer who is on duty or at a police station or sheriff's department.

(3) A social services worker who is on duty or at a local department of social services.

(4) A certified emergency medical service worker who is on duty or at a fire or emergency medical services station.

(c) An individual who takes an infant into temporary custody under subsection (b) of this section shall perform any act necessary to protect the physical health and well-being of the infant and shall immediately notify the department of social services or a local law enforcement agency. Any individual who takes an infant into temporary custody under subsection (b) of this section shall inquire as to the parents' identities and as to any relevant medical history, and the parent shall provide this information, if available.

(d) Any adult may, without a court order, take into temporary custody an infant under seven days of age that is voluntarily delivered to the individual by the infant's parent who does not express an intent to return for the infant. Any individual who takes an infant into temporary custody under this section shall perform any act necessary to protect the physical health and well-being of the infant and shall immediately notify the department of social services or a local law enforcement agency. An individual who takes an infant into temporary custody under this subsection shall inquire as to the parents' identities and as to any relevant medical history, and the parent shall provide this information, if available.

(e) An individual who takes an infant into temporary custody under subsection (b) or (d) of this section is immune from any civil or criminal liability that might otherwise be incurred or imposed as a result of any omission or action taken pursuant to the requirements of subsection (b), (c), or (d) of this section as long as that individual was acting in good faith. The immunity established by this subsection does not extend to gross negligence, wanton conduct, or intentional wrongdoing that would otherwise be actionable."

SECTION 3. G.S. 7B-1111(a)(7) reads as rewritten:

"(a) The court may terminate the parental rights upon a finding of one or more of the following:

...

(7) The parent has willfully abandoned the juvenile for at least six consecutive months immediately preceding the filing of the petition or ~~motion.~~motion, or the parent has voluntarily abandoned an infant pursuant to G.S. 7B-500 for at least 60 consecutive days immediately preceding the filing of the petition or motion."

SECTION 4. G.S. 14-318.2 is amended by adding a new subsection to read:

"(c) A parent who abandons an infant less than seven days of age pursuant to G.S. 14-322.3 shall not be prosecuted under this section for any acts or omissions related to the care of that infant. The court in its discretion may determine whether or not this subsection shall apply if the State proves that the parent has abandoned more than two infants under seven days of age as provided in G.S. 7B-500(b) or G.S. 7B-500(d)."

SECTION 5. G.S. 14-318.4 is amended by adding a new subsection to read:

"(c) Abandonment of an infant less than seven days of age pursuant to G.S. 14-322.3 may be treated as a mitigating factor in sentencing for a conviction under this section involving that infant. The court in its discretion may determine whether or not this subsection shall apply if the State proves that the parent has abandoned more than two infants under seven days of age as provided in G.S. 7B-500(b) or G.S. 7B-500(d)."

SECTION 6. Article 40 of Chapter 14 of the General Statutes is amended by adding a new section to read:

"**§ 14-322.3. Abandonment of an infant under seven days of age.**

When a parent abandons an infant less than seven days of age by voluntarily delivering the infant as provided in G.S. 7B-500(b) or G.S. 7B-500(d) and does not express an intent to return for the infant, that parent shall not be prosecuted under G.S. 14-322 or G.S. 14-322.1. The court in its discretion may determine whether or not this section shall apply if the State proves that the parent has abandoned more than two infants less than seven days of age by voluntarily delivering the infants as provided in G.S. 7B-500(b) or G.S. 7B-500(d)."

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

NORTH CAROLINA GENERAL ASSEMBLY
AMENDMENT
House Bill 275*

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

H275-ASW-14 [v.4]

Date _____,2001

Comm. Sub. [NO]
Amends Title [NO]
Second Edition

Representative Wright

moves to amend the bill on page 3, line 9, by rewriting the line to read:
"the care of the infant. The court in its discretion may determine whether or not this subsection shall apply if the State proves that the parent has abandoned more than two infants under 15 days of age as provided in G.S. 7B-500(b) or G.S. 7B-500(d).";
and on page 3, line 13, by rewriting the line to read:
"involving that infant. The court in its discretion may determine whether or not this subsection shall apply if the State proves that the parent has abandoned more than two infants under 15 days of age as provided in G.S. 7B-500(b) or G.S. 7B-500(d).";
and on page 3, line 20, by rewriting the line to read:
"G.S. 322.1. The court in its discretion may determine whether or not this section shall apply if the State proves that the parent has abandoned more than two infants less than 15 days of age by voluntarily delivering the infant as provided in G.S. 7B-500(b) or G.S. 7B-500(d).".

SIGNED _____
Amendment Sponsor
SIGNED _____
Committee Chair if Senate Committee Amendment

NORTH CAROLINA GENERAL ASSEMBLY
AMENDMENT
House Bill 275*

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

H275-ASW-14 [v.4]

ADOPTED _____ FAILED _____ TABLED _____

NORTH CAROLINA GENERAL ASSEMBLY
AMENDMENT
House Bill 275*

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

H275-ASW-11 [v.1]

Date _____,2001

Comm. Sub. [NO]
Amends Title [NO]
Second Edition

Representative Edwards

moves to amend the bill on page 2, lines 21 and 30, by deleting "may" and substituting "shall"; and
on page 2, lines 22 and 31, by deleting "but" and substituting "and"; and
on page 2, line 22, by deleting the phrase "is not required to" and substituting the phrase "shall"; and
on page 2, line 23, by rewriting the line to read "information, if available."; and
on page 2, lines 31-32, by deleting the phrase "is not required to provide this information." and substituting the phrase "shall provide this information, if available".

SIGNED _____
Amendment Sponsor

SIGNED _____
Committee Chair if Senate Committee Amendment

ADOPTED _____ FAILED _____ TABLED _____

NORTH CAROLINA GENERAL ASSEMBLY
AMENDMENT
House Bill 275*

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

H275-ASW-13 [v.1]

Date _____,2001

Comm. Sub. [NO]
Amends Title [NO]
Second Edition

Representative Edwards

moves to amend the bill on page 2, line 16, by rewriting the line to read:

"(4) An certified emergency medical service worker who is on duty or at a fire or emergency medical services station."

SIGNED _____
Amendment Sponsor

SIGNED _____
Committee Chair if Senate Committee Amendment

ADOPTED _____ FAILED _____ TABLED _____

NORTH CAROLINA GENERAL ASSEMBLY
AMENDMENT
House Bill 275*

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

H275-ALY-7 [v.1]

Date 17 APRIL ,2001

Comm. Sub. [NO]
Amends Title [NO]
Second Edition

Representative BARNHART

moves to amend the bill on page 2, line 8, by replacing the phrase "15 days" with the phrase "72 hours";

and on page 2, line 25, by replacing the phrase "15 days" with the phrase "72 hours";

and on page 3, line 7, by replacing the phrase "15 days" with the phrase "72 hours";

and on page 3, line 11, by replacing the phrase "15 days" with the phrase "72 hours";

and on page 3, line 16, by replacing the phrase "**15 days**" with the phrase "**72 hours**";

and on page 3, line 17, by replacing the phrase "15 days" with the phrase "72 hours".

SIGNED Jeffrey L Barnhart
Amendment Sponsor

NORTH CAROLINA GENERAL ASSEMBLY
AMENDMENT
House Bill 275*

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

H275-ALY-7 [v.1]

SIGNED _____
Committee Chair if Senate Committee Amendment

ADOPTED _____ FAILED _____ TABLED _____

NORTH CAROLINA GENERAL ASSEMBLY
AMENDMENT
House Bill 275*

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

H275-ASW-16 [v.1]

Date 17 APRIL ,2001

Comm. Sub. [NO]
Amends Title [YES]
Second Edition

Representative BARNHART

moves to amend the bill on page 1, line 2, by adding after the word "ACT" the phrase "TO ADD THE DEFINITION OF 'INFANT' TO SUBCHAPTER 1 OF THE JUVENILE CODE TO MEAN ANY INFANT BORN ALIVE,";
and on page 1, lines 5-6, by inserting the following:

"**SECTION 1.** G.S. 7B-101 is amended by adding a new subdivision to read:

'**§ 7B-101. Definitions.**

As used in this Subchapter, unless the context clearly requires otherwise, the following words have the listed meanings:

...

(11a) Infant. – Every infant member of the species homo sapiens who is born alive at any stage of development. As used in this subdivision, the term "born alive" means having been completely expelled or extracted from the infant's mother, at any stage of development, who after that extraction or expulsion breathes or has a beating heart, pulsation of the umbilical cord, or definite movement of voluntary muscles, regardless of whether the umbilical cord has been cut, and regardless of whether the expulsion or extraction occurs as a result of natural or induced labor, cesarean section, or induced abortion.'";

NORTH CAROLINA GENERAL ASSEMBLY
AMENDMENT
House Bill 275*

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

H275-ASW-16 [v.1]

and by renumbering the remaining sections accordingly.

SIGNED Jeffrey I Barnhart
Amendment Sponsor

SIGNED _____
Committee Chair if Senate Committee Amendment

ADOPTED _____ FAILED _____ TABLED _____

2001 COMMITTEE REPORT
HOUSE OF REPRESENTATIVES

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

☒ Committee Substitute for
H.B. 275 A BILL TO BE ENTITLED AN ACT TO DECRIMINALIZE ABANDONMENT OF AN INFANT UNDER CERTAIN CIRCUMSTANCES AND TO MODIFY SOME PROCEDURES INVOLVING ABANDONED JUVENILES.

☐ 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, #2 comm. sub. bill #1 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)

2/15/01

Covenant *with*
North Carolina's **Children**

Pam Seamans *Chairperson*
Paula A. Wolf *Chief Lobbyist*

HB 275/SB 252-Infant Homicide Prevention Act

(Rep. Phil Haire/Sen. Bill Martin)

Explanation of the Problem

- The National Association of Social Workers estimates that 5,000 babies, both alive and dead, are abandoned in the US each year. A total of 22 newborns were found dead in North Carolina between 1985 and 1997, but the actual death toll is unknown.

Explanation of the Bill

- Would permit the parent of an infant less than 15 days old to place the infant anonymously in the care of a law enforcement officer, a department of social services worker, a health care provider at a hospital, a district health department, or any other "adult of suitable discretion."
- Authorizes the persons listed above to take temporary custody of the child, without a court order, and perform any act necessary to protect the physical health and well-being of the infant, and
- Says that persons taking custody of an abandoned child may inquire as to the identities of the parents and any relevant medical history, but the parent is not required to provide that information.

Other States

- In 1999 the State of Texas enacted legislation providing an affirmative defense to prosecution for a parent who voluntarily delivers a child, 30 days old or younger, to a licensed emergency medical services provider.
- Some 25 other state legislatures considered such laws in 1999-2000, and 13 of them enacted laws.

Where the Bill Originated

- This is a recommendation of the NC Child Fatality Task Force, a 37-member legislative study commission that is responsible for studying the causes of the deaths of our children, and making recommendations to prevent as many deaths as possible in the future.
- No recommendation comes out of the Task Force without considerable discussion and an opportunity for all sides to present their views.
- The Task Force has been studying this issue for more than a year.

Letting Mothers Off the Hook

- To portray it as legislation to "decriminalize child abandonment" is to miss the point. Throwing a newborn into the trash, the landfill or the woods IS deadly abandonment. Placing that baby safe and sound into a responsible adult's arms is NOT deadly abandonment. The whole point of the bill is to encourage desperate, irrational mothers not to kill their newborn babies.

A coalition advancing public policy that benefits children in North Carolina

P.O. Box 28268 • Raleigh, NC 27611 • 919 / 846-1432 • FAX / 829-7299

To Prevent Infant Murder

- The law only has one purpose: to do whatever is within our power as a society to prevent child abuse murders. Such murders occur at least once every two weeks in North Carolina.

The Terrible Choices

- There are two bad alternatives: first, to allow mothers who cannot deal with raising the child they birthed to escape prosecution if they hand off their baby unharmed; or second, prosecute these desperate women for murder after they have tossed their newborns in the garbage.
- For the baby's sake, it is the lesser of two evils to let mothers "get away with irresponsibility" than to have to charge them with homicide. This new law should be passed because the baby's life and safety are what is most important here.

Unwanted Children-Leads to Abuse and Neglect

- The worst outcome is that these babies will not be given up -- and so, they will grow up unwanted, abused, neglected and made to suffer a childhood that is a living hell.
- There were nearly 40,000 substantiated victims of child abuse and neglect last year in our state.
- Healthy, unharmed babies are pretty quickly and easily adopted. Let's give these unwanted children the gift of life and then the gift of a childhood worth living.

Medical Information

- There is a concern that medical information on the infant would be lacking, perhaps jeopardizing the infant and also making it more difficult for such an infant to be adopted.
- The infants in question, however, are less than 15 days old. A complete physical examination at the time the infant is received would provide almost all the information needed.
- Infants this young are the most likely to be adopted, so that concern is mitigated. Finally, it should be noted that hundreds of foreign adoptions are completed each year, though only sketchy medical information is available and many children have obvious medical problems.

Father's Rights

- The bill would allow a period of 60 days for a father to come forward to claim the infant. It should be noted, however, that the Task Force could find no evidence that a father had ever come forward to claim such an infant, either alive or dead.

Increased Promiscuity

- More than one-third of current North Carolina's births are out-of-wedlock. Apparently, North Carolinians need no further encouragement in this area.
- Letters of support for the bill have been received from Bishop Joseph Gosman of the Diocese of Raleigh and the conservative national organization Focus on the Family. Both note that the bill would not only save infants, but also offer an additional alternative to abortion.

HB 275:
Infant Homicide Prevention Act.

BILL ANALYSIS

Committee:	House Health	**Introduced by:**	Representative Haire
Date:	April 14, 2001	**Summary by:**	Dianna Jessup
Version:	Second Edition		Committee Counsel

SUMMARY: House Bill 275 decriminalizes the abandonment of an infant less than 15 days old under certain circumstances. The bill requires certain persons and authorizes others to receive the infant. The bill shields a good faith "receiver" of the infant from civil and criminal liability. The bill shortens the required waiting period to terminate parental rights from six months to 60 days in cases of voluntary abandonment of infants less than 15 days old.

BILL ANALYSIS:

Abandoning an Infant Less than 15 Days of Age and Immunity from Prosecution.

Under current law, an abandoned juvenile may be taken into temporary custody by a law enforcement officer or a department of social services worker (G.S. 7B-500). In other words, the parent of a newborn infant who desires to abandon the infant could turn the infant over to an officer or to a department of social services worker. However, the parent is potentially subject to prosecution under the following statutes:

- G.S. 14-318.2 - Misdemeanor Child Abuse
- G.S. 14-318.4 - Felony Child Abuse
- G.S. 14-322 - Misdemeanor to refuse to provide child support
- G.S. 14-322.1 - Felony Abandonment

This bill would allow the parent of an infant less than 15 days of age to turn their child over to one of the following persons:

- A health care provider who is on duty or at a hospital or local health department,
- A law enforcement officer who is on duty or at a police station or sheriff's department,
- A department of social services worker who is on duty or at a local department of social services,
- An emergency medical technician who is on duty or at a fire station, or
- Any adult who willingly accepts the infant.

In addition, the parent would not be subject to prosecution under G.S. 14-322, misdemeanor to refuse to provide child support, and G.S. 14-322.1, felony abandonment. The abandoning parent would not be subject to prosecution under G.S. 14-318.2, misdemeanor child abuse, for acts or omissions related to the care of the infant. Finally, abandoning parents who also commit felony child abuse could still be prosecuted under G.S. 14-318.4, but abandoning an infant according to the provisions of this bill would be treated as a mitigating factor in the sentencing of a conviction under G.S. 14-318.4.

Taking a Juvenile into Temporary Custody.

The persons listed above **must** take an infant less than 15 of age into temporary custody without a court order when the infant is voluntarily delivered to the individual by the infant's parent and the parent does not express an intent to return for the infant. In addition, any adult **may**, under the same circumstances, take an infant less than 15 days old into temporary custody.

Obligation of the Individual Taking Temporary Custody.

Individuals taking an infant into temporary custody under the provisions of this bill must protect the health and well being of the infant and must immediately inform the department of social services or a local law enforcement agency.

Identity of the Parents.

The individual may inquire as to the parents' identities and medical history, but the parent is not required to provide this information.

Civil and Criminal Immunity.

Individuals taking an infant into temporary custody under the provisions of this bill are immune from civil or criminal liability under the temporary custody provisions of this bill so long as the individual acted in good faith. However, the immunity does not extend to gross negligence, wanton conduct, or intentional wrongdoing that would otherwise be actionable.

Director of DSS to Initiate Investigation Immediately in Cases of Abandonment.

Under current law, when abuse of a juvenile is alleged, the Director of the Division of Social Services (DSS) must initiate an investigation within 24 hours. When neglect or dependency is alleged the Director must initiate the investigation within 72 hours (G.S. 7B-302(a)).

When abandonment is alleged (abandonment is considered a type of neglect), this bill would require the Director to initiate an investigation immediately, to take temporary custody of the juvenile, and to secure an order of nonsecure custody. The Director must also request that law enforcement investigate through the N.C. Center for Missing Persons and other resources as to whether or not the juvenile is a missing child.

Termination of Parental Rights (TPR).

Under current law, a court may terminate parental rights upon various grounds including that the parent has willfully abandoned the child for at least six consecutive months immediately preceding the filing of the TPR petition.

Under this bill, the court may terminate parental rights when a parent voluntarily abandons an infant less than 15 days old for at least 60 consecutive days immediately preceding the filing of the petition.

Effective Date.

This bill is effective when it becomes law.

Esther Manheimer, Staff Attorney, contributed to this summary.

HOUSE BILL 1001

Short Title:	Hospital Licensure/Critical Access Hospital.	(Public)
Sponsors:	Representative Wright.	
Referred to:	Health.	

April 9, 2001

A BILL TO BE ENTITLED

AN ACT TO AMEND THE DEFINITION OF A PRIMARY CARE HOSPITAL TO REFLECT FEDERAL REQUIREMENTS.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 131E-76 reads as rewritten:

"**§ 131E-76. Definitions.**

As used in this article, unless otherwise specified:

(1) 'Commission' means the North Carolina Medical Care Commission.

(2) 'Governing body' means the Board of Trustees, Board of Directors, partnership, corporation, association, person or group of persons who maintain and control the hospital. The governing body may or may not be the owner of the properties in which the hospital services are provided.

(3) 'Hospital' means any facility which has an organized medical staff and which is designed, used, and operated to provide health care, diagnostic and therapeutic services, and continuous nursing care primarily to inpatients where such care and services are rendered under the supervision and direction of physicians licensed under Chapter 90 of the General Statutes, Article 1, to two or more persons over a period in excess of 24 hours. The term includes facilities for the diagnosis and treatment of disorders within the scope of specific health specialties. The term does not include private mental facilities licensed under Article 2 of Chapter 122C of the General Statutes, nursing homes licensed under G.S. 131E-102, and adult care homes licensed under G.S. 131D-2.

(4) 'Infirmary' means a unit of a school, or similar educational institution, which has the primary purpose to provide limited short-term health and nursing services to its students.

(5) 'Medical review committee' means a committee of a State or local professional society, of a medical staff of a licensed hospital or a committee of a peer review corporation or organization which is formed for the purpose of evaluating the quality, cost of, or necessity for hospitalization or health care, including medical staff credentialing.

(6) ~~'Primary care hospital'~~ 'Critical access hospital' means a hospital which has been designated as a ~~primary care~~ critical access hospital by the North Carolina Department of Health and Human Services, Office of Rural Health and Resource Development. To be designated as a ~~primary care~~ critical access hospital under this subdivision, the hospital must ~~be located in a rural community, provide primary care inpatient services that do not include inpatient surgery, and provide outpatient services which may include outpatient surgery.~~ meet the requirements of federal law for certification as a critical access hospital. ~~A primary care hospital shall have a maximum annual average daily census of 15 patients and may have psychiatric and long-term care distinct part units. A primary care hospital must be part of a rural hospital network.~~ A hospital designated as a critical access hospital shall, at a minimum, offer primary outpatient services and ensure the availability of 24-hour emergency care. A critical access hospital must be part of a rural hospital network.

(7) 'Rural hospital network' means an alliance of members that shall include at least one ~~primary care~~ critical access hospital and one other hospital. To qualify as a rural hospital network, the ~~members~~ critical access hospital must submit a comprehensive, written memorandum of understanding to the Department of Health and Human Services for the Department's approval. The memorandum of understanding must include provisions for patient referral and transfer, a plan for network-wide emergency services, and a plan for sharing patient information and services between hospital members including medical staff credentialing, risk management, quality assurance, and peer review."

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

HOUSE BILL 1001:
Hospital Licensure/Critical Access Hospital

BILL ANALYSIS

Committee:	House Health	**Introduced by:**	Rep. Wright
Date:	April 17, 2001	**Summary by:**	Linda Attarian
Version:	Introduced		Committee Counsel

SUMMARY: ***House Bill 1001 would amend G.S. 131E-76 to delete references in current law to "primary care hospital" and replace them with "critical care access hospital" for purposes of licensure as a hospital under NC law. The purpose of the change is to comply with a new federal Medicare rule allowing rural communities to convert an existing general hospital to a Critical Access Hospital, thereby preserving access to primary care and emergency health care services, and helping to improve the financial health of the hospital through improved reimbursement and different operating requirements. The act is effective when it becomes law.***

CURRENT LAW: Under current hospital licensure laws, a "primary care hospital" is a hospital designated as a primary care hospital by the Department of Health and Human Services, Office of Rural Health and Resource Development. Primary care hospitals are smaller rural hospitals that are networked with a larger hospital to form a rural hospital network. This designation is conditioned on the following requirements:

- Located in a rural community;
- Provides primary care inpatient services that do not include inpatient surgery;
- Provides outpatient services that may include outpatient surgery;
- Maximum average daily census of 15 patients;
- May have distinct long-term care or psychiatric units;
- Be a part of a rural care network.

New Federal Medicare Specialty Hospital Category: Critical Access Hospitals

In 1997, a new federal rule created a "Critical Access Hospital (CAH), a specialty category under the health facility licensure rules for Medicare. The rule is optional, and its intent is to allow rural communities to convert an existing general hospital to a CAH, to preserve access to primary care and emergency health care services, and to help improve the financial health of the hospital through improved reimbursement and different operating requirements. A CAH is reimbursed on a reasonable cost basis for inpatient services, and the facility has a choice of cost-based or all-inclusive rates for outpatient services. The standards of patient care apply to inpatient, outpatient, and satellite services. Each CAH must comply with conditions of participation set forth in the Code of Federal Regulations, Title 42, Vol. 3, Parts 430 to End, 1999. They include:

- Non-profit or public hospital that is open and operating;
- Located 35 miles from another hospital (15 miles in mountainous terrain or areas with only secondary roads) or certified by the State as being a necessary provider;

- Bed size limit of 15 except in swing-bed facilities, which may have up to 25 inpatient beds that can be used interchangeably, provided not more than 15 acute care beds are used at any one time;
- Maximum length of stay of 96 hours unless there is inclement weather, another emergency, or approval for extended stays is granted by the state;
- Make available 24 hour emergency services and nursing services but need not meet all the staffing and service requirements that apply to a full service hospital;
- Participate in a rural health network, which is defined as an organization consisting of at least one CAH and at least one full-service hospital where participants have entered into specific agreements regarding patient referral and transfer, communication, and patient transportation;
- Establish credentialing and quality assurance agreements with at least one hospital that is a member of a network, PRO or equivalent, or an entity identified in the rural health plan of the state;
- Inpatient care may be provided by a mid-level practitioner (physician assistant or nurse practitioner) under remote supervision of a physician; and
- Reimbursed on a reasonable cost basis for inpatient and outpatient services provided to Medicare beneficiaries.

BILL ANALYSIS:

Section 1 amends G.S. 131E-76 to:

- Delete references to "primary care hospital" and replace them with "critical care access hospital" for purposes of licensure as a hospital under NC law;
- Clarify that the Critical Access Hospital must complete and submit the memorandum of understanding between the hospitals participating in a rural hospital network (currently, the members of the network submit the memorandum); and
- Provide that a Critical Access Hospital must, at a minimum, offer primary outpatient services, 24-hour emergency services, and be a member of a rural hospital network.

Section 2 makes the act effective when it becomes law.

BACKGROUND:

According to the NC Hospital Association, there are currently seven Critical Access Hospitals in North Carolina:

- Our Community Hospital, Scotland Neck
- Yancy Medical Center, Burnsville
- FirstHealth Montgomery Memorial Hospital, Troy
- Bertie Memorial Hospital, Windsor
- Swain County Hospital, Bryson City
- District Memorial Hospital, Andrews
- Pender Memorial Hospital, Burgaw

2001 COMMITTEE REPORT
HOUSE OF REPRESENTATIVES

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

☐ Committee Substitute for
H.B. 1001 A BILL TO BE ENTITLED AN ACT TO AMEND THE DEFINITION OF A PRIMARY CARE HOSPITAL TO REFLECT FEDERAL REQUIREMENTS.

☒ 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)

2/15/01

HOUSE BILL 1002

Short Title:	Hospital Governing Authority.	(Public)
Sponsors:	Representative Wright.	
Referred to:	Health.	

April 9, 2001

A BILL TO BE ENTITLED

AN ACT TO PROVIDE THAT THE MEMBERS OF A HOSPITAL AUTHORITY BOARD ARE A PUBLIC BODY AND HAVE THE RIGHT TO SUE AND BE SUED.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 131E-9 reads as rewritten:

"**§ 131E-9. Governing authority of hospital facilities.**

(a) The governing body of a municipality may establish by resolution an office, board, or other municipal agency to plan, establish, construct, maintain, or operate a hospital facility. The resolution shall prescribe the powers, duties, compensation, and tenure of the members of the governing authority. The municipality shall remain responsible for the expenses of planning, establishment, construction, maintenance and operation of the hospital facilities.

(b) (1) The county board of commissioners of a county may establish by resolution a county hospital authority to plan, establish, construct, maintain, or operate a hospital facility. The authority shall be referred to as "_____ County Hospital Authority."

(2) The county hospital authority shall consist of six appointed members and one ex officio member.

(3) The appointed members of the authority shall be appointed by the county board of commissioners. All appointed members shall be residents of the county. Three of the members shall be residents of a city in the county and the remaining three members shall not be residents of the same city or cities in which the other three members appointed under this subdivision reside.

(4) For the initial appointments to the county hospital authority, two of the members shall be appointed for a term of three years, two for a term of

four years, and two for a term of five years to achieve staggered terms. All subsequent appointments shall be for five-year terms.

(5) The ex officio member of the county hospital authority shall be a member of the county board of commissioners. The ex officio member's term on the hospital authority shall be commensurate with his or her term as a member of the county board of commissioners.

(6) When any member of the county hospital authority resigns or is removed from office before the expiration of the member's term, the county board of commissioners shall appoint a person to serve the unexpired portion of the term.

(c) Any authority vested in a county under this Part or any authority or power that may be exercised by a hospital authority under the Hospital Authorities Act, Chapter 131E, Article 2, Part B, may be vested by resolution of the county board of commissioners in a county hospital authority established under this section. However, a county hospital authority shall exercise only the powers and duties prescribed in the county board of commissioners' resolution. The county board of commissioners shall determine in the resolution the compensation, traveling and any other expenses which shall be paid to each member of the county hospital authority. However, the expenses to plan, establish, construct and operate the hospital facility shall remain the responsibility of the county.

(d) The members of an office, board, or other municipal agency established by a municipality pursuant to subsection (a) of this section, or a hospital authority established by a county board of commissioners pursuant to subsection (b) of this section, are a public body and a body corporate and politic and have the right to sue and be sued."

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

HOUSE BILL 1002:
Hospital Governing Authority

BILL ANALYSIS

Committee:	House Health	**Introduced by:**	Rep. Wright
Date:	April 17, 2001	**Summary by:**	Dianna Jessup
Version:	First Edition		Committee Counsel

SUMMARY: *House Bill 1002 would make it clear that the legal status of municipal offices and boards and county hospital authorities that operate hospital facilities under Part A of Article 2, Chapter 131E are separate legal entities that may sue and be sued and are not agencies of the municipality or county. The act would become effective when it becomes law.*

CURRENT LAW: G.S. 131E-9 (within Part A of Article 2 of Chapter 131E) provides that a municipality may establish an office, board or other municipal agency to establish and operate a hospital facility. Similarly, a county board of commissioners may establish a county hospital authority to establish and operate a hospital facility. The resolution adopted by the municipality or the county prescribes the powers and duties of the municipal board or county hospital authority. Currently, these bodies could be considered agencies of the municipality or county.

Commissioners of hospital authorities created pursuant to Part B of Article 2 of Chapter 131E are a public body and a body corporate and politic and may sue and be sued.

BILL ANALYSIS: House Bill 1002 would make the legal status of hospital authorities created pursuant to G.S. 131E-9 the same as the legal status of hospital authorities created under Part B of the same article and chapter. These municipal offices and boards would be separate legal entities that are capable of suing or being sued. However, municipalities and counties would still be responsible for the expenses to establish and operate the hospital facilities.

2001 COMMITTEE REPORT
HOUSE OF REPRESENTATIVES

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

☐ Committee Substitute for
H.B. 1002 A BILL TO BE ENTITLED AN ACT TO PROVIDE THAT THE MEMBERS OF A HOSPITAL AUTHORITY BOARD ARE A PUBLIC BODY AND HAVE THE RIGHT TO SUE AND BE SUED.

☒ 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)

2/15/01

Vanda Wilson-Wormack (Rep. Wright)

From: Clarestene Stewart (Rep. Wright)
Sent: Wednesday, April 18, 2001 12:31 PM
To: Vanda Wilson-Wormack (Rep. Wright)
Subject: FW: H 1001 - Certification



H1001 - federal certification....

-----Original Message-----
From: Linda Attarian (Research)
Sent: Tuesday, April 17, 2001 6:12 PM
To: Rep. Tom Wright
Cc: Carol Shaw (Fiscal Research)
Subject: FW: H 1001 - Certification

REp. Wright, this is what you need to attach to the bill when you report it out. Linda. If you have any questions, please call me.

-----Original Message-----
From: Carol Shaw (Fiscal Research)
Sent: Tuesday, April 17, 2001 4:50 PM
To: Linda Attarian (Research)
Cc: Jim Johnson (Fiscal Research, Director)
Subject: H 1001 - Certification

We agree that this bill does not have a fiscal impact. I have added my name to the memo so Rep. Wright will know it has been reviewed by FRD.

North Carolina General Assembly
Legislative Services Office

George R. Hall, Legislative Services Officer
(919) 733-7044

Tony C. Goldman, Director
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Room 9, Legislative Building
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Terrence D. Sullivan, Director
Research Division
Suite 545, LOB
300 N. Salisbury St.
Raleigh, NC 27603-5925
(919) 733-2578

Memorandum

DATE: April 17, 2001
TO: Rep. Wright
FROM: Linda Attarian, Staff Attorney, Research Division
Fax: 715-5460; Lindaa@ncleg.net
L. Carol Shaw, Principal Fiscal Analyst, Fiscal Research Division
Fax 715-3589; carols@ncleg.net

RE: H1001 – Hospital Licensure/Critical Access Hospital

Background:

G.S. 120-36.8 requires that every introduced bill proposing any change in the law which purports to implement federal law or purports to be required or necessary for compliance with federal law, or on which is conditioned the receipt of federal funds, shall have attached a certification identifying the federal law. The certification is to be provided by the Fiscal Research Division in consultation with Bill Drafting and General Research.

House Bill 1001 proposes to amend the definition of "primary care hospital" for the purpose of conforming to provisions set forth in Title 42, Vol. 3, Parts 430 to End, 1999. This memorandum provides a summary of and citation to the relevant section of Title 42, Vol. 3, Parts 430 to End, 1999 and the corresponding part of H1001. This memorandum does not address the fiscal impact of House Bill H1001. The Fiscal Research Division will provide certification with respect to fiscal impact, if any.

Summary of Rule 432. Health, Health Systems Improvement, Health Facility Licensure. In 1997, a new federal rule created a "Critical Access Hospital (CAH), a specialty category under the health facility licensure rules for Medicare. The rule is optional, and its intent is to allow rural communities to convert an existing general hospital to a CAH, to preserve access to primary care and emergency health care services, and to help improve the financial health of the hospital through improved reimbursement and different operating requirements. A CAH is reimbursed on a reasonable cost basis for inpatient services, and the facility has a choice of cost-based or all-inclusive rates for outpatient services. The standards of patient care apply to inpatient, outpatient, and satellite services.

AN EQUAL OPPORTUNITY/AFFIRMATIVE ACTION EMPLOYER

House Bill 1001:

House Bill 1001 amends G.S. 131E-76 to delete references to "primary care hospital" and replace them with "critical care access hospital" for purposes of licensure as a hospital under NC law; to clarify that the Critical Access Hospital must complete and submit the memorandum of understanding between the hospitals participating in a rural hospital network (currently, the members of the network submit the memorandum); and to provide that a Critical Access Hospital must, at a minimum, offer primary outpatient services, 24-hour emergency services, and be a member of a rural hospital network.

Cc: Jim Johnson, Fiscal Research

VISITOR REGISTRATION SHEET

Health — 4/17/01
Name of Committee — Date

VISITORS:. PLEASE SIGN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Thomas Vance Bennett	NCCFTF
Pam Benson	NC PHCA
Tom Vitabile	NC CAI
Paula Wolf	Covenant w NC Children
Al Deitch	DOA/YAID
J. Craig Cruz	DHHS
John Rust	NCFPC
Bonnie Holleran	DHHS
Hugh Tilson	NCHA
Lon Wilson	NC ALTC 7
Gordon A Joyner	NC ARTEMIS PO Box 1914 Goldsboro NC 27533
O L Yates	NCAE

AGENDA

HOUSE COMMITTEE ON HEALTH
THURSDAY, APRIL 19, 2001
12:00 NOON, ROOM 415 LOB

OPENING REMARKS

Rep. Thomas E. Wright
Chairman

BILLS TO BE DISCUSSED

HB-1030 MENTAL HEALTH SVCES/MEDICAID BILLING. (Rep. Clary)

HB-934 C.O.N.-ADULT CARE HOMES REGULATED.(Rep. Nye)

HB-1068 ADULT CARE HOMES/QUALITY OF CARE.(Rep. Nye)

HB-994 TRAUMATIC BRAIN INJURY MEDICAID WAIVER.(Rep. Earle)

HB-1147 HOSPITAL TEMPORARY BED INCREASES. Rep. Insko)

HB-1238 MEDICAID WAIVER/PRESCRIPTION DRUGS.(Rep. Luebke)

HB-1239 PHARMACISTS/LIMIT PRESCRIPTIONS DISPENSED. (Rep. Luebke)

HB-1316 REQUIRE NOTIFICATION TO TREAT MINORS.(Rep. Morris)

COMMENTS

ADJOURNMENT

MINUTES

COMMITTEE ON HEALTH

Thursday, April 19, 2001

12:00 P.M. Room 415-LOB

The House Committee on Health met on Thursday, April 19, 2001 at 12:00 p.m. in Room 415-LOB. A silent roll was taken, (roll list denotes members present).

Chairman Wright called the meeting to order.

HB-1147 HOSPITAL TEMPORARY BED INCREASES. (Rep. Insko)

Rep. Insko explained the proposed committee substitute to the committee.

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

Rep. Nye asked what kind of damage does it do to the C.O.N. Law. Rep. Insko stated that it does not do any damages to the C.O.N. Law. The certificate of need law is the mechanism we use to allocate acute care beds. It would not change the number of acute care beds that are available through out the state. It would only let hospital use their observation beds, which are not under the CON law, on very limited bases.

Rep. Nye asked for further comment from Linda McDaniel of DHHS, Facility Services. Linda McDaniel stated that there were no problems with the concept of the bill, we know that there are certain hospitals that run into difficulties from time to time, it's a limited problem, but this should help take care of it.

Rep. Sherrill asked if there is a statue site that identifies acute care beds. Dianna Jessup, Staff, responded. Rep. Insko gave further explanation. Rep. Sherrill responded. Rep Rogers asked what is the process for approval or request for approval. Rep. Insko responded.

Rep. Allred moved for a favorable report to the proposed committee substitute, unfavorable to the original bill. So moved.

HB –1068 ADULT CARE HOMES/QUALITY OF CARE. (Rep. Nye)

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

Rep. Nye explained the committee substitute bill. Rep. Rogers asked about the incentives for the bill. Rep. Nye stated that the incentives for the bill was not to get as many

violations and to try to help people do a better job. There are no financial incentives. Rep. Rogers followed up with a question about violations. Rep. Nye responded. Rep. Rogers asked that in effect the incentive is not to get penalties. Rep. Nye stated that the incentives help people do a better job and not get penalties and provide better care for the patient. Rep. Wright asked Dianna Jessup for a further explanation and to compare the original bill and the committee substitute. Dianna Jessup explained the differences between the original bill and the committee substitute bill.

Rep. Sherrill stated that she was ready to make the motion.

Rep. Clary sent for the amendment to change the title. Dianna Jessup, staffed, asked for permission to correct the line numbers because it was based on the original bill. It just changes the title.

Chairman Wright stated that Rep. Clary moved to amend the bill on page 1 lines 2 through 4 by rewriting the lines to change the title and amend the bill on page 2 line 34 and 35 by inserting them between those lines; sections 3,4,5 with new language.

Rep. Clary explained the amendment moved for adoption of the amendment.

Rep. Wright asked Dianna Jessup, Staff, to explain the technical changes to the committee. Rep. Nye commented that Rep. Clary made a good bill a better bill.

Chairman Wright called the question before the committee for the adoption of the amendment sent forth by Rep. Clary. So moved.

Rep. Clary moved to give the committee substitute for House bill 1068 a favorable report as amended and roll the amendment into the committee substitute and then unfavorable for the original bill. So moved.

HB-1030 MENTAL HEALTH SERVICES/MEDICAID BILLING

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

Rep. Clary explained the committee substitute bill before the committee. Dianna Jessup, staff, further explained the bill. Rep. Sherrill asked if it would decrease the area mental health cost. Rep. Clary responded. Rep. Justus asked the definition of a clubhouse. Rep. Clary responded.

Rep. Clary moved to amend the bill on page 1 line 12 by deleting Medicaid eligible services and moves to adopt the amendment. So moved.

Rep. Crawford moved for a favorable report to the PCS, unfavorable to the original bill, and re-referred to the Committee on Appropriations. So moved.

HB-1238 MEDICAID WAIVER/PRESCRIPTION DRUGS. (Rep. Luebke)

Rep. Luebke explained the bill. Dianna Jessup further explained the bill. Daphne Lauren, Deputy Director from The Division of Medical Assistance, further commented on the bill. Rep. Nye asked if there was a fiscal note on the bill. Rep. Luebke responded. Rep. Nye stated that we would be giving the consumer the discount, whereas the department is getting the one hundred million dollar rebate from the drug manufactures. Rep. Luebke responded. Rep. Nye asked Daphne Lyons about Medicaid waivers. Daphne Lyons responded. Rep. Allred asked if this affects the county Medicaid costs. Daphne Lyons responded. Rep. Allred followed up with a question about the Medicaid drug rebate plan. Daphne Lyons responded. Rep. Allred commented on the bill. Rep. Clary asked for a better understanding of the difference in the slipping, QMV's and income levels. Daphne Lyons responded. Rep. Luebke also responded. Chairman Wright stated that the bill could be carried over and it was not subject to crossover.

Rep. Nye moved to re-referred House bill 1238 to appropriations without prejudice. So moved.

HB-1239 PHARMACISTS/LIMIT PRESCRIPTIONS DISPENSED. (Rep. Luebke)

Chairman Wright stated that HB-1239 would not be voted on today. Rep. Sherrill asked about not voting on the bill. Chairman Wright responded. Rep. Nye commented on the bill. Rep. Luebke explained the bill. David Warwick, Director of the Board of Pharmacy, commented on the bill. Rep. Justus asked about the average number of prescriptions filled per day. David Warwick responded. Rep. Justus followed up with a question about the staff ratio. David Warwick responded. Chairman Wright asked about the impact on rural communities. David Warwick responded. Rep. Sherrill asked about Board Authority for changes and disciplinary actions. David Warwick responded. Rep. Luebke commented on the bill. Rep. Sherrill asked the Chairman about a study committee for this bill. Chairman Wright responded. Rep. Justus asked if the bill covered Veteran Hospitals. David Warwick responded. Fran Preston, of the NC Retail Merchants Association, commented on the bill. Mike James, of the NC Association of Pharmacists, commented on the bill. Chairman Wright stated that more discussion would continue on the bill at a later date.

The meeting adjourned at 1:00pm.

Rep. Thomas E. Wright, Chairman

VandaWilson-Wormack, Committee Assistant

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2001

HOUSE BILL 1030

Short Title:	Mental Health Svces/Medicaid Billing.	(Public)
Sponsors:	Representatives Clary; Alexander, Barefoot, Cansler, Dedmon, Harrington, Hilton, Kiser, Luebke, Morris, Nye, Rayfield, and Weatherly.	
Referred to:	Health.	

April 9, 2001

A BILL TO BE ENTITLED

AN ACT TO PROVIDE THAT MEDICAID REIMBURSEMENT SHALL BE MADE DIRECTLY TO ICCD CERTIFIED CLUBHOUSE MODEL PSYCHOSOCIAL PROGRAMS FOR MEDICAID-ELIGIBLE SERVICES PROVIDED BY THE PROGRAMS.

The General Assembly of North Carolina enacts:

SECTION 1. The Department of Health and Human Services, Division of Medical Assistance, shall provide direct Medicaid reimbursement to International Center for Clubhouse Development (ICCD) Certified Clubhouse Model Psychosocial Programs for Medicaid-eligible services provided by the Programs. The Department shall amend the State plan, as necessary, to provide the direct reimbursement required under this section. The Department shall adopt temporary rules further defining qualifications and referral procedures to implement this act.

SECTION 2. Nothing in this act obligates the General Assembly to appropriate funds to implement this act.

SECTION 3. This act becomes effective July 1, 2001.

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2001

H D

HOUSE BILL 1030
PROPOSED COMMITTEE SUBSTITUTE H1030-PCS7202-RM-23

Short Title: Mental Health Svces/Medicaid Billing. (Public)

Sponsors:

Referred to:

April 9, 2001

A BILL TO BE ENTITLED

AN ACT TO PROVIDE THAT MEDICAID AND STATE APPROPRIATIONS REIMBURSEMENT SHALL BE MADE DIRECTLY TO ICCD CERTIFIED CLUBHOUSE MODEL PSYCHOSOCIAL PROGRAMS FOR SERVICES PROVIDED BY THE PROGRAMS.

The General Assembly of North Carolina enacts:

SECTION 1. The Department of Health and Human Services, Division of Medical Assistance, Division of Mental Health, Developmental Disabilities, and Substance Abuse Services, shall provide direct Medicaid and State appropriations reimbursement to International Center for Clubhouse Development (ICCD) Certified Clubhouse Model Psychosocial Programs for services provided by the Programs. The Department shall amend the State plan, as necessary, to provide the direct reimbursement required under this section. The Area Program shall not reduce appropriations and expenditures for current operations of these direct enrolled providers. The Department shall adopt temporary rules to implement this act.

SECTION 2. Nothing in this act obligates the General Assembly to appropriate funds to implement this act.

SECTION 3. This act becomes effective July 1, 2001.

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2001

H D

HOUSE BILL 1030
PROPOSED COMMITTEE SUBSTITUTE H1030-CSRM-23 [v.1]

4/19/2001 11:09:43 AM

Short Title: Mental Health Svces/Medicaid Billing. (Public)

Sponsors:

Referred to:

April 9, 2001

A BILL TO BE ENTITLED

AN ACT TO PROVIDE THAT MEDICAID AND STATE APPROPRIATIONS REIMBURSEMENT SHALL BE MADE DIRECTLY TO ICCD CERTIFIED CLUBHOUSE MODEL PSYCHOSOCIAL PROGRAMS FOR MEDICAID-ELIGIBLE SERVICES PROVIDED BY THE PROGRAMS.

The General Assembly of North Carolina enacts:

SECTION 1. The Department of Health and Human Services, Division of Medical Assistance, Division of Mental Health, Developmental Disabilities and Substance Abuse Services shall provide direct Medicaid and State appropriations reimbursement to International Center for Clubhouse Development (ICCD) Certified Clubhouse Model Psychosocial Programs for Medicaid-eligible services provided by the Programs. The Department shall amend the State plan, as necessary, to provide the direct reimbursement required under this section. The Area Program shall not reduce appropriations and expenditures for current operations of these direct enrolled providers. The Department shall adopt temporary rules to implement this act.

SECTION 2. Nothing in this act obligates the General Assembly to appropriate funds to implement this act.

SECTION 3. This act becomes effective July 1, 2001.

HOUSE BILL 1030:
Mental Health Svces/Medicaid Billing

BILL ANALYSIS

Committee:	House Health	**Introduced by:**	Clary
Date:	April 16, 2001	**Summary by:**	Linda Attarian
Version:	Introduced		Committee Counsel

SUMMARY: ***House Bill 1030 directs the Division of Medical Assistance to provide reimbursement for Medicaid-eligible services directly to International Center for Clubhouse Development (ICCD) Certified Clubhouse Model Psychosocial Programs that provide such services to Medicaid-eligible individuals. The Department is to adopt temporary rules and amend the State Medicaid Plan, if necessary, to comply with the directive. The act becomes effective on July 1, 2001.***

CURRENT LAW: ICCD (International Center for Clubhouse Development) is a model psychosocial rehabilitation program for persons living with severe mental illness. The North Carolina Medicaid program reimburses the area program for contracted psychosocial rehabilitation and transportation services for eligible individuals participating is such programs. The area program is responsible for the oversight of the delivery of services through its contract with the providers. The area programs currently reimburse the providers.

BILL ANALYSIS: **Section 1** directs the Division of Medical Assistance to provide direct reimbursement to ICCD programs for Medicaid-eligible services provided by the Programs. If the Department determines that it must amend the State Medicaid Plan to effectuate the directive, then the Department shall do so. The Department shall adopt temporary rules to implement this provision.

Section 2 states that Section 1 shall not be construed to obligate the General Assembly to appropriate funds to implement the act.

Section 3 makes the act effective July 1, 2001.

BACKGROUND: Currently, there are two ICCD Model Programs in North Carolina. The following information about ICCD is from the organization's webpage:

The Mission of the International Center for Clubhouse Development is to build and coordinate a strong international network of clubhouse model programs. Clubhouses are founded on the realization that recovery from serious mental illness must involve the whole person in a vital culturally sensitive community. A clubhouse community offers respect, hope, mutuality and unlimited opportunity to access the same worlds of friendship, housing, education and employment as the rest of society.

In pursuit of this Mission, the Center promotes the developing and strengthening of Clubhouses; oversees the creation and evolution of Clubhouse standards; facilitates and assures the quality of training, consultation, certification, research and advocacy; and provides effective communication and dissemination of information.

2001 COMMITTEE REPORT
HOUSE OF REPRESENTATIVES

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

☐ Committee Substitute for
H.B. 1030 A BILL TO BE ENTITLED AN ACT TO PROVIDE THAT MEDICAID REIMBURSEMENT SHALL BE MADE DIRECTLY TO ICCD CERTIFIED CLUBHOUSE MODEL PSYCHOSOCIAL PROGRAMS FOR MEDICAID-ELIGIBLE SERVICES PROVIDED BY THE 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 the 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 Appropriations.

☐ 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)

2/15/01

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2001

H 1

HOUSE BILL 1068

Short Title:	Adult Care Homes/Quality of Care.	(Public)
Sponsors:	Representatives Nye; and Weiss.	
Referred to:	Aging, if favorable, Rules, Calendar, and Operations of the House.	

April 10, 2001

A BILL TO BE ENTITLED

AN ACT TO DIRECT THE DEPARTMENT OF HEALTH AND HUMAN SERVICES TO EXPLORE METHODS TO IMPROVE AND REWARD QUALITY OF CARE PROVIDED BY LONG-TERM CARE FACILITIES; AND TO DIRECT THE DEPARTMENT OF HEALTH AND HUMAN SERVICES TO ESTABLISH A QUALITY IMPROVEMENT CONSULTATION PROGRAM.

The General Assembly of North Carolina enacts:

SECTION 1.(a) The General Assembly recognizes that the imposition of penalties for deficiencies in meeting licensure requirements is not the exclusive method for ensuring quality of care in licensed long-term care facilities. The Department of Health and Human Services, Office of Long-Term Care, shall explore methods to improve and reward quality of care provided by long-term care facilities. In conducting this undertaking, the Department shall consider and report specifically its findings and recommendations on all of the following:

(1) Amending current law to allow extension of the licensure period and survey period for adult care homes with a good record of compliance and in the absence of consumer complaints. A recommendation to authorize the extension shall include the recommended length of the extension of the licensure and of the survey period, and the standard for what constitutes a good record of compliance and level of consumer complaint.

(2) Increasing the reimbursement rate for long-term care providers that consistently perform over and above the minimum standard of care. A recommendation to increase the rate shall include the recommended level of increase and the basis for determining the level of increase.

(3) The feasibility and potential effectiveness of financial rewards for long-term care providers that:

a. Demonstrate innovation in problem areas such as maintaining low-staff turnover and handling difficult behavior problems. A recommendation to provide financial rewards shall include the recommended level of reward, the basis for determining the award amount, and the specific innovations that warrant an award.

b. Obtain accreditation from nationally recognized organizations attesting to performance above the minimum standards of care.

(4) Whether to cap allowable indirect costs for adult care homes similar to that imposed on nursing homes, but also allowing a higher capped direct rate of reimbursement in order to provide incentives for higher quality direct care to residents.

(5) Whether a different approach should be adopted for setting reimbursement rates for adult care homes that would replace the current 'State average' method. The purpose of the different approach is to provide incentives to facilities to operate more efficiently and reinvest resources saved from efficiency in higher quality care.

SECTION 1.(b) The Department shall report the status of its activities under this section to the Study Commission on Aging not later than October 1, 2002. Not later than March 1, 2002, the Department shall submit its final report to the Study Commission on Aging and to the House of Representatives and Senate Appropriations Committees on Health and Human Services. The final report shall include recommended legislation for consideration by the Regular Session 2002 of the 2001 General Assembly.

SECTION 2. The Department of Health and Human Services shall develop a Quality Improvement Consultation Program. The purpose of the program is to assist providers in the development of quality improvement plans for each facility and program offering long-term care in North Carolina. The Quality Improvement Consultation Program shall be developed in consultation with the Office of Long-Term Care, the Division of Facility Services, and representatives of facilities and programs. The Department shall use funds appropriated to it for this purpose for the 2001-2002 and 2002-2003 fiscal years. The Department shall report the status of its activities under this section to the North Carolina Study Commission on Aging on October 1, 2001, and March 1, 2002.

SECTION 4. This act becomes effective July 1, 2001.

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2001

H D

HOUSE BILL 1068
PROPOSED COMMITTEE SUBSTITUTE H1068-PCS7193-LN-19

Short Title: Adult Care Homes/Quality of Care. (Public)

Sponsors:

Referred to:

April 10, 2001

A BILL TO BE ENTITLED

AN ACT TO DIRECT THE DEPARTMENT OF HEALTH AND HUMAN SERVICES TO EXPLORE METHODS TO IMPROVE AND REWARD QUALITY OF CARE PROVIDED BY ADULT CARE HOMES; AND TO DIRECT THE DEPARTMENT OF HEALTH AND HUMAN SERVICES TO ESTABLISH A QUALITY IMPROVEMENT CONSULTATION PROGRAM.

The General Assembly of North Carolina enacts:

SECTION 1.(a) The General Assembly recognizes that the imposition of penalties for deficiencies in meeting licensure requirements is not the exclusive method for ensuring quality of care in licensed adult care homes. The Department of Health and Human Services shall explore methods to improve and reward quality of care provided by adult care homes. In conducting this undertaking, the Department shall consider and report specifically its findings and recommendations on all of the following:

(1) Amending current law to allow extension of the licensure period and survey period for adult care homes with a good record of compliance and in the absence of consumer complaints.

(2) Whether to cap allowable indirect costs for adult care homes similar to that imposed on nursing homes, but also allowing a higher capped direct rate of reimbursement in order to provide incentives for higher quality direct care to residents.

(3) Whether a different approach should be adopted for setting reimbursement rates for adult care homes that would replace the current 'State average' method. The purpose of the different approach is to provide incentives to facilities to operate more efficiently and reinvest resources saved from efficiency in higher quality care.

(4) Aspects of the quality assessment/monitoring process that should be changed or modified under State authority.

(5) The Department of Health and Human Services shall offer joint training of Division of Facility Services consultants, county DSS adult

home specialists, and adult care home providers. The training shall be offered not less than two times per year, and subject matter of the training should be based on one or more of the 10 deficiencies cited most frequently in the State during the immediately preceding calendar year. The joint training shall be designed to reduce inconsistencies experienced by providers in the survey process, to increase objectivity by DFS consultants and DSS specialists in conducting surveys, and to promote a higher degree of understanding between facility staff and DFS consultants and DSS specialists in what is expected during the survey process.

SECTION 1.(b) The Department shall report the status of its activities under this section to the North Carolina Study Commission on Aging not later than October 1, 2001. Not later than March 1, 2002, the Department shall submit its final report to the North Carolina Study Commission on Aging and to the Senate Appropriations Committee on Human Resources and the House of Representatives Subcommittee on Health and Human Services. The final report shall include recommended legislation for consideration by the 2002 Regular Session of the 2001 General Assembly.

SECTION 2. The Department of Health and Human Services shall develop a Quality Improvement Consultation Program. The purpose of the program is to assist providers in the development of quality improvement plans for each facility. The Quality Improvement Consultation Program shall be developed in consultation with the Division of Facility Services and representatives of facilities and programs. The Department shall use funds appropriated in its continuation budget for this purpose for the 2001-2002 and 2002-2003 fiscal years. The Department shall report the status of its activities under this section to the North Carolina Study Commission on Aging on October 1, 2001, and March 1, 2002.

SECTION 3. The Department of Health and Human Services shall convene a Quality of Standards Work Group to explore alternatives to existing oversight and survey practices that will ensure quality in adult care homes. The Work Group shall do the following:

(1) Define and provide guidance on terms applicable in the survey and oversight process to ensure uniformity. Terms that should be defined and clarified include the following:

a. Substantial evidence.
b. Imminent danger.
c. Condition detrimental to health and safety.
d. Hindrance of proper performance of duties.
e. Alleged violation.
f. Substantial failure to comply.
g. Serious physical harm.
h. Substantial risk that death or physical harm will occur.
i. Present a direct threat to health and safety.

j. Deficiency.
k. Extent of violation.
l. Probability of death or serious harm.
m Reasonable diligence.

The Department shall ensure that the definition and clarification of terms is included in basic and continuing survey training.

(2) Identify rules that impede the direct care of residents or prohibit resident choice and develop a proposal for repeal of those rules, including any necessary repeal of, or amendment to, current law that is the basis for the rule.

The Work Group shall consist of representatives of the Division of Facility Services, the North Carolina Assisted Living Association, Inc., and the North Carolina Association of Long Term Care Facilities.

SECTION 4. This act becomes effective July 1, 2001.

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2001

H D

HOUSE BILL 1068
PROPOSED COMMITTEE SUBSTITUTE H1068-PCS7199-LN-23

Short Title: Adult Care Homes/Quality of Care. (Public)

Sponsors:

Referred to:

April 10, 2001

A BILL TO BE ENTITLED

AN ACT TO DIRECT THE DEPARTMENT OF HEALTH AND HUMAN SERVICES TO STUDY ISSUES RELATING TO LONG-TERM CARE; AND TO DIRECT THE DEPARTMENT OF HEALTH AND HUMAN SERVICES TO ESTABLISH A QUALITY IMPROVEMENT CONSULTATION PROGRAM.

The General Assembly of North Carolina enacts:

SECTION 1.(a) The General Assembly recognizes that the imposition of penalties for deficiencies in meeting licensure requirements is not the exclusive method for ensuring quality of care in licensed adult care homes. The Department of Health and Human Services shall explore methods to improve and reward quality of care provided by adult care homes. In conducting this undertaking, the Department shall consider and report specifically its findings and recommendations on all of the following:

(1) Amending current law to allow extension of the licensure period and survey period for adult care homes with a good record of compliance and in the absence of consumer complaints.

(2) Whether to cap allowable indirect costs for adult care homes similar to that imposed on nursing homes, but also allowing a higher capped direct rate of reimbursement in order to provide incentives for higher quality direct care to residents.

(3) Whether a different approach should be adopted for setting reimbursement rates for adult care homes that would replace the current 'State average' method. The purpose of the different approach is to provide incentives to facilities to operate more efficiently and reinvest resources saved from efficiency in higher quality care.

(4) Aspects of the quality assessment/monitoring process that should be changed or modified under State authority.

(5) The Department of Health and Human Services shall offer joint training of Division of Facility Services consultants, county DSS adult home specialists, and adult care home providers. The training shall be

offered not less than two times per year, and subject matter of the training should be based on one or more of the 10 deficiencies cited most frequently in the State during the immediately preceding calendar year. The joint training shall be designed to reduce inconsistencies experienced by providers in the survey process, to increase objectivity by DFS consultants and DSS specialists in conducting surveys, and to promote a higher degree of understanding between facility staff and DFS consultants and DSS specialists in what is expected during the survey process.

SECTION 1.(b) The Department shall report the status of its activities under this section to the North Carolina Study Commission on Aging not later than October 1, 2001. Not later than March 1, 2002, the Department shall submit its final report to the North Carolina Study Commission on Aging and to the Senate Appropriations Committee on Human Resources and the House of Representatives Subcommittee on Health and Human Services. The final report shall include recommended legislation for consideration by the 2002 Regular Session of the 2001 General Assembly.

SECTION 2. The Department of Health and Human Services shall develop a Quality Improvement Consultation Program. The purpose of the program is to assist providers in the development of quality improvement plans for each facility. The Quality Improvement Consultation Program shall be developed in consultation with the Division of Facility Services and representatives of facilities and programs. The Department shall use funds appropriated in its continuation budget for this purpose for the 2001-2002 and 2002-2003 fiscal years. The Department shall report the status of its activities under this section to the North Carolina Study Commission on Aging on October 1, 2001, and March 1, 2002.

SECTION 3. The Department of Health and Human Services shall convene a Quality of Standards Work Group to explore alternatives to existing oversight and survey practices that will ensure quality in adult care homes. The Work Group shall do the following:

(1) Define and provide guidance on terms applicable in the survey and oversight process to ensure uniformity. Terms that should be defined and clarified include the following:

a. Substantial evidence.
b. Imminent danger.
c. Condition detrimental to health and safety.
d. Hindrance of proper performance of duties.
e. Alleged violation.
f. Substantial failure to comply.
g. Serious physical harm.
h. Substantial risk that death or physical harm will occur.
i. Present a direct threat to health and safety.
j. Deficiency.

k. Extent of violation.
l. Probability of death or serious harm.
m Reasonable diligence.

The Department shall ensure that the definition and clarification of terms is included in basic and continuing survey training.

(2) Identify rules that impede the direct care of residents or prohibit resident choice and develop a proposal for repeal of those rules, including any necessary repeal of, or amendment to, current law that is the basis for the rule.

The Work Group shall consist of representatives of the Division of Facility Services, the North Carolina Assisted Living Association, Inc., and the North Carolina Association of Long Term Care Facilities.

SECTION 4. The Department of Health and Human Services shall study the cost to the State of reducing the county share of State/County Special Assistance from fifty percent (50%) to twenty-five percent (25%), phased in over a five-year period. The Department shall report its findings to the North Carolina Study Commission on Aging and the House of Representatives and Senate Appropriations Committees on Health and Human Services not later than October 1, 2001.

SECTION 5. The Department of Health and Human Services shall study alternative ways to reimburse adult care homes for the costs of residents residing in special care units, taking into account the particular needs of those residents. The Department shall report its findings and recommendations not later than March 1, 2002, to the North Carolina Study Commission on Aging and the House of Representatives and Senate Appropriations Committees on Health and Human Services.

SECTION 6. The Department of Health and Human Services shall study and make recommendations on statutory changes that would be necessary in order to delineate the various populations currently regulated as adult care homes according to the particular needs of those populations. The Department shall report its findings and recommendations to the North Carolina Study Commission on Aging not later than March 1, 2002.

SECTION 7. This act becomes effective July 1, 2001.

NORTH CAROLINA GENERAL ASSEMBLY
AMENDMENT
House Bill 1068

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

H1068-ASW-17 [v.1]

Date _____,2001

Comm. Sub. [NO]
Amends Title [YES]
First Edition

Representative Clary

moves to amend the bill on page 1, lines 2 through 4, by rewriting the lines to read:
"AN ACT TO DIRECT THE DEPARTMENT OF HEALTH AND HUMAN SERVICES TO STUDY ISSUES RELATING TO LONG-TERM CARE; AND";
and on page 2, lines 34-35, by inserting between the lines the following:

"**SECTION 3.** The Department of Health and Human Services shall study the cost to the State of reducing the county share of State/County Special Assistance from fifty percent to twenty-five percent, phased in over a five-year period. The Department shall report its findings to the North Carolina Study Commission on Aging and the House of Representatives and Senate Appropriations Committees on Health and Human Services not later than October 1, 2001.

SECTION 4. The Department of Health and Human Services shall study alternative ways to reimburse adult care homes for the costs of residents residing in special care units, taking into account the particular needs of those residents. The Department shall report its findings and recommendations not later than March 1, 2002 to the North Carolina Study Commission on Aging and the House of Representatives and Senate Appropriations Committees on Health and Human Services.

SECTION 5. The Department of Health and Human Services shall study and make recommendations on statutory changes that would be necessary in order to delineate the various populations currently regulated as adult care homes according to

NORTH CAROLINA GENERAL ASSEMBLY
AMENDMENT
House Bill 1068

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

H1068-ASW-17 [v.1]

the particular needs of those populations. The Department shall report its findings and recommendations to the Study Commission on Aging not later than March 1, 2002."; and by renumbering the remaining section accordingly.

SIGNED _____
Amendment Sponsor

SIGNED _____
Committee Chair if Senate Committee Amendment

ADOPTED _____ FAILED _____ TABLED _____

HOUSE BILL 1068:
Adult Care Homes/Quality of Care

BILL ANALYSIS

Committee:	House Health	**Introduced by:**	Rep. Nye
Date:	April 19, 2001	**Summary by:**	Dianna Jessup
Version:	First Edition		Committee Counsel

SUMMARY: House Bill 1086 would require the Department of Health and Human Services to explore methods to improve and reward quality of care provided by long-term care facilities and to develop a Quality Improvement Consultation Program to assist providers in developing quality improvement plans for long-term care facilities and programs. The act would become effective July 1, 2001.

CURRENT LAW: Adult care homes are currently licensed for a year. Facilities report costs annually, and reimbursement rates are currently based on the 75th percentile for direct costs and the 60th percentile for indirect costs. Maximum reimbursement rates are set by the General Assembly.

BILL ANALYSIS: House Bill 1086 would require the Department of Health and Human Services to:

- Explore methods to improve and reward quality of care provided by long-term care facilities, considering and reporting its findings on:
    - Amending current law to extend the licensure period beyond a year for adult care homes with good records of compliance and no consumer complaints
    - Increasing the reimbursement rate for long-term care providers that consistently perform over the above the minimum standard of care
    - The feasibility and potential effectiveness of financial rewards for long-term care providers that demonstrate innovation in problem areas such as maintaining low-staff turnover and handling difficult behavior problems or obtain accreditation from nationally recognized organizations attesting to performance above the minimum standards of care
    - Whether to cap allowable indirect costs for adult care homes similar to that imposed on nursing homes, but also allowing a higher capped direct rate of reimbursement in order ot provide incentives for high quality direct care to residents
    - Whether a different approach should be adopted for setting reimbursement rates for adult care homes that would replace the current method

  The Department would report the status of its activities to the Study Commission on Aging not later than October 1, 2002. Not later than March 1, 2002, the Department would have to submit its final report, including legislative recommendations, to the Study Commission on Aging and to the House and Senate Appropriations Committees on Health and Human Services. (Perhaps the interim report date should be changed to October 1, 2001 so that the interim report would precede the final report).

- Develop a Quality Improvement Consultation Program to assist providers in the development of quality improvement plans for each facility and program offering long-term care in North Carolina. The Program would be developed in consultation with the Office of Long-Term Care, the Division of Facility Services, and representatives of facilities and programs. The Department would report the status of its activities to the Study Commission on Aging on October 1, 2001 and March 1, 2002. The Department would use funds appropriated to it during the biennium to develop this Program. HCFA restricts the extent to which the Division of Facility Services may offer consultation to long-term care facilities regarding quality improvement strategies using federally funded staff. Consequently, the Department may have to operate this Program within another division or use non-federal funds to fund the Program.

BACKGROUND: The study of methods to reward quality care and the development of the Quality Improvement Consultation Program are recommendations of the North Carolina Institute of Medicine's Task Force on Long-Term Care to the Department of Health and Human Services. The Task Force, in its final report of January, 2001, recognized that past efforts at ensuring quality in long-term care facilities have been largely punitive, focusing on imposing penalties and correcting deficiencies among the "bad" facilities rather than trying to raise the level of quality among all facilities. The Task Force recommended placing emphasis on providing incentives to all facilities to improve quality, and to remove regulatory and other barriers that impair those efforts.

2001 COMMITTEE REPORT
HOUSE OF REPRESENTATIVES

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

☐ Committee Substitute for
H.B. 1068 A BILL TO BE ENTITLED AN ACT TO DIRECT THE DEPARTMENT OF HEALTH AND HUMAN SERVICES TO EXPLORE METHODS TO IMPROVE AND REWARD QUALITY OF CARE PROVIDED BY LONG-TERM CARE FACILITIES; AND TO DIRECT THE DEPARTMENT OF HEALTH AND HUMAN SERVICES TO ESTABLISH A QUALITY IMPROVEMENT CONSULTATION PROGRAM.

☐ 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)

2/15/01

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2001

HOUSE 1147

Short Title:	Hospital Temporary Bed Increases.	(Public)
Sponsors:	Representatives Insko; M. Crawford and Weiss.	
Referred to:	Health.	

April 12, 2001

A BILL TO BE ENTITLED

AN ACT TO PERMIT A HOSPITAL TO TEMPORARILY INCREASE ITS BED CAPACITY AFTER NOTIFYING THE DIVISION OF FACILITY SERVICES.

The General Assembly of North Carolina enacts:

SECTION 1. Chapter 131E of the General Statutes is amended by adding a new section to read:

"**§ 131E-113. Temporary change of hospital bed capacity.**

A hospital may temporarily increase bed capacity by up to ten percent (10%) over its licensed bed capacity by utilizing observation beds for hospital inpatients if the Division of Facility Services is notified and approves, and the increase does not last for longer than 60 consecutive days."

SECTION 2. This act becomes effective October 1, 2001

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2001

H D

HOUSE BILL 1147
PROPOSED COMMITTEE SUBSTITUTE H1147-PCS5211-SW-32

Short Title: Hospital Temporary Bed Increases. (Public)

Sponsors:

Referred to:

April 12, 2001

A BILL TO BE ENTITLED

AN ACT TO PERMIT A HOSPITAL TO TEMPORARILY INCREASE ITS BED CAPACITY AFTER NOTIFYING THE DIVISION OF FACILITY SERVICES.

The General Assembly of North Carolina enacts:

SECTION 1. Chapter 131E of the General Statutes is amended by adding a new section to read:

"**§ 131E-83. Temporary change of hospital bed capacity.**

A hospital may temporarily increase its bed capacity by up to ten percent (10%) over its licensed bed capacity by utilizing observation beds for hospital inpatients if the hospital notifies and obtains the approval of the Division of Facility Services. For purposes of this section, 'temporarily' means not longer than 60 consecutive days."

SECTION 2. This act becomes effective October 1, 2001.

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2001

H D

HOUSE BILL 1147
PROPOSED COMMITTEE SUBSTITUTE H1147-CSSW-32 [v.2]

4/18/2001 5:07:37 PM

Short Title: Hospital Temporary Bed Increases. (Public)

Sponsors:

Referred to:

April 12, 2001

A BILL TO BE ENTITLED

AN ACT TO PERMIT A HOSPITAL TO TEMPORARILY INCREASE ITS BED CAPACITY AFTER NOTIFYING THE DIVISION OF FACILITY SERVICES.

The General Assembly of North Carolina enacts:

SECTION 1. Chapter 131E of the General Statutes is amended by adding a new section to read:

"**§ 131E-83. Temporary change of hospital bed capacity.**

A hospital may temporarily increase its bed capacity by up to ten percent (10%) over its licensed bed capacity by utilizing observation beds for hospital inpatients if the hospital notifies and obtains the approval of the Division of Facility Services. For purposes of this section, 'temporarily' means not longer than 60 consecutive days."

SECTION 2. This act becomes effective October 1, 2001.

HOUSE BILL 1147:
Hospital Temporary Bed Increases

BILL ANALYSIS

Committee:	House Health	**Introduced by:**	Rep. Insko
Date:	April 18, 2001	**Summary by:**	Dianna Jessup
Version:	PCS H1147-CSSW-32 [v2]		Committee Counsel

SUMMARY: ***House Bill 1147 would permit hospitals temporarily to increase their bed capacity using observation beds, without CON review, if the Division of Facility Services is notified and approves of the temporary increase. The temporary increase could last not longer than 60 days. The act would become effective October 1, 2001.***

The PCS makes technical and grammatical changes to the bill, changing the statute reference to G.S. 131E-83 and rewriting the section so that it reads more clearly.

CURRENT LAW: Hospitals currently are required to obtain a CON in order to increase their licensed bed capacity. The bed capacity of a hospital does not include observation beds. An observation bed is defined in the hospital licensure rules as a bed used for no more than 24 hours to evaluate and determine the condition and disposition of a patient.

BILL ANALYSIS: If enacted, hospitals could use observation beds to increase bed capacity for up to sixty days without CON review. The temporary increase could not exceed ten percent of the hospital's licensed bed capacity.

2001 COMMITTEE REPORT
HOUSE OF REPRESENTATIVES

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

☐ Committee Substitute for
H.B. 1147 A BILL TO BE ENTITLED AN ACT TO PERMIT A HOSPITAL TO TEMPORARILY INCREASE ITS BED CAPACITY AFTER NOTIFYING THE DIVISION OF FACILITY 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 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)

2/15/01

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2001

H 1

HOUSE BILL 1238

Short Title:	Medicaid Waiver/Prescription Drugs.	(Public)
Sponsors:	Representative Luebke.	
Referred to:	Health.	

April 12, 2001

A BILL TO BE ENTITLED

AN ACT TO DIRECT THE DEPARTMENT OF HEALTH AND HUMAN SERVICES TO APPLY FOR A MEDICAID WAIVER TO PROVIDE PRESCRIPTION DRUG COVERAGE FOR ELDERLY AND DISABLED PERSONS NOT OTHERWISE ELIGIBLE FOR MEDICAID.

The General Assembly of North Carolina enacts:

SECTION 1. The Department of Health and Human Services shall apply to the Health Care Financing Administration for a Medicaid waiver to provide prescription drug coverage for elderly and disabled persons who are:

(1) Over age 65 or disabled;

(2) Not eligible for Medicaid;

(3) Do not have coverage for prescription drugs under public or private health insurance; and

(4) Whose family income is between one hundred twenty percent (120%) and one hundred fifty percent (150%) of the federal poverty level.

SECTION 2. In the event that the federal Medicaid waiver applied for under Section 1 of this act is approved, the Department of Health and Human Services shall not implement the waiver until the General Assembly has enacted a law implementing the waiver and appropriating the necessary funds therefor. Not later than October 1, 2001, the Department shall report to the House of Representatives Appropriations Subcommittee on Health and Human Services, the Senate Appropriations Committee on Human Resources, and to the Joint Legislative Health Care Oversight Committee on the status of the waiver requested pursuant to Section 1 of this act.

SECTION 3. Nothing in this act obligates the General Assembly to appropriate funds to implement this act.

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

HOUSE BILL 1238:
Medicaid Waiver/Prescription Drugs

BILL ANALYSIS

Committee:	House Health	**Introduced by:**	Rep. Luebke
Date:	April 19, 2001	**Summary by:**	Dianna Jessup
Version:	First Edition		Committee Counsel

SUMMARY: ***House Bill 1238 would require the Department of Health and Human Services to apply to the Health Care Financing Administration for a Medicaid waiver to provide prescription drug coverage for persons who are over 65 or disabled, who do not have coverage for prescription drugs under public or private health insurance, and whose family income is between 120% -150% of poverty. The Department would not implement the waiver until the General Assembly enacts a law implementing the waiver and appropriating the necessary funds. The Department would report the status of the waiver no later than October 1, 2001 to the House and Senate Appropriations Subcommittees on Health and Human Services and to the Joint Legislative Health Care Oversight Committee. The act would become effective when it becomes law.***

CURRENT LAW: North Carolina currently provides Medicaid coverage to all elderly, blind, and disabled people who have incomes equal to or less than 100%of the federal poverty guidelines (currently, $8,590 annually for one person, $11,610 for a family of two). Medicaid reimburses for up to six prescriptions per month, including refills, with a $1.00 co-payment for each prescription.

Certain elderly and disabled adults not eligible for full Medicaid are eligible for coverage by Medicaid for certain Medicare-related costs. Qualified Medicare Beneficiaries (QMB's) have incomes up to 100% of poverty and countable assets of $4,000 or less ($6,000 or less for a couple). For QMB's, Medicaid pays the Medicare Part B premium, which covers doctor visits, surgery, therapy, home health care, etc, as well as applicable Medicare co-pays and deductibles. In addition, Medicaid pays the Part A premium for persons for whom a Part A premium charge applies. Specified Low-Income Medicare Beneficiaries (SLIMBY's) have incomes between 101% and 120% of poverty. These persons must meet the same asset limits indicated above for QMB's. For SLIMBY's, Medicaid covers only the monthly Medicare Part B premium. While Medicare does provide some prescription drug coverage, Medicare generally does not cover the cost of outpatient prescription drugs.

BILL ANALYSIS: The bill would require the Department to request a waiver from HCFA to provide prescription drug coverage for persons over 65 or disabled who do not have coverage for prescription drugs under public or private health insurance, and whose family income is between 120% of poverty ($10,308 annually for one person, $13,932 for family of two) and 150% of poverty ($12,885 annually for one person, $17,415 for family of two). The waiver would not be implemented until the General Assembly approves and appropriates funds to pay for it. The Department would be required to report on the status of the waiver to the House and Senate Appropriations Committees on Health and Human Services and the Joint Legislative Health Care Oversight Committee not later than October 1, 2001.

2001 COMMITTEE REPORT
HOUSE OF REPRESENTATIVES

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

☐ Committee Substitute for
H.B. 1238 A BILL TO BE ENTITLED AN ACT TO DIRECT THE DEPARTMENT OF HEALTH AND HUMAN SERVICES TO APPLY FOR A MEDICAID WAIVER TO PROVIDE PRESCRIPTION DRUG COVERAGE FOR ELDERLY AND DISABLED PERSONS NOT OTHERWISE ELIGIBLE FOR MEDICAID.

☐ 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 and re-referred to the Committee on Appropriations.

☐ With an indefinite postponement report.

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

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

2/15/01

VISITOR REGISTRATION SHEET

HOUSE HEALTH COMMITTEE — 04-19-01

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Steve Keene	NCMS
Polly Williams	NC Equity
John Rust	NCFPC
Stacy Flannery	NCHCFA
Joanne Schoen Stevens	NC Nurses Association
Emily Feighan	Smith Anderson
J Craig Justice	UHS
John Bowdish	Alley Associates
Bill Scoggin	Kennedy Covington
Steve Mitchell	Novartis
David Work	NC Pharmacy Bd
Rayburn Cole	Bode & Assoc
Chrissy Porter	Bode & Assoc.
Lex Cheney	Bode & Assoc

VISITOR REGISTRATION SHEET

HOUSE HEALTH COMMITTEE — 4-19-01

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Andy Ellen	NCRMA
Fran Preston	NCRMA
Becky Mercer	Albers & Company / CVS
Mike James	NCMDC
Patricia A. Yancey	APPCNC ACLU
Nicole Duesenberry	PPAF of Orange & Durham
Paula A. Hoof	Covenant w/ NC's Children
Anne King	DMH/DD/SAS
Joy Mayo	Womble Carlyle
Daphne Lyon	DMA - DHHS
Margaret Woodcock	DPH DHHS
Jerry Cooper	NCACA
Lynda McDaniel	DFS/DHHS
Bob Fitzgerald	DFS/DHHS

AGENDA

HOUSE COMMITTEE ON HEALTH
TUESDAY, APRIL 24, 2001
8:00 AM, ROOM 415 LOB

OPENING REMARKS

Rep. Thomas E. Wright
Chairman

BILLS TO BE DISCUSSED

HB-317 MEDICAID COUNTY SHARE/FUNDS-2.(Rep. Hunter)

HB-1109 MANAGED CARE/PATIENT ACCESS.(Rep. Nye)

HB-1220 COMMUNITY RESIDENCES/PEOPLE WITH DISABILITY. (Rep. Holliman)

HB-1232 PRESCRIPTION DRUG ASSISTANCE FOR SENIORS. (Rep. Redwine)

HB-1316 REQUIRE NOTIFICATION TO TREAT MINORS.(Rep. Morris)

COMMENTS

ADJOURNMENT

MINUTES

COMMITTEE ON HEALTH

TUESDAY, APRIL 24, 2001

8:00AM, ROOM 415 LOB

The House Committee on Health met on Tuesday, April 24, 2001 at 8:00am in Room 415 LOB. A silent roll was taken, (roll list denotes members present).

Chairman Wright called the meeting to order.

HB-1109 MANAGED CARE/ PATIENT ACCESS. (Rep. Nye)

Rep. Nye explained the bill. Linda Attarian, Staff, further explained the bill. Rep. Sherrill commented on the bill.

Rep. Buchanan moved for a favorable report for HB-1109.

Rep. Barnhart asked if he could hear comments from organizations interested in the bill. Harry Kaplan, with the NC Association of Health Plans, expressed opposition to the bill. Rep. Nye responded. Marion Suitt, with the NC Society of Eye Physicians and Surgeons, expressed his opposition to the bill. Rep. Nye responded that this bill improves patient access. Linda Attarian further explained subsection B, page 2 for the committee. Rep. Clary asked about the provider network. Marion Suitt responded. Rep. Nye responded.

Chairman Wright called the question. A vote was taken. So moved.

HB-1232 PRESCRIPTION DRUG ASSISTANCE FOR SENIORS.(Rep. Redwine)

Rep. Redwine explained the bill. Linda Attarian further explained the bill. Rep. Sherrill asked about the language of the bill. Rep. Redwine responded. Rep. Sherrill followed up with a question about line 15, page 2. Rep. Redwine responded. Rep. Wright asked about the relationship between the Health and Wellness Trust Fund members and the Department of Aging. Rep. Redwine responded. Rep. Edwards asked about the reimbursement rates. Linda Attarian responded. Rep. Earle commented on the distribution of the money throughout the state.

Rep. Buchanan commented and moved for a favorable report for HB-1232. So moved.

The meeting adjourned at 8:45am.

Rep. Thomas Wright, Chairman

Vanda Wilson-Wormack, Committee Assistant

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2001

H 1

HOUSE BILL 1232

Short Title:	Prescription Drug Assistance for Seniors.	(Public)
Sponsors:	Representatives Redwine; Baddour, Easterling, Oldham (Primary Sponsors), Adams, Alexander, Allen, Barefoot, Culpepper, Cunningham, Dedmon, Earle, Gibson, Goodwin, Hackney, Morris, Nesbitt, Owens, Russell, Thompson, and Wainwright.	
Referred to:	Health.	

April 12, 2001

A BILL TO BE ENTITLED

AN ACT TO DIRECT THE HEALTH AND WELLNESS TRUST FUND COMMISSION TO ENDEAVOR TO FUND PROGRAMS AND INITIATIVES TO EXPAND ACCESS TO PRESCRIPTION DRUGS FOR SENIORS.

Whereas, the affordability of prescription drugs has become a great burden to North Carolina's senior citizens; and

Whereas, Medicare typically does not pay for prescription drugs; and

Whereas, nearly half of Medicare beneficiaries do not have coverage for prescription drugs for the entire year; and

Whereas, prescription drug spending accounts for one-sixth of all out-of-pocket spending for senior citizens; and

Whereas, it is estimated that for the year 2000, Medicare fee for service beneficiaries spent on average, $1,370 for prescription drugs; and

Whereas, it has been reported that in 1998, 5% of older persons spent more than $4,100 on prescription drugs, and 1% spent more than $6,600; and

Whereas, prescription drug costs are increasing at a double digit rate per year; and

Whereas, approximately 30 communities in North Carolina have established programs to expand access to prescription drugs for local residents; and

Whereas, over 20 states have established statewide prescription drug assistance programs; and

Whereas, President Bush sent to Congress a proposal on January 29, 2001, called "Immediate Helping Hand" that would provide support to states over four years to cover the full cost of drugs for the poorest senior adults and part of the cost for those at slightly higher incomes; and

Whereas, the General Assembly established, pursuant to Article 6C of Chapter 147 of the General Statutes, the Health and Wellness Trust Fund in the Office of the State Treasurer to be used to finance programs and initiatives to improve the health and wellness of the people in North Carolina; and

Whereas, moneys from the fund may be used to address the health needs of vulnerable and underserved populations in North Carolina; and

Whereas, the Health and Wellness Trust Fund Commission has the duty to develop criteria for awarding grants under the Article that will include programs addressing the short- and long-term health and wellness of the citizens of North Carolina; Now, therefore,

The General Assembly of North Carolina enacts:

SECTION 1. The Health and Wellness Trust Fund Commission shall, as it develops criteria for awarding grants under Article 6C of Chapter 147 of the General Statutes, endeavor to include criteria that will enable programs and initiatives addressing the need to expand access to prescription drugs to North Carolina senior citizens to receive grants from the Fund. In making the grants, the Commission shall consider, and coordinate with, the availability of any federal funds allocated to North Carolina pursuant to any federal initiative to provide financial assistance to senior citizens for the cost of prescription drugs.

In making its annual report to the Joint Legislative Commission on Governmental Operations and to the chairs of the Joint Legislative Health Care Oversight Committee regarding the implementation of the Article, the chair of the Health and Wellness Trust Fund Commission shall report on the programs and initiatives to expand access to prescription drugs to senior citizens that were funded by the Trust Fund. The report shall include the amount of funds disbursed for programs and initiatives to expand access to prescription drugs to senior citizens and the success of those programs and initiatives towards helping senior citizens obtain prescription drugs.

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

HOUSE BILL 1232:
Prescription Drug Assistance for Seniors

BILL ANALYSIS

Committee:	House Health	**Introduced by:**	Rep. Redwine
Date:	April 24, 2001	**Summary by:**	Linda Attarian
Version:	First Edition		Committee Counsel

SUMMARY: ***House Bill 1232 would direct the Health and Wellness Trust Fund Commission to endeavor to fund grant proposals for programs and initiatives to expand access to prescription drugs for North Carolina senior citizens who need prescribed medications but can't afford them. Nothing in the bill redirects, or otherwise appropriates the monies held in the Health and Wellness Trust Fund. The Fund currently holds $84,196,336.44. The act is effective when it becomes law.***

CURRENT LAW:

Prescription Drug Assistance Program:

Sec. 11.1(b) of S.L. 1999-237 directed the Department of Health and Human Services to develop a proposal for the establishment of a public-private prescription drug assistance program to serve low-income elderly and disabled persons who are not eligible for Medicaid and who need prescription drugs to treat a condition that, if left untreated, could result in their admission to a nursing facility. The proposal was submitted in May of 2001. Also this section appropriated $500,000 to the Department for each year of the 1999-2001 biennium to pay for outpatient prescription drugs to persons who are over 65, not eligible for full Medicaid benefits, have incomes below 150% of the federal poverty level, and have been diagnosed with cardiovascular disease or diabetes. Sec. 11.39 of S.L. 2000-67 appropriated $1,000,000 to the Department for this purpose for fiscal year 2000-2001. The Division of Public Health, the agency that administers the program, added an additional $400,000 to the program this year to extend the program through June 30. Because the funding is limited, the assistance is being targeted to persons who are Medicare-Aid eligible. At the current time, this program is capped at 2070 participants.

The Health and Wellness Trust Fund:

S.L. 2000-147 added a new Article 6C to Chapter 147 of the General Statutes to established a Health and Wellness Trust Fund and Health and Wellness Trust Fund Commission to administer the Fund. Twenty-five percent (25%) of the Master Settlement Agreement funds received by the State in the tobacco litigation case, State of North Carolina v. Philip Morris Incorporated, et.al., are credited to a Health Trust Account in the Settlement Reserve Fund. The State Controller transfers these funds from the Health Trust Account to the Health and Wellness Trust Fund. Currently, the Fund has approximately 84 million dollars.

The Health and Wellness Trust Fund Commission consists of 15 members, appointed by the Governor and the General Assembly upon the recommendation of the Speaker of the House and the President Pro Tempore of the Senate. Commission members serve four years; term expiration dates are set forth for the initial members to create staggered terms. The Commission is placed under the Office of the State Treasure for Administrative purposes.

The Commission may expend all of the annual payments for years 1998, 1999, and 2000. The Commission is required to reserve, and never expend, 50% of each annual payment made to the Fund for years 2001 through 2025. Any earnings on the reserved funds during years 2001 through 2025 and any funds unexpended or unencumbered funds by the third June 30th following the date of the receipt of the payment will be added to the Reserve Account.

The Commission may expend monies from the Fund for the following purposes:

- To fund programs and initiatives that include research, education, prevention, and treatment of health problems and to increase the capacity of communities to respond to the public's health needs.
- To develop a comprehensive, community-based plan with goals and objectives to improve the health and wellness of the people of North Carolina with a priority on preventing, reducing, and remedying the health effects of tobacco use and an emphasis on reducing youth tobacco use. The Commission would be authorized to fund proposals and initiatives consistent with this purpose. The priority in funding all initiatives would be to address the health needs of the vulnerable and underserved populations.

Eligible recipients:

- A State agency
- A local government or other political subdivision of the State, or a combination of such entities
- A nonprofit corporation that has as a significant purpose promoting the public's health, limiting youth access to tobacco products, or reducing the health consequences of tobacco use

Reporting Requirements:

- The chair of the Commission shall make annual reports to the Joint Legislative Commission on Governmental Operations and to the Joint Legislative Health Care Oversight Committee.
- All non-State agencies receiving funds from the Commission are required to submit an annual report to the Commission. Summaries of these annual reports are to be included in any report made to the General Assembly as required under the bill.

BILL ANALYSIS: **Section 1** directs the Health and Wellness Trust Fund Commission to endeavor, as it develops its criteria for approval of grant applications, to include criteria that will enable programs and initiatives that address the need to expand access to prescription drugs to North Carolina senior citizens who would otherwise go without needed medications, to successfully apply and receive grants from the Funds. The Commission shall, in awarding such grants, consider and coordinate with, the availability of any federal funds allocated to North Carolina for this purpose.

The Commission is to report on the amount of monies disbursed from the Fund to expand access to prescription drugs to North Carolina senior citizens, and to provide a summary as to the effectiveness of the programs and initiatives that received grants for this purpose.

Section 2 makes the act effective when it becomes law.

BACKGROUND:

See "Whereas" clauses on page one of the bill.

2001 COMMITTEE REPORT
HOUSE OF REPRESENTATIVES

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

☐ Committee Substitute for
H.B. 1232 A BILL TO BE ENTITLED AN ACT TO DIRECT THE HEALTH AND WELLNESS TRUST FUND COMMISSION TO ENDEAVOR TO FUND PROGRAMS AND INITIATIVES TO EXPAND ACCESS TO PRESCRIPTION DRUGS FOR SENIORS.

☒ 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)

2/15/01

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2001

HOUSE BILL 1109

Short Title:	Managed Care/Patient Access.	(Public)
Sponsors:	Representatives Nye; and Wainwright.	
Referred to:	Insurance.	

April 11, 2001

A BILL TO BE ENTITLED

AN ACT TO IMPROVE NORTH CAROLINA'S LAWS PERTAINING TO ACCESS TO EYE CARE PROVIDERS.

The General Assembly of North Carolina enacts:

SECTION 1. Article 3 of Chapter 58 of the General Statutes is amended by adding a new section to read:

"**§ 58-3-245. Requirements for access to eye care providers.**

(a) A health benefit plan offered by an insurer that provides eye or vision care benefits and any provider network established by or on behalf of the insurer to provide those benefits shall:

(1) Allow every insured direct access, without prior referral, to the services of eye care providers within the provider network for all primary eye or vision care benefits provided by the plan.

(2) Permit any licensed eye care provider who agrees to abide by the terms, conditions, reimbursement rates, and standards of quality of the health benefit plan to serve as an eye care provider of primary eye or vision care benefits to any person covered by the plan. The plan shall allow every contracting eye care provider pursuant to this subdivision to provide covered primary eye or vision care services to covered persons within the full scope of the contracting provider's licensure in accordance with North Carolina State law.

(3) Permit every insured under the health benefit plan to choose any eye care provider licensed in this State to provide primary eye or vision care benefits covered under the health benefit plan, whether the provider is a contracting provider within the health benefit plan or a noncontracting provider. The insurer shall reimburse the noncontracting eye care provider for services covered under the health benefit plan in the same manner, to the same extent, at the same rate,

insurer's employees on the second-level grievance review panel in the same matter if the second-level grievance review panel comprises three or more persons.

(3) In addition to meeting the specified requirements of subdivision (2) of this subsection, in all cases where the matter giving rise to the second-level review involves a noncertification or clinical issue involving an eye care provider's rendering of eye or vision care services, the insurer shall include on the second-level review grievance panel at least one provider with the same type of license as that eye care provider."

SECTION 3. This act becomes effective October 1, 2001, and applies to all health benefit plans that are issued or renewed on or after that date. The renewal of a health benefit plan is presumed to occur on each anniversary date on which the coverage was first effective on the persons covered by the health benefit plan.

2001 COMMITTEE REPORT
HOUSE OF REPRESENTATIVES

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

☐ Committee Substitute for
H.B. 1109 A BILL TO BE ENTITLED AN ACT TO IMPROVE NORTH CAROLINA'S LAWS PERTAINING TO ACCESS TO EYE CARE PROVIDERS.

☒ 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)

2/15/01

VISITOR REGISTRATION SHEET

HEALTH — 04-24-01

Name of Committee — Date

VISITORS:. PLEASE SIGN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Marion Smith	NCSEPS
Steve Keene	NCMS
ANN LOVE	DUHS
Jon Wilson	NCAHTC7
Whitney Obrig	OSBPM
Frank Lewis	OSBPM
John Kuk	NCFPC
John Bowdish	Alley Associates
Anne Wiser	NCNDC
Mackie Dunnberry	PPAF of Orange & Durham
Patti A Yancey	APRNC/NHLC
Margaret Westbrook	Kennedy Covington
Steve Mitchell	Novartis
KEN MELTON	Alley Associates

AGENDA

HOUSE COMMITTEE ON HEALTH
TUESDAY, APRIL 24, 2001
12:30pm, ROOM 415 LOB

OPENING REMARKS

Rep. Thomas E. Wright
Chairman

BILLS TO BE DISCUSSED

HB-317 MEDICAID COUNTY SHARE/FUNDS-2.(Rep. Hunter)

HB-896 DATABASE/CONTROLLED SUBSTANCES.(Rep. Hensley)

HB-994 TRAUMATIC BRAIN INJURY MEDICAID WAIVER.(Rep. Earle)

HB-1316 REQUIRE NOTIFICATION TO TREAT MINORS.(Rep. Morris)

COMMENTS

ADJOURNMENT

MINUTES

COMMITTEE ON HEALTH

TUESDAY, APRIL 24, 2001

12:30pm ROOM 415 LOB

The House Committee on Health met on Tuesday, April 24, 2001 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-317 MEDICAID COUNTY SHARE/FUNDS.(Rep. Hunter)

Rep. Hunter explained the bill. Dianna Jessup, Staff, further explained the bill. Rep. Nye commented on the bill. Dr. Delilah Blanks, President of the County Commissioner Association, presented a report to the committee about the status of each county and the support of the County Commissioner Association for this bill. Rep. Wainwright asked if the bill would be re-referred to appropriations. Chairman Wright responded that the bill would be re-referred to Appropriations. Mr. Charles Archer, County Manager of Halifax County, was recognized to speak on the bill about the status of Halifax County. Rep. Wainwright asked about the establishment of the criteria for eligibility. Mr. Charles Archer responded. Rep. Wainwright asked about the Medicaid mandate handed down from the federal government. Chairman Wright responded. Rep. Wainwright followed up with a question about the possibility of a cap to slow down the growth in Medicaid expenditures. Mr. Charles Archer responded. Rep. Nye also responded that Medicaid was up in the state $108 million short this year. Rep. Justus asked if there was an increase in the Certificate of Need Beds in Halifax County. Mr. Archer responded. Rep. Justus followed up with a question about the high percentage increase. Mr. Archer responded that Halifax County had seen a growth in pharmaceuticals, prescription drugs and Nursing homes. Rep. Justus asked if there was an influx of patients from the state of Virginia to Halifax County. Mr. Archer responded. Rep. Justus asked a question to Rep. Nye about the Certificate of Need Medicaid bed cost and the cost increase. Rep. Nye responded that the Work First program, for example, expanded from 12 months to 24 months and that this program and others would probably have to be adjusted. Rep. Justus asked if other states had the 24-month period for the Work First program. Rep. Nye responded. Rep. Howard asked about the non-federal share of the Medicaid percentage. Dr. Al Wentzy, Director of the Department of Social Services(Northampton County), commented on the bill. Mr. Johnny Farmer, County Commissioner of Hertford County, commented on the bill. Rep. Hunter commented on the importance of the bill.

Rep. Nye moved for a favorable report and that the bill be re-referred to the Committee on Appropriations. So moved.

HB-994 TRAUMATIC BRAIN INJURY MEDICAID WAIVER.(Rep. Earle)

Amy Currie, staff, explained the bill.

Rep. Justus moved for a favorable report and that the bill be re-referred to the Committee on Appropriations. So moved.

HB-1316 REQUIRE NOTIFICATION TO TREAT MINORS.(Rep. Morris)

Rep. Edwards moved to adopt the proposed committee substitute before the committee. So moved.

Rep. Morris explained the bill. Linda Attarian, Staff, further explained the amendment of the bill to the committee. Rep. Wainwright asked about the language on line 8 from "shall" to "may". Chairman Wright responded. Rep. Wainwright followed up with a question about the conditions or circumstances, in which, "may" would be implemented. Rep. Morris responded. Rep. Wainwright commented on the bill and expressed his opposition to the bill. Rep. Morris responded. Rep. Sherrill read a letter from the President of the North Carolina Pediatric Association who opposed the bill. Rep. Morris responded. Rep. Justus commented on the bill. Rep. Edwards stated that the present law would save more children, than the bill before the committee at this time. Rep. Justus commented on the bill. Rep. Earle further commented on the fact that there are many dysfunctional families in the state of North Carolina and that the current law would best address the needs of the children of North Carolina. Dr. Marion Griffin, of the North Carolina Policy Council, spoke in favor of the proposed bill. Rep. Wainwright asked Dr. Griffin about the relationship between the parent and the child and would the child consult the parent, prior to a doctor's visit. Dr. Griffin responded. Rep. Wainwright followed up with a comment about the present law and asked Dr. Griffin if the new law discourages minors from seeking medical attention. Dr. Griffin responded. Rep. Morris responded. Rep. Wainwright asked Genny Lassiter, from the Pamlico County Health Department, to speak on the bill. Genny Lassiter, of the NC Health Directors Association, expressed her opposition to the bill. Rep. Morris suggested that the bill be placed in a subcommittee for further study. Rep. Sherrill commented on the bill and expressed her support of a resolution in the future.

Rep. Wainwright moved to send HB-1316 to a sub-committee, appointed by the Chair, for further study. So moved.

The Chairman appointed Representatives Sherrill, Wainwright, Earle, Clary, Edwards and Justice(Chair) to serve on the sub-committee.

HB-896 DATABASE/CONTROLLED SUBSTANCES.(Rep. Hensley)

Rep. Hensley agreed to hear the bill at a later date.

The meeting adjourned at 1:40pm

Rep. Thomas Wright, Chairman

Vanda Wilson-Wormack, Committee Assistant

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2001

HOUSE BILL 317

Short Title:	Medicaid County Share/Funds-2.	(Public)
Sponsors:	Representatives Hunter, Goodwin, and Hall.	
Referred to:	Health, if favorable, Appropriations.	

February 28, 2001

A BILL TO BE ENTITLED

AN ACT TO REDUCE THE COUNTY SHARE OF NONFEDERAL PAYMENTS FOR THE MEDICAID PROGRAM FOR CERTAIN COUNTIES AND TO APPROPRIATE FUNDS TO COVER THE REDUCTION IN COUNTY NONFEDERAL PAYMENTS.

The General Assembly of North Carolina enacts:

SECTION 1. Notwithstanding G.S. 108A-54, the nonfederal share of the Medical Assistance Program, excluding administrative costs, borne by counties designated as Tier counties under G.S. 105-129.3 for the 2001-2003 biennium is as follows:

(1) One percent (1%) for Tier 1 counties;
(2) Two percent (2%) for Tier 2 counties;
(3) Three percent (3%) for Tier 3 counties;
(4) Four percent (4%) for Tier 4 counties; and
(5) Five percent (5%) for Tier 5 counties.

SECTION 2. There is appropriated from the General Fund to the Department of Health and Human Services the sum of eighty million dollars ($80,000,000) for the 2001-2002 fiscal year and the sum of eighty million dollars ($80,000,000) for the 2002-2003 fiscal year. These funds shall be used to fund the reduction in county nonfederal payments for the Medical Assistance Program pursuant to Section 1 of this act.

SECTION 3. This act becomes effective July 1, 2001.

HOUSE BILL 317:
Medicaid County Share/Funds-2

BILL ANALYSIS

Committee:	House Health	**Introduced by:**	Reps. Hunter, Goodwin, Hall
Date:	April 25, 2001	**Summary by:**	Dianna Jessup
Version:	First Edition		Committee Counsel

SUMMARY: ***House Bill 317 would reduce the county share of the nonfederal payments for the Medicaid program from 15% to 1%-5%, depending upon the Tier county formula under G.S. 105-129.3, and appropriates $80,000,000 per fiscal year to fund the reduction. The act would become effective July 1, 2001.***

CURRENT LAW: The State and county share of the nonfederal cost of Medicaid is set each biennium in the Current Operations and Capital Improvements Appropriations Act. S.L. 2000-67, Sec. 11.12(b) set the current biennium's allocation of the nonfederal costs of all applicable Medicaid services at 85% State/15% county. Counties pay 100% of the administrative cost related to eligibility determination.

The State provides tax credits to attract and keep companies and quality jobs. Credits are provided in accordance with a "tier" system to target larger incentives to more distressed areas of the State. Each year, counties are ranked in accordance with a statutory formula from tier 1 (higher economic distress factors) to tier 5 (lower economic distress factors). A copy of the most recent tier designation is attached.

BILL ANALYSIS: House Bill 317 would reduce each county's share to 1%-5%, depending upon the tier designation of the particular county. The State would fund the difference of the nonfederal cost of Medicaid.

BACKGROUND: Attached is information provided by the National Conference of State Legislatures concerning county participation in states' health and human services costs.

2001 Tier Designations

TIER 1	TIER 2	TIER 3	TIER 4	TIER 5
ALLEGHANY	ANSON	AVERY	BRUNSWICK	ALAMANCE
ASHE	BLADEN	CASWELL	BURKE	ALEXANDER**
BEAUFORT	DUPLIN*	CHOWAN	CALDWELL	BUNCOMBE
BERTIE	HOKE	CLEVELAND	CARTERET	CABARRUS
CAMDEN	MADISON	CUMBERLAND	CRAVEN	CATAWBA
CHEROKEE	MITCHELL	CURRITUCK	DARE**	CHATHAM
CLAY	MONTGOMERY	GASTON*	FRANKLIN	DAVIDSON**
COLUMBUS	ONSLOW	GATES	GRANVILLE	DAVIE
EDGECOMBE	PAMLICO	GREENE	HARNETT	DURHAM
GRAHAM	PASQUOTANK	HAYWOOD	LINCOLN	FORSYTH
HALIFAX	ROBESON	JACKSON	MACON**	GUILFORD
HERTFORD	VANCE	LENOIR	NASH	HENDERSON
HYDE		MCDOWELL	PENDER	IREDELL
JONES		PERSON*	PITT	JOHNSTON
MARTIN		POLK	ROWAN	LEE
NORTHAMPTON		ROCKINGHAM	SAMPSON**	MECKLENBURG
PERQUIMANS		RUTHERFORD**	STOKES*	MOORE
RICHMOND		STANLY	SURRY	NEW HANOVER
SCOTLAND		WATAUGA	WILKES	ORANGE
SWAIN		WAYNE	YADKIN*	RANDOLPH
TYRRELL		WILSON		TRANSYLVANIA
WARREN				UNION
WASHINGTON				WAKE
YANCEY				

* The county's 2001 Tier designation is one tier lower than its 2000 designation
** The county's 2001 Tier designation is one tier higher than its 2000 designation

COUNTY PARTICIPATION IN STATES' HEALTH AND HUMAN SERVICES COSTS

ARIZONA
Under the Health Care Cost Containment System (a statewide Medicaid demonstration program), counties pay 100 percent of the non-federal share for long term care for the elderly and physically disabled, and fund a variable portion of acute care.

Although counties do not have responsibility for Temporary Assistance for Needy Families (TANF) or foster care, 9 out of 15 counties operate and pay the state match for the child support program through the county attorney's office, and another two counties perform clearinghouse functions. Some counties also provide support services such as child care and transportation.

CALIFORNIA
Counties contribute 2.5. percent of administrative costs of Medicaid.

Counties pay 5.8% of the state share in TANF benefits, 50% of TANF administration match, 60% of the foster care match for both maintenance and administration. There is a state mandate that counties provide and pay 100% of general assistance and of the foster care for children who are not eligible for federal payments. Child support enforcement is done by the district attorneys.

COLORADO
Counties pay 40% of the non-federal share of administrative costs related to eligibility determination. Counties administer TANF, foster care, child welfare, and child support enforcement. General assistance is funded entirely by local funds.

FLORIDA
Counties pay $55 per month for each nursing home resident, and 100 percent of the non-federal share for the 13th through 45th inpatient hospital days.

Counties do not run TANF, but some counties have small general assistance programs, that generally cover short-term emergencies. Counties may now have more of a voice in deciding how to deliver welfare reform related programs and services as a result of the state's new legislation which established local Work and Gain Economic Self-Sufficiency coalitions.

GEORGIA
Counties do not pay TANF or foster care, but some counties run general assistance programs.

IDAHO
Counties do not run the TANF or child welfare programs, but they do have general assistance programs that cover housing, rent, utilities, transportation, etc..

ILLINOIS
Counties do not run TANF or child welfare, but they do provide some general assistance to veterans and they run the child support enforcement program.

INDIANA
County tax levies provide approximately 50 percent of the non-federal share for Medicaid administrative costs at the county level. Counties contribute to a "Medical Assistance to Wards" fund used to pay the non-federal share of Medicaid for wards of the county office or juvenile court who are not eligible for TANF foster care.

Counties do not administer TANF, but county tax levies pay for 40% of the non-federal share of TANF and 100% of the non-federal share of foster care. County clerks also run the child support enforcement program.

IOWA
Counties pay 100 percent of the non-federal share of ICF/MR; 100 percent of the non-federal share of MH/MR/DD waivers for home and community based services for persons normally served by ICF/MR; "enhancements" (i.e., Medicaid case management, partial hospitalization and day treatment for the chronically mentally ill, mentally retarded and developmentally disabled.)

Counties do not operate or pay for TANF or child support, but are responsible for general assistance, and also pay part of the child welfare costs.

KANSAS
Counties do not run TANF or child welfare but provide some funding for child support enforcement run by district court trustee programs.

KENTUCKY
Counties do not run TANF or child welfare, but some counties operate homeless shelters and food pantries. Counties also administer the child support enforcement program through county attorney's offices and circuit clerk's offices.

MARYLAND
Although counties do not generally operate the federal welfare programs, they do make some contributions to the administration of the program, for example they may pay the salary for some of the program employees. Additionally, in 1996 Maryland passed a new welfare law under which Montgomery County will now administer TANF.

MICHIGAN
Counties pay 10 percent of the non-federal share for Medicaid mental health services delivered by county community mental health agencies. Counties with medical care facilities (nursing homes) provide a variable maintenance of effort payment for Medicaid patients in the facility.

Counties do not run TANF, but the do provide foster care and child welfare services. They run child support enforcement through the "friends of the courts" system.

MINNESOTA
Counties pay 100 percent of the non-federal share of administrative costs for Medicaid related to client services except for the child health plan, where the share varies. Counties loan funds to the state, without interest, for a portion of the state's benefit payments for the first six months of each fiscal year.

They also pay 100 percent of the administrative costs for TANF, foster care, and general assistance, but do not pay for the benefits. Child support is done at the county level, but in some counties it's run by the district attorney's office and in others by the social services offices. Regardless of which agency does child support, the counties pay the administrative costs.

MISSOURI
Counties do not operate TANF, child welfare, or general assistance, but they do administer the child support enforcement program either through the county attorneys or social services.

MONTANA
Counties pay 18 percent of the non-federal share of eligibility personnel costs.

All but 12 counties pay two to three percent of the state share of TANF benefits and 49% of the administrative costs. They also have some responsibility for foster care benefits, although there was a legislative proposal pending earlier this year for the state to take over the administrative costs. General assistance is a county option, there is no state general assistance.

NEBRASKA
Counties do not run the federal welfare programs, but they are responsible for general assistance to those who are not otherwise eligible for federal assistance and have not done anything through their action or inaction to lose that eligibility. General assistance is financed 100% through county property taxes.

NEVADA
Counties pay 100 percent of the non-federal share of long term care for the aged, blind and disabled whose net monthly income exceeds $714 but is less than the maximum percent of the Supplemental Security Income Federal Benefit Rate (SSI/FBR). Counties are required to pay the total administrative costs for the federal match program.

Counties do not run TANF or foster care, but have total responsibility for general assistance. Child support is administered by the county attorney's office.

NEW HAMPSHIRE
Counties pay 100 percent of the non-federal share of the Medicaid Audit unit. Counties pay 61.5 percent of the non-federal share of long term care; and 50 percent of the non-federal share of all other services.

Counties do not run TANF but do contribute 25% of the costs for court ordered foster care placements and services for children.

NEW JERSEY
Counties fund the non-federal share of administrative cost for eligibility determinations of non-SSI Medicaid applicants.

Counties administer and have some responsibility for TANF administration, but not child welfare and foster care. Counties are not responsible for general assistance, but some counties run homeless shelters and food pantries. Child support is administered at the county level through the courts.

NEW MEXICO
As of April, 1993, counties will contribute about 7 percent of the total Medicaid budget through the use of intergovernmental transfers used by the state as Medicaid match.

NEW YORK
Counties pay 50 percent of the non-federal share of Medicaid services, excluding long term care, for which they contribute 20 percent.

Counties pay 50% of TANF and foster care benefits, administration, and general assistance. The state now gives counties a foster care block grant. Counties operate the child support enforcement program.

NORTH CAROLINA
Counties pay 15 percent of the non-federal share of Medicaid services, and 100 percent of the administrative cost related to eligibility determination.

Counties pay 50 percent of the TANF and foster care benefit share and they also pay 100 percent of the administrative costs for both programs. Child support enforcement is also run at the county level.

NORTH DAKOTA
Counties pay 13.1 percent of the non-federal share except for ICF/MR, clinic services, and waivered home and community based services for mentally retarded, aged and disabled residents.

Counties also administer and pay a portion of the TANF program. Additionally, there is a state mandate that counties must provide general assistance as necessary health services.

OHIO
Counties pay a maximum of 10 percent of the non-federal share of administrative costs related to Medicaid eligibility determination, with some limitations.

Counties pay 10 percent of the non-federal share of TANF benefits and administrative costs and also have substantial financial responsibility for children's services. They also pay 10% of the non-federal food stamp administrative costs. Child support is run at the county level by various agencies.

PENNSYLVANIA
Counties pay 10 percent of the non-federal share for county nursing homes plus $3.00 per invoice.

Counties do not run the TANF program, but they are responsible for foster care and child welfare programs.

SOUTH CAROLINA
Counties provide $13 million to support Medicaid through a formula prescribed by law. Counties provide a medically indigent care program.

Counties spend some funds to help support the state's child welfare offices in each county and have responsibility for child support enforcement through the "Clerk of the Court's" offices.

SOUTH DAKOTA
Counties pay $60/month for each ICF/MR resident, and $200/month for each mentally ill resident in state inpatient facilities.

Counties do not run TANF or child welfare, but they do have emergency short-term general assistance.

UTAH
Counties provide 20 percent of the state's Medicaid non-federal payment.

VIRGINIA
Counties are responsible for part of the non-federal share of Medicaid eligibility determination costs.

Counties pay 20% of the TANF administrative costs, but not the benefits. They also administer foster care, adoption assistance, and child welfare. General assistance is a local option but most counties participate and they pay 37.5 percent of benefits and 100 percent of the administrative costs.

TENNESSEE
Counties don't have responsibility for TANF or child welfare, but do administer the child support enforcement program through a variety of agencies. Additionally, some of the large urban counties provide clearinghouse functions for child care, transportation and other services.

TEXAS
Counties don't have responsibility for TANF, but they do have responsibility for general assistance. County courts and welfare boards are also involved in foster care placement decisions, and the district clerk offices run child support enforcement.

WISCONSIN
Counties pay the nonfederal share for certain mental health programs (e.g., community support services and targeted case management).

Counties operate TANF and pay part of its administrative costs, but the new state law now allows counties to opt out of this responsibility. They are reimbursed through a state income maintenance allocation, but counties that exceed this cap may also receive federal funds for administration. Milwaukee county has been split into six regions, whereby the county still determines eligibility, but private agencies (both non-profit and for profit) provide welfare to work services. Counties administer the child support enforcement program.

Welfare information based on information provided by state associations of counties in March, 1995 and subsequent phone interviews. Updated, August, 1998. Medicaid information based on information provided by state associations of counties. Updated, 1996.

North Carolina Association of County Commissioners
Medicaid Expenditures
4/24/01

Budgeted Expenditures

County	1997-98	1998-99	1999-2000	2000-2001	Recommended 2001-2002	Projected 2002-2003	2000 Population
Alamance	3,165,916	3,562,754	3,850,929	4,891,444	5,616,316	6,301,802	130,800
Alexander	765,999	810,206	887,675	1,128,849	1,296,135	1,454,331	33,603
Alleghany	397,468	410,352	486,999	554,701	636,903	714,639	10,677
Anson	1,399,661	1,493,682	1,597,671	1,768,130	2,030,152	2,277,937	25,275
Ashe	1,105,237	1,201,504	1,306,404	1,588,607	1,824,026	2,046,653	24,384
Avery	744,555	815,762	921,694	1,018,303	1,169,207	1,311,912	17,167
Beaufort	2,065,894	2,239,239	2,251,503	2,857,870	3,281,383	3,681,885	44,958
Bertie	1,259,472	1,303,768	1,402,480	1,726,883	1,982,793	2,224,798	19,773
Bladen	1,710,972	2,015,590	2,115,687	2,593,440	2,977,767	3,341,211	32,278
Brunswick	2,077,773	2,408,431	2,414,382	3,152,228	3,619,362	4,061,115	73,143
Buncombe	6,499,089	6,901,099	7,411,658	8,899,860	10,218,747	11,465,971	206,330
Burke	2,829,153	3,218,616	3,394,581	3,575,215	4,105,033	4,606,063	89,148
Cabarrus	2,947,317	3,360,826	3,615,666	4,165,387	4,782,663	5,366,400	131,063
Caldwell	2,410,732	2,628,652	2,860,243	3,356,135	3,853,486	4,323,814	77,415
Camden	198,876	186,305	215,603	234,576	269,338	302,212	6,885
Carteret	1,743,761	1,895,607	2,002,109	2,420,168	2,778,818	3,117,980	59,383
Caswell	844,712	925,138	966,852	1,097,093	1,259,673	1,413,419	23,501
Catawba	3,191,691	3,524,878	3,642,376	4,303,823	4,941,614	5,544,751	141,685
Chatham	1,108,889	1,432,646	1,354,837	1,688,293	1,938,484	2,175,082	49,329
Cherokee	1,094,435	1,213,761	1,362,661	1,611,509	1,850,322	2,076,158	24,298
Chowan	767,284	856,850	826,535	936,489	1,075,270	1,206,509	14,526
Clay	344,210	346,308	377,055	505,932	580,907	651,808	8,775
Cleveland	3,174,898	3,586,847	3,815,022	4,788,702	5,498,348	6,169,436	96,287
Columbus	3,026,279	3,533,749	3,737,979	4,632,643	5,319,162	5,968,380	54,749
Craven	2,827,193	3,056,381	3,122,012	3,953,070	4,538,882	5,092,865	91,436
Cumberland	7,071,128	7,648,469	8,239,239	9,782,406	11,232,079	12,602,983	302,963
Currituck	376,609	388,849	435,138	505,074	579,921	650,702	18,190
Dare	608,805	711,206	649,172	787,157	903,807	1,014,119	29,967
Davidson	3,422,152	3,944,069	4,021,565	4,643,685	5,331,841	5,982,606	147,246
Davie	796,443	880,485	903,690	1,068,016	1,226,287	1,375,959	34,835
Duplin	1,902,320	2,069,139	2,202,459	2,769,787	3,180,246	3,568,404	49,063
Durham	5,951,025	6,925,839	6,515,258	8,013,764	9,201,339	10,324,386	223,314
Edgecombe	2,837,280	3,205,512	3,362,319	3,594,901	4,127,636	4,631,424	55,606
Forsyth	7,488,710	8,311,154	8,732,497	9,752,900	11,198,200	12,564,970	306,067
Franklin	1,690,441	1,843,041	1,839,511	2,087,620	2,396,988	2,689,547	47,260
Gaston	6,105,360	6,687,510	6,734,702	8,519,210	9,781,687	10,975,567	190,365
Gates	431,533	422,195	422,914	510,250	585,865	657,371	10,516
Graham	450,991	500,379	513,425	681,065	781,993	877,437	7,993
Granville	1,281,340	1,523,030	1,575,841	1,426,056	1,637,386	1,837,233	48,498
Greene	760,140	825,893	822,431	976,299	1,120,978	1,257,797	18,974
Guilford	10,516,034	12,124,299	11,960,029	14,417,954	16,554,576	18,575,106	421,048

North Carolina Association of County Commissioners
Medicaid Expenditures
4/24/01

Budgeted Expenditures

County	1997-98	1998-99	1999-2000	2000-2001	Recommended 2001-2002	Projected 2002-2003	2000 Population
Halifax	2,994,461	3,327,532	3,371,449	4,028,171	4,625,113	5,189,620	57,370
Harnett	2,727,481	2,940,116	3,231,883	3,779,997	4,340,162	4,869,890	91,025
Haywood	1,821,452	2,029,364	1,983,570	2,273,601	2,610,530	2,929,152	54,033
Henderson	2,424,677	2,644,442	2,927,412	3,610,253	4,145,263	4,651,203	89,173
Hertford	1,407,215	1,358,357	1,525,110	1,808,858	2,076,916	2,330,409	22,601
Hoke	1,085,371	1,205,274	1,166,094	1,509,086	1,732,720	1,944,203	33,646
Hyde	306,449	366,087	336,999	415,968	477,611	535,905	5,826
Iredell	2,748,576	3,033,947	3,216,412	3,701,040	4,249,503	4,768,166	122,660
Jackson	1,021,608	1,123,153	1,316,300	1,522,569	1,748,202	1,961,574	33,121
Johnston	3,404,112	3,813,947	3,820,114	4,807,012	5,519,372	6,193,025	121,965
Jones	463,607	515,711	518,433	583,608	670,093	751,880	10,381
Lee	1,465,075	1,573,006	1,772,314	1,949,024	2,237,853	2,510,989	49,040
Lenoir	2,872,489	2,971,579	3,096,121	3,591,814	4,124,091	4,627,447	59,648
Lincoln	1,543,776	1,470,870	1,594,601	2,310,116	2,652,456	2,976,195	63,780
Macon	939,841	1,011,059	1,071,389	1,329,655	1,526,700	1,713,037	29,811
Madison	786,784	876,469	892,415	1,016,326	1,166,937	1,309,365	19,635
Martin	1,246,558	1,360,960	1,501,372	1,838,095	2,110,485	2,368,076	25,593
McDowell	1,230,331	1,314,890	1,427,165	1,901,259	2,183,010	2,449,453	42,151
Mecklenburg	13,958,478	15,508,683	16,129,620	19,070,998	21,897,164	24,569,770	695,454
Mitchell	623,128	663,561	688,185	891,258	1,023,335	1,148,235	15,687
Montgomery	1,066,170	1,168,400	1,203,178	1,217,187	1,397,564	1,568,141	26,822
Moore	2,010,641	2,251,727	2,392,829	2,683,243	3,080,878	3,456,907	74,769
Nash	2,920,470	3,079,964	3,126,188	4,039,546	4,638,174	5,204,275	87,420
New Hanover	4,587,507	5,160,047	5,033,576	6,470,667	7,429,567	8,336,365	160,307
Northampton	1,266,764	1,269,216	1,389,361	1,728,929	1,985,142	2,227,434	22,086
Onslow	2,852,728	3,317,988	3,122,475	3,810,087	4,374,711	4,908,656	150,355
Orange	1,886,024	1,998,420	2,314,730	2,762,288	3,171,636	3,558,743	118,227
Pamlico	509,124	566,650	582,808	747,820	858,640	963,440	12,934
Pasquotank	1,361,132	1,566,539	1,616,734	1,734,710	1,991,780	2,234,882	34,897
Pender	1,435,560	1,595,898	1,743,771	1,938,040	2,225,242	2,496,838	41,082
Perquimans	438,531	465,300	456,207	550,473	632,049	709,192	11,368
Person	1,292,801	1,433,600	1,486,927	1,858,149	2,133,511	2,393,912	35,623
Pitt	4,775,443	4,924,584	5,043,896	5,366,501	6,161,773	6,913,834	133,798
Polk	540,776	555,304	576,185	728,558	836,524	938,624	18,324
Randolph	3,103,376	3,361,671	3,412,179	4,478,323	5,141,974	5,769,565	130,454
Richmond	2,538,700	2,663,628	2,604,101	3,079,206	3,535,519	3,967,038	46,564
Robeson	6,355,169	7,311,591	7,576,144	9,473,523	10,877,422	12,205,040	123,339
Rockingham	3,322,654	3,863,964	4,052,417	4,708,196	5,405,912	6,065,718	91,928
Rowan	3,417,140	3,749,882	3,861,620	4,771,963	5,479,129	6,147,871	130,340
Rutherford	2,158,679	2,401,979	2,477,655	2,886,107	3,313,805	3,718,264	62,899
Sampson	2,368,400	2,674,101	2,881,250	3,514,153	4,034,922	4,527,394	60,161

North Carolina Association of County Commissioners
Medicaid Expenditures
4/24/01

Budgeted Expenditures

County	1997-98	1998-99	1999-2000	2000-2001	Recommended 2001-2002	Projected 2002-2003	2000 Population
Scotland	1,884,292	2,101,900	2,259,179	2,658,363	3,052,311	3,424,854	35,998
Stanly	1,781,923	2,017,340	2,068,606	2,632,056	3,022,105	3,390,960	58,100
Stokes	1,122,748	1,251,337	1,260,140	1,562,557	1,794,115	2,013,092	44,711
Surry	2,244,846	2,348,859	2,713,445	3,225,952	3,704,012	4,156,096	71,219
Swain	639,663	612,841	616,730	787,941	904,708	1,015,130	12,968
Transylvania	916,568	908,323	1,011,834	1,272,437	1,461,001	1,639,320	29,334
Tyrrell	223,651	210,658	212,487	270,931	311,080	349,049	4,149
Union	2,336,935	2,590,956	2,495,974	3,464,409	3,977,806	4,463,308	123,677
Vance	2,148,043	2,280,459	2,252,976	2,755,095	3,163,378	3,549,476	42,954
Wake	8,882,875	10,126,391	10,531,167	13,605,603	15,621,842	17,528,528	627,846
Warren	963,328	1,027,369	983,318	1,310,747	1,504,989	1,688,677	19,972
Washington	630,308	753,071	767,316	889,631	1,021,467	1,146,140	13,723
Watauga	883,228	937,920	995,555	1,133,105	1,301,022	1,459,815	42,695
Wayne	3,880,729	4,278,242	4,231,818	4,482,001	5,146,197	5,774,304	113,329
Wilkes	2,406,074	2,499,984	2,870,303	3,297,132	3,785,741	4,247,800	65,632
Wilson	2,913,179	3,340,067	3,291,281	3,966,855	4,554,711	5,110,625	73,814
Yadkin	925,893	1,067,659	1,165,058	1,447,896	1,662,462	1,865,370	36,348
Yancey	658,629	796,038	884,018	929,350	1,067,072	1,197,311	17,774
Total	230,113,947	254,578,894	264,023,197	317,163,928	364,165,029	408,612,323	8,049,313
Percent change		11%	4%	20%	15%	12%	

The above figures do not include the costs of administering the Medicaid program. County employees at county expense manage the elibility determination process. North Carolina is the 1 of 2 states in the nation whereby the counties are required to fully fund the non-federal share of Medicaid administration, 50% of the total administrative costs. For 2001-02, an estimated $57 million will be spent by counties to administer Medicaid.

North Carolina Association of County Commissioners
Medicaid Expenditures
4/24/01

County	2000-01 Per Capita Expenditure	Percent Change 1997-98 to 2001-02	2000 Medicaid Eligibles per Pop.	2001 Tier	2000-01 County Budgeted Expenditures	1999-2000 Human Services Expenditures	Percent Total County Budget for Medicaid	1 Cent of Property Tax at 100% Collection
Alamance	37.40	99%	13%	5	81,318,435	25,002,025	6%	656,141
Alexander	33.59	90%	14%	4	21,219,449	6,786,008	5%	137,896
Alleghany	51.95	80%	16%	1	10,006,092	2,298,681	6%	93,500
Anson	69.96	63%	28%	2	21,040,549	7,659,404	8%	91,345
Ashe	65.15	85%	19%	1	17,098,080	6,232,798	9%	164,400
Avery	59.32	76%	18%	3	16,119,486	3,299,297	6%	138,383
Beaufort	63.57	78%	23%	1	39,875,407	16,197,487	7%	258,425
Bertie	87.34	77%	32%	1	15,998,349	8,341,227	11%	69,584
Bladen	80.35	95%	30%	2	24,104,255	29,645,715	11%	159,305
Brunswick	43.10	95%	18%	4	84,303,071	17,271,251	4%	950,000
Buncombe	43.13	76%	16%	5	179,989,735	59,256,135	5%	1,323,154
Burke	40.10	63%	15%	4	54,692,546	21,403,937	7%	370,904
Cabarrus	31.78	82%	12%	5	115,335,472	27,543,420	4%	1,002,962
Caldwell	43.35	79%	15%	4	55,248,563	22,601,264	6%	338,644
Camden	34.07	52%	14%	1	4,574,169	935,001	5%	30,759
Carteret	40.76	79%	13%	4	56,204,260	11,622,653	4%	546,503
Caswell	46.68	67%	17%	3	18,465,594	7,505,620	6%	99,000
Catawba	30.38	74%	13%	5	163,202,895	49,492,766	3%	1,107,709
Chatham	34.23	96%	12%	5	43,102,459	11,057,749	4%	284,000
Cherokee	66.32	90%	22%	1	19,978,780	5,203,573	8%	116,652
Chowan	64.47	57%	25%	3	16,196,976	3,600,689	6%	74,100
Clay	57.66	89%	17%	1	12,206,962	2,653,469	4%	61,628
Cleveland	49.73	94%	18%	3	84,578,153	27,467,461	6%	470,000
Columbus	84.62	97%	31%	1	50,722,789	21,864,889	9%	241,632
Craven	43.23	80%	16%	4	63,712,518	24,468,040	6%	443,462
Cumberland	32.29	78%	17%	3	224,947,587	103,677,308	4%	1,223,949
Currituck	27.77	73%	13%	3	35,372,328	4,097,586	1%	212,431
Dare	26.27	67%	10%	3	50,232,803	9,557,440	2%	486,000
Davidson	31.54	75%	14%	4	102,632,703	36,179,272	5%	740,000
Davie	30.66	73%	11%	5	29,832,005	7,749,250	4%	189,789
Duplin	56.45	88%	24%	3	30,679,610	16,996,334	9%	200,960
Durham	35.89	73%	15%	5	391,972,822	99,746,034	2%	1,432,710
Edgecombe	64.65	63%	31%	1	49,321,093	36,473,048	7%	198,597
Forsyth	31.87	68%	13%	5	269,918,990	71,729,942	4%	2,091,082
Franklin	44.17	59%	18%	4	40,645,501	13,127,489	5%	211,700
Gaston	44.75	80%	17%	4	158,986,004	51,639,617	5%	970,563
Gates	48.52	52%	17%	3	8,463,933	1,720,094	6%	38,200
Graham	85.21	95%	26%	1	8,919,402	3,526,790	8%	34,846
Granville	29.40	43%	15%	4	28,090,086	7,380,005	5%	189,781
Greene	51.45	65%	21%	3	12,104,597	5,978,596	8%	61,800
Guilford	34.24	77%	14%	5	384,614,338	146,301,995	4%	3,035,000

North Carolina Association of County Commissioners
Medicaid Expenditures
4/24/01

County	2000-01 Per Capita Expenditure	Percent Change 1997-98 to 2001-02	2000 Medicaid Eligibles per Pop.	2001 Tier	2000-01 County Budgeted Expenditures	1999-2000 Human Services Expenditures	Percent Total County Budget for Medicaid	1 Cent of Property Tax at 100% Collection
Halifax	70.21	73%	33%	1	31,321,205	30,916,191	13%	256,000
Harnett	41.53	79%	19%	4	54,766,122	19,072,847	7%	345,480
Haywood	42.08	61%	17%	3	44,092,619	13,087,915	5%	321,676
Henderson	40.49	92%	15%	5	67,304,536	18,205,779	5%	670,772
Hertford	80.03	66%	33%	1	14,623,090	7,269,430	12%	77,515
Hoke	44.85	79%	23%	2	19,333,073	6,934,125	8%	114,899
Hyde	71.40	75%	22%	1	7,854,138	3,750,223	5%	37,150
Iredell	30.17	73%	13%	5	92,004,780	21,340,756	4%	975,872
Jackson	45.97	92%	17%	3	28,577,041	7,641,148	5%	327,743
Johnston	39.41	82%	17%	5	105,590,936	34,821,186	5%	573,540
Jones	56.22	62%	23%	1	7,641,348	4,462,214	8%	47,255
Lee	39.74	71%	18%	5	42,438,981	11,609,638	5%	281,200
Lenoir	60.22	61%	25%	3	45,328,491	21,080,853	8%	287,828
Lincoln	36.22	93%	13%	4	47,196,841	12,671,444	5%	399,776
Macon	44.60	82%	12%	3	27,611,489	8,116,157	5%	354,579
Madison	51.76	66%	13%	2	12,279,754	4,945,022	8%	80,545
Martin	71.82	90%	35%	1	24,040,950	8,066,212	8%	130,151
McDowell	45.11	99%	26%	3	25,539,495	8,196,341	7%	173,259
Mecklenburg	27.42	76%	13%	5	855,900,000	265,239,555	2%	6,280,000
Mitchell	56.82	84%	18%	2	13,986,552	3,518,912	6%	83,844
Montgomery	45.38	47%	21%	2	19,517,595	5,465,632	6%	144,679
Moore	35.89	72%	14%	5	57,037,763	14,379,102	5%	505,500
Nash	46.21	78%	18%	4	64,572,593	22,582,581	6%	425,700
New Hanover	40.36	82%	15%	5	174,487,423	47,567,885	4%	1,600,000
Northampton	78.28	76%	32%	1	19,388,229	9,974,777	9%	93,434
Onslow	25.34	72%	12%	2	99,419,768	37,403,833	4%	523,180
Orange	23.36	89%	8%	5	108,982,427	21,251,250	3%	731,574
Pamlico	57.82	89%	20%	2	10,848,890	4,641,058	7%	81,513
Pasquotank	49.71	64%	22%	2	22,702,324	10,244,046	8%	139,978
Pender	47.17	74%	18%	4	31,131,865	11,471,937	6%	224,783
Perquimans	48.42	62%	22%	1	7,778,364	1,932,000	7%	65,338
Person	52.16	85%	17%	4	39,179,910	10,048,716	5%	262,600
Pitt	40.11	45%	19%	4	127,032,783	47,295,481	4%	592,528
Polk	39.76	74%	13%	3	11,437,229	3,063,188	6%	110,399
Randolph	34.33	86%	14%	5	85,142,898	29,129,829	5%	619,000
Richmond	66.13	56%	26%	1	32,188,713	11,666,368	10%	169,987
Robeson	76.81	92%	33%	2	90,330,882	37,454,704	10%	350,031
Rockingham	51.22	83%	17%	3	76,999,266	30,798,446	6%	482,500
Rowan	36.61	80%	15%	4	89,172,564	24,419,851	5%	748,333
Rutherford	45.88	72%	19%	2	39,696,827	11,068,478	7%	307,263
Sampson	58.41	91%	25%	3	41,133,498	14,433,168	9%	230,133

North Carolina Association of County Commissioners
Medicaid Expenditures
4/24/01

County	2000-01 Per Capita Expenditure	Percent Change 1997-98 to 2001-02	2000 Medicaid Eligibles per Pop.	2001 Tier	2000-01 County Budgeted Expenditures	1999-2000 Human Services Expenditures	Percent Total County Budget for Medicaid	1 Cent of Property Tax at 100% Collection
Scotland	73.85	82%	30%	1	35,521,560	12,265,654	7%	155,093
Stanly	45.30	90%	15%	3	42,060,790	11,140,969	6%	247,000
Stokes	34.95	79%	12%	5	31,918,179	9,166,517	5%	216,175
Surry	45.30	85%	16%	4	53,551,281	17,255,223	6%	413,435
Swain	60.76	59%	24%	1	6,381,953	4,761,065	12%	48,142
Transylvania	43.38	79%	15%	5	33,469,548	9,912,283	4%	234,000
Tyrrell	65.30	56%	26%	1	3,802,523	1,036,854	7%	21,293
Union	28.01	91%	12%	5	110,779,269	22,229,974	3%	832,300
Vance	64.14	65%	29%	2	34,421,749	10,906,847	8%	181,578
Wake	21.67	97%	9%	5	564,435,168	138,343,535	2%	5,775,000
Warren	65.63	75%	27%	1	19,284,291	7,332,361	7%	82,898
Washington	64.83	82%	29%	1	10,347,500	4,294,653	9%	52,237
Watauga	26.54	65%	9%	3	32,679,868	6,107,862	3%	306,069
Wayne	39.55	49%	20%	3	113,693,595	37,153,173	4%	396,001
Wilkes	50.24	77%	17%	4	47,466,537	13,456,887	7%	364,156
Wilson	53.74	75%	23%	3	69,003,176	27,159,141	6%	415,489
Yadkin	39.83	101%	13%	5	27,803,702	7,430,318	5%	203,350
Yancey	52.29	82%	19%	1	10,080,289	3,391,134	9%	126,716
Total	39.40	78%	16%		7,158,343,076	2,295,874,087	4%	
Percent change								

2001 COMMITTEE REPORT
HOUSE OF REPRESENTATIVES

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

☐ Committee Substitute for
H.B. 317 A BILL TO BE ENTITLED AN ACT TO REDUCE THE COUNTY SHARE OF NONFEDERAL PAYMENTS FOR THE MEDICAID PROGRAM FOR CERTAIN COUNTIES AND TO APPROPRIATE FUNDS TO COVER THE REDUCTION IN COUNTY NONFEDERAL PAYMENTS.

☐ 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)

2/15/01

HOUSE BILL 994

Short Title:	TBI Medicaid Waiver.	(Public)
Sponsors:	Representatives Earle; Barefoot, Russell, and Wainwright.	
Referred to:	Health.	

April 5, 2001

A BILL TO BE ENTITLED

AN ACT TO DIRECT THE DEPARTMENT OF HEALTH AND HUMAN SERVICES TO REQUEST APPROVAL FOR A MEDICAID WAIVER FOR TRAUMATIC BRAIN INJURY SERVICES.

The General Assembly of North Carolina enacts:

SECTION 1. The Department of Health and Human Services shall develop and seek approval from the Health Care Financing Administration for a Home and Community-Based Medicaid Waiver for individuals with traumatic brain injury. If the waiver is granted, the Department shall not implement the waiver unless the implementation is approved and enacted by the General Assembly, and funds are appropriated for that purpose. The Department shall report the status of the waiver to the Senate Appropriations Committee on Human Resources and the House of Representatives Appropriations Subcommittee on Health and Human Services on October 1, 2001, and March 1, 2002. The report shall include the estimated amount of funds needed to implement the waiver. Nothing in this act obligates the General Assembly to appropriate funds to implement a Medicaid waiver granted by the federal government for the purposes stated in this act.

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

2001 COMMITTEE REPORT
HOUSE OF REPRESENTATIVES

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

☐ Committee Substitute for
H.B. 994 A BILL TO BE ENTITLED AN ACT TO DIRECT THE DEPARTMENT OF HEALTH AND HUMAN SERVICES TO REQUEST APPROVAL FOR A MEDICAID WAIVER FOR TRAUMATIC BRAIN INJURY 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)

2/15/01

OUTLINE OF COMMENTS
ON BEHALF OF NC ASSOCIATION OF COUNTY COMMISSIONERS
APRIL 24, 2001
DR. DELILAH BLANKS, PRESIDENT

I. Thank House Health Committee for hearing HB 317.
   A. Rep. Hunter for introducing the bill.
   B. Rep. Wright for scheduling the bill on the agenda.

II. Acknowledge State budget problems and difficulty legislators face in balancing needs with resources.

III. Discuss Medicaid as a "budget driver" –
   A. Costs set boundaries for everything else county commissioners can do.
   B. All other needs come after Medicaid is budgeted.

IV. Explain reasons why this year is hitting commissioners so much harder than usual.
   A. Governor has embargoed reimbursements for repealed property taxes.
   B. Severe underestimates for current year's expenditures.
   C. Inflation and utilization increases for next year are showing 25-30% increases over this year. Some counties are even higher.

V. Refer to handouts.
   A. Budgeted Expenditures for Medicaid 97-01
   B. Per capita Medicaid – Eligibles per population

VI. Relate specific situation in Bladen.

A. Property tax levy can not keep pace with Medicaid inflation.
B. Possibly mention per capita income, unemployment rate or other demographics pertinent to Bladen.

VII. Point out other needs in Bladen (and other counties) that need attention.
A. Examples might be schools, industrial recruitment, landfills, jails, etc.
B. Anything you can add about things like literacy rate, end-of-grade testing, internet access, conditions of the people in your county.

VIII. Close with expression of appreciation for letting you speak and request that committee support the bill.

COUNTY MEDICAID COSTS AS A % OF RESPECTIVE COUNTY BUDGETS BY TIER *

(* DATA OBTAINED FROM NCACC & STATE MEDICAID OFFICE)

TIER 1	%	TIER 2	%	Tier 3	%	TIER 4	%	TIER 5	%
Alleghany	4.9	Anson	6.5	Avery	5.8	Alexander	4.7	Alamance	4.9
Ashe	6.3	Bladen	9	Caswell	5.4	Brunswick	3.3	Buncombe	4
Beaufort	5.8	Hoke	7.5	Chowan	5.8	Burke	6.7	Cabarrus	3.4
Bertie	9	Madison	7.4	Cleveland	5.1	Caldwell	4.9	Catawba	2.2
Camden	4.6	Mitchell	5.4	Cumberland	3.3	Carteret	3	Chatham	3
Cherokee	7.8	Montgomery	5.8	Currituck	1.6	Craven	4.9	Davie	3.2
Clay	4.4	Onslow	3.2	Dare	1.2	Davidson	4.2	Durham	1.8
Columbus	7.1	Pamlico	5.7	Duplin	7.5	Franklin	4.8	Forsyth	3
Edgecombe	6.4	Pasquotank	6.7	Gates	5.2	Gaston	4.5	Guilford	2.9
Graham	5.8	Robeson	9.3	Greene	6.7	Granville	6.3	Henderson	4.3
Halifax	9.4	Rutherford	6.3	Haywood	4.4	Harnett	6.2	Iredell	3.7
Hertford	9	Vance	6.4	Jackson	4.3	Lincoln	3.6	Johnston	4
Hyde	4			Lenoir	7	Nash	5	Lee	4.2
Jones	6			Macon	4	Pender	5.5	Mecklenberg	1.7
Martin	6.1			McDowell	6.2	Person	3.9	Moore	4
Northampton	8.8			Polk	3.4	Pitt	3.5	New Hanover	2.8
Perquimans	5.8			Rockingham	4.8	Rowan	4.6	Orange	2.1
Richmond	8.3			Sampson	7.2	Surry	5.4	Randolph	5.1
Scotland	6			Stanly	5.3	Wilkes	6	Stokes	3.8
Swain	8.9			Watauga	3.3			Transylvania	3.2
Tyrrell	5.2			Wayne	4.2			Union	2.5
Warren	5			Wilson	5.1			Wake	1.7
Washington	7.2							Yadkin	4.3
Yancey	9								

Means: 160.8 / 24 = 6.7 79.1 / 12=6.59 106.8 / 22=4.85 91 / 19 = 4.79 75.8 / 23 = 3.3

OVERVIEW: 5.14% Average Cost by Percentage of Medicaid Expenses as a Reflection of All County Budgets

Reflects by Tier and Percentage Counties Exceeding the Overall Average Cost of Medicaid in Their Budgets

Tier 1 80% Over Tier 2 92% Over Tier 3 50% Over Tier 4 32% Over Tier 5 0 % Over

County of Halifax
NORTH CAROLINA
Where It All Began

April 24, 2001

Honorable Thomas E. Wright, Chairman
House Health Committee
North Carolina House of Representatives
Legislative Office Building, Room 528
Raleigh, NC 27601-1096

SUBJECT: HOUSE BILL 317 MEDICAID COUNTY SHARE/FUNDS

Dear Chairman Wright:

On behalf of the Halifax County Board of Commissioners, I would like to urge you and the other members of the House Health Committee to support and recommend the passage of House Bill 317 by the House and Senate.

As you know, House Bill 317 is designed to level the playing field between counties in North Carolina with respect to the non-federal share of Medicaid. Counties now pay 5.66% of the non-federal share of Medicaid expenses. Linking the amount of each county's share of Medicaid to the county's tier designation as determined by the William S. Lee Act is a fair way to level the playing field and help unite the two North Carolinas.

The amount and rate of growth of this mandated expense to many counties, like Halifax, is having a detrimental impact on the overall economic vitality of our county. Attached is a graph that shows the astronomical growth of Halifax County's share of Medicaid between 1988 and 2001. In FY 1988-1989, Halifax County's share of Medicaid was $778,174. In 2001, the county's share will be over $4.8 million. The greatest single year increase is this upcoming fiscal year 2001-2002. According to the North Carolina Department of Health and Human Services, Halifax County should budget $4,875,250 for Medicaid in FY 01-02. This represents a $1,638,535 increase over FY 00-01. It will take a 7 ¢ property tax increase alone to pay for this projected increase in the county's share of Medicaid.

Please keep the following facts in mind while giving consideration to House Bill 317. Also, please remember that many counties across North Carolina are much like Halifax County – *lacking the resources to pay mandated expenses like Medicaid and also invest in the future of the county by improving schools and job opportunities.*

Halifax County Board of Commissioners
PO Box 38 . Halifax, NC 27839 . Voice 252-583-1131 . Fax 252-583-9921
www.halifaxnc.com

Facts about Halifax County:

- 33% of Halifax County's population is currently using Medicaid.
- In FY 00-01, Medicaid represents 13.5¢ of Halifax County's 71.5¢ tax rate. The Medicaid share will exceed 20¢ in FY 01-02.
- Counties have no input into eligibility criteria. During the past several years the eligibility criteria has been expanded to many deserving citizens, however, poor counties like Halifax County cannot continue to pay these escalating costs without other needed services suffering.
- North Carolina is one (1) of seven (7) states in the country that requires counties to pay a portion of the non-federal share of Medicaid. Just five years ago, fourteen (14) states required counties to participate. (Please continue this trend)

Thank you for the opportunity to share our views regarding the impact of Medicaid on Halifax County. Please give these facts your full consideration and support the passage of House Bill 317. The future of North Carolina may just depend on it. Help counties help themselves.

Again, thank you in advance for your favorable consideration.

With kindest regards,

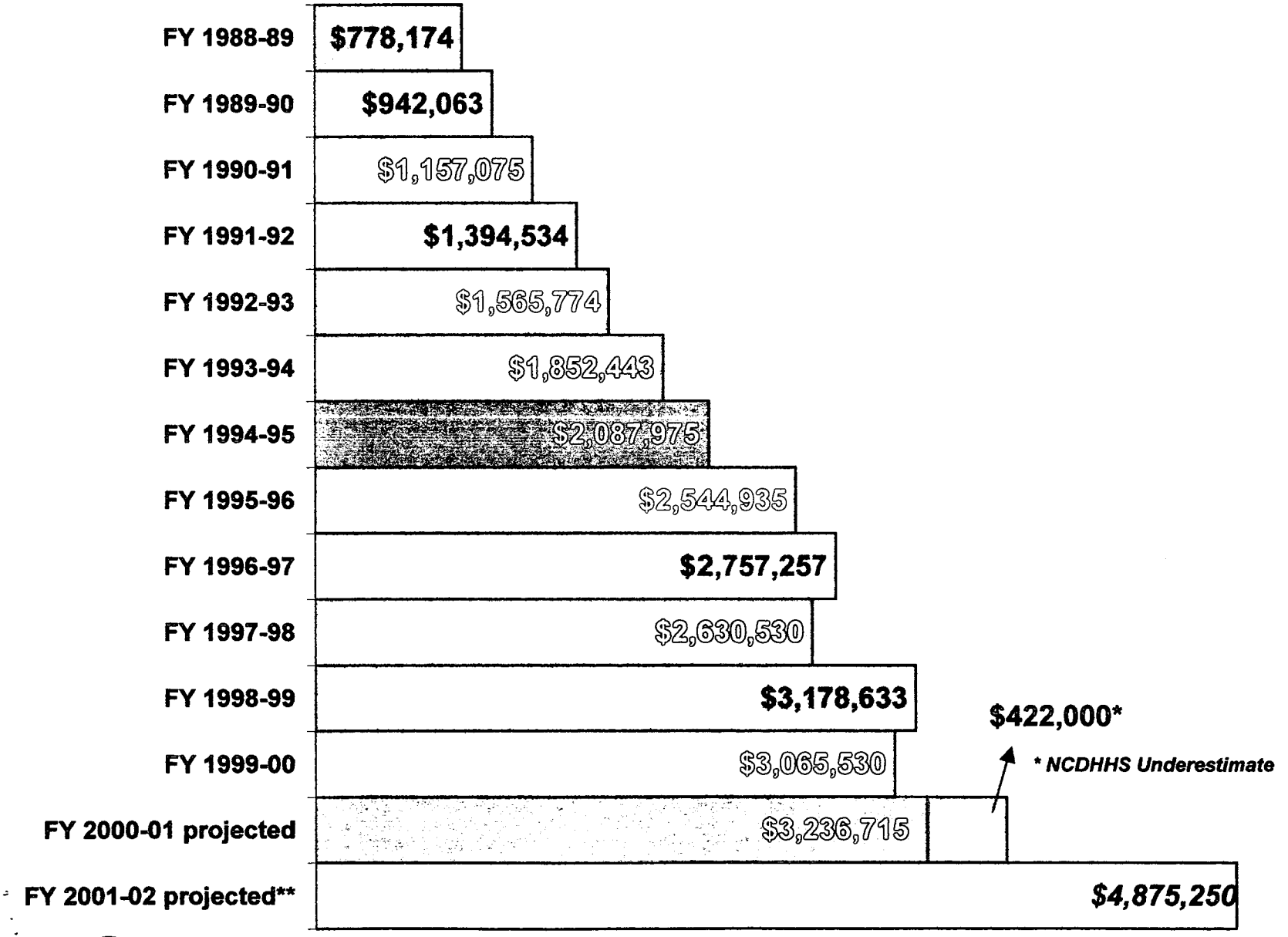
George C. Parrish, Chairman
Halifax County Board of Commissioners

Attachment

Cc: Senator Frank Balance, Jr.
Senator A. B. Swindell
Representative Gordon P. Allen
Representative James W. Crawford, Jr.
Representative John D. Hall
Halifax County Commissioners
Ron Aycock, NCACC

GCP/ca

Medicaid Expenses - Halifax County Share



VISITOR REGISTRATION SHEET

12:30 - 2:00

HOUSE HEALTH COMMITTEE — 4-24-01

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Becky Mercer	Alcoholism Comprehensive Svs
Marion Griffin MD	NC Family Policy Council
Anne King	DMH/DD/SAS
Terry Pitts	Brain Injury Assoc.
Jennifer Sullivan	Nat'l Assoc of Social Workers
Flo Stein	DMH/DD/SAS
Jon B. Nelson	NCAL707
Dr Al Wentzy	Northampton Co Rep + DSS Director
Delilah Blanks	Bladen Co + NCACC
Patrice Raccia	NCACC
[illegible]	[illegible]

VISITOR REGISTRATION SHEET

12:30-200

HOUSE HEALTH COMMITTEE — 4-24-01

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Nicole Dusenbery	PPAF Action Fund of Orange & Durham
Wayne Williams	State Budget
Whitney Otis	State Budget
Jenny Lassiter	Pamlico Co Hlth Dept
Deborah Rowe	NCPNA/ Hlth Director Assoc
Polly Williams	NC Equity
Margaret Woodcock	State Govs (DHHS – Women's Preventive Health
Stacy Flannery	NCHCFA
Pam Bo~~n~~	NC P~~H~~HCA
Brian Francis	Meck County
Don Craft	Hertford County PO Box 116 Winton 27986

VISITOR REGISTRATION SHEET 12:30 - 2:00

Health
Name of Committee

4-24-01
Date

VISITORS:. PLEASE SIGN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
CHARLES ARCHER	HALIFAX COUNTY
GEORGE PARRISH	HALIFAX COUNTY
Steve Shore	NC Pediatric Society
Madlyn Morreale	Center for Adolescent Health & the Law
HUGH TILSON	NCHA
Dempsy Harvey	Columbus County
LAIZIRY P. I. MEADOWS	JONES COUNTY
Lee Smith	Washington County
Jo Ann Hall	Hertford County
Debbie Kennedy	Nurse for the Day
Barbara G Brown	Cumberland Co DSS
Johnnie R. Farmer	Hertford County

VISITOR REGISTRATION SHEET

12:30 - 2:00
4/24/01

me of Committee — Date

VISITORS: Please sign below and return to Committee Clerk.

NAME	FIRM OR STATE AGENCY AND ADDRESS
Patricia A. Yancey	APPEAL / ACLU
Victoria Boyd	NCASBLSL HC

AGENDA

HOUSE COMMITTEE ON HEALTH
TUESDAY, MAY 8, 2001
12:00 Noon, ROOM 415 LOB

OPENING REMARKS

Rep. Thomas E. Wright
Chairman

BILLS TO BE DISCUSSED

SB-463 AMEND NURSING PRACTICE ACT. (Sen. Purcell)

SB-542 DATABASE ON PSYCHOTROPIC MEDS/CHILDREN.(Sen. Foxx)

SB-749 NURSING HOME ADMINISTRATOR ACT.(Sen. Hoyle)

COMMENTS

ADJOURNMENT

MINUTES

HOUSE COMMITTEE ON HEALTH

TUESDAY, MAY 8, 2001

12:00 NOON ROOM 415 LOB

The House Committee on Health met on Tuesday, May 8, 2001 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-463 AMEND NURSING PRACTICE ACT. (Sen. Purcell)

Sen. Purcell explained the bill.

Rep. Insko moved for a favorable report.

Rep. Sherrill asked about 'Due Process' in Section 4 of the bill. Linda Attarian, Staff, responded. Sen. Purcell stated that Mr. Kramer and Polly Johnson were in attendance from the Nursing Association to expound on the inquiry by Rep. Sherrill. Mr. Kramer stated that an applicant for a nursing license has 'Due Process' Rights. Linda Attarian referenced the committee to page 5, line 30 for further explanation.

Chairman Wright called the question. So moved.

SB-542 DATABASE ON PSYCHOTROPIC MEDS/CHILDREN.(Sen. Foxx)

Sen. Foxx explained the bill. Rep. Insko asked about the usage of the database information. Sen. Foxx responded. Rep. Insko followed up with a question about a bill that was passed last year in reference to the use of restraints and medications in the facilities. Sen. Foxx responded. Rep. Insko further commented on the bill. Amy Jo Bain of the NC Medical Society stated that their organization had no opposition to the bill. Rep. Howard inquired about children who receive state services on line 24 of the bill. Sen. Foxx responded that the line should be amended to read children that are in state facilities, rather than children who receive state services.

Rep. Howard sent forth an amendment.

Chairman Wright asked about the impact this amendment would have on children outside of state facilities. Linda Attarian, Staff, responded. Rep. Insko asked about the clarification of the definition of state facilities. Sen. Foxx responded. Linda Attarian, staff, explained that the term 'state facility' is defined in Chapter 122C of the NC General

Statutes. Rep. Insko further commented on the term 'facility'. Chairman Wright asked if the amendment would accomplish the goal of including all state facilities. Linda Attarian responded. Rep. Sherrill asked Sen. Foxx about consideration of the inclusion of the Department of Juvenile Justice. Sen. Foxx responded. Rep. Clary asked Staff to amend the bill to include the Department of Juvenile Justice and the Department of Health and Human Services. Linda Attarian responded. Linda Attarian explained the entire amendment to the committee. Rep. Howard asked for clarification of the amendment.

Rep. Howard moved for the adoption of the amendment. So moved.

Rep. Insko moved for a favorable report to the House Committee Substitute Bill, unfavorable to the Senate Committee Substitute Bill. So moved.

The meeting adjourned at 12:45pm.

Rep. Thomas E. Wright, Chairman Vanda Wilson-Wormack, Committee Assistant

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2001

S 2

SENATE BILL 463

Health Care Committee Substitute Adopted 4/9/01

Short Title: Amend Nursing Practice Act. (Public)

Sponsors:

Referred to:

March 15, 2001

A BILL TO BE ENTITLED

AN ACT TO AMEND THE LAWS RELATING TO THE PRACTICE OF NURSING.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 90-171.20 reads as rewritten:

"**§ 90-171.20. Definitions.**

As used in this Article, unless the context requires otherwise:

(1) "Board" means the North Carolina Board of Nursing.

(2) "Health care provider" means any 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. For purposes of this Article, a person enrolled in a program ~~to prepare him~~that prepares the person to be a licensed health care professional or an allied health professional shall be deemed a health care provider.

(3) "License" means a permit issued by the Board to practice nursing as a registered nurse or as a licensed practical nurse, including a renewal thereof.

(4) "Nursing" is a dynamic discipline which includes the assessing, caring, counseling, teaching, referring and implementing of prescribed treatment in the maintenance of health, prevention and management of illness, injury, disability or the achievement of a dignified death. It is ministering to; assisting; and sustained, vigilant, and continuous care of those acutely or chronically ill; supervising patients during convalescence and rehabilitation; the supportive and restorative care given to maintain the optimum health level of ~~individuals~~ individuals, groups, and communities; the supervision, teaching, and evaluation of those who perform or are preparing to perform these functions; and the administration of nursing programs and nursing services.

(5) "Nursing program" means any educational program in North Carolina offering to prepare persons to meet the educational requirements for licensure under this Article.

(6) "Person" means an individual, corporation, partnership, association, unit of government, or other legal entity.

(7) The "practice of nursing by a registered nurse" consists of the following ~~nine~~ 10 components:

a. Assessing the patient's physical and mental health, including the patient's reaction to illnesses and treatment ~~regimens;~~regimens.

b. Recording and reporting the results of the nursing ~~assessment;~~assessment.

c. Planning, initiating, delivering, and evaluating appropriate nursing ~~acts;~~acts.

d. Teaching, assigning, delegating to or supervising other personnel in implementing the treatment ~~regimen;~~regimen.

e. Collaborating with other health care providers in determining the appropriate health care for a patient but, subject to the provisions of G.S. 90-18.2, not prescribing a medical treatment regimen or making a medical diagnosis, except under supervision of a licensed ~~physician;~~physician.

f. Implementing the treatment and pharmaceutical regimen prescribed by any person authorized by State law to prescribe ~~such a regimen;~~the regimen.

g. Providing teaching and counseling about the patient's ~~health care;~~health.

h. Reporting and recording the plan for care, nursing care given, and the patient's response to that ~~care; and~~care.

i. Supervising, teaching, and evaluating those who perform or are preparing to perform nursing functions and administering nursing programs and nursing services.

j. Providing for the maintenance of safe and effective nursing care, whether rendered directly or indirectly.

(8) The "practice of nursing by a licensed practical nurse" consists of the following ~~five~~ seven components:

a. Participating in ~~assessing the patient's~~the assessment of the patient's physical and mental ~~health~~ health, including the patient's reaction to illnesses and treatment ~~regimens;~~regimens.

b. Recording and reporting the results of the nursing ~~assessment;~~assessment.

c. Participating in implementing the health care plan developed by the registered nurse and/or prescribed by any person authorized by State law to prescribe such a plan, by performing tasks

assigned or delegated by and performed under the supervision or under orders or directions of a registered nurse, physician licensed to practice medicine, dentist, or other person authorized by State law to provide ~~such supervision;~~the supervision.

c1. Assigning or delegating nursing interventions to other qualified personnel under the supervision of the registered nurse.

d. ~~Reinforcing~~Participating in the teaching and counseling of patients as assigned by a registered nurse, ~~physician~~ physician, or other qualified professional licensed to practice ~~medicine~~ in North ~~Carolina, or dentist; and~~Carolina.

e. Reporting and recording the nursing care rendered and the patient's response to that care.

f. Maintaining safe and effective nursing care, whether rendered directly or indirectly."

SECTION 2. G.S. 90-171.21(d) reads as rewritten:

"(d) Qualifications. – Three of the registered nurse members shall hold positions with primary responsibility in nursing education and shall hold baccalaureate or advanced degrees. Six shall hold positions with primary responsibility in providing nursing care to patients. Of the six registered nurse members with primary responsibility in providing nursing care to patients, two shall be employed by a hospital and at least one shall be a hospital nursing service director; one shall be employed by a physician licensed to practice medicine in North Carolina and engaged in the private practice of medicine; one shall be employed by a skilled or intermediate care facility; one shall be ~~a registered nurse, approved to perform medical acts;~~either a nurse practitioner, nurse anesthetist, nurse midwife, or clinical nurse specialist; and one shall be a community health nurse. If no nurse is nominated in one of the categories, the position shall be an at-large registered nursing position.

(1) All registered nurse members shall meet the following criteria:

a. Hold a current license to practice as a registered nurse in North ~~Carolina;~~Carolina.

b. Have at least five years' experience in nursing practice, nursing administration, and/or nursing ~~education; and~~education.

c. Have been engaged in nursing practice, nursing administration, or nursing education for at least three years immediately preceding election.

(2) Licensed practical nurse members shall meet the following criteria:

a. Hold a current license to practice as a licensed practical nurse in North ~~Carolina;~~Carolina.

b. Be a graduate of a board-approved program for the preparation of practical ~~nurses;~~nurses.

c. Have at least five years' experience as a licensed practical ~~nurse; and~~nurse.

d. Have been engaged in practical nursing for at least three years immediately preceding election.

(3) A public member shall not be a health care provider nor the spouse of a health care provider. Public members shall reasonably represent the population of the State.

(4) The nurse practitioner, nurse anesthetist, nurse midwife, or clinical nurse specialist member shall be recognized by the Board as a registered nurse who meets the following criteria:

a. Has graduated from or completed a graduate level advanced practice nursing education program accredited by a national accrediting body.

b. Maintains current certification or recertification from a national credentialing body approved by the Board or meets other requirements established by rules adopted by the Board.

c. Practices in a manner consistent with rules adopted by the Board and other applicable law."

SECTION 3. G.S. 90-171.23(b) reads as rewritten:

"(b) Duties, powers. The Board is empowered to:

(1) Administer this ~~Article;~~Article.

(2) Issue its interpretations of this ~~Article;~~Article.

(3) Adopt, amend or repeal rules and regulations as may be necessary to carry out the provisions of this ~~Article;~~Article.

(4) Establish qualifications of, employ, and set the compensation of an executive officer who shall be a registered nurse and who shall not be a member of the ~~Board;~~Board.

(5) Employ and fix the compensation of other personnel that the Board determines are necessary to carry into effect this Article and incur other expenses necessary to effectuate this ~~Article;~~Article.

(6) Examine, license, and renew the licenses of duly qualified applicants for ~~licensure;~~licensure.

(7) Cause the prosecution of all persons violating this ~~Article;~~Article.

(8) Prescribe standards to be met by the students, and to pertain to faculty, curricula, facilities, resources, and administration for any nursing program as provided in ~~G.S. 90-171.38;~~G.S. 90-171.38.

(9) Survey all nursing programs at least every five years or more often as deemed necessary by the Board or program ~~director;~~director.

(10) Grant or deny approval for nursing programs as provided in ~~G.S. 90-171.39;~~G.S. 90-171.39.

(11) Upon request, grant or deny approval of continuing education programs for nurses as provided in ~~G.S. 90-171.42;~~G.S. 90-171.42.

(12) Keep a record of all proceedings and make available to the Governor and licensees an annual summary of all actions ~~taken;~~taken.

(13) Appoint, as necessary, advisory committees which may include persons other than Board members to deal with any issue under ~~study;~~study.

(14) Appoint and maintain a subcommittee of the Board to work jointly with the subcommittee of the North Carolina Medical Board to develop rules and regulations to govern the performance of medical acts by registered nurses and to determine reasonable fees to accompany an application for approval or renewal of such approval as provided in G.S. 90-6. The fees and rules developed by this subcommittee shall govern the performance of medical acts by registered nurses and shall become effective when they have been adopted by both ~~Boards;~~Boards.

(15) Recommend and collect such fees for licensure, license renewal, examinations and reexaminations as it deems necessary for fulfilling the purposes of this ~~Article; and~~Article.

(16) Adopt a seal containing the name of the Board for use on all certificates, licenses, and official reports issued by it.

(17) Enter into interstate compacts to facilitate the practice and regulation of nursing.

(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 4. G.S. 90-171.37 reads as rewritten:

"**§ 90-171.37. Revocation, discipline, suspension, probation, or denial of licensure.**

The Board shall initiate an investigation upon receipt of information about any practice that might violate any provision of this Article or any rule or regulation promulgated by the Board. In accordance with the provisions of Chapter 150B of the General Statutes, ~~the Board may require remedial education, issue a letter of reprimand, restrict, revoke, or suspend any license to practice nursing in North Carolina or deny any application for licensure if the Board determines that the nurse or applicant:~~the Board shall have the power and authority to: (i) refuse to issue a license to practice nursing; (ii) refuse to issue a certificate of renewal of a license to practice nursing; (iii) revoke or suspend a license to practice nursing; and (iv) invoke other such disciplinary measures, censure, or probative terms against a licensee as it deems fit and proper; in any instance or instances in which the Board is satisfied that the applicant or licensee:

(1) Has given false information or has withheld material information from the Board in procuring or attempting to procure a license to practice ~~nursing;~~nursing.

(2) Has been convicted of or pleaded guilty or nolo contendere to any crime which indicates that the nurse is unfit or incompetent to practice nursing or that the nurse has deceived or defrauded the ~~public;~~public.

(3) Has a mental or physical disability or uses any drug to a degree that interferes with his or her fitness to practice ~~nursing;~~nursing.

(4) Engages in conduct that endangers the public ~~health;~~health.

(5) Is unfit or incompetent to practice nursing by reason of deliberate or negligent acts or omissions regardless of whether actual injury to the patient is ~~established;~~established.

(6) Engages in conduct that deceives, defrauds, or harms the public in the course of professional activities or ~~services;~~services.

(7) Has violated any provision of this ~~Article; or~~Article.

(8) Has willfully violated any rules enacted by the Board.

The Board may take any of the actions specified above in this section when a registered nurse approved to perform medical acts has violated rules governing the performance of medical acts by a registered nurse; provided this shall not interfere with the authority of the North Carolina Medical Board to enforce rules and regulations governing the performance of medical acts by a registered nurse.

The Board may reinstate a revoked ~~license~~ license, revoke censure or probative terms, or remove other licensure restrictions when it finds that the reasons for ~~revocation~~ revocation, censure or probative terms, or ~~restriction~~ other licensure restrictions no longer exist and that the nurse or applicant can reasonably be expected to safely and properly practice nursing."

SECTION 5. This act is effective when it becomes law.

SENATE BILL 463:
Amend Nursing Practice Act

BILL ANALYSIS

Committee:	House Health Care	**Introduced by:**	Sen. Purcell
Date:	May 8, 2001	**Summary by:**	Linda Attarian
Version:	2nd Edition		Committee Counsel

SUMMARY: ***Senate Bill 463, 2nd Edition, would make the following substantive changes to Nursing Practice Act, Article 9A of Chapter 90 of the General Statutes:***

- ***Expands the definition of the "practice of nursing by a registered nurse" to include assigning nursing acts to other personnel and providing for the maintenance of safe and effective nursing care.***
- ***Expands the definition of "practice of nursing by a licensed practical nurse", to include assigning and delegating nursing interventions to other qualified personnel under the supervision of the registered nurse; participating in the teaching and counseling of patients; and providing for the maintenance of safe and effective nursing care.***
- ***Provides that one of the six positions reserved on the Board for registered nurses who provide nursing care to patients, shall be assigned to a "nurse practitioner, nurse anesthetist, nurse midwife, or clinical nurse specialist". Currently, one of the six positions is assigned to a "registered nurse approved to perform medical acts".***
- ***Expands the Board's disciplinary authority to allow the board to place a licensee on probation or other such disciplinary measures as the Board deems appropriate.***

The act is effective when it becomes law.

CURRENT LAW: The Nursing Practice Act has not been updated since 1981, except for the fee schedule.

