2003-2004

HOUSE
HEALTH

COMMITTEE
MINUTES

HOUSE
COMMITTEE ON HEALTH

Representative Verla Insko
Representative Carolyn Justus
Chairs

Representative Bob England, Vice Chairman

2003 Session

Pamela J. Evans
Glenda Jones
Clerk

HOUSE COMMITTEE ON HEALTH
MEMBERSHIP LIST
2003-2004 Session

MEMBER	ASSISTANT	PHONE	OFFICE	SEAT
INSKO, Verla Chair	Pamela Evans Committee Assistant	733-7208	2121	70
JUSTUS, Carolyn Chair	Glenda Jones Committee Assistant	733-5956	1023	27
ENGLAND, Bob Vice Chair	Lisa Brown	733-5749	2219	117
ADAMS, Alma	Beverlee Baker	733-5902	542	67
ALLEN, Bernard	Gloria Haywood	733-5772	1325	94
ALLEN, Gordon	Nancy Brantley	733-5662	534	10
ALLRED, Cary	Jean Allred	733-5905	606	38
BARNHART, Jeff	Pamela Ahlin	715-2009	608	76
BOWIE, Joni	Sharon Gaudette	733-5877	538	78
CLARY, Debbie	Shirley Winstead	715-2002	302B	14
EARLE, Beverly	Ann Raeford	715-2530	634	95
GLAZIER, Rick	Carin Savel	733-5601	2215	107
HILTON, Mark	Anne Soles	733-5988	1021	61
McALLISTER, Mary	Johnna Smith	733-5959	638	58
MUNFORD, Don	Carla Farmer	733-5809	539	41
SETZER, Mitchell	Joanna Mills	733-4948	1204	42
SHERRILL, Wilma	Rosa Kelley	715-3026	403	17
WAINWRIGHT, William	Blinda Edwards	715-3026	302D	8
WILSON, Connie	Chris Floyd	733-5849	503	37
WRIGHT, Tom	Clarestene Stewart	733-5754	528	19

Research Staff:				
Attarian, Linda		733-2578	545	
Jessup, Dianna		733-2578	545	
Compeau, Amy		733-2578	545	
Kamprath, Sara		733-2578	545	
Alley, Sandra		733-2578	545	
Ex-Officio Members:				
Brubaker, Bru	Cindy Coley	715-4946	1229	2
Culpepper, Bill	Dot Crocker	715-3028	404	36
Cunningham, Pete	Valerie Rustin	733-5778	541	7
Eddins, Rick	Dorie Monroe	733-5800	1319	26

NORTH CAROLINA GENERAL ASSEMBLY
HOUSE HEALTH COMMITTEE
2003 – 2004 SESSION

Rep. Justus
Chair

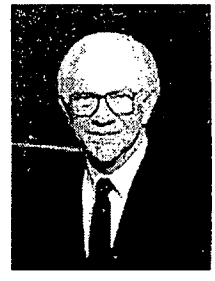
Rep. Insko
Chair

Rep. Bob England
Vice-Chair

Rep. Alma Adams

Rep. Bernard Allen

Rep. Gordon Allen



Rep. Cary Allred

Rep. Jeff Barnhart

Rep. Joni Bowie

Rep. Debbie Clary

Rep. Beverly Earle

Rep. Rick Glazier

Rep. Mark Hilton

Rep. Mary McAllister

Rep. Don Munford

Rep. Mitchell Setzer

Rep. Wilma Sherrill

Rep. William Wainwright

NORTH CAROLINA GENERAL ASSEMBLY
HOUSE HEALTH COMMITTEE
2003 – 2004 SESSION

Rep. Connie Wilson

Member

Rep. Tom Wright

Member

Rep. Harold Brubaker
Ex-officio

Rep. Bill Culpepper
Ex-officio

Member

Rep. Pete Cunningham
Ex-officio

Member

Rep. Rick Eddins
Ex-officio

ATTENDANCE

HOUSE COMMITTEE ON HEALTH

DATES		3/4/03	3/11/03	3/18/03	3/25/03	4/1/03	4/8/03	4/9/03	4/15/03	4/17/03	4/22/03	4/23/03	4/24/03	4/29/03	4/30/03	
INSKO, Verla	CHAIR	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	
JUSTUS, Carolyn	CHAIR	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	
ENGLAND, Bob	VICE-CHAIR	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓		✓	✓	
ADAMS, Alma		✓		✓	✓	✓	✓				✓				✓	
ALLEN, Bernard		✓	✓	✓	✓	✓	✓		✓		✓	✓	✓	✓	✓	
ALLEN, Gordon		✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓		✓	
ALLRED, Cary		✓	✓	✓	✓	✓				✓	✓	✓	✓		✓	
BARNHART, Jeff		✓	✓	✓	✓	✓	✓		✓	✓	✓	✓	✓		✓	
BOWIE, Joni		✓	✓	✓	✓	✓	✓		✓		✓	✓	✓			
CLARY, Debbie		✓	✓													
EARLE, Beverly						✓	✓								✓	
GLAZIER, Rick		✓	✓	✓	✓	✓	✓		✓		✓				✓	
HILTON, Mark				✓	✓	✓	✓				✓	✓	✓			
McALLISTER, Mary		✓		✓	✓		✓		✓		✓		✓			
MUNFORD, Don		✓	✓	✓	✓	✓	✓	✓		✓	✓	✓	✓		✓	
SETZER, Mitchell		✓	✓			✓	✓	✓		✓	✓	✓	✓	✓	✓	
SHERRILL, Wilma		✓	✓	✓	✓	✓			✓	✓	✓		✓	✓	✓	
WAINWRIGHT, William				✓	✓		✓	✓			✓	✓	✓			
WILSON, Connie			✓	✓			✓				✓	✓	✓			
WRIGHT, Tom		✓		✓	✓		✓				✓	✓	✓	✓	✓	
Ex officio Members																
Brubaker, Bru																
Culpepper, Bill												✓				
Cunningham, Pete																
Eddins, Rick																

ATTENDANCE

HOUSE COMMITTEE ON HEALTH

DATES	5/13/03	5/20/03	5/27/03	6/3/03	6/5/03	6/10/03	6/11/03	6/17/03	6/19/03						
INSKO, Verla CHAIR	✓		✓	✓	✓	✓	✓		✓						
JUSTUS, Carolyn CHAIR	✓		✓	✓	✓	✓	✓	✓	✓						
ENGLAND, Bob VICE-CHAIR	✓		✓	✓	✓	✓	✓	✓							
ADAMS, Alma		✓	✓	✓	✓	✓	✓	✓							
ALLEN, Bernard	✓	✓	✓	✓	✓	✓	✓	✓							
ALLEN, Gordon	✓	✓	✓	✓	✓			✓	✓						
ALLRED, Cary				✓	✓	✓		✓							
BARNHART, Jeff	✓			✓	✓	✓	✓	✓							
BOWIE, Joni	✓	✓	✓	✓	✓	✓		✓							
CLARY, Debbie				✓		✓	✓								
EARLE, Beverly				✓	✓	✓		✓							
GLAZIER, Rick	✓	✓	✓	✓	✓	✓	✓								
HILTON, Mark	✓	✓		✓	✓	✓		✓							
McALLISTER, Mary	✓	✓	✓	✓	✓	✓									
MUNFORD, Don	✓	✓	✓	✓	✓	✓		✓	✓						
SETZER, Mitchell	✓		✓	✓	✓		✓	✓	✓						
SHERRILL, Wilma	✓	✓		✓	✓	✓									
WAINWRIGHT, William				✓	✓										
WILSON, Connie				✓		✓									
WRIGHT, Tom	✓			✓	✓	✓	✓								
Ex officio Members															
Brubaker, Bru															
Culpepper, Bill															
Cunningham, Pete															
Eddins, Rick															

2003-2004 Biennium

Leg. Day: H-102/S-102

Bill	Introducer	Short Title		Latest Action	In Date	Out Date
H0036=	Womble	REPEAL INVOLUNTARY STERILIZATION.	*HR	Ch. SL 2003-13	02-19-03	03-19-03
H0080	Insko	REPORTS TO MENTAL HEALTH OVERSIGHT COMM.	*HR	Ch. SL 2003-58	02-25-03	03-12-03
$ H0155	**Warren**	**LTC WORKFORCE IMPROVEMENT PROGRAM.**	**H**	**Re-ref Com On Appropriations**	**03-03-03**	**04-14-03**
H0170=	Insko	SPECIAL ASSISTANCE IN-HOME OPTION.	*H	Re-ref Com On Appropriations	03-03-03	04-23-03
$ H0171=	**Insko**	**DHHS/ENSURE NO FELONS EMP. IN LONG-TERM CARE.**	**H**	**Ref To Com On Health**	**03-03-03**	
$ H0172	**Insko**	**LOCAL LTC PLANNING PILOT PROJECT.**	***H**	**Re-ref Com On Appropriations**	**03-03-03**	**04-09-03**
H0180	Howard	STATE HEALTH PLAN/ DEPENDENT CHILD COVERAGE.	H	Ref To Com On Health	03-04-03	
H0208	Wright	MANAGED CARE/HLTH BENEFITS CLARIFYING-AB.	*H	Re-ref Com On Rules and Operations of the Senate	03-05-03	03-25-03
H0346	Moore	EMERG. GENERATORS/ AGING STUDY COMM. STUDY.	*H	Re-ref Com On Rules, Calendar, and Operations of the House	03-06-03	04-24-03
H0354=	Insko	AMEND DISABILITY LAWS	*H	Passed 2nd & 3rd Reading	03-06-03	04-07-03
H0500	Hall	LEGISLATIVE FITNESS CENTER.	H	Ref To Com On Health	03-17-03	
H0551=	Tolson	ATTENDANCE AGE/ ELIGIBILITY/SCHOOLS FOR DEAF.	*H	Ref To Com On Education/Higher Education	03-19-03	04-14-03
H0557	Jeffus	STATE HEALTH PLAN: INCREASE WELLNESS BENEFIT.	H	Re-ref Com On Appropriations	03-19-03	06-18-03
H0642=	Wood	CONSCIENCE PROTECTION/ CONTRACEPTIVES.	H	Ref To Com On Health	03-25-03	
H0669	Wright	HOSPITAL LICENSURE/ CRITICAL ACCESS HOSPITAL.	*H	Ref To Com On Health & Human Resources	03-26-03	04-09-03
H0815	Alexander	DETOX FACILITIES NOT SUBJECT TO CON.	*H	Pres. To Gov. 7/ 18/2003	04-01-03	04-24-03
H0826=	Insko	AMEND MH CONFIDENTIALITY STATUTES.	*HR	Ch. SL 2003-313	04-01-03	04-09-03
H0835=	Blackwood	PRESC. DRUG DISCOUNTS/ UNINSURED ELDERLY.	H	Ref To Com On Health	04-02-03	
H0854=	Capps	NO ABORTIONS UNDER STATE HEALTH PLAN.	H	Ref To Com On Health	04-03-03	
H0870=	Gillespie	COMMUNITY BLDGS/ EXEMPT FROM FOOD RULES.	H	Ref To Com On Health	04-07-03	
H0874	Frye	STATE EMPLOYEES' HEALTH PLAN/EMERGENCY SVCES.	H	Re-ref Com On Appropriations	04-07-03	06-18-03
H0882=	Gillespie	MEDICAID PRIOR AUTHORIZATION.	H	Ref To Com On Health	04-07-03	

'$' indicates the bill is an appropriation bill.
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2003-2004 Biennium

Leg. Day: H-102/S-102

Bill	Introducer	Short Title		Latest Action	In Date	Out Date
H0883	Insko	MH REFORM WAIVER.	*HR	Ch. SL 2003-178	04-07-03	04-28-03
H0886	Wright	DUE PROCESS FOR PHYSICIANS.	*H	Pres. To Gov. 7/ 18/2003	04-07-03	04-28-03
H0889=	Eddins	ANALOGUES/SCHEDULE I CONTROLLED SUBSTANCE.	H	Re-ref Com On Judiciary IV	04-07-03	05-13-03
H0894	Clary	CLARIFY ADULT CARE HOME MORATORIUM.	H	Ref To Com On Health	04-07-03	
H0907=	Alexander	DEAF/HARD OF HEARING ADVISORY COUNCIL.	*H	Pres. To Gov. 7/ 11/2003	04-07-03	04-29-03
H0916	Brubaker	FIRST-RESPONDERS VACCINATION PROGRAM.	*HR	Ch. SL 2003-227	04-08-03	04-28-03
H0923	Luebke	EXEMPT ALT. MEDICINE/ PRACTICE OF MEDICINE.	H	Ref To Com On Health	04-08-03	
H0954=	Weiss	DISCHARGE FROM ADULT CARE HOMES.	H	Ref To Com On Health	04-08-03	
H0983	A. Williams	PRESCRIPTION CO-PAYMENTS/COUNTY PRISONERS.	H	Ref To Com On Health	04-09-03	
$ H1004=	**Barnhart**	**STRENGTHEN PUBLIC HEALTH INFRASTRUCTURE.**	**H**	**Ref to the Com on Health and, if favorable, to the Com on Appropriations**	**04-10-03**	
H1043	Harrell	HEALTH PROVIDER IMMUNITY/TERRORIST INCIDENTS.	*H	Ref To Com On Select Committee on Insurance and Civil Justice Reform	04-10-03	04-30-03
H1094	Justice	LOCAL HEALTH DEPARTMENTS.	*H	Re-ref Com On Health	05-14-03	
H1177	Brubaker	VOLUNTEER M.D.S AT THERAPEUTIC REC. CAMPS.	*HR	Ch. SL 2003-109	04-10-03	04-24-03
$ H1178	**Wright**	**RAISE ADAP INCOME LIMIT.**	**H**	**Re-ref Com On Appropriations**	**04-10-03**	**04-22-03**
H1191	Wright	STATE HEALTH PLAN UNDER STATE TREASURER.	H	Ref To Com On Health	04-10-03	
S0002	R. C. Soles, Jr.	DRIVERS LICENSE MEDICAL CERTIFICATION.	*HR	Ch. SL 2003-14	03-04-03	03-12-03
S0388	Virginia Foxx	UPDATE CERVICAL CANCER SCREENING COVERAGE.	*HR	Ch. SL 2003-186	05-01-03	05-21-03
S0503=	A. B Swindell	AGE/ELIGIBILITY/NC SCHOOLS FOR THE DEAF.	*HR	Ch. SL 2003-253	04-24-03	05-28-03
S0519=	William R. Purce	CHILD LEAD POISONING PREVENTION PRGM AMENDS.-AB	*HR	Ch. SL 2003-150	04-21-03	05-27-03
S0522	Tony Rand	BOARD OF NURSING.	*HR	Ch. SL 2003-146	04-17-03	05-19-03
S0582	William R. Purce	ESTABLISH COMMISSION ON CHILDHOOD OBESITY.	*H	Ref to the Com on Health and, if favorable, to the Com on Rules, Calendar, and Operations of the House	05-01-03	
S0648	Virginia Foxx	CERVICAL CANCER	*HR	Ch. SL 2003-176	05-01-03	05-21-03

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2003-2004 Biennium

Bill	Introducer	Short Title		Latest Action	In Date	Out Date
		ELIMINATION TASK FORCE.				
S0657	James Forrester	TANNING SALONS/ RESTRICTIONS ON USE.	H	Re-ref Com On Rules, Calendar, and Operations of the House	04-17-03	05-29-03
S0661	Eric Miller Reev	PRISONER HEALTH INFORMATION/EMS CHANGES.	*H	Pres. To Gov. 7/ 21/2003	05-05-03	07-16-03
S0694=	Scott Thomas	ANALOGUES/SCHEDULE I CONTROLLED SUBSTANCE.	*HR	Ch. SL 2003-249	05-01-03	05-13-03
S0704	John H. Kerr III	TRAUMATIC BRAIN INJURY ADVISORY COUNCIL.	*HR	Ch. SL 2003-114	04-24-03	05-13-03
S0876	William R. Purce	CONTROLLED SUBSTANCE/ PHYSICIAN REGISTRATION.	*HR	Ch. SL 2003-335	04-24-03	06-18-03
S0897=	Joe Sam Queen	MEDICAID PRIOR AUTHORIZATION.	*HR	Ch. SL 2003-179	04-28-03	05-28-03
$ S0926	**Tony Rand**	**CLARIFY GROUP HOMES LICENSURE & LEA REIMBURS.**	***HR**	**Ch. SL 2003-294**	**05-01-03**	**06-10-03**
S1016	Philip E. Berger	NURSING HOME/ MEDICATION ERRORS.	*H	Pres. To Gov. 7/ 17/2003	05-01-03	06-12-03

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'=' indicates that the original bill is identical to another bill.

DATES BILL WERE CONSIDERED

March 4, 2003	HB 36 Repeal Involuntary Sterilization
March 18, 2003	HB 36 Repeal Involuntary Sterilization
March 25, 2003	HB 346 Emerg. Generators/Nursing & Adlt Care Homes HB 354 Child Lead Poisoning Prevention Prgm Amends-AB
April 1, 2003	HB 354 Child Lead Poisoning Prevention Prgm Amends-AB HB 500 Legislative Fitness Center
April 8, 2003	HB 669 Hospital Licensure/Critical Access Hospital HB 172 Local LTC Planning Pilot Project HB 155 LTC Workforce Improvement Program
April 9, 2003	HB 551 Attendance Age/Eligibility/Schools for Deaf HB 835 Presc. Drug Discounts/Uninsured Elderly HB 826 Amend MH/Confidentiality Statutes HB 346 Emerg. Generators/Nursing & Adlt Care Homes
April 15, 2003	HB 346 Emerg. Generators/Nursing & Adlt Care Homes HB 815 Detox Facilities Not Subject to CON HB 883 MH Reform Waiver
April 22, 2003	HB 170 Expand Special Assistance Demo Project HB 883 MH Reform Waiver
April 23, 2003	HB 883 MH Reform Waiver HB 886 Due Process for Physicians
April 24, 2003	HB 1177Volunteer M.D.s at Therapeutic Rec. Camps HB 916 First-Responders Vaccination Program HB 815 Detox Facilities Not Subject to CON HB 907 Deaf/Hard of Hearing Advisory Council HB 886 Due Process for Physicians
April 29, 2003	HB1043 Health Provider Immunity/Terrorist Incidents
April 30, 2003	HB1043 Health Provider Immunity/Terrorist Incidents
May 13, 2003	SB 704 Traumatic Brain Injury Advisory Council SB 522 Board of Nursing SB 648 Cervical Cancer Elimination Task Force SB 388 Update Cervical Cancer Screening Coverage
May 20, 2003	SB 582 Establish Commission on Childhood Obesity

May 27, 2003	SB 897 Medicaid Prior Authorization SB 503 Age/Eligibility/NC Schools for the Deaf SB 519 Child Lead Poisoning Prevention Prgm Amends-AB
June 3, 2003	HB1094 Local Health Departments
June 5, 2003	SB 926 Clarify Group Homes Licensure & LEA Reimburs. HB1094 Local Health Departments
June 10, 2003	SB 1016 Nursing Home/Medication Errors HB 923Exempt Alt. Medicine/Practice of Medicine
June 17, 2003	HB 557 State Health Plan: Increase Wellness Benefit HB 874 State Employees' Health Plan/Emergency Svces. SB 876 Meningococcal Meningitis Immunization Info
June 19, 2003	HB 923 Exempt Alt. Medicine/Practice of Medicine

SUBCOMMITTEE BILLS
DATES BILLS WERE CONSIDERED

April 9, 2003	HB 346 Emerg. Generators/Nursing & Adlt Care Homes
May 28, 2003	SB 582 Establish Commission on Childhood Obesity
July 17, 2003	HB 835 Presc. Drug Discounts/Uninsured Elderly

DATES OF CONSIDERATION
BY BILL NUMBER

HB 36 Repeal Involuntary Sterilization	March 4 and March 18
HB 155 LTC Workforce Improvement Program	April 8
HB 170 Expand Special Assistance Demo Project	April 22
HB 172 Local LTC Planning Pilot Project	April 8
HB 346 Emerg. Generators/Nursing & Adlt Care Homes	March 25, April 9 (12 noon) and April 15 Subcommittee April 9 (10 am)
HB 354 Child Lead Poisoning Prevention Prgm Amends-AB	March 25 and April 1
HB 500 Legislative Fitness Center	April 1
HB 551 Attendance Age/Eligibility/Schools for Deaf	April 9
HB 557 State Health Plan: Increase Wellness Benefit	June 17
HB 669 Hospital Licensure/Critical Access Hospital	
HB 815 Detox Facilities Not Subject to CON	April 15, April 24
HB 826 Amend MH/Confidentiality Statutes	April 9
HB 835 Presc. Drug Discounts/Uninsured Elderly	April 9 and Subcommittee July 17
HB 874 State Employees' Health Plan/Emergency Svces	June 17
HB 883 MH Reform Waiver	April 15, April 22 and April 23
HB 886 Due Process for Physicians	April 23 and April 24
HB 907 Deaf/Hard of Hearing Advisory Council	April 24
HB 916 First-Responders Vaccination Program	April 24
HB 923 Exempt Alt. Medicine/Practice of Medicine	June 10 and June 19
HB1043Health Provider Immunity/Terrorist Incidents	April 29 and 30
HB1094 Local Health Departments	June 3 and June 5

HB 1177Volunteer M.D.s at Therapeutic Rec. Camps	April 24
SB 388 Update Cervical Cancer Screening Coverage	May 13
SB 503 Age/Eligibility/NC Schools for the Deaf	May 27
SB 519 Child Lead Poisoning Prevention Prgm Amends-AB	May 27
SB 522 Board of Nursing	May 13
SB 582 Establish Commission on Childhood Obesity	May 20 and Subcommittee May 28
SB 648 Cervical Cancer Elimination Task Force	May 13
SB 704 Traumatic Brain Injury Advisory Council	May 13
SB 876 Meningococcal Meningitis Immunization Info	June 17
SB 897 Medicaid Prior Authorization	May 27
SB 926 Clarify Group Homes Licensure & LEA Reimburs.	June 5
SB 1016 Nursing Home/Medication Errors	June 10

AGENDA

HOUSE COMMITTEE ON HEALTH

March 4, 2003
Room 415 LOB
12:00 Noon

OPENING REMARKS

Representative Verla Insko, Chair
Representative Carolyn Justus, Chair

AGENDA ITEMS

- **HB 36 Repeal Involuntary Sterilization**
  Representatives Womble, Luebke, Weiss and Insko, Sponsors

- **HB 80 Reports to Mental Health Oversight Committee**
  Representative Insko

AGENDA

HOUSE COMMITTEE ON HEALTH

March 11, 2003
Room 415 LOB
12:00 Noon

OPENING REMARKS

Representative Verla Insko, Chair
Representative Carolyn Justus, Chair

AGENDA ITEMS

- **SB 2 Drivers License Medical Certification**
  Senator R. C. Soles, Jr.

- **HB 80 Reports to Mental Health Oversight Committee**
  Representative Insko

ADJOURNMENT

AGENDA

HOUSE COMMITTEE ON HEALTH

March 18, 2003
Room 415 LOB
12:00 Noon

OPENING REMARKS

Representative Verla Insko, Chair
Representative Carolyn Justus, Chair

AGENDA ITEMS

HB 36 Repeal Involuntary Sterilization
Representatives Womble, Luebke, Weiss and Insko, Sponsors

HB 172 Local LTC Planning Pilot Project
Representatives Insko and Earle, Sponsors

ADJOURNMENT

AGENDA

HOUSE COMMITTEE ON HEALTH

March 25, 2003
Room 415 LOB
12:00 Noon

OPENING REMARKS

Representative Verla Insko, Chair
Representative Carolyn Justus, Chair

AGENDA ITEMS

HB 346 Emerg. Generators/Nursing & Adlt Care Homes
Representative Tim Moore, Primary Sponsor

HB 354 Child Lead Poisoning Prevention Prgm Amends-AB
Representative Verla Insko, Primary Sponsor

ADJOURNMENT

AGENDA

HOUSE COMMITTEE ON HEALTH

April 1, 2003
Room 415 LOB
12:00 Noon

OPENING REMARKS

Representative Verla Insko, Chair
Representative Carolyn Justus, Chair

AGENDA ITEMS

HB 354 **Child Lead Poisoning Prevention Prgm Amends-AB – Primary Sponsor: Rep. Verla Insko**

HB 500 **Legislative Fitness Center – Primary Sponsor: Rep. John Hall**

HB 551 **Attendance Age/Eligibility/Schools for Deaf – Primary Sponsor: Rep. Joe Tolson**

ADJOURNMENT

AGENDA

HOUSE COMMITTEE ON HEALTH

April 8, 2003
Room 544 LOB
12:00 Noon

OPENING REMARKS

Representative Verla Insko, Chair
Representative Carolyn Justus, Chair

LT. GOVERNOR BEVERLY PERDUE, CHAIR OF THE HEALTH AND WELLNESS COMMISSION, TO ADDRESS MEMBERS

AGENDA ITEMS

HB 669 **Hospital Licensure/Critical Access Hospital – Primary Sponsor: Rep. Thomas Wright**

HB 172 **Local LTC Planning Pilot Project – Primary Sponsors: Rep. Verla Insko and Rep. Beverly Earle**

HB 155 **LTC Workforce Improvement Program – Primary Sponsors: Rep. Edith Warren and Rep. Beverly Earle**

ADJOURNMENT

AGENDA

HOUSE COMMITTEE ON HEALTH

April 15, 2003
Room 544 LOB
12:00 Noon

OPENING REMARKS

Representative Verla Insko, Chair
Representative Carolyn Justus, Chair

AGENDA ITEMS

HB 346 **Emerg. Generators/Nursing & Adlt Care Homes – Primary Sponsor: Rep. Tim Moore**

HB 815 **Detox Facilities Not Subject to CON – Primary Sponsor: Rep. Martha Alexander**

HB 883 **MH Reform Waiver – Primary Sponsor: Rep. Verla Insko**

HB 886 **Due Process for Physicians – Primary Sponsors: Rep. Thomas Wright and Rep. Julia Howard**

ADJOURNMENT

AGENDA

HOUSE COMMITTEE ON HEALTH

April 9, 2003
Room 415 LOB
12:00 Noon

OPENING REMARKS

Representative Verla Insko, Chair
Representative Carolyn Justus, Chair

AGENDA ITEMS

HB 551 Attendance Age/Eligibility/Schools for Deaf – Primary Sponsor: Rep. Joe Tolson

HB 826 Amend MH/Confidentiality Statutes – Primary Sponsor: Rep. Verla Insko

HB 835 Presc. Drug Discounts/Uninsured Elderly – Primary Sponsor: Rep. Curtis Blackwood

ADJOURNMENT

AGENDA

HOUSE COMMITTEE ON HEALTH

April 17, 2003
Room 544 LOB
12:00 Noon

OPENING REMARKS

Representative Verla Insko, Chair
Representative Carolyn Justus, Chair

AGENDA ITEMS

HB 170 **Expand Special Assistance Demo Project – Primary Sponsors: Rep. Verla Insko and Rep. Beverly Earle**

HB 883 **MH Reform Waiver – Primary Sponsor: Rep. Verla Insko**

HB 886 **Due Process for Physicians – Primary Sponsors: Rep. Thomas Wright and Rep. Julia Howard**

HB 916 **First-Responders Vaccination Program – Primary Sponsor: Rep. Harold Brubaker**

ADJOURNMENT

AGENDA

HOUSE COMMITTEE ON HEALTH

April 22, 2003
Room 544 LOB
12:00 Noon

OPENING REMARKS

Representative Verla Insko, Chair
Representative Carolyn Justus, Chair

AGENDA ITEMS

HB 170 **Expand Special Assistance Demo Project – Reps. Insko and Earle**

HB 883 **MH Reform Waiver – Rep. Insko**

HB 815 **Detox Facilities Not Subject to CON-Rep. Alexander**

HB 907 **Deaf/Hard of Hearing Advisory Council – Rep. Alexander**

HB 886 **Due Process for Physicians – Reps. Wright and Howard**

ADJOURNMENT

AGENDA

HOUSE COMMITTEE ON HEALTH

April 23, 2003
Room 643 LOB
12:00 Noon

Representative Carolyn Justus, Chair **Representative Verla Insko, Chair**

CALL TO ORDER

INTRODUCTION OF PAGES

BILLS TO BE HEARD

HB 883 **MH Reform Waiver – Rep. Insko**

HB 886 **Due Process for Physicians – Reps. Wright and Howard**

ADJOURNMENT

AGENDA

HOUSE COMMITTEE ON HEALTH

April 24, 2003
Room 544 LOB
12:00 Noon

OPENING REMARKS

Representative Verla Insko, Chair
Representative Carolyn Justus, Chair

AGENDA ITEMS

HB 815 **Detox Facilities Not Subject to CON-Rep. Alexander**

HB 907 **Deaf/Hard of Hearing Advisory Council – Rep. Alexander**

HB 916 **First-Responders Vaccination Program – Rep. Brubaker**

HB1177 **Volunteer M.D.s at Therapeutic Rec. Camps – Rep. Brubaker**

HB 886 **Due Process for Physicians – Reps. Wright and Howard**

HB 923 **Exempt Alt. Medicine/Practice of Medicine-Rep. Luebke**

HB1043 **Health Provider Immunity/Terrorist Incidents-Rep. Harrell**

ADJOURNMENT

AGENDA

HOUSE COMMITTEE ON HEALTH

April 29, 2003
Room 544 LOB
12:00 Noon

OPENING REMARKS

Representative Verla Insko, Chair
Representative Carolyn Justus, Chair

AGENDA ITEMS

HB1043 Health Provider Immunity/Terrorist Incidents-Rep. Harrell

ADJOURNMENT

AGENDA

HOUSE COMMITTEE ON HEALTH

April 30, 2003
Room 544 LOB
12:00 Noon

OPENING REMARKS

Representative Verla Insko, Chair
Representative Carolyn Justus, Chair

AGENDA ITEMS

HB1043 Health Provider Immunity/Terrorist Incidents-Rep. Harrell

ADJOURNMENT

AGENDA

HOUSE COMMITTEE ON HEALTH

May 13, 2003
Room 544 LOB
12:00 Noon

OPENING REMARKS

Representative Verla Insko, Chair
Representative Carolyn Justus, Chair

AGENDA ITEMS

SB 648 **Cervical Cancer Elimination Task Force-Senator Virginia Foxx**

SB 388 **Update Cervical Cancer Screening Coverage-Senator Virginia Foxx**

SB 522 **Board of Nursing-Senator Tony Rand**

SB 704 **Traumatic Brain Injury Advisory Council-Senator John Kerr**

ADJOURNMENT

AGENDA

HOUSE COMMITTEE ON HEALTH

May 20, 2003
Room 544 LOB
12:00 Noon

OPENING REMARKS

Representative Verla Insko, Chair
Representative Carolyn Justus, Chair

AGENDA ITEMS

SB 582 Establish Commission on Childhood Obesity – Senator William Purcell

SB 657 Tanning Salons/Restrictions on Use – Senator James Forrester

ADJOURNMENT

AGENDA

HOUSE COMMITTEE ON HEALTH

May 27, 2003
Room 544 LOB
12:00 Noon

OPENING REMARKS

Representative Verla Insko, Chair
Representative Carolyn Justus, Chair

AGENDA ITEMS

SB 503 Age/Eligibility/NC Schools for the Deaf-Senator Swindell

SB 897 Medicaid Prior Authorization-Senator Queen

SB 519 Child Lead Poisoning Prevention Prgm Amends.-AB-Senator Purcell

ADJOURNMENT

AGENDA

HOUSE COMMITTEE ON HEALTH

June 3, 2003
Room 544 LOB
12:00 Noon

OPENING REMARKS

Representative Verla Insko, Chair
Representative Carolyn Justus, Chair

AGENDA ITEMS

HB 1094 Local Health Departments – Rep. Justice

ADJOURNMENT

AGENDA

HOUSE COMMITTEE ON HEALTH

June 5, 2003
Room 544 LOB
12:00 Noon

OPENING REMARKS

Representative Verla Insko, Chair
Representative Carolyn Justus, Chair

AGENDA ITEMS

SB 926 Clarify Group Homes Licensure & LEA Reimburs. – Sen. Rand

HB 1094 Local Health Departments – Rep. Justice

ADJOURNMENT

AGENDA

HOUSE COMMITTEE ON HEALTH

June 10, 2003
Room 544 LOB
12:00 Noon

OPENING REMARKS

Representative Verla Insko, Chair
Representative Carolyn Justus, Chair

AGENDA ITEMS

SB 1016 Nursing Home/Medication Errors – Sen. Berger

HB 923 Exempt Alt. Medicine/Practice of Medicine - Rep. Luebke

ADJOURNMENT

AGENDA

HOUSE COMMITTEE ON HEALTH

June 12, 2003
Room 544 LOB
12:00 Noon

OPENING REMARKS

Representative Verla Insko, Chair
Representative Carolyn Justus, Chair

AGENDA ITEMS

HB 557 State Health Plan: Increase Wellness Benefit – Reps. Jeffus and Culp

HB 874 State Employees' Health Plan/Emergency Svces. – Reps. Frye and Dockham

SB 876 Meningitis Immunization – Sen. Purcell

ADJOURNMENT

AGENDA

HOUSE COMMITTEE ON HEALTH

June 17, 2003
Room 544 LOB
12:00 Noon

OPENING REMARKS

Representative Verla Insko, Chair
Representative Carolyn Justus, Chair

AGENDA ITEMS

HB 557 State Health Plan: Increase Wellness Benefit – Reps. Jeffus and Culp

HB 874 State Employees' Health Plan/Emergency Svces. – Reps. Frye and Dockham

SB 876 Meningococcal Meningitis Immunization Info. – Sen. Purcell

ADJOURNMENT

AGENDA

HOUSE COMMITTEE ON HEALTH

June 19, 2003
Room 544 LOB
12:00 Noon

OPENING REMARKS

Representative Verla Insko, Chair
Representative Carolyn Justus, Chair

AGENDA ITEMS

HB 923 Exempt Alt. Medicine/Practice of Medicine - Rep. Luebke

ADJOURNMENT

North Carolina General Assembly
Legislative Services Office

George R. Hall, Legislative Services Officer
(919) 733-7044

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March 5, 2003

The Honorable Verla Insko, Cochair
House Health Committee
Room 2121
Legislative Building
Raleigh, NC 27603

Dear Representative Insko:

I have asked Ms. Linda Attarian and Ms. Dianna Jessup to serve as counsel to the House Health Committee, which you cochair. They will attend the meetings of the Committee when it meets on Tuesdays and Thursdays at noon. In accordance with the Committee's directions as expressed through the Chairs, Ms. Attarian and Ms. Jessup will aid in analyzing proposed legislation and drafting amendments and committee substitutes. Like other staff, they will also staff several other committees.

My best wishes to you and the House Health Committee in its work. If I can be of any service to you or the Committee, please contact me.

Yours truly,

Terry

Terrence D. Sullivan
Director of Research

cc: The Honorable James B. Black
The Honorable Richard T. Morgan
The Honorable Carolyn K. Justus
Ms. Linda Attarian
Ms. Dianna Jessup
Mr. George Hall

AN EQUAL OPPORTUNITY/AFFIRMATIVE ACTION EMPLOYER

HOUSE COMMITTEE
ON
HEALTH

2003-2004

MINUTES

Representative Verla Insko, Chair
Representative Carolyn Justus, Chair

Committee Assistants

Pamela Evans
Glenda Jones

House Committee on Health

March 4, 2003

Minutes

The first meeting of the House Committee on Health was held on Tuesday, March 4, 2003 at 12:00 noon in Room 415 of the Legislative Office Building. A silent roll was taken. A copy of the roll denoting members present is attached to the minutes (Attachment I) along with a copy of the agenda and Visitor Registration Sheet (Attachments II and III).

Chair Verla Insko introduced herself and Ms. Pamela Evans, Committee Clerk. Chair Carolyn Justus introduced herself and Ms. Glenda Jones, Committee Clerk and recognized Ms. Linda Attarain, Dianna Jessup and Amy Compeau who will serve as staff for the Committee. Chair Justus then introduced James Worth and Francis Poole, the sergeant-at-arms along with Brittney Murdaugh of Brunswick County sponsored by Representative Stiller, who is serving as a page. (Attachment IV) Each member of the Committee then introduced themselves as well as audience members.

Chair Insko then advised that this was an organizational meeting and no votes would to be taken.

Rep. Larry Womble was then recognized to explain his HB36, "A BILL ENTITLED AN ACT TO REPEAL THE LAW THAT AUTHORIZES THE INVOLUNTARY STERILIZATION OF PERSONS WHO ARE MENTALLY ILL OR MENTALLY RETARDED AND TO MAKE CONFORMING CHANGES TO THE GENERAL STATUTES. (Attachment V). Rep. Womble called the involuntary sterilization law a "distasteful" vestige of the state's eugenic sterilization program. The existing law allows involuntary sterilizations for the "public good" or for a patient's "mental, moral or physical improvement". While the law is seldom used, a parent or guardian of a mentally challenged person or the head of a state medical institution can request the operation. He also referred to a series of articles recently by John Ralley in the Winston Salem Journal.

Reps. Luebke and Weiss also commented on the bill. Rep. Luebke recognized that there were concerns from the disability community.

Dianna Jessup, staff, was called upon to further explain the bill. Ms. Jessup referred to the bill analysis and Article 7 provided in the member's notebooks (Attachments VI and VII). Ms. Jessup advised that if the bill were enacted, the statutory procedure for involuntary sterilizations would be repealed. Adults and married minors could still request a physician to perform a sterilization procedure. A minor, upon a finding by a juvenile court that it is in the minor's best interest, could also be sterilized if

the minor so chooses. The bill would also make the necessary conforming changes to the General Statutes.

Dianne Jessup, staff, then fielded questions from Rep. McAllister concerning the issue of a marriage contract and competency under law and Rep. Allred requested an instance when a person can be involuntary sterilized.

Deborah Greenblatt of Carolina Legal Assistance, Inc. responded by stating that a guardian for a mental disabled woman battling ovarian cancer could be barred from receiving a hysterectomy because one effect of the operation would be to leave her infertile.

Evelyn Bullock of Governor's Advocacy Council raised issue of hospitals being preventing from performing medical sterilizations.

Secretary Carmen Hooker-Odom then spoke about a group of people who in past had been selected for procedure.

The meeting adjourned at 12:09 p.m. with no vote taken.*

Verla Insko
Representative Verla Insko, Chair

Pamela J. Evans
Pamela J. Evans, Committee Clerk

Carolyn Justus
Representative Carolyn Justus, Chair

(*Note: Due to time, HB 80 Reports to Mental Health Oversight Committee was not considered. The bill and analysis provided as Attachment VIII)

ATTENDANCE

HOUSE COMMITTEE ON HEALTH

DATES	3/4/03														
INSKO, Verla CHAIR	✓														
JUSTUS, Carolyn CHAIR	✓														
ENGLAND, Bob VICE-CHAIR	✓														
ADAMS, Alma	✓														
ALLEN, Bernard	✓														
ALLEN, Gordon	✓														
ALLRED, Cary	✓														
BARNHART, Jeff	✓														
BOWIE, Joni	✓														
CLARY, Debbie	✓														
EARLE, Beverly															
GLAZIER, Rick	✓														
HILTON, Mark															
McALLISTER, Mary	✓														
MUNFORD, Don	✓														
SETZER, Mitchell	✓														
SHERRILL, Wilma	✓														
WAINWRIGHT, William															
WILSON, Connie															
WRIGHT, Tom	✓														
Ex officio Members															
Brubaker, Bru															
Culpepper, Bill															
Cunningham, Pete															
Eddins, Rick															

ATTACHMENT II

AGENDA

HOUSE COMMITTEE ON HEALTH

March 4, 2003
Room 415 LOB
12:00 Noon

OPENING REMARKS

Representative Verla Insko, Chair
Representative Carolyn Justus, Chair

AGENDA ITEMS

- **HB 36 Repeal Involuntary Sterilization**
  Representatives Womble, Luebke, Weiss and Insko, Sponsors

- **HB 80 Reports to Mental Health Oversight Committee**
  Representative Insko

ATTACHMENT III

VISITOR REGISTRATION SHEET

HOUSE COMMITTEE ON HEALTH — MARCH 4, 2003

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Cynthia Temoshenko	Governor's Advocacy Council for Persons w/ Disabilities Cameron Village, Raleigh, NC
Yvonne Bullock	GACPD North Central office, Butner, NC
Pamela Best	AOC
Jan Ramquist	NCDOS
Jon Mellon	GOV OFFICE
Anne Winn	PPCNC
Jonny Cooper	NCALA
Dave Richard	The Arc
Joyce Peters	JPRosa/NAMI-ST
Crissy Porter	Smith Anderson
Carla Farmer	NCGA - Rep. Mumford's L/A

VISITOR REGISTRATION SHEET

HOUSE COMMITTEE ON HEALTH — MARCH 4, 2003

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Sheila McKenney	NC DHHS
Carmen Hooker Odom	DHHS
Rob Lamm	" "
Tara Larson	DMH/DD/SAS
Jim Tate	Mental Health Assn in NC - C2001
Lee-Ann Coe	NCPA
Ben Holder	NAMI NC
AJ Horne	NCMS
Leslie Boyd	Asheville Citizen-Times
D DAMICO	Winston-Salem Journal
Deborah Greenblatt	Carolina Legal Assistance

VISITOR REGISTRATION SHEET

HOUSE COMMITTEE ON HEALTH — MARCH 4, 2003

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Marcos Arellano	NCGA Rep. Luebke's intern
Kendall Byrum	Rep. Kiser's intern
Scott Moorehouse	AP
Tanya Kaplan	NCAHP
Ken Melton	Alley Associates, INC.
Steve Mitchell	Novartis Pharmaceuticals
Rob Ousablon	NC Statewatch
Amy Pobson	NC Statewatch.
Patricia A. Yancey	ARPCNP

cervical

cancer

prevention

Putting Women's Health First

HPV testing for better cervical cancer prevention

Sgt. J Arms
James Smith
Frances Poole

Pages
Brittany Murdaugh
Brunswick
Rep Stiller

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2003

H 1

HOUSE BILL 36

Short Title:	Repeal Involuntary Sterilization.	(Public)
Sponsors:	Representatives Womble, Luebke, Weiss, Insko (Primary Sponsors); Adams, Alexander, B. Allen, Bell, Black, Hall, Holliman, Lucas, McAllister, McGee, Miller, Parmon, Pate, Ross, Wainwright, and Wood.	
Referred to:	Health.	

February 19, 2003

A BILL TO BE ENTITLED

AN ACT TO REPEAL THE LAW THAT AUTHORIZES THE INVOLUNTARY STERILIZATION OF PERSONS WHO ARE MENTALLY ILL OR MENTALLY RETARDED AND TO MAKE CONFORMING CHANGES TO THE GENERAL STATUTES.

The General Assembly of North Carolina enacts:

PART I. REPEAL THE LAW AUTHORIZING INVOLUNTARY STERILIZATIONS.

SECTION 1. Article 7 of Chapter 35 of the General Statutes is repealed.

PART II. CONFORMING CHANGES TO THE GENERAL STATUTES.

SECTION 2. G.S. 7A-451(a)(10) is repealed.

SECTION 3. G.S. 35A-1203(e) reads as rewritten:

"(e) Where a guardian or trustee has been appointed for a ward under former Chapter 33 or former Chapter 35 of the General Statutes, the clerk, upon his own motion or the motion of that guardian or trustee or any other interested person, may designate that guardian or trustee or appoint another qualified person as guardian of the person, guardian of the estate, or general guardian of the ward under this Chapter; provided, the authority of a guardian or trustee properly appointed under former Chapter 33 or former Chapter 35 of the General Statutes to continue serving in that capacity is not dependent on such motion and designation."

SECTION 4. G.S. 35A-1241(a) reads as rewritten:

"(a) To the extent that it is not inconsistent with the terms of any order of the clerk or any other court of competent jurisdiction, a guardian of the person has the following powers and duties:

(1) The guardian of the person is entitled to custody of the person of his ward and shall make provision for his ward's care, comfort, and maintenance, and shall, as appropriate to the ward's needs, arrange for

his training, education, employment, rehabilitation or habilitation. The guardian of the person shall take reasonable care of the ward's clothing, furniture, vehicles, and other personal effects that are with the ward.

(2) The guardian of the person may establish the ward's place of abode within or without this State. In arranging for a place of abode, the guardian of the person shall give preference to places within this State over places not in this State if in-State and out-of-State places are substantially equivalent. He also shall give preference to places that are not treatment facilities. If the only available and appropriate places of domicile are treatment facilities, he shall give preference to community-based treatment facilities, such as group homes or nursing homes, over treatment facilities that are not community-based.

(3) The guardian of the person may give any consent or approval that may be necessary to enable the ward to receive medical, legal, psychological, or other professional care, counsel, treatment, or service. He may not, however, consent to the sterilization of a mentally ill or mentally retarded ward. ~~Such sterilization may be performed only after compliance with Chapter 35, Article 7.~~ The guardian of the person may give any other consent or approval on the ward's behalf that may be required or in the ward's best interest. He may petition the clerk for the clerk's concurrence in the consent or approval."

SECTION 5. G.S. 90-21.13(e) reads as rewritten:

"(e) In the event of any conflict between the provisions of this section and those of ~~Article 7 of Chapter 35 and~~ Articles 1A and 19 of Chapter 90, the provisions of those Articles shall control and continue in full force and effect."

SECTION 6. G.S. 90-275 is repealed.

SECTION 7. G.S. 108A-14(a)(10) is repealed.

SECTION 8. G.S. 148-22.22 reads as rewritten:

"**§ 148-22.2. Procedure when surgical operations on inmates are necessary.**

The medical staff of any penal institution of the State of North Carolina is hereby authorized to perform or cause to be performed by competent and skillful surgeons surgical operations upon any inmate when such operation is necessary for the improvement of the physical condition of the inmate. The decision to perform ~~such~~an operation shall be made by the chief medical officer of the institution, with the approval of the superintendent of the institution, and with the advice of the medical staff of ~~said~~ the institution. No ~~such~~operation shall be performed without the consent of the inmate; or, if the inmate ~~be~~is a minor, without the consent of a responsible member of ~~his~~the inmate's family, a guardian, or one having legal custody of ~~such~~the minor; or, if the inmate be non compos mentis, then the consent of a responsible member of ~~his~~the inmate's family or of a guardian ~~must~~shall be obtained. Any surgical operations on inmates of State penal institutions shall also be subject to the provisions of Article 1A of Chapter 90 of the General Statutes and G.S. 90-21.13 and G.S. 90- 21.14.

If the operation on the inmate is determined by the chief medical officer to be an emergency situation in which immediate action is necessary to preserve the life or health of the inmate, and the inmate, if sui juris, is unconscious or otherwise incapacitated so as to be incapable of giving consent or in the case of a minor or inmate non compos mentis, the consent of a responsible member of ~~his~~the inmate's family, guardian, or one having legal custody of ~~such~~the inmate cannot be obtained within the time necessitated by the nature of the emergency situation, then the decision to proceed with the operation shall be made by the chief medical officer and the superintendent of the institution with the advice of the medical staff of the institution.

In all cases falling under this Article [section], the chief medical officer of the institution and the medical staff of the institution shall keep a careful and complete record of the measures taken to obtain the permission for ~~such~~the operation and a complete medical record signed by the medical superintendent or director, the surgeon performing the operation and all surgical consultants of the operation performed.

~~This Article [section] is not to be considered as affecting the provisions of Article 7 of Chapter 35 of the General Statutes dealing with eugenical sterilization.~~"

SECTION 9. This act is effective when it becomes law and applies to all petitions for sterilization pending and orders authorizing sterilization that have not been executed as of the effective date of this act.

HOUSE BILL 36:
Repeal Involuntary Sterilization

BILL ANALYSIS

Committee:	House Health	**Introduced by:**	Reps. Womble, Luebke, Weiss, Insko
Date:	March 4, 2003		
Version:	First Edition	**Summary by:**	Dianna Jessup Committee Counsel

SUMMARY: Part I of House Bill 36 would repeal the procedure that authorizes the sterilization of a mentally ill or a mentally retarded individual, whether or not the individual wishes to be sterilized, upon a petition filed in district court and an order entered by a district court judge. Part II of the bill would make conforming changes to the General Statutes. Consenting minors (upon order from a juvenile court) and adults would continue to be able to seek sterilization. The bill would become effective when it becomes law.

CURRENT LAW: Under Article 7 of Chapter 35 of the General Statutes (G.S. 35-36 through 35-50), certain persons can request an order from the district court to authorize the sterilization of a mentally ill or mentally retarded person.[1] In the case of an institutionalized mentally ill or mentally retarded person, the parent or guardian of the person or the director of the institution may make the request. In the case of a person who is not a resident of an institution, the parent or guardian of the person or the county director of social services may make the request. G.S. 35-29 makes it the duty of the petitioner to initiate sterilization proceedings under any of the following circumstances:

1) When it is in the best interest of the mental, moral, or physical improvement of the person to be sterilized.

2) When it is for the public good that the person be sterilized.

3) When the person would be likely, unless sterilized, to procreate a child who would have a tendency to serious physical, mental, or nervous disease or deficiency; or, because of a physical, mental, or nervous disease or deficiency which is not likely to materially improve, the person would be unable to care for a child.

The request to sterilize is initiated by the filing of a petition in district court. Under G.S. 35-40, the petition must contain the following:

- Allegations of the results of psychological or psychiatric tests supporting the assertion that the person is subject to the provisions of the statute.
- The statement of a physician who has examined the person who is the subject of the petition affirming whether or not there is any known contraindication to the sterilization procedure.
- The name and address of the physician who will perform the sterilization.

[1] "Mentally ill" and "mentally retarded" are not defined in Article 7 of Chapter 35. However, the mental health statutes (G.S. 122C-3) define "mental illness" "(i) when applied to an adult, an illness which so lessens the capacity of the individual to use self-control, judgment, and discretion in the conduct of his affairs and social relations as to make it necessary or advisable for him to be under treatment, care, supervision, guidance, or control; and (ii) when applied to a minor, a mental condition, other than mental retardation alone, that so impairs the youth's capacity to exercise age adequate self-control or judgment in the conduct of his activities and social relationships so that he is in need of treatment" and "mental retardation" as "significantly subaverage general intellectual functioning existing concurrently with deficits in adaptive behavior and manifested before age 22".

- The written consent or objection of the next of kin or the legal guardian. If there is no next of kin or legal guardian, the court must appoint a guardian ad litem to investigate and report to the court.
- The consent or objection or the person who is the subject of the petition. If the person is incapable of consenting or objecting, the petitioner must certify that the procedure has been explained to the person.

A copy of the petition must be served on the person who is the subject of the petition and on the legal or natural guardian[2] or next of kin of the person who is the subject of the petition. If the petitioner is someone other than the county director of social services, the judge must order the county director of social services in the county in which the person who is the subject of the petition resides to investigate and make recommendations to the court regarding the case. The person who is the subject of the petition has the right to counsel at all stages of the proceedings. If the petitioner, the person who is the subject of the petition, or any other interested party requests a hearing, a hearing must be held. In the absence of written objection filed by the subject of the petition or other interested party, the court may render judgment without the appearance of witnesses. If a hearing is requested, the district attorney may present the evidence for the petitioner. The person who is the subject of the petition is entitled to present evidence and cross-examine witnesses.

The law expressly authorizes the court to enter an order of sterilization of a mentally ill or mentally retarded person based upon either of two grounds. The first ground is if the person would probably be unable to care for a child or children. The second ground is if the person would be likely, unless sterilized, to procreate a child or children who probably would have serious physical, mental, or nervous diseases or deficiencies. In addition, the appellate courts have interpreted the statute to require the district court to find (based on clear, strong, and convincing evidence) that the person is physically capable of procreation, that there is a substantial likelihood that the person will voluntarily or otherwise engage in sexual activity likely to cause impregnation, that the person is unable or unwilling to control procreation by birth control or contraceptive methods, and that the proposed method of sterilization entails the least invasion of the person's body.

Article 7 of Chapter 35 of the General Statutes has withstood constitutional challenges, based on both substantive and procedural grounds.

Article 19 of Chapter 90 of the General Statutes permits a physician to perform a sterilization operation 1) upon a person over 18 when requested by the person in writing or 2) upon a minor when requested in writing by the minor, provided that a juvenile court determines the operation is in the best interest of the minor.

A guardian of the person may not consent to the sterilization of a mentally ill or mentally retarded ward unless the current procedure in Chapter 35 is followed.[3]

BILL ANALYSIS: If the bill is enacted, the statutory procedure for involuntary sterilizations would be repealed. Adults and married minors could still request a physician to perform a sterilization procedure. A minor, upon a finding by a juvenile court that it is in the minor's best interest, could also be sterilized if the minor so chooses. The bill would also make the necessary conforming changes to the General Statutes.

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[2] Parents are considered the natural guardians of their children. G.S. 35A-1201(a)(6).

[3] G.S. 35A-1215; G.S. 35A-1241(a)(3).

ISSUES: There are a few issues raised by the bill in its current form:

1. May a guardian of someone who is not mentally ill or mentally retarded consent to the sterilization of a ward? (Probably yes, but the guardianship statutes are not clear)

2. May a ward that is adjudicated incompetent nonetheless be able to consent to sterilization, if the ward understands the procedure and what it means? (Case law suggests the answer to be yes, but that case was not decided in this context)

3. Even if Article 7, Chapter 35 is repealed, may a person still be able to go to court and obtain an order to sterilize someone against their will? (In a couple of other states, the absence of statutory authority did not prohibit a person from going to court and obtaining an order to sterilize someone)

BACKGROUND:

Brief History of Eugenics Movement: "Eugenics" is defined as the study of methods of improving genetic qualities by selective breeding. During the early part of the 20th century, social reformers advocated eugenic sterilization as a solution to problems such as mental retardation. In 1907, Indiana was the first state to pass a eugenic sterilization program, and California followed in 1909. More than 30 states eventually enacted these laws. North Carolina's eugenics law was passed in 1929 and was rewritten in 1933. It created a Eugenics Board to review petitions for sterilization. The law authorized sterilizations for three reasons: (1) epilepsy, (2) mental disease, and (3) feeblemindedness. Because record keeping varied from state to state, the exact number of eugenic sterilizations performed in the United States may never be known. Researchers *estimate* that about 65,000 people were sterilized. More than 7,600 people were sterilized in North Carolina between 1929 and 1974. North Carolina ranked third after Virginia with about 8,000 sterilizations and California with 21,000 sterilizations. Whereas most states sharply curtailed their sterilization programs after World War II, nearly four-fifths of sterilizations in North Carolina were done after 1945. By the late 1960s, more than 60% of those sterilized in North Carolina were black, and 99% were female. The Eugenics Board was abolished in 1974, and the current process for obtaining an order to sterilize a mentally ill or mentally retarded person was put into place.

Eugenics Board of North Carolina: The Board consisted of five members as follows:

1. The Commissioner of Public Welfare
2. The Secretary of the State Board of Health
3. The Chief Medical Officer at the State Hospital in Raleigh
4. The Chief Medical Officer of an institution for the feebleminded or insane from an institution outside of Raleigh
5. A representative from the Attorney General's Office

These five members met in a conference room in Raleigh, where they worked through about 30 cases per month, determining whether people should or should not be sterilized. Sterilization was ordered in more than 90% of the cases before the Board.

Lawsuits/Cases: In *Buck v. Bell* (1927), the United States Supreme Court set a precedent allowing the sterilization of the "feebleminded." There have never been any successful lawsuits over eugenic sterilizations in the U.S. North Carolina is the first state to ever consider paying reparations to victims of a eugenic sterilization program.

How States are Making Amends: The governors of the following Virginia, Oregon, North Carolina, and South Carolina have issued apologies for forced sterilizations. In addition to issuing a public

apology, Governor Easley established a committee to investigate the eugenics program and consider reparations or counseling services for victims. The committee is chaired by the Secretary of the Department of Health and Human Services (DHHS) and consists of the following members:

- General counsel from DHHS;
- A representative from the Division of Mental Health, Developmental Disabilities, and Substance Abuse Services, DHHS; and
- Two representatives from the Department of Cultural Resources.

State Laws Regulating Sterilization: 11 states have laws that allow certain parties to petition the court for involuntary sterilization of the mentally ill, including: Colorado, Connecticut, Delaware, Georgia, Maine, Minnesota, Mississippi, North Carolina, Vermont, Virginia, and West Virginia.

More information regarding North Carolina's eugenic sterilization program is available at the link, http://againsttheirwill.journalnow.com/. This link will take you to a series of articles published by the Winston Salem Journal.

Amy Currie, Research Assistant, contributed to this summary. *H36-SMSW-001*

Article 7.

Sterilization of Persons Mentally Ill and Mentally Retarded.

§ 35-36. Sterilization of mentally retarded in State institutions.

The parent or guardian of a mentally ill or mentally retarded person or the responsible director, or other public official performing the functions of such director, of any institution operated by the State of North Carolina is hereby authorized to petition the district court of the county in which such institution is located for the sterilization operation of any mentally ill or retarded resident or patient thereof as may be considered in the best interest of the mental, moral, or physical improvement of the resident or patient, or for the public good, provided, that no operation authorized in this section shall be lawful unless and until the provisions of this Article shall first be complied with. It shall be the responsibility of the State institution to provide or pay for the cost and expense of the operations authorized in this section for those persons residents or patients in State institutions. (1933, c. 224, s. 1; 1967, c. 138, s. 1; 1973, c. 1281; 1981, c. 102, ss. 1, 2.)

§ 35-37. Sterilization of mentally retarded not in State institutions.

The parent or guardian of a mentally ill or mentally retarded person, or the county director of social services, or other public official performing the functions of such director, is hereby authorized to petition the district court of his county for the sterilization operation of any mentally ill or retarded resident of the county, not a resident or patient of any State institution, or of any mentally ill or retarded person who is on parole from a State institution considered in the best interest of the mental, moral, or physical improvement of such resident, or for the public good, provided that no operation authorized in this section shall be lawful unless and until the provisions of this Article shall first be complied with. It shall be the responsibility of the board of commissioners of the respective counties to provide or pay for the cost and expense of the operations authorized in this section for those persons residents in their respective counties. (1933, c. 224, s. 2; 1961, c. 186; 1967, c. 138, s. 2; 1973, c. 1281; 1981, c. 102, s. 3.)

§ 35-38. Who shall perform sterilization operations upon the mentally retarded.

No operation under this Article shall be performed by other than a duly qualified and licensed North Carolina physician or surgeon, pursuant to Chapter 90 of the General Statutes as amended, and by him only upon a written order signed by the court having authority under the provisions of either G.S. 35-43 or G.S. 35-44. The petitioner will select the physician or surgeon to perform the sterilization operation and notify the patient and next of kin. If however, the patient or next of kin wishes to select a physician or surgeon other than the one selected by the petitioner, it will be the responsibility of the patient or next of kin to pay for the costs and expense of the sterilization operation. In the event the patient or next of kin is unable to provide for payment of the physician or surgeon selected by them, the operation will be performed by the physician or surgeon

selected by the petitioner. (1933, c. 224, s. 3; 1961, c. 186; 1967, c. 138, s. 3; 1969, c. 982; 1973, c. 1281.)

§ 35-39. Duty of petitioner.

It shall be the duty of such petitioner promptly to institute proceedings as provided by this Article in any of the following circumstances:

(1) When in his opinion it is for the best interest of the mental, moral or physical improvement of the patient, resident of an institution, or noninstitutional individual, that he or she be sterilized.

(2) When in his opinion it is for the public good that such patient, resident of an institution, or noninstitutional individual be sterilized.

(3) When in his opinion such patient, resident of an institution, or noninstitutional individual would be likely, unless sterilized, to procreate a child or children who would have a tendency to serious physical, mental, or nervous disease or deficiency; or, because of a physical, mental, or nervous disease or deficiency which is not likely to materially improve, the person would be unable to care for a child or children.

(4) Repealed by Session Laws 1981, c. 102, s. 4. (1933, c. 224, s. 4; 1935, c. 463, s. 1; 1937, c. 243; 1961, c. 186; 1967, c. 138, s. 4; 1969, c. 982; 1973, c. 476, s. 133.3; c. 1281; 1981, c. 102, s. 4.)

§ 35-40. Contents of petition.

The petition shall contain allegations of the results of psychological or psychiatric tests supporting the assertion that such person is subject to the provisions of this Article; shall contain the statement of a physician who has examined such person affirming whether or not there is any known contraindication to the requested surgical procedure; shall state the name and address of the physician or surgeon who will perform the operation; and shall contain the written consent or objection of the next of kin, the legal guardian or, if there is no next of kin and no known legal guardian a guardian ad litem who shall be appointed by the district court judge and who shall make investigation and report to the court before the hearing shall commence. The petition should also contain the consent or objection of the person upon whom the sterilization operation is to be performed. In the event the person upon whom the operation is to be performed is not capable of giving consent or objection, there must be a certification by the petitioner that the procedure has been explained to the person upon whom the operation is to be performed. (1933, c. 224, s. 8; 1935, c. 463, s. 2; 1973, c. 476, s. 133.3; c. 1281.)

35-41. Copy of petition served on patient.

At least 20 days prior to the hearing on the petition in the district court, a copy of such petition must be served upon the resident of the institution, patient, or noninstitutional individual and to the legal or natural guardian, guardian ad litem, or next of kin of the resident of the institution, patient, or noninstitutional individual. (1933, c. 224, s. 9; 1935,

c. 463, ss. 3, 6; 1947, c. 93; 1961, c. 186; 1969, c. 982; 1971, c. 528, s. 33; c. 1231, s. 1; 1973, c. 476, s. 133.3; c. 1281.)

§ 35-42. Judge to order investigation.

If the petitioner instituting the sterilization proceedings is other than the county director of social services the judge shall order the county director of social services in the county in which the person upon whom the operation is to be performed has domicile to investigate and make recommendations to him regarding the case. (1973, c. 1281.)

§ 35-43. Hearing before the judge of district court.

Should the petitioner, the person subject to the petition, or any other interested party request a hearing, a hearing shall be held in the district court before the judge without a jury. In the absence of written objection filed with the court by the person alleged to be subject to this section or by any other interested party on his or her behalf, the court may render judgment without the appearance of witnesses. In the event a hearing is requested the district attorney for the district in which the petition is heard or the district attorney's assistant may present the evidence for the petitioner. The respondent shall be entitled to examine the petitioner's witnesses and shall be entitled to present evidence in his own behalf. If the judge of the district court shall find from the evidence that the person alleged to be subject to this section is subject to it and that because of a physical, mental, or nervous disease or deficiency which is not likely to materially improve, the person would probably be unable to care for a child or children, or because the person would be likely, unless sterilized, to procreate a child or children which probably would have serious physical, mental, or nervous diseases or deficiencies, he shall enter an order and judgment authorizing the physician or surgeon named in the petition to perform the operation. (1973, c. 1281; 1975, c. 520, s. 1.)

§ 35-44. Appeals.

An appeal to the superior court may be had by the person alleged to be subject to this section or any other interested party on such judgment in the district court if filed within 15 days following the date the court judgment is entered. The proceedings before the superior court shall constitute a trial de novo, and upon application of either party shall be heard before a jury. The district attorney for the district in which the petition is heard or his assistant may present the evidence for the petitioner. The respondent shall be entitled to examine the petitioner's witnesses and to present evidence in his own behalf. Any decision of the superior court in such cases may be appealed to the appellate courts as in other civil cases. The cost of the appeal, if any, to the superior court and higher courts shall be taxed as in other civil cases and the pendency of any appeal shall stay the proceedings in the lower court until the appeal be finally determined. Paupers' affidavits regarding court costs and costs of appeal may be filed as in other cases made and provided by the laws of this State. (1933, c. 224, ss. 13, 14; 1935, c. 463, ss. 4, 5; 1969, c. 44, s. 44; 1973, c. 476, s. 133.3; c. 1281; 1975, c. 520, s. 2.)

§ 35-45. Right to counsel.

The person alleged to be subject to the provisions of this section shall have the right to counsel at all stages of the proceedings provided for herein. This person and all others served with the notification provided for in G.S. 35-41 shall be fully informed of the person's entitlement to counsel at the time of this service of notice. This information shall be given in language and in a manner calculated to insure, insofar as such is possible in view of the individual's capability to comprehend it, that the recipient understands the entitlement. Every person subject to be sterilized under this Article after the filing of the petition shall have counsel at every stage of the proceedings. If there is a conflict between the election of the person concerned and that of the other persons being served with notice, determination of the question of representation by counsel shall be made by the court having jurisdiction of the case. The person concerned may, in any instance, be represented by counsel retained by him. In cases of claimed indigency, a request for counsel shall be processed in the manner provided for in Subchapter IX, Chapter 7A, General Statutes of North Carolina. (1973, c. 1281.)

35-46. Sterilization procedure to be performed after court judgment.

After judgment of the court in accordance with G.S. 35-43 and 35-44 shall have become final to the effect that such sterilization shall be performed upon such person subject to this section, a sterilization procedure may be performed by a physician upon such person subject to this section. (1973, c. 1281.)

§ 35-47. Sterilization procedure defined.

Wherever used in this section, the words, "sterilization procedure" shall include and authorize the performance by the physician of any procedure or operation deemed to be in the best interest of the individual patient or intended to prevent conception, but does not include castration. (1973, c. 1281.)

§ 35-48. Civil or criminal liability of parties limited.

When an operation shall have been performed in compliance with the provisions of this law, no physician duly licensed without restriction to practice medicine and surgery in this State or other person legally participating in the execution of the provisions of this Article shall be liable civilly or criminally on account of such operation or participation therein, except in the case of negligence in the performance of said procedures. (1933, c. 224, s. 16; 1973, c. 1281.)

§ 35-49. Necessary medical treatment unaffected by Article.

Nothing in this section [Article] shall be construed so as to require compliance with this section or to prevent the medical or surgical treatment for sound therapeutic purposes of any person in this State, by a physician duly licensed without restriction to practice medicine and surgery in this State, which treatment may involve the nullification or destruction of the reproductive functions at the same time that it serves such sound therapeutic purposes. (1933, c. 224, s. 17; 1973, c. 1281.)

§ 35-50. Hospitals not compelled to admit patient.

Nothing in this section shall require a hospital to admit any patient under the provisions hereof for the purpose of performing a sterilization procedure. (1973, c. 1281.)

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2003

HOUSE BILL 80

Short Title:	Reports to Mental Health Oversight Comm.	(Public)
Sponsors:	Representative Insko.	
Referred to:	Health.	

February 25, 2003

A BILL TO BE ENTITLED

AN ACT TO REQUIRE THAT CERTAIN REPORTS BE MADE TO THE JOINT LEGISLATIVE OVERSIGHT COMMITTEE ON MENTAL HEALTH, DEVELOPMENTAL DISABILITIES, AND SUBSTANCE ABUSE SERVICES.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 122C-5 reads as rewritten:

"**§ 122C-5. Report on restraint and seclusion.**

The Secretary shall report annually on October 1 to the ~~Legislative Study Commission on Mental Health, Developmental Disabilities, and Substance Abuse Services~~ Joint Legislative Oversight Committee on Mental Health, Developmental Disabilities, and Substance Abuse Services on the following for the immediately preceding fiscal year:

(1) The level of compliance of each facility with applicable State and federal laws, rules, and regulations governing the use of restraints and seclusion. The information shall indicate areas of highest and lowest levels of compliance.