BILL ANALYSIS:

Section 1: Amends G.S. 90-171.20 (7) to: include the following additional components to the definition of "practice of nursing by a registered nurse" 1) assignment (in addition to delegation) of nursing acts to other personnel and 2) being accountable for the maintenance of safe and effective nursing care, whether rendered directly or indirectly.

Amends G.S. 90-171.20 (8) to include the following additional components to the definition of the "practice of nursing by a licensed practical nurse": 1) assignment and delegation of nursing interventions to other qualified personnel under the supervision of the registered nurse; 2) participation in the teaching and counseling of patients, (instead of "reinforcing the teaching . . ."); and 3) Being accountable for the maintenance of safe and effective nursing care, whether rendered directly or indirectly.

Section 2. The Board of Nursing has seats for nine registered nurses. Six of these nurses represent nurses who provide nursing care to patients. One of the six must be a registered nurse approved to perform medical acts. Section 2 would amend this subsection to require that someone who is a *nurse practitioner, nurse anesthetist, nurse midwife, or clinical nurse specialist* fill this position on the Board. The

qualifications necessary to be recognized by the board as one of these nurse specialists are added to the section.

Section 3. Makes technical changes to G.S. 90-171.23(b).

Section 4. Currently, the Board is authorized to require remedial education, issue a letter of reprimand, restrict, revoke, or suspend any license to practice nursing in North Carolina or deny any application for licensure. This section would add the authority to invoke other disciplinary measures, such as censure, or probation against a licensee.

Section 5 makes the act effective when it becomes law.

BACKGROUND: According the Board of Nursing, as of March 1 2001, approximately 109,000 nurses (88,000 Registered Nurses and 21,000 Licensed Practical Nurses) are licensed to practice in North Carolina.

S463-SMRM-02

2001 COMMITTEE REPORT
HOUSE OF REPRESENTATIVES

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

☒ Committee Substitute for
S.B. 463 A BILL TO BE ENTITLED AN ACT TO AMEND THE LAWS RELATING TO THE PRACTICE OF NURSING.

☒ 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)

2/15/01

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2001

S 2

SENATE BILL 542
Second Edition Engrossed 4/3/01

Short Title:	Database on Psychotropic Meds/Children.	(Public)
Sponsors:	Senators Foxx; Allran, Ballantine, Berger, Bingham, Carpenter, Carrington, Forrester, Garwood, Hartsell, Kerr, Kinnaird, Metcalf, Moore, Odom, and Rucho.	
Referred to:	Children & Human Resources.	

March 19, 2001

A BILL TO BE ENTITLED

AN ACT TO DIRECT THE DEPARTMENT OF HEALTH AND HUMAN SERVICES TO REVIEW THE NEED FOR ESTABLISHMENT OF A STATEWIDE DATABASE ON THE ADMINISTRATION OF PSYCHOTROPIC MEDICATIONS TO CHILDREN WHO RECEIVE STATE SERVICES.

Whereas, during the past decade the number of American children receiving medication for behavioral and emotional disorders has increased dramatically; and

Whereas, there is a growing trend for children to receive medications for depression and other behavioral and health conditions; and

Whereas, a report in the Journal of the American Medical Association indicates that the rate of prescribing psychotropic medications for preschool children rose threefold between 1991 and 1995; and

Whereas, opponents of the use of psychotropic drugs are concerned about overuse of the drugs, and also that there is not enough information about these drugs' effect on children's development or on their long-term side effects; and

Whereas, proponents argue that the use of psychotropic medications may be needed to combat mental illness, but agree that children should not be medicated unless a qualified clinician decides that such a course is in the child's best interest and the medication is used in conjunction with other types of treatment; Now, therefore,

The General Assembly of North Carolina enacts:

SECTION 1. The Department of Health and Human Services shall review the feasibility of establishing and maintaining a statewide database containing information on the prescription and administration of psychotropic medications to children who receive State services. In conducting the review the Department shall consider that any database developed must, in accordance with State and federal law, fully protect the medical records and other privacy interests of the minors for whom the

drugs are prescribed. Not later than January 1, 2002, the Department shall report its findings and recommendations to the Joint Legislative Health Care Oversight Committee and to the Joint Legislative Oversight Committee on Mental Health, Developmental Disabilities, and Substance Abuse Services. The report shall include the cost of establishing and maintaining the database in a manner that provides data for the analysis of prescription medication usage by and effects on children. The report shall also provide detailed information on how the database will be maintained in a manner that protects medical records and other privacy interests in compliance with State and federal law.

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

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2001

S D

SENATE BILL 542

Second Edition Engrossed 4/3/01

PROPOSED HOUSE COMMITTEE SUBSTITUTE S542-PCS8218-SW-43

Short Title: Database on Psychotropic Meds/Children. (Public)

Sponsors:

Referred to:

March 19, 2001

A BILL TO BE ENTITLED

AN ACT TO DIRECT THE DEPARTMENT OF HEALTH AND HUMAN SERVICES AND THE DEPARTMENT OF JUVENILE JUSTICE AND DELINQUENCY PREVENTION TO REVIEW THE NEED FOR ESTABLISHMENT OF A STATEWIDE DATABASE ON THE ADMINISTRATION OF PSYCHOTROPIC MEDICATIONS TO CHILDREN WHO RECEIVE STATE SERVICES.

Whereas, during the past decade the number of American children receiving medication for behavioral and emotional disorders has increased dramatically; and

Whereas, there is a growing trend for children to receive medications for depression and other behavioral and health conditions; and

Whereas, a report in the Journal of the American Medical Association indicates that the rate of prescribing psychotropic medications for preschool children rose threefold between 1991 and 1995; and

Whereas, opponents of the use of psychotropic drugs are concerned about overuse of the drugs, and also that there is not enough information about these drugs' effect on children's development or on their long-term side effects; and

Whereas, proponents argue that the use of psychotropic medications may be needed to combat mental illness, but agree that children should not be medicated unless a qualified clinician decides that such a course is in the child's best interest and the medication is used in conjunction with other types of treatment; Now, therefore,

The General Assembly of North Carolina enacts:

SECTION 1. The Department of Health and Human Services and the Department of Juvenile Justice and Delinquency Prevention shall review the feasibility of establishing and maintaining a statewide database containing information on the prescription and administration of psychotropic medications to children who receive State services while residing in State facilities administered by the Department of Health and Human Services or the Department of Juvenile Justice and Delinquency

Prevention. In conducting the review the Departments shall consider that any database developed must, in accordance with State and federal law, fully protect the medical records and other privacy interests of the minors for whom the drugs are prescribed. Not later than January 1, 2002, the Department of Health and Human Services and the Department of Juvenile Justice and Delinquency Prevention shall report their findings and recommendations to the Joint Legislative Health Care Oversight Committee and to the Joint Legislative Oversight Committee on Mental Health, Developmental Disabilities, and Substance Abuse Services. The report shall include the cost of establishing and maintaining the database in a manner that provides data for the analysis of prescription medication usage by and effects on children. The report shall also provide detailed information on how the database will be maintained in a manner that protects medical records and other privacy interests in compliance with State and federal law.

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

SENATE BILL 542:
Database on Psychotropic Meds/Children

BILL ANALYSIS

Committee:	House Health	**Introduced by:**	Sen. Foxx
Date:	May 9, 2001	**Summary by:**	Dianna Jessup
Version:	Second Edition		Committee Counsel

SUMMARY: ***Senate Bill 542 directs the Department of Health and Human Services to review the feasibility of establishing a statewide database containing information on the prescription and administration of psychotropic medications to children who receive State services and report its findings and recommendations to the Joint Legislative Health Care Oversight Committee and to the Joint Legislative Oversight committee on Mental Health, Developmental Disabilities, and Substance Abuse Services, not later than January 1, 2002.***

The second edition added language directing the Department to consider in conducting its review that the database developed must, in accordance with State and federal law, fully protect the medical records and other privacy interests of the minors for whom the drugs are prescribed.

BILL ANALYSIS: The bill directs DHHS to review whether it is feasible to establish and maintain a database containing information on the prescription and administration of medications used to treat mental, behavioral, and emotional symptoms in children who are receiving State services. This would include children receiving Medicaid, Work First, Smart Start, and child protective services (foster care). The required report must include the cost of establishing and maintaining the database in a manner that provides data for the analysis of prescription medication usage by and effects on children, and that protects the medical records in accordance with State and federal law.

BACKGROUND: According to NCSL, last year, two states enacted legislation relating to psychotropic drugs and children. Georgia passed a resolution creating the Commission on Psychiatric Medication of School-Age Children and directed it to investigate the use of psychiatric medications and their effects on school-age children.

Washington state directed its Department of Social and Health Services to report to its legislature regarding the prescription of psychotropic or other psychiatric medications for children in out-of-home placements during 1999, including, specifically, the number of children who were prescribed the medication, the number, type, and frequency of the medications prescribed, the number of children receiving multiple medications, and the number of children prescribed Ritalin.

See also the Whereas clauses on page 1, lines 6-19.

This act would become effective when it becomes law.

2001 COMMITTEE REPORT
HOUSE OF REPRESENTATIVES

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

☐ Committee Substitute for
S.B. 542 A BILL TO BE ENTITLED AN ACT TO DIRECT THE DEPARTMENT OF HEALTH AND HUMAN SERVICES TO REVIEW THE NEED FOR ESTABLISHMENT OF A STATEWIDE DATABASE ON THE ADMINISTRATION OF PSYCHOTROPIC MEDICATIONS TO CHILDREN WHO RECEIVE STATE 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 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)

2/15/01

VISITOR REGISTRATION SHEET

HOUSE HEALTH COMMITTEE — 05-08-01

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Joanne Schoen Stevens	NC Nurses Assoc
Polly Johnson	NC BON
Amy Jo Bain	NC Medical Society
Barbara Canales	Manning, Fulton & Skinner
John Bowdish	Alley Associates
Sandy Sands	WCSR
Anne Cale	staff
Adrienne Lovelace	staff
Evelyn Hawthorne	UNC Chapel Hill
Bill Scoggin	Kennedy Covington
Marion Swain	NCSA

VISITOR REGISTRATION SHEET

HOUSE HEALTH COMMITTEE — 05-08-01

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
[signature]	GSK
[signature]	NPC
[signature]	NCAHP
[signature]	NCCCS
[signature]	AHHCNC
Joe Libera	AHHCNC

AGENDA

HOUSE COMMITTEE ON HEALTH
TUESDAY, MAY 15, 2001
12:00 Noon, ROOM 415 LOB

OPENING REMARKS

Rep. Thomas E. Wright
Chairman

BILLS TO BE DISCUSSED

SB-749 NURSING HOME ADMINISTRATOR ACT.(Sen. Hoyle)

SB-1075 AMEND UNIFORM ANAT. GIFT ACT.(Sen. Rucho)

COMMENTS

ADJOURNMENT

MINUTES

COMMITTEE ON HEALTH

TUESDAY, MAY 15, 2001

12:00 NOON ROOM 415 LOB

The House Committee on Health met on Tuesday, May 15, 2001 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-749 NURSING HOME ADMINISTRATOR ACT. (Sen. Hoyle)

Linda Attarian, staff, explained the bill to the committee.

Rep. Insko moved for a favorable report.

Rep. Sherrill asked if the personnel served at the pleasure of the Board. Linda Attarian responded. Rep. Sherrill followed up with a question about any opposition to the bill. Jack Nichols, from the law firm of Allen & Pennix, stated that there wasn't any opposition to the bill.

Chairman Wright called the question before the committee to give SB-749 a favorable report. So moved.

The meeting adjourned at 12:30pm.

Rep. Thomas E. Wright, Chairman

Vanda Wilson-Wormack, Committee Assistant

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2001

S 1

SENATE BILL 749

Short Title:	Nursing Home Administrator Act.	(Public)
Sponsors:	Senator Hoyle.	
Referred to:	Health Care.	

April 2, 2001

A BILL TO BE ENTITLED

AN ACT TO MAKE TECHNICAL CHANGES TO THE NURSING HOME ADMINISTRATOR ACT.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 90-276(3) reads as rewritten:

"For the purposes of this Article and as used herein:

...

(3) "Nursing home" means any institution or facility defined as such for licensing purposes under ~~G.S. 130-9(e) of the General Statutes,~~G.S. 131E-101(6), whether proprietary or nonprofit, including but not limited to nursing homes owned or administered by the federal or State government or any agency or political subdivision thereof and nursing homes operated in combination with a home for the aged or any other facility."

SECTION 2. G.S. 90-283 reads as rewritten:

"**§ 90-283. Organization of Board; compensation; employees and services.**

The Board shall elect from its membership a chairman, vice-chairman and secretary, and shall adopt rules and regulations to govern its proceedings. Board members shall be entitled to receive only such compensation and reimbursement as is prescribed by Chapter ~~138~~93B of the General Statutes for State boards generally. At any meeting a majority of the voting members shall constitute a quorum. The Board ~~may, in accordance with the State Personnel Act,~~may employ any necessary personnel to assist it in the performance of its duties and may contract for such services as may be necessary to carry out the provisions of this Article."

SECTION 3. G.S. 90-285.1(2) reads as rewritten:

"The Board may suspend, revoke, or refuse to issue a license or may reprimand or otherwise discipline a licensee after due notice and an opportunity to be heard at a formal hearing, upon substantial evidence that a licensee:

...

(2) Has violated the provisions of ~~G.S. 130-9(e)~~Part B of Article 6 of Chapter 131E of the General Statutes and rules promulgated thereunder;".

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

2001 COMMITTEE REPORT
HOUSE OF REPRESENTATIVES

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

☐ Committee Substitute for
S.B. 749 A BILL TO BE ENTITLED AN ACT TO MAKE TECHNICAL CHANGES TO THE NURSING HOME ADMINISTRATOR 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 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)

2/15/01

VISITOR REGISTRATION SHEET

HEALTH — 5/15/01

Name of Committee — Date

VISITORS:. PLEASE SIGN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Martha Bell	NC State Board for Nursing Home Administrators 3733 National Dr., Ste. 228 Raleigh NC 27612
Jack Nichols	Allen E Pinnix
John Bode	Bode Call & Stamper
Hugh Tilson	NCHA
Sandy Sands	NCSR
Lisa Todd	Carolinas Health Care
Margaret Westbrook	Kennedy Covington
Lisa Parker	DFHS
G.B. Jon Wells	DFHS
Ed Regan	N.C.A.C.C.
Sue Burbank	TORC - PO Box 501 WB, NC 28405
Joe Liberty	Assoc. Home & Hospice Care

AGENDA

HOUSE COMMITTEE ON HEALTH
TUESDAY, MAY 22, 2001
12:00 Noon, ROOM 415 LOB

OPENING REMARKS

Rep. Thomas E. Wright
Chairman

BILLS TO BE DISCUSSED

SB-390 EDUCATION ON PHYSICIAN-ASSISTED SUICIDE. ((Sen. Forrester)

SB-938 STUDY DATE RAPE DRUG ANALOGUES.(Sen. Foxx)

SB-1075 AMEND UNIFORM ANAT. GIFT ACT.(Sen. Rucho)

COMMENTS

ADJOURNMENT

MINUTES

COMMITTEE ON HEALTH

TUESDAY, MAY 22, 2001

12:00 NOON, ROOM 415 LOB

The House Committee on Health met on Tuesday, May 22, 2001 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-390 EDUCATION ON PHYSICIAN-ASSISTED SUICIDE. (Sen. Forrester)

Rep. Howard moved for the adoption of the proposed committee substitute. So moved.
Sen. Forrester explained the committee substitute to the committee. Dianna Jessup, Staff, further explained the bill and the fiscal note that was attached to the bill. Rep. Insko asked Sen. Forrester about SB-389. Sen. Forrester responded. Rep. Insko followed up with a question about the Senate Judiciary Committee findings and discussions. Sen. Forrester responded. Chairman Wright responded that the bill could be sent to the House Judiciary Committee. Chairman Wright opened the discussion for people or organizations to speak on the bill. Mary Forrester, of the Concerned Women For America, spoke in favor of the bill. David Hardin, of the Diocese of Raleigh, also spoke in favor of the bill. Rep. Barnhart asked about the language of the living will section of the bill. Sen. Forrester responded. Debra Ross, of the ACLU, suggested that the bill be re-referred to the House Judiciary Committee because of the criminal penalty. Sen. Forrester responded. Rep. Insko commented that physician suicide should be studied longer for better results.

Rep. Insko moved for an unfavorable report to the proposed committee substitute.

Rep. Howard sent forth a substitute motion to bring the original bill before the committee for discussion.

Rep. Nye asked for more information about the original bill. Sen. Forrester explained the original bill as well as the committee substitute.

Rep. Insko stated her support of Rep. Howard's motion and the need for a study.

Chairman Wright called the question on the motion that Rep. Howard put before the committee.

Rep. Allred asked Sen. Forrester about the number of euphemized people per year. Sen. Forrester responded. Rep. Allred asked if physician assisted suicide was illegal in the state of North Carolina. Rep. Insko responded. Sen. Forrester stated that there should be a law on the books stating that North Carolina does not believe in physician-assisted suicide.

Rep. Buchanan stated that there wasn't any legislation in the books that prohibited a doctor from assisting in suicide.

Chairman Wright called the question again on Rep. Howard's substitute motion. The motion failed.

Chairman Wright called the question on Rep. Insko's motion to give the proposed committee substitute an unfavorable report. The motion failed.

Rep. Nye made the motion to re-refer the House proposed committee substitute to the Judiciary committee without prejudice. So moved.

SB-1075 AMEND UNIFORM ANATOMICAL GIFT ACT. (Sen. Rucho)

Rep. Buchanan moved for adoption of the proposed committee substitute. So moved.
Sen. Rucho explained the bill. Dianna Jessup further explained the bill.

Rep. Rogers moved to give the House proposed committee substitute a favorable report. So moved.

SB-938 STUDY DATE RAPE DRUG ANALOGUE. (Sen. Foxx)

Sen. Foxx explained the bill.

Rep. Insko moved for a favorable report to SB-1075.

Rep. Insko requested a technical change on line 8 to read study commission.
Sen. Foxx responded.

Chairman Wright asked about the completion of the study. Sen. Foxx responded. Chairman Wright followed up with a question about Rep. Hensley's companion bill that went through the Judiciary committee. Sen. Foxx responded.

Chairman Wright stated that the bill would be discussed at the next meeting.
The meeting adjourned at 12:50pm.

Rep. Thomas E. Wright, Chairman Vanda Wilson-Wormack, Committee Assistant

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2001

S 1

SENATE BILL 390

Short Title:	Education on Physician-Assisted Suicide.	(Public)
Sponsors:	Senators Forrester, Purcell; Allran, Berger, Bingham, Carpenter, Hartsell, Plyler, and Shaw of Guilford.	
Referred to:	Judiciary I.	

March 12, 2001

A BILL TO BE ENTITLED

AN ACT REQUIRING THE NORTH CAROLINA MEDICAL BOARD TO IMPLEMENT POLICIES TO TRAIN AND EDUCATE PERSONS LICENSED TO PRACTICE OR PERSONS DESIRING TO PRACTICE MEDICINE IN THIS STATE ON ISSUES RELATED TO PHYSICIAN-ASSISTED SUICIDE.

Whereas, the North Carolina Medical Board was created to properly regulate the practice of medicine and surgery for the benefit and protection of the people of North Carolina; and

Whereas, the State of North Carolina has an interest in prohibiting physician-assisted suicide and protecting human life; and

Whereas, physicians are involved in promoting death with dignity and preventing terminally ill patients from suffering painful deaths; and

Whereas, there is a need for persons practicing or desiring to practice medicine in this State to receive proper training and education on the various issues related to physician-assisted suicide and pain management; Now, therefore,

The General Assembly of North Carolina enacts:

SECTION 1. The North Carolina Medical Board shall implement the following policies:

(1) Require that persons licensed to practice medicine in this State receive continuing education from the North Carolina Medical Society on the topic of pain management.

(2) Require that all schools of medicine in this State develop a curriculum and train students regarding pain management, palliative care, and the use of hospice care.

(3) Advise persons licensed to practice medicine in this State of the Board's policies relating to prescribing adequate amounts of medicine to patients with terminal diseases.

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

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2001

S D

SENATE BILL 390
PROPOSED HOUSE COMMITTEE SUBSTITUTE S390-PCS1204-LH-16

Short Title: Physician-Assisted Suicide/Education & Crime. (Public)

Sponsors:

Referred to:

March 12, 2001

A BILL TO BE ENTITLED

AN ACT REQUIRING THE NORTH CAROLINA MEDICAL BOARD TO IMPLEMENT POLICIES TO TRAIN AND EDUCATE PERSONS LICENSED TO PRACTICE OR PERSONS DESIRING TO PRACTICE MEDICINE IN THIS STATE ON ISSUES RELATED TO PHYSICIAN-ASSISTED SUICIDE AND CREATING THE CRIMINAL OFFENSE OF PHYSICIAN-ASSISTED SUICIDE.

The General Assembly of North Carolina enacts:

SECTION 1. The North Carolina Medical Board shall implement the following policies:

(1) Encourage persons licensed to practice medicine in this State to receive continuing education from the North Carolina Medical Society on the topic of pain management.

(2) Encourage all schools of medicine in this State to develop a curriculum and train students regarding pain management, palliative care, and the use of hospice care.

(3) Advise persons licensed to practice medicine in this State of the Board's policies relating to prescribing adequate amounts of medicine to patients with terminal diseases.

SECTION 2. Article 6 of Chapter 14 of the General Statutes is amended by adding a new section to read:

"**§ 14-17.2. Physician-assisted suicide.**

(a) The following definitions apply in this section:

(1) Licensed health care professional. – A duly licensed physician, surgeon, podiatrist, osteopath, osteopathic physician, osteopathic surgeon, optometrist, chiropractor, physician assistant, nurse, dentist, or pharmacist.

(2) Physician-assisted suicide. – The act of a licensed health care professional participating in a medical procedure or willfully prescribing any drug, compound, or substance for the express purpose

of assisting a patient to intentionally end the patient's life. The term does not include a person participating in the execution of a person sentenced by a court to death by lethal injection.

(b) It is unlawful for any licensed health care professional to commit the offense of physician-assisted suicide.

(c) Any licensed health care professional who violates this section is guilty of a Class D felony.

(d) None of the following shall be construed as a violation of this section:

(1) Carrying out the provisions of advanced directives or living wills.

(2) The withholding or withdrawing of a life-sustaining procedure or compliance with any other State or federal law authorizing withdrawal or refusal of medical treatments or procedures.

(3) The administering, prescribing, or dispensing of medications or procedures, by or at the direction of a licensed health care professional, for the purpose of alleviating another person's pain or discomfort, even if the medication or procedure may increase the risk of death as long as the medication or procedure is not also intentionally administered, prescribed, or dispensed for the purpose of causing death, or the purpose of assisting in causing death for any reason.

(4) The administering, prescribing, or dispensing of medications or procedures to a patient diagnosed with a medical condition that includes an element of suicidal ideation, even if the medication or procedure may increase the risk of death as long as the medication or procedure is not also intentionally administered, prescribed, or dispensed for the purpose of causing death, or the purpose of assisting in causing death for any reason."

SECTION 3. This act becomes effective December 1, 2001, and applies to offenses committed on or after that date.

SENATE BILL 390:
Education on Physician-Assisted Suicide

BILL ANALYSIS

Committee:	House Health Committee	**Introduced by:**	Senators Forrester and Purcell
Date:	May 22, 2001	**Summary by:**	Wendy Graf/Linda Attarian
Version:	S390-CSLH-16		Committee Counsel

SUMMARY: ***The proposed committee substitutes combines S390 and S389. Thus, the PCS does two things: 1) Makes it unlawful for a licensed health care professional to assist a patient in intentionally ending the patient's life. 2) Requires the North Carolina Medical Board to provide training and education on issues related to physician-assisted suicide to persons who are licensed, or wish to be licensed, to practice medicine in the State.***

CURRENT LAW: Currently there is no statute in North Carolina that makes assisting in a suicide unlawful.

BILL ANALYSIS:

Section 1 requires the North Carolina Medical Board, in the interest of protecting the people of the State, to implement the following policies:

- Encourage persons licensed to practice medicine in this State receive continuing education from the North Carolina Medical Society on the topic of pain management.
- Encourage all schools of medicine in this State to develop a curriculum and train students regarding pain management, palliative care, and the use of hospice care.
- Advise persons licensed to practice medicine in this State of the Board's policies relating to prescribing adequate amounts of medicine to patients with terminal diseases.

Section 2 makes it unlawful for a licensed health care professional to assist a patient in intentionally ending the patient's life.

Definitions: G.S. 14-17.2(a) defines "licensed health care professional". It also defines "physician- assisted suicide" as the act of a licensed health care professional either 1) participating in a medical procedure or 2) willfully prescribing any substance, for the express purpose of assisting a patient in ending his or her life.

Offense Created: G.S. 14-17.2(b) makes physician-assisted suicide by a licensed health care professional unlawful.

Penalty: G.S. 14-17.2(c) makes violation of the statute a Class D felony, for which an active sentence is required and the maximum penalty is 229 months.

Exceptions: G.S. 14-17.2(d) specifies that the following acts by a physician are not violations of the statute:

- Carrying out provisions of advanced directives or living wills.
- Withholding life sustaining procedures or complying with any law that authorizes refusal of medical treatment.

- Administering medications or procedures to alleviate pain, even when it may increase th risk of death, as long as the purpose is not to cause death.
- Administering medications or procedures to patients diagnosed with conditions that include an element of suicidal ideation, even when it may increase the risk of death, as long as the purpose is not to cause death.

EFFECTIVE DATE: The act would become effective December 1, 2001 and would apply to offenses committed on or after that date.

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2001

S D

SENATE BILL 390
PROPOSED HOUSE COMMITTEE SUBSTITUTE S390-CSLH-16 [v.5]

5/21/2001 3:45:57 PM

Short Title: Physician-Assisted Suicide/Education & Crime. (Public)

Sponsors:

Referred to:

March 12, 2001

A BILL TO BE ENTITLED

AN ACT REQUIRING THE NORTH CAROLINA MEDICAL BOARD TO IMPLEMENT POLICIES TO TRAIN AND EDUCATE PERSONS LICENSED TO PRACTICE OR PERSONS DESIRING TO PRACTICE MEDICINE IN THIS STATE ON ISSUES RELATED TO PHYSICIAN-ASSISTED SUICIDE AND CREATING THE CRIMINAL OFFENSE OF PHYSICIAN-ASSISTED SUICIDE.

The General Assembly of North Carolina enacts:

SECTION 1. The North Carolina Medical Board shall implement the following policies:

(1) Encourage persons licensed to practice medicine in this State receive continuing education from the North Carolina Medical Society on the topic of pain management.

(2) Encourage all schools of medicine in this State to develop a curriculum and train students regarding pain management, palliative care, and the use of hospice care.

(3) Advise persons licensed to practice medicine in this State of the Board's policies relating to prescribing adequate amounts of medicine to patients with terminal diseases.

SECTION 2. Article 6 of Chapter 14 of the General Statutes is amended by adding a new section to read:

"**§ 14-17.2. Physician-assisted suicide.**

(a) The following definitions apply in this section:

(1) Licensed health care professional. – A duly licensed physician, surgeon, podiatrist, osteopath, osteopathic physician, osteopathic surgeon, optometrist, chiropractor, physician assistant, nurse, dentist, or pharmacist.

(2) Physician-assisted suicide. – The act of a licensed health care professional participating in a medical procedure or willfully prescribing any drug, compound, or substance for the express purpose

of assisting a patient to intentionally end the patient's life. The term does not include a person participating in the execution of a person sentenced by a court to death by lethal injection.

(b) It is unlawful for any licensed health care professional to commit the offense of physician-assisted suicide.

(c) Any licensed health care professional who violates this section is guilty of a Class D felony.

(d) None of the following shall be construed as a violation of this section:

(1) Carrying out the provisions of advanced directives or living wills.

(2) The withholding or withdrawing of a life sustaining procedure or compliance with any other State or federal law authorizing withdrawal or refusal of medical treatments or procedures.

(3) The administering, prescribing, or dispensing of medications or procedures, by or at the direction of a licensed health care professional, for the purpose of alleviating another person's pain or discomfort, even if the medication or procedure may increase the risk of death as long as the medication or procedure is not also intentionally administered, prescribed, or dispensed for the purpose of causing death, or the purpose of assisting in causing death for any reason.

(4) The administering, prescribing, or dispensing of medications or procedures to a patient diagnosed with a medical condition that includes an element of suicidal ideation, even if the medication or procedure may increase the risk of death as long as the medication or procedure is not also intentionally administered, prescribed, or dispensed for the purpose of causing death, or the purpose of assisting in causing death for any reason."

SECTION 3. This act becomes effective December 1, 2001, and applies to offenses committed on or after that date.

2001 COMMITTEE REPORT
HOUSE OF REPRESENTATIVES

The following report(s) from standing committee(s) is/are presented:
By Representative(s) **Wright** (Chair/Chairs) for the Committee on **Health**.

☐ Committee Substitute for
S.B. 390 A BILL TO BE ENTITLED AN ACT REQUIRING THE NORTH CAROLINA MEDICAL BOARD TO IMPLEMENT POLICIES TO TRAIN AND EDUCATE PERSONS LICENSED TO PRACTICE OR PERSONS DESIRING TO PRACTICE MEDICINE IN THIS STATE ON ISSUES RELATED TO PHYSICIAN-ASSISTED SUICIDE.

☐ 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 house committee substitute bill, ☐ which changes the title, unfavorable as to the original bill and the recommendation that the committee substitute bill be re-referred to the Committee on Judiciary.

☐ 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 to the House committee substitute bill, which changes the title, unfavorable to the original bill and that the bill be re-referred to the committee on Judiciary II.

☐ With an indefinite postponement report.

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

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

2/15/01

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2001

S 1

SENATE BILL 1075

Short Title:	Amend Uniform Anat. Gift Act.	(Public)
Sponsors:	Senators Rucho, Purcell, Forrester; Ballantine and Odom.	
Referred to:	Health Care.	

April 5, 2001

A BILL TO BE ENTITLED

AN ACT TO AMEND THE DEFINITION OF THE TERMS "QUALIFIED INDIVIDUAL" AND "TISSUE BANK" IN THE UNIFORM ANATOMICAL GIFT ACT.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 130A-403 reads as rewritten:

"**§ 130A-403. Definitions.**

The following definitions shall apply throughout this Part:

(1) "Bank or storage facility" means a facility licensed, accredited or approved under the laws of any state for storage or distribution of a human body or its parts.

(2) "Decedent" means a deceased individual and includes a stillborn infant or fetus.

(3) "Donor" means an individual who makes a gift of all or part of the individual's body.

(4) "Hospital" means a hospital licensed, accredited or approved under the laws of any state and a hospital operated by the United States government, a state or its subdivision, although not required to be licensed under state laws.

(5) "Part" means organs, tissues, eyes, bones, arteries, blood, other fluids and any other portions of a human body.

(6) "Physician" or "surgeon" means a physician or surgeon licensed to practice medicine under the laws of any state.

(7) "State" includes any state, district, commonwealth, territory, insular possession and any other area subject to the legislative authority of the United States of America.

(7a) "Tissue bank" means any facility or program operating in North Carolina that is certified by the American Association of Tissue Banks

or the Eye Bank Association of ~~America~~ America, or is registered with the Food and Drug Administration as a tissue bank, and is involved in procuring, furnishing, donating, or distributing corneas, bones, or other human tissue for the purpose of injecting, transfusing, or transplanting any of them into the human body. "Tissue bank" does not include a licensed blood bank.

(8) "Qualified individual" means any of the following individuals who ~~has~~ have completed a course in eye enucleation and ~~has~~ have been certified as competent to enucleate eyes or perform in situ excision by an eye bank accredited by the Eye Bank Association of America or by an accredited school of medicine in this State:

a. An embalmer licensed to practice in this State;

b. A physician's assistant approved by the North Carolina Medical Board pursuant to G.S. 90-18(13);

c. A registered or a licensed practical nurse licensed by the Board of Nursing pursuant to Article 9A of Chapter 90 of the General Statutes;

d. A student who is enrolled in an accredited school of medicine operating within this State and who has completed two or more years of a course of study leading to the awarding of a degree of doctor of medicine;

e. A technician who has successfully completed a written examination administered by an eye bank operating within this State that is registered with the Food and Drug Administration and accredited by the Eye Bank Association of America. ~~by the North Carolina Eye and Human Tissue Bank, Inc., certified by the Eye Bank Association of America.~~"

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

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2001

S D

SENATE BILL 1075
PROPOSED HOUSE COMMITTEE SUBSTITUTE S1075-CSSW-46 [v.1]

5/16/2001 3:23:05 PM

Short Title: Amend Uniform Anat. Gift Act. (Public)

Sponsors:

Referred to:

April 5, 2001

A BILL TO BE ENTITLED

AN ACT TO AMEND THE DEFINITION OF THE TERMS "QUALIFIED INDIVIDUAL" AND "TISSUE BANK" IN THE UNIFORM ANATOMICAL GIFT ACT.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 130A-403 reads as rewritten:

"**§ 130A-403. Definitions.**

The following definitions shall apply throughout this Part:

(1) "Bank or storage facility" means a facility licensed, accredited or approved under the laws of any state for storage or distribution of a human body or its parts.

(2) "Decedent" means a deceased individual and includes a stillborn infant or fetus.

(3) "Donor" means an individual who makes a gift of all or part of the individual's body.

(4) "Hospital" means a hospital licensed, accredited or approved under the laws of any state and a hospital operated by the United States government, a state or its subdivision, although not required to be licensed under state laws.

(5) "Part" means organs, tissues, eyes, bones, arteries, blood, other fluids and any other portions of a human body.

(6) "Physician" or "surgeon" means a physician or surgeon licensed to practice medicine under the laws of any state.

(7) "State" includes any state, district, commonwealth, territory, insular possession and any other area subject to the legislative authority of the United States of America.

(7a) "Tissue bank" means any facility or program operating in North Carolina that is certified by the American Association of Tissue Banks or the Eye Bank Association of ~~America~~ America, or is registered with

the Food and Drug Administration as a tissue bank, and is involved in procuring, furnishing, donating, or distributing corneas, bones, or other human tissue for the purpose of injecting, transfusing, or transplanting any of them into the human body. "Tissue bank" does not include a licensed blood bank.

(8) "Qualified individual" means any of the following individuals who ~~has~~ have completed a course in eye enucleation and ~~has~~ have been certified as competent to enucleate eyes or perform in situ excision by an eye bank accredited by the Eye Bank Association of America or by an accredited school of medicine in this State:

a. An embalmer licensed to practice in this State;

b. A physician's assistant approved by the North Carolina Medical Board pursuant to G.S. 90-18(13);

c. A registered or a licensed practical nurse licensed by the Board of Nursing pursuant to Article 9A of Chapter 90 of the General Statutes;

d. A student who is enrolled in an accredited school of medicine operating within this State and who has completed two or more years of a course of study leading to the awarding of a degree of doctor of medicine;

e. A technician who has successfully completed a written examination administered by an eye bank that is registered with the Food and Drug Administration and accredited by the Eye Bank Association of America. ~~by the North Carolina Eye and Human Tissue Bank, Inc., certified by the Eye Bank Association of America.~~"

SECTION 2. G.S. 130A-406(e) reads as rewritten:

"(e) In respect to a gift of an eye, a qualified individual may enucleate eyes or perform in situ excision for the gift after proper certification of death by a physician and upon the express direction of a physician other than the one who certified the death of the donor."

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

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2001

S D

SENATE BILL 1075
PROPOSED HOUSE COMMITTEE SUBSTITUTE S1075-PCS3482-SW-46

Short Title: Amend Uniform Anat. Gift Act. (Public)

Sponsors:

Referred to:

April 5, 2001

A BILL TO BE ENTITLED

AN ACT TO AMEND THE DEFINITION OF THE TERMS "QUALIFIED INDIVIDUAL" AND "TISSUE BANK" IN THE UNIFORM ANATOMICAL GIFT ACT.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 130A-403 reads as rewritten:

"**§ 130A-403. Definitions.**

The following definitions shall apply throughout this Part:

(1) "Bank or storage facility" means a facility licensed, accredited or approved under the laws of any state for storage or distribution of a human body or its parts.

(2) "Decedent" means a deceased individual and includes a stillborn infant or fetus.

(3) "Donor" means an individual who makes a gift of all or part of the individual's body.

(4) "Hospital" means a hospital licensed, accredited or approved under the laws of any state and a hospital operated by the United States government, a state or its subdivision, although not required to be licensed under state laws.

(5) "Part" means organs, tissues, eyes, bones, arteries, blood, other fluids and any other portions of a human body.

(6) "Physician" or "surgeon" means a physician or surgeon licensed to practice medicine under the laws of any state.

(7) "State" includes any state, district, commonwealth, territory, insular possession and any other area subject to the legislative authority of the United States of America.

(7a) "Tissue bank" means any facility or program operating in North Carolina that is certified by the American Association of Tissue Banks or the Eye Bank Association of ~~America~~ America, or is registered with

the Food and Drug Administration as a tissue bank, and is involved in procuring, furnishing, donating, or distributing corneas, bones, or other human tissue for the purpose of injecting, transfusing, or transplanting any of them into the human body. "Tissue bank" does not include a licensed blood bank.

(8) "Qualified individual" means any of the following individuals who ~~has~~ have completed a course in eye enucleation and ~~has~~ have been certified as competent to enucleate eyes or perform in situ excision by an eye bank accredited by the Eye Bank Association of America or by an accredited school of medicine in this State:

a. An embalmer licensed to practice in this State;

b. A physician's assistant approved by the North Carolina Medical Board pursuant to G.S. 90-18(13);

c. A registered or a licensed practical nurse licensed by the Board of Nursing pursuant to Article 9A of Chapter 90 of the General Statutes;

d. A student who is enrolled in an accredited school of medicine operating within this State and who has completed two or more years of a course of study leading to the awarding of a degree of doctor of medicine;

e. A technician who has successfully completed a written examination administered by an eye bank that is registered with the Food and Drug Administration and accredited by the Eye Bank Association of America. ~~by the North Carolina Eye and Human Tissue Bank, Inc., certified by the Eye Bank Association of America.~~"

SECTION 2. G.S. 130A-406(e) reads as rewritten:

"(e) In respect to a gift of an eye, a qualified individual may enucleate eyes or perform in situ excision for the gift after proper certification of death by a physician and upon the express direction of a physician other than the one who certified the death of the donor."

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

SENATE BILL 1075:
Amend Uniform Anat. Gift Act

BILL ANALYSIS

Committee:	House Health	**Introduced by:**	Senators Rucho, Purcell, Forrester
Date:	May 22, 2001		
Version:	PCS S1075-CSSW-46[v1]	**Summary by:**	Dianna Jessup Committee Counsel

SUMMARY: The PCS for Senate Bill 1075 would amend the Uniform Anatomical Gift Act by adding tissue banks registered with the Food and Drug Administration to those tissue banks regulated under the Act and would expand the definition of a "qualified individual" to persons who are certified to enucleate eyes or perform in situ excision by an eye bank accredited by the Eye Bank Association of America. Further, technicians who have successfully completed a written examination administered by an eye bank that is registered with the Food and Drug Administration and accredited by the Eye Bank Association of America and who are otherwise certified as described above could perform eye enucleations or in situ excisions. The act would become effective when it becomes law.

The PCS differs from the first edition of the bill in two respects:

(1) the phrase "operating within this State" has been deleted in sub-subdivision (e) of subdivision (8) of G.S. 130A-403, thereby permitting technicians who have successfully completed a written examination by any FDA-registered, EBAA accredited eye bank to perform eye enucleations or in situ excisions;

(2) Section 2 was added to make a conforming change to G.S. 130A-406(e) concerning the manner in which anatomical gifts are made to add in situ excisions.

CURRENT LAW: The Uniform Anatomical Gift Act regulates the process for the making and receiving of anatomical gifts in this State. The Act specifies who is eligible to make donations of anatomical gifts, who may become donees and the purposes for which anatomical gifts may be made, the manner for making anatomical gifts, the rights and duties of the relative parties upon the death of the donor, and the duties of hospitals, organ procurement organizations and tissue banks.

Persons may donate their eyes for the purpose of transplantation. With respect to the gift of an eye, only a qualified individual may enucleate the eye for the donation. A "qualified individual" is currently defined as any of the following individuals who have completed a course in eye enucleation and have been certified as competent to enucleate eyes by an accredited school of medicine in this State:

- A licensed embalmer
- An approved physician's assistant
- A registered nurse or licensed practical nurse
- A student who is enrolled in an accredited school of medicine operating in this State and who has completed two or more years of a course of study leading to a medical degree
- A technician who has successfully completed a written examination by the North Carolina Eye and Human Tissue Bank, Inc., certified by the Eye Bank Association of America

"Tissue Bank" is currently defined as a facility or program operating in this State that is certified by the American Association of Tissue Banks or the Eye Bank Association of America and is involved in procuring, furnishing, donating, or distributing corneas, bones, or other human tissue for the purpose of injecting, transfusing, or transplanting any of them into the human body. Some tissue banks are not members of either of these two organizations. Recently, the federal Food and Drug Administration adopted a rule that would require all establishments that provide tissue products (which would include eyes) to register with the FDA.

BILL ANALYSIS: The PCS to Senate Bill 1075 would add to the definition of "tissue banks" those tissue banks that are registered with the Food and Drug Administration as a tissue bank. The bill would expand the definition of a "qualified individual" to persons who are certified to enucleate eyes or perform in situ excision by an eye bank accredited by the Eye Bank Association of America. Technicians who have successfully completed a written examination administered by an eye bank that is registered with the FDA and accredited by the Eye Bank Association and who have completed the appropriate courses and are certified may enucleate the eyes of donors or perform in situ excisions.

BACKGROUND: When the current law was enacted, most eye banks used funeral home directors to recover eye tissue and only one organization (The North Carolina Eye Bank) existed. Since that time, other eye banks have located in North Carolina, and most procedures to recover eye tissue are in situ excisions and not enucleations.

The Eye Bank Association of America, Inc. (EBAA) is a nonprofit organization of eye banks established in 1961 by the American Academy of Ophthalmology Committee on Eye Banking. It is the oldest national transplantation association with member eye banks located in 45 states. Accreditation of eye banks is awarded on a time-limited basis by vote of the EBAA Accreditation Board. The EBAA eye bank accreditation process involves a site inspection and a review of the policies and procedures of the applicant to determine whether the applicant demonstrates acceptable compliance with EBAA Medical Standards in all performance areas (i.e. pre-inspection questionnaire, policies and procedures, executive director, medical director, technical personnel and procedures, lab and equipment, and records). As of December 8, 2000, four North Carolina eye banks were accredited by the EBAA: the Lifeshare Eye Facility – Asheville (Asheville), the Lifeshare Eye Facility (Charlotte), the North Carolina Eye Bank (Durham), and the North Carolina Eye Bank, Inc. (Winston-Salem).

No medical schools in North Carolina currently offer courses on how to enucleate an eye or perform an in situ excision or certify someone as competent to perform these procedures.

2001 COMMITTEE REPORT
HOUSE OF REPRESENTATIVES

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

☐ Committee Substitute for
S.B. 1075 A BILL TO BE ENTITLED AN ACT TO AMEND THE DEFINITION OF THE TERMS "QUALIFIED INDIVIDUAL" AND "TISSUE BANK" IN THE UNIFORM ANATOMICAL GIFT 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.

☐ 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)

2/15/01

VISITOR REGISTRATION SHEET

Health — 5-22-01

Name of Committee — Date

VISITORS:. PLEASE SIGN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
[illegible]	Poyner & Spruill
[illegible]	[illegible]
Glenn Wells	DHHS
[illegible]	[illegible]
[illegible]	CCHELC
[illegible]	NCMS
[illegible]	NCMS
JR Sharpe	ACLU
Robynn Steen	ACLU
Greta Kabur	ACLU
PETER A JEANIGAN	[illegible]
ANDREW WATRY	NCMB
M T Burnette	GACPD
[illegible]	Concerned Women For America - NC
Bob Carpenter	N.C. Senate - DIST. 42
[illegible]	WCSR
DAVID HARDIN	DIOCESE OF RALEIGH
David Siegel	Durham Academy, Rep. Luebke
JOE LIBERA	Assoc. Home + Hospice Care
[illegible] TILSON	NCHA
Jane Royall	NCFIC
[illegible]	WCSR
[illegible]	Carolinas Healthcare
[illegible]	UHS
Stephanie Gibbs	Everett Gaskins Hancock & Stevens
Joanne Schoen Stevens	nc nurses Assn
John Mills	NC Association Free Clinics

AGENDA

HOUSE COMMITTEE ON HEALTH
TUESDAY, MAY 29, 2001
12:00 Noon, ROOM 415 LOB

OPENING REMARKS

Rep. Thomas E. Wright
Chairman

BILLS TO BE DISCUSSED

HB-1362 ADVANCE HEALTH CARE DIRECTIVES REGISTRY. (Rep. Fox)

HB-1449 VETERINARY PRACTICE ACT/FEES.(Rep. Blue)

SB-937 C.O.N.-ADULT CARE HOMES REGULATED. (Sen. Purcell)

SB-938 STUDY DATE RAPE DRUG ANALOGUES.(Sen. Foxx)

COMMENTS

ADJOURNMENT

MINUTES

COMMITTEE ON HEALTH

TUESDAY, MAY 29, 2001

12:00 NOON, ROOM 415 LOB

The House Committee on Health met on Tuesday, May 29, 2001 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-1362 ADVANCE HEALTH CARE DIRECTIVES REGISTRY. (Rep. Fox)

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

Rep. Fox explained the bill. Amy Currie, Staff, further explained the proposed committee substitute. Rep. Howard asked if the bill would be re-referred to the committee on finance. Rep. Wright responded.

Rep. Earle moved to give the proposed committee substitute a favorable report, unfavorable for the original bill and re-referred to the Committee on Finance. So moved.

SB-938 STUDY DATE RAPE DRUG ANALOGUES. (Sen. Foxx)

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

Sen. Foxx explained the bill.

Chairman Wright asked if there were an questions from the members of the committee.

Rep. Clary moved for a favorable report of the House proposed committee substitute, unfavorable as to the Senate committee substitute bill and the recommendation that the bill be re-referred to the Committee on Rules.

SB-937 C.O.N. ADULT CARE HOMES REGULATED. (Sen. Purcell)

Chairman Wright moved for adoption of the House proposed committee substitute. So moved.

Linda Attarian, Staff, explained the House proposed committee substitute to the committee. Sen. Purcell further explained the bill to the committee.

Rep. Nye moved for a favorable report of the House proposed committee substitute, unfavorable to the Senate committee substitute bill.

Rep. Justus asked about the cost of each bed. Bob Fitzgerald, of the Division of Facility Services, responded. Rep. Allred asked if the bill was creating a monopoly. Rep. Nye responded. Rep. Allred followed up with a question about Red-Tape. Rep. Nye responded. Rep. Earle further commented on Rep. Allred's inquiry about Red-Tape. Sen. Purcell further commented on the bill and stressed the importance of the bill.

Chairman Wright called the question on Rep. Nye's motion to give the House proposed committee substitute a favorable report, unfavorable to the Senate Committee Substitute bill. So moved.

The meeting adjourned at 12:30pm.

Rep. Thomas E. Wright, Chairman

Vanda Wilson-Wormack, Committee Assistant

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2001

H 1

HOUSE BILL 1362

Short Title:	Advance Health Care Directives Registry.	(Public)
Sponsors:	Representatives Fox; Alexander, Barbee, Barefoot, Brubaker, Church, Cole, Culp, Dedmon, Esposito, Haire, Hunter, McLawhorn, Michaux, Oldham, Owens, Preston, Rogers, Saunders, Smith, Teague, Tolson, and G. Wilson.	
Referred to:	Health, if favorable, Finance.	

April 23, 2001

A BILL TO BE ENTITLED

AN ACT TO ESTABLISH A CENTRAL REGISTRY FOR ADVANCE HEALTH CARE DIRECTIVES.

The General Assembly of North Carolina enacts:

SECTION 1. Chapter 130A of the General Statutes is amended by adding a new Article to read:

"Article 21.

"Advance Health Care Directive Registry.

"**§ 130A-465. Advance Health Care Directive Registry establishment.**

The Secretary of State shall establish and maintain a statewide, on-line, central registry in which an individual who has executed an advance health care directive or a revocation of an advance health care directive may file that document. The registry shall be accessible over the Internet through a site maintained by the Secretary of State.

"**§ 130A-466. Filing requirements.**

(a) The following documents, and revocations of these documents, may be filed with the registry:

(1) A health care power of attorney under Article 3 of Chapter 32A of the General Statutes.

(2) A declaration of a desire for a natural death under Article 23 of Chapter 90 of the General Statutes.

(3) An advance instruction for mental health treatment under Part 2 of Article 3 of Chapter 122C of the General Statutes.

(4) A declaration of an anatomical gift under Part 3 of Article 16 of Chapter 130A of the General Statutes.

(b) The document and any revocation of a document filed with the registry shall be notarized regardless of whether notarization is required for its validity.

(c) The document may be submitted only by the individual who executed the document.

(d) The individual who submits the document shall supply a return address.

(e) The document shall be accompanied by any fee required by this Article.

"**§ 130A-467. Validity of unregistered documents.**

Failure to register a document with the registry maintained by the Secretary of State pursuant to this Article does not affect the validity of the document. Failure to notify the Secretary of State of the revocation of a document filed with the registry does not affect the validity of a revocation that meets the statutory requirements for the revocation to be valid.

"**§ 130A-468. Filing of documents with the registry.**

(a) When the Secretary of State receives a document that may be filed with the registry pursuant to this Article, the Secretary shall produce a digital reproduction of that document and enter that reproduction into the registry database. The Secretary is not required to review a document to ensure that it complies with the particular statutory requirements applicable to the document. Each document entered into the registry database shall be assigned a unique file number and password.

(b) Upon entering the reproduction of the document into the registry database, the Secretary shall return the original document and a wallet-size card containing the document's file number and password to the individual who submitted the document.

(c) When the Secretary of State receives a revocation of a document that is filed with the registry along with that document's file number and password, the Secretary shall delete that document from the registry database.

(d) The Secretary of State's entry of a document into the registry database does not do any of the following:

(1) Affect the validity of the document in whole or in part.

(2) Relate to the accuracy of information contained in the document.

(3) Create a presumption regarding the validity of the document, regarding the accuracy of information contained in the document, or that the statutory requirements for the document have been met.

"**§ 130A-469. Disclosure of information contained in the registry.**

The registry shall be accessible only via the Internet. A document filed in the registry shall be accessible only if the individual attempting to access the document enters both the file number and password of the document. Documents filed in the registry, file numbers, passwords, and any other information maintained by the Secretary of State under this Article shall not be subject to disclosure pursuant to Chapter 132 of the General Statutes.

"**§ 130A-470. Fees for using the registry; other funds for the registry.**

(a) The Secretary of State shall charge a fee of ten dollars ($10.00) for filing a document, other than a revocation, with the registry. There is no fee for filing a revocation with the registry. The fee shall be applied to the maintenance of the registry and to the promotion of public education and awareness of the registry.

(b) The Secretary of State, on behalf of the State, may accept gifts, donations, bequests, and other forms of voluntary contributions; may apply for grants from public and private sources; and may expend funds received under this subsection for the purpose of promoting public education and awareness of the registry.

(c) All fees, funds, and gifts received pursuant to this section are subject to audit by the Department of State Auditor and shall be expended in conformity with Article 1 of Chapter 143 of the General Statutes. The balance of any fees, funds, and gifts held by the Secretary of State pursuant to this section at the end of each fiscal year shall not revert to the General Fund.

"**§ 130A-471. Limitation of liability.**

The Secretary of State and any agent or person employed by the Secretary of State shall be held harmless from any liability in any action brought by or on behalf of any person injured or harmed by the administration of this Article."

SECTION 2. G.S. 132-1.2 is amended by adding a new subdivision to read:

"(3) Reveals a document, file number, password, or any other information maintained by the Secretary of State pursuant to Article 21 of Chapter 130A of the General Statutes."

SECTION 3. G.S. 32A-24(a) reads as rewritten:

"(a) Any physician or other health care provider involved in the medical care of the principal may rely upon the authority of the health care agent contained in a signed and acknowledged health care power of attorney in the absence of actual knowledge of revocation of the health care power of attorney. The physician or health care provider may rely upon a copy of the health care power of attorney obtained from the Advance Health Care Directive Registry maintained by the Secretary of State pursuant to Article 21 of Chapter 130A of the General Statutes to the same extent that the individual may rely upon the original document."

SECTION 4. G.S. 90-321(c) reads as rewritten:

"(c) The attending physician may rely upon a signed, witnessed, dated and proved ~~declaration:~~declaration, or a copy of that declaration obtained from the Advance Health Care Directive Registry maintained by the Secretary of State pursuant to Article 21 of Chapter 130A of the General Statutes:

(1) Which expresses a desire of the declarant that extraordinary means or artificial nutrition or hydration not be used to prolong his life if his condition is determined to be terminal and incurable, or if the declarant is diagnosed as being in a persistent vegetative state; and

(2) Which states that the declarant is aware that the declaration authorizes a physician to withhold or discontinue the extraordinary means or artificial nutrition or hydration; and

(3) Which has been signed by the declarant in the presence of two witnesses who believe the declarant to be of sound mind and who state that they (i) are not related within the third degree to the declarant or to the declarant's spouse, (ii) do not know or have a reasonable expectation that they would be entitled to any portion of the estate of the declarant upon his death under any will of the declarant or codicil

thereto then existing or under the Intestate Succession Act as it then provides, (iii) are not the attending physician, or an employee of the attending physician, or an employee of a health facility in which the declarant is a patient, or an employee of a nursing home or any group-care home in which the declarant resides, and (iv) do not have a claim against any portion of the estate of the declarant at the time of the declaration; and

(4) Which has been proved before a clerk or assistant clerk of superior court, or a notary public who certifies substantially as set out in subsection (d) below."

SECTION 5. G.S. 122C-74 reads as rewritten:

"(b) The attending physician or other mental health treatment provider may consider valid and rely upon an advance ~~instruction~~ instruction, or a copy of that advance instruction that is obtained from the Advance Health Care Directive Registry maintained by the Secretary State pursuant to Article 21 of Chapter 130A of the General Statutes, in the absence of actual knowledge of its revocation or invalidity."

SECTION 6. G.S. 130A-409(c) reads as rewritten:

"(c) A person who acts with due care in accord with the terms of this Part or the anatomical gift laws of another state is not liable for damages in any civil action or subject to prosecution in any criminal proceeding for the act. A person may rely upon a document registered with the Advance Health Care Directive Registry maintained by the Secretary of State pursuant to Article 21 of Chapter 130A of the General Statutes to the same extent as the person can rely upon the original of that document."

SECTION 7. This act becomes effective October 1, 2001.

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2001

H D

HOUSE BILL 1362
PROPOSED COMMITTEE SUBSTITUTE H1362-PCS8223-SW-49

Short Title: Advance Health Care Directives Registry. (Public)

Sponsors:

Referred to:

April 23, 2001

A BILL TO BE ENTITLED

AN ACT TO ESTABLISH A CENTRAL REGISTRY FOR ADVANCE HEALTH CARE DIRECTIVES.

The General Assembly of North Carolina enacts:

SECTION 1. Chapter 130A of the General Statutes is amended by adding a new Article to read:

"Article 21.

"Advance Health Care Directive Registry.

"**§ 130A-465. Advance Health Care Directive Registry establishment.**

The Secretary of State shall establish and maintain a statewide, on-line, central registry for advance health care directives. The registry shall be accessible over the Internet through a site maintained by the Secretary of State.

"**§ 130A-466. Filing requirements.**

(a) A person may submit any of the following documents and the revocations of these documents to the Secretary of State for filing in the Advance Health Care Directive Registry established pursuant to this Article:

(1) A health care power of attorney under Article 3 of Chapter 32A of the General Statutes.

(2) A declaration of a desire for a natural death under Article 23 of Chapter 90 of the General Statutes.

(3) An advance instruction for mental health treatment under Part 2 of Article 3 of Chapter 122C of the General Statutes.

(4) A declaration of an anatomical gift under Part 3 of Article 16 of Chapter 130A of the General Statutes.

(b) Any document and any revocation of a document submitted for filing in the registry shall be notarized regardless of whether notarization is required for its validity.

(c) The document may be submitted for filing only by the person who executed the document.

(d) The person who submits the document shall supply a return address.

(e) The document shall be accompanied by any fee required by this Article.

"**§ 130A-467. Validity of unregistered documents.**

Failure to register a document with the registry maintained by the Secretary of State pursuant to this Article shall not affect the document's validity. Failure to notify the Secretary of State of the revocation of a document filed with the registry shall not affect the validity of a revocation that meets the statutory requirements for the revocation to be valid.

"**§ 130A-468. Filing of documents with the registry.**

(a) When the Secretary of State receives a document that may be filed with the registry pursuant to this Article, the Secretary shall create a digital reproduction of that document and enter the reproduced document into the registry database. The Secretary is not required to review a document to ensure that it complies with the particular statutory requirements applicable to the document. Each document entered into the registry database shall be assigned a unique file number and password.

(b) Upon entering the reproduced document into the registry database, the Secretary shall return the original document and a wallet-size card containing the document's file number and password to the person who submitted the document.

(c) When the Secretary of State receives a revocation of a document that is filed with the registry and that document's file number and password, the Secretary shall delete that document from the registry database.

(d) The Secretary of State's entry of a document into the registry database does not do any of the following:

(1) Affect the validity of the document in whole or in part.

(2) Relate to the accuracy of information contained in the document.

(3) Create a presumption regarding the validity of the document, regarding the accuracy of information contained in the document, or that the statutory requirements for the document have been met.

"**§ 130A-469. Disclosure of information contained in the registry.**

The registry shall be accessible only over the Internet. A document filed in the registry shall be accessible only if a person attempting to access the document enters both the file number and password of the document. Documents filed in the registry, file numbers, passwords, and any other information maintained by the Secretary of State under this Article shall not be subject to disclosure pursuant to Chapter 132 of the General Statutes.

"**§ 130A-470. Fees for using the registry; other funds for the registry.**

(a) The Secretary of State shall charge a fee of ten dollars ($10.00) for filing a document, other than a revocation, with the registry. The Secretary of State shall not charge a fee for filing a revocation with the registry. The fee shall be applied to the cost of maintaining the registry and to promoting public education and awareness of the registry.

(b) The Secretary of State, on behalf of the State, may accept gifts, donations, bequests, and other forms of voluntary contributions; may apply for grants from public

and private sources; and may expend funds received under this subsection for the purpose of promoting public education and awareness of the registry.

(c) All fees, funds, and gifts received pursuant to this section shall be subject to audit by the State Auditor and shall be expended in conformity with Article 1 of Chapter 143 of the General Statutes. The balance of any fees, funds, and gifts held by the Secretary of State pursuant to this section at the end of each fiscal year shall not revert to the General Fund.

"**§ 130A-471. Limitation of liability.**

The Secretary of State and any agent or person employed by the Secretary of State shall be held harmless from any liability in any action brought by or on behalf of any person injured or harmed by the administration of this Article."

SECTION 2. G.S. 132-1.2 is amended by adding a new subdivision to read:

"(3) Reveals a document, file number, password, or any other information maintained by the Secretary of State pursuant to Article 21 of Chapter 130A of the General Statutes."

SECTION 3. G.S. 32A-24(a) reads as rewritten:

"(a) Any physician or other health care provider involved in the medical care of the principal may rely upon the authority of the health care agent contained in a signed and acknowledged health care power of attorney in the absence of actual knowledge of revocation of the health care power of attorney. The physician or health care provider may rely upon a copy of the health care power of attorney obtained from the Advance Health Care Directive Registry maintained by the Secretary of State pursuant to Article 21 of Chapter 130A of the General Statutes to the same extent that the individual may rely upon the original document."

SECTION 4. G.S. 90-321(c) reads as rewritten:

"(c) The attending physician may rely upon a signed, witnessed, dated and proved ~~declaration:~~declaration, or a copy of that declaration obtained from the Advance Health Care Directive Registry maintained by the Secretary of State pursuant to Article 21 of Chapter 130A of the General Statutes:

(1) Which expresses a desire of the declarant that extraordinary means or artificial nutrition or hydration not be used to prolong his life if his condition is determined to be terminal and incurable, or if the declarant is diagnosed as being in a persistent vegetative state; and

(2) Which states that the declarant is aware that the declaration authorizes a physician to withhold or discontinue the extraordinary means or artificial nutrition or hydration; and

(3) Which has been signed by the declarant in the presence of two witnesses who believe the declarant to be of sound mind and who state that they (i) are not related within the third degree to the declarant or to the declarant's spouse, (ii) do not know or have a reasonable expectation that they would be entitled to any portion of the estate of the declarant upon his death under any will of the declarant or codicil

thereto then existing or under the Intestate Succession Act as it then provides, (iii) are not the attending physician, or an employee of the attending physician, or an employee of a health facility in which the declarant is a patient, or an employee of a nursing home or any group-care home in which the declarant resides, and (iv) do not have a claim against any portion of the estate of the declarant at the time of the declaration; and

(4) Which has been proved before a clerk or assistant clerk of superior court, or a notary public who certifies substantially as set out in subsection (d) below."

SECTION 5. G.S. 122C-74 reads as rewritten:

"(b) The attending physician or other mental health treatment provider may consider valid and rely upon an advance ~~instruction~~ instruction, or a copy of that advance instruction that is obtained from the Advance Health Care Directive Registry maintained by the Secretary of State pursuant to Article 21 of Chapter 130A of the General Statutes, in the absence of actual knowledge of its revocation or invalidity."

SECTION 6. G.S. 130A-409(c) reads as rewritten:

"(c) A person who acts with due care in accord with the terms of this Part or the anatomical gift laws of another state is not liable for damages in any civil action or subject to prosecution in any criminal proceeding for the act. A person may rely upon a document registered with the Advance Health Care Directive Registry maintained by the Secretary of State pursuant to Article 21 of Chapter 130A of the General Statutes to the same extent as the person can rely upon the original of that document."

SECTION 7. This act becomes effective January 1, 2002.

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2001

H D

HOUSE BILL 1362
PROPOSED COMMITTEE SUBSTITUTE H1362-CSSW-49 [v.2]

5/25/2001 9:27:15 AM

Short Title: Advance Health Care Directives Registry. (Public)

Sponsors:

Referred to:

April 23, 2001

A BILL TO BE ENTITLED

AN ACT TO ESTABLISH A CENTRAL REGISTRY FOR ADVANCE HEALTH CARE DIRECTIVES.

The General Assembly of North Carolina enacts:

SECTION 1. Chapter 130A of the General Statutes is amended by adding a new Article to read:

"Article 21.

"Advance Health Care Directive Registry.

"**§ 130A-465. Advance Health Care Directive Registry establishment.**

The Secretary of State shall establish and maintain a statewide, on-line, central registry for advance health care directives. The registry shall be accessible over the Internet through a site maintained by the Secretary of State.

"**§ 130A-466. Filing requirements.**

(a) A person may submit any of the following documents and the revocations of these documents to the Secretary of State for filing in the Advance Health Care Directive Registry established pursuant to this Article:

(1) A health care power of attorney under Article 3 of Chapter 32A of the General Statutes.

(2) A declaration of a desire for a natural death under Article 23 of Chapter 90 of the General Statutes.

(3) An advance instruction for mental health treatment under Part 2 of Article 3 of Chapter 122C of the General Statutes.

(4) A declaration of an anatomical gift under Part 3 of Article 16 of Chapter 130A of the General Statutes.

(b) Any document and any revocation of a document submitted for filing in the registry shall be notarized regardless of whether notarization is required for its validity.

(c) The document may be submitted for filing only by the person who executed the document.

(d) The person who submits the document shall supply a return address.

(e) The document shall be accompanied by any fee required by this Article.

"**§ 130A-467. Validity of unregistered documents.**

Failure to register a document with the registry maintained by the Secretary of State pursuant to this Article shall not affect the document's validity. Failure to notify the Secretary of State of the revocation of a document filed with the registry shall not affect the validity of a revocation that meets the statutory requirements for the revocation to be valid.

"**§ 130A-468. Filing of documents with the registry.**

(a) When the Secretary of State receives a document that may be filed with the registry pursuant to this Article, the Secretary shall create a digital reproduction of that document and enter the reproduced document into the registry database. The Secretary is not required to review a document to ensure that it complies with the particular statutory requirements applicable to the document. Each document entered into the registry database shall be assigned a unique file number and password.

(b) Upon entering the reproduced document into the registry database, the Secretary shall return the original document and a wallet-size card containing the document's file number and password to the person who submitted the document.

(c) When the Secretary of State receives a revocation of a document that is filed with the registry and that document's file number and password, the Secretary shall delete that document from the registry database.

(d) The Secretary of State's entry of a document into the registry database does not do any of the following:

(1) Affect the validity of the document in whole or in part.

(2) Relate to the accuracy of information contained in the document.

(3) Create a presumption regarding the validity of the document, regarding the accuracy of information contained in the document, or that the statutory requirements for the document have been met.

"**§ 130A-469. Disclosure of information contained in the registry.**

The registry shall be accessible only over the Internet. A document filed in the registry shall be accessible only if a person attempting to access the document enters both the file number and password of the document. Documents filed in the registry, file numbers, passwords, and any other information maintained by the Secretary of State under this Article shall not be subject to disclosure pursuant to Chapter 132 of the General Statutes.

"**§ 130A-470. Fees for using the registry; other funds for the registry.**

(a) The Secretary of State shall charge a fee of ten dollars ($10.00) for filing a document, other than a revocation, with the registry. The Secretary of State shall not charge a fee for filing a revocation with the registry. The fee shall be applied to the cost of maintaining the registry and to promoting public education and awareness of the registry.

(b) The Secretary of State, on behalf of the State, may accept gifts, donations, bequests, and other forms of voluntary contributions; may apply for grants from public

and private sources; and may expend funds received under this subsection for the purpose of promoting public education and awareness of the registry.

(c) All fees, funds, and gifts received pursuant to this section shall be subject to audit by the State Auditor and shall be expended in conformity with Article 1 of Chapter 143 of the General Statutes. The balance of any fees, funds, and gifts held by the Secretary of State pursuant to this section at the end of each fiscal year shall not revert to the General Fund.

"**§ 130A-471. Limitation of liability.**

The Secretary of State and any agent or person employed by the Secretary of State shall be held harmless from any liability in any action brought by or on behalf of any person injured or harmed by the administration of this Article."

SECTION 2. G.S. 132-1.2 is amended by adding a new subdivision to read:

"(3) Reveals a document, file number, password, or any other information maintained by the Secretary of State pursuant to Article 21 of Chapter 130A of the General Statutes."

SECTION 3. G.S. 32A-24(a) reads as rewritten:

"(a) Any physician or other health care provider involved in the medical care of the principal may rely upon the authority of the health care agent contained in a signed and acknowledged health care power of attorney in the absence of actual knowledge of revocation of the health care power of attorney. The physician or health care provider may rely upon a copy of the health care power of attorney obtained from the Advance Health Care Directive Registry maintained by the Secretary of State pursuant to Article 21 of Chapter 130A of the General Statutes to the same extent that the individual may rely upon the original document."

SECTION 4. G.S. 90-321(c) reads as rewritten:

"(c) The attending physician may rely upon a signed, witnessed, dated and proved ~~declaration:~~declaration, or a copy of that declaration obtained from the Advance Health Care Directive Registry maintained by the Secretary of State pursuant to Article 21 of Chapter 130A of the General Statutes:

(1) Which expresses a desire of the declarant that extraordinary means or artificial nutrition or hydration not be used to prolong his life if his condition is determined to be terminal and incurable, or if the declarant is diagnosed as being in a persistent vegetative state; and

(2) Which states that the declarant is aware that the declaration authorizes a physician to withhold or discontinue the extraordinary means or artificial nutrition or hydration; and

(3) Which has been signed by the declarant in the presence of two witnesses who believe the declarant to be of sound mind and who state that they (i) are not related within the third degree to the declarant or to the declarant's spouse, (ii) do not know or have a reasonable expectation that they would be entitled to any portion of the estate of the declarant upon his death under any will of the declarant or codicil

thereto then existing or under the Intestate Succession Act as it then provides, (iii) are not the attending physician, or an employee of the attending physician, or an employee of a health facility in which the declarant is a patient, or an employee of a nursing home or any group-care home in which the declarant resides, and (iv) do not have a claim against any portion of the estate of the declarant at the time of the declaration; and

(4) Which has been proved before a clerk or assistant clerk of superior court, or a notary public who certifies substantially as set out in subsection (d) below."

SECTION 5. G.S. 122C-74 reads as rewritten:

"(b) The attending physician or other mental health treatment provider may consider valid and rely upon an advance ~~instruction~~ instruction, or a copy of that advance instruction that is obtained from the Advance Health Care Directive Registry maintained by the Secretary State pursuant to Article 21 of Chapter 130A of the General Statutes, in the absence of actual knowledge of its revocation or invalidity."

SECTION 6. G.S. 130A-409(c) reads as rewritten:

"(c) A person who acts with due care in accord with the terms of this Part or the anatomical gift laws of another state is not liable for damages in any civil action or subject to prosecution in any criminal proceeding for the act. A person may rely upon a document registered with the Advance Health Care Directive Registry maintained by the Secretary of State pursuant to Article 21 of Chapter 130A of the General Statutes to the same extent as the person can rely upon the original of that document."

SECTION 7. This act becomes effective January 1, 2002.

HOUSE BILL 1362:
Advance Health Care Directives Registry

BILL ANALYSIS

Committee:	House Health	**Introduced by:**	Rep. Fox
Date:	May 29, 2001	**Summary by:**	Dianna Jessup
Version:	PCS H1362-CSSW-49		Committee Counsel

SUMMARY: ***House Bill 1362 would require the Secretary of State to establish and maintain a central database of voluntarily submitted advance health care directives and revocations of those directives. The registry would only be accessible over the Internet. Only a person who could provide the file number and password for a document could access the document. The Secretary of State would be held harmless from any liability in any action brought by a person injured or harmed by the administration of the registry. The act would become effective January 1, 2002.***

The PCS changes the effective date from October 1, 2001 to January 1, 2002 and makes grammatical changes.

CURRENT LAW: The Uniform Anatomical Gift Act (**G.S. 130A Part 3**) regulates the process for the making and receiving of **anatomical gifts** in this State. Any 18 years of age or older may make a gift by will, card or other document as long as the document is signed by the donor in the presence of two witnesses. The gift does not have to be made to a specified donee. Generally people become donors either through their wills or through another document that is commonly referred to as an organ donor card or a declaration of anatomical gift. A donor may amend or revoke a gift:

- By execution and delivery of a signed statement to the donee
- By an oral statement made in the presence of two persons and communicated to the donee
- By a statement addressed to an attending physician and communicated to the donee
- By a signed cared or document found on the individual or in the individual's effects, and made known to the donee

A guardian may amend or revoke the gift by the execution and delivery to the donee of a signed statement.

Article 3 of Chapter 32A regulates **health care powers of attorney**. Essentially, a health care power of attorney gives another individual the power to make health care decisions if the maker of the document is no longer able to make those decisions for himself or herself. An individual 18 years of age or older may make a health care power of attorney provided he or she has sufficient capacity and understanding to make his or her own health care decisions. A health care power of attorney may be revoked if a subsequent power of attorney is executed and is automatically revoked by the death of the principal. In instances where the health care power of attorney does not designate a successor health care agent and the current agent is the principal's spouse, it will be revoked by divorce. It can also be revoked by a signed document or in any manner by which the principal is able to communicate the intent to revoke.

A **declaration of a desire for a natural death** (living will) is a statement that an individual desires his or her life not be prolonged by extraordinary measures if the person has a terminal or incurable illness or if the person in a vegetative state. In order to be effective, a declaration of a desire for a natural death must include:

1. The desire of the declarant that extraordinary means, artificial nutrition, or hydration not be used to prolong his or her life if the condition is determined to be terminal and incurable or if the declarant is diagnosed as being in a vegetative state.
2. A statement that the declarant is aware that such a declaration authorizes a physician to withhold or discontinue the extraordinary means or artificial nutrition or hydration.
3. The signature of two witnesses, unrelated to the declarant or the delcarant's spouse with no interest in the declarant's estate and who is not an employee of the health facility where the declarant is a patient.
4. A notary certification.

The declaration may be revoked in any manner by which the declarant is able to communicate his or her intent to revoke. The revocation becomes effective only upon communication to the attending physician by the declarant or by and individual acting on behalf of the declarant.

Part 2 of Article 3 of Chapter 122C defines an **advance instruction for mental health treatment** as a written instrument, signed in the presence of two witnesses and acknowledged before a notary public, in which the principal makes a declaration of instructions, information, and preferences regarding the principal's mental health treatment and states the principal is aware that the advance instruction authorizes a mental health treatment provider to act according to the instructions. It may also state the principal's instructions regarding, but not limited to, consent to or refusal of mental health treatment when the principal is incapable. An advance instruction may be revoked at any time by the principal so long as the principal is not incapable. The principal simply notifies the treating physician or other mental health treatment provider of the revocation.

BILL ANALYSIS: The bill would require the Secretary of State to establish and maintain a statewide, on-line, central registry of advance health care directives and would make conforming changes to the various health care directive and public records statutes.

Section 1 would create a new Article 21 in the public health statutes directing the Secretary of State to establish and maintain the registry. Only the person who executes one of the following documents or revocations of those documents could submit the document to the Secretary for filing in the registry:

- A health care power of attorney
- A declaration of a desire for a natural death (i.e. living will)
- An advance instruction for mental health treatment
- A declaration of an anatomical gift

Upon submission of the document and payment of a filing fee of $10.00, the Secretary would create a digital reproduction of the document and enter the reproduced document into the registry database. If a revocation is submitted, the Secretary would delete the revoked document from the registry. Once a document is entered into the database, the Secretary would return the original document and a card containing the document's file number and password to the person who submitted the document. A filing fee would not be required for revocations of documents. The revenue collected would be used to maintain and promote the existence of the registry.

The Secretary would not be required to determine whether the document otherwise meets the requirements of the statutes governing the validity and adequacy of the document, and the presence of a

document in the registry would not create a presumption that the document is valid or accurate or that the information is correct.

Submission of a health care directive in the registry would be voluntary. Absence of a health care directive in the registry would not create a presumption that a health care directive does not exist.

Any person who obtains a document's file number and password would be able to access the document over the Internet. The documents would not be public records.

The proposed language would authorize the Secretary to accept voluntary contributions and apply for grants to help promote the registry. As is the case for all funds expended by State agencies, all funds would be subject to audit by the State Auditor and would have to be expended in conformity with the Executive Budget Act. The balance of any funds, fees, or gifts would not revert to the General Fund at the end of the fiscal year.

Finally, the proposed language would hold harmless the Secretary of State and any agent or person employed by the Secretary from any liability in any action brought by a person injured or harmed by the administration of the registry.

Section 2 would make a conforming change to the public records statutes that would make the documents, file numbers, passwords, or any other information maintained by the Secretary confidential and not subject to disclosure except as provided in the registry statute.

Sections 3 through 6 would make conforming changes to the health care power of attorney, declaration of a desire for natural death, advance instruction for mental health treatment, and anatomical gift act statutes to permit a physician or person to rely on a document registered with the Advance Health Care Directive Registry to the same extent as the person can rely upon the original of the document. The bill would not change what is required in the document in order for it to be effective and would not change the effect of relying on the document.

BACKGROUND: Twelve (12) states have created central registries for organ donors. Those states are Arkansas, Florida, Georgia, Illinois, Louisiana, Maryland, Michigan, Missouri, Ohio, Pennsylvania, Tennessee, and Texas. States either use the Division of Motor Vehicles, the Department of Health and Human Services, or the Secretary of State to create the registries.

Two states (2), Louisiana and California, have created separate registries for living wills. People submit documents to the Secretary of State's Office, which enters it into the registry. Neither of these registries have an online component. In California, the living will registry informs health care providers of the existence of a living will or health care power of attorney. A health care provider cannot obtain authorization from the Secretary of State to discontinue life-prolonging measures. In Louisiana, however, a health care provider can rely on a statement issued from the Secretary of State to terminate some of the life prolonging measures. In addition, whenever someone registers in Louisiana, they are issued a "do not resuscitate" bracelet.

Amy Currie, Research Assistant, contributed to this summary.

2001 COMMITTEE REPORT
HOUSE OF REPRESENTATIVES

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

☐ Committee Substitute for
H.B. 1362 A BILL TO BE ENTITLED AN ACT TO ESTABLISH A CENTRAL REGISTRY FOR ADVANCE HEALTH CARE DIRECTIVES.

☐ 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 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)

2/15/01

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2001

S 2

SENATE BILL 938
Judiciary II Committee Substitute Adopted 4/25/01

Short Title: Study Date Rape Drug Analogues. (Public)

Sponsors:

Referred to:

April 5, 2001

A BILL TO BE ENTITLED

AN ACT TO DIRECT THE COMMISSION FOR MENTAL HEALTH, DEVELOPMENTAL DISABILITIES, AND SUBSTANCE ABUSE SERVICES TO STUDY DATE RAPE DRUG ANALOGUES AND DETERMINE WHETHER THOSE SHOULD BE INCLUDED IN THE SCHEDULES OF CONTROLLED SUBSTANCES.

The General Assembly of North Carolina enacts:

SECTION 1. The Commission for Mental Health, Developmental Disabilities, and Substance Abuse Services shall study controlled substance analogues used as "date rape drugs". The Commission shall determine whether those substances should be added to the schedules for controlled substances as provided under G.S. 90-88, except that G.S. 90-88(e) shall not apply to this study or be a factor in the Commission's determination.

For purposes of this section, the term "analogue" means a substance other than a controlled substance that is intended for human consumption and that either has a chemical structure substantially similar to a controlled substance in Schedules I, II, or III of Chapter 90 of the General Statutes or that produces an effect substantially similar to that of a controlled substance in Schedules I, II, or III as set out in Chapter 90 of the General Statutes.

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

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2001

S D

SENATE BILL 938

Judiciary II Committee Substitute Adopted 4/25/01

PROPOSED HOUSE COMMITTEE SUBSTITUTE S938-PCS2267-SW-47

Short Title: Study Date Rape Drug Analogues. (Public)

Sponsors:

Referred to:

April 5, 2001

A BILL TO BE ENTITLED

AN ACT TO DIRECT THE COMMISSION FOR MENTAL HEALTH, DEVELOPMENTAL DISABILITIES, AND SUBSTANCE ABUSE SERVICES TO STUDY DATE RAPE DRUG ANALOGUES AND DETERMINE WHETHER THOSE SHOULD BE INCLUDED IN THE SCHEDULES OF CONTROLLED SUBSTANCES.

The General Assembly of North Carolina enacts:

SECTION 1. The Commission for Mental Health, Developmental Disabilities, and Substance Abuse Services shall study controlled substance analogues used as "date rape drugs". The Commission shall determine whether those substances should be added to the schedules for controlled substances as provided under G.S. 90-88, except that G.S. 90-88(e) shall not apply to this study or be a factor in the Commission's determination.

For purposes of this section, the term "analogue" means a substance other than a controlled substance that is intended for human consumption and that either has a chemical structure substantially similar to a controlled substance in Schedules I, II, or III of Chapter 90 of the General Statutes or that produces an effect substantially similar to that of a controlled substance in Schedules I, II, or III as set out in Chapter 90 of the General Statutes.

SECTION 2. Not later than May 1, 2002, the Commission shall submit its findings and recommendations to the Joint Legislative Oversight Committee on Mental Health, Developmental Disabilities, and Substance Abuse Services.

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

SENATE BILL 938:
Study Date Rape Drug Analogues

BILL ANALYSIS

Committee:	House Health	**Introduced by:**	Sen. Foxx
Date:	May 29, 2001	**Summary by:**	Dianna Jessup
Version:	PCS S938-CSSW-47[v1]		Committee Counsel

SUMMARY: Senate Bill 938 would direct the Commission for Mental Health, Developmental Disabilities, and Substance Abuse Services ("Commission") to study whether substances that are intended for human consumption and that either have a chemical structure substantially similar to a controlled substance or that produce an effect substantially similar to that of a controlled substance ("analogues") and that are used as "date rape drugs" should be included in the schedule of controlled substances under Chapter 90. The act would become effective when it becomes law.

The PCS would add a reporting provision to the bill, requiring the Commission to report to the Joint Legislative Oversight Committee on MH/DD/SA not later than May 1, 2002.

CURRENT LAW: The Commission has statutory authority to add, delete, or reschedule controlled substances within the guidelines and pursuant to procedures set forth in the statutes. The manufacture, sale, delivery, or possession with intent to sell or deliver a scheduled controlled substance is a felony. Gamma Hydroxybutyrate (known as the "date rape drug") is listed as a Schedule I controlled substance; drug products containing this substance are listed as Schedule III controlled substances.

Examples of GHB analogues or precursors (i.e. compounds that resemble GHB in structure or from which GHB is derived) include gamma-butyrolactone (GBL) and 1.4 butanediol, both industrial solvents. When ingested, these substances convert into GHB and produce the same effects. Last session, the General Assembly added GBL to the list of immediate precursor chemicals, thereby making it illegal to possess this chemical with the intent to manufacture a controlled substance or possess or distribute this chemical knowing that the chemical will be used to manufacture a controlled substance.

In determining whether a substance should be scheduled, the Commission must exclude any nonnarcotic substance if the substance may, under the federal Food, Drug and Cosmetic Act, lawfully be sold over-the-counter without prescription. Current law charges the Department of Health and Human Services with maintaining a list of these excluded substances.

BILL ANALYSIS: The bill would require the Commission to study date rape drug analogues and whether those analogues should be added to the schedules for controlled substances. "Analogue" for this study is defined as a substance other than a controlled substance that is intended for human consumption and that either has a chemical structure substantially similar to a controlled substance or that produces an effect substantially similar to that of a controlled substance in Schedules I, II, or III of Chapter 90. When considering whether these analogues should be added, the bill specifically directs that the Commission disregard the provision excluding nonnarcotic substances that may lawfully be sold over-the-counter.

BACKGROUND: According to a 1999 report from the Office of Legislative Research, Connecticut General Assembly, Gamma Hydroxybutyrate (GHB), known as *liquid x*, *Georgia home boy*, *Goop*,

gamma-oh, and *grievous bodily harm* is a naturally occurring chemical compound found in the nervous system, particularly in the brain. It regulates sleep patterns, body temperature, memory, and blood flow. When taken as a drug, a small dose of GHB (less than 1 gm) causes relaxation, euphoria, and loss of inhibitions. Higher doses (1-2 gm) suppress the heart rate and respiration and interfere with motor control and balance. A larger dose (2-4 gm) may produce a deep sleep and decrease respiration to the point where the patient requires a respirator. Higher doses may lead to comma and death. GHB's potential side effects include nausea, vomiting, hallucinations, depression, vertigo, seizures, and amnesia. It may also be addictive. In 1990, the Food and Drug Administration (FDA) issued an advisory declaring GHB unsafe and illicit except under FDA-approved, physician-supervised protocols. In March 2000, GHB was placed in Schedule I of the federal Controlled Substances Act.

The Connecticut OLR report states that GHB started to gain popularity in the U.S. in the late 1980's. Health food stores promoted it as a way to burn fat and build muscle. They based these claims on scientific studies showing that GHB stimulates the release of growth hormone. However, as of 1999, no studies have proven that GHB promotes muscle growth or aids in weight loss. In the last 10 years, GHB has appeared in nightclubs across the country. A typical consumer is a young adult who takes the substance to get high or engage in sexual acts. He accomplishes the latter task by adding GHB to his victim's drink in order to incapacitate her. Hence, GHB is commonly called a date rape drug. GHB is particularly dangerous when mixed with alcohol since alcohol increases the potency of GHB.

Twenty states currently consider GHB a controlled substance. New Jersey lists any substance that metabolizes to form GHB (e.g. GBL) as a controlled substance. Pennsylvania recently enlarged its analogue statutes to include chemicals that have "substantially similar structures or substantially similar effects".

2001 COMMITTEE REPORT
HOUSE OF REPRESENTATIVES

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

☒ Committee Substitute for
S.B. 938 A BILL TO BE ENTITLED AN ACT TO DIRECT THE COMMISSION FOR MENTAL HEALTH, DEVELOPMENTAL DISABILITIES, AND SUBSTANCE ABUSE SERVICES TO STUDY DATE RAPE DRUG ANALOGUES AND DETERMINE WHETHER THOSE SHOULD BE INCLUDED IN THE SCHEDULES OF CONTROLLED SUBSTANCES.

☐ 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 the Senate committee substitute bill and the recommendation that the bill be re-referred to the Committee on RULES.

☐ 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)

2/15/01

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2001

S 2

SENATE BILL 937

Health Care Committee Substitute Adopted 4/23/01

Short Title: C.O.N.-Adult Care Homes Regulated. (Public)

Sponsors:

Referred to:

March 29, 2001

A BILL TO BE ENTITLED

AN ACT TO REGULATE THE DEVELOPMENT OF ADULT CARE HOMES UNDER THE CERTIFICATE OF NEED LAW.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 131E-175 reads as rewritten:

"**§ 131E-175. Findings of fact.**

The General Assembly of North Carolina makes the following findings:

...

(8) That because persons who have received exemptions under Section 11.9(a) of S.L. 2000-67, as amended, and under Section 11.69(b) of S.L. 1997-443, as amended by Section 12.16C(a) of S.L. 1998-212, and as amended by Section 1 of S.L. 1999-135, have had sufficient time to complete development plans and initiate construction of beds in adult care homes.

(9) That because with the enactment of this legislation, beds allowed under the exemptions noted above and pending development will count in the inventory of adult care home beds available to provide care to residents in the State Medical Facilities Plan.

(10) That because State and county expenditures provide support for nearly three-quarters of the residents in adult care homes through the State County Special Assistance program, and excess bed capacity increases costs per resident day, it is in the public interest to promote efficiencies in delivering care in those facilities by controlling and directing their growth in an effort to prevent underutilization and higher costs and provide appropriate geographical distribution."

SECTION 2. G.S. 131E-176 reads as rewritten:

"**§ 131E-176. Definitions.**

As used in this Article, unless the context clearly requires otherwise, the following terms have the meanings specified:

...

(9b) "Health service facility" means a hospital; psychiatric facility; rehabilitation facility; ~~long-term care facility;~~ nursing home facility; adult care home; kidney disease treatment center, including freestanding hemodialysis units; intermediate care facility for the mentally retarded; home health agency office; chemical dependency treatment facility; diagnostic center; oncology treatment center; hospice, hospice inpatient facility, hospice residential care facility; and ambulatory surgical facility.

(9c) "Health service facility bed" means a bed licensed for use in a health service facility in the categories of (i) acute care beds; (ii) psychiatric beds; (iii) rehabilitation beds; (iv) nursing ~~care~~ home beds; (v) intermediate care beds for the mentally retarded; (vi) chemical dependency treatment beds; (vii) hospice inpatient facility beds; ~~and~~ (viii) hospice residential care facility ~~beds.~~beds; and (ix) adult care home beds.

...

(12a) "Adult care home" means a facility with seven or more beds licensed under G.S. 131D-2 or Chapter 131E of the General Statutes that provides residential care for aged or disabled persons whose principal need is a home which provides the supervision and personal care appropriate to their age and disability and for whom medical care is only occasional or incidental.

...

~~(14d) "Long-term care facility" means a health service facility whose bed complement of health service facility beds is composed principally of nursing care facility beds.~~

...

(17b) "Nursing home facility" means a health service facility whose bed complement of health service facility beds is composed principally of nursing home facility beds.

...."

SECTION 3. Section 11.69 of S.L. 1997-443, as amended by Section 12.16C(a) of S.L. 1998-212, and as further amended by Section 1 of S.L. 1999-135 as amended by Section 11.9(a) of S.L. 2000-67, reads as rewritten:

"Section 11.69. (a) The General Assembly finds:

(1) That the cost of care for seventy percent (70%) of adult care home residents is paid by the State and the counties;

(2) That the cost to the State for care for residents in adult care homes is substantial, and high vacancy rates in adult care homes further increases the cost of care;

(3) That the proliferation of unnecessary adult care home beds results in costly duplication and underuse of facilities and may result in lower quality service; and

(4) That it is necessary to protect the general welfare and lives, health, and property of the people of the State to slow temporarily licensure of adult care home beds pending a finding of a more definitive means of developing and maintaining the quality of adult care home beds so that unnecessary costs to the State do not result, adult care home beds are available where needed, and that individuals who need care in adult care homes may have access to quality care.

(b) Effective until ~~September 30, 2001,~~ December 31, 2001, the Department of Health and Human Services shall not approve the addition of any adult care home beds for any type home or facility in the State, except as follows:

(1) Plans submitted for approval prior to May 18, 1997, may continue to be processed for approval;

(2) Plans submitted for approval subsequent to May 18, 1997, may be processed for approval if the individual or organization submitting the plan demonstrates to the Department that on or before August 25, 1997, the individual or organization purchased real property, entered into a contract to purchase or obtain an option to purchase real property, entered into a binding real property lease arrangement, or has otherwise made a binding financial commitment for the purpose of establishing or expanding an adult care home facility. An owner of real property who entered into a contract prior to August 25, 1997, for the sale of an existing building together with land zoned for the development of not more than 50 adult care home beds with a proposed purchaser who failed to consummate the transaction may, after August 25, 1997, sell the property to another purchaser and the Department may process and approve plans submitted by the purchaser for the development of not more than 50 adult care home beds. It shall be the responsibility of the applicant to establish, to the satisfaction of the Department, that any of these conditions have been met;

(3) Adult care home beds in facilities for the developmentally disabled with six beds or less which are or would be licensed under G.S. 131D or G.S. 122C may continue to be approved;

(4) If the Department determines that the vacancy rate of available adult care home beds in a county is fifteen percent (15%) or less of the total number of available beds in the county as of August 26, 1997, and no new beds have been approved or licensed in the county or plans submitted for approval in accordance with subdivision (1) or (2) of this section which would raise the vacancy rate above fifteen percent (15%) in the county, then the department may accept and approve the addition of beds in that county; or

(5) If a county board of commissioners determines that a substantial need exists for the addition of adult care home beds in that county, the board of commissioners may request that a specified umber of additional beds be licensed for development in their county. In making their

determination, the board of commissioners shall give consideration to meeting the needs of Special Assistance clients. The Department may approve licensure of the additional beds from the first facility that files for licensure and subsequently meets the licensure requirements.

(b1) Any person who obtained an exemption under subsection (b) of this section and has not obtained a license for the beds for which the exemption was granted shall no longer be authorized to develop the beds, unless all of the following conditions are met:

(1) No later than June 1, 2002, the person granted the exemption shall submit to the Department of Health and Human Services fully executed copies of loan closing papers for a loan to the exempted person or a letter from a certified public accountant which states that liquid reserves have been placed in a separately identified account for the exempted person, that document sufficient funding to cover the entire capital cost of the project for which the exemption was granted.

(2) No later than December 1, 2002, the person granted the exemption shall submit to the Department of Health and Human Services documentation from the builder or architect that the foundation and footings of the facility for which the exemption was granted have been completed.

(3) No later than December 1, 2003, the person granted the exemption shall submit to the Department of Health and Human Services a copy of the certificate of occupancy for the facility for which the exemption was granted from the local building inspector.

(c) The Department shall study the issue of high vacancy rates for adult care home beds, including the impact of those vacancy rates on cost-effectiveness and quality of care for the occupants of adult care homes and other facilities, and make recommendations with respect to the need for establishing new procedures for determining the State and county reimbursement amounts for Special Assistance recipients, the need for the establishment of a certificate of need type process for adult care homes, or any changes needed in the certificate of need process for any other facilities to prevent high vacancy rates for adult care home beds. The Department also shall study the issue of the availability of beds for Special Assistance clients and how recent new bed development has impacted the availability, quality, and cost of beds available for those clients. The Department shall report the results of its study, along with the recommendations required by this section and any other proposals and recommendations, to the Chairs of the House and Senate Appropriations Subcommittees on Human Resources by February 1, 1998. The Department's report shall include any observations or recommendations it deems appropriate with respect to correlations between the vacancy rates and the condition or age of facilities.

(d) This section shall not apply to adult care home beds which are part of a continuing care facility subject to the jurisdiction of or licensed by the Department of Insurance pursuant to Article 64, Chapter 58 of the General Statutes.

(e) This section is effective when this act becomes law."

SECTION 4. Sections 1 and 2 of this act become effective January 1, 2002. The remainder of this act is effective when it becomes law.

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2001

S D

SENATE BILL 937

Health Care Committee Substitute Adopted 4/23/01

PROPOSED HOUSE COMMITTEE SUBSTITUTE S937-PCS7241-RM-42

Short Title: C.O.N.-Adult Care Homes Regulated. (Public)

Sponsors:

Referred to:

March 29, 2001

A BILL TO BE ENTITLED

AN ACT TO REGULATE THE DEVELOPMENT OF ADULT CARE HOMES UNDER THE CERTIFICATE OF NEED LAW.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 131E-175 reads as rewritten:

"**§ 131E-175. Findings of fact.**

The General Assembly of North Carolina makes the following findings:

...

(8) That because persons who have received exemptions under Section 11.9(a) of S.L. 2000-67, as amended, and under Section 11.69(b) of S.L. 1997-443, as amended by Section 12.16C(a) of S.L. 1998-212, and as amended by Section 1 of S.L. 1999-135, have had sufficient time to complete development plans and initiate construction of beds in adult care homes.

(9) That because with the enactment of this legislation, beds allowed under the exemptions noted above and pending development will count in the inventory of adult care home beds available to provide care to residents in the State Medical Facilities Plan.

(10) That because State and county expenditures provide support for nearly three-quarters of the residents in adult care homes through the State County Special Assistance program, and excess bed capacity increases costs per resident day, it is in the public interest to promote efficiencies in delivering care in those facilities by controlling and directing their growth in an effort to prevent underutilization and higher costs and provide appropriate geographical distribution."

SECTION 2. G.S. 131E-176 reads as rewritten:

"**§ 131E-176. Definitions.**

As used in this Article, unless the context clearly requires otherwise, the following terms have the meanings specified:

...

(9b) "Health service facility" means a hospital; psychiatric facility; rehabilitation facility; ~~long-term care facility;~~ nursing home facility; adult care home; kidney disease treatment center, including freestanding hemodialysis units; intermediate care facility for the mentally retarded; home health agency office; chemical dependency treatment facility; diagnostic center; oncology treatment center; hospice, hospice inpatient facility, hospice residential care facility; and ambulatory surgical facility.

(9c) "Health service facility bed" means a bed licensed for use in a health service facility in the categories of (i) acute care beds; (ii) psychiatric beds; (iii) rehabilitation beds; (iv) nursing ~~care~~ home beds; (v) intermediate care beds for the mentally retarded; (vi) chemical dependency treatment beds; (vii) hospice inpatient facility beds; ~~and~~ (viii) hospice residential care facility ~~beds.~~ beds; and (ix) adult care home beds.

...

(12a) "Adult care home" means a facility with seven or more beds licensed under G.S. 131D-2 or Chapter 131E of the General Statutes that provides residential care for aged or disabled persons whose principal need is a home which provides the supervision and personal care appropriate to their age and disability and for whom medical care is only occasional or incidental.

...

~~(14d) "Long-term care facility" means a health service facility whose bed complement of health service facility beds is composed principally of nursing care facility beds.~~

...

(17b) "Nursing home facility" means a health service facility whose bed complement of health service facility beds is composed principally of nursing home facility beds.

...."

SECTION 3. Section 11.69 of S.L. 1997-443, as amended by Section 12.16C(a) of S.L. 1998-212, and as further amended by Section 1 of S.L. 1999-135 as amended by Section 11.9(a) of S.L. 2000-67, reads as rewritten:

"Section 11.69. (a) The General Assembly finds:

(1) That the cost of care for seventy percent (70%) of adult care home residents is paid by the State and the counties;

(2) That the cost to the State for care for residents in adult care homes is substantial, and high vacancy rates in adult care homes further increases the cost of care;

(3) That the proliferation of unnecessary adult care home beds results in costly duplication and underuse of facilities and may result in lower quality service; and

(4) That it is necessary to protect the general welfare and lives, health, and property of the people of the State to slow temporarily licensure of adult care home beds pending a finding of a more definitive means of developing and maintaining the quality of adult care home beds so that unnecessary costs to the State do not result, adult care home beds are available where needed, and that individuals who need care in adult care homes may have access to quality care.

(b) Effective until ~~September 30, 2001,~~ December 31, 2001, the Department of Health and Human Services shall not approve the addition of any adult care home beds for any type home or facility in the State, except as follows:

(1) Plans submitted for approval prior to May 18, 1997, may continue to be processed for approval;

(2) Plans submitted for approval subsequent to May 18, 1997, may be processed for approval if the individual or organization submitting the plan demonstrates to the Department that on or before August 25, 1997, the individual or organization purchased real property, entered into a contract to purchase or obtain an option to purchase real property, entered into a binding real property lease arrangement, or has otherwise made a binding financial commitment for the purpose of establishing or expanding an adult care home facility. An owner of real property who entered into a contract prior to August 25, 1997, for the sale of an existing building together with land zoned for the development of not more than 50 adult care home beds with a proposed purchaser who failed to consummate the transaction may, after August 25, 1997, sell the property to another purchaser and the Department may process and approve plans submitted by the purchaser for the development of not more than 50 adult care home beds. It shall be the responsibility of the applicant to establish, to the satisfaction of the Department, that any of these conditions have been met;

(3) Adult care home beds in facilities for the developmentally disabled with six beds or less which are or would be licensed under G.S. 131D or G.S. 122C may continue to be approved;

(4) If the Department determines that the vacancy rate of available adult care home beds in a county is fifteen percent (15%) or less of the total number of available beds in the county as of August 26, 1997, and no new beds have been approved or licensed in the county or plans

submitted for approval in accordance with subdivision (1) or (2) of this section which would raise the vacancy rate above fifteen percent (15%) in the county, then the department may accept and approve the addition of beds in that county; or

(5) If a county board of commissioners determines that a substantial need exists for the addition of adult care home beds in that county, the board of commissioners may request that a specified umber of additional beds be licensed for development in their county. In making their determination, the board of commissioners shall give consideration to meeting the needs of Special Assistance clients. The Department may approve licensure of the additional beds from the first facility that files for licensure and subsequently meets the licensure requirements.

(b1) Any person who obtained an exemption under subsection (b) of this section and has not obtained a license for the beds for which the exemption was granted shall no longer be authorized to develop the beds, unless all of the following conditions are met:

(1) No later than June 1, 2002, the person granted the exemption shall submit to the Department of Health and Human Services fully executed copies of loan closing papers for a loan to the exempted person or a letter from a certified public accountant which states that liquid reserves have been placed in a separately identified account for the exempted person that document sufficient funding to cover the entire capital cost of the project for which the exemption was granted.

(2) No later than December 1, 2002, the person granted the exemption shall submit to the Department of Health and Human Services documentation from the builder or architect that the foundation and footings of the facility for which the exemption was granted have been completed.

(3) No later than December 1, 2003, the person granted the exemption shall submit to the Department of Health and Human Services a copy of the certificate of occupancy from the local building inspector for the facility for which the exemption was granted.

(b2) Notwithstanding the provisions of subsection (b1) of this section, any person who obtained an exemption under subsection (b) of this section for the construction of a new building that is not connected to any other existing structure by more than a protected walkway, and who obligated one or more Qualifying Financial Commitments for the construction of the building of a value totaling at least twenty-five thousand dollars ($25,000), before January 1, 2001, may proceed to develop the beds and obtain a license for the operation of the beds if all of the following conditions are met. Exemptions that were received for increases in bed capacity of existing buildings must meet the requirements set forth in subsection (b1) of this section.

(1) No later than the close of business on June 1, 2004, the person granted the exemption shall submit to the Department of Health and Human

Services fully executed copies of loan closing papers for a loan to the exempted person or a letter from a certified public accountant which states that liquid reserves have been placed in a separately identified account for the exempted person that document sufficient funding to cover the entire capital cost of the project for which the exemption was granted.

(2) Not later than the close of business on December 1, 2004, the person granted the exemption shall submit to the Department of Health and Human Services documentation from the builder or architect that the foundation and footings of the facility for which the exemption was granted have been completed.

(3) Not later than the close of business on December 1, 2005, the person granted the exemption shall submit to the Department of Health and Human Services a copy of the certificate of occupancy from the building inspector for the facility for which the exemption was granted.

For the purposes of this subsection, "Qualifying Financial Commitments" includes any and all of the following expenses: (i) zoning fees and expenses; (ii) marketing and other demographic research and studies; (iii) site preparation costs including soil testing and soil boring costs; (iv) water and sewer improvements; (v) professional fees associated with the foregoing activities and which are otherwise connected to the development of the site, including accounting, architectural, engineering, and legal fees.

(c) The Department shall study the issue of high vacancy rates for adult care home beds, including the impact of those vacancy rates on cost-effectiveness and quality of care for the occupants of adult care homes and other facilities, and make recommendations with respect to the need for establishing new procedures for determining the State and county reimbursement amounts for Special Assistance recipients, the need for the establishment of a certificate of need type process for adult care homes, or any changes needed in the certificate of need process for any other facilities to prevent high vacancy rates for adult care home beds. The Department also shall study the issue of the availability of beds for Special Assistance clients and how recent new bed development has impacted the availability, quality, and cost of beds available for those clients. The Department shall report the results of its study, along with the recommendations required by this section and any other proposals and recommendations, to the Chairs of the House and Senate Appropriations Subcommittees on Human Resources by February 1, 1998. The Department's report shall include any observations or recommendations it deems appropriate with respect to correlations between the vacancy rates and the condition or age of facilities.

(d) This section shall not apply to adult care home beds which are part of a continuing care facility subject to the jurisdiction of or licensed by the Department of Insurance pursuant to Article 64, Chapter 58 of the General Statutes.

(e) This section is effective when this act becomes law."

SECTION 4. The Department of Health and Human Services shall study and make recommendations regarding the State Medical Facilities Planning methodology that would be necessary in order to delineate the various populations currently being served in facilities regulated as adult care homes according to the needs of those populations. The Department shall report its findings and recommendations to the State Health Care Coordinating Council not later than May 1, 2002.

SECTION 5. Sections 1 and 2 of this act become effective January 1, 2002. The remainder of this act is effective when it becomes law.

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2001

S D

SENATE BILL 937

Health Care Committee Substitute Adopted 4/23/01

PROPOSED HOUSE COMMITTEE SUBSTITUTE S937-CSRM-42 [v.1]

5/29/2001 8:35:09 AM

Short Title: C.O.N.-Adult Care Homes Regulated. (Public)

Sponsors:

Referred to:

March 29, 2001

A BILL TO BE ENTITLED

AN ACT TO REGULATE THE DEVELOPMENT OF ADULT CARE HOMES UNDER THE CERTIFICATE OF NEED LAW.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 131E-175 reads as rewritten:

"**§ 131E-175. Findings of fact.**

The General Assembly of North Carolina makes the following findings:

...

(8) That because persons who have received exemptions under Section 11.9(a) of S.L. 2000-67, as amended, and under Section 11.69(b) of S.L. 1997-443, as amended by Section 12.16C(a) of S.L. 1998-212, and as amended by Section 1 of S.L. 1999-135, have had sufficient time to complete development plans and initiate construction of beds in adult care homes.

(9) That because with the enactment of this legislation, beds allowed under the exemptions noted above and pending development will count in the inventory of adult care home beds available to provide care to residents in the State Medical Facilities Plan.

(10) That because State and county expenditures provide support for nearly three-quarters of the residents in adult care homes through the State County Special Assistance program, and excess bed capacity increases costs per resident day, it is in the public interest to promote efficiencies in delivering care in those facilities by controlling and directing their growth in an effort to prevent underutilization and higher costs and provide appropriate geographical distribution."

SECTION 2. G.S. 131E-176 reads as rewritten:

"**§ 131E-176. Definitions.**

As used in this Article, unless the context clearly requires otherwise, the following terms have the meanings specified:

...

(9b) "Health service facility" means a hospital; psychiatric facility; rehabilitation facility; ~~long term care facility;~~ nursing home facility; adult care home; kidney disease treatment center, including freestanding hemodialysis units; intermediate care facility for the mentally retarded; home health agency office; chemical dependency treatment facility; diagnostic center; oncology treatment center; hospice, hospice inpatient facility, hospice residential care facility; and ambulatory surgical facility.

(9c) "Health service facility bed" means a bed licensed for use in a health service facility in the categories of (i) acute care beds; (ii) psychiatric beds; (iii) rehabilitation beds; (iv) nursing ~~care~~ home beds; (v) intermediate care beds for the mentally retarded; (vi) chemical dependency treatment beds; (vii) hospice inpatient facility beds; ~~and~~ (viii) hospice residential care facility ~~beds.~~beds; and (ix) adult care home beds.

...

(12a) "Adult care home" means a facility with seven or more beds licensed under G.S. 131D-2 or Chapter 131E of the General Statutes that provides residential care for aged or disabled persons whose principal need is a home which provides the supervision and personal care appropriate to their age and disability and for whom medical care is only occasional or incidental.

...

~~(14d) "Long term care facility" means a health service facility whose bed complement of health service facility beds is composed principally of nursing care facility beds.~~

...

(17b) "Nursing home facility" means a health service facility whose bed complement of health service facility beds is composed principally of nursing home facility beds.

...."

SECTION 3. Section 11.69 of S.L. 1997-443, as amended by Section 12.16C(a) of S.L. 1998-212, and as further amended by Section 1 of S.L. 1999-135 as amended by Section 11.9(a) of S.L. 2000-67, reads as rewritten:

"Section 11.69. (a) The General Assembly finds:

(1) That the cost of care for seventy percent (70%) of adult care home residents is paid by the State and the counties;

(2) That the cost to the State for care for residents in adult care homes is substantial, and high vacancy rates in adult care homes further increases the cost of care;

(3) That the proliferation of unnecessary adult care home beds results in costly duplication and underuse of facilities and may result in lower quality service; and

(4) That it is necessary to protect the general welfare and lives, health, and property of the people of the State to slow temporarily licensure of adult care home beds pending a finding of a more definitive means of developing and maintaining the quality of adult care home beds so that unnecessary costs to the State do not result, adult care home beds are available where needed, and that individuals who need care in adult care homes may have access to quality care.

(b) Effective until ~~September 30, 2001,~~ December 31, 2001, the Department of Health and Human Services shall not approve the addition of any adult care home beds for any type home or facility in the State, except as follows:

(1) Plans submitted for approval prior to May 18, 1997, may continue to be processed for approval;

(2) Plans submitted for approval subsequent to May 18, 1997, may be processed for approval if the individual or organization submitting the plan demonstrates to the Department that on or before August 25, 1997, the individual or organization purchased real property, entered into a contract to purchase or obtain an option to purchase real property, entered into a binding real property lease arrangement, or has otherwise made a binding financial commitment for the purpose of establishing or expanding an adult care home facility. An owner of real property who entered into a contract prior to August 25, 1997, for the sale of an existing building together with land zoned for the development of not more than 50 adult care home beds with a proposed purchaser who failed to consummate the transaction may, after August 25, 1997, sell the property to another purchaser and the Department may process and approve plans submitted by the purchaser for the development of not more than 50 adult care home beds. It shall be the responsibility of the applicant to establish, to the satisfaction of the Department, that any of these conditions have been met;

(3) Adult care home beds in facilities for the developmentally disabled with six beds or less which are or would be licensed under G.S. 131D or G.S. 122C may continue to be approved;

(4) If the Department determines that the vacancy rate of available adult care home beds in a county is fifteen percent (15%) or less of the total number of available beds in the county as of August 26, 1997, and no new beds have been approved or licensed in the county or plans

submitted for approval in accordance with subdivision (1) or (2) of this section which would raise the vacancy rate above fifteen percent (15%) in the county, then the department may accept and approve the addition of beds in that county; or

(5) If a county board of commissioners determines that a substantial need exists for the addition of adult care home beds in that county, the board of commissioners may request that a specified umber of additional beds be licensed for development in their county. In making their determination, the board of commissioners shall give consideration to meeting the needs of Special Assistance clients. The Department may approve licensure of the additional beds from the first facility that files for licensure and subsequently meets the licensure requirements.

(b1) Any person who obtained an exemption under subsection (b) of this section and has not obtained a license for the beds for which the exemption was granted shall no longer be authorized to develop the beds, unless all of the following conditions are met:

(1) No later than June 1, 2002, the person granted the exemption shall submit to the Department of Health and Human Services fully executed copies of loan closing papers for a loan to the exempted person or a letter from a certified public accountant which states that liquid reserves have been placed in a separately identified account for the exempted person that document sufficient funding to cover the entire capital cost of the project for which the exemption was granted.

(2) No later than December 1, 2002, the person granted the exemption shall submit to the Department of Health and Human Services documentation from the builder or architect that the foundation and footings of the facility for which the exemption was granted have been completed.

(3) No later than December 1, 2003, the person granted the exemption shall submit to the Department of Health and Human Services a copy of the certificate of occupancy from the local building inspector for the facility for which the exemption was granted.

(b2) Notwithstanding the provisions of subsection (b1) of this section, any person who obtained an exemption under subsection (b) of this section for the construction of a new building that is not connected to any other existing structure by more than a protected walkway, and who obligated one or more Qualifying Financial Commitments for the construction of the building of a value totaling at least twenty-five thousand dollars ($25,000), before January 1, 2001 may proceed to develop the beds and obtain a license for the operation of the beds if all of the following conditions are met. Exemptions that were received for increases in bed capacity of existing buildings must meet the requirements set forth in subsection (b1) of this section.

(1) No later than the close of business on June 1, 2004, the person granted the exemption shall submit to the Department of Health and Human Services fully

executed copies of loan closing papers for a loan to the exempted person or a letter from a certified public accountant which states that liquid reserves have been placed in a separately identified account for the exempted person that document sufficient funding to cover the entire capital cost of the project for which the exemption was granted.

(2) Not later than the close of business on December 1, 2004, the person granted the exemption shall submit to the Department of Health and Human Services documentation from the builder or architect that the foundation and footings of the facility for which the exemption was granted have been completed.

(3) Not later than the close of business on December 1, 2005, the person granted the exemption shall submit to the Department of Health and Human Services a copy of the certificate of occupancy from the building inspector for the facility for which the exemption was granted.

For the purposes of this subsection, "Qualifying Financial Commitments" includes any and all of the following expenses: (i) zoning fees and expenses; (ii) marketing and other demographic research and studies; (iii) site preparation costs including soil testing and soil boring costs; (iv) water and sewer improvements; (v) professional fees associated with the foregoing activities and which are otherwise connected to the development of the site, including accounting, architectural, engineering and legal fees.

(c) The Department shall study the issue of high vacancy rates for adult care home beds, including the impact of those vacancy rates on cost-effectiveness and quality of care for the occupants of adult care homes and other facilities, and make recommendations with respect to the need for establishing new procedures for determining the State and county reimbursement amounts for Special Assistance recipients, the need for the establishment of a certificate of need type process for adult care homes, or any changes needed in the certificate of need process for any other facilities to prevent high vacancy rates for adult care home beds. The Department also shall study the issue of the availability of beds for Special Assistance clients and how recent new bed development has impacted the availability, quality, and cost of beds available for those clients. The Department shall report the results of its study, along with the recommendations required by this section and any other proposals and recommendations, to the Chairs of the House and Senate Appropriations Subcommittees on Human Resources by February 1, 1998. The Department's report shall include any observations or recommendations it deems appropriate with respect to correlations between the vacancy rates and the condition or age of facilities.

(d) This section shall not apply to adult care home beds which are part of a continuing care facility subject to the jurisdiction of or licensed by the Department of Insurance pursuant to Article 64, Chapter 58 of the General Statutes.

(e) This section is effective when this act becomes law."

SECTION 4. The Department of Health and Human Services shall study and make recommendations regarding the State Medical Facilities Planning methodology that would be necessary in order to delineate the various populations currently being served in facilities regulated as adult care homes according to the needs

of those populations. The Department shall report its findings and recommendations to the State Health Care Coordinating Council not later than May 1, 2002.

SECTION 5. Sections 1 and 2 of this act become effective January 1, 2002. The remainder of this act is effective when it becomes law.

SENATE BILL 937:
C.O.N. -Adult Care Homes Regulated

BILL ANALYSIS

Committee:	House Health	**Introduced by:**	Sen. Purcell
Date:	May 29, 2001	**Summary by:**	Linda Attarian
Version:	S937-CSRM-42 [v.1]		Committee Counsel

SUMMARY OF THE SECOND EDITION OF SENATE BILL 937:

SB 937 would add adult care homes with seven or more beds to the types of new health care facilities that are subject to certificate of need review pursuant to Article 9 of Chapter 131E. The bill would also extend the current moratorium on building new adult care beds from September 30, 2001 to December 31, 2001 and provide a timetable in which holders of exemptions to the moratorium must complete the development of additional beds or lose their rights to do so. Sections 1 and 2, amending the CON laws become effective January 1, 2002 and the remainder of the bill becomes effective when the bill becomes law.

S937-CSRM-42 [v.1]:

1. Adds a new section to Section 11.9(a) of S.L. 200-67 to allow a person who obtained an exemption from the moratorium for the construction of a new building that is not connected to any other existing structure by more than a protected walkway, and who obligated one or more specified financial commitments for the construction of the building of a value totaling at least twenty-five thousand dollars before January 1, 2001, to proceed to develop the beds in accordance to a prescribed timetable.

2. Directs the Department to study and make recommendations regarding the State Medical Facilities Planning methodology that would be necessary to delineate the various populations currently being served adult care homes according to the needs of those populations. The Department is to make its report in May of 2002.

CURRENT LAW:

Definitions:

G.S. 131D-2 defines an **"adult care home"** as an assisted living residence in which the housing management provides 24-hour scheduled and unscheduled personal care services to two or more residents, either directly or, for scheduled needs, through formal written agreement with licensed home care or hospice agencies. Some licensed adult care homes provide supervision to persons with cognitive impairments whose decisions, if made independently, may jeopardize the safety or well-being of themselves or others and therefore require supervision. Medication in an adult care home may be administered by designated, trained staff. Adult care homes that provide care to two to six unrelated residents are commonly called family care homes.

This statute further defines as **"assisted living residence"** as any group housing and services program for two or more unrelated adults, by whatever name it is called, that makes available, at a minimum, one meal a day and housekeeping services and provides personal care services directly or through a formal written agreement with one or more licensed home care or hospice agencies. The Department may allow nursing service exceptions on a case-by-case basis. Settings in which services are delivered may include self-contained apartment units or single or shared room units with private or area baths. Assisted living

residences are not nursing homes. There are three types of assisted living residences: adult care homes and group homes for developmentally disabled adults, and multiunit assisted housing with services.

Certificate of Need Law:

Article 9 of Chapter 131E, Certificate of Need (CON), was enacted pursuant to a set of findings of fact providing a basis for the State's interest in enacting a CON process whereby new institutional services that are proposed to be offered within the State will be reviewed and evaluated as to need, cost of service, accessibility to services, quality of care, feasibility, and other criteria. The types of health services that are controlled by the CON law are listed in G.S. 131E-176(9b). The health related activities requiring CON review are set forth in G.S. 131E-176(16). See attached information from the Division of Facility Services.

BILL ANALYSIS: **Section 1** amends G.S. 131E-175 to add additional findings of fact concerning the State interest in controlling the growth of adult care home facilities.

Section 2 makes the following changes to the CON law:

- Amends G.S. 131E-176(9b), to include adult care homes in the definition health care facility, thereby placing them within the scope of CON regulation;
- Amends G.S. 131E-176(9c) to include beds in adult care homes within the definition of health service facility bed, thus authorizing the Health Planning Unit of the Division of Facility Services to set the maximum number of adult care home beds that may be awarded by the CON section;
- Adds a definition of "adult care home" to G.S. 131E-176 to distinguishes this type of facility from a nursing home facility. The definition limits the CON regulation to adult care homes with 7 or more beds licensed under Chapter 131D-2 or Chapter 131E. "Family care homes" are not included in the definition, and therefore not subject to the CON law;
- Eliminates the definition of "long-term care facility" in G.S. 131E-176, and adds a definition of "nursing home facility" to mean essentially same as the deleted definition of "long-term care facility".

Section 3 extends the current moratorium on adding new adult care home beds to December 31, 2001 so that the Division of Facility Services may establish the maximum number of beds for 2002. Section 3 also adds a (b1) subsection to the Session Law that establishes a timetable that holders of exemptions to the moratorium must meet in order to preserve their rights to build new beds pursuant to the exemptions.

Section 4 makes sections 1 and 2 effective January 1, 2002. Section 3 and 4 become effective when the act becomes law.

North Carolina Division of Facility Services

Certificate of Need Section

Law / General Statutes

Health Service Facilities Controlled by the CON Law [N.C. Gen. Stat. §131E-176(9b)]

1. General Acute Care Hospitals. [N.C. Gen. Stat. 131E-176(13)]
2. Inpatient Psychiatric Hospitals. [N.C. Gen. Stat. 131E-176(21)]
3. Inpatient Rehabilitation Hospitals. [N.C. Gen. Stat. 131E-176(22)]
4. Long Term Care Facilities (Nursing Facilities). [N.C. Gen. Stat. 131E-176(14d)]
5. Kidney Disease Treatment Facilities (Dialysis Facilities/ESRD).
6. Intermediate Care Facilities for the Mentally Retarded (ICF/MR). [N.C. Gen. Stat. 131E-176 (14a)]
7. Certified Home Health Agency Offices. [N.C. Gen. Stat. 131E-176(12)]
8. Chemical Dependency Treatment Facilities, including inpatient, residential and detoxification. [N.C. Gen. Stat. 131E-176(5a)]
9. Diagnostic Centers. [N.C. Gen. Stat. 131E-176(7a)]
10. Oncology Treatment Centers. [N.C. Gen. Stat. 131E-176(18a)]
11. Hospices. [N.C. Gen. Stat. 131E-176(13a)]
12. Hospice Inpatient Facilities. [N.C. Gen. Stat. 131E-176(13b)]
13. Hospice Residential Care Facilities. [N.C. Gen. Stat. 131E-176(13c)]
14. Ambulatory Surgical Facilities. [N.C. Gen. Stat. 131E-176(1a)]

Activities Requiring Certificate of Need Review [N.C. Gen. Stat. §131E-176(16)]

A. Establishment of a new health service facility (See 1 through 14 above). [N.C. Gen. Stat. 131E-176(16)a]

B. Capital expenditure by any person for health service in excess of $2 million dollars. [N.C. Gen. Stat. 131E-176(16)b]

C. Change in bed capacity. [N.C. Gen. Stat. 131E 176(16)c, 176(5) and 176(9c)]

   i. Relocation of health service facility beds or dialysis stations. [N.C. Gen. Stat. 131E-176(16)(5)(i)]
   ii. Change of health service facility beds from one category to another. [N.C. Gen. Stat. 131E-176(5)(ii)]
   iii. Increase in dialysis stations or health service facility beds. [N.C. Gen. Stat. 131E-176(5)(iii)]

   Health service facility beds [N.C. Gen. Stat. 131E-176(9c)]:

   a. acute care beds;
   b. psychiatric beds;
   c. rehabilitation beds;
   d. nursing facility beds;
   e. intermediate care beds for the mentally retarded;

f. chemical dependency treatment beds, including inpatient, residential and detoxification beds;
g. hospice inpatient facility beds; and
h. hospice residential care facility beds.

D. Establishment of new dialysis services or home health services. [N.C. Gen. Stat. 131E-176(16)d]

E. Change in project which includes cost overrun of 15% of the capital expenditure amount of an approved CON project or addition of a health service to an approved project. [N.C. Gen. Stat. 131E-176(16)e]

F. The offering of any of the following services [N.C. Gen. Stat. 131E-176(16)f]:

a. Open heart surgery;
b. Neonatal intensive care units (NICU);
c. Burn intensive care services;
d. Solid organ transplantation services; and
e. Bone marrow transplantation.

F1. The acquisition of any of the following equipment [N.C. Gen. Stat. 131E-176(16)fl]:

a. Air ambulance;
b. Cardiac catheterization and angioplasty equipment;
c. Gamma knife equipment;
d. Heart-lung bypass equipment;
e. Lithotriptor;
f. Magnetic Resonance Imaging Equipment (Mobile or Fixed); and
g. Positron Emission Tomography (PET) Equipment.

G-K. Repealed

L. The acquisition of a health service facility from a health maintenance organization. [N.C. Gen. Stat. 131E-176(16)l]

M. Conversion of non-health care beds to health care beds. [N.C. Gen. Stat. 131E-176(16)m]

N. Construction, development or establishment of a hospice, hospice inpatient facility, or hospice residential care facility. [N.C. Gen. Stat. 131E-176(16)n]

O. Opening of an additional office by an existing home health agency. [N.C. Gen. Stat. 131E-176(16)o]

P. Acquisition of major medical equipment ($750,000 including costs of studies, design, construction, renovation and installation). [N.C. Gen. Stat. 131E-176(14f)]

Q. Relocation of a health service facility from one service area to another. [N.C. Gen. Stat. 131E-176(16)q and 176(24a)]

R. Conversion of specialty ambulatory surgical program to a multispecialty ambulatory surgical

program or the addition of a specialty to a specialty ambulatory surgical program. [N.C. Gen. Stat. 131E-176(16)r, 176(15a) and 176(24c)]

S. Furnishing mobile medical equipment to any person in North Carolina if not in use in North Carolina prior to March 18, 1993. [N.C. Gen. Stat. 131E-176(16)s]

T. The relocation or expansion of part or all of an ambulatory surgical facility which requires a new license under Part D of Article 6 of this Chapter, or the relocation and addition of part or all of a hospital operating room to a building other than one within which it is currently located. [N.C. Gen. Stat. 131E-176(16)t] Ratified Bill House Bill 1184 - 1999 Legislative Session

This page was last modified on October 16, 2000

2001 COMMITTEE REPORT
HOUSE OF REPRESENTATIVES

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

☒ Committee Substitute for
S.B. 937 A BILL TO BE ENTITLED AN ACT TO REGULATE THE DEVELOPMENT OF ADULT CARE HOMES UNDER THE CERTIFICATE OF NEED LAW.

☐ 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 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)

2/15/01

VISITOR REGISTRATION SHEET

HEALTH
Name of Committee

5/29/01
Date

VISITORS: PLEASE SIGN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Jeffrey Coffey	NCALA
Lon Wilson	NCALTCF
Stacy Flannery	NCHCFA
Stephanie Gibbs	NCPA
Bob Fitzgerald	DHHS/DFS
Jim Lofchunda	DHHS/DFS
HUGH WILSON	NCHA
STEVE KEENE	NCMS
Mary Bethel	Div. of Aging/DHHS
[illegible]	SOS
Bynum Hamm	Sec of St.
Susan Williamson	NCANPHA
DAVID BARNES	Poyner + Sprull LLP
Margaret Westbrook	Kennedy Covington
Glenn Wells	DHHS
Bill Pittman	Kilpatrick Stockton
Patricia A. Young	CCHILC / FOR
JOE LIBERA	AHHC
Roger Bone	Bone + Assoc - NCALTCF
Cubby Porter	" " "

AGENDA

HOUSE COMMITTEE ON HEALTH
TUESDAY, JUNE 5, 2001
12:00 NOON, ROOM 415 LOB

OPENING REMARKS

Rep. Thomas E. Wright
Chairman

BILLS TO BE DISCUSSED

SB-160 AMEND GOOD SAMARITAN LAW/MEDICAL CARE. (Sen.Purcell)

SB-543 CONTROLLED SUBSTANCE/CLASSIF.(Sen. Forrester)

SB-826 CRIMINAL RECORD CHECK CHANGE/LONG-TERM CARE. (Sen. Rand)

COMMENTS

ADJOURNMENT

MINUTES

COMMITTEE ON HEALTH

TUESDAY, JUNE 5, 2001

12:00 NOON ROOM 415 LOB

The House Committee on Health met on Tuesday, June 5, 2001 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-160 AMEND GOOD SAMARITAN LAW/MEDICAL CARE.(Sen. Purcell)

Sen. Purcell explained the bill.

Rep. Wainwright moved to give SB-160 a favorable report. So moved.

SB-543 CONTROLLED SUBSTANCES/CLASSIF.(Sen. Forrester)

Dianna Jessup, staff, explained the bill to the committee. Rep. Earle commented on the bill. Rep. Justus asked if the drugs were new drugs. Dianna Jessup responded. Rep. Sherrill asked if the bill was technical in nature. Dianna Jessup responded. Sen. Forrester further explained the bill to the committee. Dianna Jessup further explained the statute to the committee.

Rep. Sherrill moved for a favorable report. So moved.

SB-714 AMEND CERTIFICATE OF NEED.(Sen. Rand)

Sen. Rand explained the bill.

Rep. Nye moved to give SB-714 a favorable report.

Linda Attarian,(Staff), further explained the bill. Rep. Justus asked staff about Session law 2000-135. Linda Attarian responded and asked Hugh Tilson, from the Hospital Association, to further explained that section to the committee. Hugh Tilson further explained the provision and Linda Attarian directed committee members to review the summary of the bill on page 2, section 2 for further explanation.

The question before the committee was to give SB-714 a favorable report. So moved.

The meeting adjourned at 12:50pm.

Rep. Thomas Wright, Chairman

Vanda Wilson-Wormack, Committee Assistant

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2001

S 4

SENATE BILL 160

Judiciary I Committee Substitute Adopted 4/24/01
Judiciary I Committee Substitute #2 Adopted 4/25/01
Corrected Copy 4/26/01

Short Title: Amend Good Samaritan Law/Medical Care. (Public)

Sponsors:

Referred to:

February 19, 2001

A BILL TO BE ENTITLED

AN ACT TO APPLY THE LIABILITY LIMITATIONS OF THE GOOD SAMARITAN LAW TO CERTAIN MEDICAL CARE PROVIDERS.

The General Assembly of North Carolina enacts:

SECTION 1.(a) G.S. 90-21.14(a1) is recodified as G.S. 90-21.16.

SECTION 1.(b) G.S. 90-21.16, as enacted in Section 1(a) of this act, reads as rewritten:

"**§ 90-21.16. Volunteer health care professionals; liability limitation.**

(a) This section applies as follows:

(1) Any volunteer medical or health care provider at a facility of a local health department or at a nonprofit community health center,

(2) Any volunteer medical or health care provider rendering services to a patient referred by a local health department as defined in G.S. 130A-2(5) or nonprofit community health center at the provider's place of employment,

(3) Any volunteer medical or health care provider serving as medical director of an emergency medical services (EMS) agency, ~~or~~

(4) Any retired physician holding a 'Limited Volunteer License' under G.S. 90-12(d), or

(5) Any volunteer medical or health care provider licensed or certified in this State who provides services within the scope of the provider's license or certification at a free clinic facility,

who receives no compensation for medical services or other related services rendered at the facility, center, agency, or clinic, or who neither charges nor receives a fee for medical services rendered to the patient referred by a local health department or nonprofit community health center at the provider's place of employment shall not be liable for damages for injuries or death alleged to have occurred by reason of an act or

omission in the rendering of the services unless it is established that the injuries or death were caused by gross negligence, wanton conduct, or intentional wrongdoing on the part of the person rendering the services. The free clinic, local health department facility, nonprofit community health center, or agency shall use due care in the selection of volunteer medical or health care providers, and this subsection shall not excuse the free clinic, health department facility, community health center, or agency for the failure of the volunteer medical or health care provider to use ordinary care in the provision of medical services to its patients.

(b) Nothing in this section shall be deemed or construed to relieve any person from liability for damages for injury or death caused by an act or omission on the part of such person while rendering health care services in the normal and ordinary course of his or her business or profession. Services provided by a medical or health care provider who receives no compensation for his or her services and who voluntarily renders such services at facilities of free clinics, local health departments as defined in G.S. 130A-2, nonprofit community health centers, or as a volunteer medical director of an emergency medical services (EMS) agency, are deemed not to be in the normal and ordinary course of the volunteer medical or health care provider's business or profession.

(c) As used in this section, a 'free clinic' is a nonprofit, 501(c)(3) tax-exempt organization organized for the purpose of providing health care services without charge or for a minimum fee to cover administrative costs and that maintains liability insurance covering the acts and omissions of the free clinic and any liability pursuant to subsection (a) of this section."

SECTION 2. G.S. 90-21.14(b) reads as rewritten:

"(b) Nothing in this section shall be deemed or construed to relieve any person from liability for damages for injury or death caused by an act or omission on the part of such person while rendering health care services in the normal and ordinary course of his business or profession. Services provided by a volunteer health care provider who receives no compensation for his services and who renders first aid or emergency treatment to members of athletic teams are deemed not to be in the normal and ordinary course of the volunteer health care provider's business or profession. ~~Services provided by a medical or health care provider who receives no compensation for his services and who voluntarily renders such services at facilities of local health departments as defined in G.S. 130A-2 or at a nonprofit community health center, or as a volunteer medical director of an emergency medical services (EMS) agency, are deemed not to be in the normal and ordinary course of the volunteer medical or health care provider's business or profession.~~"

SECTION 3. This act becomes effective October 1, 2001, and applies to acts or omissions occurring on and after that date.

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2001

S 2

SENATE BILL 543

Judiciary II Committee Substitute Adopted 3/28/01

Short Title: Controlled Substances/Classif.-AB. (Public)

Sponsors:

Referred to:

March 19, 2001

A BILL TO BE ENTITLED

AN ACT TO AMEND THE CLASSIFICATION OF CERTAIN CONTROLLED SUBSTANCES TO MAKE CONSISTENT WITH FEDERAL LAW GOVERNING CONTROLLED SUBSTANCES.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 90-90(1)a. reads as rewritten:

"**§ 90-90. Schedule II controlled substances.**

This schedule includes the controlled substances listed or to be listed by whatever official name, common or usual name, chemical name, or trade name designated. In determining that a substance comes within this schedule, the Commission shall find: a high potential for abuse; currently accepted medical use in the United States, or currently accepted medical use with severe restrictions; and the abuse of the substance may lead to severe psychic or physical dependence. The following controlled substances are included in this schedule:

(1) Any of the following substances whether produced directly or indirectly by extraction from substances of vegetable origin, or independently by means of chemical synthesis, or by a combination of extraction and chemical synthesis, unless specifically excepted or unless listed in another schedule:

a. Opium and opiate, and any salt, compound, derivative, or preparation of opium and opiate, excluding apomorphine, nalbuphine, dextrorphan, naloxone, naltrexone and nalmefene, and their respective salts, but including the following:

1. Raw opium.
2. Opium extracts.
3. Opium fluid extracts.
4. Powdered opium.
5. Granulated opium.
6. Tincture of opium.

7. Codeine.
8. Ethylmorphine.
9. Etorphine hydrochloride.
10. Hydrocodone.
11. Hydromorphone.
12. Metopon.
13. Morphine.
14. Oxycodone.
15. Oxymorphone.
16. Thebaine.
17. Dihydroetorphine."

SECTION 2.(a) G.S. 90-90(5) reads as rewritten:

"(5) Any material, compound, mixture, or preparation which contains any quantity of the following hallucinogenic substances, including their salts, isomers, and salts of isomers, unless specifically excepted, or listed in another schedule, whenever the existence of such salts, isomers, and salts of isomers is possible within the specific chemical designation:

~~a. Dronabinol (synthetic) in sesame oil and encapsulated in a soft gelatin capsule in a U.S. Food and Drug Administration approved drug product. [Some other names: (6aR-trans)-6a,7,8,10a-tetrahydro-6,6,9-trimethyl-3-penty 1-6H-dibenzo[b,d]pyra n-1-o1, or (-)-delta-9-(trans)-tetrahydrocannabinol].~~

b. Nabilone [Another name for nabilone: (+/-)-trans-3-(1,1-dimethylheptyl)-6,6a,7,8,10,10a-hexahydro-1-hydroxy-6,6/y-dimethyl-9H-dibenzo[b,d]pyran-9-one]."

SECTION 2.(b) G.S. 90-91 is amended by adding the following new subsection to read:

"(m) Dronabinol (synthetic) in sesame oil and encapsulated in a soft gelatin capsule in a U.S. Food and Drug Administration approved drug product. [Some other names: (6aR-trans), -6a,7,8,10a-tetrahydro-6,6,9-trimethyl-3-pentyl-6H-dibenzo [b,d]pyran-1-o1 or (-)-delta-9-(trans)-tetrahydrocannabinol]."

SECTION 3.(a) G.S. 90-91(b) reads as rewritten:

"(b) Any material, compound, mixture, or preparation which contains any quantity of the following substances having a depressant effect on the central nervous system unless specifically exempted or listed in another schedule:

1. Any substance which contains any quantity of a derivative of barbituric acid, or any salt of a derivative of barbituric acid.
2. Chlorhexadol.
3. Repealed by Session Laws 1993, c. 319, s. 5.
4. Lysergic acid.

5. Lysergic acid amide.
6. Methyprylon.
7. Sulfondiethylmethane.
8. Sulfonethylmethane.
9. Sulfonmethane.
9a. Tiletamine and zolazepam or any salt thereof. Some trade or other names for tiletamine-zolazepam combination product: Telazol. Some trade or other names for tiletamine: 2-(ethylamino)-2-(2-thienyl)-cyclohexanone. Some trade or other names for zolazepam: 4-(2-fluorophenyl)-6,8-dihydro-1,3,8-trimethylpyrazolo-[3,4-e][1,4]-diazepin-7(1H)-one. flupyrazapon.
10. Any compound, mixture or preparation containing
(i) Amobarbital.
(ii) Secobarbital.
(iii) Pentobarbital.
or any salt thereof and one or more active ingredients which are not included in any other schedule.
11. Any suppository dosage form containing
(i) Amobarbital.
(ii) Secobarbital.
(iii) Pentobarbital.
or any salt of any of these drugs and approved by the federal Food and Drug Administration for marketing as a suppository.
12. Ketamine."

SECTION 3.(b) G.S. 90-91(l) is repealed.

SECTION 4. G.S. 90-92(a) reads as rewritten:

"(a) This schedule includes the controlled substances listed or to be listed by whatever official name, common or usual name, chemical name, or trade name designated. In determining that a substance comes within this schedule, the Commission shall find: a low potential for abuse relative to the substances listed in Schedule III of this Article; currently accepted medical use in the United States; and limited physical or pyschological dependence relative to the substances listed in Schedule III of this Article. The following controlled substances are included in this schedule:

(1) Depressants. – Unless specifically excepted or unless listed in another schedule, any material, compound, mixture, or preparation which contains any quantity of the following substances, including its salts, isomers, and salts of isomers whenever the existence of such salts, isomers, and salts of isomers is possible within the specific chemical designation:
a. Alprazolam.
b. Barbital.

c. Bromazepam.
d. Camazepam.
e. Chloral betaine.
f. Chloral hydrate.
g. Chlordiazepoxide.
h. Clobazam.
i. Clonazepam.
j. Clorazepate.
k. Clotiazepam.
l. Cloxazolam.
m. Delorazepam.
n. Diazepam.
o. Estazolam.
p. Ethchlorvynol.
q. Ethinamate.
r. Ethyl loflazepate.
s. Fludiazepam.
t. Flunitrazepam.
u. Flurazepam.
v. Repealed by Session Laws 2000, c. 140, s. 92.2(c).
w. Halazepam.
x. Haloxazolam.
y. Ketazolam.
z. Loprazolam.
aa. Lorazepam.
bb. Lormetazepam.
cc. Mebutamate.
dd. Medazepam.
ee. Meprobamate.
ff. Methohexital.
gg. Methylphenobarbital (mephobarbital).
hh. Midazolam.
ii. Nimetazepam.
jj. Nitrazepam.
kk. Nordiazepam.
ll. Oxazepam.
mm. Oxazolam.
nn. Paraldehyde.
oo. Petrichloral.
pp. Phenobarbital.
qq. Pinazepam.
rr. Prazepam.

ss. Quazepam.
tt. Temazepam.
uu. Tetrazepam.
vv. Triazolam.
ww. Zolpidem.
xx. Zaleplon.

(2) Any material, compound, mixture, or preparation which contains any of the following substances, including its salts, or isomers and salts of such isomers, whenever the existence of such salts, isomers, and salts of isomers is possible:
a. Fenfluramine.
b. Pentazocine.

(3) Stimulants. – Unless specifically excepted or unless listed in another schedule, any material, compound, mixture, or preparation which contains any quantity of the following substances having a stimulant effect on the central nervous system, including its salts, isomers (whether optical, position, or geometric), and salts of such isomers whenever the existence of such salts, isomers, and salts of isomers is possible within the specific chemical designation:
a. Diethylpropion.
b. Mazindol.
c. Pemoline (including organometallic complexes and chelates thereof).
d. Phentermine.
e. Cathine.
f. Fencamfamin.
g. Fenproporex.
h. Mefenorex.
i. Sibutramine.
j. Modafinil.

(4) Other Substances. – Unless specifically excepted or unless listed in another schedule, any material, compound, mixture or preparation which contains any quantity of the following substances, including its salts:
a. Dextropropoxyphene (Alpha-(plus)-4-dimethylamino-1, 2-diphenyl-3-methyl-2-propion oxybutane).
b. Pipradrol.
c. SPA ((-)-1-dimethylamino-1, 2-diphenylethane).
d. Butorphanol.

(5) Narcotic Drugs. – Unless specifically excepted or unless listed in another schedule, any material, compound, mixture, or preparation

containing limited quantities of any of the following narcotic drugs, or any salts thereof:

a. Not more than 1 milligram of difenoxin and not less than 25 micrograms of atropine sulfate per dosage unit.

b. Buprenorphine."

SECTION 5. This act is effective when it becomes law.

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2001

S 2

SENATE BILL 714

Health Care Committee Substitute Adopted 4/5/01

110-1 2nd 3rd rye

Short Title: Amend Certificate of Need. (Public)

Sponsors:

Referred to:

March 28, 2001

A BILL TO BE ENTITLED

AN ACT TO AMEND THE DEFINITION OF "AMBULATORY SURGICAL FACILITY" BY REDUCING THE NUMBER OF REQUIRED OPERATING ROOMS FROM TWO TO ONE AND TO AMEND THE DEFINITION OF "NEW INSTITUTIONAL HEALTH SERVICE" BY INCLUDING CONSTRUCTION, DEVELOPMENT, ESTABLISHMENT, INCREASE IN NUMBER, OR RELOCATION OF AN OPERATING ROOM OR OPERATING ROOMS AND TO EXTEND THE DETERMINATIVE EFFECT OF THE STATE MEDICAL FACILITIES PLAN TO ALL OPERATING ROOMS AND TO REPEAL S.L. 2000-135.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 131E-146 reads as rewritten:

"**§ 131E-146. Definitions.**

As used in this Part, unless otherwise specified:

(1) 'Ambulatory surgical facility' means a facility designed for the provision of a specialty ambulatory surgical program or a multispecialty ambulatory surgical program. An ambulatory surgical facility serves patients who require local, regional or general anesthesia and a period of post-operative observation. An ambulatory surgical facility may only admit patients for a period of less than 24 hours and must provide at least ~~two~~ one designated operating ~~rooms~~room and at least one designated recovery room, have available the necessary equipment and trained personnel to handle emergencies, provide adequate quality assurance and assessment by an evaluation and review committee, and maintain adequate medical records for each patient. An ambulatory surgical facility may be operated as a part of a physician or dentist's office, provided the facility is licensed under G.S. Chapter 131E, Article 6, Part D, but the performance of incidental, limited ambulatory surgical procedures which do not

constitute an ambulatory surgical program as defined in subdivision (1a) and which are performed in a physician or dentist's office does not make that office an ambulatory surgical facility.

(1a) 'Ambulatory surgical program' means a formal program for providing on a same-day basis those surgical procedures which require local, regional or general anesthesia and a period of post-operative observation to patients whose admission for more than 24 hours is determined, prior to surgery, to be medically unnecessary.

(2) 'Commission' means the North Carolina Medical Care Commission."

SECTION 2. G.S. 131E-176 reads as rewritten:

"**§ 131E-176. Definitions.**

As used in this Article, unless the context clearly requires otherwise, the following terms have the meanings specified:

...

(1a) 'Ambulatory surgical facility' means a facility designed for the provision of a specialty ambulatory surgical program or a multispecialty ambulatory surgical program. An ambulatory surgical facility serves patients who require local, regional or general anesthesia and a period of post-operative observation. An ambulatory surgical facility may only admit patients for a period of less than 24 hours and must provide at least ~~two~~ one designated operating ~~rooms~~room and at least one designated recovery room, have available the necessary equipment and trained personnel to handle emergencies, provide adequate quality assurance and assessment by an evaluation and review committee, and maintain adequate medical records for each patient. An ambulatory surgical facility may be operated as a part of a physician or dentist's office, provided the facility is licensed under G.S. Chapter 131E, Article 6, Part D, but the performance of incidental, limited ambulatory surgical procedures which do not constitute an ambulatory surgical program as defined in subdivision (1b) and which are performed in a physician's or dentist's office does not make that office an ambulatory surgical facility.

...

(16) 'New institutional health services' means any of the following:

...

u. The construction, development, establishment, increase in the number, or relocation of an operating room or operating rooms, other than the relocation of an operating room or operating rooms within the same building or on the same grounds or to grounds not separated by more than a public right-of-way adjacent to the grounds where the operating room is or operating rooms are currently located."

SECTION 3. G.S. 131E-183(a)(1) reads as rewritten:

"(a) The Department shall review all applications utilizing the criteria outlined in this subsection and shall determine that an application is either consistent with or not in conflict with these criteria before a certificate of need for the proposed project shall be issued.

(1) The proposed project shall be consistent with applicable policies and need determinations in the State Medical Facilities Plan, the need determination of which constitutes a determinative limitation on the provision of any health service, health service facility, health service facility beds, dialysis stations, ~~ambulatory surgical~~ operating rooms, or home health offices that may be approved."

SECTION 4. S.L. 2000-135 is repealed.

SECTION 5. This act is effective when it becomes law. This act shall not apply to any project which was not a new institutional health service as defined in G.S. 131E-176(16) prior to the effective date of this act and for which there has been a capital expenditure exceeding fifty thousand dollars ($50,000) or there was a legally binding obligation for a capital expenditure exceeding fifty thousand dollars ($50,000) in effect on or before the effective date of this act and which was reasonably expected to be completed by December 31, 2002. A facility or office that was not licensed as an ambulatory surgical facility prior to the effective date of this act shall not become an ambulatory surgical facility by virtue of the amendment set forth in Sections 1 and 2 of this act and may not be licensed as an ambulatory surgical facility under Part D of Article 6 of Chapter 131E of the General Statutes without a certificate of need.

2001 COMMITTEE REPORT
HOUSE OF REPRESENTATIVES

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

☒ Committee Substitute for
S.B. 160 A BILL TO BE ENTITLED AN ACT TO APPLY THE LIABILITY LIMITATIONS OF THE GOOD SAMARITAN LAW TO CERTAIN MEDICAL CARE PROVIDERS.

☒ 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)

2/15/01

2001 COMMITTEE REPORT
HOUSE OF REPRESENTATIVES

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

☒ Committee Substitute for
S.B. 543 A BILL TO BE ENTITLED AN ACT TO AMEND THE CLASSIFICATION OF CERTAIN CONTROLLED SUBSTANCES TO MAKE CONSISTENT WITH FEDERAL LAW GOVERNING CONTROLLED SUBSTANCES.

☒ 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)

2/15/01

2001 COMMITTEE REPORT
HOUSE OF REPRESENTATIVES

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

☒ Committee Substitute for
S.B. 714 A BILL TO BE ENTITLED AN ACT TO AMEND THE DEFINITION OF "AMBULATORY SURGICAL FACILITY" BY REDUCING THE NUMBER OF REQUIRED OPERATING ROOMS FROM TWO TO ONE AND TO AMEND THE DEFINITION OF "NEW INSTITUTIONAL HEALTH SERVICE" BY INCLUDING CONSTRUCTION, DEVELOPMENT, ESTABLISHMENT, INCREASE IN NUMBER, OR RELOCATION OF AN OPERATING ROOM OR OPERATING ROOMS AND TO EXTEND THE DETERMINATIVE EFFECT OF THE STATE MEDICAL FACILITIES PLAN TO ALL OPERATING ROOMS AND TO REPEAL S.L. 2000-135.

☒ 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)

2/15/01

VISITOR REGISTRATION SHEET

Health — 06-05-01
Name of Committee — Date

VISITORS:. PLEASE SIGN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Steve Keene	NC Medical Society
Chris Carter	Bone & Associates
	NC Medical Society
	DHHS
Gary Salvino.	GSK
WB Robinson	NCSA / MD of the Day
Jesse Goodman	DHHS - DFS
Ed Regan	N.C.A.C.C.
	NCAHA
Clark Gaither, M.D.	N.C. Assoc. of Fee Clinics
Michelle Cotter	Dmit Idol SAS
John Mills	NC Assoc of Free Clinics
DAVID BARNES	Poyner + Spruill
	AHHC
	"
	NCHCFA
	NCHA
	Medimmune.
Heather T. Cureton	Leadership Anson / Anson Community Hospital
Scott Collier	Leadership Anson / South Piedmont Comm. College
	DURHS
Bill Wilson	NC Academy of Trial Lawyers
Carol Teal	Friends of Residents in Long Term Care
James Palmer	Research Div.
Christy Wilhelm	Research Division
Joanne Schoen Stevens	NC Nurses Assoc.

VISITOR REGISTRATION SHEET

Health — 06-05-01

Name of Committee — Date

VISITORS:. PLEASE SIGN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Carole Lawler	EGHS
Stephanie Gibbs	NCPA
Sandy Sanders	WFSR

AGENDA

HOUSE COMMITTEE ON HEALTH
TUESDAY, June 12, 2001
12:00 Noon, ROOM 544 LOB

OPENING REMARKS

Rep. Thomas E. Wright
Chairman

SPECIAL PRESENTATION

Dr. Beny J. Primm
Executive Director of the Addiction & Research Health Treatment Corporation
(Brooklyn, NY)

BILLS TO BE DISCUSSED

HB-1405 HIV/AIDS PUBLIC HEALTH CRISIS. (Rep. Wright)

COMMENTS

ADJOURNMENT

MINUTES

HOUSE COMMITTEE ON HEALTH

TUESDAY, JUNE 12, 2001

12:00 NOON ROOM 544-LOB

The House Committee on Health on Tuesday, June 12, 2001 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.

HB-1405 HIV/AIDS PUBLIC HEALTH CRISIS. (Rep. Wright)

Chairman Wright introduced Dr. Beny Primm, the Executive Director of the Addiction and Research Health Treatment Corporation of Brooklyn New York, to make a presentation about the HIV/AIDS crisis in North Carolina, as well as, the United States. Dr. Beny Primm made the presentation to the committee (see presentation document). In addition, Chairman Wright introduced Mr. Bill Hinchey, of the OraSure Group, to make a special presentation about the latest test used to detect the HIV/AIDS virus in the body (see attachment). Chairman Wright opened the floor for discussion. Rep. Insko asked if there was statistical data from other industrialized countries. Dr. Primm responded. Rep. Insko followed up with a question about the economic level of the people affected most by HIV/AIDS. Dr. Primm responded. Chairman Wright commented on the importance of the legislation being passed. Secretary Carmen Hooker-Buell, of the Department of Health and Human Services, commented on the presentation and stated her support of HB-1405. Dr. Primm gave final comments on the issue.

The meeting adjourned at 1:00pm

Rep. Thomas E. Wright, Chairman

Vanda Wilson-Wormack, Committee Assistant

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2001

HOUSE BILL 1405

Short Title:	HIV/AIDS Public Health Crisis.	(Public)
Sponsors:	Representatives Wright; Adams, Bell, Blue, Bonner, Boyd-McIntyre, Cunningham, Earle, Fitch, Fox, Haire, Hall, Hunter, Lucas, Luebke, McAllister, Michaux, Miller, Oldham, Wainwright, and Womble.	
Referred to:	Health.	

April 26, 2001

A BILL TO BE ENTITLED

AN ACT FINDING THAT A PUBLIC HEALTH EMERGENCY EXISTS IN NORTH CAROLINA IN REGARDS TO HIV/AIDS; INCREASING THE INCOME ELIGIBILITY CAP OF THE AIDS DRUG ASSISTANCE PROGRAM; INCREASING FUNDING FOR HIV/AIDS PREVENTION EFFORTS; AND DIRECTING THE DEPARTMENT OF HEALTH AND HUMAN SERVICES TO STUDY PROGRAMS RELATING TO HIV/AIDS PREVENTION AND CARE.

Whereas, over 6,600 North Carolinians have died of HIV/AIDS and currently over 13,000 North Carolinians are known to be living with HIV/AIDS; and

Whereas, the actual number of people living with HIV/AIDS in North Carolina is likely higher since it has been estimated that up to one-third of individuals in the United States who are HIV-positive are undiagnosed; and

Whereas, during year 2000 alone, 1,477 new cases of HIV/AIDS were reported in North Carolina; and

Whereas, HIV infection makes an individual more susceptible to numerous other diseases such as pneumonia, Hodgkin's disease, cervical cancer, testicular cancer, Kaposi's sarcoma, and certain types of lymphoma; and

Whereas, antiretroviral therapies for people living with HIV/AIDS alone can cost $10,000 to $12,000 annually per person with other medical treatments bringing total medical costs per person to $20,000 annually; and

Whereas, minority communities in North Carolina have been particularly affected by HIV/AIDS in that over seventy percent of reported cases of HIV/AIDS in North Carolina are attributed to members of minority communities; and

Whereas, almost an entire generation of North Carolinians has been born since the beginning of the AIDS epidemic, and there is still no cure in sight, and the

Centers for Disease Control and Prevention states that the epidemic is far from over; and

Whereas, nationwide, AIDS is the leading cause of death of African-Americans aged 25-44, the second leading cause of death of Latino-Americans aged 25-44, and the fifth leading cause of death of all Americans aged 25-44; and

Whereas, nationwide, AIDS is the leading cause of death of African-American women aged 25-44 and the fourth leading cause of death of all American women aged 25-44; and

Whereas, women represent the fastest growing group of new HIV infections in the United States; and

Whereas, the most common route of HIV transmission among women in the United States is through heterosexual transmission; and

Whereas, despite dramatic medical advances, AIDS remains a serious and usually fatal disease that requires costly, complex, and difficult treatment regimens; and

Whereas, the number of new HIV infections each year has not decreased, but has remained steady at approximately 40,000 new infections per year in the United States alone; and

Whereas, while the number of AIDS cases has decreased over recent years, the number of people living with HIV/AIDS has increased; and

Whereas, research suggests that some individuals are less concerned about becoming infected than in the past and may therefore be more inclined to engage in higher-risk behaviors; and

Whereas, the Centers for Disease Control and Prevention has asserted that complacency about the need of HIV prevention may be among the strongest barriers communities face in planning for prevention needs; Now, therefore,

The General Assembly of North Carolina enacts:

SECTION 1. The General Assembly finds that a public health crisis exists in North Carolina in regards to the HIV/AIDS epidemic. This finding does not constitute a declaration of a state of emergency under Article 36A of Chapter 14 of the General Statutes or a declaration of a state of disaster under Chapter 166A of the General Statutes.

SECTION 2. For the 2001-2003 fiscal biennium, HIV-positive individuals with incomes at or below two hundred fifty percent (250%) of the federal poverty level are eligible for participation in the AIDS Drug Assistance Program (ADAP). All individuals who are eligible for participation in ADAP shall be served by the Department of Health and Human Services. There is appropriated from the General Fund to the Department of Health and Human Services, Division of Public Health, the sum of four million five hundred thousand dollars ($4,500,000) for the 2001-2002 fiscal year and the sum of four million five hundred thousand dollars ($4,500,000) for the 2002-2003 fiscal year to carry out the provisions of this section.

SECTION 3. There is appropriated from the General Fund to the Department of Health and Human Services, Division of Public Health, the sum of one million dollars ($1,000,000) for the 2001-2002 fiscal year and the sum of one million dollars ($1,000,000) for the 2002-2003 fiscal year for community-based intervention

efforts to combat the HIV/AIDS epidemic. Funds appropriated under this section shall be allocated as follows:

(1) $300,000 each fiscal year to increase, by over 600,000 persons, the capacity of existing community-based organizations to provide outreach services to individuals at risk for HIV/AIDS.

(2) $300,000 each fiscal year to increase the capacity of local health departments in counties where increased community-based organization efforts occur for the examination and treatment of persons referred by the community-based organizations and to establish alternate counseling and testing sites that are based either at the local health department or at the community-based organization.

(3) $400,000 each fiscal year to provide funding for the development of new community-based organizations to provide outreach and referral services for persons at risk for HIV/AIDS. The primary focus of no fewer than one-half of the community-based organizations developed with funds allocated by this subdivision shall be services to racial and ethnic minority populations across the State.

SECTION 4. The Department of Health and Human Services shall study ways to improve HIV/AIDS prevention and care programs. The Department shall report to the General Assembly on the results of the study no later than May 1, 2002. The study shall include the following:

(1) Ways to improve the efficiency of current HIV/AIDS prevention and care programs to ensure that current available funds are put to the optimal use. This study shall include an analysis of the changing demographics of the HIV/AIDS epidemic to ensure that prevention funds are targeted at population subgroups most at risk.

(2) A review of prevention programs operated by other states or localities that are not currently offered by this State. This review shall include a study of the effectiveness of the programs, any barriers to offering the programs in this State, an estimate of the costs involved with offering these programs, and ways in which a specific program might be adapted to meet the needs of this State.

(3) A study of the effectiveness of various clean and safe syringe exchange programs operated in other jurisdictions. This study shall look at various models for clean and safe syringe exchange programs, such as government-funded programs, privately-funded programs, and jurisdictions where purchases of sterile syringes have been deregulated. This study shall include an analysis of transmission rates before and after the establishment of the program and of illegal drug usage rates before and after the establishment of the program.

(4) A study of the feasibility of requiring the use of safer syringes.

(5) Any other matter the Department finds relevant to the issue.

SECTION 5. This act becomes effective July 1, 2001.

HOUSE BILL 1405:
HIV/AIDS Public Health Crisis

BILL ANALYSIS

Committee:	House Health	**Introduced by:**	Rep. Wright
Date:	June 12, 2001	**Summary by:**	Dianna Jessup
Version:	First Edition		Committee Counsel

SUMMARY: ***House Bill 1405 would raise the eligibility income limit for participation in the Aids Drug Assistance Program from 125% of poverty to 250% of poverty, appropriate funds for community-based intervention efforts to combat HIV/AIDS, and require the Department of Health and Human Services to study ways to improve HIV/AIDS prevention and care programs. The act would become effective July 1, 2001.***

CURRENT LAW: The Aids Drug Assistance Program (ADAP) provides assistance to low-income, uninsured, HIV-positive individuals for purchasing medications. Currently, HIV-positive individuals with incomes at or below 125% of the federal poverty level ($10,737 per year) are eligible. The Program is funded using a combination of State and federal funds. Last biennium, a total of $13.3 million of State funds were allocated to the program.

During the last biennium, the Department of Health and Human Services was directed to study the estimated participation rates and costs if eligibility for participation in ADAP were raised to 200% of poverty or to 250% of poverty and report its results by May 15, 2000. The Department in that report projected a cost of $17.8 million to raise the eligibility level to 250% of poverty.

BILL ANALYSIS: If enacted, H1405 would do the following:

- There would be a finding by the General Assembly that a public health crisis exists in this State in regards to the HIV/AIDS epidemic. This finding would have no legal effect but would constitute an expression of the General Assembly's opinion on this issue.
- Additional persons, i.e. those persons earning income between 125% and 250% of poverty ($24,475 per year), would be entitled to assistance under ADAP.
- A total of $2,000,000 would be appropriated over the next biennium to fund community-based intervention efforts to combat HIV/AIDS, allocated to increase the capacity of community-based organizations to provide outreach, increase the capacity of local health departments to examine and treat persons with HIV/AIDS and to establish alternate counseling and testing sites, and to provide funding to develop new community-based organizations to provide outreach and referral persons for persons at risk for HIV/AIDS.
- DHHS would study ways to improve HIV/AIDS prevention and care programs, including ways to improve the efficiency of current HIV/AIDS prevention, a review of prevention programs operated by other states that are not currently offered by this State, a study of the effectiveness of various clean and safe syringe exchange programs operated in other jurisdictions, a study of the feasibility of requiring the use of safer syringes, and any other matter DHHS finds relevant.

BACKGROUND: All states currently operate some type of HIV/AIDS drug assistance program, and 37 states contribute state funds to the program. Eligibility varies, as shown in the chart below.

The chart below lists the available financing states have for ADAP:

State	Total FY 2000 Est. ADAP Budget (Federal/State Sources)	State $ Contribution as % of Total Budget	Financial Eligibility as % of FPL	Number of ADAP Clients Served in June 2000
Alabama	$6,481,619	3%	250%	596
Alaska	$363,662	0%	300%	26
Arizona	$6,687,395	15% (20%)	300% (200%)	677
Arkansas	$2,350,012	0%	300%	248
California	$131,667,849	34%	400%	12,693
Colorado	$6,397,010	17% (20%)	185%	663
Connecticut	$9,519,518	6% (7%)	300%	784
Delaware	$2,133,666	0%	230%	161
DC	$9,100,340	4% (3%)	300%	625
Florida	$68,212,766	13%	350% (300%)	10,500
Georgia	$22,014,790	12% (10%)	300% (125%)	2,312
Guam*	n/a	n/a	n/a	n/a
Hawaii	$2,121,873	25% (21%)	400%	140
Idaho	$559,828	36% (31%)	200%	85
Illinois	$23,990,143	30% (33%)	400%	2,211
Indiana	$7,831,232	0%	300%	292
Iowa	$1,006,312	0%	200%	128
Kansas	$1,825,106	0%	300%	366
Kentucky	$3,200,000	3%	300%	323
Louisiana	$9,275,299	0%	200%	1,538
Maine	$654,110	9% (10%)	200%	82
Maryland	$17,201,474	3% (4%)	400%	1,284
Massachusetts	$12,838,436	16% (23%)	<$27,000 p.a.	945
Michigan	$7,773,145	0%	450% (362%)	500
Minnesota	$3,668,309	35% (7%)	300%	328
Mississippi	$5,426,959	14%	400%	457
Missouri	$8,143,296	27% (29%)	300%	764
Montana	$349,990	0%	300% (need based)	38

Nebraska	$919,249	16% (19%)	200%	105
Nevada	$4,664,738	28% (30%)	400%	529
New Hampshire	$910,476	5% (0%)	300%	101
New Jersey	$33,713,926	5% (3%)	500%	2,416
New Mexico	$3,749,100	60% (62%)	300%	293
New York	$126,434,198	7% (5%)	<$44,000 p.a.	10,824
North Carolina	$12,381,432	39% (55%)	125%	662
North Dakota	$83,474	0%	150%	14
Ohio	$13,344,775	38% (41%)	281%	1,260
Oklahoma	$3,820,365	21% (22%)	150%	374
Oregon	$3,119,691	0% (2%)	325%	334
Pennsylvania	$26,952,661	35% (38%)	<$30,000 p.a.	1,941
Puerto Rico	$29,523,100	14% (23%)	certified as indigent	2,625
Rhode Island	$1,768,377	0%	400%	220
South Carolina	$7,975,048	6% (8%)	300%	746
South Dakota	$155,000	0%	300%	27
Tennessee	$6,469,509	0%	300%	159
Texas	$48,878,282	21% (26%)	200%	5,501
Utah	$1,447,976	5% (9%)	sliding scale	123
Vermont	$460,156	43%	200%	56
Virgin Islands*	n/a	n/a	n/a	n/a
Virginia	$14,886,652	18% (9%)	250% (200%)	1,320
Washington	$7,766,199	15% (2%)	370%	717
West Virginia	$1,113,626	9% (7%)	250%	132
Wisconsin	$2,955,551	14% (12%)	200%	278
Wyoming*	$105,536	0%	300%	n/a

Source: National ADAP Monitoring Project: Annual Report, March 2001, National Alliance of State and Territorial AIDS Directors (NASTAD) & AIDS Treatment Data Network.

*Guam, the Virgin Islands, and Wyoming did not respond to the survey. Wyoming's figures are based on those reported in 1998.

As of September, 2000, 17 states (Alaska, California, Connecticut, Hawaii, Illinois, Maine, Maryland, Massachusetts, Minnesota, New Hampshire (pilot project), New Mexico, New York, Oregon, Rhode Island, Vermont, Washington and Wisconsin, allow needle exchange programs to operate. These states differ in their approach to the issue. Although some of these states authorize needle exchange programs, other of these states has removed the legal barriers to needle exchanges without formally authorizing programs.

Amy Currie, Research Assistant, contributed to this summary.

H1405-SMSW-001

BIOGRAPHY

Beny J. Primm, M.D.

Dr. Primm has been the Executive Director of the Addiction Research and Treatment Corporation (A.R.T.C.) of Brooklyn, New York since its inception in 1969. As one of the largest minority non-profit community based substance abuse treatment programs in the country, the A.R.T.C. provides a multi-modality service and treatment program for approximately twenty-three-hundred men and women who are primarily members of severely underserved populations.

Pursuant to the corporation's commitment to treatment related research, collaborative endeavors are currently in progress with the National Institute on Drug Abuse/Veterans Administration, Augouron Pharmaceuticals, and Glaxo SmithKline.

Since 1983, Dr. Primm has served as President of the Urban Resource Institute, a non-profit organization that was established to provide supportive social and medical services to critical populations within New York City. Among them are multi-service shelters for battered women and their children, intermediate care facilities and other services for mentally challenged individuals, and out-patient alcoholic treatment services.

In recognition of his world-renowned authority on the Human Immunodeficiency Virus (HIV), addiction and AIDS, Dr. Primm was appointed to the Presidential Commission of the Human Immunodeficiency Virus Epidemic in 1987. In that capacity, Dr. Primm represented the U.S. at a meeting of the World Health Organization (W.H.O.), Geneva, Switzerland, and at the International Conference for Ministers of Health on AIDS Prevention in London.

Dr. Primm has served special committees on drug and alcohol problems for the W.H.O. on several occasions and has represented state and federal governments at special meetings in other European, and African countries, and the Caribbean. He is the chairman of the Board of Directors of the National Minority AIDS Council and is the 1st vice chairman of the National Black Leadership Commission on AIDS.

Dr. Primm has been a frequent consultant to the Drug Abuse Policy Office of the White House, beginning with the Nixon Administration, which established the first National Drug Policy Office.

In 1989 Dr. Primm as appointed by the Secretary of Health and Human Services to direct the Federal government's Center for Substance Abuse Treatment (CSAT), formerly known as the Office for Treatment Improvement (OTI).

In that capacity Dr. Primm was responsible for the development of programs, policies and initiatives relating to the treatment of addictive disorders and the improvement of the quality and effectiveness of substance abuse treatment as well as treatment capacity

expansion for the United States and it's territories. Dr. Primm's tenure as director of CSAT ended in May 1993.

Dr. Primm is widely published in treatment of drug abuse and related disorders in peer journals and textbooks.

He has presented testimonies on the medical, social and political consequences of substance abuse before the United States Congress and Senate.

He has lectured at colleges, universities, in ecumenical settings, before organizations representing the medical, and psycho-social disciplines, the business community, political representatives, and community organizations.

Dr. Primm is known nationally and internationally for his total commitment to substance abuse treatment and the treatment of the psychological, social and economic ills that fuel that disease. He teaches that all treatment modalities can be effective, that drug treatment must be mainstreamed with other human focused disciplines and finally that integration of those disciplines is the bedrock for effective treatment.

He is the recipient of numerous awards and in November 2000, was granted the Surgeon General's Medallion for U.S. Public Health Service for his lifetime of leadership in mental health and substance abuse treatment in the battle against the AIDS Epidemic.

Dr. Primm earned his medical degree from the University of Geneva, Geneva, Switzerland.

Epidemiology of HIV/AIDS in North Carolina and the United States

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United States

Of the 753,907 cumulative AIDS cases in U.S. residents reported to CDC through June, 2000:

- 43% were White
- 38% were Black
- 18% were Latino
- <1% were Asian and Pacific Islander
- <1% were American Indian/Alaska Native

Source: CDC. HIV/AIDS Surveillance Report. Atlanta: US Department of Health and Human Services, Public Health Service, 2000 (Vol. 12, no. 1).

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United States

Of the 753,907 cumulative AIDS cases in U.S. residents reported to CDC through June, 2000, African Americans accounted for:

- 38% of total cases
- 33% of cases in men
- 57% of cases in women
- 56% of cases in children (<19 yrs.)

Source: CDC. HIV/AIDS Surveillance Report. Atlanta: US Department of Health and Human Services, Public Health Service, 2000 (Vol. 12, no. 1).

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United States

Of the 43,517 AIDS cases reported July, 1999 – June, 2000 African Americans accounted for:

- 48% of total cases
- 42% of cases in men
- 63% of cases in women
- 67% of cases in children

Source: CDC. HIV/AIDS Surveillance Report. Atlanta: US Department of Health and Human Services, Public Health Service, 2000 (Vol. 12, no. 1).

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United States

Through June, 2000, 36 states have reported 130,352 cases of HIV infection* among adults and children.

Of these cases

- 52% were African American
- 37% were White
- 8% were Hispanic
- <1% were American Indian/Alaska Native
- <1% were Asian/Pacific Islander

* Cases of HIV infection includes those who have not progressed to AIDS

Source: CDC. HIV/AIDS Surveillance Report. Atlanta: US Department of Health and Human Services, Public Health Service, 2000 (Vol. 12, No.1).

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Impact of HIV/AIDS – United States

Of the estimated 40,000 new HIV infections per year; more than half are in African Americans (over 50 each day)

1 in 50 African American men and 1 in 160 African American women are infected with HIV

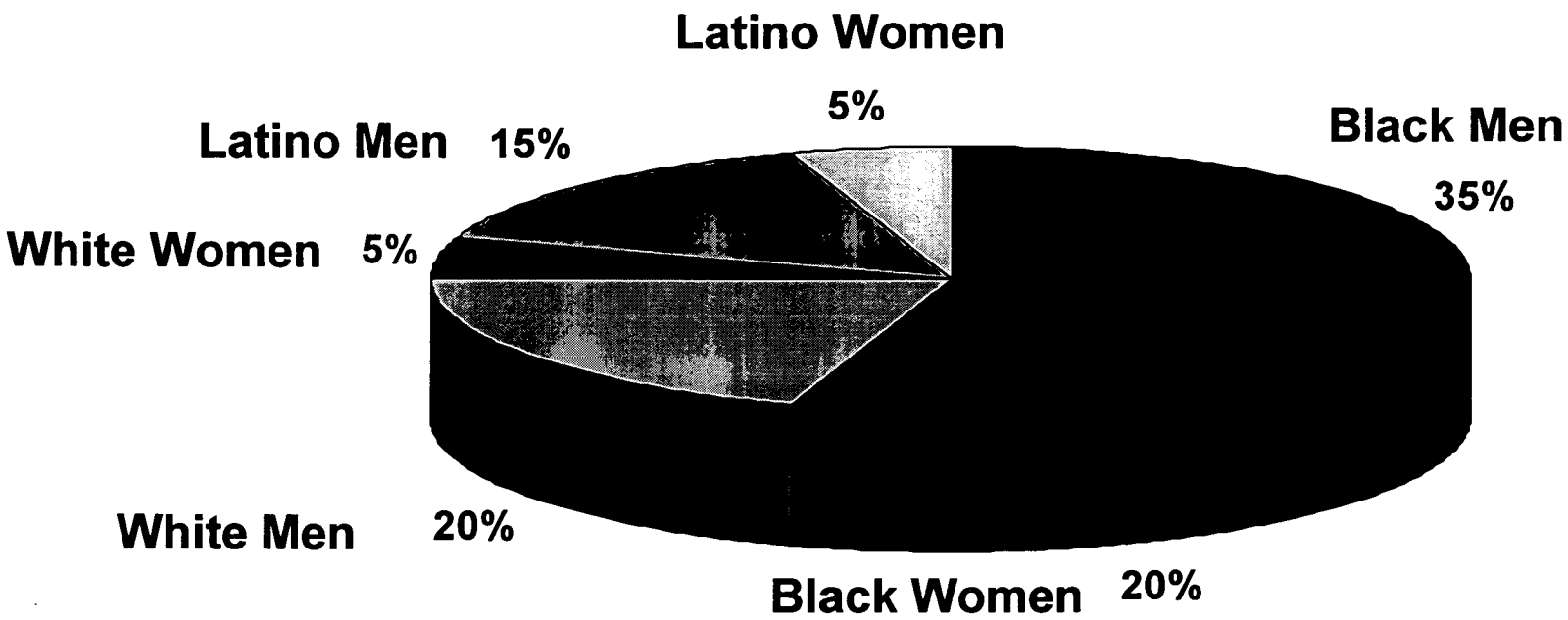
Currently, 118,525 African Americans are living with AIDS

240,000-325,000 African Americans are infected with HIV

Source: CDC. Fact Sheet: Critical need to pay attention to HIV prevention for African Americans. NCHSTP, June 1998.

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Estimates of New Infections Occurring by Gender and Race, 1999



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In North Carolina, the majority of all HIV and AIDS cases are in African Americans

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Key Findings of HIV and AIDS Cases
North Carolina

- HIV Disease Cases*
  - 20,525 cumulative cases, 14,399 in African Americans
  - 13,806 prevalence cases
  - 1,477 annual cases (2000), 1,065 in African Americans
- AIDS Cases
  - 10,329 cumulative cases, 6,740 in African Americans
  - 4,538 prevalence cases
  - 686 annual cases (2000), 490 in African Americans

*HIV Disease Cases – All reports of HIV and AIDS

Source: North Carolina 2000 HIV/AIDS Surveillance Report, HIV/STD Prevention and Care Branch, Epidemiology and Special Studies Unit, North Carolina Department of Health and Human Services, Division of Public Health

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Health Disparities in HIVAIDS
North Carolina

- Relative incidence of HIV/AIDS has increased through the 1990s among women (African American), and Latinos

- Women represented 22.7% of all HIV disease reports in 1990 and 32.4% in 1999 (43% increase)

- African American women represented 18.4% of all HIV disease reports in 1990 and 26% in 1999 (41% increase)

*HIV Disease Cases – All reports of HIV and AIDS
Source: North Carolina 2000 HIV/AIDS Surveillance Report, HIV/STD Prevention and Care Branch, Epidemiology and Special Studies Unit, North Carolina Department of Health and Human Services, Division of Public Health

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Health Disparities in HIVAIDS
North Carolina

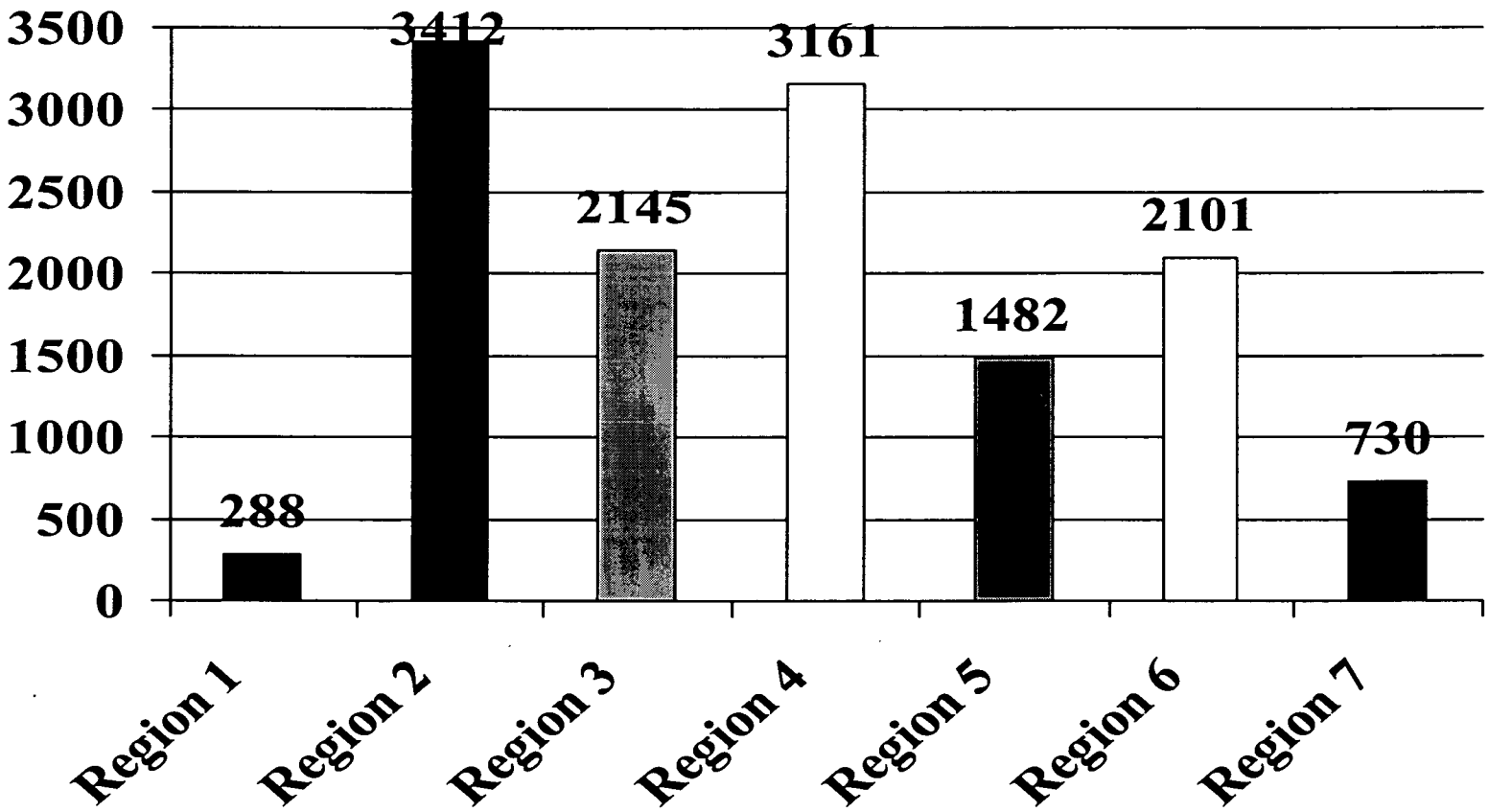
- Latinos represented less than 1% of all HIV disease reports in 1990 and 3% in 1999 (2% increase)

- African American women represented 13.5% of all AIDS cases in 1990 and 23.1% in 1999 (71% increase)

*HIV Disease Cases – All reports of HIV and AIDS
Source: North Carolina 2000 HIV/AIDS Surveillance Report, HIV/STD Prevention and Care Branch, Epidemiology and Special Studies Unit, North Carolina Department of Health and Human Services, Division of Public Health

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African American HIV Disease Cases* by Region North Carolina through 1999

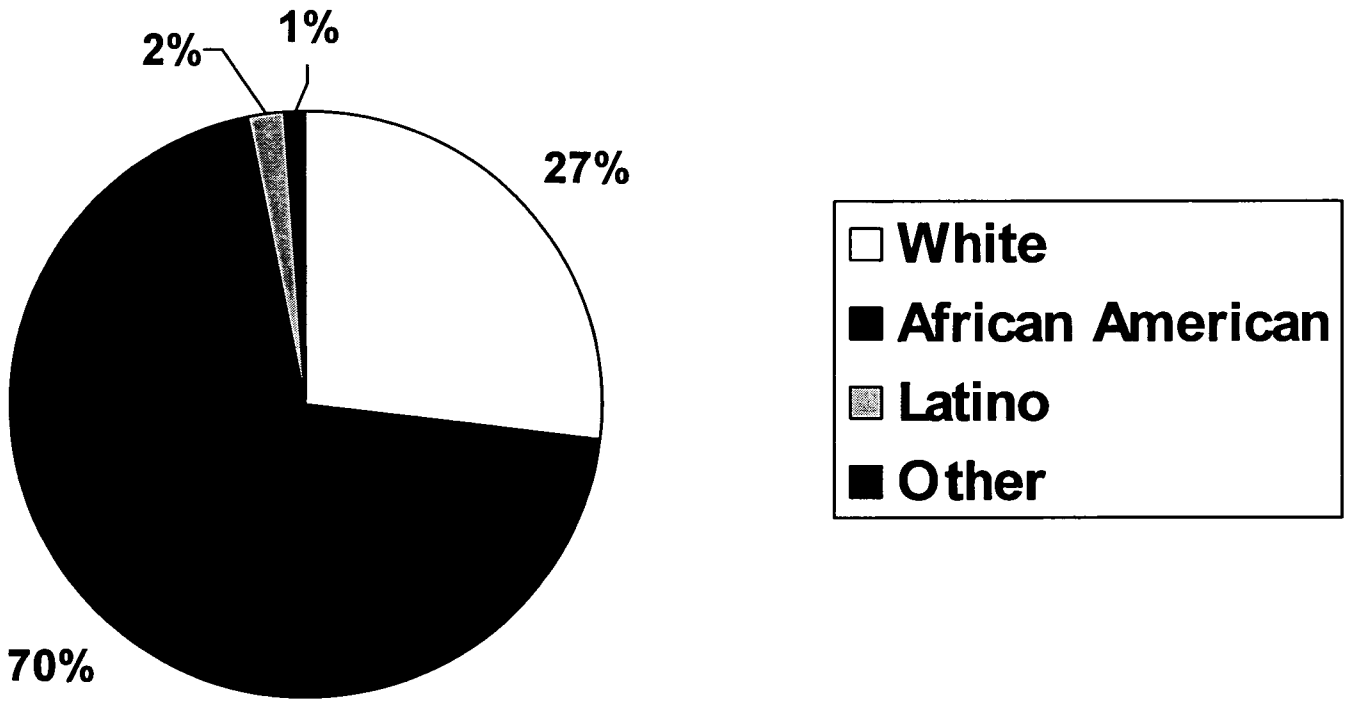


*HIV Disease Cases – All reports of HIV and AIDS

Source: North Carolina 2001 HIV/AIDS Epidemiologic Profile, HIV/STD Prevention and Care Branch, Epidemiology and Special Studies Unit, North Carolina Department of Health and Human Services, Division of Public Health

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HIV Disease Cases* by Race/Ethnicity, North Carolina, through December, 2000



*HIV Disease Cases – All reports of HIV and AIDS

Source: North Carolina 2000 HIV/AIDS Surveillance Report, HIV/STD Prevention and Care Branch, Epidemiology and Special Studies Unit, North Carolina Department of Health and Human Services, Division of Public Health

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Disproportionate Impact of HIV Disease by Race

Race/Ethnicity	(%) NC Population	(%) HIV Disease Cases thru 2000
White	72 %	27%
African American	21%	70%
Latino	5%	2%
Other	2%	1%
Total	100%	100%

*HIV Disease Cases – All reports of HIV and AIDS

Source: North Carolina 2000 HIV/AIDS Surveillance Report, HIV/STD Prevention and Care Branch, Epidemiology and Special Studies Unit, North Carolina Department of Health and Human Services, Division of Public Health

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North Carolina

Of the 20,525 HIV disease cases* reported through December, 2000, African Americans accounted for:

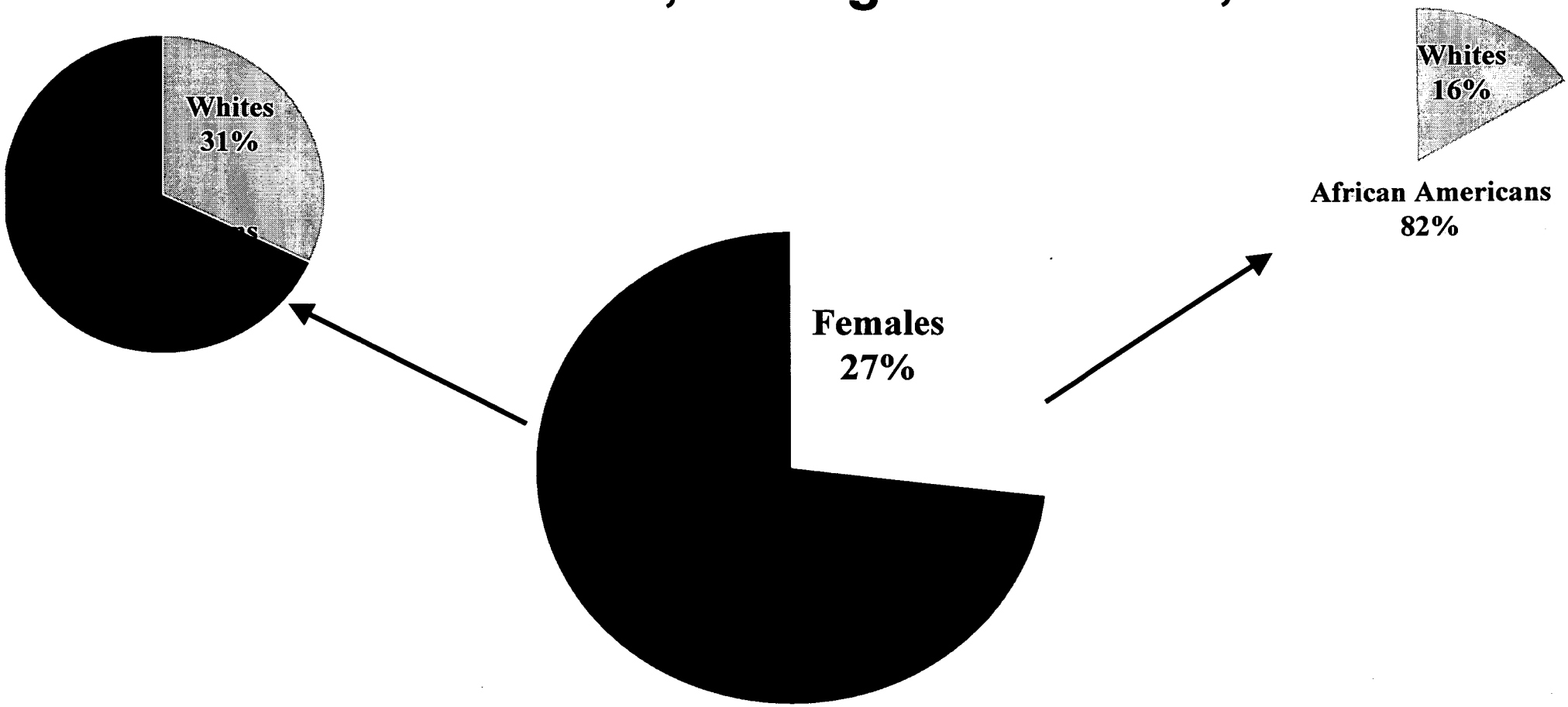
- 70% of total cases
- 66% of cases in men
- 82% of cases in women
- 54% of cases in children (<12 years)

*HIV Disease Cases – All reports of HIV and AIDS

Source: North Carolina 2000 HIV/AIDS Surveillance Report, HIV/STD Prevention and Care Branch, Epidemiology and Special Studies Unit, North Carolina Department of Health and Human Services, Division of Public Health

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Adult/Adolescent HIV Disease Cases* by Gender and Race, North Carolina, through December, 2000

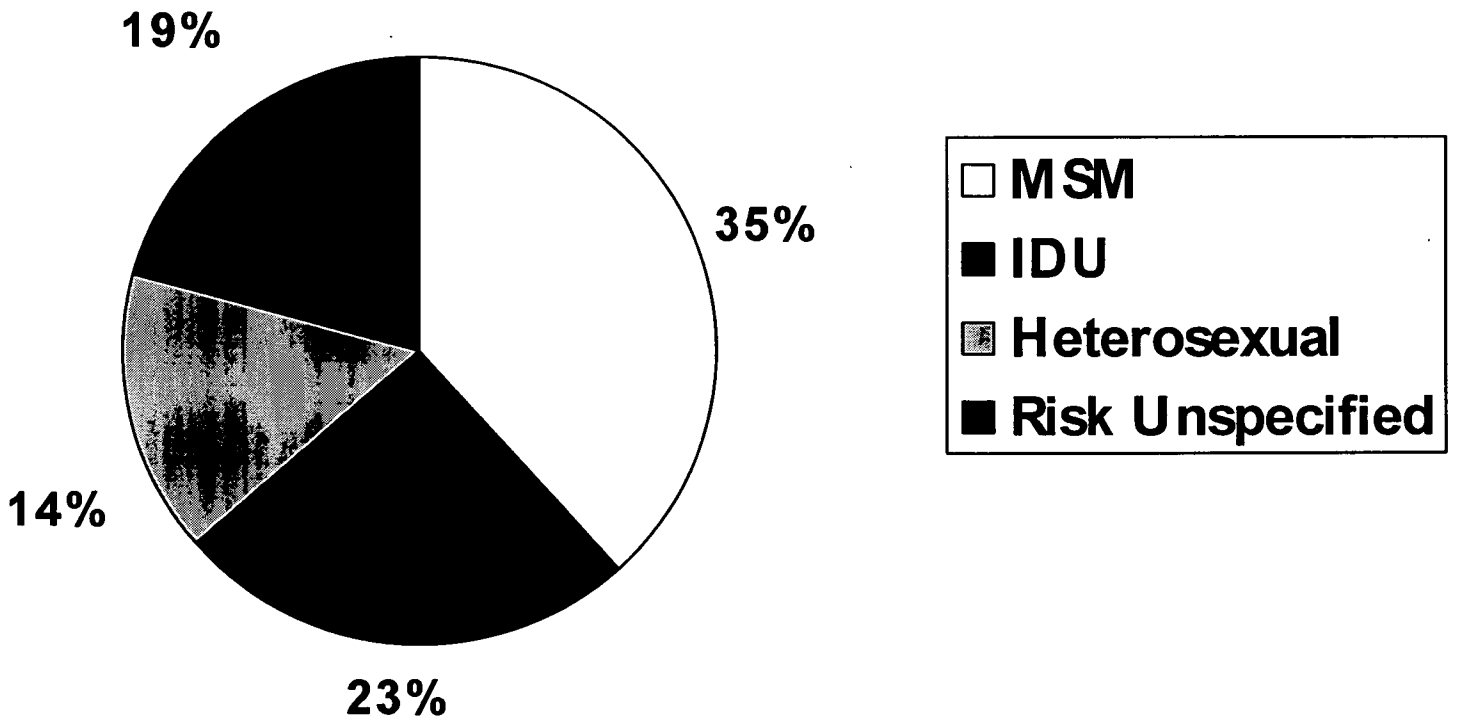


*HIV Disease Cases – All reports of HIV and AIDS

Source: North Carolina 2000 HIV/AIDS Surveillance Report, HIV/STD Prevention and Care Branch, Epidemiology and Special Studies Unit, North Carolina Department of Health and Human Services, Division of Public Health

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HIV Disease Cases* by Exposure Category, North Carolina, through December, 2000

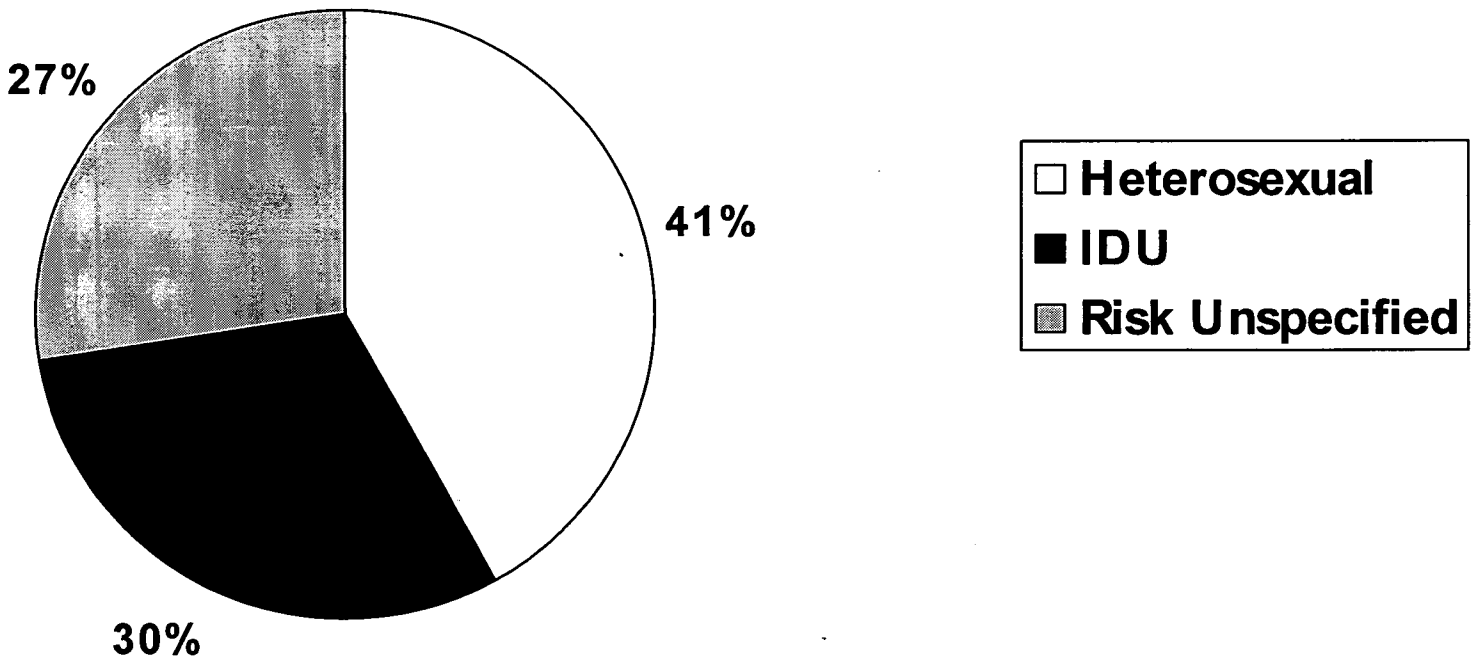


*HIV Disease Cases – All reports of HIV and AIDS

Source: North Carolina 2000 HIV/AIDS Surveillance Report, HIV/STD Prevention and Care Branch, Epidemiology and Special Studie Unit, North Carolina Department of Health and Human Services, Division of Public Health

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HIV Disease Cases* in Adult/Adolescent Females by Exposure Category, North Carolina through December, 2000

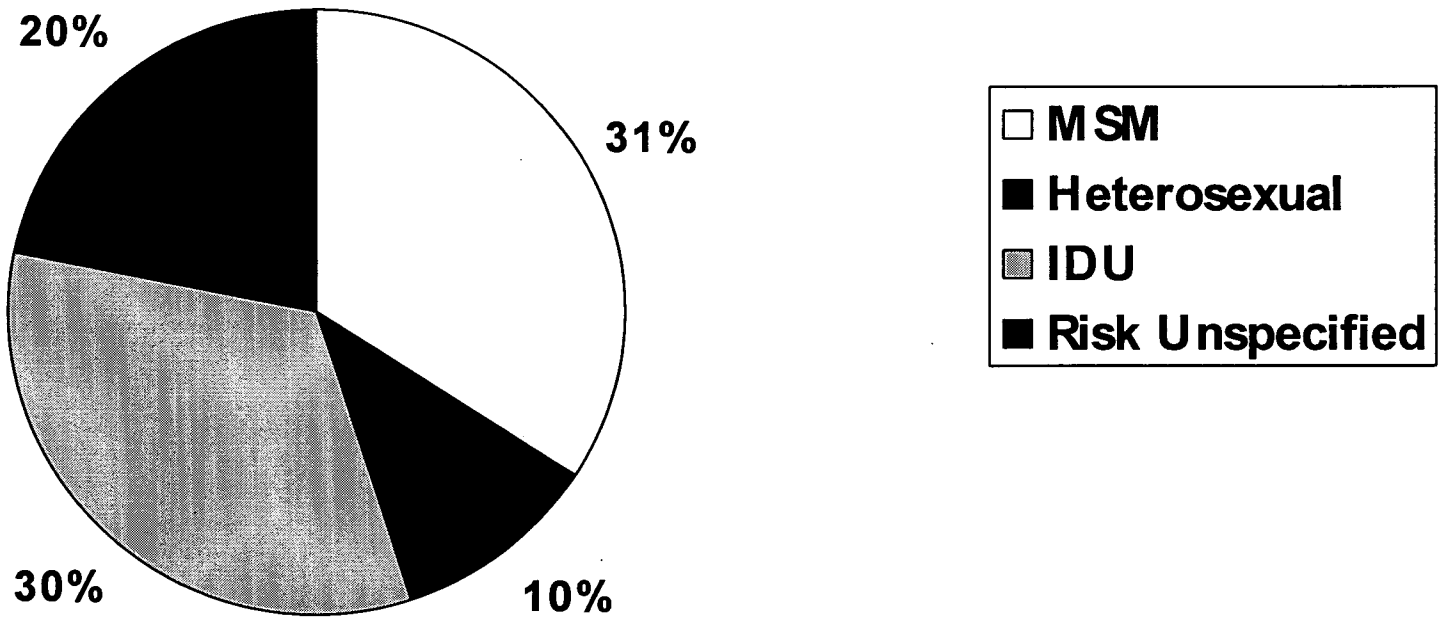


*HIV Disease Cases – All reports of HIV and AIDS

Source: North Carolina 2000 HIV/AIDS Surveillance Report, HIV/STD Prevention and Care Branch, Epidemiology and Special Studies Unit, North Carolina Department of Health and Human Services, Division of Public Health

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HIV Disease Cases* in Adult/Adolescent Males by Exposure Category, North Carolina through December, 2000

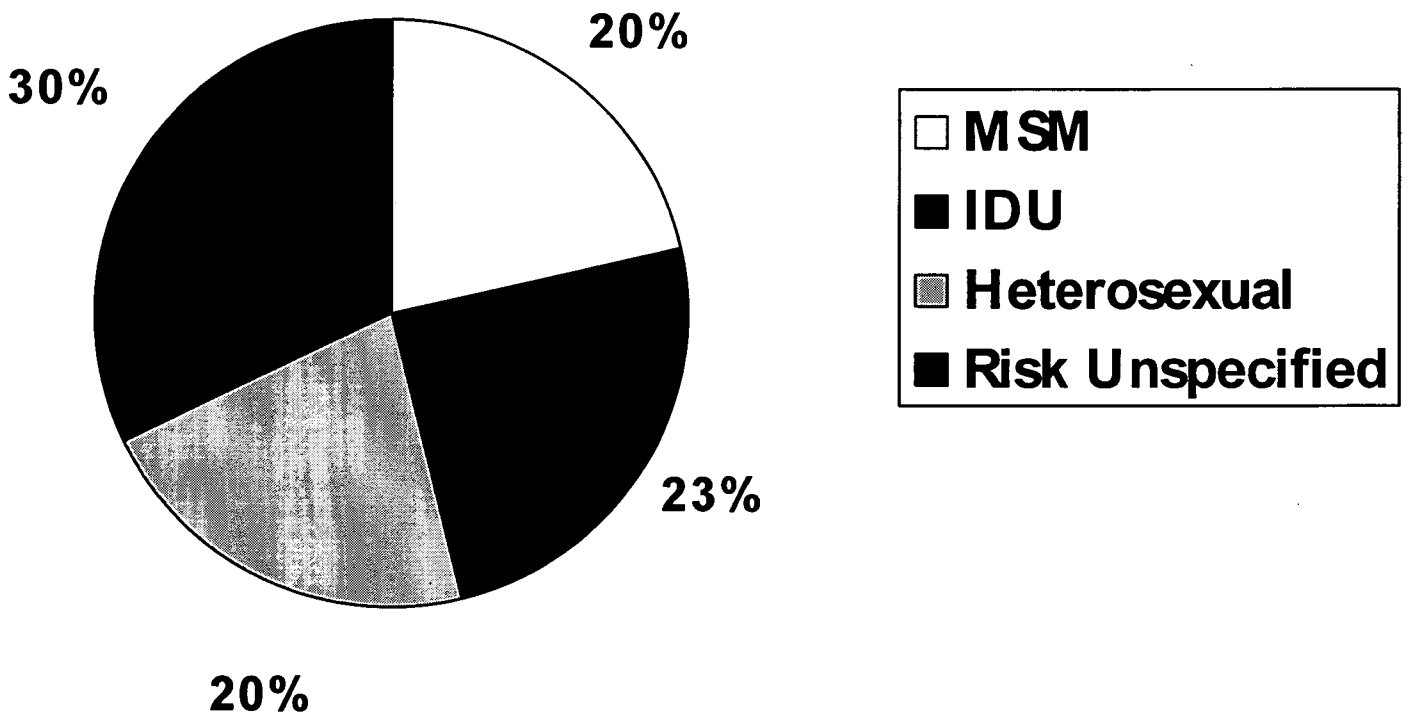


*HIV Disease Cases – All reports of HIV and AIDS

Source: North Carolina 2000 HIV/AIDS Surveillance Report, HIV/STD Prevention and Care Branch, Epidemiology and Special Studies Unit, North Carolina Department of Health and Human Services, Division of Public Health

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HIV Disease Cases* by Exposure Category in African Americans, North Carolina through December, 2000

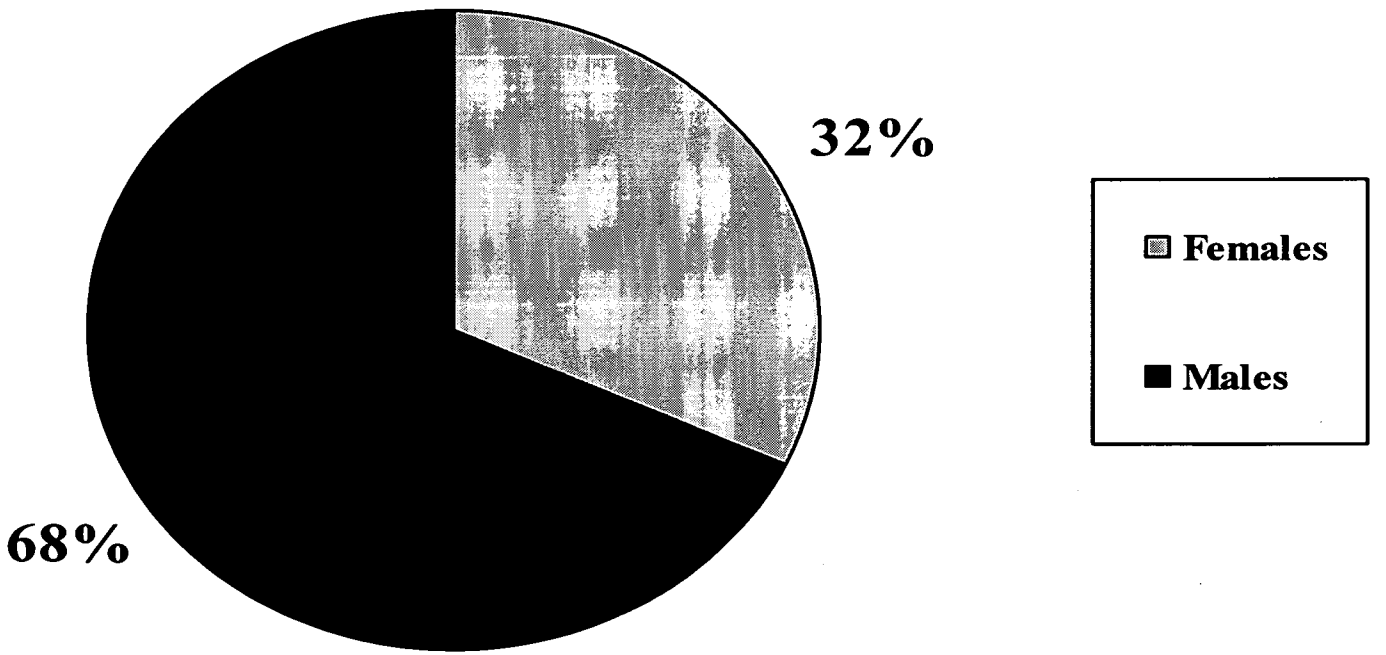


*HIV Disease Cases – All reports of HIV and AIDS

Source: North Carolina 2000 HIV/AIDS Surveillance Report, HIV/STD Prevention and Care Branch, Epidemiology and Special Studie Unit, North Carolina Department of Health and Human Services, Division of Public Health

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Cumulative African American HIV Disease Cases* by Gender, North Carolina, through December, 2000

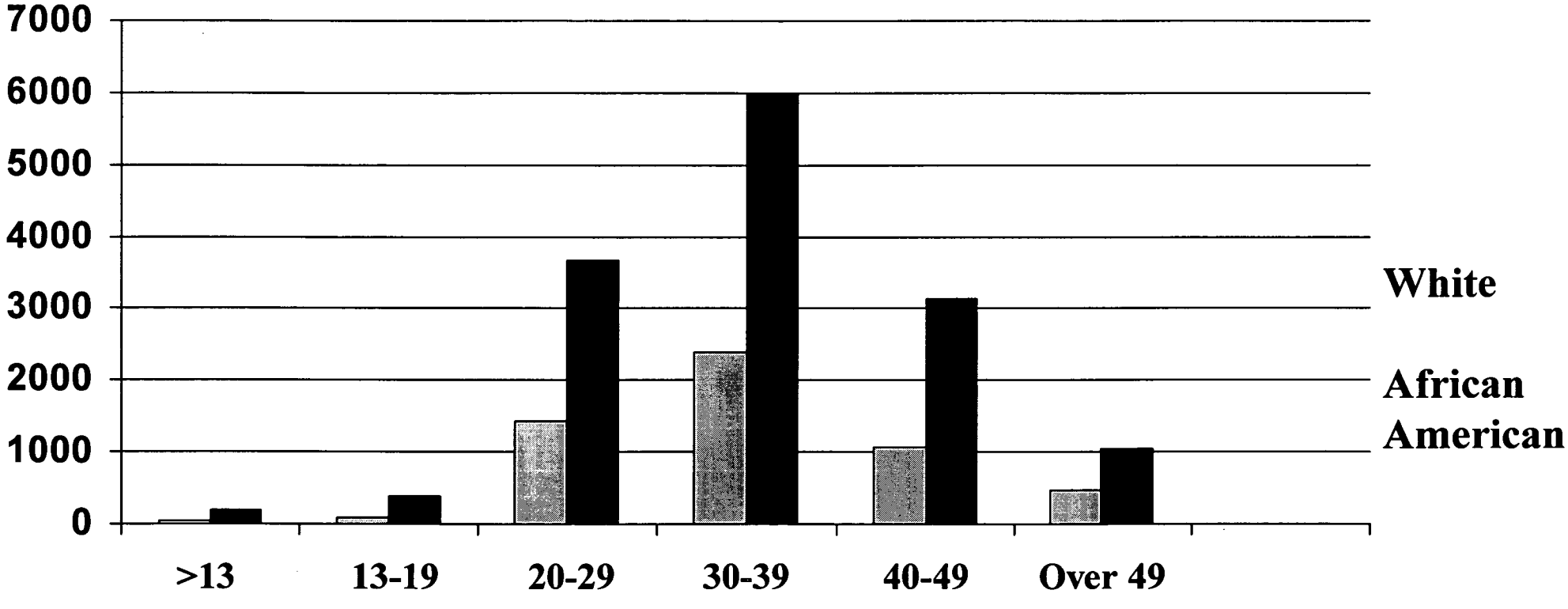


*HIV Disease Cases – All reports of HIV and AIDS

Source: Source: North Carolina 2000 HIV/AIDS Surveillance Report, HIV/STD Prevention and Care Branch, Epidemiology and Special Studies Unit, North Carolina Department of Health and Human Services, Division of Public Health

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Cumulative HIV Disease Cases* by Race and Age, North Carolina, through December, 2000

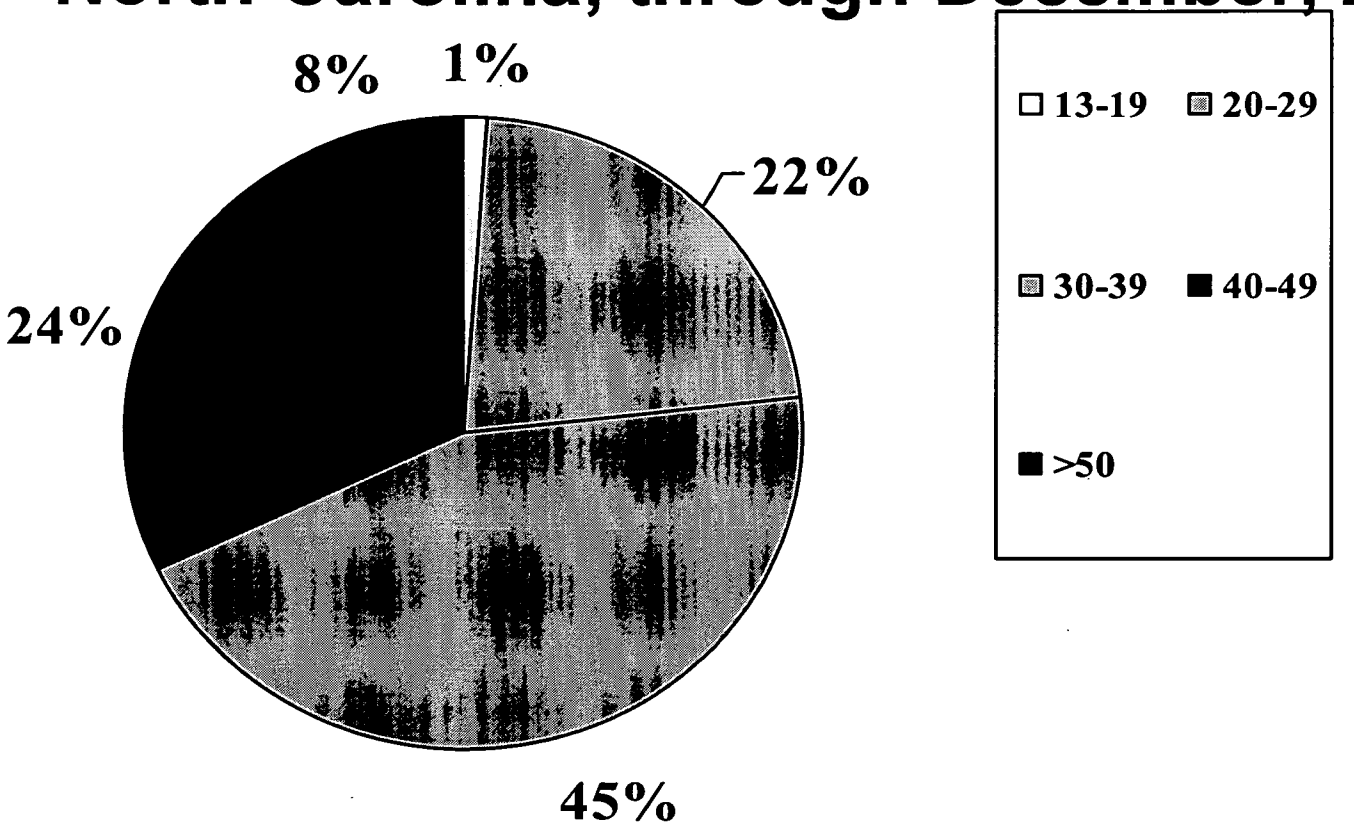


*HIV Disease Cases – All reports of HIV and AIDS

Source: North Carolina 2000 HIV/AIDS Surveillance Report, HIV/STD Prevention and Care Branch, Epidemiology and Special Studies Unit, North Carolina Department of Health and Human Services, Division of Public Health

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Cumulative African American Male HIV Disease Cases* b Age, North Carolina, through December, 2000

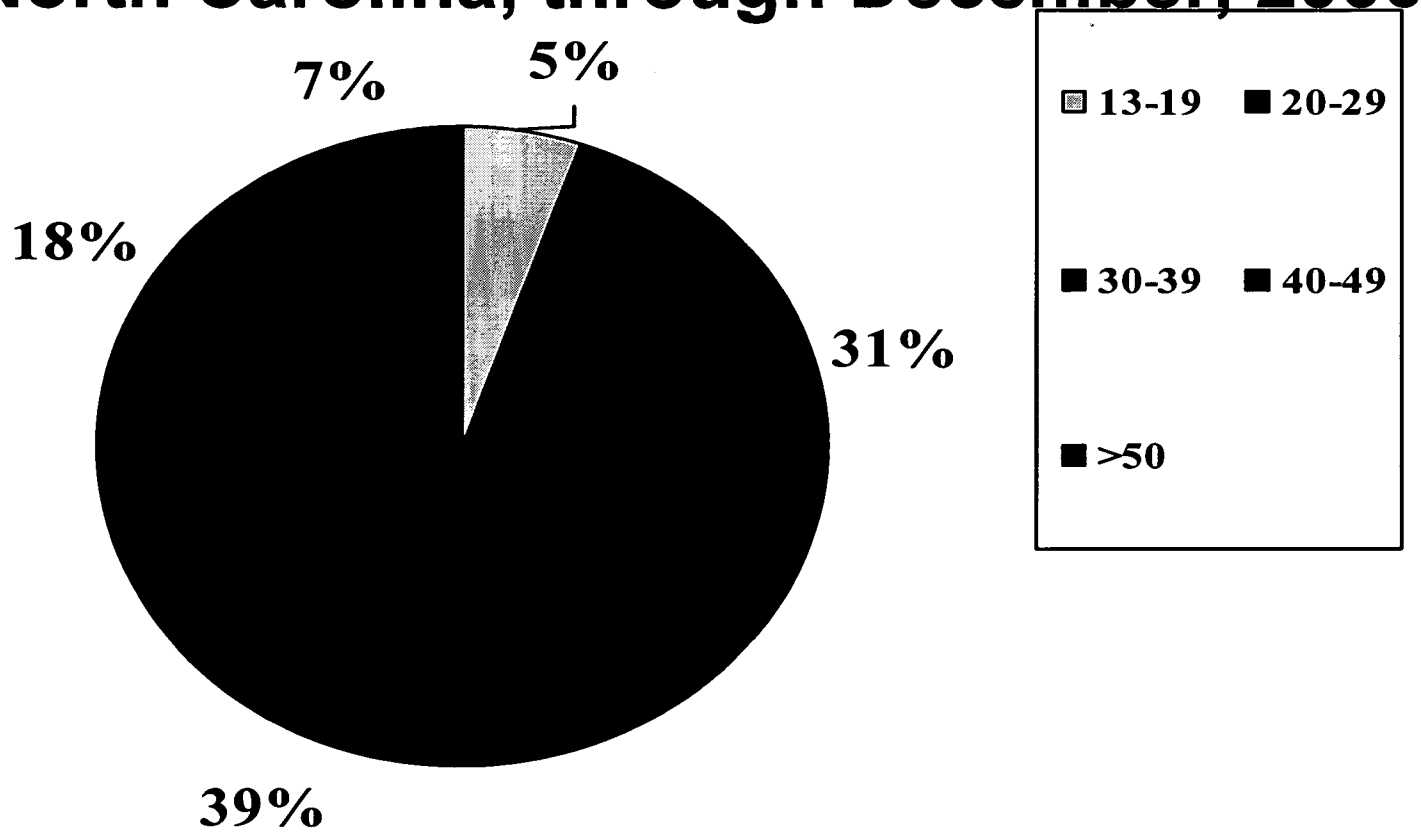


*HIV Disease Cases – All reports of HIV and AIDS

Source: Source: North Carolina 2000 HIV/AIDS Surveillance Report, HIV/STD Prevention and Care Branch, Epidemiology and Special Studies Unit, North Carolina Department of Health and Human Services, Division of Public Health

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Cumulative African American Female HIV Disease Cases* by Age, North Carolina, through December, 2000



*HIV Disease Cases – All reports of HIV and AIDS

Source: Source: North Carolina 2000 HIV/AIDS Surveillance Report, HIV/STD Prevention and Care Branch, Epidemiology and Special Studies Unit, North Carolina Department of Health and Human Services, Division of Public Health

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Summary of HIV Disease Cases*
North Carolina

- A majority of the HIV disease cases were attributed to MSM transmission

- African Americans accounted for a majority of HIV disease cases

- Young African American MSMs aged 30-39 are most impacted by HIV disease

- Young African American female heterosexuals aged 30-39 are heavily impacted by HIV disease

*HIV Disease Cases – All reports of HIV and AIDS

Source: North Carolina 2000 HIV/AIDS Surveillance Report, HIV/STD Prevention and Care Branch, Epidemiology and Special Studies Unit, North Carolina Department of Health and Human Services, Division of Public Health

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Sexually Transmitted Diseases
North Carolina

- In 1999, North Carolina ranked in the top ten in the nation in case rates for syphilis, gonorrhea, and syphilis
- African Americans accounted for a majority of sexually transmitted disease cases in North Carolina
- Sexually transmitted diseases heavily impacts young adults

Source: North Carolina 2000 HIV/AIDS Surveillance Report, HIV/STD Prevention and Care Branch, Epidemiology and Special Studies Unit, North Carolina Department of Health and Human Services, Division of Public Health

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Centers for Disease Control and Prevention

Gonorrhea, North Carolina

- In 1999, North Carolina ranked 3rd in the nation with a rate of 257.4 per 100,000
- 17,823 cases reported in 2000
- African Americans accounted for 82% (14,625) of these cases
- Gonnorhea rate for African Americans is 20 times higher than whites
- Gonorrhea mostly impacts adults (20-29 years)

•Source: North Carolina 2000 HIV/AIDS Surveillance Report, HIV/STD Prevention and Care Branch, Epidemiology and Special Studies Unit, North Carolina Department of Health and Human Services, Division of Public Health

Chlamydia, North Carolina

- In 1999, North Carolina ranked 9th in the nation with a rate of 289 per 100,000
- 21,985 cases of chlamydia were reported in 2000
- African Americans accounted for 66% (14,480) of these cases
- Chlamydia rate for African Americans is 9 times higher than Whites
- Chlamydia mostly impacts adults (20-29 years)

CDC
Centers for Disease Control and Prevention

Source: North Carolina 2000 HIV/AIDS Surveillance Report, HIV/STD Prevention and Care Branch, Epidemiology and

Syphilis, North Carolina

- In 1999, North Carolina ranked 7th in the nation with a rate of 6.1 primary and secondary cases per 100,000
- 1,101 cases reported in 2000
- African Americans accounted for 71% (783) of these cases
- Syphilis rate for African Americans is 15 times higher than Whites
- Syphilis mostly impacts adults (30 years and older)

CDC
CENTERS FOR DISEASE CONTROL AND PREVENTION

Source: North Carolina 2000 HIV/AIDS Surveillance Report, HIV/STD Prevention and Care Branch, Epidemiology and Special Studies Unit, North Carolina Department of Health and Human Services, Division of Public Health

Biography for Bill Hinchey
Senior Vice President of Marketing
OraSure Technologies, Inc.
Bethlehem, PA

Bill Hinchey is a co-founder of STC Technologies, Inc. and Senior Vice President of Marketing for OraSure Technologies, Inc. OraSure Technologies, Inc., is a public company and the result of the merger of STC Technologies, the leader in oral fluid drug and alcohol testing, and Epitope, Inc. of Beaverton, OR, the leader in oral fluid HIV testing. STC is a graduate of the Ben Franklin Technology Business Incubator at Lehigh University and has twice been names to *Inc. Magazine*'s 500 Fastest Growing Privately Held Companies list. Mr. Hinchey graduated from West Virginia University in 1982 with a BS degree in Business and Economics. He also holds a master's degree from the Graduate School of Industrial Administration at Carnegie-Mellon University. Mr. Hinchey was selected CMU's "Entrepreneur of the Year" in 1985 for a business school project which later became the basis for starting STC. Before starting STC, he worked in brand management in the beverage division of Procter & Gamble in Cincinnati, OH.

VISITOR REGISTRATION SHEET

Health
Name of Committee

6-12-06
Date

VISITORS:. PLEASE SIGN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Carolyn McAllaster	Duke AIDS Legal Assistance Project
Patricia Bartlett	Duke AIDS Research Treatment Clinic
MARY WASHINGTON	DUMC AIDS RESEARCH TREATMENT CLINIC
Gary Salamisso	GSK
Mari Smith	SKB
Dick Carlton	Carlton + Alexander PLLC
MARK H. CREECH	CAL
Amy Jo Bann	NCMS
John Rust	NCFPC
Jack McMillan	MFHS PA
Pam Benson	NCPHCA
Michelle Wallen	NC DPI
Sherry Lehman	NC DPI
TROY A. WILLIAMS	Operation Sickle Cell, Inc, Fayetteville
Sheree Cameron	intern for Senator Miller
Brian Distelberg	intern for Senator Miller
MARK DiMAIO	ASTRAZENECA
Jim Coyne	ASTRAZENECA
Margaret Westbrook	Kennedy Covington
JoWyrick	Equality NC
Rob Christensen	N+O
Wanda W. Woods	DHHS-OMHHD
Rebecca Day	DHHS-OMH/HD
GARY J. MINTER	NAACP Health Chairperson
Roz Savage	NLCC
JOHN GOODMAN	LINWOOD MERCER & ASSOC.
KIMBERLY SCOTT	DUKE UNIVERSITY
WAN HAWKINS	ENCHAC
AUDREI-LEE TYSON	ENCHAC

VISITOR REGISTRATION SHEET

Health — Name of Committee

6-12-01 — Date

VISITORS:. PLEASE SIGN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Jim Bernstein	ONHS
Wendy + Ntiros Katsinyanis	MY SON (NIINOS) IS DEAF 529 Colony Woods Dr. CH, NC 27514
Martha Saltani	Parent of a Deaf Child 3103 Harbor at Jamestown NC 27282
Robert C. Wilson	Bar of State
Shawn Luby	North Carolina Lambda Youth Network
Paula Austin	NCLYN 115 Market St. Durham 27701
Judy O'Neal	NHRMC (Wilmington)
Bill Atkinson	NHRMC (Wilmington)
Jim Blair	Private citizen
JW Blair	citizen
Cassandra Faulcon	Halifax co Health Dept. PO Box 10 Halifax NC 27839
Kathy Knight	Halifax Regional Medical Center PO Box 1089 Roanoke Rapids, NC 27870
HUGH TILSON	NCHA
Jill Moore	Inst of Govt
Meredith Henderson	Inst of Govt Law Clerk
Suzy Blum	Inst of Govt Law Clerk
Jennifer Bruno	Inst of Govt law Clerk
Jamal Rhinehardt	Inst. of Govt. Law Clerk
Kate A. Mann	APPCNC
Leo Mellon	Mayor-Chadbourn, n/a 28431
David Bone	Town Manager- Chadbourn, NC
Beth Whitfield	6209 Loy Dr Gibsonville
Ken Wright	DCRS NC
Lee Anne	DHHS

AGENDA

HOUSE COMMITTEE ON HEALTH
TUESDAY, June 19, 2001
12:00 Noon, ROOM 415 LOB

OPENING REMARKS

Rep. Thomas E. Wright
Chairman

BILLS TO BE DISCUSSED

HB-1405 HIV/AIDS PUBLIC HEALTH CRISIS. (Rep. Wright)

SB-721 NC HEALTH CHOICE/NO WAITING PERIOD.(Sen. Purcell)

SB-826 CRIMINAL RECORD CHECK CHANGE/LONG-TERM CARE. (Sen. Rand)

COMMENTS

ADJOURNMENT

MINUTES

HOUSE COMMITTEE ON HEALTH

TUESDAY, JUNE 19, 2001

12:00 NOON, ROOM 415 LOB

The House Committee on Health met on Tuesday, June 19, 2001 at 12:00 Noon in Room 415 LOB. A silent roll was taken, (roll list denotes members present).

Chairman Wright came and cancelled the meeting because of the number of members in the Appropriations meeting. Chairman Wright stated that the meeting would be rescheduled for a later date.

Rep. Thomas E. Wright, Chairman

Vanda Wilson-Wormack, Committee Assistant

AGENDA

HOUSE COMMITTEE ON HEALTH
TUESDAY, June 26, 2001
1:00 pm, ROOM 415 LOB

OPENING REMARKS

Rep. Thomas E. Wright
Chairman

BILLS TO BE DISCUSSED

SB-824 TEACHERS' AND STATE EMPLOYEES' BENEFITS.(Sen. Rand)

COMMENTS

ADJOURNMENT

MINUTES

HOUSE HEALTH COMMITTEE

TUESDAY, JUNE 26, 2001

1:00PM ROOM 415 LOB

The House Health Committee met on Tuesday, June 26, 2001 at 1:00pm in Room 415 LOB. A silent roll was taken, (roll list denotes members present).

Chairman Wright called the meeting to order.

SB-824 TEACHER'S AND STATE EMPLOYEES' BENEFITS.(Sen. Rand)

Sen. Rand explained the proposed committee substitute.

Rep. Buchanan moved for adoption of the house proposed committee substitute. So moved.

Sam Byrd, fiscal staff, further explained the house proposed committee substitute. Rep. Edwards asked about page 2, line 14 of the bill. Sam Byrd responded. Rep. Edwards followed up with a question about contract negotiations being done publicly or privately. Jack Walker, Plan Administrator, responded. Rep. Buchanan asked if this plan covers, in addition to medicare in nursing home facilities. Sam Byrd responded. Chairmen Wright commented to the committee that the language in the house proposed committee substitute is the same in the House Budget Bill, with the exception of section 2. Rep. Sherrill asked about page 7 line 26. Hugh Tilson of the NC Hospital Association responded.

Rep. Nye moved for a favorable report to the house proposed committee substitute bill, unfavorable to the senate committee substitute bill.

Rep. Edwards asked about the specific changes of the bill. Sam Byrd, staff, responded. Sen. Rand asked about the fees to the state employee. Sam Byrd responded.

Chairman Wright called the question. So moved.

The meeting adjourned at 1:30pm.

Rep. Thomas Wright, Chairman

Vanda Wilson-Wormack, Committee Assistant

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2001

S 2

SENATE BILL 824

Rules and Operations of the Senate Committee Substitute Adopted 6/21/01

Short Title: Teachers' and State Employees' Benefits. (Public)

Sponsors:

Referred to:

April 3, 2001

A BILL TO BE ENTITLED

AN ACT PERTAINING TO BENEFITS UNDER THE TEACHERS' AND STATE EMPLOYEES' COMPREHENSIVE MAJOR MEDICAL PLAN; AND TO HOSPITAL RATES UNDER WORKERS' COMPENSATION.

The General Assembly of North Carolina enacts:

SECTION 1.(a) G.S. 135-39.5 is amended by adding the following new subdivision to read:

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

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

...

(26) Increasing annually the amount of the annual deductible and annual aggregate maximum deductible. The increase shall be established by determining the ratio of the CPI-Medical Index to such index one year earlier. If the ratio indicates an increase in the CPI-Medical Index, then the amount of the annual deductible and annual aggregate maximum deductible may be increased by not more than the percentage increase in the CPI-Medical Index. As used in this subdivision, the term 'CPI-Medical Index' means the U.S. Consumer Price Index for All Urban Consumers for Total Medical Care."

SECTION 1.(b) G.S. 135-40.1(2) reads as rewritten:

"(2) Deductible. – Deductible shall mean an amount of covered expenses during a fiscal year which must be incurred after which benefits (subject to the deductible) becomes payable. The deductible for an employee, retired employee and/or his or her dependents shall be ~~two hundred fifty dollars ($250.00)~~ four hundred dollars ($400.00) for each fiscal ~~year.~~ year, except that the Executive Administrator and Board of

Trustees may increase annually the amount of the annual deductible in accordance with G.S. 135-39.5.

The deductible applies separately to each covered individual in each fiscal year, subject to an aggregate maximum of ~~seven~~ one thousand two hundred ~~fifty~~ dollars ~~($750.00)~~ ($1,200) per family (employee or retiree and his or her covered dependents) in any fiscal ~~year.~~year, except that the Executive Administrator and Board of Trustees may increase annually the amount of the annual aggregate maximum deductible in accordance with G.S. 135-39.5.

If two or more family members are injured in the same accident only one deductible is required for charges related to that accident during the benefit period."

SECTION 1.(c) G.S. 135-40.4(a) reads as rewritten:

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

The Plan is divided into two parts. The first part includes certain benefits which are not subject to a deductible or coinsurance. The second part is a comprehensive plan and includes those benefits which are subject to both a ~~two hundred fifty dollars ($250.00)~~four hundred dollars ($400.00) deductible for each covered individual to an aggregate maximum of ~~seven hundred fifty dollars ($750.00)~~ one thousand two hundred dollars ($1,200) per family and coinsurance of ~~80%/20%.~~80%/20%, except that the amount of the annual deductible and the aggregate maximum deductible may be increased annually by the Executive Administrator and Board of Trustees in accordance with G.S. 135-39.5. There is a limit on out-of-pocket expenses under the second part.

Notwithstanding the provisions of this Article, the Executive Administrator and Board of Trustees of the Teachers' and State Employees' Comprehensive Major Medical Plan may contract with providers of institutional and professional medical care and services to established preferred provider networks. The design, adoption, and implementation of such preferred provider contracts and networks are not subject to the requirements of Chapter 143 of the General Statutes, provided that for any hospital preferred provider network all hospitals will have an opportunity to contract with the Plan if they meet the contract requirements. The Executive Administrator and Board of Trustees shall, under the provisions of G.S. 135-39.5(12), pursue such preferred provider contracts on a timely basis and shall make reports as requested to the President of the Senate, the President Pro Tempore of the Senate, the Speaker of the House of Representatives, and the Committee on Employee Hospital and Medical Benefits on its progress in negotiating such preferred provider contracts. The Executive Administrator and Board of Trustees shall implement a refined diagnostic-related grouping or diagnostic-related grouping-based reimbursement system for hospitals as soon as practicable, but no later than January 1, 1995."

SECTION 1.(d) G.S. 135-40.5(d) is repealed.

SECTION 1.(e) 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 to be determined by the Plan's Executive Administrator and Board of Trustees. The Plan will pay allowable charges for each outpatient prescription drug less a copayment to be paid by each covered individual equal to the following amounts: pharmacy charges up to ten dollars ($10.00) for each generic prescription, ~~fifteen dollars ($15.00)~~ twenty-five dollars ($25.00) for each branded prescription, and ~~twenty dollars ($20.00)~~thirty-five dollars ($35.00) for each branded prescription with a generic equivalent drug, and ~~twenty-five dollars ($25.00)~~ forty dollars ($40.00) 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~~ 30-day supply for the purposes of the copayments paid by each covered individual. By accepting the copayments and any remaining allowable charges provided by this subsection, pharmacies shall not balance bill an individual covered by the Plan. A prescription legend drug is defined as an article the label of which, under the Federal Food, Drug, and Cosmetic Act, is required to bear the legend: "Caution: Federal Law Prohibits Dispensing Without Prescription." Such articles may not be sold to or purchased by the public without a prescription order. Benefits are provided for insulin even though a prescription is not required. The Plan may use a pharmacy benefit manager to help manage the Plan's outpatient prescription drug coverage. In managing the Plan's outpatient prescription drug benefits, the Plan and its pharmacy benefit manager shall not provide coverage for erectile ~~dysfunction, growth hormone, antiwrinkle, weight loss, and hair growth drugs unless such coverage is medically necessary to the health of the member.~~dysfunction, antiwrinkle, and hair growth drugs. The Plan and its pharmacy benefit manager shall not provide coverage for growth hormone and weight loss drugs and antifungal drugs for the treatment of nail fungus and botulinium toxin, and other outpatient prescription drugs authorized by the Executive Administrator, without approval in advance by the pharmacy benefit manager."

SECTION 1.(f) The first paragraph of G.S. 135-40.6 reads as rewritten:

"The following benefits are subject to a deductible of ~~two hundred fifty dollars ($250.00)~~ four hundred dollars ($400.00) or the amount established in accordance with G.S. 135-39.5, whichever is greater, per covered individual to an aggregate maximum of ~~seven hundred fifty dollars ($750.00)~~ one thousand two hundred dollars ($1,200) or the amount established in accordance with G.S. 135-39.5, whichever is greater, per family per fiscal year and are payable on the basis of eighty percent (80%) by the Plan and twenty percent (20%) by the covered individual up to a maximum of one thousand ~~dollars ($1,000)~~ five hundred dollars ($1,500) out-of-pocket per fiscal year:".

SECTION 1.(g) G.S. 135-40.6(1)f. reads as rewritten:

"(1) In-Hospital Benefits. – The Plan pays in-hospital benefits for each single confinement, when charged by a hospital, for room

accommodations, including bed, board and general nursing care, but not to exceed the charge for semiprivate room or ward accommodations, or the rate negotiated for the Plan. Under the DRG reimbursement system, the coinsurance shall be based on the lower of the DRG amount or charges.

The Plan will pay the following covered charges, when charged by a hospital, for each confinement.

...

f. ~~Physical~~ Physical, speech, and occupational therapy."

SECTION 1.(h) G.S. 135-40.6(3) reads as rewritten:

"(3) Skilled Nursing Facility Benefits. – The Plan will pay benefits in a skilled nursing facility licensed under applicable State laws for not more than 80 days per fiscal year, as follows:

After discharge from a hospital for which inpatient hospital benefits were provided by this Plan for a period of not less than three days, and treatment consistent with the same illness or condition for which the covered individual was hospitalized, the daily charges will be paid for room and board in a semiprivate room or any multibed unit up to the maximum benefit specified in subsection (1) of this section, less the days of care already provided for the same illness in a hospital. Plan allowances for total daily charges may be negotiated but will not exceed the daily semiprivate hospital room rate as determined by the Plan.

Credit will be allowed toward private room charges in an amount equal to the facility's most prevalent charge for semiprivate accommodations. Charges will also be paid for general nursing care and other services which would ordinarily be covered in a general hospital. In order to be eligible for these benefits, admission must occur within 14 days of discharge from the hospital.

In order to qualify for benefits provided by a skilled nursing facility, the following stipulations apply:

a. The services are medically required to be given on an inpatient basis because of the covered individual's need for medically necessary skilled nursing care on a continuing daily basis for any of the conditions for which he or she was receiving inpatient hospital services prior to transfer from a hospital to the skilled nursing facility or for a condition requiring such services which arose after such transfer and while he or she was still in the facility for treatment of the condition or conditions for which he or she was receiving inpatient hospital services,

b. Only on prior referral by and so long as, the patient remains under the active care of an attending doctor and the patient

requires continual hospital confinement without the care and treatment of the skilled nursing facility, and

c. Approved in advance by the Claims Processor.

For facilities not qualified for delivery of services covered by the benefits of Title XVIII of the Social Security Act (Medicare), neither the Plan nor any of its members shall be billed or held liable by such facilities for charges that otherwise would be covered by Medicare."

SECTION 1.(i) G.S. 135-40.6(8)e. reads as rewritten:

"e. Prosthetic and Orthopedic Appliances and Durable Medical Equipment: Appliances and equipment including corrective and supportive devices such as artificial limbs and eyes, wheelchairs, traction equipment, inhalation therapy and suction machines, hospital beds, braces, orthopedic corsets and trusses, not more than three hundred fifty dollars ($350.00) for therapeutic shoes for diabetes and other high-risk conditions, and other prosthetic appliances or ambulatory apparatus which are provided solely for the use of the participant. Eligible charges include repair and replacement when medically necessary. Benefits will be provided on a rental or purchase basis at the sole discretion of the Claims Processor and agreements to rent or purchase shall be between the Claims Processor and the supplier of the appliance.

For the purposes of this subdivision, the term "durable medical equipment" means standard equipment normally used in an institutional setting which can withstand repeated use, is primarily and customarily used to serve a medical purpose, is generally not useful to a person in the absence of an illness or injury and is appropriate for use in the home. Decisions of the Claims Processor, the Executive Administrator and Board of Trustees as to compliance with this definition and coverage under the Plan shall be final."

SECTION 1.(j) G.S. 135-40.6(8)m. reads as rewritten:

"m. Cardiac Rehabilitation: Charges not to exceed ~~six hundred fifty dollars ($650.00)~~ the greater of one thousand three hundred dollars ($1,300) or 60 days per fiscal ~~year for cardiac testing and exercise therapy, when determined medically necessary by an attending physician and approved by the Claims Processor for patients with a medical history of myocardial infarction, angina pectoris, arrhythmias, cardiovascular surgery, hyperlipidemia, or hypertension,~~year. Coverage is limited to patients with Coronary Artery Bypass Graft (CABG), status/post myocardial infarction, Percutaneous Transliminal

Coronary Angioplasty (PTCA) or stent, valve replacement, heart transplant, or chronic and disabling angina provided such ~~charges are incurred~~services are provided within six months of the qualifying event and in a medically supervised facility fully certified by the North Carolina Department of Health and Human Services."

SECTION 1.(k) G.S. 135-40.6(9)f. reads as rewritten:

"(9) Limitations and Exclusions to Other Covered Charges. – No benefits are available under this section of the Plan until full utilization is made of similar benefits available under other sections of this Plan.

No benefits will be payable for:

...

f. Eyeglasses or other corrective lenses (except for cataract lenses certified as medically necessary for aphakia persons), hearing aids, braces for teeth, dental plates or bridges or other dental prostheses, air-conditioners, vaporizers, humidifiers, mattresses (other than as supplied with a hospital bed) and specially built shoes (other than attached to artificial limbs or orthopedic ~~braces);~~braces, and other than therapeutic shoes for diabetes or other high-risk conditions);".

SECTION 1.(l) G.S. 135-40.6A(b) reads as rewritten:

"(b) The Executive Administrator and Board of Trustees may establish procedures to require prior medical approvals for the following services:

(1) Skilled Nursing Facility ~~Care (after the initial 30 days);~~Care.
(2) Private Duty ~~Nursing;~~Nursing.
(3) Speech Therapy (unless rendered in an inpatient ~~hospital);~~hospital).
(4) Physical Therapy (in the ~~home);~~home).
(7) Surgical Procedures:
a. Blepharoplasties
b. Surgery for Hermaphroditism
c. Excision of Keloids
d. Reduction Mammoplasty
e. Morbid Obesity Surgery
f. Penile Prosthesis
g. Excision of Gynecomastia
h. Cochlear Implants
i. Revision of the Nasal Structure
j. Abdominoplasty
k. Fimbrioplasty
l. Tubotubal ~~Anastomasis.~~Anastomasis
m. Varicose vein surgery.

(8) Subcutaneous injection of "filling" material (Example: zyderm, ~~silicone); and~~ silicone).

(8a) Botulinium toxin.

(9) Suction Lipectomy.

(10) Outpatient prescription drugs requiring prospective review under the Plan's pharmacy benefit management program.

(11) Outpatient prescription drugs for growth hormone, weight loss, and antifungal drugs for the treatment of nail fungus."

SECTION 1.(m) G.S. 135-40.8 reads as rewritten:

"**§ 135-40.8. Out-of-pocket expenditures.**

(a) For the balance of any fiscal year after each eligible employee, retired employee, or dependent satisfies the cash deductible, the Plan pays eighty percent (80%) of the eligible expenses outlined in G.S. 135-40.6. The covered individual is then responsible for the remaining twenty percent (20%) until one thousand ~~dollars ($1,000),~~five hundred dollars ($1,500), in excess of the deductible, has been paid out-of-pocket. The Plan then pays one hundred percent (100%) of the remaining covered expenses.

~~(b) Where a covered individual fails to obtain a second surgical opinion as required under the Plan, or where a covered individual elects to have a surgery performed that conflicts with a majority opinion of the rendered consultations that the surgery requiring a second or third surgical opinion is not necessary, the covered individual shall be responsible for fifty percent (50%) of the eligible expenses, provided, however, that no covered individual shall be required to pay, in addition to the expenses in subsection (a) above out-of-pocket in excess of five hundred dollars ($500.00) per fiscal year.~~

(c) Notwithstanding any other provision of this Article, on the first day of each confinement the Plan does not pay the first seventy-five dollars ($75.00) of the room accommodation charge allowable under G.S. 135-40.6(1). Any readmission within 60 days after discharge for the same reason shall be considered the same confinement for the purpose of this subsection. The exclusion made under this subsection shall not count toward the deductible nor toward the maximum amount of out-of-pocket costs.

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

SECTION 1.(n) G.S. 135-40.9 reads as rewritten:

"**§ 135-40.9. Maximum benefits.**

The maximum lifetime benefit for each covered individual will be ~~two~~ five million dollars ~~($2,000,000).~~ ($5,000,000)."

SECTION 2. G.S. 97-26(b) reads as rewritten:

"(b) Hospital Fees. – Each hospital subject to the provisions of this subsection shall be reimbursed the amount provided for in this subsection unless it has agreed under contract with the insurer, managed care organization, employer (or other payor obligated to reimburse for inpatient hospital services rendered under this Chapter) to accept a different amount or reimbursement methodology.

Except as otherwise provided herein, payment for medical treatment and services rendered to workers' compensation patients by a hospital shall be ~~equal to the payment the hospital is authorized to receive for the same treatment or service under the State Plan, provided that~~ as determined by the Commission, provided that payment

~~(1) Payment for inpatient hospital inpatient services provided on or after July 1, 1997, and on or before December 31, 1997, shall not be less than a minimum of ninety percent (90%) nor more than a maximum of one hundred percent (100%) of the hospital's itemized charges as shown on the UB-92 claim form.~~

~~(2) Payment for inpatient hospital services provided on or after January 1, 1998, through and including December 31, 1998, shall be not more than a maximum of one hundred percent (100%) of the hospital's itemized charges as shown on the UB-92 claim form nor less than a minimum percentage of such charges that the Commission determines would have been required to have produced an average payment rate equal to ninety three and one tenth percent (93.1%) of aggregate charges for all inpatient claims processed by the Commission during the fiscal year ending June 30, 1997.~~

~~(3) Payment~~

for inpatient hospital services provided on or after January 1, 1999, shall be not more than a maximum of one hundred percent (100%) of the hospital's itemized charges as shown on the UB-92 claim form nor less than the minimum percentage established annually by the ~~Commission as follows:~~Commission.

~~a. Beginning in the third quarter (July, August, and September) of 1998, and annually thereafter, the Commission shall review data from the State Plan to ascertain the aggregate hospital itemized charges and aggregate amounts authorized for payment by the State Plan (including payments actually made by the State Plan and deductible, coinsurance, or other amounts for which the patient/insured may have been liable) for inpatient hospital claims paid to participating hospitals by the State Plan during the immediately preceding fiscal year ending June 30. The Commission shall then utilize the data described in the preceding sentence to calculate the extent, if any, to which aggregate State Plan authorized payments were less than aggregate charges on inpatient hospital claims paid by the State Plan during the preceding fiscal year.~~

~~b. Beginning in the third quarter (July, August, and September) of 1998, and annually thereafter, the Commission shall calculate aggregate hospital itemized charges and aggregate payments authorized by the Commission on all inpatient hospital workers' compensation claims approved for payment by the Commission during the preceding fiscal year ending June 30.~~

~~c. Based on the data described in sub-subdivisions a. and b. of this subdivision, the Commission shall on or before December 1, 1998, and December 1 of each subsequent year establish a minimum percentage that will result in a payment rate for inpatient workers' compensation cases that in the aggregate bears a percentage relationship to hospital itemized charges that is equal to the State Plan relationship between aggregate payments authorized and aggregate itemized charges for claims paid by the State Plan during the preceding fiscal year ending June 30. The percentage rate established shall be effective for the next succeeding calendar year beginning January 1 of that year.~~

Notwithstanding any other provisions of law, the Commission's determination of payment rates under this subsection shall:

(1) Comply with the procedures for adoption of a fee schedule established in G.S. 97-26(a);

(2) Include publication on or before October 1 of each year of the proposed payment rate, and a summary of the data and calculations on which the rate is based;

(3) Be subject to the declaratory ruling provisions of G.S. 150B-4; and

(4) Be deemed to constitute a final permanent rule under Article 2A of Chapter 150B for purposes of judicial review under Article 4 of that Chapter.

~~Payment for a particular type of medical compensation that is not covered under the State Plan shall be based on the allowable charge under the State Plan for comparable services or treatment, as determined by the Commission.~~

A hospital's itemized charges on the UB-92 claim form for workers' compensation services shall be the same as itemized charges for like services for all other payers."

SECTION 2.1. G.S. 135-39.4A is amended by adding a new subsection to read:

"(f1) The following positions shall have the same status as if they were listed under G.S. 126-5(c1):

(1) CMS Operations Manager.

(2) Program Services Specialist.

(3) Administrative Secretary I.

(4) Administrative Secretary II.

(5) Accountant II.

SECTION 3. Notwithstanding G.S. 97-26, payment for medical treatment and services rendered to workers' compensation patients by a hospital on or after July 1, 2001, and before August 1, 2001, shall be equal to the payment the hospital would have received for such treatment and services on June 30, 2001.

SECTION 4. Section 1(a) of this act becomes effective July 1, 2002. The remainder of this act becomes effective July 1, 2001.

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2001

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SENATE BILL 824

Rules and Operations of the Senate Committee Substitute Adopted 6/21/01
PROPOSED HOUSE COMMITTEE SUBSTITUTE S824-PCS6315-LB-68

Short Title: State Health Plan Changes. (Public)

Sponsors:

Referred to:

April 3, 2001

A BILL TO BE ENTITLED

AN ACT PERTAINING TO BENEFITS UNDER THE TEACHERS' AND STATE EMPLOYEES' COMPREHENSIVE MAJOR MEDICAL PLAN; AND TO HOSPITAL RATES UNDER WORKERS' COMPENSATION.

The General Assembly of North Carolina enacts:

SECTION 1.(a) G.S. 135-40.1(2) reads as rewritten:

"(2) Deductible. – Deductible shall mean an amount of covered expenses during a fiscal year which must be incurred after which benefits (subject to the deductible) becomes payable. The deductible for an employee, retired employee and/or his or her dependents shall be ~~two hundred fifty dollars ($250.00)~~ three hundred fifty dollars ($350.00) for each fiscal year.

The deductible applies separately to each covered individual in each fiscal year, subject to an aggregate maximum of ~~seven hundred fifty dollars ($750.00)~~ one thousand fifty dollars ($1,050) per ~~family (employee or retiree and his or her covered dependents)~~employee and child(ren) or employee and family coverage contract in any fiscal year.

If two or more family members are injured in the same accident only one deductible is required for charges related to that accident during the benefit period."

SECTION 1.(b) G.S. 135-40.4(a) reads as rewritten:

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

The Plan is divided into two parts. The first part includes certain benefits which are not subject to a deductible or coinsurance. The second part is a comprehensive plan and includes those benefits which are subject to both a ~~two hundred fifty dollars ($250.00)~~three hundred fifty dollar ($350.00) deductible for each covered individual to

an aggregate maximum of ~~seven hundred fifty dollars ($750.00)~~ one thousand fifty dollars ($1,050) per ~~family~~ employee and child(ren) or employee and family coverage contract and coinsurance of 80%/20%. There is a limit on out-of-pocket expenses under the second part.

Notwithstanding the provisions of this Article, the Executive Administrator and Board of Trustees of the Teachers' and State Employees' Comprehensive Major Medical Plan may contract with providers of institutional and professional medical care and services to established preferred provider networks. The Plan shall, however, honor a Plan member's assignment of benefits under the Plan to a provider of health care services that does not contract with the Plan. The design, adoption, and implementation of such preferred provider contracts and networks are not subject to the requirements of Chapter 143 of the General Statutes, provided that for any hospital preferred provider network all hospitals will have an opportunity to contract with the Plan if they meet the contract requirements. Any contract entered into between a hospital and the Plan shall become effective as soon as practicable after the execution of the contract and, in any event, not later than 10 calendar days after the hospital's delivery of the executed contract to the Plan. The Executive Administrator and Board of Trustees shall, under the provisions of G.S. 135-39.5(12), pursue such preferred provider contracts on a timely basis and shall make reports as requested to the President of the Senate, the President Pro Tempore of the Senate, the Speaker of the House of Representatives, and the Committee on Employee Hospital and Medical Benefits on its progress in negotiating such preferred provider contracts. The Executive Administrator and Board of Trustees shall implement a refined diagnostic-related grouping or diagnostic-related grouping-based reimbursement system for hospitals as soon as practicable, but no later than January 1, 1995."

SECTION 1.(c) G.S. 135-40.5(d) is repealed.

SECTION 1.(d) 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 to be determined by the Plan's Executive Administrator and Board of Trustees. The Plan will pay allowable charges for each outpatient prescription drug less a copayment to be paid by each covered individual equal to the following amounts: pharmacy charges up to ten dollars ($10.00) for each generic prescription, ~~fifteen dollars ($15.00)~~ twenty-five dollars ($25.00) for each branded prescription, and ~~twenty dollars ($20.00)~~thirty-five dollars ($35.00) for each branded prescription with a generic equivalent drug, and ~~twenty-five dollars ($25.00)~~ forty dollars ($40.00) 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. In managing the Plan's outpatient prescription drug benefits, the Plan and its pharmacy benefit manager shall not provide coverage for erectile dysfunction, growth hormone, antiwrinkle, weight loss, and hair growth drugs unless such coverage is medically necessary to the health of the member. The Plan and its pharmacy benefit manager shall not provide coverage for growth hormone and weight loss drugs and antifungal drugs for the treatment of nail fungus and botulinium toxin without approval in advance by the pharmacy benefit manager. Any formulary used by the Plan's Executive Administrator and pharmacy benefit manager shall be an open formulary. Plan members shall not be assessed more than two thousand five hundred dollars ($2,500) per person per fiscal year in copayments required by this subsection."

SECTION 1.(e) The first paragraph of G.S. 135-40.6 reads as rewritten:

"The ~~following~~ benefits provided in this section are subject to a deductible of ~~two hundred fifty dollars ($250.00)~~ three hundred fifty dollars ($350.00) per covered individual to an aggregate maximum of ~~seven hundred fifty dollars ($750.00)~~ one thousand fifty dollars ($1,050) per ~~family~~ employee and child(ren) or employee and family coverage contract per fiscal year and are payable on the basis of eighty percent (80%) by the Plan and twenty percent (20%) by the covered individual up to a maximum of one thousand ~~dollars ($1,000)~~ five hundred dollars ($1,500) out-of-pocket per fiscal ~~year:~~year. The aggregate maximum out-of-pocket required of individuals covered by this section shall not be more than four thousand five hundred dollars ($4,500) per employee and child(ren) or employee and family coverage contract per fiscal year."

SECTION 1.(f) G.S. 135-40.6(1)f. reads as rewritten:

"(1) In-Hospital Benefits. – The Plan pays in-hospital benefits for each single confinement, when charged by a hospital, for room accommodations, including bed, board and general nursing care, but not to exceed the charge for semiprivate room or ward accommodations, or the rate negotiated for the Plan. Under the DRG reimbursement system, the coinsurance shall be based on the lower of the DRG amount or charges.

The Plan will pay the following covered charges, when charged by a hospital, for each confinement.

...

f. ~~Physical~~ Physical, speech, and occupational therapy."

SECTION 1.(g) G.S. 135-40.6(3) reads as rewritten:

"(3) Skilled Nursing Facility Benefits. – The Plan will pay benefits in a skilled nursing facility licensed under applicable State laws for not more than 100 days per fiscal year for the same reason, as follows:

After discharge from a hospital for which inpatient hospital benefits were provided by this Plan for a period of not less than three days, and treatment consistent with the same illness or condition for which the covered individual was hospitalized, the daily charges will be paid for room and board in a semiprivate room or any multibed unit up to the maximum benefit specified in subsection (1) of this section, less the days of care already provided for the same illness in a hospital. Plan allowances for total daily charges may be negotiated but will not exceed the daily semiprivate hospital room rate as determined by the Plan.

Credit will be allowed toward private room charges in an amount equal to the facility's most prevalent charge for semiprivate accommodations. Charges will also be paid for general nursing care and other services which would ordinarily be covered in a general hospital. In order to be eligible for these benefits, admission must occur within 14 days of discharge from the hospital.

In order to qualify for benefits provided by a skilled nursing facility, the following stipulations apply:

a. The services are medically required to be given on an inpatient basis because of the covered individual's need for medically necessary skilled nursing care on a continuing daily basis for any of the conditions for which he or she was receiving inpatient hospital services prior to transfer from a hospital to the skilled nursing facility or for a condition requiring such services which arose after such transfer and while he or she was still in the facility for treatment of the condition or conditions for which he or she was receiving inpatient hospital services,

b. Only on prior referral by and so long as, the patient remains under the active care of an attending doctor and the patient requires continual hospital confinement without the care and treatment of the skilled nursing facility, and

c. Approved in advance by the Claims Processor.

For facilities not qualified for delivery of services covered by the benefits of Title XVIII of the Social Security Act (Medicare), neither the Plan nor any of its members shall be billed or held liable by such facilities for charges that otherwise would be covered by Medicare."

SECTION 1.(h) G.S. 135-40.6(8)e. reads as rewritten:

"e. Prosthetic and Orthopedic Appliances and Durable Medical Equipment: Appliances and equipment including corrective and

supportive devices such as artificial limbs and eyes, wheelchairs, traction equipment, inhalation therapy and suction machines, hospital beds, braces, orthopedic corsets and trusses, not more than three hundred fifty dollars ($350.00) for therapeutic shoes for diabetes and other high-risk conditions, and other prosthetic appliances or ambulatory apparatus which are provided solely for the use of the participant. Eligible charges include repair and replacement when medically necessary. Benefits will be provided on a rental or purchase basis at the sole discretion of the Claims Processor and agreements to rent or purchase shall be between the Claims Processor and the supplier of the appliance.

For the purposes of this subdivision, the term "durable medical equipment" means standard equipment normally used in an institutional setting which can withstand repeated use, is primarily and customarily used to serve a medical purpose, is generally not useful to a person in the absence of an illness or injury and is appropriate for use in the home. Decisions of the Claims Processor, the Executive Administrator and Board of Trustees as to compliance with this definition and coverage under the Plan shall be final."

SECTION 1.(i) G.S. 135-40.6(8)m. reads as rewritten:

"m. Cardiac Rehabilitation: Charges not to exceed ~~six hundred fifty dollars ($650.00)~~ the lesser of one thousand eight hundred dollars ($1,800) or 90 days per fiscal ~~year for cardiac testing and exercise therapy, when determined medically necessary by an attending physician and approved by the Claims Processor for patients with a medical history of myocardial infarction, angina pectoris, arrhythmias, cardiovascular surgery, hyperlipidemia, or hypertension,~~year. Coverage is limited to patients with Coronary Artery Bypass Graft (CABG), status/post myocardial infarction, Percutaneous Transliminal Coronary Angioplasty (PTCA) or stent, valve replacement, heart transplant, or chronic and disabling angina provided such ~~charges are incurred~~services are provided within six months of the qualifying event and in a medically supervised facility fully certified by the North Carolina Department of Health and Human Services."

SECTION 1.(j) G.S. 135-40.6(9)f. reads as rewritten:

"(9) Limitations and Exclusions to Other Covered Charges. – No benefits are available under this section of the Plan until full utilization is made of similar benefits available under other sections of this Plan.

No benefits will be payable for:

...

f. Eyeglasses or other corrective lenses (except for cataract lenses certified as medically necessary for aphakia persons), hearing aids, braces for teeth, dental plates or bridges or other dental prostheses, air-conditioners, vaporizers, humidifiers, mattresses (other than as supplied with a hospital bed) and specially built shoes (other than attached to artificial limbs or orthopedic ~~braces);~~braces, and other than therapeutic shoes for diabetes or other high-risk conditions);"

SECTION 1.(k) G.S. 135-40.6A(b) reads as rewritten:

"(b) The Executive Administrator and Board of Trustees may establish procedures to require prior medical approvals for the following services:

(1) Skilled Nursing Facility ~~Care (after the initial 30 days);~~Care.

(2) Private Duty ~~Nursing;~~Nursing.

(3) Speech Therapy (unless rendered in an inpatient ~~hospital);~~hospital).

(4) Physical Therapy (in the ~~home);~~home).

(7) Surgical Procedures:

a. Blepharoplasties

b. Surgery for Hermaphroditism

c. Excision of Keloids

d. Reduction Mammoplasty

e. Morbid Obesity Surgery

f. Penile Prosthesis

g. Excision of Gynecomastia

h. Cochlear Implants

i. Revision of the Nasal Structure

j. Abdominoplasty

k. Fimbrioplasty

l. Tubotubal ~~Anastomasis.~~Anastomasis

m. Varicose Vein Surgery.

(8) Subcutaneous injection of "filling" material (Example: zyderm, ~~silicone); and~~ silicone).

(8a) Botulinium toxin.

(9) Suction Lipectomy.

(10) Outpatient prescription drugs requiring prospective review under the Plan's pharmacy benefit management program.

(11) Outpatient prescription drugs for growth hormone, weight loss, and antifungal drugs for the treatment of nail fungus."

SECTION 1.(l) G.S. 135-40.8 reads as rewritten:

"**§ 135-40.8. Out-of-pocket expenditures.**

(a) For the balance of any fiscal year after each eligible employee, retired employee, or dependent satisfies the cash deductible, the Plan pays eighty percent (80%) of the eligible expenses outlined in G.S. 135-40.6. ~~The covered individual is then responsible for the remaining twenty percent (20%) until one thousand dollars ($1,000), in excess of the deductible, has been paid out-of-pocket.~~ The remaining twenty percent (20%) is paid by the covered individual until one thousand five hundred dollars ($1,500) per covered individual up to an aggregate of four thousand five hundred dollars ($4,500) per employee and child(ren) or employee and family coverage contract per fiscal year in excess of the deductible has been paid out of pocket. The Plan then pays one hundred percent (100%) of the remaining covered expenses.

~~(b) Where a covered individual fails to obtain a second surgical opinion as required under the Plan, or where a covered individual elects to have a surgery performed that conflicts with a majority opinion of the rendered consultations that the surgery requiring a second or third surgical opinion is not necessary, the covered individual shall be responsible for fifty percent (50%) of the eligible expenses, provided, however, that no covered individual shall be required to pay, in addition to the expenses in subsection (a) above out-of-pocket in excess of five hundred dollars ($500.00) per fiscal year.~~

(c) Notwithstanding any other provision of this Article, on the first day of each confinement the Plan does not pay the first ~~seventy-five dollars ($75.00)~~ one hundred dollars ($100.00) of the room accommodation charge allowable under G.S. 135-40.6(1). Any readmission within 60 days after discharge for the same reason shall be considered the same confinement for the purpose of this subsection. The exclusion made under this subsection shall not count toward the deductible nor toward the maximum amount of coinsurance out-of-pocket costs.

(c1) Notwithstanding any other provision of this Article, the Plan does not pay the first fifty dollars ($50.00) of the facility fees and ancillary charges for allowable charges exceeding five hundred dollars ($500.00) per episode of care for hospital outpatient departments and ambulatory surgical facilities under G.S. 135-40.6(4). Readmission within 30 days after discharge for the same reason shall be considered the same episode of care for the purpose of this subsection. The exclusion made under this subsection shall not count toward the deductible nor toward the maximum amount of coinsurance out-of-pocket costs.

(c2) Notwithstanding any other provision of this Article, the Plan does not pay the first one hundred dollars ($100.00) of allowable emergency room charges when admission to a hospital pursuant to the emergency room use does not immediately follow. This subsection shall apply only when less costly alternative means of emergency medical care are reasonably available as determined by the Executive Administrator and Board of Trustees. The exclusion made under this subsection shall not count toward the deductible nor toward the maximum amount of coinsurance out-of-pocket costs.

(c3) Notwithstanding any other provision of this Article, the Plan does not pay for the first fifteen dollars ($15.00) of allowable charges for each home, office, or skilled nursing facility visit under the provisions of G.S. 134-40.6(7)a. and b., G.S. 135-40.6(4), G.S. 135-40.6(8)e.(IV therapy), i., j., k., n., r., and s., and G.S. 135-40.5(e). The copayment assessed by this subsection shall be assessed only once per person per provider per day and shall not apply to laboratory, pathology, and radiology services. The exclusion made under this subsection shall not count toward the deductible nor toward the maximum amount of coinsurance out-of-pocket costs.

(d) Where a network of qualified preferred providers of inpatient and outpatient hospital care is reasonably available for use by those individuals covered by the Plan, use of providers outside of the preferred network shall be subject to a twenty percent (20%) coinsurance rate up to five thousand dollars ($5,000) per fiscal year per covered individual up to an aggregate of fifteen thousand dollars ($15,000) per employee and child(ren) or employee and family coverage contract per fiscal year in addition to the general coinsurance percentage and maximum fiscal year amount specified by G.S. 135-40.4 and G.S. 135-40.6."

SECTION 1.(m) G.S. 135-40.9 reads as rewritten:

"**§ 135-40.9. Maximum benefits.**

The maximum lifetime benefit for each covered individual ~~will be two million dollars ($2,000,000).~~is unlimited."

SECTION 1.(n) G.S. 135-40.6(2)g. is repealed.

SECTION 1.(o) G.S. 135-40.6(7)a. reads as rewritten:

"(7) Medical Benefits. –

a. Services of Doctors. – The Plan pays the usual, reasonable and customary charges for covered inpatient medical (nonsurgical) services. Services are covered if the individual is hospital-confined and is eligible for hospitalization benefits as described in this section. Benefits are provided for exactly the same number of days as the individual is entitled to under this section, except that medical benefits are provided on both the day of admission and the day of discharge.

In the event a covered individual is treated by two or more co-attending doctors during the same hospital confinement for a medical (nonsurgical) condition, benefits are limited to payment for services provided by the primary attending doctor, except where need is established for supplementary skills for treatment of separate and distinct diagnoses or conditions.

Home, office, and skilled nursing facility visits including (i) charges for injected medications, (ii) inpatient care by attending medical doctors, radiologists, pathologists, and consultants during such time as hospital benefits are paid under any section of this Plan, (iii) care in the outpatient department of a hospital, and (iv) administration of shock therapy (drug or electric) including the services of

anesthesiologists provided on an office or hospital outpatient basis for treatment of acute psychotic reaction or severe depression. ~~The Plan does not cover the first ten dollars ($10.00) of allowable charges for each home, office, or skilled nursing facility visit.~~"

SECTION 1.(p) Effective January 1, 2002, G.S. 135-39.5(12) reads as rewritten:

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

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

...

"(12) Determining basis of payments to health care providers, including payments in accordance with G.S. 58-50-56. The Plan shall comply with G.S. 58-3-225."

SECTION 1.(q) G.S. 135-39.8 reads as rewritten:

"**§ 135-39.8. Rules and regulations.**

The Executive Administrator and Board of Trustees may issue rules and regulations to implement Parts 2, 3, 4, and 5 of this Article. The Executive Administrator and Board of Trustees shall provide to interested persons written notice and an opportunity to comment not later than 30 days prior to adopting, amending, or rescinding a rule or regulation, unless immediate adoption of the rule or regulation without notice is necessary in order to fully effectuate the purpose of the rule or regulation. Rules and regulations of the Board of Trustees shall remain in effect until amended or repealed by the Executive Administrator and Board of Trustees. The Executive Administrator and Board of Trustees shall provide a written description of the rules and regulations issued under this section to all employing units, all health benefit representatives, the oversight team provided for in G.S. 135-39.3, all relevant health care providers affected by a rule or regulation, and to any other ~~parties~~ persons requesting a written description and approved by the Executive Administrator and Board of Trustees to receive a description on a timely basis."

SECTION 1.(r) Not later than January 1, 2003, the Plan shall have developed a prospective payment system for the payment of hospital outpatient services and the services of ambulatory surgical facilities. In developing this prospective payment system, the Plan shall make use of the expertise of the North Carolina Hospital Association, including any advisory committees of member hospitals that the Association may name, and ambulatory surgical facilities in this State. In addition, not later than January 1, 2003, the Plan shall have developed a medical fee schedule for the payment of professional health care services. The fee schedule shall be developed with the participation of the North Carolina Medical Society, the North Carolina Academy of Family Physicians, and any other groups of professional medical service providers that the Society may wish to include. Any prospective payment system for hospital

outpatient services and the services of ambulatory surgical facilities and a medical fee schedule for the providers of professional medical services shall not be implemented by the Plan before July 1, 2003.

SECTION 2. Notwithstanding G.S. 97-26, payment for medical treatment and services rendered to workers' compensation patients by a hospital on or after July 1, 2001, and before August 1, 2001, shall be equal to the payment the hospital would have received for such treatment and services on June 30, 2001.

SECTION 3. This act becomes effective July 1, 2001.

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2001

S D

SENATE BILL 824

Rules and Operations of the Senate Committee Substitute Adopted 6/21/01
PROPOSED HOUSE COMMITTEE SUBSTITUTE S824-PCS6317-LB-71

Short Title: State Health Plan Changes. (Public)

Sponsors:

Referred to:

April 3, 2001

A BILL TO BE ENTITLED

AN ACT PERTAINING TO BENEFITS UNDER THE TEACHERS' AND STATE EMPLOYEES' COMPREHENSIVE MAJOR MEDICAL PLAN; AND TO HOSPITAL RATES UNDER WORKERS' COMPENSATION.

The General Assembly of North Carolina enacts:

SECTION 1.(a) G.S. 135-40.1(2) reads as rewritten:

"(2) Deductible. – Deductible shall mean an amount of covered expenses during a fiscal year which must be incurred after which benefits (subject to the deductible) becomes payable. The deductible for an employee, retired employee and/or his or her dependents shall be ~~two hundred fifty dollars ($250.00)~~ three hundred fifty dollars ($350.00) for each fiscal year.

The deductible applies separately to each covered individual in each fiscal year, subject to an aggregate maximum of ~~seven hundred fifty dollars ($750.00)~~ one thousand fifty dollars ($1,050) per ~~family (employee or retiree and his or her covered dependents)~~employee and child(ren) or employee and family coverage contract in any fiscal year.

If two or more family members are injured in the same accident only one deductible is required for charges related to that accident during the benefit period."

SECTION 1.(b) G.S. 135-40.4(a) reads as rewritten:

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

The Plan is divided into two parts. The first part includes certain benefits which are not subject to a deductible or coinsurance. The second part is a comprehensive plan and includes those benefits which are subject to both a ~~two hundred fifty dollars ($250.00)~~three hundred fifty dollar ($350.00) deductible for each covered individual to

an aggregate maximum of ~~seven hundred fifty dollars ($750.00)~~ one thousand fifty dollars ($1,050) per ~~family~~ employee and child(ren) or employee and family coverage contract and coinsurance of 80%/20%. There is a limit on out-of-pocket expenses under the second part.

Notwithstanding the provisions of this Article, the Executive Administrator and Board of Trustees of the Teachers' and State Employees' Comprehensive Major Medical Plan may contract with providers of institutional and professional medical care and services to established preferred provider networks. The Plan shall, however, honor a Plan member's assignment of benefits under the Plan to a provider of health care services that does not contract with the Plan. The design, adoption, and implementation of such preferred provider contracts and networks are not subject to the requirements of Chapter 143 of the General Statutes, provided that for any hospital preferred provider network all hospitals will have an opportunity to contract with the Plan if they meet the contract requirements. Any contract entered into between a hospital and the Plan shall become effective as soon as practicable after the execution of the contract and, in any event, not later than 10 calendar days after the hospital's delivery of the executed contract to the Plan. The Executive Administrator and Board of Trustees shall, under the provisions of G.S. 135-39.5(12), pursue such preferred provider contracts on a timely basis and shall make reports as requested to the President of the Senate, the President Pro Tempore of the Senate, the Speaker of the House of Representatives, and the Committee on Employee Hospital and Medical Benefits on its progress in negotiating such preferred provider contracts. The Executive Administrator and Board of Trustees shall implement a refined diagnostic-related grouping or diagnostic-related grouping-based reimbursement system for hospitals as soon as practicable, but no later than January 1, 1995."

SECTION 1.(c) G.S. 135-40.5(d) is repealed.

SECTION 1.(d) 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 to be determined by the Plan's Executive Administrator and Board of Trustees. The Plan will pay allowable charges for each outpatient prescription drug less a copayment to be paid by each covered individual equal to the following amounts: pharmacy charges up to ten dollars ($10.00) for each generic prescription, ~~fifteen dollars ($15.00)~~ twenty-five dollars ($25.00) for each branded prescription, and ~~twenty dollars ($20.00)~~thirty-five dollars ($35.00) for each branded prescription with a generic equivalent drug, and ~~twenty-five dollars ($25.00)~~ forty dollars ($40.00) 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. In managing the Plan's outpatient prescription drug benefits, the Plan and its pharmacy benefit manager shall not provide coverage for erectile dysfunction, growth hormone, antiwrinkle, weight loss, and hair growth drugs unless such coverage is medically necessary to the health of the member. The Plan and its pharmacy benefit manager shall not provide coverage for growth hormone and weight loss drugs and antifungal drugs for the treatment of nail fungus and botulinium toxin without approval in advance by the pharmacy benefit manager. Any formulary used by the Plan's Executive Administrator and pharmacy benefit manager shall be an open formulary. Plan members shall not be assessed more than two thousand five hundred dollars ($2,500) per person per fiscal year in copayments required by this subsection."

SECTION 1.(e) The first paragraph of G.S. 135-40.6 reads as rewritten:

"The ~~following~~ benefits provided in this section are subject to a deductible of ~~two hundred fifty dollars ($250.00)~~ three hundred fifty dollars ($350.00) per covered individual to an aggregate maximum of ~~seven hundred fifty dollars ($750.00)~~ one thousand fifty dollars ($1,050) per ~~family~~ employee and child(ren) or employee and family coverage contract per fiscal year and are payable on the basis of eighty percent (80%) by the Plan and twenty percent (20%) by the covered individual up to a maximum of one thousand ~~dollars ($1,000)~~ five hundred dollars ($1,500) out-of-pocket per fiscal ~~year:~~year. The aggregate maximum out-of-pocket required of individuals covered by this section shall not be more than four thousand five hundred dollars ($4,500) per employee and child(ren) or employee and family coverage contract per fiscal year."

SECTION 1.(f) G.S. 135-40.6(1)f. reads as rewritten:

"(1) In-Hospital Benefits. – The Plan pays in-hospital benefits for each single confinement, when charged by a hospital, for room accommodations, including bed, board and general nursing care, but not to exceed the charge for semiprivate room or ward accommodations, or the rate negotiated for the Plan. Under the DRG reimbursement system, the coinsurance shall be based on the lower of the DRG amount or charges.

The Plan will pay the following covered charges, when charged by a hospital, for each confinement.

...

f. ~~Physical~~ Physical, speech, and occupational therapy."

SECTION 1.(g) G.S. 135-40.6(3) reads as rewritten:

"(3) Skilled Nursing Facility Benefits. – The Plan will pay benefits in a skilled nursing facility licensed under applicable State laws for not more than 100 days per fiscal year for the same reason, as follows:

After discharge from a hospital for which inpatient hospital benefits were provided by this Plan for a period of not less than three days, and treatment consistent with the same illness or condition for which the covered individual was hospitalized, the daily charges will be paid for room and board in a semiprivate room or any multibed unit up to the maximum benefit specified in subsection (1) of this section, less the days of care already provided for the same illness in a hospital. Plan allowances for total daily charges may be negotiated but will not exceed the daily semiprivate hospital room rate as determined by the Plan.

Credit will be allowed toward private room charges in an amount equal to the facility's most prevalent charge for semiprivate accommodations. Charges will also be paid for general nursing care and other services which would ordinarily be covered in a general hospital. In order to be eligible for these benefits, admission must occur within 14 days of discharge from the hospital.

In order to qualify for benefits provided by a skilled nursing facility, the following stipulations apply:

a. The services are medically required to be given on an inpatient basis because of the covered individual's need for medically necessary skilled nursing care on a continuing daily basis for any of the conditions for which he or she was receiving inpatient hospital services prior to transfer from a hospital to the skilled nursing facility or for a condition requiring such services which arose after such transfer and while he or she was still in the facility for treatment of the condition or conditions for which he or she was receiving inpatient hospital services,

b. Only on prior referral by and so long as, the patient remains under the active care of an attending doctor and the patient requires continual hospital confinement without the care and treatment of the skilled nursing facility, and

c. Approved in advance by the Claims Processor.

For facilities not qualified for delivery of services covered by the benefits of Title XVIII of the Social Security Act (Medicare), neither the Plan nor any of its members shall be billed or held liable by such facilities for charges that otherwise would be covered by Medicare."

SECTION 1.(h) G.S. 135-40.6(8)e. reads as rewritten:

"e. Prosthetic and Orthopedic Appliances and Durable Medical Equipment: Appliances and equipment including corrective and

supportive devices such as artificial limbs and eyes, wheelchairs, traction equipment, inhalation therapy and suction machines, hospital beds, braces, orthopedic corsets and trusses, not more than three hundred fifty dollars ($350.00) for therapeutic shoes for diabetes and other high-risk conditions, and other prosthetic appliances or ambulatory apparatus which are provided solely for the use of the participant. Eligible charges include repair and replacement when medically necessary. Benefits will be provided on a rental or purchase basis at the sole discretion of the Claims Processor and agreements to rent or purchase shall be between the Claims Processor and the supplier of the appliance.

For the purposes of this subdivision, the term "durable medical equipment" means standard equipment normally used in an institutional setting which can withstand repeated use, is primarily and customarily used to serve a medical purpose, is generally not useful to a person in the absence of an illness or injury and is appropriate for use in the home. Decisions of the Claims Processor, the Executive Administrator and Board of Trustees as to compliance with this definition and coverage under the Plan shall be final."

SECTION 1.(i) G.S. 135-40.6(8)m. reads as rewritten:

"m. Cardiac Rehabilitation: Charges not to exceed ~~six hundred fifty dollars ($650.00)~~ the lesser of one thousand eight hundred dollars ($1,800) or 90 days per fiscal ~~year for cardiac testing and exercise therapy, when determined medically necessary by an attending physician and approved by the Claims Processor for patients with a medical history of myocardial infarction, angina pectoris, arrhythmias, cardiovascular surgery, hyperlipidemia, or hypertension,~~year. Coverage is limited to patients with Coronary Artery Bypass Graft (CABG), status/post myocardial infarction, Percutaneous Transliminal Coronary Angioplasty (PTCA) or stent, valve replacement, heart transplant, or chronic and disabling angina provided such ~~charges are incurred~~services are provided within six months of the qualifying event and in a medically supervised facility fully certified by the North Carolina Department of Health and Human Services."

SECTION 1.(j) G.S. 135-40.6(9)f. reads as rewritten:

"(9) Limitations and Exclusions to Other Covered Charges. – No benefits are available under this section of the Plan until full utilization is made of similar benefits available under other sections of this Plan.

No benefits will be payable for:

...

f. Eyeglasses or other corrective lenses (except for cataract lenses certified as medically necessary for aphakia persons), hearing aids, braces for teeth, dental plates or bridges or other dental prostheses, air-conditioners, vaporizers, humidifiers, mattresses (other than as supplied with a hospital bed) and specially built shoes (other than attached to artificial limbs or orthopedic ~~braces);~~braces, and other than therapeutic shoes for diabetes or other high-risk conditions);"

SECTION 1.(k) G.S. 135-40.6A(b) reads as rewritten:

"(b) The Executive Administrator and Board of Trustees may establish procedures to require prior medical approvals for the following services:

(1) Skilled Nursing Facility ~~Care (after the initial 30 days);~~Care.

(2) Private Duty ~~Nursing;~~Nursing.

(3) Speech Therapy (unless rendered in an inpatient ~~hospital);~~hospital).

(4) Physical Therapy (in the ~~home);~~home).

(7) Surgical Procedures:

a. Blepharoplasties

b. Surgery for Hermaphroditism

c. Excision of Keloids

d. Reduction Mammoplasty

e. Morbid Obesity Surgery

f. Penile Prosthesis

g. Excision of Gynecomastia

h. Cochlear Implants

i. Revision of the Nasal Structure

j. Abdominoplasty

k. Fimbrioplasty

l. Tubotubal ~~Anastomasis.~~Anastomasis

m. Varicose Vein Surgery.

(8) Subcutaneous injection of "filling" material (Example: zyderm, ~~silicone); and~~ silicone).

(8a) Botulinium toxin.

(9) Suction Lipectomy.

(10) Outpatient prescription drugs requiring prospective review under the Plan's pharmacy benefit management program.

(11) Outpatient prescription drugs for growth hormone, weight loss, and antifungal drugs for the treatment of nail fungus."

SECTION 1.(l) G.S. 135-40.8 reads as rewritten:

"**§ 135-40.8. Out-of-pocket expenditures.**

(a) For the balance of any fiscal year after each eligible employee, retired employee, or dependent satisfies the cash deductible, the Plan pays eighty percent (80%) of the eligible expenses outlined in G.S. 135-40.6. ~~The covered individual is then responsible for the remaining twenty percent (20%) until one thousand dollars ($1,000), in excess of the deductible, has been paid out of pocket.~~ The remaining twenty percent (20%) is paid by the covered individual until one thousand five hundred dollars ($1,500) per covered individual up to an aggregate of four thousand five hundred dollars ($4,500) per employee and child(ren) or employee and family coverage contract per fiscal year in excess of the deductible has been paid out of pocket. The Plan then pays one hundred percent (100%) of the remaining covered expenses.

~~(b) Where a covered individual fails to obtain a second surgical opinion as required under the Plan, or where a covered individual elects to have a surgery performed that conflicts with a majority opinion of the rendered consultations that the surgery requiring a second or third surgical opinion is not necessary, the covered individual shall be responsible for fifty percent (50%) of the eligible expenses, provided, however, that no covered individual shall be required to pay, in addition to the expenses in subsection (a) above out of pocket in excess of five hundred dollars ($500.00) per fiscal year.~~

(c) Notwithstanding any other provision of this Article, on the first day of each confinement the Plan does not pay the first ~~seventy-five dollars ($75.00)~~ one hundred dollars ($100.00) of the room accommodation charge allowable under G.S. 135-40.6(1). Any readmission within 60 days after discharge for the same reason shall be considered the same confinement for the purpose of this subsection. The exclusion made under this subsection shall not count toward the deductible nor toward the maximum amount of coinsurance out-of-pocket costs.

(c1) Notwithstanding any other provision of this Article, the Plan does not pay the first fifty dollars ($50.00) of the facility fees and ancillary charges for allowable charges exceeding five hundred dollars ($500.00) per episode of care for hospital outpatient departments and ambulatory surgical facilities under G.S. 135-40.6(4). Readmission within 30 days after discharge for the same reason shall be considered the same episode of care for the purpose of this subsection. The exclusion made under this subsection shall not count toward the deductible nor toward the maximum amount of coinsurance out-of-pocket costs.

(c2) Notwithstanding any other provision of this Article, the Plan does not pay the first one hundred dollars ($100.00) of allowable emergency room charges when admission to a hospital pursuant to the emergency room use does not immediately follow. This subsection shall apply only when less costly alternative means of emergency medical care are reasonably available as determined by the Executive Administrator and Board of Trustees. The exclusion made under this subsection shall not count toward the deductible nor toward the maximum amount of coinsurance out-of-pocket costs.

(c3) Notwithstanding any other provision of this Article, the Plan does not pay for the first fifteen dollars ($15.00) of allowable charges for each home, office, or skilled nursing facility visit under the provisions of G.S. 135-40.6(7)a. and b., G.S. 135-40.6(4), G.S. 135-40.6(8)e.(IV therapy), i., j., k., n., r., and s., and G.S. 135-40.5(e). The copayment assessed by this subsection shall be assessed only once per person per provider per day and shall not apply to laboratory, pathology, and radiology services. The exclusion made under this subsection shall not count toward the deductible nor toward the maximum amount of coinsurance out-of-pocket costs.

(d) Where a network of qualified preferred providers of inpatient and outpatient hospital care is reasonably available for use by those individuals covered by the Plan, use of providers outside of the preferred network shall be subject to a twenty percent (20%) coinsurance rate up to five thousand dollars ($5,000) per fiscal year per covered individual up to an aggregate of fifteen thousand dollars ($15,000) per employee and child(ren) or employee and family coverage contract per fiscal year in addition to the general coinsurance percentage and maximum fiscal year amount specified by G.S. 135-40.4 and G.S. 135-40.6."

SECTION 1.(m) G.S. 135-40.9 reads as rewritten:

"**§ 135-40.9. Maximum benefits.**

The maximum lifetime benefit for each covered individual ~~will be two million dollars ($2,000,000).~~is unlimited."

SECTION 1.(n) G.S. 135-40.6(2)g. is repealed.

SECTION 1.(o) G.S. 135-40.6(7)a. reads as rewritten:

"(7) Medical Benefits. –

a. Services of Doctors. – The Plan pays the usual, reasonable and customary charges for covered inpatient medical (nonsurgical) services. Services are covered if the individual is hospital-confined and is eligible for hospitalization benefits as described in this section. Benefits are provided for exactly the same number of days as the individual is entitled to under this section, except that medical benefits are provided on both the day of admission and the day of discharge.

In the event a covered individual is treated by two or more co-attending doctors during the same hospital confinement for a medical (nonsurgical) condition, benefits are limited to payment for services provided by the primary attending doctor, except where need is established for supplementary skills for treatment of separate and distinct diagnoses or conditions.

Home, office, and skilled nursing facility visits including (i) charges for injected medications, (ii) inpatient care by attending medical doctors, radiologists, pathologists, and consultants during such time as hospital benefits are paid under any section of this Plan, (iii) care in the outpatient department of a hospital, and (iv) administration of shock therapy (drug or electric) including the services of

anesthesiologists provided on an office or hospital outpatient basis for treatment of acute psychotic reaction or severe depression. ~~The Plan does not cover the first ten dollars ($10.00) of allowable charges for each home, office, or skilled nursing facility visit.~~"

SECTION 1.(p) Effective January 1, 2002, G.S. 135-39.5(12) reads as rewritten:

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

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

...

"(12) Determining basis of payments to health care providers, including payments in accordance with G.S. 58-50-56. The Plan shall comply with G.S. 58-3-225."

SECTION 1.(q) G.S. 135-39.8 reads as rewritten:

"**§ 135-39.8. Rules and regulations.**

The Executive Administrator and Board of Trustees may issue rules and regulations to implement Parts 2, 3, 4, and 5 of this Article. The Executive Administrator and Board of Trustees shall provide to interested persons written notice and an opportunity to comment not later than 30 days prior to adopting, amending, or rescinding a rule or regulation, unless immediate adoption of the rule or regulation without notice is necessary in order to fully effectuate the purpose of the rule or regulation. Rules and regulations of the Board of Trustees shall remain in effect until amended or repealed by the Executive Administrator and Board of Trustees. The Executive Administrator and Board of Trustees shall provide a written description of the rules and regulations issued under this section to all employing units, all health benefit representatives, the oversight team provided for in G.S. 135-39.3, all relevant health care providers affected by a rule or regulation, and to any other ~~parties~~ persons requesting a written description and approved by the Executive Administrator and Board of Trustees to receive a description on a timely basis."

SECTION 1.(r) Not later than January 1, 2003, the Plan shall have developed a prospective payment system for the payment of hospital outpatient services and the services of ambulatory surgical facilities. In developing this prospective payment system, the Plan shall make use of the expertise of the North Carolina Hospital Association, including any advisory committees of member hospitals that the Association may name, and ambulatory surgical facilities in this State. In addition, not later than January 1, 2003, the Plan shall have developed a medical fee schedule for the payment of professional health care services. The fee schedule shall be developed with the participation of the North Carolina Medical Society, the North Carolina Academy of Family Physicians, and any other groups of professional medical service providers that the Society may wish to include. Any prospective payment system for hospital

outpatient services and the services of ambulatory surgical facilities and a medical fee schedule for the providers of professional medical services shall not be implemented by the Plan before July 1, 2003.

SECTION 2. Notwithstanding G.S. 97-26, payment for medical treatment and services rendered to workers' compensation patients by a hospital on or after July 1, 2001, and before August 1, 2001, shall be equal to the payment the hospital would have received for such treatment and services on June 30, 2001.

SECTION 3. This act becomes effective July 1, 2001.

SENATE BILL 824:
Teachers' and State Employees' Benefits

BILL ANALYSIS

Committee:	House Health	**Introduced by:**	Senator Rand
Date:	June 26, 2001	**Summary by:**	Dianna Jessup
Version:	S824-PCS6315-LB-68		Committee Counsel

SUMMARY: ***The PCS for Senate Bill 824 would make various changes to the Teachers' and State Employees' Comprehensive Major Medical Plan (the "Plan") and set reimbursement for hospital treatment and services provided under the Workers Compensation Act during the month of July, 2001 at the June 30, 2001 level. Except as otherwise described below, the act would become effective July 1, 2001.***

BILL ANALYSIS: The bill would make the following changes to the Plan:

- The deductible would increase from $250/person to $350/person and from $750/aggregate to $1,050/aggregate. **[Sections 1.(a), 1.(b), 1.(e)]**
- The Plan would be required to honor a member's assignment of benefits to a provider of health care services that does not contract with the Plan, and any contract entered into between a hospital and the Plan would have to become effective not later than 10 calendar days after the hospital's delivery of the executed contract to the Plan **[Section 1.(b)]**
- Required second surgical opinions and coverage for those opinions would be deleted. **[Sections 1.(c), (l)]**
- The copay for generic prescriptions would remain at $10, the copay for branded prescriptions would increase from $15 to $25, the copay for branded prescriptions would increase from $15 to $25, the copay for branded prescriptions with a generic equivalent drug would increase from $20 to $35, and the copay for each branded or generic prescription not on a formulary used by the Plan would increase from $25 to $40. Coverage for growth hormone and weight loss drugs and antifungal drugs for the treatment of nail fungus and botulinium toxin would become subject to the prior approval of the pharmacy benefit manager. Any formulary used by the State Health Plan would be an open formulary, and Plan members would be assessed no more than $2,500 per person per fiscal year in prescription drug copayments. **[Section 1.(d)]**
- The annual maximum out-of-pocket for the 20% coinsurance for an individual would increase from $1,000 to $1,500 with an annual maximum of $4,500 per employee and child(ren) or employee and family coverage **[Sections 1.(e), 1(l)]**
- Speech and occupational therapies would specifically be covered in-hospital. **[Section 1.(f)]**
- Coverage for benefits in a skilled nursing facility would be set at not more than 100 days per fiscal year for each medical condition, and coverage without prior authorization for skilled nursing facility care for the initial 30 days after hospitalization would be eliminated. **[Sections 1.(g), 1(k)]**
- Coverage for therapeutic shoes for diabetes and other high-risk conditions would be added, subject to a $350 limit. **[Sections 1.(h), 1(j)]**

- Coverage for cardiac rehabilitation charges would increase from $650 to the lesser of $1,800 or charges for 90 days within 6 months of specified qualifying events. **[Section 1.(i)]**
- Prior medical approvals would be required for varicose vein surgery, botulinium toxin, and outpatient drugs for growth hormone, weight loss, and antifungal drugs for the treatment of nail fungus. **[Section 1.(k)]**
- The hospital inpatient copayment would increase from $75 to $100, a $50 copayment for hospital outpatient and ambulatory surgical facility services with allowable charges exceeding $500 would be added, the hospital emergency room copayment would increase from $50 to $100, the physician office visit copayment would increase from $10 to $15, a copayment of $15 for visits to other professional providers of health care services would be added, and a $15,000 annual limit on coinsurance for out-of-pocket expenses for use of non-network providers would be added. **[Sections 1.(l), 1(n), 1(o)]**
- The maximum lifetime benefit would increase from $2 million to unlimited. **[Section 1.(m)]**
- Beginning on January 1, 2002, the Plan would have to comply with the prompt payment to provider statute. **[Section 1(p)]**
- The Plan would be required to give notice and an opportunity to comment 30 days prior to adopting, amending, or rescinding a rule or regulation, unless immediate adoption without notice is necessary in order to fully effectuate the purpose of the rule or regulation. **[Section 1.(q)]**

The PCS would also require the Plan to develop a prospective payment system for payment of hospital outpatient services and the services of ambulatory surgical facilities by not later than January 1, 2003. By the same date, the Plan would be required to develop a medical fee schedule for the payment of professional health care services. Both schedules would not be implemented before July 1, 2003. **[Section 1.(r)]**

The PCS would also make a change to the provision in the Workers Compensation Act that prescribes how fees for medical compensation are set. Currently, hospital fees are set in accordance with a statutorily prescribed formula. Under the PCS, payment for medical treatment and services rendered to workers' compensation patients by a hospital during the month of July 2001 would be equal to the payment the hospital would have received for treatment and services on June 30, 2001. **[Section 2]**

BACKGROUND: See the actuarial note for further explanation and background on this bill.

NORTH CAROLINA GENERAL ASSEMBLY
LEGISLATIVE ACTUARIAL NOTE

BILL NUMBER: Senate Bill 824 (Third Edition) HCS

SHORT TITLE: Teachers' and State Employees' Benefits

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: According to available information from the Executive Administrator of the Teachers' and State Employees' Comprehensive Major Medical Plan, the Plan's self-insured indemnity program needs over $927 million in additional financial support to remain solvent and maintain minimum claim stabilization reserves for the 2001-2003 biennium. This amount of additional financial support is a net requirement for the biennium after realizing $192.708 million in reduced outpatient prescription drug claim costs from the program's pharmacy benefit manager according to the Plan ($86.876 million in 2001-2002 and $105.832 million in 2002-2003). This additional financial support can come from additional premium income, additional sources of income, reductions in payments to health care providers, a reduction in benefits provided to members of the program, a reduction in the number of members covered by the program, or from a combination of these avenues. A breakdown of this required additional financial support is:

	2001-2002	2002-2003	Biennium
Additional Financial Support ($Million)	$382.258	$545.032	$927.290

From these requirements can be deducted the additional funding provided by this Act in the way of premiums paid on behalf of teachers, state employees, and retired employees by employing agencies and the State Retirement Systems:

Employer Financing ($Million)	2001-2002	2002-2003	Biennium
General Fund	$150.000	$200.000	$350.000
Highway Fund	7.000	9.000	16.000
Other Employer Funds	30.945	41.176	72.121
Total	$187.945	$250.176	$438.121

This additional premium financing is equivalent to a 30% across-the-board premium rate increase effective October 1, 2001. The Plan's Executive Administrator has the statutory authority to set the premium rates for the spouses and dependent children of teachers, state employees, and retired employees who elect to pay for parent and child and family coverage. If the Executive Administrator were to increase the premium amounts paid by employees and retired employees for their family members by 30% across-the-board effective October 1, 2001, he says that the additional premium income to the program will be:

	2001-2002	2002-2003	Biennium
Employee Financing ($Million)	$49.960	$66.477	$116.437

After realizing the additional premium income provided by this Act and the anticipated premium income to be provided by the Plan's Executive Administrator, the program's financial condition would still be in a deficit position. However, the Plan's Executive Administrator reports that he can reduce payments to the providers of health care by the following amounts during the 2001-2003 biennium:

Reduced Provider Payments ($Million)	2001-2002	2002-2003	Biennium
Additional 20% Discount on Hospital Outpatient Charges	$19.174	$26.985	$ 46.159
Additional 3.45% Discount on Hospital Inpatient Charges	5.725	7.554	13.279
Additional 13% Discount on Charges by Non-Primary Care Physician Services	23.683	46.766	70.449
Total	$48.582	$81.305	$129.887

Assuming that the Plan's Executive Administrator is able to realize the full amount of claim cost savings that he maintains from cuts in payments to hospitals and physicians, the Plan's self-insured indemnity program would still continue to be in a deficit situation. Consequently, the Plan's Executive Administrator has recommended cuts in the benefits to members of the Plan's self-insured indemnity program. The net amount of these recommended benefit reductions for the 2001-2003 biennium is:

	2001-2002	2002-2003	Biennium
Recommended Benefit Reductions ($Million)	$95.771	$147.074	$242.845

The special provisions contained in the referenced sections of this Act reflect the amount of the benefit reductions recommended by the Plan's Executive Administrator. Subsections (a), (b), & (e) increase the program's annual deductible from $250 to $350 per individual and from $750 to $1,050 per employee and child(ren) or employee and family contracts; (b) requires the program to honor a member's assignment of benefits to non-network providers of health care services and requires the program to contract with network hospitals within 10 days after delivery of an executed contract; (c) & (l) eliminate required second surgical opinions; (d) increases outpatient prescription drug copayments for each prescription from $15 to $25 for branded drugs, from $20 to $35 for branded drugs with generic equivalents, and from $25 to $40 for non-formulary or non-preferred formulary drugs, sets a $2,500 annual limit on copayments paid by members of the program, continues the program's open formulary for drugs, and requires prior approval for growth hormone, weight loss, and anti-fungal drugs; (e) & (l) increase the program's maximum annual out-of-pocket for the 20% coinsurance paid by members of the program from $1,000 to $1,500 with an annual limit of $4,500 per employee and child(ren) or employee and family contract; (f) clarifies that hospital inpatient costs include speech and occupational therapy; (g) & (k) eliminate 30 days of skilled nursing facility care following a hospitalization and limits coverage for stays to 100 days per year for each medical condition; (h) & (j) provide coverage for therapeutic shoes for diabetes and other high-risk conditions up to $350; (i) increases coverage for cardiac rehabilitation from $650 annually to the greater of $1,800 or charges for 90 days within 6 months after a hospital discharge or other qualifying event for cardiac conditions; (k) requires prior approval for varicose vein surgery, botulinium toxin, and growth hormone, weight loss, and anti-fungal outpatient prescription drugs; (l) , (n), & (o) increase the hospital inpatient copayment from $75 to $100, add a $50 copayment for hospital outpatient and ambulatory surgical facility services with allowable charges exceeding

$500, increase the hospital emergency room copayment from $50 to $100, increase the physician office visit copayment from $10 to $15, add a $15 copayment for visits to other professional providers of health care services, and add a $15,000 annual limit on coinsurance out-of-pockets expenses per employee and child(ren) or employee & family contract for use of non-network providers; (m) increases the program's maximum lifetime benefit from $2 million to an unlimited amount; (p) requires compliance with the State's laws on prompt payment to providers of medical services beginning January, 2002; (q) requires advance written notice to interested persons on proposed rules and regulations; and (r) requires development of a prospective payment system for hospital outpatient and ambulatory surgical facility services and a medical fee schedule for professional providers of medical services by January, 2003, for implementation no sooner than July, 2003.

With the additional premium income provided by this Act and expected to be provided by the Plan's Executive Administrator, and the cuts in payments to hospitals and physicians and the benefit reductions recommended by the Plan's Executive Administrator, the Plan's self-insured indemnity program is projected to end the 2001-2003 biennium with a cash balance of $102.4 million of which only $3.7 million would not be obligated, according to the Plan.

It must be noted that the data on the amount of financial support included in this Summary comes from the Executive Administrator of the Teachers' and State Employees' Comprehensive Major Medical Plan and not from the General Assembly's Fiscal Research Division nor from its consulting actuary.

EFFECTIVE DATE: All subsections are effective July 1, 2001, except for subsection (p) which becomes effective January 1, 2002.

ESTIMATED IMPACT ON STATE: Based upon information provided by the Plan, its consulting actuary, Aon Consulting, estimates that the referenced provisions of the bill will result in a net cost reduction to the Plan's self-insured indemnity program of $113.1 million in fiscal year 2001-2002 and $147.8 million in fiscal year 2002-2003 for a total net cost reduction for the 2001-2003 biennium of $260.9 million. Aon Consulting's estimate has $121.2 million in total cost reductions for 2001-2002 and $159.8 million for 2002-2003 for a total of $281 million for the biennium. Aon Consulting's estimate has a total increase in the program's cost of $8.1 million in 2001-2002 and $12 million in 2002-2003 for a total increase in cost for the biennium of $20.1 million. Based upon information available from the Plan, the consulting actuary for the General Assembly's Fiscal Research Division, Hartman and Associates, estimates the referenced provisions of the bill will result in a net cost reduction to the Plan's self-insured indemnity program of $128.4 million in fiscal year 2001-2002 and $167.5 million in fiscal year 2002-2003 for a total net cost reduction of $295.9 million for the 2001-2003 biennium. Hartman and Associates' estimate has $130.6 million in total cost reductions for 2001-2002 and $170.7 million for 2002-2003 for a total of $301.3 million for the biennium. Hartman and Associates' estimate has a total increase in the program's cost of $2.2 million in 2001-2002 and $3.2 million in 2002-2003 for a total increase in cost for the biennium of $5.4 million.

The differences in the cost reduction estimates between Aon Consulting and Hartman and Associates are:

	2001-2002		2003-2003	
	Aon Consulting	Hartman & Associates	Aon Consulting	Hartman & Associates
Increased Deductibles	$25.4 Million	$32.1 Million	$32.7 Million	$39.2 Million
Increased Coinsurance Out-of-Pocket	$14.1 Million	$26.2 Million	$21.9 Million	$37.5 Million

Increased Drug Copayments	$57.8 Million	$48.5 Million	$72.0 Million	$63.7 Million
100 Day Limit Per Condition on Skilled Nursing Facility Care	$1.5 Million	$0.3 Million	$2.0 Million	$0.4 Million
Second Surgical Opinions Eliminated	$0.3 Million	$0.4 Million	$0.4 Million	$0.5 Million
Prior Approval of Botox/Anti-Fungal Drugs	$0.5 Million	$0.3 Million	$0.7 Million	$0.4 Million
Increased Office Visit Copayments	$4.7 Million	$5.7 Million	$6.6 Million	$7.0 Million
Copayments for Visits to Other Professionals	$7.7 Million	$8.1 Million	$10.7 Million	$10.4 Million
Increased Hospital Inpatient Copayments	$0.8 Million	$0.8 Million	$1.1 Million	$1.0 Million
Hospital Outpatient Copayments Added	$7.2 Million	$6.8 Million	$10.0 Million	$9.0 Million
Increased Hospital Emergency Room Copayments	$1.2 Million	$1.4 Million	$1.7 Million	$1.6 Million
Total	$121.2 Million	$130.6 Million	$159.8 Million	$170.7 Million

The differences in the cost increase estimates between Aon Consulting and Hartman and Associates are:

	2001-2002		2003-2003	
	Aon Consulting	Hartman & Associates	Aon Consulting	Hartman & Associates
Increased Lifetime Benefit	$6.4 Million	$1.4 Million	$10.0 Million	$2.1 Million
Annual Limit on Drug Copayments	$1.7 Million	$0.8 Million	$2.0 Million	$1.1 Million
Total	$8.1 Million	$2.2 Million	$12.0 Million	$3.2 Million

The projection of Aon Consulting for the increased lifetime benefit is based upon Aon's proprietary rating manual and claimant distributions. The projection of Hartman and Associates is based upon the Society of Actuaries' Group Medical Insurance Large Claims Database Collection and Analysis Report.

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 only had 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. Beginning in July, 2000, firefighters, rescue squad workers, and members of the National Guard and their eligible dependents were allowed to voluntarily participate in the Plan on a fully contributory basis, provided they were ineligible for any other type of group health benefits and had been without such benefits for at least six months. Employer-paid non-contributory premiums are only authorized for the indemnity program's coverage for employees and retired employees. All other types of premium in the indemnity program are fully contributory. The Plan's Executive Administrator has set the premium rates for firefighters, rescue squad workers, and members of the National Guard and their families at 47% more than the comparable rates charged for employees, retired employees, and their families. 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 three HMOs currently covering about 9% of the Plan's total population in 24 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, 2000, include:

	Self-Insured Indemnity Program	**Alternative HMOs**	**Plan Total**
Number of Participants			
Active Employees	248,518	28,822	277,340
Active Employee Dependents	134,795	17,376	152,171
Retired Employees	104,305	3,185	107,490
Retired Employee Dependents	17,936	594	18,530
Former Employees & Dependents with Continued Coverage	2,865	381	3,246
Firefighters, Rescue Squad Workers, National Guard Members & Dependents	3	-	3
Total Enrollments	508,422	50,358	558,780
Number of Contracts			
Employee Only	270,322	23,223	293,545
Employee & Child(ren)	38,775	6,006	44,781
Employee & Family	45,764	3,026	48,790
Total Contracts	354,861	32,255	387,116
Percentage of Enrollment by Age			
29 & Under	28.0%	41.6%	29.2%
30-44	20.9	26.6	21.4
45-54	21.3	19.2	21.1
55-64	14.5	9.2	14.0
65 & Over	15.4	3.4	14.3
Percentage of Enrollment by Sex			

Male	39.1%	36.9%	38.9%
Female	60.9	63.1	61.1

Assumptions for the Self-Insured Indemnity Program: For the fiscal year beginning July 1, 2000, the self-insured program started its operations with a beginning cash balance of $188 million. Receipts for the year are estimated to be $929 million from premium collections, $10 million from investment earnings, and $8 million in risk adjustment and administrative fees from HMOs, for a total of $947 million in receipts for the year. Disbursements from the self-insured program are expected to be $1.085 billion in claim payments and $31 million in administration and claims processing expenses for a total of $1.116 billion for the year beginning July 1, 2000. For the fiscal year beginning July 1, 2001, the self-insured indemnity program is expected to have an operating cash balance of only $19 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 payments to health care providers 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 formularies, and fraud detection) are maintained and improved where possible. Of particular note in these cost containment strategies is that the program's contract with its pharmacy benefit manager, AdvancePCS, calls for a further reduction in claim payments for outpatient prescription drugs for the 2001-03 biennium. Effective July 1, 2001, dispensing fees for pharmacies will be reduced from $4.00 to $1.50 per prescription. In addition, ingredient prices for pharmacies will be reduced from 90% to 85% of average wholesale price (AWP) for branded drugs and from maximum allowable charges (MAC) by the federal Health Care Financing Administration (HCFA) or 80% of AWP to 45% of AWP for generic drugs. 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 12% annually. Total enrollment in the program is expected to increase about 3% annually over the next two years due to enrollment losses from alternative HMOs. The number of enrolled active employees is expected to show a 3% increase annually over the next two years, whereas the growth in the number of retired employees is assumed to be 5% per year. The program is expected to have an increase in the number of active employee dependents and retiree dependents of 2% per year. Investment earnings are based upon a 6% 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 Changes in the Indemnity Plan's Benefits:

Overall Finances: Since the benefits in the Plan's self-insured indemnity program have not suffered any reductions since July 1, 1991, with an overall premium increase of only once since that time (30% increase in October, 1999), an overview of the program's financial condition for the last six years shows:

($ Million)	1993-94	1994-95	1995-96	1996-97	1997-98	1998-99	1999-2000
BEGINNING BALANCE	$193.205	$287.088	$348.944	$368.255	$384.924	$334.140	$234.145
RECEIPTS							
Premiums Due	$596.526	$601.680	$587.139	$574.459	$569.901	$592.920	$765.552

Plus: Receivables (Prior)	$0.162	$0.100	$0.103	$0.770	$0.291	$0.276	$0.194
Sub-Total	$596.688	$601.780	$587.242	$575.229	$570.192	$593.196	$765.746
Less: Receivables (Current)	$0.100	$0.103	$0.770	$0.291	$0.276	$0.194	$0.263
Premium Receipts							
Employees	$352.709	$355.357	$341.011	$328.462	$321.901	$334.388	$432.624
Retirees	$108.897	$113.039	$117.259	$121.477	$125.550	$131.759	$170.560
Dependents	$131.394	$129.522	$124.228	$121.040	$118.686	$122.842	$157.675
Former Members	$3.588	$3.759	$3.974	$3.959	$3.779	$4.013	$4.624
Sub-Total	$596.588	$601.677	$586.472	$574.938	$569.916	$593.002	$765.483
Less: Refunds	$1.053	$1.451	$1.006	$0.839	$1.294	$1.295	$1.641
Total Net Premiums	$595.535	$600.226	$585.466	$574.099	$568.622	$591.707	$763.842
Investment Earnings	$16.081	$21.843	$24.931	$25.471	$24.354	$20.464	$15.241
Average Annual Yield	6.1%	6.4%	6.4%	6.3%	6.2%	6.0%	5.9%
Long Term Care Fees						$0.006	$0.017
HMO Fees	$5.778	$6.104	$7.697	$13.365	$16.803	$16.473	$14.516
Total Receipts	$617.394	$628.173	$618.094	$612.935	$609.779	$628.650	$793.616
TOTAL BEGINNING BALANCE AND RECEIPTS	$810.599	$915.261	$967.038	$981.190	$994.703	$962.790	$1,027.761
DISBURSEMENTS							
Claim Receipts	$1,191.185	$1,293.920	$1,421.994	$1,431.975	$1,561.104	$1,779.548	$2,016.299
Plus: Payables (Prior)	$7.232	$5.998	$10.009	$9.165	$10.899	$13.718	$15.583
Sub-Total	$1,198.417	$1,299.918	$1,432.003	$1,441.140	$1,572.003	$1,793.266	$2,031.882
Less: Deductibles	$72.252	$82.222	$111.969	$89.069	$90.106	$96.851	$97.575
Copayments	$63.673	$89.413	$92.789	$94.526	$102.850	$114.795	$174.055
Coordination of Benefits	$306.962	$336.103	$381.565	$396.309	$449.379	$513.490	$550.578
Non-Covered Charges	$231.814	$221.744	$247.831	$263.264	$264.848	$334.009	$373.100
Payables (Current)	$5.998	$10.009	$9.165	$11.830	$13.718	$15.583	$8.079
Claim Payments							
Employees	$272.789	$289.531	$312.305	$294.382	$312.939	$346.092	$410.692
Retirees	$112.395	$132.844	$142.236	$155.322	$174.758	$201.581	$240.441
Dependents	$125.336	$131.153	$126.576	$128.195	$154.551	$161.689	$168.364
Former Members	$7.198	$6.899	$7.567	$8.243	$8.854	$9.176	$8.998
Sub-Total	$517.718	$560.427	$588.684	$586.142	$651.102	$718.538	$828.495
Less: Refunds	$10.063	$10.711	$6.580	$6.825	$7.558	$8.100	$8.402
Total Net Claims	$507.655	$549.716	$582.104	$579.317	$643.544	$710.438	$820.093
Administration	$3.335	$3.620	$3.653	$3.776	$1.374	$1.299	$1.309
Claims Processing	$12.521	$12.981	$13.026	$13.173	$15.645	$16.908	$18.340
Total Disbursements	$523.511	$566.317	$598.783	$596.266	$660.563	$728.645	$839.742

ENDING BALANCE	$287.088	$348.944	$368.255	$384.924	$334.140	$234.145	$188.019
NUMBER OF CLAIMS (000)							
Beginning Inventory	32.8	26.9	46.5	35.6	46.4	57.3	59.7
Claims Received	5,390.4	5,904.4	5,779.4	5,817.1	6,260.8	6,712.2	8,086.5
Claims Processed	5,396.4	5,884.8	5,790.3	5,806.3	6,249.9	6,709.8	8,111.4
Ending Inventory	26.8	46.5	35.6	46.4	57.3	59.7	34.8
Paid Claims	5,204.0	5,701.2	5,613.1	5,686.4	6,124.2	6,577.1	7,922.6
Paid Adjustments	69.0	79.2	83.7	84.1	89.3	103.4	141.3
Total Paid Claims	5,273.0	5,780.4	5,696.8	5,770.5	6,213.5	6,680.5	8,063.9
Average Claim Payment	$98	$97	$103	$102	$105	$108	$108
AVERAGE NUMBER OF MEMBERS (000)							
Employees	201.7	203.1	196.3	187.8	184.3	190.9	201.3
Retirees	75.7	78.7	81.5	84.5	87.2	91.5	96.1
Dependents							
Employee	119.1	117.4	111.3	105.2	102.1	105.6	109.3
Retiree	14.0	14.1	14.2	14.4	14.7	15.5	16.3
Total Dependents	133.1	131.5	125.5	119.6	116.8	121.1	125.6
Former Members	2.3	2.5	2.6	2.6	2.5	2.6	2.6
Total Membership	412.8	415.8	405.9	394.5	390.8	406.1	425.6
AVERAGE NUMBER OF CONTRACTS (000)							
Employee Only	207.3	211.7	210.3	207.8	208.2	216.8	229.6
Employee & Child(ren)	32.8	32.9	31.5	29.9	29.2	30.2	31.3
Employee & Family	39.5	39.0	37.6	36.5	36.5	38.1	39.4
Total Number of Contracts	279.6	283.6	279.4	274.2	273.9	285.1	300.3

Most of the changes in the program's benefits since July, 1991, have been benefit increases. The major increases in these benefits have been an $150 annual wellness benefit and an outpatient prescription drug card benefit, each without application of the program's annual deductible and coinsurance requirements, and coverage for reconstructive breast surgery following a mastectomy.

Outpatient Prescription Drugs: For the last five fiscal years, the Plan's self-insured indemnity program has seen the following claims experience for outpatient prescription drugs:

Type of Drug	1995-96	1996-97	1997-98	1998-99	1999-00
Brand Drugs					
Number of Prescriptions	1,876,122	2,024,409	2,186,890	2,607,203	3,059,079
% Change	5.8%	7.9%	8.0%	19.2%	17.3%
Total Charges	$84,613,583	$98,409,330	$115,927,964	$151,141,686	$208,695,902
% Change	12.2%	16.3%	17.8%	30.4%	38.1%
Total Allowed Charges	$74,410,827	$86,682,862	$101,337,962	$130,642,766	$184,280,875
% Change	12.2%	16.5%	16.9%	28.9%	41.1%
Allowed Charges Applied to Deductible	$14,127,198	$15,264,043	$16,357,937	$19,606,166	$47,647,337

% Change	11.7%	8.0%	7.2%	19.9%	143.0%
Allowed Charges Applied to Coinsurance	$10,818,606	$12,753,872	$15,109,477	$18,693,645	$9,815,126.0
% Change	12.4%	17.9%	18.5%	23.7%	-47.5%
Total Paid	$49,465,023	$58,664,947	$69,870,548	$91,478,498	$126,253,019
% Change	12.3%	18.6%	19.1%	30.9%	38.0%
Average Total Charge	$45.10	$48.61	$53.01	$57.97	$68.22
% Change	6.1%	7.8%	9.0%	9.4%	17.7%
Average Allowed Charge	$39.66	$42.82	$46.34	$50.11	$60.24
% Change	6.1%	8.0%	8.2%	8.1%	20.2%
Average Applied to Deduct.	$7.53	$7.54	$7.48	$7.52	$15.58
% Change	5.6%	0.1%	-0.8%	0.5%	107.1%
Average Applied to Coinsur.	$5.77	$6.30	$6.91	$7.17	$3.21
% Change	6.3%	9.3%	9.7%	3.8%	-55.3%
Average Paid Charge	$26.37	$28.98	$31.95	$35.09	$41.27
% Change	6.2%	9.9%	10.3%	9.8%	17.6%
Average % of Charge Paid	58.5%	59.6%	60.3%	60.5%	60.5%
Brand Drugs with Generics					
Number of Prescriptions	374,943	336,173	334,814	306,754	320,154
% Change	-10.3%	-10.3%	-0.4%	-8.4%	4.4%
Total Charges	$12,785,948	$12,313,930	$13,539,502	$13,152,741	$16,069,120
% Change	-4.0%	-3.7%	10.0%	-2.9%	22.2%
Total Allowed Charges	$10,760,774	$10,295,733	$11,412,600	$10,984,534	$13,877,689
% Change	-3.4%	-4.3%	10.8%	-3.8%	26.3%
Allowed Charges Applied to Deductible	$3,621,949	$3,328,113	$3,267,785	$3,220,917	$5,465,724
% Change	-12.8%	-8.1%	-1.8%	-1.4%	69.7%
Allowed Charges Applied to Coinsurance	$1,316,847	$1,264,286	$1,491,598	$1,337,447	$733,622
% Change	1.6%	-4.0%	18.0%	-10.3%	-45.1%
Total Paid	$5,821,978	$5,703,334	$6,653,217	$6,364,850	$7,625,886
% Change	2.2%	-2.0%	16.7%	-4.3%	19.8%
Average Total Charge	$34.10	$36.63	$40.44	$42.88	$50.19
% Change	7.0%	7.4%	10.4%	6.0%	17.1%
Average Allowed Charge	$28.70	$30.63	$34.09	$35.81	$43.35
% Change	7.6%	6.7%	11.3%	5.1%	21.1%
Average Applied to Deduct.	$9.66	$9.90	$9.76	$10.50	$17.07
% Change	-2.8%	2.5%	-1.4%	7.6%	62.6%
Average Applied to Coinsur.	$3.51	$3.76	$4.46	$4.36	$2.29
% Change	13.2%	7.1%	18.5%	-2.1%	-47.4%
Average Paid Charge	$15.53	$16.97	$19.87	$20.75	$23.82
% Change	14.0%	9.3%	17.1%	4.4%	14.8%
Average % of Charge Paid	45.5%	46.3%	49.1%	48.4%	47.5%
Generic Drugs					
Number of Prescriptions	1,476,145	1,550,269	1,612,914	1,763,012	1,882,707
% Change	3.1%	5.0%	4.0%	9.3%	6.8%
Total Charges	$22,937,681	$24,922,520	$27,740,795	$32,374,714	$40,868,165
% Change	6.8%	8.7%	11.3%	16.7%	26.2%

Total Allowed Charges	$18,368,094	$20,227,151	$22,977,094	$27,129,910	$37,744,073
% Change	9.4%	10.1%	13.6%	18.1%	39.1%
Allowed Charges Applied to Deductible	$4,487,481	$4,774,829	$4,693,580	$5,377,187	$14,820,145
% Change	7.7%	6.4%	-1.7%	14.6%	175.6%
Allowed Charges Applied to Coinsurance	$2,525,996	$2,792,401	$3,282,494	$3,755,215	$1,906,143
% Change	9.8%	10.5%	17.6%	14.4%	-49.2%
Total Paid	$11,354,617	$12,659,921	$15,001,020	$17,880,177	$20,938,996
% Change	9.9%	11.5%	18.5%	19.2%	17.1%
Average Total Charge	$15.54	$16.08	$17.20	$18.36	$21.71
% Change	3.5%	3.5%	7.0%	6.8%	18.2%
Average Allowed Charge	$12.44	$13.05	$14.25	$15.39	$20.05
% Change	6.0%	4.9%	9.2%	8.0%	30.3%
Average Applied to Deduct.	$3.04	$3.08	$2.91	$3.05	$7.87
% Change	4.5%	1.3%	-5.5%	4.8%	158.1%
Average Applied to Coinsur.	$1.71	$1.80	$2.04	$2.13	$1.01
% Change	6.5%	5.3%	13.0%	4.7%	-52.5%
Average Paid Charge	$7.69	$8.17	$9.30	$10.14	$11.12
% Change	6.6%	6.2%	13.9%	9.0%	9.7%
Average % of Charge Paid	49.5%	50.8%	54.1%	55.2%	51.2%
Compounded Drugs					
Number of Prescriptions	87	59	62	376	105
% Change	-13.0%	-32.2%	5.1%	506.5%	-72.1%
Total Charges	$4,114	$2,422	$3,116	$14,278	$6,636
% Change	-23.9%	-41.1%	28.7%	358.2%	-53.5%
Total Allowed Charges	$4,046	$2,383	$2,937	$13,664	$6,546
% Change	-24.0%	-41.1%	23.2%	365.2%	-52.1%
Allowed Charges Applied to Deductible	$24	$46	$118	$1,865	$1,393
% Change	-86.4%	91.7%	156.5%	1480.5%	-25.3%
Allowed Charges Applied to Coinsurance	$3,482	$1,230	$1,323	$1,790	$347
% Change	-12.6%	-64.7%	7.6%	35.3%	-80.6%
Total Paid	$540	$1,107	$1,496	$9,989	$4,793
% Change	-53.6%	105.0%	35.1%	567.7%	-52.0%
Average Total Charge	$47.29	$41.05	$50.26	$37.97	$63.20
% Change	-12.6%	-13.2%	22.4%	-24.4%	66.4%
Average Allowed Charge	$46.51	$40.39	$47.37	$36.34	$62.34
% Change	-12.7%	-13.2%	17.3%	-23.3%	71.6%
Average Applied to Deduct.	$0.28	$0.78	$1.90	$4.96	$13.27
% Change	-84.3%	182.6%	144.1%	160.6%	167.5%
Average Applied to Coinsur.	$40.02	$20.85	$21.34	$4.76	$3.30
% Change	0.4%	-47.9%	2.4%	-77.7%	-30.6%
Average Paid Charge	$6.21	$18.76	$24.13	$26.57	$45.65
% Change	-46.7%	202.3%	28.6%	10.1%	71.8%
Average % of Charge Paid	13.1%	45.7%	48.0%	70.0%	72.2%
Total Drugs					

Number of Prescriptions	3,727,297	3,910,910	4,134,680	4,677,345	5,262,045
% Change	2.9%	4.9%	5.7%	13.1%	12.5%
Total Charges	$120,341,326	$135,648,202	$157,211,377	$196,683,419	$265,639,823
% Change	9.2%	12.7%	15.9%	25.1%	35.1%
Total Allowed Charges	$103,543,741	$117,208,129	$135,730,593	$168,770,874	$235,909,183
% Change	9.8%	13.2%	15.8%	24.3%	39.8%
Allowed Charges Applied to Deductible	$22,236,652	$23,367,031	$24,319,420	$28,206,135	$67,934,599
% Change	6.1%	5.1%	4.1%	16.0%	140.9%
Allowed Charges Applied to Coinsurance	$14,664,931	$16,811,789	$19,884,892	$23,788,097	$12,455,238
% Change	10.9%	14.6%	18.3%	19.6%	-47.6%
Total Paid	$66,642,158	$77,029,309	$91,526,281	$115,733,514	$154,822,694
% Change	10.9%	15.6%	18.8%	26.4%	33.8%
Average Total Charge	$32.29	$34.68	$38.02	$42.05	$50.48
% Change	6.1%	7.4%	9.6%	10.6%	20.1%
Average Allowed Charge	$27.78	$29.97	$32.83	$36.08	$44.83
% Change	6.8%	7.9%	9.5%	9.9%	24.2%
Average Applied to Deduct.	$5.97	$5.97	$5.88	$6.03	$12.91
% Change	3.1%	0.1%	-1.6%	2.5%	114.1%
Average Applied to Coinsur.	$3.93	$4.30	$4.81	$5.09	$2.37
% Change	7.8%	9.3%	11.9%	5.7%	-53.5%
Average Paid Charge	$17.88	$19.70	$22.14	$24.74	$29.42
% Change	7.8%	10.2%	12.4%	11.8%	18.9%
Average % of Charge Paid	55.4%	56.8%	58.2%	58.8%	58.3%
Average Annual Per Capita Paid	$172	$197	$234	$283	$350
% Change	17.0%	14.5%	18.8%	20.9%	23.7%

During this same five-year period, the annual number of prescriptions per capita increased from 9.2 in 1995-96 to 12.4 in 1999-2000, an increase of 35%. The annual number of branded prescriptions per capita increased from 5.5 in 1995-96 to 7.9 in 1999-2000, while the annual number of generic prescriptions per capita increased from 3.6 in 1995-96 to 4.4 in 1999-2000, an increase of 22%.

For the six-month period ending December 31, 2000, the Plan's self-insured indemnity program paid some $104.8 million in outpatient prescription drug claims. An estimated 3,314,482 prescriptions were paid during this same period. Some of the changes in the program's outpatient prescription drug claim payments can be explained by changes in coverage. Beginning in January, 1992, the program's claim payments for outpatient prescription drugs were limited to 90% of average wholesale price (AWP) for each drug. Average wholesale price (AWP) is the price that drug manufacturers suggest wholesalers charge retail pharmacies for their products. The payment for these drugs was also subject to the program's overall annual deductible and coinsurance requirements paid by members of the program for all covered services, supplies, drugs, etc. Members of the program were also required to pay the full purchase price at the time of purchase and await reimbursement by the program. Effective January 1, 2000, the program's coverage was changed to a prescription drug card format. Under this change, members of the program were required to pay pharmacies copayments for each prescription drug ranging from $10 for generic drugs to $20 for brand drug with generic equivalents for each 34-day supply of the drug. Pharmacies, in turn, were paid directly by the program for the balance of allowable charges not paid by program members in the way of copayments. Allowable charges were set at 90% of a drug's AWP plus a dispensing fee of $6.00 per prescription. Outpatient prescription drugs were also removed from the program's overall annual deductible and coinsurance requirements paid by

members of the program. Effective August 1, 2000, the prescription drug card format was modified to limit allowable charges. Dispensing fees were set at $4.00 per prescription and ingredient pricing for generic drugs was reduced to 80% of AWP for those drugs not subject to maximum allowable charge limits set by the federal Health Care Financing Administration (HCFA) for use by state Medicaid programs. For those generic drugs subject to HCFA maximum allowable charge limits, ingredient pricing was changed to the HCFA limits. The program was also authorized to use a pharmacy benefit management component and an open formulary to further reduce the program's outpatient prescription drug claim costs. Virtually all pharmacies within North Carolina accept the program's payments and member copayments as payment in full for prescriptions.

During the period January through March, 2001, the program paid $765,177 in outpatient prescription drug claims for botulinium toxin and anti-fungal conditions according to the program's pharmacy benefit manager, AdvancePCS. The number of prescriptions processed was 22,316. AdvancePCS proposed to charge $7 for each prior approval in its' pharmacy benefit management contract with the program. Approximately 30% of the outpatient prescription drug claims for botulinium toxin and anti-fungal conditions are expected not to receive prior approval.

Skilled Nursing Facility Claims: The Plan's self-insured indemnity program spent the following gross claims amounts for skilled nursing facility care:

	1995-96	1996-97	1997-98	1998-99	1999-2000
Skilled Nursing Facilities ($Million)	$11.043	$12.418	$12.213	$12.346	$11.069

According to the Plan, the following claims were for stays of 30 days or less:

Year	Admissions	Billed	Allowed	Paid	Average Length-of-Stay
1998-99 ($Million)	1,058	$2.072	$1.894	$1.630	17 Days
1999-2000 ($Million)	1,203	$2.499	$2.199	$1.894	16 Days

For stays of more than 30 days, the Plan's claims data shows:

Year	Admissions	Billed	Allowed	Paid	Average Length-of-Stay
1998-99 ($Million)	553	$9.998	$8.180	$7.429	111 Days
1999-2000 ($Million)	574	$9.522	$7.312	$6.871	102 Days

Lifetime Maximum Benefits: When the State created the Plan's self-insured indemnity program in October 1982, the program had a lifetime maximum benefit of $500,000. This lifetime maximum benefit was increased to $1,000,000 effective July 1, 1991, and to $2,000,000 effective January 1, 1994. As of March 30, 2001, the program had only had one member who reached the program's current maximum of $2,000,000, and that maximum was reached in August 1998. As of the same date, only nine members of the program had accumulated benefits of between one and two million dollars, and their claim payments for the last year averaged less than $65,000. Five former members of the Plan's self-insured indemnity program had accumulated lifetime benefits of between one and two millions dollars, but two had cancelled their coverage with the Plan and three transferred their coverage to HMOs offered by the Plan.

SOURCES OF DATA:

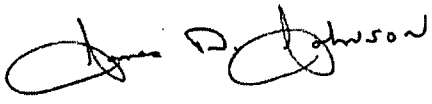
-Actuarial Note, Hartman & Associates, House Committee Substitute for Senate Bill 1005, Sections 32.20(a) through (s), June 21, 2001, original of which is on file in the General Assembly's Fiscal Research Division.
-Actuarial Note, Aon Consulting, House Committee Substitute for Senate Bill 1005, Sections 32.20(a) through (s), June 21, 2001, 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: James D. Johnson



DATE: June 26, 2001.

Clarestene Stewart (Rep. Wright)

From: Gerry Cohen (Bill Drafting, Director)
Sent: Tuesday, June 26, 2001 1:51 PM
To: Rep. Tom Wright
Subject: Navassa

I just talked to Mayor Willis, the Town Board wants to continue the discussion and not act until next Monday night, so he asks that you not calendar the bill in committee until next week.

Clarestene Stewart (Rep. Wright)

From: Annette Ethridge [Annette.Ethridge@ncmail.net]

Sent: Tuesday, June 26, 2001 9:47 AM

To: The Honorable William Wainwright; The Honorable Thomas Wright; The Honorable Ruth Easterling; The Honorable Ronnie Sutton; The Honorable Pryor Gibson; The Honorable Phil Baddour; The Honorable Pete Oldham; The Honorable Pete Cunningham; The Honorable Paul Luebke; The Honorable Martha Alexander; The Honorable Joe Hackney; The Honorable Jim Black; The Honorable Gordon Allen; The Honorable Gene Rogers; The Honorable David Redwine; The Honorable Bill Owens; The Honorable Bill Culpepper; The Honorable Beverly Earle; The Honorable Andy Dedmon; Mike Wilkins; Jane Gray; Jan Bryant; Earle; Danny Lineberry; Beverly Walker; Anita Berry; The Honorable Ronald Smith; Dave McCoy

Subject: House Breakfast-6/28

Please let me know if you will be able to attend breakfast with the Governor on Thursday, June 28th at 7:30 a.m. at the Mansion.

Please r.s.v.p. by e-mail or by calling 715-0962.

Thanks. Annette

2001 COMMITTEE REPORT
HOUSE OF REPRESENTATIVES

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

☒ Committee Substitute for
S.B. 824 A BILL TO BE ENTITLED AN ACT PERTAINING TO BENEFITS UNDER THE TEACHERS' AND STATE EMPLOYEES' COMPREHENSIVE MAJOR MEDICAL PLAN; AND TO HOSPITAL RATES UNDER WORKERS' COMPENSATION.

☐ 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, [redacted] 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)

2/15/01

VISITOR REGISTRATION SHEET

HEALTH — 6-26-01

Name of Committee — Date

VISITORS:. PLEASE SIGN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
R. Paul Wilms	NCHBA
Jack Pike	NCAG
Singleton	SEANC
Tony Rand	NCAHP
Joanne Schaefer	NCNURSES
Kay Ellen	SEAP
Gail Cabaniss	NCAE
Audrey Galloway	NCAE
Gary Simmons	GSK
Mark Smith	GSK
Steve Keene	NCMS
[illegible]	Moore & Van Allen
Jim Webster	State A. Plan
John Goodrich	Alley Assoc.
Ken McHon	Alley Associates, Inc.
Mike Jones	NCAHP
George Tennis	Johnson & Johnson
Lekita Esso	Allen Assoc
Zeb Alley	Alley Assoc
Andy Ellen	NCRMA
Mike Causey	NCOSA
Tim Minton	NC Home Building Association
Bill Scoggin	Kennedy Covington
M Murphy	Pfizer
Margaret Westbrook	Kennedy Covington
Kathryn Jo Bain	NC Medical Society
[illegible]	NCCCS
Frank Lewis	OSBPM

VISITOR REGISTRATION SHEET

Name of Committee | Date

VISITORS:. PLEASE SIGN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Hal Miller	NCACCT
Russ Eubanks	AOC
Lyn Bonner	NEO
Steve Hoffman	NCSBA

AGENDA

HOUSE COMMITTEE ON HEALTH
TUESDAY, July 3, 2001
12:00 Noon, ROOM 415 LOB

OPENING REMARKS

Rep. Thomas E. Wright
Chairman

BILLS TO BE DISCUSSED

SB-826 CRIMINAL RECORD CHECK CHANGE/ LONG-TERM CARE.
(Sen. Rand)

COMMENTS

ADJOURNMENT

MINUTES

COMMITTEE ON HEALTH

TUESDAY, JULY 3, 2001

12:00 NOON, ROOM 415 LOB

The House Committee on Health met on Tuesday, July 3, 2001 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-826 CRIMINAL RECORD CHECK CHANGE/LONG-TERM CARE.(Sen. Rand).

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

Sen. Rand explained the proposed committee substitute. Dianna Jessup further explained the bill.

Rep. Justus commented on the bill and motioned to give House proposed committee substitute a favorable report.

Rep. Clary asked about criminal record background checks through the Division of Child Development. Dianna Jessup responded. Rep. Clary followed up with a question about a list of various crimes that the Division of Child Development use to disqualify applicants. Dianna Jessup responded. Rep. Clary commented. Patricia Yancey of the Friends of Residence of Long-Term Care, stated that the group opposes the removal of the National Criminal Background Checks. Rep. Wright asked Patricia Yancey about possible solutions. Patricia Yancey responded. Rep. Clary commented about a special provision in the House and Senate budget that could possibly put all criminal background checks under the Department of Health and Human Services. Rep. Wainwright asked Rep. Clary about the current process in performing criminal background checks. Rep. Clary responded. Rep. Wainwright asked if this was a fee for service. Rep. Clary responded. Dianna Jessup, Staff, responded that the childcare provider pays for the fingerprinting and the local background check and the Department of Health and Human Services pays for the National background check. Rep. Wainwright followed up with a comment about the increase workload of the agency would mean the hiring of additional staff to conduct the criminal background checks. Rep. Wainwright addressed Sen. Rand about the possibility of a fee for service. Sen. Rand responded. Rep. Wainwright asked about obtaining criminal background checks. Chairman Wright responded. Dianna Jessup further commented on the criminal background checks. Rep. Clary asked Sen. Rand to entertain a moratorium as a substitute

solution at this time. Sen. Rand responded. Rep. Earle asked Sen. Rand of the current process. Sen. Rand responded. Lou Wilson, of the North Carolina Association of Long Term Care Facilities, further commented on the national criminal background check process for an adult care homes. Greg Souza, of the Nursing Home Association, commented further commented on the bill. Rep. Earle asked if a federal background check was done on direct care of a resident in a nursing home and home health. Greg Souza responded. Rep. Earle responded that she opposes a repeal to the current law. Rep. Insko asked if there were other states with the same problem. Sen. Rand responded that if you leave a statute in place that can't be enforced, it may impose a liability. Rep. Earle asked Sen. Rand how long has the law been in place. Sen. Rand responded. Chairman Wright asked for clarification of the bill. Rep. Earle commented that liability still exist in the waiting period of the results of the criminal background check. Rep. Wainwright asked what happens to the employee during the waiting period. Sen. Rand responded that the employee can be hired pending the outcome of the criminal background check. Rep. Clary commented on the cost and the fiscal note.