(2) The total number of facilities that reported deaths under G.S. 122C-31, the number of deaths reported by each facility, the number of deaths investigated pursuant to G.S. 122C-31, and the number found by the investigation to be related to the use of restraint or seclusion."

SECTION 2. G.S. 131D-42 reads as rewritten:

"**§ 131D-42. Report on use of restraint.**

The Department shall report annually on October 1 to the ~~Legislative Study Commission~~ Joint Legislative Oversight Committee on Mental Health, Developmental Disabilities, and Substance Abuse Services the following for the immediately preceding fiscal year:

(1) The level of compliance of each adult care home with applicable State law and rules governing the use of physical restraint and physical hold

of residents. The information shall indicate areas of highest and lowest levels of compliance.

(2) The total number of adult care homes that reported deaths under G.S. 131D-34.1, the number of deaths reported by each facility, the number of deaths investigated pursuant to G.S. 131D-34.1, and the number found by the investigation to be related to the adult care home's use of physical restraint or physical hold."

SECTION 3. G.S. 131D-10.6(10) reads as rewritten:

"**§ 131D-10.6. Powers and duties of the Department.**

In addition to other powers and duties prescribed by law, the Department shall exercise the following powers and duties:

...

(10) Report annually on October 1 to the ~~Legislative Study Commission~~ Joint Legislative Oversight Committee on Mental Health, Developmental Disabilities, and Substance Abuse Services the level of facility compliance with applicable State law governing the use of restraint and time-out in residential child-care facilities. The report shall also include the total number of facilities that reported deaths under this section, the number of deaths reported by each facility, the number of deaths investigated pursuant to this section, and the number found by the investigation to be related to the use of physical restraint or time-out."

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

HOUSE BILL 80:
Reports to Mental Health Oversight Comm.

BILL ANALYSIS

Committee:	House Health	**Introduced by:**	Rep. Insko
Date:	March 4, 2003	**Summary by:**	Linda Attarian
Version:	Introduced		Committee Counsel

SUMMARY: ***House Bill 80 amends certain provisions of law requiring the Secretary and the Department of Health and Human Services to submit annual reports regarding the use of physical restraints and seclusion in facilities regulated by DHHS to the Legislative Study Commission on Mental Health (Mental Health Study Commission). The act the Mental Health Study Commission and replaces it with the Joint Legislative Oversight Committee on Mental Health, Developmental Disabilities, and Substance Abuse Services, which was established in 2000. The act is effective when it becomes law.***

CURRENT LAW: The Mental Health Study Commission was established in 1996 (S.L. 1995-18, Sec. 24.8). It has not been repealed. The purpose of the Commission is to "study systemwide issues affecting the development, administration, and delivery of mental health, developmental disabilities, and substance abuse services, including issues relating to the governance, accountability, and quality of services delivered." The membership of this committee is comprised of members of the General Assembly and representatives of the public.

During the 2000 Regular Session of the 1999 General Session, the General Assembly enacted HB 1520, (S.L. 2000-129) to amend NC law pertaining to the use of physical restraints and seclusion in mental health facilities, residential child care facilities, and adult care homes. The legislation requires several reports by the Secretary and by the DHHS describing the extent of compliance of facilities with State and federal laws governing the use of physical restraints or seclusion and the number of deaths that may be associated with their use. The reports are to be made annually to the Mental Health Study Commission. No reports have been submitted.

Also during the 2000 Regular Session, in fact one month prior to the enactment of HB 1520, the General Assembly enacted HB 1519 (S.L. 2000-83, s.2), a bill to establish the Joint Legislative Oversight Committee on Mental Health, Developmental Disabilities, and Substance Abuse Services. The purpose of this committee is to "examine, on a continuing basis, systemwide issues affecting the development, financing, administration, and delivery of mental health, developmental disabilities, and substance abuse services, including issues relating to the governance, accountability, and quality of services delivered". The Committee is directed to "make ongoing recommendations to the General Assembly on ways to improve the quality and delivery of services and to maintain a high level of effectiveness and efficiency in system administration at the State and local levels". The membership of this Committee consists entirely of members of the General Assembly.

BILL ANALYSIS: House Bill 80 requires the reports referenced in S.L. 2000-129 to be submitted to the Joint Legislative Oversight Committee on MH/DD/SAS instead of the Mental Health Study Committee. The bill does not delete the reporting requirements nor does it repeal the statutes creating the Mental Health Study Committee. The bill is effective when it becomes law.

BACKGROUND:

Definitions of "physical restraint" and "seclusion" as follows (See NCAC 10-4P.0102):

(19) "Physical Restraint" means the application or use of any manual method of restraint that restricts freedom of movement; or the application or use of any physical or mechanical device that restricts freedom of movement or normal access to one's body, including material or equipment attached or adjacent to the client's body that he or she cannot easily remove. Holding a client in a therapeutic hold or other manner that restricts his or her movement constitutes manual restrains for that client. Mechanical devices may restrain a client to a bed or chair, or may be used as ambulatory restraints. Examples of mechanical devices include cuffs, ankle straps, sheets or restraining shirts, arm splints, posey mittens, and helmets. Excluded from this definition of physical restraint are physical guidance, gentle physical prompting techniques, escorting a client who is walking; soft ties used solely to prevent a medically ill client from removing intravenous tubes, indwelling catheters, cardiac monitor electrodes, or similar medical devices; and prosthetic devices or assistive technology which are designed and used to increase client adaptive skills. Escorting means the temporary touching or holding of the hand, wrist, arm, shoulder or back for the purpose of inducing a client to walk to a safe location.

(24) "Seclusion" means isolating a client in a separate locked room for the purpose of controlling a client's behavior.

HOUSE HEALTH COMMITTEE

MINUTES

March 11, 2003

The House Committee on Health met on Tuesday, March 11, 2003 in Room 415 of the Legislative Office Building at 12:00 p.m. The following members were present: Chairs Justus and Insko, and Vice-Chair England, and Representatives Bernard Allen, Gordon Allen, Allred, Barnhart, Bowie, Clary, Glazier, Munford, Setzer, Sherrill and Connie Wilson. The following Sergeant-at-Arms staff was present: James Worth and Tom Wilder. Committee staff in attendance was: Dianna Jessup, Linda Attarian and Amy Compeau. A Visitor Registration list is attached and made part of these minutes.

Chairperson Carolyn Justus called the meeting to order and introduced the following Pages: Megan Stone of Robeson County sponsored by Representative Bonner and Adrienne Farmer of Person County sponsored by Representative Gordon Allen.

The first bill on the agenda was SB 2, A BILL TO BE ENTITLED AN ACT TO ALLOW CERTAIN APPLICANTS FOR DRIVERS LICENSES TO SUBMIT MEDICAL CERTIFICATES FROM OUT-OF-STATE PHYSICIANS, sponsored by Senator Soles. He was recognized by Chairperson Justus to explain the bill. He explained that the bill will delete the requirement that the certifying physician hold a license to practice in North Carolina to allow DMV to consider certificates signed by physicians licensed to practice any jurisdiction. Senator Soles said there was no opposition to the bill. Chairperson Justus asked if Staff or members had any questions or would like to speak on the SB 2. Representative Barnhart was recognized to speak on the bill. He was concerned with the bill and offered an amendment. Linda Attarian explained the amendment moves to amend the bill on page 1, line 11, by rewriting that line to read: "surgeon duly licensed to practice in this State or in any other state of the United States and unless". The Chair recognized Susan Stewart to speak on behalf of DMV. She said the department had no objection with the amendment. After a few questions from Representative Sherrill and Representative Insko, Representative Barnhart made a motion to adopt the amendment and moved to give SB 2, as amended a favorable report. The motion carried. For further detailed explanation, see attachment.

The last bill to be discussed was HB 80, A BILL TO BE ENTITLED AN ACT TO REQUIRE THAT CERTAIN REPORTS BE MADE TO THE JOINT LEGISLATIVE OVERSIGHT COMMITTEE ON MENTAL HEALTH, DEVELOPMENTAL DISABILITIES, AND SUBSTANCE ABUSE SERVICES, sponsored by Representative Insko. Chairperson Justus recognized Representative Insko to explain the bill. Representative Insko gave a brief explanation and offered an amendment. The amendment moves to amend the bill on page 2, line 23, by rewriting the line to read: "SECTION 4. Adding the following new section to read amends article 27 of Chapter 120 of the General Statutes:

"§ 120 –243. Reports to Committee.

WHENEVER THE DEPARTMENT OF HEALTH AND HUMAN SERVICES, DIVISION OF MENTAL HEALTH, DEVELOPMENTAL DISABILITIES, AND SUBSTANCE ABUSE SERVICES, IS REQUIRED BY LAW TO REPORT TO THE GENERAL ASSEMBLY OR TO ANY OF ITS PERMANENT COMMITTEES OF SUBCOMMITTEES ON MATTERS AFFECTING MENTAL HEALTH, DEVELOPMENTAL DISABILITIES, AND SUBSTANCE ABUSE SERVICES, THE DEPARTMENT SHALL TRANSMIT A COPY OF THE REPORT TO THE CO-CHAIRS OF THE JOINT LEGISLATIVE OVERSIGHT COMMITTEE ON MENTAL HEALTH, DEVELOPMENTAL. Representative Insko was recognized for a motion for adoption of the amendment and HB 80 is given a favorable report as amended and rolled into a new Proposed Committee Substitute. The motion carried. For further detailed explanations see attachments.

Without further business, Chairperson Justus announced the committee would meet again on Tuesday, March 18th; 12:00 P.M. in 415 LOB and that HB 36 would be on the agenda.

The meeting adjourned at 12:45 p.m.

Respectfully submitted,

Representative Carolyn Justus
Chair

Glenda O. Jones
Assistant to the Committee

ATTENDANCE

HOUSE COMMITTEE ON HEALTH

DATES	3/11/03													
INSKO, Verla CHAIR	✓													
JUSTUS, Carolyn CHAIR	✓													
ENGLAND, Bob VICE-CHAIR	✓													
ADAMS, Alma	✓													
ALLEN, Bernard	✓													
ALLEN, Gordon	✓													
ALLRED, Cary	✓													
BARNHART, Jeff	✓													
BOWIE, Joni	✓													
CLARY, Debbie	✓													
EARLE, Beverly														
GLAZIER, Rick	✓													
HILTON, Mark														
McALLISTER, Mary														
MUNFORD, Don	✓													
SETZER, Mitchell	✓													
SHERRILL, Wilma	✓													
WAINWRIGHT, William														
WILSON, Connie	✓													
WRIGHT, Tom														
Ex officio Members														
Brubaker, Bru														
Culpepper, Bill														
Cunningham, Pete														
Eddins, Rick														

VISITOR REGISTRATION SHEET

HOUSE COMMITTEE ON HEALTH — MARCH 11, 2003

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Jim Edgerton	AHHC
Barbara Cansler	MFSS
Stacy Flannery	NCHCPA
C O Dowell	NC Medical Society
Abby Friedman	intern - Covenant w/ NC's Children
Jane Pinsky	AAA Carolinas
Andy Ellen	NC Retail Merchants Assoc.
Tom Sr.	" " " "
Susan M. Stewart	DMV - DL Medical Section
Susan Conard	DOT
ANN URE	OUHS
Jan Langenkamp	NCNP

VISITOR REGISTRATION SHEET

HOUSE COMMITTEE ON HEALTH — MARCH 11, 2003

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Jeff Horton	DHHS- DFS
BRIAN LEWIS	Planned Parenthood Health Systems, Inc.
TARA LARSON	DMH/DD/SAS
ROB LAMMÉ	DHHS
HUGH TILSON	ROB LAMMÉ
Paula A. Wolf.	Covenant w/ NC's Covenant
Crissey Porter	Smith Anderson
Cynthia Temoshenko	GACPD, Raleigh, NC
Yvonne Bullock	" "
Beth Melcher	NAMI NC
Joanne Stevens	nursing

VISITOR REGISTRATION SHEET

HOUSE COMMITTEE ON HEALTH — MARCH 11, 2003

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Julie Allen	NC Statewatch
Bill Scoggin	Kennedy Covington
Helen Lipman	Mecklenburg County

AGENDA

HOUSE COMMITTEE ON HEALTH

March 11, 2003
Room 415 LOB
12:00 Noon

OPENING REMARKS

Representative Verla Insko, Chair
Representative Carolyn Justus, Chair

AGENDA ITEMS

- **SB 2 Drivers License Medical Certification**
  Senator R. C. Soles, Jr.

- **HB 80 Reports to Mental Health Oversight Committee**
  Representative Insko

ADJOURNMENT

2003 COMMITTEE REPORT
HOUSE OF REPRESENTATIVES

The following report(s) from standing committee(s) is/are presented:
By Representatives **Verla Insko and Carolyn Justus,** Chairs for the Committee on **HEALTH.**

☒ Committee Substitute for
S.B. 2 A BILL TO BE ENTITLED AN ACT TO ALLOW CERTAIN APPLICANTS FOR DRIVERS LICENSES TO SUBMIT MEDICAL CERTIFICATES FROM OUT-OF-STATE PHYSICIANS.

☐ 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)

3/06/03

NORTH CAROLINA GENERAL ASSEMBLY
AMENDMENT
House Bill 80

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

H80-ALN-1 [v.1]

Disabilities, and Substance Abuse Services."

SECTION 5. This act is effective when it becomes law.

SIGNED Ursla Inado
Amendment Sponsor

SIGNED _____
Committee Chair if Senate Committee Amendment

ADOPTED _____ FAILED _____ TABLED _____

NORTH CAROLINA GENERAL ASSEMBLY
AMENDMENT
Senate Bill 2

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

S2-ARM-1 [v.1]

Date 11 MAR ,2003

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

Representative [redacted] BARNHART

moves to amend the bill on page 1, line 11, by rewriting that line to read:

"surgeon duly licensed to practice in this State or in any other state of the United States and unless"

SIGNED _____
Amendment Sponsor

SIGNED _____
Committee Chair if Senate Committee Amendment

ADOPTED ✓ FAILED _____ TABLED _____

2003 COMMITTEE REPORT
HOUSE OF REPRESENTATIVES

The following report(s) from standing committee(s) is/are presented:
By Representatives **Verla Insko and Carolyn Justus,** Chairs for the Committee on **HEALTH.**

☐ Committee Substitute for
H.B. 80 A BILL TO BE ENTITLED AN ACT TO REQUIRE THAT CERTAIN REPORTS BE MADE TO THE JOINT LEGISLATIVE OVERSIGHT COMMITTEE ON MENTAL HEALTH, DEVELOPMENTAL DISABILITIES, AND SUBSTANCE ABUSE 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 ~~(#), ☐ 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)

3/06/03

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2003

H D

HOUSE BILL 80
PROPOSED COMMITTEE SUBSTITUTE H80-PCS10134-RM-5

Short Title: Reports to Mental Health Oversight Comm. (Public)

Sponsors:

Referred to:

February 25, 2003

A BILL TO BE ENTITLED

AN ACT TO REQUIRE THAT CERTAIN REPORTS BE MADE TO THE JOINT LEGISLATIVE OVERSIGHT COMMITTEE ON MENTAL HEALTH, DEVELOPMENTAL DISABILITIES, AND SUBSTANCE ABUSE SERVICES.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 122C-5 reads as rewritten:

"**§ 122C-5. Report on restraint and seclusion.**

The Secretary shall report annually on October 1 to the ~~Legislative Study Commission on Mental Health, Developmental Disabilities, and Substance Abuse Services~~ Joint Legislative Oversight Committee on Mental Health, Developmental Disabilities, and Substance Abuse Services on the following for the immediately preceding fiscal year:

(1) The level of compliance of each facility with applicable State and federal laws, rules, and regulations governing the use of restraints and seclusion. The information shall indicate areas of highest and lowest levels of compliance.

(2) The total number of facilities that reported deaths under G.S. 122C-31, the number of deaths reported by each facility, the number of deaths investigated pursuant to G.S. 122C-31, and the number found by the investigation to be related to the use of restraint or seclusion."

SECTION 2. G.S. 131D-42 reads as rewritten:

"**§ 131D-42. Report on use of restraint.**

The Department shall report annually on October 1 to the ~~Legislative Study Commission~~ Joint Legislative Oversight Committee on Mental Health, Developmental Disabilities, and Substance Abuse Services the following for the immediately preceding fiscal year:

(1) The level of compliance of each adult care home with applicable State law and rules governing the use of physical restraint and physical hold

of residents. The information shall indicate areas of highest and lowest levels of compliance.

(2) The total number of adult care homes that reported deaths under G.S. 131D-34.1, the number of deaths reported by each facility, the number of deaths investigated pursuant to G.S. 131D-34.1, and the number found by the investigation to be related to the adult care home's use of physical restraint or physical hold."

SECTION 3. G.S. 131D-10.6(10) reads as rewritten:

"**§ 131D-10.6. Powers and duties of the Department.**

In addition to other powers and duties prescribed by law, the Department shall exercise the following powers and duties:

...

(10) Report annually on October 1 to the ~~Legislative Study Commission~~ Joint Legislative Oversight Committee on Mental Health, Developmental Disabilities, and Substance Abuse Services the level of facility compliance with applicable State law governing the use of restraint and time-out in residential child-care facilities. The report shall also include the total number of facilities that reported deaths under this section, the number of deaths reported by each facility, the number of deaths investigated pursuant to this section, and the number found by the investigation to be related to the use of physical restraint or time-out."

SECTION 4. Article 27 of Chapter 120 of the General Statutes is amended by adding the following new section to read:

"**§ 120-243. Reports to Committee.**

Whenever the Department of Health and Human Services, Division of Mental Health, Developmental Disabilities, and Substance Abuse Services, is required by law to report to the General Assembly or to any of its permanent committees or subcommittees on matters affecting mental health, developmental disabilities, and substance abuse services, the Department shall transmit a copy of the report to the cochairs of the Joint Legislative Oversight Committee on Mental Health, Developmental Disabilities, and Substance Abuse Services."

SECTION 5. This act is effective when it becomes law.

NORTH CAROLINA GENERAL ASSEMBLY
AMENDMENT
House Bill 80

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

H80-ALN-1 [v.1]

Date _____,2003

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

Representative Insko

moves to amend the bill on page 2, line 23,
by rewriting the line to read:

"**SECTION 4 .** Article 27 of Chapter 120 of the General Statutes is amended by adding the following new section to read:

"**§ 120-243. Reports to Committee.**

Whenever the Department of Health and Human Services, Division of Mental Health, Developmental Disabilities, and Substance Abuse Services, is required by law to report to the General Assembly or to any of its permanent committees or subcommittees on matters affecting mental health, developmental disabilities, and substance abuse services, the Department shall transmit a copy of the report to the co-chairs of the Joint Legislative Oversight Committee on Mental Health, Developmental

2003 COMMITTEE REPORT
HOUSE OF REPRESENTATIVES

The following report(s) from standing committee(s) is/are presented:
By Representatives **Verla Insko and Carolyn Justus,** Chairs for the Committee on **HEALTH.**

☒ Committee Substitute for
S.B. 2 A BILL TO BE ENTITLED AN ACT TO ALLOW CERTAIN APPLICANTS FOR DRIVERS LICENSES TO SUBMIT MEDICAL CERTIFICATES FROM OUT-OF-STATE PHYSICIANS.

☐ 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)

3/06/03

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2003

S 2

SENATE BILL 2

Health and Human Resources Committee Substitute Adopted 2/26/03

Short Title: Drivers License Medical Certification. (Public)

Sponsors:

Referred to:

February 10, 2003

A BILL TO BE ENTITLED

AN ACT TO ALLOW CERTAIN APPLICANTS FOR DRIVERS LICENSES TO SUBMIT MEDICAL CERTIFICATES FROM OUT-OF-STATE PHYSICIANS.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 20-9(g)(2) reads as rewritten:

"(g) The Division may issue a driver's license to any applicant covered by subsection (e) of this section under the following conditions:

...

(2) The Division shall not issue a license pursuant to this section unless the applicant has submitted to a physical examination by a physician or surgeon duly licensed to practice medicine ~~in this State~~ and unless such examining physician or surgeon has completed and signed the certificate required by subdivision (1). Such certificate shall be devised by the Commissioner with the advice of qualified experts in the field of diagnosing and treating physical and mental disorders as he may select to assist him and shall be designed to elicit the maximum medical information necessary to aid in determining whether or not it would be a hazard to public safety to permit the applicant to operate a motor vehicle, including, if such is the fact, the examining physician's statement that the applicant is under medication and treatment and that such person's physical or mental disability is controlled. The certificate shall contain a waiver of privilege and the recommendation of the examining physician to the Commissioner as to whether a license should be issued to the applicant."

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

NORTH CAROLINA GENERAL ASSEMBLY
AMENDMENT
Senate Bill 2

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

S2-ARM-1 [v.1]

Date 11 MAR ,2003

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

Representative [redacted] BARNHART

moves to amend the bill on page 1, line 11, by rewriting that line to read:

"surgeon duly licensed to practice in this State or in any other state of the United States and unless"

SIGNED _____
Amendment Sponsor

SIGNED _____
Committee Chair if Senate Committee Amendment

ADOPTED _____ FAILED _____ TABLED _____

SENATE BILL 2:
Drivers License Medical Certification

BILL ANALYSIS

Committee:	House Health	**Introduced by:**	Sen. Soles
Date:	March 12, 2003	**Summary by:**	Linda Attarian
Version:	Second Edition		Committee Counsel

SUMMARY: ***Senate Bill 2 amends the law that authorizes the Division of Motor Vehicles (DMV) to conditionally issue drivers license to applicants who are afflicted with or suffer from a physical or mental disability or disease that may impair their ability to safely operate a motor vehicle. The statute is amended to allow the DMV to issue the license upon the applicant's submission of a signed statement from a physician licensed by this State or by any other jurisdiction. The bill deletes the current restriction that the physician be licensed to practice in North Carolina. The act is effective when it becomes law.***

CURRENT LAW: G.S. 20-9 restricts the authority of the Division of Motor Vehicles to issue drivers licenses to certain applicants. G.S. 20-9(e) prohibits DMV from issuing a drivers license to anyone who is afflicted with or suffering from a physical or mental disability or disease that may prevent the person from exercising control over a motor vehicle on the highways or to understand highway warning or direction signs. However, the law provides an exception if DMV is able to determine that the applicant does not pose a safety hazard despite their disability. DMV must make this determination in part on reliance on a signed certificate stating that the applicant's physical or mental disability is controlled by medication and treatment. The statute requires a physician licensed to practice medicine in North Carolina conduct the examination.

Note that in 1999, the General Assembly enacted G.S. 90-18.3 to allow a nurse practitioner or a physician assistant to conduct any physical examination required to be conducted by a physician by a statute or State agency rule. The nurse or PA may also sign the form.

BILL ANALYSIS: The bill will delete the requirement that the certifying physician hold a license to practice in North Carolina to allow DMV to consider certificates signed by physicians licensed to practice any jurisdiction.

BACKGROUND: North Carolina statutes and rules contain various provisions requiring a physical examination to be conducted by a licensed physician for a variety of purposes. Only a few allow the physician to be licensed in states other than North Carolina. An example of a statute that does is G.S. 97-27(b), which governs workers compensation cases in which there is a question as to the percentage of permanent disability suffered by an employee and the employee is dissatisfied with the examination conducted by the physician designated by the Industrial Commission. Under this subsection, the employee is allowed to have another medical examination, and it may be conducted by a "*duly qualified physician or surgeon licensed and practicing in North Carolina or by a duly qualified physician or surgeon licensed to practice in South Carolina, Georgia, Virginia and Tennessee*" provided that the physician has been approved by the NC Industrial Commission.

2003 COMMITTEE REPORT
HOUSE OF REPRESENTATIVES

The following report(s) from standing committee(s) is/are presented:
By Representatives **Verla Insko and Carolyn Justus,** Chairs for the Committee on **HEALTH.**

☐ Committee Substitute for
H.B. 80 A BILL TO BE ENTITLED AN ACT TO REQUIRE THAT CERTAIN REPORTS BE MADE TO THE JOINT LEGISLATIVE OVERSIGHT COMMITTEE ON MENTAL HEALTH, DEVELOPMENTAL DISABILITIES, AND SUBSTANCE ABUSE 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 ~~(#), ☐ 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)

3/06/03

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2003

H 2

HOUSE BILL 80

Committee Substitute Favorable 3/12/03

Short Title: Reports to Mental Health Oversight Comm. (Public)

Sponsors:

Referred to:

February 25, 2003

A BILL TO BE ENTITLED

AN ACT TO REQUIRE THAT CERTAIN REPORTS BE MADE TO THE JOINT LEGISLATIVE OVERSIGHT COMMITTEE ON MENTAL HEALTH, DEVELOPMENTAL DISABILITIES, AND SUBSTANCE ABUSE SERVICES.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 122C-5 reads as rewritten:

"**§ 122C-5. Report on restraint and seclusion.**

The Secretary shall report annually on October 1 to the ~~Legislative Study Commission on Mental Health, Developmental Disabilities, and Substance Abuse Services~~ Joint Legislative Oversight Committee on Mental Health, Developmental Disabilities, and Substance Abuse Services on the following for the immediately preceding fiscal year:

(1) The level of compliance of each facility with applicable State and federal laws, rules, and regulations governing the use of restraints and seclusion. The information shall indicate areas of highest and lowest levels of compliance.

(2) The total number of facilities that reported deaths under G.S. 122C-31, the number of deaths reported by each facility, the number of deaths investigated pursuant to G.S. 122C-31, and the number found by the investigation to be related to the use of restraint or seclusion."

SECTION 2. G.S. 131D-42 reads as rewritten:

"**§ 131D-42. Report on use of restraint.**

The Department shall report annually on October 1 to the ~~Legislative Study Commission~~ Joint Legislative Oversight Committee on Mental Health, Developmental Disabilities, and Substance Abuse Services the following for the immediately preceding fiscal year:

(1) The level of compliance of each adult care home with applicable State law and rules governing the use of physical restraint and physical hold

of residents. The information shall indicate areas of highest and lowest levels of compliance.

(2) The total number of adult care homes that reported deaths under G.S. 131D-34.1, the number of deaths reported by each facility, the number of deaths investigated pursuant to G.S. 131D-34.1, and the number found by the investigation to be related to the adult care home's use of physical restraint or physical hold."

SECTION 3. G.S. 131D-10.6(10) reads as rewritten:

"**§ 131D-10.6. Powers and duties of the Department.**

In addition to other powers and duties prescribed by law, the Department shall exercise the following powers and duties:

...

(10) Report annually on October 1 to the ~~Legislative Study Commission~~ Joint Legislative Oversight Committee on Mental Health, Developmental Disabilities, and Substance Abuse Services the level of facility compliance with applicable State law governing the use of restraint and time-out in residential child-care facilities. The report shall also include the total number of facilities that reported deaths under this section, the number of deaths reported by each facility, the number of deaths investigated pursuant to this section, and the number found by the investigation to be related to the use of physical restraint or time-out."

SECTION 4. Article 27 of Chapter 120 of the General Statutes is amended by adding the following new section to read:

"**§ 120-243. Reports to Committee.**

Whenever the Department of Health and Human Services, Division of Mental Health, Developmental Disabilities, and Substance Abuse Services, is required by law to report to the General Assembly or to any of its permanent committees or subcommittees on matters affecting mental health, developmental disabilities, and substance abuse services, the Department shall transmit a copy of the report to the cochairs of the Joint Legislative Oversight Committee on Mental Health, Developmental Disabilities, and Substance Abuse Services."

SECTION 5. This act is effective when it becomes law.

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2003

HOUSE BILL 80

Short Title:	Reports to Mental Health Oversight Comm.	(Public)
Sponsors:	Representative Insko.	
Referred to:	Health.	

February 25, 2003

A BILL TO BE ENTITLED

AN ACT TO REQUIRE THAT CERTAIN REPORTS BE MADE TO THE JOINT LEGISLATIVE OVERSIGHT COMMITTEE ON MENTAL HEALTH, DEVELOPMENTAL DISABILITIES, AND SUBSTANCE ABUSE SERVICES.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 122C-5 reads as rewritten:

"**§ 122C-5. Report on restraint and seclusion.**

The Secretary shall report annually on October 1 to the ~~Legislative Study Commission on Mental Health, Developmental Disabilities, and Substance Abuse Services~~ Joint Legislative Oversight Committee on Mental Health, Developmental Disabilities, and Substance Abuse Services on the following for the immediately preceding fiscal year:

(1) The level of compliance of each facility with applicable State and federal laws, rules, and regulations governing the use of restraints and seclusion. The information shall indicate areas of highest and lowest levels of compliance.

(2) The total number of facilities that reported deaths under G.S. 122C-31, the number of deaths reported by each facility, the number of deaths investigated pursuant to G.S. 122C-31, and the number found by the investigation to be related to the use of restraint or seclusion."

SECTION 2. G.S. 131D-42 reads as rewritten:

"**§ 131D-42. Report on use of restraint.**

The Department shall report annually on October 1 to the ~~Legislative Study Commission~~ Joint Legislative Oversight Committee on Mental Health, Developmental Disabilities, and Substance Abuse Services the following for the immediately preceding fiscal year:

(1) The level of compliance of each adult care home with applicable State law and rules governing the use of physical restraint and physical hold

of residents. The information shall indicate areas of highest and lowest levels of compliance.

(2) The total number of adult care homes that reported deaths under G.S. 131D-34.1, the number of deaths reported by each facility, the number of deaths investigated pursuant to G.S. 131D-34.1, and the number found by the investigation to be related to the adult care home's use of physical restraint or physical hold."

SECTION 3. G.S. 131D-10.6(10) reads as rewritten:

"**§ 131D-10.6. Powers and duties of the Department.**

In addition to other powers and duties prescribed by law, the Department shall exercise the following powers and duties:

...

(10) Report annually on October 1 to the ~~Legislative Study Commission~~ Joint Legislative Oversight Committee on Mental Health, Developmental Disabilities, and Substance Abuse Services the level of facility compliance with applicable State law governing the use of restraint and time-out in residential child-care facilities. The report shall also include the total number of facilities that reported deaths under this section, the number of deaths reported by each facility, the number of deaths investigated pursuant to this section, and the number found by the investigation to be related to the use of physical restraint or time-out."

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

NORTH CAROLINA GENERAL ASSEMBLY
AMENDMENT
House Bill 80

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

H80-ALN-1 [v.1]

Date _____,2003

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

Representative Insko

moves to amend the bill on page 2, line 23,
by rewriting the line to read:

"**SECTION 4 .** Article 27 of Chapter 120 of the General Statutes is amended by adding the following new section to read:

"**§ 120-243. Reports to Committee.**

Whenever the Department of Health and Human Services, Division of Mental Health, Developmental Disabilities, and Substance Abuse Services, is required by law to report to the General Assembly or to any of its permanent committees or subcommittees on matters affecting mental health, developmental disabilities, and substance abuse services, the Department shall transmit a copy of the report to the co-chairs of the Joint Legislative Oversight Committee on Mental Health, Developmental

NORTH CAROLINA GENERAL ASSEMBLY
AMENDMENT
House Bill 80

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

H80-ALN-1 [v.1]

Disabilities, and Substance Abuse Services."

SECTION 5. This act is effective when it becomes law.

SIGNED _____
Amendment Sponsor

SIGNED _____
Committee Chair if Senate Committee Amendment

ADOPTED _____ FAILED _____ TABLED _____

HOUSE BILL 80:
Reports to Mental Health Oversight Comm.

BILL ANALYSIS

Committee:	House Health	**Introduced by:**	Rep. Insko
Date:	March 4, 2003	**Summary by:**	Linda Attarian
Version:	Introduced		Committee Counsel

SUMMARY: ***House Bill 80 amends certain provisions of law requiring the Secretary and the Department of Health and Human Services to submit annual reports regarding the use of physical restraints and seclusion in facilities regulated by DHHS to the Legislative Study Commission on Mental Health (Mental Health Study Commission). The act the Mental Health Study Commission and replaces it with the Joint Legislative Oversight Committee on Mental Health, Developmental Disabilities, and Substance Abuse Services, which was established in 2000. The act is effective when it becomes law.***

CURRENT LAW: The Mental Health Study Commission was established in 1996 (S.L. 1995-18, Sec. 24.8). It has not been repealed. The purpose of the Commission is to "study systemwide issues affecting the development, administration, and delivery of mental health, developmental disabilities, and substance abuse services, including issues relating to the governance, accountability, and quality of services delivered." The membership of this committee is comprised of members of the General Assembly and representatives of the public.

During the 2000 Regular Session of the 1999 General Session, the General Assembly enacted HB 1520, (S.L. 2000-129) to amend NC law pertaining to the use of physical restraints and seclusion in mental health facilities, residential child care facilities, and adult care homes. The legislation requires several reports by the Secretary and by the DHHS describing the extent of compliance of facilities with State and federal laws governing the use of physical restraints or seclusion and the number of deaths that may be associated with their use. The reports are to be made annually to the Mental Health Study Commission. No reports have been submitted.

Also during the 2000 Regular Session, in fact one month prior to the enactment of HB 1520, the General Assembly enacted HB 1519 (S.L. 2000-83, s.2), a bill to establish the Joint Legislative Oversight Committee on Mental Health, Developmental Disabilities, and Substance Abuse Services. The purpose of this committee is to "examine, on a continuing basis, systemwide issues affecting the development, financing, administration, and delivery of mental health, developmental disabilities, and substance abuse services, including issues relating to the governance, accountability, and quality of services delivered". The Committee is directed to "make ongoing recommendations to the General Assembly on ways to improve the quality and delivery of services and to maintain a high level of effectiveness and efficiency in system administration at the State and local levels". The membership of this Committee consists entirely of members of the General Assembly.

BILL ANALYSIS: House Bill 80 requires the reports referenced in S.L. 2000-129 to be submitted to the Joint Legislative Oversight Committee on MH/DD/SAS instead of the Mental Health Study Committee. The bill does not delete the reporting requirements nor does it repeal the statutes creating the Mental Health Study Committee. The bill is effective when it becomes law.

BACKGROUND:

Definitions of "physical restraint" and "seclusion" as follows (See NCAC 10-4P.0102):

(19) "Physical Restraint" means the application or use of any manual method of restraint that restricts freedom of movement; or the application or use of any physical or mechanical device that restricts freedom of movement or normal access to one's body, including material or equipment attached or adjacent to the client's body that he or she cannot easily remove. Holding a client in a therapeutic hold or other manner that restricts his or her movement constitutes manual restrains for that client. Mechanical devices may restrain a client to a bed or chair, or may be used as ambulatory restraints. Examples of mechanical devices include cuffs, ankle straps, sheets or restraining shirts, arm splints, posey mittens, and helmets. Excluded from this definition of physical restraint are physical guidance, gentle physical prompting techniques, escorting a client who is walking; soft ties used solely to prevent a medically ill client from removing intravenous tubes, indwelling catheters, cardiac monitor electrodes, or similar medical devices; and prosthetic devices or assistive technology which are designed and used to increase client adaptive skills. Escorting means the temporary touching or holding of the hand, wrist, arm, shoulder or back for the purpose of inducing a client to walk to a safe location.

(24) "Seclusion" means isolating a client in a separate locked room for the purpose of controlling a client's behavior.

House Committee on Health

March 18, 2003

Minutes

The House Committee on Health met on Tuesday, March 18, 2003 at 12:00 noon in Room 415 of the Legislative Office Building. A silent roll was taken. A copy of the roll denoting members present is attached to the minutes (Attachment I) along with a copy of the agenda and Visitor Registration Sheet (Attachments II and III).

Chair Insko opened the meeting by introducing the Pages: Dick Sexton from Johnston County sponsored by Rep. Billy Creech and Joe Seala sponsored by Don Munford. The sergeant-at-arms were Dusty Rhodes and Jackson Stancil. (Attachment IV)

Chair Insko then recognized Rep. Womble for further comments on his bill HB 36 A BILL ENTITLED AN ACT TO REPEAL THE LAW THAT AUTHORIZES THE INVOLUNTARY STERILIZATION OF PERSONS WHO ARE MENTALLY ILL OR MENTALLY RETARDED AND TO MAKE CONFORMING CHANGES TO THE GENERAL STATUTES. (Attachment V)

Rep. Womble thanked the chairs, committee members and various others for their attention and consideration of the bill. He then thanked Neil Ramirez and Elaine Riddick Jessup – the victims – for coming to share their stories and introduced each. Copies of newspaper articles were distributed to committee members (Attachment VI).

Rep. Womble then went on give a brief history of the state's eugenics program. He stated that although the law is now rarely used, his bill would erase one of the final remnants of the state sterilization program. (Attachment VII)

Chair Insko then recognized Neil Ramirez, who came forward and introduced herself as a victim of sterilization. She told that she became pregnant at age 18 and the social worker's threats to take her family off welfare if she didn't consider to be sterilized.

Chair Insko recognized Rep. McAllister who asked Ms. Ramirez where she was living at the time. Ms. Ramirez replied in Plymouth, North Carolina and that it happened in Washington County Hospital where A. F. Stanley was the doctor.

The Chair then recognized Elaine Riddick-Jessup, who came forward and introduced herself and told that she was born in Twin Falls, North Carolina. She told the committee that she was raped and became pregnant at age 13. She told that she was considered feebleminded and her father had consented to the procedure. She believed the doctors performed the sterilization procedure shortly after she gave birth to her son. After moving to New York, she found out she had been sterilized when heavy bleeding

sent her to the hospital. She began to sob as her told committee members that she was not feebleminded and had graduated from college.

The Chair recognized Rep. Joni Bowie and she asked Ms. Riddick-Jessup what year she was sterilized. Ms. Riddick-Jessup replied that it happened in March of 1968.

Deborah Chesson was then recognized and made a brief statement.

Rep. Alma Adams stated that she was embarrassed for the state for this law to remain and wanted to adjust that today. She then thanked the Board and Rep. Womble for sponsoring the bill.

Rep. Womble then requested a proposed committee substitute be handed out. (Attachment VIII). The Chair moved that the Committee accept the proposed committee substitute for discussion only and the committee voted favorably.

The Chair then introduced Tony Riddick, Ms. Elaine Riddick-Jessup's son, who told the committee about the impact his mother's sterilization had on his life.

The Chair then recognized Dianne Jessup, the staff attorney, to explain the bill.

Dianne Jessup referred to the Bill Analysis (Attachment IX) and made a brief explanation of how the committee substitute differs from the first edition. The Bill adds a section to provide a procedure to permit the sterilization of a mentally ill or a mentally retarded ward in the case of medical necessity. Under this procedure the guardian must obtain an Order from the Court permitting the guardian to consent to the procedure. To obtain the Order the guardian must file a petition and provide the Court with: (1) a sworn statement from a physician who examined the ward that the proposed procedure is medically necessary and not for the sole purpose of sterilization or for the purpose of hygiene or convenience; (2) provide the name and address of the physician performing the procedure; and (3) sworn statement from a psychiatrist or psychologist licensed in NC who examined the ward as to whether the ward is able to comprehend the nature of the proposed procedure and its consequences and is unable to give an informed consent to the procedure. If the psychiatrist indicates that the ward is capable of consenting to the procedure, the petition must contain the ward's sworn consent. The remaining changes are conforming changes. Dianne Jessup also made reference to Article 7 of the NCGS and the handout entitled, "talking points". (Attachments X and XI)

Rep. Adams was recognized and made motion for a favorable report of the Committee Substitute and unfavorable as to the original. Rep. William Wainwright seconded the motion.

Rep. Connie Wilson was then recognized with a question. How would the function in Item 3 differ if the ward was mentally retarded versus someone who is mentally ill? Diane Jessup and Chair Insko replied that a psychiatrist or psychologist is also qualified to make a determination of someone who is mentally retarded.

Rep. Connie Wilson then questioned if there was problem within group homes? She had recently read a newspaper article about employees of a group home hiring a prostitute. Chair Insko advised that reports in article did not apply to bill.

Chair Insko asked if there was any more discussion and Rep. Cary Allred was recognized.

Rep. Allred question was for Dianne Jessup. His question was if a parent or guardian of a woman or girl with down syndrome petitioned or requested that sterilization be performed could that be ordered unless some other medical necessity was present such as the requirement of a hysterectomy. Dianne Jessup advised that was correct if they are not capable of giving their informed consent.

The Chair recognized Rep. Mary McAllister who asked if this bill is voted on today what would happen to the commission – Eugenics Board. Rep. Larry Womble responded that the Eugenics Board had ceased. Rep. Adams asked when did this happen. Rep. Womble stated that the board was suspended in 1974, but the law is still on the books and we technically can still sterilize people involuntarily. Rep. Womble again stated that "we are trying to remove the law as it relates to involuntary sterilization.

Rep. William Wainwright was recognized and remarked that there was some concern raised by this Committee during the last meeting and asked Rep. Womble if the compromise language in the Committee Substitute was agreeable to all parties? Rep. Womble replied that yes the language was agreeable to all parties.

Chair Insko asked if there was any further discussion and if not there was a motion before the Committee for a favorable report as to the committee substitute and unfavorable as to the original bill. The bill passed unanimously. (Committee Report - Attachment XII)

The meeting was then adjourned at 12:03 p.m. *

Verla Insko — Rep. Verla Insko, Chair

Pamela J. Evans — Pamela Evans, Committee Clerk

*Note: Due to time HB 172 was not considered (Attachment XIII-Bill and Analysis)

ATTENDANCE

HOUSE COMMITTEE ON HEALTH

DATES	3/18/03													
INSKO, Verla CHAIR	✓													
JUSTUS, Carolyn CHAIR	✓													
ENGLAND, Bob VICE-CHAIR	✓													
ADAMS, Alma	✓													
ALLEN, Bernard	✓													
ALLEN, Gordon	✓													
ALLRED, Cary	✓													
BARNHART, Jeff	✓													
BOWIE, Joni	✓													
CLARY, Debbie														
EARLE, Beverly														
GLAZIER, Rick	✓													
HILTON, Mark	✓													
McALLISTER, Mary	✓													
MUNFORD, Don	✓													
SETZER, Mitchell														
SHERRILL, Wilma	✓													
WAINWRIGHT, William	✓													
WILSON, Connie	✓													
WRIGHT, Tom	✓													
Ex officio Members														
Brubaker, Bru														
Culpepper, Bill														
Cunningham, Pete														
Eddins, Rick														

ATTACHMENT II

AGENDA

HOUSE COMMITTEE ON HEALTH

March 18, 2003
Room 415 LOB
12:00 Noon

OPENING REMARKS

Representative Verla Insko, Chair
Representative Carolyn Justus, Chair

AGENDA ITEMS

HB 36 Repeal Involuntary Sterilization
Representatives Womble, Luebke, Weiss and Insko, Sponsors

HB 172 Local LTC Planning Pilot Project
Representatives Insko and Earle, Sponsors

ADJOURNMENT

ATTACHMENT III

VISITOR REGISTRATION SHEET

HOUSE COMMITTEE ON HEALTH — March 18, 2003

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
John Motley	Gov office
Beth Stratford Hunter	GHCRD
Jessie Ramsey	NC505
Paige Johnson	Planned Parenthood of Central NC
BRIAN LEWIS	Planned Parenthood of the TRIAD
Rob Currie	NDHHS
Dave Richard	The Hc Inc
Stacy Flannery	NCHCFA
Anne Dunn	PPNC
Dina DiMaio	NC Bar Assn.
Michelle Frazier	NC Bar Assn

VISITOR REGISTRATION SHEET

HOUSE COMMITTEE ON HEALTH — March 18, 2003

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Pat A. Young	APPCNC
Mary Cloninger	NC MGM
Stephen L DeBiasi	NC MGM
Amy Robson	NC Medical Group Managers
Todd Pittman	NC Medical Group Managers
Fran Sanborn	NC Medical Group Managers
Lorie Dawkins	NC Medical Group Managers
Elizabeth Dalton	Bond & Assoc.
Jerry Cooper	NCALA
C.L. Cochron	UCPNC
Jennifer Sullivan	NASW-NC

VISITOR REGISTRATION SHEET

HOUSE COMMITTEE ON HEALTH — March 18, 2003

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Sheila Mckenzie	NC DNHS
Carmen Hooker Odom	DHHS
Elaine Reddick Jessie	
Tony Reddick	
Deborah Chesson	
Neal Ramirez	
Kevin Beggs	Winston-Salem Journal
Ken McHam	Alley Associates
John Rustin	NCFPC
Julie Allen	NC Statewatch
Amy Jo Horne	NC Med. Society
Crissy Porter	Smith Anderson

VISITOR REGISTRATION SHEET

HOUSE COMMITTEE ON HEALTH — March 18, 2003

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Deborah Greenblatt	Carolina Legal Assistance
Michelle Gainey	Charlotte Surgical
Carol K. Bordley	Urology Specialists
Michael Jacobson	Mid-Atlantic Emergency Medical

HEALTH - 3-18-03

#415

ATTACHMENT IV.

House Pages

1. Name: Nick Sexton

   County: Johnston

   Sponsor: Billy Creech

2. Name: Joe Teague

   County: Wake

   Sponsor: Munford

3. Name: _____

   County: _____

   Sponsor: _____

4. Name: _____

   County: _____

   Sponsor: _____

5. Name: _____

   County: _____

   Sponsor: _____

Sgt-At-Arms

1. Name: Dusty Rhodes
2. Name: Jackson Stancil
3. Name: _____
4. Name: _____

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2003

HOUSE BILL 36

Short Title:	Repeal Involuntary Sterilization.	(Public)
Sponsors:	Representatives Womble, Luebke, Weiss, Insko (Primary Sponsors); Adams, Alexander, B. Allen, Bell, Black, Hall, Holliman, Lucas, McAllister, McGee, Miller, Parmon, Pate, Ross, Wainwright, and Wood.	
Referred to:	Health.	

February 19, 2003

A BILL TO BE ENTITLED

AN ACT TO REPEAL THE LAW THAT AUTHORIZES THE INVOLUNTARY STERILIZATION OF PERSONS WHO ARE MENTALLY ILL OR MENTALLY RETARDED AND TO MAKE CONFORMING CHANGES TO THE GENERAL STATUTES.

The General Assembly of North Carolina enacts:

PART I. REPEAL THE LAW AUTHORIZING INVOLUNTARY STERILIZATIONS.

SECTION 1. Article 7 of Chapter 35 of the General Statutes is repealed.

PART II. CONFORMING CHANGES TO THE GENERAL STATUTES.

SECTION 2. G.S. 7A-451(a)(10) is repealed.

SECTION 3. G.S. 35A-1203(e) reads as rewritten:

"(e) Where a guardian or trustee has been appointed for a ward under former Chapter 33 or former Chapter 35 of the General Statutes, the clerk, upon his own motion or the motion of that guardian or trustee or any other interested person, may designate that guardian or trustee or appoint another qualified person as guardian of the person, guardian of the estate, or general guardian of the ward under this Chapter; provided, the authority of a guardian or trustee properly appointed under former Chapter 33 or former Chapter 35 of the General Statutes to continue serving in that capacity is not dependent on such motion and designation."

SECTION 4. G.S. 35A-1241(a) reads as rewritten:

"(a) To the extent that it is not inconsistent with the terms of any order of the clerk or any other court of competent jurisdiction, a guardian of the person has the following powers and duties:

(1) The guardian of the person is entitled to custody of the person of his ward and shall make provision for his ward's care, comfort, and maintenance, and shall, as appropriate to the ward's needs, arrange for

his training, education, employment, rehabilitation or habilitation. The guardian of the person shall take reasonable care of the ward's clothing, furniture, vehicles, and other personal effects that are with the ward.

(2) The guardian of the person may establish the ward's place of abode within or without this State. In arranging for a place of abode, the guardian of the person shall give preference to places within this State over places not in this State if in-State and out-of-State places are substantially equivalent. He also shall give preference to places that are not treatment facilities. If the only available and appropriate places of domicile are treatment facilities, he shall give preference to community-based treatment facilities, such as group homes or nursing homes, over treatment facilities that are not community-based.

(3) The guardian of the person may give any consent or approval that may be necessary to enable the ward to receive medical, legal, psychological, or other professional care, counsel, treatment, or service. He may not, however, consent to the sterilization of a mentally ill or mentally retarded ward. ~~Such sterilization may be performed only after compliance with Chapter 35, Article 7.~~ The guardian of the person may give any other consent or approval on the ward's behalf that may be required or in the ward's best interest. He may petition the clerk for the clerk's concurrence in the consent or approval."

SECTION 5. G.S. 90-21.13(e) reads as rewritten:

"(e) In the event of any conflict between the provisions of this section and those of ~~Article 7 of Chapter 35 and~~ Articles 1A and 19 of Chapter 90, the provisions of those Articles shall control and continue in full force and effect."

SECTION 6. G.S. 90-275 is repealed.

SECTION 7. G.S. 108A-14(a)(10) is repealed.

SECTION 8. G.S. 148-22.22 reads as rewritten:

"**§ 148-22.2. Procedure when surgical operations on inmates are necessary.**

The medical staff of any penal institution of the State of North Carolina is hereby authorized to perform or cause to be performed by competent and skillful surgeons surgical operations upon any inmate when such operation is necessary for the improvement of the physical condition of the inmate. The decision to perform ~~such~~an operation shall be made by the chief medical officer of the institution, with the approval of the superintendent of the institution, and with the advice of the medical staff of ~~said~~ the institution. No ~~such~~operation shall be performed without the consent of the inmate; or, if the inmate ~~be~~is a minor, without the consent of a responsible member of ~~his~~the inmate's family, a guardian, or one having legal custody of ~~such~~the minor; or, if the inmate be non compos mentis, then the consent of a responsible member of ~~his~~the inmate's family or of a guardian ~~must~~shall be obtained. Any surgical operations on inmates of State penal institutions shall also be subject to the provisions of Article 1A of Chapter 90 of the General Statutes and G.S. 90-21.13 and G.S. 90- 21.14.

If the operation on the inmate is determined by the chief medical officer to be an emergency situation in which immediate action is necessary to preserve the life or health of the inmate, and the inmate, if sui juris, is unconscious or otherwise incapacitated so as to be incapable of giving consent or in the case of a minor or inmate non compos mentis, the consent of a responsible member of ~~his~~the inmate's family, guardian, or one having legal custody of ~~such~~the inmate cannot be obtained within the time necessitated by the nature of the emergency situation, then the decision to proceed with the operation shall be made by the chief medical officer and the superintendent of the institution with the advice of the medical staff of the institution.

In all cases falling under this Article [section], the chief medical officer of the institution and the medical staff of the institution shall keep a careful and complete record of the measures taken to obtain the permission for ~~such~~the operation and a complete medical record signed by the medical superintendent or director, the surgeon performing the operation and all surgical consultants of the operation performed.

~~This Article [section] is not to be considered as affecting the provisions of Article 7 of Chapter 35 of the General Statutes dealing with eugenical sterilization.~~"

SECTION 9. This act is effective when it becomes law and applies to all petitions for sterilization pending and orders authorizing sterilization that have not been executed as of the effective date of this act.

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Sat, March 15, 2003

Eugenics panel hears of pain

'It's like a cancer that eats you and eats you and eats you,' victim says

By John Railey
JOURNAL REPORTER

RALEIGH

Elaine Riddick Jessie and Nial Cox Ramirez, sterilized more than 30 years ago by order of state officials they never met, finally got to tell their stories yesterday of the pain that those operations caused.

"Yes, I have a lot of anger in me ... because of what I had to go through all my life," said Jessie, who was sterilized in Chowan County in 1968, when she was 14. She told a committee appointed by Gov. Mike Easley how the operation happened after she became pregnant by a man in his 20s - statutory rape by law. "I was only a child," she said.

[illegible]e and Ramirez cried as they talked, as did some members of the Eugenics Study Committee, which is considering reparations and other forms of compensation for those sterilized by the Eugenics Board of North Carolina. It ordered operations on more than 7,600 people from 1929 through 1974.

"The sadness that I feel about what has happened then turns to rage about has happened," said Carmen Hooker Odom, the chairwoman of the committee and the secretary of the N.C. Department of Health and Human Services.

Easley apologized for the eugenics program in response to a series of stories in the Winston-Salem Journal, two of which featured Jessie and Ramirez. The Eugenics Study Committee is the first of its kind in the nation.

Yesterday, committee members asked Jessie and Ramirez what they want the state to do for them.

[illegible]en Hooker Odom, left, and Rep. [illegible] Womble, right, welcome Elaine [illegible]ick Jessie, and her son Tony Riddick to the committee meeting in Raleigh.

"I want whatever I can get out of the state of North Carolina," Jessie said. "They should have just cut off my arm or just killed me."

Ramirez said she just wants to make sure that no one else is ever sterilized.

"I would want that no one would ever have to go through the pain that I went through," she said.

She and Jessie talked to attentive state officials yesterday in a conference room not far from the one where the five-member Eugenics Board voted to have them sterilized in the 1960s. They never got a chance to appear before that board.

(Photo by Karen Tam)

"Who were these people ... who can go behind closed doors and make a decision on your life, how your life is going to be run?" Ramirez asked.

[redacted]nd Jessie, who met face-to-face for the first time yesterday, have similar stories. Both come from northeastern North Carolina. They are black and were poor, as were most of those sterilized by the state in the 1960s.

Social workers prepared petitions to have both sterilized, and both were sterilized after having one child. Ramirez said that her social worker threatened to take her family off welfare if she didn't consent to be sterilized. "If I could just get my hands around her neck, I would kill her," she said.

Ramirez was sterilized in 1965 in Washington County when she was 18.

She and Jessie moved to New York, and now live in the Atlanta area. They have little use for North Carolina, and can't forget what the state did to them.

"I tried so hard to bury this, but it just won't go away," Ramirez said. "It's like a cancer that eats you and eats you and eats you."

As one justification for being sterilized, Riddick and Jessie were labeled "feeble-minded" on the basis of flawed intelligence testing. The two children born to the women work in the computer field.

Jessie's son, Tony Riddick of Winfall, and Ramirez's daughter, Deborah Chesson of Georgia, accompanied their parents to the committee hearing. [redacted] his mother couldn't talk through her tears, Riddick took over.

"Who has the audacity, or really the authority, to do these things, and where do you get it from?" he asked.

He was glad for the committee's work, he said, then placed his hands on either side of his mother's head. "I just wish we could fix this right here."

Chesson wondered what the children of those sterilized might have accomplished.

RELATED MATERIAL

The full story of North Carolina's ambitious sterilization program has never been told. It's been hidden behind sealed records. It's a story of pain and prejudice, and of good intentions and arrogance. It's a legacy that survivors still carry.

This five-part series includes **multimedia presentations** of victims, an **interactive timeline** and sample **IQ tests** used to classify the "feebleminded."

"One of those babies could have grown up and found a cure for cancer or diabetes or MS," she said.

Hooker Odom said that the committee hopes to submit in June its recommendations to Easley about what should be done.

Options include help with health-care costs incurred by those sterilized. Jessie said that the operation left her with bleeding spells for years afterward, and said she sees a psychiatrist and takes Prozac as well as another drug to help her sleep.

Jessie and Ramirez came to Raleigh at the invitation of Rep. Larry Womble, D-Forsyth, who is a member of the study committee. On Tuesday, the House Health Committee is scheduled to discuss a bill sponsored by Womble that would erase one of the final remnants of the state sterilization program: a law that gives judges the right to order sterilizations for the mentally ill. The law has rarely been used.

[redacted]mendment to the bill would give parents the right to have their mentally retarded or mentally ill children sterilized in special circumstances.

Womble and the committee are also considering other laws that might help those sterilized and make sure that such a program never happens again.

As they explore ways of helping those sterilized, committee members said they plan to ask for comments from Jessie and Ramirez and any other victims who might come forward.

Pam Young and other committee members thanked Jessie and Ramirez for telling their stories.

"You're two very strong and courageous women ... to have endured these kinds of feelings and thoughts for so many years," said Young, the deputy secretary for the N.C. Department of Cultural Resources.

- John Railey can be reached at 727-7288 or at jrailey@wsjournal.com

This story can be found at: http://www.journalnow.com/wsj/news/state/MGB9W4G2BDD.html

- Go Back To The Story

newsobserver.com

Saturday, March 15, 2003 8:22AM EST

Women recount coerced sterilizations

By AMY GARDNER, Staff Writer

Nial Ramirez was 17 in 1964, pregnant and living on welfare in Washington County with five siblings and her mother. If she didn't agree to be sterilized, North Carolina would cut off benefits to her family, a social worker told her.

On Friday, it was Ramirez's turn to tell her story to a committee appointed by Gov. Mike Easley to determine what should be done for victims of the state's eugenics program, which from 1933 to 1974 forced sterilization on more than 7,000 North Carolinians.

Ramirez, now 56, wept as she described a social worker's threats that she was "feebleminded" and that, if her mother, sisters and brothers lost their home, the blame would fall to her.

"She came every day, every day," Ramirez said of the social worker's visits. " 'It's your fault. If you don't get this operation, your sisters and brothers are not going to have anything to eat. They're not going to have any place to live. All because of what you did.' "

North Carolina's sterilization program was born from the then-popular theory that [illegible]al and physical disabilities could be bred out of the species by preventing, [illegible]gh sterilization, some people from bearing children. That principle, known as eugenics, was the basis of a state law that allowed sterilization of the "mentally diseased, feebleminded or epileptic."

For four decades, the Eugenics Board reviewed the cases of thousands of North Carolinians, many of them poor, black and female, and determined that they qualified for sterilization.

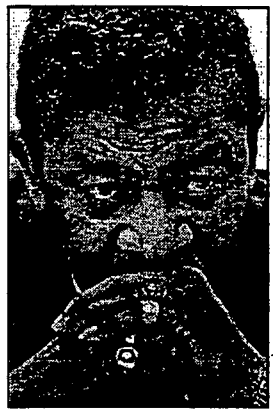
In the overwhelming majority of cases, the board did so without the individual's consent. Although such programs were common across the country during the 20th century, only California and Virginia forced more sterilizations than North Carolina.

Several state newspapers over the past year have retold this controversial chapter in North Carolina's history. Recent accounts have highlighted that eugenics, while born under a halo of science, was manipulated by public officials and doctors, nearly all of them white men, to coerce women, many of them poor and black, to submit to sterilization.

"When white people tell you you've got to do something, what are you going to do?" Ramirez told the panel. "What can you do? You've got to do what them white folks say, because they're going to give you that little bit of money to feed your kids with. That's the way it is."

In December, Easley issued an apology to victims and their families. In January, [illegible]rmed a committee to study the program, make sure it can never recur, and [illegible]mine what, if anything, can be done to help those who survive.

Elaine Riddick, 49, gets comfort from her son, Tony, 35, as she recounts her sterilization for the committee studying North Carolina's eugenics program. Riddick was sterilized after giving birth to a son conceived after she was raped at age 13.
Staff Photos by Corey Lowenstein



Rep. Larry Womble, a Forsyth County Democrat, sheds tears as victims talk.
Staff Photos by Corey Lowenstein

As part of their task, committee members listened raptly Friday to the stories of Ramirez and another woman, Elaine Riddick, who

both were sterilized against their will.

[redacted]ck was 13 and living in Perquimans County when she was raped and [redacted]ne pregnant, she told the committee. Now 49, she said she too was told she was feebleminded and must have the operation. She believes doctors severed her Fallopian tubes shortly after she gave birth to her son, Tony. She doesn't know for sure when the sterilization occurred -- or what precisely it entailed -- because no one explained it.

Riddick found out more months later, living in New York, when heavy bleeding sent her to the hospital and doctors explained what she had endured. "My little body wasn't ready for what they had done to me," she said between sobs.

Like Ramirez, Riddick was never tested for mental disability, she said. Like Ramirez, she is black. And like Ramirez, she grew up poor.

That profile was all too common among those chosen for forced sterilization by the eugenics board, according to Johanna Schoen, an assistant professor of history and women's studies at the University of Iowa. Schoen, in an article published two years ago in the Journal of Women's History, wrote that a family's economic background was often the basis of the North Carolina Eugenics Board's decisions.

Schoen described Mary Brewer, a woman brought before the Eugenics Board in the 1930s who had supported herself, her parents and her 11 siblings since age 10 by working in a hosiery mill, a cigarette factory and a knitting mill.

"[redacted] had quit work only after marriage and the birth of five children forced her to [redacted]ome," Schoen wrote. "In 1932, the worst year of the Great Depression, [redacted]n twenty-eight percent of the nation's households lacked a single breadwinner, she found herself unemployed. Despite her employment history, the Superintendent of Public Welfare in Forsyth County saw in her present inability to make a living as a symptom of feeblemindedness. 'When they reach that state [of feeblemindedness] they are rarely ever self-supporting,' he argued. 'They usually make their living by begging.' "

Exact statistics on the race and economic status of those sterilized are not available because the Eugenics Board's records are sealed at the state archives. Also unknown is how many of the 7,000 sterilized through the program are still living.

Members of Easley's committee, led by Carmen Hooker Odom, secretary of health and human services, were moved to silence by the women's remarks and engaged in a somber discussion of their options.

"This has been one of the most moving experiences of my life," Hooker Odom said. "I can't imagine it ever happened."

Among the committee's possibilities are health benefits for surviving victims who may still suffer physical ailments resulting from their sterilization; legal reform to allow victims to sue the state; and money.

One committee member, Allen Buchanan, a Duke University professor of [redacted]osophy and public policy, said another option might be to allow the victims to [redacted]hose who made these decisions so many years ago.

State Rep. Larry Womble, also on the committee, has submitted legislation to

Nial Ramirez, 56, says a social worker in Washington County threatened to withdraw state aid from her family if she did not agree to be sterilized. She had become pregnant at age 17.

Staff Photo by Corey Lowenstein

THE N.C. PROGRAM

In 1933, the legislature created the Eugenics Board of North Carolina to allow the sterilization of the "mentally diseased, feeble minded or epileptic." The law resulted from a movement in the nation that advocated sterilization as a way to solve social problems by preventing the "unfit" from having children. The board routinely approved sterilization for reasons ranging from promiscuity to homosexuality. Some sterilizations resulted from coercion of people on public assistance programs. Some resulted from flawed intelligence tests.

* States that passed similar laws: 33

* People forcibly sterilized nationwide: 65,000

* People forcibly sterilized in North Carolina: More than 7,000.

* N.C. sterilization law passed: 1929

* Time when state eugenics program existed and sterilizations occurred: 1933 to 1974.

* Year program ended: Responsibility of approving involuntary sterilization was moved to state courts in 1974. The Eugenics Board was abolished in 1977.

eliminate the government's authority to force sterilizations. Although the Eugenics Board of North Carolina was abolished in 1977, state courts still have the authority to impose sterilization.

[redacted]ble, also moved to tears during the two women's remarks, said additional legislation is likely before the end of this year's legislative session, possibly to specify financial reparations to victims.

"I don't think anything we could do could make these people whole," Womble said.

Riddick and Ramirez, meanwhile -- who, coincidentally, both live in Atlanta now -- say they are more interested in preventing any others from suffering the way they did than in receiving financial compensation.

"No child, no daughter, no mother, no father, should have to go through what I went through," Ramirez said. "It shouldn't happen again. It should not happen again."

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[BACK]

Confronting N.C.'s eugenics legacy

BY JOHANNA SCHOEN
Guest Columnist

On Feb. 10, North Carolina Gov. Mike Easley appointed a special commission to consider reparations for those sterilized under North Carolina's eugenic sterilization program. The program operated between 1929 and 1975 and led to the sterilization of more than 7,600 people. North Carolina has become the first state to officially consider reparations to victims of eugenic sterilization. After researching this history for more than a decade, I decided last summer to share my research findings and materials with Winston-Salem Journal reporter Kevin Begos in the hope of raising public awareness of the history of eugenic sterilization.

Gov. Easley's action came in response to a five-day article series by Begos and his collaborators which chronicled the history of the North Carolina program (http://againsttheirwill.journalnow.com). Easley issued a public apology immediately upon completion of the series, following earlier apologies for state sterilization programs in Virginia and Oregon.

North Carolina is the only state ever to provide a researcher access to the records of its Eugenics Board. It is important to acknowledge the courage of the N.C. Attorney General's Office and the State Archives staff in granting me access to these materials 10 years ago and, since the story broke, in opening these records further.

The secrecy surrounding such programs, which has inhibited research in other states, makes it difficult to determine how typical North Carolina's sterilization program was. The program was administered by a five-member Eugenics Board which met monthly to consider sterilization petitions submitted by county departments of public welfare, state hospitals, and state training schools.

North Carolina was the only state to allow social workers to draw up sterilization petitions for their clients. As a result, the already problematic goal of "racial improvement" via selective breeding — or eugenics — became overshadowed by the state's desire to save money by limiting the reproduction of those who might some day need public assistance. In fact, such financial considerations contributed to the longevity of the program. The board authorized thousands of sterilizations of young women who had had children outside marriage.

In an attempt to "break the cycle of poverty" and sterilize girls before they ever had children outside of marriage, the Department of Public Welfare decided in the 1950s to target the children of welfare recipients, leading to the sterilization of children as young as 10 and 11. Some of them suffered from mental illness or retardation. Many did not. Most did not want to be sterilized.

Occasionally, they begged the board or their surgeons not to perform the operation. As one teen-age girl pleaded in 1945 at a hearing before the Eugenics Board: "I don't want it. I don't approve of it, sir. I don't want a sterilize operation ... Let me go home, see if I get along all right. Have mercy on me and let me do that."

North Carolina established its sterilization program in 1929, as the country entered the Great Depression. Ambivalent about New Deal programs which acknowledged a responsibility for the health and welfare of American citizens, the state spent the Roosevelt years debating how little, not how much, state government could do to fight poverty and economic decline. Establishing a eugenic sterilization program under the authority of the state commissioner for public welfare exemplified this approach and guaranteed that financial interests would drive the program.

And if it was the creation of the welfare state that led to the creation of a state eugenic sterilization program, it was the expansion of the welfare state under President Johnson's War on Poverty that, in the 1960s, led to the drastic expansion of North Carolina's sterilization program when most other states had long stopped theirs. Studies conducted with support of the Eugenics Board concluded that receiving financial assistance from the state demonstrated the mental incompetence of the recipient.

Moreover, Eugenics Board members regularly acknowledged that a history of welfare dependency was not only an indication for feeblemindedness but could in itself constitute a reason for sterilization. They inquired about families' financial resources, the kind of work they did, how much they earned, whether they had ever received relief payments or help from the state, and how high such relief payments had been.

After Gov. Easley's apology last December, Nial Cox Ramirez, one of the women sterilized against her will, questioned the sincerity of his statements. She had reason for skepticism. In the early 1970s, she had sued the state over her forced sterilization at the age of 18 but had lost her case. After the appointment of the special commission, Ramirez feels more optimistic about the state's intention to make restitution for the past.

Reparations would be an important acknowledgement of the wrong North Carolina committed against thousands of its citizens. But if it is important to acknowledge past mistakes, it is even more important to learn from them. Reparations alone make no guarantees that current and future social policies will be more respectful of the rights of the poor.

Johanna Schoen is an assistant professor of history and women's studies at the University of Iowa. Her book on reproductive politics and the state, "A Great Thing for Poor Folks: Birth Control, Sterilization, and Abortion in Public Health and Welfare," is forthcoming from UNC Press.

Eugenics in North Carolina

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(Legislative links are at the bottom of this history)

The General Assembly of 1929 authorized the governing body or executive head of any penal or charitable public institution to order the sterilization of any patient or inmate when such an operation was deemed to be in the best interest of an individual or for the public good. Additionally, the county boards of commissioners were authorized to order sterilization at public expense of any mentally defective or feeble-minded resident upon receiving a petition from the individual's next of kin or legal guardian.

Each order for sterilization was required to be reviewed and approved by the commissioner of the Board of Charities and Public Welfare, the secretary of the State Board of Health, and the chief medical officers of any two state institutions for the feeble-minded or insane. A medical and family history of the patient or inmate was attached to the order to provide information and guidance for the reviewers.

In 1933 the General Assembly created the Eugenics Board of North Carolina to review all cases involving the sterilization of mentally diseased, feeble-minded, or epileptic patients, inmates, or non-institutionalized individuals. The five members of the board included the commissioner of the Board of Charities and Public Welfare, the secretary of the State Board of Health, the chief medical officer of a state institution for the feeble-minded or insane (appointed by the other board members), the chief medical officer of the State Hospital at Raleigh, and the attorney general.

In hearings that involved patients or inmates in a public institution, the executive head of that institution (or his representative) acted as prosecutor in presenting the case to the board. Hearings that concerned non-institutionalized individuals were prosecuted by the county superintendent of welfare or another authorized county official. Along with the petition for a hearing, the prosecutor provided a medical history signed by a physician who was familiar with the case and a social history addressing whether the person was likely to produce offspring.

A copy of the petition was sent to the individual and his or her next of kin or guardian. When the inmate, patient, or other individual could not defend himself or herself at the hearing, the next of kin, guardian, or county solicitor represented the individual and defended that person's rights and interests. The county superior court could appoint a guardian if necessary. Individuals could also be represented by legal counsel during the hearing.

Factors to be considered by the board included whether the operation seemed to be in the best interest of the individual's mental, moral, or physical health; whether it would be for the public good; and whether it was likely that the individual might produce children with serious mental or physical problems. Orders for sterilization had to be signed by at least three members of the board and returned to the prosecutor. Mentally competent individuals, at their own expense, could select their own physician for consultation or for an operation. A decision by the board could be appealed by the individual or in his or her behalf to the county superior court and further appealed to the state's supreme court. A successful appeal precluded any

further petition for the sterilization for one year unless specifically requested by the individual, or by his or her guardian or next of kin.

In 1937 the General Assembly authorized any state hospital, at the discretion of the superintendent, to provide temporary admission for any feeble-minded, epileptic, or mentally diseased person for whom the Eugenics Board had authorized sterilization. The regular or consulting staff of the hospital could then perform the operation. These hospitals were authorized to charge the appropriate state institution or county for the operation and expenses.

Under the Executive Organization Act of 1971, the Eugenics Board of North Carolina was transferred to the newly created Department of Human Resources (DHR). Although the board retained its statutory powers and actions regarding sterilization proceedings, the board's managerial and executive authority was vested in the secretary of the DHR, a cabinet-level officer appointed by the governor.

Under the Executive Organization Act of 1973, the Eugenics Board became the Eugenics Commission. The following five members of the commission were to be appointed by the governor: the director of the Division of Social and Rehabilitative Services of the DHR, the director of Health Services, the chief medical officer of a state institution for the feeble-minded or insane, the chief medical officer of the DHR in the area of mental health services, and the attorney general.

In 1974 the General Assembly transferred to the judicial system the responsibility for any sterilization proceedings against persons suffering from mental illness or mental retardation. In 1977 the General Assembly formally abolished the Eugenics Commission.

Authorities: P.L. 1929, c. 34.; P.L. 1933, c. 224.; P.L. 1937, c. 221.
S.L. 1959. c 1019.; S.L. 1971, c. 864, s 15.; S.L. 1973, c. 476, s. 133. S.L. 1973, c. 1281.; S.L. 1977, c. 497.
NC General Statutes 35-36 through 35-50.

(S.L. 1971, c. 864, s. 15 and S.L. 1973, c. 476, s. 133 are not linked because these acts are administrative in nature, and do not affect the activities of the Board. S.L. 1973, c. 1281 became NC General Statutes 35-36 through 35-50, linked above.)

Proposed Legislation: House Bill 36, 2003-2004 Session, "Repeal Involuntary Sterilization."

Source: *Guide to Research Materials in the North Carolina State Archives: State Agency Records.* © 1995 by the North Carolina Division of Archives and History.

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GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2003

H D

HOUSE BILL 36
PROPOSED COMMITTEE SUBSTITUTE H36-CSSW-2 [v.9]

3/18/2003 8:58:06 AM

Short Title: Repeal Involuntary Sterilization. (Public)

Sponsors:

Referred to:

February 19, 2003

A BILL TO BE ENTITLED

AN ACT TO REPEAL THE LAW THAT AUTHORIZES THE INVOLUNTARY STERILIZATION OF PERSONS WHO ARE MENTALLY ILL OR MENTALLY RETARDED AND TO PERMIT THE STERILIZATION OF MENTALLY ILL OR MENTALLY RETARDED WARDS ONLY WHEN THERE IS A MEDICAL NECESSITY, AND TO MAKE CONFORMING CHANGES TO THE GENERAL STATUTES.

The General Assembly of North Carolina enacts:

PART I. REPEALS THE LAW AUTHORIZING INVOLUNTARY STERILIZATIONS AND PERMITS THE STERILIZATION OF MENTALLY ILL OR MENTALLY RETARDED WARDS ONLY WHEN THERE IS A MEDICAL NECESSITY.

SECTION 1. Article 7 of Chapter 35 of the General Statutes is repealed.

SECTION 1.(a). Article 8 of Chapter 35A is amended by adding a new section to read:

"**§ 35A-1245. Procedure to permit the sterilization of a mentally ill or a mentally retarded ward in the case of medical necessity.**

(a) A guardian of the person shall not consent to the sterilization of a mentally ill or mentally retarded ward unless an order from the clerk has been obtained in accordance with this section.

(b) If a mentally ill or mentally retarded ward needs to undergo a medical procedure that would result in sterilization, the ward's guardian shall petition the clerk for an order to permit the guardian to consent to the procedure. The petition shall contain the following:

(1) A sworn statement from a physician licensed in this State who has examined the ward that the proposed procedure is medically necessary and not for the sole purpose of sterilization or for the purpose of hygiene or convenience.

(2) The name and address of the physician who will perform the procedure.

(3) A sworn statement from a psychiatrist or psychologist licensed in this State who has examined the ward as to whether the mentally ill or mentally retarded ward is able to comprehend the nature of the proposed procedure and its consequences and provide an informed consent to the procedure.

(4) If the ward is able to comprehend the nature of the proposed procedure and its consequences, the sworn consent of the ward to the procedure.

(c) A copy of the petition shall be served on the ward personally. If the ward is unable to comprehend the nature of the proposed procedure and its consequences and is unable to provide an informed consent, the clerk shall appoint an attorney to represent the ward.

(d) Should the ward or the ward's attorney request a hearing, a hearing shall be held. Otherwise, the clerk may enter an order without the appearance of witnesses. If a hearing is held, the guardian and the ward may present evidence.

(e) If the clerk finds the following, the clerk shall enter an order permitting the guardian to consent to the proposed procedure:

(1) The ward is capable of comprehending the procedure and its consequences and has consented to the procedure, or the ward is unable to comprehend the procedure and its consequences.

(2) The procedure is medically necessary and is not solely for the purpose of sterilization or for hygiene or convenience.

(f) The guardian or the ward, ward's attorney, or any other interested party may appeal the clerk's order to the superior court in accordance with G.S. 1-301.2(e)."

PART II. CONFORMING CHANGES TO THE GENERAL STATUTES.

SECTION 2.(a). G.S. 1-301.2(g) reads as rewritten:

"(g) Exception for Incompetency and Foreclosure ~~Proceedings.~~Proceedings and Proceedings to Permit Sterilization for Medical Necessity –

(1) Proceedings for adjudication of incompetency or restoration of competency under Chapter 35A of the General ~~Statutes~~ Statutes, or proceedings to determine whether a guardian may consent to the sterilization of a mentally ill or mentally retarded ward under G.S. 35A-1245 shall not be transferred even if an issue of fact, an equitable defense, or a request for equitable relief is raised. Appeals from orders entered in these proceedings are governed by Chapter 35A to the extent that the provisions of that Chapter conflict with this section.

(2) Foreclosure proceedings under Article 2A of Chapter 45 of the General Statutes shall not be transferred even if an issue of fact, an equitable defense, or a request for equitable relief is raised. Equitable issues may be raised only as provided in G.S. 45-21.34. Appeals from orders entered in these proceedings are governed by Article 2A of Chapter 45 to the extent that the provisions of that Article conflict with this section."

SECTION 2. G.S. 7A-451(a)(10) is repealed.

SECTION 3. G.S. 35A-1203(e) reads as rewritten:

"(e) Where a guardian or trustee has been appointed for a ward under former Chapter 33 or former Chapter 35 of the General Statutes, the clerk, upon his own motion or the motion of that guardian or trustee or any other interested person, may designate that guardian or trustee or appoint another qualified person as guardian of the person, guardian of the estate, or general guardian of the ward under this Chapter; provided, the authority of a guardian or trustee properly appointed under former Chapter 33 or former Chapter 35 of the General Statutes to continue serving in that capacity is not dependent on such motion and designation."

SECTION 4. G.S. 35A-1241(a) reads as rewritten:

"(a) To the extent that it is not inconsistent with the terms of any order of the clerk or any other court of competent jurisdiction, a guardian of the person has the following powers and duties:

(1) The guardian of the person is entitled to custody of the person of ~~his~~the guardian's ward and shall make provision for ~~his~~the ward's care, comfort, and maintenance, and shall, as appropriate to the ward's needs, arrange for ~~his~~ the ward's training, education, employment, rehabilitation or habilitation. The guardian of the person shall take reasonable care of the ward's clothing, furniture, vehicles, and other personal effects that are with the ward.

(2) The guardian of the person may establish the ward's place of abode within or without this State. In arranging for a place of abode, the guardian of the person shall give preference to places within this State over places not in this State if in-State and out-of-State places are substantially equivalent. ~~He~~ The guardian also shall give preference to places that are not treatment facilities. If the only available and appropriate places of domicile are treatment facilities, ~~he~~the guardian shall give preference to community-based treatment facilities, such as group homes or nursing homes, over treatment facilities that are not community-based.

(3) The guardian of the person may give any consent or approval that may be necessary to enable the ward to receive medical, legal, psychological, or other professional care, counsel, treatment, or service. ~~He~~ The guardian ~~may~~ shall not, however, consent to the sterilization of a mentally ill or mentally retarded ward. ~~Such sterilization may be performed only after compliance with Chapter 35, Article 7.~~ ward unless the guardian obtains an order from the clerk in accordance with G.S. 35A-1245. The guardian of the person may give any other consent or approval on the ward's behalf that may be required or in the ward's best interest. ~~He~~The guardian may petition the clerk for the clerk's concurrence in the consent or approval."

SECTION 5. G.S. 90-21.13(e) reads as rewritten:

"(e) In the event of any conflict between the provisions of this section and those of ~~Article 7 of Chapter 35 and~~ G.S. 35A-1245 and Articles 1A and 19 of Chapter 90, the provisions of those Articles shall control and continue in full force and effect."

SECTION 6. G.S. 90-275 reads as rewritten:

"**§ 90-275. Article does not affect ~~eugenical or therapeutical sterilization laws.~~duty of guardian to obtain order permitting guardian to consent to sterilization of a mentally ill or mentally retarded ward.**

Nothing in this Article shall be deemed to affect the provisions of ~~Article 7 of Chapter 35 of the General Statutes of North Carolina.~~ G.S. 35A-1245."

SECTION 7. G.S. 108A-14(a)(10) is repealed.

SECTION 8. G.S. 148-22.22 reads as rewritten:

"**§ 148-22.2. Procedure when surgical operations on inmates are necessary.**

The medical staff of any penal institution of the State of North Carolina is hereby authorized to perform or cause to be performed by competent and skillful surgeons surgical operations upon any inmate when such operation is necessary for the improvement of the physical condition of the inmate. The decision to perform ~~such~~an operation shall be made by the chief medical officer of the institution, with the approval of the superintendent of the institution, and with the advice of the medical staff of ~~said~~ the institution. No ~~such~~operation shall be performed without the consent of the inmate; or, if the inmate ~~be~~is a minor, without the consent of a responsible member of ~~his~~the inmate's family, a guardian, or one having legal custody of ~~such~~the minor; or, if the inmate be non compos mentis, then the consent of a responsible member of ~~his~~the inmate's family or of a guardian ~~must~~shall be obtained. Any surgical operations on inmates of State penal institutions shall also be subject to the provisions of Article 1A of Chapter 90 of the General Statutes and G.S. 90-21.13 and G.S. 90- 21.14.

If the operation on the inmate is determined by the chief medical officer to be an emergency situation in which immediate action is necessary to preserve the life or health of the inmate, and the inmate, if sui juris, is unconscious or otherwise incapacitated so as to be incapable of giving consent or in the case of a minor or inmate non compos mentis, the consent of a responsible member of ~~his~~the inmate's family, guardian, or one having legal custody of ~~such~~the inmate cannot be obtained within the time necessitated by the nature of the emergency situation, then the decision to proceed with the operation shall be made by the chief medical officer and the superintendent of the institution with the advice of the medical staff of the institution.

In all cases falling under this Article [section], the chief medical officer of the institution and the medical staff of the institution shall keep a careful and complete record of the measures taken to obtain the permission for ~~such~~the operation and a complete medical record signed by the medical superintendent or director, the surgeon performing the operation and all surgical consultants of the operation performed.

~~This Article [section] is not to be considered as affecting the provisions of Article 7 of Chapter 35 of the General Statutes dealing with eugenical sterilization.~~"

SECTION 9. This act is effective when it becomes law and applies to all petitions for sterilization pending and orders authorizing sterilization that have not been executed as of the effective date of this act.

HOUSE BILL 36:
Repeal Involuntary Sterilization

BILL ANALYSIS

Committee:	House Health	**Introduced by:**	Reps. Womble, Luebke, Weiss, Insko
Date:	March 4, 2003		
Version:	First Edition	**Summary by:**	Dianna Jessup Committee Counsel

SUMMARY: Part I of House Bill 36 would repeal the procedure that authorizes the sterilization of a mentally ill or a mentally retarded individual, whether or not the individual wishes to be sterilized, upon a petition filed in district court and an order entered by a district court judge. Part II of the bill would make conforming changes to the General Statutes. Consenting minors (upon order from a juvenile court) and adults would continue to be able to seek sterilization. The bill would become effective when it becomes law.

CURRENT LAW: Under Article 7 of Chapter 35 of the General Statutes (G.S. 35-36 through 35-50), certain persons can request an order from the district court to authorize the sterilization of a mentally ill or mentally retarded person.[1] In the case of an institutionalized mentally ill or mentally retarded person, the parent or guardian of the person or the director of the institution may make the request. In the case of a person who is not a resident of an institution, the parent or guardian of the person or the county director of social services may make the request. G.S. 35-29 makes it the duty of the petitioner to initiate sterilization proceedings under any of the following circumstances:

1) When it is in the best interest of the mental, moral, or physical improvement of the person to be sterilized.

2) When it is for the public good that the person be sterilized.

3) When the person would be likely, unless sterilized, to procreate a child who would have a tendency to serious physical, mental, or nervous disease or deficiency; or, because of a physical, mental, or nervous disease or deficiency which is not likely to materially improve, the person would be unable to care for a child.

The request to sterilize is initiated by the filing of a petition in district court. Under G.S. 35-40, the petition must contain the following:

- Allegations of the results of psychological or psychiatric tests supporting the assertion that the person is subject to the provisions of the statute.
- The statement of a physician who has examined the person who is the subject of the petition affirming whether or not there is any known contraindication to the sterilization procedure.
- The name and address of the physician who will perform the sterilization.

[1] "Mentally ill" and "mentally retarded" are not defined in Article 7 of Chapter 35. However, the mental health statutes (G.S. 122C-3) define "mental illness" "(i) when applied to an adult, an illness which so lessens the capacity of the individual to use self-control, judgment, and discretion in the conduct of his affairs and social relations as to make it necessary or advisable for him to be under treatment, care, supervision, guidance, or control; and (ii) when applied to a minor, a mental condition, other than mental retardation alone, that so impairs the youth's capacity to exercise age adequate self-control or judgment in the conduct of his activities and social relationships so that he is in need of treatment" and "mental retardation" as "significantly subaverage general intellectual functioning existing concurrently with deficits in adaptive behavior and manifested before age 22".

- The written consent or objection of the next of kin or the legal guardian. If there is no next of kin or legal guardian, the court must appoint a guardian ad litem to investigate and report to the court.
- The consent or objection or the person who is the subject of the petition. If the person is incapable of consenting or objecting, the petitioner must certify that the procedure has been explained to the person.

A copy of the petition must be served on the person who is the subject of the petition and on the legal or natural guardian[2] or next of kin of the person who is the subject of the petition. If the petitioner is someone other than the county director of social services, the judge must order the county director of social services in the county in which the person who is the subject of the petition resides to investigate and make recommendations to the court regarding the case. The person who is the subject of the petition has the right to counsel at all stages of the proceedings. If the petitioner, the person who is the subject of the petition, or any other interested party requests a hearing, a hearing must be held. In the absence of written objection filed by the subject of the petition or other interested party, the court may render judgment without the appearance of witnesses. If a hearing is requested, the district attorney may present the evidence for the petitioner. The person who is the subject of the petition is entitled to present evidence and cross-examine witnesses.

The law expressly authorizes the court to enter an order of sterilization of a mentally ill or mentally retarded person based upon either of two grounds. The first ground is if the person would probably be unable to care for a child or children. The second ground is if the person would be likely, unless sterilized, to procreate a child or children who probably would have serious physical, mental, or nervous diseases or deficiencies. In addition, the appellate courts have interpreted the statute to require the district court to find (based on clear, strong, and convincing evidence) that the person is physically capable of procreation, that there is a substantial likelihood that the person will voluntarily or otherwise engage in sexual activity likely to cause impregnation, that the person is unable or unwilling to control procreation by birth control or contraceptive methods, and that the proposed method of sterilization entails the least invasion of the person's body.

Article 7 of Chapter 35 of the General Statutes has withstood constitutional challenges, based on both substantive and procedural grounds.

Article 19 of Chapter 90 of the General Statutes permits a physician to perform a sterilization operation 1) upon a person over 18 when requested by the person in writing or 2) upon a minor when requested in writing by the minor, provided that a juvenile court determines the operation is in the best interest of the minor.

A guardian of the person may not consent to the sterilization of a mentally ill or mentally retarded ward unless the current procedure in Chapter 35 is followed.[3]

BILL ANALYSIS: If the bill is enacted, the statutory procedure for involuntary sterilizations would be repealed. Adults and married minors could still request a physician to perform a sterilization procedure. A minor, upon a finding by a juvenile court that it is in the minor's best interest, could also be sterilized if the minor so chooses. The bill would also make the necessary conforming changes to the General Statutes.

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[2] Parents are considered the natural guardians of their children. G.S. 35A-1201(a)(6).

[3] G.S. 35A-1215; G.S. 35A-1241(a)(3).

ISSUES: There are a few issues raised by the bill in its current form:

1. May a guardian of someone who is not mentally ill or mentally retarded consent to the sterilization of a ward? (Probably yes, but the guardianship statutes are not clear)

2. May a ward that is adjudicated incompetent nonetheless be able to consent to sterilization, if the ward understands the procedure and what it means? (Case law suggests the answer to be yes, but that case was not decided in this context)

3. Even if Article 7, Chapter 35 is repealed, may a person still be able to go to court and obtain an order to sterilize someone against their will? (In a couple of other states, the absence of statutory authority did not prohibit a person from going to court and obtaining an order to sterilize someone)

BACKGROUND:

Brief History of Eugenics Movement: "Eugenics" is defined as the study of methods of improving genetic qualities by selective breeding. During the early part of the 20th century, social reformers advocated eugenic sterilization as a solution to problems such as mental retardation. In 1907, Indiana was the first state to pass a eugenic sterilization program, and California followed in 1909. More than 30 states eventually enacted these laws. North Carolina's eugenics law was passed in 1929 and was rewritten in 1933. It created a Eugenics Board to review petitions for sterilization. The law authorized sterilizations for three reasons: (1) epilepsy, (2) mental disease, and (3) feeblemindedness. Because record keeping varied from state to state, the exact number of eugenic sterilizations performed in the United States may never be known. Researchers *estimate* that about 65,000 people were sterilized. More than 7,600 people were sterilized in North Carolina between 1929 and 1974. North Carolina ranked third after Virginia with about 8,000 sterilizations and California with 21,000 sterilizations. Whereas most states sharply curtailed their sterilization programs after World War II, nearly four-fifths of sterilizations in North Carolina were done after 1945. By the late 1960s, more than 60% of those sterilized in North Carolina were black, and 99% were female. The Eugenics Board was abolished in 1974, and the current process for obtaining an order to sterilize a mentally ill or mentally retarded person was put into place.

Eugenics Board of North Carolina: The Board consisted of five members as follows:

1. The Commissioner of Public Welfare
2. The Secretary of the State Board of Health
3. The Chief Medical Officer at the State Hospital in Raleigh
4. The Chief Medical Officer of an institution for the feebleminded or insane from an institution outside of Raleigh
5. A representative from the Attorney General's Office

These five members met in a conference room in Raleigh, where they worked through about 30 cases per month, determining whether people should or should not be sterilized. Sterilization was ordered in more than 90% of the cases before the Board.

Lawsuits/Cases: In *Buck v. Bell* (1927), the United States Supreme Court set a precedent allowing the sterilization of the "feebleminded." There have never been any successful lawsuits over eugenic sterilizations in the U.S. North Carolina is the first state to ever consider paying reparations to victims of a eugenic sterilization program.

How States are Making Amends: The governors of the following Virginia, Oregon, North Carolina, and South Carolina have issued apologies for forced sterilizations. In addition to issuing a public

apology, Governor Easley established a committee to investigate the eugenics program and consider reparations or counseling services for victims. The committee is chaired by the Secretary of the Department of Health and Human Services (DHHS) and consists of the following members:

- General counsel from DHHS;
- A representative from the Division of Mental Health, Developmental Disabilities, and Substance Abuse Services, DHHS; and
- Two representatives from the Department of Cultural Resources.

State Laws Regulating Sterilization: 11 states have laws that allow certain parties to petition the court for involuntary sterilization of the mentally ill, including: Colorado, Connecticut, Delaware, Georgia, Maine, Minnesota, Mississippi, North Carolina, Vermont, Virginia, and West Virginia.

More information regarding North Carolina's eugenic sterilization program is available at the link, http://againsttheirwill.journalnow.com/. This link will take you to a series of articles published by the Winston Salem Journal.

Amy Currie, Research Assistant, contributed to this summary. *H36-SMSW-001*

House Bill 36 – Repeal Involuntary Sterilization – How PCS Differs from the First Edition

- Adds Section 1.(a). that amends Chapter 35A (the guardianship statutes) to provide a procedure to permit the sterilization of a mentally ill or a mentally retarded ward in the case of medical necessity. Under this provision, a guardian of the person cannot consent to the sterilization of a mentally ill or mentally retarded ward unless the guardian obtains an order from the clerk of court that permits the guardian to do so. To obtain the order, the guardian must file a petition that contains the following:

    1. A sworn statement from a physician licensed in this State who has examined the ward that the proposed procedure is medically necessary and not for the sole purpose of sterilization or for the purpose of hygiene or convenience.
    2. The name and address of the physician who will perform the procedure.
    3. A sworn statement from a psychiatrist or psychologist licensed in this State who has examined the ward as to whether the ward is able to comprehend the nature of the proposed procedure and its consequences and is unable to give an informed consent to the procedure. If the psychiatrist indicates that the ward is capable of consenting to the procedure, the petition must contain the ward's sworn consent.

  A copy of the petition must be served on the ward, and an attorney must be appointed to represent the ward if the ward is unable to comprehend the nature and consequences of the procedure and provide an informed consent.. If the ward or the ward's attorney requests a hearing, one must be held – otherwise, the clerk may rule without a hearing. If the clerk finds **either** that the ward is capable of consenting to the procedure and consents to it, **or** the ward is unable to comprehend the procedure and its consequences, **and** the procedure is medically necessary, the clerk must enter an order permitting the guardian to consent to the procedure. The clerk's order may be appealed to the Superior Court.

- Adds Section 2.(a)., which would amend the law that governs the transfer or appeal of special proceedings to provide that the clerk may decide issues of fact in a proceeding to permit the sterilization of a mentally ill or mentally retarded ward.
- Changes Section 4 to make a conforming change to the statute governing the powers and duties of a guardian of the person.
- Changes Sections 5 and 6 to make a conforming change to the voluntary sterilization statutes.

Article 7.

Sterilization of Persons Mentally Ill and Mentally Retarded.

§ 35-36. Sterilization of mentally retarded in State institutions.

The parent or guardian of a mentally ill or mentally retarded person or the responsible director, or other public official performing the functions of such director, of any institution operated by the State of North Carolina is hereby authorized to petition the district court of the county in which such institution is located for the sterilization operation of any mentally ill or retarded resident or patient thereof as may be considered in the best interest of the mental, moral, or physical improvement of the resident or patient, or for the public good, provided, that no operation authorized in this section shall be lawful unless and until the provisions of this Article shall first be complied with. It shall be the responsibility of the State institution to provide or pay for the cost and expense of the operations authorized in this section for those persons residents or patients in State institutions. (1933, c. 224, s. 1; 1967, c. 138, s. 1; 1973, c. 1281; 1981, c. 102, ss. 1, 2.)

§ 35-37. Sterilization of mentally retarded not in State institutions.

The parent or guardian of a mentally ill or mentally retarded person, or the county director of social services, or other public official performing the functions of such director, is hereby authorized to petition the district court of his county for the sterilization operation of any mentally ill or retarded resident of the county, not a resident or patient of any State institution, or of any mentally ill or retarded person who is on parole from a State institution considered in the best interest of the mental, moral, or physical improvement of such resident, or for the public good, provided that no operation authorized in this section shall be lawful unless and until the provisions of this Article shall first be complied with. It shall be the responsibility of the board of commissioners of the respective counties to provide or pay for the cost and expense of the operations authorized in this section for those persons residents in their respective counties. (1933, c. 224, s. 2; 1961, c. 186; 1967, c. 138, s. 2; 1973, c. 1281; 1981, c. 102, s. 3.)

§ 35-38. Who shall perform sterilization operations upon the mentally retarded.

No operation under this Article shall be performed by other than a duly qualified and licensed North Carolina physician or surgeon, pursuant to Chapter 90 of the General Statutes as amended, and by him only upon a written order signed by the court having authority under the provisions of either G.S. 35-43 or G.S. 35-44. The petitioner will select the physician or surgeon to perform the sterilization operation and notify the patient and next of kin. If however, the patient or next of kin wishes to select a physician or surgeon other than the one selected by the petitioner, it will be the responsibility of the patient or next of kin to pay for the costs and expense of the sterilization operation. In the event the patient or next of kin is unable to provide for payment of the physician or surgeon selected by them, the operation will be performed by the physician or surgeon

selected by the petitioner. (1933, c. 224, s. 3; 1961, c. 186; 1967, c. 138, s. 3; 1969, c. 982; 1973, c. 1281.)

§ 35-39. Duty of petitioner.

It shall be the duty of such petitioner promptly to institute proceedings as provided by this Article in any of the following circumstances:

(1) When in his opinion it is for the best interest of the mental, moral or physical improvement of the patient, resident of an institution, or noninstitutional individual, that he or she be sterilized.

(2) When in his opinion it is for the public good that such patient, resident of an institution, or noninstitutional individual be sterilized.

(3) When in his opinion such patient, resident of an institution, or noninstitutional individual would be likely, unless sterilized, to procreate a child or children who would have a tendency to serious physical, mental, or nervous disease or deficiency; or, because of a physical, mental, or nervous disease or deficiency which is not likely to materially improve, the person would be unable to care for a child or children.

(4) Repealed by Session Laws 1981, c. 102, s. 4. (1933, c. 224, s. 4; 1935, c. 463, s. 1; 1937, c. 243; 1961, c. 186; 1967, c. 138, s. 4; 1969, c. 982; 1973, c. 476, s. 133.3; c. 1281; 1981, c. 102, s. 4.)

§ 35-40. Contents of petition.

The petition shall contain allegations of the results of psychological or psychiatric tests supporting the assertion that such person is subject to the provisions of this Article; shall contain the statement of a physician who has examined such person affirming whether or not there is any known contraindication to the requested surgical procedure; shall state the name and address of the physician or surgeon who will perform the operation; and shall contain the written consent or objection of the next of kin, the legal guardian or, if there is no next of kin and no known legal guardian a guardian ad litem who shall be appointed by the district court judge and who shall make investigation and report to the court before the hearing shall commence. The petition should also contain the consent or objection of the person upon whom the sterilization operation is to be performed. In the event the person upon whom the operation is to be performed is not capable of giving consent or objection, there must be a certification by the petitioner that the procedure has been explained to the person upon whom the operation is to be performed. (1933, c. 224, s. 8; 1935, c. 463, s. 2; 1973, c. 476, s. 133.3; c. 1281.)

35-41. Copy of petition served on patient.

At least 20 days prior to the hearing on the petition in the district court, a copy of such petition must be served upon the resident of the institution, patient, or noninstitutional individual and to the legal or natural guardian, guardian ad litem, or next of kin of the resident of the institution, patient, or noninstitutional individual. (1933, c. 224, s. 9; 1935,

c. 463, ss. 3, 6; 1947, c. 93; 1961, c. 186; 1969, c. 982; 1971, c. 528, s. 33; c. 1231, s. 1; 1973, c. 476, s. 133.3; c. 1281.)

§ 35-42. Judge to order investigation.

If the petitioner instituting the sterilization proceedings is other than the county director of social services the judge shall order the county director of social services in the county in which the person upon whom the operation is to be performed has domicile to investigate and make recommendations to him regarding the case. (1973, c. 1281.)

§ 35-43. Hearing before the judge of district court.

Should the petitioner, the person subject to the petition, or any other interested party request a hearing, a hearing shall be held in the district court before the judge without a jury. In the absence of written objection filed with the court by the person alleged to be subject to this section or by any other interested party on his or her behalf, the court may render judgment without the appearance of witnesses. In the event a hearing is requested the district attorney for the district in which the petition is heard or the district attorney's assistant may present the evidence for the petitioner. The respondent shall be entitled to examine the petitioner's witnesses and shall be entitled to present evidence in his own behalf. If the judge of the district court shall find from the evidence that the person alleged to be subject to this section is subject to it and that because of a physical, mental, or nervous disease or deficiency which is not likely to materially improve, the person would probably be unable to care for a child or children, or because the person would be likely, unless sterilized, to procreate a child or children which probably would have serious physical, mental, or nervous diseases or deficiencies, he shall enter an order and judgment authorizing the physician or surgeon named in the petition to perform the operation. (1973, c. 1281; 1975, c. 520, s. 1.)

§ 35-44. Appeals.

An appeal to the superior court may be had by the person alleged to be subject to this section or any other interested party on such judgment in the district court if filed within 15 days following the date the court judgment is entered. The proceedings before the superior court shall constitute a trial de novo, and upon application of either party shall be heard before a jury. The district attorney for the district in which the petition is heard or his assistant may present the evidence for the petitioner. The respondent shall be entitled to examine the petitioner's witnesses and to present evidence in his own behalf. Any decision of the superior court in such cases may be appealed to the appellate courts as in other civil cases. The cost of the appeal, if any, to the superior court and higher courts shall be taxed as in other civil cases and the pendency of any appeal shall stay the proceedings in the lower court until the appeal be finally determined. Paupers' affidavits regarding court costs and costs of appeal may be filed as in other cases made and provided by the laws of this State. (1933, c. 224, ss. 13, 14; 1935, c. 463, ss. 4, 5; 1969, c. 44, s. 44; 1973, c. 476, s. 133.3; c. 1281; 1975, c. 520, s. 2.)

§ 35-45. Right to counsel.

The person alleged to be subject to the provisions of this section shall have the right to counsel at all stages of the proceedings provided for herein. This person and all others served with the notification provided for in G.S. 35-41 shall be fully informed of the person's entitlement to counsel at the time of this service of notice. This information shall be given in language and in a manner calculated to insure, insofar as such is possible in view of the individual's capability to comprehend it, that the recipient understands the entitlement. Every person subject to be sterilized under this Article after the filing of the petition shall have counsel at every stage of the proceedings. If there is a conflict between the election of the person concerned and that of the other persons being served with notice, determination of the question of representation by counsel shall be made by the court having jurisdiction of the case. The person concerned may, in any instance, be represented by counsel retained by him. In cases of claimed indigency, a request for counsel shall be processed in the manner provided for in Subchapter IX, Chapter 7A, General Statutes of North Carolina. (1973, c. 1281.)

35-46. Sterilization procedure to be performed after court judgment.

After judgment of the court in accordance with G.S. 35-43 and 35-44 shall have become final to the effect that such sterilization shall be performed upon such person subject to this section, a sterilization procedure may be performed by a physician upon such person subject to this section. (1973, c. 1281.)

§ 35-47. Sterilization procedure defined.

Wherever used in this section, the words, "sterilization procedure" shall include and authorize the performance by the physician of any procedure or operation deemed to be in the best interest of the individual patient or intended to prevent conception, but does not include castration. (1973, c. 1281.)

§ 35-48. Civil or criminal liability of parties limited.

When an operation shall have been performed in compliance with the provisions of this law, no physician duly licensed without restriction to practice medicine and surgery in this State or other person legally participating in the execution of the provisions of this Article shall be liable civilly or criminally on account of such operation or participation therein, except in the case of negligence in the performance of said procedures. (1933, c. 224, s. 16; 1973, c. 1281.)

§ 35-49. Necessary medical treatment unaffected by Article.

Nothing in this section [Article] shall be construed so as to require compliance with this section or to prevent the medical or surgical treatment for sound therapeutic purposes of any person in this State, by a physician duly licensed without restriction to practice medicine and surgery in this State, which treatment may involve the nullification or destruction of the reproductive functions at the same time that it serves such sound therapeutic purposes. (1933, c. 224, s. 17; 1973, c. 1281.)

§ 35-50. Hospitals not compelled to admit patient.

Nothing in this section shall require a hospital to admit any patient under the provisions hereof for the purpose of performing a sterilization procedure. (1973, c. 1281.)

Talking Points Regarding House DRH60022-SW-11A-
Repeal Involuntary Sterilization

- The disability advocates represented are totally in support of the bill's primary purpose, which is to repeal the use of sterilization for purposes of birth control for any reason.

- For people who are under guardianship, it is important that they have access to medical procedures that are available to the general public and are medically necessary, but that have sterilization as a by-product, such as a hysterectomy to remove fibroid tumors or treatment for ovarian cancer.

- The record of cases in North Carolina in recent years indicates that involuntary sterilization has occurred in medical facilities without the use of the legal procedures (Article 7 of Chapter 35) as often or more often than it has occurred through use of the legal procedures. Thus, where abuse has occurred, it has been because of ignorance of the statutory procedure rather than abuse of the procedure in recent times.

- It is better to have a statute that clearly establishes legal standards and procedures for securing a medically necessary sterilization than to have a repealed statute that leaves a vacuum that can be interpreted differently by clerks of court and judges in the 100 counties of the state. Such standards would define what "medical necessity" is and make sure that the convenience of caregivers is not used as an excuse to get approval for medical sterilization.

- There is a need to educate medical and hospital communities about this issue. We therefore recommend some sanction for doctors and hospitals who perform medical sterilizations without legal procedures having been followed. Such a sanction would be an incentive for medical educators and insurers to undertake the needed education.

2003 COMMITTEE REPORT
HOUSE OF REPRESENTATIVES

The following report(s) from standing committee(s) is/are presented:
By Representatives **Verla Insko and Carolyn Justus,** Chairs for the Committee on **HEALTH**.

☐ Committee Substitute for
H.B. 36 A BILL TO BE ENTITLED AN ACT TO REPEAL THE LAW THAT AUTHORIZES THE INVOLUNTARY STERILIZATION OF PERSONS WHO ARE MENTALLY ILL OR MENTALLY RETARDED AND TO MAKE CONFORMING CHANGES TO THE GENERAL STATUTES.

☐ 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 (~~# H.B. 36~~), ☒ 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)

3/06/03

FOR JOURNAL USE ONLY

____ Pursuant to Rule 36(b), the bill/resolution is placed on the Calendar of _____.

____ The (committee substitute) bill/resolution (, as amended,) is (ordered engrossed and) re-referred to the Committee on _____.

____ The bill/resolution is re-referred to the Committee on _____.

____ On motion of (Rep. _____,) (the Chair,) the (committee substitute) bill/resolution is (ordered engrossed and) re-referred to the Committee on _____.

____ Pursuant to Rule 36(b), the (House)committee substitute bill (No. ____)/resolution is placed on the Calendar of _____. (The original bill) (House Committee Substitute Bill No. ____)/resolution is placed on the Unfavorable Calendar.

____ On motion of Rep. _____, (the rules are suspended) (Rule ____ is suspended) and the bill/resolution is placed on today's calendar. (for immediate consideration.)

____ On motion of Rep. _____, Committee Amendment No.(s) _____ is/are adopted (by EV____ ____).

____ On motion of Rep. _____, Committee Amendment No.(s) _____ is/are adopted (by EV____ ____).

____ Rep. _____ offers Amendment No. _____ which (is adopted.) (fails of adoption.) (by EV ____ ____.) ( ) This amendment changes the title.

____ The bill/resolution (, as amended,) passes its second reading (by following vote, ____ ____ RC) (, by EV ____ ____,) and (remains on the Calendar,) (and there being no objection is read a third time).

____ The bill/resolution (, as amended,) passes its third reading (by the following vote, ____ ____ RC) (, by EV ____ ____,) and is ordered
____ sent to the Senate.
____ without engrossment. ____ by Special message.
____ sent to the Senate for concurrence in
_____ the House amendment (s).
_____the House committee substitute bill.
____ enrolled.

____ On motion of Rep. _____, the House concurs in the (material) Senate _____ (by the following vote, ____ ____ RC) (, by EV ____ ____,) and the bill is ordered enrolled.

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2003

H 1

HOUSE BILL 172*

Short Title:	Local LTC Planning Pilot Project.	(Public)
Sponsors:	Representatives Insko, Earle (Primary Sponsors); Adams, McLawhorn, Nye, Sutton, and Warren.	
Referred to:	Health, if favorable, Appropriations.	

March 3, 2003

A BILL TO BE ENTITLED

AN ACT TO IMPLEMENT A PILOT PROJECT FOR LOCAL LONG-TERM CARE PLANNING.

The General Assembly of North Carolina enacts:

SECTION 1. In response to Recommendation #16 in the final report from the Institute of Medicine Task Force on Long-Term Care and the study report recommendations resulting from S.L. 2001-491, Part XXII, the Department of Health and Human Services shall implement a communications and planning initiative to support local planning for long-term care and shall pilot the establishment of local lead agencies to facilitate the long-term care planning process at the county or regional level. For those counties that voluntarily participate, the local long-term care planning initiative shall aid in the development of core services, coordinate local planning, and streamline access to services. The initiative shall eliminate fragmentation and barriers to information and services; provide a seamless connection among State agencies and local entities, regardless of funding sources; and allow consumers to efficiently and effectively navigate among long-term care services.

SECTION 2. The Department shall submit an interim report on the pilot project for local long-term care planning to the North Carolina Study Commission on Aging by October 1, 2004, and a final report by October 1, 2005.

SECTION 3. There is appropriated to the Department of Health and Human Services the sum of seventy thousand dollars ($70,000) for the 2003-2004 fiscal year and ninety thousand dollars ($90,000) for the 2004-2005 fiscal year to fund the pilot project established in this act.

SECTION 4. This act becomes effective July 1, 2003.

HOUSE BILL 172:
Local LTC Planning Pilot Project

BILL ANALYSIS

Committee:	House Health	**Introduced by:**	Reps. Insko, Earle
Date:	March 18, 2003	**Summary by:**	Dianna Jessup
Version:	First Edition		Committee Counsel

SUMMARY: ***House Bill 172 would appropriate funds to the Department of Health and Human Resources to implement a pilot project for local long-term care planning. The bill would become effective July 1, 2003.***

CURRENT LAW: Currently, there are a variety of groups and agencies responsible for different aspects of long term care services for older and disabled adults at the county level, including CAP-DA boards, social service boards, area mental health, developmental disabilities, and substance abuse boards, and aging planning bodies. In addition, may counties have Healthy Carolinians Task Forces and Mayors' and Local Committees for People with Disabilities. Each of these local long-term care planning bodies operate under different funding sources. While some local planning bodies work well together to accomplish similar goals, planning at the local level is generally not coordinated.

BILL ANALYSIS: **Section 1** of the bill would require the Department of Health and Human Services (DHHS) to implement a communications and planning initiative to support local planning for long-term care and to pilot the establishment of local lead agencies to facilitate the long-term care planning process at the county or regional level. The local long-term care planning initiative (Initiative) would aid participating counties with: (1) the development of core services, (2) the coordination of local planning and (3) streamlining access to services. The Initiative would do the following:

1. Eliminate fragmentation and barriers to information and services;
2. Provide a seamless connection among State agencies and local entities, regardless of funding sources; and
3. Allow consumers to efficiently and effectively navigate among long-term care services.

Section 2 of the bill would require DHHS to submit an interim report on the pilot project for local long-term care planning to the North Carolina Study Commission on Aging by October 1, 2004, and a final report by October 1, 2005.
Section 3 of the bill would appropriate $70,000 for FY 2003-2004 and $90,000 for FY 2004-2005 to DHHS to fund the pilot project.
Section 4 of the bill would make the bill become effective July 1, 2003.

BACKGROUND: This bill is a recommendation from the North Carolina Study Commission on Aging (Commission) to the 2003 General Assembly. The Commission recommended to the 2001 General Assembly that DHHS conduct a study based on the Institute of Medicine's (IOM) Long-Term Care Task Force finding that "long-term care services are often fragmented, duplicative, complex, and not consumer-friendly and that many counties lack needed core long-term care services." In response to the Commission's recommendation, the General Assembly directed DHHS in the 2001 Studies Bill (S.L. 2001-491, Part XXII) to study whether counties should designate local lead agencies to organize a local long-term care planning process, as described in Recommendation #16 of the IOM Long-Term Care Task Force final report in January 2001. The IOM had recommended that the General Assembly should

encourage county commissioners to designate a lead agency to organize a local long-term care planning process at the county or regional level and suggested how local planning processes should be organized. The Commission heard presentations from DHHS regarding their report in response to S.L. 2001-491, Part XXII and recommended that the General Assembly fund a pilot project on long-term care local lead agencies.

Amy Compeau, Research Assistant, contributed to this summary.

H172-SMSW-001

House Committee on Health

March 25, 2003

Minutes

The House Committee on Health met on March 25, 2003 at 12:00 noon in Room 415 of the Legislative Building. A silent roll was taken. A copy of the roll denoting members present is attached to the minutes (Attachment I) along with a copy of the agenda and Visitor Registration Sheet (Attachments II and III).

Chair Justus welcomes members and visitors. Chair Justus recognizes the pages: Phillip Ingram and Jonathan Stone of Forsyth County sponsored by Rep. Parmon. Dusty Rhodes and Bill Freeman are serving today as the sergeant-at-arms. (Attachment IV)

Chair Justus recognizes Rep. Tim Moore to explain his bill HB 346 A BILL TO BE ENTITLED AN ACT TO REQUIRE THAT NURSING HOMES AND ADULT CARE HOMES HAVE EMERGENCY GENERATORS FOR USE DURING POWER OUTAGES. (Attachment V) This bill will require all nursing homes and adult care homes to have emergency electrical service available for use during power outages sufficient to provide heat, lighting and other essential electrical services by January 1, 2004 in accordance with rules to be adopted by the Medical Care Commission. Currently, only nursing homes are required to have emergency backup power. (Bill Analysis – Attachment VI) Rep. Wainwright asks if anyone has done a cost analysis and Rep. Wright requests committee hear from the industry.

Chair Justus then calls upon Beverly Wheeler, representative for Friends of Residents in Long-Term Care, who speaks about the recent ice storm problems, relocation of patients, and the expense to rewire facilities for generators. She also requests that committee members give their attention to this bill and to make it work.

Rep. Adams asks how many facilities would be affected. Lou Wilson, the Director of Long-Term Care, responds with an estimate of approximately 600-730 facilities. Rep. Wainwright requests to hear from someone at DHHS as to cost. Bill Warren from the Department of Facility Services at DHHS, Construction Section, states it will cost approximately between $5,000-$6,000, but less than $10,000 for most homes. However larger facilities with 60 beds or more could cost between $50,000 to $75,000 depending on the gross square feet to be heated. Costs, availability of federal funding, areas that need to be heated, and privacy of patients are discussed among committee members. Rep. Sherrill moves that bill be sent to a subcommittee. Rep. Adams also feels there is need for more discussion. Chair Justus advises that bill will be sent to subcommittee.

Chair Justus recognizes Rep. Insko to explain her bill HB 354 A BILL TO BE ENTITLED AN ACT TO AMEND THE LAW REGARDING THE PREVENTION

AND CONTROL OF LEAD POISONING IN CHILDREN. (Attachment VII) This bill amends the law governing the Childhood Lead Poisoning Prevention Program within the Division of Environmental Health (Department) to revise the Program's environmental lead hazard and clean-up standards so that they are consistent with revised federal standards and guidelines; and to codify programmatic procedures currently in place with respect to investigations and remedial actions when a child is suspected or confirmed to have been exposed to an environmental lead hazard. This bill is recommended by the Department as an agency bill. The legislation also requires all blood lead test results for children under the age of six to be reported to the Department of Environment and Natural Resources. (Bill Analysis – Attachment VIII) A fiscal note along with a chart showing lead screening data by county and a memo from the State Health Director is provided to members, (Attachment IX, X and XI).

Chair Justus advises that time has run out and adjourns meeting at 12:05 p.m.

Carolyn Justus
Rep. Carolyn Justus, Chair

Pamela J. Evans
Pamela J. Evans, Committee Clerk

ATTACHMENT I

ATTENDANCE

HOUSE COMMITTEE ON HEALTH

DATES	3/15/23														
INSKO, Verla CHAIR	✓														
JUSTUS, Carolyn CHAIR	✓														
ENGLAND, Bob VICE-CHAIR	✓														
ADAMS, Alma	✓														
ALLEN, Bernard	✓														
ALLEN, Gordon	✓														
ALLRED, Cary	✓														
BARNHART, Jeff	✓														
BOWIE, Joni															
CLARY, Debbie															
EARLE, Beverly															
GLAZIER, Rick	✓														
HILTON, Mark	✓														
McALLISTER, Mary	✓														
MUNFORD, Don	✓														
SETZER, Mitchell															
SHERRILL, Wilma	✓														
WAINWRIGHT, William	✓														
WILSON, Connie															
WRIGHT, Tom	✓														
Ex officio Members															
Brubaker, Bru															
Culpepper, Bill															
Cunningham, Pete															
Eddins, Rick															

ATTACHMENT II

AGENDA

HOUSE COMMITTEE ON HEALTH

March 25, 2003
Room 415 LOB
12:00 Noon

OPENING REMARKS

Representative Verla Insko, Chair
Representative Carolyn Justus, Chair

AGENDA ITEMS

HB 346 Emerg. Generators/Nursing & Adlt Care Homes
Representative Tim Moore, Primary Sponsor

HB 354 Child Lead Poisoning Prevention Prgm Amends-AB
Representative Verla Insko, Primary Sponsor

ADJOURNMENT

ATTACHMENT III

VISITOR REGISTRATION SHEET

HOUSE COMMITTEE ON HEALTH — March 25, 2003

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Beverley Wheeler	Friends of Residents in LTC 832-C Washington St. Raleigh 27605
Mary Bethel	DoA
David Mayer	Triangle J Area Agency on Aging
J Craig Lawson	UNC
Jerry Cooper	NCACA
DAVID BARNES	Poyner + Spruill CLP
Amy Jo Horne	NCMS
Barbara Carsley	NFIS
Stephanie Simpson	NCAR
Ken Melton	Alley Associates
Beth Fuller	N.C. DOJ.

VISITOR REGISTRATION SHEET

HOUSE COMMITTEE ON HEALTH — March 25, 2003

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Ed Norman	DENR - Div. of Environmental Health
Laura DeVivo	DENR
Julie Allen	NC Statewatch
Brian Lewis	Planned Parenthood Health Systems, Inc
Paige Johnson	Planned Parenthood Central NC
Emilyn Hawthorne	DHHR
Debbie A. Graves	APPCNC Friends of Residents in Long Term Care
Camille Steele	Kennedy Covington
Chris Nichols	Hunton + Williams
Bill Warren	DFS | DHHS Construction Section Dix Campus.

HEALTH 3-25-03

ATTACHMENT IV

House Pages

1. Name: Phillip Ingram
   County: Forsyth
   Sponsor: Carline Parmon
2. Name: JOHNATHAN STOWE
   County: FORSYTH
   Sponsor: EARLINE PARMON
3. Name:
   County:
   Sponsor:
4. Name:
   County:
   Sponsor:
5. Name:
   County:
   Sponsor:

Sgt-At-Arms

1. Name: Dusty Rhodes
2. Name: Bill Freeman
3. Name:
4. Name:

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2003

HOUSE BILL 346

Short Title:	Emerg. Generators/Nursing & Adlt Care Homes.	(Public)
Sponsors:	Representatives Moore; L. Allen, Bowie, Insko, Pate, and Setzer.	
Referred to:	Health.	

March 6, 2003

A BILL TO BE ENTITLED

AN ACT TO REQUIRE THAT NURSING HOMES AND ADULT CARE HOMES HAVE EMERGENCY GENERATORS FOR USE DURING POWER OUTAGES.

The General Assembly of North Carolina enacts:

SECTION 1. Effective January 1, 2004, Part 1 of Article 6 of Chapter 131E of the General Statutes is amended by adding the following new section to read:

"**§ 131E-114.2. Emergency electrical service required.**

Notwithstanding any other provision of law to the contrary, all nursing homes, combination homes, and adult care homes, as those terms are defined in G.S. 131E-101, licensed and operating in this State shall provide emergency electrical service for use in the event of failure of the normal electrical service. Emergency electrical service shall be sufficient to provide heat, lighting, and other essential electrical services as required by rules of the Medical Care Commission."

SECTION 2. Effective January 1, 2004, G.S. 131D-2(b)(1a) reads as rewritten:

"**§ 131D-2. Licensing of adult care homes for the aged and disabled.**

...

(b) Licensure; inspections. –

...

(1a) In addition to the licensing and inspection requirements mandated by subdivision (1) of this subsection, the Department shall ensure that adult care homes required to be licensed by this Article are monitored for licensure compliance on a regular basis. In carrying out this requirement, the Department shall work with county departments of social services to do the routine monitoring and to have the Division of Facility Services oversee this monitoring and perform any follow-up inspection called for. The Department shall monitor regularly the enforcement of rules pertaining to air circulation, ventilation, and room temperature in resident living quarters. These rules shall include the

requirement that air conditioning or at least one fan per resident bedroom and living and dining areas be provided when the temperature in the main center corridor exceeds 80 degrees Fahrenheit. The Department shall ensure that adult care homes required to be licensed by this Article provide emergency electrical service for use in the event of failure of the normal electrical service. The emergency electrical service shall be sufficient to provide heat, lighting, and other essential electrical services as required by rules adopted by the Medical Care Commission. The Department shall also keep an up-to-date directory of all persons who are administrators as defined in subdivision (1a) of subsection (a) of this section."

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

HOUSE BILL 346:
Emerg. Generators/Nursing & Adult Care Homes

BILL ANALYSIS

Committee:	House Health	**Introduced by:**	Rep. Moore
Date:	March 25, 2003	**Summary by:**	Dianna Jessup
Version:	First Edition		Committee Counsel

SUMMARY: ***House Bill 346 would require all nursing homes and adult care homes to have emergency electrical service available for use during power outages sufficient to provide heat, lighting and other essential electrical services by January 1, 2004 in accordance with rules to be adopted by the Medical Care Commission. Currently, only nursing homes are required to have emergency backup power. The act would become effective when it becomes law.***

CURRENT LAW: Nursing homes: Nursing homes, by statutory definition, are facilities that provide nursing or convalescent care for three or more persons. By rule, since the 1980's, newly constructed/converted nursing homes have been required to provide emergency electrical service, including the following:

- In existing facilities, emergency lights and a suitable source of emergency power for life-sustaining equipment to ensure continuous operation for a minimum of 72 hours.
- An emergency generating set, including a generator, located on the premises.
- Where electricity is the only source of power normally used for space heating, the emergency service must provide for heating of patient rooms.
- Sufficient fuel must be stored for the operation of the emergency generator for a period not less than 72 hours, on a 24-hour per day operational basis.

It is estimated that approximately 90-95% of nursing homes have generators capable of providing some heat.

Adult care homes: Adult care homes, by statutory definition, are assisted living residences in which the housing management provides 24-hour scheduled and unscheduled personal care services to two or more residents. Adult care homes that provide care to two to six unrelated residents are commonly called family care homes. Adult care homes are not required to provide emergency electrical service. It is estimated that approximately 10-15% of the 600 or more adult care homes currently are capable of providing some emergency electrical service.

Nursing homes and adult care homes have to submit plans for modifications to facilities to the Division of Facility Services, DHHS, for plan review and approval.

BILL ANALYSIS: Section 1 would amend the nursing home licensure act to require all nursing homes, combination homes, and facilities operated as part of nursing homes and which provide residential care for aged or disabled persons, by January 1, 2004, to provide emergency electrical service sufficient to provide heat, lighting, and other essential electrical services as required by rules of the Medical Care Commission. This would mostly affect combination homes and assisted living facilities operated as part of nursing homes, as nursing homes are already required to provide emergency electrical service. Section 2 would similarly amend the statutes regulating the licensure of adult care homes. This change would also affect family care homes. This would affect a large number of adult care homes and family care homes, which are currently not required to have emergency electrical service.

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2003

HOUSE BILL 354

Short Title:	Child Lead Poisoning Prevention Prgm Amends.-AB	(Public)
Sponsors:	Representatives Insko; Alexander, Glazier, and Luebke.	
Referred to:	Health.	

March 6, 2003

A BILL TO BE ENTITLED

AN ACT TO AMEND THE LAW REGARDING THE PREVENTION AND CONTROL OF LEAD POISONING IN CHILDREN.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 130A-131.7 reads as rewritten:

"**§ 130A-131.7. Definitions.**

~~As used in this Part, unless the context requires otherwise, the term:~~The following definitions apply in this Part:

(1) "Abatement" means undertaking any of the following measures to eliminate a lead-based paint hazard:
   a. Removing lead-based paint from a surface and repainting the surface.
   b. Removing a component, such as a windowsill, painted with lead-based paint and replacing the component.
   c. Enclosing a surface painted with lead-based paint with paneling, vinyl siding, or another approved material.
   d. Encapsulating a surface painted with lead-based paint with a sealant.
   e. Any other measure approved by the Commission.

(2) "Child-occupied facility" means a building, or portion of a building, constructed ~~prior to~~before 1978, regularly visited by a child who is less than ~~6~~ six years of age. Child-occupied facilities may include, but are not limited to, child care facilities, preschools, nurseries, kindergarten classrooms, schools, clinics, or treatment centers including the common areas, the grounds, any outbuildings, or other structures appurtenant to the facility.

(3) "Confirmed lead poisoning" means a blood lead concentration of 20 micrograms per deciliter or greater determined by the lower of two consecutive blood tests within a six-month period.

(4) "Department" means the Department of Environment and Natural Resources or its authorized agent.

(5) "Elevated blood lead level" means a blood lead concentration of 10 micrograms per deciliter or greater determined by the lower of two consecutive blood tests within a six-month period.

(6) "Lead-based paint hazard" means a condition that is likely to ~~cause adverse health effects as a~~ result ~~of~~ in exposure to lead-based paint or to soil or dust that contains lead ~~derived from lead-based paint.~~at a concentration that constitutes a lead poisoning hazard.

(7) "Lead poisoning hazard" means any of the ~~presence of readily accessible or mouthable lead bearing substances, including lead based paint, measuring 1.0 milligram per square centimeter or greater by X-ray fluorescence or five tenths of one percent (0.5%) or greater by chemical analysis; or 15 parts per billion or greater in drinking water; or 100 micrograms per square foot or greater for dust on floors; or 500 micrograms per square foot or greater for dust on windowsills; or 800 micrograms per square foot or greater for dust in window troughs, or soil lead concentrations in an amount greater than or equal to 400 parts per million that is determined by the Department to present a hazard in light of (i) the condition and use of the land and (ii) other relevant factors.~~following:

a. Any lead-based paint or other substance that contains lead in an amount equal to or greater than 1.0 milligrams lead per square centimeter as determined by X-ray fluorescence or five-tenths of a percent (0.5%) lead by weight as determined by chemical analysis: (i) on any readily accessible or chewable surface on which there is evidence of teeth marks or mouthing; or (ii) on any other deteriorated or otherwise damaged interior or exterior surface.

b. Any substance that contains lead intended for use by children less than six years of age in an amount equal to or greater than 0.06 percent (0.06%) lead by weight as determined by chemical analysis.

c. Any concentration of lead dust that is equal to or greater than 40 micrograms per square foot on floors or 250 micrograms per square foot on interior windowsills, vinyl miniblinds, bathtubs, kitchen sinks, or lavatories.

d. Any lead-based paint or other substance that contains lead on a friction or impact surface that is subject to abrasion, rubbing, binding, or damage by repeated contact and where the lead dust concentrations on the nearest horizontal surface underneath the friction or impact surface are equal to or greater than 40 micrograms per square foot on floors or 250 micrograms per square foot on interior windowsills.

e. Any concentration of lead in bare soil in play areas, gardens, pet sleeping areas, and areas within three feet of a residential housing unit or child-occupied facility equal to or greater than 400 parts per million. Any concentration of lead in bare soil in other locations of the yard equal to or greater than 1,200 parts per million.

f. Any ceramic ware generating equal to or greater than three micrograms of lead per milliliter of leaching solution for flatware or 0.5 micrograms of lead per milliliter for cups, mugs, and pitchers as determined by Method 973.32 of the Association of Official Analytical Chemists.

g. Any concentration of lead in drinking water equal to or greater than 15 parts per billion.

(8) "Lead-safe housing" is housing that was built since 1978 or has been tested by a person that has been certified to perform risk assessments and found to have no lead-based paint hazard within the meaning of the Residential Lead-Based Paint Reduction Act of 1992, 42 U.S.C. § 4851b(15).

(9) "Maintenance standard" means the following:

a. Using safe work practices, repairing and repainting areas of deteriorated paint inside a residential housing unit and for single-family and duplex residential dwelling built ~~prior to~~before 1950, repairing and repainting areas of deteriorated paint on interior and exterior surfaces;

b. Cleaning the interior of the unit to remove dust that constitutes a lead poisoning hazard;

c. Adjusting doors and windows to minimize friction or impact on surfaces;

d. Subject to the occupant's approval, appropriately cleaning any carpets;

e. Taking such steps as are necessary to ensure that all interior surfaces on which dust might collect are readily cleanable; and

f. Providing the occupant or occupants all information required to be provided under the Residential Lead-Based Paint Hazard Reduction Act of 1992, and amendments thereto.

(10) "Managing agent" means any person who has charge, care, or control of a building or part thereof in which dwelling units or rooming units are leased.

(11) ~~"Mouthable lead-bearing substance" means any substance on surfaces or fixtures five feet or less from the floor or ground that form a protruding corner or similar edge, or protrude one half inch or more from a flat wall surface, or are freestanding, containing lead-contaminated dust at a level that constitutes a lead poisoning hazard. Mouthable surfaces or fixtures include toys, vinyl miniblinds,~~

~~doors, door jambs, stairs, stair rails, windows, windowsills, and baseboards.~~

(12) ~~"Persistent elevated blood lead level" means a blood lead concentration of 15-19 micrograms per deciliter determined by the lowest of three consecutive blood tests. The first two blood tests shall be performed within a six-month period, and the third blood test shall be performed at least 12 weeks and not more than six months after the second blood test.~~

(13) "Readily accessible ~~lead-bearing~~ substance" means any substance ~~containing lead at a level that constitutes a lead poisoning hazard which~~that can be ingested or inhaled by a child ~~under 6~~less than six years of age. Readily accessible substances include deteriorated paint that is peeling, chipping, cracking, flaking, or blistering to the extent that the paint has separated from the substrate. Readily accessible substances also include soil, ~~water,~~water, toys, vinyl miniblinds, bathtubs, lavatories, doors, door jambs, stairs, stair rails, windows, interior windowsills, baseboards, and paint that is chalking.

(14) "Regularly visits" means the presence at a residential housing unit or child-occupied facility on at least two different days within any week, provided that each day's visit lasts at least three hours and the combined weekly visits last at least six hours, and the combined annual visits last at least 60 hours.

(15) "Remediation" means the elimination or control of lead poisoning hazards by methods approved by the Department.

(16) "Residential housing unit" means a dwelling, dwelling unit, or other structure, all or part of which is designed or used for human habitation, including the common areas, the grounds, any outbuildings, or other structures appurtenant to the residential housing unit.

(17) "Supplemental address" means a residential housing unit or child-occupied facility where a child with ~~a persistent elevated blood lead level or a~~ confirmed lead poisoning regularly visits or attends. Supplemental address also means a residential housing unit or child-occupied facility where a child resided, regularly visited, or attended within the six months immediately preceding the determination of ~~a persistent elevated blood lead level or a~~ confirmed lead poisoning."

SECTION 2. G.S. 130A-131.8 reads as rewritten:

"**§ 130A-131.8. Reports of blood levels in children.**

All laboratories doing business in this State shall report to the Department all blood lead ~~levels of one microgram per deciliter or greater~~test results for children less than ~~6~~ six years of age and for individuals whose ages are unknown at the time of testing. Reports shall be made within five working days after test completion on forms provided by the Department or on self-generated forms containing: the child's full name, date of birth, sex, race, address, and Medicaid number, if any; the name, address, and telephone

number of the requesting health care provider; the name, address, and telephone number of the testing laboratory; the laboratory results, the specimen type – venous or capillary; the laboratory sample number, and the dates the sample was collected and analyzed. ~~Such~~The reports may be made by electronic submissions."

SECTION 3. G.S. 130A-131.9 reads as rewritten:

"**§ 130A-131.9. Examination and testing.**

When the Department has a reasonable suspicion that a child less than ~~6~~six years of age has ~~a persistent~~ an elevated blood lead level or a confirmed lead poisoning, the Department may require that child to be examined and tested within 30 days. The Department shall require from the owner, managing agent, or tenant of the residential housing unit or child-occupied facility information on each child who resides in, regularly visits, or attends, or, who has within the past six months, resided in, regularly visited, or attended the unit or facility. The information required shall include each child's name and date of birth, the names and addresses of each child's parents, legal guardian, or full-time custodian. The owner, managing agent, or tenant shall submit the required information within 10 days of receipt of the request from the Department."

SECTION 4. G.S. 130A-131.9A reads as rewritten:

"**§ 130A-131.9A. Investigation to identify lead poisoning hazards.**

(a) When the Department learns of ~~a persistent elevated blood lead level or a~~ confirmed lead poisoning, the Department shall conduct an investigation to identify the lead poisoning hazards to children. The Department shall investigate the residential housing unit ~~or child-occupied facility~~ where the child with ~~the persistent elevated blood lead level or the~~ confirmed lead poisoning ~~resides, regularly visits, or attends.~~resides. The Department shall also investigate the supplemental addresses of the child who has a ~~persistent elevated blood lead or a~~ confirmed lead poisoning.

(a1) When the Department learns of an elevated blood lead level, the Department shall, upon informed consent, investigate the residential housing unit where the child with the elevated blood level resides. When consent to investigate is denied, the child with the elevated blood lead level cannot be located, or the child's parent or guardian fails to respond, the Department shall document the denial of consent, inability to locate, or failure to respond.

(b) The Department shall also conduct an investigation when it reasonably suspects that a lead poisoning hazard to children exists in a residential housing unit or child-occupied facility occupied, regularly visited, or attended by a child less than ~~6~~six years of age.

(c) In conducting an investigation, the Department may take samples of surface materials, or other materials suspected of containing lead, for analysis and testing. If samples are taken, chemical determination of the lead content of the samples shall be by atomic absorption spectroscopy or equivalent methods approved by the Department."

SECTION 5. G.S. 130A-131.9B reads as rewritten:

"**§ 130A-131.9B. Notification.**

Upon determination that a lead poisoning hazard exists, the Department shall give written notice of the lead poisoning hazard to the owner or managing agent of the residential housing unit or child-occupied facility and to all persons residing in,

attending, or regularly visiting the unit or facility. The written notice to the owner or managing agent shall include a list of possible methods of ~~abatement of the lead based paint hazards and of possible methods of remediation of any other lead poisoning hazard~~. remediation."

SECTION 6. G.S. 130A-131.9C reads as rewritten:

"**§ 130A-131.9C. ~~Abatement and remediation.~~Remediation.**

(a) Upon determination that a child less than ~~6~~ six years of age has a confirmed lead poisoning of 20 micrograms per deciliter or greater and that child resides ~~in, attends, or regularly visits,~~in a residential housing unit ~~or child occupied facility~~ containing lead poisoning hazards, the Department shall require ~~abatement of the lead based paint hazards and the~~ remediation of ~~other~~ the lead poisoning hazards. The Department shall also require ~~the abatement of the lead based paint hazards and the~~ remediation of ~~other~~ the lead poisoning hazards identified at the supplemental addresses of a child less than ~~6~~ six years of age with a confirmed lead poisoning of 20 micrograms per deciliter or greater.

(b) When ~~abatement of lead based paint hazards or~~ remediation of ~~other~~ lead poisoning hazards is required under subsection (a) of this section, the owner or managing agent shall submit a written remediation plan to the Department within 14 days of receipt of the lead poisoning hazard notification and shall obtain written approval of the plan ~~prior to~~before initiating ~~abatement of lead based paint hazards or~~ remediation ~~of other lead poisoning hazards.~~activities. The remediation plan shall comply with subsections (g), (h), and (i) of this section.

(c) If the remediation plan submitted fails to meet the requirements of this section, the Department shall issue an order requiring submission of a modified plan. The order shall indicate the modifications ~~which~~ that shall be made to the remediation plan and the date ~~by which~~that the plan as modified shall be submitted to the Department.

(d) If the owner or managing agent does not submit a remediation plan within 14 days, the Department shall issue an order requiring submission of a remediation plan within five days of receipt of the order.

(e) The owner or managing agent shall notify the Department and the occupants of the dates of remediation activities at least three days ~~prior to the~~before commencement of the activities.

(f) ~~Abatement of lead based paint hazards and remediation~~Remediation of ~~other~~ the lead poisoning hazards shall be completed within 60 days of the Department's approval of the remediation plan. If ~~these~~ the remediation activities are not completed within 60 ~~days as required,~~days, the Department shall issue an order requiring completion of the activities. An owner or managing agent may apply to the Department for an extension of the deadline. The Department may issue an order extending the deadline for 30 days upon proper written application by the owner or managing agent.

(g) ~~The~~ All of the following methods of ~~abatement~~ remediation of lead-based paint hazards are prohibited:

(1) Stripping paint on-site with methylene chloride-based ~~solutions;~~solutions.