Rep. Clary sent forth an amendment and explained the amendment to the committee.

Sen. Rand responded. Dianna Jessup, Staff, further explained the amendment. Linda Attarian, Staff, further explained the amendment. Sen. Rand commented on the amendment. Rep. Wainwright commented on the amendment. Dianna Jessup, Staff, responded.

Rep. Insko sent forth a perfecting amendment to Rep. Clary's amendment.

Dianna Jessup, Staff, further explained the amendment.

Rep, Justus asked Lou Wilson if this represented a significant cost factor. Lou Wilson responded. Rep. Justus commented on the cost to the consumer. Lou Wilson responded that there would be a cost to the state also. Rep. Wainwright commented on the amendment.

Chairman Wright called the question on Rep. Insko's perfecting amendment. The amendment failed.

Chairman Wright called the question on Rep. Clary's amendment. The amendment failed.

Rep. Wainwright sent forth an amendment on page 8, section 4d on line 31-32. Dianna Jessup further explained the amendment.

Chairman Wright called the question on Rep. Wainwright's amendment. So moved.

Chairman Wright called the question on Rep. Justus's motion to give the bill, as amended, a favorable report, unfavorable to the original bill. So moved.

The meeting adjourned at 12:55pm.

Rep. Thomas E. Wright, Chairman

Vanda Wilson-Wormack, Committee Assistant

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2001

S 3

SENATE BILL 826
Health Care Committee Substitute Adopted 4/19/01
Third Edition Engrossed 4/23/01

Short Title: Criminal Record Check Change/Long-Term Care. (Public)

Sponsors:

Referred to:

April 3, 2001

A BILL TO BE ENTITLED

AN ACT TO REPEAL THE REQUIREMENT FOR A NATIONAL CRIMINAL HISTORY RECORD CHECK FOR CERTAIN LONG-TERM CARE FACILITIES BECAUSE OF FEDERAL REQUIREMENTS LIMITING DISTRIBUTION OF RECORD CHECK RESULTS.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 131E-265 reads as rewritten:

"**§ 131E-265. Criminal history record checks required for certain applicants for employment.**

(a) Requirement; Nursing Home or Home Care Agency. – An offer of employment by a nursing home licensed under this Chapter to an applicant to fill a position that does not require the applicant to have an occupational license is conditioned on consent to a criminal history record check of the applicant. ~~If the applicant has been a resident of this State for less than five years, then the offer of employment is conditioned on consent to a State and national criminal history record check of the applicant. The national criminal history record check shall include a check of the applicant's fingerprints. If the applicant has been a resident of this State for five years or more, then the offer is conditioned on consent to a State criminal history record check of the applicant.~~ An offer of employment by a home care agency licensed under this Chapter to an applicant to fill a position that requires entering the patient's home is conditioned on consent to a criminal history record check of the applicant. In addition, employment status change of a current employee of a home care agency licensed under this Chapter from a position that does not require entering the patient's home to a position that requires entering the patient's home shall be conditioned on consent to a criminal history record check of that current employee. ~~If the applicant for employment or if the current employee who is changing employment status has been a resident of this State for less than five years, then the offer of employment or change in employment status is conditioned on consent to a State and national criminal history~~

~~record check. The national criminal history record check shall include a check of the applicant's or current employee's fingerprints. If the applicant or current employee has been a resident of this State for five years or more, then the offer is conditioned on consent to a State criminal history record check of the applicant or current employee applying for a change in employment status.~~ A nursing home or a home care agency shall not employ an applicant who refuses to consent to a criminal history record check required by this section. In addition, a home care agency shall not change a current employee's employment status from a position that does not require entering the patient's home to a position that requires entering the patient's home who refuses to consent to a criminal history record check required by this section. Within five business days of making the conditional offer of employment, a nursing home or home care agency shall submit a request to the Department of Justice under G.S. 114.19.10 to conduct a State ~~or national~~ criminal history record check required by this section, or shall submit a request to a private entity to conduct a State criminal history record check required by this section. All criminal history information received by the home or agency is confidential and may not be disclosed, except to the applicant as provided in subsection (b) of this section.

(a1) Requirement; Contract Agency of Nursing Home or Home Care Agency. – An offer of employment by a contract agency of a nursing home or home care agency licensed under this Chapter to an applicant to fill a position that does not require the applicant to have an occupational license is conditioned upon consent to a criminal history record check of the applicant. ~~If the applicant has been a resident of this State for less than five years, then the offer of employment is conditioned on consent to a State and national criminal history record check of the applicant. The national criminal history record check shall include a check of the applicant's fingerprints. If the applicant has been a resident of this State for five years or more, then the offer is conditioned on consent to a State criminal history record check of the applicant.~~ A contract agency of a nursing home or home care agency shall not employ an applicant who refuses to consent to a criminal history record check required by this section. Within five business days of making the conditional offer of employment, a contract agency of a nursing home or home care agency shall submit a request to the Department of Justice under G.S. 114-19.10 to conduct a State ~~or national~~ criminal history record check required by this section, or shall submit a request to a private entity to conduct a State criminal history record check required by this section. All criminal history information received by the contract agency is confidential and may not be disclosed, except to the applicant as provided by subsection (b) of this section.

(b) Action. – If an applicant's criminal history record check reveals one or more convictions of a relevant offense, the nursing home or home care agency, or the contract agency of a nursing home or home care agency, shall consider all of the following factors in determining whether to hire the applicant:

(1) The level and seriousness of the crime.

(2) The date of the crime.

(3) The age of the person at the time of the conviction.
(4) The circumstances surrounding the commission of the crime, if known.
(5) The nexus between the criminal conduct of the person and the job duties of the position to be filled.
(6) The prison, jail, probation, parole, rehabilitation, and employment records of the person since the date the crime was committed.
(7) The subsequent commission by the person of a relevant offense.

The fact of conviction of a relevant offense alone shall not be a bar to employment; however, the listed factors shall be considered by the nursing home or home care agency, or the contract agency of the nursing home or home care agency. If a nursing home, home care agency, or contract agency of a nursing home or home care agency disqualifies an applicant after consideration of the relevant factors, then the nursing home, home care agency, or contract agency may disclose information contained in the criminal history record check that is relevant to the disqualification, but may not provide a copy of the criminal history record check to the applicant.

(c) Limited Immunity. – An entity and an officer or employee of an entity that, in good faith, complies with this section is not liable for the failure of the entity to employ an individual on the basis of information provided in the criminal history record check of the individual.

(d) Relevant Offense. – As used in this section, the term "relevant offense" has the same meaning as in G.S. 131D-40.

(e) Penalty for Furnishing False Information. – Any applicant for employment who willfully furnishes, supplies, or otherwise gives false information on an employment application that is the basis for a criminal history record check under this section shall be guilty of a Class A1 misdemeanor.

(f) Conditional Employment. – A nursing home or home care agency may employ an applicant conditionally prior to obtaining the results of a criminal history record check regarding the applicant if both of the following requirements are met:

(1) The nursing home or home care agency shall not employ an applicant prior to obtaining the applicant's consent for a criminal history record check as required in subsection (a) of this section or the completed fingerprint cards as required in G.S. 114-19.10.
(2) The nursing home or home care agency shall submit the request for a criminal history record check not later than five business days after the individual ~~begins conditional employment.~~ undertakes the functions of the job.

(g) Immunity From Liability. – An entity and officers and employees of an entity shall be immune from civil liability for failure to check an employee's history of criminal offenses if the employee's criminal history record check is requested and received in compliance with this section."

SECTION 2. G.S. 131D-40 reads as rewritten:

"**§ 131D-40. Criminal history record checks required for certain applicants for employment.**

(a) Requirement; Adult Care Home. – An offer of employment by an adult care home licensed under this Chapter to an applicant to fill a position that does not require the applicant to have an occupational license is conditioned on consent to a criminal history record check of the applicant. ~~If the applicant has been a resident of this State for less than five years, then the offer of employment is conditioned on consent to a State and national criminal history record check of the applicant. The national criminal history record check shall include a check of the applicant's fingerprints. If the applicant has been a resident of this State for five years or more, then the offer is conditioned on consent to a State criminal history record check of the applicant.~~ An adult care home shall not employ an applicant who refuses to consent to a criminal history record check required by this section. Within five business days of making the conditional offer of employment, an adult care home shall submit a request to the Department of Justice under G.S. 114-19.10 to conduct a State ~~or national~~ criminal history record check required by this section, or shall submit a request to a private entity to conduct a State criminal history record check required by this section. All criminal history information received by the home is confidential and may not be disclosed, except to the applicant as provided in subsection (b) of this section.

(a1) Requirement; Contract Agency of Adult Care Home. – An offer of employment by a contract agency of an adult care home licensed under this Chapter to an applicant to fill a position that does not require the applicant to have an occupational license is conditioned upon consent to a criminal history record check of the applicant. ~~If the applicant has been a resident of this State for less than five years, then the offer of employment is conditioned on consent to a State and national criminal history record check of the applicant. The national criminal history record check shall include a check of the applicant's fingerprints. If the applicant has been a resident of this State for five years or more, then the offer is conditioned on consent to a State criminal history record check of the applicant.~~ A contract agency of an adult care home shall not employ an applicant who refuses to consent to a criminal history record check required by this section. Within five business days of making the conditional offer of employment, a contract agency of an adult care home shall submit a request to the Department of Justice under G.S. 114-19.10 to conduct a State ~~or national~~ criminal history record check required by this section, or shall submit a request to a private entity to conduct a State criminal history record check required by this section. All criminal history information received by the contract agency is confidential and may not be disclosed, except to the applicant as provided by subsection (b) of this section.

(b) Action. – If an applicant's criminal history record check reveals one or more convictions of a relevant offense, the adult care home or a contract agency of the adult care home shall consider all of the following factors in determining whether to hire the applicant:

(1) The level and seriousness of the crime.

(2) The date of the crime.
(3) The age of the person at the time of the conviction.
(4) The circumstances surrounding the commission of the crime, if known.
(5) The nexus between the criminal conduct of the person and the job duties of the position to be filled.
(6) The prison, jail, probation, parole, rehabilitation, and employment records of the person since the date the crime was committed.
(7) The subsequent commission by the person of a relevant offense.

The fact of conviction of a relevant offense alone shall not be a bar to employment; however, the listed factors shall be considered by the adult care home or the contract agency of the adult care home. If the adult care home or a contract agency of the adult care home disqualifies an applicant after consideration of the relevant factors, then the adult care home or the contract agency may disclose information contained in the criminal history record check that is relevant to the disqualification, but may not provide a copy of the criminal history record check to the applicant.

(c) Limited Immunity. – An adult care home and an officer or employee of an adult care home that, in good faith, complies with this section is not liable for the failure of the home to employ an individual on the basis of information provided in the criminal history record check of the individual.

(d) Relevant Offense. – As used in this section, "relevant offense" means a State crime, whether a misdemeanor or felony, that bears upon an individual's fitness to have responsibility for the safety and well-being of aged or disabled persons. These crimes include the criminal offenses set forth in any of the following Articles of Chapter 14 of the General Statutes: Article 5, Counterfeiting and Issuing Monetary Substitutes; Article 5A, Endangering Executive and Legislative Officers; Article 6, Homicide; Article 7A, Rape and Other Sex Offenses; Article 8, Assaults; Article 10, Kidnapping and Abduction; Article 13, Malicious Injury or Damage by Use of Explosive or Incendiary Device or Material; Article 14, Burglary and Other Housebreakings; Article 15, Arson and Other Burnings; Article 16, Larceny; Article 17, Robbery; Article 18, Embezzlement; Article 19, False Pretenses and Cheats; Article 19A, Obtaining Property or Services by False or Fraudulent Use of Credit Device or Other Means; Article 19B, Financial Transaction Card Crime Act; Article 20, Frauds; Article 21, Forgery; Article 26, Offenses against Public Morality and Decency; Article 26A, Adult Establishments; Article 27, Prostitution; Article 28, Perjury; Article 29, Bribery; Article 31, Misconduct in Public Office; Article 35, Offenses Against the Public Peace; Article 36A, Riots and Civil Disorders; Article 39, Protection of Minors; Article 40, Protection of the Family; Article 59, Public Intoxication; and Article 60, Computer-Related Crime. These crimes also include possession or sale of drugs in violation of the North Carolina Controlled Substances Act, Article 5 of Chapter 90 of the General Statutes, and alcohol-related offenses such as sale to underage persons in violation of G.S. 18B-302 or driving while impaired in violation of G.S. 20-138.1 through G.S. 20-138.5.

(e) Penalty for Furnishing False Information. – Any applicant for employment who willfully furnishes, supplies, or otherwise gives false information on an employment application that is the basis for a criminal history record check under this section shall be guilty of a Class A1 misdemeanor.

(f) Conditional Employment. – An adult care home may employ an applicant conditionally prior to obtaining the results of a criminal history record check regarding the applicant if both of the following requirements are met:

(1) The adult care home shall not employ an applicant prior to obtaining the applicant's consent for a criminal history record check as required in subsection (a) of this section or the completed fingerprint cards as required in G.S. 114-19.10.

(2) The adult care home shall submit the request for a criminal history record check not later than five business days after the individual ~~begins conditional employment.~~undertakes the functions of the job.

(g) Immunity From Liability. – An entity and officers and employees of an entity shall be immune from civil liability for failure to check an employee's history of criminal offenses if the employee's criminal history record check is requested and received in compliance with this section."

SECTION 3. G.S. 114-19.10 reads as rewritten:

"**§ 114-19.10. Criminal record checks for adult care homes, nursing homes, home care agencies, and area mental health, developmental disabilities, and substance abuse services authorities.**

The Department of Justice may provide to the following entities ~~the criminal history from the State and National Repositories of Criminal Histories:~~a criminal record check of an individual who is employed by that entity, has applied for employment with that entity, or has volunteered to provide direct care on behalf of that entity:

(1) Nursing homes or combination homes licensed under Chapter 131E of the General Statutes.

(2) Adult care homes licensed under Chapter 131D of the General Statutes.

(3) Home care agencies licensed under Chapter 131E of the General Statutes.

(4) Area mental health, developmental disabilities, and substance abuse services authorities licensed under Chapter 122C of the General Statutes, including a contract agency of an area authority that is subject to the provisions of Article 4 of that Chapter.

The criminal history shall be provided to nursing homes and home care agencies in accordance with G.S. 131E-265, to adult care homes in accordance with G.S. 131D-40, and to area mental health, developmental disabilities, and substance abuse services authorities in accordance with G.S. 122C-80. The requesting entity shall provide to the Department of Justice, along with the request, the fingerprints of the individual to be ~~checked if a national criminal history record check is required,~~ checked, any additional

information required by the Department of Justice, and a form signed by the individual to be checked consenting to the check of the criminal record and to the use of fingerprints and other identifying information required by the State or National Repositories of Criminal Histories. If a national criminal history record check is required, the fingerprints of the individual shall be forwarded to the State Bureau of Investigation for a search of the State's criminal history record file, and the State Bureau of Investigation shall forward a set of fingerprints to the Federal Bureau of Investigation for a national criminal history record check. All information received by the entity shall be kept confidential in accordance with G.S. 131E-265, 131D-40, and 122C-80, as applicable. The Department of Justice shall charge a reasonable fee for conducting the checks authorized by this section. The fee for the State check may not exceed fourteen dollars ($14.00)."

SECTION 4.(a) There is established the Legislative Study Commission on Criminal History Record Checks. The purpose of the Commission is to study how federal law affects the distribution of national criminal history record check information requested for nursing homes, home care agencies, adult care homes, assisted living facilities, and area mental health, developmental disabilities, and substance abuse services authorities, and the problems federal restrictions pose for effective and efficient implementation of State required criminal record checks. The study shall include the following:

(1) Ways in which national record checks may be obtained and reviewed for these facilities to effectuate State policy and protections of facility residents, and the advantages, disadvantages, and costs of various approaches to implementation.

(2) A review of ways in which federal record checks are obtained by the Division of Child Development, Department of Health and Human Services, and other State agencies, and related costs to the State.

(3) Solutions adopted by other states to effectively and efficiently implement criminal record check requirements, including costs to the State in implementing these solutions.

(4) Other issues the Commission considers relevant to State requirements for criminal history record checks in long-term care facilities.

SECTION 4.(b) The Commission shall consist of 22 members, appointed as follows:

(1) Ten members of the General Assembly, five of whom shall be Senators appointed by the President Pro Tempore of the Senate, and five of whom shall be members of the House of Representatives appointed by the Speaker of the House of Representatives.

(2) A representative from each of the following, appointed by the President Pro Tempore of the Senate:

a. North Carolina Association of Long Term Care Facilities.

b. North Carolina Assisted Living Association, Inc.

c. The Secretary of Health and Human Services, or her designee.
d. The Director of the Division of Aging of the Department of Health and Human Services.
e. The Director of the Division of Mental Health, Developmental Disabilities, and Substance Abuse Services of the Department of Health and Human Services.
f. The Council on Community Programs.

(3) A representative from each of the following, appointed by the Speaker of the House of Representatives:
a. North Carolina Health Care Facilities Association.
b. Friends of Residents in Long Term Care.
c. The Director of the State Bureau of Investigation, or his designee.
d. The Director of the Division of Facility Services of the Department of Health and Human Services.
e. The Attorney General, or his designee.
f. CNC Access, Inc., an organization representing providers of mental health, developmental disabilities, and substance abuse services.

SECTION 4.(c) With the prior approval of the Legislative Services Commission, the Legislative Services Officer shall assign professional staff to assist in the work of the Legislative Study Commission on Criminal History Record Checks. With the prior approval of the Legislative Services Commission, the Study Commission may hold its meetings in the State Legislative Building or the Legislative Office Building.

SECTION 4.(d) The Commission shall submit a final written report of its findings and recommendations on or before the convening of the 2003 Session of the General Assembly and may submit a report to the 2002 Regular Session of the 2001 General Assembly. All reports shall be filed with the President Pro Tempore of the Senate and the Speaker of the House of Representatives, the Principal Clerks of the Senate and the House of Representatives, and the Legislative Librarian. Upon filing its final report, the Commission shall terminate.

SECTION 4.(e) Members of the Commission shall be paid per diem, subsistence, and travel allowances as follows:

(1) Commission members who are also members of the General Assembly, at the rate established in G.S. 120-3.1;
(2) Commission members who are officials or employees of the State or local government agencies, at the rate established in G.S. 138-6;
(3) All other Commission members, at the rate established in G.S. 138-5.

SECTION 4.(f) All State departments and agencies shall cooperate with the Commission and, upon request, shall furnish to the Commission and its staff any information in their possession or available to them.

SECTION 4.(g) From funds appropriated to the General Assembly, the Legislative Services Commission shall allocate funds for the expenses of the Legislative Study Commission on Criminal History Record Checks.

SECTION 5. This act is effective when it becomes law.

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2001

S D

SENATE BILL 826

Health Care Committee Substitute Adopted 4/19/01
Third Edition Engrossed 4/23/01
PROPOSED HOUSE COMMITTEE SUBSTITUTE S826-PCS9307-SW-53

Short Title: Criminal Record Check Change/Long-Term Care. (Public)

Sponsors:

Referred to:

April 3, 2001

A BILL TO BE ENTITLED

AN ACT TO REPEAL THE REQUIREMENT FOR A NATIONAL CRIMINAL HISTORY RECORD CHECK FOR CERTAIN LONG-TERM CARE FACILITIES BECAUSE OF FEDERAL REQUIREMENTS LIMITING DISTRIBUTION OF RECORD CHECK RESULTS AND TO ESTABLISH THE STUDY COMMISSION ON CRIMINAL HISTORY RECORD CHECKS.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 131E-265 reads as rewritten:

"**§ 131E-265. Criminal history record checks required for certain applicants for employment.**

(a) Requirement; Nursing Home or Home Care Agency. – An offer of employment by a nursing home licensed under this Chapter to an applicant to fill a position that does not require the applicant to have an occupational license is conditioned on consent to a criminal history record check of the applicant. ~~If the applicant has been a resident of this State for less than five years, then the offer of employment is conditioned on consent to a State and national criminal history record check of the applicant. The national criminal history record check shall include a check of the applicant's fingerprints. If the applicant has been a resident of this State for five years or more, then the offer is conditioned on consent to a State criminal history record check of the applicant.~~ An offer of employment by a home care agency licensed under this Chapter to an applicant to fill a position that requires entering the patient's home is conditioned on consent to a criminal history record check of the applicant. In addition, employment status change of a current employee of a home care agency licensed under this Chapter from a position that does not require entering the patient's home to a position that requires entering the patient's home shall be conditioned on consent to a criminal history record check of that current employee. ~~If the applicant for employment or if the current employee who is changing employment status has been a resident of~~

~~this State for less than five years, then the offer of employment or change in employment status is conditioned on consent to a State and national criminal history record check. The national criminal history record check shall include a check of the applicant's or current employee's fingerprints. If the applicant or current employee has been a resident of this State for five years or more, then the offer is conditioned on consent to a State criminal history record check of the applicant or current employee applying for a change in employment status.~~ A nursing home or a home care agency shall not employ an applicant who refuses to consent to a criminal history record check required by this section. In addition, a home care agency shall not change a current employee's employment status from a position that does not require entering the patient's home to a position that requires entering the patient's home who refuses to consent to a criminal history record check required by this section. Within five business days of making the conditional offer of employment, a nursing home or home care agency shall submit a request to the Department of Justice under G.S. 114.19.10 to conduct a State ~~or national~~ criminal history record check required by this section, or shall submit a request to a private entity to conduct a State criminal history record check required by this section. All criminal history information received by the home or agency is confidential and may not be disclosed, except to the applicant as provided in subsection (b) of this section.

(a1) Requirement; Contract Agency of Nursing Home or Home Care Agency. – An offer of employment by a contract agency of a nursing home or home care agency licensed under this Chapter to an applicant to fill a position that does not require the applicant to have an occupational license is conditioned upon consent to a criminal history record check of the applicant. ~~If the applicant has been a resident of this State for less than five years, then the offer of employment is conditioned on consent to a State and national criminal history record check of the applicant. The national criminal history record check shall include a check of the applicant's fingerprints. If the applicant has been a resident of this State for five years or more, then the offer is conditioned on consent to a State criminal history record check of the applicant.~~ A contract agency of a nursing home or home care agency shall not employ an applicant who refuses to consent to a criminal history record check required by this section. Within five business days of making the conditional offer of employment, a contract agency of a nursing home or home care agency shall submit a request to the Department of Justice under G.S. 114-19.10 to conduct a State ~~or national~~ criminal history record check required by this section, or shall submit a request to a private entity to conduct a State criminal history record check required by this section. All criminal history information received by the contract agency is confidential and may not be disclosed, except to the applicant as provided by subsection (b) of this section.

(b) Action. – If an applicant's criminal history record check reveals one or more convictions of a relevant offense, the nursing home or home care agency, or the contract agency of a nursing home or home care agency, shall consider all of the following factors in determining whether to hire the applicant:

(1) The level and seriousness of the crime.
(2) The date of the crime.
(3) The age of the person at the time of the conviction.
(4) The circumstances surrounding the commission of the crime, if known.
(5) The nexus between the criminal conduct of the person and the job duties of the position to be filled.
(6) The prison, jail, probation, parole, rehabilitation, and employment records of the person since the date the crime was committed.
(7) The subsequent commission by the person of a relevant offense.

The fact of conviction of a relevant offense alone shall not be a bar to employment; however, the listed factors shall be considered by the nursing home or home care agency, or the contract agency of the nursing home or home care agency. If a nursing home, home care agency, or contract agency of a nursing home or home care agency disqualifies an applicant after consideration of the relevant factors, then the nursing home, home care agency, or contract agency may disclose information contained in the criminal history record check that is relevant to the disqualification, but may not provide a copy of the criminal history record check to the applicant.

(c) Limited Immunity. – An entity and an officer or employee of an entity that, in good faith, complies with this section is not liable for the failure of the entity to employ an individual on the basis of information provided in the criminal history record check of the individual.

(d) Relevant Offense. – As used in this section, the term "relevant offense" has the same meaning as in G.S. 131D-40.

(e) Penalty for Furnishing False Information. – Any applicant for employment who willfully furnishes, supplies, or otherwise gives false information on an employment application that is the basis for a criminal history record check under this section shall be guilty of a Class A1 misdemeanor.

(f) Conditional Employment. – A nursing home or home care agency may employ an applicant conditionally prior to obtaining the results of a criminal history record check regarding the applicant if both of the following requirements are met:

(1) The nursing home or home care agency shall not employ an applicant prior to obtaining the applicant's consent for a criminal history record check as required in subsection (a) of this section or the completed fingerprint cards as required in G.S. 114-19.10.
(2) The nursing home or home care agency shall submit the request for a criminal history record check not later than five business days after the individual ~~begins conditional employment.~~ undertakes the functions of the job.

(g) Immunity From Liability. – An entity and officers and employees of an entity shall be immune from civil liability for failure to check an employee's history of criminal offenses if the employee's criminal history record check is requested and received in compliance with this section."

SECTION 2. G.S. 131D-40 reads as rewritten:

"**§ 131D-40. Criminal history record checks required for certain applicants for employment.**

(a) Requirement; Adult Care Home. – An offer of employment by an adult care home licensed under this Chapter to an applicant to fill a position that does not require the applicant to have an occupational license is conditioned on consent to a criminal history record check of the applicant. ~~If the applicant has been a resident of this State for less than five years, then the offer of employment is conditioned on consent to a State and national criminal history record check of the applicant. The national criminal history record check shall include a check of the applicant's fingerprints. If the applicant has been a resident of this State for five years or more, then the offer is conditioned on consent to a State criminal history record check of the applicant.~~ An adult care home shall not employ an applicant who refuses to consent to a criminal history record check required by this section. Within five business days of making the conditional offer of employment, an adult care home shall submit a request to the Department of Justice under G.S. 114-19.10 to conduct a State ~~or national~~ criminal history record check required by this section, or shall submit a request to a private entity to conduct a State criminal history record check required by this section. All criminal history information received by the home is confidential and may not be disclosed, except to the applicant as provided in subsection (b) of this section.

(a1) Requirement; Contract Agency of Adult Care Home. – An offer of employment by a contract agency of an adult care home licensed under this Chapter to an applicant to fill a position that does not require the applicant to have an occupational license is conditioned upon consent to a criminal history record check of the applicant. ~~If the applicant has been a resident of this State for less than five years, then the offer of employment is conditioned on consent to a State and national criminal history record check of the applicant. The national criminal history record check shall include a check of the applicant's fingerprints. If the applicant has been a resident of this State for five years or more, then the offer is conditioned on consent to a State criminal history record check of the applicant.~~ A contract agency of an adult care home shall not employ an applicant who refuses to consent to a criminal history record check required by this section. Within five business days of making the conditional offer of employment, a contract agency of an adult care home shall submit a request to the Department of Justice under G.S. 114-19.10 to conduct a State ~~or national~~ criminal history record check required by this section, or shall submit a request to a private entity to conduct a State criminal history record check required by this section. All criminal history information received by the contract agency is confidential and may not be disclosed, except to the applicant as provided by subsection (b) of this section.

(b) Action. – If an applicant's criminal history record check reveals one or more convictions of a relevant offense, the adult care home or a contract agency of the adult care home shall consider all of the following factors in determining whether to hire the applicant:

(1) The level and seriousness of the crime.
(2) The date of the crime.
(3) The age of the person at the time of the conviction.
(4) The circumstances surrounding the commission of the crime, if known.
(5) The nexus between the criminal conduct of the person and the job duties of the position to be filled.
(6) The prison, jail, probation, parole, rehabilitation, and employment records of the person since the date the crime was committed.
(7) The subsequent commission by the person of a relevant offense.

The fact of conviction of a relevant offense alone shall not be a bar to employment; however, the listed factors shall be considered by the adult care home or the contract agency of the adult care home. If the adult care home or a contract agency of the adult care home disqualifies an applicant after consideration of the relevant factors, then the adult care home or the contract agency may disclose information contained in the criminal history record check that is relevant to the disqualification, but may not provide a copy of the criminal history record check to the applicant.

(c) Limited Immunity. – An adult care home and an officer or employee of an adult care home that, in good faith, complies with this section is not liable for the failure of the home to employ an individual on the basis of information provided in the criminal history record check of the individual.

(d) Relevant Offense. – As used in this section, "relevant offense" means a State crime, whether a misdemeanor or felony, that bears upon an individual's fitness to have responsibility for the safety and well-being of aged or disabled persons. These crimes include the criminal offenses set forth in any of the following Articles of Chapter 14 of the General Statutes: Article 5, Counterfeiting and Issuing Monetary Substitutes; Article 5A, Endangering Executive and Legislative Officers; Article 6, Homicide; Article 7A, Rape and Other Sex Offenses; Article 8, Assaults; Article 10, Kidnapping and Abduction; Article 13, Malicious Injury or Damage by Use of Explosive or Incendiary Device or Material; Article 14, Burglary and Other Housebreakings; Article 15, Arson and Other Burnings; Article 16, Larceny; Article 17, Robbery; Article 18, Embezzlement; Article 19, False Pretenses and Cheats; Article 19A, Obtaining Property or Services by False or Fraudulent Use of Credit Device or Other Means; Article 19B, Financial Transaction Card Crime Act; Article 20, Frauds; Article 21, Forgery; Article 26, Offenses against Public Morality and Decency; Article 26A, Adult Establishments; Article 27, Prostitution; Article 28, Perjury; Article 29, Bribery; Article 31, Misconduct in Public Office; Article 35, Offenses Against the Public Peace; Article 36A, Riots and Civil Disorders; Article 39, Protection of Minors; Article 40, Protection of the Family; Article 59, Public Intoxication; and Article 60, Computer-Related Crime. These crimes also include possession or sale of drugs in violation of the North Carolina Controlled Substances Act, Article 5 of Chapter 90 of the General Statutes, and alcohol-related offenses such as sale to underage persons in violation of G.S. 18B-302 or driving while impaired in violation of G.S. 20-138.1 through G.S. 20-138.5.

(e) Penalty for Furnishing False Information. – Any applicant for employment who willfully furnishes, supplies, or otherwise gives false information on an employment application that is the basis for a criminal history record check under this section shall be guilty of a Class A1 misdemeanor.

(f) Conditional Employment. – An adult care home may employ an applicant conditionally prior to obtaining the results of a criminal history record check regarding the applicant if both of the following requirements are met:

(1) The adult care home shall not employ an applicant prior to obtaining the applicant's consent for a criminal history record check as required in subsection (a) of this section or the completed fingerprint cards as required in G.S. 114-19.10.

(2) The adult care home shall submit the request for a criminal history record check not later than five business days after the individual ~~begins conditional employment.~~undertakes the functions of the job.

(g) Immunity From Liability. – An entity and officers and employees of an entity shall be immune from civil liability for failure to check an employee's history of criminal offenses if the employee's criminal history record check is requested and received in compliance with this section."

SECTION 3. G.S. 114-19.10 reads as rewritten:

"**§ 114-19.10. Criminal record checks for adult care homes, nursing homes, home care agencies, and area mental health, developmental disabilities, and substance abuse services authorities.**

The Department of Justice may provide to the following entities ~~the criminal history from the State and National Repositories of Criminal Histories:~~a criminal record check of an individual who is employed by that entity, has applied for employment with that entity, or has volunteered to provide direct care on behalf of that entity:

(1) Nursing homes or combination homes licensed under Chapter 131E of the General Statutes.

(2) Adult care homes licensed under Chapter 131D of the General Statutes.

(3) Home care agencies licensed under Chapter 131E of the General Statutes.

(4) Area mental health, developmental disabilities, and substance abuse services authorities licensed under Chapter 122C of the General Statutes, including a contract agency of an area authority that is subject to the provisions of Article 4 of that Chapter.

The criminal history shall be provided to nursing homes and home care agencies in accordance with G.S. 131E-265, to adult care homes in accordance with G.S. 131D-40, and to area mental health, developmental disabilities, and substance abuse services authorities in accordance with G.S. 122C-80. The requesting entity shall provide to the Department of Justice, along with the request, the fingerprints of the individual to be ~~checked if a national criminal history record check is required,~~ checked, any additional

information required by the Department of Justice, and a form signed by the individual to be checked consenting to the check of the criminal record and to the use of fingerprints and other identifying information required by the State or National Repositories of Criminal Histories. If a national criminal history record check is required, the fingerprints of the individual shall be forwarded to the State Bureau of Investigation for a search of the State's criminal history record file, and the State Bureau of Investigation shall forward a set of fingerprints to the Federal Bureau of Investigation for a national criminal history record check. All information received by the entity shall be kept confidential in accordance with G.S. 131E-265, 131D-40, and 122C-80, as applicable. The Department of Justice shall charge a reasonable fee for conducting the checks authorized by this section. The fee for the State check may not exceed fourteen dollars ($14.00)."

SECTION 4.(a) There is established the Study Commission on Criminal History Record Checks. The purpose of the Commission is to study how federal law affects the distribution of national criminal history record check information requested for nursing homes, home care agencies, adult care homes, assisted living facilities, and area mental health, developmental disabilities, and substance abuse services authorities, and the problems federal restrictions pose for effective and efficient implementation of State-required criminal record checks. The study shall include the following:

(1) Ways in which national record checks may be obtained and reviewed for these facilities to effectuate State policy and protections of facility residents, and the advantages, disadvantages, and costs of various approaches to implementation.

(2) A review of ways in which national record checks are obtained by the Division of Child Development, Department of Health and Human Services, and other State agencies, and related costs to the State.

(3) Solutions adopted by other states to effectively and efficiently implement criminal record check requirements, including costs to the State in implementing these solutions.

(4) Other issues the Commission considers relevant to State requirements for criminal history record checks in long-term care facilities.

SECTION 4.(b) The Commission shall consist of 25 members, appointed as follows:

(1) Ten members of the General Assembly, five of whom shall be Senators appointed by the President Pro Tempore of the Senate, and five of whom shall be members of the House of Representatives appointed by the Speaker of the House of Representatives.

(2) A representative from each of the following, appointed by the President Pro Tempore of the Senate:

a. North Carolina Association of Long Term Care Facilities.

b. North Carolina Assisted Living Association, Inc.

c. The Director of the Division of Aging of the Department of Health and Human Services.
d. The Director of the Division of Mental Health, Developmental Disabilities, and Substance Abuse Services of the Department of Health and Human Services.
e. The public.

(3) A representative from each of the following, appointed by the Speaker of the House of Representatives:
a. North Carolina Health Care Facilities Association.
b. Friends of Residents in Long Term Care.
c. The Director of the Division of Facility Services of the Department of Health and Human Services.
d. CNC Access, Inc., an organization representing providers of mental health, developmental disabilities, and substance abuse services.
e. The public at large.

(4) A representative from each of the following, appointed by the Governor:
a. The Council on Community Programs.
b. The Secretary of Health and Human Services, or her designee.
c. The Attorney General, or his designee.
d. The Director of the State Bureau of Investigation, or the Director's designee.
e. Association for Home and Hospice Care in North Carolina.

SECTION 4.(c) With the prior approval of the Legislative Services Commission, the Legislative Services Officer shall assign professional staff to assist in the work of the Study Commission on Criminal History Record Checks. With the prior approval of the Legislative Services Commission, the Study Commission may hold its meetings in the State Legislative Building or the Legislative Office Building.

SECTION 4.(d) The Commission shall submit a final written report of its findings and recommendations on or before the convening of the 2002 Regular Session of the 2001 General Assembly. All reports shall be filed with the President Pro Tempore of the Senate and the Speaker of the House of Representatives, the Principal Clerks of the Senate and the House of Representatives, and the Legislative Librarian. Upon filing its final report, the Commission shall terminate.

SECTION 4.(e) Members of the Commission shall be paid per diem, subsistence, and travel allowances as follows:

(1) Commission members who are also members of the General Assembly, at the rate established in G.S. 120-3.1;
(2) Commission members who are officials or employees of the State or local government agencies, at the rate established in G.S. 138-6;
(3) All other Commission members, at the rate established in G.S. 138-5.

SECTION 4.(f) All State departments and agencies shall cooperate with the Commission and, upon request, shall furnish to the Commission and its staff any information in their possession or available to them.

SECTION 4.(g) From funds appropriated to the General Assembly, the Legislative Services Commission shall allocate funds for the expenses of the Study Commission on Criminal History Record Checks.

SECTION 5. Section 4 of this act becomes effective July 1, 2001. The remainder of this act is effective when it becomes law.

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2001

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SENATE BILL 826

Health Care Committee Substitute Adopted 4/19/01
Third Edition Engrossed 4/23/01
PROPOSED HOUSE COMMITTEE SUBSTITUTE S826-CSSW-53 [v.3]

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Short Title: Criminal Record Check Change/Long-Term Care. (Public)

Sponsors:

Referred to:

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The General Assembly of North Carolina enacts:

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~~this State for less than five years, then the offer of employment or change in employment status is conditioned on consent to a State and national criminal history record check. The national criminal history record check shall include a check of the applicant's or current employee's fingerprints. If the applicant or current employee has been a resident of this State for five years or more, then the offer is conditioned on consent to a State criminal history record check of the applicant or current employee applying for a change in employment status.~~ A nursing home or a home care agency shall not employ an applicant who refuses to consent to a criminal history record check required by this section. In addition, a home care agency shall not change a current employee's employment status from a position that does not require entering the patient's home to a position that requires entering the patient's home who refuses to consent to a criminal history record check required by this section. Within five business days of making the conditional offer of employment, a nursing home or home care agency shall submit a request to the Department of Justice under G.S. 114.19.10 to conduct a State ~~or national~~ criminal history record check required by this section, or shall submit a request to a private entity to conduct a State criminal history record check required by this section. All criminal history information received by the home or agency is confidential and may not be disclosed, except to the applicant as provided in subsection (b) of this section.

(a1) Requirement; Contract Agency of Nursing Home or Home Care Agency. – An offer of employment by a contract agency of a nursing home or home care agency licensed under this Chapter to an applicant to fill a position that does not require the applicant to have an occupational license is conditioned upon consent to a criminal history record check of the applicant. ~~If the applicant has been a resident of this State for less than five years, then the offer of employment is conditioned on consent to a State and national criminal history record check of the applicant. The national criminal history record check shall include a check of the applicant's fingerprints. If the applicant has been a resident of this State for five years or more, then the offer is conditioned on consent to a State criminal history record check of the applicant.~~ A contract agency of a nursing home or home care agency shall not employ an applicant who refuses to consent to a criminal history record check required by this section. Within five business days of making the conditional offer of employment, a contract agency of a nursing home or home care agency shall submit a request to the Department of Justice under G.S. 114-19.10 to conduct a State ~~or national~~ criminal history record check required by this section, or shall submit a request to a private entity to conduct a State criminal history record check required by this section. All criminal history information received by the contract agency is confidential and may not be disclosed, except to the applicant as provided by subsection (b) of this section.

(b) Action. – If an applicant's criminal history record check reveals one or more convictions of a relevant offense, the nursing home or home care agency, or the contract agency of a nursing home or home care agency, shall consider all of the following factors in determining whether to hire the applicant:

(1) The level and seriousness of the crime.
(2) The date of the crime.
(3) The age of the person at the time of the conviction.
(4) The circumstances surrounding the commission of the crime, if known.
(5) The nexus between the criminal conduct of the person and the job duties of the position to be filled.
(6) The prison, jail, probation, parole, rehabilitation, and employment records of the person since the date the crime was committed.
(7) The subsequent commission by the person of a relevant offense.

The fact of conviction of a relevant offense alone shall not be a bar to employment; however, the listed factors shall be considered by the nursing home or home care agency, or the contract agency of the nursing home or home care agency. If a nursing home, home care agency, or contract agency of a nursing home or home care agency disqualifies an applicant after consideration of the relevant factors, then the nursing home, home care agency, or contract agency may disclose information contained in the criminal history record check that is relevant to the disqualification, but may not provide a copy of the criminal history record check to the applicant.

(c) Limited Immunity. – An entity and an officer or employee of an entity that, in good faith, complies with this section is not liable for the failure of the entity to employ an individual on the basis of information provided in the criminal history record check of the individual.

(d) Relevant Offense. – As used in this section, the term "relevant offense" has the same meaning as in G.S. 131D-40.

(e) Penalty for Furnishing False Information. – Any applicant for employment who willfully furnishes, supplies, or otherwise gives false information on an employment application that is the basis for a criminal history record check under this section shall be guilty of a Class A1 misdemeanor.

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(1) The nursing home or home care agency shall not employ an applicant prior to obtaining the applicant's consent for a criminal history record check as required in subsection (a) of this section or the completed fingerprint cards as required in G.S. 114-19.10.
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(1) The level and seriousness of the crime.
(2) The date of the crime.
(3) The age of the person at the time of the conviction.
(4) The circumstances surrounding the commission of the crime, if known.
(5) The nexus between the criminal conduct of the person and the job duties of the position to be filled.
(6) The prison, jail, probation, parole, rehabilitation, and employment records of the person since the date the crime was committed.
(7) The subsequent commission by the person of a relevant offense.

The fact of conviction of a relevant offense alone shall not be a bar to employment; however, the listed factors shall be considered by the adult care home or the contract agency of the adult care home. If the adult care home or a contract agency of the adult care home disqualifies an applicant after consideration of the relevant factors, then the adult care home or the contract agency may disclose information contained in the criminal history record check that is relevant to the disqualification, but may not provide a copy of the criminal history record check to the applicant.

(c) Limited Immunity. – An adult care home and an officer or employee of an adult care home that, in good faith, complies with this section is not liable for the failure of the home to employ an individual on the basis of information provided in the criminal history record check of the individual.

(d) Relevant Offense. – As used in this section, "relevant offense" means a State crime, whether a misdemeanor or felony, that bears upon an individual's fitness to have responsibility for the safety and well-being of aged or disabled persons. These crimes include the criminal offenses set forth in any of the following Articles of Chapter 14 of the General Statutes: Article 5, Counterfeiting and Issuing Monetary Substitutes; Article 5A, Endangering Executive and Legislative Officers; Article 6, Homicide; Article 7A, Rape and Other Sex Offenses; Article 8, Assaults; Article 10, Kidnapping and Abduction; Article 13, Malicious Injury or Damage by Use of Explosive or Incendiary Device or Material; Article 14, Burglary and Other Housebreakings; Article 15, Arson and Other Burnings; Article 16, Larceny; Article 17, Robbery; Article 18, Embezzlement; Article 19, False Pretenses and Cheats; Article 19A, Obtaining Property or Services by False or Fraudulent Use of Credit Device or Other Means; Article 19B, Financial Transaction Card Crime Act; Article 20, Frauds; Article 21, Forgery; Article 26, Offenses against Public Morality and Decency; Article 26A, Adult Establishments; Article 27, Prostitution; Article 28, Perjury; Article 29, Bribery; Article 31, Misconduct in Public Office; Article 35, Offenses Against the Public Peace; Article 36A, Riots and Civil Disorders; Article 39, Protection of Minors; Article 40, Protection of the Family; Article 59, Public Intoxication; and Article 60, Computer-Related Crime. These crimes also include possession or sale of drugs in violation of the North Carolina Controlled Substances Act, Article 5 of Chapter 90 of the General Statutes, and alcohol-related offenses such as sale to underage persons in violation of G.S. 18B-302 or driving while impaired in violation of G.S. 20-138.1 through G.S. 20-138.5.

(e) Penalty for Furnishing False Information. – Any applicant for employment who willfully furnishes, supplies, or otherwise gives false information on an employment application that is the basis for a criminal history record check under this section shall be guilty of a Class A1 misdemeanor.

(f) Conditional Employment. – An adult care home may employ an applicant conditionally prior to obtaining the results of a criminal history record check regarding the applicant if both of the following requirements are met:

(1) The adult care home shall not employ an applicant prior to obtaining the applicant's consent for a criminal history record check as required in subsection (a) of this section or the completed fingerprint cards as required in G.S. 114-19.10.

(2) The adult care home shall submit the request for a criminal history record check not later than five business days after the individual ~~begins conditional employment.~~undertakes the functions of the job.

(g) Immunity From Liability. – An entity and officers and employees of an entity shall be immune from civil liability for failure to check an employee's history of criminal offenses if the employee's criminal history record check is requested and received in compliance with this section."

SECTION 3. G.S. 114-19.10 reads as rewritten:

"**§ 114-19.10. Criminal record checks for adult care homes, nursing homes, home care agencies, and area mental health, developmental disabilities, and substance abuse services authorities.**

The Department of Justice may provide to the following entities ~~the criminal history from the State and National Repositories of Criminal Histories:~~a criminal record check of an individual who is employed by that entity, has applied for employment with that entity, or has volunteered to provide direct care on behalf of that entity:

(1) Nursing homes or combination homes licensed under Chapter 131E of the General Statutes.

(2) Adult care homes licensed under Chapter 131D of the General Statutes.

(3) Home care agencies licensed under Chapter 131E of the General Statutes.

(4) Area mental health, developmental disabilities, and substance abuse services authorities licensed under Chapter 122C of the General Statutes, including a contract agency of an area authority that is subject to the provisions of Article 4 of that Chapter.

The criminal history shall be provided to nursing homes and home care agencies in accordance with G.S. 131E-265, to adult care homes in accordance with G.S. 131D-40, and to area mental health, developmental disabilities, and substance abuse services authorities in accordance with G.S. 122C-80. The requesting entity shall provide to the Department of Justice, along with the request, the fingerprints of the individual to be ~~checked if a national criminal history record check is required,~~ checked, any additional

information required by the Department of Justice, and a form signed by the individual to be checked consenting to the check of the criminal record and to the use of fingerprints and other identifying information required by the State or National Repositories of Criminal Histories. If a national criminal history record check is required, the fingerprints of the individual shall be forwarded to the State Bureau of Investigation for a search of the State's criminal history record file, and the State Bureau of Investigation shall forward a set of fingerprints to the Federal Bureau of Investigation for a national criminal history record check. All information received by the entity shall be kept confidential in accordance with G.S. 131E-265, 131D-40, and 122C-80, as applicable. The Department of Justice shall charge a reasonable fee for conducting the checks authorized by this section. The fee for the State check may not exceed fourteen dollars ($14.00)."

SECTION 4.(a) There is established the Study Commission on Criminal History Record Checks. The purpose of the Commission is to study how federal law affects the distribution of national criminal history record check information requested for nursing homes, home care agencies, adult care homes, assisted living facilities, and area mental health, developmental disabilities, and substance abuse services authorities, and the problems federal restrictions pose for effective and efficient implementation of State required criminal record checks. The study shall include the following:

(1) Ways in which national record checks may be obtained and reviewed for these facilities to effectuate State policy and protections of facility residents, and the advantages, disadvantages, and costs of various approaches to implementation.

(2) A review of ways in which federal record checks are obtained by the Division of Child Development, Department of Health and Human Services, and other State agencies, and related costs to the State.

(3) Solutions adopted by other states to effectively and efficiently implement criminal record check requirements, including costs to the State in implementing these solutions.

(4) Other issues the Commission considers relevant to State requirements for criminal history record checks in long-term care facilities.

SECTION 4.(b) The Commission shall consist of 25 members, appointed as follows:

(1) Ten members of the General Assembly, five of whom shall be Senators appointed by the President Pro Tempore of the Senate, and five of whom shall be members of the House of Representatives appointed by the Speaker of the House of Representatives.

(2) A representative from each of the following, appointed by the President Pro Tempore of the Senate:

a. North Carolina Association of Long Term Care Facilities.

b. North Carolina Assisted Living Association, Inc.

c. The Director of the Division of Aging of the Department of Health and Human Services.
d. The Director of the Division of Mental Health, Developmental Disabilities, and Substance Abuse Services of the Department of Health and Human Services.
e. The public.

(3) A representative from each of the following, appointed by the Speaker of the House of Representatives:
a. North Carolina Health Care Facilities Association.
b. Friends of Residents in Long Term Care.
c. The Director of the Division of Facility Services of the Department of Health and Human Services.
d. CNC Access, Inc., an organization representing providers of mental health, developmental disabilities, and substance abuse services.
e. The public at large.

(4) A representative from each of the following, appointed by the Governor:
a. The Council on Community Programs.
b. The Secretary of Health and Human Services, or her designee.
c. The Attorney General, or his designee.
d. The Director of the State Bureau of Investigation, or the Director's designee.
e. Association for Home and Hospice Care in North Carolina.

SECTION 4.(c) With the prior approval of the Legislative Services Commission, the Legislative Services Officer shall assign professional staff to assist in the work of the Study Commission on Criminal History Record Checks. With the prior approval of the Legislative Services Commission, the Study Commission may hold its meetings in the State Legislative Building or the Legislative Office Building.

SECTION 4.(d) The Commission shall submit a final written report of its findings and recommendations on or before the convening of the 2003 Session of the General Assembly and may submit a report to the 2002 Regular Session of the 2001 General Assembly. All reports shall be filed with the President Pro Tempore of the Senate and the Speaker of the House of Representatives, the Principal Clerks of the Senate and the House of Representatives, and the Legislative Librarian. Upon filing its final report, the Commission shall terminate.

SECTION 4.(e) Members of the Commission shall be paid per diem, subsistence, and travel allowances as follows:

(1) Commission members who are also members of the General Assembly, at the rate established in G.S. 120-3.1;

(2) Commission members who are officials or employees of the State or local government agencies, at the rate established in G.S. 138-6;

(3) All other Commission members, at the rate established in G.S. 138-5.

SECTION 4.(f) All State departments and agencies shall cooperate with the Commission and, upon request, shall furnish to the Commission and its staff any information in their possession or available to them.

SECTION 4.(g) From funds appropriated to the General Assembly, the Legislative Services Commission shall allocate funds for the expenses of the Study Commission on Criminal History Record Checks.

SECTION 5. Section 4 of this act becomes effective July 1, 2001. The remainder of this act is effective when it becomes law.

SENATE BILL 826:
Criminal Record Check Change/Long Term Care

BILL ANALYSIS

Committee:	House Health	**Introduced by:**	Sen. Rand
Date:	June 20, 2001	**Summary by:**	Dianna Jessup
Version:	PCS S826-CSSW-53		Committee Counsel

SUMMARY: ***Senate Bill 826 would repeal the requirement for a national criminal history record check for prospective employees of nursing homes and adult care homes. A State criminal history report would still be required. Except for Section 4, which would become effective on July 1, 2001, the act would become effective when it becomes law.***

The second edition differed from the original bill in that Section 3 from the original bill that would have repealed the national criminal history record check for prospective employees of area authorities was deleted. An amendment to the second edition added a 22-member Study Commission on Criminal Record Checks to study how federal law affects the distribution of national criminal history record check information requested for nursing homes, home care agencies, adult care homes, assisted living facilities, and area mental health, developmental disabilities, and substances abuse service authorities. The PCS would add a representative of the Association for Home and Hospice Care in North Carolina and two members of the public to the Commission.

CURRENT LAW: Currently, all applicants for employment with nursing homes and adult care homes who are not required to have an occupational license are required, as a condition for employment, to consent to a criminal history record check. If the applicant has been a resident of North Carolina for less than five years, the criminal history record check would include both a national and a State criminal history record check. If the applicant has been a resident of North Carolina for five years or more, only a State criminal history record check is required. Requests for criminal record checks must be submitted not later than five business days after the individual begins conditional employment.

Under federal law, the FBI may release results of national criminal history checks directly to nursing homes and home health care agencies on applicants for positions that involve direct patient care. Otherwise, results of criminal history checks performed by the FBI can only be released to a state agency and cannot be released directly to a provider.

BILL ANALYSIS: Sections 1 and 2 would repeal the provisions in the nursing home and adult care home statutes requiring national criminal history record checks of applicants who have resided in the state for less than five years. These sections would also change current law as to when the request for a criminal history record check must be submitted so that the request must be submitted not later than five business days after the individual undertakes the functions of the job.

Section 3 would make conforming changes to the Department of Justice statutes.

Section 4 would establish a 25-member Study Commission on Criminal History Record Checks. The Commission would study how federal law affects the distribution of national criminal history record check information requested for long-term care facilities and area mental health authorities, and the problems federal restrictions pose for effective and efficient implementation of State-required criminal record checks, including a review of the way the Division of Child Development conducts these checks and solutions adopted by other states. A final report of the Commission's findings and recommendations would be submitted to the General Assembly upon the convening of its 2003 session. S826-SMSW-004

NORTH CAROLINA GENERAL ASSEMBLY
AMENDMENT
Senate Bill 826

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

S826-ASW-30 [v.2]

Date _____,2001

Comm. Sub. [YES]
Amends Title [NO]
S826-CSSW-53

Representative Clary

moves to amend the bill on page 1, line 20, by inserting after the phrase "~~applicant.~~" the following: "If the applicant has applied for a position covered by Public Law 105-277, then an offer of employment is conditioned on consent to a State and national criminal history record check of the applicant. The national criminal history record check shall include a check of the applicant's fingerprints."; and

on page 2, line 7, by inserting after the phrase "~~status.~~" the following: "If the applicant has applied for a position covered by Public Law 105-277, then an offer of employment is conditioned on consent to a State and national criminal history record check of the applicant. The national criminal history record check shall include a check of the applicant's fingerprints."; and

on page 2, line 15, by deleting "~~or national~~" and substituting "or national"; and

on page 6, lines 23 through 38, by rewriting those lines to read:

" The Department of Justice may provide to the following entities the criminal history from the State and National Repositories of Criminal Histories:

(1) Nursing homes or combination homes licensed under Chapter 131E of the General Statutes.

(2) Adult care homes licensed under Chapter 131D of the General Statutes.

NORTH CAROLINA GENERAL ASSEMBLY
AMENDMENT
Senate Bill 826

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

S826-ASW-30 [v.2]

(3) Home care agencies licensed under Chapter 131E of the General Statutes.

(4) Area mental health, developmental disabilities, and substance abuse services authorities licensed under Chapter 122C of the General Statutes, including a contract agency of an area authority that is subject to the provisions of Article 4 of that Chapter.

~~The~~For required national checks, the criminal history shall be provided to nursing homes and home care agencies for employment positions covered by Public Law 105-277. For State checks, the criminal history shall be provided to nursing homes and home care agencies in accordance with G.S. 131E-265, to adult care homes in accordance with G.S. 131D-40,".

SIGNED _____
Amendment Sponsor

SIGNED _____
Committee Chair if Senate Committee Amendment

ADOPTED _____ FAILED _____ TABLED _____

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2001

S D

SENATE BILL 826

Health Care Committee Substitute Adopted 4/19/01
Third Edition Engrossed 4/23/01
PROPOSED HOUSE COMMITTEE SUBSTITUTE S826-PCS9307-SW-53

Short Title: Criminal Record Check Change/Long-Term Care. (Public)

Sponsors:

Referred to:

April 3, 2001

A BILL TO BE ENTITLED

AN ACT TO REPEAL THE REQUIREMENT FOR A NATIONAL CRIMINAL HISTORY RECORD CHECK FOR CERTAIN LONG-TERM CARE FACILITIES BECAUSE OF FEDERAL REQUIREMENTS LIMITING DISTRIBUTION OF RECORD CHECK RESULTS AND TO ESTABLISH THE STUDY COMMISSION ON CRIMINAL HISTORY RECORD CHECKS.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 131E-265 reads as rewritten:

"**§ 131E-265. Criminal history record checks required for certain applicants for employment.**

(a) Requirement; Nursing Home or Home Care Agency. – An offer of employment by a nursing home licensed under this Chapter to an applicant to fill a position that does not require the applicant to have an occupational license is conditioned on consent to a criminal history record check of the applicant. ~~If the applicant has been a resident of this State for less than five years, then the offer of employment is conditioned on consent to a State and national criminal history record check of the applicant. The national criminal history record check shall include a check of the applicant's fingerprints. If the applicant has been a resident of this State for five years or more, then the offer is conditioned on consent to a State criminal history record check of the applicant.~~ An offer of employment by a home care agency licensed under this Chapter to an applicant to fill a position that requires entering the patient's home is conditioned on consent to a criminal history record check of the applicant. In addition, employment status change of a current employee of a home care agency licensed under this Chapter from a position that does not require entering the patient's home to a position that requires entering the patient's home shall be conditioned on consent to a criminal history record check of that current employee. ~~If the applicant for employment or if the current employee who is changing employment status has been a resident of~~

~~this State for less than five years, then the offer of employment or change in employment status is conditioned on consent to a State and national criminal history record check. The national criminal history record check shall include a check of the applicant's or current employee's fingerprints. If the applicant or current employee has been a resident of this State for five years or more, then the offer is conditioned on consent to a State criminal history record check of the applicant or current employee applying for a change in employment status.~~ A nursing home or a home care agency shall not employ an applicant who refuses to consent to a criminal history record check required by this section. In addition, a home care agency shall not change a current employee's employment status from a position that does not require entering the patient's home to a position that requires entering the patient's home who refuses to consent to a criminal history record check required by this section. Within five business days of making the conditional offer of employment, a nursing home or home care agency shall submit a request to the Department of Justice under G.S. 114.19.10 to conduct a State ~~or national~~ criminal history record check required by this section, or shall submit a request to a private entity to conduct a State criminal history record check required by this section. All criminal history information received by the home or agency is confidential and may not be disclosed, except to the applicant as provided in subsection (b) of this section.

(a1) Requirement; Contract Agency of Nursing Home or Home Care Agency. – An offer of employment by a contract agency of a nursing home or home care agency licensed under this Chapter to an applicant to fill a position that does not require the applicant to have an occupational license is conditioned upon consent to a criminal history record check of the applicant. ~~If the applicant has been a resident of this State for less than five years, then the offer of employment is conditioned on consent to a State and national criminal history record check of the applicant. The national criminal history record check shall include a check of the applicant's fingerprints. If the applicant has been a resident of this State for five years or more, then the offer is conditioned on consent to a State criminal history record check of the applicant.~~ A contract agency of a nursing home or home care agency shall not employ an applicant who refuses to consent to a criminal history record check required by this section. Within five business days of making the conditional offer of employment, a contract agency of a nursing home or home care agency shall submit a request to the Department of Justice under G.S. 114-19.10 to conduct a State ~~or national~~ criminal history record check required by this section, or shall submit a request to a private entity to conduct a State criminal history record check required by this section. All criminal history information received by the contract agency is confidential and may not be disclosed, except to the applicant as provided by subsection (b) of this section.

(b) Action. – If an applicant's criminal history record check reveals one or more convictions of a relevant offense, the nursing home or home care agency, or the contract agency of a nursing home or home care agency, shall consider all of the following factors in determining whether to hire the applicant:

(1) The level and seriousness of the crime.
(2) The date of the crime.
(3) The age of the person at the time of the conviction.
(4) The circumstances surrounding the commission of the crime, if known.
(5) The nexus between the criminal conduct of the person and the job duties of the position to be filled.
(6) The prison, jail, probation, parole, rehabilitation, and employment records of the person since the date the crime was committed.
(7) The subsequent commission by the person of a relevant offense.

The fact of conviction of a relevant offense alone shall not be a bar to employment; however, the listed factors shall be considered by the nursing home or home care agency, or the contract agency of the nursing home or home care agency. If a nursing home, home care agency, or contract agency of a nursing home or home care agency disqualifies an applicant after consideration of the relevant factors, then the nursing home, home care agency, or contract agency may disclose information contained in the criminal history record check that is relevant to the disqualification, but may not provide a copy of the criminal history record check to the applicant.

(c) Limited Immunity. – An entity and an officer or employee of an entity that, in good faith, complies with this section is not liable for the failure of the entity to employ an individual on the basis of information provided in the criminal history record check of the individual.

(d) Relevant Offense. – As used in this section, the term "relevant offense" has the same meaning as in G.S. 131D-40.

(e) Penalty for Furnishing False Information. – Any applicant for employment who willfully furnishes, supplies, or otherwise gives false information on an employment application that is the basis for a criminal history record check under this section shall be guilty of a Class A1 misdemeanor.

(f) Conditional Employment. – A nursing home or home care agency may employ an applicant conditionally prior to obtaining the results of a criminal history record check regarding the applicant if both of the following requirements are met:

(1) The nursing home or home care agency shall not employ an applicant prior to obtaining the applicant's consent for a criminal history record check as required in subsection (a) of this section or the completed fingerprint cards as required in G.S. 114-19.10.
(2) The nursing home or home care agency shall submit the request for a criminal history record check not later than five business days after the individual ~~begins conditional employment.~~ undertakes the functions of the job.

(g) Immunity From Liability. – An entity and officers and employees of an entity shall be immune from civil liability for failure to check an employee's history of criminal offenses if the employee's criminal history record check is requested and received in compliance with this section."

SECTION 2. G.S. 131D-40 reads as rewritten:

"**§ 131D-40. Criminal history record checks required for certain applicants for employment.**

(a) Requirement; Adult Care Home. – An offer of employment by an adult care home licensed under this Chapter to an applicant to fill a position that does not require the applicant to have an occupational license is conditioned on consent to a criminal history record check of the applicant. ~~If the applicant has been a resident of this State for less than five years, then the offer of employment is conditioned on consent to a State and national criminal history record check of the applicant. The national criminal history record check shall include a check of the applicant's fingerprints. If the applicant has been a resident of this State for five years or more, then the offer is conditioned on consent to a State criminal history record check of the applicant.~~ An adult care home shall not employ an applicant who refuses to consent to a criminal history record check required by this section. Within five business days of making the conditional offer of employment, an adult care home shall submit a request to the Department of Justice under G.S. 114-19.10 to conduct a State ~~or national~~ criminal history record check required by this section, or shall submit a request to a private entity to conduct a State criminal history record check required by this section. All criminal history information received by the home is confidential and may not be disclosed, except to the applicant as provided in subsection (b) of this section.

(a1) Requirement; Contract Agency of Adult Care Home. – An offer of employment by a contract agency of an adult care home licensed under this Chapter to an applicant to fill a position that does not require the applicant to have an occupational license is conditioned upon consent to a criminal history record check of the applicant. ~~If the applicant has been a resident of this State for less than five years, then the offer of employment is conditioned on consent to a State and national criminal history record check of the applicant. The national criminal history record check shall include a check of the applicant's fingerprints. If the applicant has been a resident of this State for five years or more, then the offer is conditioned on consent to a State criminal history record check of the applicant.~~ A contract agency of an adult care home shall not employ an applicant who refuses to consent to a criminal history record check required by this section. Within five business days of making the conditional offer of employment, a contract agency of an adult care home shall submit a request to the Department of Justice under G.S. 114-19.10 to conduct a State ~~or national~~ criminal history record check required by this section, or shall submit a request to a private entity to conduct a State criminal history record check required by this section. All criminal history information received by the contract agency is confidential and may not be disclosed, except to the applicant as provided by subsection (b) of this section.

(b) Action. – If an applicant's criminal history record check reveals one or more convictions of a relevant offense, the adult care home or a contract agency of the adult care home shall consider all of the following factors in determining whether to hire the applicant:

(1) The level and seriousness of the crime.
(2) The date of the crime.
(3) The age of the person at the time of the conviction.
(4) The circumstances surrounding the commission of the crime, if known.
(5) The nexus between the criminal conduct of the person and the job duties of the position to be filled.
(6) The prison, jail, probation, parole, rehabilitation, and employment records of the person since the date the crime was committed.
(7) The subsequent commission by the person of a relevant offense.

The fact of conviction of a relevant offense alone shall not be a bar to employment; however, the listed factors shall be considered by the adult care home or the contract agency of the adult care home. If the adult care home or a contract agency of the adult care home disqualifies an applicant after consideration of the relevant factors, then the adult care home or the contract agency may disclose information contained in the criminal history record check that is relevant to the disqualification, but may not provide a copy of the criminal history record check to the applicant.

(c) Limited Immunity. – An adult care home and an officer or employee of an adult care home that, in good faith, complies with this section is not liable for the failure of the home to employ an individual on the basis of information provided in the criminal history record check of the individual.

(d) Relevant Offense. – As used in this section, "relevant offense" means a State crime, whether a misdemeanor or felony, that bears upon an individual's fitness to have responsibility for the safety and well-being of aged or disabled persons. These crimes include the criminal offenses set forth in any of the following Articles of Chapter 14 of the General Statutes: Article 5, Counterfeiting and Issuing Monetary Substitutes; Article 5A, Endangering Executive and Legislative Officers; Article 6, Homicide; Article 7A, Rape and Other Sex Offenses; Article 8, Assaults; Article 10, Kidnapping and Abduction; Article 13, Malicious Injury or Damage by Use of Explosive or Incendiary Device or Material; Article 14, Burglary and Other Housebreakings; Article 15, Arson and Other Burnings; Article 16, Larceny; Article 17, Robbery; Article 18, Embezzlement; Article 19, False Pretenses and Cheats; Article 19A, Obtaining Property or Services by False or Fraudulent Use of Credit Device or Other Means; Article 19B, Financial Transaction Card Crime Act; Article 20, Frauds; Article 21, Forgery; Article 26, Offenses against Public Morality and Decency; Article 26A, Adult Establishments; Article 27, Prostitution; Article 28, Perjury; Article 29, Bribery; Article 31, Misconduct in Public Office; Article 35, Offenses Against the Public Peace; Article 36A, Riots and Civil Disorders; Article 39, Protection of Minors; Article 40, Protection of the Family; Article 59, Public Intoxication; and Article 60, Computer-Related Crime. These crimes also include possession or sale of drugs in violation of the North Carolina Controlled Substances Act, Article 5 of Chapter 90 of the General Statutes, and alcohol-related offenses such as sale to underage persons in violation of G.S. 18B-302 or driving while impaired in violation of G.S. 20-138.1 through G.S. 20-138.5.

(e) Penalty for Furnishing False Information. – Any applicant for employment who willfully furnishes, supplies, or otherwise gives false information on an employment application that is the basis for a criminal history record check under this section shall be guilty of a Class A1 misdemeanor.

(f) Conditional Employment. – An adult care home may employ an applicant conditionally prior to obtaining the results of a criminal history record check regarding the applicant if both of the following requirements are met:

(1) The adult care home shall not employ an applicant prior to obtaining the applicant's consent for a criminal history record check as required in subsection (a) of this section or the completed fingerprint cards as required in G.S. 114-19.10.

(2) The adult care home shall submit the request for a criminal history record check not later than five business days after the individual ~~begins conditional employment.~~undertakes the functions of the job.

(g) Immunity From Liability. – An entity and officers and employees of an entity shall be immune from civil liability for failure to check an employee's history of criminal offenses if the employee's criminal history record check is requested and received in compliance with this section."

SECTION 3. G.S. 114-19.10 reads as rewritten:

"**§ 114-19.10. Criminal record checks for adult care homes, nursing homes, home care agencies, and area mental health, developmental disabilities, and substance abuse services authorities.**

The Department of Justice may provide to the following entities ~~the criminal history from the State and National Repositories of Criminal Histories:~~a criminal record check of an individual who is employed by that entity, has applied for employment with that entity, or has volunteered to provide direct care on behalf of that entity:

(1) Nursing homes or combination homes licensed under Chapter 131E of the General Statutes.

(2) Adult care homes licensed under Chapter 131D of the General Statutes.

(3) Home care agencies licensed under Chapter 131E of the General Statutes.

(4) Area mental health, developmental disabilities, and substance abuse services authorities licensed under Chapter 122C of the General Statutes, including a contract agency of an area authority that is subject to the provisions of Article 4 of that Chapter.

The criminal history shall be provided to nursing homes and home care agencies in accordance with G.S. 131E-265, to adult care homes in accordance with G.S. 131D-40, and to area mental health, developmental disabilities, and substance abuse services authorities in accordance with G.S. 122C-80. The requesting entity shall provide to the Department of Justice, along with the request, the fingerprints of the individual to be ~~checked if a national criminal history record check is required,~~ checked, any additional

information required by the Department of Justice, and a form signed by the individual to be checked consenting to the check of the criminal record and to the use of fingerprints and other identifying information required by the State or National Repositories of Criminal Histories. If a national criminal history record check is required, the fingerprints of the individual shall be forwarded to the State Bureau of Investigation for a search of the State's criminal history record file, and the State Bureau of Investigation shall forward a set of fingerprints to the Federal Bureau of Investigation for a national criminal history record check. All information received by the entity shall be kept confidential in accordance with G.S. 131E-265, 131D-40, and 122C-80, as applicable. The Department of Justice shall charge a reasonable fee for conducting the checks authorized by this section. The fee for the State check may not exceed fourteen dollars ($14.00)."

SECTION 4.(a) There is established the Study Commission on Criminal History Record Checks. The purpose of the Commission is to study how federal law affects the distribution of national criminal history record check information requested for nursing homes, home care agencies, adult care homes, assisted living facilities, and area mental health, developmental disabilities, and substance abuse services authorities, and the problems federal restrictions pose for effective and efficient implementation of State-required criminal record checks. The study shall include the following:

(1) Ways in which national record checks may be obtained and reviewed for these facilities to effectuate State policy and protections of facility residents, and the advantages, disadvantages, and costs of various approaches to implementation.

(2) A review of ways in which national record checks are obtained by the Division of Child Development, Department of Health and Human Services, and other State agencies, and related costs to the State.

(3) Solutions adopted by other states to effectively and efficiently implement criminal record check requirements, including costs to the State in implementing these solutions.

(4) Other issues the Commission considers relevant to State requirements for criminal history record checks in long-term care facilities.

SECTION 4.(b) The Commission shall consist of 25 members, appointed as follows:

(1) Ten members of the General Assembly, five of whom shall be Senators appointed by the President Pro Tempore of the Senate, and five of whom shall be members of the House of Representatives appointed by the Speaker of the House of Representatives.

(2) A representative from each of the following, appointed by the President Pro Tempore of the Senate:

a. North Carolina Association of Long Term Care Facilities.

b. North Carolina Assisted Living Association, Inc.

c. The Director of the Division of Aging of the Department of Health and Human Services.
d. The Director of the Division of Mental Health, Developmental Disabilities, and Substance Abuse Services of the Department of Health and Human Services.
e. The public.

(3) A representative from each of the following, appointed by the Speaker of the House of Representatives:
a. North Carolina Health Care Facilities Association.
b. Friends of Residents in Long Term Care.
c. The Director of the Division of Facility Services of the Department of Health and Human Services.
d. CNC Access, Inc., an organization representing providers of mental health, developmental disabilities, and substance abuse services.
e. The public at large.

(4) A representative from each of the following, appointed by the Governor:
a. The Council on Community Programs.
b. The Secretary of Health and Human Services, or her designee.
c. The Attorney General, or his designee.
d. The Director of the State Bureau of Investigation, or the Director's designee.
e. Association for Home and Hospice Care in North Carolina.

SECTION 4.(c) With the prior approval of the Legislative Services Commission, the Legislative Services Officer shall assign professional staff to assist in the work of the Study Commission on Criminal History Record Checks. With the prior approval of the Legislative Services Commission, the Study Commission may hold its meetings in the State Legislative Building or the Legislative Office Building.

SECTION 4.(d) The Commission shall submit a final written report of its findings and recommendations on or before the convening of the 2002 Regular Session of the 2001 General Assembly. All reports shall be filed with the President Pro Tempore of the Senate and the Speaker of the House of Representatives, the Principal Clerks of the Senate and the House of Representatives, and the Legislative Librarian. Upon filing its final report, the Commission shall terminate.

SECTION 4.(e) Members of the Commission shall be paid per diem, subsistence, and travel allowances as follows:

(1) Commission members who are also members of the General Assembly, at the rate established in G.S. 120-3.1;
(2) Commission members who are officials or employees of the State or local government agencies, at the rate established in G.S. 138-6;
(3) All other Commission members, at the rate established in G.S. 138-5.

SECTION 4.(f) All State departments and agencies shall cooperate with the Commission and, upon request, shall furnish to the Commission and its staff any information in their possession or available to them.

SECTION 4.(g) From funds appropriated to the General Assembly, the Legislative Services Commission shall allocate funds for the expenses of the Study Commission on Criminal History Record Checks.

SECTION 5. Section 4 of this act becomes effective July 1, 2001. The remainder of this act is effective when it becomes law.

2001 COMMITTEE REPORT
HOUSE OF REPRESENTATIVES

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

☒ Committee Substitute for
S.B. 826 A BILL TO BE ENTITLED AN ACT TO REPEAL THE REQUIREMENT FOR A NATIONAL CRIMINAL HISTORY RECORD CHECK FOR CERTAIN LONG-TERM CARE FACILITIES BECAUSE OF FEDERAL REQUIREMENTS LIMITING DISTRIBUTION OF RECORD CHECK RESULTS.

☐ 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)

2/15/01

VISITOR REGISTRATION SHEET

Hen 14 — Name of Committee

July 3, 2001 — Date

VISITORS:. PLEASE SIGN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Crissa Ponder	Bond & Associates
Jerry Cooper	NCALA
Lin Wilson	NCALTC7
John Bowdynch	Alley Associates
Gary Salamido	GSK
Gail Stewart	Rep. Howard's Office
Craig Souza	NCACA
Stacy Aaronson	"
STEVE KEENE	NC MEDICAL SOCIETY
Anne Winner	PPOP
Bryce Bond	Bond + Assoc.

AGENDA

HOUSE COMMITTEE ON HEALTH
TUESDAY, July 17, 2001
12:00 Noon, ROOM 415 LOB

OPENING REMARKS

Rep. Thomas E. Wright
Chairman

BILLS TO BE DISCUSSED

HB-1091 NATUROPATHIC PHYSICIANS. (Rep. Hill)

SB-772 ENTERAL SEDATION/DENTIST PRMITS. (Sen. Wellons)

COMMENTS

ADJOURNMENT

Vanda Wilson-Wormack (Rep. Wright)

From: Vanda Wilson-Wormack (Rep. Wright)
Sent: Monday, July 16, 2001 12:59 PM
Subject: House Health Committee Meeting-(07-17-01)-Cancellation Notice

NORTH CAROLINA HOUSE OF REPRESENTATIVES
COMMITTEE MEETING NOTICE
2001-2002 SESSION

CANCELLATION NOTICE

You are hereby notified that the Committee on **HEALTH** has been **cancelled** for:

DAY & DATE: **Tuesday, July 17, 2001**

TIME: **12:00 Noon**

LOCATION: **415 LOB**

The following bills will be considered (Bill # & Short Title & Bill Sponsor):
HB-1091 NATUROPATHIC PHYSICIANS. (Rep. Hill)

SB-772 ENTERAL SEDATION/DENTIST PERMITS. (Sen. Wellons)

Respectfully,

Representative Thomas E. Wright
Chairman

I hereby certify this notice was filed by the committee assistant at the following offices at **1:15pm** on **Monday, July 16, 2001**.

___Principal Clerk
___Reading Clerk - House Chamber

Vanda Wilson-Wormack (Committee Assistant)

AGENDA

HOUSE COMMITTEE ON HEALTH
TUESDAY, July 31, 2001
12:00 Noon, ROOM 415 LOB

OPENING REMARKS

Rep. Thomas E. Wright
Chairman

BILLS TO BE DISCUSSED

SB-199 MANAGED CARE PATIENTS' BILL OF RIGHTS-(Sen. Wellons)

COMMENTS

ADJOURNMENT

MINUTES

HOUSE COMMITTEE ON HEALTH

TUESDAY, JULY 31, 2001

12:00 NOON, ROOM 415 LOB

The House Committee met on Tuesday, July 31, 2001 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-199 MANAGED CARE PATIENT'S BILL OF RIGHTS. (Sen. Wellons)

Rep. Edward's moved for adoption of the proposed committee substitute. So moved. Sen. Wellon's explained the bill. Rep. Baddour, Majority Leader of the House, commented on the bill and urged support of the bill. Rep. Hackney, Speaker Pro Tem, further commented on the bill. Rep. Nye commented on the bill and urged support of the bill. Rep. Justus commented on the bill. Allen Hersh, from the Governor's office, explained the bill in its entirety. Rep. Hackney, further explained the bill. Rep. Edwards asked Rep. Hackney about employees as agents. Rep. Hackney responded that there was a safe harbor for employers. Phil Kirk, of NCCBI, stated that he was pleased with the compromise of the bill, but do not support the liability portion of the bill and suggested an external review process. Rep. Hackney responded. Rep. Edwards stated that an amendment would be offered on the section of clinical trials.

Rep. Earle moved for a favorable report to the proposed committee substitute.

Rep. Sherrill asked about the fee set by the Commissioner on page 9. Sen. Wellon's responded. Daschall Propes, from the Department of Insurance, responded that there were fiscal notes prepared. Rep. Nye commented on the bill. Rep. Edwards asked about the section that addresses 'the prohibition of managed care provider incentives'. Harry Kaplan, of the NC Association of Health Plans, responded.

Chairman Wright stated that the bill would be taken up at the next meeting.

The meeting adjourned at 12:50pm.

Rep. Thomas Wright, Chairman

Vanda Wilson-Wormack, Committee Assistant

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2001

S 2

SENATE BILL 199

Insurance and Consumer Protection Committee Substitute Adopted 4/25/01

Short Title: Managed Care Patients' Bill of Rights. (Public)

Sponsors:

Referred to:

February 22, 2001

A BILL TO BE ENTITLED

AN ACT TO IMPROVE ACCESS TO HEALTH CARE ADVICE, INFORMATION, AND SERVICES TO COVERED PERSONS UNDER HEALTH BENEFIT PLANS; ESTABLISH STANDARDS FOR HEALTH PLAN DISCLOSURES TO CONSUMERS; ESTABLISH A PATIENTS' ASSISTANCE PROGRAM; REQUIRE COVERAGE FOR CLINICAL TRIALS AND NEWBORN HEARING SCREENING; PROVIDE STANDARDS FOR INDEPENDENT REVIEW OF NONCERTIFICATIONS BY AN INSURER OR MANAGED CARE PLAN, AND TO HOLD MANAGED CARE ENTITIES LIABLE FOR HARM CAUSED TO INSUREDS OR ENROLLEES BY THE FAILURE TO EXERCISE ORDINARY CARE IN MAKING TREATMENT DECISIONS.

The General Assembly of North Carolina enacts:

PART I. PATIENT ACCESS TO MEDICAL ADVICE AND CARE

Subpart A. Continuity of Care in HMOs

SECTION 1. Article 67 of Chapter 58 of the General Statutes is amended by adding a new section to read:

"**§ 58-67-88. Continuity of care.**

(a) Definitions. – As used in this section:

(1) 'Ongoing special condition' means:

a. In the case of an acute illness, a condition that is serious enough to require medical care or treatment to avoid a reasonable possibility of death or permanent harm.

b. In the case of a chronic illness or condition, or a disease or condition that is life-threatening, degenerative, or disabling, and requires medical care or treatment over a prolonged period of time.

c. Pregnancy, from the start of the second trimester.
d. Terminal illness.

(2) 'Terminal illness' means an individual has a medical prognosis that the individual's life expectancy is six months or less.

(3) 'Terminated or termination'. – Includes, with respect to a contract, the expiration or nonrenewal of the contract, but does not include a termination of the contract by an HMO for failure to meet applicable quality standards or for fraud.

(b) Termination of Provider. – If a contract between an HMO benefit plan that is not a point-of-service plan and a health care provider is terminated by the provider or by the HMO, or benefits or coverage provided by the HMO are terminated because of a change in the terms of provider participation in a health benefit plan of an HMO that is not a point-of-service plan, and an individual is covered by the plan and is terminally ill or undergoing treatment from the provider for an ongoing special condition at the time of the termination, then, the HMO shall:

(1) Upon termination of the contract by the HMO or upon receipt by the HMO of written notification of termination by the provider, notify the individual on a timely basis of the termination and of the right to elect continuation of coverage of treatment by the provider under this section.

(2) Subject to subsection (h) of this section, permit the individual to elect to continue to be covered with respect to the terminal illness or treatment by the provider of the ongoing special condition during a transitional period provided under this section.

(c) Newly Covered Insured. – Each health benefit plan offered by an HMO that is not a point-of-service plan shall provide transition coverage to individuals who are newly covered under the health benefit plan because the individual's employer has changed health benefit plans, and the HMO shall:

(1) Notify the individual at the time of enrollment of the right to elect continuation of coverage of treatment by the provider under this section.

(2) Subject to subsection (h) of this section, permit the individual to elect to continue to be covered with respect to the terminal illness or treatment by the provider of the ongoing special condition during a transitional period provided under this section.

(d) Transitional Period: In General. – Except as otherwise provided in subsections (e), (f), and (g) of this section, the transitional period under this subsection shall extend up to 90 days, as determined by the treating health care provider, after the date of the notice to the individual described in subdivision (b)(1) of this section or the enrollment in a new plan described in subdivision (c)(1) of this section.

(e) Transitional Period: Scheduled Surgery, Organ Transplantation, or Institutional Care. – If surgery, organ transplantation, or other inpatient care was scheduled for an individual before the date of the notice required under subdivision

(b)(1) of this section, or the enrollment in a new plan described in subdivision (c)(1) of this section or if the individual on that date was on an established waiting list or otherwise scheduled to have the surgery, transplantation, or other inpatient care, the transitional period under this subsection with respect to the surgery, transplantation, or other inpatient care shall extend beyond the period under subsection (d) of this section through the date of discharge of the individual after completion of the surgery, transplantation, or other inpatient care, and through postdischarge follow-up care related to the surgery, transplantation, or other inpatient care occurring within 90 days after the date of discharge.

(f) Transitional Period: Pregnancy. – If an insured has entered the second trimester of pregnancy on the date of the announcement of the termination of the provider status under subdivision (b)(1) of this section, or the enrollment in a new plan described in subdivision (c)(1) of this section, and the provider was treating the pregnancy before the date of the announcement of the termination, or the enrollment in the new plan, the transitional period with respect to the provider's treatment of the pregnancy shall extend through the provision of 60 days of postpartum care.

(g) Transitional Period: Terminal Illness. – If an insured was determined to be terminally ill at the time of a provider's termination of participation, or at the time of enrollment in the new plan, and the provider was treating the terminal illness before the date of termination or enrollment in the new plan, the transitional period shall extend for the remainder of the individual's life with respect to care directly related to the treatment of the terminal illness or its medical manifestations.

(h) Permissable Terms and Conditions. – An HMO may condition coverage of continued treatment by a provider under subdivision (b)(2) or (c)(2) of this section upon the following terms and conditions:

(1) The provider agrees to accept reimbursement from the HMO and individual involved, with respect to cost-sharing, at the rates applicable before the start of the transitional period as payment in full.

(2) The provider agrees to adhere to the quality assurance standards of the HMO responsible for payment under subdivision (1) of this subsection and to provide to the HMO necessary medical information related to the care provided.

(3) The provider agrees otherwise to adhere to the HMO's established policies and procedures for participating providers, including procedures regarding referrals and obtaining prior authorization, providing services pursuant to a treatment plan, if any, approved by the HMO, and member hold harmless provisions.

(4) The insured notifies the HMO within 45 days of the date of the notice described in subdivision (b)(1) of this section or the new enrollment described in subdivision (c)(1) of this section.

(5) The provider agrees to discontinue providing services and refer the enrollee to a network provider by the end of the transition period.

(i) Construction. – Nothing in this section:

(1) Requires the coverage of benefits that would not have been covered if the provider involved remained a participating provider.

(2) Requires an HMO to offer a transitional period when the HMO terminates a provider's contract for reasons relating to quality of care or fraud; and refusal to offer a transitional period under these circumstances is not subject to the grievance review provisions of G.S. 58-50-62.

(3) Prohibits an HMO from extending any transitional period beyond that specified in this section.

(4) Prohibits an HMO from terminating the continuing services of a provider as described in this section when the HMO has determined that the provider's continued provision of services may result in, or is resulting in, a serious danger to the health or safety of the enrollee. Such terminations shall be in accordance with the contract provisions that the provider would otherwise be subject to if the provider's contract were still in effect.

(j) Disclosure of Right to Transitional Period. – Each HMO shall include a clear description of an insured's rights under this section in its evidence of coverage and summary plan description."

Subpart B. Extended or Standing Referral to Specialist

SECTION 1.2. G.S. 58-3-223 reads as rewritten:

"**§ 58-3-223. Managed care access to specialist care.**

(a) Each insurer offering a health benefit plan that does not allow direct access to all in-plan specialists shall develop and maintain written policies and procedures by which an insured may receive an extended or standing referral to an in-plan specialist. The ~~procedure~~insurer shall provide for an extended or standing referral to a specialist if the insured has a serious or chronic degenerative, disabling, or life-threatening disease or condition, which in the opinion of the insured's primary care physician, in consultation with the specialist, requires ongoing specialty care. The extended or standing referral shall be for a period not to exceed 12 months and shall be made under a treatment plan coordinated with the insurer in consultation with the primary care physician, the specialist, and the insured or the insured's designee.

(b) As used in this section:

(1) 'Health benefit plan' has the meaning applied in G.S. 58-3-167.~~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 are 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 under Article 65 of this Chapter, or a health maintenance organization under Article 67 of this Chapter, or a multiple employer welfare arrangement under Article 49 of this Chapter.~~has the meaning applied in G.S. 58-3-167.

(3) 'Serious or chronic degenerative, disabling, or life-threatening disease or condition' means a disease or condition, which in the opinion of the patient's treating primary care physician and specialist, requires frequent and periodic monitoring and consultation with the specialist on an ongoing basis.

(4) 'Specialist' includes a subspecialist."

SECTION 1.2A. 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 the out-of-network benefit levels offered under the insured's approved health benefit ~~plan~~ plan, including an insured receiving an extended or standing referral under G.S. 58-3-223, unless contracting health care providers able to meet health needs of the insured are reasonably available to the insured without unreasonable delay."

Subpart C. Selection of Specialist as Primary Care Physician

SECTION 1.3. Article 3 of Chapter 58 of the General Statutes is amended by adding a new section to read:

"§ 58-3-230. Selection of specialist as primary care provider.

(a) Each insurer shall have a procedure by which an insured diagnosed with a serious or chronic degenerative, disabling, or life-threatening disease or condition, either of which requires specialized medical care may select as his or her primary care physician a specialist with expertise in treating the disease or condition who shall be responsible for and capable of providing and coordinating the insured's primary and specialty care. If the insurer determines that the insured's care would not be appropriately coordinated by that specialist, the insurer may deny access to that specialist as a primary care provider.

(b) The selection of the specialist shall be made under a treatment plan approved by the insurer, in consultation with the specialist and the insured or the insured's designee and after notice to the insured's primary care provider, if any. The specialist may provide ongoing care to the insured and may authorize such referrals, procedures, tests, and other medical services as the insured's primary care provider would otherwise be allowed to provide or authorize, subject to the terms of the treatment plan. Services provided by a specialist who is providing and coordinating primary and specialty care remain subject to utilization review and other requirements of the insurer, including its requirements for primary care providers."

Subpart D. Direct Access to Pediatrician

SECTION 1.4. Article 3 of Chapter 58 of the General Statutes is amended by adding a new section to read:

"§ 58-3-240. Direct access to pediatrician for minors.

Each insurer offering a health benefit plan that uses a network of contracting health care providers shall allow an insured to choose a contracting pediatrician in the network as the primary care provider for the insured's children who are under the age of 18."

Subpart E. Access to Prescription Drugs

SECTION 1.5. G.S. 58-3-221 reads as rewritten:

"**§ 58-3-221. Access to nonformulary and restricted access prescription drugs.**

(a) If an insurer maintains one or more closed formularies for or restricts access to covered prescription drugs or devices, then the insurer shall do all of the following:

(1) Develop the formulary or formularies and any restrictions on access to covered prescription drugs or devices in consultation with and with the approval of a pharmacy and therapeutics committee, which shall include participating ~~providers~~ physicians who are licensed to ~~prescribe prescription drugs or devices.~~ practice medicine in this State.

(2) Make available to participating ~~providers and pharmacists~~ providers, pharmacists, and enrollees the complete drugs or devices formulary or formularies maintained by the insurer including a list of the devices and prescription drugs on the formulary by major therapeutic category

that specifies whether a particular drug or device is preferred over other drugs or devices.

(3) Establish and maintain an expeditious process or procedure that allows an enrollee or a physician acting on behalf of an enrollee to obtain, without penalty or additional cost-sharing beyond that provided for in the health benefit plan, coverage for a specific nonformulary drug or device determined to be medically necessary and appropriate by the participating physician without prior approval from the insurer, after the participating physician notifies the insurer that:

a. Either (i) the formulary alternatives have been ineffective in the treatment of the enrollee's disease or condition, or (ii) the formulary alternatives cause or are reasonably expected by the physician to cause a harmful or adverse clinical reaction in the enrollee; and

b. Either (i) the drug is prescribed in accordance with any applicable clinical protocol of the insurer for the prescribing of the drug, or (ii) the drug has been approved as an exception to the clinical protocol pursuant to the insurer's exception procedure.

(4) Provide coverage for a restricted access drug or device to an enrollee without requiring prior approval if an enrollee's physician certifies in writing that the enrollee has previously used an alternative nonrestricted access drug or device and the alternative drug or device has been ineffective or detrimental to the enrollee's health.

(b) An insurer may not void a contract or refuse to renew a contract between the insurer and a prescribing provider because the prescribing provider has prescribed a medically necessary and appropriate nonformulary or restricted access drug or device as provided in this section.

(c) As used in this section:

(1) 'Closed formulary' means a list of prescription drugs and devices reimbursed by the insurer that excludes coverage for drugs and devices not listed.

(1a) 'Health benefit plan' has definition provided in G.S. 58-3-167. ~~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 are statutorily required to be contained in any liability policy or equivalent self-insurance.~~

(2) 'Insurer' has the meaning provided in G.S. 58-3-167. ~~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, or a multiple employer welfare arrangement under Article 49 of this Chapter~~.

(3) 'Restricted access drug or device' means those covered prescription drugs or devices for which reimbursement by the insurer is conditioned on the insurer's prior approval to prescribe the drug or device or on the provider prescribing one or more alternative drugs or devices before prescribing the drug or device in question.

(d) Nothing in this section requires an insurer to pay for drugs or devices or classes of drugs or devices related to a benefit that is specifically excluded from coverage by the insurer."

Subpart F. Managed Care Patients' Assistance Program

SECTION 1.6. Article _____ of Chapter _____ of the General Statutes is amended by adding the following new section to read:

"**§ _____. Managed Care Patients' Assistance Program.**

(a) The Office of Managed Care Patients' Assistance Program is hereby established. The Director of the Office of Managed Care Patients' Assistance Program shall be appointed by the Governor.

(b) The Managed Care Patients' Assistance Program shall provide information and assistance to individuals enrolled in managed care plans. The Managed Care Patients' Assistance Program shall have expertise and experience in both health care and

advocacy and will assume the specific duties and responsibilities set forth in subsection (c) of this section.

(c) The duties and responsibilities of the Managed Care Patients' Assistance Program are as follows:

(1) Develop and distribute educational and informational materials for consumers, explaining their rights and responsibilities as managed care plan enrollees.

(2) Answer inquiries posed by consumers and refer inquiries of a regulatory nature to staff within the Department of Insurance.

(3) Advise managed care plan enrollees about the utilization review process.

(4) Assist enrollees with the grievance, appeal, and external review procedures established by Article 50 of Chapter 58 of the General Statutes.

(5) Publicize the Office of the Managed Care Patients' Assistance Program.

(6) Compile data on the activities of the Office and evaluate such data to make recommendations as to the needed activities of the Office.

(d) The Director of the Managed Care Patients' Assistance Program shall annually report the activities of the Managed Care Patients' Assistance Program, including the types of appeals, grievances, and complaints received and the outcome of these cases. The report shall be submitted to the General Assembly, upon its convening or reconvening, and shall make recommendations as to efforts that could be implemented to assist managed care consumers."

PART II. HEALTH PLAN DISCLOSURES

Subpart A. Managed Care Reporting and Disclosure Requirements

SECTION 2.1. G.S. 58-3-191(b) reads as rewritten:

"(b) Disclosure requirements. – Each health benefit plan shall provide the following applicable information to plan participants and bona fide prospective participants upon request:

(1) The evidence of coverage (G.S. 58-67-50), subscriber contract (G.S. 58-65-60, 58-65-140), health insurance policy (G.S. 58-51-80, 58-50-125, 58-50-55), or the contract and benefit summary of any other type of health benefit plan;

(2) An explanation of the utilization review criteria and treatment protocol under which treatments are provided for conditions specified by the prospective participant. This explanation shall be in writing if so requested;

(3) If denied a recommended treatment, written reasons for the denial and an explanation of the utilization review criteria or treatment protocol upon which the denial was based;

(4) The plan's ~~restrictive formularies~~ closed formularies, restricted access drugs or devices, or prior approval requirements for obtaining prescription drugs, whether a particular drug or therapeutic class of drugs is excluded from its formulary, and the circumstances under which a nonformulary drug may be covered; and

(5) The plan's procedures and medically based criteria for determining whether a specified procedure, test, or treatment is experimental."

Subpart B. Provider Directory Information

SECTION 2.2. Article 3 of Chapter 58 of the General Statutes is amended by adding a new section to read:

"**§ 58-3-245. Provider directories.**

(a) Every health benefit plan utilizing a provider network shall make a listing of network providers available to insureds and shall update the listing no less frequently than once a year. In addition, every health benefit plan shall maintain a telephone system and may maintain an electronic or on-line system through which insureds can access up-to-date network information. If the health benefit plan produces printed directories, the directories shall contain language disclosing the date of publication, frequency of updates, that the directory may not contain the latest network information, and contact information for accessing up-to-date network information.

(b) Each listing shall include:

(1) The provider's name, address, telephone number, and, if applicable, area of specialty.

(2) Whether the provider may be selected as a primary care provider.

(3) To the extent known to the health benefit plan, an indication of whether the provider:

a. Is or is not currently accepting new patients.

b. Has any other restrictions that would limit an insured's access to that provider.

(c) The listing shall include all of the types of participating providers. Upon a participating provider's written request, the insurer shall also list in the directory, as part of the participating provider's listing, the names of any allied health professionals who provide primary care services under the supervision of the participating provider and whose services are covered by virtue of the carrier's contract with the supervising participating provider and whose credentials have been verified by the supervising participating provider. These allied health professionals shall be listed as a part of the directory listing for the participating provider upon receipt of a certification by the supervising participating provider that the credentials of the allied health professional have been verified."

Subpart C. Disclosure of Payment Obligations

SECTION 2.3. Article 3 of Chapter 58 of the General Statutes is amended by adding a new section to read:

"**§ 58-3-250. Payment obligations for covered services.**

(a) If an insurer calculates a benefit amount for a covered service under a health benefit plan through a method other than a fixed dollar co-payment, the insurer shall clearly explain in its evidence of coverage and plan summaries how it determines its payment obligations and the payment obligations of the insured. The explanation shall include:

(1) An example of the steps the insurer would take in calculating the benefit amount and the payment obligations of each party.

(2) Whether the insurer has obtained the agreement of health care providers not to bill an insured for any amounts by which a provider's charge exceeds the insurer's recognized charge for a covered service and whether the insured may be liable for paying any excess amount.

(3) Which party is responsible for filing a claim or bill with the insurer.

(b) If an insured is liable for an amount that differs from a stated fixed dollar co-payment or may differ from a stated coinsurance percentage because the coinsurance amount is based on a (plan allowance or other such amount rather than the actual charges and providers are permitted to balance bill the insured, the evidence of coverage, plan summaries, and marketing and advertising materials that include information on benefit levels shall contain the following statement: 'NOTICE: Your actual expenses for covered services may exceed the stated [coinsurance percentage or co-payment amount] because actual provider charges may not be used to determine [plan/insurer or similar term] and [insured/member/enrollee or similar term] payment obligations.' "

PART III. MANDATED BENEFITS

Subpart A. Clinical Trials

SECTION 3.1. Article 3 of Chapter 58 of the General Statutes is amended by adding a new section to read:

"**§ 58-3-255. Coverage of clinical trials.**

(a) As used in this section:

(1) 'Covered clinical trials' means phase III and phase IV patient research studies designed to evaluate new treatments, including prescription drugs and that: (i) involve the treatment of life-threatening medical conditions, (ii) are medically indicated and preferable for that patient compared to available noninvestigational treatment alternatives, and (iii) have clinical and preclinical data that shows the trial will likely be

more effective for that patient than available noninvestigational alternatives. Covered clinical trials must also meet the following requirements:

a. Must involve determinations by treating physicians, relevant scientific data, and opinions of experts in relevant medical specialties.

b. Must be trials approved by centers or cooperative groups that are funded by the National Institutes of Health, the Food and Drug Administration, the Centers for Disease Control, the Agency for Health Care Research and Quality, the Department of Defense, or the Department of Veterans Affairs. The health benefit plan may also cover clinical trials sponsored by other entities.

c. Must be conducted in a setting and by personnel that maintain a high level of expertise because of their training, experience, and volume of patients.

(2) 'Health benefit plan' is defined by G.S. 58-3-167.

(3) 'Insurer' is defined by G.S. 58-3-167.

(b) Each health benefit plan shall provide coverage for participation in phase III and phase IV covered clinical trials by its insureds or enrollees who meet protocol requirements of the trials and provide informed consent.

(c) Only medically necessary costs of health care services, as defined in G.S. 58-50-61, associated with participation in a covered clinical trial, including those related to health care services typically provided absent a clinical trial, the diagnosis and treatment of complications, and medically necessary monitoring, are required to be covered by the health benefit plan and only to the extent that such costs have not been or are not funded by national agencies, commercial manufacturers, distributors, or other research sponsors of participants in clinical trials.

(d) Clinical trial costs not required to be covered by a health benefit plan include the costs of services that are not health care services, those provided solely to satisfy data collection and analysis needs, those related to investigational drugs and devices, and those that are not provided for the direct clinical management of the patient. In the event a claim contains charges related to services for which coverage is required under this section, and those charges have not been or cannot be separated from costs related to services for which coverage is not required under this section, the health benefit plan may deny the claim."

Subpart B. Newborn Hearing Screening

SECTION 3.2. Article 3 of Chapter 58 of the General Statutes is amended by adding a new section to read:

"**§ 58-3-260. Insurance coverage for newborn hearing screening mandated.**

(a) As used in this section, the terms 'health benefit plan' and 'insurer' have the meanings applied under G.S. 58-3-167.

(b) Each health benefit plan shall provide coverage for newborn hearing screening ordered by the attending physician pursuant to G.S. 130A-125. The same deductibles, coinsurance, reimbursement methodologies, and other limitations and administrative procedures as apply to similar services covered under the health benefit plan shall apply to coverage for newborn hearing screening."

PART IV. EXTERNAL REVIEW AND MANAGED CARE ENTITY LIABILITY

Subpart A. Independent, External Review Process

SECTION 4.1. The title of Article 50 of Chapter 58 of the General Statutes reads as rewritten:

"Article 50.

General Accident and Health Insurance Regulations."

SECTION 4.2. Article 50 of Chapter 58 of the General Statutes is amended as follows:

(1) By designating G.S. 58-50-1 through G.S. 58-50-45 as Part 1 with the heading "Miscellaneous Provisions."

(2) By designating G.S. 58-50-50 through G.S. 58-50-64 as Part 2 with the heading "PPOs, Utilization Review and Grievances."

(3) By designating G.S. 58-50-65 through G.S. 58-50-70 as Part 3 with the heading "Scope and Sanctions."

(4) By designating G.S. 58-50-75 through G.S. 58-50-95 as Part 4 with the heading "Health Benefit Plan External Review."

(5) By designating G.S. 58-50-100 through G.S. 58-50-156 as Part 5 with the heading "Small Employer Group Health Insurance Reform."

SECTION 4.3. G.S. 58-50-151 is recodified as G.S. 58-51-116.

SECTION 4.4. The prefatory language of G.S. 58-50-61(a) reads as rewritten:

"(a) Definitions. – As used in this ~~section and~~ section, in G.S. 58-50-62, and in Part 4 of this Article, the term:".

SECTION 4.5. Article 50 of Chapter 58 of the General Statutes is amended by adding a new Part to read:

"Part 4. Health Benefit Plan External Review.

"**§ 58-50-75. Purpose, scope, and definitions.**

(a) The purpose of this Part is to provide standards for the establishment and maintenance of external review procedures to assure that covered persons have the opportunity for an independent review of an appeal decision upholding a noncertification or a second-level grievance review decision upholding a noncertification, as defined in this Part.

(b) This Part applies to all persons that provide or perform utilization review. With respect to second-level grievance review decisions, this Part applies only to second-level grievance review decisions involving noncertification decisions.

(c) In addition to the definitions in G.S. 58-50-61(a), as used in this Part:

(1) 'Covered benefits' or 'benefits' means those benefits consisting of medical care, provided directly through insurance or otherwise and including items and services paid for as medical care, under the terms of a health benefit plan.

(2) 'Covered person' means a policyholder, subscriber, enrollee, or other individual covered by a health benefit plan. 'Covered person' includes another person, including the covered person's health care provider, acting on behalf of the covered person.

(3) 'Independent review organization' or 'organization' means an entity that conducts independent external reviews of appeals of noncertifications and second-level grievance review decisions.

"**§ 58-50-76:** Reserved.

"**§ 58-50-77. Notice of right to external review.**

(a) An insurer shall notify the covered person in writing of the covered person's right to request an external review and include the appropriate statements and information set forth in this section at the time the insurer sends written notice of:

(1) An appeal decision under G.S. 58-50-61 upholding a noncertification; and

(2) A second-level grievance review decision under G.S. 58-50-62 upholding the original noncertification.

(b) The insurer shall include in the notice required under subsection (a) of this section for a notice related to an appeal decision under G.S. 58-50-61, a statement informing the covered person that:

(1) If the covered person has a medical condition where the time frame for completion of an expedited review of a grievance involving an appeal decision under G.S. 58-50-61 would reasonably be expected to seriously jeopardize the life or health of the covered person or jeopardize the covered person's ability to regain maximum function, the covered person may file a request for an expedited external review under G.S. 58-50-82 at the same time the covered person files a request for an expedited review of a grievance involving an appeal decision under G.S. 58-50-61 and G.S. 58-50-62, but that the organization assigned to conduct the expedited external review will determine whether the covered person shall be required to complete the expedited review of the grievance before conducting the expedited external review.

(2) If the insurer has not issued a written decision to the covered person within 45 days after the date the covered person files the grievance with the insurer pursuant to G.S. 58-50-62 and the covered person has

not requested or agreed to a delay, the covered person may file a request for external review under G.S. 58-50-80 of this section and shall be considered to have exhausted the insurer's internal grievance process for purposes of G.S. 58-50-79.

(c) The insurer shall include in the notice required under subsection (a) of this section for a notice related to a final second-level grievance review decision under G.S. 58-50-62, a statement informing the covered person that:

(1) If the covered person has a medical condition where the time frame for completion of a standard external review under G.S. 58-50-80 would reasonably be expected to seriously jeopardize the life or health of the covered person or jeopardize the covered person's ability to regain maximum function, the covered person may file a request for an expedited external review under G.S. 58-50-82; or

(2) If the second-level grievance review decision concerns an admission, availability of care, continued stay, or health care service for which the covered person received emergency services but has not been discharged from a facility, the covered person may request an expedited external review under G.S. 58-50-82.

(d) In addition to the information to be provided under subsections (b) and (c) of this section, the insurer shall include a copy of the description of both the standard and expedited external review procedures the insurer is required to provide under G.S. 58-50-93, including the provisions in the external review procedures that give the covered person the opportunity to submit additional information.

"**§ 58-50-78:** Reserved.

"**§ 58-50-79. Exhaustion of internal grievance process.**

(a) Except as provided in subsections (d) and (e) of this section, a request for an external review under G.S. 58-50-80 or G.S. 58-50-82 shall not be made until the covered person has exhausted the insurer's internal grievance process under G.S. 58-50-62.

(b) A covered person shall be considered to have exhausted the insurer's internal grievance process for purposes of this section, if the covered person:

(1) Has filed a second-level grievance involving a noncertification appeal decision under G.S. 58-50-61 and G.S. 58-50-62.

(2) Except to the extent the covered person requested or agreed to a delay, has not received a written decision on the grievance from the insurer within 45 days since the date the covered person filed the grievance with the insurer.

(c) Notwithstanding subsection (b) of this section, a covered person may not make a request for an external review of a noncertification involving a retrospective review determination made under G.S. 58-50-61 until the covered person has exhausted the insurer's internal grievance process.

(d) At the same time a covered person files a request for an expedited appeal involving a noncertification as set forth in G.S. 58-50-61(l), the covered person may file

a request for an expedited external review of the noncertification under G.S. 58-50-82 if the covered person has a medical condition where the time frame for completion of an expedited review of the appeal involving a noncertification set forth in G.S. 58-50-61(l) would be reasonably expected to seriously jeopardize the life or health of the covered person or would jeopardize the covered person's ability to regain maximum function. An insurer may waive its right to conduct an expedited review of an appeal and allow the covered person to proceed with an expedited external review of the noncertification.

(e) Upon receipt of a request for an expedited external review under subsection (d) of this section, the organization conducting the external review in accordance with the provisions of G.S. 58-50-82 shall immediately determine whether the covered person shall be required to complete the expedited review process set forth in G.S. 58-50-61(l) before it conducts the expedited external review, unless the insurer has waived its right to conduct an expedited review of the appeal decision.

(f) Upon a determination made under subsection (e) of this section that the covered person must first complete the expedited appeal process under G.S. 58-50-61(l), the organization immediately shall notify the covered person and the insurer of this determination and that it will not proceed with the expedited external review under G.S. 58-50-82 until completion of the expedited appeal process and the covered person's grievance at the completion of the expedited appeal process remains unresolved.

(g) A request for an external review of a noncertification may be made before the covered person has exhausted the insurer's internal grievance procedures under G.S. 58-50-61 and G.S. 58-50-62 whenever the insurer agrees to waive the exhaustion requirement. If the requirement to exhaust the insurer's internal grievance procedures is waived, the covered person may file a request in writing for a standard external review as set forth in G.S. 58-50-80 or may make a request for an expedited external review as set forth in G.S. 58-50-82.

"**§ 58-50-80. Standard external review.**

(a) Within 60 days after the date of receipt of a notice of a noncertification appeal decision or a second-level grievance review decision under G.S. 58-50-77, a covered person may file a request for an external review with the Commissioner.

(b) Upon receipt of a request for an external review under subsection (a) of this section, the Commissioner immediately shall notify and send a copy of the request to the insurer that made the decision which is the subject of the request. The insurer shall immediately submit to the Commissioner the information required for the preliminary review under subsection (c) of this section.

(c) Within five business days after the date of receipt of a request for an external review, the Commissioner shall complete a preliminary review of the request to determine whether:

(1) The individual is or was a covered person in the health benefit plan at the time the health care service was requested or, in the case of a retrospective review, was a covered person in the health benefit plan at the time the health care service was provided.

(2) The health care service that is the subject of the noncertification appeal decision or the second-level grievance review decision upholding a noncertification reasonably appears to be a covered service under the covered person's health benefit plan.

(3) The covered person has exhausted the insurer's internal appeal and grievance processes under G.S. 58-50-61 and G.S. 58-50-62 unless the covered person is not required to exhaust the insurer's internal appeal or grievance process under G.S. 58-50-79.

(4) The covered person has provided all the information and forms required by the Commissioner that are necessary to process an external review.

(d) Upon completion of the preliminary review under subsection (c) of this section, the Commissioner immediately shall notify the covered person in writing whether the request is complete and whether the request has been accepted for external review. If the request is not complete, the Commissioner shall request from the covered person the information or materials needed to make the request complete. The covered person shall furnish the Commissioner with the requested information or materials within 90 days after the date of the insurer's decision for which external review is requested. If the request is not accepted for external review, the Commissioner shall inform the covered person and the insurer in writing of the reasons for its nonacceptance.

(e) If the request is accepted for external review, the Commissioner shall:

(1) Include in the notice provided under subsection (d) of this section a statement that the covered person may submit to the Commissioner in writing within seven days after the date of the notice additional information and supporting documentation relevant to the initial denial that the organization shall consider when conducting the external review.

(2) Immediately notify the insurer in writing of the acceptance of the request for external review.

The Commissioner shall maintain an alphabetical listing of independent review organizations approved under G.S. 58-50-85 and shall systematically assign on a rotating basis the next independent review organization on that list capable of performing the review to conduct the external review. After the last organization on the list has been assigned a review, the commissioner shall return to the top of the list to continue assigning reviews.

(f) The Commissioner shall forward to the review organization that was assigned by the Commissioner any documents that were received relating to the request for external review. At the same time the Commissioner forwards the information to the review organization, the Commissioner shall forward the information to the insurer.

(g) Within seven days after the date of receipt of the notice provided under subsection (d) of this section, the insurer or its designee utilization review organization shall provide to the assigned organization the documents and any information

considered in making the noncertification appeal decision or the second-level grievance review decision. Except as provided in subsection (h) of this section, failure by the insurer or its designee utilization review organization to provide the documents and information within the time specified in this subsection shall not delay the conduct of the external review.

(h) If the insurer or its utilization review organization fails to provide the documents and information within the time specified in subsection (g) of this section, the assigned organization may terminate the external review and make a decision to reverse the noncertification appeal decision or the second-level grievance review decision. Immediately upon making the decision under this subsection, the organization shall notify the covered person, the insurer, and the Commissioner.

(i) Upon receipt of the information required to be forwarded under subsection (f) of this section, the insurer may reconsider its noncertification appeal decision or second-level grievance review decision that is the subject of the external review. Reconsideration by the insurer of its noncertification appeal decision or second-level grievance review decision under this subsection shall not delay or terminate the external review. The external review shall be terminated if the insurer decides, upon completion of its reconsideration, to reverse its noncertification appeal decision or second-level grievance review decision and provide coverage or payment for the requested health care service that is the subject of the noncertification appeal decision or second-level grievance review decision.

(j) Immediately upon making the decision to reverse its noncertification appeal decision or second-level grievance review decision under subsection (i) of this section, the insurer shall notify the covered person, the organization, and the Commissioner in writing of its decision. The organization shall terminate the external review upon receipt of the notice from the insurer sent under this subsection.

(k) The assigned organization shall review all of the information and documents received under subsections (f) and (g) of this section that have been forwarded to the organization by the Commissioner and the insurer, including the most recent updated information available. In addition, the assigned review organization, to the extent the documents or information are available and the review organization considers them appropriate, shall consider the following in reaching a decision:

(1) The covered person's medical records.

(2) The attending health care provider's recommendation.

(3) Consulting reports from appropriate health care providers and other documents submitted by the insurer, covered person, or the covered person's treating provider.

(4) The most appropriate practice guidelines that are based on sound clinical evidence and that are periodically evaluated to assure ongoing efficacy.

(5) Any applicable clinical review criteria developed and used by the insurer or its designee utilization review organization.

(6) Medical necessity, as defined in G.S. 58-3-200(b).

(7) Any documentation supporting the medical necessity and appropriateness of the provider's recommendation.

The assigned organization shall review the terms of coverage under the covered person's health benefit plan with the insurer to ensure that the organization's decision shall not be contrary to the terms of coverage under the covered person's health benefit plan with the insurer.

The assigned organization's determination shall be based on the covered person's medical condition at the time of the initial noncertification decision.

(l) Within 45 days after the date of receipt by the Commissioner of the request for external review, the assigned organization shall provide written notice of its decision to uphold or reverse the noncertification appeal decision or second-level grievance review decision to the covered person, the insurer, and the Commissioner. In reaching a decision, the assigned review organization is not bound by any decisions or conclusions reached during the insurer's utilization review process or the insurer's internal grievance process under G.S. 58-50-61 and G.S 58-50-62.

(m) The organization shall include in the notice sent under subsection (l) of this section:

(1) A general description of the reason for the request for external review.

(2) The date the organization received the assignment from the Commissioner to conduct the external review.

(3) The date the organization received information and documents submitted by the covered person and by the insurer.

(4) The date the external review was conducted.

(5) The date of its decision.

(6) The principal reason or reasons for its decision.

(7) The clinical rationale for its decision.

(8) References to the evidence or documentation, including the practice guidelines, considered in reaching its decision.

(9) The professional qualifications and licensure of the clinical peer reviewers.

(10) Notice to the covered person that he or she is not liable for the cost of the external review.

(n) Upon receipt of a notice of a decision under subsection (m) of this section reversing the noncertification appeal decision or second-level grievance review decision, the insurer shall immediately reverse the noncertification appeal decision or second-level grievance review decision that was the subject of the review and shall process the claim accordingly. In the event the covered person is no longer enrolled in the health benefit plan when the insurer receives notice of a decision under subsection (m) of this section reversing the noncertification appeal decision or second-level grievance review decision at the time the decision is rendered, the insurer shall be responsible under this section only for the costs of those services or supplies the covered person would have received prior to disenrollment.

"**§ 58-50-81:** Reserved.

"**§ 58-50-82. Expedited external review.**

(a) Except as provided in subsection (h) of this section, a covered person may make a written or oral request for an expedited external review with the Commissioner at the time the covered person receives:

(1) An appeal decision under G.S. 58-50-61(k) or (l) upholding a noncertification if:

a. The noncertification appeal decision involves a medical condition of the covered person for which the time frame for completion of an expedited second-level grievance review of a noncertification set forth in G.S. 58-50-62(i) would reasonably be expected to seriously jeopardize the life or health of the covered person or jeopardize the covered person's ability to regain maximum function; and

b. The covered person has filed a request for an expedited second-level review of a noncertification as set forth in G.S. 58-50-61(i); or

(2) A second-level grievance review decision under G.S. 58-60-62(h) or (i) upholding a noncertification:

a. If the covered person has a medical condition where the time frame for completion of a standard external review under G.S. 58-50-80 would reasonably be expected to seriously jeopardize the life or health of the covered person or jeopardize the covered person's ability to regain maximum function; or

b. If the second-level grievance concerns a noncertification of an admission, availability of care, continued stay, or health care service for which the covered person received emergency services, but has not been discharged from a facility.

(b) At the time the Commissioner receives a request for an expedited external review, the Commissioner immediately shall:

(1) Notify and provide a copy of the request to the insurer that made the noncertification appeal decision or second-level grievance review decision which is the subject of the request.

(2) For a request that the Commissioner has determined meets the reviewability requirements set forth in G.S. 58-50-80(c), the Commissioner shall immediately determine, based on medical advice from a medical professional who is not affiliated with the organization that will be assigned to conduct the external review of the request, whether the request should be reviewed on an expedited basis because the time frame for completion of a standard external review under G.S. 58-50-80 would reasonably be expected to seriously jeopardize the life or health of the covered person or would jeopardize the covered person's ability to regain maximum function. The Commissioner shall then inform the covered person and the insurer whether the review will

be conducted using an expedited or standard time frame, and shall, in accordance with G.S. 58-50-80, assign an organization to conduct the review within the appropriate time frame.

(c) In reaching a decision, the assigned organization is not bound by any decisions or conclusions reached during the insurer's utilization review process or internal grievance process under G.S. 58-50-61 and G.S. 58-50-62.

(d) At the time the insurer receives the notice under subsection (b) of this section, the insurer or its designee utilization review organization shall immediately provide or transmit all documents and information considered in making the noncertification appeal decision or the second-level grievance review decision to the assigned review organization electronically or by telephone or facsimile or any other available expeditious method.

(e) In addition to the documents and information provided or transmitted under subsection (d) of this section, the assigned organization, to the extent the information or documents are available and the organization considers them appropriate, shall consider the following in reaching a decision:

(1) The covered person's pertinent medical records.

(2) The attending health care provider's recommendation.

(3) Consulting reports from appropriate health care providers and other documents submitted by the insurer, covered person, or the covered person's treating provider.

(4) The most appropriate practice guidelines that are based on sound clinical evidence and that are periodically evaluated to assure ongoing efficacy.

(5) Any applicable clinical review criteria developed and used by the insurer or its designee utilization review organization in making noncertification decisions.

(6) Medical necessity, as defined in G.S. 58-3-200(b).

(7) Any documentation supporting the medical necessity and appropriateness of the provider's recommendation.

The assigned organization shall review the terms of coverage under the covered person's health benefit plan to ensure that the organization's decision shall not be contrary to the terms of coverage under the covered person's health benefit plan.

The assigned organization's determination shall be based on the covered person's medical condition at the time of the initial noncertification decision.

(f) As expeditiously as the covered person's medical condition or circumstances require, but not more than four days after the date of receipt of the request for an expedited external review, the assigned organization shall make a decision to uphold or reverse the noncertification appeal decision or second-level grievance review decision and notify the covered person, the insurer, and the Commissioner of the decision.

(g) If the notice provided under subsection (f) of this section was not in writing, within two days after the date of providing that notice, the assigned organization shall provide written confirmation of the decision to the covered person, the insurer, and the

Commissioner and include the information set forth in G.S. 58-50-80(o). Upon receipt of the notice, a decision under subsection (f) of this section reversing the noncertification appeal decision or second-level grievance review decision, the insurer shall immediately reverse the noncertification appeal decision or second-level grievance review decision that was the subject of the review and shall process the claim accordingly.

(h) An expedited external review shall not be provided for retrospective noncertifications.

"§ 58-50-83: Reserved.

"**§ 58-50-84. Binding nature of external review decision.**

(a) An external review decision is binding on the insurer.

(b) An external review decision is binding on the covered person except to the extent the covered person has other remedies available under applicable federal or State law.

(c) A covered person may not file a subsequent request for external review involving the same noncertification appeal decision or second-level grievance review decision for which the covered person has already received an external review decision under this Part.

"**§ 58-50-85. Approval of independent review organizations.**

(a) The Commissioner shall approve independent review organizations eligible to be assigned to conduct external reviews under this Part to ensure that an organization satisfies the minimum qualifications established under G.S. 58-50-87. The Commissioner shall develop an application form for initially approving and for reapproving organizations to conduct external reviews.

(b) Any organization wishing to be approved to conduct external reviews under this Part shall submit the application form and include with the form all documentation and information necessary for the Commissioner to determine if the organization satisfies the minimum qualifications established under G.S. 58-50-87. Applicants must submit pricing information sufficient to demonstrate that if selected, the applicant's total fee per review will not exceed commercially reasonable fees charged for similar services in the industry. The Commissioner shall not approve any independent review organization that either fails to provide sufficient pricing information or has fees that do not meet the guidelines established under this subsection.

(c) The Commissioner may, in his discretion, determine that accreditation by a nationally recognized private accrediting entity with established and maintained standards for independent review organizations that meet the minimum qualifications established under G.S. 58-50-87 will cause an independent review organization to be deemed to have met, in whole or in part, the requirements of this section and G.S. 58-50-87. A decision by the Commissioner to recognize an accreditation program for the purpose of granting deemed status may be made only after reviewing the accreditation standards and program information submitted by the accrediting body. An independent review organization seeking deemed status due to its accreditation shall submit original documentation issued by the accrediting body to demonstrate its accreditation.

(d) An approval is effective for two years, unless the Commissioner determines before expiration of the approval that the independent review organization is not satisfying the minimum qualifications established under G.S. 58-50-87.

(e) Whenever the Commissioner determines that an independent review organization no longer satisfies the minimum requirements established under G.S. 58-50-87, the Commissioner shall terminate the approval of the independent review organization.

"**§ 58-50-86:** Reserved.

"**§ 58-50-87. Minimum qualifications for independent review organizations.**

(a) As a condition of approval under G.S. 58-50-85 to conduct external reviews, an independent review organization shall have and maintain written policies and procedures that govern all aspects of both the standard external review process and the expedited external review process set forth in G.S. 58-50-80 and G.S. 58-50-82 that include, at a minimum:

(1) A quality assurance mechanism in place that ensures:

a. That external reviews are conducted within the specified time frames and required notices are provided in a timely manner.

b. The selection of qualified and impartial clinical peer reviewers to conduct external reviews on behalf of the independent review organization and suitable matching of reviewers to specific cases.

c. The confidentiality of medical and treatment records and clinical review criteria.

d. That any person employed by or under contract with the independent review organization adheres to the requirements of this Part.

e. The independence and impartiality of the independent review organization and the external review process and limits the ability of any person to improperly influence the external review decision.

(2) A toll-free telephone service to receive information on a 24-hour-day, seven-day-a-week basis related to external reviews that is capable of accepting, recording, or providing appropriate instruction to incoming telephone callers during other than normal business hours.

(3) Agree to maintain and provide to the Commissioner the information set out in G.S. 58-50-90.

(4) A program for credentialing clinical peer reviewers.

(5) Agree to contractual terms or written requirements established by the Commissioner regarding the procedures for handling a review.

(6) The independent review organization shall consult with a medical doctor licensed to practice in North Carolina to advise the independent review organization on issues related to the standard of practice,

technology, and training of North Carolina physicians with respect to the organization's North Carolina business.

(b) All clinical peer reviewers assigned by an independent review organization to conduct external reviews shall be medical doctors or other appropriate health care providers who meet the following minimum qualifications:

(1) Be an expert in the treatment of the covered person's injury, illness, or medical condition that is the subject of the external review.

(2) Be knowledgeable about the recommended health care service or treatment through recent or current actual clinical experience treating patients with the same or similar injury, illness, or medical condition of the covered person.

(3) If the covered person's treating provider is a medical doctor, hold a nonrestricted license, and, if a specialist medical doctor, a current certification by a recognized American medical specialty board in the area or areas appropriate to the subject of the external review.

(4) If the covered person's treating provider is not a medical doctor, hold a nonrestricted license, registration, or certification in the same allied health occupation as the covered person's treating provider.

(5) Have no history of disciplinary actions or sanctions, including loss of staff privileges or participation restrictions, that have been taken or are pending by any hospital, governmental agency or unit, or regulatory body that raise a substantial question as to the clinical peer reviewer's physical, mental, or professional competence or moral character.

(c) In addition to the requirements set forth in subsection (a) of this section, an independent review organization may not own or control, be a subsidiary of, or in any way be owned or controlled by, or exercise control with a health benefit plan, a national, State, or local trade association of health benefit plans, or a national, State, or local trade association of health care providers.

(d) In addition to the requirements set forth in subsections (a), (b), and (c) of this section, to be approved under G.S. 58-50-85 to conduct an external review of a specified case, neither the independent review organization selected to conduct the external review nor any clinical peer reviewer assigned by the independent organization to conduct the external review may have a material professional, familial, or financial conflict of interest with any of the following:

(1) The insurer that is the subject of the external review.

(2) The covered person whose treatment is the subject of the external review or the covered person's authorized representative.

(3) Any officer, director, or management employee of the insurer that is the subject of the external review.

(4) The health care provider, the health care provider's medical group, or independent practice association recommending the health care service or treatment that is the subject of the external review.

(5) The facility at which the recommended health care service or treatment would be provided.

(6) The developer or manufacturer of the principal drug, device, procedure, or other therapy being recommended for the covered person whose treatment is the subject of the external review.

(e) In determining whether an independent review organization or a clinical peer reviewer of the independent review organization has a material professional, familial, or financial conflict of interest for purposes of subsection (d) of this section, the Commissioner shall take into consideration situations where the independent review organization to be assigned to conduct an external review of a specified case or a clinical peer reviewer to be assigned by the independent review organization to conduct an external review of a specified case may have an apparent professional, familial, or financial relationship or connection with a person described in subsection (d) of this section, but that the characteristics of that relationship or connection are such that they are not a material professional, familial, or financial conflict of interest that results in the disapproval of the independent review organization or the clinical peer reviewer from conducting the external review.

"**§ 58-50-88:** Reserved.

"**§ 58-50-89. Hold harmless for Commissioner and independent review organizations.**

The Commissioner or an independent review organization or clinical peer reviewer working on behalf of an organization shall not be liable for damages to any person for any opinions rendered during or upon completion of an external review conducted under this Part, unless the opinion was rendered in bad faith or involved gross negligence.

"**§ 58-50-90. External review reporting requirements.**

(a) An organization assigned under G.S. 58-50-80 or G.S. 58-50-82 to conduct an external review shall maintain written records in the aggregate and by insurer on all requests for external review for which it conducted an external review during a calendar year and submit a report to the Commissioner, as required under subsection (b) of this section.

(b) Each organization required to maintain written records on all requests for external review under subsection (a) of this section for which it was assigned to conduct an external review shall submit to the Commissioner, at least annually, a report in the format specified by the Commissioner.

(c) The report shall include in the aggregate and for each insurer:

(1) The total number of requests for external review.

(2) The number of requests for external review resolved and, of those resolved, the number resolved upholding the noncertification appeal decision or second-level grievance review decision and the number resolved reversing the noncertification appeal decision or second-level grievance review decision.

(3) The average length of time for resolution.

(4) A summary of the types of coverages or cases for which an external review was sought, as provided in the format required by the Commissioner.

(5) The number of external reviews under G.S. 58-50-80(k) and (l) that were terminated as the result of a reconsideration by the insurer of its noncertification appeal decision or second-level grievance review decision after the receipt of additional information from the covered person.

(6) Any other information the Commissioner may request or require.

(d) The organization shall retain the written records required under this section for at least three years.

(e) Each insurer shall maintain written records in the aggregate and for each type of health benefit plan offered by the insurer on all requests for external review of which the insurer receives notice from the Commissioner under this Part. The insurer shall retain the written records required under this section for at least three years.

"**§ 58-50-91:** Reserved.

"**§ 58-50-92. Funding of external review.**

The insurer against which a request for a standard external review or an expedited external review is filed shall reimburse the Department of Insurance for the fees charged by the organization in conducting the external review.

"**§ 58-50-93. Disclosure requirements.**

(a) Each insurer shall include a description of the external review procedures in or attached to the policy, certificate, membership booklet, outline of coverage, or other evidence of coverage it provides to covered persons.

(b) The description required under subsection (a) of this section shall include a statement that informs the covered person of the right of the covered person to file a request for an external review of a noncertification appeal decision or a second-level grievance review decision upholding a noncertification with the Commissioner. The statement shall include the telephone number and address of the Commissioner.

(c) In addition to subsection (b) of this section, the statement shall inform the covered person that, when filing a request for an external review, the covered person will be required to authorize the release of any medical records of the covered person that may be required to be reviewed for the purpose of reaching a decision on the external review.

"**§ 58-50-94. Competitive selection of independent review organizations.**

(a) The Commissioner shall prepare and publish requests for proposals from independent review organizations that want to be approved under G.S. 58-50-85. All proposals shall be sealed. The Commissioner shall open all proposals in public.

(b) After the public opening, the Commissioner shall review the proposals, examining the costs and quality of the services offered by the independent review organizations, the reputation and capabilities of the independent review organizations submitting the proposals, and the provisions in G.S. 58-50-85 and G.S. 58-50-87. The Commissioner shall determine which proposal or proposals would satisfy the provisions

of this Part. The Commissioner shall make his determination in consultation with an evaluation committee whose membership includes representatives of insurers subject to Part 4 of Article 50 of Chapter 58 of the General Statutes, health care providers, and insureds. In selecting the review organizations, in addition to considering cost, quality, and adherence to the requirements of the request for proposals, the Commissioner shall consider the desirability and feasibility of contracting with multiple review organizations in order to allow insureds a choice of review organizations and shall ensure that at least one review organization is available to and capable of reviewing cases involving highly specialized services and treatments of any nature. The Commissioner may reject any or all proposals.

(c) An independent review organization may seek to modify or withdraw a proposal only after the public opening and only on the basis that the proposal contains an unintentional clerical error as opposed to an error in judgment. An independent review organization seeking to modify or withdraw a proposal shall submit to the Commissioner a written request, with facts and evidence in support of its position, before the determination made by the Commissioner under subsection (b) of this section, but not later than two days after the public opening of the proposals. The Commissioner shall promptly review the request, examine the nature of the error, and determine whether to permit or deny the request.

(d) The provisions of Article 3C of Chapter 143 of the General Statutes do not apply to this Part.

"**§ 58-50-95. Report by Commissioner.**

The Commissioner shall report semiannually to the Joint Legislative Health Care Oversight Committee regarding the nature and appropriateness of reviews conducted under this Part. The report, which shall be provided to the public upon request, should include the number of reviews, underlying issues in dispute, character of the reviews, dollar amounts in question, whether the review was decided in favor of the covered person or the health benefit plan, the cost of review, and any other information relevant to the evaluation of the effectiveness of this Part."

SECTION 4.6. G.S. 58-50-62(h)(7) reads as rewritten:

"(7) A statement that the decision is the insurer's final determination in the matter. In cases where the review concerned a noncertification and the insurer's decision on the second-level grievance review is to uphold its initial noncertification, a statement advising the covered person of his or her right to request an external review and a description of the procedure for submitting a request for external review to the Commissioner of Insurance."

Subpart B. Health Plan Liability

SECTION 4.7. Chapter 90 of the General Statutes is amended by adding a new Article to read:

"Article 1G.

"Health Care Liability.

"**§ 90-21.50. Definitions.**

As used in this Article, unless the context clearly indicates otherwise, 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. 'Health benefit plan' does not mean any plan implemented or administered through the Department of Health and Human Services 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 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. Insurance under which benefits are payable with or without regard to fault and that are statutorily required to be contained in any liability policy or equivalent self-insurance; and
l. Hospital income or indemnity.

(2) 'Health care provider' means:

a. An individual who is licensed, certified, or otherwise authorized under this Chapter to provide health care services in the ordinary course of business or practice of a profession or in an approved education or training program; or
b. A health care facility, licensed under Chapters 131E or 122C of the General Statutes, where health care services are provided to patients;

'Health care provider' includes:

1. An agent or employee of a health care facility that is licensed, certified, or otherwise authorized to provide health care services;
2. The officers and directors of a health care facility; and
3. An agent or employee of a health care provider who is licensed, certified, or otherwise authorized to provide health care services.

(3) 'Health care service' means a health or medical procedure or service rendered by a health care provider that:

a. Provides testing, diagnosis, or treatment of a human disease or dysfunction; or

b. Dispenses drugs, medical devices, medical appliances, or medical goods for the treatment of a human disease or dysfunction.

(4) 'Health care decision' means a determination by a managed care entity which is subject to external review under Part 4 of Article 50 of the General Statutes and is also a determination that:

a. A prospective or concurrent request for approval of coverage is denied or reduced because it is not medically necessary or appropriate or because it is experimental or investigational; provided, however, that a health care decision does not include a decision based solely on the application of a specific exclusion under the health benefit plan; and

b. Affects the quality of the diagnosis, care, or treatment provided under the health benefit plan to an enrollee or insured of the health benefit plan.

(5) 'Insured or enrollee' means a person that is insured by or enrolled in a health benefit plan under a policy, plan, certificate, or contract issued or delivered in this State by an insurer.

(6) 'Insurer' means an entity that writes a health benefit plan and that is an insurance company subject to Chapter 58 of the General Statutes, a service corporation organized under Article 65 of Chapter 58 of the General Statutes, a health maintenance organization organized under Article 67 of Chapter 58 of the General Statutes, or a multiple employer welfare arrangement subject to Article 49 of Chapter 58 of the General Statutes.

(7) 'Managed care entity' means an insurer that:

a. Delivers, administers, or undertakes to provide for, arrange for, or reimburse for health care services, or assumes the risk for the delivery of health care services; and

b. Has a system or technique to control or influence the quality, accessibility, utilization, or costs and prices of health care services delivered or to be delivered to a defined enrollee population.

'Managed care entity' does not include: (i) an employer purchasing coverage or acting on behalf of its employees or the employees of one or more subsidiaries or affiliated corporations of the employer, or (ii) a health care provider.

(8) 'Ordinary care' means that degree of care prevailing at the time the managed care entity made the health care decision that a managed care entity of ordinary prudence would use under the same or similar circumstances.

(9) 'Physician' means:
a. An individual licensed to practice medicine in this State;
b. A professional association or corporation organized under Chapter 55B of the General Statutes; or
c. A person or entity wholly owned by physicians.
(10) 'Successor external review process' means an external review process equivalent in all respects to G.S. 58-50-75 through G.S. 58-50-95 approved by the Department and implemented by a health benefit plan in the event that G.S. 58-50-75 through G.S. 58-50-95 are found by a court of competent jurisdiction to be void, unenforceable, or preempted by federal law, in whole or in part.

"**§ 90-21.51. Duty to exercise ordinary care; liability for damages for harm.**

(a) Each managed care entity for a health benefit plan has the duty to exercise ordinary care when making health care treatment decisions and is liable for damages for harm to an insured or enrollee proximately caused by its failure to exercise ordinary care.

(b) In addition to the duty imposed under subsection (a) of this section, each managed care entity for a health benefit plan is liable for damages for harm to an insured or enrollee proximately caused by the health care treatment decisions made by:
(1) Its agents or employees; or
(2) Representatives that are acting on its behalf and over whom it has exercised sufficient influence or control to reasonably effect the actual care and treatment of the insured or enrollee which results in the failure to exercise ordinary care.

(c) It shall be a defense to any action brought under this section against a managed care entity for a health benefit plan that:
(1) Neither the managed care entity nor an agent or employee or representative for whom the managed care entity is liable under subsection (b) of this section controlled, influenced, or participated in the health care treatment decision; and
(2) The managed care entity did not deny or delay payment for any health care service or treatment prescribed or recommended by a physician or health care provider to the insured or enrollee.

(d) In an action brought under this Article against a managed care entity, a finding that a physician or health care provider is an agent or employee of the managed care entity may not be based solely on proof that the physician or health care provider appears in a listing of approved physicians or health care providers made available to insureds or enrollees under the managed care entity's health benefit plan.

(e) An action brought under this Article is not a medical malpractice action as defined in Article 1B of this Chapter. A managed care entity may not use as a defense in an action brought under this Article any law that prohibits the corporate practice of medicine.

(f) A managed care entity shall not be liable for the independent actions of a health care provider, who is not an agent or employee of the managed care entity, when that health care provider fails to exercise the standard of care required by G.S. 90-21.12. A health care provider shall not be liable for the independent actions of a managed care entity when the managed care entity fails to exercise the standard of care required by this Article.

(g) Nothing in this Article shall be construed to create an obligation on the part of a managed care entity to provide to an insured or enrollee a health care service or treatment that is not covered under its health benefit plan.

(h) A managed care entity may not enter into a contract with a health care provider, or with an employer or employer group organization, that includes an indemnification or hold harmless clause for the acts or conduct of the managed care entity. Any such indemnification or hold harmless clause is void and unenforceable to the extent of the restriction.

"**§ 90-21.52. No liability under this Article on the part of an employer or employer group organization that purchases coverage or assumes risk on behalf of its employees or a physician or health care provider.**

(a) This Article does not create any liability on the part of an employer or employer group purchasing organization that purchases health care coverage or assumes risk on behalf of its employees.

(b) This Article does not create any liability on the part of a physician or health care provider in addition to that otherwise imposed under existing law. No managed care entity held liable under this Article shall be entitled to contribution under Chapter 1B of the General Statutes from a physician or health care provider.

"**§ 90-21.53. Separate trial required.**

Upon motion of any party in an action that includes a claim brought pursuant to this Article involving a managed care entity, the court shall order separate discovery and a separate trial of any claim, cross-claim, counterclaim, or third-party claim against any physician or other health care provider.

"**§ 90-21.54. Punitive damages; exhaustion of administrative remedies and appeals; evidence.**

(a) An action brought under this Article is subject to the provisions and limitations of Chapter 1D of the General Statutes for recovery of punitive damages.

(b) No action may be commenced under this Article until the plaintiff has exhausted all administrative remedies and appeals, including those internal remedies and appeals established under G.S. 58-50-61 through G.S. 58-50-62, and G.S. 58-50-75 through G.S. 58-50-95, and including those established under any successor external review process.

(c) Any information, documents, or other records or materials considered by the Independent Review Organization in conducting its review shall be admissible in any action commenced under this article in accordance with the North Carolina Rules of Evidence.

"**§ 90-21.55. External review decision.**

Either the insured or enrollee or their personal representative or the managed care entity may use an external review decision made in accordance with G.S. 58-50-75 through G.S. 58-50-95, or made in accordance with any successor external review process, as evidence in any cause of action which includes an action brought under this Part, provided that an adequate foundation is laid for the introduction of the external review decision into evidence and the testimony is subject to cross-examination."

SECTION 4.8. G.S. 1A-1, Rule 42, reads as rewritten:

"**Rule 42. Consolidation; separate trials.**

(a) Consolidation. – ~~When~~ Except as provided in subdivision (b)(2) of this section, when actions involving a common question of law or fact are pending in one division of the court, the judge may order a joint hearing or trial of any or all the matters in issue in the actions; he may order all the actions consolidated; and he may make such orders concerning proceedings therein as may tend to avoid unnecessary costs or delay. When actions involving a common question of law or fact are pending in both the superior and the district court of the same county, a judge of the superior court in which the action is pending may order all the actions consolidated, and he may make such orders concerning proceedings therein as may tend to avoid unnecessary costs or delay.

(b) Separate trials. –

(1) The court may in furtherance of convenience or to avoid prejudice and shall for considerations of venue upon timely motion order a separate trial of any claim, ~~crosselaims~~ cross-claim, counterclaim, or third-party claim, or of any separate issue or of any number of claims, ~~crosselaims,~~ cross-claims, counterclaims, third-party claims, or issues.

(2) Upon motion of any party in an action that includes a claim commenced under Article 1G of Chapter 90 of the General Statutes involving a managed care entity as defined in G.S. 90-21.50, the court shall order separate discovery and a separate trial of any claim, cross-claim, counterclaim, or third-party claim against a physician or other medical provider."

SECTION 5.(a) G.S. 58-2-105 reads as rewritten:

"**§ 58-2-105. Confidentiality of medical records.**

(a) All patient medical records in the possession of the Department are confidential and are not public records pursuant to G.S. 58-2-100 or G.S. 132-1. As used in this section, "patient medical records" includes personal information that relates to an individual's physical or mental condition, medical history, or medical treatment, and that has been obtained from the individual patient, a health care provider, or from the patient's spouse, parent, or legal guardian.

(b) Under Part 4 of Article 50 of this Chapter, the Department may disclose patient medical records to an independent review organization, and the organization shall maintain the confidentiality of those records as required by this section, except as allowed by G.S. 58-30-75."

SECTION 5.(b) G.S. 58-3-200(b) reads as rewritten:

"(b) Medical Necessity. – An insurer that limits its health benefit plan coverage to medically necessary services and supplies shall define "medically necessary services or supplies" in its health benefit plan as those covered services or supplies that are:

(1) Provided for the diagnosis, treatment, cure, or relief of a health condition, illness, injury, or disease; ~~and~~ and, except as allowed under G.S. 58-3-255, not for experimental, investigational, or cosmetic purposes.

(2) Necessary for and appropriate to the diagnosis, treatment, cure, or relief of a health condition, illness, injury, disease, or its symptoms.

(3) Within generally accepted standards of medical care in the community.

(4) Not solely for the convenience of the insured, the insured's family, or the provider.

For medically necessary services, nothing in this subsection precludes an insurer from comparing the cost-effectiveness of alternative services or supplies when determining which of the services or supplies will be covered."

SECTION 5.(c) G.S. 58-50-61(a)(12) reads as rewritten:

"(12) "Medically necessary services or supplies" means those covered services or supplies that are:

a. Provided for the diagnosis, treatment, cure, or relief of a health condition, illness, injury, or disease.

b. Except as allowed under G.S. 58-3-255, ~~Not~~ not for experimental, investigational, or cosmetic purposes.

c. Necessary for and appropriate to the diagnosis, treatment, cure, or relief of a health condition, illness, injury, disease, or its symptoms.

d. Within generally accepted standards of medical care in the community.

e. Not solely for the convenience of the insured, the insured's family, or the provider.

For medically necessary services, nothing in this subdivision precludes an insurer from comparing the cost-effectiveness of alternative services or supplies when determining which of the services or supplies will be covered."

SECTION 6. If any section or provision of this act is declared unconstitutional or invalid by the courts, it does not affect the validity of the act as a whole or any part other than the part so declared to be unconstitutional or invalid.

SECTION 7. Section 1.6 of this act becomes effective January 1, 2002. Sections 3.1 and 3.2 of this act become effective December 1, 2001, and apply to health benefit plans that are delivered, issued for delivery, or renewed on or after that date. Sections 4.1 through 4.8 of this act become effective March 1, 2002. The remainder of this act is effective when it becomes law and applies to health benefit plans that are delivered, issued for delivery, or renewed on or after January 1, 2002. Nothing in this act obligates the General Assembly to appropriate funds to implement this act.

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2001

S D

SENATE BILL 199

Insurance and Consumer Protection Committee Substitute Adopted 4/25/01

PROPOSED HOUSE COMMITTEE SUBSTITUTE S199-PCS9323-LN-36

Short Title: Managed Care Patients' Bill of Rights. (Public)

Sponsors:

Referred to:

February 22, 2001

A BILL TO BE ENTITLED

AN ACT TO IMPROVE ACCESS TO HEALTH CARE ADVICE, INFORMATION, AND SERVICES TO COVERED PERSONS UNDER HEALTH BENEFIT PLANS; ESTABLISH STANDARDS FOR HEALTH PLAN DISCLOSURES TO CONSUMERS; ESTABLISH A PATIENT ASSISTANCE PROGRAM; REQUIRE COVERAGE FOR CLINICAL TRIALS AND NEWBORN HEARING SCREENING; PROVIDE STANDARDS FOR INDEPENDENT REVIEW OF NONCERTIFICATIONS BY AN INSURER OR MANAGED CARE PLAN, AND TO HOLD MANAGED CARE ENTITIES LIABLE FOR HARM CAUSED TO INSUREDS OR ENROLLEES BY THE FAILURE TO EXERCISE ORDINARY CARE IN MAKING HEALTH CARE TREATMENT DECISIONS.

The General Assembly of North Carolina enacts:

PART I. PATIENT ACCESS TO MEDICAL ADVICE AND CARE

Subpart A. Continuity of Care in HMOs

SECTION 1. Article 67 of Chapter 58 of the General Statutes is amended by adding a new section to read:

"**§ 58-67-88. Continuity of care.**

(a) Definitions. – As used in this section:

(1) 'Ongoing special condition' means:

a. In the case of an acute illness, a condition that is serious enough to require medical care or treatment to avoid a reasonable possibility of death or permanent harm.

b. In the case of a chronic illness or condition, a disease or condition that is life-threatening, degenerative, or disabling, and

requires medical care or treatment over a prolonged period of time.

c. In the case of pregnancy, pregnancy from the start of the second trimester.

d. In the case of a terminal illness, an individual has a medical prognosis that the individual's life expectancy is six months or less.

(2) 'Terminated or termination'. – Includes, with respect to a contract, the expiration or nonrenewal of the contract, but does not include a termination of the contract by an HMO for failure to meet applicable quality standards or for fraud.

(b) Termination of Provider. – If a contract between an HMO benefit plan that is not a point-of-service plan and a health care provider is terminated by the provider or by the HMO, or benefits or coverage provided by the HMO are terminated because of a change in the terms of provider participation in a health benefit plan of an HMO that is not a point-of-service plan, and an individual is covered by the plan and is undergoing treatment from the provider for an ongoing special condition on the date of the termination, then, the HMO shall:

(1) Upon termination of the contract by the HMO or upon receipt by the HMO of written notification of termination by the provider, notify the individual on a timely basis of the termination and of the right to elect continuation of coverage of treatment by the provider under this section.

(2) Subject to subsection (h) of this section, permit the individual to elect to continue to be covered with respect to the treatment by the provider of the ongoing special condition during a transitional period provided under this section.

(c) Newly Covered Insured. – Each health benefit plan offered by an HMO that is not a point-of-service plan shall provide transition coverage to individuals who are undergoing treatment from a provider for an ongoing special condition and are newly covered under the health benefit plan because the individual's employer has changed health benefit plans, and the HMO shall:

(1) Notify the individual on the date of enrollment of the right to elect continuation of coverage of treatment by the provider under this section.

(2) Subject to subsection (h) of this section, permit the individual to elect to continue to be covered with respect to the treatment by the provider of the ongoing special condition during a transitional period provided under this section.

(d) Transitional Period: In General. – Except as otherwise provided in subsections (e), (f), and (g) of this section, the transitional period under this subsection shall extend up to 90 days, as determined by the treating health care provider, after the

date of the notice to the individual described in subdivision (b)(1) of this section or the date of enrollment in a new plan described in subdivision (c)(1) of this section.

(e) Transitional Period: Scheduled Surgery, Organ Transplantation, or Inpatient Care. – If surgery, organ transplantation, or other inpatient care was scheduled for an individual before the date of the notice required under subdivision (b)(1) of this section, or the date of enrollment in a new plan described in subdivision (c)(1) of this section, or if the individual on that date was on an established waiting list or otherwise scheduled to have the surgery, transplantation, or other inpatient care, the transitional period under this subsection with respect to the surgery, transplantation, or other inpatient care shall extend beyond the period under subsection (d) of this section through the date of discharge of the individual after completion of the surgery, transplantation, or other inpatient care, and through postdischarge follow-up care related to the surgery, transplantation, or other inpatient care occurring within 90 days after the date of discharge.

(f) Transitional Period: Pregnancy. – If an insured has entered the second trimester of pregnancy on the date of the notice required under subdivision (b)(1) of this section, or the date of enrollment in a new plan described in subdivision (c)(1) of this section, and the provider was treating the pregnancy before the date of the notice, or the date of enrollment in the new plan, the transitional period with respect to the provider's treatment of the pregnancy shall extend through the provision of 60 days of postpartum care.

(g) Transitional Period: Terminal Illness. – If an insured was determined to be terminally ill at the time of the notice required under subdivision (b)(1) of this section, or at the time of enrollment in the new plan under subdivision (c)(1) of this section, and the provider was treating the terminal illness before the date of the notice, or enrollment in the new plan, the transitional period shall extend for the remainder of the individual's life with respect to care directly related to the treatment of the terminal illness or its medical manifestations.

(h) Permissible Terms and Conditions. – An HMO may condition coverage of continued treatment by a provider under subdivision (b)(2) or (c)(2) of this section upon the following terms and conditions:

(1) The provider agrees to accept reimbursement from the HMO and individual involved, with respect to cost-sharing, at the rates applicable before the start of the transitional period as payment in full.

(2) The provider agrees to adhere to the quality assurance standards of the HMO responsible for payment under subdivision (1) of this subsection and to provide to the HMO necessary medical information related to the care provided.

(3) The provider agrees otherwise to adhere to the HMO's established policies and procedures for participating providers, including procedures regarding referrals and obtaining prior authorization, providing services pursuant to a treatment plan, if any, approved by the HMO, and member hold harmless provisions.

(4) The insured or the insured's representative notifies the HMO within 45 days of the date of the notice described in subdivision (b)(1) of this section or the new enrollment described in subdivision (c)(1) of this section, that the insured elects to continue receiving treatment by the provider.

(5) The provider agrees to discontinue providing services and refer the insured to a network provider by the end of the transition period.

(i) Construction. – Nothing in this section:

(1) Requires the coverage of benefits that would not have been covered if the provider involved remained a participating provider.

(2) Requires an HMO to offer a transitional period when the HMO terminates a provider's contract for reasons relating to quality of care or fraud; and refusal to offer a transitional period under these circumstances is not subject to the grievance review provisions of G.S. 58-50-62.

(3) Prohibits an HMO from extending any transitional period beyond that specified in this section.

(4) Prohibits an HMO from terminating the continuing services of a provider as described in this section when the HMO has determined that the provider's continued provision of services may result in, or is resulting in, a serious danger to the health or safety of the insured. Such terminations shall be in accordance with the contract provisions that the provider would otherwise be subject to if the provider's contract were still in effect.

(j) Disclosure of Right to Transitional Period. – Each HMO shall include a clear description of an insured's rights under this section in its evidence of coverage and summary plan description."

Subpart B. Extended or Standing Referral to Specialist

SECTION 1.2. G.S. 58-3-223 reads as rewritten:

"**§ 58-3-223. Managed care access to specialist care.**

(a) Each insurer offering a health benefit plan that does not allow direct access to all in-plan specialists shall develop and maintain written policies and procedures by which an insured may receive an extended or standing referral to an in-plan specialist. The ~~procedure~~insurer shall provide for an extended or standing referral to a specialist if the insured has a serious or chronic degenerative, disabling, or life-threatening disease or condition, which in the opinion of the insured's primary care physician, in consultation with the specialist, requires ongoing specialty care. The extended or standing referral shall be for a period not to exceed 12 months and shall be made under a treatment plan coordinated with the insurer in consultation with the primary care physician, the specialist, and the insured or the insured's designee.

(b) As used in this section:

(1) 'Health benefit plan' has the meaning applied in G.S. 58-3-167. ~~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 are 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 under Article 65 of this Chapter, or a health maintenance organization under Article 67 of this Chapter, or a multiple employer welfare arrangement under Article 49 of this Chapter.~~ has the meaning applied in G.S. 58-3-167.

(3) 'Serious or chronic degenerative, disabling, or life-threatening disease or condition' means a disease or condition, which in the opinion of the patient's treating primary care physician and specialist, requires frequent and periodic monitoring and consultation with the specialist on an ongoing basis.

(4) 'Specialist' includes a subspecialist."

SECTION 1.2A. 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 the out-of-network benefit levels offered under the insured's approved health benefit ~~plan~~ plan, including an insured receiving an extended or

standing referral under G.S. 58-3-223, unless contracting health care providers able to meet health needs of the insured are reasonably available to the insured without unreasonable delay."

Subpart C. Selection of Specialist as Primary Care Physician

SECTION 1.3. Article 3 of Chapter 58 of the General Statutes is amended by adding a new section to read:

"**§ 58-3-235. Selection of specialist as primary care provider.**

(a) Each insurer shall have a procedure by which an insured diagnosed with a serious or chronic degenerative, disabling, or life-threatening disease or condition, either of which requires specialized medical care may select as his or her primary care physician a specialist with expertise in treating the disease or condition who shall be responsible for and capable of providing and coordinating the insured's primary and specialty care. If the insurer determines that the insured's care would not be appropriately coordinated by that specialist, the insurer may deny access to that specialist as a primary care provider.

(b) The selection of the specialist shall be made under a treatment plan approved by the insurer, in consultation with the specialist and the insured or the insured's designee and after notice to the insured's primary care provider, if any. The specialist may provide ongoing care to the insured and may authorize such referrals, procedures, tests, and other medical services as the insured's primary care provider would otherwise be allowed to provide or authorize, subject to the terms of the treatment plan. Services provided by a specialist who is providing and coordinating primary and specialty care remain subject to utilization review and other requirements of the insurer, including its requirements for primary care providers."

Subpart D. Direct Access to Pediatrician

SECTION 1.4. Article 3 of Chapter 58 of the General Statutes is amended by adding a new section to read:

"**§ 58-3-240. Direct access to pediatrician for minors.**

Each insurer offering a health benefit plan that uses a network of contracting health care providers shall allow an insured to choose a contracting pediatrician in the network as the primary care provider for the insured's children who are under the age of 18."

Subpart E. Access to Prescription Drugs

SECTION 1.5. G.S. 58-3-221 reads as rewritten:

"**§ 58-3-221. Access to nonformulary and restricted access prescription drugs.**

(a) If an insurer maintains one or more closed formularies for or restricts access to covered prescription drugs or devices, then the insurer shall do all of the following:

(1) Develop the formulary or formularies and any restrictions on access to covered prescription drugs or devices in consultation with and with the approval of a pharmacy and therapeutics committee, which shall include participating ~~providers~~ physicians who are licensed to ~~prescribe prescription drugs or devices.~~ practice medicine in this State.

(2) Make available to participating ~~providers and pharmacists~~ providers, pharmacists, and enrollees the complete drugs or devices formulary or formularies maintained by the insurer including a list of the devices and prescription drugs on the formulary by major therapeutic category that specifies whether a particular drug or device is preferred over other drugs or devices.

(3) Establish and maintain an expeditious process or procedure that allows an enrollee or the enrollee's physician acting on behalf of the enrollee to obtain, without penalty or additional cost-sharing beyond that provided for in the health benefit plan, coverage for a specific nonformulary drug or device determined to be medically necessary and appropriate by the enrollee's participating physician without prior approval from the insurer, after the enrollee's participating physician notifies the insurer that:

a. Either (i) the formulary alternatives have been ineffective in the treatment of the enrollee's disease or condition, or (ii) the formulary alternatives cause or are reasonably expected by the physician to cause a harmful or adverse clinical reaction in the enrollee; and

b. Either (i) the drug is prescribed in accordance with any applicable clinical protocol of the insurer for the prescribing of the drug, or (ii) the drug has been approved as an exception to the clinical protocol pursuant to the insurer's exception procedure.

(4) Provide coverage for a restricted access drug or device to an enrollee without requiring prior approval if an enrollee's physician certifies in writing that the enrollee has previously used an alternative nonrestricted access drug or device and the alternative drug or device has been ineffective or detrimental to the enrollee's health.

(b) An insurer may not void a contract or refuse to renew a contract between the insurer and a prescribing provider because the prescribing provider has prescribed a medically necessary and appropriate nonformulary or restricted access drug or device as provided in this section.

(c) As used in this section:

(1) 'Closed formulary' means a list of prescription drugs and devices reimbursed by the insurer that excludes coverage for drugs and devices not listed.

(1a) 'Health benefit plan' has definition provided in G.S. 58-3-167. ~~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 are statutorily required to be contained in any liability policy or equivalent self-insurance.~~

(2) 'Insurer' has the meaning provided in G.S. 58-3-167. ~~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, or a multiple employer welfare arrangement under Article 49 of this Chapter~~.

(3) 'Restricted access drug or device' means those covered prescription drugs or devices for which reimbursement by the insurer is conditioned on the insurer's prior approval to prescribe the drug or device or on the provider prescribing one or more alternative drugs or devices before prescribing the drug or device in question.

(d) Nothing in this section requires an insurer to pay for drugs or devices or classes of drugs or devices related to a benefit that is specifically excluded from coverage by the insurer."

Subpart F. Managed Care Patient Assistance Program

SECTION 1.6.(a) Chapter 114 of the General Statutes is amended by adding the following new Article to read:

"Article 7.

"Managed Care Patient Assistance Program.

"**§ 114-45. Managed Care Patient Assistance Program.**

(a) The Office of Managed Care Patient Assistance Program is established in the Department of Justice. The Director of the Office of Managed Care Patient Assistance Program shall be appointed by the Governor.

(b) The Managed Care Patient Assistance Program shall provide information and assistance to individuals enrolled in managed care plans. The Managed Care Patient Assistance Program shall have expertise and experience in both health care and advocacy and will assume the specific duties and responsibilities set forth in subsection (c) of this section.

(c) The duties and responsibilities of the Managed Care Patient Assistance Program are as follows:

(1) Develop and distribute educational and informational materials for consumers, explaining their rights and responsibilities as managed care plan enrollees.

(2) Answer inquiries posed by consumers and refer inquiries of a regulatory nature to staff within the Department of Insurance.

(3) Advise managed care plan enrollees about the utilization review process.

(4) Assist enrollees with the grievance, appeal, and external review procedures established by Article 50 of Chapter 58 of the General Statutes.

(5) Publicize the Office of the Managed Care Patient Assistance Program.

(6) Compile data on the activities of the Office and evaluate such data to make recommendations as to the needed activities of the Office.

(d) The Director of the Managed Care Patient Assistance Program shall annually report the activities of the Managed Care Patient Assistance Program, including the types of appeals, grievances, and complaints received and the outcome of these cases. The report shall be submitted to the General Assembly, upon its convening or reconvening, and shall make recommendations as to efforts that could be implemented to assist managed care consumers."

SECTION 1.6.(b) Article 6 of Chapter 58 of the General Statutes is amended by adding the following new section to read:

"**§ 58-6-30. Annual fee for support of Managed Care Patient Assistance Program.**

The Commissioner shall collect from each insurer offering a managed care plan as defined in G.S. 58-50-61 an annual, nonrefundable fee for the support of the Managed Care Patient Assistance Program established under G.S. 114-45. The Commissioner shall establish the amount of the fee which shall be based on the cost to administer the Program."

Subpart G. No Discrimination in the Selection of Providers

SECTION 1.7. G.S. 58-50-30, as amended by Section 1 of S.L. 2001-297, reads as rewritten:

"**§ 58-50-30. Right to choose services of optometrist, podiatrist, certified clinical social worker, certified substance abuse professional, licensed professional counselor, dentist, chiropractor, psychologist, pharmacist, certified fee-based practicing pastoral counselor, advanced practice nurse, or physician assistant.**

(a1) Whenever any health benefit plan, subscriber contract, or policy of insurance issued by a health maintenance organization, hospital or medical service corporation, or insurer governed by Articles 1 through ~~65~~67 of this Chapter provides for coverage for, payment ~~of or~~ of, or reimbursement for any service rendered in connection with a condition or complaint that is within the scope of practice of a duly licensed optometrist, a duly licensed podiatrist, a duly licensed dentist, a duly licensed chiropractor, a duly certified clinical social worker, a duly certified substance abuse professional, a duly licensed professional counselor, a duly licensed psychologist, a duly licensed pharmacist, a duly certified fee-based practicing pastoral counselor, a duly licensed physician assistant, or an advanced practice registered nurse, the insured or other persons entitled to benefits under the policy shall be entitled to coverage of, payment ~~of or~~ of, or reimbursement for the services, whether the services be performed by a duly licensed physician, or a provider listed in this subsection, notwithstanding any provision contained in the ~~policy.~~ plan or policy limiting access to the providers. The policyholder, insured, or beneficiary shall have the right to choose the provider of services notwithstanding any provision to the contrary in any other statute; provided that for plans that require the use of network providers either as a condition of obtaining benefits under the plan or policy or to access a higher level of benefits under the plan or policy, the policyholder, insured, or beneficiary must choose a provider of the services within the network, subject to the requirements of the plan or policy.

(a2) Whenever any policy of insurance governed by Articles 1 through ~~65~~64 of this Chapter provides for certification of disability that is within the scope of practice of a duly licensed physician, a duly licensed physician assistant, a duly licensed optometrist, a duly licensed podiatrist, a duly licensed dentist, a duly licensed chiropractor, a duly certified clinical social worker, a duly certified substance abuse professional, a duly licensed professional counselor, a duly licensed psychologist, a duly certified fee-based practicing pastoral counselor, or an advanced practice registered nurse, the insured or other persons entitled to benefits under the policy shall be entitled to payment of or reimbursement for the disability whether the disability be certified by a duly licensed physician, or a provider listed in this subsection, notwithstanding any provisions contained in the policy. The policyholder, insured, or beneficiary shall have the right to choose the provider of the services notwithstanding any provision to the contrary in any other ~~statute.~~statute; provided that for plans that require the use of

network providers either as a condition of obtaining benefits under the plan or policy or to access a higher level of benefits under the plan or policy, the policyholder, insured, or beneficiary must choose a provider of the services within the network, subject to the requirements of the plan or policy.

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

(b) For the purposes of this section, a "duly licensed psychologist" is a licensed psychologist who holds permanent licensure and certification as a health services provider psychologist issued by the North Carolina Psychology Board.

(c) For the purposes of this section, a "duly certified clinical social worker" is a "certified clinical social worker" as defined in G.S. 90B-3(2) and certified by the North Carolina Certification Board for Social Work pursuant to Chapter 90B of the General Statutes.

(c1) For purposes of this section, a "duly certified fee-based practicing pastoral counselor" shall be defined only to include fee-based practicing pastoral counselors certified by the North Carolina State Board of Examiners of Fee-Based Practicing Pastoral Counselors pursuant to Article 26 of Chapter 90 of the General Statutes.

(c2) For purposes of this section, a "duly certified substance abuse professional" is a person certified by the North Carolina Substance Abuse Professional Certification Board pursuant to Article 5C of Chapter 90 of the General Statutes.

(c3) For purposes of this section, a "duly licensed professional counselor" is a person licensed by the North Carolina Board of Licensed Professional Counselors pursuant to Article 24 of Chapter 90 of the General Statutes.

(d) Payment or reimbursement is required by this section for a service performed by an advanced practice registered nurse only when:

(1) The service performed is within the nurse's lawful scope of practice;

(2) The policy currently provides benefits for identical services performed by other licensed health care providers;

(3) The service is not performed while the nurse is a regular employee in an office of a licensed physician;

(4) The service is not performed while the registered nurse is employed by a nursing facility (including a hospital, skilled nursing facility, intermediate care facility, or home care agency); and

(5) Nothing in this section is intended to authorize payment to more than one provider for the same service.

No lack of signature, referral, or employment by any other health care provider may be asserted to deny benefits under this provision.

For purposes of this section, an "advanced practice registered nurse" means only a registered nurse who is duly licensed or certified as a nurse practitioner, clinical specialist in psychiatric and mental health nursing, or nurse midwife.

(e) Payment or reimbursement is required by this section for a service performed by a duly licensed pharmacist only when:

(1) The service performed is within the lawful scope of practice of the pharmacist;

(2) The service performed is not initial counseling services required under State or federal law or regulation of the North Carolina Board of Pharmacy;

(3) The policy currently provides reimbursement for identical services performed by other licensed health care providers; and

(4) The service is identified as a separate service that is performed by other licensed health care providers and is reimbursed by identical payment methods.

Nothing in this subsection authorizes payment to more than one provider for the same service.

(f) Payment or reimbursement is required by this section for a service performed by a duly licensed physician assistant only when:

(1) The service performed is within the lawful scope of practice of the physician assistant in accordance with rules adopted by the North Carolina Medical Board pursuant to G.S. 90-18.1;

(2) The policy currently provides reimbursement for identical services performed by other licensed health care providers; and

(3) The reimbursement is made to the physician, clinic, agency, or institution employing the physician assistant.

Nothing in this subsection is intended to authorize payment to more than one provider for the same service. For the purposes of this section, a "duly licensed physician assistant" is a physician assistant as defined by G.S. 90-18.1.

(g) A health maintenance organization, hospital or medical service corporation, or insurer governed by Articles 1 through 67 of this Chapter shall not exclude from participation in its provider network or from eligibility to provide particular covered services under the plan or policy any duly licensed physician or provider listed in subsection (a1) of this section, acting within the scope of the provider's license or certification under North Carolina law, solely on the basis of the provider's license or certification. Any health maintenance organization, hospital or medical service corporation, or insurer governed by Articles 1 through 67 of this Chapter that offers coverage through a network plan may condition participation in the network on satisfying written participation criteria, including credentialing, quality, and accessibility criteria. The participation criteria shall be developed and applied in a like manner consistent with the licensure and scope of practice for each type of provider. Any health maintenance organization, hospital or medical service corporation, or insurer governed by Articles 1 through 67 of this Chapter that excludes a provider listed in

subsection (a1) of this section from participation in its network or from eligibility to provide particular covered services under the plan or policy shall provide the affected listed provider with a written explanation of the basis for its decision. A health maintenance organization, hospital or medical service corporation, or insurer governed by Articles 1 through 67 of this Chapter shall not exclude from participation in its provider network a provider listed in subsection (a1) of this section acting within the scope of the provider's license or certification under North Carolina law solely on the basis that the provider lacks hospital privileges, unless use of hospital services by the provider on behalf of a policy holder, insured, or beneficiary reasonably could be expected."

Subpart H. Prohibition on Provider Incentives

SECTION 1.8. Article 3 of Chapter 58 of the General Statutes is amended by adding the following new section to read:

"**§ 58-3-265. Prohibition on managed care provider incentives.**

An insurer offering a health benefit plan may not offer or pay any type of material inducement, bonus, or other financial incentive to a participating provider to deny, reduce, withhold, limit, or delay specific medically necessary and appropriate health care services covered under the health benefit plan to an insured or enrollee."

PART II. HEALTH PLAN DISCLOSURES

Subpart A. Managed Care Reporting and Disclosure Requirements

SECTION 2.1. G.S. 58-3-191(b) reads as rewritten:

"(b) Disclosure requirements. – Each health benefit plan shall provide the following applicable information to plan participants and bona fide prospective participants upon request:

(1) The evidence of coverage (G.S. 58-67-50), subscriber contract (G.S. 58-65-60, 58-65-140), health insurance policy (G.S. 58-51-80, 58-50-125, 58-50-55), or the contract and benefit summary of any other type of health benefit plan;

(2) An explanation of the utilization review criteria and treatment protocol under which treatments are provided for conditions specified by the prospective participant. This explanation shall be in writing if so requested;

(3) If denied a recommended treatment, written reasons for the denial and an explanation of the utilization review criteria or treatment protocol upon which the denial was based;

(4) The plan's ~~restrictive formularies~~ closed formularies, restricted access drugs or devices, or prior approval requirements for obtaining prescription drugs, whether a particular drug or therapeutic class of

drugs is excluded from its formulary, and the circumstances under which a nonformulary drug may be covered; and

(5) The plan's procedures and medically based criteria for determining whether a specified procedure, test, or treatment is experimental."

Subpart B. Provider Directory Information

SECTION 2.2. Article 3 of Chapter 58 of the General Statutes is amended by adding a new section to read:

"**§ 58-3-245. Provider directories.**

(a) Every health benefit plan utilizing a provider network shall make a listing of network providers available to insureds and shall update the listing no less frequently than once a year. In addition, every health benefit plan shall maintain a telephone system and an electronic or on-line system through which insureds can access up-to-date network information. If the health benefit plan produces printed directories, the directories shall contain language disclosing the date of publication, frequency of updates, that the directory may not contain the latest network information, and contact information for accessing up-to-date network information.

(b) Each listing shall include:

(1) The provider's name, address, telephone number, and, if applicable, area of specialty.

(2) Whether the provider may be selected as a primary care provider.

(3) An indication of whether the provider:

a. Is or is not currently accepting new patients.

b. Has any other restrictions that would limit an insured's access to that provider.

(c) The listing shall include all of the types of participating providers. Upon a participating provider's written request, the insurer shall also list in the directory, as part of the participating provider's listing, the names of any allied health professionals who provide primary care services under the supervision of the participating provider and whose services are covered by virtue of the insurer's contract with the supervising participating provider and whose credentials have been verified by the supervising participating provider. These allied health professionals shall be listed as a part of the directory listing for the participating provider upon receipt of a certification by the supervising participating provider that the credentials of the allied health professional have been verified."

Subpart C. Disclosure of Payment Obligations

SECTION 2.3. Article 3 of Chapter 58 of the General Statutes is amended by adding a new section to read:

"**§ 58-3-250. Payment obligations for covered services.**

(a) If an insurer calculates a benefit amount for a covered service under a health benefit plan through a method other than a fixed dollar co-payment, the insurer shall clearly explain in its evidence of coverage and plan summaries how it determines its payment obligations and the payment obligations of the insured. The explanation shall include:

(1) An example of the steps the insurer would take in calculating the benefit amount and the payment obligations of each party.

(2) Whether the insurer has obtained the agreement of health care providers not to bill an insured for any amounts by which a provider's charge exceeds the insurer's recognized charge for a covered service and whether the insured may be liable for paying any excess amount.

(3) Which party is responsible for filing a claim or bill with the insurer.

(b) If an insured is liable for an amount that differs from a stated fixed dollar co-payment or may differ from a stated coinsurance percentage because the coinsurance amount is based on a plan allowance or other such amount rather than the actual charges and providers are permitted to balance bill the insured, the evidence of coverage, plan summaries, and marketing and advertising materials that include information on benefit levels shall contain the following statement: 'NOTICE: Your actual expenses for covered services may exceed the stated [coinsurance percentage or co-payment amount] because actual provider charges may not be used to determine [plan/insurer or similar term] and [insured/member/enrollee or similar term] payment obligations.' "

PART III. MANDATED BENEFITS

Subpart A. Clinical Trials

SECTION 3.1. Article 3 of Chapter 58 of the General Statutes is amended by adding a new section to read:

"**§ 58-3-255. Coverage of clinical trials.**

(a) As used in this section:

(1) 'Covered clinical trials' means phase III and phase IV patient research studies designed to evaluate new treatments, including prescription drugs, and that: (i) involve the treatment of life-threatening medical conditions, (ii) are medically indicated and preferable for that patient compared to available noninvestigational treatment alternatives, and (iii) have clinical and preclinical data that shows the trial will likely be more effective for that patient than available noninvestigational alternatives. Covered clinical trials must also meet the following requirements:

a. Must involve determinations by treating physicians, relevant scientific data, and opinions of experts in relevant medical specialties.

b. Must be trials approved by centers or cooperative groups that are funded by the National Institutes of Health, the Food and Drug Administration, the Centers for Disease Control, the Agency for Health Care Research and Quality, the Department of Defense, or the Department of Veterans Affairs. The health benefit plan may also cover clinical trials sponsored by other entities.

c. Must be conducted in a setting and by personnel that maintain a high level of expertise because of their training, experience, and volume of patients.

(2) 'Health benefit plan' is defined by G.S. 58-3-167.

(3) 'Insurer' is defined by G.S. 58-3-167.

(b) Each health benefit plan shall provide coverage for participation in phase III and phase IV covered clinical trials by its insureds or enrollees who meet protocol requirements of the trials and provide informed consent.

(c) Only medically necessary costs of health care services, as defined in G.S. 58-50-61, associated with participation in a covered clinical trial, including those related to health care services typically provided absent a clinical trial, the diagnosis and treatment of complications, and medically necessary monitoring, are required to be covered by the health benefit plan and only to the extent that such costs have not been or are not funded by national agencies, commercial manufacturers, distributors, or other research sponsors of participants in clinical trials.

(d) Clinical trial costs not required to be covered by a health benefit plan include the costs of services that are not health care services, those provided solely to satisfy data collection and analysis needs, those related to investigational drugs and devices, and those that are not provided for the direct clinical management of the patient. In the event a claim contains charges related to services for which coverage is required under this section, and those charges have not been or cannot be separated from costs related to services for which coverage is not required under this section, the health benefit plan may deny the claim."

Subpart B. Newborn Hearing Screening

SECTION 3.2. Article 3 of Chapter 58 of the General Statutes is amended by adding a new section to read:

"**§ 58-3-260. Insurance coverage for newborn hearing screening mandated.**

(a) As used in this section, the terms 'health benefit plan' and 'insurer' have the meanings applied under G.S. 58-3-167.

(b) Each health benefit plan shall provide coverage for newborn hearing screening ordered by the attending physician pursuant to G.S. 130A-125. The same deductibles, coinsurance, reimbursement methodologies, and other limitations and administrative procedures as apply to similar services covered under the health benefit plan shall apply to coverage for newborn hearing screening."

PART IV. EXTERNAL REVIEW AND MANAGED CARE ENTITY LIABILITY

Subpart A. Independent, External Review Process

SECTION 4.1. The title of Article 50 of Chapter 58 of the General Statutes reads as rewritten:

"Article 50.

General Accident and Health Insurance Regulations."

SECTION 4.2. Article 50 of Chapter 58 of the General Statutes is amended as follows:

(1) By designating G.S. 58-50-1 through G.S. 58-50-45 as Part 1 with the heading "Miscellaneous Provisions."

(2) By designating G.S. 58-50-50 through G.S. 58-50-64 as Part 2 with the heading "PPOs, Utilization Review and Grievances."

(3) By designating G.S. 58-50-65 through G.S. 58-50-70 as Part 3 with the heading "Scope and Sanctions."

(4) By designating G.S. 58-50-75 through G.S. 58-50-95 as Part 4 with the heading "Health Benefit Plan External Review."

(5) By designating G.S. 58-50-100 through G.S. 58-50-156 as Part 5 with the heading "Small Employer Group Health Insurance Reform."

SECTION 4.3. G.S. 58-50-151 is recodified as G.S. 58-51-116.

SECTION 4.4. The prefatory language of G.S. 58-50-61(a) reads as rewritten:

"(a) Definitions. – As used in this ~~section and~~ section, in G.S. 58-50-62, and in Part 4 of this Article, the term:".

SECTION 4.5. Article 50 of Chapter 58 of the General Statutes is amended by adding a new Part to read:

"Part 4. Health Benefit Plan External Review.

"**§ 58-50-75. Purpose, scope, and definitions.**

(a) The purpose of this Part is to provide standards for the establishment and maintenance of external review procedures to assure that covered persons have the opportunity for an independent review of an appeal decision upholding a noncertification or a second-level grievance review decision upholding a noncertification, as defined in this Part.

(b) This Part applies to all persons that provide or perform utilization review. With respect to second-level grievance review decisions, this Part applies only to second-level grievance review decisions involving noncertification decisions.

(c) In addition to the definitions in G.S. 58-50-61(a), as used in this Part:

(1) 'Covered benefits' or 'benefits' means those benefits consisting of medical care, provided directly through insurance or otherwise and including items and services paid for as medical care, under the terms of a health benefit plan.

(2) 'Covered person' means a policyholder, subscriber, enrollee, or other individual covered by a health benefit plan. 'Covered person' includes another person, including the covered person's health care provider, acting on behalf of the covered person.

(3) 'Independent review organization' or 'organization' means an entity that conducts independent external reviews of appeals of noncertifications and second-level grievance review decisions.

"**§ 58-50-76:** Reserved.

"**§ 58-50-77. Notice of right to external review.**

(a) An insurer shall notify the covered person in writing of the covered person's right to request an external review and include the appropriate statements and information set forth in this section at the time the insurer sends written notice of:

(1) An appeal decision under G.S. 58-50-61 upholding a noncertification; and

(2) A second-level grievance review decision under G.S. 58-50-62 upholding the original noncertification.

(b) The insurer shall include in the notice required under subsection (a) of this section for a notice related to an appeal decision under G.S. 58-50-61, a statement informing the covered person that:

(1) If the covered person has a medical condition where the time frame for completion of an expedited review of a grievance involving an appeal decision under G.S. 58-50-61 would reasonably be expected to seriously jeopardize the life or health of the covered person or jeopardize the covered person's ability to regain maximum function, the covered person may file a request for an expedited external review under G.S. 58-50-82 at the same time the covered person files a request for an expedited review of a grievance involving an appeal decision under G.S. 58-50-61 and G.S. 58-50-62, but that the Commissioner will determine whether the covered person shall be required to complete the expedited review of the grievance before conducting the expedited external review.

(2) If the insurer has not issued a written decision to the covered person within 45 days after the date the covered person files the grievance with the insurer pursuant to G.S. 58-50-62 and the covered person has not requested or agreed to a delay, the covered person may file a request for external review under G.S. 58-50-80 of this section and shall be considered to have exhausted the insurer's internal grievance process for purposes of G.S. 58-50-79.

(c) The insurer shall include in the notice required under subsection (a) of this section for a notice related to a final second-level grievance review decision under G.S. 58-50-62, a statement informing the covered person that:

(1) If the covered person has a medical condition where the time frame for completion of a standard external review under G.S. 58-50-80 would

reasonably be expected to seriously jeopardize the life or health of the covered person or jeopardize the covered person's ability to regain maximum function, the covered person may file a request for an expedited external review under G.S. 58-50-82; or

(2) If the second-level grievance review decision concerns an admission, availability of care, continued stay, or health care service for which the covered person received emergency services but has not been discharged from a facility, the covered person may request an expedited external review under G.S. 58-50-82.

(d) In addition to the information to be provided under subsections (b) and (c) of this section, the insurer shall include a copy of the description of both the standard and expedited external review procedures the insurer is required to provide under G.S. 58-50-93, including the provisions in the external review procedures that give the covered person the opportunity to submit additional information.

"**§ 58-50-78:** Reserved.

"**§ 58-50-79. Exhaustion of internal grievance process.**

(a) Except as provided in subsections (d) and (e) of this section, a request for an external review under G.S. 58-50-80 or G.S. 58-50-82 shall not be made until the covered person has exhausted the insurer's internal grievance process under G.S. 58-50-62.

(b) A covered person shall be considered to have exhausted the insurer's internal grievance process for purposes of this section, if the covered person:

(1) Has filed a second-level grievance involving a noncertification appeal decision under G.S. 58-50-61 and G.S. 58-50-62.

(2) Except to the extent the covered person requested or agreed to a delay, has not received a written decision on the grievance from the insurer within 45 days since the date the covered person filed the grievance with the insurer.

(c) Notwithstanding subsection (b) of this section, a covered person may not make a request for an external review of a noncertification involving a retrospective review determination made under G.S. 58-50-61 until the covered person has exhausted the insurer's internal grievance process.

(d) At the same time a covered person files a request for an expedited appeal involving a noncertification as set forth in G.S. 58-50-61(l), the covered person may file a request for an expedited external review of the noncertification under G.S. 58-50-82 if the covered person has a medical condition where the time frame for completion of an expedited review of the appeal involving a noncertification set forth in G.S. 58-50-61(l) would be reasonably expected to seriously jeopardize the life or health of the covered person or would jeopardize the covered person's ability to regain maximum function. An insurer may waive its right to conduct an expedited review of an appeal and allow the covered person to proceed with an expedited external review of the noncertification.

(e) Upon receipt of a request for an expedited external review under subsection (d) of this section, the Commissioner shall immediately determine whether the covered

person shall be required to complete the expedited internal appeal process set forth in G.S. 58-50-61(l) before the organization conducts the expedited external review, unless the insurer has waived its right to conduct an expedited review of the appeal decision.

(f) Upon a determination made under subsection (e) of this section that the covered person must first complete the expedited internal appeal process under G.S. 58-50-61(l), the Commissioner shall notify immediately the covered person and the insurer of this determination and that the expedited external review under G.S. 58-50-82 shall not proceed until completion of the expedited internal appeal process.

(g) A request for an external review of a noncertification may be made before the covered person has exhausted the insurer's internal grievance and appeal procedures under G.S. 58-50-61 and G.S. 58-50-62 whenever the insurer agrees to waive the exhaustion requirement. If the requirement to exhaust the insurer's internal grievance procedures is waived, the covered person may file a request in writing for a standard external review as set forth in G.S. 58-50-80 or may make a request for an expedited external review as set forth in G.S. 58-50-82.

"**§ 58-50-80. Standard external review.**

(a) Within 60 days after the date of receipt of a notice under G.S. 58-50-77, a covered person may file a request for an external review with the Commissioner.

(b) Upon receipt of a request for an external review under subsection (a) of this section, the Commissioner immediately shall notify and send a copy of the request to the insurer that made the decision which is the subject of the request. The insurer shall immediately submit to the Commissioner the information required for the preliminary review under subsection (c) of this section.

(c) Within five business days after the date of receipt of a request for an external review, the Commissioner shall complete a preliminary review of the request to determine whether:

(1) The individual is or was a covered person in the health benefit plan at the time the health care service was requested or, in the case of a retrospective review, was a covered person in the health benefit plan at the time the health care service was provided.

(2) The health care service that is the subject of the noncertification appeal decision or the second-level grievance review decision upholding a noncertification reasonably appears to be a covered service under the covered person's health benefit plan.

(3) The covered person has exhausted the insurer's internal appeal and grievance processes under G.S. 58-50-61 and G.S. 58-50-62 unless the covered person is not required to exhaust the insurer's internal appeal or grievance process under G.S. 58-50-79.

(4) The covered person has provided all the information and forms required by the Commissioner that are necessary to process an external review.

(d) Upon completion of the preliminary review under subsection (c) of this section, the Commissioner immediately shall notify the covered person in writing

whether the request is complete and whether the request has been accepted for external review. If the request is not complete, the Commissioner shall request from the covered person the information or materials needed to make the request complete. The covered person shall furnish the Commissioner with the requested information or materials within 90 days after the date of the insurer's decision for which external review is requested. If the request is not accepted for external review, the Commissioner shall inform the covered person and the insurer in writing of the reasons for its nonacceptance.

(e) If the request is accepted for external review, the Commissioner shall:

(1) Include in the notice provided under subsection (d) of this section a statement that the covered person may submit to the Commissioner in writing within seven days after the date of the notice additional information and supporting documentation relevant to the initial denial that the organization shall consider when conducting the external review.

(2) Immediately notify the insurer in writing of the acceptance of the request for external review.

The Commissioner shall maintain an alphabetical listing of independent review organizations approved under G.S. 58-50-85 and shall systematically assign on a rotating basis the next independent review organization on that list capable of performing the review to conduct the external review. After the last organization on the list has been assigned a review, the Commissioner shall return to the top of the list to continue assigning reviews.

(f) The Commissioner shall forward to the review organization that was assigned by the Commissioner any documents that were received relating to the request for external review. At the same time the Commissioner forwards the information to the review organization, the Commissioner shall forward the information to the insurer and the covered person.

(g) Within seven days after the date of receipt of the notice provided under subsection (d) of this section, the insurer or its designee utilization review organization shall provide to the assigned organization the documents and any information considered in making the noncertification appeal decision or the second-level grievance review decision. Except as provided in subsection (h) of this section, failure by the insurer or its designee utilization review organization to provide the documents and information within the time specified in this subsection shall not delay the conduct of the external review.

(h) If the insurer or its utilization review organization fails to provide the documents and information within the time specified in subsection (g) of this section, the assigned organization may terminate the external review and make a decision to reverse the noncertification appeal decision or the second-level grievance review decision. Immediately upon making the decision under this subsection, the organization shall notify the covered person, the insurer, and the Commissioner.

(i) Upon receipt of the information required to be forwarded under subsection (f) of this section, the insurer may reconsider its noncertification appeal decision or second-level grievance review decision that is the subject of the external review. Reconsideration by the insurer of its noncertification appeal decision or second-level grievance review decision under this subsection shall not delay or terminate the external review. The external review shall be terminated if the insurer decides, upon completion of its reconsideration, to reverse its noncertification appeal decision or second-level grievance review decision and provide coverage or payment for the requested health care service that is the subject of the noncertification appeal decision or second-level grievance review decision.

(j) Immediately upon making the decision to reverse its noncertification appeal decision or second-level grievance review decision under subsection (i) of this section, the insurer shall notify the covered person, the organization, and the Commissioner in writing of its decision. The organization shall terminate the external review upon receipt of the notice from the insurer sent under this subsection.

(k) The assigned organization shall review all of the information and documents received under subsections (f) and (g) of this section that have been forwarded to the organization by the Commissioner and the insurer. In addition, the assigned review organization, to the extent the documents or information are available, shall consider the following in reaching a decision:

(1) The covered person's medical records.

(2) The attending health care provider's recommendation.

(3) Consulting reports from appropriate health care providers and other documents submitted by the insurer, covered person, or the covered person's treating provider.

(4) The most appropriate practice guidelines that are based on sound clinical evidence and that are periodically evaluated to assure ongoing efficacy.

(5) Any applicable clinical review criteria developed and used by the insurer or its designee utilization review organization.

(6) Medical necessity, as defined in G.S. 58-3-200(b).

(7) Any documentation supporting the medical necessity and appropriateness of the provider's recommendation.

The assigned organization shall review the terms of coverage under the covered person's health benefit plan to ensure that the organization's decision shall not be contrary to the terms of coverage under the covered person's health benefit plan with the insurer.

The assigned organization's determination shall be based on the covered person's medical condition at the time of the initial noncertification decision.

(l) Within 45 days after the date of receipt by the Commissioner of the request for external review, the assigned organization shall provide written notice of its decision to uphold or reverse the noncertification appeal decision or second-level grievance review decision to the covered person, the insurer, and the Commissioner. In reaching a

decision, the assigned review organization is not bound by any decisions or conclusions reached during the insurer's utilization review process or the insurer's internal grievance process under G.S. 58-50-61 and G.S 58-50-62.

(m) The organization shall include in the notice sent under subsection (l) of this section:

(1) A general description of the reason for the request for external review.

(2) The date the organization received the assignment from the Commissioner to conduct the external review.

(3) The date the organization received information and documents submitted by the covered person and by the insurer.

(4) The date the external review was conducted.

(5) The date of its decision.

(6) The principal reason or reasons for its decision.

(7) The clinical rationale for its decision.

(8) References to the evidence or documentation, including the practice guidelines, considered in reaching its decision.

(9) The professional qualifications and licensure of the clinical peer reviewers.

(10) Notice to the covered person that he or she is not liable for the cost of the external review.

(n) Upon receipt of a notice of a decision under subsection (l) of this section reversing the noncertification appeal decision or second-level grievance review decision, the insurer shall immediately reverse the noncertification appeal decision or second-level grievance review decision that was the subject of the review and shall process the claim accordingly. In the event the covered person is no longer enrolled in the health benefit plan when the insurer receives notice of a decision under subsection (l) of this section reversing the noncertification appeal decision or second-level grievance review decision, the insurer shall be responsible under this section only for the costs of those services or supplies the covered person received or would have received prior to disenrollment.

"**§ 58-50-81:** Reserved.

"**§ 58-50-82. Expedited external review.**

(a) Except as provided in subsection (h) of this section, a covered person may make a written or oral request for an expedited external review with the Commissioner at the time the covered person receives:

(1) An appeal decision under G.S. 58-50-61(k) or (l) upholding a noncertification if:

a. The noncertification appeal decision involves a medical condition of the covered person for which the time frame for completion of an expedited second-level grievance review of a noncertification set forth in G.S. 58-50-62(i) would reasonably be expected to seriously jeopardize the life or health of the

covered person or jeopardize the covered person's ability to regain maximum function; and

b. The covered person has filed a request for an expedited second-level review of a noncertification as set forth in G.S. 58-50-61(i); or

(2) A second-level grievance review decision under G.S. 58-60-62(h) or (i) upholding a noncertification:

a. If the covered person has a medical condition where the time frame for completion of a standard external review under G.S. 58-50-80 would reasonably be expected to seriously jeopardize the life or health of the covered person or jeopardize the covered person's ability to regain maximum function; or

b. If the second-level grievance concerns a noncertification of an admission, availability of care, continued stay, or health care service for which the covered person received emergency services, but has not been discharged from a facility.

(b) At the time the Commissioner receives a request for an expedited external review, the Commissioner immediately shall:

(1) Notify and provide a copy of the request to the insurer that made the noncertification appeal decision or second-level grievance review decision which is the subject of the request.

(2) For a request that the Commissioner has determined meets the reviewability requirements set forth in G.S. 58-50-80(c), the Commissioner shall immediately determine, based on medical advice from a medical professional who is not affiliated with the organization that will be assigned to conduct the external review of the request, whether the request should be reviewed on an expedited basis because the time frame for completion of a standard external review under G.S. 58-50-80 would reasonably be expected to seriously jeopardize the life or health of the covered person or would jeopardize the covered person's ability to regain maximum function. The Commissioner shall then inform the covered person and the insurer whether the review will be conducted using an expedited or standard time frame, and shall, in accordance with G.S. 58-50-80, assign an organization to conduct the review within the appropriate time frame.

(c) In reaching a decision, the assigned organization is not bound by any decisions or conclusions reached during the insurer's utilization review process or internal grievance process under G.S. 58-50-61 and G.S. 58-50-62.

(d) At the time the insurer receives the notice under subsection (b) of this section, the insurer or its designee utilization review organization shall immediately provide or transmit all documents and information considered in making the noncertification appeal decision or the second-level grievance review decision to the assigned review

organization electronically or by telephone or facsimile or any other available expeditious method.

(e) In addition to the documents and information provided or transmitted under subsection (d) of this section, the assigned organization, to the extent the information or documents are available, shall consider the following in reaching a decision:

(1) The covered person's pertinent medical records.

(2) The attending health care provider's recommendation.

(3) Consulting reports from appropriate health care providers and other documents submitted by the insurer, covered person, or the covered person's treating provider.

(4) The most appropriate practice guidelines that are based on sound clinical evidence and that are periodically evaluated to assure ongoing efficacy.

(5) Any applicable clinical review criteria developed and used by the insurer or its designee utilization review organization in making noncertification decisions.

(6) Medical necessity, as defined in G.S. 58-3-200(b).

(7) Any documentation supporting the medical necessity and appropriateness of the provider's recommendation.

The assigned organization shall review the terms of coverage under the covered person's health benefit plan to ensure that the organization's decision shall not be contrary to the terms of coverage under the covered person's health benefit plan.

The assigned organization's determination shall be based on the covered person's medical condition at the time of the initial noncertification decision.

(f) As expeditiously as the covered person's medical condition or circumstances require, but not more than four days after the date of receipt of the request for an expedited external review, the assigned organization shall make a decision to uphold or reverse the noncertification appeal decision or second-level grievance review decision and notify the covered person, the insurer, and the Commissioner of the decision.

(g) If the notice provided under subsection (f) of this section was not in writing, within two days after the date of providing that notice, the assigned organization shall provide written confirmation of the decision to the covered person, the insurer, and the Commissioner and include the information set forth in G.S. 58-50-80(o). Upon receipt of the notice, a decision under subsection (f) of this section reversing the noncertification appeal decision or second-level grievance review decision, the insurer shall immediately reverse the noncertification appeal decision or second-level grievance review decision that was the subject of the review and shall process the claim accordingly.

(h) An expedited external review shall not be provided for retrospective noncertifications.

"**§ 58-50-83:** Reserved.

"**§ 58-50-84. Binding nature of external review decision.**

(a) An external review decision is binding on the insurer.

(b) An external review decision is binding on the covered person except to the extent the covered person has other remedies available under applicable federal or State law.

(c) A covered person may not file a subsequent request for external review involving the same noncertification appeal decision or second-level grievance review decision for which the covered person has already received an external review decision under this Part.

"**§ 58-50-85. Approval of independent review organizations.**

(a) The Commissioner shall approve independent review organizations eligible to be assigned to conduct external reviews under this Part to ensure that an organization satisfies the minimum qualifications established under G.S. 58-50-87. The Commissioner shall develop an application form for initially approving and for reapproving organizations to conduct external reviews.

(b) Any organization wishing to be approved to conduct external reviews under this Part shall submit the application form and include with the form all documentation and information necessary for the Commissioner to determine if the organization satisfies the minimum qualifications established under G.S. 58-50-87. Applicants must submit pricing information sufficient to demonstrate that if selected, the applicant's total fee per review will not exceed commercially reasonable fees charged for similar services in the industry. The Commissioner shall not approve any independent review organization that either fails to provide sufficient pricing information or has fees that do not meet the guidelines established under this subsection.

(c) The Commissioner may determine that accreditation by a nationally recognized private accrediting entity with established and maintained standards for independent review organizations that meet the minimum qualifications established under G.S. 58-50-87 will cause an independent review organization to be deemed to have met, in whole or in part, the requirements of this section and G.S. 58-50-87. A decision by the Commissioner to recognize an accreditation program for the purpose of granting deemed status may be made only after reviewing the accreditation standards and program information submitted by the accrediting body. An independent review organization seeking deemed status due to its accreditation shall submit original documentation issued by the accrediting body to demonstrate its accreditation.

(d) An approval is effective for two years, unless the Commissioner determines before expiration of the approval that the independent review organization is not satisfying the minimum qualifications established under G.S. 58-50-87.

(e) Whenever the Commissioner determines that an independent review organization no longer satisfies the minimum requirements established under G.S. 58-50-87, the Commissioner shall terminate the approval of the independent review organization.

"**§ 58-50-86:** Reserved.

"**§ 58-50-87. Minimum qualifications for independent review organizations.**

(a) As a condition of approval under G.S. 58-50-85 to conduct external reviews, an independent review organization shall have and maintain written policies and

procedures that govern all aspects of both the standard external review process and the expedited external review process set forth in G.S. 58-50-80 and G.S. 58-50-82 that include, at a minimum:

(1) A quality assurance mechanism in place that ensures:

a. That external reviews are conducted within the specified time frames and required notices are provided in a timely manner.

b. The selection of qualified and impartial clinical peer reviewers to conduct external reviews on behalf of the independent review organization and suitable matching of reviewers to specific cases.

c. The confidentiality of medical and treatment records and clinical review criteria.

d. That any person employed by or under contract with the independent review organization adheres to the requirements of this Part.

e. The independence and impartiality of the independent review organization and the external review process and limits the ability of any person to improperly influence the external review decision.

(2) A toll-free telephone service to receive information on a 24-hour-day, seven-day-a-week basis related to external reviews that is capable of accepting or recording inquiries or providing appropriate instruction to incoming telephone callers during other than normal business hours.

(3) An agreement to maintain and provide to the Commissioner the information set out in G.S. 58-50-90.

(4) A program for credentialing clinical peer reviewers.

(5) An agreement to contractual terms or written requirements established by the Commissioner regarding the procedures for handling a review.

(6) That the independent review organization consult with a medical doctor licensed to practice in North Carolina to advise the independent review organization on issues related to the standard of practice, technology, and training of North Carolina physicians with respect to the organization's North Carolina business.

(b) All clinical peer reviewers assigned by an independent review organization to conduct external reviews shall be medical doctors or other appropriate health care providers who meet the following minimum qualifications:

(1) Be an expert in the treatment of the covered person's injury, illness, or medical condition that is the subject of the external review.

(2) Be knowledgeable about the recommended health care service or treatment through recent or current actual clinical experience treating patients with the same or similar injury, illness, or medical condition of the covered person.

(3) If the covered person's treating provider is a medical doctor, hold a nonrestricted license and, if a specialist medical doctor, a current certification by a recognized American medical specialty board in the area or areas appropriate to the subject of the external review.

(4) If the covered person's treating provider is not a medical doctor, hold a nonrestricted license, registration, or certification in the same allied health occupation as the covered person's treating provider.

(5) Have no history of disciplinary actions or sanctions, including loss of staff privileges or participation restrictions, that have been taken or are pending by any hospital, governmental agency or unit, or regulatory body that raise a substantial question as to the clinical peer reviewer's physical, mental, or professional competence or moral character.

(c) In addition to the requirements set forth in subsection (a) of this section, an independent review organization may not own or control, be a subsidiary of, or in any way be owned or controlled by, or exercise control with a health benefit plan, a national, State, or local trade association of health benefit plans, or a national, State, or local trade association of health care providers.

(d) In addition to the requirements set forth in subsections (a), (b), and (c) of this section, to be approved under G.S. 58-50-85 to conduct an external review of a specified case, neither the independent review organization selected to conduct the external review nor any clinical peer reviewer assigned by the independent organization to conduct the external review may have a material professional, familial, or financial conflict of interest with any of the following:

(1) The insurer that is the subject of the external review.

(2) The covered person whose treatment is the subject of the external review or the covered person's authorized representative.

(3) Any officer, director, or management employee of the insurer that is the subject of the external review.

(4) The health care provider, the health care provider's medical group, or independent practice association recommending the health care service or treatment that is the subject of the external review.

(5) The facility at which the recommended health care service or treatment would be provided.

(6) The developer or manufacturer of the principal drug, device, procedure, or other therapy being recommended for the covered person whose treatment is the subject of the external review.

(e) In determining whether an independent review organization or a clinical peer reviewer of the independent review organization has a material professional, familial, or financial conflict of interest for purposes of subsection (d) of this section, the Commissioner shall take into consideration situations where the independent review organization to be assigned to conduct an external review of a specified case or a clinical peer reviewer to be assigned by the independent review organization to conduct an external review of a specified case may have an apparent professional, familial, or

financial relationship or connection with a person described in subsection (d) of this section, but that the characteristics of that relationship or connection are such that they are not a material professional, familial, or financial conflict of interest that results in the disapproval of the independent review organization or the clinical peer reviewer from conducting the external review.

"**§ 58-50-88:** Reserved.

"**§ 58-50-89. Hold harmless for Commissioner and independent review organizations.**

The Commissioner or an independent review organization or clinical peer reviewer working on behalf of an organization shall not be liable for damages to any person for any opinions rendered during or upon completion of an external review conducted under this Part, unless the opinion was rendered in bad faith or involved gross negligence.

"**§ 58-50-90. External review reporting requirements.**

(a) An organization assigned under G.S. 58-50-80 or G.S. 58-50-82 to conduct an external review shall maintain written records in the aggregate and by insurer on all requests for external review for which it conducted an external review during a calendar year and submit a report to the Commissioner, as required under subsection (b) of this section.

(b) Each organization required to maintain written records on all requests for external review under subsection (a) of this section for which it was assigned to conduct an external review shall submit to the Commissioner, at least annually, a report in the format specified by the Commissioner.

(c) The report shall include in the aggregate and for each insurer:

(1) The total number of requests for external review.

(2) The number of requests for external review resolved and, of those resolved, the number resolved upholding the noncertification appeal decision or second-level grievance review decision and the number resolved reversing the noncertification appeal decision or second-level grievance review decision.

(3) The average length of time for resolution.

(4) A summary of the types of coverages or cases for which an external review was sought, as provided in the format required by the Commissioner.

(5) The number of external reviews under G.S. 58-50-80(k) and (l) that were terminated as the result of a reconsideration by the insurer of its noncertification appeal decision or second-level grievance review decision after the receipt of additional information from the covered person.

(6) Any other information the Commissioner may request or require.

(d) The organization shall retain the written records required under this section for at least three years.

(e) Each insurer shall maintain written records in the aggregate and for each type of health benefit plan offered by the insurer on all requests for external review of which

the insurer receives notice from the Commissioner under this Part. The insurer shall retain the written records required under this section for at least three years.

"**§ 58-50-91:** Reserved.

"**§ 58-50-92. Funding of external review.**

The insurer against which a request for a standard external review or an expedited external review is filed shall reimburse the Department of Insurance for the fees charged by the organization in conducting the external review.

"**§ 58-50-93. Disclosure requirements.**

(a) Each insurer shall include a description of the external review procedures in or attached to the policy, certificate, membership booklet, outline of coverage, or other evidence of coverage it provides to covered persons.

(b) The description required under subsection (a) of this section shall include a statement that informs the covered person of the right of the covered person to file a request for an external review of a noncertification appeal decision or a second-level grievance review decision upholding a noncertification with the Commissioner. The statement shall include the telephone number and address of the Commissioner.

(c) In addition to subsection (b) of this section, the statement shall inform the covered person that, when filing a request for an external review, the covered person will be required to authorize the release of any medical records of the covered person that may be required to be reviewed for the purpose of reaching a decision on the external review.

"**§ 58-50-94. Competitive selection of independent review organizations.**

(a) The Commissioner shall prepare and publish requests for proposals from independent review organizations that want to be approved under G.S. 58-50-85. All proposals shall be sealed. The Commissioner shall open all proposals in public.

(b) After the public opening, the Commissioner shall review the proposals, examining the costs and quality of the services offered by the independent review organizations, the reputation and capabilities of the independent review organizations submitting the proposals, and the provisions in G.S. 58-50-85 and G.S. 58-50-87. The Commissioner shall determine which proposal or proposals would satisfy the provisions of this Part. The Commissioner shall make his determination in consultation with an evaluation committee whose membership includes representatives of insurers subject to Part 4 of Article 50 of Chapter 58 of the General Statutes, health care providers, and insureds. In selecting the review organizations, in addition to considering cost, quality, and adherence to the requirements of the request for proposals, the Commissioner shall consider the desirability and feasibility of contracting with multiple review organizations in order to allow insureds a choice of review organizations and shall ensure that at least one review organization is available and capable of reviewing cases involving highly specialized services and treatments of any nature. The Commissioner may reject any or all proposals.

(c) An independent review organization may seek to modify or withdraw a proposal only after the public opening and only on the basis that the proposal contains an unintentional clerical error as opposed to an error in judgment. An independent

review organization seeking to modify or withdraw a proposal shall submit to the Commissioner a written request, with facts and evidence in support of its position, before the determination made by the Commissioner under subsection (b) of this section, but not later than two days after the public opening of the proposals. The Commissioner shall promptly review the request, examine the nature of the error, and determine whether to permit or deny the request.

(d) The provisions of Article 3C of Chapter 143 of the General Statutes do not apply to this Part.

"**§ 58-50-95. Report by Commissioner.**

The Commissioner shall report semiannually to the Joint Legislative Health Care Oversight Committee regarding the nature and appropriateness of reviews conducted under this Part. The report, which shall be provided to the public upon request, should include the number of reviews, underlying issues in dispute, character of the reviews, dollar amounts in question, whether the review was decided in favor of the covered person or the health benefit plan, the cost of review, and any other information relevant to the evaluation of the effectiveness of this Part."

SECTION 4.6. G.S. 58-50-62(h)(7) reads as rewritten:

"(7) A statement that the decision is the insurer's final determination in the matter. In cases where the review concerned a noncertification and the insurer's decision on the second-level grievance review is to uphold its initial noncertification, a statement advising the covered person of his or her right to request an external review and a description of the procedure for submitting a request for external review to the Commissioner of Insurance."

SECTION 4.6A. G.S. 143-64.24 reads as rewritten:

"**§ 143-64.24. Applicability of Article.**

This Article shall not apply to the General Assembly, special study commissions, the Research Triangle Institute, or the Institute of Government, nor shall it apply to attorneys employed by the North Carolina Department of Justice, or physicians or doctors performing contractual services for any State agency. This Article shall not apply to Independent Review Organizations selected by the Commissioner of Insurance pursuant to G.S. 58-50-85."

Subpart B. Health Plan Liability

SECTION 4.7. Chapter 90 of the General Statutes is amended by adding a new Article to read:

"Article 1G.

"Health Care Liability.

"**§ 90-21.50. Definitions.**

As used in this Article, unless the context clearly indicates otherwise, the term:

(1) 'Health benefit plan' has the meaning applied in G.S. 58-3-167.

(2) 'Health care provider' means:

a. An individual who is licensed, certified, or otherwise authorized under this Chapter to provide health care services in the ordinary course of business or practice of a profession or in an approved education or training program; or

b. A health care facility, licensed under Chapters 131E or 122C of the General Statutes, where health care services are provided to patients;

'Health care provider' includes: (i) an agent or employee of a health care facility that is licensed, certified, or otherwise authorized to provide health care services; (ii) the officers and directors of a health care facility; and (iii) an agent or employee of a health care provider who is licensed, certified, or otherwise authorized to provide health care services.

(3) 'Health care service' means a health or medical procedure or service rendered by a health care provider that:

a. Provides testing, diagnosis, or treatment of a health condition, illness, injury, or disease; or

b. Dispenses drugs, medical devices, medical appliances, or medical goods for the treatment of a health condition, illness, injury, or disease.

(4) 'Health care treatment decision' means a determination that:

a. Is made by a managed care entity;

b. Governs the extent to which health care services are provided for, arranged for, paid for, or reimbursed for under a health benefit plan; and

c. Affects the quality of the diagnosis, care, or treatment provided under the health benefit plan to an enrollee or insured of the health benefit plan.

(5) 'Insured or enrollee' means a person that is insured by or enrolled in a health benefit plan under a policy, plan, certificate, or contract issued or delivered in this State by an insurer.

(6) 'Insurer' has the meaning applied in G.S. 58-3-167.

(7) 'Managed care entity' means an insurer that:

a. Delivers, administers, or undertakes to provide for, arrange for, or reimburse for health care services or assumes the risk for the delivery of health care services; and

b. Has a system or technique to control or influence the quality, accessibility, utilization, or costs and prices of health care services delivered or to be delivered to a defined enrollee population.

'Managed care entity' does not include: (i) an employer purchasing coverage or acting on behalf of its employees or the employees of one

or more subsidiaries or affiliated corporations of the employer, or (ii) a health care provider.

(8) 'Ordinary care' means that degree of care that a managed care entity of ordinary prudence situated in the same or similar communities at the time of the alleged act giving rise to the cause of action would use under the same or similar circumstances.

(9) 'Physician' means:

a. An individual licensed to practice medicine in this State;

b. A professional association or corporation organized under Chapter 55B of the General Statutes; or

c. A person or entity wholly owned by physicians.

(10) 'Successor external review process' means an external review process equivalent in all respects to G.S. 58-50-75 through G.S. 58-50-95 that is approved by the Department and implemented by a health benefit plan in the event that G.S. 58-50-75 through G.S. 58-50-95 are found by a court of competent jurisdiction to be void, unenforceable, or preempted by federal law, in whole or in part.

"**§ 90-21.51. Duty to exercise ordinary care; liability for damages for harm.**

(a) Each managed care entity for a health benefit plan has the duty to exercise ordinary care when making health care treatment decisions and is liable for damages for harm to an insured or enrollee proximately caused by its failure to exercise ordinary care.

(b) In addition to the duty imposed under subsection (a) of this section, each managed care entity for a health benefit plan is liable for damages for harm to an insured or enrollee proximately caused by the health care treatment decisions made by:

(1) Its agents or employees; or

(2) Representatives that are acting on its behalf and over whom it has exercised sufficient influence or control to reasonably affect the actual care and treatment of the insured or enrollee which results in the failure to exercise ordinary care.

(c) It shall be a defense to any action brought under this section against a managed care entity for a health benefit plan that:

(1) The managed care entity and its agents or employees, or representatives for whom the managed care entity is liable under subsection (b) of this section, did not control or influence or participate in the health care treatment decision; and

(2) The managed care entity did not deny or delay payment for any health care service or treatment prescribed or recommended by a physician or health care provider to the insured or enrollee.

(d) In an action brought under this Article against a managed care entity, a finding that a physician or health care provider is an agent or employee of the managed care entity may not be based solely on proof that the physician or health care provider

appears in a listing of approved physicians or health care providers made available to insureds or enrollees under the managed care entity's health benefit plan.

(e) An action brought under this Article is not a medical malpractice action as defined in Article 1B of this Chapter. A managed care entity may not use as a defense in an action brought under this Article any law that prohibits the corporate practice of medicine.

(f) A managed care entity shall not be liable for the independent actions of a health care provider, who is not an agent or employee of the managed care entity, when that health care provider fails to exercise the standard of care required by G.S. 90-21.12. A health care provider shall not be liable for the independent actions of a managed care entity when the managed care entity fails to exercise the standard of care required by this Article.

(g) Nothing in this Article shall be construed to create an obligation on the part of a managed care entity to provide to an insured or enrollee a health care service or treatment that is not covered under its health benefit plan.

(h) A managed care entity may not enter into a contract with a health care provider, or with an employer or employer group organization, that includes an indemnification or hold harmless clause for the acts or conduct of the managed care entity. Any such indemnification or hold harmless clause is void and unenforceable to the extent of the restriction.

"**§ 90-21.52. No liability under this Article on the part of an employer or employer group organization that purchases coverage or assumes risk on behalf of its employees or a physician or health care provider.**

(a) This Article does not create any liability on the part of an employer or employer group purchasing organization that purchases health care coverage or assumes risk on behalf of its employees.

(b) This Article does not create any liability on the part of a physician or health care provider in addition to that otherwise imposed under existing law. No managed care entity held liable under this Article shall be entitled to contribution under Chapter 1B of the General Statutes from a physician or health care provider.

"**§ 90-21.53. Separate trial required.**

Upon motion of any party in an action that includes a claim brought pursuant to this Article involving a managed care entity, the court shall order separate discovery and a separate trial of any claim, cross-claim, counterclaim, or third-party claim against any physician or other health care provider.

"**§ 90-21.54. Exhaustion of administrative remedies and appeals.**

(a) Except as provided in this section, no action may be commenced under this Article until the plaintiff has exhausted all administrative remedies and appeals, including those internal remedies and appeals established under G.S. 58-50-51 through G.S. 58-50-52, and G.S. 58-50-75 through G.S. 58-50-95, and including those established under any successor external review process.

(b) The plaintiff may file a claim without exhausting all administrative remedies and appeals if both of the following conditions are met:

(1) The plaintiff has already been harmed by the conduct of the managed care entity or because of an act or omission of an employee, agent, ostensible agent, or representative of the managed care entity for whose conduct the managed care entity is liable.

(2) The circumstances are such that no administrative remedy or appeal is available or that the administrative review would not be beneficial to the plaintiff.

"**§ 90-21.55. External review decision.**

(a) Either the insured or enrollee or the personal representative of the insured or enrollee or the managed care entity may use an external review decision made in accordance with G.S. 58-50-75 through G.S. 58-50-95, or made in accordance with any successor external review process, as evidence in any cause of action which includes an action brought under this Part, provided that an adequate foundation is laid for the introduction of the external review decision into evidence and the testimony is subject to cross-examination.

(b) Any information, documents, or other records or materials considered by the Independent Review Organization licensed under Part 4 of Article 50 of Chapter 58 of the General Statutes, or the successor review process, in conducting its review shall be admissible in any action commenced under this Article in accordance with Chapter 8 of the General Statutes and the North Carolina Rules of Evidence.

"**§ 90-21.56. Remedies.**

(a) An insured or enrollee who has been found to have been harmed by the managed care entity pursuant to an action brought under this Article may recover actual or nominal damages and punitive damages under the provisions and limitations of Chapter 1D of the General Statutes.

(b) This Article does not limit a plaintiff from pursuing any other remedy existing under the law or seeking any other relief that may be available.

(c) The rights conferred under this Article may not be waived, deferred, or lost pursuant to any contract that provides for the use of arbitration or mediation to resolve a controversy arising out of or relating to a dispute involving the provisions of health plan benefits. Arbitration or mediation may not be used to settle the controversy unless and until after the controversy arises the insured or enrollee, or the estate of the insured or enrollee, voluntarily and knowingly consents in writing to use arbitration or mediation to settle the controversy. Consent to an arbitration or mediation process shall not limit the rights of the insured or enrollee or the estate of the insured or enrollee to seek any remedies provided under this Article."

SECTION 4.8. G.S. 1A-1, Rule 42, reads as rewritten:

"**Rule 42. Consolidation; separate trials.**

(a) Consolidation. – ~~When~~ Except as provided in subdivision (b)(2) of this section, when actions involving a common question of law or fact are pending in one division of the court, the judge may order a joint hearing or trial of any or all the matters in issue in the actions; he may order all the actions consolidated; and he may make such orders concerning proceedings therein as may tend to avoid unnecessary costs or delay.

When actions involving a common question of law or fact are pending in both the superior and the district court of the same county, a judge of the superior court in which the action is pending may order all the actions consolidated, and he may make such orders concerning proceedings therein as may tend to avoid unnecessary costs or delay.

(b) Separate trials. –

(1) The court may in furtherance of convenience or to avoid prejudice and shall for considerations of venue upon timely motion order a separate trial of any claim, ~~crossclaim~~cross-claim, counterclaim, or third-party claim, or of any separate issue or of any number of claims, ~~crossclaims~~cross-claims, counterclaims, third-party claims, or issues.

(2) Upon motion of any party in an action that includes a claim commenced under Article 1G of Chapter 90 of the General Statutes involving a managed care entity as defined in G.S. 90-21.50, the court shall order separate discovery and a separate trial of any claim, cross-claim, counterclaim, or third-party claim against a physician or other medical provider."

SECTION 5.(a) G.S. 58-2-105 reads as rewritten:

"**§ 58-2-105. Confidentiality of medical records.**

(a) All patient medical records in the possession of the Department are confidential and are not public records pursuant to G.S. 58-2-100 or G.S. 132-1. As used in this section, "patient medical records" includes personal information that relates to an individual's physical or mental condition, medical history, or medical treatment, and that has been obtained from the individual patient, a health care provider, or from the patient's spouse, parent, or legal guardian.

(b) Under Part 4 of Article 50 of this Chapter, the Department may disclose patient medical records to an independent review organization, and the organization shall maintain the confidentiality of those records as required by this section, except as allowed by G.S. 58-30-75."

SECTION 5.(b) G.S. 58-3-200(b) reads as rewritten:

"(b) Medical Necessity. – An insurer that limits its health benefit plan coverage to medically necessary services and supplies shall define "medically necessary services or supplies" in its health benefit plan as those covered services or supplies that are:

(1) Provided for the diagnosis, treatment, cure, or relief of a health condition, illness, injury, or disease; ~~and~~ and, except as allowed under G.S. 58-3-255, not for experimental, investigational, or cosmetic purposes.

(2) Necessary for and appropriate to the diagnosis, treatment, cure, or relief of a health condition, illness, injury, disease, or its symptoms.

(3) Within generally accepted standards of medical care in the community.

(4) Not solely for the convenience of the insured, the insured's family, or the provider.

For medically necessary services, nothing in this subsection precludes an insurer from comparing the cost-effectiveness of alternative services or supplies when determining which of the services or supplies will be covered."

SECTION 5.(c) G.S. 58-50-61(a)(12) reads as rewritten:

"(12) "Medically necessary services or supplies" means those covered services or supplies that are:

a. Provided for the diagnosis, treatment, cure, or relief of a health condition, illness, injury, or disease.

b. Except as allowed under G.S. 58-3-255, ~~Not~~ not for experimental, investigational, or cosmetic purposes.

c. Necessary for and appropriate to the diagnosis, treatment, cure, or relief of a health condition, illness, injury, disease, or its symptoms.

d. Within generally accepted standards of medical care in the community.

e. Not solely for the convenience of the insured, the insured's family, or the provider.

For medically necessary services, nothing in this subdivision precludes an insurer from comparing the cost-effectiveness of alternative services or supplies when determining which of the services or supplies will be covered."

SECTION 6. If any section or provision of this act is declared unconstitutional or invalid by the courts, it does not affect the validity of the act as a whole or any part other than the part so declared to be unconstitutional or invalid.

SECTION 7. Section 1.6 of this act becomes effective January 1, 2002. Sections 3.1 and 3.2 of this act become effective December 1, 2001, and apply to health benefit plans that are delivered, issued for delivery, or renewed on or after that date. Sections 4.1 through 4.8 of this act become effective March 1, 2002. The remainder of this act is effective when it becomes law and applies to health benefit plans that are delivered, issued for delivery, or renewed on or after January 1, 2002. Nothing in this act obligates the General Assembly to appropriate funds to implement this act.

SENATE BILL 199:
Managed Care Patients' Bill of Rights

BILL ANALYSIS

Committee:	House Health Committee	**Introduced by:**	Sen. Wellons
Date:	July 31, 2001	**Summary by:**	Linda Attarian
Version:	2nd Edition		Committee Counsel

SUMMARY: ***The Second Edition of Senate Bill 199 proposes new mandated benefits and new protections for patients enrolled in managed care plans to ensure timely access to covered benefits and providers. Sections 3.1 and 3.2 (mandated benefits) become effective December 1, 2001, Sections 4.1-4.7 (External Review and HMO liability) become effective on March 1, 2002; and the remainder of the act is effective when it becomes law and applies to health benefit plans that are delivered, issued for delivery, or renewed on or after January 1, 2002. Specifically, the bill would enact the following new managed care patient protections:***

- ***"Continuity of Care in HMOs" to allow enrollees in managed care plans continued access to their health care providers for ongoing treatment for special conditions when the provider's contract is terminated or the enrollee's employer changes health plans. (Section 1)***
- ***"Extended or Standing Referral to a Specialist" to provide that the term specialist includes a "subspecialist"; and to allow enrollees in managed care plans to select a specialist as their primary care physician under certain conditions, and to allow children direct access to a pediatrician. (Sections. 1.2-1.4)***
- ***"Access to Prescription Drugs" to allow enrollees in managed care plans access to information concerning a health benefit plans list of drugs for which access is limited or restricted. (Section 1.5)***
- ***"Managed Care Patient Assistance Program" to establish an office to provide information and assistance to patients enrolled in managed care plans. (Section 1.6)***
- ***"Provider Directories" to enhance the scope of information insures must provide enrollees in managed care plans about the plan's network of providers. (Section 2.2)***
- ***"Disclosure of Payment Obligations" to provide enrollees in preferred provider networks access to information about how their payment obligations are calculated and that their payment could exceed their copayment. (Section 2.3)***
- ***"Mandated Benefits" to require insurers to provider coverage of medically necessary costs related to clinical trials and also to cover newborn hearing screening. (Section 3.1-3.2)***
- ***"Independent, External Review Process" to provide enrollees in managed care plans with an external standard and expedited review by an independent review organization of lower appeal decisions upholding a health plan's decision not to pay for a requested covered service. (Sections 4.1-4.5)***
- ***"Health Plan Liability" to provide enrollees with a statutory right of action against managed care organizations that fail to use ordinary care in making health care treatment decisions regarding covered services. (Section 4.7)***

CURRENT LAW AND BILL ANALYSIS

SECTION 1. Continuity of Care in HMOs

Current Practice: An HMO's relationship with providers is contractual in nature and is subject to termination by either party for various reasons specified in the contract. In certain circumstances, for example, when the provider's contract with the HMO terminates while a person is undergoing treatment for an ongoing chronic or terminal condition, changing providers on short notice is a hardship and may possibly have an adverse impact on the treatment.

Bill Analysis:

Section 1 would add a new section to Article 67 of Chapter 58, which is applicable only to HMOs, to require HMOs to allow enrollees suffering from ongoing special conditions as defined in the bill to elect to continue receiving services, on a transitional basis from a provider who leaves the HMO's network or under circumstances when the patient becomes enrolled in a new group health plan because the patient's employer has changed health benefit plans.

- Generally the transitional coverage period may extend up to 90 days for treatment for an acute or chronic illness, but may extend to the death of a patient whose condition is terminal (defined as someone with a life expectancy of more than 6 months), or up to 90 days post-discharge the when the patient is on a waiting list for surgery or a transplant, or up to 60 days postpartum.
- The transitional period begins the day after the patient is notified of the right to elect to continue coverage.
- The transition coverage is conditioned upon the patient's notification to the HMO within 45 days of notice that the patient wishes to continue coverage.
- The patient and the provider must adhere to certain conditions in order to obtain the transitional coverage, including agreeing to accept the reimbursement rates, etc. of the new HMO.
- An HMO is not required to offer the transitional coverage when the HMO terminates the provider's contract for reasons relating to quality of care or fraud. Denials of transitional coverage under these circumstances are not subject to appeal by the patient.

SECTION 1.2. AND 1.2A. Extending or Standing Referral to a Specialist

Current Law:

- G.S. 58-3-223 requires insurers to implement procedures to provide extended or standing referrals to a IN-PLAN specialist when the patient has a serious or chronic degenerative, disabling, or life threatening disease or condition, which in the opinion of the patient's primary care physician, in consultation with a specialist, requires ongoing specialty care. The referral is "standing" in that it is valid for up to 12 months.

- G.S. 58-3-200(d) prohibits an insurer from subjecting a patient that must seek treatment from a provider that is not in the insurer's network of providers due to the unavailability of a provider (not specialist) in the network to treat the patient's condition from higher fees or co-payments. .

Bill Analysis: Sections 1.2 and 1.2A will allow a patient to see an out-of-network specialist, including a sub-specialist without penalty if the patient has a standing referral and no such specialist is available within the health plan's provider panel.

- **Section 1.2** clarifies that the definition of "specialist" in G.S. 58-3-223 includes "subspecialist."
- **Section 1.2A** extends the scope of G.S. 58-3-200(d), to prohibit an insurer from subjecting a patient to higher fees or co-payments when the patient must seek treatment from an out-of-network specialist to which the patient has a standing referral due to the unavailability of an in-network specialist.

SECTION 1.3. Selection of a Specialist as a Primary Care Physician

Current Law:
Generally, health benefit plans require a patient to have a primary care physician who is responsible for providing or authorizing tests and procedures, etc., and coordinating the patient's treatment. When a patient requires ongoing specialty care, the patient may receive a standing referral to a specialist for up to 12 months, and will see the referring physician as their primary care physician.

Bill Analysis:
Section 1.3 adds a new section to Article 3 of Chapter 58 to require insurers to allow enrollees that need specialized medical care to select a specialist as their primary care physician. The insurer retains the authority to deny the patient's access to the specialist as a primary care provider if the insurer determines that the specialist is inappropriately coordinating the patient's care.

SECTION 1.4. Direct Access to Pediatrician

Current Law: Under current North Carolina law, HMOs and PPOs (preferred provider networks) must allow enrollees direct access without prior authorization to obstetrician-gynecologist services.

Bill Analysis:
Section 1.4 adds a new section to Article 3 of Chapter 58 to require any health benefit plan that uses a network of providers to allow an insured to choose a contracting pediatrician as the primary care provider for the insured's children (under 18).

SECTION 1.5: Access to Prescription Drugs

Current Law: Managed care organizations (MCOs) use drug formularies to control the cost of prescription drugs. A *closed* formulary is a list of drugs and devices that the MCO will cover if prescribed. MCO will not cover any drug or device that is not included in the formulary. A restricted access formulary is a list of drugs and devices that require prior approval. G.S. 58-3-221 requires the MCOs to develop any closed formularies in consultation and with the approval of a pharmacy and therapeutics committee, comprised of pharmacists and health care providers who are licensed to prescribe medications. The closed formulary must be made available to the participating providers and pharmacists in the MCO's network. When an enrollee needs a drug or device excluded from the formulary, the MCO must cover it ONLY if it is medically necessary and if alternative drugs or devices on the formulary have been shown to be ineffective, or would, in the physician's opinion, cause the patient harm. Currently, G.S. 58-3-221 applies only to closed formularies.

Bill Analysis:
Section 1.5 amends G.S. 58-3-221 to:

- Apply the current patient access provisions of G.S. 58-3-221 to drugs and devices included on restricted formularies;
- Provide that the pharmacy and therapeutics committee shall include ONLY NC licensed physicians (physician may include;

- Require the MCO to make the formulary available to *enrollees* as well as participating pharmacists and providers; and
- Allow the *enrollee's physician*, acting on behalf of the enrollee, to negotiate with the MCO to obtain coverage of a non-formulary drug or device *or a restricted access drug or device*.

SECTION 1.6. Managed Care Patient Assistance Program

Current law/practice:
Information provided to enrollees by health plans regarding their benefits may be confusing, especially with respect to benefit rights. The Department of Insurance maintains a Division of Consumer Services and the Department of Justice maintains a Consumer Protection Division to assist insureds with questions and complaints about their health insurance coverage, etc.

Bill Analysis:
Section 1.6 creates a Managed Care Patient Assistance Program. The Governor will appoint the Director. The Program will assist persons enrolled in a managed care organization (MCO). The Office would have the following duties and responsibilities:

1. Develop and distribute educational and informational materials for consumers explaining their rights and responsibilities as managed care plan enrollees.
2. Assist enrollees with the grievance, appeal, and external review procedures.
3. Publicize the Office of the Managed Care Patient Assistance Program.
4. Answer inquiries posed by consumer and refer inquiries of a regulatory nature to staff within the Department of Insurance.
5. Advise enrollees about the utilization review process.
6. Compile data on the activities of the Office, and evaluate such data to make recommendations as to the needed activities of the Office.
7. Report annually to the General Assembly.

SECTION 2.1. Managed Care Reporting and Disclosure Requirements to Plan Participants

Current Law:
G.S. 58-3-191 require health plans to make reports to the Department of Insurance and to make certain disclosures to plan participants upon request.

Bill Analysis:
Section 2.1 amends the disclosure requirements currently set forth in G.S. 58-3-191 regarding the health plan's "restrictive formularies." The statute is amended to conform and clarify that the plan must disclose the plan's "closed formularies and restricted access drugs and devices."

SECTION 2.2. Provider Directory Information

Current Law/Practice:
Provider directory information is important to consumers when they are selecting a health plan, and consumers sometimes have difficulty in obtaining complete and/or updated directory information. Currently there are no statutory standards for insurers or health benefit plans to distribute provider network directories to enrollees or to update the information they provide voluntarily.

Bill Analysis:
Section 2.2 amends Article 3 of Chapter 58 to add a new section to require health plans that utilize a provider network to develop a listing of all participating providers and update the listing at least annually. The health plan must also provide enrollee access to a telephonic system and MAY provide an on-line system to access up-to-date information. The directory must include the following minimum information (to the extent known) in addition to name, address, etc., about each provider:

- Area of specialty (if applicable);
- An indication of whether the provider may be selected as a primary care provider;
- Whether the provider is accepting new patients, and any restrictions that may limit the enrollee's access to the provider;
- Types of participating providers; and, upon request of a provider, the names of any allied health professionals that work with the provider.

SECTION 2.3. Disclosure of Payment Obligations

Current Law/Practice:
PPO (Preferred Provider Organizations) plans are not required to guarantee that participating providers will not bill enrollees for the difference between the payment amount specified in the provider contract and the provider's actual charges. (i.e., balance bill). In any case where the insurer bases its payment to a provider or benefit to the insured on an amount other than actual provider charges and has not arranged to prohibit balance billing, a provider can balance bill a patient for any charges that remain unpaid. When this occurs, the member's share of the bill may actually be higher than the nominal share of costs advertised in the policy. This is confusing to enrollees, especially when they believe that their benefits will be reduced by only a defined percent when they receive care from a non-network provider. Even though PPO policies do state that the insurer will base its benefit on the plan's "allowed amount" or "usual, customary, and reasonable charge," the insured has no information to evaluate the impact of such a provision.

Bill Analysis:
Section 2.3 amends Article 3 of Chapter 58 to add a new section that will require health benefit plans (PPOs) that do not utilize the fixed dollar co-payment method to calculate benefit amounts for covered services to:

- Explain how the plan calculates its share and the insured's share of the claim
- Indicate whether the insured may be liable for paying any excess amount.
- Indicate which party is responsible for filing a claim or bill with the insurer.
- Include information about how the actual calculation was made for each claim.
- *Notice Requirement*: If an insured is liable for an amount that differs from a fixed dollar co-payment or from a stated coinsurance percentage, and the provider is allowed to balance bill the insured, then the plan must include in plan materials and its marketing and advertising materials a notice advising that the insured's actual share of a claim may exceed the stated coinsurance percentage because the provider charges are not used to determine the plan's and the insurer's payment obligations.

SECTION 3.1. Clinical Trials/Mandated Coverage

Current Law: The Teachers' and State Employees' Comprehensive Major Medical Plan provides limited coverage of medically necessary health care services associated with investigational treatment protocols provided in phase III and IV clinical trials, and in phase II clinical trials when approved by the Plan.

Bill Analysis:

Section 3.1 amends Article 3 of Chapter 58 to add a new section to require all health benefit plans to provide limited coverage of medically necessary costs of health care services associated with participation in a covered clinical trial, which is limited to a phase III or IV clinical trials designed to evaluate new treatments, including prescription drugs and that meet a number of requirements outlined in the section. Costs of services that are not health care services or are not related to the direct clinical management of the patient are not covered.

SECTION 3.2. Newborn Hearing Screening/Mandated Coverage

Current Law: No current mandate under NC law. G.S. 130A-125, the Newborn Screening Program, requires each newborn to receive a hearing screening.

Bill Analysis:

Section 3.2 amends Article 3 of Chapter 58 to add a new section to require health benefit plans to provide coverage for newborn hearing and screening ordered by physicians pursuant to G.S.130A-125.

SECTIONS 4.1-4.5. Independent, External Review

Sections 4.1-4.4 make non-substantive, organizational changes to Article 50 of Chapter 58.

Section 4.5 adds a new Part to Article 50 of Chapter 58 to require insurers to establish procedures to allow enrollees access to an independent, external review of decisions upholding a denial of a requested covered service and provides standards for those procedures.

Current Law: The following is an explanation of the current appeal procedures available under G.S. 58-50-61 and 58-50-62. Section 4.5 would amend Article 50 of Chapter 58 to add an additional <u>independent</u> review procedure.

North Carolina law provides for a two-step internal appeal and grievance procedure that allows consumers to appeal denials of preauthorization's of covered services or other matters in dispute between the consumer and the health benefit plan. Consumers whose appeal of a preauthorization denial or whose first-level grievance review has been decided in favor of the insurer have a right to file a written grievance with the insurer and to have a panel investigate and make a determination regarding the grievance. Consumers also have a right to request that the review be conducted expeditiously, under certain circumstances.

Appeals of Utilization Review Decisions: Under current law, when a consumer requests authorization of a particular procedure or service or continued authorization of ongoing care, the insurer must decide whether to authorize within two business days of the request. If the insurer denies authorization (referred to as a noncertification), the consumer may formally appeal the denial. This formal appeal procedure allows the consumer to explain why the procedure should have been authorized. This appeal must be reviewed by at least one medical doctor, licensed in NC, who was not involved in the denial. The insurer must issue a written decision to the consumer and the health care provider within *30 days* of the request

for review. The insurer must provide an expedited review and issue a decision within *4 days* when an expedited decision is necessary to avoid seriously jeopardizing the life or health of the patient.

First-Level Grievance Appeal: If the dispute concerns a matter of dissatisfaction *other* than a request for covered services, the consumer has a right to a formal review of the grievance. The current law requires that the insurer select someone with appropriate expertise, who was not involved in the matter, to evaluate the grievance. A written decision must be issued within 30 days of the request.

Second-Level Grievance Appeal: If the consumer is dissatisfied with the outcome of the first level grievance appeal, or of the appeal of the denial of preauthorization of a request for a covered service, the consumer has a right to file a formal, second-level grievance appeal with the insurer. At this stage, persons who were not previously involved in the matter, who are not employed by the insurer and who do not have a financial interest in the outcome of the appeal, must evaluate the matter giving rise to the appeal. *However, these persons are appointed to serve on the panel by the insurer.*

When the grievance concerns a utilization review matter or clinical issue, all members of the review panel must be health care professionals with appropriate expertise, including at least one clinical peer. One member of the panel may be an employee of the insurer if the panel is made up of three or more persons and the insurer included a clinical peer in the review of an appeal or first level grievance. The review must be held within *45 days* of receipt of request and a written decision must be provided to the consumer *7 days* after the review meeting. An expedited review of the second-level grievance must be provided and a decision rendered within 4 days, if this timeframe is necessary to avoid seriously jeopardizing the life or health of the patient.

Bill Analysis of Section 4.5

Section 4.5 would add a new Part to Article 50 of Chapter 58, entitled "Health Benefit Plan External Review." The following chart provides a brief explanation of each of the key features of the proposal.

General Features of External Review Plan	
Benchmark Standards for an Independent External Review Plan.	1. Requires health plans to establish independent external review procedures for covered persons to appeal internal review decisions upholding a denial of a requested covered service. 2. Applies to all persons that provide or perform utilization review. 3. The insurer, not the covered person, pays for the external review. 4. No minimum dollar threshold. Effective date: December 1, 2002.

Notice Standard: G.S. 58-50-77	
Full Notice to Covered Persons Required.	1. The insurer is required to provide written notice of the right to seek the independent appeal. 2. The notice must tell the covered person what procedures to follow to request an *expedited* review if one is warranted. 3. The insurer must inform the covered person upfront about the review process and what kind of information the covered person can provide in support of the appeal.
Internal Review Required: G.S. 58-50-79	
Exhaustion of Internal Grievance Process.	1. The insurer's internal grievance process must first be exhausted. 2. Except for retrospective review decisions, the internal review process is *deemed* exhausted if the insurer has failed to make a decision within 45 days concerning a second –level grievance appeal. 3. Exception: If an expedited external appeal is requested and approved by the Commissioner or insurer *waives* the requirement.
Standard External Review Procedures	
Filing Deadline for Covered Person. G.S. 58-50-80(a).	1. Covered person must file a written request within *60 days* after receiving the final decision of the internal review. 2. Exception: If an expedited external appeal is requested and approved.
Requirements for the Commissioner of Insurance Once a Request is Filed. G.S. 58-50-80(b) and (c).	1. The Commissioner must *immediately* send a copy of the request to the insurer and complete a preliminary review of the request *within five days* to make sure it meets all the filing requirements.
If Request is Incomplete. G.S. 58-50-80(d).	1. The Commissioner must request necessary information from the covered person. The covered person has 90 days from the date of the appeal decision to submit.
If Request is Not Accepted. G.S. 58-50-80(d).	1. The Commissioner must inform the covered person and the insurer *in writing* of the reasons the request was not accepted. There is no appeal to the Commissioner's decision.
If Request is Complete and Accepted: Duties of Commissioner. G.S. 58-50-80(i)-(j).	1. The covered person and the insurer must be *immediately* notified in writing. 2. The covered person has 7 days to submit

	additional information and supporting documentation to the Commissioner. 3. The Commissioner will assign an independent review organization (IRO). 4. The Commissioner forwards all information and supporting documents to the IRO, insurer and the covered person.
If Request is Complete and Accepted: Duties of Insurer. G.S. 58-50-80(g) and (h).	1. Within *7 days* of receipt of notice that request was complete and accepted, the insurer must provide all documents and information considered in the internal review process to the designated IRO. 2. Penalty for failure to supply information within 7 days: The IRO is authorized to terminate the review and reverse the internal review decision.
Reconsideration of the Internal Review Decision. G.S. 58-50-80(i)-(j).	1. The insurer has the option of informally reconsidering and reversing its internal review decision based on the information forwarded by the Commissioner. 2. Reconsideration may not be used to delay the external review timeline.
Deadline for External Review Decision. G.S. 58-50-80(e).	1. IRO must make its decision within *45 days* from the date the covered person filed the written request with the Commissioner.
Decision is Binding. 58-50-84	1. Binding on the covered person, except to the extent that other remedies are available under State or federal law. 2. Binding on the insurer. If the IRO reverses the internal review decision, the insurer must *immediately* process the claim accordingly.
Expedited External Review Procedures	
Criteria for Requesting an Expedited External Review. 58-50-82(a)	1. The timeframe for the completion of the *2nd level internal grievance review* is such that it would reasonably be expected to seriously jeopardize the life or the health of the covered person or jeopardize the covered person's ability to regain maximum function. OR 2. The timeframe for the completion of a *standard external* review process is such that it would reasonably be expected to seriously jeopardize the life or the health of the covered person or jeopardize the covered person's ability to regain maximum

	function. OR 3. The covered person has lost the first level internal appeal and the subject of appeal concerns an admission, availability of care, continued stay, or a health care service provided under emergency circumstances AND the covered person is still a patient in the facility.
Differences Between Expedited and Standard External Review Procedures.	1. The request may be made *orally* instead of in writing. 2. The Commissioner must *immediately* perform its duties instead of within 5 days. 3. The Commissioner must consult with a medical professional who is not affiliated with the organization and who will not be assigned to conduct the external review as to whether the review should be reviewed on an expedited basis BEFORE the Commissioner makes the assignment. 4. The insurer must *immediately* provide all documents and information considered in the noncertification decision by telephone, fax or email. 5. The IRO must make its decision within 4 days.
Retrospective Non-Certification Appeals	
Appeal of Claim Denial for Services Already Provided. 58-50-79(c).	1. The enrollee *must* exhaust internal appeal before a request for an external appeal may be approved. 2. The enrollee does not have a right to an *expedited* external review. 3. Retrospective review includes review of claims for emergency services to determine whether the 'prudent layperson standard' has been met.
Informal Reconsideration of Grievances	
Deadline to Issue a Decision.	1. If an insurer is unable to render an informal reconsideration decision within 10 days, the insurer must consider the request for informal reconsideration a request for a formal internal review unless the enrollee requests an informal review before the 10th day.

Approval of Independent Review Organizations	
Commissioner Approves. G.S. 58-50-85.	1. Organizations must submit an application to the Commissioner.. 2. The Commissioner issues approval only if the organization meets minimum statutory qualifications. 3. Approval is valid for two years. 4. The Commissioner must terminate approval if the organization is not meeting the minimum requirements. 5. Commissioner may deem approval if IRO is accredited by a National Accreditation Organization.
Minimum Qualifications for IROs. 58-50-87(a).	1. The IRO must have quality assurance mechanisms in place. 2. The IRO must maintain a toll-free information line. 3. The IRO must have a program for credentialing clinical peer reviewers. 4. The IRO must agree to contractual terms or written requirements established by the Commissioner. 5. Must have consult with a medical doctor licensed to practice in North Carolina to advise the IRO on issues related to local standards of practice.
Minimum Qualifications of Reviewers. 58-50-87(b).	1. All must be medical doctors or other appropriate health care providers who may or may not be licensed to practice in North Carolina. 2. All must have clinical experience and expertise in the treatment of the injury, illness, or medical condition that is the subject of the review. 3. All must have no history of disciplinary actions against them that raise a question of their competence or moral character.
Conflict of Interest Protections. 58-50-87(d).	1. The IRO may not have any financial association with any health benefit plan or provider organization or trade association. 2. No IRO or clinical reviewer may have a material professional, familial, or financial conflict of interest.

Competitive Selection of IROs. G.S. 58-50-94.	1. The Commissioner must publish RFPs from IROs that want to be an approved IRO. 2. The Commissioner will determine which applicants meet the requirements for approval. 3. In making the selection, the Commissioner must consult with representatives of insurers, providers, and insureds. 4. The Commissioner must consider cost, quality, statutory requirements, and assurance of consumer choice and fair competition. 5. The Commissioner must ensure that at least one IRO is capable of reviewing cases involving highly specialized services and treatments.
Immunity From Liability	
Hold Harmless. G.S. 58-50-89.	1. The Commissioner, the IRO and clinical reviewers are immune from liability to persons for opinions made pursuant to the review process, unless the opinion was made in bad faith or involved gross negligence.
Reporting Requirements by IRO	
Required Written Records. G.S. 58-50-90.	1. IROs must keep written records on all requests for external review. The records must be retained for at least 3 years. 2. IROs must report to the Commissioner at least annually. 3. The report must include the number and outcome of requests for external review, the average length of time of the reviews, a summary of the types of claims, and the number of requests that were terminated as a result of reconsideration by the insurer. 4. Insurers must keep written records for each type of health benefit plan offered by the insurer on all requests for external review. These records must be retained for 3 years.
Disclosure Requirements by Insurer	
Insurer Must Disclose Information to Enrollee. G.S. 58-50-93.	1. The insurer must describe the external review procedures in its handbook and inform all enrollees of their right to an external review and how and when to request it.

Funding	
Payment of fees charged by the IRO. G.S. 58-50-92.	1. The insurer must reimburse the Department of Insurance for the fees charged by the IRO.

SECTION 4.6 makes conforming amendments to internal appeal provisions of current law.

SECTION 4.7 Health Plan Liability: A new Article 1G is added to Chapter 90 to be entitled "Health Care Liability"

Definitions:

- A *managed care entity* is defined as an insurer that delivers, administers, or undertakes to provide for, arrange for, or reimburse for, health care services, or assumes the risk for the delivery of health care services. Specifically excluded from the definition are employers who purchase coverage for or on behalf of their employees and health care providers, including (1) individuals who are licensed health care providers under Chapter 90 of the General Statutes and (2) health care facilities licensed under Chapters 131E (hospitals) and 122C (mental health facilities and hospitals) and their agents and employees, including any officers and directors of health care facilities.
- A *health care decision* means a determination which is subject to external review under Part 4 of Article 50 of the General Statutes and is also a determination that:
  - A request for approval of coverage that is denied or reduced because it is not medically necessary or appropriate or because it is investigational or experimental and
  - The determination affects the quality of the diagnosis, care, or treatment provided under the plan.
- A *successor external review process* means an external review process equivalent in all respects to G.S. 58-50-75 through G.S. 58-50-95 approved by the Department and implemented by a health benefit plan in the event that G.S. 58-50-75 through 58-50-95 are found by a court of competent jurisdiction to be void, unenforceable, or pre-empted by federal law, in whole or in part.

Imposition of Duty of Care: The Article places a duty upon the managed care entity to exercise ordinary care when making health care decisions. Actions brought under this Article are not medical malpractice actions as defined in Article 1B of Chapter 90.

- Ordinary care is defined to mean that degree of care prevailing at the time the managed care entity made the health care decision that a managed care entity of ordinary prudence would use under the same or similar circumstances.
- Liability is imposed for damages resulting from harm to an insured or enrollee proximately caused by the managed care entity's failure to exercise ordinary care in making health care treatment decisions.

Vicarious Liability: Managed care entities are liable for damages proximately caused by the failure of its agents, employees, and representatives over whom it has exercised influence and control, to exercise ordinary care in making health care treatment decisions.

Safe Harbors:

- The fact that a physician or health care provider is listed in the managed care entity's directory of approved providers is not enough to prove that the physician or health care provider is an agent or employee of the managed care entity.
- The Article does *not* create any risk of liability on the part of an employer or employer group purchasing organization that purchases a health benefit plan or assumes risk on behalf of its employees.
- The Article does *not* create any risk of liability on a physician or health care provider in addition to medical malpractice liability that exists under current law. No managed care entity held liable under the Article shall be entitled to contribution from a physician or health care provider.

Statutory Defense to Liability: The managed care entity nor its employee, agent, or representative have participated or had any influence or control over the health care treatment decision.

No Hold Harmless Provisions Allowed: The Article prohibits a managed care entity from entering into contracts with employers and physicians that include a hold harmless clause or an indemnification provision for the acts or conduct of the managed care entity.

Exhaustion of administrative remedies required. An enrollee may not bring an action under the Article unless they first exhaust their administrative remedies.

Admissibility of External Review Decision and Documents:

- Any information, documents, or other records or materials considered by the Independent Review Organization in conducing the review are admissible in accordance with Chapter 8 of the North Carolina General Statutes and the North Carolina Rules of Evidence.
- The external review decision is admissible if an adequate foundation for admissibility is laid.

Cap on Punitive Damages. Actions brought under the Article would be subject to the limitations and restrictions placed on punitive damage awards by Chapter 1D of the General Statutes.

- The award for punitive damages may not exceed three times the compensatory damages or $250,000 whichever is greater.

Separate Trials: Upon a motion of any party to an action under the act to order a separate trial of any claim, cross-claim, counterclaim, or third-party claim involving a physician or other health care provider.

SECTION 5(a). Makes a conforming change to 58-2-105, to authorize the Department of Insurance to disclose a patient' s medical records to an independent review organization under specified limitations, and to extend a duty of confidentiality upon the IRO.

SECTION 5(b) and (c). Make conforming changes to the definition of medically necessary.

SECTION 6 is a severability clause.

SECTION 7 makes sections 3.1 and 3.2 (mandated benefits) effective December 1, 2001, sections 4.1-4.8 (External Review and HMO liability) effective on March 1, 2002; and the remainder of the act is effective when it becomes law and applies to health benefit plans that are delivered, issued for delivery, or

renewed on or after January 1, 2002. Section 1.6 (Patient Assistance Program) is effective January 1, 2002. Nothing in this act shall obligate the General Assembly to appropriate funds to implement this act.

VISITOR REGISTRATION SHEET

Health
Name of Committee

July 31, 2001
Date

VISITORS:. PLEASE SIGN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Robin A. James	Carolina Center for Health Care
Lori Ann Harris	L.A. Harris & Assoc
Margaret Westbrook	Kennedy Covington
Shawn Bram	MAMH
Joyce Peters	MAMH
Elizabeth Quats	NCPIRG
Mary Abernethy	Poyner & Spruill
M D Jones	NCMHD
John Bowdish	Alley Assoc
Julia White	NC DOJ
Josh Stein	AGO
Adam Searing	NCHAC
Mike Okun	NC State AFL CIO
Drew Nelson	Rep Hackney's Office
David Warren	DC-NC
Jack Hamlett	N.C. Sr. Tar Heel Legis
Dick Taylor	NCAOC
Hallie Bonnell	NCAOC
[illegible]	NCDHHS
[illegible]	N.C. Advis Com on Cancer Coal. & Cancer Control
Sen Bob Carpenter	Senate
JOHN THOMPSON	AMERICAN CANCER SOC.
Abby Carter	National MS Society
Gary Robertson	AP
DR. BILL SUGG	CHARLOTTE MEDICAL CLINIC
Mark Stenmark	BCBSNC
Nicole Duckenberry	NC EQUITY
Jennifer M. Sullivan	NC. NASW

VISITOR REGISTRATION SHEET

Health
Name of Committee

July 31, 2001
Date

VISITORS:. PLEASE SIGN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Barbara Cansler	MFES, PA
[illegible]	NCMS
Julie Campbell	NCCBI
Leslie Bensaw	NCCBI
STEVE ROBERTS	AARP
McPherson	Dept of Justice
[illegible]	NCAHP
PERRI MORGAN	NFIB
[illegible]	NCAHP
Julianne Burdett	NCAHP
PAUL MALTONEY	NCAHP
Phil Kirk	NCCBI
[illegible]	NCFIS
Michelle Frazier	NC Bar Assoc.
Ellen Murphy	Hunton & Williams
Sam Taylor	DDPNC
Beth [illegible]	BCBSNC
Delanne Nelson	BCBSNC
Ken Wright	BCBSNC
Sharla M McClung	NCDOT
Dascril Pippen	NCDOT
Barbara Brooks Burke	NCDOT
Bill [illegible]	NCDOT
Ben Dover	NCDORD
[illegible]	NCAHP
Robert PASchal	Young, Moore
[illegible]	NCAIG
Audrey A Galloway	NCAE

AGENDA

HOUSE COMMITTEE ON HEALTH
TUESDAY, August 7, 2001
12:00 Noon, ROOM 415 LOB

OPENING REMARKS

Rep. Thomas E. Wright
Chairman

BILLS TO BE DISCUSSED

SB-199 MANAGED CARE PATIENTS' BILL OF RIGHTS-(Sen. Wellons)

COMMENTS

ADJOURNMENT

MINUTES

HOUSE COMMITTEE ON HEALTH

TUESDAY, AUGUST 7, 2001

12:00 NOON, ROOM 415 LOB

The House Committee on Health met on Tuesday, August 7, 2001 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-199 MANAGED CARE PATIENTS' BILL OF RIGHTS-(Sen. Wellons)

Chairman Wright recapped the last discussion of SB-199 at the previous Committee on Health meeting. The motion made by Rep. Earle to give the House proposed committee substitute a favorable report was on the table.

Rep. Edwards sent forth an amendment and moved for adoption of the amendment.

Rep. Edwards explained the amendment. Dr. Joseph Pagono, of the UNC Cancer Center, spoke on Phase II trials in the bill. Dr. Michael Colvin, Director, of the UNC Cancer Center, also spoke on the bill. Sen. Wellons asked about the cost of phase II trials. Linda Attarian, staff, responded. Paul Mahoney, of the NC Association of Health Plans, Inc. commented on the Phase II trials and cost. Dr. Pagono responded. Rep. Insko asked about the percentage of drugs that go through Phase II that are effective for Phase III or IV. Dr. Colvin responded. Rep. Barnhart commented on the bill. Rep. Baddour asked if the bill could be drafted in a way that the drugs would not be required to be covered, but would be required to cover associated care. Rep. Hackney referred members to page 16, subsection C of the bill. Rep. Baddour responded and requested that the amendment be displaced. Rep. Hackney asked Dr. Pagono and Dr. Colvin about their interpretation of the bill. Dr. Pagono responded. Rep. Justus suggested that Rep. Edwards modify his amendment. Rep. Edwards withdrew the amendment for further language modification.

Rep. Nye sent forth an amendment and moved for adoption.

Dascheil Propes, of the Department of Insurance, spoke on the bill. Rep. Nye asked about the fees. Dascheil Propes responded.

Chairman Wright called the question on Rep. Nye's amendment for adoption. So moved.

Rep. Baddour stated that he would like to hear from the people who have an interest in the bill. Rep. Sherrill commented on the protection of State Employees in the bill and stated that further research was being done on the plan coverage. Adam Searing, of the North Carolina Health Access Coalition, spoke on the bill and stressed his support of the bill. Rep. Brubaker asked about actuarial notes on the bill as it stands. Chairman Wright stated that a fiscal note would be provided for the bill by the next meeting. Pam Silberman, Associate Director of the Sheps Center for Health Services Research, spoke in support of the bill. Rep. Brubaker asked Pam Silberman if she referred to the original bill or the House proposed committee substitute for support. Pam Silberman responded that she supported both bills and both bills reflected the work of the study commission. Rep. Edwards asked Pam Silberman about a cap on legal suits. Pam Silberman responded. Rep. Barnhart asked about the fiscal note to members before the next meeting. Chairman Wright responded.

Rep. Edwards sent forth an amendment.

Sam Taylor, of the Licensed Professional Counselors Association, spoke on the amendment. Rep. Baddour asked if there were any objections to the language of the amendment. Rep. Hackney spoke on the amendment and suggested that the language be rewritten.

Rep. Edwards withdrew the amendment.

Chairman Wright stated that the Committee on Health would continue the discussion at the next meeting.

The meeting adjourned at 12:45pm.

Rep. Thomas E. Wright, Chairman

Vanda Wilson-Wormack, Committee Assistant

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2001

S 2

SENATE BILL 199

Insurance and Consumer Protection Committee Substitute Adopted 4/25/01

Short Title: Managed Care Patients' Bill of Rights. (Public)

Sponsors:

Referred to:

February 22, 2001

A BILL TO BE ENTITLED

AN ACT TO IMPROVE ACCESS TO HEALTH CARE ADVICE, INFORMATION, AND SERVICES TO COVERED PERSONS UNDER HEALTH BENEFIT PLANS; ESTABLISH STANDARDS FOR HEALTH PLAN DISCLOSURES TO CONSUMERS; ESTABLISH A PATIENTS' ASSISTANCE PROGRAM; REQUIRE COVERAGE FOR CLINICAL TRIALS AND NEWBORN HEARING SCREENING; PROVIDE STANDARDS FOR INDEPENDENT REVIEW OF NONCERTIFICATIONS BY AN INSURER OR MANAGED CARE PLAN, AND TO HOLD MANAGED CARE ENTITIES LIABLE FOR HARM CAUSED TO INSUREDS OR ENROLLEES BY THE FAILURE TO EXERCISE ORDINARY CARE IN MAKING TREATMENT DECISIONS.

The General Assembly of North Carolina enacts:

PART I. PATIENT ACCESS TO MEDICAL ADVICE AND CARE

Subpart A. Continuity of Care in HMOs

SECTION 1. Article 67 of Chapter 58 of the General Statutes is amended by adding a new section to read:

"§ 58-67-88. Continuity of care.

(a) Definitions. – As used in this section:

(1) 'Ongoing special condition' means:

a. In the case of an acute illness, a condition that is serious enough to require medical care or treatment to avoid a reasonable possibility of death or permanent harm.

b. In the case of a chronic illness or condition, or a disease or condition that is life-threatening, degenerative, or disabling, and requires medical care or treatment over a prolonged period of time.

c. Pregnancy, from the start of the second trimester.
d. Terminal illness.

(2) 'Terminal illness' means an individual has a medical prognosis that the individual's life expectancy is six months or less.

(3) 'Terminated or termination'. – Includes, with respect to a contract, the expiration or nonrenewal of the contract, but does not include a termination of the contract by an HMO for failure to meet applicable quality standards or for fraud.

(b) Termination of Provider. – If a contract between an HMO benefit plan that is not a point-of-service plan and a health care provider is terminated by the provider or by the HMO, or benefits or coverage provided by the HMO are terminated because of a change in the terms of provider participation in a health benefit plan of an HMO that is not a point-of-service plan, and an individual is covered by the plan and is terminally ill or undergoing treatment from the provider for an ongoing special condition at the time of the termination, then, the HMO shall:

(1) Upon termination of the contract by the HMO or upon receipt by the HMO of written notification of termination by the provider, notify the individual on a timely basis of the termination and of the right to elect continuation of coverage of treatment by the provider under this section.

(2) Subject to subsection (h) of this section, permit the individual to elect to continue to be covered with respect to the terminal illness or treatment by the provider of the ongoing special condition during a transitional period provided under this section.

(c) Newly Covered Insured. – Each health benefit plan offered by an HMO that is not a point-of-service plan shall provide transition coverage to individuals who are newly covered under the health benefit plan because the individual's employer has changed health benefit plans, and the HMO shall:

(1) Notify the individual at the time of enrollment of the right to elect continuation of coverage of treatment by the provider under this section.

(2) Subject to subsection (h) of this section, permit the individual to elect to continue to be covered with respect to the terminal illness or treatment by the provider of the ongoing special condition during a transitional period provided under this section.

(d) Transitional Period: In General. – Except as otherwise provided in subsections (e), (f), and (g) of this section, the transitional period under this subsection shall extend up to 90 days, as determined by the treating health care provider, after the date of the notice to the individual described in subdivision (b)(1) of this section or the enrollment in a new plan described in subdivision (c)(1) of this section.

(e) Transitional Period: Scheduled Surgery, Organ Transplantation, or Institutional Care. – If surgery, organ transplantation, or other inpatient care was scheduled for an individual before the date of the notice required under subdivision

(b)(1) of this section, or the enrollment in a new plan described in subdivision (c)(1) of this section or if the individual on that date was on an established waiting list or otherwise scheduled to have the surgery, transplantation, or other inpatient care, the transitional period under this subsection with respect to the surgery, transplantation, or other inpatient care shall extend beyond the period under subsection (d) of this section through the date of discharge of the individual after completion of the surgery, transplantation, or other inpatient care, and through postdischarge follow-up care related to the surgery, transplantation, or other inpatient care occurring within 90 days after the date of discharge.

(f) Transitional Period: Pregnancy. – If an insured has entered the second trimester of pregnancy on the date of the announcement of the termination of the provider status under subdivision (b)(1) of this section, or the enrollment in a new plan described in subdivision (c)(1) of this section, and the provider was treating the pregnancy before the date of the announcement of the termination, or the enrollment in the new plan, the transitional period with respect to the provider's treatment of the pregnancy shall extend through the provision of 60 days of postpartum care.

(g) Transitional Period: Terminal Illness. – If an insured was determined to be terminally ill at the time of a provider's termination of participation, or at the time of enrollment in the new plan, and the provider was treating the terminal illness before the date of termination or enrollment in the new plan, the transitional period shall extend for the remainder of the individual's life with respect to care directly related to the treatment of the terminal illness or its medical manifestations.

(h) Permissable Terms and Conditions. – An HMO may condition coverage of continued treatment by a provider under subdivision (b)(2) or (c)(2) of this section upon the following terms and conditions:

(1) The provider agrees to accept reimbursement from the HMO and individual involved, with respect to cost-sharing, at the rates applicable before the start of the transitional period as payment in full.

(2) The provider agrees to adhere to the quality assurance standards of the HMO responsible for payment under subdivision (1) of this subsection and to provide to the HMO necessary medical information related to the care provided.

(3) The provider agrees otherwise to adhere to the HMO's established policies and procedures for participating providers, including procedures regarding referrals and obtaining prior authorization, providing services pursuant to a treatment plan, if any, approved by the HMO, and member hold harmless provisions.

(4) The insured notifies the HMO within 45 days of the date of the notice described in subdivision (b)(1) of this section or the new enrollment described in subdivision (c)(1) of this section.

(5) The provider agrees to discontinue providing services and refer the enrollee to a network provider by the end of the transition period.

(i) Construction. – Nothing in this section:

(1) Requires the coverage of benefits that would not have been covered if the provider involved remained a participating provider.

(2) Requires an HMO to offer a transitional period when the HMO terminates a provider's contract for reasons relating to quality of care or fraud; and refusal to offer a transitional period under these circumstances is not subject to the grievance review provisions of G.S. 58-50-62.

(3) Prohibits an HMO from extending any transitional period beyond that specified in this section.

(4) Prohibits an HMO from terminating the continuing services of a provider as described in this section when the HMO has determined that the provider's continued provision of services may result in, or is resulting in, a serious danger to the health or safety of the enrollee. Such terminations shall be in accordance with the contract provisions that the provider would otherwise be subject to if the provider's contract were still in effect.

(j) Disclosure of Right to Transitional Period. – Each HMO shall include a clear description of an insured's rights under this section in its evidence of coverage and summary plan description."

Subpart B. Extended or Standing Referral to Specialist

SECTION 1.2. G.S. 58-3-223 reads as rewritten:

"**§ 58-3-223. Managed care access to specialist care.**

(a) Each insurer offering a health benefit plan that does not allow direct access to all in-plan specialists shall develop and maintain written policies and procedures by which an insured may receive an extended or standing referral to an in-plan specialist. The ~~procedure~~insurer shall provide for an extended or standing referral to a specialist if the insured has a serious or chronic degenerative, disabling, or life-threatening disease or condition, which in the opinion of the insured's primary care physician, in consultation with the specialist, requires ongoing specialty care. The extended or standing referral shall be for a period not to exceed 12 months and shall be made under a treatment plan coordinated with the insurer in consultation with the primary care physician, the specialist, and the insured or the insured's designee.

(b) As used in this section:

(1) 'Health benefit plan' has the meaning applied in G.S. 58-3-167.~~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 are 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 under Article 65 of this Chapter, or a health maintenance organization under Article 67 of this Chapter, or a multiple employer welfare arrangement under Article 49 of this Chapter.~~has the meaning applied in G.S. 58-3-167.

(3) 'Serious or chronic degenerative, disabling, or life-threatening disease or condition' means a disease or condition, which in the opinion of the patient's treating primary care physician and specialist, requires frequent and periodic monitoring and consultation with the specialist on an ongoing basis.

(4) 'Specialist' includes a subspecialist."

SECTION 1.2A. 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 the out-of-network benefit levels offered under the insured's approved health benefit ~~plan~~ plan, including an insured receiving an extended or standing referral under G.S. 58-3-223, unless contracting health care providers able to meet health needs of the insured are reasonably available to the insured without unreasonable delay."

Subpart C. Selection of Specialist as Primary Care Physician

SECTION 1.3. Article 3 of Chapter 58 of the General Statutes is amended by adding a new section to read:

"§ 58-3-230. Selection of specialist as primary care provider.

(a) Each insurer shall have a procedure by which an insured diagnosed with a serious or chronic degenerative, disabling, or life-threatening disease or condition, either of which requires specialized medical care may select as his or her primary care physician a specialist with expertise in treating the disease or condition who shall be responsible for and capable of providing and coordinating the insured's primary and specialty care. If the insurer determines that the insured's care would not be appropriately coordinated by that specialist, the insurer may deny access to that specialist as a primary care provider.

(b) The selection of the specialist shall be made under a treatment plan approved by the insurer, in consultation with the specialist and the insured or the insured's designee and after notice to the insured's primary care provider, if any. The specialist may provide ongoing care to the insured and may authorize such referrals, procedures, tests, and other medical services as the insured's primary care provider would otherwise be allowed to provide or authorize, subject to the terms of the treatment plan. Services provided by a specialist who is providing and coordinating primary and specialty care remain subject to utilization review and other requirements of the insurer, including its requirements for primary care providers."

Subpart D. Direct Access to Pediatrician

SECTION 1.4. Article 3 of Chapter 58 of the General Statutes is amended by adding a new section to read:

"**§ 58-3-240. Direct access to pediatrician for minors.**

Each insurer offering a health benefit plan that uses a network of contracting health care providers shall allow an insured to choose a contracting pediatrician in the network as the primary care provider for the insured's children who are under the age of 18."

Subpart E. Access to Prescription Drugs

SECTION 1.5. G.S. 58-3-221 reads as rewritten:

"**§ 58-3-221. Access to nonformulary and restricted access prescription drugs.**

(a) If an insurer maintains one or more closed formularies for or restricts access to covered prescription drugs or devices, then the insurer shall do all of the following:

(1) Develop the formulary or formularies and any restrictions on access to covered prescription drugs or devices in consultation with and with the approval of a pharmacy and therapeutics committee, which shall include participating ~~providers~~ physicians who are licensed to ~~prescribe prescription drugs or devices.~~ practice medicine in this State.

(2) Make available to participating ~~providers and pharmacists~~ providers, pharmacists, and enrollees the complete drugs or devices formulary or formularies maintained by the insurer including a list of the devices and prescription drugs on the formulary by major therapeutic category

that specifies whether a particular drug or device is preferred over other drugs or devices.

(3) Establish and maintain an expeditious process or procedure that allows an enrollee or a physician acting on behalf of an enrollee to obtain, without penalty or additional cost-sharing beyond that provided for in the health benefit plan, coverage for a specific nonformulary drug or device determined to be medically necessary and appropriate by the participating physician without prior approval from the insurer, after the participating physician notifies the insurer that:

a. Either (i) the formulary alternatives have been ineffective in the treatment of the enrollee's disease or condition, or (ii) the formulary alternatives cause or are reasonably expected by the physician to cause a harmful or adverse clinical reaction in the enrollee; and

b. Either (i) the drug is prescribed in accordance with any applicable clinical protocol of the insurer for the prescribing of the drug, or (ii) the drug has been approved as an exception to the clinical protocol pursuant to the insurer's exception procedure.

(4) Provide coverage for a restricted access drug or device to an enrollee without requiring prior approval if an enrollee's physician certifies in writing that the enrollee has previously used an alternative nonrestricted access drug or device and the alternative drug or device has been ineffective or detrimental to the enrollee's health.

(b) An insurer may not void a contract or refuse to renew a contract between the insurer and a prescribing provider because the prescribing provider has prescribed a medically necessary and appropriate nonformulary or restricted access drug or device as provided in this section.

(c) As used in this section:

(1) 'Closed formulary' means a list of prescription drugs and devices reimbursed by the insurer that excludes coverage for drugs and devices not listed.

(1a) 'Health benefit plan' has definition provided in G.S. 58-3-167. ~~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 are statutorily required to be contained in any liability policy or equivalent self-insurance.~~

(2) 'Insurer' has the meaning provided in G.S. 58-3-167. ~~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, or a multiple employer welfare arrangement under Article 49 of this Chapter~~.

(3) 'Restricted access drug or device' means those covered prescription drugs or devices for which reimbursement by the insurer is conditioned on the insurer's prior approval to prescribe the drug or device or on the provider prescribing one or more alternative drugs or devices before prescribing the drug or device in question.

(d) Nothing in this section requires an insurer to pay for drugs or devices or classes of drugs or devices related to a benefit that is specifically excluded from coverage by the insurer."

Subpart F. Managed Care Patients' Assistance Program

SECTION 1.6. Article _____ of Chapter _____ of the General Statutes is amended by adding the following new section to read:

"§ _____. **Managed Care Patients' Assistance Program.**

(a) The Office of Managed Care Patients' Assistance Program is hereby established. The Director of the Office of Managed Care Patients' Assistance Program shall be appointed by the Governor.

(b) The Managed Care Patients' Assistance Program shall provide information and assistance to individuals enrolled in managed care plans. The Managed Care Patients' Assistance Program shall have expertise and experience in both health care and

advocacy and will assume the specific duties and responsibilities set forth in subsection (c) of this section.

(c) The duties and responsibilities of the Managed Care Patients' Assistance Program are as follows:

(1) Develop and distribute educational and informational materials for consumers, explaining their rights and responsibilities as managed care plan enrollees.

(2) Answer inquiries posed by consumers and refer inquiries of a regulatory nature to staff within the Department of Insurance.

(3) Advise managed care plan enrollees about the utilization review process.

(4) Assist enrollees with the grievance, appeal, and external review procedures established by Article 50 of Chapter 58 of the General Statutes.

(5) Publicize the Office of the Managed Care Patients' Assistance Program.

(6) Compile data on the activities of the Office and evaluate such data to make recommendations as to the needed activities of the Office.

(d) The Director of the Managed Care Patients' Assistance Program shall annually report the activities of the Managed Care Patients' Assistance Program, including the types of appeals, grievances, and complaints received and the outcome of these cases. The report shall be submitted to the General Assembly, upon its convening or reconvening, and shall make recommendations as to efforts that could be implemented to assist managed care consumers."

PART II. HEALTH PLAN DISCLOSURES

Subpart A. Managed Care Reporting and Disclosure Requirements

SECTION 2.1. G.S. 58-3-191(b) reads as rewritten:

"(b) Disclosure requirements. – Each health benefit plan shall provide the following applicable information to plan participants and bona fide prospective participants upon request:

(1) The evidence of coverage (G.S. 58-67-50), subscriber contract (G.S. 58-65-60, 58-65-140), health insurance policy (G.S. 58-51-80, 58-50-125, 58-50-55), or the contract and benefit summary of any other type of health benefit plan;

(2) An explanation of the utilization review criteria and treatment protocol under which treatments are provided for conditions specified by the prospective participant. This explanation shall be in writing if so requested;

(3) If denied a recommended treatment, written reasons for the denial and an explanation of the utilization review criteria or treatment protocol upon which the denial was based;

(4) The plan's ~~restrictive formularies~~ closed formularies, restricted access drugs or devices, or prior approval requirements for obtaining prescription drugs, whether a particular drug or therapeutic class of drugs is excluded from its formulary, and the circumstances under which a nonformulary drug may be covered; and

(5) The plan's procedures and medically based criteria for determining whether a specified procedure, test, or treatment is experimental."

Subpart B. Provider Directory Information

SECTION 2.2. Article 3 of Chapter 58 of the General Statutes is amended by adding a new section to read:

"**§ 58-3-245. Provider directories.**

(a) Every health benefit plan utilizing a provider network shall make a listing of network providers available to insureds and shall update the listing no less frequently than once a year. In addition, every health benefit plan shall maintain a telephone system and may maintain an electronic or on-line system through which insureds can access up-to-date network information. If the health benefit plan produces printed directories, the directories shall contain language disclosing the date of publication, frequency of updates, that the directory may not contain the latest network information, and contact information for accessing up-to-date network information.

(b) Each listing shall include:

(1) The provider's name, address, telephone number, and, if applicable, area of specialty.

(2) Whether the provider may be selected as a primary care provider.

(3) To the extent known to the health benefit plan, an indication of whether the provider:

a. Is or is not currently accepting new patients.

b. Has any other restrictions that would limit an insured's access to that provider.

(c) The listing shall include all of the types of participating providers. Upon a participating provider's written request, the insurer shall also list in the directory, as part of the participating provider's listing, the names of any allied health professionals who provide primary care services under the supervision of the participating provider and whose services are covered by virtue of the carrier's contract with the supervising participating provider and whose credentials have been verified by the supervising participating provider. These allied health professionals shall be listed as a part of the directory listing for the participating provider upon receipt of a certification by the supervising participating provider that the credentials of the allied health professional have been verified."

Subpart C. Disclosure of Payment Obligations

SECTION 2.3. Article 3 of Chapter 58 of the General Statutes is amended by adding a new section to read:

"**§ 58-3-250. Payment obligations for covered services.**

(a) If an insurer calculates a benefit amount for a covered service under a health benefit plan through a method other than a fixed dollar co-payment, the insurer shall clearly explain in its evidence of coverage and plan summaries how it determines its payment obligations and the payment obligations of the insured. The explanation shall include:

(1) An example of the steps the insurer would take in calculating the benefit amount and the payment obligations of each party.

(2) Whether the insurer has obtained the agreement of health care providers not to bill an insured for any amounts by which a provider's charge exceeds the insurer's recognized charge for a covered service and whether the insured may be liable for paying any excess amount.

(3) Which party is responsible for filing a claim or bill with the insurer.

(b) If an insured is liable for an amount that differs from a stated fixed dollar co-payment or may differ from a stated coinsurance percentage because the coinsurance amount is based on a (plan allowance or other such amount rather than the actual charges and providers are permitted to balance bill the insured, the evidence of coverage, plan summaries, and marketing and advertising materials that include information on benefit levels shall contain the following statement: 'NOTICE: Your actual expenses for covered services may exceed the stated [coinsurance percentage or co-payment amount] because actual provider charges may not be used to determine [plan/insurer or similar term] and [insured/member/enrollee or similar term] payment obligations.' "

PART III. MANDATED BENEFITS

Subpart A. Clinical Trials

SECTION 3.1. Article 3 of Chapter 58 of the General Statutes is amended by adding a new section to read:

"**§ 58-3-255. Coverage of clinical trials.**

(a) As used in this section:

(1) 'Covered clinical trials' means phase III and phase IV patient research studies designed to evaluate new treatments, including prescription drugs and that: (i) involve the treatment of life-threatening medical conditions, (ii) are medically indicated and preferable for that patient compared to available noninvestigational treatment alternatives, and (iii) have clinical and preclinical data that shows the trial will likely be

more effective for that patient than available noninvestigational alternatives. Covered clinical trials must also meet the following requirements:

a. Must involve determinations by treating physicians, relevant scientific data, and opinions of experts in relevant medical specialties.

b. Must be trials approved by centers or cooperative groups that are funded by the National Institutes of Health, the Food and Drug Administration, the Centers for Disease Control, the Agency for Health Care Research and Quality, the Department of Defense, or the Department of Veterans Affairs. The health benefit plan may also cover clinical trials sponsored by other entities.

c. Must be conducted in a setting and by personnel that maintain a high level of expertise because of their training, experience, and volume of patients.

(2) 'Health benefit plan' is defined by G.S. 58-3-167.

(3) 'Insurer' is defined by G.S. 58-3-167.

(b) Each health benefit plan shall provide coverage for participation in phase III and phase IV covered clinical trials by its insureds or enrollees who meet protocol requirements of the trials and provide informed consent.

(c) Only medically necessary costs of health care services, as defined in G.S. 58-50-61, associated with participation in a covered clinical trial, including those related to health care services typically provided absent a clinical trial, the diagnosis and treatment of complications, and medically necessary monitoring, are required to be covered by the health benefit plan and only to the extent that such costs have not been or are not funded by national agencies, commercial manufacturers, distributors, or other research sponsors of participants in clinical trials.

(d) Clinical trial costs not required to be covered by a health benefit plan include the costs of services that are not health care services, those provided solely to satisfy data collection and analysis needs, those related to investigational drugs and devices, and those that are not provided for the direct clinical management of the patient. In the event a claim contains charges related to services for which coverage is required under this section, and those charges have not been or cannot be separated from costs related to services for which coverage is not required under this section, the health benefit plan may deny the claim."

Subpart B. Newborn Hearing Screening

SECTION 3.2. Article 3 of Chapter 58 of the General Statutes is amended by adding a new section to read:

"**§ 58-3-260. Insurance coverage for newborn hearing screening mandated.**

(a) As used in this section, the terms 'health benefit plan' and 'insurer' have the meanings applied under G.S. 58-3-167.

(b) Each health benefit plan shall provide coverage for newborn hearing screening ordered by the attending physician pursuant to G.S. 130A-125. The same deductibles, coinsurance, reimbursement methodologies, and other limitations and administrative procedures as apply to similar services covered under the health benefit plan shall apply to coverage for newborn hearing screening."

PART IV. EXTERNAL REVIEW AND MANAGED CARE ENTITY LIABILITY

Subpart A. Independent, External Review Process

SECTION 4.1. The title of Article 50 of Chapter 58 of the General Statutes reads as rewritten:

"Article 50.

General Accident and Health Insurance Regulations."

SECTION 4.2. Article 50 of Chapter 58 of the General Statutes is amended as follows:

(1) By designating G.S. 58-50-1 through G.S. 58-50-45 as Part 1 with the heading "Miscellaneous Provisions."

(2) By designating G.S. 58-50-50 through G.S. 58-50-64 as Part 2 with the heading "PPOs, Utilization Review and Grievances."

(3) By designating G.S. 58-50-65 through G.S. 58-50-70 as Part 3 with the heading "Scope and Sanctions."

(4) By designating G.S. 58-50-75 through G.S. 58-50-95 as Part 4 with the heading "Health Benefit Plan External Review."

(5) By designating G.S. 58-50-100 through G.S. 58-50-156 as Part 5 with the heading "Small Employer Group Health Insurance Reform."

SECTION 4.3. G.S. 58-50-151 is recodified as G.S. 58-51-116.

SECTION 4.4. The prefatory language of G.S. 58-50-61(a) reads as rewritten:

"(a) Definitions. – As used in this ~~section and~~ section, in G.S. 58-50-62, and in Part 4 of this Article, the term:".

SECTION 4.5. Article 50 of Chapter 58 of the General Statutes is amended by adding a new Part to read:

"Part 4. Health Benefit Plan External Review.

"**§ 58-50-75. Purpose, scope, and definitions.**

(a) The purpose of this Part is to provide standards for the establishment and maintenance of external review procedures to assure that covered persons have the opportunity for an independent review of an appeal decision upholding a noncertification or a second-level grievance review decision upholding a noncertification, as defined in this Part.

(b) This Part applies to all persons that provide or perform utilization review. With respect to second-level grievance review decisions, this Part applies only to second-level grievance review decisions involving noncertification decisions.

(c) In addition to the definitions in G.S. 58-50-61(a), as used in this Part:

(1) 'Covered benefits' or 'benefits' means those benefits consisting of medical care, provided directly through insurance or otherwise and including items and services paid for as medical care, under the terms of a health benefit plan.

(2) 'Covered person' means a policyholder, subscriber, enrollee, or other individual covered by a health benefit plan. 'Covered person' includes another person, including the covered person's health care provider, acting on behalf of the covered person.

(3) 'Independent review organization' or 'organization' means an entity that conducts independent external reviews of appeals of noncertifications and second-level grievance review decisions.

"**§ 58-50-76:** Reserved.

"**§ 58-50-77. Notice of right to external review.**

(a) An insurer shall notify the covered person in writing of the covered person's right to request an external review and include the appropriate statements and information set forth in this section at the time the insurer sends written notice of:

(1) An appeal decision under G.S. 58-50-61 upholding a noncertification; and

(2) A second-level grievance review decision under G.S. 58-50-62 upholding the original noncertification.

(b) The insurer shall include in the notice required under subsection (a) of this section for a notice related to an appeal decision under G.S. 58-50-61, a statement informing the covered person that:

(1) If the covered person has a medical condition where the time frame for completion of an expedited review of a grievance involving an appeal decision under G.S. 58-50-61 would reasonably be expected to seriously jeopardize the life or health of the covered person or jeopardize the covered person's ability to regain maximum function, the covered person may file a request for an expedited external review under G.S. 58-50-82 at the same time the covered person files a request for an expedited review of a grievance involving an appeal decision under G.S. 58-50-61 and G.S. 58-50-62, but that the organization assigned to conduct the expedited external review will determine whether the covered person shall be required to complete the expedited review of the grievance before conducting the expedited external review.

(2) If the insurer has not issued a written decision to the covered person within 45 days after the date the covered person files the grievance with the insurer pursuant to G.S. 58-50-62 and the covered person has

not requested or agreed to a delay, the covered person may file a request for external review under G.S. 58-50-80 of this section and shall be considered to have exhausted the insurer's internal grievance process for purposes of G.S. 58-50-79.

(c) The insurer shall include in the notice required under subsection (a) of this section for a notice related to a final second-level grievance review decision under G.S. 58-50-62, a statement informing the covered person that:

(1) If the covered person has a medical condition where the time frame for completion of a standard external review under G.S. 58-50-80 would reasonably be expected to seriously jeopardize the life or health of the covered person or jeopardize the covered person's ability to regain maximum function, the covered person may file a request for an expedited external review under G.S. 58-50-82; or

(2) If the second-level grievance review decision concerns an admission, availability of care, continued stay, or health care service for which the covered person received emergency services but has not been discharged from a facility, the covered person may request an expedited external review under G.S. 58-50-82.

(d) In addition to the information to be provided under subsections (b) and (c) of this section, the insurer shall include a copy of the description of both the standard and expedited external review procedures the insurer is required to provide under G.S. 58-50-93, including the provisions in the external review procedures that give the covered person the opportunity to submit additional information.

"**§ 58-50-78:** Reserved.

"**§ 58-50-79. Exhaustion of internal grievance process.**

(a) Except as provided in subsections (d) and (e) of this section, a request for an external review under G.S. 58-50-80 or G.S. 58-50-82 shall not be made until the covered person has exhausted the insurer's internal grievance process under G.S. 58-50-62.

(b) A covered person shall be considered to have exhausted the insurer's internal grievance process for purposes of this section, if the covered person:

(1) Has filed a second-level grievance involving a noncertification appeal decision under G.S. 58-50-61 and G.S. 58-50-62.

(2) Except to the extent the covered person requested or agreed to a delay, has not received a written decision on the grievance from the insurer within 45 days since the date the covered person filed the grievance with the insurer.

(c) Notwithstanding subsection (b) of this section, a covered person may not make a request for an external review of a noncertification involving a retrospective review determination made under G.S. 58-50-61 until the covered person has exhausted the insurer's internal grievance process.

(d) At the same time a covered person files a request for an expedited appeal involving a noncertification as set forth in G.S. 58-50-61(l), the covered person may file

a request for an expedited external review of the noncertification under G.S. 58-50-82 if the covered person has a medical condition where the time frame for completion of an expedited review of the appeal involving a noncertification set forth in G.S. 58-50-61(l) would be reasonably expected to seriously jeopardize the life or health of the covered person or would jeopardize the covered person's ability to regain maximum function. An insurer may waive its right to conduct an expedited review of an appeal and allow the covered person to proceed with an expedited external review of the noncertification.

(e) Upon receipt of a request for an expedited external review under subsection (d) of this section, the organization conducting the external review in accordance with the provisions of G.S. 58-50-82 shall immediately determine whether the covered person shall be required to complete the expedited review process set forth in G.S. 58-50-61(l) before it conducts the expedited external review, unless the insurer has waived its right to conduct an expedited review of the appeal decision.

(f) Upon a determination made under subsection (e) of this section that the covered person must first complete the expedited appeal process under G.S. 58-50-61(l), the organization immediately shall notify the covered person and the insurer of this determination and that it will not proceed with the expedited external review under G.S. 58-50-82 until completion of the expedited appeal process and the covered person's grievance at the completion of the expedited appeal process remains unresolved.

(g) A request for an external review of a noncertification may be made before the covered person has exhausted the insurer's internal grievance procedures under G.S. 58-50-61 and G.S. 58-50-62 whenever the insurer agrees to waive the exhaustion requirement. If the requirement to exhaust the insurer's internal grievance procedures is waived, the covered person may file a request in writing for a standard external review as set forth in G.S. 58-50-80 or may make a request for an expedited external review as set forth in G.S. 58-50-82.

"**§ 58-50-80. Standard external review.**

(a) Within 60 days after the date of receipt of a notice of a noncertification appeal decision or a second-level grievance review decision under G.S. 58-50-77, a covered person may file a request for an external review with the Commissioner.

(b) Upon receipt of a request for an external review under subsection (a) of this section, the Commissioner immediately shall notify and send a copy of the request to the insurer that made the decision which is the subject of the request. The insurer shall immediately submit to the Commissioner the information required for the preliminary review under subsection (c) of this section.

(c) Within five business days after the date of receipt of a request for an external review, the Commissioner shall complete a preliminary review of the request to determine whether:

(1) The individual is or was a covered person in the health benefit plan at the time the health care service was requested or, in the case of a retrospective review, was a covered person in the health benefit plan at the time the health care service was provided.

(2) The health care service that is the subject of the noncertification appeal decision or the second-level grievance review decision upholding a noncertification reasonably appears to be a covered service under the covered person's health benefit plan.

(3) The covered person has exhausted the insurer's internal appeal and grievance processes under G.S. 58-50-61 and G.S. 58-50-62 unless the covered person is not required to exhaust the insurer's internal appeal or grievance process under G.S. 58-50-79.

(4) The covered person has provided all the information and forms required by the Commissioner that are necessary to process an external review.

(d) Upon completion of the preliminary review under subsection (c) of this section, the Commissioner immediately shall notify the covered person in writing whether the request is complete and whether the request has been accepted for external review. If the request is not complete, the Commissioner shall request from the covered person the information or materials needed to make the request complete. The covered person shall furnish the Commissioner with the requested information or materials within 90 days after the date of the insurer's decision for which external review is requested. If the request is not accepted for external review, the Commissioner shall inform the covered person and the insurer in writing of the reasons for its nonacceptance.

(e) If the request is accepted for external review, the Commissioner shall:

(1) Include in the notice provided under subsection (d) of this section a statement that the covered person may submit to the Commissioner in writing within seven days after the date of the notice additional information and supporting documentation relevant to the initial denial that the organization shall consider when conducting the external review.

(2) Immediately notify the insurer in writing of the acceptance of the request for external review.

The Commissioner shall maintain an alphabetical listing of independent review organizations approved under G.S. 58-50-85 and shall systematically assign on a rotating basis the next independent review organization on that list capable of performing the review to conduct the external review. After the last organization on the list has been assigned a review, the commissioner shall return to the top of the list to continue assigning reviews.

(f) The Commissioner shall forward to the review organization that was assigned by the Commissioner any documents that were received relating to the request for external review. At the same time the Commissioner forwards the information to the review organization, the Commissioner shall forward the information to the insurer.

(g) Within seven days after the date of receipt of the notice provided under subsection (d) of this section, the insurer or its designee utilization review organization shall provide to the assigned organization the documents and any information

considered in making the noncertification appeal decision or the second-level grievance review decision. Except as provided in subsection (h) of this section, failure by the insurer or its designee utilization review organization to provide the documents and information within the time specified in this subsection shall not delay the conduct of the external review.

(h) If the insurer or its utilization review organization fails to provide the documents and information within the time specified in subsection (g) of this section, the assigned organization may terminate the external review and make a decision to reverse the noncertification appeal decision or the second-level grievance review decision. Immediately upon making the decision under this subsection, the organization shall notify the covered person, the insurer, and the Commissioner.

(i) Upon receipt of the information required to be forwarded under subsection (f) of this section, the insurer may reconsider its noncertification appeal decision or second-level grievance review decision that is the subject of the external review. Reconsideration by the insurer of its noncertification appeal decision or second-level grievance review decision under this subsection shall not delay or terminate the external review. The external review shall be terminated if the insurer decides, upon completion of its reconsideration, to reverse its noncertification appeal decision or second-level grievance review decision and provide coverage or payment for the requested health care service that is the subject of the noncertification appeal decision or second-level grievance review decision.

(j) Immediately upon making the decision to reverse its noncertification appeal decision or second-level grievance review decision under subsection (i) of this section, the insurer shall notify the covered person, the organization, and the Commissioner in writing of its decision. The organization shall terminate the external review upon receipt of the notice from the insurer sent under this subsection.

(k) The assigned organization shall review all of the information and documents received under subsections (f) and (g) of this section that have been forwarded to the organization by the Commissioner and the insurer, including the most recent updated information available. In addition, the assigned review organization, to the extent the documents or information are available and the review organization considers them appropriate, shall consider the following in reaching a decision:

(1) The covered person's medical records.

(2) The attending health care provider's recommendation.

(3) Consulting reports from appropriate health care providers and other documents submitted by the insurer, covered person, or the covered person's treating provider.

(4) The most appropriate practice guidelines that are based on sound clinical evidence and that are periodically evaluated to assure ongoing efficacy.

(5) Any applicable clinical review criteria developed and used by the insurer or its designee utilization review organization.

(6) Medical necessity, as defined in G.S. 58-3-200(b).

(7) Any documentation supporting the medical necessity and appropriateness of the provider's recommendation.

The assigned organization shall review the terms of coverage under the covered person's health benefit plan with the insurer to ensure that the organization's decision shall not be contrary to the terms of coverage under the covered person's health benefit plan with the insurer.

The assigned organization's determination shall be based on the covered person's medical condition at the time of the initial noncertification decision.

(l) Within 45 days after the date of receipt by the Commissioner of the request for external review, the assigned organization shall provide written notice of its decision to uphold or reverse the noncertification appeal decision or second-level grievance review decision to the covered person, the insurer, and the Commissioner. In reaching a decision, the assigned review organization is not bound by any decisions or conclusions reached during the insurer's utilization review process or the insurer's internal grievance process under G.S. 58-50-61 and G.S 58-50-62.

(m) The organization shall include in the notice sent under subsection (l) of this section:

(1) A general description of the reason for the request for external review.

(2) The date the organization received the assignment from the Commissioner to conduct the external review.

(3) The date the organization received information and documents submitted by the covered person and by the insurer.

(4) The date the external review was conducted.

(5) The date of its decision.

(6) The principal reason or reasons for its decision.

(7) The clinical rationale for its decision.

(8) References to the evidence or documentation, including the practice guidelines, considered in reaching its decision.

(9) The professional qualifications and licensure of the clinical peer reviewers.

(10) Notice to the covered person that he or she is not liable for the cost of the external review.

(n) Upon receipt of a notice of a decision under subsection (m) of this section reversing the noncertification appeal decision or second-level grievance review decision, the insurer shall immediately reverse the noncertification appeal decision or second-level grievance review decision that was the subject of the review and shall process the claim accordingly. In the event the covered person is no longer enrolled in the health benefit plan when the insurer receives notice of a decision under subsection (m) of this section reversing the noncertification appeal decision or second-level grievance review decision at the time the decision is rendered, the insurer shall be responsible under this section only for the costs of those services or supplies the covered person would have received prior to disenrollment.

"**§ 58-50-81:** Reserved.

"**§ 58-50-82. Expedited external review.**

(a) Except as provided in subsection (h) of this section, a covered person may make a written or oral request for an expedited external review with the Commissioner at the time the covered person receives:

(1) An appeal decision under G.S. 58-50-61(k) or (l) upholding a noncertification if:

a. The noncertification appeal decision involves a medical condition of the covered person for which the time frame for completion of an expedited second-level grievance review of a noncertification set forth in G.S. 58-50-62(i) would reasonably be expected to seriously jeopardize the life or health of the covered person or jeopardize the covered person's ability to regain maximum function; and

b. The covered person has filed a request for an expedited second-level review of a noncertification as set forth in G.S. 58-50-61(i); or

(2) A second-level grievance review decision under G.S. 58-60-62(h) or (i) upholding a noncertification:

a. If the covered person has a medical condition where the time frame for completion of a standard external review under G.S. 58-50-80 would reasonably be expected to seriously jeopardize the life or health of the covered person or jeopardize the covered person's ability to regain maximum function; or

b. If the second-level grievance concerns a noncertification of an admission, availability of care, continued stay, or health care service for which the covered person received emergency services, but has not been discharged from a facility.

(b) At the time the Commissioner receives a request for an expedited external review, the Commissioner immediately shall:

(1) Notify and provide a copy of the request to the insurer that made the noncertification appeal decision or second-level grievance review decision which is the subject of the request.

(2) For a request that the Commissioner has determined meets the reviewability requirements set forth in G.S. 58-50-80(c), the Commissioner shall immediately determine, based on medical advice from a medical professional who is not affiliated with the organization that will be assigned to conduct the external review of the request, whether the request should be reviewed on an expedited basis because the time frame for completion of a standard external review under G.S. 58-50-80 would reasonably be expected to seriously jeopardize the life or health of the covered person or would jeopardize the covered person's ability to regain maximum function. The Commissioner shall then inform the covered person and the insurer whether the review will

be conducted using an expedited or standard time frame, and shall, in accordance with G.S. 58-50-80, assign an organization to conduct the review within the appropriate time frame.

(c) In reaching a decision, the assigned organization is not bound by any decisions or conclusions reached during the insurer's utilization review process or internal grievance process under G.S. 58-50-61 and G.S. 58-50-62.

(d) At the time the insurer receives the notice under subsection (b) of this section, the insurer or its designee utilization review organization shall immediately provide or transmit all documents and information considered in making the noncertification appeal decision or the second-level grievance review decision to the assigned review organization electronically or by telephone or facsimile or any other available expeditious method.

(e) In addition to the documents and information provided or transmitted under subsection (d) of this section, the assigned organization, to the extent the information or documents are available and the organization considers them appropriate, shall consider the following in reaching a decision:

(1) The covered person's pertinent medical records.

(2) The attending health care provider's recommendation.

(3) Consulting reports from appropriate health care providers and other documents submitted by the insurer, covered person, or the covered person's treating provider.

(4) The most appropriate practice guidelines that are based on sound clinical evidence and that are periodically evaluated to assure ongoing efficacy.

(5) Any applicable clinical review criteria developed and used by the insurer or its designee utilization review organization in making noncertification decisions.

(6) Medical necessity, as defined in G.S. 58-3-200(b).

(7) Any documentation supporting the medical necessity and appropriateness of the provider's recommendation.

The assigned organization shall review the terms of coverage under the covered person's health benefit plan to ensure that the organization's decision shall not be contrary to the terms of coverage under the covered person's health benefit plan.

The assigned organization's determination shall be based on the covered person's medical condition at the time of the initial noncertification decision.

(f) As expeditiously as the covered person's medical condition or circumstances require, but not more than four days after the date of receipt of the request for an expedited external review, the assigned organization shall make a decision to uphold or reverse the noncertification appeal decision or second-level grievance review decision and notify the covered person, the insurer, and the Commissioner of the decision.

(g) If the notice provided under subsection (f) of this section was not in writing, within two days after the date of providing that notice, the assigned organization shall provide written confirmation of the decision to the covered person, the insurer, and the

Commissioner and include the information set forth in G.S. 58-50-80(o). Upon receipt of the notice, a decision under subsection (f) of this section reversing the noncertification appeal decision or second-level grievance review decision, the insurer shall immediately reverse the noncertification appeal decision or second-level grievance review decision that was the subject of the review and shall process the claim accordingly.

(h) An expedited external review shall not be provided for retrospective noncertifications.

"§ 58-50-83: Reserved.

"**§ 58-50-84. Binding nature of external review decision.**

(a) An external review decision is binding on the insurer.

(b) An external review decision is binding on the covered person except to the extent the covered person has other remedies available under applicable federal or State law.

(c) A covered person may not file a subsequent request for external review involving the same noncertification appeal decision or second-level grievance review decision for which the covered person has already received an external review decision under this Part.

"**§ 58-50-85. Approval of independent review organizations.**

(a) The Commissioner shall approve independent review organizations eligible to be assigned to conduct external reviews under this Part to ensure that an organization satisfies the minimum qualifications established under G.S. 58-50-87. The Commissioner shall develop an application form for initially approving and for reapproving organizations to conduct external reviews.

(b) Any organization wishing to be approved to conduct external reviews under this Part shall submit the application form and include with the form all documentation and information necessary for the Commissioner to determine if the organization satisfies the minimum qualifications established under G.S. 58-50-87. Applicants must submit pricing information sufficient to demonstrate that if selected, the applicant's total fee per review will not exceed commercially reasonable fees charged for similar services in the industry. The Commissioner shall not approve any independent review organization that either fails to provide sufficient pricing information or has fees that do not meet the guidelines established under this subsection.

(c) The Commissioner may, in his discretion, determine that accreditation by a nationally recognized private accrediting entity with established and maintained standards for independent review organizations that meet the minimum qualifications established under G.S. 58-50-87 will cause an independent review organization to be deemed to have met, in whole or in part, the requirements of this section and G.S. 58-50-87. A decision by the Commissioner to recognize an accreditation program for the purpose of granting deemed status may be made only after reviewing the accreditation standards and program information submitted by the accrediting body. An independent review organization seeking deemed status due to its accreditation shall submit original documentation issued by the accrediting body to demonstrate its accreditation.

(d) An approval is effective for two years, unless the Commissioner determines before expiration of the approval that the independent review organization is not satisfying the minimum qualifications established under G.S. 58-50-87.

(e) Whenever the Commissioner determines that an independent review organization no longer satisfies the minimum requirements established under G.S. 58-50-87, the Commissioner shall terminate the approval of the independent review organization.

"**§ 58-50-86:** Reserved.

"**§ 58-50-87. Minimum qualifications for independent review organizations.**

(a) As a condition of approval under G.S. 58-50-85 to conduct external reviews, an independent review organization shall have and maintain written policies and procedures that govern all aspects of both the standard external review process and the expedited external review process set forth in G.S. 58-50-80 and G.S. 58-50-82 that include, at a minimum:

(1) A quality assurance mechanism in place that ensures:

a. That external reviews are conducted within the specified time frames and required notices are provided in a timely manner.

b. The selection of qualified and impartial clinical peer reviewers to conduct external reviews on behalf of the independent review organization and suitable matching of reviewers to specific cases.

c. The confidentiality of medical and treatment records and clinical review criteria.

d. That any person employed by or under contract with the independent review organization adheres to the requirements of this Part.

e. The independence and impartiality of the independent review organization and the external review process and limits the ability of any person to improperly influence the external review decision.

(2) A toll-free telephone service to receive information on a 24-hour-day, seven-day-a-week basis related to external reviews that is capable of accepting, recording, or providing appropriate instruction to incoming telephone callers during other than normal business hours.

(3) Agree to maintain and provide to the Commissioner the information set out in G.S. 58-50-90.

(4) A program for credentialing clinical peer reviewers.

(5) Agree to contractual terms or written requirements established by the Commissioner regarding the procedures for handling a review.

(6) The independent review organization shall consult with a medical doctor licensed to practice in North Carolina to advise the independent review organization on issues related to the standard of practice,

technology, and training of North Carolina physicians with respect to the organization's North Carolina business.

(b) All clinical peer reviewers assigned by an independent review organization to conduct external reviews shall be medical doctors or other appropriate health care providers who meet the following minimum qualifications:

(1) Be an expert in the treatment of the covered person's injury, illness, or medical condition that is the subject of the external review.

(2) Be knowledgeable about the recommended health care service or treatment through recent or current actual clinical experience treating patients with the same or similar injury, illness, or medical condition of the covered person.

(3) If the covered person's treating provider is a medical doctor, hold a nonrestricted license, and, if a specialist medical doctor, a current certification by a recognized American medical specialty board in the area or areas appropriate to the subject of the external review.

(4) If the covered person's treating provider is not a medical doctor, hold a nonrestricted license, registration, or certification in the same allied health occupation as the covered person's treating provider.

(5) Have no history of disciplinary actions or sanctions, including loss of staff privileges or participation restrictions, that have been taken or are pending by any hospital, governmental agency or unit, or regulatory body that raise a substantial question as to the clinical peer reviewer's physical, mental, or professional competence or moral character.

(c) In addition to the requirements set forth in subsection (a) of this section, an independent review organization may not own or control, be a subsidiary of, or in any way be owned or controlled by, or exercise control with a health benefit plan, a national, State, or local trade association of health benefit plans, or a national, State, or local trade association of health care providers.

(d) In addition to the requirements set forth in subsections (a), (b), and (c) of this section, to be approved under G.S. 58-50-85 to conduct an external review of a specified case, neither the independent review organization selected to conduct the external review nor any clinical peer reviewer assigned by the independent organization to conduct the external review may have a material professional, familial, or financial conflict of interest with any of the following:

(1) The insurer that is the subject of the external review.

(2) The covered person whose treatment is the subject of the external review or the covered person's authorized representative.

(3) Any officer, director, or management employee of the insurer that is the subject of the external review.

(4) The health care provider, the health care provider's medical group, or independent practice association recommending the health care service or treatment that is the subject of the external review.

(5) The facility at which the recommended health care service or treatment would be provided.

(6) The developer or manufacturer of the principal drug, device, procedure, or other therapy being recommended for the covered person whose treatment is the subject of the external review.

(e) In determining whether an independent review organization or a clinical peer reviewer of the independent review organization has a material professional, familial, or financial conflict of interest for purposes of subsection (d) of this section, the Commissioner shall take into consideration situations where the independent review organization to be assigned to conduct an external review of a specified case or a clinical peer reviewer to be assigned by the independent review organization to conduct an external review of a specified case may have an apparent professional, familial, or financial relationship or connection with a person described in subsection (d) of this section, but that the characteristics of that relationship or connection are such that they are not a material professional, familial, or financial conflict of interest that results in the disapproval of the independent review organization or the clinical peer reviewer from conducting the external review.

"§ 58-50-88: Reserved.

"**§ 58-50-89. Hold harmless for Commissioner and independent review organizations.**

The Commissioner or an independent review organization or clinical peer reviewer working on behalf of an organization shall not be liable for damages to any person for any opinions rendered during or upon completion of an external review conducted under this Part, unless the opinion was rendered in bad faith or involved gross negligence.

"**§ 58-50-90. External review reporting requirements.**

(a) An organization assigned under G.S. 58-50-80 or G.S. 58-50-82 to conduct an external review shall maintain written records in the aggregate and by insurer on all requests for external review for which it conducted an external review during a calendar year and submit a report to the Commissioner, as required under subsection (b) of this section.

(b) Each organization required to maintain written records on all requests for external review under subsection (a) of this section for which it was assigned to conduct an external review shall submit to the Commissioner, at least annually, a report in the format specified by the Commissioner.

(c) The report shall include in the aggregate and for each insurer:

(1) The total number of requests for external review.

(2) The number of requests for external review resolved and, of those resolved, the number resolved upholding the noncertification appeal decision or second-level grievance review decision and the number resolved reversing the noncertification appeal decision or second-level grievance review decision.

(3) The average length of time for resolution.

(4) A summary of the types of coverages or cases for which an external review was sought, as provided in the format required by the Commissioner.

(5) The number of external reviews under G.S. 58-50-80(k) and (l) that were terminated as the result of a reconsideration by the insurer of its noncertification appeal decision or second-level grievance review decision after the receipt of additional information from the covered person.

(6) Any other information the Commissioner may request or require.

(d) The organization shall retain the written records required under this section for at least three years.

(e) Each insurer shall maintain written records in the aggregate and for each type of health benefit plan offered by the insurer on all requests for external review of which the insurer receives notice from the Commissioner under this Part. The insurer shall retain the written records required under this section for at least three years.

"§ 58-50-91: Reserved.

"**§ 58-50-92. Funding of external review.**

The insurer against which a request for a standard external review or an expedited external review is filed shall reimburse the Department of Insurance for the fees charged by the organization in conducting the external review.

"**§ 58-50-93. Disclosure requirements.**

(a) Each insurer shall include a description of the external review procedures in or attached to the policy, certificate, membership booklet, outline of coverage, or other evidence of coverage it provides to covered persons.

(b) The description required under subsection (a) of this section shall include a statement that informs the covered person of the right of the covered person to file a request for an external review of a noncertification appeal decision or a second-level grievance review decision upholding a noncertification with the Commissioner. The statement shall include the telephone number and address of the Commissioner.

(c) In addition to subsection (b) of this section, the statement shall inform the covered person that, when filing a request for an external review, the covered person will be required to authorize the release of any medical records of the covered person that may be required to be reviewed for the purpose of reaching a decision on the external review.

"**§ 58-50-94. Competitive selection of independent review organizations.**

(a) The Commissioner shall prepare and publish requests for proposals from independent review organizations that want to be approved under G.S. 58-50-85. All proposals shall be sealed. The Commissioner shall open all proposals in public.

(b) After the public opening, the Commissioner shall review the proposals, examining the costs and quality of the services offered by the independent review organizations, the reputation and capabilities of the independent review organizations submitting the proposals, and the provisions in G.S. 58-50-85 and G.S. 58-50-87. The Commissioner shall determine which proposal or proposals would satisfy the provisions

of this Part. The Commissioner shall make his determination in consultation with an evaluation committee whose membership includes representatives of insurers subject to Part 4 of Article 50 of Chapter 58 of the General Statutes, health care providers, and insureds. In selecting the review organizations, in addition to considering cost, quality, and adherence to the requirements of the request for proposals, the Commissioner shall consider the desirability and feasibility of contracting with multiple review organizations in order to allow insureds a choice of review organizations and shall ensure that at least one review organization is available to and capable of reviewing cases involving highly specialized services and treatments of any nature. The Commissioner may reject any or all proposals.

(c) An independent review organization may seek to modify or withdraw a proposal only after the public opening and only on the basis that the proposal contains an unintentional clerical error as opposed to an error in judgment. An independent review organization seeking to modify or withdraw a proposal shall submit to the Commissioner a written request, with facts and evidence in support of its position, before the determination made by the Commissioner under subsection (b) of this section, but not later than two days after the public opening of the proposals. The Commissioner shall promptly review the request, examine the nature of the error, and determine whether to permit or deny the request.

(d) The provisions of Article 3C of Chapter 143 of the General Statutes do not apply to this Part.

"**§ 58-50-95. Report by Commissioner.**

The Commissioner shall report semiannually to the Joint Legislative Health Care Oversight Committee regarding the nature and appropriateness of reviews conducted under this Part. The report, which shall be provided to the public upon request, should include the number of reviews, underlying issues in dispute, character of the reviews, dollar amounts in question, whether the review was decided in favor of the covered person or the health benefit plan, the cost of review, and any other information relevant to the evaluation of the effectiveness of this Part."

SECTION 4.6. G.S. 58-50-62(h)(7) reads as rewritten:

"(7) A statement that the decision is the insurer's final determination in the matter. In cases where the review concerned a noncertification and the insurer's decision on the second-level grievance review is to uphold its initial noncertification, a statement advising the covered person of his or her right to request an external review and a description of the procedure for submitting a request for external review to the Commissioner of Insurance."

Subpart B. Health Plan Liability

SECTION 4.7. Chapter 90 of the General Statutes is amended by adding a new Article to read:

"Article 1G.

"Health Care Liability.

"**§ 90-21.50. Definitions.**

As used in this Article, unless the context clearly indicates otherwise, 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. 'Health benefit plan' does not mean any plan implemented or administered through the Department of Health and Human Services 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 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. Insurance under which benefits are payable with or without regard to fault and that are statutorily required to be contained in any liability policy or equivalent self-insurance; and
l. Hospital income or indemnity.

(2) 'Health care provider' means:

a. An individual who is licensed, certified, or otherwise authorized under this Chapter to provide health care services in the ordinary course of business or practice of a profession or in an approved education or training program; or
b. A health care facility, licensed under Chapters 131E or 122C of the General Statutes, where health care services are provided to patients;

'Health care provider' includes:

1. An agent or employee of a health care facility that is licensed, certified, or otherwise authorized to provide health care services;
2. The officers and directors of a health care facility; and
3. An agent or employee of a health care provider who is licensed, certified, or otherwise authorized to provide health care services.

(3) 'Health care service' means a health or medical procedure or service rendered by a health care provider that:

a. Provides testing, diagnosis, or treatment of a human disease or dysfunction; or

b. Dispenses drugs, medical devices, medical appliances, or medical goods for the treatment of a human disease or dysfunction.

(4) 'Health care decision' means a determination by a managed care entity which is subject to external review under Part 4 of Article 50 of the General Statutes and is also a determination that:

a. A prospective or concurrent request for approval of coverage is denied or reduced because it is not medically necessary or appropriate or because it is experimental or investigational; provided, however, that a health care decision does not include a decision based solely on the application of a specific exclusion under the health benefit plan; and

b. Affects the quality of the diagnosis, care, or treatment provided under the health benefit plan to an enrollee or insured of the health benefit plan.

(5) 'Insured or enrollee' means a person that is insured by or enrolled in a health benefit plan under a policy, plan, certificate, or contract issued or delivered in this State by an insurer.

(6) 'Insurer' means an entity that writes a health benefit plan and that is an insurance company subject to Chapter 58 of the General Statutes, a service corporation organized under Article 65 of Chapter 58 of the General Statutes, a health maintenance organization organized under Article 67 of Chapter 58 of the General Statutes, or a multiple employer welfare arrangement subject to Article 49 of Chapter 58 of the General Statutes.

(7) 'Managed care entity' means an insurer that:

a. Delivers, administers, or undertakes to provide for, arrange for, or reimburse for health care services, or assumes the risk for the delivery of health care services; and

b. Has a system or technique to control or influence the quality, accessibility, utilization, or costs and prices of health care services delivered or to be delivered to a defined enrollee population.

'Managed care entity' does not include: (i) an employer purchasing coverage or acting on behalf of its employees or the employees of one or more subsidiaries or affiliated corporations of the employer, or (ii) a health care provider.

(8) 'Ordinary care' means that degree of care prevailing at the time the managed care entity made the health care decision that a managed care entity of ordinary prudence would use under the same or similar circumstances.

(9) 'Physician' means:
a. An individual licensed to practice medicine in this State;
b. A professional association or corporation organized under Chapter 55B of the General Statutes; or
c. A person or entity wholly owned by physicians.
(10) 'Successor external review process' means an external review process equivalent in all respects to G.S. 58-50-75 through G.S. 58-50-95 approved by the Department and implemented by a health benefit plan in the event that G.S. 58-50-75 through G.S. 58-50-95 are found by a court of competent jurisdiction to be void, unenforceable, or preempted by federal law, in whole or in part.

"**§ 90-21.51. Duty to exercise ordinary care; liability for damages for harm.**

(a) Each managed care entity for a health benefit plan has the duty to exercise ordinary care when making health care treatment decisions and is liable for damages for harm to an insured or enrollee proximately caused by its failure to exercise ordinary care.

(b) In addition to the duty imposed under subsection (a) of this section, each managed care entity for a health benefit plan is liable for damages for harm to an insured or enrollee proximately caused by the health care treatment decisions made by:
(1) Its agents or employees; or
(2) Representatives that are acting on its behalf and over whom it has exercised sufficient influence or control to reasonably effect the actual care and treatment of the insured or enrollee which results in the failure to exercise ordinary care.

(c) It shall be a defense to any action brought under this section against a managed care entity for a health benefit plan that:
(1) Neither the managed care entity nor an agent or employee or representative for whom the managed care entity is liable under subsection (b) of this section controlled, influenced, or participated in the health care treatment decision; and
(2) The managed care entity did not deny or delay payment for any health care service or treatment prescribed or recommended by a physician or health care provider to the insured or enrollee.

(d) In an action brought under this Article against a managed care entity, a finding that a physician or health care provider is an agent or employee of the managed care entity may not be based solely on proof that the physician or health care provider appears in a listing of approved physicians or health care providers made available to insureds or enrollees under the managed care entity's health benefit plan.

(e) An action brought under this Article is not a medical malpractice action as defined in Article 1B of this Chapter. A managed care entity may not use as a defense in an action brought under this Article any law that prohibits the corporate practice of medicine.

(f) A managed care entity shall not be liable for the independent actions of a health care provider, who is not an agent or employee of the managed care entity, when that health care provider fails to exercise the standard of care required by G.S. 90-21.12. A health care provider shall not be liable for the independent actions of a managed care entity when the managed care entity fails to exercise the standard of care required by this Article.

(g) Nothing in this Article shall be construed to create an obligation on the part of a managed care entity to provide to an insured or enrollee a health care service or treatment that is not covered under its health benefit plan.

(h) A managed care entity may not enter into a contract with a health care provider, or with an employer or employer group organization, that includes an indemnification or hold harmless clause for the acts or conduct of the managed care entity. Any such indemnification or hold harmless clause is void and unenforceable to the extent of the restriction.

"**§ 90-21.52. No liability under this Article on the part of an employer or employer group organization that purchases coverage or assumes risk on behalf of its employees or a physician or health care provider.**

(a) This Article does not create any liability on the part of an employer or employer group purchasing organization that purchases health care coverage or assumes risk on behalf of its employees.

(b) This Article does not create any liability on the part of a physician or health care provider in addition to that otherwise imposed under existing law. No managed care entity held liable under this Article shall be entitled to contribution under Chapter 1B of the General Statutes from a physician or health care provider.

"**§ 90-21.53. Separate trial required.**

Upon motion of any party in an action that includes a claim brought pursuant to this Article involving a managed care entity, the court shall order separate discovery and a separate trial of any claim, cross-claim, counterclaim, or third-party claim against any physician or other health care provider.

"**§ 90-21.54. Punitive damages; exhaustion of administrative remedies and appeals; evidence.**

(a) An action brought under this Article is subject to the provisions and limitations of Chapter 1D of the General Statutes for recovery of punitive damages.

(b) No action may be commenced under this Article until the plaintiff has exhausted all administrative remedies and appeals, including those internal remedies and appeals established under G.S. 58-50-61 through G.S. 58-50-62, and G.S. 58-50-75 through G.S. 58-50-95, and including those established under any successor external review process.

(c) Any information, documents, or other records or materials considered by the Independent Review Organization in conducting its review shall be admissible in any action commenced under this article in accordance with the North Carolina Rules of Evidence.

"**§ 90-21.55. External review decision.**

Either the insured or enrollee or their personal representative or the managed care entity may use an external review decision made in accordance with G.S. 58-50-75 through G.S. 58-50-95, or made in accordance with any successor external review process, as evidence in any cause of action which includes an action brought under this Part, provided that an adequate foundation is laid for the introduction of the external review decision into evidence and the testimony is subject to cross-examination."

SECTION 4.8. G.S. 1A-1, Rule 42, reads as rewritten:

"**Rule 42. Consolidation; separate trials.**

(a) Consolidation. – ~~When~~ Except as provided in subdivision (b)(2) of this section, when actions involving a common question of law or fact are pending in one division of the court, the judge may order a joint hearing or trial of any or all the matters in issue in the actions; he may order all the actions consolidated; and he may make such orders concerning proceedings therein as may tend to avoid unnecessary costs or delay. When actions involving a common question of law or fact are pending in both the superior and the district court of the same county, a judge of the superior court in which the action is pending may order all the actions consolidated, and he may make such orders concerning proceedings therein as may tend to avoid unnecessary costs or delay.

(b) Separate trials. –

(1) The court may in furtherance of convenience or to avoid prejudice and shall for considerations of venue upon timely motion order a separate trial of any claim, ~~crossclaims~~ cross-claim, counterclaim, or third-party claim, or of any separate issue or of any number of claims, ~~crossclaims,~~ cross-claims, counterclaims, third-party claims, or issues.

(2) Upon motion of any party in an action that includes a claim commenced under Article 1G of Chapter 90 of the General Statutes involving a managed care entity as defined in G.S. 90-21.50, the court shall order separate discovery and a separate trial of any claim, cross-claim, counterclaim, or third-party claim against a physician or other medical provider."

SECTION 5.(a) G.S. 58-2-105 reads as rewritten:

"**§ 58-2-105. Confidentiality of medical records.**

(a) All patient medical records in the possession of the Department are confidential and are not public records pursuant to G.S. 58-2-100 or G.S. 132-1. As used in this section, "patient medical records" includes personal information that relates to an individual's physical or mental condition, medical history, or medical treatment, and that has been obtained from the individual patient, a health care provider, or from the patient's spouse, parent, or legal guardian.

(b) Under Part 4 of Article 50 of this Chapter, the Department may disclose patient medical records to an independent review organization, and the organization shall maintain the confidentiality of those records as required by this section, except as allowed by G.S. 58-30-75."

SECTION 5.(b) G.S. 58-3-200(b) reads as rewritten:

"(b) Medical Necessity. – An insurer that limits its health benefit plan coverage to medically necessary services and supplies shall define "medically necessary services or supplies" in its health benefit plan as those covered services or supplies that are:

(1) Provided for the diagnosis, treatment, cure, or relief of a health condition, illness, injury, or disease; ~~and~~ and, except as allowed under G.S. 58-3-255, not for experimental, investigational, or cosmetic purposes.

(2) Necessary for and appropriate to the diagnosis, treatment, cure, or relief of a health condition, illness, injury, disease, or its symptoms.

(3) Within generally accepted standards of medical care in the community.

(4) Not solely for the convenience of the insured, the insured's family, or the provider.

For medically necessary services, nothing in this subsection precludes an insurer from comparing the cost-effectiveness of alternative services or supplies when determining which of the services or supplies will be covered."

SECTION 5.(c) G.S. 58-50-61(a)(12) reads as rewritten:

"(12) "Medically necessary services or supplies" means those covered services or supplies that are:

a. Provided for the diagnosis, treatment, cure, or relief of a health condition, illness, injury, or disease.

b. Except as allowed under G.S. 58-3-255, ~~Not~~ not for experimental, investigational, or cosmetic purposes.

c. Necessary for and appropriate to the diagnosis, treatment, cure, or relief of a health condition, illness, injury, disease, or its symptoms.

d. Within generally accepted standards of medical care in the community.

e. Not solely for the convenience of the insured, the insured's family, or the provider.

For medically necessary services, nothing in this subdivision precludes an insurer from comparing the cost-effectiveness of alternative services or supplies when determining which of the services or supplies will be covered."

SECTION 6. If any section or provision of this act is declared unconstitutional or invalid by the courts, it does not affect the validity of the act as a whole or any part other than the part so declared to be unconstitutional or invalid.

SECTION 7. Section 1.6 of this act becomes effective January 1, 2002. Sections 3.1 and 3.2 of this act become effective December 1, 2001, and apply to health benefit plans that are delivered, issued for delivery, or renewed on or after that date. Sections 4.1 through 4.8 of this act become effective March 1, 2002. The remainder of this act is effective when it becomes law and applies to health benefit plans that are delivered, issued for delivery, or renewed on or after January 1, 2002. Nothing in this act obligates the General Assembly to appropriate funds to implement this act.

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2001

S D

SENATE BILL 199

Insurance and Consumer Protection Committee Substitute Adopted 4/25/01
PROPOSED HOUSE COMMITTEE SUBSTITUTE S199-PCS9323-LN-36

Short Title: Managed Care Patients' Bill of Rights. (Public)

Sponsors:

Referred to:

February 22, 2001

A BILL TO BE ENTITLED

AN ACT TO IMPROVE ACCESS TO HEALTH CARE ADVICE, INFORMATION, AND SERVICES TO COVERED PERSONS UNDER HEALTH BENEFIT PLANS; ESTABLISH STANDARDS FOR HEALTH PLAN DISCLOSURES TO CONSUMERS; ESTABLISH A PATIENT ASSISTANCE PROGRAM; REQUIRE COVERAGE FOR CLINICAL TRIALS AND NEWBORN HEARING SCREENING; PROVIDE STANDARDS FOR INDEPENDENT REVIEW OF NONCERTIFICATIONS BY AN INSURER OR MANAGED CARE PLAN, AND TO HOLD MANAGED CARE ENTITIES LIABLE FOR HARM CAUSED TO INSUREDS OR ENROLLEES BY THE FAILURE TO EXERCISE ORDINARY CARE IN MAKING HEALTH CARE TREATMENT DECISIONS.

The General Assembly of North Carolina enacts:

PART I. PATIENT ACCESS TO MEDICAL ADVICE AND CARE

Subpart A. Continuity of Care in HMOs

SECTION 1. Article 67 of Chapter 58 of the General Statutes is amended by adding a new section to read:

"**§ 58-67-88. Continuity of care.**

(a) Definitions. – As used in this section:

(1) 'Ongoing special condition' means:

a. In the case of an acute illness, a condition that is serious enough to require medical care or treatment to avoid a reasonable possibility of death or permanent harm.

b. In the case of a chronic illness or condition, a disease or condition that is life-threatening, degenerative, or disabling, and

requires medical care or treatment over a prolonged period of time.

c. In the case of pregnancy, pregnancy from the start of the second trimester.

d. In the case of a terminal illness, an individual has a medical prognosis that the individual's life expectancy is six months or less.

(2) 'Terminated or termination'. – Includes, with respect to a contract, the expiration or nonrenewal of the contract, but does not include a termination of the contract by an HMO for failure to meet applicable quality standards or for fraud.

(b) Termination of Provider. – If a contract between an HMO benefit plan that is not a point-of-service plan and a health care provider is terminated by the provider or by the HMO, or benefits or coverage provided by the HMO are terminated because of a change in the terms of provider participation in a health benefit plan of an HMO that is not a point-of-service plan, and an individual is covered by the plan and is undergoing treatment from the provider for an ongoing special condition on the date of the termination, then, the HMO shall:

(1) Upon termination of the contract by the HMO or upon receipt by the HMO of written notification of termination by the provider, notify the individual on a timely basis of the termination and of the right to elect continuation of coverage of treatment by the provider under this section.

(2) Subject to subsection (h) of this section, permit the individual to elect to continue to be covered with respect to the treatment by the provider of the ongoing special condition during a transitional period provided under this section.

(c) Newly Covered Insured. – Each health benefit plan offered by an HMO that is not a point-of-service plan shall provide transition coverage to individuals who are undergoing treatment from a provider for an ongoing special condition and are newly covered under the health benefit plan because the individual's employer has changed health benefit plans, and the HMO shall:

(1) Notify the individual on the date of enrollment of the right to elect continuation of coverage of treatment by the provider under this section.

(2) Subject to subsection (h) of this section, permit the individual to elect to continue to be covered with respect to the treatment by the provider of the ongoing special condition during a transitional period provided under this section.

(d) Transitional Period: In General. – Except as otherwise provided in subsections (e), (f), and (g) of this section, the transitional period under this subsection shall extend up to 90 days, as determined by the treating health care provider, after the

date of the notice to the individual described in subdivision (b)(1) of this section or the date of enrollment in a new plan described in subdivision (c)(1) of this section.

(e) Transitional Period: Scheduled Surgery, Organ Transplantation, or Inpatient Care. – If surgery, organ transplantation, or other inpatient care was scheduled for an individual before the date of the notice required under subdivision (b)(1) of this section, or the date of enrollment in a new plan described in subdivision (c)(1) of this section, or if the individual on that date was on an established waiting list or otherwise scheduled to have the surgery, transplantation, or other inpatient care, the transitional period under this subsection with respect to the surgery, transplantation, or other inpatient care shall extend beyond the period under subsection (d) of this section through the date of discharge of the individual after completion of the surgery, transplantation, or other inpatient care, and through postdischarge follow-up care related to the surgery, transplantation, or other inpatient care occurring within 90 days after the date of discharge.

(f) Transitional Period: Pregnancy. – If an insured has entered the second trimester of pregnancy on the date of the notice required under subdivision (b)(1) of this section, or the date of enrollment in a new plan described in subdivision (c)(1) of this section, and the provider was treating the pregnancy before the date of the notice, or the date of enrollment in the new plan, the transitional period with respect to the provider's treatment of the pregnancy shall extend through the provision of 60 days of postpartum care.

(g) Transitional Period: Terminal Illness. – If an insured was determined to be terminally ill at the time of the notice required under subdivision (b)(1) of this section, or at the time of enrollment in the new plan under subdivision (c)(1) of this section, and the provider was treating the terminal illness before the date of the notice, or enrollment in the new plan, the transitional period shall extend for the remainder of the individual's life with respect to care directly related to the treatment of the terminal illness or its medical manifestations.

(h) Permissible Terms and Conditions. – An HMO may condition coverage of continued treatment by a provider under subdivision (b)(2) or (c)(2) of this section upon the following terms and conditions:

(1) The provider agrees to accept reimbursement from the HMO and individual involved, with respect to cost-sharing, at the rates applicable before the start of the transitional period as payment in full.

(2) The provider agrees to adhere to the quality assurance standards of the HMO responsible for payment under subdivision (1) of this subsection and to provide to the HMO necessary medical information related to the care provided.

(3) The provider agrees otherwise to adhere to the HMO's established policies and procedures for participating providers, including procedures regarding referrals and obtaining prior authorization, providing services pursuant to a treatment plan, if any, approved by the HMO, and member hold harmless provisions.

(4) The insured or the insured's representative notifies the HMO within 45 days of the date of the notice described in subdivision (b)(1) of this section or the new enrollment described in subdivision (c)(1) of this section, that the insured elects to continue receiving treatment by the provider.

(5) The provider agrees to discontinue providing services and refer the insured to a network provider by the end of the transition period.

(i) Construction. – Nothing in this section:

(1) Requires the coverage of benefits that would not have been covered if the provider involved remained a participating provider.

(2) Requires an HMO to offer a transitional period when the HMO terminates a provider's contract for reasons relating to quality of care or fraud; and refusal to offer a transitional period under these circumstances is not subject to the grievance review provisions of G.S. 58-50-62.

(3) Prohibits an HMO from extending any transitional period beyond that specified in this section.

(4) Prohibits an HMO from terminating the continuing services of a provider as described in this section when the HMO has determined that the provider's continued provision of services may result in, or is resulting in, a serious danger to the health or safety of the insured. Such terminations shall be in accordance with the contract provisions that the provider would otherwise be subject to if the provider's contract were still in effect.

(j) Disclosure of Right to Transitional Period. – Each HMO shall include a clear description of an insured's rights under this section in its evidence of coverage and summary plan description."

Subpart B. Extended or Standing Referral to Specialist

SECTION 1.2. G.S. 58-3-223 reads as rewritten:

"**§ 58-3-223. Managed care access to specialist care.**

(a) Each insurer offering a health benefit plan that does not allow direct access to all in-plan specialists shall develop and maintain written policies and procedures by which an insured may receive an extended or standing referral to an in-plan specialist. The ~~procedure~~insurer shall provide for an extended or standing referral to a specialist if the insured has a serious or chronic degenerative, disabling, or life-threatening disease or condition, which in the opinion of the insured's primary care physician, in consultation with the specialist, requires ongoing specialty care. The extended or standing referral shall be for a period not to exceed 12 months and shall be made under a treatment plan coordinated with the insurer in consultation with the primary care physician, the specialist, and the insured or the insured's designee.

(b) As used in this section:

(1) 'Health benefit plan' has the meaning applied in G.S. 58-3-167. ~~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 are 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 under Article 65 of this Chapter, or a health maintenance organization under Article 67 of this Chapter, or a multiple employer welfare arrangement under Article 49 of this Chapter.~~ has the meaning applied in G.S. 58-3-167.

(3) 'Serious or chronic degenerative, disabling, or life-threatening disease or condition' means a disease or condition, which in the opinion of the patient's treating primary care physician and specialist, requires frequent and periodic monitoring and consultation with the specialist on an ongoing basis.

(4) 'Specialist' includes a subspecialist."

SECTION 1.2A. 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 the out-of-network benefit levels offered under the insured's approved health benefit ~~plan~~ plan, including an insured receiving an extended or

standing referral under G.S. 58-3-223, unless contracting health care providers able to meet health needs of the insured are reasonably available to the insured without unreasonable delay."

Subpart C. Selection of Specialist as Primary Care Physician

SECTION 1.3. Article 3 of Chapter 58 of the General Statutes is amended by adding a new section to read:

"**§ 58-3-235. Selection of specialist as primary care provider.**

(a) Each insurer shall have a procedure by which an insured diagnosed with a serious or chronic degenerative, disabling, or life-threatening disease or condition, either of which requires specialized medical care may select as his or her primary care physician a specialist with expertise in treating the disease or condition who shall be responsible for and capable of providing and coordinating the insured's primary and specialty care. If the insurer determines that the insured's care would not be appropriately coordinated by that specialist, the insurer may deny access to that specialist as a primary care provider.

(b) The selection of the specialist shall be made under a treatment plan approved by the insurer, in consultation with the specialist and the insured or the insured's designee and after notice to the insured's primary care provider, if any. The specialist may provide ongoing care to the insured and may authorize such referrals, procedures, tests, and other medical services as the insured's primary care provider would otherwise be allowed to provide or authorize, subject to the terms of the treatment plan. Services provided by a specialist who is providing and coordinating primary and specialty care remain subject to utilization review and other requirements of the insurer, including its requirements for primary care providers."

Subpart D. Direct Access to Pediatrician

SECTION 1.4. Article 3 of Chapter 58 of the General Statutes is amended by adding a new section to read:

"**§ 58-3-240. Direct access to pediatrician for minors.**

Each insurer offering a health benefit plan that uses a network of contracting health care providers shall allow an insured to choose a contracting pediatrician in the network as the primary care provider for the insured's children who are under the age of 18."

Subpart E. Access to Prescription Drugs

SECTION 1.5. G.S. 58-3-221 reads as rewritten:

"**§ 58-3-221. Access to nonformulary and restricted access prescription drugs.**

(a) If an insurer maintains one or more closed formularies for or restricts access to covered prescription drugs or devices, then the insurer shall do all of the following:

(1) Develop the formulary or formularies and any restrictions on access to covered prescription drugs or devices in consultation with and with the approval of a pharmacy and therapeutics committee, which shall include participating ~~providers~~ physicians who are licensed to ~~prescribe prescription drugs or devices.~~ practice medicine in this State.

(2) Make available to participating ~~providers and pharmacists~~ providers, pharmacists, and enrollees the complete drugs or devices formulary or formularies maintained by the insurer including a list of the devices and prescription drugs on the formulary by major therapeutic category that specifies whether a particular drug or device is preferred over other drugs or devices.

(3) Establish and maintain an expeditious process or procedure that allows an enrollee or the enrollee's physician acting on behalf of the enrollee to obtain, without penalty or additional cost-sharing beyond that provided for in the health benefit plan, coverage for a specific nonformulary drug or device determined to be medically necessary and appropriate by the enrollee's participating physician without prior approval from the insurer, after the enrollee's participating physician notifies the insurer that:

a. Either (i) the formulary alternatives have been ineffective in the treatment of the enrollee's disease or condition, or (ii) the formulary alternatives cause or are reasonably expected by the physician to cause a harmful or adverse clinical reaction in the enrollee; and

b. Either (i) the drug is prescribed in accordance with any applicable clinical protocol of the insurer for the prescribing of the drug, or (ii) the drug has been approved as an exception to the clinical protocol pursuant to the insurer's exception procedure.

(4) Provide coverage for a restricted access drug or device to an enrollee without requiring prior approval if an enrollee's physician certifies in writing that the enrollee has previously used an alternative nonrestricted access drug or device and the alternative drug or device has been ineffective or detrimental to the enrollee's health.

(b) An insurer may not void a contract or refuse to renew a contract between the insurer and a prescribing provider because the prescribing provider has prescribed a medically necessary and appropriate nonformulary or restricted access drug or device as provided in this section.

(c) As used in this section:

(1) 'Closed formulary' means a list of prescription drugs and devices reimbursed by the insurer that excludes coverage for drugs and devices not listed.

(1a) 'Health benefit plan' has definition provided in G.S. 58-3-167. ~~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 are statutorily required to be contained in any liability policy or equivalent self-insurance.~~

(2) 'Insurer' has the meaning provided in G.S. 58-3-167. ~~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, or a multiple employer welfare arrangement under Article 49 of this Chapter~~.

(3) 'Restricted access drug or device' means those covered prescription drugs or devices for which reimbursement by the insurer is conditioned on the insurer's prior approval to prescribe the drug or device or on the provider prescribing one or more alternative drugs or devices before prescribing the drug or device in question.

(d) Nothing in this section requires an insurer to pay for drugs or devices or classes of drugs or devices related to a benefit that is specifically excluded from coverage by the insurer."

Subpart F. Managed Care Patient Assistance Program

SECTION 1.6.(a) Chapter 114 of the General Statutes is amended by adding the following new Article to read:

"Article 7.

"Managed Care Patient Assistance Program.

"**§ 114-45. Managed Care Patient Assistance Program.**

(a) The Office of Managed Care Patient Assistance Program is established in the Department of Justice. The Director of the Office of Managed Care Patient Assistance Program shall be appointed by the Governor.

(b) The Managed Care Patient Assistance Program shall provide information and assistance to individuals enrolled in managed care plans. The Managed Care Patient Assistance Program shall have expertise and experience in both health care and advocacy and will assume the specific duties and responsibilities set forth in subsection (c) of this section.

(c) The duties and responsibilities of the Managed Care Patient Assistance Program are as follows:

(1) Develop and distribute educational and informational materials for consumers, explaining their rights and responsibilities as managed care plan enrollees.

(2) Answer inquiries posed by consumers and refer inquiries of a regulatory nature to staff within the Department of Insurance.

(3) Advise managed care plan enrollees about the utilization review process.

(4) Assist enrollees with the grievance, appeal, and external review procedures established by Article 50 of Chapter 58 of the General Statutes.

(5) Publicize the Office of the Managed Care Patient Assistance Program.

(6) Compile data on the activities of the Office and evaluate such data to make recommendations as to the needed activities of the Office.

(d) The Director of the Managed Care Patient Assistance Program shall annually report the activities of the Managed Care Patient Assistance Program, including the types of appeals, grievances, and complaints received and the outcome of these cases. The report shall be submitted to the General Assembly, upon its convening or reconvening, and shall make recommendations as to efforts that could be implemented to assist managed care consumers."