(2) Torch or flame ~~burning;~~burning.
(3) Heating paint with a heat gun above 1,100 degrees ~~Fahrenheit;~~Fahrenheit.
(4) Covering with new paint or wallpaper unless all readily accessible lead-based paint has been ~~removed;~~removed.
(5) Uncontrolled abrasive ~~blasting; or~~ blasting, machine sanding, or grinding, except when used with High Efficiency Particulate Air (HEPA) exhaust control that removes particles of 0.3 microns or larger from the air at ninety-nine and seven-tenths percent (99.7%) or greater efficiency.
(6) Uncontrolled waterblasting.
(7) Dry scraping, unless used in conjunction with heat guns, or around electrical outlets, or when treating no more than two square feet on interior surfaces, or no more than 20 square feet on exterior surfaces.

(h) All lead-containing waste and residue shall be removed and disposed of in accordance with applicable federal, State, and local laws and rules. Other substances containing lead that are intended for use by children less than six years of age and vinyl miniblinds that constitute a lead poisoning hazard shall be removed and disposed of in accordance with applicable federal, State, and local laws and rules.

(i) All remediation plans shall require that the lead poisoning hazards be reduced to ~~below~~ the following levels:

(1) ~~Floor lead dust levels~~Less ~~are less~~ than ~~100~~ 40 micrograms per square ~~foot;~~foot for lead dust on floors.
(2) ~~Windowsill lead dust levels are less~~Less than ~~500~~ 250 micrograms per square ~~foot;~~foot for lead dust on interior windowsills, bathtubs, kitchen sinks, and lavatories.
(3) ~~Window trough lead dust levels are less~~Less than ~~800~~ 400 micrograms per square ~~foot;~~foot for lead dust on window troughs.
(4) ~~Soil lead levels are less~~Less than 400 parts per million ~~or such other level higher than 400 parts per million as determined by the Department to prevent a hazard in light of the condition and use of the land and in light of other relevant factors; and~~for lead in bare soil in play areas, gardens, pet sleeping areas, and areas within three feet of the residential housing unit or child-occupied facility. Lead in bare soil in other locations of the yard shall be reduced to less than 1,200 parts per million.
(5) ~~Drinking water lead levels less~~ Less than 15 parts per ~~billion.~~ billion for lead in drinking water.

(j) The Department shall verify by visual inspection that the approved remediation plan has been completed. The Department may also verify plan completion by residual lead dust monitoring and soil or drinking water lead level measurement.

(j1) Compliance with the maintenance standard satisfies the remediation requirements for confirmed lead poisoning cases identified on or after 1 October 1990 as long as all lead poisoning hazards identified on interior and exterior surfaces are

addressed by remediation. Except for owner-occupied residential housing units, continued compliance shall be verified by means of an annual monitoring inspection conducted by the Department. For owner-occupied residential housing units, continued compliance shall be verified (i) by means of an annual monitoring inspection, (ii) by documentation that no child less than six years of age has resided in or regularly visited the residential housing unit within the past year, or (iii) by documentation that no child less than six years of age residing in or regularly visiting the unit has an elevated blood lead level.

(k) Removal of children from the residential housing unit or child-occupied facility shall not constitute ~~abatement or~~ remediation if the property continues to be used for a residential housing unit or child-occupied ~~facility.~~facility. The remediation requirements imposed in subsection (a) of this section apply so long as the property continues to be used as a residential housing unit or child-occupied facility."

SECTION 7. G.S. 130A-131.9G reads as rewritten:

"**§ 130A-131.9G. Resident responsibilities.**

In any residential housing unit occupied by a child less than ~~6~~ six years ~~old~~ of age who has an elevated blood lead level of 10 micrograms per deciliter or greater, the Department shall advise, in writing, the owner or managing agent and the child's parents or legal guardian ~~as to~~of the importance of carrying out routine cleaning activities in the units they occupy, own, or manage. ~~Such~~ The cleaning activities shall ~~include:~~include all of the following:

(1) Wiping clean all windowsills with a damp cloth or sponge at least ~~weekly;~~weekly.

(2) Regularly washing all surfaces accessible to ~~children;~~children.

(3) In the case of a leased residential housing unit, identifying any deteriorated paint in the unit and notifying the owner or managing agent of ~~such~~ the conditions within 72 hours of ~~discovery;~~ ~~and~~discovery.

(4) Identifying and understanding potential lead poisoning hazards in the environment of each child ~~under the age of 6~~ less than six years of age in the unit (including toys, vinyl miniblinds, playground equipment, drinking water, soil, and painted surfaces), and taking steps to prevent children from ingesting lead such as encouraging children to wash their faces and hands frequently and especially after playing outdoors."

SECTION 8. This act becomes effective 1 July 2003.

HOUSE BILL 354:
Child Lead Poisoning Prevention Prgm. Amends

BILL ANALYSIS

Committee:	House Heatlh	**Introduced by:**	Rep. Insko
Date:	March 25, 2003	**Summary by:**	Linda Attarian
Version:	Introduced		Committee Counsel

SUMMARY: ***House Bill 354 amends the law governing the Childhood Lead Poisoning Prevention Program within the Division of Environmental Health (Department) to revise the Program's environmental lead hazard and clean-up standards so that they are consistent with revised federal standards and guidelines; and to codify programmatic procedures currently in place with respect to investigations and remedial actions when a child is suspected or confirmed to have been exposed an environmental lead hazard. The bill is recommended by the Department as an agency bill and becomes effective July 1, 2003***

CURRENT LAW: The statutes governing the environmental lead hazard detection and remediation aspects of the North Carolina Childhood Lead Poisoning Prevention Program (NC CLPPP) are set forth in Part 4 of Article 5 of Chapter 130A.

Screening: Childhood lead poisoning has been a reportable condition under NC state law since 1990. Laboratories are required to report any test with a lead blood level of 1 microgram per deciliter (*u*g/dL) or greater to the Department. When the Department has a reasonable suspicion that a child less than 6 years old has a blood lead level of 15 *u*g/dL, the Department is authorized to require that the child be examined and tested for lead. Since 1994 the State Laboratory provides blood lead analysis at no charge for children who are uninsured.

Since 1998 NC CLPPP has implemented a statewide screening program targeting children between the ages of 12 and 24 months who are participating in the Medicaid, WIC, or Health Choice programs. Children under 6 years with lead poisoning (blood lead level of 20 *u*g/dL or higher) are provided with medical follow-up and health education as recommended by the National Centers for Disease Control (CDC) at the clinic where the child was screened.

Investigations: Under current law, when a child less than 6 years old has been screened and is found to have blood lead levels of 10 *u*g/dL or higher, the Department must advise the owner or manager of any residential housing unit occupied by the child about the importance of routine cleaning to prevent potential lead hazards.

When a child less than 6 years old has been identified with a blood lead levels of 15 *u*g/dL or higher, the Department is required to conduct an environmental investigation of residential housing unit or child care facility where the child resides, regularly visits, or attends. If the child has a blood lead level of 20 *u*g/dL or greater, the Department must also conduct an investigation of any supplemental addresses the child may have. During such an investigation, the family is interviewed and environmental samples are collected for laboratory analysis. Once the sources of lead exposure are identified, the owners of the residence or facility are notified. The costs associated with the investigation are reimbursable under Medicaid (up to $438 per child).

Note: Childcare facilities are routinely inspected as a condition of licensure for lead hazards. If an inspector has a reasonable suspicion that a lead hazard exists the Department is notified and an investigation is initiated for the presence of lead hazards.

Abatement and remediation: Owners who have been notified that a lead hazard exists are required to abate lead-based *paint* hazards (i.e., permanently remove, enclose or encapsulate) and remediate all other lead poisoning hazards. The owner must submit a written remediation plan to the local health department for approval prior to commencing. The plan must include specific information as required by rules adopted by the Commission for Health Services, including time frames for completion, methods, and clearance procedures to be performed. Local health departments receive $2,000 per child from State appropriations for each child requiring an environmental investigation. This funding supports childhood screening and follow-up medical services as well as costs related to conducting environmental investigations.

BILL ANALYSIS:

Programmatic changes:

Sections 2 through 4 codify current environmental intervention policies in place pursuant to recommendations issued by the State Health Director in 1999. These policies include:

1. All blood lead level test results from screenings conducted on children less than 6 years of age must be reported to the Department, including tests that are negative for lead. See Section 2.
2. A reasonable suspicion that a child has a blood lead level of 10 *u*g/dL or greater will trigger an intervention by the Department. The current law's threshold is 15 *u*g/dL. See Section 3 and 4.
3. The Department is given new authority to investigate the residential housing unit where a child with a blood lead level of 10 *u*g/dL or greater IF the Department obtains informed consent of the owner or tenant of the property. See Section 4.

Sections 5 and 6 delete all references to "*abatement of lead-based paint hazards*" from the statutes governing the clean up lead hazards. The reason for the deletions is that "abatement" (see definition, page 1, lines 9-19), falls within the definition of "remediation" (see definition, page 2, lines 23-24), and therefore it is redundant to use both terms.

Section 6 also:

1. Updates the law to conform to revised environmental lead hazard standards (see explanation below);
2. Requires the removal of vinyl miniblinds that constitute a lead hazard and any substances containing lead that intended for use by children less than 6 years old. (See page 7, lines 17-19); and
3. Provides that remediation is only necessary so long as the property continues to be used as a residential housing unit or child occupied facility. (See page 8, lines 11-13.)

Changes to environmental lead hazard and clean-up standards:

The bill makes significant changes to the definition of "*lead poisoning hazard*". Briefly, under the new definition, lead is considered to be a hazard if there are greater than 40 micrograms of lead in dust per square foot on floors; 250 micrograms of lead in dust per square foot on interior window sills and 400 parts per million of lead in bare soil in children's play area or 1200 parts per million average for bare soil in the rest of the yard. To compare current statutory thresholds with the proposed thresholds, see the table on the next page.

Substance/Surface	Current Standard	Revised Standard	Other Changes Proposed
Lead-based paint	1 milligram per square centimeter or greater measured by x-ray fluorescence or 0.5% by chemical analysis and on "a readily accessible substance or mouthable lead bearing substance"	Same	Lead-based paint will meet the definition of "lead poisoning hazard" only if it is on either a readily accessible or chewable surface (must see evidence of teeth marks) OR a deteriorated or damaged interior or exterior surface
Dust on floors	100 micrograms per square foot or greater	40 micrograms per square foot or greater	
Dust on interior windowsills	800 micrograms per square foot or greater	250 micrograms per square foot or greater	Bill adds the following surfaces to this standard: *vinyl miniblinds, bathtubs, kitchen sinks, and lavatories*
Bare soil in children's play areas	800 parts per million (ppm) or greater	400 ppm or greater	Allows 1200 ppm in any other part of a yard
Drinking water	Less than 15 parts per billion	Same	
Any substance that contains lead and is intended for use by children less than 6 years of age.	No existing standard	0.06% lead by weight as determined by chemical analysis -- a standard allowed by the Consumer Products Safety Center	
Ceramic ware	No existing standard	3 micrograms of lead per milliliter of leaching solution for flatware or 0.5 micrograms per milliliter for cups, mugs and pitchers	Standard allows measurements of leaching potential of lead, rather than total lead content
Window trough	800 micrograms per square foot or greater	400 micrograms per square foot or greater	

The bill makes conforming amendments to other definitions.

BACKGROUND:

The health effects of lead exposure: Health problems from exposure to lead can include profound developmental and neurological impairment in children. The Environmental Protection Agency (EPA) estimates that nearly 1 million children in the US have dangerously elevated levels of lead in their blood. The CDC defines an elevated blood lead level as 10 *u*g/dL or greater. According to CDC survey data, elevated blood lead levels are more common among low-income children, urban children, and those living in subsidized housing.

Revised EPA standards: The EPA adopted new, more protective environmental lead hazard standards in 2001. The standards are intended to guide state and local governments and the federal Housing and Urban Development (HUD) in adopting benchmarks upon which to base remedial actions to safeguard children and the public from the dangers of lead. Landlords, parents, and childcare providers use these standards to make informed decisions regarding lead found in their homes, yards or play areas. The standards proposed in this legislation will bring NC laws in line with the current EPA standards.

North Carolina Childhood Lead Surveillance Data: In the most recent year that data is available (2002), over 120,000 children under 6 years old were screened for lead and 528 children had blood lead levels of 10 *u*g/dL or greater. Of those 528 children, 68 children had blood lead levels of 20 *u*g/dL or greater.

NORTH CAROLINA GENERAL ASSEMBLY

LEGISLATIVE FISCAL NOTE

BILL NUMBER: HB 354 (First Edition)

SHORT TITLE: Child Lead Poisoning Prevention Program Amendments

SPONSOR(S): Representative Insko

FISCAL IMPACT

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

	FY 2003-04	FY 2004-05	FY 2005-06	FY 2006-07	FY 2007-08
REVENUES					
EXPENDITURES DENR	*See Assumptions and Methodology*				

PRINCIPAL DEPARTMENT(S) & PROGRAM(S) AFFECTED: Department of Environment and Natural Resources (DENR)

EFFECTIVE DATE: July 1, 2003

BILL SUMMARY: The bill amends the law regarding the prevention and control of lead poisoning in children by changing the definition of a "lead poisoning hazard". The legislation also requires all blood lead test results for children under the age of six (and unknown ages) be reported to the Department of Environment and Natural Resources (DENR.) Informed consent would now be required to investigate elevated blood lead levels, with denials, inability to locate, or failure to respond being documented. Confirmed lead poisoning cases continue to require a mandatory investigation. Remediation plans and guidelines are amended based on more recent federally issued guidelines.

ASSUMPTIONS AND METHODOLOGY: The Environmental Protection Agency and Housing and Urban Development reduced two of the three standards for lead in contaminated household dust (i.e., floors and window sills) to be more protective of young children. A third dust hazard level (i.e., windows troughs) was eliminated. The standard for lead in bare soil was also reduced and the concentration defining lead-based paint was unchanged. Clearance levels for dust and soil were similarly reduced except that a reduced clearance standard was also adopted for window troughs. These changes are reflected in amendments proposed to G.S. 130A-131.7(7) and G.S. 130A-131.9C(i).

In general, the proposed changes are more restrictive and would have a slight impact on the regulated community. The primary impact would be to require more thorough cleaning after the completion of repairs and other maintenance activities to remove residual lead-contaminated dust

using a low cost wet mopping and vacuuming protocol. Adoption of the proposed amendments would not alter the action level for when DENR is required to investigate a home environment or to enforce remedial action against a property owner, because those activities are initially triggered by a child's blood lead exposure rather than the presence of an environmental hazard. Hence, adoption of the revised environmental standards would not require additional properties to be addressed, rather they would dictate when a residence or child care facility, already subject to environmental intervention under existing state law, is considered lead safe. **The estimated cost is expected to be minimal.**

The legislation also authorizes DENR to offer a home investigation to the parents of all children with exposure to lead at a lower action level than is currently required by law. Current law requires investigations at persistent levels of ≥15 *u*g/dL (milligrams of lead per deciliter), and the proposed revisions would reduce the number to ≥10 *u*g/dL and make investigations voluntary. DENR has already been offering the expanded investigation services since a November 1999 directive issued from the State Health Director. Medicaid agreed to reimburse DENR for this service ($438 per child), and DENR allocates state appropriated aid-to-county funds (approximately $280,000 in FY 2002-2003) to local health departments and employs seven regional inspectors to assure comprehensive environmental follow-up for lead-exposed children. In 2002, there were 68 children confirmed blood lead poisoning at ≥20 *u*g/dL; 11 children with persistent elevated blood lead levels at ≥15 *u*g/dL; and 460 children with confirmed elevations in the 10-19 *u*g/dL range. The number of children screened continues to increase annually, while the number of children with confirmed elevated blood lead levels continues to decrease annually. **Thus, the estimated cost of expanding home investigation services is expected to be minimal, if not cost-neutral for DENR.**

Confirmed cases of blood lead poisoning (≥20 *u*g/dL) will continue to require mandatory investigations. The investigations for children classified as having persistent elevated blood lead levels are currently mandatory. Under the proposed legislation, informed consent would now be required to investigate elevated blood lead levels (10-19 *u*g/dL range). Though no estimate is available as to the number of investigation requests that may be turned down under the proposed legislation, **it can be expected that the investigation caseload in DENR would drop slightly.**

SOURCES OF DATA: Ed Norman, Department of Environmental and Natural Resources

TECHNICAL CONSIDERATIONS: None.

FISCAL RESEARCH DIVISION: (919) 733-4910

PREPARED BY: Stephanie Schmitt Stephanie Schmitt

APPROVED BY: James D. Johnson, Director, Fiscal Research Division

James D. Johnson

DATE: March 28, 2003

DRAFT

2002 NORTH CAROLINA CHILDHOOD LEAD SCREENING DATA BY COUNTY

	Ages 1 and 2 Years					Ages 6 Months to 6 Years		
County	Target Population*	Number Screened	Percent Screened	Lead ≥10	Percent ≥10	Number Screened	Confirmed 10-19	Confirmed ≥20
ALAMANCE	3,801	865	22.8	9	1.0	1,267	3	
ALEXANDER	882	357	40.5	6	1.7	514	1	
ALLEGHANY	230	79	34.3	2	2.5	108	1	
ANSON	676	360	53.3	9	2.5	634	2	
ASHE	532	225	42.3	1	0.4	376	1	
AVERY	364	229	62.9	3	1.3	292		
BEAUFORT	1,290	830	64.3	19	2.3	920	7	2
BERTIE	530	416	78.5	17	4.1	580	5	
BLADEN	968	450	46.5	9	2.0	607	5	1
BRUNSWICK	1,759	906	51.5	11	1.2	1,388	4	
BUNCOMBE	5,087	893	17.6	15	1.7	1,312	3	1
BURKE	2,226	761	34.2	12	1.6	1,395	7	
CABARRUS	4,333	2,374	54.8	18	0.8	3,311	6	2
CALDWELL	2,015	489	24.3	3	0.6	1,325	3	
CAMDEN	149	66	44.3	1	1.5	100		
CARTERET	1,213	684	56.4	7	1.0	878	2	
CASWELL	507	148	29.2	6	4.1	196	2	
CATAWBA	4,190	1,547	36.9	16	1.0	1,892	2	
CHATHAM	1,313	445	33.9	10	2.2	587	1	2
CHEROKEE	533	142	26.6	2	1.4	233	1	
CHOWAN	389	197	50.6	4	2.0	270	2	
CLAY	147	83	56.5	5	6.0	118		
CLEVELAND	2,630	1,339	50.9	19	1.4	1,829	4	
COLUMBUS	1,613	913	56.6	20	2.2	1,599	7	1
CRAVEN	3,227	1,671	51.8	19	1.1	2,158	3	
CUMBERLAND	10,980	2,695	24.5	41	1.5	3,684	7	1
CURRITUCK	447	158	35.3	3	1.9	287	2	
DARE	704	128	18.2	2	1.6	171		
DAVIDSON	3,900	1,595	40.9	22	1.4	2,044	5	
DAVIE	934	292	31.3	3	1.0	422		1
DUPLIN	1,619	945	58.4	24	2.5	1,399	4	
DURHAM	7,600	2,310	30.4	37	1.6	3,561	15	6
EDGECOMBE	1,664	1,135	68.2	45	4.0	1,639	17	5
FORSYTH	9,232	2,852	30.9	61	2.1	3,544	14	2
FRANKLIN	1,315	441	33.5	4	0.9	614	5	
GASTON	5,296	1,210	22.8	15	1.2	1,632	5	1
GATES	224	96	42.9	6	6.3	131	4	
GRAHAM	195	121	62.1	0	0.0	168		
GRANVILLE	1,225	669	54.6	21	3.1	824	3	
GREENE	497	240	48.3	8	3.3	359	4	1
GUILFORD	12,013	4,406	36.7	83	1.9	6,248	16	2
HALIFAX	1,562	1,192	76.3	36	3.0	1,392	17	3
HARNETT	2,937	1,179	40.1	36	3.1	1,852	3	1
HAYWOOD	1,104	420	38.0	11	2.6	638		
HENDERSON	2,145	493	23.0	12	2.4	661	2	
HERTFORD	554	407	73.5	10	2.5	468	5	
HOKE	1,338	484	36.2	11	2.3	671	5	
HYDE	119	57	47.9	1	1.8	66		
IREDELL	3,725	1,005	27.0	20	2.0	1,223	4	
JACKSON	735	284	38.6	1	0.4	423		
JOHNSTON	4,146	1,190	28.7	11	0.9	1,693	5	

DRAFT

2002 NORTH CAROLINA CHILDHOOD LEAD SCREENING DATA BY COUNTY

County	Ages 1 and 2 Years					Ages 6 Months to 6 Years		
	Target Population*	Number Screened	Percent Screened	Lead ≥10	Percent ≥10	Number Screened	Confirmed 10-19	Confirmed ≥20
JONES	185	130	70.3	3	2.3	151		
LEE	1,663	683	41.1	10	1.5	1,122	1	
LENOIR	1,666	1,017	61.0	39	3.8	1,619	8	1
LINCOLN	1,824	356	19.5	5	1.4	509	1	1
MACON	620	280	45.2	6	2.1	425		
MADISON	441	181	41.0	6	3.3	275		
MARTIN	654	420	64.2	10	2.4	624	1	1
MCDOWELL	1,075	440	40.9	12	2.7	576	2	2
MECKLENBURG	24,133	6,032	25.0	105	1.7	7,599	29	2
MITCHELL	325	180	55.4	2	1.1	240	1	
MONTGOMERY	833	480	57.6	6	1.3	762	2	
MOORE	1,789	617	34.5	8	1.3	1,352	4	
NASH	2,551	1,544	60.5	50	3.2	1,944	14	3
NEW HANOVER	4,056	2,699	66.5	40	1.5	4,052	12	1
NORTHAMPTON	517	366	70.8	12	3.3	485	3	1
ONSLOW	6,449	904	14.0	16	1.8	1,287	2	
ORANGE	2,558	553	21.6	9	1.6	734	4	
PAMLICO	206	112	54.4	1	0.9	189	1	
PASQUOTANK	919	488	53.1	14	2.9	744	7	1
PENDER	989	616	62.3	4	0.6	965	2	
PERQUIMANS	239	102	42.7	2	2.0	153	3	
PERSON	915	322	35.2	10	3.1	558	3	
PITT	4,017	1,171	29.2	22	1.9	1,758	10	
POLK	371	55	14.8	1	1.8	82		
RANDOLPH	3,812	1,325	34.8	26	2.0	1,728	7	2
RICHMOND	1,384	725	52.4	16	2.2	1,115	7	1
ROBESON	4,263	2,271	53.3	36	1.6	2,959	9	1
ROCKINGHAM	2,361	695	29.4	6	0.9	1,021	1	
ROWAN	3,375	729	21.6	18	2.5	1,071	2	
RUTHERFORD	1,705	449	26.3	16	3.6	782	9	
SAMPSON	1,862	1,136	61.0	37	3.3	1,623	12	3
SCOTLAND	992	610	61.5	8	1.3	673	2	
STANLY	1,507	1,090	72.3	20	1.8	1,250	1	2
STOKES	1,030	456	44.3	7	1.5	619	2	
SURRY	1,924	991	51.5	19	1.9	1,352	2	1
SWAIN	362	270	74.6	6	2.2	358	1	
TRANSYLVANIA	552	134	24.3	0	0.0	221		
TYRRELL	92	90	97.8	1	1.1	111		
UNION	4,544	919	20.2	22	2.4	1,479	7	5
VANCE	1,490	979	65.7	21	2.1	1,175	6	2
WAKE	20,924	5,111	24.4	70	1.4	7,574	17	2
WARREN	406	252	62.1	11	4.4	315	4	
WASHINGTON	368	264	71.7	2	0.8	343	3	
WATAUGA	701	328	46.8	3	0.9	456		
WAYNE	3,501	2,621	74.9	52	2.0	3,275	17	1
WILKES	1,791	497	27.7	5	1.0	688	3	
WILSON	2,187	1,181	54.0	32	2.7	1,753	21	2
YADKIN	1,001	397	39.7	10	2.5	491	1	
YANCEY	416	219	52.6	4	1.8	300	2	1
STATE	238,359	85,960	36.1	1,608	1.9	120,640	460	68

North Carolina
Department of Health and Human Services
101 Blair Drive • Post Office Box 29526 • Raleigh, North Carolina 27626-0526
(919) 733 4534 • Courier 56-20-00

James B. Hunt Jr., Governor September 21, 1999 H. David Bruton, M.D., Secretary

MEMORANDUM

To: Local Health Directors
Family Physicians
Pediatricians
Community & Migrant Health Centers

From: A. Dennis McBride, M.D., M.P.H.
State Health Director

Re: Enhanced Recommendations for Lead Poisoning Prevention

Last October I issued recommendations for lead poisoning prevention in North Carolina based upon guidelines that had been issued by CDC. Recommendations included a more targeted approach to screening, but also required blood lead screening at ages 12 months and again at 24 months for all children participating in Health Check (Medicaid), Health Choice, or WIC. The recommendations also required an environmental investigation by the local health department when a child's blood lead level persists at $\geq$ 15 ug/dL or is confirmed to be $\geq$ 20 ug/dL.

Lead remains the top environmental health threat for our young children, and I am particularly concerned about children in lower socio-economic groups who are at higher risk for elevated blood lead levels and their deleterious effects. I am, therefore, issuing "enhanced" recommendations, which include two significant changes from the prior document:

1. Because screening rates of high-risk children remain low, I am requesting that local health directors take leadership in the development of county-based plans to dramatically increase blood lead screening rates. The goal should at least be the universal blood lead screening of 12 and 24 month-old children participating in Health Check, Health Choice, or WIC. I am also requesting that WIC Programs make screening available for 18-and 30 month-old children when they appear for WIC recertification and there is no evidence that screening was performed by the "medical home." By bringing together the resources of Carolina Access, Health Check Coordinators, and WIC and other local health programs, the challenge is to create the most effective and efficient way of achieving universal screening of these children in each community. We have had great success in increasing

immunization rates: this success needs to be replicated with regard to blood lead screening.

2. Because there is growing evidence that even low blood lead levels are harmful to young children, and because simple and inexpensive environmental interventions (such as careful and frequent dusting and mopping) can significantly reduce exposure, environmental investigations shall now be offered for all children less than six years-of-age with confirmed blood lead levels $\geq$ 10 ug/dL. The Division of Environmental Health will conduct investigations for children with confirmed elevations between 10 and 19 ug/dL, unless the local health department chooses to offer this expanded coverage. Local health departments are still responsible for mandated environmental investigations for children with blood lead levels $\geq$ 20 ug/dL.

We are grateful for the cooperation of all providers as we seek to make North Carolina's children "lead free." We hope these "enhanced" recommendations will help us achieve that goal. If you should have any questions regarding these recommendations, please contact Ed Norman in the Division of Environmental Health at 919-715-3293.

ADM:tv

House Committee on Health

April 1, 2003

Minutes

The House Committee on Health met on Tuesday, April 1, 2003 at 12:00 noon in Room 415 of the Legislative Office Building. A silent roll was taken. A copy of the roll denoting members present is attached to the minutes (Attachment I) along with a copy of the agenda and Visitor Registration Sheet (Attachments II and III).

Chair Verla Insko welcomed members and visitors and recognized the pages: Chelsea Sigman from Watauga County sponsored by Rep. Gene Wilson and Sarah Robertson from Stokes County sponsored by Rep. Rex Baker. She also acknowledged the sergeant-at-arms: Dusty Rhodes and Brian Doughtery. (Attachment IV)

Chair Insko turned the meeting over to Chair Justus who recognized Rep. Insko to recap her explanation for her bill HB 354, A BILL ENTITLED AN ACT TO AMEND THE LAW REGARDING THE PREVENTION AND CONTROL OF LEAD POISONING IN CHILDREN. (Attachment V) Rep. Insko then called upon Ed Norman of DENR, Div. of Environmental Health, to continue his explanation of the screening process for children. Rep. Insko moved to make a technical amendment to insert the word substance after acceptable on page 2, line 26. Rep. Mary McAllister made motion to accept amendment and said motion was adopted. Rep. Mary McAllister then made motion to roll the amendment into a committee substitute, favorable as to the committee substitute and unfavorable as to the original bill. Motion passed. (Bill Analysis and handouts attached as Attachments VI and VII).

Chair Justus then turned the chair back over to Chair Insko. Rep. John Hall was then recognized to explain his bill, HB 500, AN ACT ENTITLED TO PROVIDE AN ON-SITE PHYSICAL FITNESS CENTER IN THE LEGISLATIVE BUILDING OR THE LEGISLATIVE OFFICE BUILDING FOR LEGISLATORS AND STAFF. (Attachment VIII) This bill would direct the Legislative Services Commission to provide, at an undefined future time, an on-site fitness center in the Legislative Building or the Legislative Office Building for use by members and staff. Staff offered an analysis of bill (Attachment IX). Rep. Hall offered an amendment to remove Section 2 of the bill, which was adopted. After much discussion among the committee members as to location, need, donation and contributions of equipment and budgeting requirements Rep. Sherill requested a fiscal note. No vote was taken and bill postponed.

The Chair adjourned the meeting at 12:58 a.m.*

Verla Insko
Rep. Verla Insko, Chair

Pamela J Evans
Pamela Evans, Committee Clerk

Carolyn Justus
Rep. Carolyn Justus, Chair

*Note: Due to time HB 551 was not considered. (Attachment XI - Bill and Analysis)

ATTACHMENT I

ATTENDANCE

HOUSE COMMITTEE ON HEALTH

DATES	4/1/03														
INSKO, Verla CHAIR	✓														
JUSTUS, Carolyn CHAIR	✓														
ENGLAND, Bob VICE-CHAIR	✓														
ADAMS, Alma	✓														
ALLEN, Bernard	✓														
ALLEN, Gordon	✓														
ALLRED, Cary	✓														
BARNHART, Jeff	✓														
BOWIE, Joni	✓														
CLARY, Debbie															
EARLE, Beverly	✓														
GLAZIER, Rick	✓														
HILTON, Mark	✓														
McALLISTER, Mary															
MUNFORD, Don	✓														
SETZER, Mitchell	✓														
SHERRILL, Wilma	✓														
WAINWRIGHT, William															
WILSON, Connie															
WRIGHT, Tom															
Ex officio Members															
Brubaker, Bru															
Culpepper, Bill															
Cunningham, Pete															
Eddins, Rick															

ATTACHMENT II

AGENDA

HOUSE COMMITTEE ON HEALTH

April 1, 2003
Room 415 LOB
12:00 Noon

OPENING REMARKS

Representative Verla Insko, Chair
Representative Carolyn Justus, Chair

AGENDA ITEMS

- **HB 354** **Child Lead Poisoning Prevention Prgm Amends-AB – Primary Sponsor: Rep. Verla Insko**

- **HB 500** **Legislative Fitness Center – Primary Sponsor: Rep. John Hall**

- **HB 551** **Attendance Age/Eligibility/Schools for Deaf – Primary Sponsor: Rep. Joe Tolson**

ADJOURNMENT

ATTACHMENT III

VISITOR REGISTRATION SHEET

HOUSE COMMITTEE ON HEALTH — APRIL 1, 2003

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Bert Fields	DOJ
Ed Norman	DENR
Julie Allen	NC Statewatch
Cathy Wright	self Chapel Hill
Camille Stell	KCLH
STEVE KEENE	NC MEDICAL SOCIETY
Linda Sewell	DEH, DENR
Sheila McKinney	NC DHHS
Chris Nichols	Hunton & Williams
Butch Gunnells	NC SDA
Paige Johnson	Planned Parenthood

VISITOR REGISTRATION SHEET

HOUSE COMMITTEE ON HEALTH — APRIL 1, 2003

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
ANN LOKE	DVHS
HUGH TILSON	NCHA
R. Paul Williams	NCHIBA
Jamie Ramsey	NC SOS
W A Potter Jr	NCPTA
Mark Benson	Capitol Group

ATTACHMENT IV

HEALTH 4-1-03
RM - 415

House Pages

1. Name: Chelsea Sigmon
   County: Watauga
   Sponsor: Gene Wilson
2. Name: Sarah Robertson
   County: Stokes
   Sponsor: Rex Baker
3. Name: _____
   County: _____
   Sponsor: _____
4. Name: _____
   County: _____
   Sponsor: _____
5. Name: _____
   County: _____
   Sponsor: _____

Sgt-At-Arms

1. Name: Dusty Rhodes
2. Name: Brian Daughtery
3. Name: _____
4. Name: _____

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2003

HOUSE BILL 354

Short Title:	Child Lead Poisoning Prevention Prgm Amends.-AB	(Public)
Sponsors:	Representatives Insko; Alexander, Glazier, and Luebke.	
Referred to:	Health.	

March 6, 2003

A BILL TO BE ENTITLED

AN ACT TO AMEND THE LAW REGARDING THE PREVENTION AND CONTROL OF LEAD POISONING IN CHILDREN.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 130A-131.7 reads as rewritten:

"**§ 130A-131.7. Definitions.**

~~As used in this Part, unless the context requires otherwise, the term:~~The following definitions apply in this Part:

(1) "Abatement" means undertaking any of the following measures to eliminate a lead-based paint hazard:
   a. Removing lead-based paint from a surface and repainting the surface.
   b. Removing a component, such as a windowsill, painted with lead-based paint and replacing the component.
   c. Enclosing a surface painted with lead-based paint with paneling, vinyl siding, or another approved material.
   d. Encapsulating a surface painted with lead-based paint with a sealant.
   e. Any other measure approved by the Commission.

(2) "Child-occupied facility" means a building, or portion of a building, constructed ~~prior to~~before 1978, regularly visited by a child who is less than ~~6~~ six years of age. Child-occupied facilities may include, but are not limited to, child care facilities, preschools, nurseries, kindergarten classrooms, schools, clinics, or treatment centers including the common areas, the grounds, any outbuildings, or other structures appurtenant to the facility.

(3) "Confirmed lead poisoning" means a blood lead concentration of 20 micrograms per deciliter or greater determined by the lower of two consecutive blood tests within a six-month period.

(4) "Department" means the Department of Environment and Natural Resources or its authorized agent.

(5) "Elevated blood lead level" means a blood lead concentration of 10 micrograms per deciliter or greater determined by the lower of two consecutive blood tests within a six-month period.

(6) "Lead-based paint hazard" means a condition that is likely to ~~cause adverse health effects as a~~ result ~~of~~ in exposure to lead-based paint or to soil or dust that contains lead ~~derived from lead-based paint.~~ at a concentration that constitutes a lead poisoning hazard.

(7) "Lead poisoning hazard" means any of the ~~presence of readily accessible or mouthable lead-bearing substances, including lead-based paint, measuring 1.0 milligram per square centimeter or greater by X-ray fluorescence or five-tenths of one percent (0.5%) or greater by chemical analysis; or 15 parts per billion or greater in drinking water; or 100 micrograms per square foot or greater for dust on floors; or 500 micrograms per square foot or greater for dust on windowsills; or 800 micrograms per square foot or greater for dust in window troughs, or soil lead concentrations in an amount greater than or equal to 400 parts per million that is determined by the Department to present a hazard in light of (i) the condition and use of the land and (ii) other relevant factors.~~ following:

a. Any lead-based paint or other substance that contains lead in an amount equal to or greater than 1.0 milligrams lead per square centimeter as determined by X-ray fluorescence or five-tenths of a percent (0.5%) lead by weight as determined by chemical analysis: (i) on any readily accessible or chewable surface on which there is evidence of teeth marks or mouthing; or (ii) on any other deteriorated or otherwise damaged interior or exterior surface.

b. Any substance that contains lead intended for use by children less than six years of age in an amount equal to or greater than 0.06 percent (0.06%) lead by weight as determined by chemical analysis.

c. Any concentration of lead dust that is equal to or greater than 40 micrograms per square foot on floors or 250 micrograms per square foot on interior windowsills, vinyl miniblinds, bathtubs, kitchen sinks, or lavatories.

d. Any lead-based paint or other substance that contains lead on a friction or impact surface that is subject to abrasion, rubbing, binding, or damage by repeated contact and where the lead dust concentrations on the nearest horizontal surface underneath the friction or impact surface are equal to or greater than 40 micrograms per square foot on floors or 250 micrograms per square foot on interior windowsills.

e. Any concentration of lead in bare soil in play areas, gardens, pet sleeping areas, and areas within three feet of a residential housing unit or child-occupied facility equal to or greater than 400 parts per million. Any concentration of lead in bare soil in other locations of the yard equal to or greater than 1,200 parts per million.

f. Any ceramic ware generating equal to or greater than three micrograms of lead per milliliter of leaching solution for flatware or 0.5 micrograms of lead per milliliter for cups, mugs, and pitchers as determined by Method 973.32 of the Association of Official Analytical Chemists.

g. Any concentration of lead in drinking water equal to or greater than 15 parts per billion.

(8) "Lead-safe housing" is housing that was built since 1978 or has been tested by a person that has been certified to perform risk assessments and found to have no lead-based paint hazard within the meaning of the Residential Lead-Based Paint Reduction Act of 1992, 42 U.S.C. § 4851b(15).

(9) "Maintenance standard" means the following:

a. Using safe work practices, repairing and repainting areas of deteriorated paint inside a residential housing unit and for single-family and duplex residential dwelling built ~~prior to~~before 1950, repairing and repainting areas of deteriorated paint on interior and exterior surfaces;

b. Cleaning the interior of the unit to remove dust that constitutes a lead poisoning hazard;

c. Adjusting doors and windows to minimize friction or impact on surfaces;

d. Subject to the occupant's approval, appropriately cleaning any carpets;

e. Taking such steps as are necessary to ensure that all interior surfaces on which dust might collect are readily cleanable; and

f. Providing the occupant or occupants all information required to be provided under the Residential Lead-Based Paint Hazard Reduction Act of 1992, and amendments thereto.

(10) "Managing agent" means any person who has charge, care, or control of a building or part thereof in which dwelling units or rooming units are leased.

(11) ~~"Mouthable lead-bearing substance" means any substance on surfaces or fixtures five feet or less from the floor or ground that form a protruding corner or similar edge, or protrude one half inch or more from a flat wall surface, or are freestanding, containing lead-contaminated dust at a level that constitutes a lead poisoning hazard. Mouthable surfaces or fixtures include toys, vinyl miniblinds,~~

~~doors, door jambs, stairs, stair rails, windows, windowsills, and baseboards.~~

(12) ~~"Persistent elevated blood lead level" means a blood lead concentration of 15-19 micrograms per deciliter determined by the lowest of three consecutive blood tests. The first two blood tests shall be performed within a six-month period, and the third blood test shall be performed at least 12 weeks and not more than six months after the second blood test.~~

(13) "Readily accessible ~~lead-bearing~~ substance" means any substance ~~containing lead at a level that constitutes a lead poisoning hazard which~~that can be ingested or inhaled by a child ~~under 6~~less than six years of age. Readily accessible substances include deteriorated paint that is peeling, chipping, cracking, flaking, or blistering to the extent that the paint has separated from the substrate. Readily accessible substances also include soil, ~~water,~~water, toys, vinyl miniblinds, bathtubs, lavatories, doors, door jambs, stairs, stair rails, windows, interior windowsills, baseboards, and paint that is chalking.

(14) "Regularly visits" means the presence at a residential housing unit or child-occupied facility on at least two different days within any week, provided that each day's visit lasts at least three hours and the combined weekly visits last at least six hours, and the combined annual visits last at least 60 hours.

(15) "Remediation" means the elimination or control of lead poisoning hazards by methods approved by the Department.

(16) "Residential housing unit" means a dwelling, dwelling unit, or other structure, all or part of which is designed or used for human habitation, including the common areas, the grounds, any outbuildings, or other structures appurtenant to the residential housing unit.

(17) "Supplemental address" means a residential housing unit or child-occupied facility where a child with ~~a persistent elevated blood lead level or a~~ confirmed lead poisoning regularly visits or attends. Supplemental address also means a residential housing unit or child-occupied facility where a child resided, regularly visited, or attended within the six months immediately preceding the determination of ~~a persistent elevated blood lead level or a~~ confirmed lead poisoning."

SECTION 2. G.S. 130A-131.8 reads as rewritten:

"**§ 130A-131.8. Reports of blood levels in children.**

All laboratories doing business in this State shall report to the Department all blood lead ~~levels of one microgram per deciliter or greater~~test results for children less than ~~6~~ six years of age and for individuals whose ages are unknown at the time of testing. Reports shall be made within five working days after test completion on forms provided by the Department or on self-generated forms containing: the child's full name, date of birth, sex, race, address, and Medicaid number, if any; the name, address, and telephone

number of the requesting health care provider; the name, address, and telephone number of the testing laboratory; the laboratory results, the specimen type – venous or capillary; the laboratory sample number, and the dates the sample was collected and analyzed. ~~Such~~The reports may be made by electronic submissions."

SECTION 3. G.S. 130A-131.9 reads as rewritten:

"**§ 130A-131.9. Examination and testing.**

When the Department has a reasonable suspicion that a child less than ~~6~~ six years of age has ~~a persistent~~ an elevated blood lead level or a confirmed lead poisoning, the Department may require that child to be examined and tested within 30 days. The Department shall require from the owner, managing agent, or tenant of the residential housing unit or child-occupied facility information on each child who resides in, regularly visits, or attends, or, who has within the past six months, resided in, regularly visited, or attended the unit or facility. The information required shall include each child's name and date of birth, the names and addresses of each child's parents, legal guardian, or full-time custodian. The owner, managing agent, or tenant shall submit the required information within 10 days of receipt of the request from the Department."

SECTION 4. G.S. 130A-131.9A reads as rewritten:

"**§ 130A-131.9A. Investigation to identify lead poisoning hazards.**

(a) When the Department learns of ~~a persistent elevated blood lead level or a~~ confirmed lead poisoning, the Department shall conduct an investigation to identify the lead poisoning hazards to children. The Department shall investigate the residential housing unit ~~or child-occupied facility~~ where the child with ~~the persistent elevated blood lead level or the~~ confirmed lead poisoning ~~resides, regularly visits, or attends.~~resides. The Department shall also investigate the supplemental addresses of the child who has ~~a persistent elevated blood lead or a~~ confirmed lead poisoning.

(a1) When the Department learns of an elevated blood lead level, the Department shall, upon informed consent, investigate the residential housing unit where the child with the elevated blood level resides. When consent to investigate is denied, the child with the elevated blood lead level cannot be located, or the child's parent or guardian fails to respond, the Department shall document the denial of consent, inability to locate, or failure to respond.

(b) The Department shall also conduct an investigation when it reasonably suspects that a lead poisoning hazard to children exists in a residential housing unit or child-occupied facility occupied, regularly visited, or attended by a child less than ~~6~~ six years of age.

(c) In conducting an investigation, the Department may take samples of surface materials, or other materials suspected of containing lead, for analysis and testing. If samples are taken, chemical determination of the lead content of the samples shall be by atomic absorption spectroscopy or equivalent methods approved by the Department."

SECTION 5. G.S. 130A-131.9B reads as rewritten:

"**§ 130A-131.9B. Notification.**

Upon determination that a lead poisoning hazard exists, the Department shall give written notice of the lead poisoning hazard to the owner or managing agent of the residential housing unit or child-occupied facility and to all persons residing in,

attending, or regularly visiting the unit or facility. The written notice to the owner or managing agent shall include a list of possible methods of ~~abatement of the lead-based paint hazards and of possible methods of remediation of any other lead poisoning hazard~~. remediation."

SECTION 6. G.S. 130A-131.9C reads as rewritten:

"**§ 130A-131.9C. ~~Abatement and remediation.~~Remediation.**

(a) Upon determination that a child less than ~~6~~ six years of age has a confirmed lead poisoning of 20 micrograms per deciliter or greater and that child resides ~~in, attends, or regularly visits,~~in a residential housing unit ~~or child-occupied facility~~ containing lead poisoning hazards, the Department shall require ~~abatement of the lead-based paint hazards and the~~ remediation of ~~other~~ the lead poisoning hazards. The Department shall also require ~~the abatement of the lead-based paint hazards and the~~ remediation of ~~other~~ the lead poisoning hazards identified at the supplemental addresses of a child less than ~~6~~ six years of age with a confirmed lead poisoning of 20 micrograms per deciliter or greater.

(b) When ~~abatement of lead-based paint hazards or~~ remediation of ~~other~~ lead poisoning hazards is required under subsection (a) of this section, the owner or managing agent shall submit a written remediation plan to the Department within 14 days of receipt of the lead poisoning hazard notification and shall obtain written approval of the plan ~~prior to~~before initiating ~~abatement of lead-based paint hazards or~~ remediation ~~of other lead poisoning hazards.~~activities. The remediation plan shall comply with subsections (g), (h), and (i) of this section.

(c) If the remediation plan submitted fails to meet the requirements of this section, the Department shall issue an order requiring submission of a modified plan. The order shall indicate the modifications ~~which~~ that shall be made to the remediation plan and the date ~~by which~~that the plan as modified shall be submitted to the Department.

(d) If the owner or managing agent does not submit a remediation plan within 14 days, the Department shall issue an order requiring submission of a remediation plan within five days of receipt of the order.

(e) The owner or managing agent shall notify the Department and the occupants of the dates of remediation activities at least three days ~~prior to the~~before commencement of the activities.

(f) ~~Abatement of lead-based paint hazards and remediation~~Remediation of ~~other~~ the lead poisoning hazards shall be completed within 60 days of the Department's approval of the remediation plan. If ~~these~~ the remediation activities are not completed within 60 ~~days as required,~~days, the Department shall issue an order requiring completion of the activities. An owner or managing agent may apply to the Department for an extension of the deadline. The Department may issue an order extending the deadline for 30 days upon proper written application by the owner or managing agent.

(g) ~~The~~ All of the following methods of ~~abatement~~ remediation of lead-based paint hazards are prohibited:

(1) Stripping paint on-site with methylene chloride-based ~~solutions;~~solutions.

(2) Torch or flame ~~burning;~~burning.
(3) Heating paint with a heat gun above 1,100 degrees ~~Fahrenheit;~~Fahrenheit.
(4) Covering with new paint or wallpaper unless all readily accessible lead-based paint has been ~~removed;~~removed.
(5) Uncontrolled abrasive ~~blasting; or~~ blasting, machine sanding, or grinding, except when used with High Efficiency Particulate Air (HEPA) exhaust control that removes particles of 0.3 microns or larger from the air at ninety-nine and seven-tenths percent (99.7%) or greater efficiency.
(6) Uncontrolled waterblasting.
(7) Dry scraping, unless used in conjunction with heat guns, or around electrical outlets, or when treating no more than two square feet on interior surfaces, or no more than 20 square feet on exterior surfaces.

(h) All lead-containing waste and residue shall be removed and disposed of in accordance with applicable federal, State, and local laws and rules. Other substances containing lead that are intended for use by children less than six years of age and vinyl miniblinds that constitute a lead poisoning hazard shall be removed and disposed of in accordance with applicable federal, State, and local laws and rules.

(i) All remediation plans shall require that the lead poisoning hazards be reduced to ~~below~~ the following levels:

(1) ~~Floor lead dust levels~~Less ~~are less~~ than ~~100~~ 40 micrograms per square ~~foot;~~foot for lead dust on floors.
(2) ~~Windowsill lead dust levels are less~~Less than ~~500~~ 250 micrograms per square ~~foot;~~foot for lead dust on interior windowsills, bathtubs, kitchen sinks, and lavatories.
(3) ~~Window trough lead dust levels are less~~Less than ~~800~~ 400 micrograms per square ~~foot;~~foot for lead dust on window troughs.
(4) ~~Soil lead levels are less~~Less than 400 parts per million ~~or such other level higher than 400 parts per million as determined by the Department to prevent a hazard in light of the condition and use of the land and in light of other relevant factors; and~~for lead in bare soil in play areas, gardens, pet sleeping areas, and areas within three feet of the residential housing unit or child-occupied facility. Lead in bare soil in other locations of the yard shall be reduced to less than 1,200 parts per million.
(5) ~~Drinking water lead levels less~~ Less than 15 parts per ~~billion.~~ billion for lead in drinking water.

(j) The Department shall verify by visual inspection that the approved remediation plan has been completed. The Department may also verify plan completion by residual lead dust monitoring and soil or drinking water lead level measurement.

(j1) Compliance with the maintenance standard satisfies the remediation requirements for confirmed lead poisoning cases identified on or after 1 October 1990 as long as all lead poisoning hazards identified on interior and exterior surfaces are

addressed by remediation. Except for owner-occupied residential housing units, continued compliance shall be verified by means of an annual monitoring inspection conducted by the Department. For owner-occupied residential housing units, continued compliance shall be verified (i) by means of an annual monitoring inspection, (ii) by documentation that no child less than six years of age has resided in or regularly visited the residential housing unit within the past year, or (iii) by documentation that no child less than six years of age residing in or regularly visiting the unit has an elevated blood lead level.

(k) Removal of children from the residential housing unit or child-occupied facility shall not constitute ~~abatement or~~ remediation if the property continues to be used for a residential housing unit or child-occupied ~~facility.~~facility. The remediation requirements imposed in subsection (a) of this section apply so long as the property continues to be used as a residential housing unit or child-occupied facility."

SECTION 7. G.S. 130A-131.9G reads as rewritten:

"**§ 130A-131.9G. Resident responsibilities.**

In any residential housing unit occupied by a child less than ~~6~~ six years ~~old~~ of age who has an elevated blood lead level of 10 micrograms per deciliter or greater, the Department shall advise, in writing, the owner or managing agent and the child's parents or legal guardian ~~as to~~of the importance of carrying out routine cleaning activities in the units they occupy, own, or manage. ~~Such~~ The cleaning activities shall ~~include:~~include all of the following:

(1) Wiping clean all windowsills with a damp cloth or sponge at least ~~weekly;~~weekly.

(2) Regularly washing all surfaces accessible to ~~children;~~children.

(3) In the case of a leased residential housing unit, identifying any deteriorated paint in the unit and notifying the owner or managing agent of ~~such~~ the conditions within 72 hours of ~~discovery; and~~discovery.

(4) Identifying and understanding potential lead poisoning hazards in the environment of each child ~~under the age of 6~~ less than six years of age in the unit (including toys, vinyl miniblinds, playground equipment, drinking water, soil, and painted surfaces), and taking steps to prevent children from ingesting lead such as encouraging children to wash their faces and hands frequently and especially after playing outdoors."

SECTION 8. This act becomes effective 1 July 2003.

ATTACHMENT VI

HOUSE BILL 354:
Child Lead Poisoning Prevention Prgm. Amends

BILL ANALYSIS

Committee:	House Heatlh	**Introduced by:**	Rep. Insko
Date:	March 25, 2003	**Summary by:**	Linda Attarian
Version:	Introduced		Committee Counsel

SUMMARY: ***House Bill 354 amends the law governing the Childhood Lead Poisoning Prevention Program within the Division of Environmental Health (Department) to revise the Program's environmental lead hazard and clean-up standards so that they are consistent with revised federal standards and guidelines; and to codify programmatic procedures currently in place with respect to investigations and remedial actions when a child is suspected or confirmed to have been exposed an environmental lead hazard. The bill is recommended by the Department as an agency bill and becomes effective July 1, 2003***

CURRENT LAW: The statutes governing the environmental lead hazard detection and remediation aspects of the North Carolina Childhood Lead Poisoning Prevention Program (NC CLPPP) are set forth in Part 4 of Article 5 of Chapter 130A.

Screening: Childhood lead poisoning has been a reportable condition under NC state law since 1990. Laboratories are required to report any test with a lead blood level of 1 microgram per deciliter (*u*g/dL) or greater to the Department. When the Department has a reasonable suspicion that a child less than 6 years old has a blood lead level of 15 *u*g/dL, the Department is authorized to require that the child be examined and tested for lead. Since 1994 the State Laboratory provides blood lead analysis at no charge for children who are uninsured.

Since 1998 NC CLPPP has implemented a statewide screening program targeting children between the ages of 12 and 24 months who are participating in the Medicaid, WIC, or Health Choice programs. Children under 6 years with lead poisoning (blood lead level of 20 *u*g/dL or higher) are provided with medical follow-up and health education as recommended by the National Centers for Disease Control (CDC) at the clinic where the child was screened.

Investigations: Under current law, when a child less than 6 years old has been screened and is found to have blood lead levels of 10 *u*g/dL or higher, the Department must advise the owner or manager of any residential housing unit occupied by the child about the importance of routine cleaning to prevent potential lead hazards.

When a child less than 6 years old has been identified with a blood lead levels of 15 *u*g/dL or higher, the Department is required to conduct an environmental investigation of residential housing unit or child care facility where the child resides, regularly visits, or attends. If the child has a blood lead level of 20 *u*g/dL or greater, the Department must also conduct an investigation of any supplemental addresses the child may have. During such an investigation, the family is interviewed and environmental samples are collected for laboratory analysis. Once the sources of lead exposure are identified, the owners of the residence or facility are notified. The costs associated with the investigation are reimbursable under Medicaid (up to $438 per child).

Note: Childcare facilities are routinely inspected as a condition of licensure for lead hazards. If an inspector has a reasonable suspicion that a lead hazard exists the Department is notified and an investigation is initiated for the presence of lead hazards.

Abatement and remediation: Owners who have been notified that a lead hazard exists are required to abate lead-based *paint* hazards (i.e., permanently remove, enclose or encapsulate) and remediate all other lead poisoning hazards. The owner must submit a written remediation plan to the local health department for approval prior to commencing. The plan must include specific information as required by rules adopted by the Commission for Health Services, including time frames for completion, methods, and clearance procedures to be performed. Local health departments receive $2,000 per child from State appropriations for each child requiring an environmental investigation. This funding supports childhood screening and follow-up medical services as well as costs related to conducting environmental investigations.

BILL ANALYSIS:

Programmatic changes:

Sections 2 through 4 codify current environmental intervention policies in place pursuant to recommendations issued by the State Health Director in 1999. These policies include:

1. All blood lead level test results from screenings conducted on children less than 6 years of age must be reported to the Department, including tests that are negative for lead. See Section 2.
2. A reasonable suspicion that a child has a blood lead level of 10 *u*g/dL or greater will trigger an intervention by the Department. The current law's threshold is 15 *u*g/dL. See Section 3 and 4.
3. The Department is given new authority to investigate the residential housing unit where a child with a blood lead level of 10 *u*g/dL or greater IF the Department obtains informed consent of the owner or tenant of the property. See Section 4.

Sections 5 and 6 delete all references to "*abatement of lead-based paint hazards*" from the statutes governing the clean up lead hazards. The reason for the deletions is that "abatement" (see definition, page 1, lines 9-19), falls within the definition of "remediation" (see definition, page 2, lines 23-24), and therefore it is redundant to use both terms.

Section 6 also:

1. Updates the law to conform to revised environmental lead hazard standards (see explanation below);
2. Requires the removal of vinyl miniblinds that constitute a lead hazard and any substances containing lead that intended for use by children less than 6 years old. (See page 7, lines 17-19); and
3. Provides that remediation is only necessary so long as the property continues to be used as a residential housing unit or child occupied facility. (See page 8, lines 11-13.)

Changes to environmental lead hazard and clean-up standards:

The bill makes significant changes to the definition of "*lead poisoning hazard*". Briefly, under the new definition, lead is considered to be a hazard if there are greater than 40 micrograms of lead in dust per square foot on floors; 250 micrograms of lead in dust per square foot on interior window sills and 400 parts per million of lead in bare soil in children's play area or 1200 parts per million average for bare soil in the rest of the yard. To compare current statutory thresholds with the proposed thresholds, see the table on the next page.

Substance/Surface	Current Standard	Revised Standard	Other Changes Proposed
Lead-based paint	1 milligram per square centimeter or greater measured by x-ray fluorescence or 0.5% by chemical analysis and on "a readily accessible substance or mouthable lead bearing substance"	Same	Lead-based paint will meet the definition of "lead poisoning hazard" only if it is on either a readily accessible or chewable surface (must see evidence of teeth marks) OR a deteriorated or damaged interior or exterior surface
Dust on floors	100 micrograms per square foot or greater	40 micrograms per square foot or greater	
Dust on interior windowsills	800 micrograms per square foot or greater	250 micrograms per square foot or greater	Bill adds the following surfaces to this standard: *vinyl miniblinds, bathtubs, kitchen sinks, and lavatories*
Bare soil in children's play areas	800 parts per million (ppm) or greater	400 ppm or greater	Allows 1200 ppm in any other part of a yard
Drinking water	Less than 15 parts per billion	Same	
Any substance that contains lead and is intended for use by children less than 6 years of age.	No existing standard	0.06% lead by weight as determined by chemical analysis -- a standard allowed by the Consumer Products Safety Center	
Ceramic ware	No existing standard	3 micrograms of lead per milliliter of leaching solution for flatware or 0.5 micrograms per milliliter for cups, mugs and pitchers	Standard allows measurements of leaching potential of lead, rather than total lead content
Window trough	800 micrograms per square foot or greater	400 micrograms per square foot or greater	

The bill makes conforming amendments to other definitions.

BACKGROUND:

The health effects of lead exposure: Health problems from exposure to lead can include profound developmental and neurological impairment in children. The Environmental Protection Agency (EPA) estimates that nearly 1 million children in the US have dangerously elevated levels of lead in their blood. The CDC defines an elevated blood lead level as 10 *u*g/dL or greater. According to CDC survey data, elevated blood lead levels are more common among low-income children, urban children, and those living in subsidized housing.

Revised EPA standards: The EPA adopted new, more protective environmental lead hazard standards in 2001. The standards are intended to guide state and local governments and the federal Housing and Urban Development (HUD) in adopting benchmarks upon which to base remedial actions to safeguard children and the public from the dangers of lead. Landlords, parents, and childcare providers use these standards to make informed decisions regarding lead found in their homes, yards or play areas. The standards proposed in this legislation will bring NC laws in line with the current EPA standards.

North Carolina Childhood Lead Surveillance Data: In the most recent year that data is available (2002), over 120,000 children under 6 years old were screened for lead and 528 children had blood lead levels of 10 *u*g/dL or greater. Of those 528 children, 68 children had blood lead levels of 20 *u*g/dL or greater.

North Carolina
Department of Health and Human Services
101 Blair Drive • Post Office Box 29526 • Raleigh, North Carolina 27626-0526
(919) 733 4534 • Courier 56-20-00

James B. Hunt Jr., Governor | September 21, 1999 | H. David Bruton, M.D., Secretary

MEMORANDUM

To: Local Health Directors
Family Physicians
Pediatricians
Community & Migrant Health Centers

From: A. Dennis McBride, M.D., M.P.H.
State Health Director

Re: Enhanced Recommendations for Lead Poisoning Prevention

Last October I issued recommendations for lead poisoning prevention in North Carolina based upon guidelines that had been issued by CDC. Recommendations included a more targeted approach to screening, but also required blood lead screening at ages 12 months and again at 24 months for all children participating in Health Check (Medicaid), Health Choice, or WIC. The recommendations also required an environmental investigation by the local health department when a child's blood lead level persists at $\geq$ 15 ug/dL or is confirmed to be $\geq$ 20 ug/dL.

Lead remains the top environmental health threat for our young children, and I am particularly concerned about children in lower socio-economic groups who are at higher risk for elevated blood lead levels and their deleterious effects. I am, therefore, issuing "enhanced" recommendations, which include two significant changes from the prior document:

1. Because screening rates of high-risk children remain low, I am requesting that local health directors take leadership in the development of county-based plans to dramatically increase blood lead screening rates. The goal should at least be the universal blood lead screening of 12 and 24 month-old children participating in Health Check, Health Choice, or WIC. I am also requesting that WIC Programs make screening available for 18-and 30 month-old children when they appear for WIC recertification and there is no evidence that screening was performed by the "medical home." By bringing together the resources of Carolina Access, Health Check Coordinators, and WIC and other local health programs, the challenge is to create the most effective and efficient way of achieving universal screening of these children in each community. We have had great success in increasing

immunization rates: this success needs to be replicated with regard to blood lead screening.

2. Because there is growing evidence that even low blood lead levels are harmful to young children, and because simple and inexpensive environmental interventions (such as careful and frequent dusting and mopping) can significantly reduce exposure, environmental investigations shall now be offered for all children less than six years-of-age with confirmed blood lead levels $\geq$ 10 ug/dL. The Division of Environmental Health will conduct investigations for children with confirmed elevations between 10 and 19 ug/dL, unless the local health department chooses to offer this expanded coverage. Local health departments are still responsible for mandated environmental investigations for children with blood lead levels $\geq$ 20 ug/dL.

We are grateful for the cooperation of all providers as we seek to make North Carolina's children "lead free." We hope these "enhanced" recommendations will help us achieve that goal. If you should have any questions regarding these recommendations, please contact Ed Norman in the Division of Environmental Health at 919-715-3293.

ADM:tv

DRAFT

2002 NORTH CAROLINA CHILDHOOD LEAD SCREENING DATA BY COUNTY

	Ages 1 and 2 Years					Ages 6 Months to 6 Years		
County	Target Population*	Number Screened	Percent Screened	Lead ≥10	Percent ≥10	Number Screened	Confirmed 10-19	Confirmed ≥20
ALAMANCE	3,801	865	22.8	9	1.0	1,267	3	
ALEXANDER	882	357	40.5	6	1.7	514	1	
ALLEGHANY	230	79	34.3	2	2.5	108	1	
ANSON	676	360	53.3	9	2.5	634	2	
ASHE	532	225	42.3	1	0.4	376	1	
AVERY	364	229	62.9	3	1.3	292		
BEAUFORT	1,290	830	64.3	19	2.3	920	7	2
BERTIE	530	416	78.5	17	4.1	580	5	
BLADEN	968	450	46.5	9	2.0	607	5	1
BRUNSWICK	1,759	906	51.5	11	1.2	1,388	4	
BUNCOMBE	5,087	893	17.6	15	1.7	1,312	3	1
BURKE	2,226	761	34.2	12	1.6	1,395	7	
CABARRUS	4,333	2,374	54.8	18	0.8	3,311	6	2
CALDWELL	2,015	489	24.3	3	0.6	1,325	3	
CAMDEN	149	66	44.3	1	1.5	100		
CARTERET	1,213	684	56.4	7	1.0	878	2	
CASWELL	507	148	29.2	6	4.1	196	2	
CATAWBA	4,190	1,547	36.9	16	1.0	1,892	2	
CHATHAM	1,313	445	33.9	10	2.2	587	1	2
CHEROKEE	533	142	26.6	2	1.4	233	1	
CHOWAN	389	197	50.6	4	2.0	270	2	
CLAY	147	83	56.5	5	6.0	118		
CLEVELAND	2,630	1,339	50.9	19	1.4	1,829	4	
COLUMBUS	1,613	913	56.6	20	2.2	1,599	7	1
CRAVEN	3,227	1,671	51.8	19	1.1	2,158	3	
CUMBERLAND	10,980	2,695	24.5	41	1.5	3,684	7	1
CURRITUCK	447	158	35.3	3	1.9	287	2	
DARE	704	128	18.2	2	1.6	171		
DAVIDSON	3,900	1,595	40.9	22	1.4	2,044	5	
DAVIE	934	292	31.3	3	1.0	422		1
DUPLIN	1,619	945	58.4	24	2.5	1,399	4	
DURHAM	7,600	2,310	30.4	37	1.6	3,561	15	6
EDGECOMBE	1,664	1,135	68.2	45	4.0	1,639	17	5
FORSYTH	9,232	2,852	30.9	61	2.1	3,544	14	2
FRANKLIN	1,315	441	33.5	4	0.9	614	5	
GASTON	5,296	1,210	22.8	15	1.2	1,632	5	1
GATES	224	96	42.9	6	6.3	131	4	
GRAHAM	195	121	62.1	0	0.0	168		
GRANVILLE	1,225	669	54.6	21	3.1	824	3	
GREENE	497	240	48.3	8	3.3	359	4	1
GUILFORD	12,013	4,406	36.7	83	1.9	6,248	16	2
HALIFAX	1,562	1,192	76.3	36	3.0	1,392	17	3
HARNETT	2,937	1,179	40.1	36	3.1	1,852	3	1
HAYWOOD	1,104	420	38.0	11	2.6	638		
HENDERSON	2,145	493	23.0	12	2.4	661	2	
HERTFORD	554	407	73.5	10	2.5	468	5	
HOKE	1,338	484	36.2	11	2.3	671	5	
HYDE	119	57	47.9	1	1.8	66		
IREDELL	3,725	1,005	27.0	20	2.0	1,223	4	
JACKSON	735	284	38.6	1	0.4	423		
JOHNSTON	4,146	1,190	28.7	11	0.9	1,693	5	

DRAFT

2002 NORTH CAROLINA CHILDHOOD LEAD SCREENING DATA BY COUNTY

County	Ages 1 and 2 Years					Ages 6 Months to 6 Years		
	Target Population*	Number Screened	Percent Screened	Lead ≥10	Percent ≥10	Number Screened	Confirmed 10-19	Confirmed ≥20
JONES	185	130	70.3	3	2.3	151		
LEE	1,663	683	41.1	10	1.5	1,122	1	
LENOIR	1,666	1,017	61.0	39	3.8	1,619	8	1
LINCOLN	1,824	356	19.5	5	1.4	509	1	1
MACON	620	280	45.2	6	2.1	425		
MADISON	441	181	41.0	6	3.3	275		
MARTIN	654	420	64.2	10	2.4	624	1	1
MCDOWELL	1,075	440	40.9	12	2.7	576	2	2
MECKLENBURG	24,133	6,032	25.0	105	1.7	7,599	29	2
MITCHELL	325	180	55.4	2	1.1	240	1	
MONTGOMERY	833	480	57.6	6	1.3	762	2	
MOORE	1,789	617	34.5	8	1.3	1,352	4	
NASH	2,551	1,544	60.5	50	3.2	1,944	14	3
NEW HANOVER	4,056	2,699	66.5	40	1.5	4,052	12	1
NORTHAMPTON	517	366	70.8	12	3.3	485	3	1
ONSLOW	6,449	904	14.0	16	1.8	1,287	2	
ORANGE	2,558	553	21.6	9	1.6	734	4	
PAMLICO	206	112	54.4	1	0.9	189	1	
PASQUOTANK	919	488	53.1	14	2.9	744	7	1
PENDER	989	616	62.3	4	0.6	965	2	
PERQUIMANS	239	102	42.7	2	2.0	153	3	
PERSON	915	322	35.2	10	3.1	558	3	
PITT	4,017	1,171	29.2	22	1.9	1,758	10	
POLK	371	55	14.8	1	1.8	82		
RANDOLPH	3,812	1,325	34.8	26	2.0	1,728	7	2
RICHMOND	1,384	725	52.4	16	2.2	1,115	7	1
ROBESON	4,263	2,271	53.3	36	1.6	2,959	9	1
ROCKINGHAM	2,361	695	29.4	6	0.9	1,021	1	
ROWAN	3,375	729	21.6	18	2.5	1,071	2	
RUTHERFORD	1,705	449	26.3	16	3.6	782	9	
SAMPSON	1,862	1,136	61.0	37	3.3	1,623	12	3
SCOTLAND	992	610	61.5	8	1.3	673	2	
STANLY	1,507	1,090	72.3	20	1.8	1,250	1	2
STOKES	1,030	456	44.3	7	1.5	619	2	
SURRY	1,924	991	51.5	19	1.9	1,352	2	1
SWAIN	362	270	74.6	6	2.2	358	1	
TRANSYLVANIA	552	134	24.3	0	0.0	221		
TYRRELL	92	90	97.8	1	1.1	111		
UNION	4,544	919	20.2	22	2.4	1,479	7	5
VANCE	1,490	979	65.7	21	2.1	1,175	6	2
WAKE	20,924	5,111	24.4	70	1.4	7,574	17	2
WARREN	406	252	62.1	11	4.4	315	4	
WASHINGTON	368	264	71.7	2	0.8	343	3	
WATAUGA	701	328	46.8	3	0.9	456		
WAYNE	3,501	2,621	74.9	52	2.0	3,275	17	1
WILKES	1,791	497	27.7	5	1.0	688	3	
WILSON	2,187	1,181	54.0	32	2.7	1,753	21	2
YADKIN	1,001	397	39.7	10	2.5	491	1	
YANCEY	416	219	52.6	4	1.8	300	2	1
STATE	238,359	85,960	36.1	1,608	1.9	120,640	460	68

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2003

HOUSE BILL 500

Short Title:	Legislative Fitness Center.	(Public)
Sponsors:	Representatives Hall; B. Allen, Bell, Earle, Haire, Hunter, Lucas, McAllister, Michaux, Sutton, Wainwright, Wright, and Yongue.	
Referred to:	Health.	