SECTION 1.6.(b) Article 6 of Chapter 58 of the General Statutes is amended by adding the following new section to read:

"**§ 58-6-30. Annual fee for support of Managed Care Patient Assistance Program.**

The Commissioner shall collect from each insurer offering a managed care plan as defined in G.S. 58-50-61 an annual, nonrefundable fee for the support of the Managed Care Patient Assistance Program established under G.S. 114-45. The Commissioner shall establish the amount of the fee which shall be based on the cost to administer the Program."

Subpart G. No Discrimination in the Selection of Providers

SECTION 1.7. G.S. 58-50-30, as amended by Section 1 of S.L. 2001-297, reads as rewritten:

"**§ 58-50-30. Right to choose services of optometrist, podiatrist, certified clinical social worker, certified substance abuse professional, licensed professional counselor, dentist, chiropractor, psychologist, pharmacist, certified fee-based practicing pastoral counselor, advanced practice nurse, or physician assistant.**

(a1) Whenever any health benefit plan, subscriber contract, or policy of insurance issued by a health maintenance organization, hospital or medical service corporation, or insurer governed by Articles 1 through ~~65~~ 67 of this Chapter provides for coverage for, payment ~~of or~~ of, or reimbursement for any service rendered in connection with a condition or complaint that is within the scope of practice of a duly licensed optometrist, a duly licensed podiatrist, a duly licensed dentist, a duly licensed chiropractor, a duly certified clinical social worker, a duly certified substance abuse professional, a duly licensed professional counselor, a duly licensed psychologist, a duly licensed pharmacist, a duly certified fee-based practicing pastoral counselor, a duly licensed physician assistant, or an advanced practice registered nurse, the insured or other persons entitled to benefits under the policy shall be entitled to coverage of, payment ~~of or~~ of, or reimbursement for the services, whether the services be performed by a duly licensed physician, or a provider listed in this subsection, notwithstanding any provision contained in the ~~policy.~~ plan or policy limiting access to the providers. The policyholder, insured, or beneficiary shall have the right to choose the provider of services notwithstanding any provision to the contrary in any other statute; provided that for plans that require the use of network providers either as a condition of obtaining benefits under the plan or policy or to access a higher level of benefits under the plan or policy, the policyholder, insured, or beneficiary must choose a provider of the services within the network, subject to the requirements of the plan or policy.

(a2) Whenever any policy of insurance governed by Articles 1 through ~~65~~64 of this Chapter provides for certification of disability that is within the scope of practice of a duly licensed physician, a duly licensed physician assistant, a duly licensed optometrist, a duly licensed podiatrist, a duly licensed dentist, a duly licensed chiropractor, a duly certified clinical social worker, a duly certified substance abuse professional, a duly licensed professional counselor, a duly licensed psychologist, a duly certified fee-based practicing pastoral counselor, or an advanced practice registered nurse, the insured or other persons entitled to benefits under the policy shall be entitled to payment of or reimbursement for the disability whether the disability be certified by a duly licensed physician, or a provider listed in this subsection, notwithstanding any provisions contained in the policy. The policyholder, insured, or beneficiary shall have the right to choose the provider of the services notwithstanding any provision to the contrary in any other ~~statute.~~statute; provided that for plans that require the use of

network providers either as a condition of obtaining benefits under the plan or policy or to access a higher level of benefits under the plan or policy, the policyholder, insured, or beneficiary must choose a provider of the services within the network, subject to the requirements of the plan or policy.

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

(b) For the purposes of this section, a "duly licensed psychologist" is a licensed psychologist who holds permanent licensure and certification as a health services provider psychologist issued by the North Carolina Psychology Board.

(c) For the purposes of this section, a "duly certified clinical social worker" is a "certified clinical social worker" as defined in G.S. 90B-3(2) and certified by the North Carolina Certification Board for Social Work pursuant to Chapter 90B of the General Statutes.

(c1) For purposes of this section, a "duly certified fee-based practicing pastoral counselor" shall be defined only to include fee-based practicing pastoral counselors certified by the North Carolina State Board of Examiners of Fee-Based Practicing Pastoral Counselors pursuant to Article 26 of Chapter 90 of the General Statutes.

(c2) For purposes of this section, a "duly certified substance abuse professional" is a person certified by the North Carolina Substance Abuse Professional Certification Board pursuant to Article 5C of Chapter 90 of the General Statutes.

(c3) For purposes of this section, a "duly licensed professional counselor" is a person licensed by the North Carolina Board of Licensed Professional Counselors pursuant to Article 24 of Chapter 90 of the General Statutes.

(d) Payment or reimbursement is required by this section for a service performed by an advanced practice registered nurse only when:

(1) The service performed is within the nurse's lawful scope of practice;

(2) The policy currently provides benefits for identical services performed by other licensed health care providers;

(3) The service is not performed while the nurse is a regular employee in an office of a licensed physician;

(4) The service is not performed while the registered nurse is employed by a nursing facility (including a hospital, skilled nursing facility, intermediate care facility, or home care agency); and

(5) Nothing in this section is intended to authorize payment to more than one provider for the same service.

No lack of signature, referral, or employment by any other health care provider may be asserted to deny benefits under this provision.

For purposes of this section, an "advanced practice registered nurse" means only a registered nurse who is duly licensed or certified as a nurse practitioner, clinical specialist in psychiatric and mental health nursing, or nurse midwife.

(e) Payment or reimbursement is required by this section for a service performed by a duly licensed pharmacist only when:

(1) The service performed is within the lawful scope of practice of the pharmacist;

(2) The service performed is not initial counseling services required under State or federal law or regulation of the North Carolina Board of Pharmacy;

(3) The policy currently provides reimbursement for identical services performed by other licensed health care providers; and

(4) The service is identified as a separate service that is performed by other licensed health care providers and is reimbursed by identical payment methods.

Nothing in this subsection authorizes payment to more than one provider for the same service.

(f) Payment or reimbursement is required by this section for a service performed by a duly licensed physician assistant only when:

(1) The service performed is within the lawful scope of practice of the physician assistant in accordance with rules adopted by the North Carolina Medical Board pursuant to G.S. 90-18.1;

(2) The policy currently provides reimbursement for identical services performed by other licensed health care providers; and

(3) The reimbursement is made to the physician, clinic, agency, or institution employing the physician assistant.

Nothing in this subsection is intended to authorize payment to more than one provider for the same service. For the purposes of this section, a "duly licensed physician assistant" is a physician assistant as defined by G.S. 90-18.1.

(g) A health maintenance organization, hospital or medical service corporation, or insurer governed by Articles 1 through 67 of this Chapter shall not exclude from participation in its provider network or from eligibility to provide particular covered services under the plan or policy any duly licensed physician or provider listed in subsection (a1) of this section, acting within the scope of the provider's license or certification under North Carolina law, solely on the basis of the provider's license or certification. Any health maintenance organization, hospital or medical service corporation, or insurer governed by Articles 1 through 67 of this Chapter that offers coverage through a network plan may condition participation in the network on satisfying written participation criteria, including credentialing, quality, and accessibility criteria. The participation criteria shall be developed and applied in a like manner consistent with the licensure and scope of practice for each type of provider. Any health maintenance organization, hospital or medical service corporation, or insurer governed by Articles 1 through 67 of this Chapter that excludes a provider listed in

subsection (a1) of this section from participation in its network or from eligibility to provide particular covered services under the plan or policy shall provide the affected listed provider with a written explanation of the basis for its decision. A health maintenance organization, hospital or medical service corporation, or insurer governed by Articles 1 through 67 of this Chapter shall not exclude from participation in its provider network a provider listed in subsection (a1) of this section acting within the scope of the provider's license or certification under North Carolina law solely on the basis that the provider lacks hospital privileges, unless use of hospital services by the provider on behalf of a policy holder, insured, or beneficiary reasonably could be expected."

Subpart H. Prohibition on Provider Incentives

SECTION 1.8. Article 3 of Chapter 58 of the General Statutes is amended by adding the following new section to read:

"**§ 58-3-265. Prohibition on managed care provider incentives.**

An insurer offering a health benefit plan may not offer or pay any type of material inducement, bonus, or other financial incentive to a participating provider to deny, reduce, withhold, limit, or delay specific medically necessary and appropriate health care services covered under the health benefit plan to an insured or enrollee."

PART II. HEALTH PLAN DISCLOSURES

Subpart A. Managed Care Reporting and Disclosure Requirements

SECTION 2.1. G.S. 58-3-191(b) reads as rewritten:

"(b) Disclosure requirements. – Each health benefit plan shall provide the following applicable information to plan participants and bona fide prospective participants upon request:

(1) The evidence of coverage (G.S. 58-67-50), subscriber contract (G.S. 58-65-60, 58-65-140), health insurance policy (G.S. 58-51-80, 58-50-125, 58-50-55), or the contract and benefit summary of any other type of health benefit plan;

(2) An explanation of the utilization review criteria and treatment protocol under which treatments are provided for conditions specified by the prospective participant. This explanation shall be in writing if so requested;

(3) If denied a recommended treatment, written reasons for the denial and an explanation of the utilization review criteria or treatment protocol upon which the denial was based;

(4) The plan's ~~restrictive formularies~~ closed formularies, restricted access drugs or devices, or prior approval requirements for obtaining prescription drugs, whether a particular drug or therapeutic class of

drugs is excluded from its formulary, and the circumstances under which a nonformulary drug may be covered; and

(5) The plan's procedures and medically based criteria for determining whether a specified procedure, test, or treatment is experimental."

Subpart B. Provider Directory Information

SECTION 2.2. Article 3 of Chapter 58 of the General Statutes is amended by adding a new section to read:

"**§ 58-3-245. Provider directories.**

(a) Every health benefit plan utilizing a provider network shall make a listing of network providers available to insureds and shall update the listing no less frequently than once a year. In addition, every health benefit plan shall maintain a telephone system and an electronic or on-line system through which insureds can access up-to-date network information. If the health benefit plan produces printed directories, the directories shall contain language disclosing the date of publication, frequency of updates, that the directory may not contain the latest network information, and contact information for accessing up-to-date network information.

(b) Each listing shall include:

(1) The provider's name, address, telephone number, and, if applicable, area of specialty.

(2) Whether the provider may be selected as a primary care provider.

(3) An indication of whether the provider:

a. Is or is not currently accepting new patients.

b. Has any other restrictions that would limit an insured's access to that provider.

(c) The listing shall include all of the types of participating providers. Upon a participating provider's written request, the insurer shall also list in the directory, as part of the participating provider's listing, the names of any allied health professionals who provide primary care services under the supervision of the participating provider and whose services are covered by virtue of the insurer's contract with the supervising participating provider and whose credentials have been verified by the supervising participating provider. These allied health professionals shall be listed as a part of the directory listing for the participating provider upon receipt of a certification by the supervising participating provider that the credentials of the allied health professional have been verified."

Subpart C. Disclosure of Payment Obligations

SECTION 2.3. Article 3 of Chapter 58 of the General Statutes is amended by adding a new section to read:

"**§ 58-3-250. Payment obligations for covered services.**

(a) If an insurer calculates a benefit amount for a covered service under a health benefit plan through a method other than a fixed dollar co-payment, the insurer shall clearly explain in its evidence of coverage and plan summaries how it determines its payment obligations and the payment obligations of the insured. The explanation shall include:

(1) An example of the steps the insurer would take in calculating the benefit amount and the payment obligations of each party.

(2) Whether the insurer has obtained the agreement of health care providers not to bill an insured for any amounts by which a provider's charge exceeds the insurer's recognized charge for a covered service and whether the insured may be liable for paying any excess amount.

(3) Which party is responsible for filing a claim or bill with the insurer.

(b) If an insured is liable for an amount that differs from a stated fixed dollar co-payment or may differ from a stated coinsurance percentage because the coinsurance amount is based on a plan allowance or other such amount rather than the actual charges and providers are permitted to balance bill the insured, the evidence of coverage, plan summaries, and marketing and advertising materials that include information on benefit levels shall contain the following statement: 'NOTICE: Your actual expenses for covered services may exceed the stated [coinsurance percentage or co-payment amount] because actual provider charges may not be used to determine [plan/insurer or similar term] and [insured/member/enrollee or similar term] payment obligations.' "

PART III. MANDATED BENEFITS

Subpart A. Clinical Trials

SECTION 3.1. Article 3 of Chapter 58 of the General Statutes is amended by adding a new section to read:

"**§ 58-3-255. Coverage of clinical trials.**

(a) As used in this section:

(1) 'Covered clinical trials' means phase III and phase IV patient research studies designed to evaluate new treatments, including prescription drugs, and that: (i) involve the treatment of life-threatening medical conditions, (ii) are medically indicated and preferable for that patient compared to available noninvestigational treatment alternatives, and (iii) have clinical and preclinical data that shows the trial will likely be more effective for that patient than available noninvestigational alternatives. Covered clinical trials must also meet the following requirements:

a. Must involve determinations by treating physicians, relevant scientific data, and opinions of experts in relevant medical specialties.

b. Must be trials approved by centers or cooperative groups that are funded by the National Institutes of Health, the Food and Drug Administration, the Centers for Disease Control, the Agency for Health Care Research and Quality, the Department of Defense, or the Department of Veterans Affairs. The health benefit plan may also cover clinical trials sponsored by other entities.

c. Must be conducted in a setting and by personnel that maintain a high level of expertise because of their training, experience, and volume of patients.

(2) 'Health benefit plan' is defined by G.S. 58-3-167.

(3) 'Insurer' is defined by G.S. 58-3-167.

(b) Each health benefit plan shall provide coverage for participation in phase III and phase IV covered clinical trials by its insureds or enrollees who meet protocol requirements of the trials and provide informed consent.

(c) Only medically necessary costs of health care services, as defined in G.S. 58-50-61, associated with participation in a covered clinical trial, including those related to health care services typically provided absent a clinical trial, the diagnosis and treatment of complications, and medically necessary monitoring, are required to be covered by the health benefit plan and only to the extent that such costs have not been or are not funded by national agencies, commercial manufacturers, distributors, or other research sponsors of participants in clinical trials.

(d) Clinical trial costs not required to be covered by a health benefit plan include the costs of services that are not health care services, those provided solely to satisfy data collection and analysis needs, those related to investigational drugs and devices, and those that are not provided for the direct clinical management of the patient. In the event a claim contains charges related to services for which coverage is required under this section, and those charges have not been or cannot be separated from costs related to services for which coverage is not required under this section, the health benefit plan may deny the claim."

Subpart B. Newborn Hearing Screening

SECTION 3.2. Article 3 of Chapter 58 of the General Statutes is amended by adding a new section to read:

"**§ 58-3-260. Insurance coverage for newborn hearing screening mandated.**

(a) As used in this section, the terms 'health benefit plan' and 'insurer' have the meanings applied under G.S. 58-3-167.

(b) Each health benefit plan shall provide coverage for newborn hearing screening ordered by the attending physician pursuant to G.S. 130A-125. The same deductibles, coinsurance, reimbursement methodologies, and other limitations and administrative procedures as apply to similar services covered under the health benefit plan shall apply to coverage for newborn hearing screening."

PART IV. EXTERNAL REVIEW AND MANAGED CARE ENTITY LIABILITY

Subpart A. Independent, External Review Process

SECTION 4.1. The title of Article 50 of Chapter 58 of the General Statutes reads as rewritten:

"Article 50.

General Accident and Health Insurance Regulations."

SECTION 4.2. Article 50 of Chapter 58 of the General Statutes is amended as follows:

(1) By designating G.S. 58-50-1 through G.S. 58-50-45 as Part 1 with the heading "Miscellaneous Provisions."

(2) By designating G.S. 58-50-50 through G.S. 58-50-64 as Part 2 with the heading "PPOs, Utilization Review and Grievances."

(3) By designating G.S. 58-50-65 through G.S. 58-50-70 as Part 3 with the heading "Scope and Sanctions."

(4) By designating G.S. 58-50-75 through G.S. 58-50-95 as Part 4 with the heading "Health Benefit Plan External Review."

(5) By designating G.S. 58-50-100 through G.S. 58-50-156 as Part 5 with the heading "Small Employer Group Health Insurance Reform."

SECTION 4.3. G.S. 58-50-151 is recodified as G.S. 58-51-116.

SECTION 4.4. The prefatory language of G.S. 58-50-61(a) reads as rewritten:

"(a) Definitions. – As used in this ~~section and~~ section, in G.S. 58-50-62, and in Part 4 of this Article, the term:".

SECTION 4.5. Article 50 of Chapter 58 of the General Statutes is amended by adding a new Part to read:

"Part 4. Health Benefit Plan External Review.

"**§ 58-50-75. Purpose, scope, and definitions.**

(a) The purpose of this Part is to provide standards for the establishment and maintenance of external review procedures to assure that covered persons have the opportunity for an independent review of an appeal decision upholding a noncertification or a second-level grievance review decision upholding a noncertification, as defined in this Part.

(b) This Part applies to all persons that provide or perform utilization review. With respect to second-level grievance review decisions, this Part applies only to second-level grievance review decisions involving noncertification decisions.

(c) In addition to the definitions in G.S. 58-50-61(a), as used in this Part:

(1) 'Covered benefits' or 'benefits' means those benefits consisting of medical care, provided directly through insurance or otherwise and including items and services paid for as medical care, under the terms of a health benefit plan.

(2) 'Covered person' means a policyholder, subscriber, enrollee, or other individual covered by a health benefit plan. 'Covered person' includes another person, including the covered person's health care provider, acting on behalf of the covered person.

(3) 'Independent review organization' or 'organization' means an entity that conducts independent external reviews of appeals of noncertifications and second-level grievance review decisions.

"**§ 58-50-76:** Reserved.

"**§ 58-50-77. Notice of right to external review.**

(a) An insurer shall notify the covered person in writing of the covered person's right to request an external review and include the appropriate statements and information set forth in this section at the time the insurer sends written notice of:

(1) An appeal decision under G.S. 58-50-61 upholding a noncertification; and

(2) A second-level grievance review decision under G.S. 58-50-62 upholding the original noncertification.

(b) The insurer shall include in the notice required under subsection (a) of this section for a notice related to an appeal decision under G.S. 58-50-61, a statement informing the covered person that:

(1) If the covered person has a medical condition where the time frame for completion of an expedited review of a grievance involving an appeal decision under G.S. 58-50-61 would reasonably be expected to seriously jeopardize the life or health of the covered person or jeopardize the covered person's ability to regain maximum function, the covered person may file a request for an expedited external review under G.S. 58-50-82 at the same time the covered person files a request for an expedited review of a grievance involving an appeal decision under G.S. 58-50-61 and G.S. 58-50-62, but that the Commissioner will determine whether the covered person shall be required to complete the expedited review of the grievance before conducting the expedited external review.

(2) If the insurer has not issued a written decision to the covered person within 45 days after the date the covered person files the grievance with the insurer pursuant to G.S. 58-50-62 and the covered person has not requested or agreed to a delay, the covered person may file a request for external review under G.S. 58-50-80 of this section and shall be considered to have exhausted the insurer's internal grievance process for purposes of G.S. 58-50-79.

(c) The insurer shall include in the notice required under subsection (a) of this section for a notice related to a final second-level grievance review decision under G.S. 58-50-62, a statement informing the covered person that:

(1) If the covered person has a medical condition where the time frame for completion of a standard external review under G.S. 58-50-80 would

reasonably be expected to seriously jeopardize the life or health of the covered person or jeopardize the covered person's ability to regain maximum function, the covered person may file a request for an expedited external review under G.S. 58-50-82; or

(2) If the second-level grievance review decision concerns an admission, availability of care, continued stay, or health care service for which the covered person received emergency services but has not been discharged from a facility, the covered person may request an expedited external review under G.S. 58-50-82.

(d) In addition to the information to be provided under subsections (b) and (c) of this section, the insurer shall include a copy of the description of both the standard and expedited external review procedures the insurer is required to provide under G.S. 58-50-93, including the provisions in the external review procedures that give the covered person the opportunity to submit additional information.

"**§ 58-50-78:** Reserved.

"**§ 58-50-79. Exhaustion of internal grievance process.**

(a) Except as provided in subsections (d) and (e) of this section, a request for an external review under G.S. 58-50-80 or G.S. 58-50-82 shall not be made until the covered person has exhausted the insurer's internal grievance process under G.S. 58-50-62.

(b) A covered person shall be considered to have exhausted the insurer's internal grievance process for purposes of this section, if the covered person:

(1) Has filed a second-level grievance involving a noncertification appeal decision under G.S. 58-50-61 and G.S. 58-50-62.

(2) Except to the extent the covered person requested or agreed to a delay, has not received a written decision on the grievance from the insurer within 45 days since the date the covered person filed the grievance with the insurer.

(c) Notwithstanding subsection (b) of this section, a covered person may not make a request for an external review of a noncertification involving a retrospective review determination made under G.S. 58-50-61 until the covered person has exhausted the insurer's internal grievance process.

(d) At the same time a covered person files a request for an expedited appeal involving a noncertification as set forth in G.S. 58-50-61(l), the covered person may file a request for an expedited external review of the noncertification under G.S. 58-50-82 if the covered person has a medical condition where the time frame for completion of an expedited review of the appeal involving a noncertification set forth in G.S. 58-50-61(l) would be reasonably expected to seriously jeopardize the life or health of the covered person or would jeopardize the covered person's ability to regain maximum function. An insurer may waive its right to conduct an expedited review of an appeal and allow the covered person to proceed with an expedited external review of the noncertification.

(e) Upon receipt of a request for an expedited external review under subsection (d) of this section, the Commissioner shall immediately determine whether the covered

person shall be required to complete the expedited internal appeal process set forth in G.S. 58-50-61(l) before the organization conducts the expedited external review, unless the insurer has waived its right to conduct an expedited review of the appeal decision.

(f) Upon a determination made under subsection (e) of this section that the covered person must first complete the expedited internal appeal process under G.S. 58-50-61(l), the Commissioner shall notify immediately the covered person and the insurer of this determination and that the expedited external review under G.S. 58-50-82 shall not proceed until completion of the expedited internal appeal process.

(g) A request for an external review of a noncertification may be made before the covered person has exhausted the insurer's internal grievance and appeal procedures under G.S. 58-50-61 and G.S. 58-50-62 whenever the insurer agrees to waive the exhaustion requirement. If the requirement to exhaust the insurer's internal grievance procedures is waived, the covered person may file a request in writing for a standard external review as set forth in G.S. 58-50-80 or may make a request for an expedited external review as set forth in G.S. 58-50-82.

"**§ 58-50-80. Standard external review.**

(a) Within 60 days after the date of receipt of a notice under G.S. 58-50-77, a covered person may file a request for an external review with the Commissioner.

(b) Upon receipt of a request for an external review under subsection (a) of this section, the Commissioner immediately shall notify and send a copy of the request to the insurer that made the decision which is the subject of the request. The insurer shall immediately submit to the Commissioner the information required for the preliminary review under subsection (c) of this section.

(c) Within five business days after the date of receipt of a request for an external review, the Commissioner shall complete a preliminary review of the request to determine whether:

(1) The individual is or was a covered person in the health benefit plan at the time the health care service was requested or, in the case of a retrospective review, was a covered person in the health benefit plan at the time the health care service was provided.

(2) The health care service that is the subject of the noncertification appeal decision or the second-level grievance review decision upholding a noncertification reasonably appears to be a covered service under the covered person's health benefit plan.

(3) The covered person has exhausted the insurer's internal appeal and grievance processes under G.S. 58-50-61 and G.S. 58-50-62 unless the covered person is not required to exhaust the insurer's internal appeal or grievance process under G.S. 58-50-79.

(4) The covered person has provided all the information and forms required by the Commissioner that are necessary to process an external review.

(d) Upon completion of the preliminary review under subsection (c) of this section, the Commissioner immediately shall notify the covered person in writing

whether the request is complete and whether the request has been accepted for external review. If the request is not complete, the Commissioner shall request from the covered person the information or materials needed to make the request complete. The covered person shall furnish the Commissioner with the requested information or materials within 90 days after the date of the insurer's decision for which external review is requested. If the request is not accepted for external review, the Commissioner shall inform the covered person and the insurer in writing of the reasons for its nonacceptance.

(e) If the request is accepted for external review, the Commissioner shall:

(1) Include in the notice provided under subsection (d) of this section a statement that the covered person may submit to the Commissioner in writing within seven days after the date of the notice additional information and supporting documentation relevant to the initial denial that the organization shall consider when conducting the external review.

(2) Immediately notify the insurer in writing of the acceptance of the request for external review.

The Commissioner shall maintain an alphabetical listing of independent review organizations approved under G.S. 58-50-85 and shall systematically assign on a rotating basis the next independent review organization on that list capable of performing the review to conduct the external review. After the last organization on the list has been assigned a review, the Commissioner shall return to the top of the list to continue assigning reviews.

(f) The Commissioner shall forward to the review organization that was assigned by the Commissioner any documents that were received relating to the request for external review. At the same time the Commissioner forwards the information to the review organization, the Commissioner shall forward the information to the insurer and the covered person.

(g) Within seven days after the date of receipt of the notice provided under subsection (d) of this section, the insurer or its designee utilization review organization shall provide to the assigned organization the documents and any information considered in making the noncertification appeal decision or the second-level grievance review decision. Except as provided in subsection (h) of this section, failure by the insurer or its designee utilization review organization to provide the documents and information within the time specified in this subsection shall not delay the conduct of the external review.

(h) If the insurer or its utilization review organization fails to provide the documents and information within the time specified in subsection (g) of this section, the assigned organization may terminate the external review and make a decision to reverse the noncertification appeal decision or the second-level grievance review decision. Immediately upon making the decision under this subsection, the organization shall notify the covered person, the insurer, and the Commissioner.

(i) Upon receipt of the information required to be forwarded under subsection (f) of this section, the insurer may reconsider its noncertification appeal decision or second-level grievance review decision that is the subject of the external review. Reconsideration by the insurer of its noncertification appeal decision or second-level grievance review decision under this subsection shall not delay or terminate the external review. The external review shall be terminated if the insurer decides, upon completion of its reconsideration, to reverse its noncertification appeal decision or second-level grievance review decision and provide coverage or payment for the requested health care service that is the subject of the noncertification appeal decision or second-level grievance review decision.

(j) Immediately upon making the decision to reverse its noncertification appeal decision or second-level grievance review decision under subsection (i) of this section, the insurer shall notify the covered person, the organization, and the Commissioner in writing of its decision. The organization shall terminate the external review upon receipt of the notice from the insurer sent under this subsection.

(k) The assigned organization shall review all of the information and documents received under subsections (f) and (g) of this section that have been forwarded to the organization by the Commissioner and the insurer. In addition, the assigned review organization, to the extent the documents or information are available, shall consider the following in reaching a decision:

(1) The covered person's medical records.

(2) The attending health care provider's recommendation.

(3) Consulting reports from appropriate health care providers and other documents submitted by the insurer, covered person, or the covered person's treating provider.

(4) The most appropriate practice guidelines that are based on sound clinical evidence and that are periodically evaluated to assure ongoing efficacy.

(5) Any applicable clinical review criteria developed and used by the insurer or its designee utilization review organization.

(6) Medical necessity, as defined in G.S. 58-3-200(b).

(7) Any documentation supporting the medical necessity and appropriateness of the provider's recommendation.

The assigned organization shall review the terms of coverage under the covered person's health benefit plan to ensure that the organization's decision shall not be contrary to the terms of coverage under the covered person's health benefit plan with the insurer.

The assigned organization's determination shall be based on the covered person's medical condition at the time of the initial noncertification decision.

(l) Within 45 days after the date of receipt by the Commissioner of the request for external review, the assigned organization shall provide written notice of its decision to uphold or reverse the noncertification appeal decision or second-level grievance review decision to the covered person, the insurer, and the Commissioner. In reaching a

decision, the assigned review organization is not bound by any decisions or conclusions reached during the insurer's utilization review process or the insurer's internal grievance process under G.S. 58-50-61 and G.S 58-50-62.

(m) The organization shall include in the notice sent under subsection (l) of this section:

(1) A general description of the reason for the request for external review.

(2) The date the organization received the assignment from the Commissioner to conduct the external review.

(3) The date the organization received information and documents submitted by the covered person and by the insurer.

(4) The date the external review was conducted.

(5) The date of its decision.

(6) The principal reason or reasons for its decision.

(7) The clinical rationale for its decision.

(8) References to the evidence or documentation, including the practice guidelines, considered in reaching its decision.

(9) The professional qualifications and licensure of the clinical peer reviewers.

(10) Notice to the covered person that he or she is not liable for the cost of the external review.

(n) Upon receipt of a notice of a decision under subsection (l) of this section reversing the noncertification appeal decision or second-level grievance review decision, the insurer shall immediately reverse the noncertification appeal decision or second-level grievance review decision that was the subject of the review and shall process the claim accordingly. In the event the covered person is no longer enrolled in the health benefit plan when the insurer receives notice of a decision under subsection (l) of this section reversing the noncertification appeal decision or second-level grievance review decision, the insurer shall be responsible under this section only for the costs of those services or supplies the covered person received or would have received prior to disenrollment.

"**§ 58-50-81:** Reserved.

"**§ 58-50-82. Expedited external review.**

(a) Except as provided in subsection (h) of this section, a covered person may make a written or oral request for an expedited external review with the Commissioner at the time the covered person receives:

(1) An appeal decision under G.S. 58-50-61(k) or (l) upholding a noncertification if:

a. The noncertification appeal decision involves a medical condition of the covered person for which the time frame for completion of an expedited second-level grievance review of a noncertification set forth in G.S. 58-50-62(i) would reasonably be expected to seriously jeopardize the life or health of the

covered person or jeopardize the covered person's ability to regain maximum function; and

b. The covered person has filed a request for an expedited second-level review of a noncertification as set forth in G.S. 58-50-61(i); or

(2) A second-level grievance review decision under G.S. 58-60-62(h) or (i) upholding a noncertification:

a. If the covered person has a medical condition where the time frame for completion of a standard external review under G.S. 58-50-80 would reasonably be expected to seriously jeopardize the life or health of the covered person or jeopardize the covered person's ability to regain maximum function; or

b. If the second-level grievance concerns a noncertification of an admission, availability of care, continued stay, or health care service for which the covered person received emergency services, but has not been discharged from a facility.

(b) At the time the Commissioner receives a request for an expedited external review, the Commissioner immediately shall:

(1) Notify and provide a copy of the request to the insurer that made the noncertification appeal decision or second-level grievance review decision which is the subject of the request.

(2) For a request that the Commissioner has determined meets the reviewability requirements set forth in G.S. 58-50-80(c), the Commissioner shall immediately determine, based on medical advice from a medical professional who is not affiliated with the organization that will be assigned to conduct the external review of the request, whether the request should be reviewed on an expedited basis because the time frame for completion of a standard external review under G.S. 58-50-80 would reasonably be expected to seriously jeopardize the life or health of the covered person or would jeopardize the covered person's ability to regain maximum function. The Commissioner shall then inform the covered person and the insurer whether the review will be conducted using an expedited or standard time frame, and shall, in accordance with G.S. 58-50-80, assign an organization to conduct the review within the appropriate time frame.

(c) In reaching a decision, the assigned organization is not bound by any decisions or conclusions reached during the insurer's utilization review process or internal grievance process under G.S. 58-50-61 and G.S. 58-50-62.

(d) At the time the insurer receives the notice under subsection (b) of this section, the insurer or its designee utilization review organization shall immediately provide or transmit all documents and information considered in making the noncertification appeal decision or the second-level grievance review decision to the assigned review

organization electronically or by telephone or facsimile or any other available expeditious method.

(e) In addition to the documents and information provided or transmitted under subsection (d) of this section, the assigned organization, to the extent the information or documents are available, shall consider the following in reaching a decision:

(1) The covered person's pertinent medical records.

(2) The attending health care provider's recommendation.

(3) Consulting reports from appropriate health care providers and other documents submitted by the insurer, covered person, or the covered person's treating provider.

(4) The most appropriate practice guidelines that are based on sound clinical evidence and that are periodically evaluated to assure ongoing efficacy.

(5) Any applicable clinical review criteria developed and used by the insurer or its designee utilization review organization in making noncertification decisions.

(6) Medical necessity, as defined in G.S. 58-3-200(b).

(7) Any documentation supporting the medical necessity and appropriateness of the provider's recommendation.

The assigned organization shall review the terms of coverage under the covered person's health benefit plan to ensure that the organization's decision shall not be contrary to the terms of coverage under the covered person's health benefit plan.

The assigned organization's determination shall be based on the covered person's medical condition at the time of the initial noncertification decision.

(f) As expeditiously as the covered person's medical condition or circumstances require, but not more than four days after the date of receipt of the request for an expedited external review, the assigned organization shall make a decision to uphold or reverse the noncertification appeal decision or second-level grievance review decision and notify the covered person, the insurer, and the Commissioner of the decision.

(g) If the notice provided under subsection (f) of this section was not in writing, within two days after the date of providing that notice, the assigned organization shall provide written confirmation of the decision to the covered person, the insurer, and the Commissioner and include the information set forth in G.S. 58-50-80(o). Upon receipt of the notice, a decision under subsection (f) of this section reversing the noncertification appeal decision or second-level grievance review decision, the insurer shall immediately reverse the noncertification appeal decision or second-level grievance review decision that was the subject of the review and shall process the claim accordingly.

(h) An expedited external review shall not be provided for retrospective noncertifications.

"**§ 58-50-83:** Reserved.

"**§ 58-50-84. Binding nature of external review decision.**

(a) An external review decision is binding on the insurer.

(b) An external review decision is binding on the covered person except to the extent the covered person has other remedies available under applicable federal or State law.

(c) A covered person may not file a subsequent request for external review involving the same noncertification appeal decision or second-level grievance review decision for which the covered person has already received an external review decision under this Part.

"**§ 58-50-85. Approval of independent review organizations.**

(a) The Commissioner shall approve independent review organizations eligible to be assigned to conduct external reviews under this Part to ensure that an organization satisfies the minimum qualifications established under G.S. 58-50-87. The Commissioner shall develop an application form for initially approving and for reapproving organizations to conduct external reviews.

(b) Any organization wishing to be approved to conduct external reviews under this Part shall submit the application form and include with the form all documentation and information necessary for the Commissioner to determine if the organization satisfies the minimum qualifications established under G.S. 58-50-87. Applicants must submit pricing information sufficient to demonstrate that if selected, the applicant's total fee per review will not exceed commercially reasonable fees charged for similar services in the industry. The Commissioner shall not approve any independent review organization that either fails to provide sufficient pricing information or has fees that do not meet the guidelines established under this subsection.

(c) The Commissioner may determine that accreditation by a nationally recognized private accrediting entity with established and maintained standards for independent review organizations that meet the minimum qualifications established under G.S. 58-50-87 will cause an independent review organization to be deemed to have met, in whole or in part, the requirements of this section and G.S. 58-50-87. A decision by the Commissioner to recognize an accreditation program for the purpose of granting deemed status may be made only after reviewing the accreditation standards and program information submitted by the accrediting body. An independent review organization seeking deemed status due to its accreditation shall submit original documentation issued by the accrediting body to demonstrate its accreditation.

(d) An approval is effective for two years, unless the Commissioner determines before expiration of the approval that the independent review organization is not satisfying the minimum qualifications established under G.S. 58-50-87.

(e) Whenever the Commissioner determines that an independent review organization no longer satisfies the minimum requirements established under G.S. 58-50-87, the Commissioner shall terminate the approval of the independent review organization.

"**§ 58-50-86:** Reserved.

"**§ 58-50-87. Minimum qualifications for independent review organizations.**

(a) As a condition of approval under G.S. 58-50-85 to conduct external reviews, an independent review organization shall have and maintain written policies and

procedures that govern all aspects of both the standard external review process and the expedited external review process set forth in G.S. 58-50-80 and G.S. 58-50-82 that include, at a minimum:

(1) A quality assurance mechanism in place that ensures:

a. That external reviews are conducted within the specified time frames and required notices are provided in a timely manner.

b. The selection of qualified and impartial clinical peer reviewers to conduct external reviews on behalf of the independent review organization and suitable matching of reviewers to specific cases.

c. The confidentiality of medical and treatment records and clinical review criteria.

d. That any person employed by or under contract with the independent review organization adheres to the requirements of this Part.

e. The independence and impartiality of the independent review organization and the external review process and limits the ability of any person to improperly influence the external review decision.

(2) A toll-free telephone service to receive information on a 24-hour-day, seven-day-a-week basis related to external reviews that is capable of accepting or recording inquiries or providing appropriate instruction to incoming telephone callers during other than normal business hours.

(3) An agreement to maintain and provide to the Commissioner the information set out in G.S. 58-50-90.

(4) A program for credentialing clinical peer reviewers.

(5) An agreement to contractual terms or written requirements established by the Commissioner regarding the procedures for handling a review.

(6) That the independent review organization consult with a medical doctor licensed to practice in North Carolina to advise the independent review organization on issues related to the standard of practice, technology, and training of North Carolina physicians with respect to the organization's North Carolina business.

(b) All clinical peer reviewers assigned by an independent review organization to conduct external reviews shall be medical doctors or other appropriate health care providers who meet the following minimum qualifications:

(1) Be an expert in the treatment of the covered person's injury, illness, or medical condition that is the subject of the external review.

(2) Be knowledgeable about the recommended health care service or treatment through recent or current actual clinical experience treating patients with the same or similar injury, illness, or medical condition of the covered person.

(3) If the covered person's treating provider is a medical doctor, hold a nonrestricted license and, if a specialist medical doctor, a current certification by a recognized American medical specialty board in the area or areas appropriate to the subject of the external review.

(4) If the covered person's treating provider is not a medical doctor, hold a nonrestricted license, registration, or certification in the same allied health occupation as the covered person's treating provider.

(5) Have no history of disciplinary actions or sanctions, including loss of staff privileges or participation restrictions, that have been taken or are pending by any hospital, governmental agency or unit, or regulatory body that raise a substantial question as to the clinical peer reviewer's physical, mental, or professional competence or moral character.

(c) In addition to the requirements set forth in subsection (a) of this section, an independent review organization may not own or control, be a subsidiary of, or in any way be owned or controlled by, or exercise control with a health benefit plan, a national, State, or local trade association of health benefit plans, or a national, State, or local trade association of health care providers.

(d) In addition to the requirements set forth in subsections (a), (b), and (c) of this section, to be approved under G.S. 58-50-85 to conduct an external review of a specified case, neither the independent review organization selected to conduct the external review nor any clinical peer reviewer assigned by the independent organization to conduct the external review may have a material professional, familial, or financial conflict of interest with any of the following:

(1) The insurer that is the subject of the external review.

(2) The covered person whose treatment is the subject of the external review or the covered person's authorized representative.

(3) Any officer, director, or management employee of the insurer that is the subject of the external review.

(4) The health care provider, the health care provider's medical group, or independent practice association recommending the health care service or treatment that is the subject of the external review.

(5) The facility at which the recommended health care service or treatment would be provided.

(6) The developer or manufacturer of the principal drug, device, procedure, or other therapy being recommended for the covered person whose treatment is the subject of the external review.

(e) In determining whether an independent review organization or a clinical peer reviewer of the independent review organization has a material professional, familial, or financial conflict of interest for purposes of subsection (d) of this section, the Commissioner shall take into consideration situations where the independent review organization to be assigned to conduct an external review of a specified case or a clinical peer reviewer to be assigned by the independent review organization to conduct an external review of a specified case may have an apparent professional, familial, or

financial relationship or connection with a person described in subsection (d) of this section, but that the characteristics of that relationship or connection are such that they are not a material professional, familial, or financial conflict of interest that results in the disapproval of the independent review organization or the clinical peer reviewer from conducting the external review.

"**§ 58-50-88:** Reserved.

"**§ 58-50-89. Hold harmless for Commissioner and independent review organizations.**

The Commissioner or an independent review organization or clinical peer reviewer working on behalf of an organization shall not be liable for damages to any person for any opinions rendered during or upon completion of an external review conducted under this Part, unless the opinion was rendered in bad faith or involved gross negligence.

"**§ 58-50-90. External review reporting requirements.**

(a) An organization assigned under G.S. 58-50-80 or G.S. 58-50-82 to conduct an external review shall maintain written records in the aggregate and by insurer on all requests for external review for which it conducted an external review during a calendar year and submit a report to the Commissioner, as required under subsection (b) of this section.

(b) Each organization required to maintain written records on all requests for external review under subsection (a) of this section for which it was assigned to conduct an external review shall submit to the Commissioner, at least annually, a report in the format specified by the Commissioner.

(c) The report shall include in the aggregate and for each insurer:

(1) The total number of requests for external review.

(2) The number of requests for external review resolved and, of those resolved, the number resolved upholding the noncertification appeal decision or second-level grievance review decision and the number resolved reversing the noncertification appeal decision or second-level grievance review decision.

(3) The average length of time for resolution.

(4) A summary of the types of coverages or cases for which an external review was sought, as provided in the format required by the Commissioner.

(5) The number of external reviews under G.S. 58-50-80(k) and (l) that were terminated as the result of a reconsideration by the insurer of its noncertification appeal decision or second-level grievance review decision after the receipt of additional information from the covered person.

(6) Any other information the Commissioner may request or require.

(d) The organization shall retain the written records required under this section for at least three years.

(e) Each insurer shall maintain written records in the aggregate and for each type of health benefit plan offered by the insurer on all requests for external review of which

the insurer receives notice from the Commissioner under this Part. The insurer shall retain the written records required under this section for at least three years.

"**§ 58-50-91:** Reserved.

"**§ 58-50-92. Funding of external review.**

The insurer against which a request for a standard external review or an expedited external review is filed shall reimburse the Department of Insurance for the fees charged by the organization in conducting the external review.

"**§ 58-50-93. Disclosure requirements.**

(a) Each insurer shall include a description of the external review procedures in or attached to the policy, certificate, membership booklet, outline of coverage, or other evidence of coverage it provides to covered persons.

(b) The description required under subsection (a) of this section shall include a statement that informs the covered person of the right of the covered person to file a request for an external review of a noncertification appeal decision or a second-level grievance review decision upholding a noncertification with the Commissioner. The statement shall include the telephone number and address of the Commissioner.

(c) In addition to subsection (b) of this section, the statement shall inform the covered person that, when filing a request for an external review, the covered person will be required to authorize the release of any medical records of the covered person that may be required to be reviewed for the purpose of reaching a decision on the external review.

"**§ 58-50-94. Competitive selection of independent review organizations.**

(a) The Commissioner shall prepare and publish requests for proposals from independent review organizations that want to be approved under G.S. 58-50-85. All proposals shall be sealed. The Commissioner shall open all proposals in public.

(b) After the public opening, the Commissioner shall review the proposals, examining the costs and quality of the services offered by the independent review organizations, the reputation and capabilities of the independent review organizations submitting the proposals, and the provisions in G.S. 58-50-85 and G.S. 58-50-87. The Commissioner shall determine which proposal or proposals would satisfy the provisions of this Part. The Commissioner shall make his determination in consultation with an evaluation committee whose membership includes representatives of insurers subject to Part 4 of Article 50 of Chapter 58 of the General Statutes, health care providers, and insureds. In selecting the review organizations, in addition to considering cost, quality, and adherence to the requirements of the request for proposals, the Commissioner shall consider the desirability and feasibility of contracting with multiple review organizations in order to allow insureds a choice of review organizations and shall ensure that at least one review organization is available and capable of reviewing cases involving highly specialized services and treatments of any nature. The Commissioner may reject any or all proposals.

(c) An independent review organization may seek to modify or withdraw a proposal only after the public opening and only on the basis that the proposal contains an unintentional clerical error as opposed to an error in judgment. An independent

review organization seeking to modify or withdraw a proposal shall submit to the Commissioner a written request, with facts and evidence in support of its position, before the determination made by the Commissioner under subsection (b) of this section, but not later than two days after the public opening of the proposals. The Commissioner shall promptly review the request, examine the nature of the error, and determine whether to permit or deny the request.

(d) The provisions of Article 3C of Chapter 143 of the General Statutes do not apply to this Part.

"**§ 58-50-95. Report by Commissioner.**

The Commissioner shall report semiannually to the Joint Legislative Health Care Oversight Committee regarding the nature and appropriateness of reviews conducted under this Part. The report, which shall be provided to the public upon request, should include the number of reviews, underlying issues in dispute, character of the reviews, dollar amounts in question, whether the review was decided in favor of the covered person or the health benefit plan, the cost of review, and any other information relevant to the evaluation of the effectiveness of this Part."

SECTION 4.6. G.S. 58-50-62(h)(7) reads as rewritten:

"(7) A statement that the decision is the insurer's final determination in the matter. In cases where the review concerned a noncertification and the insurer's decision on the second-level grievance review is to uphold its initial noncertification, a statement advising the covered person of his or her right to request an external review and a description of the procedure for submitting a request for external review to the Commissioner of Insurance."

SECTION 4.6A. G.S. 143-64.24 reads as rewritten:

"**§ 143-64.24. Applicability of Article.**

This Article shall not apply to the General Assembly, special study commissions, the Research Triangle Institute, or the Institute of Government, nor shall it apply to attorneys employed by the North Carolina Department of Justice, or physicians or doctors performing contractual services for any State agency. This Article shall not apply to Independent Review Organizations selected by the Commissioner of Insurance pursuant to G.S. 58-50-85."

Subpart B. Health Plan Liability

SECTION 4.7. Chapter 90 of the General Statutes is amended by adding a new Article to read:

"Article 1G.

"Health Care Liability.

"**§ 90-21.50. Definitions.**

As used in this Article, unless the context clearly indicates otherwise, the term:

(1) 'Health benefit plan' has the meaning applied in G.S. 58-3-167.

(2) 'Health care provider' means:

a. An individual who is licensed, certified, or otherwise authorized under this Chapter to provide health care services in the ordinary course of business or practice of a profession or in an approved education or training program; or

b. A health care facility, licensed under Chapters 131E or 122C of the General Statutes, where health care services are provided to patients;

'Health care provider' includes: (i) an agent or employee of a health care facility that is licensed, certified, or otherwise authorized to provide health care services; (ii) the officers and directors of a health care facility; and (iii) an agent or employee of a health care provider who is licensed, certified, or otherwise authorized to provide health care services.

(3) 'Health care service' means a health or medical procedure or service rendered by a health care provider that:

a. Provides testing, diagnosis, or treatment of a health condition, illness, injury, or disease; or

b. Dispenses drugs, medical devices, medical appliances, or medical goods for the treatment of a health condition, illness, injury, or disease.

(4) 'Health care treatment decision' means a determination that:

a. Is made by a managed care entity;

b. Governs the extent to which health care services are provided for, arranged for, paid for, or reimbursed for under a health benefit plan; and

c. Affects the quality of the diagnosis, care, or treatment provided under the health benefit plan to an enrollee or insured of the health benefit plan.

(5) 'Insured or enrollee' means a person that is insured by or enrolled in a health benefit plan under a policy, plan, certificate, or contract issued or delivered in this State by an insurer.

(6) 'Insurer' has the meaning applied in G.S. 58-3-167.

(7) 'Managed care entity' means an insurer that:

a. Delivers, administers, or undertakes to provide for, arrange for, or reimburse for health care services or assumes the risk for the delivery of health care services; and

b. Has a system or technique to control or influence the quality, accessibility, utilization, or costs and prices of health care services delivered or to be delivered to a defined enrollee population.

'Managed care entity' does not include: (i) an employer purchasing coverage or acting on behalf of its employees or the employees of one

or more subsidiaries or affiliated corporations of the employer, or (ii) a health care provider.

(8) 'Ordinary care' means that degree of care that a managed care entity of ordinary prudence situated in the same or similar communities at the time of the alleged act giving rise to the cause of action would use under the same or similar circumstances.

(9) 'Physician' means:

a. An individual licensed to practice medicine in this State;

b. A professional association or corporation organized under Chapter 55B of the General Statutes; or

c. A person or entity wholly owned by physicians.

(10) 'Successor external review process' means an external review process equivalent in all respects to G.S. 58-50-75 through G.S. 58-50-95 that is approved by the Department and implemented by a health benefit plan in the event that G.S. 58-50-75 through G.S. 58-50-95 are found by a court of competent jurisdiction to be void, unenforceable, or preempted by federal law, in whole or in part.

"**§ 90-21.51. Duty to exercise ordinary care; liability for damages for harm.**

(a) Each managed care entity for a health benefit plan has the duty to exercise ordinary care when making health care treatment decisions and is liable for damages for harm to an insured or enrollee proximately caused by its failure to exercise ordinary care.

(b) In addition to the duty imposed under subsection (a) of this section, each managed care entity for a health benefit plan is liable for damages for harm to an insured or enrollee proximately caused by the health care treatment decisions made by:

(1) Its agents or employees; or

(2) Representatives that are acting on its behalf and over whom it has exercised sufficient influence or control to reasonably affect the actual care and treatment of the insured or enrollee which results in the failure to exercise ordinary care.

(c) It shall be a defense to any action brought under this section against a managed care entity for a health benefit plan that:

(1) The managed care entity and its agents or employees, or representatives for whom the managed care entity is liable under subsection (b) of this section, did not control or influence or participate in the health care treatment decision; and

(2) The managed care entity did not deny or delay payment for any health care service or treatment prescribed or recommended by a physician or health care provider to the insured or enrollee.

(d) In an action brought under this Article against a managed care entity, a finding that a physician or health care provider is an agent or employee of the managed care entity may not be based solely on proof that the physician or health care provider

appears in a listing of approved physicians or health care providers made available to insureds or enrollees under the managed care entity's health benefit plan.

(e) An action brought under this Article is not a medical malpractice action as defined in Article 1B of this Chapter. A managed care entity may not use as a defense in an action brought under this Article any law that prohibits the corporate practice of medicine.

(f) A managed care entity shall not be liable for the independent actions of a health care provider, who is not an agent or employee of the managed care entity, when that health care provider fails to exercise the standard of care required by G.S. 90-21.12. A health care provider shall not be liable for the independent actions of a managed care entity when the managed care entity fails to exercise the standard of care required by this Article.

(g) Nothing in this Article shall be construed to create an obligation on the part of a managed care entity to provide to an insured or enrollee a health care service or treatment that is not covered under its health benefit plan.

(h) A managed care entity may not enter into a contract with a health care provider, or with an employer or employer group organization, that includes an indemnification or hold harmless clause for the acts or conduct of the managed care entity. Any such indemnification or hold harmless clause is void and unenforceable to the extent of the restriction.

"**§ 90-21.52. No liability under this Article on the part of an employer or employer group organization that purchases coverage or assumes risk on behalf of its employees or a physician or health care provider.**

(a) This Article does not create any liability on the part of an employer or employer group purchasing organization that purchases health care coverage or assumes risk on behalf of its employees.

(b) This Article does not create any liability on the part of a physician or health care provider in addition to that otherwise imposed under existing law. No managed care entity held liable under this Article shall be entitled to contribution under Chapter 1B of the General Statutes from a physician or health care provider.

"**§ 90-21.53. Separate trial required.**

Upon motion of any party in an action that includes a claim brought pursuant to this Article involving a managed care entity, the court shall order separate discovery and a separate trial of any claim, cross-claim, counterclaim, or third-party claim against any physician or other health care provider.

"**§ 90-21.54. Exhaustion of administrative remedies and appeals.**

(a) Except as provided in this section, no action may be commenced under this Article until the plaintiff has exhausted all administrative remedies and appeals, including those internal remedies and appeals established under G.S. 58-50-51 through G.S. 58-50-52, and G.S. 58-50-75 through G.S. 58-50-95, and including those established under any successor external review process.

(b) The plaintiff may file a claim without exhausting all administrative remedies and appeals if both of the following conditions are met:

(1) The plaintiff has already been harmed by the conduct of the managed care entity or because of an act or omission of an employee, agent, ostensible agent, or representative of the managed care entity for whose conduct the managed care entity is liable.

(2) The circumstances are such that no administrative remedy or appeal is available or that the administrative review would not be beneficial to the plaintiff.

"**§ 90-21.55. External review decision.**

(a) Either the insured or enrollee or the personal representative of the insured or enrollee or the managed care entity may use an external review decision made in accordance with G.S. 58-50-75 through G.S. 58-50-95, or made in accordance with any successor external review process, as evidence in any cause of action which includes an action brought under this Part, provided that an adequate foundation is laid for the introduction of the external review decision into evidence and the testimony is subject to cross-examination.

(b) Any information, documents, or other records or materials considered by the Independent Review Organization licensed under Part 4 of Article 50 of Chapter 58 of the General Statutes, or the successor review process, in conducting its review shall be admissible in any action commenced under this Article in accordance with Chapter 8 of the General Statutes and the North Carolina Rules of Evidence.

"**§ 90-21.56. Remedies.**

(a) An insured or enrollee who has been found to have been harmed by the managed care entity pursuant to an action brought under this Article may recover actual or nominal damages and punitive damages under the provisions and limitations of Chapter 1D of the General Statutes.

(b) This Article does not limit a plaintiff from pursuing any other remedy existing under the law or seeking any other relief that may be available.

(c) The rights conferred under this Article may not be waived, deferred, or lost pursuant to any contract that provides for the use of arbitration or mediation to resolve a controversy arising out of or relating to a dispute involving the provisions of health plan benefits. Arbitration or mediation may not be used to settle the controversy unless and until after the controversy arises the insured or enrollee, or the estate of the insured or enrollee, voluntarily and knowingly consents in writing to use arbitration or mediation to settle the controversy. Consent to an arbitration or mediation process shall not limit the rights of the insured or enrollee or the estate of the insured or enrollee to seek any remedies provided under this Article."

SECTION 4.8. G.S. 1A-1, Rule 42, reads as rewritten:

"**Rule 42. Consolidation; separate trials.**

(a) Consolidation. – ~~When~~ Except as provided in subdivision (b)(2) of this section, when actions involving a common question of law or fact are pending in one division of the court, the judge may order a joint hearing or trial of any or all the matters in issue in the actions; he may order all the actions consolidated; and he may make such orders concerning proceedings therein as may tend to avoid unnecessary costs or delay.

When actions involving a common question of law or fact are pending in both the superior and the district court of the same county, a judge of the superior court in which the action is pending may order all the actions consolidated, and he may make such orders concerning proceedings therein as may tend to avoid unnecessary costs or delay.

(b) Separate trials. –

(1) The court may in furtherance of convenience or to avoid prejudice and shall for considerations of venue upon timely motion order a separate trial of any claim, ~~crossclaim~~cross-claim, counterclaim, or third-party claim, or of any separate issue or of any number of claims, ~~crossclaims~~cross-claims, counterclaims, third-party claims, or issues.

(2) Upon motion of any party in an action that includes a claim commenced under Article 1G of Chapter 90 of the General Statutes involving a managed care entity as defined in G.S. 90-21.50, the court shall order separate discovery and a separate trial of any claim, cross-claim, counterclaim, or third-party claim against a physician or other medical provider."

SECTION 5.(a) G.S. 58-2-105 reads as rewritten:

"**§ 58-2-105. Confidentiality of medical records.**

(a) All patient medical records in the possession of the Department are confidential and are not public records pursuant to G.S. 58-2-100 or G.S. 132-1. As used in this section, "patient medical records" includes personal information that relates to an individual's physical or mental condition, medical history, or medical treatment, and that has been obtained from the individual patient, a health care provider, or from the patient's spouse, parent, or legal guardian.

(b) Under Part 4 of Article 50 of this Chapter, the Department may disclose patient medical records to an independent review organization, and the organization shall maintain the confidentiality of those records as required by this section, except as allowed by G.S. 58-30-75."

SECTION 5.(b) G.S. 58-3-200(b) reads as rewritten:

"(b) Medical Necessity. – An insurer that limits its health benefit plan coverage to medically necessary services and supplies shall define "medically necessary services or supplies" in its health benefit plan as those covered services or supplies that are:

(1) Provided for the diagnosis, treatment, cure, or relief of a health condition, illness, injury, or disease; ~~and~~ and, except as allowed under G.S. 58-3-255, not for experimental, investigational, or cosmetic purposes.

(2) Necessary for and appropriate to the diagnosis, treatment, cure, or relief of a health condition, illness, injury, disease, or its symptoms.

(3) Within generally accepted standards of medical care in the community.

(4) Not solely for the convenience of the insured, the insured's family, or the provider.

For medically necessary services, nothing in this subsection precludes an insurer from comparing the cost-effectiveness of alternative services or supplies when determining which of the services or supplies will be covered."

SECTION 5.(c) G.S. 58-50-61(a)(12) reads as rewritten:

"(12) "Medically necessary services or supplies" means those covered services or supplies that are:

a. Provided for the diagnosis, treatment, cure, or relief of a health condition, illness, injury, or disease.

b. Except as allowed under G.S. 58-3-255, ~~Not~~ not for experimental, investigational, or cosmetic purposes.

c. Necessary for and appropriate to the diagnosis, treatment, cure, or relief of a health condition, illness, injury, disease, or its symptoms.

d. Within generally accepted standards of medical care in the community.

e. Not solely for the convenience of the insured, the insured's family, or the provider.

For medically necessary services, nothing in this subdivision precludes an insurer from comparing the cost-effectiveness of alternative services or supplies when determining which of the services or supplies will be covered."

SECTION 6. If any section or provision of this act is declared unconstitutional or invalid by the courts, it does not affect the validity of the act as a whole or any part other than the part so declared to be unconstitutional or invalid.

SECTION 7. Section 1.6 of this act becomes effective January 1, 2002. Sections 3.1 and 3.2 of this act become effective December 1, 2001, and apply to health benefit plans that are delivered, issued for delivery, or renewed on or after that date. Sections 4.1 through 4.8 of this act become effective March 1, 2002. The remainder of this act is effective when it becomes law and applies to health benefit plans that are delivered, issued for delivery, or renewed on or after January 1, 2002. Nothing in this act obligates the General Assembly to appropriate funds to implement this act.

SENATE BILL 199:
Managed Care Patients' Bill of Rights

BILL ANALYSIS

Committee:	House Health Committee	**Introduced by:**	Sen. Wellons
Date:	July 31, 2001	**Summary by:**	Linda Attarian
Version:	2nd Edition		Committee Counsel

SUMMARY: The Second Edition of Senate Bill 199 proposes new mandated benefits and new protections for patients enrolled in managed care plans to ensure timely access to covered benefits and providers. Sections 3.1 and 3.2 (mandated benefits) become effective December 1, 2001, Sections 4.1-4.7 (External Review and HMO liability) become effective on March 1, 2002; and the remainder of the act is effective when it becomes law and applies to health benefit plans that are delivered, issued for delivery, or renewed on or after January 1, 2002. Specifically, the bill would enact the following new managed care patient protections:

- *"Continuity of Care in HMOs" to allow enrollees in managed care plans continued access to their health care providers for ongoing treatment for special conditions when the provider's contract is terminated or the enrollee's employer changes health plans. (Section 1)*
- *"Extended or Standing Referral to a Specialist" to provide that the term specialist includes a "subspecialist"; and to allow enrollees in managed care plans to select a specialist as their primary care physician under certain conditions, and to allow children direct access to a pediatrician. (Sections. 1.2-1.4)*
- *"Access to Prescription Drugs" to allow enrollees in managed care plans access to information concerning a health benefit plans list of drugs for which access is limited or restricted. (Section 1.5)*
- *"Managed Care Patient Assistance Program" to establish an office to provide information and assistance to patients enrolled in managed care plans. (Section 1.6)*
- *"Provider Directories" to enhance the scope of information insures must provide enrollees in managed care plans about the plan's network of providers. (Section 2.2)*
- *"Disclosure of Payment Obligations" to provide enrollees in preferred provider networks access to information about how their payment obligations are calculated and that their payment could exceed their copayment. (Section 2.3)*
- *"Mandated Benefits" to require insurers to provider coverage of medically necessary costs related to clinical trials and also to cover newborn hearing screening. (Section 3.1-3.2)*
- *"Independent, External Review Process" to provide enrollees in managed care plans with an external standard and expedited review by an independent review organization of lower appeal decisions upholding a health plan's decision not to pay for a requested covered service. (Sections 4.1-4.5)*
- *"Health Plan Liability" to provide enrollees with a statutory right of action against managed care organizations that fail to use ordinary care in making health care treatment decisions regarding covered services. (Section 4.7)*

CURRENT LAW AND BILL ANALYSIS

SECTION 1. Continuity of Care in HMOs

Current Practice: An HMO's relationship with providers is contractual in nature and is subject to termination by either party for various reasons specified in the contract. In certain circumstances, for example, when the provider's contract with the HMO terminates while a person is undergoing treatment for an ongoing chronic or terminal condition, changing providers on short notice is a hardship and may possibly have an adverse impact on the treatment.

Bill Analysis:

Section 1 would add a new section to Article 67 of Chapter 58, which is applicable only to HMOs, to require HMOs to allow enrollees suffering from ongoing special conditions as defined in the bill to elect to continue receiving services, on a transitional basis from a provider who leaves the HMO's network or under circumstances when the patient becomes enrolled in a new group health plan because the patient's employer has changed health benefit plans.

- Generally the transitional coverage period may extend up to 90 days for treatment for an acute or chronic illness, but may extend to the death of a patient whose condition is terminal (defined as someone with a life expectancy of more than 6 months), or up to 90 days post-discharge the when the patient is on a waiting list for surgery or a transplant, or up to 60 days postpartum.
- The transitional period begins the day after the patient is notified of the right to elect to continue coverage.
- The transition coverage is conditioned upon the patient's notification to the HMO within 45 days of notice that the patient wishes to continue coverage.
- The patient and the provider must adhere to certain conditions in order to obtain the transitional coverage, including agreeing to accept the reimbursement rates, etc. of the new HMO.
- An HMO is not required to offer the transitional coverage when the HMO terminates the provider's contract for reasons relating to quality of care or fraud. Denials of transitional coverage under these circumstances are not subject to appeal by the patient.

SECTION 1.2. AND 1.2A. Extending or Standing Referral to a Specialist

Current Law:

- G.S. 58-3-223 requires insurers to implement procedures to provide extended or standing referrals to a IN-PLAN specialist when the patient has a serious or chronic degenerative, disabling, or life threatening disease or condition, which in the opinion of the patient's primary care physician, in consultation with a specialist, requires ongoing specialty care. The referral is "standing" in that it is valid for up to 12 months.

- G.S. 58-3-200(d) prohibits an insurer from subjecting a patient that must seek treatment from a provider that is not in the insurer's network of providers due to the unavailability of a provider (not specialist) in the network to treat the patient's condition from higher fees or co-payments. .

Bill Analysis: Sections 1.2 and 1.2A will allow a patient to see an out-of-network specialist, including a sub-specialist without penalty if the patient has a standing referral and no such specialist is available within the health plan's provider panel.

- **Section 1.2** clarifies that the definition of "specialist" in G.S. 58-3-223 includes "subspecialist."
- **Section 1.2A** extends the scope of G.S. 58-3-200(d), to prohibit an insurer from subjecting a patient to higher fees or co-payments when the patient must seek treatment from an out-of-network specialist to which the patient has a standing referral due to the unavailability of an in-network specialist.

SECTION 1.3. Selection of a Specialist as a Primary Care Physician

Current Law:
Generally, health benefit plans require a patient to have a primary care physician who is responsible for providing or authorizing tests and procedures, etc., and coordinating the patient's treatment. When a patient requires ongoing specialty care, the patient may receive a standing referral to a specialist for up to 12 months, and will see the referring physician as their primary care physician.

Bill Analysis:
Section 1.3 adds a new section to Article 3 of Chapter 58 to require insurers to allow enrollees that need specialized medical care to select a specialist as their primary care physician. The insurer retains the authority to deny the patient's access to the specialist as a primary care provider if the insurer determines that the specialist is inappropriately coordinating the patient's care.

SECTION 1.4. Direct Access to Pediatrician

Current Law: Under current North Carolina law, HMOs and PPOs (preferred provider networks) must allow enrollees direct access without prior authorization to obstetrician-gynecologist services.

Bill Analysis:
Section 1.4 adds a new section to Article 3 of Chapter 58 to require any health benefit plan that uses a network of providers to allow an insured to choose a contracting pediatrician as the primary care provider for the insured's children (under 18).

SECTION 1.5: Access to Prescription Drugs

Current Law: Managed care organizations (MCOs) use drug formularies to control the cost of prescription drugs. A *closed* formulary is a list of drugs and devices that the MCO will cover if prescribed. MCO will not cover any drug or device that is not included in the formulary. A restricted access formulary is a list of drugs and devices that require prior approval. G.S. 58-3-221 requires the MCOs to develop any closed formularies in consultation and with the approval of a pharmacy and therapeutics committee, comprised of pharmacists and health care providers who are licensed to prescribe medications. The closed formulary must be made available to the participating providers and pharmacists in the MCO's network. When an enrollee needs a drug or device excluded from the formulary, the MCO must cover it ONLY if it is medically necessary and if alternative drugs or devices on the formulary have been shown to be ineffective, or would, in the physician's opinion, cause the patient harm. Currently, G.S. 58-3-221 applies only to closed formularies.

Bill Analysis:
Section 1.5 amends G.S. 58-3-221 to:

- Apply the current patient access provisions of G.S. 58-3-221 to drugs and devices included on restricted formularies;
- Provide that the pharmacy and therapeutics committee shall include ONLY NC licensed physicians (physician may include;

- Require the MCO to make the formulary available to *enrollees* as well as participating pharmacists and providers; and
- Allow the *enrollee's physician*, acting on behalf of the enrollee, to negotiate with the MCO to obtain coverage of a non-formulary drug or device *or a restricted access drug or device.*

SECTION 1.6. Managed Care Patient Assistance Program

Current law/practice:

Information provided to enrollees by health plans regarding their benefits may be confusing, especially with respect to benefit rights. The Department of Insurance maintains a Division of Consumer Services and the Department of Justice maintains a Consumer Protection Division to assist insureds with questions and complaints about their health insurance coverage, etc.

Bill Analysis:

Section 1.6 creates a Managed Care Patient Assistance Program. The Governor will appoint the Director. The Program will assist persons enrolled in a managed care organization (MCO). The Office would have the following duties and responsibilities:

1. Develop and distribute educational and informational materials for consumers explaining their rights and responsibilities as managed care plan enrollees.
2. Assist enrollees with the grievance, appeal, and external review procedures.
3. Publicize the Office of the Managed Care Patient Assistance Program.
4. Answer inquiries posed by consumer and refer inquiries of a regulatory nature to staff within the Department of Insurance.
5. Advise enrollees about the utilization review process.
6. Compile data on the activities of the Office, and evaluate such data to make recommendations as to the needed activities of the Office.
7. Report annually to the General Assembly.

SECTION 2.1. Managed Care Reporting and Disclosure Requirements to Plan Participants

Current Law:

G.S. 58-3-191 require health plans to make reports to the Department of Insurance and to make certain disclosures to plan participants upon request.

Bill Analysis:

Section 2.1 amends the disclosure requirements currently set forth in G.S. 58-3-191 regarding the health plan's "restrictive formularies." The statute is amended to conform and clarify that the plan must disclose the plan's "closed formularies and restricted access drugs and devices."

SECTION 2.2. Provider Directory Information

Current Law/Practice:

Provider directory information is important to consumers when they are selecting a health plan, and consumers sometimes have difficulty in obtaining complete and/or updated directory information. Currently there are no statutory standards for insurers or health benefit plans to distribute provider network directories to enrollees or to update the information they provide voluntarily.

Bill Analysis:
Section 2.2 amends Article 3 of Chapter 58 to add a new section to require health plans that utilize a provider network to develop a listing of all participating providers and update the listing at least annually. The health plan must also provide enrollee access to a telephonic system and MAY provide an on-line system to access up-to-date information. The directory must include the following minimum information (to the extent known) in addition to name, address, etc., about each provider:

- Area of specialty (if applicable);
- An indication of whether the provider may be selected as a primary care provider;
- Whether the provider is accepting new patients, and any restrictions that may limit the enrollee's access to the provider;
- Types of participating providers; and, upon request of a provider, the names of any allied health professionals that work with the provider.

SECTION 2.3. Disclosure of Payment Obligations

Current Law/Practice:
PPO (Preferred Provider Organizations) plans are not required to guarantee that participating providers will not bill enrollees for the difference between the payment amount specified in the provider contract and the provider's actual charges. (i.e., balance bill). In any case where the insurer bases its payment to a provider or benefit to the insured on an amount other than actual provider charges and has not arranged to prohibit balance billing, a provider can balance bill a patient for any charges that remain unpaid. When this occurs, the member's share of the bill may actually be higher than the nominal share of costs advertised in the policy. This is confusing to enrollees, especially when they believe that their benefits will be reduced by only a defined percent when they receive care from a non-network provider. Even though PPO policies do state that the insurer will base its benefit on the plan's "allowed amount" or "usual, customary, and reasonable charge," the insured has no information to evaluate the impact of such a provision.

Bill Analysis:
Section 2.3 amends Article 3 of Chapter 58 to add a new section that will require health benefit plans (PPOs) that do not utilize the fixed dollar co-payment method to calculate benefit amounts for covered services to:

- Explain how the plan calculates its share and the insured's share of the claim
- Indicate whether the insured may be liable for paying any excess amount.
- Indicate which party is responsible for filing a claim or bill with the insurer.
- Include information about how the actual calculation was made for each claim.
- *Notice Requirement*: If an insured is liable for an amount that differs from a fixed dollar co-payment or from a stated coinsurance percentage, and the provider is allowed to balance bill the insured, then the plan must include in plan materials and its marketing and advertising materials a notice advising that the insured's actual share of a claim may exceed the stated coinsurance percentage because the provider charges are not used to determine the plan's and the insurer's payment obligations.

SECTION 3.1. Clinical Trials/Mandated Coverage

Current Law: The Teachers' and State Employees' Comprehensive Major Medical Plan provides limited coverage of medically necessary health care services associated with investigational treatment protocols provided in phase III and IV clinical trials, and in phase II clinical trials when approved by the Plan.

Bill Analysis:

Section 3.1 amends Article 3 of Chapter 58 to add a new section to require all health benefit plans to provide limited coverage of medically necessary costs of health care services associated with participation in a covered clinical trial, which is limited to a phase III or IV clinical trials designed to evaluate new treatments, including prescription drugs and that meet a number of requirements outlined in the section. Costs of services that are not health care services or are not related to the direct clinical management of the patient are not covered.

SECTION 3.2. Newborn Hearing Screening/Mandated Coverage

Current Law: No current mandate under NC law. G.S. 130A-125, the Newborn Screening Program, requires each newborn to receive a hearing screening.

Bill Analysis:

Section 3.2 amends Article 3 of Chapter 58 to add a new section to require health benefit plans to provide coverage for newborn hearing and screening ordered by physicians pursuant to G.S.130A-125.

SECTIONS 4.1-4.5. Independent, External Review

Sections 4.1-4.4 make non-substantive, organizational changes to Article 50 of Chapter 58.

Section 4.5 adds a new Part to Article 50 of Chapter 58 to require insurers to establish procedures to allow enrollees access to an independent, external review of decisions upholding a denial of a requested covered service and provides standards for those procedures.

Current Law: The following is an explanation of the current appeal procedures available under G.S. 58-50-61 and 58-50-62. Section 4.5 would amend Article 50 of Chapter 58 to add an additional independent review procedure.

North Carolina law provides for a two-step internal appeal and grievance procedure that allows consumers to appeal denials of preauthorization's of covered services or other matters in dispute between the consumer and the health benefit plan. Consumers whose appeal of a preauthorization denial or whose first-level grievance review has been decided in favor of the insurer have a right to file a written grievance with the insurer and to have a panel investigate and make a determination regarding the grievance. Consumers also have a right to request that the review be conducted expeditiously, under certain circumstances.

Appeals of Utilization Review Decisions: Under current law, when a consumer requests authorization of a particular procedure or service or continued authorization of ongoing care, the insurer must decide whether to authorize within two business days of the request. If the insurer denies authorization (referred to as a noncertification), the consumer may formally appeal the denial. This formal appeal procedure allows the consumer to explain why the procedure should have been authorized. This appeal must be reviewed by at least one medical doctor, licensed in NC, who was not involved in the denial. The insurer must issue a written decision to the consumer and the health care provider within *30 days* of the request

for review. The insurer must provide an expedited review and issue a decision within *4 days* when an expedited decision is necessary to avoid seriously jeopardizing the life or health of the patient.

First-Level Grievance Appeal: If the dispute concerns a matter of dissatisfaction *other* than a request for covered services, the consumer has a right to a formal review of the grievance. The current law requires that the insurer select someone with appropriate expertise, who was not involved in the matter, to evaluate the grievance. A written decision must be issued within 30 days of the request.

Second-Level Grievance Appeal: If the consumer is dissatisfied with the outcome of the first level grievance appeal, or of the appeal of the denial of preauthorization of a request for a covered service, the consumer has a right to file a formal, second-level grievance appeal with the insurer. At this stage, persons who were not previously involved in the matter, who are not employed by the insurer and who do not have a financial interest in the outcome of the appeal, must evaluate the matter giving rise to the appeal. *However, these persons are appointed to serve on the panel by the insurer.*

When the grievance concerns a utilization review matter or clinical issue, all members of the review panel must be health care professionals with appropriate expertise, including at least one clinical peer. One member of the panel may be an employee of the insurer if the panel is made up of three or more persons and the insurer included a clinical peer in the review of an appeal or first level grievance. The review must be held within *45 days* of receipt of request and a written decision must be provided to the consumer *7 days* after the review meeting. An expedited review of the second-level grievance must be provided and a decision rendered within 4 days, if this timeframe is necessary to avoid seriously jeopardizing the life or health of the patient.

Bill Analysis of Section 4.5

Section 4.5 would add a new Part to Article 50 of Chapter 58, entitled "Health Benefit Plan External Review." The following chart provides a brief explanation of each of the key features of the proposal.

General Features of External Review Plan	
Benchmark Standards for an Independent External Review Plan.	1. Requires health plans to establish independent external review procedures for covered persons to appeal internal review decisions upholding a denial of a requested covered service. 2. Applies to all persons that provide or perform utilization review. 3. The insurer, not the covered person, pays for the external review. 4. No minimum dollar threshold. Effective date: December 1, 2002.

Notice Standard: G.S. 58-50-77	
Full Notice to Covered Persons Required.	1. The insurer is required to provide written notice of the right to seek the independent appeal. 2. The notice must tell the covered person what procedures to follow to request an *expedited* review if one is warranted. 3. The insurer must inform the covered person upfront about the review process and what kind of information the covered person can provide in support of the appeal.
Internal Review Required: G.S. 58-50-79	
Exhaustion of Internal Grievance Process.	1. The insurer's internal grievance process must first be exhausted. 2. Except for retrospective review decisions, the internal review process is *deemed* exhausted if the insurer has failed to make a decision within 45 days concerning a second –level grievance appeal. 3. Exception: If an expedited external appeal is requested and approved by the Commissioner or insurer *waives* the requirement.
Standard External Review Procedures	
Filing Deadline for Covered Person. G.S. 58-50-80(a).	1. Covered person must file a written request within *60 days* after receiving the final decision of the internal review. 2. Exception: If an expedited external appeal is requested and approved.
Requirements for the Commissioner of Insurance Once a Request is Filed. G.S. 58-50-80(b) and (c).	1. The Commissioner must *immediately* send a copy of the request to the insurer and complete a preliminary review of the request *within five days* to make sure it meets all the filing requirements.
If Request is Incomplete. G.S. 58-50-80(d).	1. The Commissioner must request necessary information from the covered person. The covered person has 90 days from the date of the appeal decision to submit.
If Request is Not Accepted. G.S. 58-50-80(d).	1. The Commissioner must inform the covered person and the insurer *in writing* of the reasons the request was not accepted. There is no appeal to the Commissioner's decision.
If Request is Complete and Accepted: Duties of Commissioner. G.S. 58-50-80(i)-(j).	1. The covered person and the insurer must be *immediately* notified in writing. 2. The covered person has 7 days to submit

	additional information and supporting documentation to the Commissioner. 3. The Commissioner will assign an independent review organization (IRO). 4. The Commissioner forwards all information and supporting documents to the IRO, insurer and the covered person.
If Request is Complete and Accepted: Duties of Insurer. G.S. 58-50-80(g) and (h).	1. Within *7 days* of receipt of notice that request was complete and accepted, the insurer must provide all documents and information considered in the internal review process to the designated IRO. 2. Penalty for failure to supply information within 7 days: The IRO is authorized to terminate the review and reverse the internal review decision.
Reconsideration of the Internal Review Decision. G.S. 58-50-80(i)-(j).	1. The insurer has the option of informally reconsidering and reversing its internal review decision based on the information forwarded by the Commissioner. 2. Reconsideration may not be used to delay the external review timeline.
Deadline for External Review Decision. G.S. 58-50-80(e).	1. IRO must make its decision within *45 days* from the date the covered person filed the written request with the Commissioner.
Decision is Binding. 58-50-84	1. Binding on the covered person, except to the extent that other remedies are available under State or federal law. 2. Binding on the insurer. If the IRO reverses the internal review decision, the insurer must *immediately* process the claim accordingly.
Expedited External Review Procedures	
Criteria for Requesting an Expedited External Review. 58-50-82(a)	1. The timeframe for the completion of the *2nd level internal grievance review* is such that it would reasonably be expected to seriously jeopardize the life or the health of the covered person or jeopardize the covered person's ability to regain maximum function. OR 2. The timeframe for the completion of a *standard external* review process is such that it would reasonably be expected to seriously jeopardize the life or the health of the covered person or jeopardize the covered person's ability to regain maximum

	function. OR 3. The covered person has lost the first level internal appeal and the subject of appeal concerns an admission, availability of care, continued stay, or a health care service provided under emergency circumstances AND the covered person is still a patient in the facility.
Differences Between Expedited and Standard External Review Procedures.	1. The request may be made *orally* instead of in writing. 2. The Commissioner must *immediately* perform its duties instead of within 5 days. 3. The Commissioner must consult with a medical professional who is not affiliated with the organization and who will not be assigned to conduct the external review as to whether the review should be reviewed on an expedited basis BEFORE the Commissioner makes the assignment. 4. The insurer must *immediately* provide all documents and information considered in the noncertification decision by telephone fax or email. 5. The IRO must make its decision within 4 days.
Retrospective Non-Certification Appeals	
Appeal of Claim Denial for Services Already Provided. 58-50-79(c).	1. The enrollee *must* exhaust internal appeal before a request for an external appeal may be approved. 2. The enrollee does not have a right to an *expedited* external review. 3. Retrospective review includes review of claims for emergency services to determine whether the 'prudent layperson standard' has been met.
Informal Reconsideration of Grievances	
Deadline to Issue a Decision.	1. If an insurer is unable to render an informal reconsideration decision within 10 days, the insurer must consider the request for informal reconsideration a request for a formal internal review unless the enrollee requests an informal review before the 10th day.

Approval of Independent Review Organizations	
Commissioner Approves. G.S. 58-50-85.	1. Organizations must submit an application to the Commissioner.. 2. The Commissioner issues approval only if the organization meets minimum statutory qualifications. 3. Approval is valid for two years. 4. The Commissioner must terminate approval if the organization is not meeting the minimum requirements. 5. Commissioner may deem approval if IRO is accredited by a National Accreditation Organization.
Minimum Qualifications for IROs. 58-50-87(a).	1. The IRO must have quality assurance mechanisms in place. 2. The IRO must maintain a toll-free information line. 3. The IRO must have a program for credentialing clinical peer reviewers. 4. The IRO must agree to contractual terms or written requirements established by the Commissioner. 5. Must have consult with a medical doctor licensed to practice in North Carolina to advise the IRO on issues related to local standards of practice.
Minimum Qualifications of Reviewers. 58-50-87(b).	1. All must be medical doctors or other appropriate health care providers who may or may not be licensed to practice in North Carolina. 2. All must have clinical experience and expertise in the treatment of the injury, illness, or medical condition that is the subject of the review. 3. All must have no history of disciplinary actions against them that raise a question of their competence or moral character.
Conflict of Interest Protections. 58-50-87(d).	1. The IRO may not have any financial association with any health benefit plan or provider organization or trade association. 2. No IRO or clinical reviewer may have a material professional, familial, or financial conflict of interest.

Competitive Selection of IROs. G.S. 58-50-94.	1. The Commissioner must publish RFPs from IROs that want to be an approved IRO. 2. The Commissioner will determine which applicants meet the requirements for approval. 3. In making the selection, the Commissioner must consult with representatives of insurers, providers, and insureds. 4. The Commissioner must consider cost, quality, statutory requirements, and assurance of consumer choice and fair competition. 5. The Commissioner must ensure that at least one IRO is capable of reviewing cases involving highly specialized services and treatments.
Immunity From Liability	
Hold Harmless. G.S. 58-50-89.	1. The Commissioner, the IRO and clinical reviewers are immune from liability to persons for opinions made pursuant to the review process, unless the opinion was made in bad faith or involved gross negligence.
Reporting Requirements by IRO	
Required Written Records. G.S. 58-50-90.	1. IROs must keep written records on all requests for external review. The records must be retained for at least 3 years. 2. IROs must report to the Commissioner at least annually. 3. The report must include the number and outcome of requests for external review, the average length of time of the reviews, a summary of the types of claims, and the number of requests that were terminated as a result of reconsideration by the insurer. 4. Insurers must keep written records for each type of health benefit plan offered by the insurer on all requests for external review. These records must be retained for 3 years.
Disclosure Requirements by Insurer	
Insurer Must Disclose Information to Enrollee. G.S. 58-50-93.	1. The insurer must describe the external review procedures in its handbook and inform all enrollees of their right to an external review and how and when to request it.

Funding	
Payment of fees charged by the IRO. G.S. 58-50-92.	1. The insurer must reimburse the Department of Insurance for the fees charged by the IRO.

SECTION 4.6 makes conforming amendments to internal appeal provisions of current law.

SECTION 4.7 Health Plan Liability: A new Article 1G is added to Chapter 90 to be entitled "Health Care Liability"

Definitions:

- A *managed care entity* is defined as an insurer that delivers, administers, or undertakes to provide for, arrange for, or reimburse for, health care services, or assumes the risk for the delivery of health care services. Specifically excluded from the definition are employers who purchase coverage for or on behalf of their employees and health care providers, including (1) individuals who are licensed health care providers under Chapter 90 of the General Statutes and (2) health care facilities licensed under Chapters 131E (hospitals) and 122C (mental health facilities and hospitals) and their agents and employees, including any officers and directors of health care facilities.
- A *health care decision* means a determination which is subject to external review under Part 4 of Article 50 of the General Statutes and is also a determination that:
  - A request for approval of coverage that is denied or reduced because it is not medically necessary or appropriate or because it is investigational or experimental and
  - The determination affects the quality of the diagnosis, care, or treatment provided under the plan.

- A *successor external review process* means an external review process equivalent in all respects to G.S. 58-50-75 through G.S. 58-50-95 approved by the Department and implemented by a health benefit plan in the event that G.S. 58-50-75 through 58-50-95 are found by a court of competent jurisdiction to be void, unenforceable, or pre-empted by federal law, in whole or in part.

Imposition of Duty of Care: The Article places a duty upon the managed care entity to exercise ordinary care when making health care decisions. Actions brought under this Article are not medical malpractice actions as defined in Article 1B of Chapter 90.

- Ordinary care is defined to mean that degree of care prevailing at the time the managed care entity made the health care decision that a managed care entity of ordinary prudence would use under the same or similar circumstances.
- Liability is imposed for damages resulting from harm to an insured or enrollee proximately caused by the managed care entity's failure to exercise ordinary care in making health care treatment decisions.

Vicarious Liability: Managed care entities are liable for damages proximately caused by the failure o agents, employees, and representatives over whom it has exercised influence and control, to exercise ordinary care in making health care treatment decisions.

Safe Harbors:

- The fact that a physician or health care provider is listed in the managed care entity's directory of approved providers is not enough to prove that the physician or health care provider is an agent or employee of the managed care entity.
- The Article does *not* create any risk of liability on the part of an employer or employer group purchasing organization that purchases a health benefit plan or assumes risk on behalf of its employees.
- The Article does *not* create any risk of liability on a physician or health care provider in addition to medical malpractice liability that exists under current law. No managed care entity held liable under the Article shall be entitled to contribution from a physician or health care provider.

Statutory Defense to Liability: The managed care entity nor its employee, agent, or representative have participated or had any influence or control over the health care treatment decision.

No Hold Harmless Provisions Allowed: The Article prohibits a managed care entity from entering into contracts with employers and physicians that include a hold harmless clause or an indemnification provision for the acts or conduct of the managed care entity.

Exhaustion of administrative remedies required. An enrollee may not bring an action under the Article unless they first exhaust their administrative remedies.

Admissibility of External Review Decision and Documents:

- Any information, documents, or other records or materials considered by the Independent Review Organization in conducing the review are admissible in accordance with Chapter 8 of the North Carolina General Statutes and the North Carolina Rules of Evidence.
- The external review decision is admissible if an adequate foundation for admissibility is laid.

Cap on Punitive Damages. Actions brought under the Article would be subject to the limitations and restrictions placed on punitive damage awards by Chapter 1D of the General Statutes.

- The award for punitive damages may not exceed three times the compensatory damages or $250,000 whichever is greater.

Separate Trials: Upon a motion of any party to an action under the act to order a separate trial of any claim, cross-claim, counterclaim, or third-party claim involving a physician or other health care provider.

SECTION 5(a). Makes a conforming change to 58-2-105, to authorize the Department of Insurance to disclose a patient' s medical records to an independent review organization under specified limitations, and to extend a duty of confidentiality upon the IRO.

SECTION 5(b) and (c). Make conforming changes to the definition of medically necessary.

SECTION 6 is a severability clause.

SECTION 7 makes sections 3.1 and 3.2 (mandated benefits) effective December 1, 2001, sections 4.1 4.8 (External Review and HMO liability) effective on March 1, 2002; and the remainder of the act is effective when it becomes law and applies to health benefit plans that are delivered, issued for delivery, or

renewed on or after January 1, 2002. Section 1.6 (Patient Assistance Program) is effective January 1, 2002. Nothing in this act shall obligate the General Assembly to appropriate funds to implement this act.

NORTH CAROLINA GENERAL ASSEMBLY
AMENDMENT
Senate Bill 199

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

S199-ASO-27 [v.1]

Date _____,2001

Comm. Sub. [YES]
Amends Title [NO]
S199-PCS9323-LN-36

Representative Edwards

moves to amend the bill on page 15, line 31 by rewriting the line to read:
"(1) 'Covered clinical trials' means phase II, phase III, and phase IV patient research"
and on page 16, lines 13 –14, by rewriting the lines to read:
"(b) Each health benefit plan shall provide coverage for participation in phase II, phase III, and phase IV covered clinical trials by its insureds or enrollees who meet protocol".

SIGNED _____
Amendment Sponsor

SIGNED _____
Committee Chair if Senate Committee Amendment

ADOPTED _____ FAILED _____ TABLED _____

NORTH CAROLINA GENERAL ASSEMBLY
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Committee Chair if Senate Committee Amendment

ADOPTED _____ FAILED _____ TABLED _____

68365 SHIELDS BUSINESS FORMS, RALEIGH, NC 27605

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NORTH CAROLINA GENERAL ASSEMBLY AMENDMENT

(Please type or use ballpoint pen)

EDITION No. _____

H. B. No. _____ DATE 8-7-01

S. B. No. S 199 - PCS9323-LN36 Amendment No. _____
(to be filled in by Principal Clerk)

COMMITTEE SUBSTITUTE ✓

(Rep.) Edwards
Sen.)

1 moves to amend the bill on page 10, line 30
2 ( ) WHICH CHANGES THE TITLE
3 by Rewriting the line to Read:
4
5 "within the network in order to obtain the benefit
6 or access a higher level of benefits, as the case may
7 be, subject to the requirements of the plan or
8 policy."
9
10
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19

SIGNED _____

ADOPTED _____ FAILED _____ TABLED _____

Rep. Nye

NORTH CAROLINA GENERAL ASSEMBLY
AMENDMENT
Senate Bill 199

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

S199-ASO-26 [v.3]

Date _____,2001

Comm. Sub. [YES]
Amends Title [YES]
S199-PCS9323-LN-36

Representative Nye

moves to amend the bill on page 1, lines 8-11, by rewriting the lines to read:
"NONCERTIFICATIONS BY AN INSURER OR MANAGED CARE PLAN; TO HOLD MANAGED CARE ENTITIES LIABLE FOR HARM CAUSED TO INSUREDS OR ENROLLEES BY THE FAILURE TO EXERCISE ORDINARY CARE IN MAKING HEALTH CARE TREATMENT DECISIONS; AND TO PROVIDE THAT ENROLLEES OF HEALTH MAINTENANCE ORGANIZATIONS RECEIVE THE PROTECTIONS PROVIDED BY THE NORTH CAROLINA LIFE AND HEALTH INSURANCE GUARANTY ASSOCIATION."
and on page 37, lines 20-21, by inserting between the lines a new Part:
"PART V. PATIENT PROTECTION AGAINST HMO FINANCIAL FAILURE

SECTION 6. G.S. 58-62-16 reads as rewritten:
"§ 58-62-16. Definitions.
As used in this Article:
(1) "Account" means any of the two accounts created under G.S. 58-62-26.
(2) "Association" means the North Carolina Life and Health Insurance Guaranty Association created under G.S. 58-62-26.

(3) "Board" means the board of directors of the Association established under G.S. 58-62-31.

(4) "Contractual obligation" means any obligation under a policy or certificate under a group policy, or part thereof, for which coverage is provided under G.S. 58-62-21.

(5) "Covered policy" means any policy within the scope of this Article under G.S. 58-62-21.

(6) "Delinquent insurer" means an impaired insurer or an insolvent insurer; and "delinquency" means an insurer impairment or insolvency.

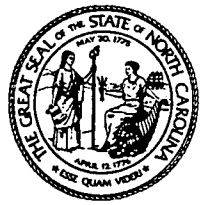
(7) "Health insurance" includes hospital or medical service corporation contracts, accident and health insurance, accident insurance, and disability insurance.

(8) "Impaired insurer" means a member insurer that, after the effective date of this Article, is not an insolvent insurer, and (i) is deemed by the Commissioner to be potentially unable to fulfill its contractual obligations or (ii) is placed under an order of rehabilitation or conservation by a court of competent jurisdiction.

(9) "Insolvent insurer" means a member insurer that, after the effective date of this Article, is placed under an order of liquidation with a finding of insolvency by a court of competent jurisdiction.

(10) "Insurance regulator" means the official or agency of another state that is responsible for the regulation of a foreign insurer.

(11) "Member insurer" means any ~~insurer and~~ insurer, any hospital or medical service corporation ~~that is~~ governed by Article 65 of this ~~Chapter and~~ Chapter, and any HMO governed by Article 67 of this Chapter, that is licensed or that holds a license to transact in this State any kind of insurance for which coverage is provided under G.S. 58-62-21; and includes any insurer whose license in this State



NORTH CAROLINA GENERAL ASSEMBLY
AMENDMENT
Senate Bill 199

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

S199-ASO-26 [v.3]

may have been suspended, revoked, not renewed or voluntarily ~~withdrawn, but does not include an entity governed by Article 67 of this Chapter;~~ withdrawn; fraternal order or fraternal benefit society; mandatory State pooling plan; mutual assessment company or any entity that operates on an assessment basis; insurance exchange; or any entity similar to any of the foregoing.

(12) "Moody's Corporate Bond Yield Average" means the Monthly Average Corporates as published by Moody's Investors Service, Inc., or any successor thereto."

SIGNED _____
Amendment Sponsor

SIGNED _____
Committee Chair if Senate Committee Amendment

ADOPTED _____ FAILED _____ TABLED _____

NORTH CAROLINA GENERAL ASSEMBLY
AMENDMENT
Senate Bill 199

AMENDMENT NO. _____
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Principal Clerk)

S199-ASO-27 [v.1]

Date _____,2001

Comm. Sub. [YES]
Amends Title [NO]
S199-PCS9323-LN-36

Representative Edwards

moves to amend the bill on page 15, line 31 by rewriting the line to read:
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and on page 16, lines 13 –14, by rewriting the lines to read:
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Amendment Sponsor

SIGNED _____
Committee Chair if Senate Committee Amendment

ADOPTED _____ FAILED _____ TABLED _____

VISITOR REGISTRATION SHEET

HOUSE HEALTH COMMITTEE — 04-27-2001

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
[signature]	NCAHP
PERRI MORGAN	NFIB
[signature]	MAPP, INC.
[signature]	NCAHP
Paul Mahoney	NCAHP
Barbara Cansler	MFES, PA
[signature]	NCMS
Jay Chaudhuri	DOJ
[signature]	NCAE
[signature]	NCCBI

VISITOR REGISTRATION SHEET

HOUSE HEALTH COMMITTEE — 8-7-2001

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Julie Campbell	NCCBI
A Roberts	NCBAHC
John Peters	NCBAHC
Tina Dunn	NCASA
Carol Lauer	EGHS
Ed Fulghum	Brooks Pierce
Jessica Jones	WHNC Radio / NCPJRA
Charles Cramer	NCATL
NPK Patel	NCDOI
Barbara Morales Burke	NCDOT
Ben Dover	NCDORD

VISITOR REGISTRATION SHEET

HOUSE HEALTH COMMITTEE — 8-7-2001

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Sam Taylor	Licensed Professional Counselors Ass'n
Daschiel Propes	NC DOI
Starla McKenney	"
Stella Boswell	NCATL
Dick Taylor	"
Pam Silberman	Steps Ctr for Health Svc Research
Adam Searing	NCHAE
Allan Hirsch	Gov's Office
K Fisher	ACT
M. Quinn	NCAHP

AGENDA

HOUSE COMMITTEE ON HEALTH
TUESDAY, August 14, 2001
12:00 Noon, ROOM 1228 LB

OPENING REMARKS

Rep. Thomas E. Wright
Chairman

BILLS TO BE DISCUSSED

SB-199 MANAGED CARE PATIENTS' BILL OF RIGHTS-(Sen. Wellons)

COMMENTS

ADJOURNMENT

MINUTES

HOUSE COMMITTEE ON HEALTH

TUESDAY, AUGUST 14, 2001

12:00 NOON, ROOM 1228 LB

The House Committee on Health met on Tuesday, August 14, 2001 at 12:00 Noon in Room 1228 LB. A silent roll was taken, (roll list denotes members present).

Chairman Wright called the meeting to order.

SB-199 MANAGED CARE PATIENT'S BILL OF RIGHTS-(Sen. Wellons)

Chairman Wright called the question before the committee to give the House proposed committee substitute a favorable report, unfavorable to the original bill.

Rep. Earle moved to withdraw the previous House proposed committee substitute and moved to have a new proposed committee substitute placed before the committee for discussion. So moved.

Rep. Baddour commented on the bill. Linda Attarian, Staff, explained the House proposed committee substitute to the committee. Rep. Earle asked if the person would have to go through the external process, or exceptions included. Linda Attarian responded. Rep. Justus asked about page 10, line 38, in reference to network providers. Sam Taylor, of the Licensed Professional Counselors Association, responded. Rep. Hackney commented on the amendment.

Rep. Hackney sent forth an amendment to amend the bill on page 36, line 38 and page 36, lines 40-43, and page 35, line 1. Rep. Hackney explained the amendment.

Chairman Wright called the question for the adoption of the amendment. The amendment passed.

Rep. Baddour sent forth an amendment to amend the bill on page 4, line 4, page 4, line 7, page 4, line 18-19 and page 18, line 21. Jan Watson, Staff, explained the amendment.

Chairman Wright called the question for the adoption of the amendment. The amendment passed.

Rep. Sherrill sent forth an amendment to amend the bill on page 18, line 10, page 33, line 12, page 34, line 8, page 39, line 13 and page 39 and moved for adoption. Jan Watson, Staff, explained the amendment. Rep. Allred asked about the difference between the

Rights of Patients in a private HMO and the State Health Plan. Sam Byrd, fiscal staff, responded. Rep. Hackney asked about the current external review process. Sam Byrd responded. Rep. Baddour spoke on the motion made by Rep. Sherrill and urged for support. Rep. Allred stated that he supported the amendment made by Rep. Sherrill. Rep. Insko asked about the indemnity plans. Rep. Baddour responded. Rep. Hackney commented on the bill. Sen. Wellons stated that he supports the amendment sent forth by Rep. Sherrill. Rep. Cunningham asked about the cost to the plan. Sam Byrd responded.

Chairman Wright called the question for the adoption of the amendment sent forth by Rep. Sherrill. The amendment was adopted.

Rep. Edwards sent forth an amendment to amend the bill on page 16, line 16, page 16, lines 30-31 and page 16, line 39 and moved for adoption. Rep. Edwards commented on the amendment. Jan Watson, Staff, explained the amendment to the committee.

Chairman Wright called the question for the adoption of the amendment sent forth by Rep. Edwards. The amendment was adopted.

Rep. Nye sent forth an amendment to amend the bill on page 4, line 1, page 4, line 3, page 19, line 34, page 20, lines 7-25, page 20, line 41, page 21, line 1, page 25, line 22, page 21, line 15 and page 21, lines 36-39 and moved for adoption. Rep. Nye stated that this was a clarifying amendment. Jan Watson, Staff, explained the amendment.

Chairman Wright called the question for the adoption of the amendment sent forth by Rep. Nye. The amendment was adopted.

Rep. Baddour sent forth an amendment to amend the bill page 1, line 25 and moved for adoption. Rep. Baddour explained the amendment.

Chairman Wright called the question for the adoption of the amendment sent forth by Rep. Baddour. The amendment was adopted.

Rep. Earle moved for a favorable report to the House proposed committee, with all amendments rolled into a committee substitute, unfavorable to the original bill.

Chairman Wright opened the floor for interested parties to speak on the bill. Paul Mahoney, of the NC Association of Health Plans, commented on the bill. Sheila Ogle, President of Media Research Planning and Placement, commented on the bill. Perry Morgan, of the National Federation of Independent Businesses, spoke on the bill. Steve Keene, of the NC Medical Society, commented on the bill and urged support. Ken Wright, of Blue Cross and Blue Shield, commented on the bill.

Chairman Wright called the question on the motion to give the proposed committee substitute a favorable report, unfavorable to the original bill. So moved.

The meeting adjourned at 1:50pm.

Rep. Thomas E. Wright, Chairman

Vanda Wilson-Wormack, Committee Assistant

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2001

S D

SENATE BILL 199

Insurance and Consumer Protection Committee Substitute Adopted 4/25/01
PROPOSED HOUSE COMMITTEE SUBSTITUTE S199-PCS6342-RM-65

Short Title: Managed Care Patients' Bill of Rights. (Public)

Sponsors:

Referred to:

February 22, 2001

A BILL TO BE ENTITLED

AN ACT TO IMPROVE PATIENT ACCESS TO HEALTH CARE ADVICE, INFORMATION, AND SERVICES TO COVERED PERSONS UNDER HEALTH BENEFIT PLANS BY PROVIDING FOR: CONTINUITY OF CARE IN HMOs, EXTENDED OR STANDING REFERRAL TO A SPECIALIST, SELECTION OF SPECIALIST AS PRIMARY CARE PROVIDER, DIRECT ACCESS TO PEDIATRICIANS, ACCESS TO NONFORMULARY AND RESTRICTED ACCESS PRESCRIPTION DRUGS, ESTABLISHMENT OF THE MANAGED CARE PATIENT ASSISTANCE PROGRAM, PATIENT'S RIGHT TO CHOOSE THE PROVIDER OF SERVICES UNDER A HEALTH BENEFIT PLAN AND PROHIBITION OF DISCRIMINATION AGAINST PROVIDERS AS PARTICIPATING PROVIDERS BASED ON THE PROVIDER'S LICENSE OR CERTIFICATION, PROHIBITION ON CERTAIN MANAGED CARE PROVIDER INCENTIVES, MANAGED CARE REPORTING AND DISCLOSURE REQUIREMENTS, PROVIDER DIRECTORY INFORMATION, DISCLOSURE OF PAYMENT OBLIGATIONS, MANDATED COVERAGE FOR CLINICAL TRIALS AND NEWBORN HEARING SCREENING, AND STANDARDS FOR INDEPENDENT REVIEW OF NONCERTIFICATIONS BY AN INSURER OR MANAGED CARE PLAN; TO PROVIDE THAT ENROLLEES OF HEALTH MAINTENANCE ORGANIZATIONS RECEIVE THE PROTECTIONS PROVIDED BY THE NORTH CAROLINA LIFE AND HEALTH INSURANCE GUARANTY ASSOCIATION; AND TO HOLD MANAGED CARE ENTITIES LIABLE FOR HARM CAUSED TO INSUREDS OR ENROLLEES BY THE FAILURE TO EXERCISE ORDINARY CARE IN MAKING HEALTH CARE DECISIONS.

The General Assembly of North Carolina enacts:

PART I. PATIENT ACCESS TO MEDICAL ADVICE AND CARE

Subpart A. Continuity of Care in HMOs

SECTION 1. Article 67 of Chapter 58 of the General Statutes is amended by adding a new section to read:

"**§ 58-67-88. Continuity of care.**

(a) Definitions. – As used in this section:

(1) 'Ongoing special condition' means:

a. In the case of an acute illness, a condition that is serious enough to require medical care or treatment to avoid a reasonable possibility of death or permanent harm.

b. In the case of a chronic illness or condition, a disease or condition that is life-threatening, degenerative, or disabling, and requires medical care or treatment over a prolonged period of time.

c. In the case of pregnancy, pregnancy from the start of the second trimester.

d. In the case of a terminal illness, an individual has a medical prognosis that the individual's life expectancy is six months or less.

(2) 'Terminated or termination'. – Includes, with respect to a contract, the expiration or nonrenewal of the contract, but does not include a termination of the contract by an HMO for failure to meet applicable quality standards or for fraud.

(b) Termination of Provider. – If a contract between an HMO benefit plan that is not a point-of-service plan and a health care provider is terminated by the provider or by the HMO, or benefits or coverage provided by the HMO are terminated because of a change in the terms of provider participation in a health benefit plan of an HMO that is not a point-of-service plan, and an individual is covered by the plan and is undergoing treatment from the provider for an ongoing special condition on the date of the termination, then, the HMO shall:

(1) Upon termination of the contract by the HMO or upon receipt by the HMO of written notification of termination by the provider, notify the individual on a timely basis of the termination and of the right to elect continuation of coverage of treatment by the provider under this section.

(2) Subject to subsection (h) of this section, permit the individual to elect to continue to be covered with respect to the treatment by the provider of the ongoing special condition during a transitional period provided under this section.

(c) Newly Covered Insured. – Each health benefit plan offered by an HMO that is not a point-of-service plan shall provide transition coverage to individuals who are undergoing treatment from a provider for an ongoing special condition and are newly

covered under the health benefit plan because the individual's employer has changed health benefit plans, and the HMO shall:

(1) Notify the individual on the date of enrollment of the right to elect continuation of coverage of treatment by the provider under this section.

(2) Subject to subsection (h) of this section, permit the individual to elect to continue to be covered with respect to the treatment by the provider of the ongoing special condition during a transitional period provided under this section.

(d) Transitional Period: In General. – Except as otherwise provided in subsections (e), (f), and (g) of this section, the transitional period under this subsection shall extend up to 90 days, as determined by the treating health care provider, after the date of the notice to the individual described in subdivision (b)(1) of this section or the date of enrollment in a new plan described in subdivision (c)(1) of this section.

(e) Transitional Period: Scheduled Surgery, Organ Transplantation, or Inpatient Care. – If surgery, organ transplantation, or other inpatient care was scheduled for an individual before the date of the notice required under subdivision (b)(1) of this section, or the date of enrollment in a new plan described in subdivision (c)(1) of this section, or if the individual on that date was on an established waiting list or otherwise scheduled to have the surgery, transplantation, or other inpatient care, the transitional period under this subsection with respect to the surgery, transplantation, or other inpatient care shall extend beyond the period under subsection (d) of this section through the date of discharge of the individual after completion of the surgery, transplantation, or other inpatient care, and through postdischarge follow-up care related to the surgery, transplantation, or other inpatient care occurring within 90 days after the date of discharge.

(f) Transitional Period: Pregnancy. – If an insured has entered the second trimester of pregnancy on the date of the notice required under subdivision (b)(1) of this section, or the date of enrollment in a new plan described in subdivision (c)(1) of this section, and the provider was treating the pregnancy before the date of the notice, or the date of enrollment in the new plan, the transitional period with respect to the provider's treatment of the pregnancy shall extend through the provision of 60 days of postpartum care.

(g) Transitional Period: Terminal Illness. – If an insured was determined to be terminally ill at the time of a provider's termination of participation under subsection (b) of this section, or at the time of enrollment in the new plan under subdivision (c)(1) of this section, and the provider was treating the terminal illness before the date of the termination or enrollment in the new plan, the transitional period shall extend for the remainder of the individual's life with respect to care directly related to the treatment of the terminal illness or its medical manifestations.

(h) Permissible Terms and Conditions. – An HMO may condition coverage of continued treatment by a provider under subdivision (b)(2) or (c)(2) of this section upon the following terms and conditions:

(1) When care is provided pursuant to subdivision (b)(2) of this section, the provider agrees to accept reimbursement from the HMO and individual involved, with respect to cost-sharing, at the rates applicable before the start of the transitional period as payment in full. When care is provided pursuant to subdivision (c)(2) of this section, the provider agrees to accept the prevailing rate based on contracts the insurer has with the same or similar providers in the same or similar geographic area, plus the applicable copayment, as reimbursement in full from the HMO and the insured for all covered services.

(2) The provider agrees to comply with the quality assurance programs of the HMO responsible for payment under subdivision (1) of this subsection and to provide to the HMO necessary medical information related to the care provided. The quality assurance programs shall not override the professional or ethical responsibility of the provider or interfere with the provider's ability to provide information or assistance to the patient.

(3) The provider agrees otherwise to adhere to the HMO's established policies and procedures for participating providers, including procedures regarding referrals and obtaining prior authorization, providing services pursuant to a treatment plan, if any, approved by the HMO, and member hold harmless provisions.

(4) The insured or the insured's representative notifies the HMO within 45 days of the date of the notice described in subdivision (b)(1) of this section or the new enrollment described in subdivision (c)(1) of this section, that the insured elects to continue receiving treatment by the provider.

(5) The provider agrees to discontinue providing services pursuant to this section and to assist the insured in an orderly transition to a network provider. Nothing in this section shall prohibit the insured from continuing to receive services from the provider at the insured's expense.

(i) Construction. – Nothing in this section:

(1) Requires the coverage of benefits that would not have been covered if the provider involved remained a participating provider.

(2) Requires an HMO to offer a transitional period when the HMO terminates a provider's contract for reasons relating to quality of care or fraud; and refusal to offer a transitional period under these circumstances is not subject to the grievance review provisions of G.S. 58-50-62.

(3) Prohibits an HMO from extending any transitional period beyond that specified in this section.

(4) Prohibits an HMO from terminating the continuing services of a provider as described in this section when the HMO has determined

that the provider's continued provision of services may result in, or is resulting in, a serious danger to the health or safety of the insured. Such terminations shall be in accordance with the contract provisions that the provider would otherwise be subject to if the provider's contract were still in effect.

(j) Disclosure of Right to Transitional Period. – Each HMO shall include a clear description of an insured's rights under this section in its evidence of coverage and summary plan description."

Subpart B. Extended or Standing Referral to Specialist

SECTION 1.2. G.S. 58-3-223 reads as rewritten:

"**§ 58-3-223. Managed care access to specialist care.**

(a) Each insurer offering a health benefit plan that does not allow direct access to all in-plan specialists shall develop and maintain written policies and procedures by which an insured may receive an extended or standing referral to an in-plan specialist. The ~~procedure~~insurer shall provide for an extended or standing referral to a specialist if the insured has a serious or chronic degenerative, disabling, or life-threatening disease or condition, which in the opinion of the insured's primary care physician, in consultation with the specialist, requires ongoing specialty care. The extended or standing referral shall be for a period not to exceed 12 months and shall be made under a treatment plan coordinated with the insurer in consultation with the primary care physician, the specialist, and the insured or the insured's designee.

(b) As used in this section:

(1) 'Health benefit plan' has the meaning applied in G.S. 58-3-167.~~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 are 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 under Article 65 of this Chapter, or a health maintenance organization under Article 67 of this Chapter, or a multiple employer welfare arrangement under Article 49 of this Chapter.~~has the meaning applied in G.S. 58-3-167.

(3) 'Serious or chronic degenerative, disabling, or life-threatening disease or condition' means a disease or condition, which in the opinion of the patient's treating primary care physician and specialist, requires frequent and periodic monitoring and consultation with the specialist on an ongoing basis.

(4) 'Specialist' includes a subspecialist."

SECTION 1.2A. 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 the out-of-network benefit levels offered under the insured's approved health benefit ~~plan~~ plan, including an insured receiving an extended or standing referral under G.S. 58-3-223, unless contracting health care providers able to meet health needs of the insured are reasonably available to the insured without unreasonable delay."

Subpart C. Selection of Specialist as Primary Care Physician

SECTION 1.3. Article 3 of Chapter 58 of the General Statutes is amended by adding a new section to read:

"**§ 58-3-235. Selection of specialist as primary care provider.**

(a) Each insurer shall have a procedure by which an insured diagnosed with a serious or chronic degenerative, disabling, or life-threatening disease or condition, either of which requires specialized medical care may select as his or her primary care physician a specialist with expertise in treating the disease or condition who shall be responsible for and capable of providing and coordinating the insured's primary and specialty care. If the insurer determines that the insured's care would not be appropriately coordinated by that specialist, the insurer may deny access to that specialist as a primary care provider.

(b) The selection of the specialist shall be made under a treatment plan approved by the insurer, in consultation with the specialist and the insured or the insured's

designee and after notice to the insured's primary care provider, if any. The specialist may provide ongoing care to the insured and may authorize such referrals, procedures, tests, and other medical services as the insured's primary care provider would otherwise be allowed to provide or authorize, subject to the terms of the treatment plan. Services provided by a specialist who is providing and coordinating primary and specialty care remain subject to utilization review and other requirements of the insurer, including its requirements for primary care providers."

Subpart D. Direct Access to Pediatrician

SECTION 1.4. Article 3 of Chapter 58 of the General Statutes is amended by adding a new section to read:

"**§ 58-3-240. Direct access to pediatrician for minors.**

Each insurer offering a health benefit plan that uses a network of contracting health care providers shall allow an insured to choose a contracting pediatrician in the network as the primary care provider for insured children under the age of 18 and covered under the policy."

Subpart E. Access to Prescription Drugs

SECTION 1.5. G.S. 58-3-221 reads as rewritten:

"**§ 58-3-221. Access to nonformulary and restricted access prescription drugs.**

(a) If an insurer maintains one or more closed formularies for or restricts access to covered prescription drugs or devices, then the insurer shall do all of the following:

(1) Develop the formulary or formularies and any restrictions on access to covered prescription drugs or devices in consultation with and with the approval of a pharmacy and therapeutics committee, which shall include participating ~~providers~~ physicians who are licensed to ~~prescribe prescription drugs or devices.~~ practice medicine in this State.

(2) Make available to participating ~~providers and pharmacists~~ providers, pharmacists, and enrollees the complete drugs or devices formulary or formularies maintained by the insurer including a list of the devices and prescription drugs on the formulary by major therapeutic category that specifies whether a particular drug or device is preferred over other drugs or devices.

(3) Establish and maintain an expeditious process or procedure that allows an enrollee or the enrollee's physician acting on behalf of the enrollee to obtain, without penalty or additional cost-sharing beyond that provided for in the health benefit plan, coverage for a specific nonformulary drug or device determined to be medically necessary and appropriate by the enrollee's participating physician without prior approval from the insurer, after the enrollee's participating physician notifies the insurer that:

a. Either (i) the formulary alternatives have been ineffective in the treatment of the enrollee's disease or condition, or (ii) the formulary alternatives cause or are reasonably expected by the physician to cause a harmful or adverse clinical reaction in the enrollee; and

b. Either (i) the drug is prescribed in accordance with any applicable clinical protocol of the insurer for the prescribing of the drug, or (ii) the drug has been approved as an exception to the clinical protocol pursuant to the insurer's exception procedure.

(4) Provide coverage for a restricted access drug or device to an enrollee without requiring prior approval if an enrollee's physician certifies in writing that the enrollee has previously used an alternative nonrestricted access drug or device and the alternative drug or device has been detrimental to the enrollee's health or has been ineffective in treating the same condition and, in the opinion of the prescribing physician, is likely to be detrimental to the enrollee's health or ineffective in treating the condition again.

(b) An insurer may not void a contract or refuse to renew a contract between the insurer and a prescribing provider because the prescribing provider has prescribed a medically necessary and appropriate nonformulary or restricted access drug or device as provided in this section.

(c) As used in this section:

(1) 'Closed formulary' means a list of prescription drugs and devices reimbursed by the insurer that excludes coverage for drugs and devices not listed.

(1a) 'Health benefit plan' has definition provided in G.S. 58-3-167. ~~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 are statutorily required to be contained in any liability policy or equivalent self-insurance.~~

(2) 'Insurer' has the meaning provided in G.S. 58-3-167. ~~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, or a multiple employer welfare arrangement under Article 49 of this Chapter~~.

(3) 'Restricted access drug or device' means those covered prescription drugs or devices for which reimbursement by the insurer is conditioned on the insurer's prior approval to prescribe the drug or device or on the provider prescribing one or more alternative drugs or devices before prescribing the drug or device in question.

(d) Nothing in this section requires an insurer to pay for drugs or devices or classes of drugs or devices related to a benefit that is specifically excluded from coverage by the insurer."

Subpart F. Managed Care Patient Assistance Program

SECTION 1.6. Chapter 143 of the General Statutes is amended by adding the following new Article to read:

"Article 76.

"Managed Care Patient Assistance Program.

"**§ 143-725. Managed Care Patient Assistance Program.**

(a) The Office of Managed Care Patient Assistance Program is established. The Director of the Office of Managed Care Patient Assistance Program shall be appointed by the Governor.

(b) The Managed Care Patient Assistance Program shall provide information and assistance to individuals enrolled in managed care plans. The Managed Care Patient Assistance Program shall have expertise and experience in both health care and advocacy and will assume the specific duties and responsibilities set forth in subsection (c) of this section.

(c) The duties and responsibilities of the Managed Care Patient Assistance Program are as follows:

(1) Develop and distribute educational and informational materials for consumers, explaining their rights and responsibilities as managed care plan enrollees.
(2) Answer inquiries posed by consumers and refer inquiries of a regulatory nature to staff within the Department of Insurance.
(3) Advise managed care plan enrollees about the utilization review process.
(4) Assist enrollees with the grievance, appeal, and external review procedures established by Article 50 of Chapter 58 of the General Statutes.
(5) Publicize the Office of the Managed Care Patient Assistance Program.
(6) Compile data on the activities of the Office and evaluate such data to make recommendations as to the needed activities of the Office.

(d) The Director of the Managed Care Patient Assistance Program shall annually report the activities of the Managed Care Patient Assistance Program, including the types of appeals, grievances, and complaints received and the outcome of these cases. The report shall be submitted to the General Assembly, upon its convening or reconvening, and shall make recommendations as to efforts that could be implemented to assist managed care consumers."

Subpart G. No Discrimination in the Selection of Providers

SECTION 1.7. G.S. 58-50-30, as amended by Section 1 of S.L. 2001-297, reads as rewritten:

"**§ 58-50-30. Right to choose services of optometrist, podiatrist, certified clinical social worker, certified substance abuse professional, licensed professional counselor, dentist, chiropractor, psychologist, pharmacist, certified fee-based practicing pastoral counselor, advanced practice nurse, or physician assistant.**

(a1) Whenever any health benefit plan, subscriber contract, or policy of insurance issued by a health maintenance organization, hospital or medical service corporation, or insurer governed by Articles 1 through ~~65~~ 67 of this Chapter provides for coverage for, payment ~~of or~~ of, or reimbursement for any service rendered in connection with a condition or complaint that is within the scope of practice of a duly licensed optometrist, a duly licensed podiatrist, a duly licensed dentist, a duly licensed chiropractor, a duly certified clinical social worker, a duly certified substance abuse professional, a duly licensed professional counselor, a duly licensed psychologist, a duly licensed pharmacist, a duly certified fee-based practicing pastoral counselor, a duly licensed physician assistant, or an advanced practice registered nurse, the insured or other persons entitled to benefits under the policy shall be entitled to coverage of, payment ~~of or~~ of, or reimbursement for the services, whether the services be performed by a duly licensed physician, or a provider listed in this subsection, notwithstanding any provision contained in the ~~policy.~~ plan or policy limiting access to the providers. The

policyholder, insured, or beneficiary shall have the right to choose the provider of services notwithstanding any provision to the contrary in any other statute; provided that:

(1) In the case of plans that require the use of network providers as a condition of obtaining benefits under the plan or policy, the policyholder, insured, or beneficiary must choose a provider of the services within the network; and

(2) In the case of plans that require the use of network providers as a condition of obtaining a higher level of benefits under the plan or policy, the policyholder, insured, or beneficiary must choose a provider of the services within the network in order to obtain the higher level of benefits.

(a2) Whenever any policy of insurance governed by Articles 1 through ~~65~~64 of this Chapter provides for certification of disability that is within the scope of practice of a duly licensed physician, a duly licensed physician assistant, a duly licensed optometrist, a duly licensed podiatrist, a duly licensed dentist, a duly licensed chiropractor, a duly certified clinical social worker, a duly certified substance abuse professional, a duly licensed professional counselor, a duly licensed psychologist, a duly certified fee-based practicing pastoral counselor, or an advanced practice registered nurse, the insured or other persons entitled to benefits under the policy shall be entitled to payment of or reimbursement for the disability whether the disability be certified by a duly licensed physician, or a provider listed in this subsection, notwithstanding any provisions contained in the policy. The policyholder, insured, or beneficiary shall have the right to choose the provider of the services notwithstanding any provision to the contrary in any other ~~statute.~~statute; provided that for plans that require the use of network providers either as a condition of obtaining benefits under the plan or policy or to access a higher level of benefits under the plan or policy, the policyholder, insured, or beneficiary must choose a provider of the services within the network, subject to the requirements of the plan or policy.

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

(b) For the purposes of this section, a "duly licensed psychologist" is a licensed psychologist who holds permanent licensure and certification as a health services provider psychologist issued by the North Carolina Psychology Board.

(c) For the purposes of this section, a "duly certified clinical social worker" is a "certified clinical social worker" as defined in G.S. 90B-3(2) and certified by the North

Carolina Certification Board for Social Work pursuant to Chapter 90B of the General Statutes.

(c1) For purposes of this section, a "duly certified fee-based practicing pastoral counselor" shall be defined only to include fee-based practicing pastoral counselors certified by the North Carolina State Board of Examiners of Fee-Based Practicing Pastoral Counselors pursuant to Article 26 of Chapter 90 of the General Statutes.

(c2) For purposes of this section, a "duly certified substance abuse professional" is a person certified by the North Carolina Substance Abuse Professional Certification Board pursuant to Article 5C of Chapter 90 of the General Statutes.

(c3) For purposes of this section, a "duly licensed professional counselor" is a person licensed by the North Carolina Board of Licensed Professional Counselors pursuant to Article 24 of Chapter 90 of the General Statutes.

(d) Payment or reimbursement is required by this section for a service performed by an advanced practice registered nurse only when:

(1) The service performed is within the nurse's lawful scope of practice;

(2) The policy currently provides benefits for identical services performed by other licensed health care providers;

(3) The service is not performed while the nurse is a regular employee in an office of a licensed physician;

(4) The service is not performed while the registered nurse is employed by a nursing facility (including a hospital, skilled nursing facility, intermediate care facility, or home care agency); and

(5) Nothing in this section is intended to authorize payment to more than one provider for the same service.

No lack of signature, referral, or employment by any other health care provider may be asserted to deny benefits under this provision.

For purposes of this section, an "advanced practice registered nurse" means only a registered nurse who is duly licensed or certified as a nurse practitioner, clinical specialist in psychiatric and mental health nursing, or nurse midwife.

(e) Payment or reimbursement is required by this section for a service performed by a duly licensed pharmacist only when:

(1) The service performed is within the lawful scope of practice of the pharmacist;

(2) The service performed is not initial counseling services required under State or federal law or regulation of the North Carolina Board of Pharmacy;

(3) The policy currently provides reimbursement for identical services performed by other licensed health care providers; and

(4) The service is identified as a separate service that is performed by other licensed health care providers and is reimbursed by identical payment methods.

Nothing in this subsection authorizes payment to more than one provider for the same service.

(f) Payment or reimbursement is required by this section for a service performed by a duly licensed physician assistant only when:

(1) The service performed is within the lawful scope of practice of the physician assistant in accordance with rules adopted by the North Carolina Medical Board pursuant to G.S. 90-18.1;

(2) The policy currently provides reimbursement for identical services performed by other licensed health care providers; and

(3) The reimbursement is made to the physician, clinic, agency, or institution employing the physician assistant.

Nothing in this subsection is intended to authorize payment to more than one provider for the same service. For the purposes of this section, a "duly licensed physician assistant" is a physician assistant as defined by G.S. 90-18.1.

(g) A health maintenance organization, hospital or medical service corporation, or insurer governed by Articles 1 through 67 of this Chapter shall not exclude from participation in its provider network or from eligibility to provide particular covered services under the plan or policy any duly licensed physician or provider listed in subsection (a1) of this section, acting within the scope of the provider's license or certification under North Carolina law, solely on the basis of the provider's license or certification. Any health maintenance organization, hospital or medical service corporation, or insurer governed by Articles 1 through 67 of this Chapter that offers coverage through a network plan may condition participation in the network on satisfying written participation criteria, including credentialing, quality, and accessibility criteria. The participation criteria shall be developed and applied in a like manner consistent with the licensure and scope of practice for each type of provider. Any health maintenance organization, hospital or medical service corporation, or insurer governed by Articles 1 through 67 of this Chapter that excludes a provider listed in subsection (a1) of this section from participation in its network or from eligibility to provide particular covered services under the plan or policy shall provide the affected listed provider with a written explanation of the basis for its decision. A health maintenance organization, hospital or medical service corporation, or insurer governed by Articles 1 through 67 of this Chapter shall not exclude from participation in its provider network a provider listed in subsection (a1) of this section acting within the scope of the provider's license or certification under North Carolina law solely on the basis that the provider lacks hospital privileges, unless use of hospital services by the provider on behalf of a policy holder, insured, or beneficiary reasonably could be expected."

Subpart H. Prohibition on Provider Incentives

SECTION 1.8. Article 3 of Chapter 58 of the General Statutes is amended by adding the following new section to read:

"**§ 58-3-265. Prohibition on managed care provider incentives.**

An insurer offering a health benefit plan may not offer or pay any type of material inducement, bonus, or other financial incentive to a participating provider to deny, reduce, withhold, limit, or delay specific medically necessary and appropriate health care services covered under the health benefit plan to a specific insured or enrollee. This section does not prohibit insurers from paying a provider on a capitated basis or withholding payment or paying a bonus based on the aggregate services rendered by the provider or the insurer's financial performance."

PART II. HEALTH PLAN DISCLOSURES

Subpart A. Managed Care Reporting and Disclosure Requirements

SECTION 2.1. G.S. 58-3-191(b) reads as rewritten:

"(b) Disclosure requirements. – Each health benefit plan shall provide the following applicable information to plan participants and bona fide prospective participants upon request:

(1) The evidence of coverage (G.S. 58-67-50), subscriber contract (G.S. 58-65-60, 58-65-140), health insurance policy (G.S. 58-51-80, 58-50-125, 58-50-55), or the contract and benefit summary of any other type of health benefit plan;

(2) An explanation of the utilization review criteria and treatment protocol under which treatments are provided for conditions specified by the prospective participant. This explanation shall be in writing if so requested;

(3) If denied a recommended treatment, written reasons for the denial and an explanation of the utilization review criteria or treatment protocol upon which the denial was based;

(4) The plan's ~~restrictive formularies~~ formularies, restricted access drugs or devices, or prior approval requirements for obtaining prescription drugs, whether a particular drug or therapeutic class of drugs is excluded from its formulary, and the circumstances under which a nonformulary drug may be covered; and

(5) The plan's procedures and medically based criteria for determining whether a specified procedure, test, or treatment is experimental."

Subpart B. Provider Directory Information

SECTION 2.2. Article 3 of Chapter 58 of the General Statutes is amended by adding a new section to read:

"**§ 58-3-245. Provider directories.**

(a) Every health benefit plan utilizing a provider network shall make a listing of network providers available to insureds and shall update the listing no less frequently than once a year. In addition, every health benefit plan shall maintain a telephone

system and may maintain an electronic or on-line system through which insureds can access up-to-date network information. If the health benefit plan produces printed directories, the directories shall contain language disclosing the date of publication, frequency of updates, that the directory may not contain the latest network information, and contact information for accessing up-to-date network information.

(b) Each listing shall include:

(1) The provider's name, address, telephone number, and, if applicable, area of specialty.

(2) Whether the provider may be selected as a primary care provider.

(3) To the extent known to the health benefit plan, an indication of whether the provider:

a. Is or is not currently accepting new patients.

b. Has any other restrictions that would limit an insured's access to that provider.

(c) The listing shall include all of the types of participating providers. Upon a participating provider's written request, the insurer shall also list in the directory, as part of the participating provider's listing, the names of any allied health professionals who provide primary care services under the supervision of the participating provider and whose services are covered by virtue of the insurer's contract with the supervising participating provider and whose credentials have been verified by the supervising participating provider. These allied health professionals shall be listed as a part of the directory listing for the participating provider upon receipt of a certification by the supervising participating provider that the credentials of the allied health professional have been verified."

Subpart C. Disclosure of Payment Obligations

SECTION 2.3. Article 3 of Chapter 58 of the General Statutes is amended by adding a new section to read:

"**§ 58-3-250. Payment obligations for covered services.**

(a) If an insurer calculates a benefit amount for a covered service under a health benefit plan through a method other than a fixed dollar co-payment, the insurer shall clearly explain in its evidence of coverage and plan summaries how it determines its payment obligations and the payment obligations of the insured. The explanation shall include:

(1) An example of the steps the insurer would take in calculating the benefit amount and the payment obligations of each party.

(2) Whether the insurer has obtained the agreement of health care providers not to bill an insured for any amounts by which a provider's charge exceeds the insurer's recognized charge for a covered service and whether the insured may be liable for paying any excess amount.

(3) Which party is responsible for filing a claim or bill with the insurer.

(b) If an insured is liable for an amount that differs from a stated fixed dollar co-payment or may differ from a stated coinsurance percentage because the coinsurance amount is based on a plan allowance or other such amount rather than the actual charges and providers are permitted to balance bill the insured, the evidence of coverage, plan summaries, and marketing and advertising materials that include information on benefit levels shall contain the following statement: 'NOTICE: Your actual expenses for covered services may exceed the stated [coinsurance percentage or co-payment amount] because actual provider charges may not be used to determine [plan/insurer or similar term] and [insured/member/enrollee or similar term] payment obligations.' "

PART III. MANDATED BENEFITS

Subpart A. Clinical Trials

SECTION 3.1. Article 3 of Chapter 58 of the General Statutes is amended by adding a new section to read:

"**§ 58-3-255. Coverage of clinical trials.**

(a) As used in this section:

(1) 'Covered clinical trials' means phase II, phase III, and phase IV patient research studies designed to evaluate new treatments, including prescription drugs, and that: (i) involve the treatment of life-threatening medical conditions, (ii) are medically indicated and preferable for that patient compared to available noninvestigational treatment alternatives, and (iii) have clinical and preclinical data that shows the trial will likely be more effective for that patient than available noninvestigational alternatives. Covered clinical trials must also meet the following requirements:

a. Must involve determinations by treating physicians, relevant scientific data, and opinions of experts in relevant medical specialties.

b. Must be trials approved by centers or cooperative groups that are funded by the National Institutes of Health, the Food and Drug Administration, the Centers for Disease Control, the Agency for Health Care Research and Quality, the Department of Defense, or the Department of Veterans Affairs. The health benefit plan may also cover clinical trials sponsored by other entities.

c. Must be conducted in a setting and by personnel that maintain a high level of expertise because of their training, experience, and volume of patients.

(2) 'Health benefit plan' is defined by G.S. 58-3-167.

(3) 'Insurer' is defined by G.S. 58-3-167.

(b) Each health benefit plan shall provide coverage for participation in phase II, phase III, and phase IV covered clinical trials by its insureds or enrollees who meet protocol requirements of the trials and provide informed consent.

(c) Only medically necessary costs of health care services, as defined in G.S. 58-50-61, associated with participation in a covered clinical trial, including those related to health care services typically provided absent a clinical trial, the diagnosis and treatment of complications, and medically necessary monitoring, are required to be covered by the health benefit plan and only to the extent that such costs have not been or are not funded by national agencies, commercial manufacturers, distributors, or other research sponsors of participants in clinical trials. Nothing in this section shall be construed to require a health benefit plan to pay or reimburse for non-FDA approved drugs provided or made available to a patient who received the drug during a covered clinical trial after the clinical trial has been discontinued.

(d) Clinical trial costs not required to be covered by a health benefit plan include the costs of services that are not health care services, those provided solely to satisfy data collection and analysis needs, those related to investigational drugs and devices, and those that are not provided for the direct clinical management of the patient. In the event a claim contains charges related to services for which coverage is required under this section, and those charges have not been or cannot be separated from costs related to services for which coverage is not required under this section, the health benefit plan may deny the claim."

Subpart B. Newborn Hearing Screening

SECTION 3.2. Article 3 of Chapter 58 of the General Statutes is amended by adding a new section to read:

"**§ 58-3-260. Insurance coverage for newborn hearing screening mandated.**

(a) As used in this section, the terms 'health benefit plan' and 'insurer' have the meanings applied under G.S. 58-3-167.

(b) Each health benefit plan shall provide coverage for newborn hearing screening ordered by the attending physician pursuant to G.S. 130A-125. The same deductibles, coinsurance, reimbursement methodologies, and other limitations and administrative procedures as apply to similar services covered under the health benefit plan shall apply to coverage for newborn hearing screening."

PART IV. EXTERNAL REVIEW AND MANAGED CARE ENTITY LIABILITY

Subpart A. Independent, External Review Process

SECTION 4.1. The title of Article 50 of Chapter 58 of the General Statutes reads as rewritten:

"Article 50.

General Accident and Health Insurance Regulations."

SECTION 4.2. Article 50 of Chapter 58 of the General Statutes is amended as follows:

(1) By designating G.S. 58-50-1 through G.S. 58-50-45 as Part 1 with the heading "Miscellaneous Provisions."

(2) By designating G.S. 58-50-50 through G.S. 58-50-64 as Part 2 with the heading "PPOs, Utilization Review and Grievances."

(3) By designating G.S. 58-50-65 through G.S. 58-50-70 as Part 3 with the heading "Scope and Sanctions."

(4) By designating G.S. 58-50-75 through G.S. 58-50-95 as Part 4 with the heading "Health Benefit Plan External Review."

(5) By designating G.S. 58-50-100 through G.S. 58-50-156 as Part 5 with the heading "Small Employer Group Health Insurance Reform."

SECTION 4.3. G.S. 58-50-151 is recodified as G.S. 58-51-116.

SECTION 4.4. The prefatory language of G.S. 58-50-61(a) reads as rewritten:

"(a) Definitions. – As used in this ~~section and~~ section, in G.S. 58-50-62, and in Part 4 of this Article, the term:".

SECTION 4.5. Article 50 of Chapter 58 of the General Statutes is amended by adding a new Part to read:

"Part 4. Health Benefit Plan External Review.

"**§ 58-50-75. Purpose, scope, and definitions.**

(a) The purpose of this Part is to provide standards for the establishment and maintenance of external review procedures to assure that covered persons have the opportunity for an independent review of an appeal decision upholding a noncertification or a second-level grievance review decision upholding a noncertification, as defined in this Part.

(b) This Part applies to all persons that provide or perform utilization review, including the Teachers' and State Employees' Comprehensive Major Medical Plan and the Health Insurance Program for Children. With respect to second-level grievance review decisions, this Part applies only to second-level grievance review decisions involving noncertification decisions.

(c) In addition to the definitions in G.S. 58-50-61(a), as used in this Part:

(1) 'Covered benefits' or 'benefits' means those benefits consisting of medical care, provided directly through insurance or otherwise and including items and services paid for as medical care, under the terms of a health benefit plan.

(2) 'Covered person' means a policyholder, subscriber, enrollee, or other individual covered by a health benefit plan. 'Covered person' includes another person, including the covered person's health care provider, acting on behalf of the covered person. Nothing in this subdivision shall require the covered person's health care provider to act on behalf of the covered person.

(3) 'Independent review organization' or 'organization' means an entity that conducts independent external reviews of appeals of noncertifications and second-level grievance review decisions.

"§ 58-50-76: Reserved.

"**§ 58-50-77. Notice of right to external review.**

(a) An insurer shall notify the covered person in writing of the covered person's right to request an external review and include the appropriate statements and information set forth in this section at the time the insurer sends written notice of:

(1) An appeal decision under G.S. 58-50-61 upholding a noncertification; and

(2) A second-level grievance review decision under G.S. 58-50-62 upholding the original noncertification.

(b) The insurer shall include in the notice required under subsection (a) of this section for a notice related to an appeal decision under G.S. 58-50-61, a statement informing the covered person that:

(1) If the covered person has a medical condition where the time frame for completion of an expedited review of a grievance involving an appeal decision under G.S. 58-50-61 would reasonably be expected to seriously jeopardize the life or health of the covered person or jeopardize the covered person's ability to regain maximum function, the covered person may file a request for an expedited external review under G.S. 58-50-82 at the same time the covered person files a request for an expedited review of a grievance involving an appeal decision under G.S. 58-50-61 and G.S. 58-50-62, but that the Commissioner will determine whether the covered person shall be required to complete the expedited review of the grievance before conducting the expedited external review.

(2) If the insurer has not issued a written decision to the covered person within 45 days after the date the covered person files the grievance with the insurer pursuant to G.S. 58-50-62 and the covered person has not requested or agreed to a delay, the covered person may file a request for external review under G.S. 58-50-80 of this section and shall be considered to have exhausted the insurer's internal grievance process for purposes of G.S. 58-50-79.

(c) The insurer shall include in the notice required under subsection (a) of this section for a notice related to a final second-level grievance review decision under G.S. 58-50-62, a statement informing the covered person that:

(1) If the covered person has a medical condition where the time frame for completion of a standard external review under G.S. 58-50-80 would reasonably be expected to seriously jeopardize the life or health of the covered person or jeopardize the covered person's ability to regain maximum function, the covered person may file a request for an expedited external review under G.S. 58-50-82; or

(2) If the second-level grievance review decision concerns an admission, availability of care, continued stay, or health care service for which the covered person received emergency services but has not been discharged from a facility, the covered person may request an expedited external review under G.S. 58-50-82.

(d) In addition to the information to be provided under subsections (b) and (c) of this section, the insurer shall include a copy of the description of both the standard and expedited external review procedures the insurer is required to provide under G.S. 58-50-93, including the provisions in the external review procedures that give the covered person the opportunity to submit additional information.

"**§ 58-50-78:** Reserved.

"**§ 58-50-79. Exhaustion of internal grievance process.**

(a) Except as provided in G.S. 58-50-82, a request for an external review under G.S. 58-50-80 or G.S. 58-50-82 shall not be made until the covered person has exhausted the insurer's internal grievance process under G.S. 58-50-62.

(b) A covered person shall be considered to have exhausted the insurer's internal grievance process for purposes of this section, if the covered person:

(1) Has filed a second-level grievance involving a noncertification appeal decision under G.S. 58-50-61 and G.S. 58-50-62, and

(2) Except to the extent the covered person requested or agreed to a delay, has not received a written decision on the grievance from the insurer within 57 days since the date the covered person filed the grievance with the insurer.

(c) Notwithstanding subsection (b) of this section, a covered person may not make a request for an external review of a noncertification involving a retrospective review determination made under G.S. 58-50-61 until the covered person has exhausted the insurer's internal grievance process.

(d) A request for an external review of a noncertification may be made before the covered person has exhausted the insurer's internal grievance and appeal procedures under G.S. 58-50-61 and G.S. 58-50-62 whenever the insurer agrees to waive the exhaustion requirement. If the requirement to exhaust the insurer's internal grievance procedures is waived, the covered person may file a request in writing for a standard external review as set forth in G.S. 58-50-80 or may make a request for an expedited external review as set forth in G.S. 58-50-82. In addition, the insurer may choose to eliminate the second-level grievance review under G.S. 58-50-62. In such case, the covered person may file a request in writing for a standard external review under G.S. 58-50-80 or may make a request for an expedited external review as set forth in G.S. 58-50-82 within 60 days after an appeal decision upholding a noncertification.

"**§ 58-50-80. Standard external review.**

(a) Within 60 days after the date of receipt of a notice under G.S. 58-50-77, a covered person may file a request for an external review with the Commissioner.

(b) Upon receipt of a request for an external review under subsection (a) of this section, the Commissioner shall within three business days notify and send a copy of the

request to the insurer that made the decision which is the subject of the request. The insurer shall within three business days submit to the Commissioner the information required for the preliminary review under subsection (c) of this section.

(c) Within five business days after the date of receipt of a request for an external review, the Commissioner shall complete a preliminary review of the request to determine whether:

(1) The individual is or was a covered person in the health benefit plan at the time the health care service was requested or, in the case of a retrospective review, was a covered person in the health benefit plan at the time the health care service was provided.

(2) The health care service that is the subject of the noncertification appeal decision or the second-level grievance review decision upholding a noncertification reasonably appears to be a covered service under the covered person's health benefit plan.

(3) The covered person has exhausted the insurer's internal appeal and grievance processes under G.S. 58-50-61 and G.S. 58-50-62, unless the covered person is considered to have exhausted the insurer's internal appeal or grievance process under G.S. 58-50-79, or unless the insurer has waived its right to conduct an expedited review of the appeal decision.

(4) The covered person has provided all the information and forms required by the Commissioner that are necessary to process an external review.

(d) Upon completion of the preliminary review under subsection (c) of this section, the Commissioner immediately shall notify the covered person in writing whether the request is complete and whether the request has been accepted for external review. If the request is not complete, the Commissioner shall request from the covered person the information or materials needed to make the request complete. The covered person shall furnish the Commissioner with the requested information or materials within 90 days after the date of the insurer's decision for which external review is requested. If the request is not accepted for external review, the Commissioner shall inform the covered person and the insurer in writing of the reasons for its nonacceptance.

(e) If the request is complete and accepted for external review, the Commissioner shall:

(1) Include in the notice provided under subsection (d) of this section a statement that the covered person may submit to the Commissioner in writing within seven days after the date of the notice additional information and supporting documentation relevant to the initial denial that the organization shall consider when conducting the external review.

(2) Immediately notify the insurer in writing of the acceptance of the request for external review.

The Commissioner shall maintain an alphabetical listing of independent review organizations approved under G.S. 58-50-85 and shall systematically assign on a rotating basis the next independent review organization on that list capable of performing the review to conduct the external review. After the last organization on the list has been assigned a review, the Commissioner shall return to the top of the list to continue assigning reviews.

(f) The Commissioner shall forward to the review organization that was assigned by the Commissioner any documents that were received relating to the request for external review. At the same time the Commissioner forwards the information to the review organization, the Commissioner shall forward the information to the insurer and the covered person.

(g) Within seven days after the date of receipt of the notice provided under subsection (d) of this section, the insurer or its designee utilization review organization shall provide to the assigned organization the documents and any information considered in making the noncertification appeal decision or the second-level grievance review decision. Except as provided in subsection (h) of this section, failure by the insurer or its designee utilization review organization to provide the documents and information within the time specified in this subsection shall not delay the conduct of the external review.

(h) If the insurer or its utilization review organization fails to provide the documents and information within the time specified in subsection (g) of this section, the assigned organization may terminate the external review and make a decision to reverse the noncertification appeal decision or the second-level grievance review decision. Immediately upon making the decision under this subsection, the organization shall notify the covered person, the insurer, and the Commissioner.

(i) Upon receipt of the information required to be forwarded under subsection (f) of this section, the insurer may reconsider its noncertification appeal decision or second-level grievance review decision that is the subject of the external review. Reconsideration by the insurer of its noncertification appeal decision or second-level grievance review decision under this subsection shall not delay or terminate the external review. The external review shall be terminated if the insurer decides, upon completion of its reconsideration, to reverse its noncertification appeal decision or second-level grievance review decision and provide coverage or payment for the requested health care service that is the subject of the noncertification appeal decision or second-level grievance review decision.

(j) Immediately upon making the decision to reverse its noncertification appeal decision or second-level grievance review decision under subsection (i) of this section, the insurer shall notify the covered person, the organization, and the Commissioner in writing of its decision. The organization shall terminate the external review upon receipt of the notice from the insurer sent under this subsection.

(k) The assigned organization shall review all of the information and documents received under subsections (f) and (g) of this section that have been forwarded to the organization by the Commissioner and the insurer. In addition, the assigned review

organization, to the extent the documents or information are available, shall consider the following in reaching a decision:

(1) The covered person's medical records.
(2) The attending health care provider's recommendation.
(3) Consulting reports from appropriate health care providers and other documents submitted by the insurer, covered person, or the covered person's treating provider.
(4) The most appropriate practice guidelines that are based on sound clinical evidence and that are periodically evaluated to assure ongoing efficacy.
(5) Any applicable clinical review criteria developed and used by the insurer or its designee utilization review organization.
(6) Medical necessity, as defined in G.S. 58-3-200(b).
(7) Any documentation supporting the medical necessity and appropriateness of the provider's recommendation.

The assigned organization shall review the terms of coverage under the covered person's health benefit plan to ensure that the organization's decision shall not be contrary to the terms of coverage under the covered person's health benefit plan with the insurer.

The assigned organization's determination shall be based on the covered person's medical condition at the time of the initial noncertification decision.

(l) Within 45 days after the date of receipt by the Commissioner of the request for external review, the assigned organization shall provide written notice of its decision to uphold or reverse the noncertification appeal decision or second-level grievance review decision to the covered person, the insurer, the covered person's provider, and the Commissioner. In reaching a decision, the assigned review organization is not bound by any decisions or conclusions reached during the insurer's utilization review process or the insurer's internal grievance process under G.S. 58-50-61 and G.S. 58-50-62.

(m) The organization shall include in the notice sent under subsection (l) of this section:

(1) A general description of the reason for the request for external review.
(2) The date the organization received the assignment from the Commissioner to conduct the external review.
(3) The date the organization received information and documents submitted by the covered person and by the insurer.
(4) The date the external review was conducted.
(5) The date of its decision.
(6) The principal reason or reasons for its decision.
(7) The clinical rationale for its decision.
(8) References to the evidence or documentation, including the practice guidelines, considered in reaching its decision.
(9) The professional qualifications and licensure of the clinical peer reviewers.

(10) Notice to the covered person that he or she is not liable for the cost of the external review.

(n) Upon receipt of a notice of a decision under subsection (l) of this section reversing the noncertification appeal decision or second-level grievance review decision, the insurer shall immediately reverse the noncertification appeal decision or second-level grievance review decision that was the subject of the review and shall provide coverage or payment for the requested health care service or supply that was the subject of the noncertification appeal decision or second-level grievance review decision. In the event the covered person is no longer enrolled in the health benefit plan when the insurer receives notice of a decision under subsection (l) of this section reversing the noncertification appeal decision or second-level grievance review decision, the insurer that made the noncertification appeal decision or second-level grievance review decision shall be responsible under this section only for the costs of those services or supplies the covered person received or would have received prior to disenrollment.

"**§ 58-50-81:** Reserved.

"**§ 58-50-82. Expedited external review.**

(a) Except as provided in subsection (h) of this section, a covered person may make a written or oral request for an expedited external review with the Commissioner at the time the covered person receives:

(1) An appeal decision under G.S. 58-50-61(k) or (l) upholding a noncertification if:

a. The noncertification appeal decision involves a medical condition of the covered person for which the time frame for completion of an expedited second-level grievance review of a noncertification set forth in G.S. 58-50-62(i) would reasonably be expected to seriously jeopardize the life or health of the covered person or jeopardize the covered person's ability to regain maximum function; and

b. The covered person has filed a request for an expedited second-level review of a noncertification as set forth in G.S. 58-50-61(i); or

(2) A second-level grievance review decision under G.S. 58-60-62(h) or (i) upholding a noncertification:

a. If the covered person has a medical condition where the time frame for completion of a standard external review under G.S. 58-50-80 would reasonably be expected to seriously jeopardize the life or health of the covered person or jeopardize the covered person's ability to regain maximum function; or

b. If the second-level grievance concerns a noncertification of an admission, availability of care, continued stay, or health care service for which the covered person received emergency services, but has not been discharged from a facility.

(b) At the time the Commissioner receives a request for an expedited external review, the Commissioner immediately shall:

(1) Notify and provide a copy of the request to the insurer that made the noncertification appeal decision or second-level grievance review decision which is the subject of the request. The Commissioner shall also request any information from the insurer necessary to make the preliminary review set forth in G.S. 58-50-80(c).

(2) For a request made pursuant to subdivision (a)(1) of this section that the Commissioner has determined meets the reviewability requirements set forth in G.S. 58-50-80(c), the Commissioner shall immediately determine, based on medical advice from a medical professional who is not affiliated with the organization that will be assigned to conduct the external review of the request, whether the request should be reviewed on an expedited basis because the time frame for completion of an expedited review under G.S. 58-50-62 would reasonably be expected to seriously jeopardize the life or health of the covered person or would jeopardize the covered person's ability to regain maximum function. The Commissioner shall then inform the covered person and the insurer whether the Commissioner has accepted the covered person's request for an expedited external review. If the Commissioner has accepted the covered person's request for an expedited external review, then the Commissioner shall, in accordance with G.S. 58-50-80, assign an organization to conduct the review within the appropriate time frame. Upon receipt of a request for an expedited external review under G.S. 58-50-79, the Commissioner shall immediately determine whether the covered person shall be required to complete the expedited internal appeal process set forth in G.S. 58-50-61(1) before the organization conducts the expedited external review, unless the insurer has waived its right to conduct an expedited review of the appeal decision. If the Commissioner has not accepted the covered person's request for an expedited external review, then the covered person must exhaust the insurer's internal grievance process under G.S. 58-50-62 before making another request for an external review with the Commissioner.

(3) For a request made pursuant to sub-subdivision (a)(2)a. of this section that the Commissioner has determined meets the reviewability requirements set forth in G.S. 58-50-80(c), the Commissioner shall immediately determine, based on medical advice from a medical professional who is not affiliated with the organization that will be assigned to conduct the external review of the request, whether the request should be reviewed on an expedited basis because the time frame for completion of a standard external review under G.S. 58-50-80 would reasonably be expected to seriously jeopardize the life

or health of the covered person or would jeopardize the covered person's ability to regain maximum function. The Commissioner shall then inform the covered person and the insurer whether the review will be conducted using an expedited or standard time frame and shall, in accordance with G.S. 58-50-80, assign an organization to conduct the review within the appropriate time frame.

(4) For a request made pursuant to sub-subdivision (a)(2)b. of this section, that the Commissioner has determined meets the reviewability requirements set forth in G.S. 58-50-80(c), the Commissioner shall, in accordance with G.S. 58-50-80, assign an organization to conduct the expedited review and inform the covered person and the insured of its decision.

(c) At the time the insurer receives notice under subsection (b) of this section that the request has been assigned to a review organization, the insurer or its designee utilization review organization shall immediately provide or transmit all documents and information considered in making the noncertification appeal decision or the second-level grievance review decision to the assigned review organization electronically or by telephone or facsimile or any other available expeditious method.

(d) In addition to the documents and information provided or transmitted under subsection (d) of this section, the assigned organization, to the extent the information or documents are available, shall consider the following in reaching a decision:

(1) The covered person's pertinent medical records.

(2) The attending health care provider's recommendation.

(3) Consulting reports from appropriate health care providers and other documents submitted by the insurer, covered person, or the covered person's treating provider.

(4) The most appropriate practice guidelines that are based on sound clinical evidence and that are periodically evaluated to assure ongoing efficacy.

(5) Any applicable clinical review criteria developed and used by the insurer or its designee utilization review organization in making noncertification decisions.

(6) Medical necessity, as defined in G.S. 58-3-200(b).

(7) Any documentation supporting the medical necessity and appropriateness of the provider's recommendation.

The assigned organization shall review the terms of coverage under the covered person's health benefit plan to ensure that the organization's decision shall not be contrary to the terms of coverage under the covered person's health benefit plan.

The assigned organization's determination shall be based on the covered person's medical condition at the time of the initial noncertification decision.

(e) As expeditiously as the covered person's medical condition or circumstances require, but not more than four days after the date of receipt of the request for an expedited external review, the assigned organization shall make a decision to uphold or

reverse the noncertification appeal decision or second-level grievance review decision and notify the covered person, the insurer, and the Commissioner of the decision. In reaching a decision, the assigned organization is not bound by any decisions or conclusions reached during the insurer's utilization review process or internal grievance process under G.S. 58-50-61 and G.S. 58-50-62.

(f) If the notice provided under subsection (e) of this section was not in writing, within two days after the date of providing that notice, the assigned organization shall provide written confirmation of the decision to the covered person, the insurer, and the Commissioner and include the information set forth in G.S. 58-50-80(m). Upon receipt of the notice, a decision under subsection (e) of this section reversing the noncertification appeal decision or second-level grievance review decision, the insurer shall immediately reverse the noncertification appeal decision or second-level grievance review decision that was the subject of the review and shall provide coverage or payment for the requested health care service or supply that was the subject of the noncertification appeal decision or second-level grievance review decision.

(g) An expedited external review shall not be provided for retrospective noncertifications.

"**§ 58-50-83:** Reserved.

"**§ 58-50-84. Binding nature of external review decision.**

(a) An external review decision is binding on the insurer.

(b) An external review decision is binding on the covered person except to the extent the covered person has other remedies available under applicable federal or State law.

(c) A covered person may not file a subsequent request for external review involving the same noncertification appeal decision or second-level grievance review decision for which the covered person has already received an external review decision under this Part.

"**§ 58-50-85. Approval of independent review organizations.**

(a) The Commissioner shall approve independent review organizations eligible to be assigned to conduct external reviews under this Part to ensure that an organization satisfies the minimum qualifications established under G.S. 58-50-87. The Commissioner shall develop an application form for initially approving and for reapproving organizations to conduct external reviews.

(b) Any organization wishing to be approved to conduct external reviews under this Part shall submit the application form and include with the form all documentation and information necessary for the Commissioner to determine if the organization satisfies the minimum qualifications established under G.S. 58-50-87. Applicants must submit pricing information sufficient to demonstrate that if selected, the applicant's total fee per review will not exceed commercially reasonable fees charged for similar services in the industry. The Commissioner shall not approve any independent review organization that either fails to provide sufficient pricing information or has fees that do not meet the guidelines established under this subsection.

(c) The Commissioner may determine that accreditation by a nationally recognized private accrediting entity with established and maintained standards for independent review organizations that meet the minimum qualifications established under G.S. 58-50-87 will cause an independent review organization to be deemed to have met, in whole or in part, the requirements of this section and G.S. 58-50-87. A decision by the Commissioner to recognize an accreditation program for the purpose of granting deemed status may be made only after reviewing the accreditation standards and program information submitted by the accrediting body. An independent review organization seeking deemed status due to its accreditation shall submit original documentation issued by the accrediting body to demonstrate its accreditation.

(d) An approval is effective for two years, unless the Commissioner determines before expiration of the approval that the independent review organization is not satisfying the minimum qualifications established under G.S. 58-50-87.

(e) Whenever the Commissioner determines that an independent review organization no longer satisfies the minimum requirements established under G.S. 58-50-87, the Commissioner shall terminate the approval of the independent review organization.

"**§ 58-50-86:** Reserved.

"**§ 58-50-87. Minimum qualifications for independent review organizations.**

(a) As a condition of approval under G.S. 58-50-85 to conduct external reviews, an independent review organization shall have and maintain written policies and procedures that govern all aspects of both the standard external review process and the expedited external review process set forth in G.S. 58-50-80 and G.S. 58-50-82 that include, at a minimum:

(1) A quality assurance mechanism in place that ensures:

a. That external reviews are conducted within the specified time frames and required notices are provided in a timely manner.

b. The selection of qualified and impartial clinical peer reviewers to conduct external reviews on behalf of the independent review organization and suitable matching of reviewers to specific cases.

c. The confidentiality of medical and treatment records and clinical review criteria.

d. That any person employed by or under contract with the independent review organization adheres to the requirements of this Part.

e. The independence and impartiality of the independent review organization and the external review process and limits the ability of any person to improperly influence the external review decision.

(2) A toll-free telephone service to receive information on a 24-hour-day, seven-day-a-week basis related to external reviews that is capable of

accepting or recording inquiries or providing appropriate instruction to incoming telephone callers during other than normal business hours.

(3) An agreement to maintain and provide to the Commissioner the information set out in G.S. 58-50-90.

(4) A program for credentialing clinical peer reviewers.

(5) An agreement to contractual terms or written requirements established by the Commissioner regarding the procedures for handling a review.

(6) That the independent review organization consult with a medical doctor licensed to practice in North Carolina to advise the independent review organization on issues related to the standard of practice, technology, and training of North Carolina physicians with respect to the organization's North Carolina business.

(b) All clinical peer reviewers assigned by an independent review organization to conduct external reviews shall be medical doctors or other appropriate health care providers who meet the following minimum qualifications:

(1) Be an expert in the treatment of the covered person's injury, illness, or medical condition that is the subject of the external review.

(2) Be knowledgeable about the recommended health care service or treatment through recent or current actual clinical experience treating patients with the same or similar injury, illness, or medical condition of the covered person.

(3) If the covered person's treating provider is a medical doctor, hold a nonrestricted license and, if a specialist medical doctor, a current certification by a recognized American medical specialty board in the area or areas appropriate to the subject of the external review.

(4) If the covered person's treating provider is not a medical doctor, hold a nonrestricted license, registration, or certification in the same allied health occupation as the covered person's treating provider.

(5) Have no history of disciplinary actions or sanctions, including loss of staff privileges or participation restrictions, that have been taken or are pending by any hospital, governmental agency or unit, or regulatory body that raise a substantial question as to the clinical peer reviewer's physical, mental, or professional competence or moral character.

(c) In addition to the requirements set forth in subsection (a) of this section, an independent review organization may not own or control, be a subsidiary of, or in any way be owned or controlled by, or exercise control with a health benefit plan, a national, State, or local trade association of health benefit plans, or a national, State, or local trade association of health care providers.

(d) In addition to the requirements set forth in subsections (a), (b), and (c) of this section, to be approved under G.S. 58-50-85 to conduct an external review of a specified case, neither the independent review organization selected to conduct the external review nor any clinical peer reviewer assigned by the independent organization

to conduct the external review may have a material professional, familial, or financial conflict of interest with any of the following:

(1) The insurer that is the subject of the external review.

(2) The covered person whose treatment is the subject of the external review or the covered person's authorized representative.

(3) Any officer, director, or management employee of the insurer that is the subject of the external review.

(4) The health care provider, the health care provider's medical group, or independent practice association recommending the health care service or treatment that is the subject of the external review.

(5) The facility at which the recommended health care service or treatment would be provided.

(6) The developer or manufacturer of the principal drug, device, procedure, or other therapy being recommended for the covered person whose treatment is the subject of the external review.

(e) In determining whether an independent review organization or a clinical peer reviewer of the independent review organization has a material professional, familial, or financial conflict of interest for purposes of subsection (d) of this section, the Commissioner shall take into consideration situations where the independent review organization to be assigned to conduct an external review of a specified case or a clinical peer reviewer to be assigned by the independent review organization to conduct an external review of a specified case may have an apparent professional, familial, or financial relationship or connection with a person described in subsection (d) of this section, but that the characteristics of that relationship or connection are such that they are not a material professional, familial, or financial conflict of interest that results in the disapproval of the independent review organization or the clinical peer reviewer from conducting the external review.

"§ 58-50-88: Reserved.

"**§ 58-50-89. Hold harmless for Commissioner and independent review organizations.**

The Commissioner or an independent review organization or clinical peer reviewer working on behalf of an organization shall not be liable for damages to any person for any opinions rendered during or upon completion of an external review conducted under this Part, unless the opinion was rendered in bad faith or involved gross negligence.

"**§ 58-50-90. External review reporting requirements.**

(a) An organization assigned under G.S. 58-50-80 or G.S. 58-50-82 to conduct an external review shall maintain written records in the aggregate and by insurer on all requests for external review for which it conducted an external review during a calendar year and submit a report to the Commissioner, as required under subsection (b) of this section.

(b) Each organization required to maintain written records on all requests for external review under subsection (a) of this section for which it was assigned to conduct

an external review shall submit to the Commissioner, at least annually, a report in the format specified by the Commissioner.

(c) The report shall include in the aggregate and for each insurer:

(1) The total number of requests for external review.

(2) The number of requests for external review resolved and, of those resolved, the number resolved upholding the noncertification appeal decision or second-level grievance review decision and the number resolved reversing the noncertification appeal decision or second-level grievance review decision.

(3) The average length of time for resolution.

(4) A summary of the types of coverages or cases for which an external review was sought, as provided in the format required by the Commissioner.

(5) The number of external reviews under G.S. 58-50-80(k) and (l) that were terminated as the result of a reconsideration by the insurer of its noncertification appeal decision or second-level grievance review decision after the receipt of additional information from the covered person.

(6) Any other information the Commissioner may request or require.

(d) The organization shall retain the written records required under this section for at least three years.

(e) Each insurer shall maintain written records in the aggregate and for each type of health benefit plan offered by the insurer on all requests for external review of which the insurer receives notice from the Commissioner under this Part. The insurer shall retain the written records required under this section for at least three years.

"**§ 58-50-91:** Reserved.

"**§ 58-50-92. Funding of external review.**

The insurer against which a request for a standard external review or an expedited external review is filed shall reimburse the Department of Insurance for the fees charged by the organization in conducting the external review.

"**§ 58-50-93. Disclosure requirements.**

(a) Each insurer shall include a description of the external review procedures in or attached to the policy, certificate, membership booklet, outline of coverage, or other evidence of coverage it provides to covered persons.

(b) The description required under subsection (a) of this section shall include a statement that informs the covered person of the right of the covered person to file a request for an external review of a noncertification appeal decision or a second-level grievance review decision upholding a noncertification with the Commissioner. The statement shall include the telephone number and address of the Commissioner.

(c) In addition to subsection (b) of this section, the statement shall inform the covered person that, when filing a request for an external review, the covered person will be required to authorize the release of any medical records of the covered person

that may be required to be reviewed for the purpose of reaching a decision on the external review.

"**§ 58-50-94. Competitive selection of independent review organizations.**

(a) The Commissioner shall prepare and publish requests for proposals from independent review organizations that want to be approved under G.S. 58-50-85. All proposals shall be sealed. The Commissioner shall open all proposals in public.

(b) After the public opening, the Commissioner shall review the proposals, examining the costs and quality of the services offered by the independent review organizations, the reputation and capabilities of the independent review organizations submitting the proposals, and the provisions in G.S. 58-50-85 and G.S. 58-50-87. The Commissioner shall determine which proposal or proposals would satisfy the provisions of this Part. The Commissioner shall make his determination in consultation with an evaluation committee whose membership includes representatives of insurers subject to Part 4 of Article 50 of Chapter 58 of the General Statutes, health care providers, and insureds. In selecting the review organizations, in addition to considering cost, quality, and adherence to the requirements of the request for proposals, the Commissioner shall consider the desirability and feasibility of contracting with multiple review organizations in order to allow insureds a choice of review organizations and shall ensure that at least one review organization is available and capable of reviewing cases involving highly specialized services and treatments of any nature. The Commissioner may reject any or all proposals.

(c) An independent review organization may seek to modify or withdraw a proposal only after the public opening and only on the basis that the proposal contains an unintentional clerical error as opposed to an error in judgment. An independent review organization seeking to modify or withdraw a proposal shall submit to the Commissioner a written request, with facts and evidence in support of its position, before the determination made by the Commissioner under subsection (b) of this section, but not later than two days after the public opening of the proposals. The Commissioner shall promptly review the request, examine the nature of the error, and determine whether to permit or deny the request.

(d) The provisions of Article 3C of Chapter 143 of the General Statutes do not apply to this Part.

"**§ 58-50-95. Report by Commissioner.**

The Commissioner shall report semiannually to the Joint Legislative Health Care Oversight Committee regarding the nature and appropriateness of reviews conducted under this Part. The report, which shall be provided to the public upon request, should include the number of reviews, underlying issues in dispute, character of the reviews, dollar amounts in question, whether the review was decided in favor of the covered person or the health benefit plan, the cost of review, and any other information relevant to the evaluation of the effectiveness of this Part."

SECTION 4.6. G.S. 58-50-62(h)(7) reads as rewritten:

"(7) A statement that the decision is the insurer's final determination in the matter. In cases where the review concerned a noncertification and the

insurer's decision on the second-level grievance review is to uphold its initial noncertification, a statement advising the covered person of his or her right to request an external review and a description of the procedure for submitting a request for external review to the Commissioner of Insurance."

SECTION 4.6A. G.S. 143-64.24 reads as rewritten:

"**§ 143-64.24. Applicability of Article.**

This Article shall not apply to the General Assembly, special study commissions, the Research Triangle Institute, or the Institute of Government, nor shall it apply to attorneys employed by the North Carolina Department of Justice, or physicians or doctors performing contractual services for any State agency. This Article shall not apply to Independent Review Organizations selected by the Commissioner of Insurance pursuant to G.S. 58-50-85."

Subpart B. Health Plan Liability

SECTION 4.7. Chapter 90 of the General Statutes is amended by adding a new Article to read:

"Article 1G.

"Health Care Liability.

"**§ 90-21.50. Definitions.**

As used in this Article, unless the context clearly indicates otherwise, 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 self-insured indemnity program or prepaid hospital and medical benefits plan offered under the Teachers' and State Employees' Comprehensive Major Medical Plan and subject to the requirements of Article 3 of Chapter 135 of the General Statutes, 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. Except for the Health Insurance Program for Children established under Part 8 of Article 2 of Chapter 108A of the General Statutes, '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. "Health benefit plan" does not mean any of the following kinds of insurance:

a. Accident.
b. Credit.
c. Disability income.
d. Long-term 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.
m. Short-term limited duration health insurance policies as defined in Part 144 of Title 45 of the Code of Federal Regulations.

(2) 'Health care provider' means:
a. An individual who is licensed, certified, or otherwise authorized under this Chapter to provide health care services in the ordinary course of business or practice of a profession or in an approved education or training program; or
b. A health care facility, licensed under Chapters 131E or 122C of the General Statutes, where health care services are provided to patients;

'Health care provider' includes: (i) an agent or employee of a health care facility that is licensed, certified, or otherwise authorized to provide health care services; (ii) the officers and directors of a health care facility; and (iii) an agent or employee of a health care provider who is licensed, certified, or otherwise authorized to provide health care services.