March 17, 2003

A BILL TO BE ENTITLED

AN ACT TO PROVIDE AN ON-SITE PHYSICAL FITNESS CENTER IN THE LEGISLATIVE BUILDING OR THE LEGISLATIVE OFFICE BUILDING FOR LEGISLATORS AND STAFF.

The General Assembly of North Carolina enacts:

SECTION 1. The Legislative Services Commission shall provide an on-site physical fitness center in the Legislative Building or the Legislative Office Building for legislators and staff.

SECTION 2. The "Doctor of the Day" would be in charge with hopes of a full-time physician in place after two years of operation.

SECTION 3. Equipment for the physical fitness center shall be provided through donations and contributions from corporations, foundations, and other individuals interested in health care.

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

HOUSE BILL 500:
Legislative Fitness Center

BILL ANALYSIS

Committee:	House Health	**Introduced by:**	Rep. Hall
Date:	April 1, 2003	**Summary by:**	Dianna Jessup
Version:	First Edition		Committee Counsel

SUMMARY: ***House Bill 500 would direct the Legislative Services Commission to provide, at an undefined future time, an on-site physical fitness center in the Legislative Building or the Legislative Office Building for use by members and staff. The "Doctor of the Day" would be in charge (with the hopes of a full-time in physician in place after two years, and equipment would be provided through donations and contributions. The act would become effective when it becomes law.***

CURRENT LAW: The Legislative Services Commission (Commission) is a statutory commission[1] comprised of the President Pro Tempore of the Senate, the Speaker of the House of Representatives, seven Senators appointed by the President Pro Tempore, and seven Representatives appointed by the Speaker. The Commission is responsible for making decisions concerning the operation of the General Assembly, including establishing and classifying positions and determining the compensation of General Assembly employees; acquiring and disposing of equipment and supplies; contracting for services required by the operation of the General Assembly; selecting the locations for buildings occupied by the General Assembly; and specifying the use within the General Assembly budget of funds appropriated to the General Assembly. The Commission allocates the space within the Legislative Building and the Legislative Office Building. Currently, there is no unallocated space within the Legislative Building or the Legislative Office Building.

The "Doctor of the Day" provides voluntary on-site medical assistance to members and staff of the General Assembly. The "Doctor of the Day" typically serves for one day and is present only during session times. The North Carolina Medical Society provides the physicians who serve as "Doctor of the Day".

BILL ANALYSIS: If enacted, at some time in the future, the Commission would have to provide an on-site physical fitness center in the Legislative Building or the Legislative Office Building for members and staff. The Commission would have to vote on allocating space for the center. Whoever is serving as "Doctor of the Day" would be "in charge" (currently undefined in the bill). This would expand the current duties and time commitment for the "Doctor of the Day". The bill expresses the intent to have a full-time physician in charge after two years. Equipment would be provided through donations and contributions.

[1] Article 7, Chapter 120 of the General Statutes.

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2003

H 1

HOUSE BILL 551

Short Title: Attendance Age/Eligibility/Schools for Deaf. (Public)

Sponsors: Representative Tolson.

Referred to: Health.

March 19, 2003

A BILL TO BE ENTITLED

AN ACT TO UPDATE THE LAWS RELATING TO THE ATTENDANCE AGES AND ELIGIBILITY OF STUDENTS FOR NORTH CAROLINA SCHOOLS FOR THE DEAF.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 143B-216.41 reads as rewritten:

"**§ 143B-216.41. Pupils admitted; education.**

The Department of Health and Human Services ~~shall~~ shall, according to ~~such~~ reasonable regulations ~~as~~ prescribed by the ~~Board of Directors may prescribe,~~ Superintendent of the Office of Education Services, on application, receive into the schools for the purposes of education all ~~deaf~~ deaf, hard-of-hearing, and deaf/blind children ~~resident~~ who: (i) have been referred by their local education agencies and meet the criteria for admission; (ii) are residents of the ~~State who~~State; and (iii) are from age five through age ~~20 years: Provided, that the Department of Health and Human Services may admit students who are not within the age limits set forth above when in its judgment, such admission will be in the best interests of the applicant and the facilities of the school permit such admission.~~21 years. Only those who are bona fide citizens or residents of North Carolina shall be eligible to and entitled to receive free tuition and maintenance. The Department may fix charges and the ~~Board of Directors~~Superintendent of the Office of Education Services may prescribe rules whereby nonresident ~~deaf~~ deaf, hard-of-hearing, and deaf/blind children may be admitted, but in no event shall the admission of nonresidents in any way prevent the attendance of any eligible ~~deaf child,~~deaf, hard-of-hearing, or deaf/blind child who is a resident of North Carolina. The Department shall provide for the instruction of all pupils in the branches of study now prescribed by law for the public schools of the State and in ~~such~~ any other branches as may be of special benefit to the ~~deaf.~~deaf, hard of hearing, and deaf/blind.

The Department shall encourage the State to provide the classrooms with modern auditory training equipment, audiovisual media equipment, and any other special

equipment to provide the best educational conditions for the ~~deaf.~~deaf, hard of hearing, and deaf/blind. The Department shall provide a teacher training program in the State. The Department shall provide for a comprehensive vocational and technical training program for ~~boys and girls~~students as may be useful to them in making themselves self-supporting."

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

HOUSE BILL 551:
Attendance Age/Eligibility/Schools for the Deaf

BILL ANALYSIS

Committee:	House Health	**Introduced by:**	Rep. Tolson
Date:	April 1, 2003	**Summary by:**	Linda Attarian
Version:	Introduced		Committee Co-Counsel

SUMMARY: ***House Bill 551 conforms NC law governing the eligibility and admission of deaf children to the NC Schools for the deaf to current admission policies and practices and makes other technical and clarifying changes. The bill is effective when it becomes law.***

CURRENT LAW: In accordance with G.S. 143B-216.41, a statute enacted in 1961, all hearing impaired children between the ages of 6 and 21 are eligible for admission to either the Eastern North Carolina School for the Deaf at Wilson (K-12) or the North Carolina School for the Deaf in Morganton (K-12). The Department of Health and Human Services (DHHS) is responsible for the operation and maintenance of the schools. Current law authorizes the Board of Directors of each of the Schools to adopt rules governing the admission of students. Children under the age of six may be admitted if admission is in the best interests of the applicant and the school. Non-residents may be admitted if space is available, but only residents of North Carolina may receive free tuition and maintenance. Non-residents must pay the per capita costs.

NC Schools for the Deaf provide instruction in all branches of study as required by law for the public schools and in other branches of study that may be beneficial to deaf or hard-of-hearing students. The DHHS tries to ensure that classrooms in the Schools for the Deaf are equipped with the necessary tools and media equipment to ensure the best educational conditions for deaf or hear-of-hearing students attending the schools. DHHS is also required to provide a teacher training program to train teachers in public schools.

BILL ANALYSIS: The bill makes the following changes to the statute governing the eligibility and admission to the NC Schools for the Deaf:

1. Shifts rule making authority over admission policies from the Board of Directors of the Schools for the Deaf to the Superintendent of the Office of Education Services in DHHS. *This change is made because the Schools for the Deaf no longer have Boards of Directors.* See page 1, lines 10 and 20.
2. Adds a provision stating that all applicants for admission to a School for the Deaf must be referred by their local education agencies. (DHHS is a local education agency). See page 1, line 12.
3. Adds a provision stating that applicants must meet certain criteria for admission. It is unclear what the criteria is or what entity is responsible for defining it. See page 1, line 13.
4. Clarifies that children who are deaf, hard-of-hearing or deaf and blind are eligible for admission, not *just* deaf children. *This is the current policy.* See page 1, lines 11, 21, 23 and page 2, line 2.
5. Clarifies that children between the ages of 5 and 21 are eligible for admission and deletes language that gave DHHS discretion to admit students outside the age range of 5 and 20. *This is the current policy.* See page 1, line 17.

BACKGROUND:

As of December 1, 2002, 2249 deaf and hard-of-hearing children in North Carolina are eligible for special educational assistance under State and federal law (Individuals with Disabilities Education Act). Of those 2249, 2014 attend school in the public school system. 235 children attend the Schools for the Deaf.

House Committee on Health

April 8, 2003

Minutes

The House Committee on Health met on Tuesday, April 8, 2003 at 12:00 noon in Room 544 of the Legislative Building. A silent roll was taken. A copy of the roll denoting members present is attached to the minutes (Attachment I) along with a copy of the agenda and Visitor Registration Sheet (Attachments II and III).

Chair Justus welcomed members and visitors. Dusty Rhodes and Chares Grady were recognized as the sergeant-at-arms. (Note: no pages were present)

Chair Justus introduced Lt. Governor Beverly Perdue, Chair of the Health and Wellness Commission. Lt. Governor Perdue updated the members on the Health and Wellness Commission (Attachment IV)

Chair Justus thanked the Lt. Governor for coming and providing this update to the committee members.

Chair Justus then recognizes Rep. Wright to explain his bill HB 669 A BILL TO BE ENTITLED AN ACT TO AMEND THE DEFINITION OF A "PRIMARY CARE HOSPITAL" TO REFLECT FEDERAL REQUIREMENTS. (Attachment V) This bill would amend the definition of "primary care hospital" in Article 5, of Chapter 131E, governing the licensure of hospitals. This change is necessary to conform the definition to changes in federal law that has resulted in the conversion of "primary care" hospitals to "critical care" hospitals. (Bill Analysis – Attachment VI) Rep. Wright then makes a technical amendment to change emergency care to emergency services to be consistent with federal law. Rep. B. Allen makes motion to adopt amendment. Rep. Adams moves to roll the amendment into a committee substitute, to give the committee substitute a favorable report and unfavorable as to the original bill. Motion adopted. (Committee Report – Attachment VII)

The next bill to be heard is sponsored by Reps. Insko and Earle. Chair Justus recognizes Rep. Insko to explain the bill HB 172 A BILL TO BE ENTITLED AN ACT TO IMPLEMENT A PILOT PROJECT FOR LOCAL LONG-TERM CARE PLANNING. (Attachment VIII) This bill would appropriate funds to the Department of Health and Human Resources to implement a pilot project for local long-term care planning. (Bill Analysis – Attachment IX) Rep. Insko offers an amendment to bill (Attachment X). Motion made and amendments approved. Rep. Wright makes motion to roll the amendments into a committee substitute, to give a favorable report to the committee substitute, which changes the title, unfavorable as to the original bill and recommends that the committee substitute be re-referred to the Committee on Appropriations. Motion adopted (Committee Report – Attachment XI)

Chair Justus then recognizes Rep. Edith Warren to explain her bill HB 155 A BILL TO BE ENTITLED AN AT TO IMPLEMENT A LONG-TERM CARE WORKFORCE IMPROVEMENT PROGRAM FOR DIRECT CARE WORKERS EMPLOYED BY ADULT CARE HOMES AND HOME CARE AGENCIES IN AN EFFORT TO INCREASE SKILL LEVELS, JOB SATISFACTION, AND RETENTION RATES. (Attachment XII) This bill is a recommendation of the North Carolina Study Commission on Aging and would implement a workforce improvement program for direct care workers employed in adult homes and home care situations similar to a workforce improvement program currently in place for nurse aides in nursing homes. Rep. B. Allen moves that the bill be given a favorable report and recommends that the bill be re-referred to the Committee on Appropriations. Motion adopted. (Committee Report – Attachment XIII)

Meeting adjourned at 11:57 a.m.

Rep. Carolyn Justus, Chair

Pamela J. Evans, Committee Clerk

ATTENDANCE

HOUSE COMMITTEE ON HEALTH

DATES	4/8/03														
INSKO, Verla CHAIR	✓														
JUSTUS, Carolyn CHAIR	✓														
ENGLAND, Bob VICE-CHAIR	✓														
ADAMS, Alma	✓														
ALLEN, Bernard	✓														
ALLEN, Gordon	✓														
ALLRED, Cary															
BARNHART, Jeff	✓														
BOWIE, Joni	✓														
CLARY, Debbie															
EARLE, Beverly	✓														
GLAZIER, Rick	✓														
HILTON, Mark	✓														
McALLISTER, Mary	✓														
MUNFORD, Don	✓														
SETZER, Mitchell	✓														
SHERRILL, Wilma															
WAINWRIGHT, William	✓														
WILSON, Connie	✓														
WRIGHT, Tom	✓														
Ex officio Members															
Brubaker, Bru															
Culpepper, Bill															
Cunningham, Pete															
Eddins, Rick															

AGENDA

HOUSE COMMITTEE ON HEALTH

April 8, 2003
Room 544 LOB
12:00 Noon

OPENING REMARKS

Representative Verla Insko, Chair
Representative Carolyn Justus, Chair

LT. GOVERNOR BEVERLY PERDUE, CHAIR OF THE HEALTH AND WELLNESS COMMISSION, TO ADDRESS MEMBERS

AGENDA ITEMS

HB 669 **Hospital Licensure/Critical Access Hospital – Primary Sponsor: Rep. Thomas Wright**

HB 172 **Local LTC Planning Pilot Project – Primary Sponsors: Rep. Verla Insko and Rep. Beverly Earle**

HB 155 **LTC Workforce Improvement Program – Primary Sponsors: Rep. Edith Warren and Rep. Beverly Earle**

ADJOURNMENT

ATTACHMENT III

House Pages

1. Name: _____

   County: _____

   Sponsor: _____

2. Name: _____

   County: _____

   Sponsor: _____

3. Name: _____

   County: _____

   Sponsor: _____

4. Name: _____

   County: _____

   Sponsor: _____

5. Name: _____

   County: _____

   Sponsor: _____

Sgt-At-Arms

1. Name: Dusty Rhodes
2. Name: Charles Grady
3. Name: _____
4. Name: _____

VISITOR REGISTRATION SHEET

HOUSE COMMITTEE ON HEALTH — **Name of Committee**

APRIL 8, 2003 — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Michael Keough	ORH/DHHS
Phil Telfer	Governor's Policy office
Mike Hawkins	AWK
Elizabeth Dalton	Bone & Associates
Amy Dobson	NC Statewatch
Robert Keck	Brian Center Nursing Home
Paul Shogren	Brian Cntr. Health + Rehab / Hendersonville
Cliff Calloway MD	NC Medical Society / Charlotte
Susan Hammett	NC DHHS
Karen Gottovi	Division of Aging DHHS
Paul Harlow	Hair Council
Rachel E. Clark	Lung Association
Elizabeth B. Davis	

VISITOR REGISTRATION SHEET

HOUSE COMMITTEE ON HEALTH — APRIL 8, 2003

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Camille Stell	Kennedy Covington
Jim Blackburn	County Commissioners Assoc.
[signature]	[signature]
Jennifer M Sullivan	NASW-NC
[signature]	NCAHP
John Burdish	AstraZeneca
David Bonner	Poyner Spruill
[signature]	Bone and Assoc.
HUGH TILSON	NCHA
Steve Mitchell	Novartis
[signature]	[signature]
[signature]	NCTCPA

VISITOR REGISTRATION SHEET

HOUSE COMMITTEE ON HEALTH — APRIL 8, 2003

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Kimberly Yarborough MD	Person Emergency Physicians, PA Person Memorial Hospital 615 Ridge Rd Roxboro NC, 27573
Larry Yarborough	" "
Michael Thompson	Dominion NC Power
Hoyle Hall	Carolinas HealthCare System
Patrick Yancey	FORLTC / APPCNC

Chapter 147

Article 6C.

Health and Wellness Trust Fund.

§ 147-86.30. Health and Wellness Trust Fund established.

(a) Fund Established. - There is established the Health and Wellness Trust Fund in the Office of the State Treasurer that shall be used to develop a comprehensive plan to finance programs and initiatives to improve the health and wellness of the people of North Carolina. As used in this Article, the term "Fund" means the Health and Wellness Trust Fund. It is the intent of the General Assembly that the funds provided pursuant to this Article to address the health needs of North Carolinians be used to supplement, not supplant, existing funding of health and wellness programs.

(b) Fund Earnings, Assets, and Balances. - The State Treasurer shall hold the Fund separate and apart from all other moneys, funds, and accounts. The State Treasurer shall be the custodian of the Fund and shall invest its assets in accordance with G.S. 147-69.2 and G.S. 147-69.3. Investment earnings credited to the assets of the Fund shall become part of the Fund. Any balance remaining in the Fund at the end of any fiscal year shall be carried forward in the Fund for the next succeeding fiscal year. Payments from the Fund shall be made on the warrant of the chair of the Commission, pursuant to directives of the Commission. The Commission may expend moneys in the Fund only as provided in subsections (c) and (d) of this section.

(c) Creation of Fund Reserve. - The Commission shall reserve, and shall not expend, fifty percent (50%) of each annual payment allocated to the Health and Wellness Trust Fund pursuant to G.S.143-16.4 during years 2001 through 2025 to create and build the Fund Reserve. During years 2001 through 2025, the Commission may expend any investment earnings on the reserved funds. Beginning in year 2026, and thereafter, the Commission shall not expend the reserved funds but may continue to expend any investment earnings on the reserved funds.

(d) Use of Nonreserved Funds. - The Commission may expend all of the annual payments for years 1998, 1999, and 2000 and may expend the remaining fifty percent (50%) portion of each annual payment thereafter through the year 2025 that is not reserved pursuant to subsection (c) of this section. Any unexpended or unencumbered portion of the nonreserved portion of each annual payment for years 2001 through 2025 that has not been expended or encumbered by the third June 30th following the date of the receipt of the payment shall be reserved pursuant to subsection (c) of this section. The Commission may expend any investment earnings on the nonreserved funds in the year in which the investment earnings are received by the Fund.

(e) Fund Purposes. - Moneys from the Fund may be used for any of the following purposes:

(1) To address the health needs of vulnerable and underserved populations in North Carolina.
(2) To fund programs and initiatives that include research, education, prevention, and treatment of health problems in North Carolina and to increase the capacity of communities to respond to the public's health needs.
(3) 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 with an emphasis on reducing youth tobacco use. The plan shall include measurable health and wellness objectives and a proposed timetable for achieving these objectives. In developing the plan, the Commission shall consider all facets of health, including prevention, education, treatment, research, and related areas.

(f) Limit on Operating and Administrative Expenses. - No more than two and one-half percent (2 1/2%) of the annual receipts of the Fund for the fiscal year beginning July 1 or a total sum of one million dollars ($1,000,000), whichever is less, may be used each fiscal year for administrative and operating expenses of the Commission and its staff. All administrative expenses of the Commission shall be paid from the Fund. (2000-147, s. 2.)

§ 147-86.31. Health and Wellness Trust Fund; eligibility for grants; annual reports from non-State agencies.

(a) Eligible Grant Applicants. - Any of the following are eligible to apply for a grant from the Fund:
- (1) A State agency.
- (2) A local government or other political subdivision of the State or a combination of such entities.
- (3) A nonprofit corporation which has as a significant purpose promoting the public's health, limiting youth access to tobacco products, or reducing the health consequences of tobacco use.

(b) Annual Report From Non-State Agencies. - Grant or financial assistance recipients that are non-State agencies shall submit an annual report to the Commission. The report shall include information concerning how the funds are used, the intended goals and objectives of the recipient's grant proposal or program initiative, and the results of an evaluation of the extent to which the outcomes of the initiatives or proposal achieved those goals and objectives. (2000-147, s. 2.)

§ 147-86.32. Health and Wellness Trust Fund; Commission established; membership qualifications; vacancies.

(a) Commission Established. - There is established the Health and Wellness Trust Fund Commission. As used in this Article, the term "Commission" means the Health and Wellness Trust Fund Commission. The Commission shall exercise its powers independently, but for administrative purposes, the Commission shall be located within the Office of the State Treasurer.

(b) Membership. - The Commission shall consist of 18 members. The members shall not be employed by or be agents of tobacco product manufacturing companies. The Commission shall be appointed as follows: six members by the Governor, six members by the President Pro Tempore of the Senate, and six members by the Speaker of the House of Representatives. These members shall be appointed as follows:

(1) The Governor shall make the following appointments:
- a. A person involved in public health.
- b. A person involved in the operation of health care delivery systems.
- c. A health care practitioner.
- d. An at-large appointee.
- e. An at-large appointee.
- f. An at-large appointee.

(2) The President Pro Tempore of the Senate shall make the following appointments:
- a. A person involved in health research.
- b. A person involved in tobacco-related health care issues.
- c. A person involved in health promotion and disease prevention.
- d. An at-large appointee.
- e. An at-large appointee.
- f. An at-large appointee.

(3) The Speaker of the House of Representatives shall make the following appointments:
- a. A person involved in health policy trends.
- b. A person involved with health care for underserved populations.
- c. A person involved with child health care.
- d. An at-large appointee.
- e. An at-large appointee.
- f. An at-large appointee.

It is the intent of the General Assembly that the appointing authorities, in appointing members, shall appoint members who represent the geographic, political, gender, and racial diversity of the State.

(c) Initial Appointments; Term Limits; Officers. - To provide for a staggered membership, the members initially appointed pursuant to sub-subdivisions (b)(1)a., (1)b., (2)d., and (3)d. of this section shall serve one-year terms ending on June 30, 2001. The members initially appointed pursuant to sub-subdivisions (b)(2)c., (2)e., (3)a., and (3)e. shall serve two-year terms ending on June 30, 2002. The members initially appointed pursuant to sub-subdivisions (b)(1)c., (1)d., (1)e., (2)b., and (3)c. shall serve three-year terms ending June 30,
2003. The remaining members initially appointed pursuant to subsection (b) of this section shall serve four-year terms ending June 30, 2004.

Except as provided for the initial members under this subsection, members shall serve four-year terms beginning July 1. No member may serve more than two full consecutive terms. Members may continue to serve beyond their terms until their successors are duly appointed, but any holdover shall not affect the expiration date of the succeeding term. A member may be removed from the Commission for cause by the authority that appointed the member.

The Commission shall elect from its membership a chair, vice-chair, and other officers as necessary for two-year terms beginning July 1 at the first meeting of the Commission held on or after July 1 of every even-numbered year. The vice-chair may act for the chair in the absence of the chair as authorized by the Commission.

(d) Vacancies. - Vacancies shall be filled by the designated appointing authority for the remainder of the unexpired term.

(e) Frequency of Meetings. - The Commission shall meet at least twice each year and may hold special meetings at the call of the chair or a majority of the voting members. The Governor shall call the initial meeting of the Commission.

(f) Quorum; Majority. - Ten members shall constitute a quorum of the Commission. The Commission may act upon a majority vote of all the members of the Commission on matters involving the disbursement of funds and personnel matters properly before the Commission. On all other matters, the Commission may act by majority vote of the members of the Commission at a meeting at which a quorum is present.

(g) Meeting Facilities. - The Office of the State Treasurer shall provide meeting facilities for the Commission and its staff as requested by the chair of the Commission.

(h) Per Diem and Expenses. - The members of the Commission shall receive per diem and necessary travel and subsistence expenses in accordance with the provisions of G.S. 138-5. Per diem, subsistence, and travel expenses of the members shall be paid from the Fund.

(i) Conflict of Interest. - The members of the Commission shall comply with the provisions of G.S. 14-234 prohibiting conflicts of interest. In addition to the restrictions imposed under G.S. 14-234, a member shall not vote on, participate in the deliberations of, or otherwise attempt through his or her official capacity to influence the vote on a grant or other financial assistance award by the Commission to a nonprofit entity of which the member is an officer, director, or employee or to a governmental entity of which the member is an employee or a member of the governing board. A violation of this subsection is a Class 1 misdemeanor. (2000-147, s. 2.)

§ 147-86.33. Health and Wellness Trust Fund; powers and duties.

(a) The Commission shall do the following:

(1) Allocate moneys from the Fund as grants. A grant may be awarded only for a program or initiative that satisfies the criteria and furthers the purposes of this Article, but the provisions of this Article shall be liberally construed. The Commission shall strive to avoid imposing any unnecessary barriers in the grant application process.

(2) Develop criteria for awarding grants under this Article. The criteria shall include types of programs and initiatives to be funded, including programs which address the short- and long-term health and wellness of the citizens of North Carolina.

(3) Develop criteria by which to measure the outcomes of funded programs to evaluate the extent to which those programs achieved the goals for which funds were awarded.

(4) Develop a mechanism with which to evaluate individual applications.

(5) Ensure that good faith efforts are made to achieve federal mandates targeting the reduction of youth access to tobacco products.

(6) Administer the provisions of this Article.

(7) Adopt rules to implement this Article.

(b) The Commission is authorized to hire staff or contract for other expertise for the administration of the Fund.

(c) Gifts and Grants. - The Commission is authorized to accept gifts or grants from other sources. (2000-147, s. 2.)

§ 147-86.34. Advisory Council.

The Commission shall create an Advisory Council to advise it with regard to issues as requested by the Commission. The Advisory Council shall include the Secretary of the Department of Health and Human Services, the State Health Director, the Dean of the School of Public Health of the University of North Carolina, and others the Commission considers necessary. (2000-147, s. 2.)

§ 147-86.35. Health and Wellness Trust Fund; reporting requirements.

(a) The chair of the Commission shall report each year by November 1 to the Joint Legislative Commission on Governmental Operations and to the chairs of the Joint Legislative Health Care Oversight Committee regarding implementation of this Article, including a report on funds disbursed during the fiscal year by amount, purpose, and category of recipient, and other information as requested by the Joint Legislative Commission on Governmental Operations. The annual report shall also include a summary of each recipient's annual report submitted to the Health and Wellness Trust Fund Commission pursuant to G.S. 147-86.31(b) and an analysis of progress toward the goals and objectives of any comprehensive, community-based plan established pursuant to G.S. 147-86.30(e)(3). A written copy of the annual report shall also be sent to the Legislative Library by November 1 each year. Written reports shall also be sent on a quarterly basis to the Joint Legislative Commission on Governmental Operations.

(b) Any non-State corporation, organization, or institution that receives, uses, or expends any funds from the Commission is subject to the applicable reporting requirements of G.S. 143-6.1. (2000-147, s. 2.)

§ 147-86.36. Health and Wellness Trust Fund; open meeting and public records requirements.

The Open Meetings Law (Article 33 of Chapter 143 of the General Statutes) and the Public Records Act (Chapter 132 of the General Statutes) shall apply to the Fund and the Commission, and the Fund and the Commission shall be subject to audit by the State Auditor as provided by law. The Commission shall reimburse the State Auditor for the actual cost of the audit. (2000-147, s. 2.)

State of North Carolina
Health & Wellness Trust Fund Commission

Governor
Michael F. Easley

Lieutenant Governor
Beverly E. Perdue,
Chair

Hon. MaryAnn E. Black,
County Commissioner,
Durham County, Durham

Carole W. Bruce,
Partner,
Smith Moore LLP

Donald E. Ensley, PhD,
Associate Professor and Chair,
Dept. of Community Health,
East Carolina University,
Greenville

Dan Gottovi, MD,
Physician,
Wilmington Health Associates,
Wilmington

Jeffrey L. Houpt, MD,
Dean, School of Medicine,
Vice Chancellor for Medical Affairs,
CEO,
UNC Health Care System,
Chapel Hill

Olson Huff, MD,
Asheville

Anita L. Jackson, MD, MPH, FACS
President,
Greater Carolina Ear, Nose,
and Thoat, PA
Lumberton

Elizabeth H. Locke, PhD,
President,
The Duke Endowment,
Charlotte

Ann Franklin Maxwell,
Charlotte

Leigh Harvey McNairy,
Officer/Director
Harvey Enterprises and Associates,
Kinston

Edwin W. Monroe, MD,
Emeritus Executive Dean,
Brody School of Medicine,
Greenville

Robert S. (Bob) Parker,
Vice President,
Home and Community Health,
North Carolina Baptist Hospital,
Tobacco Related Health
Care Issues,
Winston-Salem

Ralph Snyderman, MD,
Chancellor for Health Affairs,
Duke University,
Durham

Rebecca H. Wartman, OD,
Optometrist,
Doctors Vision Center,
Asheville

Paul M. Wiles,
President and CEO,
Novant Health,
Winston-Salem

Charles Willson, MD,
Clinical Professor and Asst. Dean,
Physicians Affairs,
School of Medicine,
East Carolina University,
Greenville

Robert E. Zaytoun,
Partner,
Zaytoun & Miller, PLLC,
Raleigh

Date: February 10, 2003

To: NC General Assembly Members

From: Lt. Governor Beverly Perdue

Subject: Health and Wellness Trust Fund Commission Progress Report

The vision expressed by the General Assembly in creating a Commission to improve the health and wellness of all North Carolinians is being realized today. The Health and Wellness Trust Fund Commission is using its 25% share of the state's tobacco settlement funds to vigorously implement a variety of initiatives addressing the most critical health challenges facing our population. Enclosed you will find a summary of achievements since our establishment in May 2001.

In addition to creating a prescription drug program for seniors, the Commission has awarded 63 grants to organizations statewide to reduce teen tobacco use, to assist low-income citizens in obtaining prescription drugs and to counsel seniors about safe use of their medicines. In awarding these grants, the Commission was mindful of its obligation to build capacity in underserved communities and to ensure geographic dispersion of resources. Enclosed is a map showing grant service areas established thus far. As its next priority, the Commission will be tackling the alarming epidemic of obesity among our youth.

The state's budget crisis has already claimed $70 million from the Health and Wellness Trust Fund. Any additional erosion of the funds will necessitate cancellation of grants and services already promised to our state's neediest citizens. Survival of these programs will not only result in direct services to your constituents in the near term, but will yield measurable outcomes that can be used to shape effective health care policy in the future.

If you have questions, or require additional information, please feel free to contact the Commission's Executive Director, Jim Davis.

Jim Davis, Executive Director
Post Office Box 24976, Raleigh, NC 27611 • 116 West Jones Street, Raleigh, NC 27603
Phone (919) 733-4011 • Fax (919) 733-1240

OVERVIEW OF HWTFC FUNDED INITIATIVES

Senior Care- the prescription drug plan for NC Seniors

The Commission allocated funding of $32 million dollars per year for three years for a prescription drug plan for North Carolina seniors. *Senior Care* covers those aged 65 and over, whose annual incomes total no more than 200% of the Federal Poverty Guidelines ($17,180 for an individual and $23,220 per couple) and who are without third party insurance (public or private). Approximately 100,000 seniors will be covered.

The program is disease-specific, covering three diseases that affect 70% of NC's seniors: cardiovascular disease, diabetes mellitus and chronic obstructive pulmonary disease (COPD). Using the *Senior Care* card, participants can purchase up to $1,000 worth of covered drugs per year, with the plan covering 60% of that expense, and the participant paying the other 40%.

The Commission designated NCDHHS to hire a commercial vendor to manage the program. Through competitive bidding, ACS was selected to serve as the Pharmacy Benefit Manager. Seniors began using their cards to access their drug benefit on November 1, 2002. Enrollment outreach is being conducted statewide through health departments, senior centers, pharmacies and physicians.

Senior Care's annual budget could expand from $32 million to $90 million if the federal government approves North Carolina's Medicaid waiver application that was recently submitted. The Commission's funds represent the state match required to access federal funds upon approval of this waiver request. With increased funding *Senior Care* would be expanded to cover prescriptions for all disease states. Also, the program would pay for the first $1,000 of prescription drug expenditure, at a nominal co-pay of $5 for generic drugs and $15 for brand name drugs, per 30-day prescription.

At the end of each year of the program, the General Assembly will receive the results of an outcomes analysis being conducted jointly by the UNC Schools of Public Health and Pharmacy and North Carolina A&T State University School of Nursing.

Prescription Assistance Centers.

On October 23, 2002, the Commission awarded a total of $8.7 million over three years to fund 24 community-based programs (list enclosed) to assist North Carolina seniors and low-income individuals of all ages in acquiring free, low-cost or discounted medications. In addition, any senior will be able to receive counseling on the safe and wise use of prescription drugs. In awarding these grants, the Commission gave priority to organizations proposing to serve diverse populations, ensured geographic dispersion, and emphasized the creation of new health care capacity within local communities.

Grant recipients will contract with local pharmacists to counsel seniors in identifying drug utilization issues such as drug-to-drug interactions and duplicative therapies. Seniors who are eligible for *Senior Care* will receive such counseling services at no cost. Other seniors will be able to use the service through payment of a minimal fee, based upon ability to pay. The UNC School of Pharmacy will provide medication counseling through a toll-free hotline for those seniors who reside in counties without a local Prescription Assistance Center present.

National studies have shown that nearly 17% of hospitalizations involving seniors are the result of adverse reactions to medications, costing tens of billions of dollars to the health care system.

The grant will also cover the cost of both salary and training for Prescription Access Coordinators who will operate specially designed software provided by DHHS. These Coordinators will use the software to help clients locate and apply for the lowest-cost prescription drugs available, including card programs offered by pharmaceutical companies. The grantees may also provide educational services to help low-income seniors manage chronic diseases.

Approval of the Medicaid waiver discussed above would expand the annual budget for these Prescription Assistance Centers from $3 million to $12 million.

Teen Tobacco Use Prevention and Cessation Initiative

The Commission allocated $18.6 million to this initiative for a three-year pilot program, and completed grant awards in December of 2002. The plan conforms to recommendations from the CDC by providing NC communities with training and resources necessary to design and implement local prevention and cessation programs. Further, it places emphasis on reducing youth tobacco use through public education using both paid and earned media, school-based interventions, teen cessation programs and enforcement of the state law restricting tobacco sales to minors (G.S. 14-313).

Tobacco use rates among NC high school and middle school students are above the national rate. An alarming 38.3% of NC high school students and 18.4% of middle school students are current users of tobacco. This initiative is the largest investment the State has made to reduce teen tobacco use. It is estimated that North Carolina's health care costs attributable to tobacco use exceed $1 billion annually *(NC VISION 2010, 2001)*. This upfront investment to reduce tobacco use among teens could greatly reduce these costs.

The program is organized into these specific components:

$7,003,377 - for 27 local community/school prevention programs, plus training and technical support services (list enclosed).

$2,425,000 - for 4 statewide organizations to address the disproportionate health impacts of tobacco use among African American, American Indian, and Latino youth; plus training and technical support (list enclosed).

$3,600,000 - for media messages designed to prevent and reduce youth tobacco use.

$1,500,000 - to reduce tobacco sales to minors through statewide enforcement of North Carolina's law prohibiting the sale and distribution of tobacco products to youth (G.S. 14-313).

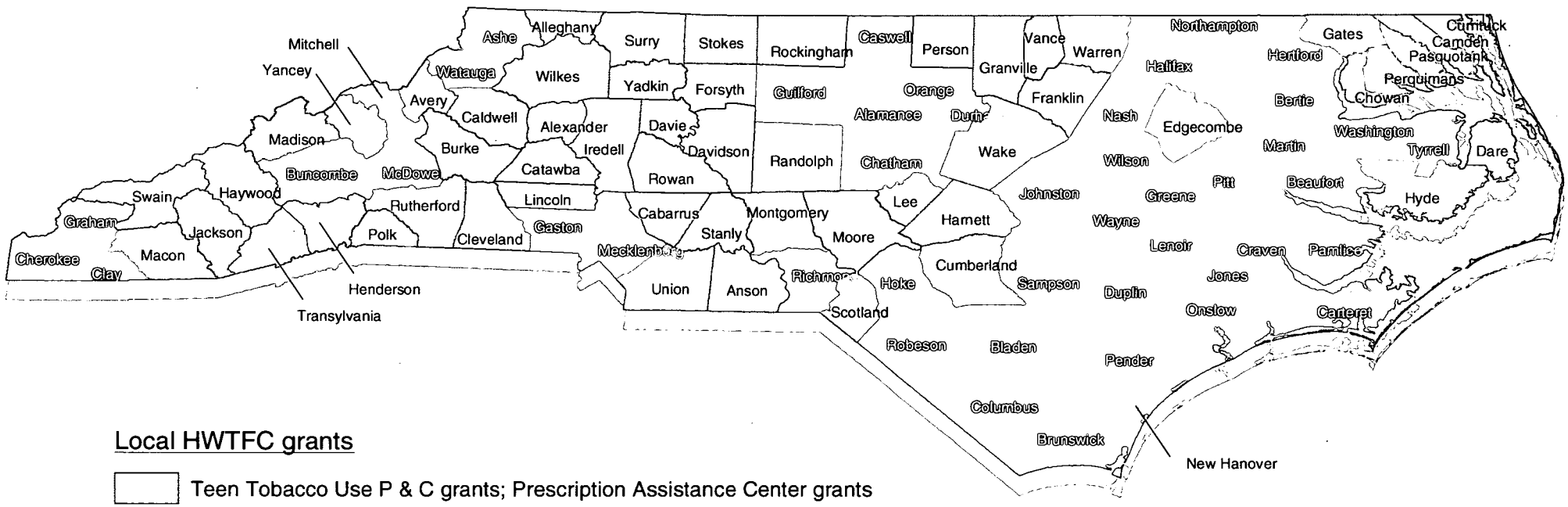
$2,365,000 - for a toll-free Quit Line and website in years 2 and 3 of the initiative that will help callers quit, provide information on treatment options, and offer follow-up support.

$600,000 - for training, technical assistance and implementation of the school-based teen cessation program Not-on-Tobacco (N-O-T), which is provided by the American Lung Association.

$300,000 - to expand smoking cessation intervention in the routine health care visits of pregnant teenage women.

$800,000 - for an ongoing outcome analysis that will assure that the funded programs are having their intended impact of reducing teen tobacco use.

HWTFC Grants Awarded in 2002



Local HWTFC grants

- Teen Tobacco Use P & C grants; Prescription Assistance Center grants
- Prescription Assistance Center grants
- Teen Tobacco Use Prevention and Cessation grants
- Access to Medication Management Hotline; statewide Teen Tobacco Use P & C programs

Map created at the UNC School of Public Health by Lisa E. Fastnaught, MPH, and Kurt M. Ribisl, Ph.D. on January 29, 2002

HWTFC PRESCRIPTION ASSISTANCE CENTER GRANT AWARDS

Name of Organization	Counties Served	3-year Funding
Alamance Regional Medical Center	Alamance, Caswell	$ 287,500
Bladen HealthWatch	Bladen	$ 280,768
Caldwell Senior Center	Caldwell	$ 176,500
Cape Fear Council of Government AAA	New Hanover, Brunswick, Columbus, Pender	$ 398,000
Cherokee County Health Department	Cherokee, Clay, Graham	$ 444,696
Cumberland County Hospital System, Inc.	Cumberland	$ 450,000
Eastern Carolina Council AAA	Carteret, Duplin, Greene, Lenoir, Craven, Onslow, Pamlico, Jones, Wayne	$ 802,000
Gaston Family Health Center	Gaston	$ 232,750
Guilford County Health Department	Guilford	$ 448,957
Isothermal Planning AAA	Rutherford, Cleveland, Polk, McDowell	$ 514,521
Lumber River Council of Governments	Robeson, Bladen, Hoke, Richmond and Scotland	$ 416,000
Martin-Tyrrell-Washington District Health Department	Washington, Martin, Tyrrell	$ 409,000
MedAssist	Mecklenburg	$ 268,000
Mid-East Commission AAA	Beaufort, Bertie, Hertford and Pitt	$ 456,960
Mission St. Joseph	Buncombe, Madison, Yancey, Mitchell	$ 396,000
NC Commission of Indian Affairs	Bladen, Columbus, Cumberland, Harnett, Hoke, Sampson	$ 243,302
Piedmont Triad Council of Government AAA	Montgomery, Randolph	$ 145,000
Resources for Seniors, Inc.	Wake, Franklin, Johnston, Lee	$ 466,000
Rural Health Group, Inc.	Halifax, Northampton	$ 412,200
Senior PHARMAssist, Inc.	Durham	$ 208,000
The Hunger Coalition	Ashe, Avery, Watauga	$ 336,000
UNC School of Pharmacy (includes hotline)	Orange, Chatham	$ 256,846
Wilson Community Health Center	Wilson, Nash	$ 389,000
Winston-Salem Urban League*	Forsyth	$ 262,000
Total:		$ **8,700,000**

2/4/03

HWTFC COMMUNITY/SCHOOL GRANT AWARDS
TEEN TOBACCO USE PREVENTION AND CESSATION INITIATIVE

Organization Name	Counties Served	3-Year Budget
Alamance-Caswell Area MH/DD/SA Authority	Alamance, Caswell	$ 200,000
Ashe County Schools/Ashe County Health Council	Ashe	$ 199,640
Buncombe County Schools/Safe and Drug Free Schools	Buncombe	$ 299,727
Cancer Services of Gaston County, Inc.	Gaston	$ 170,000
Catawba County Public Health Department	Catawba	$ 294,000
Chatham County Health Department	Chatham	$ 219,046
Chowan Regional Health Care Foundation	Bertie, Chowan, Perquimans, Tyrrell, Washington	$ 300,000
Durham County Health Department	Durham	$ 287,156
FirstHealth of the Carolinas	Richmond, Hoke	$ 280,613
Guilford County Project ASSIST	Guilford	$ 210,000
Halifax County Schools	Halifax	$ 292,080
Hertford-Gates Health Agency	Hertford, Gates	$ 198,307
Macon County Public Health Center	Macon	$ 135,366
McDowell County Schools	McDowell	$ 285,000
Mecklenburg County Health Department	Mecklenburg	$ 300,000
Mitchell County Schools	Mitchell	$ 278,750
N.C. Amateur Sports/State Games of North Carolina	Statewide	$ 285,000
Orange County Health Department	Orange	$ 232,848
Public Schools of Robeson County	Robeson	$ 283,500
Rowan County Health Department	Rowan	$ 228,000
SAVE of NC GASP	Statewide	$ 210,000

HWTFC COMMUNITY/SCHOOL GRANT AWARDS
TEEN TOBACCO USE PREVENTION AND CESSATION INITIATIVE

Organization Name	Counties Served	3-Year Budget
Surry County Health and Nutrition Center	Surry	$ 272,346
Toe River Health District	Yancey	Budget combined with Mitchell Co. Schools
Tri-County Community Health Partnership	Cherokee, Clay, Graham	$ 150,000
Union County Public Schools	Union	$ 283,998
Watauga County Schools	Watauga	$ 300,000
Wilmington Health Acces for Teens, Inc. (WHAT)	37 counties in Eastern NC: Beaufort, Bertie, Bladen, Brunswick, Camden, Carteret, Chowan, Columbus, Craven, Currituck, Dare, Duplin, Edgecombe, Gates, Greene, Halifax, Hertford, Hyde, Johnston, Jones, Lenoir, Martin, Nash, New Hanover, Northampton, Onslow, Pamlico, Pasquotank, Pender, Perquimans, Pitt, Sampson, Tyrell, Warren, Washington, Wayne, Wilson	$ 418,000
Total:		**$ 6,707,377**

* Indicates funds requested for counter-marketing, which have been earmarked for use by the grantee, and transferred into the centrally managed media fund.

HWTFC PRIORITY POPULATIONS GRANT AWARDS
TEEN TOBACCO USE PREVENTION AND CESSATION INITIATIVE

Organization Name	3-Year Budget
El Pueblo	$ 465,000
North Carolina Commission on Indian Affairs	$ 475,000
General Baptist State Convention	$ 475,000
Old North State Medical Society	$ 785,000
Total 3 Year Allocation	**$ 2,200,000**

2/4/03

Charlotte.com

Posted on Tue, Jan. 21, 2003

The Charlotte Observer

Program will help needy get medicine

Anyone within income rules is eligible for new statefunded program

MIKE STOBBE
Staff Writer

Peggy Jones placed vial after vial of prescription medicine on the table, 10 in all.

Jones, 65, couldn't afford all the pills. She was prescribed most of them last month, after doctors diagnosed a heart problem. The first month's supplies were free, but the pills were almost gone and would cost several hundred dollars to refill.

So she went to see Suzanne Walshe, who coordinates a free prescription assistance program that started in Charlotte last week.

The program is designed to help in two ways. It enrolls patients in pharmaceutical company programs that provide brand-name medications to needy patients for free or at a discount. It will also use volunteer doctors to check for drug interactions in patients who take an assortment of pills.

Walshe, 26, met with Jones Friday and quickly sorted through the yellow vials.

Walshe placed six to one side. "These are the ones we'll be able to help you with," she said.

The new program is housed at MedAssist of Mecklenburg, a charitable pharmacy at 5516 Central Ave., (704) 536-1790.

The program's funding comes from North Carolina's Health and Wellness Trust Fund Commission, which controls a portion of the state's $160 million annual share of the national tobacco litigation settlement.

The commission devoted $9 million over the next three years to establish 23 N.C. prescription assistance centers. The funding includes $268,000 for a center in the Charlotte area, awarded to MedAssist.

MedAssist normally serves only seniors, but the new prescription assistance program will serve anyone who meets income guidelines. A single person may not make more than $1,477 monthly, a couple no more than $1,900 monthly.

"Seniors especially need help paying for their prescription drugs, but this grant also will help people of any age who cannot afford their medication," said Lt. Gov. Beverly Perdue, who chairs the Health and Wellness Trust Fund Commission.

Perdue is to speak at MedAssist this morning to officially launch the program.

Jones, a retired photo retoucher, went to Carolinas Medical Center last month for breathing problems and was diagnosed with congestive heart failure.

She spent five days in the hospital, emerging Christmas Eve with prescriptions for five new medications, including two heart pills, a pain pill, a fluid pill and a blood pressure medicine.

She already was on five others, including medicines for diabetes and a thyroid problem.

Jones and her husband, Tom, a retired box factory maintenance worker, have Medicare coverage, but it doesn't cover prescriptions. Her monthly income is $1,288, with no spare cash for the new medicines.

"I could never afford it. I'd get it and instead of taking it every day, I'd probably skip a day. That's the only way I could afford to take this medicine," Jones said.

Jones said she wants to help MedAssist get the word out. "I think it's a good thing for people. I told a couple of my friends about it," she said.

The News Reporter
Whiteville, NC
D - 9,959 S - NO DATA
November 14, 2002
Carolina Clipping Service
Raleigh, NC 27603

tion.

103 -1423C -224-15

Prescription assistance grant for seniors awarded

The North Carolina Health and Wellness Trust Fund Commission has announced a grant of $398,000 to Cape Fear Council of Government AAA for prescription assistance service covering New Hanover, Brunswick, Columbus and Pender counties.

The grant will provide assistance to seniors and low-income individuals of all ages in acquiring free, low cost or discounted medications. In addition, any senior can receive counseling on the safe and wise use of prescription drugs.

"Educating seniors about appropriate drug use is a unique feature of our State's prescription drug benefit program, Senior Care. Seniors especially need help paying for their prescription drugs, but this grant also will help people of any age who cannot afford their medication. This innovative medical management program will help all our seniors get the proper treatment they need and deserve. It is a real win for North Carolina's communities and our elderly," said Lieutenant Governor Beverly Perdue, chair of the Health and Wellness Trust Fund Commission.

Funded organizations will contract with local pharmacists to counsel seniors in identifying drug utilization issues such as drug-to-drug interactions and duplicative therapies. Seniors who are eligible for Senior Care will receive counseling services at no cost. Other seniors will be able to use the service through payment of a minimal fee, based upon ability to pay.

Under this initiative, 23 new and existing community-based programs were selected by the Commission to receive a total of approximately $3 million annually. In awarding these grants, the Commission gave priority to organizations proposing to serve diverse populations, ensured geographic dispersion, and building capacity within local communities to response to area health needs.

The Health and Wellness Trust Fund Commission was established by the General Assembly to receive and allocate 25 percent of North Carolina's share of the multi-billion dollar national tobacco settlement agreement reached in 1999. The Commission is comprised of 18 individuals representing a wide background of health care experience throughout North Carolina.

The Wallace Enterprise
Wallace, NC
D - 7,020 S - NO DATA
November 14, 2002
Carolina Clipping Service
Raleigh, NC 27603

30-16-224 (142)

2

Local Organizations Awarded Prescription Assistance Grant for Seniors

The North Carolina Health and Wellness Trust Fund Commission today announced a grant of $802,000 to Eastern Carolina Council AAA for prescription assistance services covering Carteret, Duplin, Greene, Lenoir, Craven, Onslow, Pamlico, Jones and Wayne counties. The grant will provide assistance to seniors and low-income individuals of all ages in acquiring free, low cost or discounted medications. In addition, any senior can receive counseling on the safe and wise use of prescription drugs.

"Educating seniors about appropriate drug use is a unique feature of our State's prescription drug benefit program, Senior Care. Seniors especially need help paying for their prescription drugs, but this grant also will help people of any age who cannot afford their medication. This innovative medical management program will help all our seniors get the proper treatment they need and deserve. It is a reality in North Carolina's communities and for elderly," said Lieutenant Governor Beverly Perdue, chair of the Health and Wellness Trust Fund Commission.

Funded organizations will contract with local pharmacists to counsel seniors in identifying drug utilization issues such as drug-to-drug interactions and duplicative therapies. Seniors who are eligible for Senior Care will receive counseling services at no cost. Other seniors will be able to use the service through payment of a minimal fee, based upon ability to pay.

Under this initiative, 23 new and existing community-based programs were selected by the Commission to receive a total of approximately $3 million annually. In awarding these grants, the Commission gave priority to organizations proposing to serve diverse populations, ensured geographic dispersion, and building capacity within local communities to respond to area health needs.

The Health and Wellness Trust Fund Commission was established by the General Assembly to receive and allocate 25% of North Carolina's share of the multi-billion dollar national tobacco settlement agreement reached in 1999. The Commission is comprised of 18 individuals representing a wide background of health care experience throughout North Carolina.

AD

Black Mountain News
Black Mountain, NC
D - 3,550 S - NO DATA
November 21, 2002
Carolina Clipping Service
Raleigh, NC 27603

143

Community Notes

Local organizations awarded impressive prescription assistance grant for seniors

From Staff Reports

The North Carolina Health and Wellness Trust Fund Commission announced a grant of $396,000 to Mission St. Joseph for prescription assistance services covering Buncombe, Madison, Yancey and Mitchell counties. The grant will provide assistance to seniors and low-income individuals of all ages in acquiring free, low cost or discounted medications. In addition, any senior can receive counseling on the safe and wise use of prescription drugs.

"Educating seniors about appropriate drug use is a unique feature of our state's prescription drug benefit program, "Senior Care." Seniors especially need help paying for their prescription drugs, but this grant also will help all our seniors get the proper treatment they need and deserve. It is a real win for North Carolina's communities and our elderly," said Lieutenant Governor Beverly Perdue, chair of the Health and Wellness Trust Fund Commission.

Funded organizations will contract with local pharmacists to counsel seniors in identifying drug utilization issues such as drug-to-drug interactions and duplicative therapies. Seniors who are eligible for "Senior Care" will receive counseling services at no cost. Other seniors will be able to use the service through payment of a minimal fee, based upon ability to pay.

Under the initiative, 23 new and existing community-based programs were selected by the commission to receive a total of approximately $3 million annually. In awarding these grants, the Commission gave priority to organizations proposing to serve diverse populations, ensured geographic dispersion, and building capacity within local communities to respond to area health needs.

The Health and Wellness Trust Fund Commission was established by the General Assembly to receive and allocate 25 percent of North Carolina's share of the multi-billion dollar national tobacco settlement agreement reached in 1999. The commission is comprised of 18 individuals representing a wide background of health care experience throughout North Carolina.

Carolina Times
Durham, NC
D - 5,823 S - NO DATA
December 7, 2002
Carolina Clipping Service
Raleigh, NC 27603

142

Local Organization Awarded Prescription Assistance Grant for Seniors

RALEIGH - The North Carolina Health and Wellness Trust Fund Commission Nov. 7 announced a grant of $208,000 to Senior PHARMAssist, Inc. for prescription assistance services covering Durham County. The grant will provide assistance to seniors and low-income individuals of all ages in acquiring free, low cost or discounted medications. In addition, any senior can receive counseling on the safe and wise use of prescription drugs.

"Educating seniors about appropriate drug use is feature of our State's prescription drug benefit program, *Senior Care*. Seniors especially need help for their prescription drugs, but this grant also will help people of any age who cannot afford their medication. This innovative medical management program will help all our seniors get the proper treatment they need and deserve. It is real win for North Carolina's communities and our elderly." Said Lieutenant Governor Beverly Perdue, chair of the Health and Wellness Trust Fun Commission.

Funded organizations will contract with local pharmacist to counsel seniors in identifying drug utilization issues such as drug-to-drug interaction and duplicative therapies. Seniors who are eligible for Senior Care will receive counseling services at no cost. Other seniors will be able to use the service through payment of a minimal fee, based upon ability to pay.

Under this initiative, 23 new and existing community-based programs were selected by the Commission to receive a total of approximately $5 million annually. In awarding these grants, the Commission gave priority to organizations proposing to serve diverse populations, ensured geographic dispersion, and building capacity within local communities to respond to area health needs.

The Health and Wellness Trust Fund was established by the General Assembly to receive and allocate 25% of North Carolina's share of the multi-billion dollar national tobacco settlement agreement reached in 1999. The Commission is comprised of 18 individual representing a wide background of health care experience throughout North Carolina.

$8 million in grants announced to combat teen tobacco use

Winston – Salem Chronicle
Winston – Salem, NC
D – 5,818 S – NO DATA
August 29, 2002

SPECIAL TO THE CHRONICLE

The Health and Wellness Trust Fund Commission has announced the availability of $8 million in grants for community-based programs to dissuade North Carolina teens from using tobacco products.

These grants constitute the initial phase of an $18.6 million, three-year initiative that will employ multiple strategies to promote tobacco prevention and cessation among teens statewide.

"We're breaking new ground by investing state resources on this issue in North Carolina," said Lt. Gov. Beverly Perdue, who chairs the commission. "People understand that teens are a vulnerable segment of the population, and that with nearly 40 percent of North Carolina high school students already using tobacco, it is a problem that must be addressed right now."

According to the Centers for Disease Control (CDC), more than 90 percent of first-time tobacco use occurs before age 20, with the average age of initiation being 13. The health effects of prolonged tobacco use among the general population are well documented, and studies by the CDC show that African-Americans suffer disproportionately high rates of heart disease, stroke and lung cancer.

The commission has followed the CDC's guidelines in structuring its overall plan, which includes the effective use of media as well as cessation services and programs designed to help teens who want to quit using tobacco be successful.

The commission last week released two separate requests for proposals. The Community/Schools Prevention Programs Initiative will award between 20 and 30 grants, at an annual level of $25,000 to $100,000 each for three years, for local coalitions capable of organizing and managing tobacco prevention programs for teens. These coalitions will be made up of entities such as schools, public health agencies, local governments, faith-based organizations, state agencies and nonprofit organizations.

Additionally, the Priority Populations Initiative will provide $700,000 annually for three years, to fund three organizations or partnerships capable of projecting statewide reach to address disparities in the use of tobacco by African-American, Native American and Hispanic/Latino youths in North Carolina.

Applicants can obtain a copy of both requests for proposals and application forms online at www.HWTFC.org or by contacting the commission directly.

The Health and Wellness Trust Fund was established by the General Assembly to receive and allocate 25 percent of North Carolina's share of the multibillion dollar national tobacco settlement agreement reached in 1999. The commission is made up of 18 individuals representing a wide background of health-care experience throughout North Carolina.

Charlotte Post
Charlotte, NC
D - 16,900 S - NO DATA
August 29, 2002
Carolina Clipping Service
Raleigh NC 27603

N.C. settlement money targets youth tobacco usage

By Herbert L. White
THE CHARLOTTE POST

Part of an N.C. grant to curb teen tobacco use specifically targets African Americans.

The Health and Wellness Trust Fund Commission has made available $8 million in grants for community-based programs to dissuade teens from using tobacco products. The grants constitute the first phase of an $18.6 million, three-year initiative. "We're breaking new ground by investing state resources on this issue in North Carolina," said Lt. Gov. Beverly Perdue, who chairs the commission. "People understand that teens are a vulnerable segment of the population, and that with nearly 40 percent of North Carolina high school students already using tobacco, it is a problem that must be addressed right now."

Perdue

The Health and Wellness Trust Fund was established by the General Assembly to receive and allocate 25 percent of North Carolina's share of the multi-billion dollar national tobacco settlement agreement reached in 1999.

According to the U.S. Centers for Disease Control, over 90 percent of first-time tobacco use occurs before age 20, with the average age of initiation being 13. The health effects of prolonged tobacco use among the general population are well documented, and studies by the CDC show that African Americans suffer dis-

Please see GRANTS/6A

Continued from page 1A

proportionately high rates of heart disease, stroke and lung cancer. The Commission has followed the CDC's guidelines in structuring its overall plan, which includes the effective use of media as well as cessation services and programs designed to help teens who want to quit using tobacco be successful.

The commission has released two requests for proposals. The Community/Schools Prevention Programs Initiative will award up to 30 grants ranging from $25,000 to $100,000 each for three years, for local coalitions to manage tobacco prevention programs.

The Priority Populations Initiative will provide $700,000 annually for three years, to fund three organizations or partnerships capable of projecting statewide reach to address disparities in the use of tobacco by African-American, Native American and Latino kids.

Applicants can obtain a copy of both requests for proposals and applications online at www.HWTFC.org.

Opinion

Published on: 2002-12-29

A Good Start

State finally begins anti-smoking efforts

Tobacco has put a lot of North Carolina's children through school. It's put food on the table, kept a roof over countless heads. Since King Cotton died, tobacco has been Tar Heel farmers' last best chance at survival; and in some parts of the state, cigarette manufacturers remain one of the major industries.

So it's little wonder that this state has long wrestled with the issue of smoking-cessation programs, and almost invariably, tobacco won. But as tobacco production declines and science paints an increasingly accurate picture of tobacco's impact on human health, North Carolina finally is joining other states in efforts to prevent our children from becoming smokers. It's a modest start, but at this point, any effort is welcome, and any start at all is a positive step.

The N.C. Health and Wellness Trust Fund Commission has given 31 grants, worth nearly $9 million, for programs designed to prevent teen smoking. The bulk of the grants went to 27 local groups - school districts, health departments and community organizations. About $2.2 million will fund efforts to reach African American, Hispanic and American Indian teens. The fund also will spend $1.2 million a year on anti-smoking media efforts and $500,000 a year for additional enforcement of laws prohibiting sale of tobacco to minors.

Credit for the anti-smoking effort goes to Lt. Gov. Beverly Perdue, who chairs the Health and Wellness Fund and who is the first major political figure in the state to make a successful effort to fund anti-smoking programs.

The fund receives 25 percent of the state's proceeds from the national tobacco settlement, and until now, it's been a major embarrassment that none of it has been used to fund smoking-cessation efforts. The new programs are a welcome change, but can't be seen as anything more than a starter, a door-opener. This state loses huge sums every year to the health costs related to smoking, and as other states have already learned, large and aggressive stop-smoking programs pay great dividends in reduced health-care costs and less lost time among employees.

We applaud the Health and Wellness Trust Fund's first anti-smoking initiative, and urge the fund to pursue more aggressive programs in the future.

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Contact Us

THE NEWS & OBSERVER
SUNDAY, DECEMBER 1, 2002

Up in smoke

The poverty of anti-smoking programs is unsettling as other uses are found for the national tobacco settlement's millions.

Billions due from the national legal settlement with tobacco companies — once widely believed to be the ticket to a smoke-free America — turn out to be a slush fund. Only three of the 46 states that signed the deal are spending significant amounts of their payments to cut tobacco use and reduce smoking-related disease, according to a recent N&O article.

Instead, the money is defraying legal costs from a Los Angeles police scandal, financing a video history of tobacco growing in North Carolina and buying a sprinkler system for a public golf course in upstate New York, to cite a few examples.

Squandered resources are always disturbing. But the mass defection from the settlement's purposes is more upsetting because, to receive those payments, the states traded off their rights and those of their localities to sue cigarette companies for the damage caused by smoking.

The consolation for losing that option might have been that the industry would help pay to prevent future suffering. That hasn't happened as quickly as many had hoped, largely because a faltering economy has sent state tax revenues plummeting and politicians scrambling to keep services up and running.

Yet if the nation's poorest state, Mississippi, can provide adequate funding for smoking prevention, as can Maine and Minnesota, it's a mystery why North Carolina and others can't. A commitment is needed from state leaders to increase funding regularly until health officials can mount a truly aggressive campaign.

Half of North Carolina's share of the settlement money goes to the Golden LEAF Foundation, which makes grants to develop economic alternatives to tobacco. The other half of the money is split between tobacco growers and the Health and Wellness Trust Fund, which has been spending it to help seniors pay for prescription drugs. Those are worthwhile programs, but until now, anti-smoking programs have been an after-thought.

At last, the current budget sets aside $6.2 million from the settlement for prevention, as budgets for the next two years also are expected to do. And the state is receiving another $3.2 million from federal and private sources for anti-smoking efforts. While that's better than many states have done, it's a fraction of the $43 million minimum funding recommended by the Centers for Disease Control.

Nor has North Carolina chosen to raise its cigarette tax, a move that 19 other states have made this year, from its extremely modest 5 cents per pack. Higher prices could well have helped depress smoking rates among young people with less money to burn. Instead, it's estimated that 38,000 Tar Heel teenagers take up smoking every year.

In fact, cigarette sales have fallen nationally, due in some measure to tax hikes. Under terms of the settlement, declining sales are expected to reduce the payment to the state by 17 percent next year. North Carolina loses all the way around. For the state to be a winner, our leaders must renew their resolve to awaken people to the dangers of smoking and to relieve economic dependence on tobacco. Their example then would be one for other states to follow.

N+O
12/30/02

Policy smoke signals

Stipulated: North Carolina residents will benefit by a decision by the Health and Wellness Trust Fund Commission to spend $3 million a year on programs to combat obesity. Like the rest of the nation, residents here are adding pounds at a dangerous rate, especially children.

Raising awareness of the serious, long-term health dangers of obesity and reversing the trend will add years to North Carolinians' lives and can save untold tax dollars that otherwise would be spent on treating diabetes, stroke, heart ailments and other illnesses caused by overeating.

Yet the commission fails the state by spending far too little on stop-smoking efforts. Indeed, smoking-related health problems should be the point of the commission. The legislature created it as a result of North Carolina's 1998 settlement with tobacco companies, and designated 25 percent of the $4.6 billion the state will receive over 25 years as its funding source.

Maybe the commission would have spent more than $18.6 million on stop-smoking programs so far had Governor Easley not taken part of its proceeds last year to close a budget shortfall. That should discourage state legislators, hunting for money to fill another big budget hole next year, from raiding the fund again. Doing so defeats its purpose. Trust fund commissioners also dedicated $105 million last year to a three-year prescription drug program for the elderly. Ideally, that important benefit would have come out of the national treasury — and could have been a more robust program had Congress and the Bush administration made it a priority.

Still, smoking prevention and cessation needs to be a focus for state government. The U.S. Centers for Disease Control and Prevention says smoking costs North Carolina $4.75 billion annually in health-care expenses and lost productivity. More than 24,000 North Carolina children become regular, daily smokers each year, which surpasses the national rate. The CDC estimates the state needs to spend at least $43 million a year on tobacco-control efforts.

Stipulated: Lt. Governor Beverly Perdue's recent prediction — that the trust fund, of which she is the chairwoman, will develop into a policy-making board — is on target. Any public body that controls so large a pot of money inevitably will steer policy. Its members need to consider setting anti-tobacco programs as their North Star.

Obesity war

Panel carries its battle a step further

Recent word of funding commitments to combat obesity comes appropriately at a time when many individuals are contemplating personal resolutions to the same end. It's appropriate, not just because it's New Year's, but because it's serious business.

The state Health and Wellness Trust Fund Commission recently placed obesity prevention on its list of projects. The commission, which acts as steward for funds coming to the state from its share of the national tobacco settlement, has earmarked a small portion of this money — $3 million a year — for obesity-fighting projects and another $1 million for research. The commission's move follows recent warnings from both the federal Centers for Disease Control and Prevention and the state Division of Public Health about growing national concerns over obesity.

The CDC says the percentage of overweight children has doubled in the last 20 years.

These sources indicate that obesity contributes to as many as 300,000 premature deaths each year. Being overweight increases chances for diabetes, heart disease, stroke, high blood pressure and cancer. A CDC study out this week reports that both obesity and diabetes rates nationally continued to climb in 2001.

According to the state health department, 60 percent of North Carolina adults are overweight or obese. And a recent East Carolina University test showed that 55 percent of all fourth-graders in one eastern North Carolina county were either overweight or obese. The CDC says the percentage of overweight children has doubled in the last 20 years.

The commission is doing the right thing to target this problem, although in light of these statistics the question might be asked: Is it enough? And this question becomes more ominous when we think of the weight-related problems burgeoning among children. It's problem enough when adults must fight to stay healthy, but the ramifications of a generation or more of overweight and unhealthy children are more than sobering.

As the commission gets down to specifics over the next few months to decide exactly how to use this funding, its challenge will be to find approaches that are dramatic and aggressive. It's easy to talk about losing weight and being healthy. But as anyone who has ever resolved at New Year's to get fit, it's quite another thing to just do it.

The commission's work can help with this struggle.

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State's trust fund money well-spent on battling growing obesity in kids

By Asheville Citizen-Times
POSTED: Jan. 3, 2003 3:21 p.m.

There is no greater health problem in the United States than obesity. Teaching young people the importance of weight control and exercise is a smart use of $3 million in state Health and Wellness Trust Fund money.

Nearly two out of every three adults, 64 percent, were overweight in 2000, according to the National Center for Health Statistics. Nearly half that group, or 31 percent of the total, was obese. A person 5-feet-7 is overweight at 160 pounds and obese at 192 while someone 5-feet-11 is overweight at 179 and obese at 215.

In North Carolina, nearly 60 percent of adults are overweight, according to the state Health Department.

That is a bit better than the national figure, but nothing to brag about. "The problem keeps getting worse," said Tommy G. Thompson, secretary of the U.S. Department of Health and Human Services. "We've seen a virtual doubling in the number of obese persons over the past two decades and this has profound health implications."

Among the health risks associated with obesity are high blood pressure, high cholesterol, Type 2 diabetes and other insulin-related problems, heart disease, stroke, gallstones, gout, osteoarthritis, respiratory problems, some cancers, complications of pregnancy, female reproductive problems, bladder control problems, kidney disorders and psychological problems.

"Overweight and obesity may soon cause as much preventable disease and death as cigarette smoking," said Surgeon General David Satcher. "People tend to think of overweight and obesity as strictly a personal matter, but there is much that communities can and should do to address these problems."

Some 300,000 U.S. deaths a year are associated with obesity and overweight, as compared with more than 400,000 associated with cigarette smoking. The total direct and indirect costs attributable to overweight and obesity in 2000 amounted to $117 billion.

The weight figures for children, as measured by the Centers for Disease Control and Prevention growth charts, may sound better, in that only 15 percent of children are overweight, but they aren't, because the trend is alarming. This is three times the percentage in 1980.

More than 10 percent of preschoolers older than age 2 are overweight. Rates of 20 percent or more are reported for Mexican-American and African-American

school-age children.

"One of the most significant concerns from a public health perspective is that we know a lot of children who are overweight grow up to be overweight or obese adults, and thus at greater risk for some major health problems," said Dr. Julie Gerberding, CDC director. "One critical answer to this problem is that we all must work together to help our children make physical activity a life-long habit."

That is how Laurel Broadbent, a Weaverville physician, hopes most of the $3 million in state trust-fund money, which comes from the national tobacco settlement, will be used. "If those of us in our 40s don't know better by now, you're not going to reach us," she said. "But you can catch the next generation."

The state Public Health Division is leading a Healthy Weight Initiative seeking to get children to exercise more and eat sensibly.

In addition to the $3 million to combat obesity, the Health and Wellness Trust Fund Commission plans to spend $1 million a year for two years on research, said Dr. Charles Wilson, a medical professor at East Carolina University and a commission member. Broadbent says she hopes some of that money will be used to seek causes.

"I'm not saying we'll ever find a pill that will prevent or cure it, but we may understand why some people are more prone to it than others, and intervene before it becomes a threat to health."

Some people undoubtedly are obese due to a genetic or medical condition, but in most case it is simply because they eat too much and don't exercise enough. Saying that, however, does not mean that losing weight and keeping it off is simply a matter of willpower. Guidelines issued by the National Institutes of Health stress the importance of behavioral therapy in treating obesity, and in some cases recommend medications or surgery.

The trust fund commission has been basically a grant-making agency,but its chairman, Lt. Gov. Beverly Perdue, wants to see it making policy decisions. "You'll see the commission, I believe ... trying to lead the state in the conversation and the decision-making about health care and health status of our citizens."

Given the perils posed by the obesity epidemic, reaching out to North Carolina's young is an excellent place to start.

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N+O 12/26/02

Health fund wants state to slim down

Fighting obesity is priority in 2003

By Lynn Bonner
STAFF WRITER

The Health and Wellness Trust Fund Commission has placed preventing obesity and protecting its money at the top of its 2003 priority list.

The decision to set aside $3 million a year for projects aimed at combating obesity and an additional $1 million for research comes as the commission continues to refine its goals.

Its two major commitments, a three-year, $105 million prescription drug program for the elderly and a three-year, $18.6 million plan to combat youth smoking, will eat up most of the available money for the next few years.

The trust fund receives 25 percent of the money coming to the state from the national tobacco settlement. The commission's job is to use a portion of that money to dispense grants to health programs and state agencies. But its chairwoman, Lt. Gov. Beverly Perdue, wants the commission to be more than a group that hands out checks.

"You'll see the commission, I believe, become also a policy board in terms of trying to lead the state in the conversation and the decision-making about health care and health status of our citizens," she said.

With the decision to spend money to combat obesity, the commission joins several state and national agencies pushing weight loss as a health priority. The federal Centers for Disease Control and Prevention and the state Division of Public Health have been warning about health risks associated with obesity, such as heart disease and a form of diabetes.

The Public Health Division is leading a Healthy Weight Initiative aimed at getting children to exercise more and eat healthy food. Nearly 60 percent of North Carolina adults are overweight or obese, according to the state health department. The CDC says the percentage of overweight children has doubled in the past 20 years.

Within the next few months, commission members will discuss how they will use the trust fund to tackle obesity. In addition, the commission will spend

SEE **HEALTH FUND**, PAGE 10B

HEALTH FUND

CONTINUED FROM PAGE 1B

$1 million a year for two years on research, said Dr. Charles Willson, a commission member who is on the medical school faculty at East Carolina University in Greenville.

The commission hasn't decided what kinds of research to support, but Willson said the grants could yield important information about health problems related to lifestyle.

"There are definitely some things that could be done for less than $1 million," he said. "If we could link the obesity project to research as well, I think that we could really have something that could really be fruitful."

As the commission drafts its blueprint, the weight of the state's financial problems — and the possibility that the commission could lose control of some of the trust fund money — hangs around its neck.

Last April, Gov. Mike Easley intercepted $30 million headed for the trust fund to help close the state's budget gap. Legislators scrounging for money to address next year's shortfall might turn again to the trust fund, or the interest building in its account, to help shore up the budget.

Perdue told the commission members that they will soon begin another campaign to persuade the legislature to stay out of the trust fund account.

"We have to start this battle all over again, y'all," she said.

Staff writer Lynn Bonner can be reached at 829-4821 or at lbonner@newsobserver.com.

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2003

HOUSE BILL 669

Short Title:	Hospital Licensure/Critical Access Hospital.	(Public)
Sponsors:	Representative Wright.	
Referred to:	Health.	

March 26, 2003

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. 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.~~ meet the requirements of federal law for certification as a critical access hospital. 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 669:
Hospital Licensure/Critical Care Access Hospital

BILL ANALYSIS

Committee:	House Health	**Introduced by:**	Rep. Wright
Date:	April 8, 2003	**Summary by:**	Linda Attarian
Version:	Introduced		Committee Counsel

SUMMARY: ***House Bill 669 would amend the definition of "primary care hospital" in Article 5, of Chapter 131E, governing the licensure of hospitals. The change is necessary to conform the definition to changes in federal law that has resulted in the conversion of "primary care" hospitals to "critical access" hospitals. The bill is identical to House Bill 1001, introduced by Rep. Wright during the 2001 General Session. H1001 received a favorable report by the House Health Committee on April 19, 2001, and passed the full House on April 25, 2001. The act is effective when it becomes law.***

CURRENT LAW: Under current law, the Department of Health and Human Services, Office of Rural Health and Resource Development designates a hospital as a "primary care hospital" if the hospital:

- Is located in a rural community;
- Provides primary care inpatient services that do not include inpatient surgery;
- Provides outpatient services that may include outpatient surgery;
- Has a maximum average daily census of 15 patients;
- May have distinct long-term care or psychiatric units;
- Be a part of a rural care network that includes a larger hospital.

These primary care hospitals are likely to meet the conditions necessary to be certified under federal law as a critical access hospital and as a result the current definition is out of date.

BILL ANALYSIS: The bill makes the following changes to G.S. 131E-76:

- Deletes the term "primary care hospital" and replaces it with "critical care access hospital";
- Provides that to be a critical access hospital must meet the requirements of federal law to become certified; and
- Offer primary outpatient services, 24-hour emergency services, and be a member of a rural hospital network.

Effective when it becomes law.

BACKGROUND:

Rural hospitals are very dependent on Medicare and Medicaid reimbursement dollars. Some rural hospitals rely on Medicare to pay for 60 to 80 percent of the health care services provided. When Congress made changes to the Medicare program in the mid 1980, small rural hospitals were particularly hard hit. Congress established the Critical Access Program through the Balanced Budget Act of 1997. A critical access hospital is not very different from other hospitals, but Medicare uses a different method to pay a critical access hospital for services that is used for larger hospitals. A critical access hospital 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. Rural hospitals are not required to convert to critical access hospitals, but the improved reimbursement method is designed to allow rural communities to convert an

existing general hospital to a critical access hospital to preserve access to primary care and emergency health care services by improving the financial health of the hospital.

2003 COMMITTEE REPORT
HOUSE OF REPRESENTATIVES

The following report(s) from standing committee(s) is/are presented:
By Representatives **Verla Insko and Carolyn Justus** (Chairs) for the Committee on **HEALTH**.

☐ Committee Substitute for
H.B. 669 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 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)

03/19/03

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2003

HOUSE BILL 172*

Short Title:	Local LTC Planning Pilot Project.	(Public)
Sponsors:	Representatives Insko, Earle (Primary Sponsors); Adams, McLawhorn, Nye, Sutton, and Warren.	
Referred to:	Health, if favorable, Appropriations.	

March 3, 2003

A BILL TO BE ENTITLED

AN ACT TO IMPLEMENT A PILOT PROJECT FOR LOCAL LONG-TERM CARE PLANNING.

The General Assembly of North Carolina enacts:

SECTION 1. In response to Recommendation #16 in the final report from the Institute of Medicine Task Force on Long-Term Care and the study report recommendations resulting from S.L. 2001-491, Part XXII, the Department of Health and Human Services shall implement a communications and planning initiative to support local planning for long-term care and shall pilot the establishment of local lead agencies to facilitate the long-term care planning process at the county or regional level. For those counties that voluntarily participate, the local long-term care planning initiative shall aid in the development of core services, coordinate local planning, and streamline access to services. The initiative shall eliminate fragmentation and barriers to information and services; provide a seamless connection among State agencies and local entities, regardless of funding sources; and allow consumers to efficiently and effectively navigate among long-term care services.

SECTION 2. The Department shall submit an interim report on the pilot project for local long-term care planning to the North Carolina Study Commission on Aging by October 1, 2004, and a final report by October 1, 2005.

SECTION 3. There is appropriated to the Department of Health and Human Services the sum of seventy thousand dollars ($70,000) for the 2003-2004 fiscal year and ninety thousand dollars ($90,000) for the 2004-2005 fiscal year to fund the pilot project established in this act.

SECTION 4. This act becomes effective July 1, 2003.

HOUSE BILL 172:
Local LTC Planning Pilot Project

BILL ANALYSIS

Committee:	House Health	**Introduced by:**	Reps. Insko, Earle
Date:	April 8, 2003	**Summary by:**	Dianna Jessup
Version:	First Edition		Committee Counsel

SUMMARY: ***House Bill 172 would appropriate funds to the Department of Health and Human Resources to implement a pilot project for local long-term care planning. The bill would become effective July 1, 2003.***

CURRENT LAW: Currently, there are a variety of groups and agencies responsible for different aspects of long term care services for older and disabled adults at the county level, including CAP-DA boards, social service boards, area mental health, developmental disabilities, and substance abuse boards, and aging planning bodies. In addition, may counties have Healthy Carolinians Task Forces and Mayors' and Local Committees for People with Disabilities. Each of these local long-term care planning bodies operate under different funding sources. While some local planning bodies work well together to accomplish similar goals, planning at the local level is generally not coordinated.

BILL ANALYSIS: **Section 1** of the bill would require the Department of Health and Human Services (DHHS) to implement a communications and planning initiative to support local planning for long-term care and to pilot the establishment of local lead agencies to facilitate the long-term care planning process at the county or regional level. The local long-term care planning initiative (Initiative) would aid participating counties with: (1) the development of core services, (2) the coordination of local planning and (3) streamlining access to services. The Initiative would do the following:

1. Eliminate fragmentation and barriers to information and services;
2. Provide a seamless connection among State agencies and local entities, regardless of funding sources; and
3. Allow consumers to efficiently and effectively navigate among long-term care services.

Section 2 of the bill would require DHHS to submit an interim report on the pilot project for local long-term care planning to the North Carolina Study Commission on Aging by October 1, 2004, and a final report by October 1, 2005.
Section 3 of the bill would appropriate $70,000 for FY 2003-2004 and $90,000 for FY 2004-2005 to DHHS to fund the pilot project.
Section 4 of the bill would make the bill become effective July 1, 2003.

BACKGROUND: This bill is a recommendation from the North Carolina Study Commission on Aging (Commission) to the 2003 General Assembly. The Commission recommended to the 2001 General Assembly that DHHS conduct a study based on the Institute of Medicine's (IOM) Long-Term Care Task Force finding that "long-term care services are often fragmented, duplicative, complex, and not consumer-friendly and that many counties lack needed core long-term care services." In response to the Commission's recommendation, the General Assembly directed DHHS in the 2001 Studies Bill (S.L. 2001-491, Part XXII) to study whether counties should designate local lead agencies to organize a local long-term care planning process, as described in Recommendation #16 of the IOM Long-Term Care Task Force final report in January 2001. The IOM had recommended that the General Assembly should

encourage county commissioners to designate a lead agency to organize a local long-term care planning process at the county or regional level and suggested how local planning processes should be organized. The Commission heard presentations from DHHS regarding their report in response to S.L. 2001-491, Part XXII and recommended that the General Assembly fund a pilot project on long-term care local lead agencies.

Amy Compeau, Research Assistant, contributed to this summary.

H172-SMSW-001

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ATTACHMENT X

NORTH CAROLINA GENERAL ASSEMBLY AMENDMENT

(Please type or use ballpoint pen)

EDITION No. _____

H. B. No. 112 DATE 4/8/03

S. B. No. _____ Amendment No. 1
(to be filled in by Principal Clerk)

COMMITTEE SUBSTITUTE _____

Rep.) Insko
)
Sen.)

moves to amend the bill on page 1, line s 2-3

( ) WHICH CHANGES THE TITLE

by rewriting the lines to read:

"AN ACT TO IMPLEMENT A PILOT PROJECT FOR LONG-TERM CARE COMMUNITY SERVICE COORDINATION." ; and

on page 1, lines 8, by deleting "planning" and substituting "coordination"; and

on page 1, line 9, by deleting "planning for" and substituting "Coordinator of"; and

on page 1, lines 10-11, by deleting "planning" wherever it occurs and substituting "coordinator"; and

on page 1, line 12, by deleting "planning," and substituting "services,"; and

on page 1, line 18 by deleting "planning" and substituting "coordinator"; and

on page 1, lines 20-24, by rewriting the lines to read:

"SECTION 3. This act becomes effective July 1, 2003."

SIGNED Ursula Insko

ADOPTED _____ FAILED _____ TABLED _____

ATTACHMENT XI

2003 COMMITTEE REPORT
HOUSE OF REPRESENTATIVES

The following report(s) from standing committee(s) is/are presented:
By Representatives **Verla Insko and Carolyn Justus** (Chairs) for the Committee on **HEALTH**.

☐ Committee Substitute for
H.B. 172 A BILL TO BE ENTITLED AN ACT TO IMPLEMENT A PILOT PROJECT FOR LOCAL LONG-TERM CARE PLANNING.

☐ 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 Approp.)

☐ 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)

03/19/03

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2003

H 1

HOUSE BILL 155*

Short Title:	LTC Workforce Improvement Program.	(Public)
Sponsors:	Representatives Warren, Earle (Primary Sponsors); Nye, Insko, and Weiss.	
Referred to:	Health, if favorable, Appropriations.	

March 3, 2003

A BILL TO BE ENTITLED

AN ACT TO IMPLEMENT A LONG-TERM CARE WORKFORCE IMPROVEMENT PROGRAM FOR DIRECT CARE WORKERS EMPLOYED BY ADULT CARE HOMES AND HOME CARE AGENCIES IN AN EFFORT TO INCREASE SKILL LEVELS, JOB SATISFACTION, AND RETENTION RATES.

The General Assembly of North Carolina enacts:

SECTION 1. The Department of Health and Human Services shall implement the Workforce Improvement for Nursing Assistants: Supporting Training, Education, and Payment for Upgrading Performance (WIN A STEP UP) program, or a similar workforce improvement program, for direct care workers employed by adult care homes and home care agencies.

SECTION 2. The Department shall monitor the progress of direct care workers participating in this program and shall make an interim report on program outcomes to the North Carolina Study Commission on Aging by October 1, 2004, and a final report by October 1, 2005. The reports shall include the change in skill base and the level of job satisfaction of program participants employed by adult care homes and home care agencies as compared to those participants employed by nursing homes that participate in the WIN A STEP UP program. The report shall also include turnover rates for program participants as compared to the general direct care population, as well as a measure of employers' satisfaction with the program, and whether employers increased wages or awarded retention bonuses to direct care workers following completion of the training.

SECTION 3. There is appropriated to the Department of Health and Human Services the sum of four hundred seventy-nine thousand five hundred sixty-five dollars ($479,565) for 500 participants for the 2003-2004 fiscal year and the sum of four hundred thirty thousand nine hundred ninety-nine dollars ($430,999) for the second group of 500 participants for the 2004-2005 fiscal year. The program shall be made

available to direct care employees of adult care homes and home care agencies employed in diverse settings and geographic locations across North Carolina.

SECTION 4. This act becomes effective July 1, 2003.

HOUSE BILL 155:
LTC Workforce Improvement Program

BILL ANALYSIS

Committee:	House Health	**Introduced by:**	Reps. Warren and Earle
Date:	April 8, 2003	**Summary by:**	Dianna Jessup
Version:	First Edition		Committee Counsel

SUMMARY: ***House Bill 155 is a recommendation of the North Carolina Study Commission on Aging. The bill would implement a workforce improvement program for direct care workers employed in adult care homes and home care situations similar to a workforce improvement program currently in place for nurse aides in nursing homes. The act would become effective July 1, 2003.***

BACKGROUND AND BILL ANALYSIS:

WIN-A-STEP-UP stands for Workforce Improvement for Nursing Assistants: Supporting Training, Education and Payment for Upgrading Performance. The UNC Institute on Aging offers the WIN-A-STEP-UP program WIN-A-STEP-UP is a workforce improvement program that includes continuing education and paymen incentives for nursing assistants. The program is designed to reduce turnover, and to enhance skill base whil providing incentives for continuing education. At least 570 nurse aides employed in nursing homes ar participating in the program. The program for nurse aides in nursing homes is paid for with civil penalty mone that can only be used for nursing homes. Nurse aides are direct care workers.

HOUSE BILL 155 would direct the Department of Health and Human Services (DHHS) to implement the WIN A-STEP-UP program, or a similar workforce improvement program, for direct care workers employed **by adul care homes and home care agencies**. The bill would appropriate funds to DHHS as follows:

- $479,565 for FY 2003-04 for 500 program participants; and
- $430,999 for FY 2004-05 for the second group of 500 program participants.

The program would be available to direct care employees of adult care homes and home care agencies employed in diverse settings and geographic locations across the State.

The bill would require DHHS to monitor the progress of workers participating in the program and make an interim report to the North Carolina Study Commission on Aging by October 1, 2004, and a final report by October 1, 2005. The reports shall include the following:

- A comparison of the change in skill base and level of job satisfaction of program participants to WIN-A-STEP-UP participants employed by nursing homes.
- A comparison of turnover rates for program participants to the general direct care population.
- A measure of employers' satisfaction with the program; and
- Whether employers increased wages or awarded retention bonuses to direct care workers following program completion.

DIRECT CARE WORKFORCE

HB 155 is a recommendation from the North Carolina Study Commission on Aging (Commission) to the 2003 General Assembly. The Commission heard a presentation from DHHS staff regarding the workforce issue. The Commission learned the following:

- The distribution of the direct care workforce in 2000 was 17% Personal and Home Care Aides, 25% Home Health Aides and 58% Nurse Aides, Orderlies, and Attendants.
- From the year 2000 to 2010, the direct care workforce will need 874,000 additional workers, or 1.2 million workers including replacements.
- The direct care workforce will grow by 36.3% between 2000 and 2010 while the overall workforce will grow by only 15.2% between 2000 and 2010.
- The median hourly wage for direct care workers in 2000 was $7.86/hr. or an annual salary of $16,349.

Amy Compeau, Research Assistant, substantially contributed to this summary.

H155-SMSW-001

2003 COMMITTEE REPORT
HOUSE OF REPRESENTATIVES

The following report(s) from standing committee(s) is/are presented:
By Representatives **Verla Insko and Carolyn Justus** (Chairs) for the Committee on **HEALTH**.

☐ Committee Substitute for
H.B. 155 A BILL TO BE ENTITLED AN ACT TO IMPLEMENT A LONG-TERM CARE WORKFORCE IMPROVEMENT PROGRAM FOR DIRECT CARE WORKERS EMPLOYED BY ADULT CARE HOMES AND HOME CARE AGENCIES IN AN EFFORT TO INCREASE SKILL LEVELS, JOB SATISFACTION, AND RETENTION RATES.

☐ 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)

03/19/03

House Committee on Health

April 9, 2003

Minutes

The House Committee on Health met on Wednesday, April 9, 2003 at 12:00 noon in Room 1228 of the Legislative Building. A silent roll was taken. A copy of the roll denoting members present is attached to the minutes (Attachment I) along with a copy of the agenda and Visitor Registration Sheet (Attachments II and III).

Chair Insko welcomed members and visitors. Bob Fowler and Jackson Stancil were recognized as the sergeant-at-arms. (Note: no pages were present)

Chair Insko recognized Rep. Joe Tolson to explain his bill HB 551 A BILL TO BE ENTITLED AN ACT TO UPDATE THE LAWS RELATING TO THE ATTENDANCE AGES AND ELIGIBILITY OF STUDENTS FOR NORTH CAROLINA SCHOOLS FOR THE DEAF. (Attachment IV) Rep. Tolson advised he had added a technical amendment and a proposed committee substitute was passed out to members (Attachment V) Rep. Gordon Allen made motion to accept the proposed committee substitute and same was adopted. Linda Attarain, staff, was then called upon to provide an explanation of the bill (Attachment VI). Rep. Gordon Allen moved for a favorable report as to the committee substitute and unfavorable as to the original bill. Motion passed. (Attachment VII-Committee Report)

Rep. Curtis Blackwood was then called to explain his bill HB 835 A BILL TO BE ENTITLED AN ACT REQUIRING CERTAIN PHARMACIES TO PROVIDE PRESCRIPTION DRUG DISCOUNTS TO CERTAIN INDIVIDUALS. (Attachment VIII) Dianne Jessup, staff, came forward to explain the bill. (Attachment IX) After much discussion concerning additional expense to pharmacies – new software – and the need for qualifying criteria, motion was made by Rep. Wainwright to send bill to subcommittee. Bill will be sent to a subcommittee.

Chair Insko then turned the meeting over to Chair Justus who then called upon Rep. Insko to explain her bill HB 826, A BILL TO BE ENTITLED AN ACT TO AMEND THE CONFIDENTIALLY PROVISIONS OF CHAPTER 122C OF THE GENERAL STATUTES TO PERMIT IMPLEMENTATION OF MENTAL HEALTH SYSTEM REFORM. (Attachment X) Dianne Jessup, staff, was also called to provide a bill explanation (Attachment XI). Upon motion made by Rep. McAllister, the Committee voted to give HB 826 a favorable report and be re-referred to Judiciary I. (Attachment XII – Committee Report)

Chair Insko resumed as chair and called upon Rep. Moore to report on the subcommittee decision on his bill, HB 346, A BILL TO BE ENTITLED AN ACT TO REQUIRE THAT NURSING HOMES AND ADULT CARE HOMES HAVE

EMERGENCY GENERATORS FOR USE DURING POWER OUTAGES (Attachment XIII) Rep. Moore advised members that the subcommittee had proposed to turn the bill into a study bill and recommended it be referred to the NC Study Commission on Aging. The vote was postponed until next week.

The Chair adjourned the meeting at 1:09 p.m

Rep. Verla Insko, Chair

Pamela Evans, Committee Clerk

Rep. Carolyn Justus, Chair

ATTACHMENT I

ATTENDANCE

HOUSE COMMITTEE ON HEALTH

DATES	4/9/03													
INSKO, Verla CHAIR	✓													
JUSTUS, Carolyn CHAIR	✓													
ENGLAND, Bob VICE-CHAIR	✓													
ADAMS, Alma														
ALLEN, Bernard														
ALLEN, Gordon	✓													
ALLRED, Cary														
BARNHART, Jeff														
BOWIE, Joni														
CLARY, Debbie														
EARLE, Beverly														
GLAZIER, Rick														
HILTON, Mark														
McALLISTER, Mary														
MUNFORD, Don	✓													
SETZER, Mitchell	✓													
SHERRILL, Wilma														
WAINWRIGHT, William	✓													
WILSON, Connie														
WRIGHT, Tom														
Ex officio Members														
Brubaker, Bru														
Culpepper, Bill														
Cunningham, Pete														
Eddins, Rick														

ATTACHMENT II

AGENDA

HOUSE COMMITTEE ON HEALTH

April 9, 2003
Room 415 LOB
12:00 Noon

OPENING REMARKS

Representative Verla Insko, Chair
Representative Carolyn Justus, Chair

AGENDA ITEMS

HB 551 **Attendance Age/Eligibility/Schools for Deaf – Primary Sponsor: Rep. Joe Tolson**

HB 826 **Amend MH/Confidentiality Statutes – Primary Sponsor: Rep. Verla Insko**

HB 835 **Presc. Drug Discounts/Uninsured Elderly – Primary Sponsor: Rep. Curtis Blackwood**

ADJOURNMENT

Sgt. @ Arms Fowler & Stancil

ATTACHMENT III

VISITOR REGISTRATION SHEET

HOUSE COMMITTEE ON HEALTH — APRIL 9, 2003

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Cara Benedetto	Citizens for Health Care Freedom * Health Care Fradom *
Elena Terry	Citizens for Healthcare Freedom Health Care Freedom.
MANFRED MUELLER, D4TH, CCH, RSHOM(NA)	CITIZENS FOR HEALTHCARE FREEDOM *
Jonathan Gottlieb	Citizens For Health Care Freedom *
Barbara Zelter * 919-455-9450	Citizens for Healthcare Freedom *
Christy Beacham	Citizens for Healthcare Freedom *
David L. Herteberg	Citizens for Healthcare Freedom

* Our HB 932 was introduced today, and we are here to ask the committee to please hear about our bill in committee before April 23. Thank you. We have a press packet for the clerk / chairs.

VISITOR REGISTRATION SHEET

HOUSE COMMITTEE ON HEALTH — APRIL 9, 2003

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Gary Sacknoff	GSK
Ann Lee	DUHS
Lori Ann Harris	L. A. Harris & Associates
Kay Shipley	Abbott
Glenn Wells	Hoffmann-La Roche
Brian Shank	Astra Zeneca
John Bowdish	Astra Zeneca
Julie Insley	Citizens for Healthcare Freedom - Durham & entire state *
Heather Swaith	Citizens for Healthcare Freedom *
Nora Gotthelf	Citizens for Health Care Freedom *
Sharon Ryan	Health Care Freedom *

* Our HO 932 was introduced today, referred here, and we ask you to add #932 to your list of bills you will consider before Crossover day. Press packet is here, for clerk + Chairs.

VISITOR REGISTRATION SHEET

HOUSE COMMITTEE ON HEALTH — APRIL 9, 2003

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Ken Melton	Alley Associates
Bill Rustin	ACP
Andy Elen	NCRMA
Fran Preston	NCRMA
Tom Sri	NCAMA
Emilyn Stackhouse	EHSR
Mary Watson	NCDPI
Martha Downing	NCDPI
Don Willis	DMH/DD/SAS
Rob Lamm	NCDHHS
Mark Jones	GSK

VISITOR REGISTRATION SHEET

HOUSE SUBCOMMITTEE ON HEALTH — APRIL 9, 2003

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Carol Teal	Friends of Residents

VISITOR REGISTRATION SHEET

HOUSE SUBCOMMITTEE ON HEALTH — APRIL 9, 2003

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Regina Bone	Bone and Assoc.
Lee Vilas	NCALTC7
Jenny Cooper	NCACA
Stacy Flannery	NCHCFA
Bill Warren	DFS Council Bld - Dix Campus
Beverley Wheeler	Friends of Residents in LTC
Bill Wilson	NCALTL
Patricia A. Yancey	FOR LTC
Mari Smith	NCSEPS
Jennifer Talbert	Prevent Blindness
Bob Havely	Prevent Blindness NC

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2003

HOUSE BILL 551

Short Title: Attendance Age/Eligibility/Schools for Deaf. (Public)

Sponsors: Representative Tolson.

Referred to: Health.

March 19, 2003

A BILL TO BE ENTITLED

AN ACT TO UPDATE THE LAWS RELATING TO THE ATTENDANCE AGES AND ELIGIBILITY OF STUDENTS FOR NORTH CAROLINA SCHOOLS FOR THE DEAF.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 143B-216.41 reads as rewritten:

"**§ 143B-216.41. Pupils admitted; education.**

The Department of Health and Human Services ~~shall~~ shall, according to ~~such~~ reasonable regulations ~~as~~ prescribed by the ~~Board of Directors may prescribe,~~ Superintendent of the Office of Education Services, on application, receive into the schools for the purposes of education all ~~deaf~~ deaf, hard-of-hearing, and deaf/blind children ~~resident~~ who: (i) have been referred by their local education agencies and meet the criteria for admission; (ii) are residents of the ~~State who~~State; and (iii) are from age five through age ~~20 years: Provided, that the Department of Health and Human Services may admit students who are not within the age limits set forth above when in its judgment, such admission will be in the best interests of the applicant and the facilities of the school permit such admission.~~21 years. Only those who are bona fide citizens or residents of North Carolina shall be eligible to and entitled to receive free tuition and maintenance. The Department may fix charges and the ~~Board of Directors~~Superintendent of the Office of Education Services may prescribe rules whereby nonresident ~~deaf~~ deaf, hard-of-hearing, and deaf/blind children may be admitted, but in no event shall the admission of nonresidents in any way prevent the attendance of any eligible ~~deaf child,~~deaf, hard-of-hearing, or deaf/blind child who is a resident of North Carolina. The Department shall provide for the instruction of all pupils in the branches of study now prescribed by law for the public schools of the State and in ~~such~~ any other branches as may be of special benefit to the ~~deaf.~~deaf, hard of hearing, and deaf/blind.

The Department shall encourage the State to provide the classrooms with modern auditory training equipment, audiovisual media equipment, and any other special

equipment to provide the best educational conditions for the ~~deaf.~~deaf, hard of hearing, and deaf/blind. The Department shall provide a teacher training program in the State. The Department shall provide for a comprehensive vocational and technical training program for ~~boys and girls~~students as may be useful to them in making themselves self-supporting."

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

ATTACHMENT V

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2003

H D

HOUSE BILL 551
PROPOSED COMMITTEE SUBSTITUTE H551-CSRM-16 [v.4]

4/9/2003 12:30:24 PM

Short Title: Attendance Age/Eligibility/Schools for Deaf. (Public)

Sponsors:

Referred to:

March 19, 2003

A BILL TO BE ENTITLED

AN ACT TO UPDATE THE LAWS RELATING TO THE ATTENDANCE AGES AND ELIGIBILITY OF STUDENTS FOR NORTH CAROLINA SCHOOLS FOR THE DEAF.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 143B-216.41 reads as rewritten:

"**§ 143B-216.41. Pupils admitted; education.**

~~The Department of Health and Human Services shall according to such reasonable regulations as the Board of Directors may prescribe, on application, receive into the schools for the purposes of education all deaf children resident of the State who are from age five through age 20 years: Provided, that the Department of Health and Human Services may admit students who are not within the age limits set forth above when in its judgment, such admission will be in the best interests of the applicant and the facilities of the school permit such admission. Only those who are bona fide citizens or residents of North Carolina shall be eligible to and entitled to receive free tuition and maintenance. The Department may fix charges and the Board of Directors may prescribe rules whereby nonresident deaf children may be admitted, but in no event shall the admission of nonresidents in any way prevent the attendance of any eligible deaf child, resident of North Carolina. The Department shall provide for the instruction of all pupils in the branches of study now prescribed by law for the public schools of the State and in such other branches as may be of special benefit to the deaf.~~

~~The Department shall encourage the State to provide the classrooms with modern auditory training equipment, audiovisual media equipment, and any other special equipment to provide the best educational conditions for the deaf. The Department shall provide a teacher training program in the State. The Department shall provide for a comprehensive vocational and technical training program for boys and girls as may be useful to them in making themselves self-supporting.~~

(a) The Department of Health and Human Services shall admit all deaf and deaf/multi-disabled children into the schools for the deaf who meet the following criteria and in accordance with federal and State law and rules adopted by the Office of Education Services:

(1) The child has been referred by their local education agency and deemed appropriate by their Individualized Education Programs (IEP) Team.

(2) Are residents of this State, except as provided in subsection (b).

(3) The child is least five years of age but not older than 21 years of age."

(b) Nonresident deaf or deaf/multi-disabled children may be admitted to the schools for the deaf in accordance with rules adopted by the Office of Education Services if the admission does not prevent the attendance of any deaf or deaf/multi-disabled child who is a resident of the State. Only children who are residents of North Carolina are entitled to free tuition and room and board.

(c) The Department, through the Office of Education Services, shall provide unique instructional programs to meet the needs of all students admitted to the schools for the deaf. The Department shall encourage the State to provide classrooms with modern auditory training equipment, audiovisual media equipment, and any other special equipment to provide the best educational conditions for the deaf and deaf/multi-disabled.

(d) The Department, through the Office of Education Services, shall do the following:

(1) Maintain a collaborative relationship with institutions of higher education to provide teacher-training opportunities.

(2) Provide for a comprehensive vocational and technical training program as directed in the transition component of the IEP Programs of students.

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

HOUSE BILL 551:
Attendance Age/Eligibility/Schools for the Deaf

BILL ANALYSIS

Committee:	House Health	**Introduced by:**	Rep. Tolson
Date:	April 9, 2003	**Summary by:**	Linda Attarian
Version:	Introduced/PCS		Committee Co-Counsel

SUMMARY: ***House Bill 551 conforms NC law governing the eligibility and admission of deaf children to the NC Schools for the deaf to current admission policies and practices and makes other technical and clarifying changes. The bill is effective when it becomes law.***

CURRENT LAW: In accordance with G.S. 143B-216.41, a statute enacted in 1961, all hearing impaired children between the ages of 6 and 21 are eligible for admission to either the Eastern North Carolina School for the Deaf at Wilson (K-12) or the North Carolina School for the Deaf in Morganton (K-12). The Department of Health and Human Services (DHHS) is responsible for the operation and maintenance of the schools. Current law authorizes the Board of Directors of each of the Schools to adopt rules governing the admission of students. Children under the age of six may be admitted if admission is in the best interests of the applicant and the school. Non-residents may be admitted if space is available, but only residents of North Carolina may receive free tuition and maintenance. Non-residents must pay the per capita costs.

G.S. 143B-216.41 also requires the NC Schools for the Deaf to provide instruction in all branches of study as required by law for the public schools and in other branches of study that may be beneficial to deaf or hard-of-hearing students. The DHHS is required to encourage the State to ensure that classrooms in the Schools for the Deaf are equipped with the necessary tools and media equipment to ensure the best educational conditions for deaf or head-of-hearing students attending the schools. DHHS is also required to provide a teacher training program to train teachers in public schools.

THE PROPOSED COMMITTEE SUBSTITUTE makes the following substantive changes to the original bill:

- Deletes "criteria for admission" on line 13 and replaces the phrase with "deemed appropriate by their Individualized Education Program (IEP) team";
- Changes the description of the disability from "deaf, hard-of-hearing and deaf/blind" to "deaf/multi-disabled";
- Changes current law provides regarding the scope of instruction that the Department must provide students enrolled in the school for the deaf to limit the scope of instruction to programs to meet the unique needs of the students;
- Changes current law to provide that the Department, through the Office of Education Services, must maintain a collaborative relationship with institutions of higher education to provide teacher training opportunities; and
- Changes current law to provide that the Department, through the Office of Education Services, must provide a comprehensive vocational and technical training program as directed by the child's IEP plan instead of "as may be useful to make the child self-supporting".

BILL ANALYSIS: The bill makes the following changes to the statute governing the eligibility and admission to the NC Schools for the Deaf:

1. Shifts rule making authority over admission policies from the Board of Directors of the Schools for the Deaf to the Superintendent of the Office of Education Services in DHHS. *This change is made because the Schools for the Deaf no longer have Boards of Directors.* See page 1, lines 10 and 20.
2. Adds a provision stating that all applicants for admission to a School for the Deaf must be referred by their local education agencies. (DHHS is a local education agency). See page 1, line 12.
3. Adds a provision stating that applicants must meet certain criteria for admission. It is unclear what the criteria is or what entity is responsible for defining it. See page 1, line 13.
4. Clarifies that children who are deaf, hard-of-hearing or deaf and blind are eligible for admission, not *just* deaf children. *This is the current policy.* See page 1, lines 11, 21, 23 and page 2, line 2.
5. Clarifies that children between the ages of 5 and 21 are eligible for admission and deletes language that gave DHHS discretion to admit students outside the age range of 5 and 20. *This is the current policy.* See page 1, line 17.

BACKGROUND:

Prevalence of deafness: In the United States, hearing loss is the leading birth defect. Since 2001, North Carolina has implemented an infant screening program and from that data, it is estimated that the number of children who are born deaf or hard of hearing range between 3 and 6 per 100,000. It is expected that approximately 75 children will be born profoundly deaf in North Carolina each year. This number will gradually rise with the birthrate and is expected to reach 82 in 2011.

Residency of students attending NC Schools for the Deaf: All children attending the NC Schools for the Deaf are residents of North Carolina. According to DHHS, no non-resident students have attended the NC Schools for the Deaf for at least the last five years. However, there are currently 8 students enrolled who are NC residents, but who are not US citizens.

The following Tables provide comparison data regarding enrollment, staffing and costs related to the education of deaf students attending the NC Schools for the Deaf and student enrolled in non-residential public school. The data is provided by DPI.

Table 1 is the number of students in public schools vs the schools for the deaf.

Category	Num. In Public Schools	Num. in Schools for Deaf
Hearing Impaired	2,031	218

Table 2 contains the number of teachers in public schools vs the schools for the deaf.

Category	Employed Fully Certified	Employed Not Fully Certified	Vacant Position	Total Employed
LEA - 6-21	155.16	20	6	181.16
LEA - Preschool	26.77	3.80	0.24	30.81
Schools for Deaf - 6-21	64.26	0	7	71.26
Schools for Deaf - PreSchool	0	0	0	0

Table 3 contains the State and federal funding that the public schools receive for each student who is deaf.

Allotment	State	Federal
Ages 6-20	$2,670.28	
PreSchool	$2,124.73	
Ages 6-21		$942.77 - Base Amount
PreSchool		$486.19 - Formula-Based

ATTACHMENT VII

2003 COMMITTEE REPORT
HOUSE OF REPRESENTATIVES

The following report(s) from standing committee(s) is/are presented:
By Representatives **Verla Insko and Carolyn Justus,** Chairs for the Committee on **HEALTH**.

☐ Committee Substitute for
H.B. 551 A BILL TO BE ENTITLED AN ACT TO UPDATE THE LAWS RELATING TO THE ATTENDANCE AGES AND ELIGIBILITY OF STUDENTS FOR NORTH CAROLINA SCHOOLS FOR THE DEAF.

☐ 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 ~~(# H.B.), ☐ 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)

3/06/03

FOR JOURNAL USE ONLY

____ Pursuant to Rule 36(b), the bill/resolution is placed on the Calendar of _____.

____ The (committee substitute) bill/resolution (, as amended,) is (ordered engrossed and) re-referred to the Committee on _____.

____ The bill/resolution is re-referred to the Committee on _____.

____ On motion of (Rep. _____,) (the Chair,) the (committee substitute) bill/resolution is (ordered engrossed and) re-referred to the Committee on _____.

____ Pursuant to Rule 36(b), the (House)committee substitute bill (No. ____)/resolution is placed on the Calendar of _____. (The original bill) (House Committee Substitute Bill No. ____)/resolution is placed on the Unfavorable Calendar.

____ On motion of Rep. _____, (the rules are suspended) (Rule ____ is suspended) and the bill/resolution is placed on today's calendar. (for immediate consideration.)

____ On motion of Rep. _____, Committee Amendment No.(s) _____ is/are adopted (by EV____ ____).

____ On motion of Rep. _____, Committee Amendment No.(s) _____ is/are adopted (by EV____ ____).

____ Rep. _____ offers Amendment No. _____ which (is adopted.) (fails of adoption.) (by EV ____ ____.) ( ) This amendment changes the title.

____ The bill/resolution (, as amended,) passes its second reading (by following vote, ____ ____ RC) (, by EV ____ ____,) and (remains on the Calendar,) (and there being no objection is read a third time).

____ The bill/resolution (, as amended,) passes its third reading (by the following vote, ____ ____ RC) (, by EV ____ ____,) and is ordered
____ sent to the Senate.
____ without engrossment. ____ by Special message.
____ sent to the Senate for concurrence in
_____ the House amendment (s).
_____the House committee substitute bill.
____ enrolled.

____ On motion of Rep. _____, the House concurs in the (material) Senate _____ (by the following vote, ____ ____ RC) (, by EV ____ ____,) and the bill is ordered enrolled.

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2003

H 1

HOUSE BILL 835

Short Title:	Presc. Drug Discounts/Uninsured Elderly.	(Public)
Sponsors:	Representatives Blackwood; Dockham, Frye, Gibson, Glazier, Insko, Justus, Kiser, Luebke, McMahan, C. Wilson, and Womble.	
Referred to:	Health.	

April 2, 2003

A BILL TO BE ENTITLED

AN ACT REQUIRING CERTAIN PHARMACIES TO PROVIDE PRESCRIPTION DRUG DISCOUNTS TO CERTAIN INDIVIDUALS.

The General Assembly of North Carolina enacts:

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

"**§ 90-85.42. Prescription drug discount required for certain individuals.**

(a) A pharmacy, by or through a pharmacist acting on its behalf as its employee, agent, or owner, that dispenses prescription drugs pursuant to reimbursement under the North Carolina Medical Assistance Program (Medicaid) shall comply with the requirements of this section.

(b) In dispensing prescription drugs to individuals who meet the requirements of this section, the pharmacy shall accept as payment in full from the individual the applicable rate for which the pharmacy is reimbursed from the North Carolina Medical Assistance Program (Medicaid). The discount required under this section shall be offered to individuals:

(1) Over the age of 60 and not eligible for full Medicaid benefits; and

(2) Not otherwise covered for prescription drugs under a health benefit plan or public or private prescription drug program.

(c) A pharmacy subject to this section shall display prominently at the point of service and at the point of sale, a sign reminding discount beneficiaries to ask that the charge for the beneficiary's prescription be the same amount as the fee charged to the North Carolina Medical Assistance Program (Medicaid)."

SECTION 2. This act becomes effective January 1, 2004.

ATTACHMENT IX

HOUSE BILL 835:
Presc. Drug Discounts/Uninsured Elderly

BILL ANALYSIS

Committee:	House Health	**Introduced by:**	Rep. Blackwood
Date:	April 9, 2003	**Summary by:**	Dianna Jessup
Version:	First Edition		Committee Counsel

*SUMMARY: **House Bill 835 would amend the Pharmacy Practice Act to require pharmacies that dispense prescriptions under the Medicaid program to charge the same rate it receives from Medicaid to the following: (1) individuals who are over 60 and who are not eligible for full Medicaid benefits and (2) individuals not otherwise covered for prescription drugs under a health benefit plan or public or private prescription drug program. The act would become effective January 1, 2004.***

CURRENT LAW: State law does not currently regulate prices pharmacies can charge persons for prescriptions. *Medicaid* generally covers up to 6 prescriptions per month for elderly (over age 65), blind and disabled persons who have incomes equal to or less than 100% of the federal poverty guidelines, which currently is $8,980 annually for a family of one.

Reimbursement to Pharmacies under Medicaid: Under Medicaid, pharmacies are reimbursed under a two-tier system: (1) one price for generic drugs and (2) one price for brand name drugs. The reimbursements are as follows:

- GENERIC DRUGS: The Maximum Allowable Cost (MAC) List price plus a $5.60 dispensing fee. There is a federal MAC List maintained by the Centers for Medicare and Medicaid Services (CMS) and a State MAC List maintained by the Division of Medical Assistance (DMA), DHHS. Drugs are placed in different classes in the MAC List. For any drug dispensed by a pharmacist in a certain class such as acid indigestion, that pharmacist will receive a set reimbursement rate for all drugs in the acid indigestion class. Currently, there are over 400 drugs on the MAC List.
- BRAND NAME DRUGS: The Average Wholesale Price (AWP) minus 10% plus a $4.00 dispensing fee.

Medicaid recipients pay co pays for drugs as follows: a $1 co pay for generics and a $3 co pay for brand name drugs. DMA deducts this co pay from the price reimbursed to pharmacists. Most of the claims for reimbursement to pharmacies under Medicaid are handled electronically through a point of sale system. This software system is linked to Electronic Data Systems (EDS) who is the fiscal agent that handles all the claims for DMA. EDS calculates the Medicaid price and compares the Medicaid price with the pharmacy's cash price. EDS then transmits back to the pharmacy the lesser of the two prices as the pharmacist's reimbursement.

BILL ANALYSIS: House Bill 835 would require a pharmacy that dispenses prescriptions under the Medicaid Program to charge the same rate it receives from Medicaid to individuals: (1) over the age of 60 and not eligible for full Medicaid benefits **and** (2) not otherwise covered for prescription drugs under a health benefit plan or public or private prescription drug program. The bill would require the pharmacy to display a sign at the point of service and at the point of sale that would remind discount beneficiaries to ask to be charged the Medicaid rate. The bill does not require a pharmacy to charge the Medicaid rate automatically (see line 13 – "accept as payment").

BACKGROUND:

NC Medicaid Snapshots

The following information comes from a Fiscal Research Division publication entitled, Medicaid Program Overview, February 2003.

About $7.4 billion dollars was spent on the Medicaid program in SFY 2002. Today, Medicaid is 15.3% of the General Fund operating budget compared to 8.2% ten years ago. NC Medicaid covered 1.4 million state residents in SFY 2002 (17% of the State's population). 30.8% of recipients including the aged, blind, and disabled, consumed 71.1% of resources. Expenditures under Medicaid for prescription drugs exceeded one billion dollars in SFY 2002. Since 1995, drug expenditures have doubled from 8.2% to 17%.

National Prescription Drug Trends

The following information comes from The Henry J. Kaiser Family Foundation, Prescription Drug Trends, March 2003 report.

23% of Americans under age 65 in 1996 and 38% of Medicare beneficiaries in the fall of 1999 had no prescription coverage. Seniors lack drug coverage because Medicare does not cover outpatient prescription drugs, and because they do not have or cannot afford a private policy that supplements Medicare with drug coverage. Furthermore, U.S. spending for prescription drugs was $140.6 billion in 2001, more than tripling since 1990. Three main factors are driving the increases in prescription drug spending: (1) the increasing number of prescriptions (utilization), (2) changes in the types of drugs used (with newer, higher-priced drugs replacing older, less-expensive drugs), and (3) manufacturer price increases for existing drugs. U.S. spending for prescription drugs is expected to continue to rise rapidly, reaching $445.9 billion (17% of personal health care spending) by 2012.

A February 2002 Kaiser Family Foundation study found that 38% of non-institutionalized elderly are without prescription drug coverage. In addition, there has been an increase of 29% in Medicare beneficiaries' average annual out-of-pocket costs from $813 in 2000 to $1,051 in 2002. Furthermore, a Kaiser Family foundation 2001 Survey of Seniors in Eight States found that 35% of seniors without prescription coverage skipped doses or did not have prescriptions filled.

Amy Compeau, Research Assistant, contributed to this summary.
H835-SMSW-001

ATTACHMENT X

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2003

H 1

HOUSE BILL 826*

Short Title:	Amend MH Confidentiality Statutes.	(Public)
Sponsors:	Representative Insko.	
Referred to:	Health, if favorable, Judiciary I.	

April 1, 2003

A BILL TO BE ENTITLED

AN ACT TO AMEND THE CONFIDENTIALITY PROVISIONS OF CHAPTER 122C OF THE GENERAL STATUTES TO PERMIT IMPLEMENTATION OF MENTAL HEALTH SYSTEM REFORM.

The General Assembly of North Carolina enacts:

SECTION 1.(a) G.S. 122C-3 is amended by inserting the following term in alphabetical order to read:

"**§ 122C-3. Definitions.**

As used in this Chapter, unless another meaning is specified or the context clearly requires otherwise, the following terms have the meanings specified:

(1) 'Applicant' means an individual who contacts an area facility for services.

..."

SECTION 1.(b) G.S. 122C-3(14) reads as rewritten:

"**§ 122C-3. Definitions.**

As used in this Chapter, unless another meaning is specified or the context clearly requires otherwise, the following terms have the meanings specified:

...

(14) "Facility" means any person at one location whose primary purpose is to provide services for the care, treatment, habilitation, or rehabilitation of the mentally ill, the developmentally disabled, or substance abusers, and includes:

a. An "area facility", which is a facility that is operated by or under contract with the area ~~authority.~~authority or county program. For the purposes of this subparagraph, a contract is a contract, memorandum of understanding, or other written agreement whereby the facility agrees to provide services to one or more clients of the area authority or county program. ~~A facility that is providing services under contract with the area~~

~~authority is an area facility for purposes of the contracted services only.~~ Area facilities may also be licensable facilities in accordance with Article 2 of this Chapter. A State facility is not an area facility;

b. A "licensable facility", which is a facility that provides services for one or more minors or for two or more adults. When the services offered are provided to individuals who are mentally ill or developmentally disabled, these services shall be day services offered to the same individual for a period of three hours or more during a 24-hour period, or residential services provided for 24 consecutive hours or more. When the services offered are provided to individuals who are substance abusers, these services shall include all outpatient services, day services offered to the same individual for a period of three hours or more during a 24-hour period, or residential services provided for 24 consecutive hours or more. Facilities for individuals who are substance abusers include chemical dependency facilities;

c. A "private facility", which is a facility that is either a licensable facility or a special unit of a general hospital or a part of either in which the specific service provided is not covered under the terms of a contract with an area authority;

d. The psychiatric service of the University of North Carolina Hospitals at Chapel Hill;

e. A "residential facility", which is a 24-hour facility that is not a hospital, including a group home;

f. A "State facility", which is a facility that is operated by the Secretary;

g. A "24-hour facility", which is a facility that provides a structured living environment and services for a period of 24 consecutive hours or more and includes hospitals that are facilities under this Chapter; and

h. A Veterans Administration facility or part thereof that provides services for the care, treatment, habilitation, or rehabilitation of the mentally ill, the developmentally disabled, or substance abusers."

SECTION 2. G.S. 122C-54(b) reads as rewritten:

"**§ 122C-54. Exceptions; abuse reports and court proceedings.**

...

(b) If an individual is a defendant in a criminal case and a mental examination of the defendant has been ordered by the ~~court,~~ court as provided in G.S. 15A-1002, the facility ~~may~~ shall send the results or the report of the mental examination to the clerk of court, to the district attorney or prosecuting officer, and to the attorney of record for the defendant as provided in G.S. 15A-1002(d)."

SECTION 3. G.S. 122C-55 reads as rewritten:

"§ 122C-55. Exceptions; care and treatment.

(a) Any area or State facility or the psychiatric service of the University of North Carolina Hospitals at Chapel Hill may share confidential information regarding any client of that facility with any other area or State facility or the psychiatric service of the University of North Carolina Hospitals at Chapel Hill when necessary to coordinate appropriate and effective care, treatment or habilitation of ~~the client and when failure to share this information would be detrimental to the care, treatment or habilitation of the client.~~ the client. For the purposes of this subsection, coordinate means the provision, coordination, or management of mental health, developmental disabilities, and substance abuse services and related services by one or more facilities and includes the referral of a client from one facility to another. ~~Under the circumstances described in this subsection, the consent of the client or legally responsible person is not required for this information to be furnished, and the information may be furnished despite objection by the client.~~

(a1) Any State or area facility or the psychiatric service of the University of North Carolina Hospitals at Chapel Hill may share confidential information regarding any client of that facility with the Secretary, and the Secretary may share confidential information regarding any client with an area or State facility or the psychiatric service of the University of North Carolina Hospitals at Chapel Hill when the responsible professional or the Secretary determines that disclosure is necessary to coordinate appropriate and effective care, treatment or habilitation of ~~the client and that failure to share this information would be detrimental to the care, treatment or habilitation of the client. Under the circumstances described in this subsection, the consent of the client or legally responsible person is not required for this information to be furnished, and the information may be furnished despite objection by the client.~~client.

(a2) Any area or State facility or the psychiatric service of the University of North Carolina Hospitals at Chapel Hill may share confidential information regarding any client of that facility with any other area facility or State facility or the psychiatric service of the University of North Carolina Hospitals at Chapel Hill when necessary to conduct payment activities relating to an individual served by the facility. Payment activities are activities undertaken by a facility to obtain or provide reimbursement for the provision of services and may include, but are not limited to, determinations of eligibility or coverage, coordination of benefits, determinations of cost sharing amounts, claims management, claims processing, claims adjudication, claims appeals, billing and collection activities, medical necessity reviews, utilization management and review, precertification and preauthorization of services, concurrent and retrospective review of services, and appeals related to utilization management and review.

(a3) Whenever there is reason to believe that a client is eligible for benefits through a Department program, any State or area facility or the psychiatric service of the University of North Carolina Hospitals at Chapel Hill may share confidential information regarding any client of that facility with the Secretary, and the Secretary may share confidential information regarding any client with an area facility or State facility or the psychiatric services of the University of North Carolina Hospitals at Chapel Hill. Disclosure is limited to that information necessary to establish initial

eligibility for benefits, determine continued eligibility over time, and obtain reimbursement for the costs of services provided to the client.

(a4) An area authority or county program may share confidential information regarding any client with any area facility, and any area facility may share confidential information regarding any client of that facility with the area authority or county program, when the area authority or county program determines the disclosure is necessary to develop, manage, monitor, or evaluate the area authority's or county programs network of qualified providers as provided in G.S. 122C-115.2(b)(1)b., G.S. 122C-141(a), the State Plan, and rules of the Secretary. For the purposes of this subsection, the purposes or activities for which confidential information may be disclosed include, but are not limited to, quality assessment and improvement activities, provider accreditation and staff credentialing, developing contracts and negotiating rates, investigating and responding to client grievances and complaints, evaluating practitioner and provider performance, auditing functions, on-site monitoring, conducting consumer satisfaction studies and collecting and analyzing performance data.

(a5) Any area facility may share confidential information with any other area facility regarding an applicant when necessary to determine whether the applicant is eligible for area facility services.

(b) A facility, physician, or other individual responsible for evaluation, management, supervision, or treatment of respondents examined or committed for outpatient treatment under the provisions of Article 5 of this Chapter may request, receive, and disclose confidential information to the extent necessary to enable them to fulfill their responsibilities.

(c) A facility may furnish confidential information in its possession to the Department of Correction when requested by that department regarding any client of that facility when the inmate has been determined by the Department of Correction to be in need of treatment for mental illness, developmental disabilities, or substance abuse. The Department of Correction may furnish to a facility confidential information in its possession about treatment for mental illness, developmental disabilities, or substance abuse that the Department of Correction has provided to any present or former inmate if the inmate is presently seeking treatment from the requesting facility or if the inmate has been involuntarily committed to the requesting facility for inpatient or outpatient treatment. Under the circumstances described in this subsection, the consent of the client or inmate shall not be required in order for this information to be furnished and the information shall be furnished despite objection by the client or inmate. Confidential information disclosed pursuant to this subsection is restricted from further disclosure.

(d) A responsible professional may disclose confidential information when in his opinion there is an imminent danger to the health or safety of the client or another individual or there is a likelihood of the commission of a felony or violent misdemeanor.

(e) A responsible professional may exchange confidential information with a physician or other health care provider who is providing emergency medical services to

a client. Disclosure of the information is limited to that necessary to meet the emergency as determined by the responsible professional.

(e1) A State facility may furnish client identifying information to the Department for the purpose of maintaining an index of clients served in State facilities which may be used by State facilities only if that information is necessary for the appropriate and effective evaluation, care and treatment of the client.

(e2) A responsible professional may disclose an advance instruction for mental health treatment or confidential information from an advance instruction to a physician, psychologist, or other qualified professional when the responsible professional determines that disclosure is necessary to give effect to or provide treatment in accordance with the advance instruction.

(f) A facility may disclose confidential information to a provider of support services whenever the facility has entered into a written agreement with a person to provide support services and the agreement includes a provision in which the provider of support services acknowledges that in receiving, storing, processing, or otherwise dealing with any confidential information, he will safeguard and not further disclose the information.

(g) Whenever there is reason to believe that the client is eligible for financial benefits through a governmental agency, a facility may disclose confidential information to ~~State~~ State, local, or federal government agencies. ~~Disclosure~~ Except as provided in G.S. 122C-55(a3), disclosure is limited to that confidential information necessary to establish financial benefits for a client. After establishment of these benefits, the consent of the client or his legally responsible person is required for further release of confidential information under this subsection.

(h) Within a facility, employees, students, consultants or volunteers involved in the care, treatment, or habilitation of a client may exchange confidential information as needed for the purpose of carrying out their responsibility in serving the client.

(i) Upon specific request, a responsible professional may release confidential information to a physician or psychologist who referred the client to the facility.

(j) Upon request of the next of kin or other family member who has a legitimate role in the therapeutic services offered, or other person designated by the client or his legally responsible person, the responsible professional shall provide the next of kin or other family member or the designee with notification of the client's diagnosis, the prognosis, the medications prescribed, the dosage of the medications prescribed, the side effects of the medications prescribed, if any, and the progress of the client, provided that the client or his legally responsible person has consented in writing, or the client has consented orally in the presence of a witness selected by the client, prior to the release of this information. Both the client's or the legally responsible person's consent and the release of this information shall be documented in the client's medical record. This consent shall be valid for a specified length of time only and is subject to revocation by the consenting individual.

(k) Notwithstanding the provisions of G.S. 122C-53(b) or G.S. 122C-206, upon request of the next of kin or other family member who has a legitimate role in the therapeutic services offered, or other person designated by the client or his legally

responsible person, the responsible professional shall provide the next of kin, or family member, or the designee, notification of the client's admission to the facility, transfer to another facility, decision to leave the facility against medical advice, discharge from the facility, and referrals and appointment information for treatment after discharge, after notification to the client that this information has been requested.

(l) In response to a written request of the next of kin or other family member who has a legitimate role in the therapeutic services offered, or other person designated by the client, for additional information not provided for in subsections (j) and (k) of this section, and when such written request identifies the intended use for this information, the responsible professional shall, in a timely manner:

(1) Provide the information requested based upon the responsible professional's determination that providing this information will be to the client's therapeutic benefit, and provided that the client or his legally responsible person has consented in writing to the release of the information requested; or

(2) Refuse to provide the information requested based upon the responsible professional's determination that providing this information will be detrimental to the therapeutic relationship between client and professional; or

(3) Refuse to provide the information requested based upon the responsible professional's determination that the next of kin or family member or designee does not have a legitimate need for the information requested.

(m) The Commission for Mental Health, Developmental Disabilities, and Substance Abuse Services shall adopt rules specifically to define the legitimate role referred to in subsections (j), (k), and (l) of this section."

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

ATTACHMENT XI

HOUSE BILL 826:
Amend MH Confidentiality Statutes

BILL ANALYSIS

Committee:	House Health	**Introduced by:**	Rep. Insko
Date:	April 9, 2003	**Summary by:**	Dianna Jessup
Version:	First Edition		Committee Counsel

SUMMARY: ***House Bill 826 would amend the confidentiality provisions of Chapter 122C of the General Statutes and related definitions. The act would become effective when it becomes law.***

CURRENT LAW AND BILL ANALYSIS:

Changes to Definitions.

Section 1.(a): Adds a definition of "applicant" to the definitions section of the mental health statutes. "Applicant" would mean an individual who contacts an area facility for services. A change to the mental health confidentiality provisions in Section 3 (page 4, lines 17-19) would permit area facilities to share confidential information with any other area facilities regarding an "applicant" when necessary to determine whether the applicant is eligible for area facility services. An "area facility" is a "facility" that is operated by or under contact with an area authority or county program. A "facility" is any person at one location whose primary purpose is to provide services for the care, treatment, habilitation, or rehabilitation of the mentally ill, the developmentally disabled, or substance abusers.

Section 1.(b): Amends the definition of "area facility" to specify that if a facility by written agreement agrees to provide services to one or more clients of an area authority or county program, it is an "area facility". The bill would also delete the proviso that stated that these facilities are area facilities for purposes of the contracted services only, making all facilities that contract with area authorities or county programs to provide mental health services "area facilities".

Changes to Confidentiality Provisions. Confidential information acquired in attending or treating mental health clients is not a public record, and except as specifically authorized by statute, no one who has access to the confidential information can disclose it.

Section 2: G.S. 122C-54 permits facilities to disclose confidential client information under certain circumstances in court proceedings. Current law permits facilities to send the results of a court-ordered mental examination to the clerk of court, to the district attorney, and to the defendant's attorney. This section would require a facility to send the results of a mental examination ordered by the court to determine whether a defendant is competent to stand trial to the clerk, district attorney, and the defendant's attorney.

Section 3: G.S. 122C-55 permits facilities and hospitals to disclose confidential client information under certain circumstances:

- Area or State facilities and the psychiatric service of UNC Hospitals may share confidential information among themselves, and between themselves and the Secretary of DHHS, when necessary to coordinate treatment for the client and when failure to do so would be detrimental to the client's care, and the client's consent is not required. The bill would remove the limitation that permitted disclosure only when failure to do so would be detrimental to the client's care. For purposes of disclosure among facilities and UNC Hospitals, "coordination" would include client referral from one facility to another.

- New language on page 3, lines 26-37 would permit area or State facilities or the psychiatric service of UNC Hospitals to share confidential information regarding a client with each other when necessary to conduct payment activities, i.e. activities undertaken by a facility to obtain or provide reimbursement for providing services.
- New language on page 3, lines 38-44 and page 4, lines 1-2, would permit area or State facilities or the psychiatric service of UNC Hospitals and the Secretary to share confidential information regarding a client with each other whenever there is a reason to believe that a client is eligible for benefits through a Department program. Disclosure would be limited to the information necessary to make initial and continuing eligibility determinations and to obtain reimbursement.
- New language on page 4, lines 3-16, would permit area authorities and county programs to share confidential information regarding a client when necessary to develop, manage, monitor, or evaluate the area authority's or county program's network of qualified providers.
- Currently, a facility may disclose confidential client information to State or federal agencies whenever there is a reason to believe the client is eligible for financial benefits through a governmental agency. The bill would permit facilities to disclose information to local agencies under these circumstances.

Effective date. **Section 4** would make the act effective when it becomes law.

BACKGROUND: As enacted by the 2001 General Assembly, S.L. 2001-437 (HB 381), amended the mental health statutes to provide counties an alternative to establishing area authorities to ensure the provision of public mental health, developmentally disabled and substance abuse (MH/DD/SA) services to consumers. Counties were authorized to withdraw from existing area authorities and to ensure the delivery of public MH/DD/SA services through a single county program or jointly with one or more counties through a joint agency established pursuant to the terms of an interlocal agreement.

Other elements of the act include:

- Several new or amended provisions designed to enhance accountability and cooperation between boards of county commissioners, area authorities, and the Department of Health and Human Services(DHHS);
- Requirements to develop a 'business plan' to guide the management and delivery of public services at the local level and State level;
- Requirements for the universal availability of core services (including 'front-end' services such as screening, assessment, and emergency triage, and 'indirect services' such as prevention, education, and consultation at the community level) within available State and local resources;
- Enhanced powers and duties of local and State governing structures relating to quality assurance and accountability at the State and local levels;
- Establishment of a consumer advocacy program to operate at the State and local levels and to coordinate their functions with local consumer groups;
- Directives to DHHS to implement a certification process and to follow specific procedures to prepare for the reforms provided for in the legislation;
- Directives to the Secretary of DHHS to establish schedules for implementing a phased-in plan to eliminate disparities in the allocation of State funding across county programs and area authorities;
- A requirement that prior to requesting approval to close a State facility, the Secretary shall notify the Joint Legislative Commission on Governmental Operations and the Joint Legislative

Committee on MH/DD/SAS and the members of the General Assembly who represent catchment areas affected by the closure and shall present a plan for the closure that addresses how patients will be cared for after the closure, how support services to community-based agencies and outreach services will be continued, and the impact on remaining facilities; and

- New limitations on the authority of the Secretary to close a State facility.

Amy Compeau, Research Assistant, substantially contributed to this summary.

H826-SMSW-001

ATTACHMENT XII

2003 COMMITTEE REPORT
HOUSE OF REPRESENTATIVES

The following report(s) from standing committee(s) is/are presented:
By Representatives **Verla Insko and Carolyn Justus,** Chairs for the Committee on **HEALTH.**

☐ Committee Substitute for
H.B. 826 A BILL TO BE ENTITLED AN ACT TO AMEND THE CONFIDENTIALITY PROVISIONS OF CHAPTER 122C OF THE GENERAL STATUTES TO PERMIT IMPLEMENTATION OF MENTAL HEALTH SYSTEM REFORM.

☐ With a favorable report.

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

☐ 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 (# H.B.), ☐ 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)

3/06/03

FOR JOURNAL USE ONLY

____ Pursuant to Rule 36(b), the bill/resolution is placed on the Calendar of _____.

____ The (committee substitute) bill/resolution (, as amended,) is (ordered engrossed and) re-referred to the Committee on _____.

____ The bill/resolution is re-referred to the Committee on _____.

____ On motion of (Rep. _____,) (the Chair,) the (committee substitute) bill/resolution is (ordered engrossed and) re-referred to the Committee on _____.

____ Pursuant to Rule 36(b), the (House)committee substitute bill (No. ____)/resolution is placed on the Calendar of _____. (The original bill) (House Committee Substitute Bill No. ____)/resolution is placed on the Unfavorable Calendar.

____ On motion of Rep. _____, (the rules are suspended) (Rule ____ is suspended) and the bill/resolution is placed on today's calendar. (for immediate consideration.)

____ On motion of Rep. _____, Committee Amendment No.(s) _____ is/are adopted (by EV____ ____).

____ On motion of Rep. _____, Committee Amendment No.(s) _____ is/are adopted (by EV____ ____).

____ Rep. _____ offers Amendment No. _____ which (is adopted.) (fails of adoption.) (by EV ____ ____.) ( ) This amendment changes the title.

____ The bill/resolution (, as amended,) passes its second reading (by following vote, ____ ____ RC) (, by EV ____ ____,) and (remains on the Calendar,) (and there being no objection is read a third time).

____ The bill/resolution (, as amended,) passes its third reading (by the following vote, ____ ____ RC) (, by EV ____ ____,) and is ordered
____ sent to the Senate.
____ without engrossment. ____ by Special message.
____ sent to the Senate for concurrence in
_____ the House amendment (s).
_____the House committee substitute bill.
____ enrolled.

____ On motion of Rep. _____, the House concurs in the (material) Senate _____ (by the following vote, ____ ____ RC) (, by EV ____ ____,) and the bill is ordered enrolled.

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2003

HOUSE BILL 346

Short Title:	Emerg. Generators/Nursing & Adlt Care Homes.	(Public)
Sponsors:	Representatives Moore; L. Allen, Bowie, Insko, Pate, and Setzer.	
Referred to:	Health.	

March 6, 2003

A BILL TO BE ENTITLED

AN ACT TO REQUIRE THAT NURSING HOMES AND ADULT CARE HOMES HAVE EMERGENCY GENERATORS FOR USE DURING POWER OUTAGES.

The General Assembly of North Carolina enacts:

SECTION 1. Effective January 1, 2004, Part 1 of Article 6 of Chapter 131E of the General Statutes is amended by adding the following new section to read:

"**§ 131E-114.2. Emergency electrical service required.**

Notwithstanding any other provision of law to the contrary, all nursing homes, combination homes, and adult care homes, as those terms are defined in G.S. 131E-101, licensed and operating in this State shall provide emergency electrical service for use in the event of failure of the normal electrical service. Emergency electrical service shall be sufficient to provide heat, lighting, and other essential electrical services as required by rules of the Medical Care Commission."