(3) 'Health care service' means a health or medical procedure or service rendered by a health care provider that:
a. Provides testing, diagnosis, or treatment of a health condition, illness, injury, or disease; or
b. Dispenses drugs, medical devices, medical appliances, or medical goods for the treatment of a health condition, illness, injury, or disease.

(4) 'Health care decision' means a determination that is made by a managed care entity and is subject to external review under Part 4 of Article 50 of Chapter 58 of the General Statutes and is also a determination that:
a. Is a noncertification, as defined in G.S. 58-50-61, of a prospective or concurrent request for health care services, and
b. Affects the quality of the diagnosis, care, or treatment provided to an enrollee or insured of the health benefit plan.

(5) 'Insured or enrollee' means a person that is insured by or enrolled in a health benefit plan under a policy, plan, certificate, or contract issued or delivered in this State by an insurer.

(6) 'Insurer' means an entity that writes a health benefit plan and that is an insurance company subject to Chapter 58 of the General Statutes, a service corporation organized under Article 65 of Chapter 58 of the General Statutes, a health maintenance organization organized under Article 67 of Chapter 58 of the General Statutes, a self-insured health maintenance organization or managed care entity operated or administered by or under contract with the Executive Administrator and Board of Trustees of the Teachers' and State Employees' Comprehensive Major Medical Plan pursuant to Article 3 of Chapter 135 of the General Statutes, or a multiple employer welfare arrangement subject to Article 49 of Chapter 58 of the General Statutes.

(7) 'Managed care entity' means an insurer that:

a. Delivers, administers, or undertakes to provide for, arrange for, or reimburse for health care services or assumes the risk for the delivery of health care services; and

b. Has a system or technique to control or influence the quality, accessibility, utilization, or costs and prices of health care services delivered or to be delivered to a defined enrollee population.

'Managed care entity' does not include: (i) an employer purchasing coverage or acting on behalf of its employees or the employees of one or more subsidiaries or affiliated corporations of the employer, or (ii) a health care provider.

(8) 'Ordinary care' means that degree of care that, under the same or similar circumstances, a managed care entity of ordinary prudence would have used at the time the managed care entity made the health care decision.

(9) 'Physician' means:

a. An individual licensed to practice medicine in this State;

b. A professional association or corporation organized under Chapter 55B of the General Statutes; or

c. A person or entity wholly owned by physicians.

(10) 'Successor external review process' means an external review process equivalent in all respects to G.S. 58-50-75 through G.S. 58-50-95 that is approved by the Department and implemented by a health benefit plan in the event that G.S. 58-50-75 through G.S. 58-50-95 are found by a court of competent jurisdiction to be void, unenforceable, or preempted by federal law, in whole or in part.

"**§ 90-21.51. Duty to exercise ordinary care; liability for damages for harm.**

(a) Each managed care entity for a health benefit plan has the duty to exercise ordinary care when making health care decisions and is liable for damages for harm to an insured or enrollee proximately caused by its failure to exercise ordinary care.

(b) In addition to the duty imposed under subsection (a) of this section, each managed care entity for a health benefit plan is liable for damages for harm to an insured or enrollee proximately caused by decisions regarding whether or when the insured or enrollee would receive a health care service made by:

(1) Its agents or employees; or

(2) Representatives that are acting on its behalf and over whom it has exercised sufficient influence or control to reasonably affect the actual care and treatment of the insured or enrollee which results in the failure to exercise ordinary care.

(c) It shall be a defense to any action brought under this section against a managed care entity for a health benefit plan that:

(1) The managed care entity and its agents or employees, or representatives for whom the managed care entity is liable under subsection (b) of this section, did not control or influence or advocate for the decision regarding whether or when the insured or enrollee would receive a health care service; or

(2) The managed care entity did not deny or delay payment for any health care service or treatment prescribed or recommended by a physician or health care provider to the insured or enrollee.

(d) In an action brought under this Article against a managed care entity, a finding that a physician or health care provider is an agent or employee of the managed care entity may not be based solely on proof that the physician or health care provider appears in a listing of approved physicians or health care providers made available to insureds or enrollees under the managed care entity's health benefit plan.

(e) An action brought under this Article is not a medical malpractice action as defined in Article 1B of this Chapter. A managed care entity may not use as a defense in an action brought under this Article any law that prohibits the corporate practice of medicine.

(f) A managed care entity shall not be liable for the independent actions of a health care provider, who is not an agent or employee of the managed care entity, when that health care provider fails to exercise the standard of care required by G.S. 90-21.12. A health care provider shall not be liable for the independent actions of a managed care entity when the managed care entity fails to exercise the standard of care required by this Article.

(g) Nothing in this Article shall be construed to create an obligation on the part of a managed care entity to provide to an insured or enrollee a health care service or treatment that is not covered under its health benefit plan.

(h) A managed care entity may not enter into a contract with a health care provider, or with an employer or employer group organization, that includes an indemnification or hold harmless clause for the acts or conduct of the managed care

entity. Any such indemnification or hold harmless clause is void and unenforceable to the extent of the restriction.

"**§ 90-21.52. No liability under this Article on the part of an employer or employer group organization that purchases coverage or assumes risk on behalf of its employees or a physician or health care provider.**

(a) This Article does not create any liability on the part of an employer or employer group purchasing organization that purchases health care coverage or assumes risk on behalf of its employees.

(b) This Article does not create any liability on the part of a physician or health care provider in addition to that otherwise imposed under existing law. No managed care entity held liable under this Article shall be entitled to contribution under Chapter 1B of the General Statutes or indemnity from a physician or health care provider.

"**§ 90-21.53. Separate trial required.**

Upon motion of any party in an action that includes a claim brought pursuant to this Article involving a managed care entity, the court shall order separate discovery and a separate trial of any claim, cross-claim, counterclaim, or third-party claim against any physician or other health care provider.

"**§ 90-21.54. Exhaustion of administrative remedies and appeals.**

No action may be commenced under this Article until the plaintiff has exhausted all administrative remedies and appeals, including those internal remedies and appeals established under G.S. 58-50-61 through G.S. 58-50-62, and G.S. 58-50-75 through G.S. 58-50-95, and including those established under any successor external review process.

"**§ 90-21.55. External review decision.**

(a) Either the insured or enrollee or the personal representative of the insured or enrollee or the managed care entity may use an external review decision made in accordance with G.S. 58-50-75 through G.S. 58-50-95, or made in accordance with any successor external review process, as evidence in any cause of action which includes an action brought under this Part, provided that an adequate foundation is laid for the introduction of the external review decision into evidence and the testimony is subject to cross-examination.

(b) Any information, documents, or other records or materials considered by the Independent Review Organization licensed under Part 4 of Article 50 of Chapter 58 of the General Statutes, or the successor review process, in conducting its review shall be admissible in any action commenced under this Article in accordance with Chapter 8 of the General Statutes and the North Carolina Rules of Evidence.

"**§ 90-21.56. Remedies.**

(a) An insured or enrollee who has been found to have been harmed by the managed care entity pursuant to an action brought under this Article may recover actual or nominal damages and, subject to the provisions and limitations of Chapter 1D of the General Statutes, punitive damages.

(b) This Article does not limit a plaintiff from pursuing any other remedy existing under the law or seeking any other relief that may be available outside of the cause of action and relief provided under this Article.

(c) The rights conferred under this Article as well as any rights conferred by the Constitution of North Carolina or the Constitution of the United States may not be waived, deferred, or lost pursuant to any contract between the insured or enrollee and the managed care entity that relates to a dispute involving a health care decision. Arbitration or mediation may be used to settle the controversy if, after the controversy arises, the insured or enrollee, or the estate of the insured or enrollee, voluntarily and knowingly consents in writing to use arbitration or mediation to settle the controversy."

SECTION 4.8. G.S. 1A-1, Rule 42, reads as rewritten:

"**Rule 42. Consolidation; separate trials.**

(a) Consolidation. – ~~When~~ Except as provided in subdivision (b)(2) of this section, when actions involving a common question of law or fact are pending in one division of the court, the judge may order a joint hearing or trial of any or all the matters in issue in the actions; he may order all the actions consolidated; and he may make such orders concerning proceedings therein as may tend to avoid unnecessary costs or delay. When actions involving a common question of law or fact are pending in both the superior and the district court of the same county, a judge of the superior court in which the action is pending may order all the actions consolidated, and he may make such orders concerning proceedings therein as may tend to avoid unnecessary costs or delay.

(b) Separate trials. –

(1) The court may in furtherance of convenience or to avoid prejudice and shall for considerations of venue upon timely motion order a separate trial of any claim, ~~crossclaim~~cross-claim, counterclaim, or third-party claim, or of any separate issue or of any number of claims, ~~crossclaims~~cross-claims, counterclaims, third-party claims, or issues.

(2) Upon motion of any party in an action that includes a claim commenced under Article 1G of Chapter 90 of the General Statutes involving a managed care entity as defined in G.S. 90-21.50, the court shall order separate discovery and a separate trial of any claim, cross-claim, counterclaim, or third-party claim against a physician or other medical provider."

SECTION 5.(a) G.S. 58-2-105 reads as rewritten:

"**§ 58-2-105. Confidentiality of medical records.**

(a) All patient medical records in the possession of the Department are confidential and are not public records pursuant to G.S. 58-2-100 or G.S. 132-1. As used in this section, "patient medical records" includes personal information that relates to an individual's physical or mental condition, medical history, or medical treatment, and that has been obtained from the individual patient, a health care provider, or from the patient's spouse, parent, or legal guardian.

(b) Under Part 4 of Article 50 of this Chapter, the Department may disclose patient medical records to an independent review organization, and the organization

shall maintain the confidentiality of those records as required by this section, except as allowed by G.S. 58-39-75 and 58-39-76."

SECTION 5.(b) G.S. 58-3-200(b) reads as rewritten:

"(b) Medical Necessity. – An insurer that limits its health benefit plan coverage to medically necessary services and supplies shall define "medically necessary services or supplies" in its health benefit plan as those covered services or supplies that are:

(1) Provided for the diagnosis, treatment, cure, or relief of a health condition, illness, injury, or disease; ~~and~~ and, except as allowed under G.S. 58-3-255, not for experimental, investigational, or cosmetic purposes.

(2) Necessary for and appropriate to the diagnosis, treatment, cure, or relief of a health condition, illness, injury, disease, or its symptoms.

(3) Within generally accepted standards of medical care in the community.

(4) Not solely for the convenience of the insured, the insured's family, or the provider.

For medically necessary services, nothing in this subsection precludes an insurer from comparing the cost-effectiveness of alternative services or supplies when determining which of the services or supplies will be covered."

SECTION 5.(c) G.S. 58-50-61(a)(12) reads as rewritten:

"(12) "Medically necessary services or supplies" means those covered services or supplies that are:

a. Provided for the diagnosis, treatment, cure, or relief of a health condition, illness, injury, or disease.

b. Except as allowed under G.S. 58-3-255, ~~Not~~ not for experimental, investigational, or cosmetic purposes.

c. Necessary for and appropriate to the diagnosis, treatment, cure, or relief of a health condition, illness, injury, disease, or its symptoms.

d. Within generally accepted standards of medical care in the community.

e. Not solely for the convenience of the insured, the insured's family, or the provider.

For medically necessary services, nothing in this subdivision precludes an insurer from comparing the cost-effectiveness of alternative services or supplies when determining which of the services or supplies will be covered."

SECTION 6.(a) G.S. 58-62-16(11) and (15) read as rewritten:

"(11) 'Member insurer' means any ~~insurer and~~ insurer, any hospital or medical service corporation ~~that is~~ governed by Article 65 of this ~~Chapter and~~ Chapter, and any HMO governed by Article 67 of this Chapter that is licensed or that holds a license to transact in this State any kind of insurance for which coverage is provided under G.S. 58-62-21; and includes any insurer whose license in this State may have been suspended, revoked, not renewed or voluntarily ~~withdrawn,~~

~~but does not include an entity governed by Article 67 of this Chapter;~~withdrawn; fraternal order or fraternal benefit society; mandatory State pooling plan; mutual assessment company or any entity that operates on an assessment basis; insurance exchange; or any entity similar to any of the foregoing.

(15) 'Policy' includes a master group contract and subscriber contract under Article 65 of this Chapter, a master group contract, certificate, and evidence of coverage under Article 67 of this Chapter, a contract of ~~insurance~~ insurance, and an annuity contract."

SECTION 6.(b) G.S. 58-62-21(b) reads as rewritten:

"(b) This Article provides coverage to the persons specified in subsection (a) of this section for direct, nongroup life, health, hospital or medical service corporation, HMO, annuity, and supplemental policies, for certificates under direct group policies and contracts, and for unallocated annuity contracts issued by member insurers, except as limited by this Article. Annuity contracts and certificates under group annuity contracts include guaranteed investment contracts, deposit administration contracts, unallocated funding agreements, allocated funding agreements, structured settlement agreements, lottery contracts, and any immediate or deferred annuity contracts."

SECTION 7. G.S. 135-39.4A(g) reads as rewritten:

"(g) The Executive Administrator shall be responsible for:

(1) Cost management programs;
(2) Education and illness prevention programs;
(3) Training programs for Health Benefit Representatives;
(4) Membership functions;
(5) Long-range planning;
(6) Provider and participant relations; and
(7) Communications.

Managed care practices used by the Executive Administrator in cost management programs are subject to the requirements of G.S. 58-3-191, 58-3-221, 58-3-223, 58-3-235, 58-3-240, 58-3-245, 58-3-250, 58-3-265, 58-67-88, and 58-50-30."

SECTION 8. If any section or provision of this act is declared unconstitutional or invalid by the courts, it does not affect the validity of the act as a whole or any part other than the part so declared to be unconstitutional or invalid.

SECTION 9. Section 1.6 of this act becomes effective January 1, 2002. Sections 3.1 and 3.2 of this act become effective December 1, 2001, and apply to health benefit plans that are delivered, issued for delivery, or renewed on or after that date. Sections 4.1 through 4.8 of this act become effective March 1, 2002. The remainder of this act is effective when it becomes law and applies to health benefit plans that are delivered, issued for delivery, or renewed on or after January 1, 2002. Nothing in this act obligates the General Assembly to appropriate funds to implement this act.

SENATE BILL 199:
Managed Care Patients' Bill of Rights

BILL ANALYSIS

Committee:	House Health Committee	**Introduced by:**	Sen. Allen Wellons
Date:	July 31, 2002	**Summary by:**	Linda Attarian
Version:	Comparison Chart		Committee Counsel

SUMMARY: ***Comparison of House Proposed Committee Substitute, S199-PCS9323-LN-36, and the Second Edition of S199. The following is a chart that lists and explains the provisions in the PCS that differ from the Second Edition of S199.***

Provision	S199 2nd Edition	S199-PCS9323-LN-36
Patient Care Assistance Program	S199 establishes a Patient Assistance Program, but does not provide which State agency will have administrative oversight of the Program or how the Program will be funded. *See page 8-9. (Sec. 1.6)*	The PCS places the Patient Assistance Program in the Department of Justice and provides that the Program shall be fee-supported from annual, nonrefundable fees collected by the Department of Insurance from each managed care entity governed under Chapter 58. The Commissioner shall determine the amount of the fee. *See pages 12-13. (Secs. 1.6.(a) and (b).*
Non-discrimination in selection of providers.	No provision.	The PCS amends G.S. 58-50-30 to (1) prohibit insurers, HMOs and Medical Service Corporations (BC/BS) from (a) limiting patient access to certain providers for covered services within the providers' scope of practice; and from (b) restricting the listed providers' participation in provider networks solely upon the basis of the provider's license or certification; and (2) allow HMOs, insurers and BC/BS to (a) require patients to use network providers if health plan is network based, and (b) condition network participation of providers on credentialing, quality, and accessibility criteria. *See pages 13-16, (Sec. 1.7).*

Provision	S199 2nd Edition	S199-PCS9323-LN-36
Prohibition on provider incentives.	No Provision.	The PCS adds a new section to Chapter 58 to prohibit insurers that offer health benefit plans from offering or paying a contracted provider any type of payment or financial incentive to delay, reduce, withhold, or limit medically necessary and appropriate health care services to an enrollee. *See page 16, (Sec. 1.8).*
Provider directories.	S199 requires health benefit plans using a provider network to make a listing of network providers available to insureds. The bill requires the plan to update the list at least once per year. In addition, the plan must maintain either a telephonic *or* electronic system through which insureds may access the information. The listing must include, to the extent known by the health plan, an indication of whether the provider is accepting new patients or has other restrictions that would limit a patient's access. *See page 10, (Sec. 2.2)*	The PCS, like the bill, requires health plans to make a listing of providers available and to update the list at least once per year. The PCS however, requires the plan to make up-to-date information available to insureds through both a telephone and electronic system. The PCS also requires health plans to know about the provider's availability and any limitations that would limit a patient's access and include this information in the listing. *See page 17, (Sec. 2.2).*
MCO Liability: Definition of 'health care decision'.	The definition of 'health care decision' in S199 may be construed to include decisions about whether a particular service is/was covered under the plan. Federal courts have held State statutes governing coverage decisions for self-funded health plans are preempted by ERISA. *See page 29, line 6.*	The definition of health care decision is changed to 'health care treatment decision' in the PCS applies only to health care *treatment* decisions relating to a covered services, not whether the service is covered to avoid ERISA preemption. *See pages 35-36.*

Provision	S199 2nd Edition	S199-PCS9323-LN-36
Definition of 'ordinary care'.	The definition of 'ordinary care' in S199 requires the court to determine whether the MCO used the same degree of care in making its health care decision that a MCO of ordinary prudence under the same or similar circumstances would have used at the time the MCO made its decision. *See page 29, line 40.*	The PCS deletes the definition in S199 and inserts the following definition of 'ordinary care' (from H1133, 4th Ed. 1999): '. . . that degree of care that a managed care entity of ordinary prudence *situated in the same or similar communities* at the time of the alleged act giving rise to the cause of action would use under the same or similar circumstances.' The significant difference is the italicized language. *See page36, lines 20-21.*
Exhaustion of Administrative Remedies.	S199 requires the plaintiff to first exhaust the internal appeals procedures and the external review procedures before a suit may be brought. *See page 31, lines 34- 38.*	The PCS requires the plaintiff to exhaust administrative remedies, but provides an exception to this requirement when the plaintiff has suffered harm by the conduct of the MCO or its agent, etc., and the circumstances are such that no administrative remedy is available, (for example there was no noncertification decision made) or the administrative review would not be beneficial to the plaintiff (for example, the reversal of the noncertification decision would not help the plaintiff). *See page 38, lines 8-22.*
Remedies.	S199 provides that any action is subject to the limitation on punitive damages (limiting such damages to $250,000). *See page 31, lines 32-33.*	The PCS provides that a plaintiff may recover nominal or actual damages. The PCS further provides that the right to sue an MCO may not be contracted away, nor shall a plaintiff be pressured into settling the dispute by arbitration or medication. If the plaintiff voluntarily consents to arbitration or medication, the consent shall not limit the right to sue. *See page 3 and 39.*

NORTH CAROLINA GENERAL ASSEMBLY
AMENDMENT
Senate Bill 199

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

S199-ALN-56 [v.5]

Date 8-14 ,2001

Comm. Sub. [YES]
Amends Title [NO]
S199-PCS9333-LN-41

Representative

moves to amend the bill on page 36, lines 38 and 39,
by rewriting the lines to read:
"existing under the law or seeking any other relief that may be available outside of the cause of action and relief provided under this Article."; and

further moves to amend the bill on page 36 , lines 40 through 43, through page 37, line 3, by rewriting the lines to read:
"(c) The rights conferred under this Article as well as any rights conferred by the Constitution of North Carolina or the Constitution of the United States may not be waived, deferred, or lost pursuant to any contract between the insured or enrollee and the managed care entity that relates to a dispute involving a health care decision. Arbitration or mediation may be used to settle the controversy if, after the controversy arises, the insured or enrollee, or the estate of the insured or enrollee, voluntarily and knowingly consents in writing to use arbitration or mediation to settle the controversy."; and

further moves to amend the bill ~~on~~ on page 35, line 1,

NORTH CAROLINA GENERAL ASSEMBLY
AMENDMENT
Senate Bill 199

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

S199-ALN-56 [v.5]

by deleting "the" the first time it occurs on that line.

SIGNED _____
Amendment Sponsor

SIGNED _____
Committee Chair if Senate Committee Amendment

ADOPTED ✓ FAILED _____ TABLED _____

NORTH CAROLINA GENERAL ASSEMBLY
AMENDMENT
Senate Bill 199

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

S199-ALN-55 [v.2]

Date 8-14 ,2001

Comm. Sub. [YES]
Amends Title [NO]
S199-PCS9333-LN-42

Representative _____

moves to amend the bill on page 4, line 4,
by deleting the words "adhere to the quality assurance standards" and substituting the words "comply with the quality assurance programs"; and

further moves to amend the bill on page 4, line 7,
by inserting after the word "provided." the following sentence: "The quality assurance programs shall not override the professional or ethical responsibility of the provider or interfere with the provider's ability to provide information or assistance to the patient.";

and further moves to amend the bill on page 4, lines 18 and 19,
by rewriting the lines to read:

"(5) The provider agrees to discontinue providing services pursuant to this section and assist the insured in an orderly transition to a network provider. Nothing in this section shall prohibit the insured from continuing to receive services from the provider at the insured's expense."; and

further moves to amend the bill on page 18, line 21,

NORTH CAROLINA GENERAL ASSEMBLY
AMENDMENT
Senate Bill 199

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

S199-ALN-55 [v.2]

by inserting after the word "person." the following: "Nothing in this subdivision shall require the covered person's health care provider to act on behalf of the covered person.".

SIGNED _____
Amendment Sponsor

SIGNED _____
Committee Chair if Senate Committee Amendment

ADOPTED ✓ FAILED _____ TABLED _____

(3)

NORTH CAROLINA GENERAL ASSEMBLY
AMENDMENT
Senate Bill 199

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

S199-ALN-53 [v.5]

Date 8-14 ,2001

Comm. Sub. [YES]
Amends Title [NO]
S199-PCS9333-LN-41

Representative Sherrill

moves to amend the bill on page 18, line 10,
by rewriting the line to read:
"(b) This part applies to all persons that provide or perform utilization review, including the Teachers' and State Employees' Comprehensive Major Medical Plan and the Health Insurance Program for Children."; and

further moves to amend the bill on page 33, line 12,
by rewriting the line to read:
"(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 self-insured indemnity program or prepaid hospital and medical benefits plan offered under the Teachers' and State Employees' Comprehensive Major Medical Plan and subject to the requirements of Article 3 of Chapter 135 of the General Statutes, 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. Except for the Health Insurance Program for Children established under Part 8 of Article 2 of Chapter 108A of the General Statutes, '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. "Health benefit plan" does not mean any of the following kinds of insurance:

a. Accident.
b. Credit.
c. Disability income.
d. Long-term 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.
m. Short-term limited duration health insurance policies as defined in Part 144 of Title 45 of the Code of Federal Regulations.";

and further moves to amend the bill on page 34, line 8,
by rewriting the line to read:
"Article 67 of Chapter 58 of the General Statutes, a self-insured health maintenance organization or managed care entity operated or administered by or under contract with the Executive Administrator and Board of Trustees of the Teachers' and State

NORTH CAROLINA GENERAL ASSEMBLY
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Senate Bill 199

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

S199-ALN-53 [v.5]

Employees' Comprehensive Major Medical Plan pursuant to Article 3 of Chapter 135 of the General Statutes, or a multiple"; and

further moves to amend the bill on page 39, line 13,
by inserting between lines 13 and 14 the following:

SECTION 7. G.S. 135-39.4A(g) reads as rewritten:

"(g) The Executive Administrator shall be responsible for:

(1) Cost management programs;
(2) Education and illness prevention programs;
(3) Training programs for Health Benefit Representatives;
(4) Membership functions;
(5) Long-range planning;
(6) Provider and participant relations; and
(7) Communications.

Managed care practices used by the Executive Administrator in cost management programs are subject to the requirements of G.S. 58-3-191, G.S. 58-3-221, G.S. 58-3-223, G.S. 58-3-235, G.S. 58-3-240, G.S. 58-3-245, G.S. 58-3-250, G.S. 58-3-265, 58-67-88, and 58-50-30."; and

further moves to amend the bill on page 39 by renumbering the remaining sections accordingly.

SIGNED _____
Amendment Sponsor

SIGNED _____
Committee Chair if Senate Committee Amendment

NORTH CAROLINA GENERAL ASSEMBLY
AMENDMENT
Senate Bill 199

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

S199-ALN-53 [v.5]

ADOPTED ✓ FAILED _____ TABLED _____

(4)

NORTH CAROLINA GENERAL ASSEMBLY
AMENDMENT
Senate Bill 199

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

S199-ALN-54 [v.2]

Date 8-14 ,2001

Comm. Sub. [YES]
Amends Title [NO]
S199-PCS9333-LN-41

Representative Edwards

moves to amend the bill 16, line 6,
by deleting "phase III and phase IV" and substituting "phase II, phase III, and phase IV"; and

further moves to amend the bill on page 16, lines 30 and 31,
by deleting "phase III and phase IV" and substituting "phase II, phase III, and phase IV"; and

further moves to amend the bill on page 16, line 39,
by inserting after the word "trials." the following: "Nothing in this section shall be construed to require a health benefit plan to pay or reimburse for non-FDA approved drugs provided or made available to a patient who received the drug during a covered clinical trial after the clinical trial has been discontinued.".

SIGNED Rene L Edwards Jr
Amendment Sponsor

NORTH CAROLINA GENERAL ASSEMBLY
AMENDMENT
Senate Bill 199

S199-ALN-54 [v.2]

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

SIGNED _____
Committee Chair if Senate Committee Amendment

ADOPTED ✓ FAILED _____ TABLED _____

(5)

NORTH CAROLINA GENERAL ASSEMBLY
AMENDMENT
Senate Bill 199

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

S199-ALN-57 [v.3]

Date 8-14 ,2001

Comm. Sub. [YES]
Amends Title [NO]
S199-PCS9333-LN-41

Representative Nye

moves to amend the bill on page 4, line 1
by deleting "The" and substituting the following:
"When care is provided pursuant to subdivision (b)(2) of this section, the"; and

further moves to amend the bill on page 4, line 3,
by inserting after the word "full." the following:
"When care is provided pursuant to subdivision (c)(2) of this section, the provider agrees to accept the prevailing rate based on contracts the insurer has with the same or similar providers in the same or similar geographic area, plus the applicable copayment, as reimbursement in full from the HMO and the insured for all covered services."; and

and further moves to amend the bill on page 19, line 34,
by rewriting the line to read:
"Except as provided in G.S. 58-50-82, a request for an"; and

further moves to amend the bill on page 20, lines 7 through 25,
by deleting the lines and redesignating the remaining subsection accordingly; and

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

S199-ALN-57 [v.3]

further moves to amend the bill on page 20, line 41,
by deleting "immediately shall" and substituting "shall within three business days"; and

further moves to amend the bill on page 21, line 1,
by deleting "immediately" and substituting "within three business days"; and

further moves to amend the bill on page 25, line 22,
by rewriting the line to read:
"within the appropriate time frame. Upon receipt of a request for an expedited external review under G.S. 58-50-79, the Commissioner shall immediately determine whether the covered person shall be required to complete the expedited internal appeal process set forth in G.S. 58-50-61(1) before the organization conducts the expedited external review, unless the insurer has waived its right to conduct an expedited review of the appeal decision. If the Commissioner has not"; and

further moves to amend the bill on page 21, line 15,
by deleting "G.S. 58-50-62." And substituting "G.S. 58-50-62, unless the covered person is considered to have exhausted the insurer's internal appeal or grievance process under G.S. 58-50-79, or unless the insurer has waived its right to conduct an expedited review of the appeal decision."; and

further moves to amend the bill on page 21, lines 36 through 39,

NORTH CAROLINA GENERAL ASSEMBLY
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AMENDMENT NO._____
(to be filled in by
Principal Clerk)

S199-ALN-57 [v.3]

by rewriting the lines to read:
"review.".

SIGNED _____
Amendment Sponsor

SIGNED _____
Committee Chair if Senate Committee Amendment

ADOPTED _____ FAILED _____ TABLED _____

NORTH CAROLINA GENERAL ASSEMBLY AMENDMENT

(6)

(Please type or use ballpoint pen)

EDITION No. _____

H. B. No. _____ DATE 8/14/01

S. B. No. 199 Amendment No. _____

(to be filled in by Principal Clerk)

COMMITTEE SUBSTITUTE ✓ S199-PCS9333-LN-41

(Rep.)
Sen.) _____

1 moves to amend the bill on page 1, line 25

2 ( ) WHICH CHANGES THE TITLE

3 by deleting the word "TREATMENT".

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SIGNED _____

ADOPTED ✓ FAILED _____ TABLED _____

GA-33-A

PRINCIPAL CLERK'S OFFICE (FOR ENGROSSMENT)

2001 COMMITTEE REPORT
HOUSE OF REPRESENTATIVES

The following report(s) from standing committee(s) is/are presented:
By Representative(s) **Wright** (Chair/Chairs) for the Committee on **Health**.

☒ Committee Substitute for
S.B. 199 A BILL TO BE ENTITLED AN ACT TO IMPROVE ACCESS TO HEALTH CARE ADVICE, INFORMATION, AND SERVICES TO COVERED PERSONS UNDER HEALTH BENEFIT PLANS; ESTABLISH STANDARDS FOR HEALTH PLAN DISCLOSURES TO CONSUMERS; ESTABLISH A PATIENTS' ASSISTANCE PROGRAM; REQUIRE COVERAGE FOR CLINICAL TRIALS AND NEWBORN HEARING SCREENING; PROVIDE STANDARDS FOR INDEPENDENT REVIEW OF NONCERTIFICATIONS BY AN INSURER OR MANAGED CARE PLAN, AND TO HOLD MANAGED CARE ENTITIES LIABLE FOR HARM CAUSED TO INSUREDS OR ENROLLEES BY THE FAILURE TO EXERCISE ORDINARY CARE IN MAKING TREATMENT DECISIONS.

☐ 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)

2/15/01

NORTH CAROLINA
ASSOCIATION OF HEALTH PLANS
PUTTING PEOPLE FIRST

August 8, 2001

The Honorable Thomas Wright
Chair, House Health Committee
528 Legislative Office Building
Raleigh, NC 27601-1096

Dear Representative Wright:

The House Proposed Committee Substitute for Senate Bill 199, Managed Care Patients Bill of Rights, makes a number of complex changes in an already complicated insurance bill. The members of our organization are extremely concerned that the House Health Committee will be asked to vote on this bill before committee members receive critical information about the ultimate impact of this bill on their constituents, including possible unintended consequences such as higher insurance premiums and more uninsured North Carolinians.

We respectfully request the opportunity to address the committee at its next meeting to identify a number of significant concerns that have not yet been debated. My members do not oppose most provisions in the bill as drafted in the Senate, but we have significant concerns about expanded health plan liability and the new sections of the bill. We also understand that additional amendments to the bill are expected, and we hope that we will have the opportunity to analyze these amendments and present our comments to the House Health Committee before a vote is called.

At the last meeting of House Health, a number of committee members expressed an interest in obtaining information about the potential cost of the provisions of the Patients Bill of Rights. Attached please find an executive summary of an analysis of the likely costs of expanded health plan liability that was compiled by Dr. Christopher Conover of Duke University. We hope this study will assist legislators in their efforts to "cost out" the PBR. Please be advised that Dr. Conover's numbers are based on the far narrower version of health plan liability passed by the Senate. The version of health plan liability in the Proposed House Committee Substitute, with its broad loophole in the exhaustion of administrative remedies and broader definition of "health plan," would likely cost a great deal more.

Thank you in advance for allowing us to present our arguments to the House Health Committee.

Sincerely,

Paul Mahoney

Paul J. Mahoney
Executive Director

Cc: House Health Committee Members

5 WEST HARGETT ST., SUITE 310 • RALEIGH, NC 27601 • PHONE (919) 833-3470 FAX (919) 833-4122

Estimated Cost Impact of Health Plan Liability Provisions Of Managed Care Patients' Bill of Rights

BILL NUMBER: Senate Bill 199 *Managed Care Patients' Bill of Rights* as passed by NC Senate, April 25, 2001

SECTION: Subpart B. Health Plan Liability

SPONSOR(S): Senators Wellons, Purcell, Forrester and others

ENTITIES AFFECTED: This bill would apply to all managed care entities used by any health benefits plan, including commercial accident and health policies, non-profit health insurance contracts (e.g., Blue Cross and Blue Shield of North Carolina), health maintenance organization subscriber contracts and multiple employer welfare arrangements (MEWAs).

The bill specifically *excludes* the State Employees Health Benefits Plan (SEHBP), the Health Insurance Program for Children (CHIP), Medicaid, workers' compensation, Medicare supplements or other specialized health coverage policies (e.g.., long-term care, dental, vision).

FUNDS AFFECTED: Local government expenditures to the extent that local government employers provide managed care coverage through group health benefits for their employees and retired employees and their covered spouses and dependent children. Local government employees and retired employees also would be affected to the extent that they purchase managed care coverage for themselves and their covered spouses and dependent children on a fully or partially contributory basis. This bill also would affect health plan premium payments made by private employers and their employees.

BILL SUMMARY: This section of the bill provides:

Duty to exercise ordinary care. Managed care entities have the duty to exercise ordinary care when making health care treatment decisions;

Liability. A managed care entity is liable for damages for harm to an enrollee caused by:

1. its failure to exercise ordinary care; or
2. a health care treatment decision made by an employee or representative who is acting on its behalf if the plan has "exercised sufficient influence or to reasonably affect actual care and treatment which results in the failure to exercise ordinary care."

A finding that a health care provider meets number (2) above cannot be based solely on proof that such person's name appears in a listing of approved providers.

Restrictions on Liability. It is a defense to any action that:

1. Neither the managed care entity, nor any employee, agent or representative for whose conduct the plan is liable, "controlled, influenced, or participated in the health care treatment decision;" and
2. The insurer did not deny or delay payment for any treatment prescribed or recommended by a health care provider to an enrollee.
3. The law may not be construed to obligate the managed care entity to provide services or treatments not covered by the benefit plan.
4. It may *not* be asserted as a defense that health plans are prohibited from the corporate practice of medicine.
5. A managed care entity is not liable for the independent actions of a health care provider who is not an agent or employee of the managed care entity if that provider fails to exercise the current required standard of care required of such providers.
6. No action may be commenced until the plaintiff has exhausted all internal and external administrative remedies and appeals.

Employer Exemption: The bill states that it does not create any liability on behalf of an employer or an employer group purchasing organization that purchases coverage or assumes risk on behalf of its employees.

Provider Indemnification: The bill states that:

1. It prohibits plans entering into contracts with providers that include an indemnification or hold harmless clause for the acts or conduct of the plan;
2. It does not create any liability on behalf of a physician or health care provider in addition to those already provided under existing law;
3. A health care provider is not liable for the actions of a managed care entity if it fails to exercise ordinary care;
4. A separate trial is required upon motion of any party in an action involving a managed care plan, including separate discovery and separate trial of any claim, cross-claim, counterclaim, or third party claim against any physician or other health care provider.

EFFECTIVE DATE: December 1, 2002.

ESTIMATED COST IMPACT: Overall, this section of the bill would result in an estimated annual increase in *premiums for managed care entities that would be at least 0.9% and may be as high as 7.7%* (Table 1). These increases would arise from three major factors:

- **Plan Purchases of Liability Coverage.** First, not all managed care entities currently carry liability coverage, so the extension of liability will require some managed care plans to purchase liability coverage for the first time. This will increase the average health coverage premium across all plans by 0.0% to 0.2% annually.
- **Increase in Liability Premiums.** Second, the cost of liability coverage would increase for all plans to reflect the increase in their exposure to malpractice lawsuits. This will increase average health coverage premiums for managed care plans by a minimum of 0.4% to as much as 2.0%.
- **Defensive Medicine.** The largest impact will arise from higher defensive medicine costs. It is well-established that physicians faced with the risk of liability for medical malpractice order more tests and procedures (a good

synthesis of this evidence is found in Rubin and Mendelson 1994). Conversely, it has been demonstrated that when the exposure to liability is reduced, physicians change their behavior in ways that reduce the cost of medical care without any detectable adverse effect on patient health (Kessler and McClellan 2000).

Similarly, there is extensive literature that managed care plans are able to achieve their cost savings (relative to fee-for-service plans) while providing patient care whose quality is generally equal or better than under fee-for-service. Miller and Luft (1994) and Miller and Luft (1997) provide an exhaustive summary of this literature; Miller and Luft (2000) also provides a convincing rebuttal to a re-analysis of their results by Sullivan (1999) that reached less sanguine conclusions about the impact of managed care on quality. Exposing plans to the risk of lawsuits can reasonably be expected to result in an erosion of the utilization review and other mechanisms managed care plans now use to encourage prudent utilization by their members. It simply will be more cost-effective to overlook some amount of unnecessary utilization rather than risk a lawsuit. Overall, the increased costs of defensive medicine would add a minimum of 0.5% annually to managed care premiums; this increase may be as high as 5.5%.

- **Denials of Coverage**. Note that the cost estimate only takes into account the increased liability of health plans regarding medical malpractice. However, as passed by the NC Senate, SB 199 specifically includes language to the effect that medical treatment decisions include prospective or concurrent requests denied on medical necessity grounds. In contrast to medical malpractice, where one can extrapolate from the actual experience of physicians and other providers to estimate how much exposure to such suits might affect behavior of managed care plans, there has been no empirical research about patterns of claims against organizations for wrongful denial or delay of care authorization or payment (Gresenz et al. 1999). That is, physicians are not subject to such claims and hence we cannot extrapolate from their experience to assess how consumers might behave if this avenue for lawsuits were opened up.

The RAND Corporation has conducted a careful analysis of the evidence regarding rates of internal and external appeals and used these as a basis for predicting the potential pool of litigants were these individuals permitted to take their appeals into court (Gresenz et al. 1999). If, as the NC legislation specifies, potential litigants are first required to exhaust their internal and external appeals, RAND researchers estimate there would be roughly 20 litigants per 100,000 enrollees. How many of these end up in court would depend on the fraction seeking legal advice and how many of these ultimately retained an attorney to pursue the matter. The RAND study concluded that in this situation, the actual number of litigants would range from 0.8 to 8 per 100,000 (Table 2 in Gresenz et al., 1999). A Coopers and Lybrand study estimates that the average cost to a plan per litigation claim is roughly $100,000 (Hunt et al. 1998). Based on current managed care enrollment, annual litigants would range from 14 to 140 if self-insured plans were exempt and from 30 to 350. Thus, this would add roughly $1.4 to $14 million to the annual estimates provided above were self-insured plans exempt and from $3.0 to $35 million if self-insured plans are included.

Total Cost Increase to Managed Care Plans. All of the effects described are independent and therefore additive. Cumulatively, based on the estimated amount of managed care premiums written in 2001, *managed care plan spending would rise by a minimum of $26.6 million to as much as $215.9 million.* The bill currently exempts employer self-insured plans from liability, but this would appear not necessarily to extend to any managed care plans with which such self-insured plans might contract for benefits. Texas uses the identical language regarding self-insured plans in legislation enacted September 1, 1997. This law was challenged on grounds that it was preempted by ERISA, which prohibits state regulation of self-insured plans. On September 18, 1998, a federal judged ruled in *Corporate Health Insurance vs. Texas Department of Insurance* that the right to sue was not pre-empted by ERISA (Patterson 2000). Assuming that North Carolina courts would rule in a similar fashion that ERISA does not exempt HMOs from liability under their contracts with self-insured plans, *managed care plan spending would instead rise by $46.6 million to $456.6 million.*

Total Cost to Non-Managed Care Sector. There also is growing evidence that managed care care plans have "spillover" effects on the fee-for-service sector, by changing provider practice styles or slowing the acquisition of expensive medical technology that may provide only marginal improvements in medical efficacy (see Table 1D). If managed care premiums were to rise, some people currently enrolled in managed care plans would either would drop coverage altogether or would shift to fee-for-service plans. The resulting decline in managed care market share would therefore reduce the amount of spillover savings now provided by managed care plans in North Carolina. This would increase non-managed care costs from $2.3 to $293.8 million a year but would rise as high as $348.6 million if self-insured HMO plans are ruled to be covered by the legislation.

Grand Total Cost Increase. All told, therefore, *health costs in North Carolina would be expected to rise by a minimum of $28.9 million to $509.7 million* assuming ERISA preempts suits against managed care plans provided through self-insured employer arrangements. But if the courts rule in the same fashion as they have so far in Texas, *North Carolina's health spending would instead rise from $48.9 to $750.4 million.*

Effects on the Uninsured. In March 1999, there were 1,111,000 uninsured individuals in North Carolina, although this number probably has increased since then and is likely to increase even further during an economic slowdown. The best currently available evidence suggests that as a result of premium increases facing managed care plans in North Carolina, *between 3,799 and 36,568 of those currently covered by managed care plans would become uninsured* (Table 2). In the event ERISA were found not to preempt suits against self-funded managed care plans, the impact would be considerably larger, resulting in an increase in uninsured of at least 7,670 and possibly as high as 86,685.

As demonstrated below, North Carolina's health spending per person has essentially caught up to the U.S. average in recent years. Therefore, it is not unreasonable to assume that employer health costs in North Carolina will rise at least as fast as the

national average, if not faster. Data from independent sources confirm that after plummeting to their lowest levels in the mid-1990's (from historic double-digit rates of increases in the early 1990's), inflation in employer health insurance costs now has resumed its upward climb, reaching 7 to 8% last year. Coming in the face of an economic slowdown, a rise in the number of uninsured is all but inevitable. The increased costs associated with SB 199 will simply aggravate that trend.

Health Cost Trends in North Carolina. Since 1980, *North Carolina has seen a substantial margin of advantage in health spending vis-à-vis the U.S. nearly disappear entirely.* In 1980, North Carolina's health spending per person was fully 25% below the national average. By 1998, this difference had shrunk to 3.7% (Table 3). Leaving aside health spending by Medicare and Medicaid, spending per person not on Medicare and Medicaid went from being 26.3% below the national average in 1980 to less than 1% below that average today. This has occurred because the *annual rate of inflation in North Carolina's health costs has been 1 to 2 percentage points higher than the national average for nearly every year between 1980 and 1998.*

Given the strong evidence about the extent to which managed care saves money both for its subscribers and for those outside of managed care, a case could be made that at least part of the reason North Carolina under-performed the rest of the nation in terms of taming health care costs is because it has had too *little* managed care. In nearly a half dozen studies, a 10% increase in HMO market share in a given market area has been associated with a reduction in fee-for-service spending in that area of between 3 to 5% (Table 1D). Since 1990, HMO market penetration rather consistently has been roughly 10 percentage points below the U.S. average (Table 3). The increased costs that are likely under SB 199 will simply accelerate the trend towards eroding if not eliminating North Carolina's historical health cost margin of advantage.

ASSUMPTIONS AND METHODOLOGY: Due to uncertainties about the cost impact, and in keeping with standard conventions in similar analyses conducted on other state (Barents Group 1997) and federal legislation (Barents Group 1998), both lower bound and upper bound cost estimates have been calculated using reasonable ranges of assumptions from a variety of authoritative sources. Where extrapolations from national estimates or parameters were inevitably necessary, every effort has been made to make the appropriate adjustments to arrive at figures that reasonably depict the likely impact in North Carolina, taking into account any known differences between North Carolina and the U.S. in terms of its demographic/economic characteristics, health insurance coverage, costs or the types of managed care entities that are in operation. As an illustration, group/staff model HMOs (such as Kaiser, which no longer operates in North Carolina) have been found in repeated studies to be more effective than Independent Practice Associations (IPAs) at reducing utilization and expenditures. However, no group/staff model HMOs are in operation in North Carolina at this time; therefore, we relied on lower estimates of cost savings to reflect the unique mix of managed care plans (i.e., IPA plans relative to Preferred Provider Organizations) and relative membership in each type.

All summary estimates of cost increases are summarized in Table 1. All methods and assumptions underlying these estimates are provided in more detailed back-up tables.

These include:

- Table 1A, showing the cost increase due to of expanded managed care liability coverage;
- Table 1B, showing the cost increase due to higher managed care liability premiums;
- Table 1C, showing the cost increase due to greater use of defensive medicine; and
- Table 1D, showing the cost increase due to spillover effects.

Table 2 provides estimates of the potential increase in costs associated with SB 199 on the size of the uninsured population.

Table 3 provides estimates of trends in health care spending between 1990 and 2000. *[Note: these tables are available on the Internet at http://www.ncahp.org/HP_Liability_Cost_Study/liabilityfin.XLS}*

What About Texas? Since Texas was the first state to pass patient protection legislation and since the NC legislation is modeled in some ways on the Texas approach, it is legitimate to ask why one cannot simply look at the Texas experience to determine what might happen in NC were such legislation enacted. First, the NC legislation appears to creating a new cause of action by permitting suits over denials or reductions in coverage on medical necessity grounds. But much more importantly is that the Texas law has had very little time to actually work. The Texas law was enacted on September 1, 1997, but was immediately challenged in federal court on grounds it was preempted by ERISA. On September 18, 1998, a federal judge ruled in Corporate Health Insurance vs. Texas Department of Insurance that the right to sue was not pre-empted, but the independent review provisions of the new law were. This decision is being appealed by both sides. On October 19, 1998, Plocica vs. NYLCare was filed in state district court and on November 18, 1998, the court granted the defendant's motion to remove the case to federal court. However, in March 1999, the federal court remanded the case back to state district court. Until this was resolved, there was a great deal of uncertainty among Texas attorneys about where such suits were even to be filed. Moreover, by early 2000, fewer than ten cases had been filed, but none had yet gone to trial. Texas trial attorneys are holding seminars and encouraging a judicious selection of cases so that the first few decided will be good precedents that will induce defendants in subsequent cases to settle rather than fight a suit (Patterson 2000). Thus, it may be many years before high dollar settlements result, but once they do, they will have an eventual effect on malpractice premiums as well as defensive medicine by plans fearful of liability exposure.

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VISITOR REGISTRATION SHEET

HEALTH COMMITTEE — 8-14-01

Name of Committee — Date

VISITORS:. PLEASE SIGN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
[illegible]	NCAHP
Michael Colvin	Duke Comprehensive Cancer Center
Judy Wright	NCDHHS - DPH - Advis Comm on Cancer
JOHN THOMPSON	AMERICAN CANCER SOCIETY
DAVID BARNES	Poyner + Spruill, LLP
Marvin Musselwhite	Poyner + Spruill, LLP
[illegible]	Merris + Van Hill
Ken Wright	BCBSNC
DeAnne Nelson	BCBSNC
Shawn Brown	MAMH
[illegible]	[illegible]
Jim Bendel	MAMSP
Lynda Upchurch	UICI
Jon Ran Harris	LR Harris & Assoc
Lucille Calhoun	NCAE
Nicole Dusenberry	NC Equity
Jay J. Chaudhuri	Attorney General's Office
Barbara Canaday	NFFS, PA
Alan Hirsch	Gov's Office
Stacy Flannery	NCHCFA
Pam Silberman	Sheps Center Health Services Research
FRAN PRESSON	NCRMA
MIKE MANN	NCCA
[illegible]	NFFS PA
[illegible]	NCMA
Wendy Ellen	NCLMA
Matthew Shaw	Goldsboro News-Argus
John Bowdish	Alley Associates

VISITOR REGISTRATION SHEET

HOUSE HEALTH COMMITTEE — 9-14-01

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Bob Jackson	AARP
Richard W Hatch	AARP, Oak Island NC
Adam Searing	NCHAC
Elizabeth Quetts	NCPIRG
Anna Rabon	[illegible]
JOHN PETERSON	CSI
VL McBride	[illegible]
[illegible]	PCBSNC
Phil Telfer	Gov. Office
Robert Pasichal	Young, Moore
Julie Campbell	NCCBI

VISITOR REGISTRATION SHEET

HEALTH COMMITTEE — 9-14-01

Name of Committee — Date

VISITORS:. PLEASE SIGN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
[illegible]	S&P
Jay Walker	S+P
Mike Causey	McDonald + Meyer, PLLC
BILL RUSTIN	—
Tally Hobson	NASW
[illegible]	NCASA
[illegible]	NCATL
[illegible]	NCATL
Stella Boswell	NCATL
Mark Stennefort	BCBSNC
[illegible]	MRPP, Inc.
PERRI MORGAN	NFIB
[illegible]	Bone + Assoc.
[illegible]	Colonial Life + Accident Ins.
Margaret Westbrook	Kennedy Covington
Michelle Frazier	NC Bar Assoc.
[illegible]	NC-NOW
PAUL MAHONEY	NCANP
[illegible]	"
[illegible]	DHHS
[illegible]	DHHS
[illegible]	Office of the Governor
[illegible]	" " "

VISITOR REGISTRATION SHEET

HOUSE HEALTH COMMITTEE — 8-14-01

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
K A Gilligan	BMS
Christopher Robert Cannizzaro	North Carolina Society of Eye Physicians and Surgeons
Carri Derrick	SEANC
Sherry Mellon	SEANC
Crissy Ponder	Bone & Associates
Carol Scheele	NCMS
Anne Jo Bain	NCMS
Richard E. Choi	Richard E. Choi & Associates
[illegible]	DPH-Cancer Prevention + Control
ANN LOCE	DOHS
Cam Coney	BPOHL

VISITOR REGISTRATION SHEET

HOUSE HEALTH COMMITTEE 4-14-01

Name of Committee **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Jessie Bevaqua	NCCBI
Joe Libera	AAHC
Michelle McPhee	Atty Gen
Ben Dover	NCDORD
Stacia McKenny	NC DOI
Barbara Morales Burke	NC DOI
Daschell Propes	NC DOI
Joanne Schoen Stevens	NC Nurses Assoc.
Gary Salamido	GSK
Wink Hilliard	NCSA
Mari Lewis	BCBSCPS

AGENDA

HOUSE COMMITTEE ON HEALTH
TUESDAY, September 25, 2001
12:00 Noon, ROOM 415 LB

OPENING REMARKS

Rep. Thomas E. Wright
Chairman

BILLS TO BE DISCUSSED

SB-703 IMMUNITY/ HONORING PORTABLE DNR ORDER(Sen. Purcell)

SB-772 ENTERAL SEDATION/ DENTIST PERMITS. (Sen. Wellons)

COMMENTS

ADJOURNMENT

MINUTES

COMMITTEE ON HEALTH

TUESDAY, SEPTEMBER 25, 2001

12:00 NOON, ROOM 415 LOB

The House Committee on Health met on Tuesday, September 25, 2001 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-703 IMMUNITY/HONORING PORTABLE DNR ORDER. (Sen. Purcell)

Sen. Purcell explained the bill.

Rep. Edwards sent forth an amendment and moved for adoption. So moved. Rep. Barnhart asked Sen. Purcell if the DNR required a notary. Sen. Purcell responded. Dianna Jessup, Staff, responded that the proposed language would not require a notary.

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

Rep. Wright, Chair, asked Sen. Purcell about the process when EMS arrives at a scene. Sen. Purcell responded. Dianna Jessup further commented on Rep. Wright's inquiry. Judi Lund Person of the Carolina Center for Hospice and End of Life Care responded. Rep. Wright followed up with a question to the Chief of the Office of Emergency Medical Services. Drexdall Pratt responded. Rep. Gibson commented on the bill.

Chairman Wright called the question before the Committee. So moved.

SB-772 ENTERAL SEDATION/DENTIST PERMITS.(Sen. Wellons)

Rep. Edwards explained the bill.

Rep. Buchanan moved for a favorable report. So moved.

The meeting adjourned at 12:45pm

Rep. Thomas E. Wright, Chairman

Vanda Wilson-Wormack, Committee Assistant

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2001

S 2

SENATE BILL 703

Judiciary I Committee Substitute Adopted 4/25/01

Short Title: Immunity/Honoring Portable DNR Order. (Public)

Sponsors:

Referred to:

March 27, 2001

A BILL TO BE ENTITLED

AN ACT TO CLARIFY IMMUNITY FOR HONORING A PORTABLE DO NOT RESUSCITATE ORDER.

The General Assembly of North Carolina enacts:

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

"**§ 90-21.16. Portable do not resuscitate order.**

(a) It is the intent of this section to recognize a patient's desire and right to withhold cardiopulmonary resuscitation to avoid loss of dignity and unnecessary pain and suffering through the use of a portable do not resuscitate ("DNR") order. This section establishes an optional and nonexclusive procedure by which a patient or the patient's representative may exercise this right.

(b) A physician may issue a portable DNR order for a patient:

(1) With the consent of the patient;

(2) If the patient is a minor, with the consent of the patient's parent or guardian; or

(3) If the patient is not a minor but is incapable of making an informed decision regarding consent for the order, with the consent of the patient's representative.

The physician shall document the basis for the order in the patient's medical record.

(c) The Department of Health and Human Services shall develop a portable DNR order form. The official form shall include fields for the name of the patient; the name, address, and telephone number of the physician; the signature of the physician; and other relevant information. The form may be approved by reference to a standard form that meets the requirements of this subsection. For purposes of this section, the "patient's representative" means an individual from the list of persons authorized to consent to the withholding of extraordinary care pursuant to G.S. 90-322 or an individual who has an established relationship with the patient, who is acting in good faith on behalf of the patient, and who can reliably convey the patient's wishes.

(d) No physician, emergency medical professional, hospice provider, or other health care provider shall be subject to criminal prosecution, civil liability, or disciplinary action by any professional licensing or certification agency for withholding cardiopulmonary resuscitation from a patient in good faith reliance on an original DNR form adopted pursuant to subsection (c) of this section, provided that (i) there are no reasonable grounds for doubting the validity of the order or the identity of the patient, and (ii) the provider does not have actual knowledge of the revocation of the portable DNR order. No physician, emergency medical professional, hospice provider, or other health care provider shall be subject to criminal prosecution, civil liability, or disciplinary action by any professional licensing or certification agency for failure to follow a DNR form adopted pursuant to subsection (c) of this section if the provider had no actual knowledge of the existence of the DNR order.

(e) A health care facility may develop policies and procedures that authorize the facility's provider to accept a portable DNR order as if it were an order of the medical staff of that facility. This section does not prohibit a physician in a health care facility from issuing a written order, other than a portable DNR order, not to resuscitate a patient in the event of cardiac or respiratory arrest, in accordance with acceptable medical practice and the facility's policies.

(f) Nothing in this section shall affect the validity of portable DNR forms in existence prior to the effective date of this section."

SECTION 2. This act becomes effective October 1, 2001.

NORTH CAROLINA GENERAL ASSEMBLY
AMENDMENT
Senate Bill 703

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

S703-ASW-52 [v.1]

Date _____,2001

Comm. Sub. [NO]
Amends Title [NO]
Second Edition

Representative

1 moves to amend the bill on page 2, line 21, by deleting "October 1, 2001." and
2 substituting "December 1, 2001.".

SIGNED _____
Amendment Sponsor

SIGNED _____
Committee Chair if Senate Committee Amendment

ADOPTED _____ FAILED _____ TABLED _____

SENATE BILL 703:
Immunity/Honoring Portable DNR Order

BILL ANALYSIS

Committee:	House Health	**Introduced by:**	Senator Purcell
Date:	September 25, 2001	**Summary by:**	Amy Currie
Version:	Second Edition		Committee Staff

SUMMARY: ***The second edition of Senate Bill 703 would establish a procedure for physicians to issue portable do not resuscitate (DNR) orders for patients. It also provides immunity from criminal prosecution, civil liability or disciplinary action to any physician or health care provider when honoring portable DNR orders. The act would become effective October 1, 2001.***

CURRENT LAW: The Office of Emergency Medical Services within the Division of Facility Services oversees the current DNR order process in the State. Local organizations act as lead distribution agents for DNR order forms and related information. The DNR order form currently used is printed on special safety paper and is approved by the North Carolina Medical Society. Medical doctors, hospitals, hospice and other health care facilities obtain copies of DNR order forms along with the following:

- A sheet entitled "Information for Physicians: How to Complete the Do Not Resuscitate (DNR) Order and Documentation Form"
- A copy of the "Documentation Form for DNR Orders"
- A sheet entitled "Do not Resuscitate Orders (DNRs) Information for Interested Individuals and Families"

Both the physician and the patient, or the patient's representative must agree that a DNR order is appropriate in order for the physician to write a DNR order. A DNR order must be signed by a physician. Currently, no provision in the North Carolina General Statutes regulates DNR orders; however, a request to forgo CPR may be a part of an advance directive such as the following:

Article 3 of Chapter 32A regulates **health care powers of attorney**. Essentially, a health care power of attorney gives another individual the power to make health care decisions if the maker of the document is no longer able to make those decisions for himself or herself. A health care power of attorney is a written instrument, signed in the presence of 2 witnesses, and acknowledged before a notary public, pursuant to which an attorney-in –fact or agent is appointed to act for the individual in matters relating to health care. Any health care provider or physician who in good faith relies on the health care power of attorney is not liable for actions taken pursuant to a decision of the health care agent.

G.S. 90-321 regulates living wills. A **declaration of a desire for a natural death** (living will) is a statement that an individual desires his or her life not be prolonged by extraordinary measures if the person has a terminal or incurable illness or if the person in a vegetative state. In order to be effective, a declaration of a desire for a natural death must include:

1. The desire of the declarant that extraordinary means, artificial nutrition, or hydration not be used to prolong his or her life if the condition is determined to be terminal and incurable or if the declarant is diagnosed as being in a vegetative state.
2. A statement that the declarant is aware that such a declaration authorizes a phys physician to withhold or discontinue the extraordinary means or artificial nutrition or hydration.
3. The signature of two witnesses, unrelated to the declarant or the delcarant's spouse with no interest in the declarant's estate and who is not an employee of the health facility where the declarant is a patient.
4. A notary certification.

BILL ANALYSIS: The second edition of Senate Bill 703 establishes a procedure by which a patient or a patient's representative may exercise the patient's right to withhold cardiopulmonary resuscitation through use of a portable DNR order.

The act would allow a physician to issue a portable DNR order, in a form developed by the Department of Health and Human Services, with the consent of (1) the patient, (2) the patient's parent if the patient is a minor, or (3) the patient's representative if the patient is not a minor but is incapable of making an informed decision.

The act would clarify that the term "patient's representative" shall have the same meaning as the following list of persons authorized to consent to the withholding of extraordinary care pursuant to G.S. 90-322:

1. A health care agent appointed pursuant to a health care power of attorney meeting the requirements of Article 3, Chapter 32A
2. A guardian of the person
3. The person's spouse
4. A majority of the relatives of the first degree

In addition, a "patient's representative" would mean an individual who has an established relationship with the patient, who is acting in good faith on behalf of the patient, and who can reliably convey the patient's wishes.

The act would also clarify that a health care provider could not be held liable for honoring a DNR order issued pursuant to this section as long as (i) there are no reasonable grounds for doubting the validity of the order or the identity of the patient, and (ii) the provider has no actual knowledge that the DNR order has been revoked. The act further clarifies that a health care provider could not be held liable for failure to follow a DNR order if the provider had no actual knowledge of the order's existence.

BACKGROUND: A Do Not Resuscitate Order is a physician's order not to use cardiopulmonary resuscitation (CPR) in case of cardiac or pulmonary arrest. A DNR order represents a forgoing of all emergent CPR procedure, including chest compressions, invasive airway management, assisted ventilation, defibrillation, and cardioversion. A request to forgo CPR may also be part of an Advance Directive such as a health care power of attorney or living will. The latter two documents, however, are executed by the patient before a notary public and witnessed by two individuals. A DNR order is a physician's order executed by the physician with the consent of the patient. A portable DNR order allows such an order to be honored from institution to institution and by paramedics, emergency medical technicians, and other emergency personnel. The second edition of Senate Bill 703 would recognize portable DNR orders as valid so that a health care provider would be able to rely on them.

In 1997, the Attorney General issued an opinion that a health care provider is not liable for honoring a portable DNR order in certain cases, but without statutory immunity from liability, some health care providers have been unwilling to honor their patients' wishes. This act would allow health care providers to honor the orders in good faith without being subject to liability.

ISSUE: The committee may want to consider moving the effective date to December 1, 2001.

Wendy Graf Ray, Staff attorney, contributed to this summary.

2001 COMMITTEE REPORT
HOUSE OF REPRESENTATIVES

The following report(s) from standing committee(s) is/are presented:
By Representative(s) **Wright** (Chair/Chairs) for the Committee on **Health**.

☒ Committee Substitute for
S.B. 703 A BILL TO BE ENTITLED AN ACT TO CLARIFY IMMUNITY FOR HONORING A PORTABLE DO NOT RESUSCITATE ORDER.

☒ With a favorable report as amended.

☐ 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)

2/15/01

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2001

S 1

SENATE BILL 772

Short Title:	Enteral Sedation/Dentist Permits.	(Public)
Sponsors:	Senators Wellons; Forrester, Purcell, and Rucho.	
Referred to:	Health Care.	

April 2, 2001

A BILL TO BE ENTITLED

AN ACT AUTHORIZING THE NORTH CAROLINA BOARD OF DENTAL EXAMINERS TO ESTABLISH REGULATORY STANDARDS FOR THE ADMINISTRATION AND MONITORING OF ENTERAL SEDATION FOR OUTPATIENTS IN THE DENTAL SETTING IN ADDITION TO EXISTING STANDARDS FOR GENERAL ANESTHESIA AND PARENTERAL SEDATION.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 90-30.1 reads as rewritten:

"**§ 90-30.1. Standards for general anesthesia and enteral and parenteral sedation; fees authorized.**

The North Carolina Board of Dental Examiners may establish by regulation reasonable education, training, and equipment standards for safe administration and monitoring of general anesthesia and enteral and parenteral sedation for outpatients in the dental setting. Regulatory standards may include a permit process for general anesthesia and enteral and parenteral sedation by dentists. The requirements of any permit process adopted under the authority of this section ~~must~~shall include provisions that will allow a dentist to qualify for continued use of ~~general anesthesia,~~enteral sedation, if he or she is licensed to practice dentistry in North Carolina and shows the Board that he or she has been utilizing ~~general anesthesia~~enteral sedation in a competent manner for the five years preceding ~~July 1, 1988,~~January 1, 2002, and his or her office facilities pass an on-site examination and inspection by qualified representatives of the Board. For purposes of this section, oral premedication administered for minimal sedation (anxiolysis) shall not be included in the definition of enteral sedation. In order to provide the means of regulating general anesthesia and enteral and parenteral sedation, including examination and inspection of dental offices involved, the Board may charge and collect fees established by its rules for each permit application, each

annual permit renewal, and each office inspection in an amount not to exceed the maximum fee amounts set forth in G.S. 90-39."

SECTION 2. This act becomes effective January 1, 2002.

SENATE BILL 772:
Enteral Sedation/Dentist Permits

BILL ANALYSIS

Committee:	Senate Health Care	**Introduced by:**	Sen. Wellons
Date:	September 18, 2001	**Summary by:**	Linda Attarian
Version:	Introduced		Committee Counsel

SUMMARY: Senate Bill 772, if enacted, would expand the NC Dental Board's to regulate the administration and monitoring of the use of general anesthesia in an outpatient office setting to allow the Board to regulate the administration of enteral sedation medications. The scope of the current statute is limited to sedation medication administered by inhalants or into the blood through a vein. "Enteral sedation" includes medications absorbed through the intestinal tract. The bill would become effective January 1, 2002

CURRENT LAW: G.S. 90-30.1 authorizes the Board to adopt standards for the safe administration and monitoring of general anesthesia and parenteral (inter-veinous) sedation in an outpatient dental setting. The Board's rules generally provide for the credentialing and educational requirements necessary for a dentist to administer general anesthesia in the outpatient practice setting. The Board may conduct onsite inspections to monitor the practice.

BILL ANALYSIS: Section 1 amends G.S. 90-30.1 to add "enteral sedation" to the types of administration of general anesthesia that fall within the Board's authority to regulate. The section also clarifies that the Board's authority under this statute does not extend to oral premedication administered for minimal sedation.

Section 2 makes the act effective January 1, 2002.

BACKGROUND:

Parenteral (pah REN ter ul) -- medication given into the blood with a needle through a vein.

Enteral (EN ter al) --medication absorbed through the intestinal tract.

2001 COMMITTEE REPORT
HOUSE OF REPRESENTATIVES

The following report(s) from standing committee(s) is/are presented:
By Representative(s) **Wright** (Chair/Chairs) for the Committee on **Health.**

☐ Committee Substitute for
S.B. 772 A BILL TO BE ENTITLED AN ACT AUTHORIZING THE NORTH CAROLINA BOARD OF DENTAL EXAMINERS TO ESTABLISH REGULATORY STANDARDS FOR THE ADMINISTRATION AND MONITORING OF ENTERAL SEDATION FOR OUTPATIENTS IN THE DENTAL SETTING IN addition TO EXISTING STANDARDS FOR GENERAL ANESTHESIA AND PARENTERAL SEDATION.

☒ 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)

2/15/01

VISITOR REGISTRATION SHEET

Health — Name of Committee

9-25-01 — Date

VISITORS:. PLEASE SIGN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
John Austin	NCFPC
HUGH TILSON	NCHA
Lisa Tofil	CHS
Martha Ann McConnell	CHS
Amy Jo Bain	NCMS
Eddie Caldwell	NCCEP
Peyton Mayo	GR
Bill Holtzman	Kilpatrick Stockton
Joe LIBERNA	Assoc. Home + Hospice Care
Drexdal Pratt	NC Office of EMS
Joanne Schorr Stevens	NC Nurses Association
Anne Winner	NCAWA
Wink Hilliard	NCCEP/NCSA
Marion Smith	NC SA
John Bowdish	Alley Associates
Mary Kathryn Brame	NCDS
Lisa Pierce	NCDS
Marion Monteith	Poyner + Spruill
Judith Lenard Benson	Carolinas Ctr for Hospice + End of Life Care
Patricia A Yancey	Carolinas Ctr for Hospice & End of Life Care

AGENDA

HOUSE COMMITTEE ON HEALTH
Thursday, October 18, 2001
12:00 Noon, ROOM 415 LB

OPENING REMARKS

Rep. Thomas E. Wright
Chairman

BILLS TO BE DISCUSSED

SB-721 NC HEALTH CHOICE/NO WAITING PERIOD. (Sen. Purcell)

COMMENTS

ADJOURNMENT

MINUTES

HOUSE COMMITTEE ON HEALTH

THURSDAY, OCTOBER 18, 2001

12:00 NOON, ROOM 415 LOB

The House Committee on Health met on Thursday, October 18, 2001 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-721 NC HEALTH CHOICE/NO WAITING PERIOD. (Sen. Purcell)

Vice-Chairman Edwards recognized Chairman Wright to explained the bill.

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

Chairman Wright explained the proposed committee substitute. Rep. Wainwright asked about the fees. Vice-Chairman Edwards responded.

Rep. Wainwright moved for a favorable report to the House proposed committee substitute, unfavorable to the original bill and re-referred to the Committee on Finance.

Dr. Robinson, of the NC Board of Optometry, commented on the bill. William Potter, of the NC Dental Society, commented on the bill. Andy Watry, of the NC Medical Board, spoke on the bill. Janis Ramquist, of the NC Dental Hygiene Association, spoke in opposition to the proposed committee substitute. Steve Keene, of the NC Medical Society, spoke on the committee substitute and opposed the bill. William Potter, of the NC Dental Society, commented on the bill.

Vice-Chairman Edwards called the question on Rep. Wainwright's motion to give the committee substitute a favorable report, unfavorable to the original bill an re-referred to the Committee on Finance. So moved.

Chairman Wright adjourned the meeting at 12:35pm.

Rep. Thomas Wright, Chairman

Vanda Wilson-Wormack, Committee Assistant

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2001

S 1

SENATE BILL 721

Short Title:	NC Health Choice/No Waiting Period.	(Public)
Sponsors:	Senators Purcell; Albertson, Kinnaird, Lee, Lucas, and Martin of Guilford.	
Referred to:	Health Care.	

March 29, 2001

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.**

As used in this Part, 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 is <u>not covered under any private or employer-sponsored comprehensive health</u>

insurance plan on the date of enrollment. ~~and was not covered under any private or employer-sponsored comprehensive health insurance plan for 60 days immediately preceding the date of application. The waiting periods required under this subdivision shall be waived if:~~

~~a. The child has been enrolled in Medicaid and has lost Medicaid eligibility;~~

~~b. The child has lost health care benefits due to cessation of a nonprofit organization program that provides health care benefits to low-income children;~~

~~c. The child 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; or~~

~~d. Health insurance benefits available to the family of a special needs child have been terminated due to a long-term disability or a substantial reduction in or limitation of lifetime medical benefits or benefit category. As used in this paragraph, "special needs child" has the definition applied in G.S. 108A-70.23(a).~~"

SECTION 2. This act becomes effective July 1, 2001.

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2001

S D

SENATE BILL 721
PROPOSED HOUSE COMMITTEE SUBSTITUTE S721-PCS6353-RM-69

Short Title: Occupational Licensing Fees and Per Diem Changes (Public)

Sponsors:

Referred to:

March 29, 2001

A BILL TO BE ENTITLED

AN ACT TO AUTHORIZE THE BOARD OF EXAMINERS IN OPTOMETRY, THE NORTH CAROLINA STATE BOARD OF DENTAL EXAMINERS, THE STATE BOARD OF CHIROPRACTIC EXAMINERS TO INCREASE CERTAIN FEES AND TO INCREASE THE COMPENSATION OF BOARD MEMBERS AND TO AUTHORIZE THE NORTH CAROLINA MEDICAL BOARD TO INCREASE THE ANNUAL REGISTRATION FEE.

The General Assembly of North Carolina enacts:

SECTION 1. 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~~ two hundred dollars ~~($50.00)~~ ($200.00) 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.~~ by the 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 2. G.S. 90-123 reads as rewritten:

"**§ 90-123. Fees.**

In order to provide the means of carrying out and enforcing the provisions of this Article and the duties of devolving upon the North Carolina State Board of Examiners in Optometry, said Board is hereby authorized to charge and collect fees established ~~by its rules~~ at its annual meeting for the next succeeding year, not exceeding the following:

(1) Each application for general optometry examination ..... ~~$400.00~~$800.00

(2) Each general optometry license renewal, which fee shall be annually fixed by the Board, and not later than December 15 of each year written notice of the amount of the renewal fee shall be given to each optometrist licensed to practice in this State by mailing the notice to the last address of record with the Board of each such optometrist ..... ~~250.00~~$400.00

~~(3) Each certificate of license to a resident optometrist desiring to change to another state or territory ..... 200.00~~

~~(4) Each license issued to a practitioner of another state or territory to practice in this State ..... 250.00~~

(5) Each license to resume practice issued to an optometrist who has retired from the practice of optometry or who has removed from and returned to this State ..... ~~250.00~~$250.00

(6) Each application for registration as an optometric assistant or renewal thereof ..... ~~50.00~~$100.00

(7) Each application for registration as an optometric technician or renewal thereof ..... ~~50.00~~$100.00

(8) Each duplicate license or renewal thereof for each branch office ..... ~~50.00~~$100.00."

SECTION 3. G.S. 90-15.1 reads as rewritten:

"**§ 90-15.1. Registration every year with Board.**

Every person licensed to practice medicine by the North Carolina Medical Board shall register annually with the Board within 30 days of the person's birthday. A person who registers with the Board shall report to the Board the person's name and office and residence address and any other information required by the Board, and shall pay a registration fee fixed by the Board not in excess of one hundred twenty-five dollars ~~($100.00)~~($125.00). A physician who is not actively engaged in the practice of medicine in North Carolina and who does not wish to register the license may direct the Board to place the license on inactive status. For purposes of annual registration, the Board shall use a simplified registration form which allows registrants to confirm

information on file with the Board. A physician who fails to register as required by this section shall pay an additional fee of twenty dollars ($20.00) to the Board. The license of any physician who fails to register and who remains unregistered for a period of 30 days after certified notice of the failure is automatically inactive. Except as provided in G.S. 90-12(d), a person whose license is inactive shall not practice medicine in North Carolina nor be required to pay the annual registration fee. Upon payment of all accumulated fees and penalties, the license of the physician may be reinstated, subject to the Board requiring the physician to appear before the Board for an interview and to comply with other licensing requirements. The penalty may not exceed the maximum fee for a license under G.S. 90-13."

SECTION 4. G.S. 90-39 reads as rewritten:

"**§ 90-39. Fees.**

In order to provide the means of carrying out and enforcing the provisions of this Article and the duties devolving upon the North Carolina State Board of Dental Examiners, it is authorized to charge and collect fees established by its rules and regulations not exceeding the following:

(1) Each application for general dentistry examination ..... ~~$500.00~~$800.00

(2) Each general dentistry license renewal, which fee shall be annually fixed by the Board and not later than November 30 of each year it shall give written notice of the amount of the renewal fee to each dentist licensed to practice in this State by mailing such notice to the last address of record with the board of each such dentist ..... ~~140.00~~250.00

(2a) Penalty for late renewal of any license or permit 50.00

(3) Each provisional license 150.00

(4) Each intern permit or renewal thereof 150.00

(5) Each certificate of license to a resident dentist desiring to change to another state or territory 30.00

(6) Repealed by Session Laws 1995, (Reg. Sess., 1996), c. 584, s. 1.

(7) Each license to resume the practice issued to a dentist who has retired from and returned to this State 300.00

(8) Each instructor's license or renewal thereof 140.00

(9) With each renewal of a dentistry license, an annual fee to help fund special peer review organizations for impaired dentists 50.00

(10) Each duplicate of any license, permit, or certificate issued by the Board 25.00

(11) Each office inspection for general anesthesia and parenteral sedation permits 350.00

(12) Each general anesthesia and parenteral sedation permit application or renewal of permit ..... 50.00."

SECTION 5. G.S. 90-43 reads as rewritten:

"**§ 90-43. Compensation and expenses of Board.**

Notwithstanding G.S. 93B-5(a), each member of the North Carolina State Board of Dental Examiners shall receive as compensation for his services in the performance of his duties under this Article a sum not exceeding ~~one~~ two hundred dollars ~~($100.00)~~ ($200.00) 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 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 6. G.S. 90-232 reads as rewritten:

"**§ 90-232. Fees.**

In order to provide the means of carrying out and enforcing the provisions of this Article and the duties devolving upon the North Carolina State Board of Dental Examiners, it is authorized to charge and collect fees established by its rules and regulations not exceeding the following:

(1) Each applicant for examination ..... ~~$125.00~~$200.00

(2) Each renewal certificate, which fee shall be annually fixed by the Board and not later than November 30 of each year it shall give written notice of the amount of the renewal fee to each dental hygienist licensed to practice in this State by mailing such notice to the last address of record with the Board of each such dental hygienist ..... ~~60.00~~125.00

(3) Each restoration of license 60.00

(4) Each provisional license 60.00

(5) Each certificate of license to a resident dental hygienist desiring to change to another state or territory 25.00

(6) Annual fee to be paid upon license renewal to assist in funding programs for impaired dental hygienists ..... 40.00.

In no event may the annual fee imposed on dental hygienists to fund the impaired dental hygienists program exceed the annual fee imposed on dentists to fund the impaired dentist program. All fees shall be payable in advance to the Board and shall be disposed of by the Board in the discharge of its duties under this Article."

SECTION 7. 90-155 reads as rewritten:

"**§ 90-155. Annual fee for renewal of license.**

Any person practicing chiropractic in this State, in order to renew his license, shall, on or before the first Tuesday after the first Monday in January in each year after a license is issued to him as herein provided, pay to the secretary of the Board of Chiropractic Examiners a renewal license fee as prescribed and set by the said Board which fee shall not be more than ~~one~~two hundred fifty dollars ~~($100.00)~~($250.00), and shall furnish the Board evidence that he has attended two days of educational sessions or programs approved by the Board during the preceding 12 months, provided the Board may waive this educational requirement due to sickness or other hardship of applicant.

Any license or certificate granted by the Board under this Article shall automatically be canceled if the holder thereof fails to secure a renewal within 30 days from the time herein provided; but any license thus canceled may, upon evidence of good moral character and proper proficiency, be restored upon the payment of the renewal fee and an additional twenty-five dollars ($25.00) reinstatement fee.

If any licensee of the Board retires from active practice, the licensee may renew his license annually by paying the license fee and shall not be required to furnish the Board proof of continuing education; however, if at a later time the licensee desires to resume active practice, the licensee shall first appear before the Board and the Board shall determine his competency to practice."

SECTION 8. G.S. 90-156 reads as rewritten:

"**§ 90-156. Pay of Board and authorized expenditures.**

The members of the Board of Chiropractic Examiners shall receive a sum not exceeding two hundred dollars ($200.00 as compensation for their actual expenses, including transportation and lodging, when meeting for the purpose of holding examinations, and performing any other duties placed upon them by this Article, ~~such expenses~~ to be paid by the treasurer of the Board out of the moneys received by him as license fees, or from renewal fees. The Board shall also expend out of such fund so much as may be necessary for preparing licenses, securing seal, providing for programs for licensed doctors of chiropractic in North Carolina, and all other necessary expenses in connection with the duties of the Board."

SECTION 9. G.S. 90-149 reads as rewritten:

"**§ 90-149. Application fee.**

Each applicant shall pay the secretary of said Board a fee as prescribed and set by the Board which fee shall not be more than ~~one~~three hundred dollars ~~($100.00)~~($300.00)."

SECTION 10. This act is effective when it becomes law.

S721-PCS6353-RM-69: Occupational Licensing Fee and Per Diem Changes

BILL ANALYSIS

Committee:	House Health Committee	**Introduced by:**	
Date:	October 18, 2001	**Summary by:**	Linda Attarian
Version:	S721-PCS6353-RM-69]		Committee Counsel

SUMMARY: ***The Proposed Committee Substitute of Senate Bill 721 updates the Optometry Practice Act to conform to administrative changes that have occurred within the Board of Examiners in Optometry and further authorizes the Board to increase certain fees and the per diem allowance of its Board members. The PCS also authorizes the North Carolina Medical Board to increase the annual registration fee required of all licensees from $100.00 to $125.00. The PCS is effective when it becomes law.***

BILL ANALYSIS:

Section 1 amends G.S. 90-122 regulating the compensation and expenses of the North Carolina State Board of Examiners in Optometry by increasing each member's compensation from *$50.00 to $200.00* for each day engaged in the performance of the duties of his office. The secretary treasurer's annual salary and expenses requirements are deleted from the act and all per diem allowances and expenses are to be paid upon a voucher drawn by the Executive Director the Board rather than the secretary treasurer. When the current law was enacted, the Board did not have an Executive Director.

Section 2 amends G.S. 90-123 by making the following changes to the fees collectible by the North Carolina Board of Examiners in Optometry.

	G.S. 90-123	PCS of SB 721
Examination fee	$400.00	$800.00
Optometry license renewal fee	$250.00	$400.00
Certificate of license issued to optometrist moving to another state	$200.00	Section deleted.
License issued to a practitioner of another state to practice in NC	$250.00	Section deleted.
License fee to resume practice in NC	$250.00	$250.00
Optometric assist. registration fee	$50.00	$100.00
Optometric assist. renewal fee	$50.00	$100.00
Optometric tech. registration fee	$50.00	$100.00
Optometric tech. renewal fee	$50.00	$100.00
Each duplicate license or renewal threeof for each branch office	$50.00	$100.00

Optometry fees have not been updated since Session Law 1987-645.

Section 3 amends G.S. 90-15.1 by increasing the maximum registration fee allowable from $100.00 to $125.00 for those who practice medicine. This fee was last revised by Session Law 1995-634 which lowered the maximum allowable fee of $200.00 to the current $100.00.

Section 4 makes the act effective when it becomes law.

Amy Currie, Staff Research Assistant, contributed to this summary.

2001 COMMITTEE REPORT
HOUSE OF REPRESENTATIVES

The following report(s) from standing committee(s) is/are presented:
By Representative(s) **Wright** (Chair/Chairs) for the Committee on **Health**.

☐ Committee Substitute for
S.B. 721 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).

☐ 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 House committee substitute bill, ☒ which changes the title, unfavorable as to the original bill, and the recommendation that the House 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.

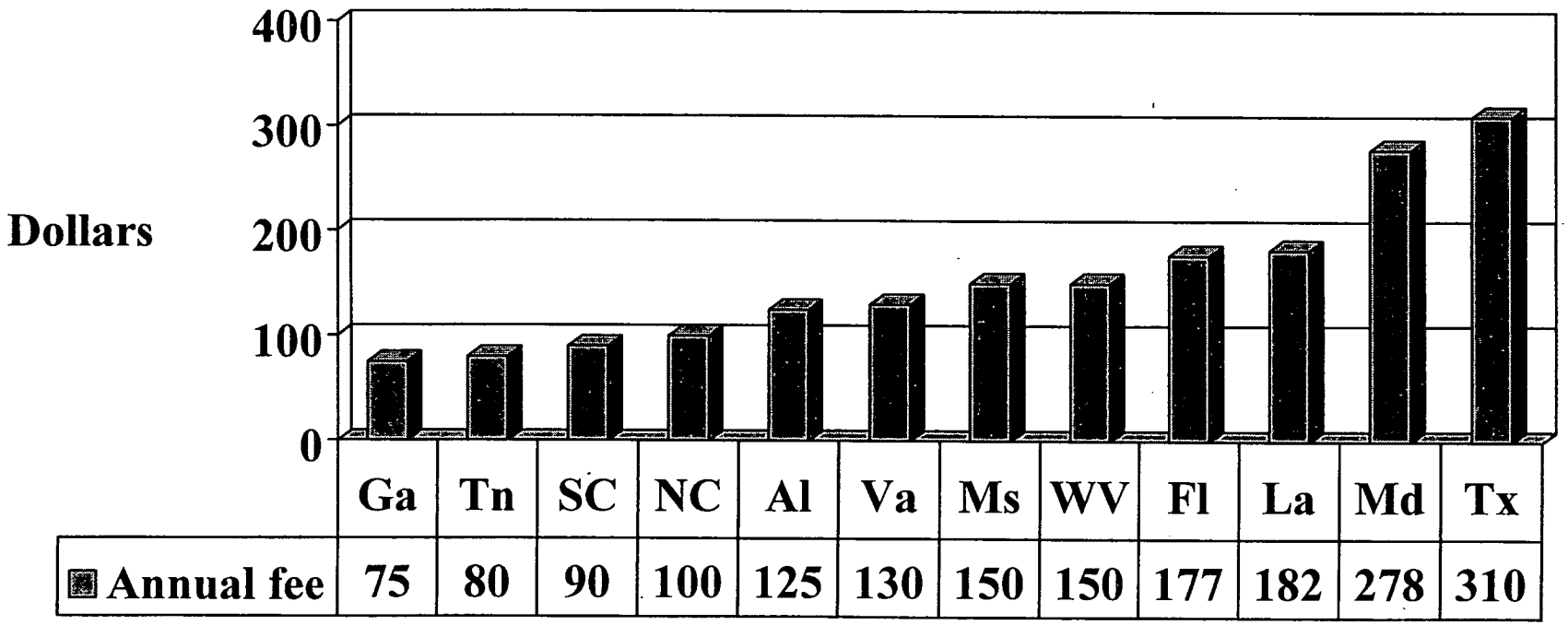
☐ With an indefinite postponement report.

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

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

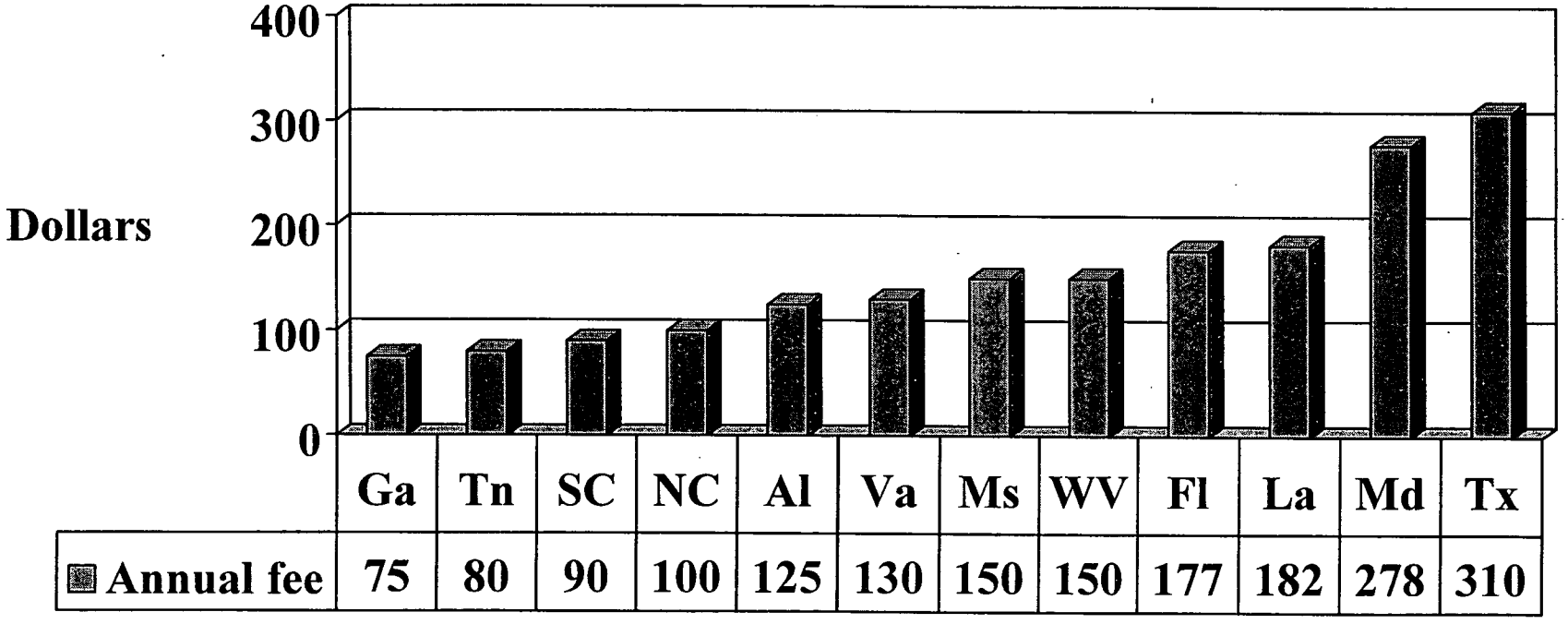
2/15/01

Annual Registration Fees- Other Medical Boards



	Ga	Tn	SC	NC	Al	Va	Ms	WV	Fl	La	Md	Tx
Annual fee	75	80	90	100	125	130	150	150	177	182	278	310

Annual Registration Fees- Other Medical Boards



VISITOR REGISTRATION SHEET

Health
Name of Committee

10-18-01
Date

VISITORS:. PLEASE SIGN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
andy Watson	NC Med Board
[illegible]	NC DHHS
[illegible]	NC Dept of Corr.
[illegible]	UNC Chapel Hill
Sunny Kearns	SHP
[illegible]	NC Justice Ctr.
[illegible]	RGBSNC
DAVID M. BARNES	Poyner + Spruill LLP
Michelle Frazier	NC Bar Asso.
[illegible]	CCHILC
[illegible]	NCFPC
[illegible]	NCMS
[illegible]	GSK
[illegible]	NCNAP
[illegible]	[illegible]
John Bourdeau	Alley Associates
Joanne Schorr Stevens	NC Nurses
Alicia Gruenebaum	YAI
Alan Skinner	NC Med. Soc.
William R Purnell	NC Senate
Lorraine Beard	"
Christopher Hemmer	NCSEPS

AGENDA

HOUSE COMMITTEE ON HEALTH
Tuesday, October 23, 2001
12:00 Noon, ROOM 415 LB

OPENING REMARKS

Rep. Thomas E. Wright
Chairman

BILLS TO BE DISCUSSED

SB-907 ORGAN, EYE, AND TISSUE DONOR REGISTRY. (Sen. Lee)

COMMENTS

ADJOURNMENT

MINUTES

COMMITTEE ON HEALTH

TUESDAY, OCTOBER 23, 2001

12:00 NOON ROOM 415 LOB

The House Committee on Health met on Tuesday, October 23, 2001 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-907 ORGAN, EYE, AND TISSUE DONOR REGISTRY.(Sen. Lee)

Rep. Wright(Chairman) explained the bill. Dianna Jessup, Staff, further explained the bill.

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

Rep. Wright further commented on the bill and recognized advocates of the bill. Lloyd Jordan of the Carolina Donor Services spoke on the bill. and expressed his support of the bill. Also, Renee' Miller of the Carolina Donor Services spoke on the bill. Steve Keene of the NC Medical Society expressed his support of the bill. Janette Poole with the NC Eye Bank spoke in support of the bill. Michelle Peele, an advocate, spoke in support of the bill. Wayne Herndon of the Department of Transportation, Charles Jeffries, advocate, and Hugh Tilson of the NC Hospital Association all spoke in support of the bill. Rep. Rogers asked about the purpose of the study. Dianna Jessup, staff, referred to section 1 of the bill. Rep. Sherrill asked about the mechanics of the Registry. Lloyd Jordan with NC Donor Services explained to the committee that a 24-hour service is available to get the information that is needed about the descendent. Rep. Rogers asked about duplication of efforts with other agencies. Lloyd Jordan responded. Dianna Jessup, Staff, responded. Renee' Miller further commented on the bill.

Rep. Insko sent forth an amendment on page 1, line 9 and page 2, lines 13 and 14.

Glen Wells with the Department of Health and Human Services asked the committee for direction and clarity on handling the registry. Rep. Rogers commented that the Secretary of State's office should be included in the bill. Chairman Wright commented. Rep. Sherrill asked about the fee. Dianna Jessup responded that there was a $10 registration fee. Janet Poole of the NC Eye Bank commented that the US Department of Health and Human Services has guidelines for States to follow to set up a donor registry. Rep. Wright responded.

Chairman Wright called the question. So moved.

Rep. Rogers asked about 'Living Wills'. Chairman Wright responded. Dianna Jessup responded.

Rep. Earle moved for a favorable to the proposed committee substitute, and unfavorable to the original bill and that the bill be re-referred to the Committee on Appropriations.

Rep. Sherrill asked about other states and the sharing of the registry by other states. Lloyd Jordan responded. Dianna Jessup responded. Rep. Wright responded.

Chairman Wright called the question before the committee to give the proposed committee substitute a favorable report and have the bill re-referred to Appropriations. So moved.

The meeting adjourned at 12:45pm.

Rep. Thomas Wright, Chairman

Vanda Wilson-Wormack, Committee Assistant

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2001

S 2

SENATE BILL 907

Appropriations/Base Budget Committee Substitute Adopted 10/3/01

Short Title: Organ, Eye, and Tissue Donor Registry. (Public)

Sponsors:

Referred to:

April 5, 2001

A BILL TO BE ENTITLED

AN ACT TO REQUIRE THE DEPARTMENT OF HEALTH AND HUMAN SERVICES AND OTHER APPROPRIATE STATE AGENCIES TO STUDY THE ESTABLISHMENT OF A STATEWIDE ORGAN, EYE, AND TISSUE DONOR REGISTRY, AND TO CLARIFY THE CURRENT LAW PERTAINING TO ANATOMICAL GIFT DONATION.

The General Assembly of North Carolina enacts:

SECTION 1. The Department of Health and Human Services, Division of Public Health, in consultation with the Department of Transportation, federally designated organ, eye, and tissue procurement organizations, and tissue banks shall study the establishment of a statewide organ, eye, and tissue donor registry. In conducting the study, the Department of Health and Human Services shall solicit advice and comment from citizens or citizen advisory groups interested in organ and tissue donation. The purpose of the study is to determine the feasibility and potential benefits of maintaining a statewide registry of persons who have indicated a willingness to donate organs, eyes, and tissue for transplantation or research in order to expedite the identification of potential organ, eye, and tissue donors. The study shall address the following:

(1) The potential benefits to the general public in maintaining the registry.

(2) The most efficient process for State administration of the registry, including the particular State agency that should be charged with registry administration and maintenance.

(3) Type of information to be included in the registry and maintenance of the information in a manner that ensures protection of privacy of registered donors.

(4) How to streamline the process for individuals to become registered donors and to remove their names from the registry.

(5) How to ensure informed, witnessed consent by registered donors and whether listing in the registry should be considered informed, witnessed consent.

(6) Process for informing the general public about organ, eye, and tissue donation, how to become registered and unregistered, and the legal effect of donor cards, drivers license donor symbols, and informed consent.

(7) How to evaluate the effectiveness of educational initiatives and the registry itself in improving identification of potential donors and procuring donations for transplantation.

(8) The experience of other states that have established organ and tissue donor registries.

(9) The cost to the State of establishing and maintaining the registry.

The Department shall report its findings and recommendations to the Joint Legislative Health Care Oversight Committee on or before May 1, 2002.

SECTION 2. G.S. 130A-404 reads as rewritten:

"**§ 130A-404. Persons who may make an anatomical gift.**

(a) An individual of sound mind and 18 years of age or more may give all or any part of that individual's body for any purpose specified in G.S. 130A-405. A gift made in accordance with G.S. 130A-406 shall be sufficient legal authority for procurement without additional authority from the donor or the donor's family or estate. The gift shall take effect upon death. A gift made by the donor in accordance with G.S. 130A-406 may not be revoked upon the donor's death, and neither the donor's family nor the donor's health care agent appointed pursuant to Article 3 of Chapter 32A of the General Statutes may refuse to honor the gift or thwart the procurement of the donation.

(b) ~~Any~~ If the decedent has not made a gift in the manner prescribed in G.S. 130A-406, then any of the following persons, in order of priority stated, when persons in prior classes are not available at the time of death, and in the absence of actual notice of contrary indications by the decedent or actual notice of opposition by a member of the same or a prior class, may give all or any part of the decedent's body for any purpose specified in G.S. 130A-405.

(1) The spouse;

(2) An adult child;

(3) Either parent;

(4) An adult sibling;

(5) A guardian of the person of the decedent at the time of decedent's death;

(5a) An individual who has an established relationship with the decedent, who is acting in good faith on behalf of the decedent, and who can reliably convey the decedent's wishes; or

(6) Any other person authorized or under obligation to dispose of the body.

(c) The persons authorized by subsection (b) may make the gift after or immediately before death. However, the guardian of the person of a ward may make the gift at any time during the guardianship and the gift shall become effective upon the death of the ward unless the guardianship terminated before death.

(d) If the donee has actual notice of contrary indications by the decedent or that a gift by a member of a class is opposed by a member of the same or a prior class, the donee shall not accept the gift.

(e) A gift of all or part of a body authorizes any examination necessary to assure medical acceptability of the gift for the purposes intended.

(f) The rights of the donee created by the gift are paramount to the rights of others except as provided by G.S. 130A-409(d)."

SECTION 3. Article 2 of Chapter 20 of the General Statutes is amended by adding the following section to read:

"**§ 20-7.3. Availability of organ, eye, and tissue donor cards at motor vehicle offices.**

The Department shall make organ, eye, and tissue donor cards available to interested individuals in each office authorized to issue drivers licenses or special identification cards. The Department shall obtain donor cards from qualified organ, eye, or tissue procurement organizations or tissue banks, as defined in G.S. 130A-403. The Department shall offer a donor card to each applicant for a drivers license."

SECTION 4. The Department of Transportation and the Department of Health and Human Services may use funds appropriated to it for the 2001-2003 fiscal biennium to implement this act.

SECTION 5. Sections 2 and 3 of this act become effective January 1, 2002. The remainder of this act is effective when it becomes law.

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2001

S D

SENATE BILL 907
PROPOSED COMMITTEE SUBSTITUTE S907-PCS3897-LN-39

Short Title: Organ, Eye, and Tissue Donor Registry. (Public)

Sponsors:

Referred to:

April 5, 2001

A BILL TO BE ENTITLED

AN ACT TO REQUIRE THE DEPARTMENT OF HEALTH AND HUMAN SERVICES AND OTHER APPROPRIATE STATE AGENCIES TO STUDY THE ESTABLISHMENT OF A STATEWIDE ORGAN, EYE, AND TISSUE DONOR REGISTRY, AND TO CLARIFY THE CURRENT LAW PERTAINING TO ANATOMICAL GIFT DONATION.

The General Assembly of North Carolina enacts:

SECTION 1. The Department of Health and Human Services, Division of Public Health, in consultation with the Department of Transportation, federally designated organ, eye, and tissue procurement organizations, and tissue banks shall study the establishment of a statewide organ, eye, and tissue donor registry. In conducting the study, the Department of Health and Human Services shall solicit advice and comment from citizens or citizen advisory groups interested in organ and tissue donation. The purpose of the study is to determine the feasibility and potential benefits of maintaining a statewide registry of persons who have indicated a willingness to donate organs, eyes, and tissue for transplantation or research in order to expedite the identification of potential organ, eye, and tissue donors. The study shall address the following:

(1) The potential benefits to the general public in maintaining the registry.

(2) The most efficient process for State administration of the registry, including the particular State agency that should be charged with registry administration and maintenance.

(3) Type of information to be included in the registry and maintenance of the information in a manner that ensures protection of privacy of registered donors.

(4) How to streamline the process for individuals to become registered donors and to remove their names from the registry.

(5) How to ensure informed, witnessed consent by registered donors and whether listing in the registry should be considered informed, witnessed consent.

(6) Process for informing the general public about organ, eye, and tissue donation, how to become registered and unregistered, and the legal effect of donor cards, drivers license donor symbols, and informed consent.

(7) How to evaluate the effectiveness of educational initiatives and the registry itself in improving identification of potential donors and procuring donations for transplantation.

(8) The experience of other states that have established organ and tissue donor registries.

(9) The cost to the State of establishing and maintaining the registry.

The Department shall report its findings and recommendations to the Joint Legislative Health Care Oversight Committee on or before May 1, 2002.

SECTION 2. G.S. 130A-404 reads as rewritten:

"**§ 130A-404. Persons who may make an anatomical gift.**

(a) An individual of sound mind and 18 years of age or more may give all or any part of that individual's body for any purpose specified in G.S. 130A-405. A gift made in accordance with G.S. 130A-406 shall be sufficient legal authority for procurement without additional authority from the donor or the donor's family or estate. The gift shall take effect upon death. A gift made by the donor in accordance with G.S. 130A-406 may not be revoked upon the donor's death, and neither the donor's family nor the donor's health care agent appointed pursuant to Article 3 of Chapter 32A of the General Statutes may refuse to honor the gift or thwart the procurement of the donation.

(b) ~~Any~~ If the decedent has not made a gift in the manner prescribed in G.S. 130A-406, then any of the following persons, in order of priority stated, when persons in prior classes are not available at the time of death, and in the absence of actual notice of contrary indications by the decedent or actual notice of opposition by a member of the same or a prior class, may give all or any part of the decedent's body for any purpose specified in G.S. 130A-405.

(1) The spouse;

(2) An adult child;

(3) Either parent;

(4) An adult sibling;

(5) A guardian of the person of the decedent at the time of decedent's death;

(5a) An individual who has an established relationship with the decedent, who is acting in good faith on behalf of the decedent, and who can reliably convey the decedent's wishes; or

(6) Any other person authorized or under obligation to dispose of the body.

(c) The persons authorized by subsection (b) may make the gift after or immediately before death. However, the guardian of the person of a ward may make the gift at any time during the guardianship and the gift shall become effective upon the death of the ward unless the guardianship terminated before death.

(d) If the donee has actual notice of contrary indications by the decedent or that a gift by a member of a class is opposed by a member of the same or a prior class, the donee shall not accept the gift.

(e) A gift of all or part of a body authorizes any examination necessary to assure medical acceptability of the gift for the purposes intended.

(f) The rights of the donee created by the gift are paramount to the rights of others except as provided by G.S. 130A-409(d)."

SECTION 3. Article 2 of Chapter 20 of the General Statutes is amended by adding the following section to read:

"**§ 20-7.3. Availability of organ, eye, and tissue donor cards at motor vehicle offices.**

The Department shall make organ, eye, and tissue donor cards available to interested individuals in each office authorized to issue drivers licenses or special identification cards. The Department shall obtain donor cards from qualified organ, eye, or tissue procurement organizations or tissue banks, as defined in G.S. 130A-403. The Department shall offer a donor card to each applicant for a drivers license."

SECTION 4. The Department of Transportation and the Department of Health and Human Services may use funds appropriated to it for the 2001-2003 fiscal biennium to implement this act.

SECTION 5. Sections 2 and 3 of this act become effective January 1, 2002. The remainder of this act is effective when it becomes law.

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2001

S D

SENATE BILL 907

Appropriations/Base Budget Committee Substitute Adopted 10/3/01

PROPOSED HOUSE COMMITTEE SUBSTITUTE S907-PCS9368-SW-68

Short Title: Organ, Eye, and Tissue Donor Registry. (Public)

Sponsors:

Referred to:

April 5, 2001

A BILL TO BE ENTITLED

AN ACT TO REQUIRE THE DEPARTMENT OF HEALTH AND HUMAN SERVICES AND OTHER APPROPRIATE STATE AGENCIES TO STUDY THE ESTABLISHMENT OF A STATEWIDE ORGAN, EYE, AND TISSUE DONOR REGISTRY, AND TO CLARIFY THE CURRENT LAW PERTAINING TO ANATOMICAL GIFT DONATION.

The General Assembly of North Carolina enacts:

SECTION 1. The Department of Health and Human Services, Division of Public Health, in consultation with the Department of Transportation and the Office of the Secretary of State, federally designated organ, eye, and tissue procurement organizations, and tissue banks shall study the establishment of a statewide organ, eye, and tissue donor registry. In conducting the study, the Department of Health and Human Services shall solicit advice and comment from citizens or citizen advisory groups interested in organ and tissue donation. The purpose of the study is to determine the feasibility and potential benefits of maintaining a statewide registry of persons who have indicated a willingness to donate organs, eyes, and tissue for transplantation or research in order to expedite the identification of potential organ, eye, and tissue donors. The study shall address the following:

(1) The potential benefits to the general public in maintaining the registry.

(2) The most efficient process for State administration of the registry, including the particular State agency that should be charged with registry administration and maintenance.

(3) Type of information to be included in the registry and maintenance of the information in a manner that ensures protection of privacy of registered donors.

(4) How to streamline the process for individuals to become registered donors and to remove their names from the registry.

(5) How to ensure informed, witnessed consent by registered donors and whether listing in the registry should be considered informed, witnessed consent.

(6) Process for informing the general public about organ, eye, and tissue donation, how to become registered and unregistered, and the legal effect of donor cards, drivers license donor symbols, and informed consent.

(7) How to evaluate the effectiveness of educational initiatives and the registry itself in improving identification of potential donors and procuring donations for transplantation.

(8) The experience of other states that have established organ and tissue donor registries.

(9) The cost to the State of establishing and maintaining the registry.

(10) Coordinating programs to avoid duplication of efforts.

The Department shall report its findings and recommendations to the Joint Legislative Health Care Oversight Committee on or before May 1, 2002.

SECTION 2. G.S. 130A-404 reads as rewritten:

"**§ 130A-404. Persons who may make an anatomical gift.**

(a) An individual of sound mind and 18 years of age or more may give all or any part of that individual's body for any purpose specified in G.S. 130A-405. A gift made in accordance with G.S. 130A-406 shall be sufficient legal authority for procurement without additional authority from the donor or the donor's family or estate. The gift shall take effect upon death. A gift made by the donor in accordance with G.S. 130A-406 may not be revoked upon the donor's death, and neither the donor's family nor the donor's health care agent appointed pursuant to Article 3 of Chapter 32A of the General Statutes may refuse to honor the gift or thwart the procurement of the donation.

(b) ~~Any~~ If the decedent has not made a gift in the manner prescribed in G.S. 130A-406, then any of the following persons, in order of priority stated, when persons in prior classes are not available at the time of death, and in the absence of actual notice of contrary indications by the decedent or actual notice of opposition by a member of the same or a prior class, may give all or any part of the decedent's body for any purpose specified in G.S. 130A-405.

(1) The spouse;

(2) An adult child;

(3) Either parent;

(4) An adult sibling;

(5) A guardian of the person of the decedent at the time of decedent's death;

(5a) An individual who has an established relationship with the decedent, who is acting in good faith on behalf of the decedent, and who can reliably convey the decedent's wishes; or

(6) Any other person authorized or under obligation to dispose of the body.

(c) The persons authorized by subsection (b) may make the gift after or immediately before death. However, the guardian of the person of a ward may make the gift at any time during the guardianship and the gift shall become effective upon the death of the ward unless the guardianship terminated before death.

(d) If the donee has actual notice of contrary indications by the decedent or that a gift by a member of a class is opposed by a member of the same or a prior class, the donee shall not accept the gift.

(e) A gift of all or part of a body authorizes any examination necessary to assure medical acceptability of the gift for the purposes intended.

(f) The rights of the donee created by the gift are paramount to the rights of others except as provided by G.S. 130A-409(d)."

SECTION 3. Article 2 of Chapter 20 of the General Statutes is amended by adding the following section to read:

"**§ 20-7.3. Availability of organ, eye, and tissue donor cards at motor vehicle offices.**

The Division shall make organ, eye, and tissue donor cards available to interested individuals in each office authorized to issue drivers licenses or special identification cards. The Division shall obtain donor cards from qualified organ, eye, or tissue procurement organizations or tissue banks, as defined in G.S. 130A-403. The Division shall offer a donor card to each applicant for a drivers license."

SECTION 4. The Department of Transportation and the Department of Health and Human Services may use funds appropriated to it for the 2001-2003 fiscal biennium to implement this act.

SECTION 5. Sections 2 and 3 of this act become effective January 1, 2002. The remainder of this act is effective when it becomes law.

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2001

S D

SENATE BILL 907

Appropriations/Base Budget Committee Substitute Adopted 10/3/01
PROPOSED HOUSE COMMITTEE SUBSTITUTE S907-CSSW-68 [v.1]

10/22/2001 3:13:20 PM

Short Title: Organ, Eye, and Tissue Donor Registry. (Public)

Sponsors:

Referred to:

April 5, 2001

A BILL TO BE ENTITLED

AN ACT TO REQUIRE THE DEPARTMENT OF HEALTH AND HUMAN SERVICES AND OTHER APPROPRIATE STATE AGENCIES TO STUDY THE ESTABLISHMENT OF A STATEWIDE ORGAN, EYE, AND TISSUE DONOR REGISTRY, AND TO CLARIFY THE CURRENT LAW PERTAINING TO ANATOMICAL GIFT DONATION.

The General Assembly of North Carolina enacts:

SECTION 1. The Department of Health and Human Services, Division of Public Health, in consultation with the Department of Transportation, federally designated organ, eye, and tissue procurement organizations, and tissue banks shall study the establishment of a statewide organ, eye, and tissue donor registry. In conducting the study, the Department of Health and Human Services shall solicit advice and comment from citizens or citizen advisory groups interested in organ and tissue donation. The purpose of the study is to determine the feasibility and potential benefits of maintaining a statewide registry of persons who have indicated a willingness to donate organs, eyes, and tissue for transplantation or research in order to expedite the identification of potential organ, eye, and tissue donors. The study shall address the following:

(1) The potential benefits to the general public in maintaining the registry.
(2) The most efficient process for State administration of the registry, including the particular State agency that should be charged with registry administration and maintenance.
(3) Type of information to be included in the registry and maintenance of the information in a manner that ensures protection of privacy of registered donors.
(4) How to streamline the process for individuals to become registered donors and to remove their names from the registry.

(5) How to ensure informed, witnessed consent by registered donors and whether listing in the registry should be considered informed, witnessed consent.
(6) Process for informing the general public about organ, eye, and tissue donation, how to become registered and unregistered, and the legal effect of donor cards, drivers license donor symbols, and informed consent.
(7) How to evaluate the effectiveness of educational initiatives and the registry itself in improving identification of potential donors and procuring donations for transplantation.
(8) The experience of other states that have established organ and tissue donor registries.
(9) The cost to the State of establishing and maintaining the registry.

The Department shall report its findings and recommendations to the Joint Legislative Health Care Oversight Committee on or before May 1, 2002.

SECTION 2. G.S. 130A-404 reads as rewritten:

"**§ 130A-404. Persons who may make an anatomical gift.**

(a) An individual of sound mind and 18 years of age or more may give all or any part of that individual's body for any purpose specified in G.S. 130A-405. A gift made in accordance with G.S. 130A-406 shall be sufficient legal authority for procurement without additional authority from the donor or the donor's family or estate. The gift shall take effect upon death. A gift made by the donor in accordance with G.S. 130A-406 may not be revoked upon the donor's death, and neither the donor's family nor the donor's health care agent appointed pursuant to Article 3 of Chapter 32A of the General Statutes may refuse to honor the gift or thwart the procurement of the donation.

(b) ~~Any~~ If the decedent has not made a gift in the manner prescribed in G.S. 130A-406, then any of the following persons, in order of priority stated, when persons in prior classes are not available at the time of death, and in the absence of actual notice of contrary indications by the decedent or actual notice of opposition by a member of the same or a prior class, may give all or any part of the decedent's body for any purpose specified in G.S. 130A-405.

(1) The spouse;
(2) An adult child;
(3) Either parent;
(4) An adult sibling;
(5) A guardian of the person of the decedent at the time of decedent's death;
(5a) An individual who has an established relationship with the decedent, who is acting in good faith on behalf of the decedent, and who can reliably convey the decedent's wishes; or
(6) Any other person authorized or under obligation to dispose of the body.

(c) The persons authorized by subsection (b) may make the gift after or immediately before death. However, the guardian of the person of a ward may make the gift at any time during the guardianship and the gift shall become effective upon the death of the ward unless the guardianship terminated before death.

(d) If the donee has actual notice of contrary indications by the decedent or that a gift by a member of a class is opposed by a member of the same or a prior class, the donee shall not accept the gift.

(e) A gift of all or part of a body authorizes any examination necessary to assure medical acceptability of the gift for the purposes intended.

(f) The rights of the donee created by the gift are paramount to the rights of others except as provided by G.S. 130A-409(d)."

SECTION 3. Article 2 of Chapter 20 of the General Statutes is amended by adding the following section to read:

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The Division shall make organ, eye, and tissue donor cards available to interested individuals in each office authorized to issue drivers licenses or special identification cards. The Division shall obtain donor cards from qualified organ, eye, or tissue procurement organizations or tissue banks, as defined in G.S. 130A-403. The Division shall offer a donor card to each applicant for a drivers license."

SECTION 4. The Department of Transportation and the Department of Health and Human Services may use funds appropriated to it for the 2001-2003 fiscal biennium to implement this act.

SECTION 5. Sections 2 and 3 of this act become effective January 1, 2002. The remainder of this act is effective when it becomes law.

SENATE BILL 907:
Organ, Eye, and Tissue Donor Registry

BILL ANALYSIS

Committee:	House Health	**Introduced by:**	Sen. Lee
Date:	October 23, 2001	**Summary by:**	Dianna W. Jessup
Version:	**PCS S907-CSSW-68**		Committee Counsel

SUMMARY: The Proposed Committee Substitute to Senate Bill 907 would:

- *Require the Department of Health and Human Services and other agencies to study the establishment of a statewide organ, eye and tissue donor registry. This section would become effective when the bill becomes law.*
- *Amend the Uniform Anatomical Gift Act to make it clear that organ donations made in the manner prescribed in statute cannot be later revoked by anyone other than the donor and to permit individuals who have an established relationship with the decedent to make an gift of all or part of the decedent's body. This section would become effective January 1, 2002.*
- *Require the Division of Motor Vehicles to make donor cards available to interested individuals in driver's license offices. This section would become effective January 1, 2002.*

The PCS changes the word "Department" in proposed G.S. 20-7.3 set forth in Section 2 to "Division" to mean the Division of Motor Vehicles, as the Division is the agency charged with issuing drivers' licenses and identification cards.

CURRENT LAW: The Uniform Anatomical Gift Act (**G.S. 130A Part 3**) regulates the process for the making and receiving of **anatomical gifts** in this State. **G.S. 130A-406** specifies a donor may make a gift by will, card or other document as long as the document is signed by the donor in the presence of two witnesses. The gift does not have to be made to a specified donee.

Anyone 18 years of age or older can make an anatomical gift of some or all of that person's own body. Generally people become donors either through their wills or through another document that is commonly referred to as a donor card or a declaration of anatomical gift. In addition, **G.S. 130A-404(b)** lists the following persons who, in the absence of actual notice of contrary indications by a decedent or actual notice of opposition by a member of the same or a prior class, may give all or any part of a decedent's body for the purposes otherwise set forth in the statutes:

- The spouse
- An adult child
- Either parent
- An adult sibling
- The decedent's guardian
- Any other person authorized or under obligation to dispose of a body.

G.S. 130A-408 lists the below methods whereby a donor may amend or revoke an anatomical gift:

- By execution and delivery of a signed statement to the donee
- By an oral statement made in the presence of two persons and communicated to the donee
- By a statement addressed to an attending physician and communicated to the donee

- By a signed cared or document found on the individual or in the individual's effects, and made known to the donee

A guardian may amend or revoke the gift by the execution and delivery to the donee of a signed statement.

Current law does not clearly address whether and under what circumstances a family member or other person authorized to make a gift of a decedent's body may decline to make the gift of the decedent's body, even when the decedent had executed a donor card or other document indicating that the decedent intended the gift.

BILL ANALYSIS: **Section 1** would require DHHS, in consultation with DOT and federally designated organ, eye, and tissue procurement organizations and tissue banks to study the establishment of a statewide organ, eye, and tissue donor registry. It is not clear from the language whether this proposed registry would be separate from the registry established in H1362 (see below). **Section 2** would amend the Uniform Anatomical Gift Act to make it clear that if prior to death a person has made an anatomical gift in the manner set forth in the statutes, the gift cannot be revoked, and no one can refuse to honor the gift. The bill would not change the right of the donee not to accept an anatomical gift. The bill would also expand the class of persons who can make a gift of a decedent's body to include a person who has an established relationship with the decedent. **Section** 3 would require DMV to make donor cards available to persons at drivers' license offices. **Section 4** would authorize DHHS and DOT to use funds appropriated during this biennium to implement the act. **Section 5** is the effective date.

ISSUE: On October 18, 2001, as a result of a LRC study, the General Assembly passed H1362 that establishes a central registry for advance health care directives, including declarations of anatomical gifts.

Amy Currie contributed to this summary.

2001 COMMITTEE REPORT
HOUSE OF REPRESENTATIVES

The following report(s) from standing committee(s) is/are presented:
By Representative(s) **Wright** (Chair/Chairs) for the Committee on **Health**.

☒ Committee Substitute for
S.B. 907 A BILL TO BE ENTITLED AN ACT TO REQUIRE THE DEPARTMENT OF HEALTH AND HUMAN SERVICES AND OTHER APPROPRIATE STATE AGENCIES TO STUDY THE ESTABLISHMENT OF A STATEWIDE ORGAN, EYE, AND TISSUE DONOR REGISTRY, AND TO CLARIFY THE CURRENT LAW PERTAINING TO ANATOMICAL GIFT DONATION.

☐ 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 House committee substitute bill , unfavorable as to the original bill, and recommendation that the committee substitute bill be re-referred to the Committee on Appropriations.

☐ 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)

2/15/01

Senate Bill 907 – Organ, Eye, and Tissue Donor Registry

The Need for a Registry –

- The red heart designation on your drivers license does not mean that you wish to be an organ donor – it merely states your interest. A fully executed organ donation card is the legal document designating a persons intent to be a donor – not the drivers license. Current legislation allows for a family member to override the decedent's wishes, even if they have a signed organ donation card.
- As of July 31st, 2,836 people are waiting for transplants in North Carolina and the number is increasing daily
- In the United States, every day 15 people die waiting for an organ transplant.
- In the Year 2000
  - 196 North Carolinians died while waiting for a transplant
  - In the US this number totaled 5,542
- One donor can save the lives of up to 8 people and enhance the lives of over 50 others through tissue and eye donation.

Summary of the Bill

1. The bill directs the Department of Health and Human Services, in consultation with the Department of Transportation, and other stakeholder and citizen groups to study the establishment of a statewide organ, eye and tissue donor registry. The study will address:
   - the benefits to the public of maintaining a registry
   - process for administration of a registry, type of information included, maintenance of the information, the process to add or remove a name
   - how to protect information and ensure informed witnessed consent
   - cost to establish and maintain registry
   - educational initiatives about donation and the registry

DHHS will report its findings to the Joint Legislative Health Care Oversight Committee by May 1, 2001.

2. The second part of the bill clarifies the current law pertaining to anatomical gift donation. Strengthens existing laws that declare that any person who effectively signed an organ donation card, that card shall serve as legal authority for procurement without additional authority needed.

   For example, if a person has made it known that they wish to donate their organs upon their death and have signed an organ donation card, then upon their death, a family member cannot override the decedent's wishes.

3. Additionally, the bill directs the Department of Transportation to make organ donation cards available to customers at offices, which provide drivers licenses and identification cards. The cards will be provided by organ, tissue and eye procurement organizations.

Support for the Bill
This bill is supported by DHHS, Division of Motor Vehicles in DOT, Carolina Donor Services, and a long list of citizens and health related organizations that have interests in increasing organ donation.

Organ Donation/Registry in other States
According to Carolina Donors Services 18 states currently have statewide Organ Donation Registries including Pennsylvania, Arkansas, Louisiana, Ohio, Virginia and Colorado. Numerous others are currently considering or in the process of establishing one.

The US Department of Health and Human Services, lead by Secretary Tommy Thompson, has made a long term commitment to encourage and enable Americans to "Donate the Gift of Life". The Secretary is currently evaluating partnerships and programs to increase the number of donors throughout the nation.

"THE LIST OF LIFE"

The United Network for Organ Sharing (UNOS) maintains a national patient waiting list for organ transplants. These figures are from UNOS, which maintains a website at www.unos.org

Patient Waiting List for Organ Transplants as of July 31, 2001*

ORGAN NEEDED	PATIENTS IN US	PATIENTS IN NC
KIDNEY	49,769	1,669
LIVER	18,210	668
PANCREAS	1,125	8
KIDNEY - PANCREAS	2,536	62
INTESTINE	173	4
HEART	4,195	101
HEART-LUNG	215	21
LUNG	3,768	303
TOTAL	**77,860**	**2,836**

*Based on UNOS Scientific Registry data as of July 31, 2001.

	PATIENTS IN US	PATIENTS IN NC
PATIENTS WHO RECEIVED TRANSPLANTS IN 2000	21,692	667
PATIENTS WHO DIED WHILE WAITING IN 2000	5,542	196

**Based on UNOS Scientific Registry data as of July 31, 2001.

Every 12 minutes, a new name is added to the waiting list.
Every day, 15 people die while waiting for a transplant.

DONATE LIFE

VISITOR REGISTRATION SHEET

Health — Name of Committee

10/23/01 — Date

VISITORS:. PLEASE SIGN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
[illegible]	NCASA
Crissy Porter	Bone & Associates
[illegible]	NCSOS
Robin [illegible]	NCHA
Carole Lawler	EGHS
Teresa Bordeaux	Carolina Donor Services & American Liver Foundation
Charley Jeffress	CAROLINA DONOR SERVICES
Sharon Matthews	DOT-DMV
DAVID M. Barnes	Poyner Spruill, LLP
Renee Miller	Carolina Donor Services
Lloyd Jordan	Carolina Donor Services
Wayne Hurder	DMV-DOT
[illegible]	BCBSNC
John Bowdish	Alley Associates
[illegible]	NCFPC
Glenn [illegible]	DHHS
[illegible]	GSK
[illegible]	Morris VanAllen
WILLIAM H. PUTTER, JR	NCDS & NCPIA
[illegible]	CCHILC
[illegible]	NC-NCW
Roz Sawicki	NCCCS
[illegible]	SHP
Michelle Peele	CDS donor MDM

AGENDA

HOUSE COMMITTEE ON HEALTH
Tuesday, December 4, 2001
12:00 Noon, ROOM 415 LB

OPENING REMARKS

Rep. Thomas E. Wright
Chairman

BILLS TO BE DISCUSSED

SB-822 State Self-Funded Health Care Plan. (Sen. Rand)

SB-861 License by Credentials/Dentistry. (Sen. Purcell)

COMMENTS

ADJOURNMENT

MINUTES

HOUSE COMMITTEE ON HEALTH

TUESDAY, DECEMBER 4, 2001

12:00 NOON, ROOM 415 LOB

The House Committee on Health met on Tuesday, December 4, 2001 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 stated that SB-861 would not be taken up today.

SB-822 STATE SELF-FUNDED HEALTH CARE PLAN.(Sen. Rand)

Sam Byrd, fiscal staff, explained the bill section by section. Rep. Edwards asked about the confidentiality language in the bill. Sam Byrd responded. Chairman Wright asked for further clarification. Sam Byrd responded. Chairman Wright asked if the process would save the plan money. Sam Byrd referred the members of the committee to the actuarial note for the answer to Chairman Wright's question. Rep. Nye asked if there was a cost available for an optional benefits plan. Sam Byrd responded. Rep. Nye followed up with a question about section 3 of the bill, which dealt with long term care benefits. Sam Byrd responded. Rep. Nye asked if the program was underwritten by an out of state contractor. Sam Byrd responded yes that it was underwritten by Med America, out of the State of New York. Rep. Nye asked about the reason for asking the State Treasurer's office for administering the program. Sam Byrd responded. Rep. Nye asked if the State Treasure's office was considered to take the entire plan. Sam Byrd responded. Chairman Wright responded. Rep. Justus asked about the cost per child and per family. Sam Byrd responded. Rep. Justus commented on the bill. Rep. Insko asked about the impact of Section 5 of the bill. Sam Byrd responded. Rep. Edwards asked if this bill would be an addendum to the bill that is in the budget. Chairman Wright responded. Rep. Insko asked about the actuarial note that dealt monthly premiums. Sam Byrd responded. Rep. Sherrill asked about the number of days to study the bill. Chairman Wright responded. Sherry Melton, of the State Employee Association of North Carolina, spoke on the Associations concern on the bill. Rep. Earle asked if other plans had other options. Sam Byrd responded. Rep. Earle followed up with a question about high and low options of other plans. Chairman Wright responded. Sam Byrd responded. Rep. Buchanan asked if the plan would cover all 100 counties. Sam Byrd responded that 90 counties at the most were covered in 1990. Rep. Buchanan asked if the bill would cover all 100 counties. Sam Byrd. responded No. Rep. Buchanan commented on the bill. Chairman Wright responded.

Rep. Sherrill asked about the family coverage under the State plan. Sherry Melton responded. Rep. Sherrill followed up with a question about the savings to the plan. Sam Byrd responded. Rep. Insko asked if reduced coverage produce extra money. Sam Byrd responded.

Chairman Wright adjourned the meeting .

The meeting adjourned at 12:45pm.

Rep. Thomas Wright, Chairman

Vanda Wilson-Wormack, Committee Assistant

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2001

S 2

SENATE BILL 822

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

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

Sponsors:

Referred to:

April 3, 2001

A BILL TO BE ENTITLED

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

The General Assembly of North Carolina enacts:

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

"**§ 135-39.5B. Prepaid plans.**

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

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

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

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

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

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

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

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

...

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

...."

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

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

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

"Article 7.

"Long-Term Care Plan.

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

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

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

"**§ 135-121. Administration.**

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

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

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

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

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

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

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

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

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

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

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

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

"**§ 135-40.4. Benefits in general.**

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

SENATE BILL 822:
State Self-Funded Health Plan

BILL ANALYSIS

Committee:	House Health	**Introduced by:**	Senator Rand
Date:	December 4, 2001	**Summary by:**	Frank W. Folger
Version:	2nd Edition		Committee Counsel

SUMMARY: This bill would amend the State Health Plan (Plan) to:

- *Authorize development of optional hospital and medical benefits programs;*
- *Transfer administration of the Plan's long term benefits program to the State Treasurer;*
- *Provide confidentiality for certain information in contracts between hospitals, physicians or other medical providers, or a pharmacy benefit manager and the Plan;*
- *Clarify the amount of reimbursement allowable under the Plan for private duty nursing services;*
- *Provide Plan coverage of and direct reimbursement for services by Clinical Pharmacist Practitioners; and*
- *Provide for competitive selection of supplemental insurance products for retired State employees.*

Effective: Sections 3 through 3.3 –July 31, 2002; Sections 6 through 13 – January 1, 2002; Remainder of the act – when it becomes law.

BILL ANALYSIS:

Sections 1 – 2 Optional Hospital and Medical Benefits Programs Would amend G.S. 135-39.5B to expressly allow the Executive Administrator and Board of Trustees to develop an optional hospital and medical benefits programs, including one underwritten by the state and programs that operate in rural areas. It would also authorize use of a pilot program to determine cost savings and improvements through such local, provider driven medical management.

Sections 3 – 3.3. Long-Term Care Benefits Program Transfer Would transfer from the State Health Plan to the State Treasurer, authority over the long-term care benefits offered optionally to qualified employees, retired employees, and dependents of those employees. It would repeal the existing statutes found in Part 4 of Article 3 of Chapter 135 and create a new Article 7 within the same Chapter to provide for establishment of the "Long-Term Care Plan of North Carolina" to be administered by the State Treasurer in accordance with rules and regulations adopted by the Treasurer. Benefits will be available to those qualified employees and retired employees who voluntarily elect to provide those benefits for themselves and their qualified dependents by contribution. Payroll deduction would be available from employee salary and disability benefit payments and from retired employee benefit payments for fully contributory payment of premiums.

Section 4. Confidentiality of Contract Terms Would make confidential (and likewise, not a public record) the terms of any contract, including reimbursement rates, between the State Health Plan and hospitals, hospital authorities, doctors or other medical providers, or a pharmacy benefit manager. The confidential status would not prohibit release of information to the State Auditor, Attorney General,

Director of the State Budget, the Plan's Executive Administrator, and the Joint Legislative Oversight Committee solely and exclusively for their use in furthering their duties and responsibilities.

Sections 5 – 5.1 Reimbursement Provisions Would clarify that reimbursement of private duty nursing services under the Plan could not exceed the lesser of the Plan's usual, customary and reasonable allowances or 90% of the daily semiprivate rate at skilled nursing facilities as determined by the Plan. These sections would also add to the list of the State Health Plan's comprehensive benefits coverage for services of a Clinical Pharmacist Practitioner when certain threshold conditions are met and thus allow direct reimbursement to Clinical Pharmacist Practitioners.

Sections 6 –12 Reduced Contribution Optional Benefits Alternative Would allow a State employee to elect to receive optional benefits coverage under the State Health Plan, instead of standard benefits, to reduce that employee's contribution costs. Below is a comparison chart highlighting differences between the two plans.

	Standard Plan	**Optional Benefits Plan (Proposed)**
Deductible (for each covered individual)	$350	$500
Maximum Deductible for Each Contract	$1050	$1500
Coinsurance	80% / 20%	70% / 30%
Maximum Out-of-Pocket For Each Individual	$1500	$2000
Maximum Out-of-Pocket for Each Contract	$4500	$6000
Prescription Deductible	N/A	$50 for each covered individual
Home Office or Skilled Nursing Facility Visit Copay	$15	$25

Provisions of the optional benefits plan do not apply to dependents for which Medicare is the primary payer of health benefits.

The section would also require former employees seeking coverage under the State Health Plan under the Plan's continuation coverage provisions to elect coverage under G.S. 135-40.2(b)(12) within 90 days after coverage terminates under the 12-month continuation provisions of G.S.135-40.2(a)(6).

The section would also remove the "medically necessary" requirement for coverage of medication for erectile dysfunction under the Plan but would limit coverage to three doses per month.

Section 13 Supplemental Insurance Products for Retired State Employees Would create a new statute requiring the Board of Trustees of the Teachers' and State Employees' Retirement System to competitively select supplemental insurance products for retired State employees. The Board, using a sealed bid process, would select the supplemental insurance products meeting the needs and desires of retired State employees. A retired employee electing coverage under a product or products would have the premiums for the product or products deducted from the retired employee's retirement benefit payment. A committee of at least 5 constituent members of the Board may complete the selection process but the full Board must approve the committee's decision before the product is considered selected.

NORTH CAROLINA GENERAL ASSEMBLY
LEGISLATIVE ACTUARIAL NOTE

BILL NUMBER: Senate Bill 822, Second Edition

SHORT TITLES: State Self-Funded Health Plan (HMO).

SPONSOR(S): Sen. Rand.

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: Section 1: The section allows the Executive Administrator and Board of Trustees of the Teachers' and State Employees' Comprehensive Major Medical Plan, after consulting with the Legislative Committee on Employee Hospital and Medical Benefits, to adopt any arrangement for offering health maintenance organization (HMO) alternatives to members of the Plan, including ones underwritten by the State. The Plan has, since 1986, provided HMO alternatives with HMOs assuming all of the risk for the coverages offered. HMOs have further been required to compensate the Plan for administrative costs and for enrolling members of the Plan with more favorable risk factors.

The Plan's Executive Administrator says he intends to offer, under the bill, a self-insured HMO alternative to the Plan's self-insured indemnity program under the following circumstances: (a) the Plan will competitively select open-access HMOs that will be required to have a viable health care provider network in all of the State's 100 counties; (b) the HMOs will be provided an administrative fee no greater than the fee paid to the claims processing contractor for the Plan's self-insured indemnity program (Blue Cross & Blue Shield of North Carolina); (c) monthly premiums will be the same as the monthly premiums for the Plan's self-insured indemnity program; (d) most benefits will be actuarially 5-10% better than the benefits of the Plan's self-insured indemnity program with member cost-sharing limited to copayments; (e) outpatient prescription drug benefits and mental health and substance abuse benefits will be carved-out and will continue to be managed by the self-insured indemnity program's pharmacy benefit manager (AdvancePCS) and mental health case manager (Value Options); (f) a point-of-service option in which HMO members can use out-of-network providers in exchange for higher copayments will not be offered: and (g) conversion to non-group benefits upon a member's termination of eligibility for group benefits will be provided by the selected HMOs on an insured arrangement.

Section 2: The section allows the Plan's Executive Administrator to conduct a pilot program in a county that has at least 10,000 members of the Plan to measure the potential cost savings and patient care improvements from medical management by local providers of health care services.

Sections 3, 3.1, 3.2, and 3.3: The sections transfer a long-term care benefit program from the Plan to the Department of State Treasurer.

Section 4: The section makes the terms of any contract, including reimbursement rates, between the Plan and hospitals, hospital authorities, physicians, a pharmacy benefit manager, or any other provider of medical services under the Plan confidential and not a public record under state law. Only the State Auditor, the

Attorney General, the Director of the State Budget, the Plan's Executive Administrator, and members of the Joint Legislative Health Care Oversight Committee would have sole and exclusive access to the contracts.

Section 5: The section clarifies that the Plan's allowable charges for private duty nursing services are the lesser of the Plan's usual, customary, and reasonable allowances or 90% of the daily semi-private rate at skilled nursing facilities.

Section 5.1: The section provides for the reimbursement of services to clinical pharmacist practitioners who are approved by the North Carolina Board of Pharmacy and North Carolina Medical Board. Clinical pharmacist practitioners became a new level of pharmacy in North Carolina in July, 2000, with rules promulgated by the Board of Pharmacy and Medical Board in April, 2001. These pharmacists have advanced training and work collaboratively with licensed physicians to implement pre-determined agreements for drug therapy such as aminoglycoside dosing, anti-coagulation management, theophylline dosing, pain management, refill programs, and disease management programs for chronic diseases such as asthma and diabetes.

Sections 6, 7, 8, 9, 10, and 11: The sections permit employees, retired employees, and their spouses and dependent children to choose reduced coverage under the Plan's self-insured indemnity program in order to get lower monthly premiums. The sections apply only to persons for whom Medicare is not the primary payer of health benefits. Employees and retired employees would have the same reduced levels of coverage that would be chosen for spouses and dependent children. Premiums paid to the Plan by employers for employees and retired employees would however remain the same under each coverage option. A comparison between the self-insured program's standard and reduced levels of coverage under the sections is:

	Standard Coverage	Reduced Coverage
Annual Deductible Per Person	$350	$500
Maximum Annual Deductible Per Family	$1,050	$1,500
Coinsurance Paid by Members	20%	30%
Maximum Annual Coinsurance Per Person	$1,500	$2,000
Maximum Annual Coinsurance Per Family	$4,500	$6,000
Copayment for Professional Services Paid by Members	$15	$25
Annual Deductible for Prescription Drugs Per Person	None	$50

All other benefits of the two levels of coverage remain the same as provided under the standard coverage. Premiums paid by employees and retired employees for the coverage of their spouses and dependent children would increase an estimated 8% over 2000-2001 amounts under the reduced level of coverage as opposed to a 30% increase under the standard level of coverage. Premiums paid by employees and retired employees for the coverage of their dependent children only would be reduced by an estimated 4% under the reduced level of coverage as compared to 2000-2001 rates as opposed to a 30% increase under the standard level of coverage.

Section 8: The section also provides coverage for erectile dysfunction up to three dosages of medication per month. Drugs that are affected are Viagra, Caverject, Muse, and Edex.

Section 12: The section requires an election of contributory coverage by employees who have had 12 months of non-contributory coverage following an elimination of a job because of a reduction in funds supporting the job within 90 days after the last day of non-contributory coverage.

EFFECTIVE DATE: Sections 3, 3.1, 3.2, and 3.3 become effective July 1, 2002. Sections 6, 7, 8, 9, 10, and 11 become effective January 1, 2002. The other sections become effective when they become law.

ESTIMATED IMPACT ON STATE: Self-Insured HMO: The consulting actuary for the Teachers' and State Employees' Comprehensive Major Medical Plan, Aon Consulting, says that the Plan will design a self-insured HMO that will be cost neutral to the State. Aon Consulting further states that the cost savings to the State will come from greater discounts from an HMO's network of institutional and professional health care providers,

notwithstanding the fact that changes in utilization management may result in an increase or decrease in cost to the State. In any event, Aon Consulting concludes that the bill results in the risk of adverse experience being transferred to the State by an HMO. The consulting actuary for the General Assembly's Fiscal Research Division, Hartman & Associates, states that the financial impact of the bill is currently indeterminable, but that a considerable amount of uncompensated risk will be transferred from the commercial HMO market and Plan members selecting an HMO option to the State. Factors related to this observation include: inconclusive evidence that splitting the Plan's self-insured efforts into two parts will generate savings not realized by the Plan in total, the likelihood that Plan members will self-select the self-insured option most advantageous at the time which will result in an overall cost increase to the Plan, the likelihood of a viable health care provider network and HMO option with higher benefits in all of the State's 100 counties is quite uncertain, the addition of another self-insured option to the Plan will likely create additional administrative costs to the Plan, the addition of another self-funded option will likely result in increased total claims processing fees since the indemnity program's claims processor's fees are based upon a minimum enrollment to adequately cover fixed expenses, and with the State's anticipation of subjecting managed care plans to malpractice liabilities and increased defensive medical practices, the commercial HMO industry will in all likelihood transfer all of the increased costs for protection against these liabilities and defensive medical practices to the State rather than to its owners and other books of business.

Pilot Program for Local Management of Health Care Services: The Plan's consulting actuary, Aon Consulting, and the consulting actuary for the General Assembly's Fiscal Research Division, Hartman and Associates, both state that the financial impact of the pilot program is indeterminable. Hartman and Associates further notes that to the extent that local management's costs duplicate those included in the indemnity program's claims processors' fees, the Plan's total administrative expense would be expected to increase.

Transfer of Long-Term Care Program to the Department of State Treasurer: The Plan's consulting actuary, Aon Consulting, and the consulting actuary for the General Assembly's Fiscal Research Division, Hartman and Associates, do not see any financial impact to the Plan for the transfer.

Confidentiality of Provider Contracts: The Plan's consulting actuary, Aon Consulting, states that the Plan could see cost increases up to 25% without the confidentiality of provider contracts. The consulting actuary for the General Assembly's Fiscal Research Division, Hartman and Associates, does not expect the confidentiality of provider contracts to have a significant financial impact.

Allowable Charges for Private Duty Nursing Set at Lesser of UCR or 90% of Daily Semi-Private Rates at Skilled Nursing Facilities: The Plan's consulting actuary, Aon Consulting, states that the change should result in minimal cost savings. The consulting actuary for the General Assembly's Fiscal Research Division, Hartman and Associates, does not expect the change to have a significant financial impact.

Clinical Pharmacist Practitioners Added as Providers of Health Care Services: The Plan's consulting actuary, Aon Consulting, expects the addition to have a negligible cost. The consulting actuary for the General Assembly's Fiscal Research Division, Hartman and Associates, does not expect the addition to have a significant financial impact.

Optional Benefit Levels for Lower Monthly Premiums: Although the draft legislation does not specify that the optional benefit levels would incorporate a preferred provider organization (PPO) structure, the Plan's consulting actuary, Aon Consulting, specifies that the low option premium rates are predicated on a PPO format for an approximate 10% reduction in rates. The low option's monthly rates would be:

Contract	Employer	Employee	Total
Employee & Child(ren)	$244.37	$112.64	$357.01
Employee & Family	$244.37	$304.38	$548.75

Under a PPO structure, the Plan selects certain hospitals, physicians, and other providers of health care services for which Plan members will receive expected benefits. Use of hospitals, physicians, and other

providers of health care services by Plan members other than the ones selected by the Plan will result in members paying a coinsurance rate of 50% up to $7,000 per person per year with no annual contract maximum amount. The consulting actuary for the General Assembly's Fiscal Research Division, Hartman and Associates, did not calculate the amount of the lower premiums.

Three Monthly Dosages for Erectile Dysfunction Drugs: The Plan's consulting actuary, Aon Consulting, expects the change in outpatient prescription drug coverage to have an additional cost of $147,000 for fiscal year 2001-02 and $600,000 for fiscal year 2002-03. The consulting actuary for the General Assembly's Fiscal Research Division, Hartman and Associates, does not expect the change in coverage to have a significant financial impact.

Election Time for Contributory Continuation Coverage Following Job Losses: The Plan's consulting actuary, Aon Consulting, expects negligible cost savings from the change in eligibility. The consulting actuary for the General Assembly's Fiscal Research Division, Hartman and Associates, does not expect the change in eligibility to have a significant financial impact.

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 only had 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., $350 annual deductible, 20% coinsurance up to $1,500 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. Beginning in July, 2000, firefighters, rescue squad workers, and members of the National Guard and their eligible dependents were allowed to voluntarily participate in the Plan on a fully contributory basis, provided they were ineligible for any other type of group health benefits and had been without such benefits for at least six months. Employer-paid non-contributory premiums are only authorized for the indemnity program's coverage for employees and retired employees. All other types of premium in the indemnity program are fully contributory. The Plan's Executive Administrator has set the premium rates for firefighters, rescue squad workers, and members of the National Guard and their families at 47% more than the comparable rates charged for employees, retired employees, and their families. 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 three HMOs currently covering about 9% of the Plan's total population in 24 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, 2000, include:

	Self-Insured Indemnity Program	Alternative HMOs	Plan Total
Number of Participants			
Active Employees	248,518	28,822	277,340
Active Employee Dependents	134,795	17,376	152,171
Retired Employees	104,305	3,185	107,490
Retired Employee Dependents	17,936	594	18,530
Former Employees & Dependents with Continued Coverage	2,865	381	3,246
Firefighters, Rescue Squad			

Workers, National Guard Members & Dependents	3	-	3
Total Enrollments	508,422	50,358	558,780
Number of Contracts			
Employee Only	270,322	23,223	293,545
Employee & Child(ren)	38,775	6,006	44,781
Employee & Family	45,764	3,026	48,790
Total Contracts	354,861	32,255	387,116
Percentage of Enrollment by Age			
29 & Under	28.0%	41.6%	29.2%
30-44	20.9	26.6	21.4
45-54	21.3	19.2	21.1
55-64	14.5	9.2	14.0
65 & Over	15.4	3.4	14.3
Percentage of Enrollment by Sex			
Male	39.1%	36.9%	38.9%
Female	60.9	63.1	61.1

Assumptions for the Self-Insured Indemnity Program: For the fiscal year beginning July 1, 2000, the self-insured program started its operations with a cash balance of $188 million. Receipts for the year were $930.5 million from premium collections, $9.9 million from investment earnings, and $8.4 million in risk adjustment and administrative fees from HMOs, for a total of $948.8 million in receipts for the year. Disbursements from the self-insured program were $1.056 billion in claim payments and $29.2 million in administration and claims processing expenses for a total of $1.085 billion for the year beginning July 1, 2000. For the fiscal year beginning July 1, 2001, the self-insured indemnity program began the year with a cash balance of only $51 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 payments to health care providers 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, mental health case management, pharmacy benefit 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 formularies, and fraud detection) are maintained and improved where possible. Of particular note in these cost containment strategies is that the program's contract with its pharmacy benefit manager, AdvancePCS, calls for a further reduction in claim payments for outpatient prescription drugs for the 2001-03 biennium. Effective July 1, 2001, dispensing fees for pharmacies were reduced from $4.00 to $1.50 per prescription. In addition, ingredient prices for pharmacies were reduced from 90% to 85% of average wholesale price (AWP) for branded drugs and from maximum allowable charges (MAC) by the federal Health Care Financing Administration (HCFA) or 80% of AWP to 45% of AWP for generic drugs. 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 12%

annually. Total enrollment in the program is expected to increase about 3% annually over the next two years due to enrollment losses from alternative HMOs. The number of enrolled active employees is expected to show a 3% increase annually over the next two years, whereas the growth in the number of retired employees is assumed to be 5% per year. The program is expected to have an increase in the number of active employee dependents and retiree dependents of 2% per year. Investment earnings are based upon a 6% 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.

In response to the Plan's financial condition, the Plan has said it needs the following amounts for its self-insured indemnity program to remain solvent during the 2001-2003 biennium:

	($Million)	
2001-2002	2002-2003	Biennium
$382.258	$545.032	$927.290

Of these requirements, Governor Easley recommended the following amounts of additional premium income to be paid on behalf of teachers, state employees, and retired teachers and state employees:

Employer Financing ($Million)	2001-2002	2002-2003	Biennium
General Fund	$150.000	$200.000	$350.000
Highway Fund	7.000	9.000	16.000
Other Employer Funds	30.945	41.176	72.121
Total	$187.945	$250.176	$438.121

The General and Highway Fund parts of this additional premium income are included in both the House and Senate versions of the Appropriation Act for the 2001-2003 biennium. This additional premium income is equivalent to a 30% across-the-board increase in rates effective October 1, 2001. With this increase in premium financing for teachers, state employees, and retired teachers and state employees, premiums for these individuals will continue to be non-contributory. The Plan's Executive Administrator sets the premium rates for spouses and dependent children covered under the Plan by teachers, state employees, and retired teachers and state employees. A 30% across-the-board increase in these premiums effective October 1, 2001, will generate additional premium income paid by employees:

	2001-2002	2002-2003	Biennium
Employee Financing ($Million)	$49.960	$66.477	$116.437

In addition to these amounts of additional premium income for the Plan for the biennium, the Plan's Executive Administrator says he will reduce the program's payments to hospitals and physicians by the following amounts:

Reduced Provider Payments ($Million)	2001-2002	2002-2003	Biennium
Additional 20% Discount on Hospital Outpatient Charges	$19.174	$26.985	$ 46.159
Additional 3.45% Discount on Hospital Inpatient Charges	5.725	7.554	13.279
Additional 13% Discount on Charges for Non-Primary Care Physician Services	23.683	46.766	70.449
Total	$48.582	$81.305	$129.887

Even after a reduction in payments to hospitals and physicians, the program still would need additional financial support. This remaining support comes in the form of benefit reductions. Benefits in the program have not been reduced since 1991. To remain solvent, the benefit reductions would have to equal the following amounts:

	($Million)	
2001-2002	2002-2003	Biennium
$95.771	$147.074	$242.845

Changes in the benefits of the Plan's self-insured indemnity program were enacted by the General Assembly and signed into law by the Governor effective July 1, 2001.

Assumptions for the Plan's HMO Offerings: Summary data for the Plan's HMO offerings during the last 10 years shows:

	2000	1999	1998	1997	1996	1995	1994
No. of HMOs	3	11	10	12	12	7	7
No. of Counties Covered	24	66	66	90	84	73	72
Most Counties Covered by an HMO	22	39	36	62	61	56	56
Member Copayments							
Inpatient	$75	None	None	None	None	None	None
Emergency Room	$50	None	None	None	None	None	None
Office Visit	$10-$30	$10-$20	$10-$15	$10-$20	$5-$20	$10-$20	$10-$20
Prescrip. Drug	$5-$20	$5-$40	$5-$40	$5-$20	$5-$20	$5-$10	$5-$10
Monthly Premium Over Indemnity Plan							
Individual	$71-$78	$30-$61	$21-$82	$14-$62	$14-$49	$13-$44	$26-$41
Parent/Child	$135-$148	$65-$119	$46-$152	$34-$117	$33-$94	$33-$85	$43-$80
Family	$211-$229	$103-$187	$73-$237	$55-$183	$53-$201	$52-$134	$56-$126
(Non-Medicare Only)							
HMO Memb. Ages							
<30	20,932	51,043	59,945	63,877	57,965	47,445	35,793
Plan Penetration	12.8%	30.8%	35.2%	38.0%	35.1%	29.6%	22.8%
30-44	13,414	33,504	35,897	39,060	36,235	30,750	23,994
Plan Penetration	11.2%	28.0%	30.3%	32.7%	29.9%	25.2%	19.5%
45-54	9,693	24,054	24,962	26,153	23,092	18,816	14,009
Plan Penetration	8.2%	21.0%	22.6%	24.6%	22.7%	19.5%	15.2%
55-64	4,627	10,659	10,852	10,812	9,161	7,412	5,754
Plan Penetration	5.9%	14.3%	15.3%	16.3%	14.5%	12.1%	9.7%
65>	1,692	3,482	3,635	3,618	3,170	2,716	2,270
Plan Penetration	2.1%	4.5%	4.8%	5.0%	4.5%	3.9%	3.4%
Total	50,358	122,742	135,291	143,520	129,623	107,139	81,820

Plan Penetration	9.0%	22.2%	24.8%	26.9%	24.8%	21.1%	16.4%
HMO Memb. Types							
Employees	28,822	70,681	74,413	78,462	70,454	57,898	43,717
Plan Penetration	10.4%	25.8%	27.8%	29.9%	27.4%	23.0%	17.7%
Employ. Depend.	17,376	44,369	52,163	56,361	51,767	43,330	33,606
Plan Penetration	11.4%	28.7%	32.7%	35.6%	33.1%	28.3%	22.2%
Retirees	3,185	5,712	6,682	6,400	5,441	4,390	3,338
Plan Penetration	3.0%	5.6%	6.8%	6.8%	6.1%	5.1%	4.1%
Retiree Depend.	594	1,165	1,334	1,304	1,169	978	738
Plan Penetration	3.2%	6.6%	7.9%	8.2%	7.5%	6.4%	5.0%
Former Memb.	381	815	699	993	792	543	421
Plan Penetration	11.7%	22.0%	20.1%	27.3%	22.7%	16.5%	13.9%
Total	50,358	122,742	135,291	143,520	129,623	107,139	81,820
Plan Penetration	9.0%	22.2%	24.8%	26.9%	24.8%	21.1%	16.4%
HMO Contract Types							
Individual	23,223	54,059	55,100	57,538	51,777	41,134	30,705
Plan Penetration	7.9%	19.0%	20.2%	21.7%	20.1%	16.5%	12.7%
Parent/Child	6,006	14,644	16,564	17,155	14,476	13,261	10,223
Plan Penetration	13.4%	31.7%	35.1%	37.1%	32.6%	29.9%	23.7%
Family	3,026	8,182	9,864	10,767	10,126	8,247	6,373
Plan Penetration	6.2%	17.1%	20.5%	22.8%	21.6%	18.0%	14.0%
Total	32,255	76,885	81,528	85,460	76,379	62,642	47,301
Plan Penetration	8.3%	20.3%	22.2%	23.9%	21.9%	18.4%	14.3%

	1993	1992	1991
No. of HMOs	6	6	4
No. of Counties Covered	50	46	22
Most Counties Covered by an HMO	24	22	22
Member Copayments			
Inpatient	None	None	None
Emergency Room	None	None	None
Office Visit	$5-$20	$5-$20	$5-$15
Prescrip. Drug	$5-$10	$5-$10	$5-$10
Monthly Premium Over Indemnity Plan			
Individual	$24-$41	$17-$29	$8-$19
Parent/Child	$45-$81	$28-$61	$9-$40
Family	$63-$128	$36-$97	$5-$53
(Non-Medicare Only)			
HMO Memb. Ages			
<30	31,581	28,458	22,288

Plan Penetration	20.7%	19.0%	15.0%
30-44	21,773	20,301	16,258
Plan Penetration	17.6%	16.3%	12.9%
45-54	11,649	9,702	7,079
Plan Penetration	13.4%	11.9%	9.3%
55-64	4,818	4,141	3,257
Plan Penetration	8.4%	7.4%	5.9%
65>	1,977	1,644	1,302
Plan Penetration	3.1%	2.6%	2.2%
Total	71,798	64,246	50,184
Plan Penetration	14.8%	13.6%	10.8%
HMO Memb. Types			
Employees	38,324	34,784	26,903
Plan Penetration	15.9%	14.8%	11.8%
Employ. Depend.	29,663	26,499	20,945
Plan Penetration	19.9%	18.0%	14.0%
Retirees	2,781	2,212	1,680
Plan Penetration	3.5%	3.0%	2.3%
Retiree Depend.	673	523	434
Plan Penetration	4.6%	3.6%	3.0%
Former Memb.	357	228	222
Plan Penetration	12.8%	8.7%	6.7%
Total	71,798	64,246	50,184
Plan Penetration	14.8%	26.9%	10.8%
HMO Contract Types			
Individual	26,682	24,132	18,385
Plan Penetration	11.4%	10.7%	8.6%
Parent/Child	9,057	7,848	6,023
Plan Penetration	21.7%	19.3%	15.1%
Family	5,599	5,164	4,311
Plan Penetration	12.4%	11.4%	9.1%
Total	41,338	37,144	28,719
Plan Penetration	12.9%	11.9%	9.5%

This summary data is based upon statistics on December 31st of each year. For the same ten-year period, the Plan assessed HMOs a monthly administrative fee of $1.00 per contract and the following monthly risk selection fees per affected enrollee in the HMOs:

Age of Enrollee	1991-1997	1998-2000
2 and Under	None	$12.00
3-4	None	$12.00
5-19	$12.00	$12.00
20-29	$18.00	$18.00
30-39	$16.00	$16.00
40-49	$6.00	$2.00
50 and Over	None	None

The total amount of fees collected by the Plan from HMOs have been:

Year	($Million) Fees	Year	($Million) Fees
1990-1991	$3.139	1995-1996	$7.697
1991-1992	$3.477	1996-1997	$13.365
1992-1993	$4.813	1997-1998	$16.803
1993-1994	$5.778	1998-1999	$16.473
1994-1995	$6.104	1999-2000	$14.516

An additional factor expected to impact the bill is the availability of primary care physicians on a statewide basis within North Carolina. According to 1999 information provided by the Cecil G. Sheps Center for Health Services Research at the University of North Carolina at Chapel Hill, there are eight counties within the State that have less than 5 family practitioners, general practitioners, and internists. These same counties had an October, 2000, enrollment of over 7,000 members of the Plan. Another nine counties have 5 but less than 10 family practitioners, general practitioners, and internists. The Plan had another 11,000 enrollees in these counties as of October, 2000. As far as OB/Gyn physicians are concerned, twenty-eight counties within the State do not have an OB/Gyn practitioner. These counties had an enrollment of over 38,000 members in the Plan in October, 2000. Another seventeen counties in the State have one but less than three OB/Gyn physicians. The Plan had an enrollment of over 55,000 in these counties in October, 2000. Furthermore, twenty-four counties within the State do not have a pediatrician. The Plan had an enrollment of 31,000 members in these counties in October, 2000. Another sixteen counties have one but less than three pediatricians. The Plan had an enrollment of over 42,000 members in these counties in October, 2000.

Assumptions for the Plan's Counties with 10,000 Members and Medical Management Programs: In October, 2000, the Plan had the following counties with an enrollment of at least 10,000 members: Wake (64,232), Mecklenburg (27,108), Guilford (24,576), Orange (19,642), Durham (16,677), Cumberland (15,474), Pitt (15,047), Forsyth (14,660), Buncombe (12,602), Wayne (12,147), Johnston (10,971), and Burke (10,139). The medical management components of the Plan's self-insured indemnity program include mental health case management, pharmacy benefit management, case management for high risk maternity, organ transplants, extended home health, private duty nursing, extended skilled nursing facility stays, extended hospital stays, HIV, metastatic cancer, spinal cord injuries, traumatic brain injuries, and conditions with death expected within 6 months, disease management for diabetes and cardio-vascular disease, pre-admission and length-of-stay certification for hospital inpatient admissions, and prior approval of certain durable medical equipment, extended ambulance services, outpatient physical, occupational, and speech therapies, private duty nursing, skilled nursing facility stays, home care aide services, hospice care, and certain other surgical procedures.

Assumptions for the Plan's Long-Term Care Benefits Program: The Plan has since February, 1998 offered a long-term care benefits program to members of the Plan as well as to retired members of the Local Governmental Employees' Retirement System. These benefits are provided through an insurance contract with MedAmerica Insurance Company. This contract expires December 31, 2003, although the Plan can extend the contract through December 31, 2005. The Plan can cancel this contract upon 180 days notice. Benefits include the following daily amounts for nursing home or home care: $75, $100, $125, or $150. Daily benefits for assisted living facility care are $60, $80, $100, and $120. Inflation protection can be chosen for these daily amounts. Benefit periods can be for 2 years, 3 years, 5 years, or for a lifetime. Elimination periods can be for 30, 60, or 90 days. An option is also available for no elimination period. Other optional features include a return of premium death benefit, a shortened benefit period upon failure to pay premiums, and a 10-year paid in full premium. At the beginning of August, 2001, the Plan had the following coverages issued:

	Employees	Spouses	Children	Parents/G'Parents	Total
State Employees	864	214	10	66	1,154
State Retirees	1,567	453	18	10	2,048

Local Retirees	182	85	1	2	270
Total	2,613	752	29	78	3,472

The annualized premium for these coverages was $4,836,773.

Assumptions for the Plan's Confidential Expenditures: For each of the last six fiscal years, the following expenditures are representative of those that could be confidential and exempt from the State's public record laws.

($Million)

	1995-96	1996-97	1997-98	1998-99	1999-2000	2000-01
Cost Categories						
Hospital						
Inpatient Room & Board	$8.938	$7.015	$7.353	$8.092	$7.178	$8.242
Inpatient Ancillaries	$14.736	$11.443	$12.301	$13.129	$14.496	$17.203
Inpatient DRGs	$172.081	$135.536	$140.456	$143.044	$144.143	$172.532
Total Inpatient	$195.755	$153.994	$160.110	$164.265	$165.817	$197.977
Outpatient Ancillaries	$103.770	$111.346	$125.213	$146.009	$168.118	$216.646
Total Hospital	$299.525	$265.340	$285.323	$310.274	$333.935	$414.623
Medical, Surgical, Other Professional Services						
Medical	$58.161	$61.915	$67.390	$75.670	$75.139	$88.507
Surgical	$64.025	$64.961	$68.362	$77.346	$87.655	$102.612
Dental	$0.192	$0.219	$0.164	$0.159	$0.199	$0.156
Anesthesia	$11.906	$11.479	$11.219	$11.544	$15.196	$16.335
Pathology	$4.282	$4.485	$5.135	$5.768	$6.783	$8.253
Radiology	$19.363	$20.856	$22.812	$27.487	$34.267	$42.776
Laboratory	$21.374	$23.150	$26.664	$30.596	$37.317	$45.999
Chemotherapy	$2.553	$3.325	$3.504	$4.396	$5.092	$5.899
Inhalation Therapy	$0.038	$0.046	$0.051	$0.071	$0.096	$0.135
Radiation Therapy	$2.976	$3.043	$3.255	$4.369	$5.077	$5.681
Physical Therapy	$0.000	$0.000	$0.000	$1.093	$6.087	$7.648
Speech Therapy	$0.082	$0.071	$0.096	$0.109	$0.146	$0.207
Cardiac Rehabilitation	$0.009	$0.003	$0.000	$0.001	$0.000	$0.000
Chemical Dependency	$0.507	$0.397	$0.379	$0.388	$0.373	$0.398
Diabetes Education	$0.008	$0.010	$0.008	$0.009	$0.007	$0.000
Chiropractic	$5.504	$6.323	$7.012	$7.203	$8.731	$10.719
Podiatry	$0.844	$0.834	$0.973	$1.056	$1.156	$1.410
Other	$4.963	$15.053	$15.792	$15.709	$13.738	$15.451
Total Services	$196.787	$216.170	$232.816	$262.974	$297.059	$352.186
Outpatient Prescription Drugs	$69.626	$77.711	$91.793	$115.001	$172.714	$260.195
Skilled Nursing Facilities	$11.043	$12.418	$12.213	$12.346	$11.069	$9.872
Home Health	$5.972	$5.754	$5.194	$3.592	$3.465	$2.894
Hospice	$0.747	$0.629	$0.571	$0.639	$0.728	$0.872
Private Duty Nursing	$2.082	$1.883	$1.967	$1.839	$1.517	$1.825
Medical Equipment & Supplies	$0.868	$0.938	$0.910	$1.114	$1.102	$1.237
Ambulance Service	$0.051	$0.056	$0.059	$0.025	$0.034	$0.023
Other	$1.983	$5.243	$20.256	$10.734	$6.872	$28.703
TOTAL GROSS CLAIMS	$588.684	$586.142	$651.102	$718.538	$828.495	$1,072.430

Assumptions for the Plan's Use of Clinical Pharmacist Practitioners: According to the Board of Pharmacy, 9 pharmacists have been approved as clinical pharmacist practitioners to date in North Carolina. These pharmacists reside in the following counties: Guilford (4), Buncombe (2), Orange (2), and Rockingham (1).

Assumptions for the Plan's Potential Enrollment for Optional Benefits and Reduced Premiums: The estimated number of employee and child(ren) and employee and family contracts by employee income for the Plan's active employee group as of December 31, 2000, shows:

	Indemnity Program	HMOs	Total
Employee & Child(ren)-Tot.	36,756	5,871	42,627
Earnings less than $29,000	13,915	2,266	16,181
Earnings of $29,000-$35,000	5,562	906	6,468
Earnings of $35,000-$40,000	4,162	678	4,840
Earnings of $40,000-$44,000	4,015	654	4,669
Earnings of $44,000-$50,000	4,089	666	4,755
Earnings over $50,000	5,013	701	5,830
Employee & Family-Tot.	31,945	2,653	34,598
Earnings less than $29,000	10,145	883	11,028
Earnings of $29,000-$35,000	3,716	324	4,040
Earnings of $35,000-$40,000	3,099	270	3,369
Earnings of $40,000-$44,000	3,416	298	3,714
Earnings of $44,000-$50,000	3,667	319	3,986
Earnings over $50,000	7,902	559	8,461

Assumptions for the Plan's Limited Coverage of Erectile Dysfunction Drugs: For the period January through November, 2000, the claims experience for erectile dysfunction outpatient prescription drugs for the Plan's self-insured indemnity program was:

Drug Name	No. of Members	No. of Prescriptions	No. of Pills
Caverject	187	420	2,815
Edex	1	2	12
Edex Cartridge Starter Pack	5	10	29
Edex Patient Pack	20	42	269
Muse	188	354	2,387
Viagra	9,399	27,450	322,815
Total	9,800	28,278	328,327
Average Charge		$107.86	$9.29
Average Allowed Charge		$100.28	$8.64
Average Paid		$84.80	$7.30

For the period January, 1999, through June, 2000, approximately 81% of the number of members of the self-insured indemnity program receiving Viagra pills received 54 or fewer for the 18 month period. However, the remaining 19% accounted for 56% of the total number of pills received.

SOURCES OF DATA:
-Actuarial Note, Hartman & Associates, Senate Committee Substitute for Senate Bill 822, September 14, 2001, original of which is on file in the General Assembly's Fiscal Research Division.
-Actuarial Note, Aon Consulting, Senate Committee Substitute for Senate Bill 822, September 14, 2001, 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: James D. Johnson



DATE: September 17, 2001

VISITOR REGISTRATION SHEET

HEALTH — 12-04-01

Name of Committee — Date

VISITORS:. PLEASE SIGN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Howard Swann	Officer - Raleigh NC
Bill Scoggin	Kennedy Cov. Nestod
Kenwood Jones	NCHA
Ann Lucas	OUHS
Suzanne Ivey	NCCCS
Charles Case	Hunton & Williams
Frank Lewis	OSBM
Leigh H Hammond	NC Retired Govt Employees Assn
Lucy Presnell	NC Retired School Pens
J.C. Dawson	" " "
Joseph Sanson	TREAS
Clifton B. Metcalf	UNC
Marshall Bowers	Dept of State Treasurer
Michael Williamson	"
Ronnie Condrey	DOT
Sherri Preddy	SEANC
Connie Norwick	SEANC
Hayley Kaplan	FCC
John Dyer	NCASA
Peggy Mahan	
Ken Melton	Allen Associates, Inc.
Beckie Street	PPAB
Molly Freeman	NCAE
Jeri Cahoon	NCAE
Anne Wilson	ASA
Audrey A. Galloway	NCAE
Glenda Wells	DHHS

AGENDA

HOUSE COMMITTEE ON HEALTH
Thursday, December 6, 2001
11:30am , ROOM 415 LB

OPENING REMARKS

Rep. Thomas E. Wright
Chairman

BILLS TO BE DISCUSSED

SB-772-Enteral Sedation/Dentist Permits.

COMMENTS

ADJOURNMENT

Minutes

House Health Committee

Thursday, December 6, 2001

11:30am ROOM 415 LOB

The House Health Committee met on Thursday, December 6, 2001 at 11:30am in Room 415 LOB. A silent roll was taken (roll list denotes members present).

Chairman Wright called the meeting to order.

SB-772 ENTERAL SEDATION/DENTIST PERMITS. (Sen. Wellons)

Chairman Wright recognized Linda Attarian, Staff, for an explanation of the bill. Linda Attarian explained the bill. William Potter, NC Dental Society, commented on the bill. Rep. Nye asked Rep. Edwards about his comments on the bill. Rep. Edwards responded.

Rep. Nye moved to give SB-772 a favorable report. So moved.

The meeting adjourned at 11:45am .

Rep. Thomas E. Wright, Chairman

Vanda Wilson-Wormack, Committee Assistant

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2001

S 1

SENATE BILL 772

Short Title:	Enteral Sedation/Dentist Permits.	(Public)
Sponsors:	Senators Wellons; Forrester, Purcell, and Rucho.	
Referred to:	Health Care.	

April 2, 2001

A BILL TO BE ENTITLED

AN ACT AUTHORIZING THE NORTH CAROLINA BOARD OF DENTAL EXAMINERS TO ESTABLISH REGULATORY STANDARDS FOR THE ADMINISTRATION AND MONITORING OF ENTERAL SEDATION FOR OUTPATIENTS IN THE DENTAL SETTING IN ADDITION TO EXISTING STANDARDS FOR GENERAL ANESTHESIA AND PARENTERAL SEDATION.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 90-30.1 reads as rewritten:

"**§ 90-30.1. Standards for general anesthesia and enteral and parenteral sedation; fees authorized.**

The North Carolina Board of Dental Examiners may establish by regulation reasonable education, training, and equipment standards for safe administration and monitoring of general anesthesia and enteral and parenteral sedation for outpatients in the dental setting. Regulatory standards may include a permit process for general anesthesia and enteral and parenteral sedation by dentists. The requirements of any permit process adopted under the authority of this section ~~must~~shall include provisions that will allow a dentist to qualify for continued use of ~~general anesthesia,~~enteral sedation, if he or she is licensed to practice dentistry in North Carolina and shows the Board that he or she has been utilizing ~~general anesthesia~~enteral sedation in a competent manner for the five years preceding ~~July 1, 1988,~~January 1, 2002, and his or her office facilities pass an on-site examination and inspection by qualified representatives of the Board. For purposes of this section, oral premedication administered for minimal sedation (anxiolysis) shall not be included in the definition of enteral sedation. In order to provide the means of regulating general anesthesia and enteral and parenteral sedation, including examination and inspection of dental offices involved, the Board may charge and collect fees established by its rules for each permit application, each

annual permit renewal, and each office inspection in an amount not to exceed the maximum fee amounts set forth in G.S. 90-39."

SECTION 2. This act becomes effective January 1, 2002.

SENATE BILL 772:
Enteral Sedation/Dentist Permits

BILL ANALYSIS

Committee:	House Health Care	**Introduced by:**	Sen. Wellons
Date:	December 6, 2001	**Summary by:**	Linda Attarian
Version:	Introduced		Committee Counsel

SUMMARY: ***Senate Bill 772, if enacted, would expand the NC Dental Board's to regulate the administration and monitoring of the use of general anesthesia in an outpatient office setting to allow the Board to regulate the administration of enteral sedation medications. The scope of the current statute is limited to sedation medication administered by inhalants or into the blood through a vein. "Enteral sedation" includes medications absorbed through the intestinal tract. The bill would become effective January 1, 2002***

CURRENT LAW: G.S. 90-30.1 authorizes the Board to adopt standards for the safe administration and monitoring of general anesthesia and parenteral (inter-veinous) sedation in an outpatient dental setting. The Board's rules generally provide for the credentialing and educational requirements necessary for a dentist to administer general anesthesia in the outpatient practice setting. The Board may conduct onsite inspections to monitor the practice.

BILL ANALYSIS: Section 1 amends G.S. 90-30.1 to add "enteral sedation" to the types of administration of general anesthesia that fall within the Board's authority to regulate. The section also clarifies that the Board's authority under this statute does not extend to oral premedication administered for minimal sedation.

Section 2 makes the act effective January 1, 2002.

BACKGROUND:

Parenteral (pah REN ter ul) -- medication given into the blood with a needle through a vein.

Enteral (EN ter al) --medication absorbed through the intestinal tract.

2001 COMMITTEE REPORT
HOUSE OF REPRESENTATIVES

The following report(s) from standing committee(s) is/are presented:
By Representative(s) **Wright** (Chair/Chairs) for the Committee on **Health.**

☐ Committee Substitute for
S.B. 772 A BILL TO BE ENTITLED AN ACT AUTHORIZING THE NORTH CAROLINA BOARD OF DENTAL EXAMINERS TO ESTABLISH REGULATORY STANDARDS FOR THE ADMINISTRATION AND MONITORING OF ENTERAL SEDATION FOR OUTPATIENTS IN THE DENTAL SETTING IN addition TO EXISTING STANDARDS FOR GENERAL ANESTHESIA AND PARENTERAL SEDATION.

☒ 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)

2/15/01

VISITOR REGISTRATION SHEET

Health
Name of Committee

12/06/01
Date

VISITORS:. PLEASE SIGN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Suzanne Wynn	NCCCS
Bill Brooks	NCFPC
Stan Flannery	NCHCFA
Amy Jo Baum	NCMS
Linda Porter	Bone & Associates
[illegible]	NCAHP
Penelope Hawthorne	UNC Chapel Hill
Addis Watkins	SEANC
Ken McHan	Alley Associates, Inc.
Gary Robertson	AP
[illegible]	NC Family Policy Council
[illegible]	NCFPC
Margaret Westbrook	Kennedy Covington
Jessie Ramquist	NC DHHS

2002

HOUSE
HEALTH

MINUTES

HOUSE COMMITTEE ON HEALTH

2002 SESSION, BOOK 1 OF 1

Rep. Thomas E. Wright
Chair

Vanda Wilson-Wormack
Committee Assistant

HOUSE HEALTH COMMITTEE
2002 SESSION

MEMBER	ASSISTANT	PHONE	OFFICE	SEAT
Wright, Thomas **Chairman**	Vanda Wilson-Wormack **Committee Assistant**	733-5754	528 LOB	5
Edwards, Zeno **Vice-Chairman**	Jo Hinton	733-5906	637 LOB	3
Allred, Cary	Jean Allread	733-5607	609 LOB	26
Barnhart, Jeff	Melanie McNeely	733-5934	1104 LB	118
Buchanan, Charles	Glenda Jones	733-5824	536 LOB	30
Brubaker, Harold	Cindy Coley	715-4946	1229 LB	39
Clary, Debbie	Elena Askey	733-5624	1211 LB	110
Crawford, James	Linda Winstead	733-5824	1301 LB	24
Earle, Beverly	Ann Raeford	733-5754	535 LOB	95
Howard, Julia	Gail Stewart	733-5904	1023 LB	104
Hunter, Howard	Barbara Phillips	733-2962	613 LOB	68
Insko, Verla	Linda McCrodden	733-5775	1323 LB	70
Justus, Larry	Carolyn Justus	733-5956	640 LOB	13
Nye, Edd	Jo Bobbitt	733-5477	639 LOB	1
Rogers, Gene	Sally Gillis	715-3023	416A LOB	35
Sherrill, Wilma	Rosa Kelley	715-4466	602 LB	37
Wainwright, William	Blinda Edwards	715-3001	420 LOB	8
Linda Attarian Staff Counsel		733-2578		
Dianna Jessup Staff Counsel		733-2578		

NORTH CAROLINA GENERAL ASSEMBLY

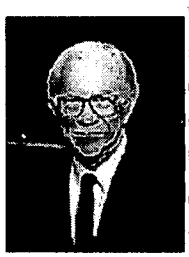
HOUSE HEALTH COMMITTEE
2001 – 2002 SESSION



Rep. Wright
Chair



Rep. Edwards
Vice-Chair



Rep. Allred



Rep. Barnhart



Rep. Brubaker



Rep. Buchanan



Rep. Clary



Rep. Crawford



Rep. Earle



Rep. Howard



Rep. Hunter



Rep. Insko



Rep. Justus



Rep. Nye



Rep. Rogers



Rep. Sherrill



Rep. Wainwright

Bill	Introducer	Short Title		Latest Action	In Date	Out Date
H0109=	Alexander	REIMBURSEMENT FOR MARRIAGE/FAMILY THERAPISTS.	HR	Ch. SL 2001-258	02-20-01	03-20-01
H0162=	Insko	RATE SETTING/ADULT DAY CARE.	*H	Re-ref Com On Appropriations/ Base Budget	02-19-01	03-14-01
H0204=	Nesbitt	NC HEALTH CHOICE/NO WAITING PERIOD.	*HF	Postponed Indefinitely	02-22-01	03-20-01
H0216=	Warren	MEDICAID DRAFT PLAN AMEND/ADULT DAY HEALTH.	*H	Ref To Com On Health Care	02-22-01	03-28-01
H0226	Culpepper	ALLOW PHARMACY BOARD TO ACQUIRE PROPERTY.	*HR	Ch. SL 2001-407	02-26-01	04-04-01
$ H0245=	**Earle**	**ADULT CARE HOME ASSESSMENT.**	**H**	**Re-ref Com On Health**	**02-26-01**	**03-13-01**
$ H0245=	**Earle**	**ADULT CARE HOME ASSESSMENT.**	**H**	**Re-ref Com On Health**	**03-28-01**	
H0275=	Haire	INFANT HOMICIDE PREVENTION ACT.	*HR	Ch. SL 2001-291	03-27-01	04-19-01
$ H0317=	**Hunter**	**MEDICAID COUNTY SHARE/ FUNDS-2.**	**HF**	**Postponed Indefinitely**	**02-28-01**	**04-24-01**
H0329=	Warren	ADULT DAY CARE TRANSPORTATION	HR	Ch. SL 2001-90	03-01-01	03-13-01
H0437=	Tolson	DELIVERY OF DEVICES/ MEDICAL EQUIPMENT.	*HR	Ch. SL 2001-339	03-01-01	04-04-01
H0452	Wright	EMERGENCY MEDICAL SERVICES ACT UPDATE.	*HR	Ch. SL 2001-220	03-01-01	04-16-01
H0453	Wright	REGULATION OF EMERGENCY MEDICAL SERVICES.	*HR	Ch. SL 2001-210	03-01-01	04-16-01
/736=	Earle	LONG-TERM CARE/POST STAFFING.	*HR	Ch. SL 2001-85	03-22-01	04-16-01
H0896	Hensley	DATABASE/CONTROLLED SUBSTANCES.	H	Ref To Com On Health	03-29-01	
H0934	Nye	C.O.N.-ADULT CARE HOMES REGULATED.	H	Ref To Com On Health	03-29-01	
H0936=	Wright	ENTERAL SEDATION/ DENTIST PERMITS.	H	Ref To Com On Health	03-29-01	
$ H0950	**Wright**	**RAISE AIDS DRUG ASSISTANCE PROGRAM INCOME LIMIT.**	**HF**	**Postponed Indefinitely**	**04-03-01**	**04-05-01**
H0958	Cansler	COST REPORTS-SPECIAL CARE UNITS.	*HR	Ch. SL 2001-157	04-03-01	04-05-01
H0994	Earle	TRAUMATIC BRAIN INJURY MEDICAID WAIVER.	HF	Postponed Indefinitely	04-05-01	04-24-01
H0996	Earle	ELEC. MONITORING IN NURSING/ADULT CARE HOMES.	H	Ref To Com On Health	04-05-01	
H1001	Wright	HOSPITAL LICENSURE/ CRITICAL ACCESS HOSPITAL.	H	Ref To Com On Health Care	04-09-01	04-19-01
H1002	Wright	HOSPITAL GOVERNING AUTHORITY.	H	Ref To Com On Judiciary I	04-09-01	04-17-01
H1030	Clary	MENTAL HEALTH SVCES/ MEDICAID BILLING.	*H	Ref To Com On Health Care	04-09-01	04-24-01

'$' indicates the bill is an appropriation bill.
A bold line indicates the bill is an appropriation bill.
'*' indicates that the text of the original bill was changed by some action.
'=' indicates that the original bill is identical to another bill.

Bill	Introducer	Short Title		Latest Action	In Date	Out Date
H1038=	Capps	NO ABORTIONS UNDER STATE HEALTH PLAN.	HF	Postponed Indefinitely	04-10-01	10-02-02
H1068	Nye	LONG-TERM CARE FACIL./ QUALITY OF CARE.	*HR	Ch. SL 2001-385	04-11-01	04-23-01
H1091	Hill	NATUROPATHIC PHYSICIANS.	H	Ref To Com On Health	04-11-01	
H1109	Nye	MANAGED CARE/PATIENT ACCESS.	*H	Ref To Com On Health Care	04-12-01	04-24-01
H1147	Insko	HOSPITAL TEMPORARY BED INCREASES.	*HR	Ch. SL 2001-410	04-12-01	04-23-01
H1220	Holliman	COMMUNITY RESIDENCES/ PEOPLE WITH DISABILITY.	H	Ref To Com On Health	04-12-01	
H1222	Nesbitt	REGULATE NURSE PRACTITIONERS/NURSE MIDWIVES.	H	Ref To Com On Health	04-12-01	
H1232	Redwine	PRESCRIPTION DRUG ASSISTANCE FOR SENIORS.	*H	Re-ref Com On Appropriations/ Base Budget	04-12-01	04-24-01
H1238	Luebke	MEDICAID WAIVER/ PRESCRIPTION DRUGS.	HF	Postponed Indefinitely	04-12-01	04-19-01
H1239	Luebke	PHARMACISTS/LIMIT PRESCRIPTIONS DISPENSED.	H	Ref To Com On Health	04-12-01	
H1254	Pope	C.O.N. MODIFICATIONS.	H	Ref To Com On Health	04-12-01	
H1259	Davis	ABORTION CLINIC REQUIREMENTS.	HF	Postponed Indefinitely	04-12-01	10-02-02
H1280	Carpenter	ABORTION - WOMAN'S RIGHT TO KNOW.	HF	Postponed Indefinitely	04-12-01	10-02-02
H1306	Gibson	IMMUNITY/HONORING PORTABLE DNR ORDER.	H	Ref To Com On Health	04-12-01	
H1316	Morris	REQUIRE NOTIFICATION TO TREAT MINORS.	H	Ref To Com On Health	04-12-01	
H1335	Wilson, C	C.O.N.-LICENSING PROCEDURES.	HF	Postponed Indefinitely	04-12-01	10-02-02
H1362	Fox	ADVANCE HEALTH CARE DIRECTIVES REGISTRY.	*HR	Ch. SL 2001-455	04-23-01	05-30-01
$ H1405	**Wright**	**HIV/AIDS PUBLIC HEALTH CRISIS.**	**HF**	**Postponed Indefinitely**	**04-26-01**	**06-19-01**
H1449		VETERINARY PRACTICE ACT/FEES.	H	Ref to the Com on Health and, if favorable, to the Com on Finance	05-10-01	
H1514=		DHHS RULES COORDINATION.	H	Ref To Com On Health	06-04-02	
$ H1636=		**CARE FOR SCHOOL CHILDREN WITH DIABETES ACT.**	**H**	**Re-ref Com On Health**	**07-30-02**	
H1682		STATE HEALTH PLAN/ POOL PURCHASE OF DRUGS.	H	Ref To Com On Health	06-13-02	
H1719		STATE EMPLOYEES' HEALTH PLAN/PRESC. DRUGS.	H	Ref To Com On Health	06-13-02	
S0118	James Forrester	MEDICAL TREATMENT BY	*HR	Ch. SL 2001-27	03-15-01	03-28-01

'$' indicates the bill is an appropriation bill.
A bold line indicates the bill is an appropriation bill.
'*' indicates that the text of the original bill was changed by some action.
'=' indicates that the original bill is identical to another bill.

Bill	Introducer	Short Title		Latest Action	In Date	Out Date
		INTERNET/TOLL-FREE NUMBER.				
S0160	William R. Purce	AMEND GOOD SAMARITAN LAW/MEDICAL CARE.	*HR	Ch. SL 2001-230	04-30-01	06-05-01
S0199=	Allen H. Wellons	MANAGED CARE PATIENTS' BILL OF RIGHTS.	*HR	Ch. SL 2001-446	07-26-01	08-16-01
S0390	James Forrester	PHYSICIAN-ASSISTED SUICIDE/EDUCATION & CRIME.	*H	Re-ref Com On Judiciary I	04-26-01	05-24-01
S0463	William R. Purce	AMEND NURSING PRACTICE ACT.	*HR	Ch. SL 2001-98	04-12-01	05-08-01
S0542	Virginia Foxx	DATABASE ON PSYCHOTROPIC MEDS/ CHILDREN.	*HR	Ch. SL 2001-124	04-04-01	05-09-01
S0543	James Forrester	CONTROLLED SUBSTANCES/ CLASSIF.	*HR	Ch. SL 2001-233	04-25-01	06-05-01
S0703	William R. Purce	IMMUNITY/HONORING PORTABLE DNR ORDER.	*HR	Ch. SL 2001-445	04-26-01	09-26-01
S0714	Tony Rand	AMEND CERTIFICATE OF NEED.	*HR	Ch. SL 2001-242	04-11-01	06-05-01
S0721=	William R. Purce	OCCUPATIONAL LICENSING FEES & PER DIEM CHANGES.	*HR	Ch. SL 2001-493	04-26-01	10-22-01
S0749	David W. Hoyle	NURSING HOME ADMINISTRATOR ACT.	HR	Ch. SL 2001-153	04-17-01	05-16-01
S0772=	Allen H. Wellons	ENTERAL SEDATION/ DENTIST PERMITS.	HR	Ch. SL 2001-511	04-17-01	09-26-01
S0772=	Allen H. Wellons	ENTERAL SEDATION/ DENTIST PERMITS.	HR	Ch. SL 2001-511	10-02-01	12-06-01
S0822	Tony Rand	STATE SELF-FUNDED HEALTH CARE PLAN.	*H	Re-ref Com On Appropriations	09-27-01	12-06-01
S0824	Tony Rand	TEACHERS' AND STATE EMPLOYEES' BENEFITS.	*HR	Ch. SL 2001-253	06-21-01	06-26-01
S0826	Tony Rand	CRIMINAL RECORD CHECK CHANGE/LONG-TERM CARE.	*HR	Ch. SL 2001-465	04-25-01	07-10-01
S0861=	William R. Purce	LICENSE BY CREDENTIALS/DENTISTRY.	*HR	Ch. SL 2002-37	08-23-01	06-19-02
S0907	Howard N. Lee	ORGAN, EYE, AND TISSUE DONOR REGISTRY	*HR	Ch. SL 2001-481	10-18-01	10-25-01
S0911	Tony Rand	CARE FOR SCHOOL CHILDREN WITH DIABETES ACT.	*HR	Ch. SL 2002-103	04-25-01	08-21-02
S0937	William R. Purce	C.O.N.-ADULT CARE HOMES REGULATED.	*HR	Ch. SL 2001-234	04-26-01	05-30-01
S0938	Virginia Foxx	STUDY DATE RAPE DRUG ANALOGUES.	*HF	Postponed Indefinitely	04-30-01	05-30-01
S1075	Robert A. Rucho	AMEND UNIFORM ANAT. GIFT ACT.	*HR	Ch. SL 2001-255	04-24-01	06-07-01

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ATTENDANCE

House Health Committee

2002 Session

(Name of Committee)

DATES	6-18-02	8-20-02	10-2-02												
Wright, Thomas, **Chairman**	✓	✓													
Edwards, Zeno, **Vice-Chair**	✓	✓													
Allred, Cary	✓	✓													
Barnhart, Jeff	✓														
Buchanan, Charles	✓	✓													
Brubaker, Harold	✓	✓													
Clary, Debbie	✓														
Crawford, James	✓	✓													
Earle, Beverly	✓	✓													
Howard, Julia	✓	✓													
Hunter, Howard															
Insko, Verla	✓	✓													
Justus, Larry	✓	✓													
Nye, Edd	✓	✓													
Rogers, Eugene	✓	✓													
Sherrill, Wilma	✓	✓													
Wainwright, William		✓													
Ex-Officio Members															
Hackney, Joe															
Baddour, Phillip															
Dedmon, Andrew															
Earle, Beverly															
Cunningham, Pete															

Chamber
House
In
Met

AGENDA

HOUSE COMMITTEE ON HEALTH
TUESDAY, JUNE 18, 2002
12:00 NOON , ROOM 415 LB

OPENING REMARKS

Rep. Thomas E. Wright
Chairman

BILLS TO BE DISCUSSED

HB-1514 DHHS RULES COORDINATION. (Rep. Alexander & Rep. Insko)

SB-861 LICENSE BY CREDENTIALS/DENTISTRY. (Sen. Purcell)

COMMENTS

ADJOURNMENT

MINUTES

COMMITTEE ON HEALTH

TUESDAY, JUNE 18, 2002

ROOM 415 LOB, 12:00 NOON

The House Committee on Health met on Tuesday, June 18, 2002 in Room 415 LOB at 12:00 Noon. A silent roll was taken, (roll list denotes members present).

SB-861 LICENSE BY CREDENTIALS/DENTISTRY. (Sen. Purcell)

Sen. Purcell explained the original bill to the committee.

Rep. Rogers moved for the adoption of the House Proposed Committee Substitute of SB-861. So moved.

Vice-Chairman Edwards introduced Chairman Wright to explain the committee substitute. Linda Attarian, Staff, further explained the bill. Chairman Wright commented that the bill would need to be re-referred to the Finance Committee. Rep. Justus asked if all interested parties had signed off on the bill. Chairman Wright responded.

Rep. Justus moved for a favorable report to the House Proposed Committee Substitute, unfavorable to the original bill, and that the bill be re-referred to the Committee on Finance.

Rep. Earle asked about the Legislative Study of the bill. Linda Attarian, Staff, responded. Chairman Wright further responded. Rep. Howard asked about the national examination versus the state examination. Vice-Chairman Edwards responded. William Potter, of the NC Dental Society, responded to the question. Rep. Buchanan asked about the military trained dentist and their credentials. Vice-Chairman Edwards responded.

Vice-Chairman Edwards called the question. The proposed committee substitute passed.

The meeting adjourned at 12:40pm.

Rep. Thomas E. Wright, Chairman

Vanda Wilson-Wormack, Committee Assistant

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2001

S 4

SENATE BILL 861*

Health Care Committee Substitute Adopted 6/11/01
Finance Committee Substitute Adopted 8/14/01
Fourth Edition Engrossed 8/21/01

Short Title: License by Credentials/Dentistry. (Public)

Sponsors:

Referred to:

April 4, 2001

A BILL TO BE ENTITLED

AN ACT TO INCREASE THE NUMBER OF QUALIFIED DENTAL PRACTITIONERS IN THE STATE BY AUTHORIZING THE BOARD OF DENTAL EXAMINERS TO LICENSE BY CREDENTIALS PERSONS WHO ARE LICENSED TO PRACTICE DENTISTRY OR DENTAL HYGIENE IN OTHER STATES AND WHO OTHERWISE MEET STATE REQUIREMENTS FOR LICENSE BY CREDENTIALS, TO LICENSE BY EXAMINATION PERSONS WHO HAVE PRACTICED AS DENTAL HYGIENISTS IN THE UNITED STATES MILITARY AND WHO OTHERWISE MEET STATE REQUIREMENTS FOR LICENSURE BY EXAMINATION, TO ISSUE A LIMITED VOLUNTEER DENTAL LICENSE, TO ISSUE AN INSTRUCTOR'S LICENSE, AND TO IMPOSE APPLICATION AND RENEWAL FEES FOR LICENSURE AUTHORIZED UNDER THIS ACT, AND BY AUTHORIZING STUDIES PERTAINING TO CLASS ENROLLMENT AT THE UNC SCHOOL OF DENTISTRY AND TO THE FEASIBILITY OF ESTABLISHING AN ADDITIONAL DENTAL SCHOOL.

The General Assembly of North Carolina enacts:

SECTION 1. Article 14 of Chapter 130A of the General Statutes is amended by adding the following new section to read:

"**§ 130A-367. Dental providers for problem access areas.**

The State's dental public health program shall encourage the expansion of current educational and training programs for dentists, dental hygienists, and dental assistants targeted to serve citizens' unmet needs, particularly in the rural and low-income areas that have traditionally had problems in accessing dental care. The program shall also promote and encourage the recruitment of in-State and out-of-state private sector dental personnel to work in these dental health professional shortage areas."

SECTION 2. G.S. 90-36 reads as rewritten:

"**§ 90-36. Licensing practitioners of other states.**

~~The North Carolina State Board of Dental Examiners may, in its discretion, issue a license to practice dentistry in this State without an examination other than clinical to a legal and ethical practitioner of dentistry who moves into North Carolina from another state or territory of the United States, whose standard of requirements is equal to that of the State of North Carolina and in which such applicant has conducted a legal and ethical practice of dentistry for at least five years, next preceding his or her removal and who has not, during his period of practice, been found guilty by the state regulatory agency charged with the responsibility therefor of the violation of the ethics of his profession, nor found guilty by a court of competent jurisdiction of the violation of the laws of the state which issued license to him or of the criminal laws of the United States, nor whose license to practice dentistry has been revoked or suspended by a duly constituted authority.~~

~~Application for license to be issued under the provisions of this section shall be accompanied by a certificate from the dental board or like board of the state from which said applicant removed, certifying that the applicant is the legal holder of a license to practice dentistry in that state, and for a period of five years immediately preceding the application has engaged in the practice of dentistry; is of good moral character and that during the period of his practice no charges have been filed with said board against the applicant for the violation of the laws of the state or of the United States, or for the violation of the ethics of the profession of dentistry.~~

~~Application for a license under this section shall be made to the North Carolina State Board of Dental Examiners within the six months of the date of the issuance of the certificate hereinbefore required, and said certificate shall be accompanied by the diploma or other evidence of the graduation from a reputable, recognized and approved dental college, school or dental department of a college or university.~~

~~Any license issued upon the application of any dentist from any other state or territory shall be subject to all of the provisions of this Article with reference to the license issued by the North Carolina State Board of Dental Examiners upon examination of applicants and the rights and privileges to practice the profession of dentistry under any license so issued shall be subject to the same duties, obligations, restrictions and the conditions as imposed by this Article on dentists originally examined by the North Carolina State Board of Dental Examiners.~~

(a) The North Carolina State Board of Dental Examiners may issue a license by credentials to an applicant who has been licensed to practice dentistry in any state or territory of the United States if the applicant produces satisfactory evidence to the Board that the applicant has the required education, training, and qualifications, is in good standing with the licensing jurisdiction, has passed satisfactory examinations of proficiency in the knowledge and practice of dentistry as determined by the Board, and meets all other requirements of this section and rules adopted by the Board. The Board may conduct examinations and interviews to test the qualifications of the applicant and may require additional information that would affect the applicant's ability to render

competent dental care. The Board may, in its discretion, refuse to issue a license by credentials to an applicant who the Board determines is unfit to practice dentistry.

(b) The applicant for licensure by credentials shall be of good moral character and shall have graduated from and have a DDS or DMD degree from a program of dentistry in a school or college accredited by the Commission on Dental Accreditation of the American Dental Association and approved by the Board.

(c) The applicant must meet all of the following conditions:

(1) Has been actively practicing dentistry, as defined in G.S. 90-29(b)(1) through (b)(9), for a minimum of five years immediately preceding the date of application.

(2) Has not been the subject of final or pending disciplinary action in the military, in any state or territory in which the applicant is or has ever been licensed to practice dentistry, or in any state or territory in which the applicant has held any other professional license.

(3) Presents evidence that the applicant has no felony convictions and that the applicant has no other criminal convictions that would affect the applicant's ability to render competent dental care.

(4) Has not failed an examination conducted by the North Carolina State Board of Dental Examiners.

(d) The applicant for licensure by credentials shall submit an application to the North Carolina State Board of Dental Examiners, the form of which shall be determined by the Board, pay the fee required by G.S. 90-39, successfully complete examinations in Jurisprudence and Sterilization and Infection Control, and meet the criteria or requirements established by the Board.

(e) The holder of a license issued under this section shall establish a practice location and actively practice dentistry, as defined in G.S. 90-29(b)(1) through (b)(9), in North Carolina within one year from the date the license is issued. The license issued under this section shall be void upon a finding by the Board that the licensee fails to limit the licensee's practice to North Carolina or that the licensee no longer actively practices dentistry in North Carolina.

(f) The Board may adopt temporary rules in accordance with G.S. 150B-21.1(a8) to implement this section."

SECTION 3. Article 16 of Chapter 90 of the General Statutes is amended by adding a new section to read:

"**§ 90-224.1. Licensure by credentials.**

(a) The Board may issue a license by credentials to an applicant who has been licensed to practice dental hygiene in any state or territory of the United States if the applicant produces satisfactory evidence to the Board that the applicant has the required education, training, and qualifications; is in good standing with the licensing jurisdiction; has passed the National Board Dental Hygiene Examination administered by the Joint Commission on National Dental Examinations; has passed satisfactory examinations of proficiency in the knowledge and practice of dental hygiene as

determined by the Board; and meets all other requirements of this section and rules adopted by the Board. The Board may, in its discretion, refuse to issue a license by credentials to an applicant who the Board determines is unfit to practice dental hygiene.

(b) The applicant for licensure shall be of good moral character, have graduated from an accredited high school or hold a high school equivalency certificate duly issued by a governmental agency or authorized unit, and have satisfactorily completed dental hygiene education and training, as required by a United States state- or territory-controlled program, which has been approved by the Board.

(c) The applicant must meet all of the following conditions:

(1) Has been actively practicing dental hygiene, as defined in G.S. 90-221, under the supervision of a licensed dentist for a minimum of two years immediately preceding the date of application.

(2) Has no history of disciplinary action or pending disciplinary action in the military or in any state or territory in which the applicant is or has ever been licensed.

(3) Has no felony convictions and has no other criminal convictions that would affect the applicant's ability to render competent dental hygiene care.

(4) Has not failed a licensure examination administered by the North Carolina State Board of Dental Examiners.

(d) The applicant for licensure by credentials shall submit an application, the form of which shall be determined by the Board, pay the fee required by G.S. 90-232, successfully complete examinations in Jurisprudence and Sterilization and Infection Control, and meet other criteria or requirements established by the Board, which may include an examination or interview before the Board or its authorized agents.

(e) This section shall not be construed to include licensure by reciprocity, which is prohibited.

(f) The Board may adopt temporary rules in accordance with G.S. 150B-21.1(a8) to implement this section."

SECTION 4. G.S. 90-224 reads as rewritten:

"**§ 90-224. Licensure by~~Examination~~ examination.**

(a) The applicant for licensure by examination ~~must~~ shall meet all of the following conditions:

(1) ~~be~~ Be of good moral ~~character,~~ character;

(2) ~~have~~ Be a ~~graduated from~~ graduate of an accredited high school or hold a high school equivalency certificate duly issued by a governmental agency or unit authorized to issue the ~~same, and~~ certificate.

(3) ~~be~~ Be either a graduate of a program of dental hygiene in a school or college approved by the ~~Board.~~ Board, or have satisfactorily completed the dental hygiene education and training prescribed by the United States military service and have practiced dental hygiene in the

military service for a minimum of five years and be in good standing with the military service as a dental hygienist.

(4) Has passed the National Board Dental Hygiene Examination administered by the Joint Commission on National Dental Examinations.

(b) The Board ~~shall have the authority to~~ may establish in its ~~rules and regulations:~~rules:

(1) The form of application;

(2) The time and place of examination;

(3) The type of examination;

(4) The qualifications for passing the examination.

(c) All examinations administered by the Board under this section shall be substantially equivalent in content."

SECTION 5. Article 2 of Chapter 90 of the General Statutes is amended by adding a new section to read:

"**§ 90-37.1. Limited volunteer dental license.**

(a) The North Carolina State Board of Dental Examiners may issue to an applicant a 'Limited Volunteer Dental License' to practice dentistry only in nonprofit health care facilities serving low-income populations in the State. Holders of a limited volunteer dental license may volunteer their professional services, without compensation, only for the purpose of helping to meet the dental health needs of these persons served by these facilities. The Board may issue a limited license to an applicant under this section who:

(1) Has an out-of-state current or expired license, or an expired license in this State, or is authorized to treat veterans or personnel enlisted in the United States armed services; and

(2) Has actively practiced dentistry, as defined in G.S. 90-29(b)(1) through (b)(9), within the past five years.

(b) The limited license may be issued to an applicant who produces satisfactory evidence to the Board that the applicant has the required education, training, and qualifications; is in good standing with the licensing jurisdiction; has passed satisfactory examinations of proficiency in the knowledge and practice of dentistry as determined by the Board; and meets all other requirements of this section and rules adopted by the Board. The Board may conduct examinations and interviews to test the qualifications of the applicant and may require additional information that would affect the applicant's ability to render competent dental care. The Board may, in its discretion, refuse to issue a 'limited volunteer dental license' to an applicant who the Board determines is unfit to practice dentistry.

(c) The applicant shall be of good moral character and shall have graduated from and have a DDS or DMD degree from a program of dentistry in a school or college accredited by the Commission on Dental Accreditation of the American Dental Association and approved by the Board.

(d) The applicant shall meet all of the following conditions:

(1) Show that the applicant has actively practiced dentistry, as defined in G.S. 90-29(b)(1) through (b)(9), for a minimum of five years.

(2) Show that the applicant has not been the subject of final or pending disciplinary action in any state in which the applicant has ever been licensed to practice dentistry or in any state in which the applicant has held any other professional license.

(3) Present evidence that the applicant has no felony convictions and that the applicant has no other criminal convictions that would affect the applicant's ability to render competent care.

(4) Present evidence that the applicant has no pending Veterans Administration or military disciplinary actions or any history of such disciplinary action.

(5) Show that the applicant has not failed an examination conducted by the North Carolina State Board of Dental Examiners.

(e) The applicant shall submit an application, the form of which shall be determined by the Board, pay the fee required under G.S. 90-39, and successfully complete examinations in Jurisprudence and Sterilization and Infection Control. The Board may charge and collect fees for license application and annual renewal as required under G.S. 90-39, except that credentialing fees applicable under G.S. 90-39(13) are waived for holders of a limited volunteer dental license.

(f) Holders of a limited volunteer dental license shall comply with the continuing dental education requirements adopted by the Board including CPR training.

(g) The holder of a limited license under this section who practices dentistry other than as authorized in this section shall be guilty of a Class 1 misdemeanor with each day's violation constituting a separate offense. Upon proof of practice other than as authorized in this section, the Board may suspend or revoke the limited license after notice to the licensee. For violations of the dental practice act or rules adopted under the act that are applicable to a limited license practice, the Board has the same authority to investigate and impose sanctions on limited license holders as it has for those holding an unlimited license.

(h) The Board shall maintain a nonexclusive list of nonprofit health care facilities serving the dental health needs of low-income populations in the State. Upon request, the Board shall consider adding other facilities to the list.

(i) The Board may adopt rules in accordance with Chapter 150B of the General Statutes to implement this section."

SECTION 6. G.S. 90-39 reads as rewritten:

"**§ 90-39. Fees.**

In order to provide the means of carrying out and enforcing the provisions of this Article and the duties devolving upon the North Carolina State Board of Dental Examiners, it is authorized to charge and collect fees established by its rules ~~and regulations~~ not exceeding the following:

(1) Each application for general dentistry examination $500.00
(2) Each general dentistry license renewal, which fee shall be annually fixed by the Board and not later than November 30 of each year it shall give written notice of the amount of the renewal fee to each dentist licensed to practice in this State by mailing such notice to the last address of record with the board of each such dentist 140.00
(2a) Penalty for late renewal of any license or permit 50.00
(3) Each provisional license 150.00
(4) Each intern permit or renewal thereof 150.00
(5) Each certificate of license to a resident dentist desiring to change to another state or territory 30.00
(6) Repealed by Session Laws 1995, (Reg. Sess., 1996), c. 584, s. 1.
(7) Each license to resume the practice issued to a dentist who has retired from and returned to this State 300.00
(8) Each instructor's license or renewal thereof 140.00
(9) With each renewal of a dentistry license, an annual fee to help fund special peer review organizations for impaired dentists 50.00
(10) Each duplicate of any license, permit, or certificate issued by the Board 25.00
(11) Each office inspection for general anesthesia and parenteral sedation permits 350.00
(12) Each general anesthesia and parenteral sedation permit application or renewal of permit ..... ~~50.00~~ 50.00
(13) Each application for license by credentials 2000.00
(14) Each application for limited volunteer dental license 100.00
(15) Each limited volunteer dental license annual renewal ..... 25.00."

SECTION 7. G.S. 90-232 reads as rewritten:

"**§ 90-232. Fees.**

In order to provide the means of carrying out and enforcing the provisions of this Article and the duties devolving upon the North Carolina State Board of Dental Examiners, it is authorized to charge and collect fees established by its rules ~~and regulations~~ not exceeding the following:

(1) Each applicant for examination $125.00
(2) Each renewal certificate, which fee shall be annually fixed by the Board and not later than November 30 of each year it shall give written notice of the amount of the renewal fee to each dental hygienist licensed to practice in this State by mailing such notice to the last address of record with the Board of each such dental hygienist ... 60.00
(3) Each restoration of license 60.00
(4) Each provisional license 60.00
(5) Each certificate of license to a resident dental hygienist desiring to change to another state or territory 25.00

(6) Annual fee to be paid upon license renewal to assist in funding programs for impaired dental hygienists .....~~40.00.~~ 40.00

(7) Each license by credentials ..... 1000.00.

In no event may the annual fee imposed on dental hygienists to fund the impaired dental hygienists program exceed the annual fee imposed on dentists to fund the impaired dentist program. All fees shall be payable in advance to the Board and shall be disposed of by the Board in the discharge of its duties under this Article."

SECTION 8. G.S. 90-29.5 reads as rewritten:

"**§ 90-29.5. Instructor's license.**

~~The Board may issue an instructor's license to a person who is not otherwise licensed to practice dentistry in the State, but whom the Board finds to be qualified by professional training and experience and upon the same examination as that offered to licensed dentists in North Carolina plus an oral examination. An instructor's license will authorize him to teach and to practice dentistry in or on behalf of a dental school or college offering a doctoral degree in dentistry, operated and conducted in this State and approved by the North Carolina State Board of Dental Examiners, but only within the confines of the principal facility of the school or college and of any teaching hospital adjacent thereto. Application for an instructor's license shall be made in accordance with rules and regulations of the North Carolina State Board of Dental Examiners. A person holding an instructor's license shall have, within the scope of his authorized practice, all the duties and responsibilities of any dentist who has been licensed upon examination by the North Carolina State Board of Dental Examiners, and shall be subject to those various disciplinary measures and penalties set forth in G.S. 90-41 upon a determination by the Board that he has violated any of the terms or provisions of this Article. An instructor's license shall be subject to annual renewal by the North Carolina State Board of Dental Examiners, as provided in G.S. 90-31.~~

(a) The Board may issue an instructor's license to a person who is not otherwise licensed to practice dentistry in this State if the person meets both of the following conditions:

(1) Is licensed to practice dentistry anywhere in the United States or in any country, territory, or other recognized jurisdiction.

(2) Has met or been approved under the credentialing standards of a dental school or an academic medical center with which the person is to be affiliated; such dental school or academic medical center shall be accredited by the American Dental Association's Commission on Accreditation or the Joint Commission on Accreditation of Health Care Organizations.

(b) The holder of an instructor's license may teach and practice dentistry:

(1) In or on behalf of a dental school or college offering a doctoral degree in dentistry operated and conducted in this State and approved by the North Carolina State Board of Dental Examiners;

(2) In connection with an academic medical center; and

(3) At any teaching hospital adjacent to a dental school or an academic medical center.

(c) Application for an instructor's license shall be made in accordance with the rules of the North Carolina State Board of Dental Examiners. On or after January 1, 2002, all dentists previously practicing under G.S. 90-29(c)(3) shall be granted an instructor's license upon application to the Board and payment of the required fee. The holder of an instructor's license shall be subject to the provisions of this Article."

SECTION 9. G.S. 90-29(c)(3) reads as rewritten:

"(3) The teaching or practice of dentistry, in dental schools or colleges operated and conducted in this State and approved by the North Carolina State Board of Dental Examiners, by any person or persons licensed to practice dentistry anywhere in the United States or in any country, territory or other recognized ~~jurisdiction;~~jurisdiction until December 31, 2001. On or after January 1, 2002, all dentists previously practicing under G.S. 90-29(c)(3) shall be granted an instructor's license upon application to the Board and payment of the required fee."

SECTION 10. G.S. 90-41(f) reads as rewritten:

"(f) As used in this section the term "licensee" includes licensees, provisional licensees and holders of intern permits, and the term "license" includes license, provisional ~~license~~license, instructor's license, and intern permit."

SECTION 11. G.S. 90-29.4(1) reads as rewritten:

"(1) An intern permit shall be valid for no more than one year from the date of issue thereof; provided, however, that the Board may, in its discretion, renew such permit for not more than ~~three~~ five additional one-year periods; and, provided, further, that no person shall be granted an intern permit or intern permits embracing or covering an aggregate time span of more than ~~48~~ 72 calendar months;".

SECTION 12. G.S. 150B-21.1 is amended by adding a new subsection to read:

"(a8) Notwithstanding the provisions of subsection (a) of this section, the North Carolina State Board of Dental Examiners may adopt temporary rules to implement the provisions of G.S. 90-36 and G.S. 90-224.1. After having the proposed temporary rules published in the North Carolina Register and at least 30 days prior to adopting a temporary rule pursuant to this subsection, the Board shall:

(1) Notify persons on its mailing list maintained pursuant to G.S. 21.2(d) and any other interested parties of its intent to adopt a temporary rule.

(2) Accept oral and written comments on the proposed temporary rule.

(3) Hold at least one public hearing on the proposed temporary rule.

When the Board adopts a temporary rule pursuant to this subsection, the Board must submit a reference to this subsection as the Board's statement of need to the Codifier of Rules.

Notwithstanding any other provision of this Chapter, the Codifier of Rules shall publish in the North Carolina Register a proposed temporary rule received from the Board in accordance with this subsection."

SECTION 13.(a) The Board of Trustees of the University of North Carolina at Chapel Hill shall study and develop procedures for increasing the University of North Carolina School of Dentistry's entering class to 100 students. The report shall include a timeline for increasing the number of students of the entering class of the University of North Carolina to 100 and for the costs of expansion. In addition, the report shall include an analysis of the impact of this expansion on improving access to dental care in North Carolina.

SECTION 13.(b) Not later than May 1, 2002, the Board of Trustees of the University of North Carolina at Chapel Hill shall report to the 2002 Regular Session of the 2001 General Assembly with a complete proposal and a timeline for increasing the number of students of the entering class of the University of North Carolina School of Dentistry to 100 students.

SECTION 14.(a) The Board of Governors of The University of North Carolina shall study the feasibility of establishing an additional State School of Dentistry. The report shall include an analysis of the feasibility of establishing an additional State School of Dentistry, including costs, possible locations for the new facility, and a proposed timeline for implementation. In addition, the report shall include an analysis of the impact of this expansion on improving access to dental care in North Carolina.

SECTION 14.(b) Not later than May 1, 2002, the Board of Governors shall report to the 2002 Regular Session of the 2001 General Assembly, with a feasibility analysis of establishing a new State Dental School.

SECTION 15. If any section of this act is declared to be unconstitutional, preempted, or otherwise invalid by the courts, except where a contrary intent is clearly indicated by the text of the section, it shall not affect the validity of the act as a whole or any part other than the section declared to be invalid, and any previous statutory law replaced or modified by the section declared invalid shall be reinstated as if the previous law had not been changed. If any part of a numbered section of this act is declared invalid, the whole section shall fail.

SECTION 16. Sections 1 through 12 of this act become effective January 1, 2002. Sections 2, 3, 4, and 12 of this act expire June 30, 2003. The remainder of this act is effective when it becomes law.

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2001

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SENATE BILL 861

Health Care Committee Substitute Adopted 6/11/01
Finance Committee Substitute Adopted 8/14/01
Fourth Edition Engrossed 8/21/01
PROPOSED HOUSE COMMITTEE SUBSTITUTE S861-CSRM-74 [v.1]

6/18/2002 10:40:35 AM

Short Title: License by Credentials/Dentistry. (Public)

Sponsors:

Referred to:

April 4, 2001

A BILL TO BE ENTITLED

AN ACT TO INCREASE THE NUMBER OF QUALIFIED DENTAL PRACTITIONERS IN THE STATE BY AUTHORIZING THE BOARD OF DENTAL EXAMINERS TO LICENSE BY CREDENTIALS PERSONS WHO ARE LICENSED TO PRACTICE DENTISTRY OR DENTAL HYGIENE IN OTHER STATES AND WHO OTHERWISE MEET STATE REQUIREMENTS FOR LICENSE BY CREDENTIALS, TO ISSUE A LIMITED VOLUNTEER DENTAL LICENSE, TO ISSUE AN INSTRUCTOR'S LICENSE, AND TO IMPOSE APPLICATION AND RENEWAL FEES FOR LICENSURE AUTHORIZED UNDER THIS ACT.

The General Assembly of North Carolina enacts:

SECTION 1. Article 14 of Chapter 130A of the General Statutes is amended by adding the following new section to read:

"**§ 130A-367. Dental providers for problem access areas.**

The State's dental public health program shall encourage the expansion of current educational and training programs for dentists, dental hygienists, and dental assistants targeted to serve citizens' unmet needs, particularly in the rural and low-income areas that have traditionally had problems in accessing dental care. The program shall also promote and encourage the recruitment of in-State and out-of-state private sector dental personnel to work in these dental health professional shortage areas."

SECTION 2. G.S. 90-36 reads as rewritten:

"**§ 90-36. Licensing practitioners of other states.**

~~The North Carolina State Board of Dental Examiners may, in its discretion, issue a license to practice dentistry in this State without an examination other than clinical to a legal and ethical practitioner of dentistry who moves into North Carolina from another~~

~~state or territory of the United States, whose standard of requirements is equal to that of the State of North Carolina and in which such applicant has conducted a legal and ethical practice of dentistry for at least five years, next preceding his or her removal and who has not, during his period of practice, been found guilty by the state regulatory agency charged with the responsibility therefor of the violation of the ethics of his profession, nor found guilty by a court of competent jurisdiction of the violation of the laws of the state which issued license to him or of the criminal laws of the United States, nor whose license to practice dentistry has been revoked or suspended by a duly constituted authority.~~

~~Application for license to be issued under the provisions of this section shall be accompanied by a certificate from the dental board or like board of the state from which said applicant removed, certifying that the applicant is the legal holder of a license to practice dentistry in that state, and for a period of five years immediately preceding the application has engaged in the practice of dentistry; is of good moral character and that during the period of his practice no charges have been filed with said board against the applicant for the violation of the laws of the state or of the United States, or for the violation of the ethics of the profession of dentistry.~~

~~Application for a license under this section shall be made to the North Carolina State Board of Dental Examiners within the six months of the date of the issuance of the certificate hereinbefore required, and said certificate shall be accompanied by the diploma or other evidence of the graduation from a reputable, recognized and approved dental college, school or dental department of a college or university.~~

~~Any license issued upon the application of any dentist from any other state or territory shall be subject to all of the provisions of this Article with reference to the license issued by the North Carolina State Board of Dental Examiners upon examination of applicants and the rights and privileges to practice the profession of dentistry under any license so issued shall be subject to the same duties, obligations, restrictions and the conditions as imposed by this Article on dentists originally examined by the North Carolina State Board of Dental Examiners.~~

(a) The North Carolina State Board of Dental Examiners may issue a license by credentials to an applicant who has been licensed to practice dentistry in any state or territory of the United States if the applicant produces satisfactory evidence to the Board that the applicant has the required education, training, and qualifications, is in good standing with the licensing jurisdiction, has passed satisfactory examinations of proficiency in the knowledge and practice of dentistry as determined by the Board, and meets all other requirements of this section and rules adopted by the Board. The Board may conduct examinations and interviews to test the qualifications of the applicant and may require additional information that would affect the applicant's ability to render competent dental care. The Board may, in its discretion, refuse to issue a license by credentials to an applicant who the Board determines is unfit to practice dentistry.

(b) The applicant for licensure by credentials shall be of good moral character and shall have graduated from and have a DDS or DMD degree from a program of dentistry in a school or college accredited by the Commission on Dental Accreditation of the American Dental Association and approved by the Board.

(c) The applicant must meet all of the following conditions:

(1) Has been actively practicing dentistry, as defined in G.S. 90-29(b)(1) through (b)(9), for a minimum of five years immediately preceding the date of application.

(2) Has not been the subject of final or pending disciplinary action in the military, in any state or territory in which the applicant is or has ever been licensed to practice dentistry, or in any state or territory in which the applicant has held any other professional license.

(3) Presents evidence that the applicant has no felony convictions and that the applicant has no other criminal convictions that would affect the applicant's ability to render competent dental care.

(4) Has not failed an examination conducted by the North Carolina State Board of Dental Examiners.

(d) The applicant for licensure by credentials shall submit an application to the North Carolina State Board of Dental Examiners, the form of which shall be determined by the Board, pay the fee required by G.S. 90-39, successfully complete examinations in Jurisprudence and Sterilization and Infection Control, and meet the criteria or requirements established by the Board.

(e) The holder of a license issued under this section shall establish a practice location and actively practice dentistry, as defined in G.S. 90-29(b)(1) through (b)(9), in North Carolina within one year from the date the license is issued. The license issued under this section shall be void upon a finding by the Board that the licensee fails to limit the licensee's practice to North Carolina or that the licensee no longer actively practices dentistry in North Carolina.

(f) The Board may adopt temporary rules in accordance with G.S. 150B-21.1(a10) to implement this section."

SECTION 3. Article 16 of Chapter 90 of the General Statutes is amended by adding a new section to read:

"**§ 90-224.1. Licensure by credentials.**

(a) The Board may issue a license by credentials to an applicant who has been licensed to practice dental hygiene in any state or territory of the United States if the applicant produces satisfactory evidence to the Board that the applicant has the required education, training, and qualifications; is in good standing with the licensing jurisdiction; has passed the National Board Dental Hygiene Examination administered by the Joint Commission on National Dental Examinations; has passed satisfactory examinations of proficiency in the knowledge and practice of dental hygiene as determined by the Board; and meets all other requirements of this section and rules adopted by the Board. The Board may, in its discretion, refuse to issue a license by credentials to an applicant who the Board determines is unfit to practice dental hygiene.

(b) The applicant for licensure shall be of good moral character, have graduated from an accredited high school or hold a high school equivalency certificate duly issued by a governmental agency or authorized unit, and have graduated from a dental hygiene program or school accredited by the Commission on Dental Accreditation of the American Dental Association and approved by the Board.

(c) The applicant must meet all of the following conditions:

(1) Has been actively practicing dental hygiene, as defined in G.S. 90-221, under the supervision of a licensed dentist for a minimum of two years immediately preceding the date of application.

(2) Has no history of disciplinary action or pending disciplinary action in the military or in any state or territory in which the applicant is or has ever been licensed.

(3) Has no felony convictions and has no other criminal convictions that would affect the applicant's ability to render competent dental hygiene care.

(4) Has not failed a licensure examination administered by the North Carolina State Board of Dental Examiners.

(d) The applicant for licensure by credentials shall submit an application, the form of which shall be determined by the Board, pay the fee required by G.S. 90-232, successfully complete examinations in Jurisprudence and Sterilization and Infection Control, and meet other criteria or requirements established by the Board, which may include an examination or interview before the Board or its authorized agents.

(e) This section shall not be construed to include licensure by reciprocity, which is prohibited.

(f) The Board may adopt temporary rules in accordance with G.S. 150B-21.1(a8) to implement this section."

SECTION 4. Article 2 of Chapter 90 of the General Statutes is amended by adding a new section to read:

"**§ 90-37.1. Limited volunteer dental license.**

(a) The North Carolina State Board of Dental Examiners may issue to an applicant a 'Limited Volunteer Dental License' to practice dentistry only in nonprofit health care facilities serving low-income populations in the State. Holders of a limited volunteer dental license may volunteer their professional services, without compensation, only for the purpose of helping to meet the dental health needs of these persons served by these facilities. The Board may issue a limited license to an applicant under this section who:

(1) Has an out-of-state current or expired license, or an expired license in this State, or is authorized to treat veterans or personnel enlisted in the United States armed services; and

(2) Has actively practiced dentistry, as defined in G.S. 90-29(b)(1) through (b)(9), within the past five years.

(b) The limited license may be issued to an applicant who produces satisfactory evidence to the Board that the applicant has the required education, training, and qualifications; is in good standing with the licensing jurisdiction; has passed satisfactory examinations of proficiency in the knowledge and practice of dentistry as determined by the Board; and meets all other requirements of this section and rules adopted by the Board. The Board may conduct examinations and interviews to test the qualifications of the applicant and may require additional information that would affect the applicant's ability to render competent dental care. The Board may, in its discretion, refuse to issue

a 'limited volunteer dental license' to an applicant who the Board determines is unfit to practice dentistry.

(c) The applicant shall be of good moral character and shall have graduated from and have a DDS or DMD degree from a program of dentistry in a school or college accredited by the Commission on Dental Accreditation of the American Dental Association and approved by the Board.

(d) The applicant shall meet all of the following conditions:

(1) Show that the applicant has actively practiced dentistry, as defined in G.S. 90-29(b)(1) through (b)(9), for a minimum of five years.

(2) Show that the applicant has not been the subject of final or pending disciplinary action in any state in which the applicant has ever been licensed to practice dentistry or in any state in which the applicant has held any other professional license.

(3) Present evidence that the applicant has no felony convictions and that the applicant has no other criminal convictions that would affect the applicant's ability to render competent care.

(4) Present evidence that the applicant has no pending Veterans Administration or military disciplinary actions or any history of such disciplinary action.

(5) Show that the applicant has not failed an examination conducted by the North Carolina State Board of Dental Examiners.

(e) The applicant shall submit an application, the form of which shall be determined by the Board, pay the fee required under G.S. 90-39, and successfully complete examinations in Jurisprudence and Sterilization and Infection Control. The Board may charge and collect fees for license application and annual renewal as required under G.S. 90-39, except that credentialing fees applicable under G.S. 90-39(13) are waived for holders of a limited volunteer dental license.

(f) Holders of a limited volunteer dental license shall comply with the continuing dental education requirements adopted by the Board including CPR training.

(g) The holder of a limited license under this section who practices dentistry other than as authorized in this section shall be guilty of a Class 1 misdemeanor with each day's violation constituting a separate offense. Upon proof of practice other than as authorized in this section, the Board may suspend or revoke the limited license after notice to the licensee. For violations of the dental practice act or rules adopted under the act that are applicable to a limited license practice, the Board has the same authority to investigate and impose sanctions on limited license holders as it has for those holding an unlimited license.

(h) The Board shall maintain a nonexclusive list of nonprofit health care facilities serving the dental health needs of low-income populations in the State. Upon request, the Board shall consider adding other facilities to the list.

(i) The Board may adopt rules in accordance with Chapter 150B of the General Statutes to implement this section."

SECTION 5. G.S. 90-39 reads as rewritten:

"**§ 90-39. Fees.**

In order to provide the means of carrying out and enforcing the provisions of this Article and the duties devolving upon the North Carolina State Board of Dental Examiners, it is authorized to charge and collect fees established by its rules ~~and regulations~~ not exceeding the following:

(1) Each application for general dentistry examination $500.00
(2) Each general dentistry license renewal, which fee shall be annually fixed by the Board and not later than November 30 of each year it shall give written notice of the amount of the renewal fee to each dentist licensed to practice in this State by mailing such notice to the last address of record with the board of each such dentist 140.00
(2a) Penalty for late renewal of any license or permit 50.00
(3) Each provisional license 150.00
(4) Each intern permit or renewal thereof 150.00
(5) Each certificate of license to a resident dentist desiring to change to another state or territory 30.00
(6) Repealed by Session Laws 1995, (Reg. Sess., 1996), c. 584, s. 1.
(7) Each license to resume the practice issued to a dentist who has retired from and returned to this State 300.00
(8) Each instructor's license or renewal thereof 140.00
(9) With each renewal of a dentistry license, an annual fee to help fund special peer review organizations for impaired dentists 50.00
(10) Each duplicate of any license, permit, or certificate issued by the Board 25.00
(11) Each office inspection for general anesthesia and parenteral sedation permits 350.00
(12) Each general anesthesia and parenteral sedation permit application or renewal of permit ..... ~~50.00~~ 50.00
(13) Each application for license by credentials 2,000.00
(14) Each application for limited volunteer dental license 100.00
(15) Each limited volunteer dental license annual renewal ..... 25.00."

SECTION 6. G.S. 90-232 reads as rewritten:

"**§ 90-232. Fees.**

In order to provide the means of carrying out and enforcing the provisions of this Article and the duties devolving upon the North Carolina State Board of Dental Examiners, it is authorized to charge and collect fees established by its rules ~~and regulations~~ not exceeding the following:

(1) Each applicant for examination $125.00
(2) Each renewal certificate, which fee shall be annually fixed by the Board and not later than November 30 of each year it shall give written notice of the amount of the renewal fee to each dental hygienist licensed to practice in this State by mailing such notice to the last address of record with the Board of each such dental hygienist ... 60.00
(3) Each restoration of license 60.00
(4) Each provisional license 60.00

(5) Each certificate of license to a resident dental hygienist desiring to change to another state or territory 25.00

(6) Annual fee to be paid upon license renewal to assist in funding programs for impaired dental hygienists ..... ~~40.00.~~ 40.00

(7) Each license by credentials ..... 1,000.00.

In no event may the annual fee imposed on dental hygienists to fund the impaired dental hygienists program exceed the annual fee imposed on dentists to fund the impaired dentist program. All fees shall be payable in advance to the Board and shall be disposed of by the Board in the discharge of its duties under this Article."

SECTION 7. G.S. 90-29.5 reads as rewritten:

"**§ 90-29.5. Instructor's license.**

~~The Board may issue an instructor's license to a person who is not otherwise licensed to practice dentistry in the State, but whom the Board finds to be qualified by professional training and experience and upon the same examination as that offered to licensed dentists in North Carolina plus an oral examination. An instructor's license will authorize him to teach and to practice dentistry in or on behalf of a dental school or college offering a doctoral degree in dentistry, operated and conducted in this State and approved by the North Carolina State Board of Dental Examiners, but only within the confines of the principal facility of the school or college and of any teaching hospital adjacent thereto. Application for an instructor's license shall be made in accordance with rules and regulations of the North Carolina State Board of Dental Examiners. A person holding an instructor's license shall have, within the scope of his authorized practice, all the duties and responsibilities of any dentist who has been licensed upon examination by the North Carolina State Board of Dental Examiners, and shall be subject to those various disciplinary measures and penalties set forth in G.S. 90-41 upon a determination by the Board that he has violated any of the terms or provisions of this Article. An instructor's license shall be subject to annual renewal by the North Carolina State Board of Dental Examiners, as provided in G.S. 90-31.~~

(a) The Board may issue an instructor's license to a person who is not otherwise licensed to practice dentistry in this State if the person meets both of the following conditions:

(1) Is licensed to practice dentistry anywhere in the United States or in any country, territory, or other recognized jurisdiction.

(2) Has met or been approved under the credentialing standards of a dental school or an academic medical center with which the person is to be affiliated; such dental school or academic medical center shall be accredited by the American Dental Association's Commission on Accreditation or the Joint Commission on Accreditation of Health Care Organizations.

(b) The holder of an instructor's license may teach and practice dentistry:

(1) In or on behalf of a dental school or college offering a doctoral degree in dentistry operated and conducted in this State and approved by the North Carolina State Board of Dental Examiners;

(2) In connection with an academic medical center; and

(3) At any teaching hospital adjacent to a dental school or an academic medical center.

(c) Application for an instructor's license shall be made in accordance with the rules of the North Carolina State Board of Dental Examiners. On or after January 1, 2003, all dentists previously practicing under G.S. 90-29(c)(3) shall be granted an instructor's license upon application to the Board and payment of the required fee. The holder of an instructor's license shall be subject to the provisions of this Article."

SECTION 8. G.S. 90-29(c)(3) reads as rewritten:

"(3) The teaching or practice of dentistry, in dental schools or colleges operated and conducted in this State and approved by the North Carolina State Board of Dental Examiners, by any person or persons licensed to practice dentistry anywhere in the United States or in any country, territory or other recognized ~~jurisdiction;~~jurisdiction until December 31, 2002. On or after January 1, 2003, all dentists previously practicing under G.S. 90-29(c)(3) shall be granted an instructor's license upon application to the Board and payment of the required fee."

SECTION 9. G.S. 90-41(f) reads as rewritten:

"(f) As used in this section the term "licensee" includes licensees, provisional licensees and holders of intern permits, and the term "license" includes license, provisional ~~license~~license, instructor's license, and intern permit."

SECTION 10. G.S. 90-29.4(1) reads as rewritten:

"(1) An intern permit shall be valid for no more than one year from the date of issue thereof; provided, however, that the Board may, in its discretion, renew such permit for not more than ~~three~~ five additional one-year periods; and, provided, further, that no person shall be granted an intern permit or intern permits embracing or covering an aggregate time span of more than ~~48~~ 72 calendar months;".

SECTION 11. G.S. 150B-21.1 is amended by adding a new subsection to read:

"(a10) Notwithstanding the provisions of subsection (a) of this section, the North Carolina State Board of Dental Examiners may adopt temporary rules to implement the provisions of G.S. 90-36 and G.S. 90-224.1. After having the proposed temporary rules published in the North Carolina Register and at least 30 days prior to adopting a temporary rule pursuant to this subsection, the Board shall:

(1) Notify persons on its mailing list maintained pursuant to G.S. 90-21.2(d) and any other interested parties of its intent to adopt a temporary rule.

(2) Accept oral and written comments on the proposed temporary rule.

(3) Hold at least one public hearing on the proposed temporary rule.

When the Board adopts a temporary rule pursuant to this subsection, the Board must submit a reference to this subsection as the Board's statement of need to the Codifier of Rules.

Notwithstanding any other provision of this Chapter, the Codifier of Rules shall publish in the North Carolina Register a proposed temporary rule received from the Board in accordance with this subsection."

SECTION 12. If any section of this act is declared to be unconstitutional, preempted, or otherwise invalid by the courts, except where a contrary intent is clearly indicated by the text of the section, it shall not affect the validity of the act as a whole or any part other than the section declared to be invalid, and any previous statutory law replaced or modified by the section declared invalid shall be reinstated as if the previous law had not been changed. If any part of a numbered section of this act is declared invalid, the whole section shall fail.

SECTION 13. This act becomes effective July 1, 2003.

S861-CSRM-74[V1]: House PCS License by Credentials/Dentistry

BILL ANALYSIS

Committee:	House Health	**Introduced by:**	Rep. Wright
Date:	June 18, 2002	**Summary by:**	Linda Attarian
Version:	PCS of 4th Edition		Committee Counsel

S861-CSRM-74 makes the following changes to the 4th Edition: (page and line numbers refer to the PCS)

1) Page 3, lines 42-44: The PCS amends the 4th Edition of S861 to provide that an applicant for dental hygiene licensure by credential review must, among other requirements, have graduated from a ***dental hygiene program or school accredited by the Commission on Dental Accreditation of the American Dental Association.***

The 4th Edition provides that the applicant must have completed ***dental hygiene education and training required by a program approved by the Board.***

2) Page 4, line 22: The PCS deletes Section 4 of the 4th Edition, which amends current dental hygiene licensure law governing the educational prerequisites to take the NC dental hygiene licensure examination.

> ***What Section 4 of the 4th Edition would do if enacted***: The 4th Edition amends G.S. 90-224 to allow a person who obtained dental hygiene training in the U.S. military with a minimum of 5 years of military service as a dental hygienist to take the NC licensure examination. The 4th Edition further amends G.S. 90-224 to codify a current Board requirement adopted by rule that requires all applicants for examination to have passed the National Board of Dental Hygiene Examination to take the NC licensure examination. Finally, the 4th Edition amends G.S. 90-224 to require that all applicants must be given examinations that are substantially equivalent in content.
>
> ***What the PCS would do if enacted:*** The result of deleting Section 4 from the 4th Edition of S861 is that G.S. 90-224 will remain unchanged under the bill. Thus, with respect to educational prerequisites, only applicants who are graduates of a program of dental hygiene in a school or college approved by the Board may take NC licensure examination

3) Deletes sections 13(a), (b) and 14(a), (b) (Study provisions): The two study issues required under these sections were addressed this year pursuant to a directive to the UNC Board of Governors, the State Board of Community Colleges, and the Department of Public Instruction contained S.L. 2001-491 (Senate Bill 166).

4) Effective date: The PCS increase the effective date by one year. It also deletes the sunset provision in the 4th Edition that makes Sections 2, 3, 4, and 12 of the 4th Edition effective for only for 18 months.

Background: The accrediting agency recognized by the U.S. Department of Education to accredit programs that provide basic preparation for licensure or certification in dentistry and the related disciplines is the Commission on Dental Accreditation. The Commission has established 61 standards that a dental hygiene program must meet the standards in order to be accredited. 43 states, via statute or administrative rule, require dental hygienists to have graduated from accredited programs. Currently, more than 250 accredited dental hygiene programs exist in the U.S., and approximately 6000 dental hygiene students graduate per year.

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2001

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SENATE BILL 861

Health Care Committee Substitute Adopted 6/11/01
Finance Committee Substitute Adopted 8/14/01
Fourth Edition Engrossed 8/21/01
PROPOSED HOUSE COMMITTEE SUBSTITUTE S861-PCS6870-RM-74

Short Title: License by Credentials/Dentistry. (Public)

Sponsors:

Referred to:

April 4, 2001

A BILL TO BE ENTITLED

AN ACT TO INCREASE THE NUMBER OF QUALIFIED DENTAL PRACTITIONERS IN THE STATE BY AUTHORIZING THE BOARD OF DENTAL EXAMINERS TO LICENSE BY CREDENTIALS PERSONS WHO ARE LICENSED TO PRACTICE DENTISTRY OR DENTAL HYGIENE IN OTHER STATES AND WHO OTHERWISE MEET STATE REQUIREMENTS FOR LICENSE BY CREDENTIALS, TO ISSUE A LIMITED VOLUNTEER DENTAL LICENSE, TO ISSUE AN INSTRUCTOR'S LICENSE, AND TO IMPOSE APPLICATION AND RENEWAL FEES FOR LICENSURE AUTHORIZED UNDER THIS ACT.

The General Assembly of North Carolina enacts:

SECTION 1. Article 14 of Chapter 130A of the General Statutes is amended by adding the following new section to read:

"**§ 130A-367. Dental providers for problem access areas.**

The State's dental public health program shall encourage the expansion of current educational and training programs for dentists, dental hygienists, and dental assistants targeted to serve citizens' unmet needs, particularly in the rural and low-income areas that have traditionally had problems in accessing dental care. The program shall also promote and encourage the recruitment of in-State and out-of-state private sector dental personnel to work in these dental health professional shortage areas."

SECTION 2. G.S. 90-36 reads as rewritten:

"**§ 90-36. Licensing practitioners of other states.**

~~The North Carolina State Board of Dental Examiners may, in its discretion, issue a license to practice dentistry in this State without an examination other than clinical to a legal and ethical practitioner of dentistry who moves into North Carolina from another~~

~~state or territory of the United States, whose standard of requirements is equal to that of the State of North Carolina and in which such applicant has conducted a legal and ethical practice of dentistry for at least five years, next preceding his or her removal and who has not, during his period of practice, been found guilty by the state regulatory agency charged with the responsibility therefor of the violation of the ethics of his profession, nor found guilty by a court of competent jurisdiction of the violation of the laws of the state which issued license to him or of the criminal laws of the United States, nor whose license to practice dentistry has been revoked or suspended by a duly constituted authority.~~

~~Application for license to be issued under the provisions of this section shall be accompanied by a certificate from the dental board or like board of the state from which said applicant removed, certifying that the applicant is the legal holder of a license to practice dentistry in that state, and for a period of five years immediately preceding the application has engaged in the practice of dentistry; is of good moral character and that during the period of his practice no charges have been filed with said board against the applicant for the violation of the laws of the state or of the United States, or for the violation of the ethics of the profession of dentistry.~~

~~Application for a license under this section shall be made to the North Carolina State Board of Dental Examiners within the six months of the date of the issuance of the certificate hereinbefore required, and said certificate shall be accompanied by the diploma or other evidence of the graduation from a reputable, recognized and approved dental college, school or dental department of a college or university.~~

~~Any license issued upon the application of any dentist from any other state or territory shall be subject to all of the provisions of this Article with reference to the license issued by the North Carolina State Board of Dental Examiners upon examination of applicants and the rights and privileges to practice the profession of dentistry under any license so issued shall be subject to the same duties, obligations, restrictions and the conditions as imposed by this Article on dentists originally examined by the North Carolina State Board of Dental Examiners.~~

(a) The North Carolina State Board of Dental Examiners may issue a license by credentials to an applicant who has been licensed to practice dentistry in any state or territory of the United States if the applicant produces satisfactory evidence to the Board that the applicant has the required education, training, and qualifications, is in good standing with the licensing jurisdiction, has passed satisfactory examinations of proficiency in the knowledge and practice of dentistry as determined by the Board, and meets all other requirements of this section and rules adopted by the Board. The Board may conduct examinations and interviews to test the qualifications of the applicant and may require additional information that would affect the applicant's ability to render competent dental care. The Board may, in its discretion, refuse to issue a license by credentials to an applicant who the Board determines is unfit to practice dentistry.

(b) The applicant for licensure by credentials shall be of good moral character and shall have graduated from and have a DDS or DMD degree from a program of dentistry in a school or college accredited by the Commission on Dental Accreditation of the American Dental Association and approved by the Board.

(c) The applicant must meet all of the following conditions:

(1) Has been actively practicing dentistry, as defined in G.S. 90-29(b)(1) through (b)(9), for a minimum of five years immediately preceding the date of application.

(2) Has not been the subject of final or pending disciplinary action in the military, in any state or territory in which the applicant is or has ever been licensed to practice dentistry, or in any state or territory in which the applicant has held any other professional license.

(3) Presents evidence that the applicant has no felony convictions and that the applicant has no other criminal convictions that would affect the applicant's ability to render competent dental care.

(4) Has not failed an examination conducted by the North Carolina State Board of Dental Examiners.

(d) The applicant for licensure by credentials shall submit an application to the North Carolina State Board of Dental Examiners, the form of which shall be determined by the Board, pay the fee required by G.S. 90-39, successfully complete examinations in Jurisprudence and Sterilization and Infection Control, and meet the criteria or requirements established by the Board.

(e) The holder of a license issued under this section shall establish a practice location and actively practice dentistry, as defined in G.S. 90-29(b)(1) through (b)(9), in North Carolina within one year from the date the license is issued. The license issued under this section shall be void upon a finding by the Board that the licensee fails to limit the licensee's practice to North Carolina or that the licensee no longer actively practices dentistry in North Carolina.

(f) The Board may adopt temporary rules in accordance with G.S. 150B-21.1(a10) to implement this section."

SECTION 3. Article 16 of Chapter 90 of the General Statutes is amended by adding a new section to read:

"**§ 90-224.1. Licensure by credentials.**

(a) The Board may issue a license by credentials to an applicant who has been licensed to practice dental hygiene in any state or territory of the United States if the applicant produces satisfactory evidence to the Board that the applicant has the required education, training, and qualifications; is in good standing with the licensing jurisdiction; has passed the National Board Dental Hygiene Examination administered by the Joint Commission on National Dental Examinations; has passed satisfactory examinations of proficiency in the knowledge and practice of dental hygiene as determined by the Board; and meets all other requirements of this section and rules adopted by the Board. The Board may, in its discretion, refuse to issue a license by credentials to an applicant who the Board determines is unfit to practice dental hygiene.

(b) The applicant for licensure shall be of good moral character, have graduated from an accredited high school or hold a high school equivalency certificate duly issued by a governmental agency or authorized unit, and have graduated from a dental hygiene program or school accredited by the Commission on Dental Accreditation of the American Dental Association and approved by the Board.

(c) The applicant must meet all of the following conditions:

(1) Has been actively practicing dental hygiene, as defined in G.S. 90-221, under the supervision of a licensed dentist for a minimum of two years immediately preceding the date of application.

(2) Has no history of disciplinary action or pending disciplinary action in the military or in any state or territory in which the applicant is or has ever been licensed.

(3) Has no felony convictions and has no other criminal convictions that would affect the applicant's ability to render competent dental hygiene care.

(4) Has not failed a licensure examination administered by the North Carolina State Board of Dental Examiners.

(d) The applicant for licensure by credentials shall submit an application, the form of which shall be determined by the Board, pay the fee required by G.S. 90-232, successfully complete examinations in Jurisprudence and Sterilization and Infection Control, and meet other criteria or requirements established by the Board, which may include an examination or interview before the Board or its authorized agents.

(e) This section shall not be construed to include licensure by reciprocity, which is prohibited.

(f) The Board may adopt temporary rules in accordance with G.S. 150B-21.1(a10) to implement this section."

SECTION 4. Article 2 of Chapter 90 of the General Statutes is amended by adding a new section to read:

"**§ 90-37.1. Limited volunteer dental license.**

(a) The North Carolina State Board of Dental Examiners may issue to an applicant a 'Limited Volunteer Dental License' to practice dentistry only in nonprofit health care facilities serving low-income populations in the State. Holders of a limited volunteer dental license may volunteer their professional services, without compensation, only for the purpose of helping to meet the dental health needs of these persons served by these facilities. The Board may issue a limited license to an applicant under this section who:

(1) Has an out-of-state current or expired license, or an expired license in this State, or is authorized to treat veterans or personnel enlisted in the United States armed services; and

(2) Has actively practiced dentistry, as defined in G.S. 90-29(b)(1) through (b)(9), within the past five years.

(b) The limited license may be issued to an applicant who produces satisfactory evidence to the Board that the applicant has the required education, training, and qualifications; is in good standing with the licensing jurisdiction; has passed satisfactory examinations of proficiency in the knowledge and practice of dentistry as determined by the Board; and meets all other requirements of this section and rules adopted by the Board. The Board may conduct examinations and interviews to test the qualifications of the applicant and may require additional information that would affect the applicant's ability to render competent dental care. The Board may, in its discretion, refuse to issue

a 'limited volunteer dental license' to an applicant who the Board determines is unfit to practice dentistry.

(c) The applicant shall be of good moral character and shall have graduated from and have a DDS or DMD degree from a program of dentistry in a school or college accredited by the Commission on Dental Accreditation of the American Dental Association and approved by the Board.

(d) The applicant shall meet all of the following conditions:

(1) Show that the applicant has actively practiced dentistry, as defined in G.S. 90-29(b)(1) through (b)(9), for a minimum of five years.

(2) Show that the applicant has not been the subject of final or pending disciplinary action in any state in which the applicant has ever been licensed to practice dentistry or in any state in which the applicant has held any other professional license.

(3) Present evidence that the applicant has no felony convictions and that the applicant has no other criminal convictions that would affect the applicant's ability to render competent care.

(4) Present evidence that the applicant has no pending Veterans Administration or military disciplinary actions or any history of such disciplinary action.

(5) Show that the applicant has not failed an examination conducted by the North Carolina State Board of Dental Examiners.

(e) The applicant shall submit an application, the form of which shall be determined by the Board, pay the fee required under G.S. 90-39, and successfully complete examinations in Jurisprudence and Sterilization and Infection Control. The Board may charge and collect fees for license application and annual renewal as required under G.S. 90-39, except that credentialing fees applicable under G.S. 90-39(13) are waived for holders of a limited volunteer dental license.

(f) Holders of a limited volunteer dental license shall comply with the continuing dental education requirements adopted by the Board including CPR training.

(g) The holder of a limited license under this section who practices dentistry other than as authorized in this section shall be guilty of a Class 1 misdemeanor with each day's violation constituting a separate offense. Upon proof of practice other than as authorized in this section, the Board may suspend or revoke the limited license after notice to the licensee. For violations of the dental practice act or rules adopted under the act that are applicable to a limited license practice, the Board has the same authority to investigate and impose sanctions on limited license holders as it has for those holding an unlimited license.

(h) The Board shall maintain a nonexclusive list of nonprofit health care facilities serving the dental health needs of low-income populations in the State. Upon request, the Board shall consider adding other facilities to the list.

(i) The Board may adopt rules in accordance with Chapter 150B of the General Statutes to implement this section."

SECTION 5. G.S. 90-39 reads as rewritten:

"**§ 90-39. Fees.**

In order to provide the means of carrying out and enforcing the provisions of this Article and the duties devolving upon the North Carolina State Board of Dental Examiners, it is authorized to charge and collect fees established by its rules ~~and regulations~~ not exceeding the following:

(1) Each application for general dentistry examination $500.00
(2) Each general dentistry license renewal, which fee shall be annually fixed by the Board and not later than November 30 of each year it shall give written notice of the amount of the renewal fee to each dentist licensed to practice in this State by mailing such notice to the last address of record with the board of each such dentist 140.00
(2a) Penalty for late renewal of any license or permit 50.00
(3) Each provisional license 150.00
(4) Each intern permit or renewal thereof 150.00
(5) Each certificate of license to a resident dentist desiring to change to another state or territory 30.00
(6) Repealed by Session Laws 1995, (Reg. Sess., 1996), c. 584, s. 1.
(7) Each license to resume the practice issued to a dentist who has retired from and returned to this State 300.00
(8) Each instructor's license or renewal thereof 140.00
(9) With each renewal of a dentistry license, an annual fee to help fund special peer review organizations for impaired dentists 50.00
(10) Each duplicate of any license, permit, or certificate issued by the Board 25.00
(11) Each office inspection for general anesthesia and parenteral sedation permits 350.00
(12) Each general anesthesia and parenteral sedation permit application or renewal of permit ..... ~~50.00~~ 50.00
(13) Each application for license by credentials 2,000.00
(14) Each application for limited volunteer dental license 100.00
(15) Each limited volunteer dental license annual renewal ..... 25.00."

SECTION 6. G.S. 90-232 reads as rewritten:

"**§ 90-232. Fees.**

In order to provide the means of carrying out and enforcing the provisions of this Article and the duties devolving upon the North Carolina State Board of Dental Examiners, it is authorized to charge and collect fees established by its rules ~~and regulations~~ not exceeding the following:

(1) Each applicant for examination $125.00
(2) Each renewal certificate, which fee shall be annually fixed by the Board and not later than November 30 of each year it shall give written notice of the amount of the renewal fee to each dental hygienist licensed to practice in this State by mailing such notice to the last address of record with the Board of each such dental hygienist ... 60.00
(3) Each restoration of license 60.00
(4) Each provisional license 60.00

(5) Each certificate of license to a resident dental hygienist desiring to change to another state or territory 25.00

(6) Annual fee to be paid upon license renewal to assist in funding programs for impaired dental hygienists ..... ~~40.00.~~ 40.00

(7) Each license by credentials ..... 1,000.00.

In no event may the annual fee imposed on dental hygienists to fund the impaired dental hygienists program exceed the annual fee imposed on dentists to fund the impaired dentist program. All fees shall be payable in advance to the Board and shall be disposed of by the Board in the discharge of its duties under this Article."

SECTION 7. G.S. 90-29.5 reads as rewritten:

"**§ 90-29.5. Instructor's license.**

~~The Board may issue an instructor's license to a person who is not otherwise licensed to practice dentistry in the State, but whom the Board finds to be qualified by professional training and experience and upon the same examination as that offered to licensed dentists in North Carolina plus an oral examination. An instructor's license will authorize him to teach and to practice dentistry in or on behalf of a dental school or college offering a doctoral degree in dentistry, operated and conducted in this State and approved by the North Carolina State Board of Dental Examiners, but only within the confines of the principal facility of the school or college and of any teaching hospital adjacent thereto. Application for an instructor's license shall be made in accordance with rules and regulations of the North Carolina State Board of Dental Examiners. A person holding an instructor's license shall have, within the scope of his authorized practice, all the duties and responsibilities of any dentist who has been licensed upon examination by the North Carolina State Board of Dental Examiners, and shall be subject to those various disciplinary measures and penalties set forth in G.S. 90-41 upon a determination by the Board that he has violated any of the terms or provisions of this Article. An instructor's license shall be subject to annual renewal by the North Carolina State Board of Dental Examiners, as provided in G.S. 90-31.~~

(a) The Board may issue an instructor's license to a person who is not otherwise licensed to practice dentistry in this State if the person meets both of the following conditions:

(1) Is licensed to practice dentistry anywhere in the United States or in any country, territory, or other recognized jurisdiction.

(2) Has met or been approved under the credentialing standards of a dental school or an academic medical center with which the person is to be affiliated; such dental school or academic medical center shall be accredited by the American Dental Association's Commission on Accreditation or the Joint Commission on Accreditation of Health Care Organizations.

(b) The holder of an instructor's license may teach and practice dentistry:

(1) In or on behalf of a dental school or college offering a doctoral degree in dentistry operated and conducted in this State and approved by the North Carolina State Board of Dental Examiners;

(2) In connection with an academic medical center; and

(3) At any teaching hospital adjacent to a dental school or an academic medical center.

(c) Application for an instructor's license shall be made in accordance with the rules of the North Carolina State Board of Dental Examiners. On or after January 1, 2003, all dentists previously practicing under G.S. 90-29(c)(3) shall be granted an instructor's license upon application to the Board and payment of the required fee. The holder of an instructor's license shall be subject to the provisions of this Article."

SECTION 8. G.S. 90-29(c)(3) reads as rewritten:

"(3) The teaching or practice of dentistry, in dental schools or colleges operated and conducted in this State and approved by the North Carolina State Board of Dental Examiners, by any person or persons licensed to practice dentistry anywhere in the United States or in any country, territory or other recognized ~~jurisdiction;~~jurisdiction until December 31, 2002. On or after January 1, 2003, all dentists previously practicing under G.S. 90-29(c)(3) shall be granted an instructor's license upon application to the Board and payment of the required fee."

SECTION 9. G.S. 90-41(f) reads as rewritten:

"(f) As used in this section the term "licensee" includes licensees, provisional licensees and holders of intern permits, and the term "license" includes license, provisional ~~license~~license, instructor's license, and intern permit."

SECTION 10. G.S. 90-29.4(1) reads as rewritten:

"(1) An intern permit shall be valid for no more than one year from the date of issue thereof; provided, however, that the Board may, in its discretion, renew such permit for not more than ~~three~~ five additional one-year periods; and, provided, further, that no person shall be granted an intern permit or intern permits embracing or covering an aggregate time span of more than ~~48~~ 72 calendar months;".

SECTION 11. G.S. 150B-21.1 is amended by adding a new subsection to read:

"(a10) Notwithstanding the provisions of subsection (a) of this section, the North Carolina State Board of Dental Examiners may adopt temporary rules to implement the provisions of G.S. 90-36 and G.S. 90-224.1. After having the proposed temporary rules published in the North Carolina Register and at least 30 days prior to adopting a temporary rule pursuant to this subsection, the Board shall:

(1) Notify persons on its mailing list maintained pursuant to G.S. 150B-21.2(d) and any other interested parties of its intent to adopt a temporary rule.

(2) Accept oral and written comments on the proposed temporary rule.

(3) Hold at least one public hearing on the proposed temporary rule.

When the Board adopts a temporary rule pursuant to this subsection, the Board must submit a reference to this subsection as the Board's statement of need to the Codifier of Rules.

Notwithstanding any other provision of this Chapter, the Codifier of Rules shall publish in the North Carolina Register a proposed temporary rule received from the Board in accordance with this subsection."

SECTION 12. If any section of this act is declared to be unconstitutional, preempted, or otherwise invalid by the courts, except where a contrary intent is clearly indicated by the text of the section, it shall not affect the validity of the act as a whole or any part other than the section declared to be invalid, and any previous statutory law replaced or modified by the section declared invalid shall be reinstated as if the previous law had not been changed. If any part of a numbered section of this act is declared invalid, the whole section shall fail.

SECTION 13. This act becomes effective July 1, 2003.

2002 COMMITTEE REPORT
HOUSE OF REPRESENTATIVES

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

☒ Committee Substitute for
S.B. 861 A BILL TO BE ENTITLED AN ACT TO INCREASE THE NUMBER OF QUALIFIED DENTAL PRACTITIONERS IN THE STATE BY AUTHORIZING THE BOARD OF DENTAL EXAMINERS TO LICENSE BY CREDENTIALS PERSONS WHO ARE LICENSED TO PRACTICE DENTISTRY OR DENTAL HYGIENE IN OTHER STATES AND WHO OTHERWISE MEET STATE REQUIREMENTS FOR LICENSE BY CREDENTIALS, TO LICENSE BY EXAMINATION PERSONS WHO HAVE PRACTICED AS DENTAL HYGIENTISTS IN THE UNITED STATES MILITARY AND WHO OTHERWISE MEET STATE REQUIREMENTS FOR LICENSURE BY EXAMINATION, TO ISSUE A LIMITED VOLUNTEER DENTAL LICENSE, TO ISSUE AN ISTRUCTOR'S LICENSE, AND TO IMPOSE APPLICATION AND RENEWAL FEES FOR LICENSURE AUTHORIZED UNDER THIS ACT, AND BY AUTHORIZING STUDIES PERTAINING TO CLASS ENROLLMENT AT THE UNC SCHOOL OF DENTISTRY AND TO THE FEASIBILITY OF ESTABLISHING AND ADDITIONAL DENTAL SCHOOL.

☐ 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) (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 , and the recommendation that the house committee substitute bill be re-referred to the Committee on Finance.

☐ 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.

Vanda Wilson-Wormack (Rep. Wright)

From: Vanda Wilson-Wormack (Rep. Wright)
Sent: Thursday, June 13, 2002 10:47 AM
Subject: House Health Committee Meeting-06-18-

NORTH CAROLINA HOUSE OF REPRESENTATIVES
COMMITTEE MEETING NOTICE
2001-2002 SESSION

You are hereby notified that the Committee on **HEALTH** will meet as follows:

DAY & DATE: **Tuesday, June 18, 2002**

TIME: **12:00 Noon**

LOCATION: **415 LOB**

The following bills will be considered (Bill # & Short Title & Bill Sponsor):
HB-1514 DHHS RULES COORDINATION. (Rep. Alexander & Rep. Insko)

SB-861 LICENSE BY CREDENTIALS/DENTISTRY. (Sen. Purcell)

Respectfully,

Representative Thomas E. Wright
Chairman

I hereby certify this notice was filed by the committee assistant at the following offices at **11:00am** on **Thursday, June 13, 2002.**

___Principal Clerk
___Reading Clerk - House Chamber

Vanda Wilson-Wormack (Committee Assistant)

NORTH CAROLINA HOUSE OF REPRESENTATIVES
NOTIFICATION TO BILL SPONSOR
2001-2002

BILL SPONSOR: **Rep. Alexander & Rep. Insko**

OFFICE:

NOTIFICATION DATE: **Thursday, June 13, 2002**

The House Committee on Health will meet as follows:

DAY & DATE: **Tuesday, June 18, 2002**

TIME: **12:00 Noon**

LOCATION: **415 LOB**

Your Bill (or Bills) will be discussed at this time:
HB-1514 DHHS RULES COORDINATION

We would like to have you attend this meeting.

Representative Thomas E. Wright
Chairman

Vanda Wilson-Wormack (Committee Assistant)

NORTH CAROLINA HOUSE OF REPRESENTATIVES
NOTIFICATION TO BILL SPONSOR
2001-2002

BILL SPONSOR: **Sen. Purcell**

OFFICE:

NOTIFICATION DATE: **Thursday, June 13, 2002**

The House Committee on Health will meet as follows:

DAY & DATE: **Tuesday, June 18, 2002**

TIME: **12:00 Noon**

LOCATION: **415 LOB**

Your Bill (or Bills) will be discussed at this time:
SB 861-LICENSE BY CREDENTIALS/DENTISTRY.

We would like to have you attend this meeting.

Representative Thomas E. Wright
Chairman

Vanda Wilson-Wormack (Committee Assistant)

VISITOR REGISTRATION SHEET

HOUSE HEALTH COMMITTEE — 6-18-02

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
John Bowdish	Alley Associates
Colleen Kochanek	Hafer & Caldwell, P.A.
Eddie Caldwell	NC Dental Hygiene Assn.
Abigail Yarmosh	Rep. Insko (Intern)
Stacey Flannery	NCMCFA
Amy Jo Horne	NCMS
Lon B. Walker	NC A&TC 7
Letitia Whitmore	NC State Water
Claire Flye	mutual intern
Mary K. Brewer	NC Dental Society
Martha Abernathy McKeown	Carolinas HealthCare Sys.

VISITOR REGISTRATION SHEET

HOUSE HEALTH COMMITTEE — 6-18-02

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Tony Kaplan	NCAHP
Lori Gusto	NCRIH
Larry B Vann	Fayetteville Tech Com. College
Hal Miller	NCACCT
Jerry Cooper	NCALA
Evelyn Hawthorne	EHA
Ashley Shuffstetler	The Capitol Group
Dean Shatley	Speaker's Office
Fran Percy	NC Dental Society
Joni Allen	BEGINNINGS
ANN LOVE	DUHS

VISITOR REGISTRATION SHEET

HOUSE HEALTH COMMITTEE — 6-18-02

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Sandy Sands	WCSR
Hugh Tilson	NCHA

AGENDA

HOUSE COMMITTEE ON HEALTH
TUESDAY, August 20, 2002
12:00 NOON , ROOM 415 LB

OPENING REMARKS

Rep. Thomas E. Wright
Chairman

BILLS TO BE DISCUSSED

HB-1636 CARE FOR SCHOOL CHILDREN WITH DIABETES ACT. (Rep. Rogers)

SB-911 COMPETITIVE HEALTH CARE INFO. (Sen. Rand)

COMMENTS

ADJOURNMENT

MINUTES

COMMITTEE ON HEALTH

TUESDAY, AUGUST 20, 2002

12:00 NOON ROOM 415 LOB

The House Committee on Health met on Tuesday, August 20, 2002 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-1636 CARE FOR SCHOOL CHILDREN WITH DIABETES ACT.(Rep. Rogers)
SB-911 COMPETITIVE HEALTH CARE INFO.(Sen. Rand)

Chairman Wright stated that the proposed language for HB-1636 would be placed in SB-911 because SB-911 was a blank bill.

Rep. Edwards moved for adoption of the proposed committee substitute for SB-911. So moved.

Rep. Rogers explained the committee substitute to the committee. Linda Attarian, Staff, further explained the committee substitute. Rep. Howard asked about Section 504 of the bill, page one of the bill summary. Linda Attarian, Staff, responded. Rep. Howard asked about the cost involved. Rep. Rogers responded. Rep. Rogers expressed her support of the bill.

Rep. Edwards sent forth an amendment to amend the bill on page 1, lines 20 and 21.

Rep. Edwards explained the amendment to the committee. Linda Attarian, Staff, further explained the amendment. Rep. Howard responded.

Chairman Wright called for a vote on the adoption of the amendment and the amendment passed.

Rep. Sherrill asked about the immunity for teachers. Rep. Rogers responded. Rep. Sherrill asked about the reporting requirements. Rep. Rogers responded. Chairman Wright asked Dr. Paula Gallant Eckard, Parent Advocate, to speak on the bill. Rachel Piche', School Nurse Consultant, spoke on the bill. Rep. Wainwright asked the development of a plan. Rep. Rogers responded. Rep. Justus asked about the statistical information on children with diabetes. Rep. Rogers responded. Rachel Piche', school nurse consultant, responded. Rep. Rogers commented on the bill.

Rep. Edwards moved that the committee substitute for SB-911 be given a favorable report, which includes the amendment, unfavorable to the original bill. So moved.

Rep. Thomas E. Wright, Chair

Vanda Wilson-Wormack, Committee Assistant

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2001

HOUSE BILL 1636*

Short Title:	Care for School Children With Diabetes Act.	(Public)
Sponsors:	Representatives Rogers; Alexander, Baddour, Baker, Bowie, Buchanan, Cox, J. Crawford, Culp, Culpepper, Earle, Easterling, Edwards, Fox, Gulley, Haire, Hall, Hunter, Hurley, Insko, Jarrell, Lucas, McLawhorn, Oldham, Preston, Saunders, Smith, Tolson, Tucker, Underhill, Walend, Warren, West, Willingham, and Womble.	
Referred to:	Education, if favorable, Appropriations.	

June 13, 2002

A BILL TO BE ENTITLED

AN ACT TO REQUIRE ALL LOCAL SCHOOL ADMINISTRATIVE AGENCIES TO ENSURE THAT EVERY SCHOOL DEVELOP AND MAINTAIN AN INDIVIDUALIZED DIABETES CARE PLAN FOR A CHILD WITH DIABETES AT THE REQUEST OF THE CHILD'S PARENT OR GUARDIAN AND TO ASSIST THE CHILD WITH THE MANAGEMENT OF THE CHILD'S DIABETES IN ACCORDANCE WITH THE CHILD'S DIABETES CARE PLAN, TO PROVIDE IMMUNITY FROM LIABILITY, TO DIRECT THE STATE BOARD OF EDUCATION TO DISSEMINATE GUIDELINES, AND TO APPROPRIATE FUNDS.

The General Assembly of North Carolina enacts:

SECTION 1. Chapter 115C is amended by adding the following new Article to read:

"Article 9C.

"Children With Diabetes.

"**§ 115C-150.9. Individual diabetes care plan.**

(a) All local school administrative agencies and charter schools shall develop and maintain or cause to be developed and maintained, at the written request of a parent or guardian of a child with diabetes, an individualized diabetes care plan for the child at or before the time of the child's enrollment in school. In the event a child is diagnosed with diabetes after the school year begins, the individualized diabetes care plan shall be developed at the time the request is made by the child's parent or guardian. The diabetes care plan shall be developed by the child's parent or guardian, the child's health care

provider, the school nurse where available, and appropriate school personnel where the child is enrolled. The diabetes care plan shall be developed in accordance with guidelines disseminated by the State Board of Education pursuant to G.S. 115C-150.12. The diabetes care plan shall be reviewed and, if appropriate, revised at least annually and at other times as needed at the written request of the child's parent or guardian. The diabetes care plan shall address the specific needs of the child and provide specific instructions for each of the following:

(1) Blood glucose monitoring, including frequency and circumstances requiring testing.

(2) Insulin administration if necessary, including dosage, injection times prescribed for specific blood glucose values, and the storage of insulin.

(3) Meals and snacks, including food content, amounts and timing.

(4) Symptoms and treatment of hypoglycemia, including administration of glucagon, if appropriate.

(5) Symptoms and treatment of hyperglycemia.

(6) Testing for ketones and appropriate action to take for the presence of ketones.

(7) Emergency care plan, including the child's target blood glucose range, and the appropriate actions to take in the event that the child's blood glucose levels fall outside of this target range.

(8) The extent of the child's ability to participate in the child's diabetes care and management.

(9) The roles and expectations of the child, the child's parent or guardian, and school personnel in providing assistance to the child during extracurricular activities, including any special arrangements that may be necessary.

"**§ 115C-150.10. Care of a child with a diabetes care plan in the school setting.**

(a) All local school administrative agencies and charter schools shall ensure that each school in which a child with a diabetes care plan developed in accordance to G.S. 115C-150.9 is enrolled, provides or causes to be provided the following to that child:

(1) An adult and backup adult trained to be able to:

a. Administer insulin if needed, in accordance with the child's diabetes care plan;

b. Administer glucagon if needed, in accordance with the child's diabetes care plan;

c. Perform finger stick blood glucose monitoring and record results;

d. Take appropriate actions for blood glucose levels outside of the target ranges as indicated in the child's emergency care plan; and

e. Test the urine for ketones, when necessary, and respond to the results of the test.

(2) An adult and backup adult responsible for knowing the schedule of the child's meals and snacks and who will notify the parent or guardian in advance of any expected changes in the school schedule that affect the child's mealtime or exercise routine.

(3) At least one adult trained to perform the necessary diabetes care procedures in subdivision (a)(1) available for field trips and extracurricular activities to enable the child's full participation.

(4) Permission for the child to test their blood glucose levels in the classroom or anywhere else as necessary and to administer corrective measures immediately if the child is able to demonstrate the following:

a. Accurate finger-stick technique;

b. Appropriate infection control practices consistently;

c. Disposal of sharps appropriately;

d. Ability to interpret blood sugar results; and

e. Ability to administer appropriate corrective measures if necessary.

(5) If requested, a location in the school to provide privacy during glucose and urine testing and insulin administration.

(6) Permission for the child to eat a snack anywhere, including the classroom or bus, if necessary to prevent hypoglycemia.

(7) Permission to miss school without consequences for required medical appointments to monitor the student's diabetes management.

(8) Permission for the child to use the restroom and have access to fluids as necessary.

(9) An appropriate location for insulin or glucagon storage if necessary.

(10) Immediate access to the child's diabetes supplies at all times, with supervision as needed. Immediate access includes permission for the child to carry the child's diabetes supplies.

(11) Training to all school personnel who provide education for the child on the symptoms and treatment of hypoglycemia and hyperglycemia and where the child's emergency care plan is located.

(b) Children with a diabetes care plan developed in accordance with G.S. 115C-150.9 shall be permitted to participate with written parental consent in their diabetes care at school to the extent that is appropriate for the child's development and the child's experience with diabetes. The extent of the child's ability to participate in diabetes care shall be specifically described in the child's diabetes care plan.

"**§ 115C-150.11. Immunity from liability.**

(a) Any person authorized to render assistance or services to a child in accordance to the child's diabetes care plan under subdivision (a)(1) of G.S. 115C-150.10 shall not be liable for civil damages for any act rendered in accordance to the child's diabetes care plan or for any omission relating to such act, unless the acts or omissions amount to gross negligence, wanton conduct, or intentional wrongdoing on the part of the person rendering the services or assistance.

(b) Any person authorized to render assistance or services to a child in accordance to the child's diabetes care plan under subdivision (a)(1) of G.S. 115C-150.10 shall not be liable for civil damages for failure to render the services or assistance, unless the failure to render the assistance or services amounts to gross negligence, wanton conduct or intentional wrongdoing on the part of the person failing to render the assistance or services.

(c) No person shall be liable for civil damages for any act or omission resulting from the rendering of assistance to a child with diabetes if the person has a reason to believe that the child is suffering or is about to suffer life-threatening hypoglycemia, unless the acts or omissions amount to gross negligence, wanton conduct, or intentional wrongdoing on the part of the person rendering the assistance.

(d) Whenever any person is found to be not liable for civil damages under this section, the local school administrative agency that authorized that person to render services or assistance shall also not be liable for any civil damages.

(e) Nothing in this section shall be deemed or construed to relieve any health care professional from liability for civil damages for injury or death caused by an act or omission on the part of that person while rendering health care services in accordance with this Article that are in the normal and ordinary course of that person's profession.

"**§ 115C-150.12. State Board of Education responsibilities.**

In order to implement this Article, the State Board of Education shall disseminate guidelines for developing diabetes care plans and training as required under this Article, and shall ensure that all parents or guardians of children that are served by the North Carolina public school system are informed of the requirements of this Article through routine information dissemination procedures and schedules currently established at each school. The guidelines disseminated under this section shall be in accordance with standards adopted by The North Carolina Diabetes Advisory Council established by the Department of Health and Human Services, and shall include information necessary for teachers, administrators, coaches, food service personnel, and other school personnel to gain an understanding of basic information about diabetes, to participate in diabetes care management, and to offer assistance and support to students with diabetes.

"**§ 115C-150.13. Applicability of Article.**

This Article applies to any public school or charter school in the State authorized under Chapter 115C of the General Statutes. This Article does not apply to nonpublic schools or to home schools."

SECTION 2. There is appropriated from the General Fund to State Aid to Local School Administrative Units the sum of fifty-eight thousand dollars ($58,000) for the 2002-2003 fiscal year to implement this act.

SECTION 3. Section 2 of this act becomes effective July 1, 2002, and the remainder of this act is effective when it becomes law.

HOUSE BILL 1636
Care for School Children With Diabetes Act

BILL ANALYSIS

Committee:	House Health	**Introduced by:**	Rep. Gene Rogers
Date:	August 20, 2002	**Summary by:**	Linda Attarian, Staff Attorney
Version:	First Edition		

BRIEF SUMMARY: ***House Bill 1636 would add a new Article to Chapter 115C of the General Statutes to allow children with diabetes to control their diabetes at school and during extra-curricular activities, including monitoring their blood glucose level wherever and whenever necessary and taking appropriate actions. The act requires an individualized diabetes care plan to be developed by the child's parent or guardian, the child's health care provider, the school nurse where available and other appropriate school personnel. The diabetes care plan must address the specific management needs of each child. The act would require schools to provide the necessary assistance and support to the child from adults trained to facilitate the child's management of the child's diabetes.***

The act provides limited statutory immunity from civil damages for acts or omissions by laypersons authorized to assist the child, those responding to an emergency. The immunity also extends to the school. Guidelines for the development of the diabetes care plans and the training of school personnel are to be developed in accordance with standards adopted by the NC Diabetes Advisory Council. The bill appropriates $58,000 from the General Fund to the State School Board to provide funding for the dissemination of the guidelines to local school administrative units and to parents. The bill becomes effective when it becomes law, the appropriation would become effective July 1, 2002.

CURRENT LAW:

Anti-discrimination protections: Generally, federal and State law provide protections against discrimination to children with disabilities against exclusion from participation in school programs and activities because of the child's diabetes. Pursuant to federal anti-discrimination lawsuits, diabetes has been held to be a disability, and it is illegal for schools to discriminate against children with diabetes. Schools receiving federal funding from the Department of Education must ensure that the child receive an individualized education program (Section 504 plan) that will take into consideration the child's unique health care needs so that the child is able to remain in school and fully participate in all school activities. Within the last two years, there have been two published cases of alleged discrimination against a child with diabetes in North Carolina, and in both cases, after thorough investigation of the allegations, each school districts entered into a "Commitment to Resolve" with the Office of Civil Rights, Southern Division, of the US Department of Education to address the allegations. Hendersonville (May of 2000) and Onslow County (May of 2002) Public School districts have undertaken substantial actions to make system-wide improvements regarding addressing the diabetes-related needs of the District's students with diabetes.

Role of school personnel in providing health care services to students: *G.S. 115C-307*(c) authorizes schools to establish medical care program and to designate volunteer teachers and other school personnel to administer drugs or medication prescribed by a doctor at the request of the child's parents and to give emergency health care when reasonably apparent circumstances indicate that any delay would seriously worsen the physical condition or endanger the life of the pupil, and to perform any other first aid or life saving techniques in which the employee has been trained in a program approved by the State Board of Education.

Individualized care plan required for student with special health care needs: North Carolina rules *NCAC 16-6D.0402,* provides that local school administrative units must make available a registered nurse for assessment; care planning, and on-going evaluation of students with special health care service needs, including diabetes, in the school setting. If care planning is provided, it must include the identification and training of appropriate persons to perform any invasive procedure or test and a mechanism for an RN or other qualified health care professional to

plan and implement the plan and to provide ongoing supervision and monitoring of the student's response to the plan. The rule is to be implemented in compliance with G.S. 115C-307(c).

BILL ANALYSIS:

Section 1. The bill amends Chapter 115C to add a new Article 9C titled "Children with Diabetes". The Article requires the following:

Individualized Diabetes Care Plan: Local school administrative agencies and charter schools must, at the request of a parent or guardian, develop and maintain an *individualized diabetes care plan* (plan) for a child with diabetes. The plan must be developed by the parent or guardian, the school nurse where available, the child's health care provider and appropriate school personnel. The plan must address the specific needs of the child and provide specific instructions for the following: insulin administration, blood glucose testing and monitoring, insulin administration, meals and snacks, symptoms and treatment of hypoglycemia and hyperglycemia, testing for ketones, emergency care plan, the roles and expectations of school personnel, the child and the child's parent in providing assistance, if any, to the child during extracurricular activities, and the extent the child is able to participate in the child's diabetes care and management.

Assistance and support: The school must provide the following assistance to a child *in accordance with the child's diabetes care plan (i.e. – must provide a level of assistance that meets the individualized needs of the child)*:

1. An adult and an adult back-up trained and able to assist the student as needed with insulin or glucagon administration, finger-stick blood glucose monitoring, urine ketone testing, at least one of these adults must be available for field trips and extracurricular activities to enable the child's full participation;
2. An adult and an adult back-up responsible for knowing the child's dietary needs and schedule;
3. A location in the school to provide privacy during testing and injections *if requested*;
4. Storage location for insulin and glucagons *if necessary*;
5. Permission for the student to:
    a. Have immediate access to diabetes supplies, including permission to carry the supplies with them;
    b. Test their blood glucose levels in the classroom or anywhere else as necessary and to administer corrective measures immediately *if the child is able to demonstrate the following*:
        i. Accurate finger-stick technique;
        ii. Appropriate infection control practices consistently;
        iii. Disposal of "sharps" appropriately;
        iv. Ability to interpret blood testing results; and
        v. Ability to administer appropriate corrective measures if necessary;
    c. Eat a snack anywhere, including the classroom or bus if necessary;
    d. Miss school without consequences for required medical appointments;
    e. Use the restroom or leave the room to get a drink of water as necessary; and
6. Training to all school personnel who provide education for the child on the symptoms and treatment of hypoglycemia and hyperglycemia.

Child's Self-Management Responsibilities: The child must be allowed to participate in their diabetes care with the consent of the child's parent or guardian to the extent of the child's ability.

Liability: The act provides immunity for civil damages for acts or omissions relating to assistance provided by authorized adults and other school personnel to the child. The act does not provide immunity for civil damages if the act or omission amounts to gross negligence, wanton conduct or intentional wrongdoing.

Applicability: The article applies to all State schools, including charter schools and schools administered by the Department of Corrections or the Department of Juvenile Justice and Delinquency Prevention. It does not apply to private schools or to home schools.

Role of State Board of Education. The State Board of Education is disseminate guidelines to schools for training and to follow in the development of the diabetes care plans, and must ensure that parents or guardians are informed of the requirements of the act through normal information dissemination procedures and schedules in place. The guidelines are to be in accordance with medical or clinical standards adopted by the NC Diabetes Advisory Board established by the Department of Health and Human Services.

Section 2. Appropriates $58,000 to State Aid to Local School Administrative Units to fund the dissemination of guidelines to schools.

Section 3. Makes Section 2 effective July 1, 2002 and the remainder of the act effective when it becomes law.

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2001

S 1

SENATE BILL 911

Short Title:	Competitive Health Care Info.	(Public)
Sponsors:	Senator Rand.	
Referred to:	Judiciary I.	

April 5, 2001

A BILL TO BE ENTITLED

AN ACT CONCERNING CONFIDENTIALITY OF COMPETITIVE HEALTH CARE INFORMATION.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 131E-97.3 reads as rewritten:

"**§ 131E-97.3. Confidentiality of competitive health care information.**

Information relating to competitive health care activities by or on behalf of hospitals and hospital authorities shall be confidential and not a public record under Chapter 132 of the General ~~Statutes; provided that any contract entered into by or on behalf of a public hospital, as defined in G.S. 159-39, shall be a public record unless otherwise exempted by law.~~Statutes."

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

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2001

S D

SENATE BILL 911
PROPOSED HOUSE COMMITTEE SUBSTITUTE S911-CSRM-81 [v.1]

8/16/2002 3:20:39 PM

Short Title: Care for School Children With Diabetes Act (Public)

Sponsors:

Referred to:

April 5, 2001

A BILL TO BE ENTITLED

AN ACT TO REQUIRE THE STATE BOARD OF EDUCATION TO ADOPT AND DISSEMINATE GUIDELINES FOR THE DEVELOPMENT AND IMPLEMENTATION OF INDIVIDUAL DIABETES CARE PLANS AND TO REQUIRE LOCAL BOARDS OF EDUCATION TO IMPLEMENT THESE GUIDELINES.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 115C-47 is amended by adding a new subdivision to read:

"(31) To Adopt Guidelines for Individual Diabetes Care Plans. – The State Board shall adopt guidelines for the development and implementation of individual diabetes care plans. The State Board shall consult with the North Carolina Diabetes Advisory Council established by the Department of Health and Human Services in the development of these guidelines. The State Board also shall consult with local school administrative unit employees who have been designated as responsible for coordinating their individual unit's efforts to comply with federal regulations adopted under Section 504 of the Rehabilitation Act of 1973, as amended, 29 U.S. C. § 794. In its development of these guidelines, the State Board shall refer to the guidelines adopted by the American Diabetes Association and shall consider recent resolutions by the United States Department of Education's Office of Civil Rights of investigations into complaints alleging discrimination against students with diabetes.

The guidelines adopted by the State Board shall include:

a. Procedures for the development of an individual diabetes care plan at the written request of the student's parent or guardian, and involving the parent or guardian, the student's health care provider, the student's classroom teacher, the student if

appropriate, the school nurse if available, and other appropriate school personnel.

b. Procedures for regular review of an individual care plan.

c. Information to be included in a diabetes care plan, including the responsibilities and appropriate staff development for teachers and other school personnel, an emergency care plan, the identification of allowable actions to be taken, the extent to which the student is able to participate in the student's diabetes care and management, and other information necessary for teachers and other school personnel in order to offer appropriate assistance and support to the student.

d. Information and staff development to be made available to teachers and other school personnel in order to appropriately support and assist students with diabetes.

The State Board shall ensure that these guidelines are updated as necessary and shall ensure that the guidelines and any subsequent changes are published and disseminated to local school administrative units."

SECTION 2. G.S. 115C-47 is amended by adding a new subdivision to read:

(42) To Implement Guidelines to Support and Assist Students with Diabetes. – Local boards of education shall ensure that the guidelines adopted by the State Board of Education under G.S. 115C-12(31) are implemented in schools in which students with diabetes are enrolled. In particular, the boards shall require the implementation of the procedures set forth in those guidelines for the development and implementation of individual diabetes care plans. Local boards also shall make available necessary information and staff development to teachers and school personnel in order to appropriately support and assist students with diabetes in accordance with their individual diabetes care plans."

SECTION 3. The State Board of Education shall report no later than September 1, 2003 to the Joint Legislative Education Oversight Committee on the Board's progress regarding the adoption, dissemination and implementation of the guidelines under Sections 1 and 2 of this act.

SECTION 4. This act is effective when it becomes law. The guidelines under Section 1 of this act shall be adopted no later than January 15, 2003, and shall be implemented under Section 2 of this act beginning with the 2003-2004 school year.

SENATE BILL 911 (PCS):
Care for School Children with Diabetes Act

BILL ANALYSIS

Committee:	House Health	**Introduced by:**	Sen. Tony Rand
Date:	August 20, 2002	**Summary by:**	Linda Attarian
Version:	S911-CSRM-81[v.1]		Committee Counsel

SUMMARY: ***The PCS deletes the contents of Senate Bill 911 and inserts provisions that would require the State Board of Education to adopt, publish and disseminate guidelines for developing and implementing individualized diabetes care plans, and would require local boards of education to implement these guidelines in schools. The guidelines must be adopted by January 1, 2003, and implemented by the 2003-2004 school year. The State Board would be required to report on its progress no later than September 1, 2003. The bill is effective when it becomes law.***

The provisions contained in S911 were enacted by S.L. 2001-516, HB 1284, and became law on January 4, 2002.

CURRENT LAW: Refer to Bill Analysis for H1636.

BILL ANALYSIS: The PCS would direct the State Board of Education to adopt, publish, and disseminate guidelines for developing and implementing diabetes care plans. The PCS would direct local boards of education to implement the guidelines in schools in which a child with diabetes is enrolled.

The State Board must consult with the North Carolina Diabetes Advisory Council and local Section 504 representatives in the development of these guidelines. They also must refer to the guidelines adopted by the American Diabetes Association and must consider recent OCR investigations.

The guidelines adopted by the State Board must include:

- Procedures for the development of individual diabetes care plans at the written request of the student's parent or guardian. The procedures must provide for the involvement of the student's parent or guardian, health care provider, school nurse where available, and other appropriate school personnel. And the procedures must provide for regular review of the plan.
- Information that must be included in a plan, including an emergency plan, responsibilities and appropriate staff development for teachers and other school personnel, allowable actions to be taken (such as meals and snacks), the extent to which the child can participate in the management of the child's plan, and other necessary information.
- Information and staff development to be made available to teachers and other school personnel.

DIFFERENCES BETWEEN H1636, first edition and S911-CSRM-81:

- ***Individualized diabetes care plan***: H1636 would enact new law to require schools to work with parents and health care providers to develop individualized diabetes care plans to assist children with diabetes with the management of their diabetes at school and during extra-curricular activities. H1636 is specific as to what procedures must be included in the diabetes care plan, the assistance the school must provide the child if needed, requires that schools must adopt policies that allow a child to self-manage their diabetes to the extent they are capable, and specifies the

allowances schools must make to accommodate and facilitate the child with the management of the child's diabetes. The PCS deletes the statutory requirements and directs the State Board of Education to develop guidelines for determining the requirements of the of diabetes care plan, the responsibilities of teachers and other school personnel, and the allowances schools must make to accommodate the needs of students with diabetes.

- ***Immunity from civil damages:*** H1636 would enact a new law providing for immunity from liability for civil damages resulting from injuries caused by negligent acts or omissions by school personnel and/or volunteers acting in good faith to assist students with the management of their diabetes or to assist students who are suffering from hypoglycemia. The PCS deletes this section.
- ***Staff training and development***: H1636 would require an adult and a back-up adult to be trained to assist students with the management of their diabetes if necessary and would require all school personnel that provide education to the student to be trained in the signs and symptoms of hypoglycemia and hyperglycemia and to have knowledge of the child's emergency care plan. The PCS requires the State Board of Education to develop guidelines for staff development in order to appropriately support and assist students.
- ***Report to the Joint Education Legislative Oversight Committee:*** The PCS requires the State Board to submit a progress report no later than September 1, 2003. H1636 does not require a report.
- ***Appropriation:*** H 1636 appropriates $58,000 from the General Fund. The PCS deletes the appropriation provision.

Robin Johnson, committee counsel to the House Education Committee made significant contributions to this document.

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2001

S D

SENATE BILL 911
PROPOSED HOUSE COMMITTEE SUBSTITUTE S911-PCS6900-RM-81

Short Title: Care for School Children With Diabetes Act. (Public)

Sponsors:

Referred to:

April 5, 2001

A BILL TO BE ENTITLED

AN ACT TO REQUIRE THE STATE BOARD OF EDUCATION TO ADOPT AND DISSEMINATE GUIDELINES FOR THE DEVELOPMENT AND IMPLEMENTATION OF INDIVIDUAL DIABETES CARE PLANS AND TO REQUIRE LOCAL BOARDS OF EDUCATION TO IMPLEMENT THESE GUIDELINES.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 115C-47 is amended by adding a new subdivision to read:

"(31) To Adopt Guidelines for Individual Diabetes Care Plans. – The State Board shall adopt guidelines for the development and implementation of individual diabetes care plans. The State Board shall consult with the North Carolina Diabetes Advisory Council established by the Department of Health and Human Services in the development of these guidelines. The State Board also shall consult with local school administrative unit employees who have been designated as responsible for coordinating their individual unit's efforts to comply with federal regulations adopted under Section 504 of the Rehabilitation Act of 1973, as amended, 29 U.S.C. § 794. In its development of these guidelines, the State Board shall refer to the guidelines recommended by the American Diabetes Association for the management of children with diabetes in the school and day care setting and shall consider recent resolutions by the United States Department of Education's Office of Civil Rights of investigations into complaints alleging discrimination against students with diabetes.

The guidelines adopted by the State Board shall include:

a. Procedures for the development of an individual diabetes care plan at the written request of the student's parent or guardian, and involving the parent or guardian, the student's health care

provider, the student's classroom teacher, the student if appropriate, the school nurse if available, and other appropriate school personnel.

b. Procedures for regular review of an individual care plan.

c. Information to be included in a diabetes care plan, including the responsibilities and appropriate staff development for teachers and other school personnel, an emergency care plan, the identification of allowable actions to be taken, the extent to which the student is able to participate in the student's diabetes care and management, and other information necessary for teachers and other school personnel in order to offer appropriate assistance and support to the student. The State Board shall ensure that the information and allowable actions included in a diabetes care plan as required in this subdivision meet or exceed the American Diabetes Association's recommendations for the management of children with diabetes in the school and day care setting.

d. Information and staff development to be made available to teachers and other school personnel in order to appropriately support and assist students with diabetes.

The State Board shall ensure that these guidelines are updated as necessary and shall ensure that the guidelines and any subsequent changes are published and disseminated to local school administrative units."

SECTION 2. G.S. 115C-47 is amended by adding a new subdivision to read:

"(42) To Implement Guidelines to Support and Assist Students With Diabetes. – Local boards of education shall ensure that the guidelines adopted by the State Board of Education under G.S. 115C-12(31) are implemented in schools in which students with diabetes are enrolled. In particular, the boards shall require the implementation of the procedures set forth in those guidelines for the development and implementation of individual diabetes care plans. Local boards also shall make available necessary information and staff development to teachers and school personnel in order to appropriately support and assist students with diabetes in accordance with their individual diabetes care plans."

SECTION 3. The State Board of Education shall report no later than September 1, 2003, to the Joint Legislative Education Oversight Committee on the Board's progress regarding the adoption, dissemination, and implementation of the guidelines under Sections 1 and 2 of this act.

SECTION 4. This act is effective when it becomes law. The guidelines under Section 1 of this act shall be adopted no later than January 15, 2003, and shall be implemented under Section 2 of this act beginning with the 2003-2004 school year.

NORTH CAROLINA GENERAL ASSEMBLY
AMENDMENT
Senate Bill 911

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

S911-ARM-77 [v.2]

Date 8-20 ,2002

Comm. Sub. [YES]
Amends Title [NO]
First Edition

Representative Edwards

moves to amend the bill on page 1, lines 20 and 21, by rewriting those lines to read:

"guidelines recommended by the American Diabetes Association for the management of children with diabetes in the school and daycare setting and shall"; and further moves to amend the bill on page 2, line 11, by adding the following sentence at the end of that line:
"The State Board shall ensure that the information and allowable actions included in a diabetes care plan as required in this subdivision meet or exceed the American Diabetes Association's recommendations for the management of children with diabetes in the school and daycare setting.".

SIGNED Eva L Edwards
Amendment Sponsor

SIGNED _____
Committee Chair if Senate Committee Amendment

ADOPTED ✓ FAILED _____ TABLED _____

SENATE BILL 911:
Competitive Health Care Information

BILL ANALYSIS

Committee:	House Health	**Introduced by:**	Sen. Tony Rand
Date:	August 20, 2002	**Summary by:**	Linda Attarian
Version:	S911-CSRM-81[v.1]		Committee Counsel

SUMMARY: ***The PCS deletes the contents of Senate Bill 911 and inserts provisions that would require the State Board of Education to adopt, publish and disseminate guidelines for developing and implementing individualized diabetes care plans, and would require local boards of education to implement these guidelines in schools. The guidelines must be adopted by January 1, 2003, and implemented by the 2003-2004 school year. The State Board would be required to report on its progress no later than September 1, 2003. The bill is effective when it becomes law.***

The provisions contained in S911 were enacted by S.L. 2001-516, HB 1284, and became law on January 4, 2002.

CURRENT LAW: Refer to Bill Analysis for H1636.

BILL ANALYSIS: The PCS would direct the State Board of Education to adopt, publish, and disseminate guidelines for developing and implementing diabetes care plans. The PCS would direct local boards of education to implement the guidelines in schools in which a child with diabetes is enrolled.

The State Board must consult with the North Carolina Diabetes Advisory Council and local Section 504 representatives in the development of these guidelines. They also must refer to the guidelines adopted by the American Diabetes Association and must consider recent OCR investigations.

The guidelines adopted by the State Board must include:

- Procedures for the development of individual diabetes care plans at the written request of the student's parent or guardian. The procedures must provide for the involvement of the student's parent or guardian, health care provider, school nurse where available, and other appropriate school personnel. And the procedures must provide for regular review of the plan.
- Information that must be included in a plan, including an emergency plan, responsibilities and appropriate staff development for teachers and other school personnel, allowable actions to be taken (such as meals and snacks), the extent to which the child can participate in the management of the child's plan, and other necessary information.
- Information and staff development to be made available to teachers and other school personnel.

DIFFERENCES BETWEEN H1636, first edition and S911-CSRM-81:

- ***Individualized diabetes care plan***: H1636 would enact new law to require schools to work with parents and health care providers to develop individualized diabetes care plans to assist children with diabetes with the management of their diabetes at school and during extra-curricular activities. H1636 is specific as to what procedures must be included in the diabetes care plan, the assistance the school must provide the child if needed, requires that schools must adopt policies that allow a child to self-manage their diabetes to the extent they are capable, and specifies the

allowances schools must make to accommodate and facilitate the child with the management of the child's diabetes. The PCS deletes the statutory requirements and directs the State Board of Education to develop guidelines for determining the requirements of the of diabetes care plan, the responsibilities of teachers and other school personnel, and the allowances schools must make to accommodate the needs of students with diabetes.

- ***Immunity from civil damages:*** H1636 would enact a new law providing for immunity from liability for civil damages resulting from injuries caused by negligent acts or omissions by school personnel and/or volunteers acting in good faith to assist students with the management of their diabetes or to assist students who are suffering from hypoglycemia. The PCS deletes this section.
- ***Staff training and development***: H1636 would require an adult and a back-up adult to be trained to assist students with the management of their diabetes if necessary and would require all school personnel that provide education to the student to be trained in the signs and symptoms of hypoglycemia and hyperglycemia and to have knowledge of the child's emergency care plan. The PCS requires the State Board of Education to develop guidelines for staff development in order to appropriately support and assist students.
- ***Report to the Joint Education Legislative Oversight Committee:*** The PCS requires the State Board to submit a progress report no later than September 1, 2003. H1636 does not require a report.
- ***Appropriation:*** H 1636 appropriates $58,000 from the General Fund. The PCS deletes the appropriation provision.

Robin Johnson, committee counsel to the House Education Committee made significant contributions to this document.

2002 COMMITTEE REPORT
HOUSE OF REPRESENTATIVES

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

☐ Committee Substitute for
S.B. 911 A BILL TO BE ENTITLED AN ACT CONCERNING CONFIDENTIALITY OF COMPETITIVE HEALTH CARE 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 the committee substitute bill (#), ☐ which changes the title, unfavorable as to (the 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 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)

5/13/02

Vanda Wilson-Wormack (Rep. Wright)

From: Vanda Wilson-Wormack (Rep. Wright)
Sent: Wednesday, August 14, 2002 12:45 PM
Subject: House Health Committee Meeting-08-20-

NORTH CAROLINA HOUSE OF REPRESENTATIVES
COMMITTEE MEETING NOTICE
2001-2002 SESSION

You are hereby notified that the Committee on **HEALTH** will meet as follows:

DAY & DATE: **Tuesday, August 20, 2002**

TIME: **12:00 Noon**

LOCATION: **415 LOB**

The following bills will be considered (Bill # & Short Title & Bill Sponsor):
HB-1636 CARE FOR SCHOOL CHILDREN WITH DIABETES ACT.
(Rep. Rogers)

Respectfully,

Representative Thomas E. Wright
Chairman

I hereby certify this notice was filed by the committee assistant at the following offices at on **Wednesday, August 14, 2002.**

___Principal Clerk
___Reading Clerk - House Chamber

Vanda Wilson-Wormack (Committee Assistant)

NORTH CAROLINA HOUSE OF REPRESENTATIVES
NOTIFICATION TO BILL SPONSOR
2001-2002

BILL SPONSOR: **Rep. Rogers**

OFFICE:

NOTIFICATION DATE: **Wednesday, August 14, 2002**

The House Committee on Health will meet as follows:

DAY & DATE: **Tuesday, August 20, 2002**

TIME: **12:00 Noon**

LOCATION: **415 LOB**

Your Bill (or Bills) will be discussed at this time:
HB-1636 CARE FOR SCHOOL CHILDREN WITH DIABETES ACT.
(Rep. Rogers)

We would like to have you attend this meeting.

Representative Thomas E. Wright
Chairman

Vanda Wilson-Wormack (Committee Assistant)

VISITOR REGISTRATION SHEET

Health Committee — Name of Committee

8/20/02 — Date

VISITORS: PLEASE SIGN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Joann Schorn Stevens	Nursing
Rachel E. Picklé	Nursing & Association of School Nurses of NC
Rob Dusckless	State Watch
Tommy Suter	Wyeth
Steve Mitchell	Novartis
John Bowdish	American Diabetes Assoc
Paula Caldwell Eckel	self + families of diabetic children
Melinda Dudley	self & families of diabetic children
Hubert Tilson	NCHA
Amy Jo Horne	NCMS
Stacy Flannery	NCHCFA
Jeanne Winner	NCSBA
Bob Schmidt	Hoffmann-La Roche
George Thuring	Johnson & Johnson
J. Edgar Geddie	NC Dept. of Labor, OSH Division
Kevin Leonard	NCDOL
Butch Gunnells	NCSDA
Mark & Samantha Ritchie	Parent Advocate of 6yr old diabetic
Jenny Rabon	APPSSA
Elydie Caldwell	EEBC
Linda Dupp	SBE
Neil Shipman	parent of child with diabetes
Linda Shipman	parent of child with diabetes
TAMARA BURNS	PARENT DIABETES ADVOCATE
LEXIE BURNS	4 YR OLD W/ DIABETES
Pamela Taynor	Parent of child w/diabetes
MICHELLE Taynor	4yr old w/Diabetes
Audrey L. Galloway	NCAE

VISITOR REGISTRATION SHEET

Name of Committee

Date

VISITORS:. PLEASE SIGN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Carol Lauer	EGHS

MINUTES

HOUSE COMMITTEE ON HEALTH

WEDNESDAY, OCTOBER 2, 2002

HOUSE CHAMBER

The House Committee on Health met on Wednesday, October 2, 2002 around the desk of Vice-Chairman Edwards-(Presided as Chair) in the House Chamber to postpone the following bills indefinitely:

HB-1038 NO ABORTIONS UNDER STATE HEALTH PLAN. (Rep. Capps)

HB-1259 ABORTION CLINIC REQUIREMENTS.(Rep. Davis & Rep. Carpenter)

HB-1280 ABORTION- WOMAN'S RIGHT TO KNOW. (Rep. Carpenter)

HB-1335 C.O.N.- LICENSING PROCEDURES. (Rep. C. Wilson)

A vote was taken and the bills were postponed indefinitely.

Zeno Edwards — Vanda Wilson-Wormack

Rep. Zeno Edwards,(Presiding Chair) Vanda Wilson-Wormack, Committee Assistant

2002 COMMITTEE REPORT
HOUSE OF REPRESENTATIVES

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

☐ Committee Substitute for
H.B. 1038 A BILL TO BE ENTITLED AN ACT TO PROHIBIT COVERAGE FOR ABORTIONS 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 the committee substitute bill (#), ☐ which changes the title, unfavorable as to (the 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)

5/13/02

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2001

H 1

HOUSE BILL 1038*

Short Title:	No Abortions Under State Health Plan.	(Public)
Sponsors:	Representatives Capps; Allred, Barnhart, Blust, Brubaker, Carpenter, Clary, Creech, Culp, Davis, Decker, Eddins, Ellis, Esposito, Gillespie, Grady, Gulley, Harrington, Hiatt, Hilton, Howard, Johnson, Justus, Kiser, McComas, McCombs, Morris, Rayfield, Setzer, Sexton, Shubert, Starnes, Thompson, Walend, Walker, West, and C. Wilson.	
Referred to:	Health.	

April 10, 2001

A BILL TO BE ENTITLED

AN ACT TO PROHIBIT COVERAGE FOR ABORTIONS UNDER THE TEACHERS' AND STATE EMPLOYEES' COMPREHENSIVE MAJOR MEDICAL PLAN.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 135-40.1(16) reads as rewritten:

"**§ 135-40.1. General definitions.**

As used in Parts 2 and 3 of this Article, the following terms have the meaning specified as follows:

...

(16) Pregnancy. – Shall include resulting ~~childbirth, miscarriage or abortion.~~childbirth or miscarriage.

...."

SECTION 2. G.S. 135-40.6(5)d. reads as rewritten:

"(5) Surgical Benefits. – The Plan pays the usual, customary and reasonable charges for covered surgical services as follows:

...

"d. Maternity Care: Independent operative procedures in connection with pregnancy, such as: manipulative obstetrical delivery, delivery by Caesarean section, removal of ectopic pregnancy, dilation and curettage. Benefits for manipulative obstetrical delivery include use of forceps and/or episiotomy. No benefits are provided for antepartum or postpartum care, except for direct surgical procedures of delivery and surgical

treatment. No benefits are provided for medical or surgical abortion procedures.

...."

SECTION 3. G.S. 135-40.7 is amended by adding the following new subdivision to read:

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

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

...

"(24) Charges for medical or surgical abortion procedures."

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

2002 COMMITTEE REPORT
HOUSE OF REPRESENTATIVES

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

☐ Committee Substitute for
H.B. 1259 A BILL TO BE ENTITLED AN ACT TO DEFINE PUBLIC HEALTH REQUIREMENTS FOR ABORTION CLINICS.

☐ 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) (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)

5/13/02

HOUSE BILL 1259

Short Title:	Abortion Clinic Requirements.	(Public)
Sponsors:	Representatives Davis, Carpenter (Primary Sponsors); Blust, Capps, Culp, Gillespie, Harrington, Hiatt, Hilton, Morris, Setzer, and G. Wilson.	
Referred to:	Health.	

April 12, 2001

A BILL TO BE ENTITLED

AN ACT TO DEFINE PUBLIC HEALTH REQUIREMENTS FOR ABORTION CLINICS.

The General Assembly of North Carolina enacts:

SECTION 1. Chapter 130A of the General Statutes is amended by adding a new Article to read:

"Article 21.

"Abortion.

"**§ 130A-465. Abortion clinics.**

(a) Definitions. – The following definitions apply in this section:

(1) Abortion clinic. – A facility certified by the Department of Health and Human Services in which abortions are performed during the first 20 weeks of pregnancy and that is neither physically attached to a licensed hospital nor operated by a licensed hospital.

(2) Backup hospital. – A hospital that can be reached within one hour by motor vehicle under average traveling conditions.

(b) Admitting Patients. – Only a physician who is licensed to practice medicine in this State and who has admitting privileges to perform obstetric and gynecological procedures at a backup hospital may admit a patient for treatment at an abortion clinic.

(c) Emergency Transfer Plan. – Each abortion clinic shall enter into a written agreement with a backup hospital to facilitate the transfer of patients who are in need of emergency care. A copy of this agreement shall be presented to each patient at the time of admittance to the abortion clinic. In any case in which transfer of a patient to a hospital is necessary, a staff member of the abortion clinic shall accompany the patient to the hospital and shall assist the patient in obtaining admission to the hospital."

SECTION 2. G.S. 130A-466 through G.S. 130A-469 are reserved for future codification.

SECTION 3. This act becomes effective October 1, 2001.

2002 COMMITTEE REPORT
HOUSE OF REPRESENTATIVES

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

☐ Committee Substitute for
H.B. 1280 A BILL TO BE ENTITLED AN ACT TO REQUIRE A TWENTY-FOUR-HOUR WAITING PERIOD AND THE INFORMED CONSENT OF A PREGNANT WOMAN BEFORE AN ABORTION MAY BE PERFORMED.

☐ 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) (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)

5/13/02

HOUSE BILL 1280

Short Title:	Abortion - Woman's Right to Know.	(Public)
Sponsors:	Representatives Carpenter; Barnhart, Capps, Davis, Gillespie, Harrington, Hiatt, Hilton, Howard, Hurley, Johnson, Kiser, McComas, Morris, Starnes, Walend, and C. Wilson.	
Referred to:	Health.	

April 12, 2001

A BILL TO BE ENTITLED

AN ACT TO REQUIRE A TWENTY-FOUR-HOUR WAITING PERIOD AND THE INFORMED CONSENT OF A PREGNANT WOMAN BEFORE AN ABORTION MAY BE PERFORMED.

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 1G.

"Woman's Right to Know Act.

"**§ 90-21.50. Short title.**

This act shall be known and may be cited as the Woman's Right to Know Act.

"**§ 90-21.51. Definitions.**

As used in this Article, unless the context clearly requires otherwise, the term:

(1) 'Abortion' means the use or prescription of any instrument, medicine, drug, or any other substance or device intentionally to terminate the pregnancy of a woman known to be pregnant with an intention other than to increase the probability of a live birth, to preserve the life or health of the child after live birth, or to remove a dead fetus.

(2) 'Attempt to perform an abortion' means an act, or an omission of a statutorily required act, that, under the circumstances as the actor believes them to be, constitutes a substantial step in a course of conduct planned to culminate in the performance of an abortion in North Carolina in violation of this Article.

(3) 'Coercion' means restraining or dominating the choice of a female by force, threat of force, or deprivation of food or shelter by a person obligated to provide food or shelter.

(4) 'Complication' means that condition which includes, but is not limited to, hemorrhage, infection, uterine perforation, cervical laceration, pelvic inflammatory disease, endometriosis, and retained products. The Department may further define 'complication'.

(5) 'Department' means the Department of Health and Human Services.

(6) 'Medical emergency' means that condition which, on the basis of the physician's good faith clinical judgment, so complicates the medical condition of a pregnant woman as to necessitate the immediate abortion of her pregnancy to avert her death or for which a delay will create serious risk of substantial and irreversible impairment of a major bodily function.

(7) 'Medical risks' means the usual and most frequent risks and hazards, both physical and emotional, inherent in a proposed abortion procedure and the risks, both physical and emotional, inherent in carrying the unborn child to term.

(8) 'Physician' means an individual licensed to practice medicine or osteopathy in accordance with this Chapter.

(9) 'Probable gestational age' means what, in the judgment of the physician, will with reasonable probability be the gestational age of the unborn child at the time the abortion is planned to be performed.

(10) 'Qualified person' means an agent of the physician who is a licensed psychologist, licensed social worker, licensed professional counselor, registered nurse, licensed physician, or a certified health educator.

"**§ 90-21.52. Informed consent to abortion; coercion prohibited.**

No abortion shall be performed upon a woman in this State without her voluntary and informed consent. It shall be unlawful for any individual to coerce a woman to undergo an abortion. Except in the case of a medical emergency, consent to an abortion is voluntary and informed only if all of the following conditions are satisfied:

(1) At least 24 hours prior to the abortion, the physician who is to perform the abortion, the referring physician, or a qualified person has orally informed the woman, by telephone or in person, of all of the following:

a. The particular medical risks associated with the particular abortion procedure to be employed including, when medically accurate, the risks of infection, hemorrhage, breast cancer, danger to subsequent pregnancies, and infertility.

b. The probable gestational age of the unborn child at the time the abortion is to be performed.

c. If the physician who is to perform the abortion has no liability insurance for malpractice in the performance or attempted performance of an abortion, that information shall be communicated.

d. If the physician who will perform the abortion has no local hospital admitting privileges, that information shall be communicated.

The information required by this subdivision may be provided orally, by telephone or in person, without conducting a physical examination or tests of the patient, in which case the required information may be based on facts supplied by the woman to the physician or the qualified person. The information required by this section may not be provided by a tape recording but must be provided during a consultation in which the physician or the qualified person is able to ask questions of the woman, and the woman is able to ask questions of the physician or the qualified person. If in the medical judgment of the physician, a physical examination, tests, or the availability of other information to the physician subsequently indicates a revision of the information previously supplied to the patient, then that revised information may be communicated to the patient at any time prior to the performance of the abortion. Nothing in this section may be construed to preclude provision of required information in a language understood by the patient through a translator.

(2) The physician who is to perform the abortion, the referring physician, or the qualified person informs the woman, by telephone or in person, of each of the following at least 24 hours before the abortion:

a. That medical assistance benefits may be available for prenatal care, childbirth, and neonatal care.

b. That public assistance programs under Chapter 108A of the General Statutes may or may not be available as benefits under federal and State assistance programs.

c. That the father is liable to assist in the support of the child, even if the father has offered to pay for the abortion.

d. That the woman has the right to review the printed materials described in G.S. 90-21.53. The physician or the qualified person shall orally inform the woman that the materials have been provided by the Department and that they describe the unborn child and list agencies that offer alternatives to abortion. If the woman requests the materials, they shall either be given to her at least 24 hours before the abortion or mailed to her at least 72 hours before the abortion by certified mail, restricted delivery to addressee.

e. That information concerning access to local domestic violence services will be provided if the woman acknowledges involvement in an abusive relationship.

f. That she is free to withhold or withdraw her consent to the abortion at any time before or during the abortion without affecting her right to future care or treatment and without the loss of any State or federally funded benefits to which she might otherwise be entitled.

g. That Medicaid covers the cost of an abortion for eligible women if the pregnancy was the result of rape or incest, or if the abortion is necessary to save the life of the mother.

The information required by this subdivision may be provided by a tape recording if provision is made to record or otherwise register specifically whether the woman does or does not choose to review the printed materials.

(3) The woman certifies in writing, prior to the abortion, that the information described in subdivisions (1) and (2) of this section has been furnished her, and that she has been informed of her opportunity to review the information referred to in sub-subdivision d. of subdivision (2) of this section. The original of this certification shall be maintained in the woman's medical records, and a copy shall be given to her.

(4) Prior to the performance of the abortion, the woman must be informed of the name of the physician who will perform the abortion, and that physician or the qualified person must receive a copy of the written certification required by subdivision (3) of this section.

(5) The information required under this section and under G.S. 90-21.53 is provided to the woman individually to protect her privacy and maintain the confidentiality of her decision, and to ensure that the information focuses on her individual circumstances, and that she has an adequate opportunity to ask questions. If, at the time the information is provided, the woman is on the premises of the physician who is to perform the abortion, then the information shall be provided in a private room in order to further the protections and purposes of this subdivision.

(6) The woman is not required to pay any amount for the abortion procedure until the 24-hour waiting period has expired.

"**§ 90-21.53. Printed information required.**

(a) The Department shall publish the following printed materials in a manner that ensures that the information is easily comprehensible:

(1) Geographically indexed materials designed to inform a woman of public and private agencies and services available to assist her through pregnancy, upon childbirth, and while the child is dependent, including adoption agencies. The information shall include a comprehensive list of the agencies available, a description of the services they offer, and a

description of the manner, including telephone numbers, in which they might be contacted.

(2) Materials designed to inform the woman of the probable anatomical and physiological characteristics of the unborn child at two-week gestational increments from the time of conception until full term, including any relevant information on the possibility of the unborn child's survival and pictures representing the development of the unborn child at two-week gestational increments. The pictures must contain the dimensions of the unborn child and must be realistic and appropriate for the stage of pregnancy depicted. The materials shall be objective, nonjudgmental, and designed to convey only accurate scientific information about the unborn child at the various gestational ages. The material shall also contain objective information describing the methods of abortion procedures employed, the medical risks associated with each procedure, the possible detrimental psychological effects of abortion, and the medical risks associated with each procedure, and the medical risks associated with carrying an unborn child to term.

(3) The materials shall state that it is unlawful for any individual to coerce a woman to undergo an abortion, that any physician who performs an abortion upon a woman without her informed consent may be liable to her for damages in a civil action at law, and that the law permits adoptive parents to pay costs of prenatal care, childbirth, and neonatal care.

(b) The materials required under this section shall be available at no cost from the Department upon request and in appropriate numbers to any physician, qualified person, facility, or hospital.

"**§ 90-21.54. Procedure in case of medical emergency.**

When a medical emergency compels the performance of an abortion, the physician shall inform the woman, prior to the abortion if possible, of the medical indications supporting the physician's judgment that an abortion is necessary to avert her death or that a 24-hour delay will create a serious risk to her life. As soon as feasible, the physician shall document in writing the medical indications upon which the physician relied and shall cause the original of the writing to be maintained in the woman's medical records and a copy given to her.

"**§ 90-21.55. Informed consent for a minor.**

If the woman upon whom an abortion is to be performed is an unemancipated minor, the voluntary and informed written consent required under G.S. 90-21.52 shall be obtained from the minor and from the adult individual who gives consent pursuant to G.S. 90-21.7(a), unless the waiver order of G.S. 90-21.8(e) and (f) has been issued.

"**§ 90-21.56. Protection of privacy in court proceedings.**

In every civil proceeding or action brought under this Article, the court may rule whether the anonymity of any woman upon whom an abortion has been performed or attempted shall be preserved from public disclosure if she does not give her consent to disclosure. The court, upon its own motion or upon motion of a party, and upon determining that the woman's anonymity should be preserved, shall issue appropriate orders to the parties, witnesses, and counsel. Nothing in this section shall be construed to conceal from the defendant the identity of the plaintiff in a civil case.

"**§ 90-21.57. Civil remedies.**

(a) Any person upon whom an abortion has been performed or attempted to be performed may maintain an action against the person who performed or attempted to perform the abortion in knowing or reckless violation of this Article for actual damages and, to the extent allowed by law, for punitive damages.

(b) If judgment is rendered in favor of the plaintiff in any action authorized under this section, the court shall also tax as part of the costs reasonable attorneys' fees in favor of the plaintiff against the defendant. If judgment is rendered in favor of the defendant and the court finds that the plaintiff's suit was frivolous and brought in bad faith, then the court shall tax as part of the costs reasonable attorneys' fees in favor of the defendant against the plaintiff."

SECTION 2. If any provision, word, phrase, or clause of this act or the application thereof to any person or circumstance is held invalid, the invalidity shall not affect the provisions, words, phrases, clauses, or applications of this act which can be given effect without the invalid provision, word, phrase, clause, or application and, to this end, the provisions, words, phrases, and clauses of this act are declared to be severable.

SECTION 3. Nothing in this act shall be construed as creating or recognizing a right to abortion. It is not the intention of this act to make lawful an abortion that is currently unlawful.

SECTION 4. The Department of Health and Human Services shall use funds available to cover the costs of implementing this act.

SECTION 5. This act becomes effective October 1, 2001, and applies to claims for relief arising on or after that date.

2002 COMMITTEE REPORT
HOUSE OF REPRESENTATIVES

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

☐ Committee Substitute for
H.B. 1335 A BILL TO BE ENTITLED AN ACT RELATING TO THE CERTIFICATE OF NEED LICENSING PROCESS.

☐ 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) (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)

5/13/02

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2001

HOUSE BILL 1335

Short Title:	C.O.N.-Licensing Procedures.	(Public)
Sponsors:	Representatives C. Wilson; and Harrington.	
Referred to:	Health.	

April 12, 2001

A BILL TO BE ENTITLED

AN ACT RELATING TO THE CERTIFICATE OF NEED LICENSING PROCESS.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 131E-147(b) reads as rewritten:

"**§ 131E-147. Licensure requirement.**

"(b) Applications shall be available from the Department, and each application filed with the Department shall contain all necessary and reasonable information that the Department may by rule require. A license shall be granted to the applicant upon a determination by the Department that the applicant has complied with the provisions of this Part and the rules promulgated by the Commission under this Part. The Department shall have a maximum of 60 days to approve or comment on plans or specifications submitted for construction of new buildings, additions, or material alterations to existing buildings."

SECTION 2. G.S. 131E-182 is amended by adding a new subsection to read:

"(d) The Department shall establish by rule uniform procedures for issuing opinions on whether projects described in writing by proponents are subject to Certificate of Need review, based on the Department's application and interpretation of the requirements of this Chapter. These opinions shall be known as "no review opinions." The Department's procedures shall be subject to the following requirements and limitations:

(1) No review opinion procedures shall provide a method by which any person may request in writing to receive notice of the issuance of no review opinions as generally described in the request for notice and procedures for how the Department will provide the requested notices.

(2) The issuance of no review opinions shall be in addition and separate from the expenditures exempted from review by this section.

(3) The Department shall not require a person to seek a no review opinion from the Department before proceeding to operate or develop a project that the proponent determines is not a "new institutional health service" as defined in G.S. 131E-176(16)."

SECTION 3. This act becomes effective October 1, 2001.

MEMORANDUM

DATE: **09/26/02**

TO: **Representative Morris**

FROM: **Representative Wright**

SUBJECT: **Bills Pending in the Committee on Health**

Pursuant to House Rule 36(a) all House bills and resolutions shall be reported from the standing committee or permanent subcommittee to which referred with such recommendations as the standing committee or permanent subcommittee may desire to make **except in the case where the principal introducer requests in writing to the Chair(s) of the standing committee or permanent subcommittee that the bill not be considered.**

If you would like to request that your bill not be considered by the Committee on Health, for your convenience, a printed form is included at the bottom of this page. Please complete, sign and return the form to Room 528 LOB. This form may not be e-mailed because it requires the sponsor's signature.

MEMORANDUM

TO: **Representative Wright**

FROM: **Representative Morris**
Bill Sponsor

SUBJECT: **HB 1316, REQUIRE NOTIFICATION TO TREAT MINORS** (Short Title)

I request that HB 1316 not be considered by the Committee on HEALTH.

Mia Morris
(Sponsor's Signature)

10 Oct 2002
Date

MEMORANDUM

DATE: 10/02/02

TO: Representative Baddour

FROM: Representative Wright

SUBJECT: Bills Pending in the Committee on Health

Pursuant to House Rule 36(a) all House bills and resolutions shall be reported from the standing committee or permanent subcommittee to which referred with such recommendations as the standing committee or permanent subcommittee may desire to make **except in the case where the principal introducer requests in writing to the Chair(s) of the standing committee or permanent subcommittee that the bill not be considered.**

If you would like to request that your bill not be considered by the Committee on Health, for your convenience, a printed form is included at the bottom of this page. Please complete, sign and return the form to Room 528 LOB. This form may not be e-mailed because it requires the sponsor's signature.

MEMORANDUM

TO: Representative Wright

FROM: Representative Baddour
Bill Sponsor

SUBJECT: HB 1719, STATE EMPLOYEES' HEALTH PLAN/PRESC. DRUGS.
(Short Title)

I request that HB 1719 not be considered by the Committee on HEALTH.

(Sponsor's Signature)

10/2/02 Date

MEMORANDUM

DATE: **10/02/02**

TO: **Representative Insko**

FROM: **Representative Wright**

SUBJECT: **Bills Pending in the Committee on Health**

Pursuant to House Rule 36(a) all House bills and resolutions shall be reported from the standing committee or permanent subcommittee to which referred with such recommendations as the standing committee or permanent subcommittee may desire to make **except in the case where the principal introducer requests in writing to the Chair(s) of the standing committee or permanent subcommittee that the bill not be considered.**

If you would like to request that your bill not be considered by the Committee on Health, for your convenience, a printed form is included at the bottom of this page. Please complete, sign and return the form to Room 528 LOB. This form may not be e-mailed because it requires the sponsor's signature.

MEMORANDUM

TO: **Representative Wright**

FROM: **Representative Insko**
Bill Sponsor

SUBJECT: **HB 1222, REGULATE NURSE PRACTIONERS/NURSE MIDWIVES.** (Short Title)

I request that HB 1222 not be considered by the Committee on HEALTH.

Ursula Insko
(Sponsor's Signature)

10-2-02
Date

MEMORANDUM

DATE: **10/02/02**

TO: **Representative Wright**

FROM: **Representative Edwards, Vice Chair**

SUBJECT: **Bills Pending in the Committee on Health**

Pursuant to House Rule 36(a) all House bills and resolutions shall be reported from the standing committee or permanent subcommittee to which referred with such recommendations as the standing committee or permanent subcommittee may desire to make **except in the case where the principal introducer requests in writing to the Chair(s) of the standing committee or permanent subcommittee that the bill not be considered.**

If you would like to request that your bill not be considered by the Committee on Health, for your convenience, a printed form is included at the bottom of this page. Please complete, sign and return the form to Room 528 LOB. This form may not be e-mailed because it requires the sponsor's signature.

MEMORANDUM

TO: **Representative Edwards**

FROM: **Representative Wright**
Bill Sponsor

SUBJECT: **HB 1222, REGULATE NURSE PRACTIONERS/NURSE MIDWIVES.** (Short Title)

I request that HB 1222 not be considered by the Committee on HEALTH.

(Sponsor's Signature)

10-2-02 Date

MEMORANDUM

DATE: **10/02/02**

TO: **Representative Earle**

FROM: **Representative Wright**

SUBJECT: **Bills Pending in the Committee on Health**

Pursuant to House Rule 36(a) all House bills and resolutions shall be reported from the standing committee or permanent subcommittee to which referred with such recommendations as the standing committee or permanent subcommittee may desire to make **except in the case where the principal introducer requests in writing to the Chair(s) of the standing committee or permanent subcommittee that the bill not be considered.**

If you would like to request that your bill not be considered by the Committee on Health, for your convenience, a printed form is included at the bottom of this page. Please complete, sign and return the form to Room 528 LOB. This form may not be e-mailed because it requires the sponsor's signature.

MEMORANDUM

TO: **Representative Wright**

FROM: **Representative Earle**
Bill Sponsor

SUBJECT: **HB 934, C.O.N. ADULT CARE HOMES REGULATED.** (Short Title)

I request that HB 934 not be considered by the Committee on HEALTH.

Beverly Earle
(Sponsor's Signature)

10-2-02 Date

MEMORANDUM

DATE: **09/26/02**

TO: **Representative Nye**

FROM: **Representative Wright**

SUBJECT: **Bills Pending in the Committee on Health**

Pursuant to House Rule 36(a) all House bills and resolutions shall be reported from the standing committee or permanent subcommittee to which referred with such recommendations as the standing committee or permanent subcommittee may desire to make **except in the case where the principal introducer requests in writing to the Chair(s) of the standing committee or permanent subcommittee that the bill not be considered.**

If you would like to request that your bill not be considered by the Committee on Health, for your convenience, a printed form is included at the bottom of this page. Please complete, sign and return the form to Room 528 LOB. This form may not be e-mailed because it requires the sponsor's signature.

MEMORANDUM

TO: **Representative Wright**

FROM: **Representative Nye**
Bill Sponsor

SUBJECT: **HB 934, C.O.N. ADULT CARE HOMES REGULATED.** (Short Title)

I request that HB 934 not be considered by the Committee on HEALTH.

Gwen Nye
(Sponsor's Signature)

9-25-02 Date

MEMORANDUM

DATE: **09/26/02**

TO: **Representative Blue, Jr.**

FROM: **Representative Wright**

SUBJECT: **Bills Pending in the Committee on Health**

Pursuant to House Rule 36(a) all House bills and resolutions shall be reported from the standing committee or permanent subcommittee to which referred with such recommendations as the standing committee or permanent subcommittee may desire to make **except in the case where the principal introducer requests in writing to the Chair(s) of the standing committee or permanent subcommittee that the bill not be considered.**

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MEMORANDUM

TO: **Representative Wright**

FROM: **Representative Blue**
Bill Sponsor

SUBJECT: **HB 896, DATABASE/CONTROLLED SUBSTANCES.** (Short Title)

I request that HB 896 not be considered by the Committee on HEALTH.

(Sponsor's Signature)

9/25/02 Date

MEMORANDUM

DATE: **09/26/02**

TO: **Representative Blue, Jr.**

FROM: **Representative Wright**

SUBJECT: **Bills Pending in the Committee on Health**

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MEMORANDUM

TO: **Representative Wright**

FROM: **Representative Blue, Jr.**
Bill Sponsor

SUBJECT: **HB 1449, VETERINARY PRACTICE ACT/FEES.** (Short Title)

I request that HB 1449 not be considered by the Committee on HEALTH.

(Sponsor's Signature)

9-26-02 Date

MEMORANDUM

DATE: **09/26/02**

TO: **Representative Blue, Jr.**

FROM: **Representative Wright**

SUBJECT: **Bills Pending in the Committee on Health**

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MEMORANDUM

TO: **Representative Wright**

FROM: **Representative Blue, Jr.**
Bill Sponsor

SUBJECT: **HB 1682, STATE HEALTH PLAN/POOL PURCHASE OF DRUGS.**
(Short Title)

I request that HB 1682 not be considered by the Committee on HEALTH.

(Sponsor's Signature)

9-26-02 Date

MEMORANDUM

DATE: **09/26/02**

TO: **Representative Hensley**

FROM: **Representative Wright**

SUBJECT: **Bills Pending in the Committee on Health**

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MEMORANDUM

TO: **Representative Wright**

FROM: **Representative Hensley**
Bill Sponsor

SUBJECT: **HB 896, DATABASE/CONTROLLED SUBSTANCES.** (Short Title)

I request that HB 896 not be considered by the Committee on HEALTH.

R J Hensley
(Sponsor's Signature)

9/26/02
Date

MEMORANDUM

DATE: **09/26/02**

TO: **Representative Gibson**

FROM: **Representative Wright**

SUBJECT: **Bills Pending in the Committee on Health**

Pursuant to House Rule 36(a) all House bills and resolutions shall be reported from the standing committee or permanent subcommittee to which referred with such recommendations as the standing committee or permanent subcommittee may desire to make **except in the case where the principal introducer requests in writing to the Chair(s) of the standing committee or permanent subcommittee that the bill not be considered.**

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MEMORANDUM

TO: **Representative Wright**

FROM: **Representative Gibson**
Bill Sponsor

SUBJECT: **HB 1306, IMMUNITY/HONORING PORTABLE DNR ORDER**
(Short Title)

I request that HB 1306 not be considered by the Committee on HEALTH.

(Sponsor's Signature)

9-26-02 Date

MEMORANDUM

DATE: **09/26/02**

TO: **Representative Hill**

FROM: **Representative Wright**

SUBJECT: **Bills Pending in the Committee on Health**

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MEMORANDUM

TO: **Representative Wright**

FROM: **Representative Hill**
Bill Sponsor

SUBJECT: **HB 1091, NATUROPATHIC PHYSICIANS** (Short Title)

I request that HB 1091 not be considered by the Committee on HEALTH.

Doug C Hill
(Sponsor's Signature)

9/26/02
Date

MEMORANDUM

DATE: **09/26/02**

TO: **Representative Alexander**

FROM: **Representative Wright**

SUBJECT: **Bills Pending in the Committee on Health**

Pursuant to House Rule 36(a) all House bills and resolutions shall be reported from the standing committee or permanent subcommittee to which referred with such recommendations as the standing committee or permanent subcommittee may desire to make **except in the case where the principal introducer requests in writing to the Chair(s) of the standing committee or permanent subcommittee that the bill not be considered.**

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MEMORANDUM

TO: **Representative Wright**

FROM: **Representative Alexander**
Bill Sponsor

SUBJECT: **HB 1514, DHHS RULES COORDINATION.** (Short Title)

I request that HB 1514 not be considered by the Committee on HEALTH.

(Sponsor's Signature)

September 25, 2002 Date

MEMORANDUM

DATE: **09/26/02**

TO: **Representative Nesbitt**

FROM: **Representative Wright**

SUBJECT: **Bills Pending in the Committee on Health**

Pursuant to House Rule 36(a) all House bills and resolutions shall be reported from the standing committee or permanent subcommittee to which referred with such recommendations as the standing committee or permanent subcommittee may desire to make **except in the case where the principal introducer requests in writing to the Chair(s) of the standing committee or permanent subcommittee that the bill not be considered.**

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MEMORANDUM

TO: **Representative Wright**

FROM: **Representative Nesbitt**
Bill Sponsor

SUBJECT: **HB 1222, REGULATE NURSE PRACTIONERS/NURSE MIDWIVES.** (Short Title)

I request that HB 1222 not be considered by the Committee on HEALTH.

Martin Nesbitt
(Sponsor's Signature)

9-25-02
Date

MEMORANDUM

DATE: 09/26/02

TO: Representative Insko

FROM: Representative Wright

SUBJECT: Bills Pending in the Committee on Health

Pursuant to House Rule 36(a) all House bills and resolutions shall be reported from the standing committee or permanent subcommittee to which referred with such recommendations as the standing committee or permanent subcommittee may desire to make **except in the case where the principal introducer requests in writing to the Chair(s) of the standing committee or permanent subcommittee that the bill not be considered.**

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MEMORANDUM

TO: Representative Wright

FROM: Representative Insko
Bill Sponsor

SUBJECT: HB 1514, DHHS RULES COORDINATION. (Short Title)

I request that HB 1514 not be considered by the Committee on HEALTH.

Ursula Insko
(Sponsor's Signature)

9/25/02 Date

MEMORANDUM

DATE: **09/26/02**

TO: **Representative Rogers**

FROM: **Representative Wright**

SUBJECT: **Bills Pending in the Committee on Health**

Pursuant to House Rule 36(a) all House bills and resolutions shall be reported from the standing committee or permanent subcommittee to which referred with such recommendations as the standing committee or permanent subcommittee may desire to make **except in the case where the principal introducer requests in writing to the Chair(s) of the standing committee or permanent subcommittee that the bill not be considered.**

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MEMORANDUM

TO: **Representative Wright**

FROM: **Representative Rogers**
Bill Sponsor

SUBJECT: **HB 1636, CARE FOR SCHOOL CHILDREN WITH DIABETES ACT.** (Short Title)

I request that HB 1636 not be considered by the Committee on HEALTH.

Jane Rogers
(Sponsor's Signature)

Sept 26 '02 Date

MEMORANDUM

DATE: **09/26/02**

TO: **Representative Earle**

FROM: **Representative Wright**

SUBJECT: **Bills Pending in the Committee on Health**

Pursuant to House Rule 36(a) all House bills and resolutions shall be reported from the standing committee or permanent subcommittee to which referred with such recommendations as the standing committee or permanent subcommittee may desire to make **except in the case where the principal introducer requests in writing to the Chair(s) of the standing committee or permanent subcommittee that the bill not be considered.**

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MEMORANDUM

TO: **Representative Wright**

FROM: **Representative Earle**
Bill Sponsor

SUBJECT: **HB 245, ADULT CARE HOME ASSESSMENT** (Short Title)

I request that HB 245 not be considered by the Committee on HEALTH.

Beverly Earle
(Sponsor's Signature)

9/26/02 Date

MEMORANDUM

DATE: **09/26/02**

TO: **Representative Earle**

FROM: **Representative Wright**

SUBJECT: **Bills Pending in the Committee on Health**

Pursuant to House Rule 36(a) all House bills and resolutions shall be reported from the standing committee or permanent subcommittee to which referred with such recommendations as the standing committee or permanent subcommittee may desire to make **except in the case where the principal introducer requests in writing to the Chair(s) of the standing committee or permanent subcommittee that the bill not be considered.**

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MEMORANDUM

TO: **Representative Wright**

FROM: **Representative Earle**
Bill Sponsor

SUBJECT: **HB 996, ELEC. MONITORING IN NURSING/ADULT CARE HOMES.** (Short Title)

I request that HB 996 not be considered by the Committee on HEALTH.

Beverly Earle
(Sponsor's Signature)

9/26/02 Date

MEMORANDUM

DATE: **09/26/02**

TO: **Representative Luebke**

FROM: **Representative Wright**

SUBJECT: **Bills Pending in the Committee on Health**

Pursuant to House Rule 36(a) all House bills and resolutions shall be reported from the standing committee or permanent subcommittee to which referred with such recommendations as the standing committee or permanent subcommittee may desire to make **except in the case where the principal introducer requests in writing to the Chair(s) of the standing committee or permanent subcommittee that the bill not be considered.**

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MEMORANDUM

TO: **Representative Wright**

FROM: **Representative Luebke**
Bill Sponsor

SUBJECT: **HB 1239, PHARMACISTS/LIMIT PRESCRIPTIONS DISPENSED.**
(Short Title)

I request that HB 1239 not be considered by the Committee on HEALTH.

(Sponsor's Signature)

9/26/02 Date

MEMORANDUM

DATE: **09/26/02**

~~TO:~~ From **Representative Holliman**

~~FROM:~~ To **Representative Wright**

SUBJECT: **Bills Pending in the Committee on Health**

Pursuant to House Rule 36(a) all House bills and resolutions shall be reported from the standing committee or permanent subcommittee to which referred with such recommendations as the standing committee or permanent subcommittee may desire to make **except in the case where the principal introducer requests in writing to the Chair(s) of the standing committee or permanent subcommittee that the bill not be considered.**

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MEMORANDUM

TO: **Representative Wright**

FROM: **Representative Holliman**
Bill Sponsor

SUBJECT: **HB 1220, COMMUNITY RESIDENCES/PEOPLE WITH DISABILITY** (Short Title)

I request that HB 1220 not be considered by the Committee on HEALTH.

(Sponsor's Signature)

9/26/02 Date

MEMORANDUM

DATE: **09/26/02**

TO: **Representative Wright**

FROM: **Representative Edwards/Vice Chairman**

SUBJECT: **Bills Pending in the Committee on Health**

Pursuant to House Rule 36(a) all House bills and resolutions shall be reported from the standing committee or permanent subcommittee to which referred with such recommendations as the standing committee or permanent subcommittee may desire to make **except in the case where the principal introducer requests in writing to the Chair(s) of the standing committee or permanent subcommittee that the bill not be considered.**

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MEMORANDUM

TO: **Representative Edwards**

FROM: **Representative Wright**
Bill Sponsor

SUBJECT: **HB 1719, STATE EMPLOYEES' HEALTH PLAN/PRESC. DRUGS.**
(Short Title)

I request that HB 1719 not be considered by the Committee on HEALTH.

(Sponsor's Signature)

9/26/02 Date

MEMORANDUM

DATE: **09/26/02**

TO: **Representative Wright**

FROM: **Representative Edwards; Vice-Chairman**

SUBJECT: **Bills Pending in the Committee on Health**

Pursuant to House Rule 36(a) all House bills and resolutions shall be reported from the standing committee or permanent subcommittee to which referred with such recommendations as the standing committee or permanent subcommittee may desire to make **except in the case where the principal introducer requests in writing to the Chair(s) of the standing committee or permanent subcommittee that the bill not be considered.**

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MEMORANDUM

TO: **Representative Edwards**

FROM: **Representative Wright**
Bill Sponsor

SUBJECT: **HB 936, ENTERNAL SEDATION/DENTIST PERMITS.** (Short Title)

I request that HB 936 not be considered by the Committee on HEALTH.

(Sponsor's Signature)

9/26/02 Date

MEMORANDUM

DATE: **09/26/02**

TO: **Representative Pope**

FROM: **Representative Wright**

SUBJECT: **Bills Pending in the Committee on Health**

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MEMORANDUM

TO: **Representative Wright**

FROM: **Representative Pope**
Bill Sponsor

SUBJECT: **HB 1254, C.O.N. MODIFICATIONS** (Short Title)

I request that HB 1254 not be considered by the Committee on HEALTH.

Rep Pope
(Sponsor's Signature)

9/25/02
Date

MEMORANDUM

DATE: **09/26/02**

TO: **Representative Nesbitt**

FROM: **Representative Wright**

SUBJECT: **Bills Pending in the Committee on Health**

Pursuant to House Rule 36(a) all House bills and resolutions shall be reported from the standing committee or permanent subcommittee to which referred with such recommendations as the standing committee or permanent subcommittee may desire to make **except in the case where the principal introducer requests in writing to the Chair(s) of the standing committee or permanent subcommittee that the bill not be considered.**

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MEMORANDUM

TO: **Representative Wright**

FROM: **Representative Nesbitt**
Bill Sponsor

SUBJECT: **HB 1222, REGULATE NURSE PRACTIONERS/NURSE MIDWIVES.** (Short Title)

I request that HB 1222 not be considered by the Committee on HEALTH.

Martin Nesbitt
(Sponsor's Signature)

9-25-02 Date

MEMORANDUM

DATE: **09/26/02**

TO: **Representative Davis**

FROM: **Representative Wright**

SUBJECT: **Bills Pending in the Committee on Health**

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MEMORANDUM

TO: **Representative Wright**

FROM: **Representative Davis**
Bill Sponsor

SUBJECT: **HB 1259, ABORTION CLINIC REQUIREMENTS** (Short Title)

I request that HB 1259 not be considered by the Committee on HEALTH.

(Sponsor's Signature)

10-1-02
Date