SECTION 2. Effective January 1, 2004, G.S. 131D-2(b)(1a) reads as rewritten:

"**§ 131D-2. Licensing of adult care homes for the aged and disabled.**

...

(b) Licensure; inspections. –

...

(1a) In addition to the licensing and inspection requirements mandated by subdivision (1) of this subsection, the Department shall ensure that adult care homes required to be licensed by this Article are monitored for licensure compliance on a regular basis. In carrying out this requirement, the Department shall work with county departments of social services to do the routine monitoring and to have the Division of Facility Services oversee this monitoring and perform any follow-up inspection called for. The Department shall monitor regularly the enforcement of rules pertaining to air circulation, ventilation, and room temperature in resident living quarters. These rules shall include the

requirement that air conditioning or at least one fan per resident bedroom and living and dining areas be provided when the temperature in the main center corridor exceeds 80 degrees Fahrenheit. The Department shall ensure that adult care homes required to be licensed by this Article provide emergency electrical service for use in the event of failure of the normal electrical service. The emergency electrical service shall be sufficient to provide heat, lighting, and other essential electrical services as required by rules adopted by the Medical Care Commission. The Department shall also keep an up-to-date directory of all persons who are administrators as defined in subdivision (1a) of subsection (a) of this section."

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

House Committee on Health

April 15, 2003

Minutes

The House Committee on Health met on Tuesday, April 15, 2003 at 12:00 noon in Room 544 of the Legislative Office Building. A silent roll was taken. A copy of the roll denoting members present is attached to the minutes (Attachment I) along with a copy of the agenda and Visitor Registration Sheet (Attachments II and III).

Chair Justus welcomed members and visitors. Dusty Rhodes and Charles Grady were recognized as the sergeant-at-arms (Note: no pages were present)

Chair Justus recognized Rep. Barnhart, Chair of the Subcommittee to study HB 346 A BILL TO BE ENTITLED AN ACT TO REQUIRE THAT NURSING HOMES AND ADULT CARE HOMES HAVE EMERGENCY GENERATORS FOR USE DURING POWER OUTAGES (Attachment IV) to give his report. A committee substituted was proposed (Attachment V) and Rep. Sherrill moved to accept the proposed committee substitute for discussion. The Bill Analysis and 10 NCAC 03H .3402 were also provided (Attachments VI and VII). Rep. Barnhart reported it was the recommendation of the subcommittee that the bill be turned into a study bill. Chair Insko moved to give the committee substitute a favorable report, unfavorable as to the original bill. Motion passed. (Committee Report – Attachment VIII)

Martha Alexander was then called upon to explain her bill, HB 815, AN ACT TO AMEND THE DEFINITION OF CHEMICAL DEPENDENCY TREATMENT FACILITY TO PROVIDE THAT SOCIAL SETTING DETOXIFICATION FACILITIES AND MEDICAL DETOXIFICATION FACILITIES FOR THE PURPOSES OF CERTIFICATE OF NEED REQUIREMENTS AND TO AMEND THE DEFINITION OF CHEMICAL DEPENDENCY TREATMENT BED TO PROVIDE THAT BEDS LICENSED FOR DETOXIFICATION ARE NOT CHEMICAL DEPENDENCY TREATMENT BEDS FOR THE PURPOSES OF CERTIFICATE OF NEED REQUIREMENTS. (Attachment IX). A bill analysis was provided (Attachment X) This bill would exempt social setting detoxification facilities and medical detoxification facilities from Certificate of Need requirements, the same as halfway houses and recovery farms. Persons who want to offer or develop these facilities would not have to seek the prior approval of DHHS, but licensing requirements would still apply. Rep. McAllister makes motion for a favorable report at appropriate time. Tony Mulvihill, Executive Director of the Alcohol/Drug Council of North Carolina, Tara Larson of the Department of Mental Health/DDSAS, Starleen Scott Robbins of the DHHS/DFS and Bob Fitzgerald of the DHHS/DFS were called upon to answer several concerns raised by committee members about procedures and detox facilities. Rep. Sherrill requested a fiscal note. After much additional discussion, the bill was displaced until a fiscal note could be provided.

The Chair adjourned the meeting at 1:00 p.m.*

*Due to time, HB 883 MH Reform Waiver and HB 886 Due Process for Physicians were not considered. (Bills with Analysis attached as Attachments XI and XII)

Carolyn Justus, Chair

Pamela J. Evans, Committee Clerk

ATTENDANCE

HOUSE COMMITTEE ON HEALTH

DATES		4/15/03														
INSKO, Verla	CHAIR	✓														
JUSTUS, Carolyn	CHAIR	✓														
ENGLAND, Bob	VICE-CHAIR	✓														
ADAMS, Alma																
ALLEN, Bernard		✓														
ALLEN, Gordon		✓														
ALLRED, Cary																
BARNHART, Jeff		✓														
BOWIE, Joni		✓														
CLARY, Debbie																
EARLE, Beverly																
GLAZIER, Rick		✓														
HILTON, Mark																
McALLISTER, Mary		✓														
MUNFORD, Don																
SETZER, Mitchell																
SHERRILL, Wilma		✓														
WAINWRIGHT, William																
WILSON, Connie																
WRIGHT, Tom																
Ex officio Members																
Brubaker, Bru																
Culpepper, Bill																
Cunningham, Pete																
Eddins, Rick																

ATTACHMENT II

AGENDA

HOUSE COMMITTEE ON HEALTH

April 15, 2003
Room 544 LOB
12:00 Noon

OPENING REMARKS

Representative Verla Insko, Chair
Representative Carolyn Justus, Chair

AGENDA ITEMS

HB 346 **Emerg. Generators/Nursing & Adlt Care Homes – Primary Sponsor: Rep. Tim Moore**

HB 815 **Detox Facilities Not Subject to CON – Primary Sponsor: Rep. Martha Alexander**

HB 883 **MH Reform Waiver – Primary Sponsor: Rep. Verla Insko**

HB 886 **Due Process for Physicians – Primary Sponsors: Rep. Thomas Wright and Rep. Julia Howard**

ADJOURNMENT

ATTACHMENT III

VISITOR REGISTRATION SHEET

HOUSE COMMITTEE ON HEALTH — APRIL 15, 2003

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Linwood Jones	NCHA
Roz Sabbith	NC Child Care Coalition
[signature]	Project Challenge NC
[signature]	[signature]

VISITOR REGISTRATION SHEET

HOUSE COMMITTEE ON HEALTH — APRIL 15, 2003

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Lee-Ann Coe	NC Psychiatric Assoc
Richard C Hatch	AARP
Bob Fitzgerald	DHHS/DFS
Tony McIntyre	ABCNC
Starleen Scott Robbins	DMH/DD/SAS
Amy Dobson	NC State Watch.
Kathy Boyd	Nat Assoc of Social Workers-NC Chapter
Jeremy Kingdon	NCALA
Jared Schumann	NC Council
Jim Runyan	NCIMS
Ellen Holleman	The Durham Center

VISITOR REGISTRATION SHEET

HOUSE COMMITTEE ON HEALTH — APRIL 15, 2003

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Beth McIcher	NAMI NC
Jennifer M. Sullivan	NASW-NC
Amy Gotthorne	NCMS
Tara Lee	DMH/DDSAS
Sheila McKenney	NC DHHS
Wayne Williams	State Budget Office
Drew Erdeschik	Rep. Rick Glazier
Stacy Flannery	NCFICFA
Cathy S. Cheek	NCPA
Camille Stelle	Kennedy Covington
Sally Cameron	NC Psychological Assoc

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2003

HOUSE BILL 346

Short Title:	Emerg. Generators/Nursing & Adlt Care Homes.	(Public)
Sponsors:	Representatives Moore; L. Allen, Bowie, Insko, Pate, and Setzer.	
Referred to:	Health.	

March 6, 2003

A BILL TO BE ENTITLED

AN ACT TO REQUIRE THAT NURSING HOMES AND ADULT CARE HOMES HAVE EMERGENCY GENERATORS FOR USE DURING POWER OUTAGES.

The General Assembly of North Carolina enacts:

SECTION 1. Effective January 1, 2004, Part 1 of Article 6 of Chapter 131E of the General Statutes is amended by adding the following new section to read:

"**§ 131E-114.2. Emergency electrical service required.**

Notwithstanding any other provision of law to the contrary, all nursing homes, combination homes, and adult care homes, as those terms are defined in G.S. 131E-101, licensed and operating in this State shall provide emergency electrical service for use in the event of failure of the normal electrical service. Emergency electrical service shall be sufficient to provide heat, lighting, and other essential electrical services as required by rules of the Medical Care Commission."

SECTION 2. Effective January 1, 2004, G.S. 131D-2(b)(1a) reads as rewritten:

"**§ 131D-2. Licensing of adult care homes for the aged and disabled.**

...

(b) Licensure; inspections. –

...

(1a) In addition to the licensing and inspection requirements mandated by subdivision (1) of this subsection, the Department shall ensure that adult care homes required to be licensed by this Article are monitored for licensure compliance on a regular basis. In carrying out this requirement, the Department shall work with county departments of social services to do the routine monitoring and to have the Division of Facility Services oversee this monitoring and perform any follow-up inspection called for. The Department shall monitor regularly the enforcement of rules pertaining to air circulation, ventilation, and room temperature in resident living quarters. These rules shall include the

requirement that air conditioning or at least one fan per resident bedroom and living and dining areas be provided when the temperature in the main center corridor exceeds 80 degrees Fahrenheit. The Department shall ensure that adult care homes required to be licensed by this Article provide emergency electrical service for use in the event of failure of the normal electrical service. The emergency electrical service shall be sufficient to provide heat, lighting, and other essential electrical services as required by rules adopted by the Medical Care Commission. The Department shall also keep an up-to-date directory of all persons who are administrators as defined in subdivision (1a) of subsection (a) of this section."

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

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2003

H D

HOUSE BILL 346
PROPOSED COMMITTEE SUBSTITUTE H346-CSSW-11 [v.2]

4/9/2003 12:46:06 PM

Short Title: Emerg. Generators/Aging Study Comm Study. (Public)

Sponsors:

Referred to:

March 6, 2003

A BILL TO BE ENTITLED

AN ACT TO DIRECT THE NORTH CAROLINA STUDY COMMISSION ON AGING TO STUDY REQUIRING NURSING HOMES AND ADULT CARE HOMES TO HAVE EMERGENCY GENERATORS FOR USE DURING POWER OUTAGES.

The General Assembly of North Carolina enacts:

SECTION 1. (a) The North Carolina Study Commission on Aging shall study whether nursing homes licensed under Chapter 131E and adult care homes licensed under Chapter 131D should be required to provide emergency electrical service for use in the event of failure of the normal electrical service. In undertaking this study, the Commission shall consider the following:

(1) The extent to which electrical service should be provided, both between and among care settings.

(2) The logistical and monetary factors that are barriers to requiring emergency electrical power and options to address those barriers.

(3) Sources of funding for any mandate.

(b) The North Carolina Study Commission on Aging shall report its findings and recommendations, including recommended legislation, to the 2003 General Assembly, Regular Session 2004, prior to its convening.

SECTION 2. This act becomes effective July 1, 2003.

HOUSE BILL 346:
Emerg. Generators/Nursing & Adult Care Homes

BILL ANALYSIS

Committee:	House Health	**Introduced by:**	Rep. Moore
Date:	March 25, 2003	**Summary by:**	Dianna Jessup
Version:	First Edition		Committee Counsel

SUMMARY: ***House Bill 346 would require all nursing homes and adult care homes to have emergency electrical service available for use during power outages sufficient to provide heat, lighting and other essential electrical services by January 1, 2004 in accordance with rules to be adopted by the Medical Care Commission. Currently, only nursing homes are required to have emergency backup power. The act would become effective when it becomes law.***

CURRENT LAW: Nursing homes: Nursing homes, by statutory definition, are facilities that provide nursing or convalescent care for three or more persons. By rule, since the 1980's, newly constructed/converted nursing homes have been required to provide emergency electrical service, including the following:

- In existing facilities, emergency lights and a suitable source of emergency power for life-sustaining equipment to ensure continuous operation for a minimum of 72 hours.
- An emergency generating set, including a generator, located on the premises.
- Where electricity is the only source of power normally used for space heating, the emergency service must provide for heating of patient rooms.
- Sufficient fuel must be stored for the operation of the emergency generator for a period not less than 72 hours, on a 24-hour per day operational basis.

It is estimated that approximately 90-95% of nursing homes have generators capable of providing some heat.

Adult care homes: Adult care homes, by statutory definition, are assisted living residences in which the housing management provides 24-hour scheduled and unscheduled personal care services to two or more residents. Adult care homes that provide care to two to six unrelated residents are commonly called family care homes. Adult care homes are not required to provide emergency electrical service. It is estimated that approximately 10-15% of the 600 or more adult care homes currently are capable of providing some emergency electrical service.

Nursing homes and adult care homes have to submit plans for modifications to facilities to the Division of Facility Services, DHHS, for plan review and approval.

BILL ANALYSIS: Section 1 would amend the nursing home licensure act to require all nursing homes, combination homes, and facilities operated as part of nursing homes and which provide residential care for aged or disabled persons, by January 1, 2004, to provide emergency electrical service sufficient to provide heat, lighting, and other essential electrical services as required by rules of the Medical Care Commission. This would mostly affect combination homes and assisted living facilities operated as part of nursing homes, as nursing homes are already required to provide emergency electrical service. Section 2 would similarly amend the statutes regulating the licensure of adult care homes. This change would also affect family care homes. This would affect a large number of adult care homes and family care homes, which are currently not required to have emergency electrical service.

10 NCAC 03H .3402 EMERGENCY ELECTRICAL SERVICE

Emergency electrical service shall be provided for use in the event of failure of the normal electrical service. This emergency service shall consist of the following:

(1) In any existing facility, the following shall be provided:
   (a) type 1 or 2 emergency lights as required by the North Carolina State Building Code;
   (b) additional emergency lights for all nursing stations, drug preparation and storage areas, and for the telephone switchboard, if applicable;
   (c) one or more portable battery-powered lamps at each nursing station; and
   (d) a suitable source of emergency power for life-sustaining equipment, if the facility admits or cares for occupants needing such equipment, to ensure continuous operation for a minimum of 72 hours.

(2) Any new addition to an existing facility shall meet the same requirements as new construction.

(3) Any conversion of an existing building (hotel, motel, abandoned hospital, abandoned school, or other building) shall meet the same requirements for emergency electrical services as required for new construction.

(4) An emergency generating set, including the prime mover and generator, shall be located on the premises and shall be reserved exclusively for supplying the emergency electrical system.

(5) Emergency electrical services shall be provided as required by Rule .3101(b) of this Subchapter with the following modifications:
   (a) Exception No. 2 and Exception No. 3 contained in Section 517-10 of the North Carolina State Building Code, Volume IV shall not apply to new facilities.
   (b) Egress lighting shall be connected to the essential electrical system at exterior of exits.
   (c) Task illumination in the switchgear and boiler rooms shall be connected to the essential electrical system.

(6) The following equipment, devices, and systems which are essential to life, safety, and the protection of important equipment or vital materials shall be connected to the emergency electrical system as follows:
   (a) nurses' calling system;
   (b) fire pump if installed;
   (c) sewerage lift or sump pumps if installed;
   (d) one elevator, where elevators are used for vertical transportation of patients;
   (e) equipment such as burners and pumps necessary for operation of one or more boilers and their necessary auxiliaries and controls, required for heating and sterilization, if installed;
   (f) equipment necessary for maintaining telephone service.

(7) A minimum of one dedicated emergency branch circuit per bed for ventilator dependent patients is required in addition to the normal system receptacle at each bed location required by the North Carolina State Building Code, Volume IV. This emergency circuit shall be provided with a minimum of two duplex receptacles identified for emergency use. Additional emergency branch circuits/receptacles shall be provided where the electrical life support needs of the patient exceed the minimum requirements stated in this Paragraph. Each emergency circuit serving ventilator dependent patients shall be fed from the automatically transferred critical branch of the essential electrical system. This Paragraph shall apply to both new and existing facilities.

(8) Heating equipment provided for ventilator dependent patient bedrooms shall be connected to the critical branch of the essential electrical system and arranged for delayed automatic or manual connection to the emergency power source if the heating equipment depends upon electricity for proper operation. This Paragraph shall apply to both new and existing facilities.

(9) Task lighting connected to the automatically transferred critical branch of the essential electrical system shall be provided for each ventilator dependent patient bedroom. This Paragraph shall apply to both new and existing facilities.

(10) Where electricity is the only source of power normally used for space heating, the emergency service shall provide for heating of patient rooms. Emergency heating of patient rooms will not be required in areas where the facility is supplied by at least two separate generating sources, or a network distribution system with the facility feeders so routed, connected, and protected that a fault any place between the generators and the facility will not likely cause an interruption.

(11) The emergency electrical system shall be so controlled that after interruption of the normal electric power supply, the generator is brought to full voltage and frequency and connected with 10 seconds through one or more primary automatic transfer switches to all emergency lighting, alarms, nurses' call, and equipment necessary for maintaining telephone service. All other lighting and equipment required to be connected to the emergency system shall either be connected through the 10 second primary automatic transfer switching or shall be subsequently connected through other automatic or manual transfer switching. Receptacles connected to the emergency system shall be distinctively marked for identification.

(12) Sufficient fuel shall be stored for the operation of the emergency generator for a period not less than 72 hours, on a 24-hour per day operational basis. The generator system shall be tested and maintained per National Fire Protection Association (NFPA) code 99, current addition with all subsequent amendments, which is adopted by reference. Copies of this code may be obtained from the National Fire Protection Association, 1 Batterymarch Park, P.O. Box 9101, Quincy, MA 02269-9101 at a cost of thirty one dollars ($31.00). Records of running time shall be maintained and kept available for reference.

(13) Existing facilities shall have electrical systems that comply with licensure standards in effect at the time a license is first issued. Any remodeling that results in changes in service delivery shall comply with current licensure requirements to support the delivery of those services.

History Note: *Authority G.S. 131E-104;*
Eff. January 1, 1996.

2003 COMMITTEE REPORT
HOUSE OF REPRESENTATIVES

The following report(s) from standing committee(s) is/are presented:
By Representatives **Verla Insko and Carolyn Justus,** Chairs for the Committee on **HEALTH.**

☐ Committee Substitute for
H.B. 346 A BILL TO BE ENTITLED AN ACT TO REQUIRE THAT NURSING HOMES AND ADULT CARE HOMES HAVE EMERGENCY GENERATORS FOR USE DURING POWER OUTAGES.

☐ 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 ~~(# H.B.)~~, ☒ 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)

3/06/03

FOR JOURNAL USE ONLY

____ Pursuant to Rule 36(b), the bill/resolution is placed on the Calendar of _____.

____ The (committee substitute) bill/resolution (, as amended,) is (ordered engrossed and) re-referred to the Committee on _____.

____ The bill/resolution is re-referred to the Committee on _____.

____ On motion of (Rep. _____,) (the Chair,) the (committee substitute) bill/resolution is (ordered engrossed and) re-referred to the Committee on _____.

____ Pursuant to Rule 36(b), the (House)committee substitute bill (No. ____)/resolution is placed on the Calendar of _____. (The original bill) (House Committee Substitute Bill No. ____)/resolution is placed on the Unfavorable Calendar.

____ On motion of Rep. _____, (the rules are suspended) (Rule ____ is suspended) and the bill/resolution is placed on today's calendar. (for immediate consideration.)

____ On motion of Rep. _____, Committee Amendment No.(s) _____ is/are adopted (by EV____ ____).

____ On motion of Rep. _____, Committee Amendment No.(s) _____ is/are adopted (by EV____ ____).

____ Rep. _____ offers Amendment No. _____ which (is adopted.) (fails of adoption.) (by EV ____ ____.) ( ) This amendment changes the title.

____ The bill/resolution (, as amended,) passes its second reading (by following vote, ____ ____ RC) (, by EV ____ ____,) and (remains on the Calendar,) (and there being no objection is read a third time).

____ The bill/resolution (, as amended,) passes its third reading (by the following vote, ____ ____ RC) (, by EV ____ ____,) and is ordered
____ sent to the Senate.
____ without engrossment. ____ by Special message.
____ sent to the Senate for concurrence in
_____ the House amendment (s).
_____ the House committee substitute bill.
____ enrolled.

____ On motion of Rep. _____, the House concurs in the (material) Senate _____ (by the following vote, ____ ____ RC) (, by EV ____ ____,) and the bill is ordered enrolled.

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2003

H 1

HOUSE BILL 815

Short Title:	Detox Facilities Not Subject to CON.	(Public)
Sponsors:	Representatives Alexander; and Insko.	
Referred to:	Health.	

April 1, 2003

A BILL TO BE ENTITLED

AN ACT TO AMEND THE DEFINITION OF CHEMICAL DEPENDENCY TREATMENT FACILITY TO PROVIDE THAT SOCIAL SETTING DETOXIFICATION FACILITIES AND MEDICAL DETOXIFICATION FACILITIES ARE NOT CHEMICAL DEPENDENCY TREATMENT FACILITIES FOR THE PURPOSES OF CERTIFICATE OF NEED REQUIREMENTS AND TO AMEND THE DEFINITION OF CHEMICAL DEPENDENCY TREATMENT BED TO PROVIDE THAT BEDS LICENSED FOR DETOXIFICATION ARE NOT CHEMICAL DEPENDENCY TREATMENT BEDS FOR THE PURPOSES OF CERTIFICATE OF NEED REQUIREMENTS.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 131E-176(5a) reads as rewritten:

"(5a) "Chemical dependency treatment facility" means a public or private facility, or unit in a facility, which is engaged in providing 24-hour a day treatment for chemical dependency or substance abuse. This treatment may include detoxification, administration of a therapeutic regimen for the treatment of chemically dependent or substance abusing persons and related services. The facility or unit may be:

a. A unit within a general hospital or an attached or freestanding unit of a general hospital licensed under Article 5, Chapter 131E, of the General Statutes,

b. A unit within a psychiatric hospital or an attached or freestanding unit of a psychiatric hospital licensed under Article 1A of General Statutes Chapter 122 or Article 2 of General Statutes Chapter 122C,

c. A freestanding facility specializing in treatment of persons who are substance abusers or chemically dependent licensed under Article 1A of General Statutes Chapter 122 or Article 2 of General Statutes Chapter 122C; and may be identified as

"chemical dependency, substance abuse, alcoholism, or drug abuse treatment units," "residential chemical dependency, substance abuse, alcoholism or drug abuse facilities," ~~"social setting detoxification facilities" and "medical detoxification facilities,"~~ or by other names if the purpose is to provide treatment of chemically dependent or substance abusing persons, but shall not include social setting detoxification facilities, medical detoxification facilities, halfway houses or recovery farms."

SECTION 2. G.S. 131E-176(5b) reads as rewritten:

"(5b) "Chemical dependency treatment beds" means beds that are licensed ~~for detoxification or~~ for the inpatient treatment of chemical dependency. Residential treatment beds for the treatment of chemical dependency or substance abuse are chemical dependency treatment beds. Chemical dependency treatment beds shall not include beds licensed for detoxification."

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

HOUSE BILL 815:
Detox Facilities Not Subject to CON

BILL ANALYSIS

Committee:	House Health	**Introduced by:**	Rep. Alexander
Date:	April 15, 2003	**Summary by:**	Dianna Jessup
Version:	First Edition		Committee Counsel

SUMMARY: House Bill 815 would exempt social setting detoxification facilities and medical detoxification facilities from Certificate of Need requirements. The act would become effective when it becomes law.

CURRENT LAW:

Certificate of Need: State law prohibits health care providers from acquiring, replacing, or adding to their facilities and equipment unless the provider obtains a Certificate of Need from the Department of Health and Human Services (DHHS). A Certificate of Need is also required before beginning to offer certain health services. The purpose of the CON is to control health care costs by preventing the unnecessary duplication of medical facilities and services and to help ensure the geographic distribution of health care facilities and services. All new hospitals, psychiatric facilities, chemical dependency treatment facilities, nursing homes, adult care homes, kidney disease treatment centers, intermediate care facilities for the mentally retarded, rehabilitation facilities, home health agencies hospices, diagnostic centers, oncology treatment centers, and ambulatory surgical facilities must first obtain a CON before developing new facilities or offering new services.

Chemical Dependency Treatment Facilities: Chemical dependency treatment facilities are currently subject to CON requirements. G.S. 131E-176 defines a "chemical dependency treatment facility" to be a public or private facility, or unit in a facility, which is engaged in providing 24-hour a day treatment for chemical dependency or substance abuse. This treatment may include detoxification, therapy, and related services. "Halfway houses" and "recovery farms" are not considered "chemical dependency treatment facilities" for CON purposes.

Social Setting Detoxification Facilities and Medical Detoxification Facilities: Social setting detoxification facilities and medical detoxification facilities are considered "chemical dependency treatment facilities" under G.S. 131E-176. They are licensed under Article 2 of Chapter 122C of the General Statutes. Services provided by social setting detoxification facilities are not eligible for reimbursement under Medicaid. Medicaid does cover medical detoxification if provided at an acute care hospital. These facilities do not engage in treatment for substance abuse.

BILL ANALYSIS: House Bill 815 would exempt social setting detoxification facilities and medical detoxification facilities from CON requirements, the same as halfway houses and recovery farms. Persons who want to offer or develop these facilities would not have to seek the prior approval of DHHS. Licensing requirements would still apply. The act would become effective when it becomes law.

H815-SMSW-001

Amy Compeau, Research Assistant, contributed to this summary.

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2003

H 1

HOUSE BILL 883

Short Title:	MH Reform Waiver.	(Public)
Sponsors:	Representative Insko.	
Referred to:	Health.	

April 7, 2003

A BILL TO BE ENTITLED

AN ACT TO AUTHORIZE THE SECRETARY OF HEALTH AND HUMAN SERVICES TO TEMPORARILY WAIVE CERTAIN REQUIREMENTS OF THE MENTAL HEALTH COMMITMENT STATUTES TO FURTHER MENTAL HEALTH REFORM EFFORTS.

The General Assembly of North Carolina enacts:

SECTION 1. The Secretary of Health and Human Services may, upon request of a phase-one local management entity, waive temporarily the requirements of G.S. 122C-261 through G.S. 122C-263 and G.S. 122C-281 through G.S. 122C-283 pertaining to initial (first-level) examinations by a physician or eligible psychologist of individuals meeting the criteria of G.S. 122C-261(a) or G.S. 122C-281(a), as applicable, as follows:

(1) The Secretary has received a request from a phase-one local management entity to substitute for a physician or eligible psychologist, a licensed clinical social worker, a masters level psychiatric nurse, or a masters level certified clinical addiction specialist to conduct the initial (first-level) examinations of individuals meeting the criteria of G.S. 122C-261(a) or G.S. 122C-281(a). The waiver shall be implemented on a pilot-program basis. The request from the local management entity shall be submitted as part of the entity's local business plan and shall specifically describe:

a. How the purpose of the statutory requirement would be better served by waiving the requirement and substituting the proposed change under the waiver.

b. How the waiver will enable the local management entity to improve the delivery or management of mental health, developmental disabilities, and substance abuse services.

c. How the services to be provided by the licensed clinical social worker, the masters level psychiatric nurse, or the masters level

certified clinical addiction specialist under the waiver are within each of these professional's scope of practice.

d. How the health, safety, and welfare of individuals will continue to be at least as well protected under the waiver as under the statutory requirement.

e. The method to be used to evaluate the effectiveness and efficiency of mental health, developmental disabilities, and substance abuse services and protection of health, safety, and welfare under the waiver.

(2) The Secretary shall review the request and may approve it upon finding that:

a. The request meets the requirements of this section.

b. The request furthers the purposes of State policy under G.S. 122C-2, and mental health, developmental disabilities, and substance abuse services reform.

c. The request improves the delivery of mental health, developmental disabilities, and substance abuse services in the counties affected by the waiver and also protects the health, safety, and welfare of individuals receiving these services.

d. The duties and responsibilities performed by the licensed clinical social worker, the masters level psychiatric nurse, or the masters level certified clinical addiction specialist are within the individual's scope of practice.

(3) The waiver granted by the Secretary under this section shall be in effect for a period not to exceed three years, or the period for which the requesting local management entity's business plan is approved, whichever is shorter.

(4) The Secretary may grant a waiver under this section only to those local management entities that have been designated as phase-one entities as of July 1, 2003.

(5) In no event shall the substitution of a licensed clinical social worker, masters level psychiatric nurse, or masters level certified clinical addiction specialist under a waiver granted under this section be construed as authorization to expand the scope of practice of the licensed clinical social worker, the masters level psychiatric nurse, or the masters level certified clinical addiction specialist.

(6) The Department shall assure that staff performing the duties are trained and privileged to perform the functions identified in the waiver.

(7) The local management entity shall assure that a psychiatrist is available at all times to provide back-up services.

SECTION 2. This act becomes effective July 1, 2003, and expires July 1, 2006.

HOUSE BILL 883:
MH Reform Waiver

BILL ANALYSIS

Committee:	House Health	**Introduced by:**	Rep. Insko
Date:	April 15, 2003	**Summary by:**	Dianna Jessup
Version:	PCS for First Edition H883-CSSW-13[v.3]		Committee Counsel

SUMMARY: ***The proposed committee substitute for House Bill 883 would authorize the Secretary of the Department of Health and Human Services (Secretary) to permit phase one, mental health local management entities (LMEs) to substitute for a physician or eligible psychologist, a licensed clinical social worker, a masters level psychiatric nurse, or a masters level certified clinical addictions specialist to conduct the initial (first-level) examination of individuals in involuntary commitment proceedings. Any waiver could only be in effect for a period not to exceed three years. The proposed bill would not expand the scope of practice for licensed clinical social workers, masters level psychiatric nurses, or masters level certified clinical addictions specialists. The act would become effective July 1, 2003 and expire July 1, 2006.***

Differences between the First Edition and the PCS

1. The PCS shifted the responsibility for an evaluation of the effectiveness, quality and efficiency of services under the waiver from the phase-one local management entity to the Secretary of Health and Human Services.

2. The PCS also changes the local management entities that the Secretary may grant a waiver to under the provisions of the bill. Originally, the Secretary could grant a waiver only to the local management entities that have been designated as phase-one entities by July 1, 2003. The proposed committee substitute limits the number of waivers to only three local management entities that have been designated as phase-one entities by July 1, 2003.

CURRENT LAW:

Mental Health Reform: As enacted by the 2001 General Assembly, S.L. 2001-437 (HB 381), amended the mental health statutes to provide counties an alternative to establishing area authorities to ensure the provision of public mental health, developmentally disabled and substance abuse (MH/DD/SA) services to consumers. Counties were authorized to withdraw from existing area authorities and to ensure the delivery of public MH/DD/SA services through a single county program or jointly with one or more counties through a joint agency established pursuant to the terms of an interlocal agreement. (County programs and area authorities are known as LMEs). By October 1, 2002, each county was to have sent a letter of intent to the Secretary indicating the intent of the county or counties to provide services through an existing area authority or through a county program. The bill provided for phased-in implementation of reform, requiring the Secretary to certify the business plans of one-third of the area authorities and county programs by July 1, 2003; two-thirds of the area authorities and county programs by January 1, 2004; and complete certification of all area authorities and county programs by July 1, 2004.

Under the new governance scheme, LMEs are required to develop "business plans" to guide the management and delivery of services. These business plans are required to be submitted to the Secretary for review and certification. The business plans must provide a description of how core administrative functions will be carried out, including planning to ensure the provision of services, ensuring available,

qualified providers to deliver services, service management, financial management, service monitoring, evaluation, and collaboration with other local service systems. Business plans are effective for three State fiscal years.

Involuntary Commitment: Anyone who has knowledge that a person who is mentally ill or is a substance abuser and who is dangerous to self or dangerous to others may petition the court for issuance of an order to take the respondent into custody for examination by a physician or eligible psychologist. If the clerk finds reasonable grounds to believe that the facts in the petition are true and the respondent is dangerous to self or others, the clerk may order the respondent to be taken into custody for an initial examination by a physician or eligible psychologist. If the physician or eligible psychologist recommends inpatient commitment, then a *physician* is required to perform an examination of the respondent within 24 hours after the respondent is admitted into a facility. This examination would determine whether the respondent is mentally ill or a substance abuser and is dangerous to self or dangerous to others, and the results of this examination are considered by the court at the hearing to determine whether the respondent should be involuntarily committed.

Licensed Clinical Social Workers (LCSW): Social workers are licensed under Chapter 90B of the General Statutes. G.S. 90B-3 defines a LCSW to mean a person who is competent to function independently, who holds himself or herself out to the public as a social worker, and who offers or provides clinical social work services or supervises others engaging in clinical social work practice. According to the North Carolina Social Work Board website, the requirements for becoming a LCSW include the following:

- A Masters in Social Work (MSW), a Doctorate in Social Work (DSW), or a Doctorate in Philosophy (PhD) from a Council on Social Work Education (CSWE) accredited program.
- 3,000 hours of paid employment accumulated in no less than two years nor more than six years. (No more than 1500 hours accumulated in one year.)
- 100 hours of clinical supervision from a LCSW with a graduate degree in Social Work and two years of supervised clinical experience. Of these 100 hours at least 75 hours must have been individual supervision.
- Take and pass the American Association of Social Work Boards "Clinical level" examination.

Psychiatric Nurses: 10-3C.5202 of the NC Administrative Code defines a psychiatric nurse to mean an individual who is licensed to practice as a registered nurse in the State by the NC Board of Nursing; and has the following:

- A graduate degree from an accredited master's level program in psychiatric mental health nursing with two years of experience; or
- A master's degree in behavioral science with two years of supervised clinical experience in psychiatric mental health nursing; or
- A baccalaureate degree in behavioral science with four years of supervised clinical experience in psychiatric mental health nursing.

According to the NC Board of Nursing, a masters level psychiatric nurse is an advanced practice registered nurse generally referred to as a psychiatric-mental health clinical nurse specialist. A masters level psychiatric nurse would be eligible for direct reimbursement of services.

Certified Clinical Addictions Specialists: G.S. 90-113.31 defines a certified clinical addictions specialist to be a person certified by the NC Substance Abuse Professional Certification Board to practice as a clinical addictions specialist in accordance with the provisions of Article 5C of the General Statutes. G.S. 90-113.40 requires the Board to issue a certificate certifying an applicant as a certified clinical addictions specialist if it meets certain requirements for a certified substance abuse counselor or a certified substance abuse prevention consultant and meets one of four sets of criteria specified in statute.

BILL ANALYSIS: The proposed committee substitute for House Bill 883 would authorize the Secretary, upon request of a phase-one LME, to waive temporarily the requirements of the involuntary commitment statutes regarding who can conduct the initial examination to permit LCSWs, masters level psychiatric nurses, or masters level certified clinical addictions specialists to conduct the examination. In order to obtain this waiver, the LME must, as part of its business plan, describe how the purpose of the statutory requirement would be better served by waiving the requirement, how the waiver will enable the LME to improve the delivery or management of services, how the services to be provided by the LCSWs, masters level psychiatric nurses, and masters level certified clinical addictions specialists are within the scope of practice for those professions, and how the health, safety, and welfare of persons will be protected. In order to approve the LME's request for the waiver, the Secretary must find that: (1) the request meets the requirements of the bill, (2) the request furthers the purposes of State policy, and MH/DD/SA services reform, (3) the request improves the delivery of MH/DD/SA services in the counties affected by the waiver and protects the health, safety, and welfare of individuals receiving these services, and (4) the duties and responsibilities performed by the LCSWs, masters level psychiatric nurses, or the masters level certified clinical addictions specialists are within the scope of practice for these professions. The Secretary shall evaluate the services and the protection of health, safety, and welfare under the waiver. Waivers could be in effect for a period not to exceed three years or the period, for which the business plan is approved, whichever is shorter. The Secretary may grant a waiver under this section only to those LMEs that have been designated as phase-one entities as of July 1, 2003. **According to the Division of MH/DD/SA services, there are currently 13 LMEs that have been designated as phase-one entities.** The Department would have to ensure that staff performing the duties are trained and privileged to perform the functions identified in the waiver, and the LME would have to ensure that a psychiatrist is available at all times to provide back-up services.

The act would become effective July 1, 2003 and expire July 1, 2006.

Amy Compeau, Research Assistant, contributed to this summary.

H883-SMSW-001

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2003

HOUSE BILL 886

Short Title:	Due Process for Physicians.	(Public)
Sponsors:	Representatives Wright and Howard (Primary Sponsors).	
Referred to:	Health.	

April 7, 2003

A BILL TO BE ENTITLED

AN ACT TO AMEND VARIOUS PROVISIONS RELATING TO THE NORTH CAROLINA MEDICAL BOARD UNDER THE LAWS REGULATING THE PRACTICE OF MEDICINE.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 90-2 reads as rewritten:

"**§ 90-2. Medical Board.**

(a) In order to properly regulate the practice of medicine and surgery for the benefit and protection of the people of North Carolina, there is established the North Carolina Medical Board. The Board shall consist of 12 members.

(1) Seven of the members shall be duly licensed physicians elected and nominated ~~to~~ by the ~~Governor by the North Carolina Medical Society.~~ Governor. Of the seven members appointed by the Governor, one member shall be a faculty member at one of the medical schools in North Carolina.

(2) Of the remaining five members, all to be appointed by the Governor, at least three shall be public members and at least one shall be a physician assistant as defined in G.S. 90-18.1 or a nurse practitioner as defined in G.S. 90-18.2. A public member shall not be a health care provider nor the spouse of a health care provider. For purposes of board membership, "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 section, a person enrolled in a program to prepare him to be a licensed health care professional or an allied health professional shall be deemed a health care provider. For purposes of this section, any person with significant financial interest in a health service or profession is not a public member.

(b) No member appointed to the Board on or after November 1, 1981, shall serve more than two complete consecutive three-year terms, except that each member shall serve until his successor is chosen and qualifies.

(c) In order to establish regularly overlapping terms, the terms of office of the members shall expire as follows: two on October 31, 1993; four on October 31, 1994; four on October 31, 1995; and two on October 31, 1996.

(d) ~~Any~~A member of the Board ~~may~~ shall be removed from office by the Governor for good cause ~~shown.~~shown, including malicious prosecution or abuse of power. Any vacancy in the physician membership of the Board shall be filled for the period of the unexpired term by the ~~Governor from a list of physicians submitted by the North Carolina Medical Society Executive Council.~~Governor. Any vacancy in the public, physician assistant, or nurse practitioner membership of the Board shall be filled by the Governor for the unexpired term.

(e) The North Carolina Medical Board shall have the power to acquire, hold, rent, encumber, alienate, and otherwise deal with real property in the same manner as any 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."

SECTION 2. G.S. 90-8 reads as rewritten:

"**§ 90-8. Officers may administer oaths, and subpoena witnesses, records and other materials.**

The president and secretary of the Board may administer oaths to all persons appearing before it as the Board may deem necessary to perform its duties, and may summon and issue subpoenas for the appearance of any witnesses deemed necessary to testify concerning any matter to be heard before or inquired into by the Board. The power of the Board to subpoena is limited to persons with knowledge related to a matter before the Board. Medical expert witnesses, including medical practitioners licensed in the United States, must routinely and actively practice in the specialty that is under investigation by the Board. Each party must disclose the identity of an expert, the subjects on which the expert is expected to testify, the substance of the facts and opinions on which the expert is expected to rely, and the qualifications of the expert. Statements contained in medical or scientific literature may be relied upon in direct and cross-examination and admitted into evidence. The Board may order that any patient records, documents or other material concerning any matter to be heard before or inquired into by the Board shall be produced before the Board or made available for inspection, notwithstanding any other provisions of law providing for the application of any physician-patient privilege with respect to such records, documents or other material. All records, documents, or other material compiled by the Board are subject to the provisions of G.S. 90-16. Notwithstanding the provisions of G.S. 90-16, in any proceeding before the Board, in any record of any hearing before the Board, and in the notice of charges against any licensee, the Board shall withhold from public disclosure the identity of a patient including information relating to dates and places of treatment, or any other information that would tend to identify the patient, unless the patient or the

representative of the patient expressly consents to the disclosure. Upon written request, the Board shall revoke a subpoena if, upon a hearing, it finds that the evidence the production of which is required does not relate to a matter in issue, or if the subpoena does not describe with sufficient particularity the evidence the production of which is required, or if for any other reason in law the subpoena is invalid."

SECTION 3. G.S. 90-14(a) reads as rewritten:

"(a) The Board shall have the power to deny, annul, suspend, or revoke a license, or other authority to practice medicine in this State, issued by the Board to any person who has been found by the Board to have committed any of the following acts or conduct, or for any of the following reasons:

(1) Immoral or dishonorable conduct.

(2) Producing or attempting to produce an abortion contrary to law.

(3) Made false statements or representations to the Board, or who has willfully concealed from the Board material information in connection with an application for a license.

(4) Repealed by Session Laws 1977, c. 838, s. 3.

(5) Being unable to practice medicine with reasonable skill and safety to patients by reason of illness, drunkenness, excessive use of alcohol, drugs, chemicals, or any other type of material or by reason of any physical or mental abnormality. The Board is empowered and authorized to require a physician licensed by it to submit to a mental or physical examination by physicians designated by the Board before or after charges may be presented against the physician, and the results of the examination shall be admissible in evidence in a hearing before the Board.

(6) Unprofessional conduct, including, but not limited to, departure from, or the failure to conform to, the standards of acceptable and prevailing medical practice, or the ethics of the medical profession, irrespective of whether or not a patient is injured thereby, or the committing of any act contrary to honesty, justice, or good morals, whether the same is committed in the course of the physician's practice or otherwise, and whether committed within or without North Carolina. The standards of practice in any specialty, including complementary treatments, shall be defined by specialists in that field. The Board shall not annul, suspend, revoke the license of or deny a license to a ~~person~~ person, harass, or initiate an investigation solely because of that person's practice of a therapy that is experimental, nontraditional, or that departs from acceptable and prevailing medical practices unless, by ~~competent~~ a preponderance of the evidence, the Board can establish that the treatment has a ~~safety~~ risk of harm to the patient greater than the prevailing treatment or that the treatment is generally not ~~effective.~~as effective in comparison to the effective rates of other prevailing treatments.

(7) Conviction in any court of a crime involving moral turpitude, or the violation of a law involving the practice of medicine, or a conviction of a felony; provided that a felony conviction shall be treated as provided in subsection (c) of this section.

(8) By false representations has obtained or attempted to obtain practice, money or anything of value.

(9) Has advertised or publicly professed to treat human ailments under a system or school of treatment or practice other than that for which the physician has been educated. A duly licensed physician shall not be prohibited from displaying all of his or her certifications in public documents.

(10) Adjudication of mental incompetency, which shall automatically suspend a license unless the Board orders otherwise.

(11) Lack of professional competence to practice medicine with a reasonable degree of skill and safety for patients. In this connection the Board may consider repeated acts of a physician indicating the physician's failure to properly treat a patient. The Board may, upon reasonable grounds, require a physician to submit to inquiries or examinations, written or oral, by members of the Board or by other physicians licensed to practice medicine in this State, as the Board deems necessary to determine the professional qualifications of such licensee.

(12) Promotion of the sale of drugs, devices, appliances or goods for a patient, or providing services to a patient, in such a manner as to exploit the patient, and upon a finding of the exploitation, the Board may order restitution be made to the payer of the bill, whether the patient or the insurer, by the physician; provided that a determination of the amount of restitution shall be based on credible testimony in the record. Selling nutritional supplements or vitamins shall have the same financial disclosures as those required with drugs, devices, appliances, or goods. Nothing in this subdivision shall restrain free trade or limit the legitimate trade activities involved in the course of the practice of medicine.

(13) Having a license to practice medicine or the authority to practice medicine revoked, suspended, restricted, or acted against or having a license to practice medicine denied by the licensing authority of any jurisdiction. For purposes of this subdivision, the licensing authority's acceptance of a license to practice medicine voluntarily relinquished by a physician or relinquished by stipulation, consent order, or other settlement in response to or in anticipation of the filing of administrative charges against the physician's license, is an action against a license to practice medicine.

(14) The failure to respond, within a reasonable period of time and in a reasonable manner as determined by the Board, to inquiries from the

Board concerning any matter affecting the license to practice medicine. However, the Board shall conclude an investigation pursuant to a violation of this subdivision within 18 months from the date the incident was initially reported.

(15) The failure to complete an amount not to exceed 150 hours of continuing medical education during any three consecutive calendar years pursuant to rules adopted by the Board.

For any of the foregoing reasons, the Board may deny the issuance of a license to an applicant or revoke a license issued to a physician, may suspend such a license for a period of time, and may impose conditions upon the continued practice after such period of suspension as the Board may deem advisable, may limit the accused physician's practice of medicine with respect to the extent, nature or location of the physician's practice as the Board deems advisable. The Board may, in its discretion and upon such terms and conditions and for such period of time as it may prescribe, restore a license so revoked or rescinded, except that no license that has been revoked shall be restored for a period of two years following the date of revocation."

SECTION 4. G.S. 90-14 is amended by adding a new subsection to read:

"(g) In order to annul, suspend, deny, or revoke a license of an accused physician, the Board must find that the facts satisfy, by the greater weight of the evidence, that there is a pattern of incompetence and that the care provided was not in accordance with the standards of practice for the procedures or treatments administered."

SECTION 5. G.S. 90-14.2 reads as rewritten:

"**§ 90-14.2. Hearing before revocation or suspension of a license.**

Before the Board shall revoke, restrict or suspend any license granted by it, the licensee shall be given a written notice indicating the general nature of the charges, accusation, or complaint made against him, which notice may be prepared by a committee or one or more members of the Board designated by the Board, and stating that such licensee will be given an opportunity to be heard concerning such charges or complaint at a time and place stated in such notice, or at a time and place to be thereafter designated by the Board, and the Board shall hold a public hearing not less than 30 days from the date of the service of such notice upon such licensee, at which such licensee may appear personally and through counsel, may cross examine witnesses and present evidence in his own behalf. A physician who is mentally incompetent shall be represented at such hearing and shall be served with notice as herein provided by and through a guardian ad litem appointed by the clerk of the court of the county in which the physician has his residence. Such licensee or physician may, if he desires, file written answers to the charges or complaints preferred against him within 30 days after the service of such notice, which answer shall become a part of the record but shall not constitute evidence in the case. Members of the Board participating on the hearing committee shall not have been involved in any part of the investigation."

SECTION 6. G.S. 90-14.5 reads as rewritten:

"**§ 90-14.5. Use of trial examiner or depositions.**

~~Where the licensee requests~~The licensee may request that the hearing herein provided for be held by the Board in a county other than the county designated for the

holding of the meeting of the Board at which the matter is to be heard, the Board may designate in writing one or more of its members to conduct the hearing as a trial examiner or trial committee, to take evidence and report a written transcript thereof to the Board at a meeting where a majority of the members are present and participating in the decision. Evidence and testimony may also be presented at such hearings and to the Board in the form of depositions taken before any person designated in writing by the Board for such purpose or before any person authorized to administer oaths, in accordance with the procedure for the taking of depositions in civil actions in the superior court. When a trial examiner or trial committee recommends license revocation, suspension, or retraction, the licensee shall be granted a full Board hearing at the licensee's request if the request is made in a timely manner as determined by the Board."

SECTION 7. G.S. 90-14.6 reads as rewritten:

"**§ 90-14.6. Evidence admissible.**

In proceedings held pursuant to this Article the Board shall admit and hear evidence in the same manner and form as prescribed by law for civil actions. A complete record of such evidence shall be made, together with the other proceedings incident to such hearing. The physician under investigation may call witnesses, including medical practitioners licensed in the United States, with expertise in the same field of practice as the physician under investigation. Witnesses shall not be restricted to experts certified by the American Board of Medical Specialties. In an investigative meeting, the physician being investigated may present testimony from medical practitioners licensed in the United States with expertise in the same field of practice as the physician under investigation. Members of the Board shall not be immune from civil or criminal liability for failing to exercise, in good faith, its powers and duties authorized by law."

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

HOUSE BILL 886:
Due Process for Physicians

BILL ANALYSIS

Committee:	House Health	**Introduced by:**	Rep. Wright and Howard
Date:	April 22, 2003	**Summary by:**	Dianna Jessup
Version:	PCS H886-CSSW-14		Committee Counsel

SUMMARY: ***House Bill 886 would amend various provisions relating to the North Carolina Medical Board under the laws regulating the practice of medicine. The act would become effective when it becomes law.***

The PCS makes the changes described more fully below.

CURRENT LAW: The North Carolina Medical Board (Board) is charged with regulating the practice of medicine and surgery in this State. The Board is comprised of 12 members who serve for three-year terms. Of the terms of the current members, four are due to expire in October 2003.

Currently, the North Carolina Medical Society (an association of physicians) nominates seven members for appointment to the Board by the Governor. Nominees from the Society's Executive Council fill any vacancies in these positions.

The Board is authorized to adopt rules governing applicants for licensure, admission, and the conduct of examinations for licensure and admission and to deny, annul, suspend, or revoke the license or other authority to practice medicine in this State. The Board conducts both informal meetings to inquire into matters (called investigative meetings) and formal hearings.

The president and the secretary of the Board may administer oaths and issue subpoenas for the appearance of witnesses to testify concerning any matter before the Board. The Board may also order pertinent documents, including patient records, to be produced for inspection.

The Board can deny, annul, suspend, or revoke a license for a variety of reasons enumerated by statute. Reasons pertinent to this bill include:

1. Unprofessional conduct that departs from the standard of acceptable and prevailing medical practice. The Board cannot, however, revoke the license of or deny a license to a person solely because that person's practice of an experimental or nontraditional therapy unless, by competent evidence, the Board can establish a safety risk greater than the prevailing treatment.
2. Advertising or publicly professing to treat ailments under a system or school of treatment or practice other than that for which the physician has been educated.
3. Promoting the sale of drugs, devices, appliances or goods for a patient or providing services to a patient, in a manner to exploit the patient. There are ethical guidelines from the Board and the American Medical Society relating to the sale of goods from physicians' offices.

Before the Board can revoke, restrict or suspend a license, the licensee must be given notice and an opportunity to be heard. At the hearing, the licensee may cross-examine witnesses and present evidence. The rules of procedure and evidence for civil actions apply. If the licensee requests that the hearing be held in a county other than where the full Board meets, the Board may designate a committee of its members to conduct the hearing.

BILL ANALYSIS:

Section 1 would amend the provisions of the statute related to the appointment and removal of members of the North Carolina Medical Board as follows:

- The original bill provided that the Governor's physician appointees would not be appointed from nominees provided by the North Carolina Medical Society. *The PCS provides that of the physician appointments, three shall be physicians nominated by the North Carolina Medical Society, three shall be physicians nominated by The Old North State Medical Society, and one shall be a physician nominated by the North Carolina Osteopathic Medical Association. Vacancies would be filled from nominees provided by the applicable professional organization.*
- One of the physician appointees would have to be a faculty member at one of the State's medical schools.
- The Governor would be required to remove a member of the Board for "good cause shown", including malicious prosecution or abuse of power.
- *The PCS adds language that would provide that each appointing and nominating authority shall ensure, insofar as possible, that its appointees and nominees reflect the composition of the State with regard to ethnic, racial, age, and religious composition.*

Section 2 would amend the provisions relating to the Board's power to administer oaths and subpoena witnesses to specify that the Board's power to subpoena would be limited to persons with knowledge related to a matter before the Board. *The PCS moves the following language to Sections 5 and 7 of the bill:* Language in this section would specify that medical expert witnesses must routinely and actively practice in the specialty under investigation by the Board, and that for expert witnesses, the parties must disclose *(at least 15 days prior to any hearing)* the expert's identity, the subjects on which the expert is expected to testify, the substance of the facts and opinion on which the expert is expected to rely, and the qualifications of the expert. Statements contained in medical or scientific literature would be competent evidence.

Section 3 would amend the law relating to the grounds for denying, annulling, suspending, or revoking a license to provide as follows:

- The standards of practice in any specialty, including complementary treatments, shall be defined by specialists in that field.
- The Board cannot annul or suspend a license, and the Board cannot initiate an investigation solely because a person's practice is experimental, nontraditional, or departs from acceptable and prevailing medical practice unless by a preponderance of the evidence, the Board can establish that the treatment has a risk of harm to the patient greater than the prevailing treatment or that the treatment is generally not as effective in comparison to the effective rates of other prevailing treatments.
- A duly licensed physician cannot be prohibited from displaying the physician's certifications in public documents.
- Selling nutritional supplements or vitamins shall have the same financial disclosures as those required with drugs, devices, appliances, or goods. *The PCS clarifies that the Board shall not deny, annul, suspend, or revoke a license for selling these goods so long as the physician provides the financial disclosures recommended by the Board for drugs, devices, appliances, or goods.*

- The Board must conclude an investigation into a failure to respond to a Board inquiry within 18 months from the date the incident was initially reported. *The PCS makes this provision generally applicable to all investigations and would provide that the Board must notify the accused person of the conclusion of the investigation.*

Section 4 would require the Board to find, by a greater weight of the evidence, a pattern of incompetence and a deviation from the standard of practice in order to be able to annul, suspend, deny, or revoke the license of an accused physician.

Section 5 would prohibit members of the Board who investigated a licensee from serving on the hearing committee that conducts the hearing concerning that licensee. *See Section 2 for the changes made by the PCS.*

Section 6 would require a full Board hearing in cases where a trial examiner or trial committee recommends license revocation, suspension, or retraction, if the licensee requests one in a timely manner (to be determined by the Board). *The PCS provides that a full hearing must be held if the licensee requests one within ten days after the Board decides the matter.*

Section 7 would specify that for Board proceedings, a physician under investigation may call witnesses, including medical practitioners, with expertise in the same field of practice as the physician under investigation. Witnesses would not be restricted to experts certified by the American Board of Medical Specialties. In an investigative meeting (a non-public, informal meeting), the physician being investigated may present testimony from licensed medical practitioners with expertise in the same field of practice as the physician. *See Section 2 for other changes made by the PCS.*

This section also adds language that prevents Board members from being immune from civil or criminal liability for failing to exercise, in good faith, its powers and duties authorized by law. *The PCS removes this language.*

Section 8 makes the act effective when it becomes law.

H866-SMSW-001

House Committee on Health

April 17, 2003

Minutes

The House Committee on Health met on Thursday, April 17, 2003 at 12:00 noon in Room 544 of the Legislative Office Building. A silent roll was taken. A copy of the roll denoting members present is attached to the minutes (Attachment I) along with a copy of the agenda* and Visitor Registration Sheet (Attachments II and III).

Chair Insko welcomed members and visitors. Dusty Rhodes, Francis Poole and Jackson Stancil were recognized as the sergeant-at-arms. (Attachment IV) No pages were present at meeting.

Immediately after the meeting was called to order. Rep. Sherill made motion to adjourn. Motion adopted.

Chair adjourned meeting at 11:07 a.m.

Verla Insko
Rep. Verla Insko, Chair

Pamela J. Evans
Pamela Evans, Committee Clerk

(*Note: Bills, bill analysis, fiscal notes, etc. referred to in the Agenda are attached for the record as Attachment V)

ATTENDANCE

HOUSE COMMITTEE ON HEALTH

DATES	4/17/03														
INSKO, Verla CHAIR	✓														
JUSTUS, Carolyn CHAIR	✓														
ENGLAND, Bob VICE-CHAIR	✓														
ADAMS, Alma															
ALLEN, Bernard															
ALLEN, Gordon	✓														
ALLRED, Cary	✓														
BARNHART, Jeff	✓														
BOWIE, Joni															
CLARY, Debbie															
EARLE, Beverly															
GLAZIER, Rick															
HILTON, Mark															
McALLISTER, Mary															
MUNFORD, Don	✓														
SETZER, Mitchell	✓														
SHERRILL, Wilma	✓														
WAINWRIGHT, William															
WILSON, Connie															
WRIGHT, Tom															
Ex officio Members															
Brubaker, Bru															
Culpepper, Bill															
Cunningham, Pete															
Eddins, Rick															

AGENDA

HOUSE COMMITTEE ON HEALTH

April 17, 2003
Room 544 LOB
12:00 Noon

OPENING REMARKS

Representative Verla Insko, Chair
Representative Carolyn Justus, Chair

AGENDA ITEMS

HB 170 **Expand Special Assistance Demo Project – Primary Sponsors: Rep. Verla Insko and Rep. Beverly Earle**

HB 883 **MH Reform Waiver – Primary Sponsor: Rep. Verla Insko**

HB 886 **Due Process for Physicians – Primary Sponsors: Rep. Thomas Wright and Rep. Julia Howard**

HB 916 **First-Responders Vaccination Program – Primary Sponsor: Rep. Harold Brubaker**

ADJOURNMENT

ATTACHMENT III

VISITOR REGISTRATION SHEET

HOUSE COMMITTEE ON HEALTH — APRIL 17, 2003

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
	DBS/DHHS
	Abbott Labs
C. Porter	Swidler Anderson.
Stacy Flannery	NCHCFA

ATTACHMENT IV Health
504
4/17/03

House Pages

1. Name: _____

   County: _____

   Sponsor: _____

2. Name: _____

   County: _____

   Sponsor: _____

3. Name: _____

   County: _____

   Sponsor: _____

4. Name: _____

   County: _____

   Sponsor: _____

5. Name: _____

   County: _____

   Sponsor: _____

Sgt-At-Arms

1. Name: Dusty Rhodes
2. Name: Francis Poole
3. Name: Jackson Stancil
4. Name: _____

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2003

H 1

HOUSE BILL 170*

Short Title:	Expand Special Assistance Demo Project.	(Public)
Sponsors:	Representatives Insko, Earle; Adams, Alexander, Bonner, Farmer-Butterfield, Luebke, Walend, Warren, Weiss, and Yongue.	
Referred to:	Health, if favorable, Appropriations.	

March 4, 2003

A BILL TO BE ENTITLED

AN ACT TO EXPAND THE STATE/COUNTY SPECIAL ASSISTANCE IN-HOME DEMONSTRATION PROJECT BY PERMITTING THE DEPARTMENT OF HEALTH AND HUMAN SERVICES TO INCREASE THE NUMBER OF INDIVIDUALS WHO MAY BE ENROLLED IN THE PROJECT.

The General Assembly of North Carolina enacts:

SECTION 1.(a) The Department of Health and Human Services may use funds from the existing State/County Special Assistance for Adults budget to provide Special Assistance payments to eligible individuals in in-home living arrangements. These payments may be made for up to a two-year period beginning July 1, 2003, and ending June 30, 2005. The standard monthly payment to individuals enrolled in the Special Assistance demonstration project shall be fifty percent (50%) of the monthly payment the individual would receive if the individual resided in an adult care home and qualified for Special Assistance, except if a lesser payment amount is appropriate for the individual as determined by the local case manager. The Department shall implement Special Assistance in-home eligibility policies and procedures to assure that demonstration project participants are those individuals who need and, but for the demonstration project, would seek placement in an adult care home facility. The Department shall make this demonstration project available to all counties on a voluntary basis. To the maximum extent possible, the Department shall consider geographic balance in the dispersion of payments to individuals across the State. The Department shall make an interim report to the cochairs of the House of Representatives Appropriations Committee, the cochairs of the House of Representatives Appropriations Subcommittee on Health and Human Services, the cochairs of the Senate Appropriations Committee, and the Chair of the Senate Appropriations Committee on Human Resources by June 30, 2004, and a final report by January 1, 2005. The final report shall also be sent to the North Carolina Study Commission on Aging. This report shall include the following information:

(1) A description of cost savings that could occur by allowing individuals eligible for State/County Special Assistance the option of remaining in the home.
(2) Which activities of daily living or other need criteria are reliable indicators for identifying individuals with the greatest need for income supplements for in-home living arrangements.
(3) How much case management is needed and which types of individuals are most in need of case management.
(4) The geographic location of individuals receiving payments under this section.
(5) A description of the services purchased with these payments.
(6) A description of the income levels of individuals who receive payments under this section and the impact on the Medicaid program.
(7) Findings and recommendations as to the feasibility of continuing or expanding the demonstration program.
(8) The level and quantity of services (including personal care services) provided to the demonstration project participants compared to the level and quantity of services for residents in adult care homes.
(9) A fiscal analysis and programmatic results of increasing the demonstration project participant's monthly assistance payment to fifty percent (50%) of the Special Assistance monthly payment.
(10) A fiscal analysis of the budgetary impact of any increases in staff responsibility resulting from utilization of the Demonstration Program.

SECTION 1.(b) The Department shall incorporate data collection tools designed to compare quality of life among institutionalized vs. noninstitutionalized populations (i.e. an individual's perception of his or her own health and well-being, years of healthy life, and activity limitations). To the extent national standards are available, the Department shall utilize those standards.

SECTION 1.(c) The Department shall expand its report of the Demonstration Program in order to fully assess the success of the pilot. The Department shall contract with an independent consultant to develop an evaluation design that ensures that the evaluation includes an assessment of the impact of the Program on the economic security, health, and well-being of the participants.

SECTION 2. The Department of Health and Human Services shall use funds appropriated to it for the 2003 biennium for the Special Assistance payments authorized in Section 1 of this act.

SECTION 3. This act becomes effective July 1, 2003.

HOUSE BILL 170:
Special Assistance In-Home Option

BILL ANALYSIS

Committee:	House Health	**Introduced by:**	Reps. Insko and Earle
Date:	April 17, 2003	**Summary by:**	Dianna Jessup
Version:	H170-CSSW-9 [v.2]		Committee Counsel

SUMMARY: ***House Bill 170 would expand the State/County Special Assistance In-Home Demonstration Project (Demonstration Project) by permitting the Department of Health and Human Services (DHHS) to increase the number of individuals who may be enrolled in the project.***

The PCS for House Bill 170 would eliminate the pilot status of the Demonstration Project and would rename it the State/County Special Assistance In-Home Option (In-Home Option). Special Assistance payments would be made to no more than 2,000 eligible individuals in in-home living arrangements. The PCS would also change the reporting requirements for DHHS. The act would become effective July 1, 2003.

CURRENT LAW: Sec. 11.21 of S.L. 1999-237 (The Appropriations Act) permitted DHHS to establish a Demonstration Project allowing participants to remain in their homes and receive Special Assistance payments. These payments would be made for up to 400 individuals and the Demonstration Project would end June 30, 2001. Subsequent Appropriations Act provisions extended the Demonstration Project. Section 21.29 of S.L. 2001-424 provides that individuals enrolled in the Demonstration Project as of June 30, 2002 would continue to receive payments through June 30, 2003.

According to a final report submitted by the Division of Social Services, DHHS in January 2003, a total of 377 individuals received Special Assistance at home during the September 2000-August 2002 period. Currently, this program is available in 22 counties. Special Assistance payments supplement an individual's income so that the individual will have sufficient income to pay for care in an adult care home, or during this Demonstration Project, to live at home. The individual must need adult care home level of care, as verified by a physician, in order to qualify for either payment. An individual participating in the program is assessed using the Residential Assessment Instrument (RAI), and the information from the RAI is sent to a centralized database. From that database, DHHS is able to determine the characteristics of the individuals in the program and what services are being purchased. Based on the comparison of the relative costs of in-home payments versus payments to adult care homes, DHHS recommended expanding this program both geographically and programmatically to include more individuals.

BILL ANALYSIS: The PCS for HB 170 would permit DHHS to use funds appropriated to it for the 2003 biennium to provide Special Assistance payments to no more than 2,000 eligible individuals in in-home living arrangements. The standard monthly payment to individuals enrolled in the In-Home Option would be 50% of the monthly payment the individual would have received had the individual resided in an adult care home and qualified for special assistance, unless the local case manager determines that a lesser amount is appropriate. DHHS would make the In-Home Option available to all counties on a voluntary basis and would consider geographic balance in the dispersion of payments to individuals across the State.

REPORT: DHHS would be required to make a report to the cochairs of the House of Representatives Appropriations Committee, the co-chairs of the House Appropriations Subcommittee on Health and

Human Services, the co-chairs of the Senate Appropriations Committee, and the chair of the Senate Appropriations Committee on Human Resources by January 1, 2005. The report would also be sent to the North Carolina Study Commission on Aging. The report would include the following information:

- A description of cost savings that results from allowing individuals eligible for State/County Special Assistance the option of remaining in the home.
- The geographic location of individuals receiving payments under this section.
- A description of the services purchased with these payments.

BACKGROUND: The original bill was a recommendation from the North Carolina Study Commission on Aging (Commission) to the 2003 General Assembly. Based upon the final report prepared by the Division of Social Services, DHHS, and its presentation to the Commission, the Commission recommended that the General Assembly expand the State/County Special Assistance in-home component by permitting DHHS to increase the number of individuals who may be enrolled in the Demonstration Project. The Commission also recommended that the Demonstration Project be made available to all counties on a voluntary basis.

Amy Compeau, Research Assistant contributed to this summary.

H170-SMSW-001

FISCAL ANALYSIS MEMORANDUM

[This confidential fiscal memorandum is a fiscal analysis of a draft bill, amendment, committee substitute, or conference committee report that has not been formally introduced or adopted on the chamber floor or in committee. This is not an official fiscal note. If upon introduction of the bill you determine that a formal fiscal note is needed, please make a fiscal note request to the Fiscal Research Division, and one will be provided under the rules of the House and the Senate.]

DATE: **April 16, 2003**

TO: Representative Verla Insko

FROM: Susan Morgan
Fiscal Research Division

RE: House Bill 170-(Proposed Committee Substitute)
"Special Assistance In-Home Option"

FISCAL IMPACT

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

	FY 2003-04	FY 2004-05	FY 2005-06	FY 2006-07	FY 2007-08
EXPENDITURES	See Assumptions				

PRINCIPAL DEPARTMENT(S) & PROGRAM(S) AFFECTED: Department of Health and Human Services – Division of Social Services

EFFECTIVE DATE: July 1, 2003

ISSUE BACKGROUND:

State/County Special Assistance (SA) provides payments to eligible individuals who live in the following types of facilities that are licensed under state law by the Division of Facility Services: adult care homes, family care homes, group homes for developmentally disabled adults, group homes for mentally ill adults, and adult care homes that are located in nursing homes (known as combination facilities). SA is funded 50% by the state and 50% by the county. In 1999, the General Assembly authorized the Department of Health and Human

Services to implement a demonstration project that would provide SA payments to individuals who qualified for SA, but chose to remain in their home. Individuals were identified as potential participants in the demonstration project upon applying for SA and seeking placement in an adult care home or other facility. Participants were allowed to receive an SA payment (50% of the standard SA payment) and remain in their home while receiving additional community-based services determined necessary by a social services case manager at the local level. The number of participants in the demonstration project was capped at 400 participants, and 22 counties participated in the project.

BILL SUMMARY:

The bill will allow all North Carolina counties to participate in a Special Assistance In-Home Program, and increases the maximum number of participants from 400 to 2,000. Counties are not required to participate in the In-Home Program. The bill maintains the stipulation that participants shall receive 50% of the payment they would have received in entering a facility, unless a lesser amount is determined appropriate as determined by a local case manager. The Department is directed to implement policies to assure that the participants in the In-Home Program would have required placement in a facility had this option not been available. The bill requires the In-Home Program to be funded within existing resources allocated for State/County Special Assistance.

ASSUMPTIONS AND METHODOLOGY:

The impact of this bill on the general fund and on local budgets is based on a basic analysis of allowing a maximum of 50% of the standard SA payment for participants in the In-Home Program. This analysis considers *only* the impact to the SA budget and does not address the potential impact on other services such as Medicaid and other community-based services, such as the Home and Community Care Block Grant.

A comparison of Standard State/County Special Assistance, and the proposed In-Home Program follows:

	Standard SA	**In-Home Program**
Number of Participants	2000[1]	2000
Average Monthly Payment/Person	$426	$184
Average Annual Payment/Person	$5,112	$2,208
Total Expenditures	$10,224,000	$4,416,000
Total *State* Expenditures (50%)	$$5,112,000	$2,208,000
Projected Savings/Year	N/A	$2,904,000
Cumulative Savings/ 5 Years[2]		$14,520,000

[1]SA is an entitlement program and anyone determined to be eligible is entitled to benefits, including Medicaid Benefits.
[2]Assumes SA rates would remain at current rate of $1,091/month/person.

SOURCES OF DATA: Special Assistance Demonstration Project Final Report, January 2003 – Average payment data based on 377 participants.

TECHNICAL CONSIDERATIONS:

The projected savings identified are calculated with the assumption that the Department will be successful in assuring that participants would have been placed in a facility and received standard SA payments had this program not been available. If any of the 2000 participants in the In-Home Program would not have entered a facility had this program not been offered, then the projected savings would be decreased by the average annual per person expenditure ($2,208).

This analysis is also based on the continued "cap" of the program at 2,000 participants, and does not included the impact to other programs at the local level.

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2003

H D

HOUSE BILL 883
PROPOSED COMMITTEE SUBSTITUTE H883-CSSW-13 [v.1]

4/15/2003 9:13:23 AM

Short Title: MH Reform Waiver. (Public)

Sponsors:

Referred to:

April 7, 2003

A BILL TO BE ENTITLED

AN ACT TO AUTHORIZE THE SECRETARY OF HEALTH AND HUMAN SERVICES TO TEMPORARILY WAIVE CERTAIN REQUIREMENTS OF THE MENTAL HEALTH COMMITMENT STATUTES TO FURTHER MENTAL HEALTH REFORM EFFORTS.

The General Assembly of North Carolina enacts:

SECTION 1. The Secretary of Health and Human Services may, upon request of a phase-one local management entity, waive temporarily the requirements of G.S. 122C-261 through G.S. 122C-263 and G.S. 122C-281 through G.S. 122C-283 pertaining to initial (first-level) examinations by a physician or eligible psychologist of individuals meeting the criteria of G.S. 122C-261(a) or G.S. 122C-281(a), as applicable, as follows:

(1) The Secretary has received a request from a phase-one local management entity to substitute for a physician or eligible psychologist, a licensed clinical social worker, a masters level psychiatric nurse, or a masters level certified clinical addictions specialist to conduct the initial (first-level) examinations of individuals meeting the criteria of G.S. 122C-261(a) or G.S. 122C-281(a). The waiver shall be implemented on a pilot-program basis. The request from the local management entity shall be submitted as part of the entity's local business plan and shall specifically describe:

a. How the purpose of the statutory requirement would be better served by waiving the requirement and substituting the proposed change under the waiver.

b. How the waiver will enable the local management entity to improve the delivery or management of mental health, developmental disabilities, and substance abuse services.

c. How the services to be provided by the licensed clinical social worker, the masters level psychiatric nurse, or the masters level certified clinical addictions specialist under the waiver are within each of these professional's scope of practice.

d. How the health, safety, and welfare of individuals will continue to be at least as well protected under the waiver as under the statutory requirement.

e. The method to be used to evaluate the effectiveness and efficiency of mental health, developmental disabilities, and substance abuse services and protection of health, safety, and welfare under the waiver.

(2) The Secretary shall review the request and may approve it upon finding that:

a. The request meets the requirements of this section.

b. The request furthers the purposes of State policy under G.S. 122C-2, and mental health, developmental disabilities, and substance abuse services reform.

c. The request improves the delivery of mental health, developmental disabilities, and substance abuse services in the counties affected by the waiver and also protects the health, safety, and welfare of individuals receiving these services.

d. The duties and responsibilities performed by the licensed clinical social worker, the masters level psychiatric nurse, or the masters level certified clinical addictions specialist are within the individual's scope of practice.

(3) The waiver granted by the Secretary under this section shall be in effect for a period not to exceed three years, or the period for which the requesting local management entity's business plan is approved, whichever is shorter.

(4) The Secretary may grant a waiver under this section only to those local management entities that have been designated as phase-one entities as of July 1, 2003.

(5) In no event shall the substitution of a licensed clinical social worker, masters level psychiatric nurse, or masters level certified clinical addictions specialist under a waiver granted under this section be construed as authorization to expand the scope of practice of the licensed clinical social worker, the masters level psychiatric nurse, or the masters level certified clinical addictions specialist.

(6) The Department shall assure that staff performing the duties are trained and privileged to perform the functions identified in the waiver.

(7) The local management entity shall assure that a psychiatrist is available at all times to provide back-up services.

SECTION 2. This act becomes effective July 1, 2003, and expires July 1, 2006.

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2003

HOUSE BILL 883

Short Title:	MH Reform Waiver.	(Public)
Sponsors:	Representative Insko.	
Referred to:	Health.	

April 7, 2003

A BILL TO BE ENTITLED

AN ACT TO AUTHORIZE THE SECRETARY OF HEALTH AND HUMAN SERVICES TO TEMPORARILY WAIVE CERTAIN REQUIREMENTS OF THE MENTAL HEALTH COMMITMENT STATUTES TO FURTHER MENTAL HEALTH REFORM EFFORTS.

The General Assembly of North Carolina enacts:

SECTION 1. The Secretary of Health and Human Services may, upon request of a phase-one local management entity, waive temporarily the requirements of G.S. 122C-261 through G.S. 122C-263 and G.S. 122C-281 through G.S. 122C-283 pertaining to initial (first-level) examinations by a physician or eligible psychologist of individuals meeting the criteria of G.S. 122C-261(a) or G.S. 122C-281(a), as applicable, as follows:

(1) The Secretary has received a request from a phase-one local management entity to substitute for a physician or eligible psychologist, a licensed clinical social worker, a masters level psychiatric nurse, or a masters level certified clinical addiction specialist to conduct the initial (first-level) examinations of individuals meeting the criteria of G.S. 122C-261(a) or G.S. 122C-281(a). The waiver shall be implemented on a pilot-program basis. The request from the local management entity shall be submitted as part of the entity's local business plan and shall specifically describe:

a. How the purpose of the statutory requirement would be better served by waiving the requirement and substituting the proposed change under the waiver.

b. How the waiver will enable the local management entity to improve the delivery or management of mental health, developmental disabilities, and substance abuse services.

c. How the services to be provided by the licensed clinical social worker, the masters level psychiatric nurse, or the masters level

certified clinical addiction specialist under the waiver are within each of these professional's scope of practice.

d. How the health, safety, and welfare of individuals will continue to be at least as well protected under the waiver as under the statutory requirement.

e. The method to be used to evaluate the effectiveness and efficiency of mental health, developmental disabilities, and substance abuse services and protection of health, safety, and welfare under the waiver.

(2) The Secretary shall review the request and may approve it upon finding that:

a. The request meets the requirements of this section.

b. The request furthers the purposes of State policy under G.S. 122C-2, and mental health, developmental disabilities, and substance abuse services reform.

c. The request improves the delivery of mental health, developmental disabilities, and substance abuse services in the counties affected by the waiver and also protects the health, safety, and welfare of individuals receiving these services.

d. The duties and responsibilities performed by the licensed clinical social worker, the masters level psychiatric nurse, or the masters level certified clinical addiction specialist are within the individual's scope of practice.

(3) The waiver granted by the Secretary under this section shall be in effect for a period not to exceed three years, or the period for which the requesting local management entity's business plan is approved, whichever is shorter.

(4) The Secretary may grant a waiver under this section only to those local management entities that have been designated as phase-one entities as of July 1, 2003.

(5) In no event shall the substitution of a licensed clinical social worker, masters level psychiatric nurse, or masters level certified clinical addiction specialist under a waiver granted under this section be construed as authorization to expand the scope of practice of the licensed clinical social worker, the masters level psychiatric nurse, or the masters level certified clinical addiction specialist.

(6) The Department shall assure that staff performing the duties are trained and privileged to perform the functions identified in the waiver.

(7) The local management entity shall assure that a psychiatrist is available at all times to provide back-up services.

SECTION 2. This act becomes effective July 1, 2003, and expires July 1, 2006.

HOUSE BILL 883:
MH Reform Waiver

BILL ANALYSIS

Committee:	House Health	**Introduced by:**	Rep. Insko
Date:	April 15, 2003	**Summary by:**	Dianna Jessup
Version:	First Edition		Committee Counsel

SUMMARY: ***House Bill 883 would authorize the Secretary of the Department of Health and Human Services (Secretary) to permit phase one, mental health local management entities (LMEs) to substitute for a physician or eligible psychologist, a licensed clinical social worker, a masters level psychiatric nurse, or a masters level certified clinical addictions specialist to conduct the initial (first-level) examination of individuals in involuntary commitment proceedings. Any waiver could only be in effect for a period not to exceed three years. The bill would not expand the scope of practice for licensed clinical social workers, masters level psychiatric nurses, or masters level certified clinical addictions specialists. The act would become effective July 1, 2003 and expire July 1, 2006.***

CURRENT LAW:

Mental Health Reform: As enacted by the 2001 General Assembly, S.L. 2001-437 (HB 381), amended the mental health statutes to provide counties an alternative to establishing area authorities to ensure the provision of public mental health, developmentally disabled and substance abuse (MH/DD/SA) services to consumers. Counties were authorized to withdraw from existing area authorities and to ensure the delivery of public MH/DD/SA services through a single county program or jointly with one or more counties through a joint agency established pursuant to the terms of an interlocal agreement. (County programs and area authorities are known as LMEs). By October 1, 2002, each county was to have sent a letter of intent to the Secretary indicating the intent of the county or counties to provide services through an existing area authority or through a county program. The bill provided for phased-in implementation of reform, requiring the Secretary to certify the business plans of one-third of the area authorities and county programs by July 1, 2003; two-thirds of the area authorities and county programs by January 1, 2004; and complete certification of all area authorities and county programs by July 1, 2004.

Under the new governance scheme, LMEs are required to develop "business plans" to guide the management and delivery of services. These business plans are required to be submitted to the Secretary for review and certification. The business plans must provide a description of how core administrative functions will be carried out, including planning to ensure the provision of services, ensuring available, qualified providers to deliver services, service management, financial management, service monitoring, evaluation, and collaboration with other local service systems. Business plans are effective for three State fiscal years.

Involuntary Commitment: Anyone who has knowledge that a person who is mentally ill or is a substance abuser and who is dangerous to self or dangerous to others may petition the court for issuance of an order to take the respondent into custody for examination by a physician or eligible psychologist. If the clerk finds reasonable grounds to believe that the facts in the petition are true and the respondent is dangerous to self or others, the clerk may order the respondent to be taken into custody for an initial examination by a physician or eligible psychologist. If the physician or eligible psychologist recommends inpatient commitment, then a *physician* is required to perform an examination of the respondent within 24 hours after the respondent is admitted into a facility. This examination would determine whether the respondent is mentally ill or a substance abuser and is dangerous to self or dangerous to others, and the results of this

examination are considered by the court at the hearing to determine whether the respondent should be involuntarily committed.

Licensed Clinical Social Workers (LCSW): Social workers are licensed under Chapter 90B of the General Statutes. G.S. 90B-3 defines a LCSW to mean a person who is competent to function independently, who holds himself or herself out to the public as a social worker, and who offers or provides clinical social work services or supervises others engaging in clinical social work practice. According to the North Carolina Social Work Board website, the requirements for becoming a LCSW include the following:

- A Masters in Social Work (MSW), a Doctorate in Social Work (DSW), or a Doctorate in Philosophy (PhD) from a Council on Social Work Education (CSWE) accredited program.
- 3,000 hours of paid employment accumulated in no less than two years nor more than six years. (No more than 1500 hours accumulated in one year.)
- 100 hours of clinical supervision from a LCSW with a graduate degree in Social Work and two years of supervised clinical experience. Of these 100 hours at least 75 hours must have been individual supervision.
- Take and pass the American Association of Social Work Boards "Clinical level" examination.

Psychiatric Nurses: 10-3C.5202 of the NC Administrative Code defines a psychiatric nurse to mean an individual who is licensed to practice as a registered nurse in the State by the NC Board of Nursing; and has the following:

- A graduate degree from an accredited master's level program in psychiatric mental health nursing with two years of experience; or
- A master's degree in behavioral science with two years of supervised clinical experience in psychiatric mental health nursing; or
- A baccalaureate degree in behavioral science with four years of supervised clinical experience in psychiatric mental health nursing.

According to the NC Board of Nursing, a masters level psychiatric nurse is an advanced practice registered nurse generally referred to as a psychiatric-mental health clinical nurse specialist. A masters level psychiatric nurse would be eligible for direct reimbursement of services.

Certified Clinical Addictions Specialists: G.S. 90-113.31 defines a certified clinical addictions specialist to be a person certified by the NC Substance Abuse Professional Certification Board to practice as a clinical addictions specialist in accordance with the provisions of Article 5C of the General Statutes. G.S. 90-113.40 requires the Board to issue a certificate certifying an applicant as a certified clinical addictions specialist if it meets certain requirements for a certified substance abuse counselor or a certified substance abuse prevention consultant and meets one of four sets of criteria specified in statute.

BILL ANALYSIS: House Bill 883 would authorize the Secretary, upon request of a phase-one LME, to waive temporarily the requirements of the involuntary commitment statutes regarding who can conduct the initial examination to permit LCSWs, masters level psychiatric nurses, or masters level certified clinical addictions specialists to conduct the examination. In order to obtain this waiver, the LME must, as part of its business plan, describe how the purpose of the statutory requirement would be better served by waiving the requirement, how the waiver will enable the LME to improve the delivery or management

of services, how the services to be provided by the LCSWs, masters level psychiatric nurses, and masters level certified clinical addictions specialists are within the scope of practice for those professions, how the health, safety, and welfare of persons will be protected, and the method to be used to evaluate the effectiveness and efficiency of services under the waiver. In order to approve the LME's request for the waiver, the Secretary must find that: (1) the request meets the requirements of the bill, (2) the request furthers the purposes of State policy, and MH/DD/SA services reform, (3) the request improves the delivery of MH/DD/SA services in the counties affected by the waiver and protects the health, safety, and welfare of individuals receiving these services, and (4) the duties and responsibilities performed by the LCSWs, masters level psychiatric nurses, or the masters level certified clinical addictions specialists are within the scope of practice for these professions. Waivers could be in effect for a period not to exceed three years or the period, for which the business plan is approved, whichever is shorter. The Secretary may grant a waiver under this section only to those LMEs that have been designated as phase-one entities as of July 1, 2003. **According to the Division of MH/DD/SA services, there are currently 13 LMEs that have been designated as phase-one entities.** The Department would have to ensure that staff performing the duties are trained and privileged to perform the functions identified in the waiver, and the LME would have to ensure that a psychiatrist is available at all times to provide back-up services.

The act would become effective July 1, 2003 and expire July 1, 2006.

Amy Compeau, Research Assistant, contributed to this summary.

H883-SMSW-001

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2003

HOUSE BILL 886

Short Title:	Due Process for Physicians.	(Public)
Sponsors:	Representatives Wright and Howard (Primary Sponsors).	
Referred to:	Health.	

April 7, 2003

A BILL TO BE ENTITLED

AN ACT TO AMEND VARIOUS PROVISIONS RELATING TO THE NORTH CAROLINA MEDICAL BOARD UNDER THE LAWS REGULATING THE PRACTICE OF MEDICINE.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 90-2 reads as rewritten:

"**§ 90-2. Medical Board.**

(a) In order to properly regulate the practice of medicine and surgery for the benefit and protection of the people of North Carolina, there is established the North Carolina Medical Board. The Board shall consist of 12 members.

(1) Seven of the members shall be duly licensed physicians elected and nominated ~~to~~ by the ~~Governor by the North Carolina Medical Society.~~ Governor. Of the seven members appointed by the Governor, one member shall be a faculty member at one of the medical schools in North Carolina.

(2) Of the remaining five members, all to be appointed by the Governor, at least three shall be public members and at least one shall be a physician assistant as defined in G.S. 90-18.1 or a nurse practitioner as defined in G.S. 90-18.2. A public member shall not be a health care provider nor the spouse of a health care provider. For purposes of board membership, "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 section, a person enrolled in a program to prepare him to be a licensed health care professional or an allied health professional shall be deemed a health care provider. For purposes of this section, any person with significant financial interest in a health service or profession is not a public member.

(b) No member appointed to the Board on or after November 1, 1981, shall serve more than two complete consecutive three-year terms, except that each member shall serve until his successor is chosen and qualifies.

(c) In order to establish regularly overlapping terms, the terms of office of the members shall expire as follows: two on October 31, 1993; four on October 31, 1994; four on October 31, 1995; and two on October 31, 1996.

(d) ~~Any~~A member of the Board ~~may~~ shall be removed from office by the Governor for good cause ~~shown.~~shown, including malicious prosecution or abuse of power. Any vacancy in the physician membership of the Board shall be filled for the period of the unexpired term by the ~~Governor from a list of physicians submitted by the North Carolina Medical Society Executive Council.~~Governor. Any vacancy in the public, physician assistant, or nurse practitioner membership of the Board shall be filled by the Governor for the unexpired term.

(e) The North Carolina Medical Board shall have the power to acquire, hold, rent, encumber, alienate, and otherwise deal with real property in the same manner as any 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."

SECTION 2. G.S. 90-8 reads as rewritten:

"**§ 90-8. Officers may administer oaths, and subpoena witnesses, records and other materials.**

The president and secretary of the Board may administer oaths to all persons appearing before it as the Board may deem necessary to perform its duties, and may summon and issue subpoenas for the appearance of any witnesses deemed necessary to testify concerning any matter to be heard before or inquired into by the Board. The power of the Board to subpoena is limited to persons with knowledge related to a matter before the Board. Medical expert witnesses, including medical practitioners licensed in the United States, must routinely and actively practice in the specialty that is under investigation by the Board. Each party must disclose the identity of an expert, the subjects on which the expert is expected to testify, the substance of the facts and opinions on which the expert is expected to rely, and the qualifications of the expert. Statements contained in medical or scientific literature may be relied upon in direct and cross-examination and admitted into evidence. The Board may order that any patient records, documents or other material concerning any matter to be heard before or inquired into by the Board shall be produced before the Board or made available for inspection, notwithstanding any other provisions of law providing for the application of any physician-patient privilege with respect to such records, documents or other material. All records, documents, or other material compiled by the Board are subject to the provisions of G.S. 90-16. Notwithstanding the provisions of G.S. 90-16, in any proceeding before the Board, in any record of any hearing before the Board, and in the notice of charges against any licensee, the Board shall withhold from public disclosure the identity of a patient including information relating to dates and places of treatment, or any other information that would tend to identify the patient, unless the patient or the

representative of the patient expressly consents to the disclosure. Upon written request, the Board shall revoke a subpoena if, upon a hearing, it finds that the evidence the production of which is required does not relate to a matter in issue, or if the subpoena does not describe with sufficient particularity the evidence the production of which is required, or if for any other reason in law the subpoena is invalid."

SECTION 3. G.S. 90-14(a) reads as rewritten:

"(a) The Board shall have the power to deny, annul, suspend, or revoke a license, or other authority to practice medicine in this State, issued by the Board to any person who has been found by the Board to have committed any of the following acts or conduct, or for any of the following reasons:

(1) Immoral or dishonorable conduct.

(2) Producing or attempting to produce an abortion contrary to law.

(3) Made false statements or representations to the Board, or who has willfully concealed from the Board material information in connection with an application for a license.

(4) Repealed by Session Laws 1977, c. 838, s. 3.

(5) Being unable to practice medicine with reasonable skill and safety to patients by reason of illness, drunkenness, excessive use of alcohol, drugs, chemicals, or any other type of material or by reason of any physical or mental abnormality. The Board is empowered and authorized to require a physician licensed by it to submit to a mental or physical examination by physicians designated by the Board before or after charges may be presented against the physician, and the results of the examination shall be admissible in evidence in a hearing before the Board.

(6) Unprofessional conduct, including, but not limited to, departure from, or the failure to conform to, the standards of acceptable and prevailing medical practice, or the ethics of the medical profession, irrespective of whether or not a patient is injured thereby, or the committing of any act contrary to honesty, justice, or good morals, whether the same is committed in the course of the physician's practice or otherwise, and whether committed within or without North Carolina. The standards of practice in any specialty, including complementary treatments, shall be defined by specialists in that field. The Board shall not annul, suspend, revoke the license of or deny a license to a ~~person~~ person, harass, or initiate an investigation solely because of that person's practice of a therapy that is experimental, nontraditional, or that departs from acceptable and prevailing medical practices unless, by ~~competent~~ a preponderance of the evidence, the Board can establish that the treatment has a ~~safety~~ risk of harm to the patient greater than the prevailing treatment or that the treatment is generally not ~~effective.~~as effective in comparison to the effective rates of other prevailing treatments.

(7) Conviction in any court of a crime involving moral turpitude, or the violation of a law involving the practice of medicine, or a conviction of a felony; provided that a felony conviction shall be treated as provided in subsection (c) of this section.

(8) By false representations has obtained or attempted to obtain practice, money or anything of value.

(9) Has advertised or publicly professed to treat human ailments under a system or school of treatment or practice other than that for which the physician has been educated. A duly licensed physician shall not be prohibited from displaying all of his or her certifications in public documents.

(10) Adjudication of mental incompetency, which shall automatically suspend a license unless the Board orders otherwise.

(11) Lack of professional competence to practice medicine with a reasonable degree of skill and safety for patients. In this connection the Board may consider repeated acts of a physician indicating the physician's failure to properly treat a patient. The Board may, upon reasonable grounds, require a physician to submit to inquiries or examinations, written or oral, by members of the Board or by other physicians licensed to practice medicine in this State, as the Board deems necessary to determine the professional qualifications of such licensee.

(12) Promotion of the sale of drugs, devices, appliances or goods for a patient, or providing services to a patient, in such a manner as to exploit the patient, and upon a finding of the exploitation, the Board may order restitution be made to the payer of the bill, whether the patient or the insurer, by the physician; provided that a determination of the amount of restitution shall be based on credible testimony in the record. Selling nutritional supplements or vitamins shall have the same financial disclosures as those required with drugs, devices, appliances, or goods. Nothing in this subdivision shall restrain free trade or limit the legitimate trade activities involved in the course of the practice of medicine.

(13) Having a license to practice medicine or the authority to practice medicine revoked, suspended, restricted, or acted against or having a license to practice medicine denied by the licensing authority of any jurisdiction. For purposes of this subdivision, the licensing authority's acceptance of a license to practice medicine voluntarily relinquished by a physician or relinquished by stipulation, consent order, or other settlement in response to or in anticipation of the filing of administrative charges against the physician's license, is an action against a license to practice medicine.

(14) The failure to respond, within a reasonable period of time and in a reasonable manner as determined by the Board, to inquiries from the

Board concerning any matter affecting the license to practice medicine. However, the Board shall conclude an investigation pursuant to a violation of this subdivision within 18 months from the date the incident was initially reported.

(15) The failure to complete an amount not to exceed 150 hours of continuing medical education during any three consecutive calendar years pursuant to rules adopted by the Board.

For any of the foregoing reasons, the Board may deny the issuance of a license to an applicant or revoke a license issued to a physician, may suspend such a license for a period of time, and may impose conditions upon the continued practice after such period of suspension as the Board may deem advisable, may limit the accused physician's practice of medicine with respect to the extent, nature or location of the physician's practice as the Board deems advisable. The Board may, in its discretion and upon such terms and conditions and for such period of time as it may prescribe, restore a license so revoked or rescinded, except that no license that has been revoked shall be restored for a period of two years following the date of revocation."

SECTION 4. G.S. 90-14 is amended by adding a new subsection to read:

"(g) In order to annul, suspend, deny, or revoke a license of an accused physician, the Board must find that the facts satisfy, by the greater weight of the evidence, that there is a pattern of incompetence and that the care provided was not in accordance with the standards of practice for the procedures or treatments administered."

SECTION 5. G.S. 90-14.2 reads as rewritten:

"**§ 90-14.2. Hearing before revocation or suspension of a license.**

Before the Board shall revoke, restrict or suspend any license granted by it, the licensee shall be given a written notice indicating the general nature of the charges, accusation, or complaint made against him, which notice may be prepared by a committee or one or more members of the Board designated by the Board, and stating that such licensee will be given an opportunity to be heard concerning such charges or complaint at a time and place stated in such notice, or at a time and place to be thereafter designated by the Board, and the Board shall hold a public hearing not less than 30 days from the date of the service of such notice upon such licensee, at which such licensee may appear personally and through counsel, may cross examine witnesses and present evidence in his own behalf. A physician who is mentally incompetent shall be represented at such hearing and shall be served with notice as herein provided by and through a guardian ad litem appointed by the clerk of the court of the county in which the physician has his residence. Such licensee or physician may, if he desires, file written answers to the charges or complaints preferred against him within 30 days after the service of such notice, which answer shall become a part of the record but shall not constitute evidence in the case. Members of the Board participating on the hearing committee shall not have been involved in any part of the investigation."

SECTION 6. G.S. 90-14.5 reads as rewritten:

"**§ 90-14.5. Use of trial examiner or depositions.**

~~Where the licensee requests~~The licensee may request that the hearing herein provided for be held by the Board in a county other than the county designated for the

holding of the meeting of the Board at which the matter is to be heard, the Board may designate in writing one or more of its members to conduct the hearing as a trial examiner or trial committee, to take evidence and report a written transcript thereof to the Board at a meeting where a majority of the members are present and participating in the decision. Evidence and testimony may also be presented at such hearings and to the Board in the form of depositions taken before any person designated in writing by the Board for such purpose or before any person authorized to administer oaths, in accordance with the procedure for the taking of depositions in civil actions in the superior court. When a trial examiner or trial committee recommends license revocation, suspension, or retraction, the licensee shall be granted a full Board hearing at the licensee's request if the request is made in a timely manner as determined by the Board."

SECTION 7. G.S. 90-14.6 reads as rewritten:

"**§ 90-14.6. Evidence admissible.**

In proceedings held pursuant to this Article the Board shall admit and hear evidence in the same manner and form as prescribed by law for civil actions. A complete record of such evidence shall be made, together with the other proceedings incident to such hearing. The physician under investigation may call witnesses, including medical practitioners licensed in the United States, with expertise in the same field of practice as the physician under investigation. Witnesses shall not be restricted to experts certified by the American Board of Medical Specialties. In an investigative meeting, the physician being investigated may present testimony from medical practitioners licensed in the United States with expertise in the same field of practice as the physician under investigation. Members of the Board shall not be immune from civil or criminal liability for failing to exercise, in good faith, its powers and duties authorized by law."

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

HOUSE BILL 886:
Due Process for Physicians

BILL ANALYSIS

Committee:	House Health	**Introduced by:**	Rep. Wright and Howard
Date:	April 14, 2003	**Summary by:**	Dianna Jessup
Version:	First Edition		Committee Counsel

SUMMARY: ***House Bill 886 would amend various provisions relating to the North Carolina Medical Board under the laws regulating the practice of medicine. The act would become effective when it becomes law.***

CURRENT LAW: The North Carolina Medical Board is charged with regulating the practice of medicine and surgery in this State. The Board is comprised of 12 members who serve for three-year terms. Of the terms of the current members, four are due to expire in October 2003.

Currently, the North Carolina Medical Society (an association of physicians) nominates seven members for appointment to the Board by the Governor. Nominees from the Society's Executive Council fill any vacancies in these positions.

The Board is authorized to adopt rules governing applicants for license, admission, and the conduct of examinations for licensure and admission and to deny, annul, suspend, or revoke the license or other authority to practice medicine in this State. The Board conducts both informal meetings to inquire into matters (called investigative meetings) and formal hearings.

The president and the secretary of the Board may administer oaths and issue subpoenas for the appearance of witnesses to testify concerning any matter before the Board. The Board may also order pertinent documents, including patient records, to be produced for inspection.

The Board can deny, annul, suspend, or revoke a license for a variety of reasons enumerated by statute. Reasons pertinent to this bill include:

1. Unprofessional conduct that departs from the standard of acceptable and prevailing medical practice. The Board cannot, however, revoke the license of or deny a license to a person solely because that person's practice of an experimental or nontraditional therapy unless, by competent evidence, the Board can establish a safety risk greater than the prevailing treatment.
2. Advertising or publicly professing to treat ailments under a system or school of treatment or practice other than that for which the physician has been educated.
3. Promoting the sale of drugs, devices, appliances or goods for a patient, providing services to a patient, in a manner to exploit the patient. There are ethical guidelines from the Board and the American Medical Society relating to the sale of goods from physicians' offices.
4. Failing to respond to inquiries of the Board within a reasonable time.

Before the Board can revoke, restrict or suspend a license, the licensee must be given notice and an opportunity to be heard. At the hearing, the physician and cross-examine witnesses and present evidence. The rules of procedure and evidence for civil actions apply. If the licensee requests that the hearing be held in a county other than where the full Board meets, the Board may designate a committee of its members to conduct the hearing.

The Board and its members are immune from civil and criminal liability for exercising, in good faith, the powers and duties authorized by law.

BILL ANALYSIS:

Section 1 would amend the provisions of the statute related to the appointment and removal of members of the North Carolina Medical Board as follows:

- The Governor's physician appointees will not be appointed from nominees provided by the North Carolina Medical Society. **Note: If this provision is retained, it appears that G.S. 90-3 should be repealed.**
- One of the physician appointees would have to be a faculty member at one of the State's medical schools.
- The Governor would be required to remove a member of the Board for "good cause shown", including malicious prosecution or abuse of power.

Section 2 would amend the provisions relating to the Board's power to administer oaths and subpoena witnesses to specify that the Board's power to subpoena would be limited to persons with knowledge related to a matter before the Board. Language in this section would also specify that medical expert witnesses must routinely and actively practice in the specialty under investigation by the Board, and that for expert witnesses, the parties must disclose the expert's identity, the subjects on which the expert is expected to testify, the substance of the facts and opinion on which the expert is expected to rely, and the qualifications of the expert. Statements contained in medical or scientific literature may be relied upon and admitted into evidence.

Section 3 would amend the law relating to the grounds for denying, annulling, suspending, or revoking a license to provide as follows:

- The standards of practice in any specialty, including complementary treatments, shall be defined by specialists in that field.
- A license cannot be annulled or suspended or harass or initiate an investigation solely because a person's practice is experimental, nontraditional, or departs from acceptable and prevailing medical practice unless by a preponderance of the evidence, the Board can establish that the treatment has a risk of harm to the patient greater than the prevailing treatment or that the treatment is generally not as effective in comparison to the effective rates of other prevailing treatments.
- A duly licensed physician cannot be prohibited from displaying the physician's certifications in public documents.
- Selling nutritional supplements or vitamins shall have the same financial disclosures as those required with drugs, devices, appliances, or goods.
- The Board must conclude an investigation into a failure to respond to a Board inquiry within 18 months from the date the incident was initially reported.

Section 4 would require the Board to find, by a greater weight of the evidence, a pattern of incompetence and a deviation from the standard of practice in order to be able to annul, suspend, deny, or revoke the license of an accused physician.

Section 5 would prohibit members of the Board who investigated a licensee from serving on the hearing committee that conducts the hearing concerning that licensee.

Section 6 would require a full Board hearing in cases where a trial examiner or trial committee recommends license revocation, suspension, or retraction, if the licensee requests one in a timely manner (to be determined by the Board).

Section 7 would specify that for Board proceedings, a physician under investigation may call witnesses, including medical practitioners, with expertise in the same field of practice as the physician under investigation. Witnesses would not be restricted to experts certified by the American Board of Medical Specialties. In an investigative meeting (a non-public, informal meeting), the physician being investigated may present testimony from licensed medical practitioners with expertise in the same field of practice as the physician.

This section also language which provides that "members of the Board shall not be immune from civil or criminal liability for failing to exercise, in good faith, its powers and duties authorized by law". **Note: This appears to contradict G.S. 90-14(e), which provides: "The Board and its members and staff shall not be held liable in any civil or criminal proceeding for exercising, in good faith, the powers and duties authorized by law."** If the language in the bill is retained, G.S. 90-14(e) should be repealed or changed.

Section 8 makes the act effective when it becomes law.

H866-SMSW-001

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2003

HOUSE BILL 916

Short Title:	First-Responders Vaccination Program.	(Public)
Sponsors:	Representatives Brubaker; and Insko.	
Referred to:	Health.	

April 8, 2003

A BILL TO BE ENTITLED

AN ACT TO ESTABLISH A VACCINATION PROGRAM FOR FIRST RESPONDERS TO TERRORIST INCIDENTS, CATASTROPHIC OR NATURAL DISASTERS, OR EMERGENCIES.

The General Assembly of North Carolina enacts:

SECTION 1. Article 22 of Chapter 130A of the General Statutes is amended by adding the following new section to read:

"**§ 130A-485. Vaccination program established; definitions.**

(a) The Department shall offer a vaccination program for first responders who may be exposed to infectious diseases when deployed to disaster locations. The vaccinations shall include, but are not limited to, hepatitis A vaccination, hepatitis B vaccination, diptheria-tetanus vaccination, influenza vaccination, pneumococcal vaccination, and other vaccinations when recommended by the United States Public Health Service and in accordance with Federal Emergency Management Directors Policy. Immune globulin will be made available when necessary, as determined by the State Health Director.

(b) Participation in the vaccination program is voluntary by the first responders, except for first responders who are classified as having "occupational exposure" to bloodborne pathogens as defined by the Occupational Safety and Health Administration Standard contained at 29 C.F.R. § 1910.10300 who shall be required to take the designated vaccinations or otherwise required by law.

(c) The Department shall exempt from vaccinations first responders who present a written statement from a licensed physician indicating that a vaccine is medically contraindicated for the first responder or the first responder signs a written statement that the administration of a vaccination conflicts with the first responder's religious tenets.

(d) In the event of a vaccine shortage, the State Public Health Director, in consultation with the Centers for Disease Control and Prevention, shall give priority for vaccination to first responders.

(e) The Department shall notify first responders of the availability of the vaccination program and shall provide educational materials on ways to prevent exposure to infectious diseases.

(f) The Department may contract with local and district health departments, not-for-profit home health care agencies, hospitals, and physicians to administer a vaccination program for first responders.

(g) As used in this section, unless the context clearly requires otherwise, the term:

(1) 'Bioterrorism' means the intentional use of any microorganism, virus, infectious substance, biological product, or biological agent as defined in G.S. 130A-479 that may be engineered as a result of biotechnology or any naturally occurring or bioengineered component of any microorganism, virus, infectious substance, or biological product to cause or attempt to cause death, disease, or other biological malfunction in any living organism.

(2) 'Disaster locations' means any geographical location where a bioterrorism attack, terrorist incident, catastrophic or natural disaster, or emergency occurs.

(3) 'First responders' means State and local law enforcement personnel, fire department personnel, and emergency medical personnel who will be deployed to bioterrorism attacks, terrorist attacks, catastrophic or natural disasters, or emergencies."

SECTION 2. Nothing in this act obligates the General Assembly to appropriate State funds for the implementation of this act. The Department of Health and Human Services shall apply for federal funds available to implement a vaccination program for first responders as enacted in Section 1 of this act and, upon receipt of federal funds, shall implement the vaccination program established by this act.

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

2003-2004

HOUSE
HEALTH

COMMITTEE
MINUTES

House Committee on Health

April 22, 2003

Minutes

The House Committee on Health met on Tuesday, April 22, 2003 at 12:00 noon in Room 544 of the Legislative Office Building. A silent roll was taken. A copy of the roll denoting members present is attached to the minutes (Attachment I) along with a copy of the agenda and Visitor Registration Sheet (Attachments II and III).

Rep. Carolyn Justus, Chair calls meeting to order and recognizes Pages: Hope Patterson from Stokes County sponsored by Rep. Parmon and Linda McAckvoyd from Fayetteville sponsored by Rep. Glazier. The sergeant-in-arms are Dusty Rhodes, Charles Williams and Francis Poole.

Chair Justus calls upon Rep. Insko to explain her bill HB 170 A BILL TO BE ENTITLED AN ACT TO EXTEND THE STATE/COUNTY SPECIAL ASSISTANCE IN-HOME DEMONSTRATION PROJECT BY PERMITTING THE DEPARTMENT OF HEALTH AND HUMAN SERVICES TO INCREASE THE NUMBER OF INDIVIDUALS WHO MAY BE ENROLLED IN THE PROJECT. (Attachment IV) A Proposed Committee Substitute is introduced and adopted for discussion purposes (Attachment V). This bill will eliminate the pilot status of the Demonstration Project and would rename it the State/County Special Assistance In-Home Option (In-Home Option). Special Assistance payments would be made to no more than 2,000 eligible individuals in in-home living arrangements. The proposed committee substitute would also change the reporting requirements for DHHS. (Attachment VI) After discussion of the members concerning the fiscal impact of the bill (Fiscal Analysis – Attachment VII), Rep. Sherrill moves to amend the bill (Amendment VIII) and amendment is adopted. Rep. Wright makes motion that the amendment be rolled into a committee substitute and the committee substitute be given a favorable report, which changes the title, unfavorable as to the original bill and be referred to the Committee on Appropriations. Motion is carried. (Committee Report – Attachment IX)

Chair Justus calls upon Rep. Insko to explain her bill HB 883 A BILL TO BE ENTITLED AN ACT TO AUTHORIZE THE SECRETARY OF HEALTH AND HUMAN SERVICES TO TEMPORARILY WAIVE CERTAIN REQUIREMENTS OF THE MENTAL HEALTH COMMITMENT STATUTES TO FURTHER MENTAL HEALTH REFORM EFFORTS. (Attachment X). Motion made for adoption of the proposed committee substitute. (Attachment XI) Proposed committee substitute is adopted for discussion purposes. Bill would authorize the Secretary of the Department of Health and Human Services (Secretary) to permit phase one, mental health local management entitles (LMEs) to substitute for a physician or eligible psychologist, a licensed clinical social worker, a masters level psychiatric nurse, or a masters level certified clinical addictions specialist to conduct the initial (first –level) examination of

individuals in involuntary commitment proceedings. Any waiver could only be in effect for a period not to exceed three years. The proposed bill would not expand the scope of practice for licensed clinical social workers, masters level psychiatric nurses, or masters level certified clinical addictions specialists. According to the Division of MH/DD/SAS services, there are currently 13 LMEs that have been designated as phase-one entities. Rep. Glazier expresses concerns about the overall expansion of project, but states that he understands need to try a pilot programs. He also expresses concerns about the ultimate fundamental right to restrict a person's liberty and whether it will be constitutional. Rep. Insko suggests bill could be referred to a judiciary committee to look specifically at this question.

Tara Larson and Dan Beeman speak briefly concerning the bill. After which, Chair Justus advises that time has run out.

Meeting is adjourned at 12:51 p.m.*

Carolyn Justus
Rep. Carolyn Justus, Chair

Pamela J. Evans
Pamela J. Evans, Committee Clerk

(*Note: Due to time, HB815 Detox Facilities Not Subject to CON, HB 907 Deaf/Hard of Hearing Advisory Council, and HB 886 Due Process for Physicians were not heard today)

ATTENDANCE

HOUSE COMMITTEE ON HEALTH

DATES	5/10													
INSKO, Verla CHAIR	✓													
JUSTUS, Carolyn CHAIR	✓													
ENGLAND, Bob VICE-CHAIR	✓													
ADAMS, Alma	✓													
ALLEN, Bernard	✓													
ALLEN, Gordon	✓													
ALLRED, Cary	✓													
BARNHART, Jeff	✓													
BOWIE, Joni	✓													
CLARY, Debbie														
EARLE, Beverly														
GLAZIER, Rick	✓													
HILTON, Mark	✓													
McALLISTER, Mary	✓													
MUNFORD, Don	✓													
SETZER, Mitchell	✓													
SHERRILL, Wilma	✓													
WAINWRIGHT, William														
WILSON, Connie	✓													
WRIGHT, Tom	✓													
Ex officio Members														
Brubaker, Bru														
Culpepper, Bill														
Cunningham, Pete														
Eddins, Rick														

ATTACHMENT II

AGENDA

HOUSE COMMITTEE ON HEALTH

April 22, 2003
Room 544 LOB
12:00 Noon

OPENING REMARKS

Representative Verla Insko, Chair
Representative Carolyn Justus, Chair

AGENDA ITEMS

HB 170 Expand Special Assistance Demo Project – Reps. Insko and Earle

HB 883 MH Reform Waiver – Rep. Insko

HB 815 Detox Facilities Not Subject to CON-Rep. Alexander

HB 907 Deaf/Hard of Hearing Advisory Council – Rep. Alexander

HB 886 Due Process for Physicians – Reps. Wright and Howard

ADJOURNMENT

ATTACHMENT III

VISITOR REGISTRATION SHEET

HEALTH — Name of Committee

APRIL 22, 2003 — Date

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Richard C. Hatch	AARP / NC Coalition on Aging
Polly Williams	Justice Center / NC Coalition on Aging
NANCHE BRYAN	NAMI DURHAM NEXT STEP HOUSING DURHAM AREA PROGRAM
Amelia Thorpe	Durham Center, CRC-Durham Center
Lu-Ann Coe	NC PA
Robin Huffman	NC Psychiatric Assoc
Joe GLOVER	NATIONAL Drug Search LLC
STEVE ROBERTS	AARP
William E. Schoney	AARP - State Office, Raleigh
Susan Siegel	UNC-CH School of Medicine
Angie Manning	NC Lyme Disease Support Group

VISITOR REGISTRATION SHEET

HEALTH — APRIL 22, 2003

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
	UHS
Bert Bennett	DHHS
Spencer Harrison	Rep. Glazier
Josh Hartford	Williams Communications, Chapel Hill
W Hilliard	NCSA
	NCSA
Hubb Tilson	NCHA
	NCIMS
Roy Williams	UNC
Susan Gaylord	2307 Bedford, Durham, NC
S. Norton	Fernwood Ln, Chapel Hill

VISITOR REGISTRATION SHEET

HEALTH — **Name of Committee**

APRIL 22, 2003 — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
YOUNGER MATTOX	CAROLINIANS FOR HEALTH CARE ACCESS
Paul Pulley	Pulley Watson King & Lischer
Stacy Flannery	NCHCFA
Lou Wilson	NCALTC7
Sam Taylor	LPCANC
Beth Melchor	NAMI NC
Dave Richard	The Arc
Janet Sohaney Lowe	NC Council
RASHID BUTTAR	NC Integrative Medical Society (NCIMS)
Thea Monet	Old North State Medical Society
Ken McHon	Alley Associates, Inc.

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2003

H 1

HOUSE BILL 170*

Short Title:	Expand Special Assistance Demo Project.	(Public)
Sponsors:	Representatives Insko, Earle; Adams, Alexander, Bonner, Farmer-Butterfield, Luebke, Walend, Warren, Weiss, and Yongue.	
Referred to:	Health, if favorable, Appropriations.	

March 4, 2003

A BILL TO BE ENTITLED

AN ACT TO EXPAND THE STATE/COUNTY SPECIAL ASSISTANCE IN-HOME DEMONSTRATION PROJECT BY PERMITTING THE DEPARTMENT OF HEALTH AND HUMAN SERVICES TO INCREASE THE NUMBER OF INDIVIDUALS WHO MAY BE ENROLLED IN THE PROJECT.

The General Assembly of North Carolina enacts:

SECTION 1.(a) The Department of Health and Human Services may use funds from the existing State/County Special Assistance for Adults budget to provide Special Assistance payments to eligible individuals in in-home living arrangements. These payments may be made for up to a two-year period beginning July 1, 2003, and ending June 30, 2005. The standard monthly payment to individuals enrolled in the Special Assistance demonstration project shall be fifty percent (50%) of the monthly payment the individual would receive if the individual resided in an adult care home and qualified for Special Assistance, except if a lesser payment amount is appropriate for the individual as determined by the local case manager. The Department shall implement Special Assistance in-home eligibility policies and procedures to assure that demonstration project participants are those individuals who need and, but for the demonstration project, would seek placement in an adult care home facility. The Department shall make this demonstration project available to all counties on a voluntary basis. To the maximum extent possible, the Department shall consider geographic balance in the dispersion of payments to individuals across the State. The Department shall make an interim report to the cochairs of the House of Representatives Appropriations Committee, the cochairs of the House of Representatives Appropriations Subcommittee on Health and Human Services, the cochairs of the Senate Appropriations Committee, and the Chair of the Senate Appropriations Committee on Human Resources by June 30, 2004, and a final report by January 1, 2005. The final report shall also be sent to the North Carolina Study Commission on Aging. This report shall include the following information:

(1) A description of cost savings that could occur by allowing individuals eligible for State/County Special Assistance the option of remaining in the home.
(2) Which activities of daily living or other need criteria are reliable indicators for identifying individuals with the greatest need for income supplements for in-home living arrangements.
(3) How much case management is needed and which types of individuals are most in need of case management.
(4) The geographic location of individuals receiving payments under this section.
(5) A description of the services purchased with these payments.
(6) A description of the income levels of individuals who receive payments under this section and the impact on the Medicaid program.
(7) Findings and recommendations as to the feasibility of continuing or expanding the demonstration program.
(8) The level and quantity of services (including personal care services) provided to the demonstration project participants compared to the level and quantity of services for residents in adult care homes.
(9) A fiscal analysis and programmatic results of increasing the demonstration project participant's monthly assistance payment to fifty percent (50%) of the Special Assistance monthly payment.
(10) A fiscal analysis of the budgetary impact of any increases in staff responsibility resulting from utilization of the Demonstration Program.

SECTION 1.(b) The Department shall incorporate data collection tools designed to compare quality of life among institutionalized vs. noninstitutionalized populations (i.e. an individual's perception of his or her own health and well-being, years of healthy life, and activity limitations). To the extent national standards are available, the Department shall utilize those standards.

SECTION 1.(c) The Department shall expand its report of the Demonstration Program in order to fully assess the success of the pilot. The Department shall contract with an independent consultant to develop an evaluation design that ensures that the evaluation includes an assessment of the impact of the Program on the economic security, health, and well-being of the participants.

SECTION 2. The Department of Health and Human Services shall use funds appropriated to it for the 2003 biennium for the Special Assistance payments authorized in Section 1 of this act.

SECTION 3. This act becomes effective July 1, 2003.

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2003

H D

HOUSE BILL 170*
PROPOSED COMMITTEE SUBSTITUTE H170-CSSW-9 [v.2]

4/8/2003 9:33:48 AM

Short Title: Special Assistance In-Home Option. (Public)

Sponsors:

Referred to:

March 4, 2003

A BILL TO BE ENTITLED

AN ACT TO MAKE THE STATE/COUNTY SPECIAL ASSISTANCE IN-HOME OPTION AVAILABLE TO ALL COUNTIES.

The General Assembly of North Carolina enacts:

SECTION 1.(a) The Department of Health and Human Services may use funds from the existing State/County Special Assistance for Adults budget to provide Special Assistance payments to up to a total of 2,000 eligible individuals in in-home living arrangements. The standard monthly payment to individuals enrolled in the Special Assistance in-home option shall be fifty percent (50%) of the monthly payment the individual would receive if the individual resided in an adult care home and qualified for Special Assistance, except if a lesser payment amount is appropriate for the individual as determined by the local case manager. The Department shall implement Special Assistance in-home eligibility policies and procedures to assure that in-home option participants are those individuals who need and, but for the in-home option, would seek placement in an adult care home facility. The Department's policies and procedures shall include the use of a functional assessment. The Department shall make this in-home option available to all counties on a voluntary basis. To the maximum extent possible, the Department shall consider geographic balance in the dispersion of payments to individuals across the State. The Department shall make a report to the cochairs of the House of Representatives Appropriations Committee, the cochairs of the House of Representatives Appropriations Subcommittee on Health and Human Services, the cochairs of the Senate Appropriations Committee, and the Chair of the Senate Appropriations Committee on Human Resources by January 1, 2005. The report shall also be sent to the North Carolina Study Commission on Aging. This report shall include the following information:

(1) A description of cost savings that results from allowing individuals eligible for State/County Special Assistance the option of remaining in the home.

(2) The geographic location of individuals receiving payments under this section.

(3) A description of the services purchased with these payments.

SECTION 2. The Department of Health and Human Services shall use funds appropriated to it for the 2003 biennium for the Special Assistance payments authorized in Section 1 of this act.

SECTION 3. This act becomes effective July 1, 2003.

HOUSE BILL 170:
Special Assistance In-Home Option

BILL ANALYSIS

Committee:	House Health	**Introduced by:**	Reps. Insko and Earle
Date:	April 17, 2003	**Summary by:**	Dianna Jessup
Version:	H170-CSSW-9 [v.2]		Committee Counsel

SUMMARY: ***House Bill 170 would expand the State/County Special Assistance In-Home Demonstration Project (Demonstration Project) by permitting the Department of Health and Human Services (DHHS) to increase the number of individuals who may be enrolled in the project.***

The PCS for House Bill 170 would eliminate the pilot status of the Demonstration Project and would rename it the State/County Special Assistance In-Home Option (In-Home Option). Special Assistance payments would be made to no more than 2,000 eligible individuals in in-home living arrangements. The PCS would also change the reporting requirements for DHHS. The act would become effective July 1, 2003.

CURRENT LAW: Sec. 11.21 of S.L. 1999-237 (The Appropriations Act) permitted DHHS to establish a Demonstration Project allowing participants to remain in their homes and receive Special Assistance payments. These payments would be made for up to 400 individuals and the Demonstration Project would end June 30, 2001. Subsequent Appropriations Act provisions extended the Demonstration Project. Section 21.29 of S.L. 2001-424 provides that individuals enrolled in the Demonstration Project as of June 30, 2002 would continue to receive payments through June 30, 2003.

According to a final report submitted by the Division of Social Services, DHHS in January 2003, a total of 377 individuals received Special Assistance at home during the September 2000-August 2002 period. Currently, this program is available in 22 counties. Special Assistance payments supplement an individual's income so that the individual will have sufficient income to pay for care in an adult care home, or during this Demonstration Project, to live at home. The individual must need adult care home level of care, as verified by a physician, in order to qualify for either payment. An individual participating in the program is assessed using the Residential Assessment Instrument (RAI), and the information from the RAI is sent to a centralized database. From that database, DHHS is able to determine the characteristics of the individuals in the program and what services are being purchased. Based on the comparison of the relative costs of in-home payments versus payments to adult care homes, DHHS recommended expanding this program both geographically and programmatically to include more individuals.

BILL ANALYSIS: The PCS for HB 170 would permit DHHS to use funds appropriated to it for the 2003 biennium to provide Special Assistance payments to no more than 2,000 eligible individuals in in-home living arrangements. The standard monthly payment to individuals enrolled in the In-Home Option would be 50% of the monthly payment the individual would have received had the individual resided in an adult care home and qualified for special assistance, unless the local case manager determines that a lesser amount is appropriate. DHHS would make the In-Home Option available to all counties on a voluntary basis and would consider geographic balance in the dispersion of payments to individuals across the State.

REPORT: DHHS would be required to make a report to the cochairs of the House of Representatives Appropriations Committee, the co-chairs of the House Appropriations Subcommittee on Health and

Human Services, the co-chairs of the Senate Appropriations Committee, and the chair of the Senate Appropriations Committee on Human Resources by January 1, 2005. The report would also be sent to the North Carolina Study Commission on Aging. The report would include the following information:

- A description of cost savings that results from allowing individuals eligible for State/County Special Assistance the option of remaining in the home.
- The geographic location of individuals receiving payments under this section.
- A description of the services purchased with these payments.

BACKGROUND: The original bill was a recommendation from the North Carolina Study Commission on Aging (Commission) to the 2003 General Assembly. Based upon the final report prepared by the Division of Social Services, DHHS, and its presentation to the Commission, the Commission recommended that the General Assembly expand the State/County Special Assistance in-home component by permitting DHHS to increase the number of individuals who may be enrolled in the Demonstration Project. The Commission also recommended that the Demonstration Project be made available to all counties on a voluntary basis.

Amy Compeau, Research Assistant contributed to this summary.

H170-SMSW-001

FISCAL ANALYSIS MEMORANDUM

[This confidential fiscal memorandum is a fiscal analysis of a draft bill, amendment, committee substitute, or conference committee report that has not been formally introduced or adopted on the chamber floor or in committee. This is not an official fiscal note. If upon introduction of the bill you determine that a formal fiscal note is needed, please make a fiscal note request to the Fiscal Research Division, and one will be provided under the rules of the House and the Senate.]

DATE: **April 16, 2003**

TO: Representative Verla Insko

FROM: Susan Morgan
Fiscal Research Division

RE: House Bill 170-(Proposed Committee Substitute)
"Special Assistance In-Home Option"

FISCAL IMPACT

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

	FY 2003-04	FY 2004-05	FY 2005-06	FY 2006-07	FY 2007-08
EXPENDITURES	See Assumptions				

PRINCIPAL DEPARTMENT(S) & PROGRAM(S) AFFECTED: Department of Health and Human Services – Division of Social Services

EFFECTIVE DATE: July 1, 2003

ISSUE BACKGROUND:

State/County Special Assistance (SA) provides payments to eligible individuals who live in the following types of facilities that are licensed under state law by the Division of Facility Services: adult care homes, family care homes, group homes for developmentally disabled adults, group homes for mentally ill adults, and adult care homes that are located in nursing homes (known as combination facilities). SA is funded 50% by the state and 50% by the county. In 1999, the General Assembly authorized the Department of Health and Human

Services to implement a demonstration project that would provide SA payments to individuals who qualified for SA, but chose to remain in their home. Individuals were identified as potential participants in the demonstration project upon applying for SA and seeking placement in an adult care home or other facility. Participants were allowed to receive an SA payment (50% of the standard SA payment) and remain in their home while receiving additional community-based services determined necessary by a social services case manager at the local level. The number of participants in the demonstration project was capped at 400 participants, and 22 counties participated in the project.

BILL SUMMARY:

The bill will allow all North Carolina counties to participate in a Special Assistance In-Home Program, and increases the maximum number of participants from 400 to 2,000. Counties are not required to participate in the In-Home Program. The bill maintains the stipulation that participants shall receive 50% of the payment they would have received in entering a facility, unless a lesser amount is determined appropriate as determined by a local case manager. The Department is directed to implement policies to assure that the participants in the In-Home Program would have required placement in a facility had this option not been available. The bill requires the In-Home Program to be funded within existing resources allocated for State/County Special Assistance.

ASSUMPTIONS AND METHODOLOGY:

The impact of this bill on the general fund and on local budgets is based on a basic analysis of allowing a maximum of 50% of the standard SA payment for participants in the In-Home Program. This analysis considers *only* the impact to the SA budget and does not address the potential impact on other services such as Medicaid and other community-based services, such as the Home and Community Care Block Grant.

A comparison of Standard State/County Special Assistance, and the proposed In-Home Program follows:

	Standard SA	**In-Home Program**
Number of Participants	2000[1]	2000
Average Monthly Payment/Person	$426	$184
Average Annual Payment/Person	$5,112	$2,208
Total Expenditures	$10,224,000	$4,416,000
Total *State* Expenditures (50%)	$$5,112,000	$2,208,000
Projected Savings/Year	N/A	$2,904,000
Cumulative Savings/ 5 Years[2]		$14,520,000

[1]SA is an entitlement program and anyone determined to be eligible is entitled to benefits, including Medicaid Benefits.
[2]Assumes SA rates would remain at current rate of $1,091/month/person.

SOURCES OF DATA: Special Assistance Demonstration Project Final Report, January 2003 – Average payment data based on 377 participants.

TECHNICAL CONSIDERATIONS:

The projected savings identified are calculated with the assumption that the Department will be successful in assuring that participants would have been placed in a facility and received standard SA payments had this program not been available. If any of the 2000 participants in the In-Home Program would not have entered a facility had this program not been offered, then the projected savings would be decreased by the average annual per person expenditure ($2,208).

This analysis is also based on the continued "cap" of the program at 2,000 participants, and does not included the impact to other programs at the local level.

NORTH CAROLINA GENERAL ASSEMBLY
AMENDMENT
House Bill 170*

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

H170-ASW-9 [v.1]

Date _____,2003

Comm. Sub. [NO]
Amends Title [NO]
PCS H170-CSSW-9

Representative Sherrill

moves to amend the bill on page 1, line 7, by deleting "2,000" and substituting "~~4,000~~ 800";

and on page 2, lines 3-4, by inserting between the lines the following:

"(4) A complete fiscal analysis of the in-home option to include all federal, State, and local funds expended.

(5) An analysis of the differences in the needs and characteristics of persons living in adult care homes and those persons in the CAP/DA program with those persons receiving the Special Assistance payments under this section.".

SIGNED Thelma Sherrill
Amendment Sponsor

SIGNED _____
Committee Chair if Senate Committee Amendment

ADOPTED _____ FAILED _____ TABLED _____

2003 COMMITTEE REPORT
HOUSE OF REPRESENTATIVES

The following report(s) from standing committee(s) is/are presented:
By Representatives **Verla Insko and Carolyn Justus** (Chairs) for the Committee on **HEALTH**.

☐ Committee Substitute for
H.B. 170 A BILL TO BE ENTITLED AN ACT TO EXPAND THE STATE/COUNTY SPECIAL ASSISTANCE IN-HOME DEMONSTRATION PROJECT BY PERMITTING THE DEPARTMENT OF HEALTH AND HUMAN SERVICES TO INCREASE THE NUMBER OF INDIVIDUALS WHO MAY BE ENROLLED IN THE PROJECT.

☐ 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 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)

03/19/03

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2003

HOUSE BILL 883

Short Title:	MH Reform Waiver.	(Public)
Sponsors:	Representative Insko.	
Referred to:	Health.	

April 7, 2003

A BILL TO BE ENTITLED

AN ACT TO AUTHORIZE THE SECRETARY OF HEALTH AND HUMAN SERVICES TO TEMPORARILY WAIVE CERTAIN REQUIREMENTS OF THE MENTAL HEALTH COMMITMENT STATUTES TO FURTHER MENTAL HEALTH REFORM EFFORTS.

The General Assembly of North Carolina enacts:

SECTION 1. The Secretary of Health and Human Services may, upon request of a phase-one local management entity, waive temporarily the requirements of G.S. 122C-261 through G.S. 122C-263 and G.S. 122C-281 through G.S. 122C-283 pertaining to initial (first-level) examinations by a physician or eligible psychologist of individuals meeting the criteria of G.S. 122C-261(a) or G.S. 122C-281(a), as applicable, as follows:

(1) The Secretary has received a request from a phase-one local management entity to substitute for a physician or eligible psychologist, a licensed clinical social worker, a masters level psychiatric nurse, or a masters level certified clinical addiction specialist to conduct the initial (first-level) examinations of individuals meeting the criteria of G.S. 122C-261(a) or G.S. 122C-281(a). The waiver shall be implemented on a pilot-program basis. The request from the local management entity shall be submitted as part of the entity's local business plan and shall specifically describe:

a. How the purpose of the statutory requirement would be better served by waiving the requirement and substituting the proposed change under the waiver.

b. How the waiver will enable the local management entity to improve the delivery or management of mental health, developmental disabilities, and substance abuse services.

c. How the services to be provided by the licensed clinical social worker, the masters level psychiatric nurse, or the masters level

certified clinical addiction specialist under the waiver are within each of these professional's scope of practice.

d. How the health, safety, and welfare of individuals will continue to be at least as well protected under the waiver as under the statutory requirement.

e. The method to be used to evaluate the effectiveness and efficiency of mental health, developmental disabilities, and substance abuse services and protection of health, safety, and welfare under the waiver.

(2) The Secretary shall review the request and may approve it upon finding that:

a. The request meets the requirements of this section.

b. The request furthers the purposes of State policy under G.S. 122C-2, and mental health, developmental disabilities, and substance abuse services reform.

c. The request improves the delivery of mental health, developmental disabilities, and substance abuse services in the counties affected by the waiver and also protects the health, safety, and welfare of individuals receiving these services.

d. The duties and responsibilities performed by the licensed clinical social worker, the masters level psychiatric nurse, or the masters level certified clinical addiction specialist are within the individual's scope of practice.

(3) The waiver granted by the Secretary under this section shall be in effect for a period not to exceed three years, or the period for which the requesting local management entity's business plan is approved, whichever is shorter.

(4) The Secretary may grant a waiver under this section only to those local management entities that have been designated as phase-one entities as of July 1, 2003.

(5) In no event shall the substitution of a licensed clinical social worker, masters level psychiatric nurse, or masters level certified clinical addiction specialist under a waiver granted under this section be construed as authorization to expand the scope of practice of the licensed clinical social worker, the masters level psychiatric nurse, or the masters level certified clinical addiction specialist.

(6) The Department shall assure that staff performing the duties are trained and privileged to perform the functions identified in the waiver.

(7) The local management entity shall assure that a psychiatrist is available at all times to provide back-up services.

SECTION 2. This act becomes effective July 1, 2003, and expires July 1, 2006.

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2003

H D

HOUSE BILL 883
PROPOSED COMMITTEE SUBSTITUTE H883-CSSW-13 [v.3]

4/15/2003 10:07:47 PM

Short Title: MH Reform Waiver. (Public)

Sponsors:

Referred to:

April 7, 2003

A BILL TO BE ENTITLED

AN ACT TO AUTHORIZE THE SECRETARY OF HEALTH AND HUMAN SERVICES TO TEMPORARILY WAIVE CERTAIN REQUIREMENTS OF THE MENTAL HEALTH COMMITMENT STATUTES TO FURTHER MENTAL HEALTH REFORM EFFORTS.

The General Assembly of North Carolina enacts:

SECTION 1. The Secretary of Health and Human Services may, upon request of a phase-one local management entity, waive temporarily the requirements of G.S. 122C-261 through G.S. 122C-263 and G.S. 122C-281 through G.S. 122C-283 pertaining to initial (first-level) examinations by a physician or eligible psychologist of individuals meeting the criteria of G.S. 122C-261(a) or G.S. 122C-281(a), as applicable, as follows:

(1) The Secretary has received a request from a phase-one local management entity to substitute for a physician or eligible psychologist, a licensed clinical social worker, a masters level psychiatric nurse, or a masters level certified clinical addictions specialist to conduct the initial (first-level) examinations of individuals meeting the criteria of G.S. 122C-261(a) or G.S. 122C-281(a). The waiver shall be implemented on a pilot-program basis. The request from the local management entity shall be submitted as part of the entity's local business plan and shall specifically describe:

a. How the purpose of the statutory requirement would be better served by waiving the requirement and substituting the proposed change under the waiver.

b. How the waiver will enable the local management entity to improve the delivery or management of mental health, developmental disabilities, and substance abuse services.

c. How the services to be provided by the licensed clinical social worker, the masters level psychiatric nurse, or the masters level certified clinical addictions specialist under the waiver are within each of these professional's scope of practice.

d. How the health, safety, and welfare of individuals will continue to be at least as well protected under the waiver as under the statutory requirement.

(2) The Secretary shall review the request and may approve it upon finding that:

a. The request meets the requirements of this section.

b. The request furthers the purposes of State policy under G.S. 122C-2, and mental health, developmental disabilities, and substance abuse services reform.

c. The request improves the delivery of mental health, developmental disabilities, and substance abuse services in the counties affected by the waiver and also protects the health, safety, and welfare of individuals receiving these services.

d. The duties and responsibilities performed by the licensed clinical social worker, the masters level psychiatric nurse, or the masters level certified clinical addictions specialist are within the individual's scope of practice.

(3) The Secretary shall evaluate the effectiveness, quality, and efficiency of mental health, developmental disabilities, and substance abuse services and protection of health, safety, and welfare under the waiver.

(4) The waiver granted by the Secretary under this section shall be in effect for a period not to exceed three years, or the period for which the requesting local management entity's business plan is approved, whichever is shorter.

(5) The Secretary may grant a waiver under this section only to three local management entities that have been designated as phase-one entities as of July 1, 2003.

(6) In no event shall the substitution of a licensed clinical social worker, masters level psychiatric nurse, or masters level certified clinical addictions specialist under a waiver granted under this section be construed as authorization to expand the scope of practice of the licensed clinical social worker, the masters level psychiatric nurse, or the masters level certified clinical addictions specialist.

(7) The Department shall assure that staff performing the duties are trained and privileged to perform the functions identified in the waiver.

(8) The local management entity shall assure that a psychiatrist is available at all times to provide back-up services.

SECTION 2. This act becomes effective July 1, 2003, and expires July 1, 2006.

HOUSE BILL 883:
MH Reform Waiver

BILL ANALYSIS

Committee:	House Health	**Introduced by:**	Rep. Insko
Date:	April 15, 2003	**Summary by:**	Dianna Jessup
Version:	PCS for First Edition H883-CSSW-13[v.3]		Committee Counsel

SUMMARY: ***The proposed committee substitute for House Bill 883 would authorize the Secretary of the Department of Health and Human Services (Secretary) to permit phase one, mental health local management entities (LMEs) to substitute for a physician or eligible psychologist, a licensed clinical social worker, a masters level psychiatric nurse, or a masters level certified clinical addictions specialist to conduct the initial (first-level) examination of individuals in involuntary commitment proceedings. Any waiver could only be in effect for a period not to exceed three years. The proposed bill would not expand the scope of practice for licensed clinical social workers, masters level psychiatric nurses, or masters level certified clinical addictions specialists. The act would become effective July 1, 2003 and expire July 1, 2006.***

Differences between the First Edition and the PCS

1. The PCS shifted the responsibility for an evaluation of the effectiveness, quality and efficiency of services under the waiver from the phase-one local management entity to the Secretary of Health and Human Services.

2. The PCS also changes the local management entities that the Secretary may grant a waiver to under the provisions of the bill. Originally, the Secretary could grant a waiver only to the local management entities that have been designated as phase-one entities by July 1, 2003. The proposed committee substitute limits the number of waivers to only three local management entities that have been designated as phase-one entities by July 1, 2003.

CURRENT LAW:

Mental Health Reform: As enacted by the 2001 General Assembly, S.L. 2001-437 (HB 381), amended the mental health statutes to provide counties an alternative to establishing area authorities to ensure the provision of public mental health, developmentally disabled and substance abuse (MH/DD/SA) services to consumers. Counties were authorized to withdraw from existing area authorities and to ensure the delivery of public MH/DD/SA services through a single county program or jointly with one or more counties through a joint agency established pursuant to the terms of an interlocal agreement. (County programs and area authorities are known as LMEs). By October 1, 2002, each county was to have sent a letter of intent to the Secretary indicating the intent of the county or counties to provide services through an existing area authority or through a county program. The bill provided for phased-in implementation of reform, requiring the Secretary to certify the business plans of one-third of the area authorities and county programs by July 1, 2003; two-thirds of the area authorities and county programs by January 1, 2004; and complete certification of all area authorities and county programs by July 1, 2004.

Under the new governance scheme, LMEs are required to develop "business plans" to guide the management and delivery of services. These business plans are required to be submitted to the Secretary for review and certification. The business plans must provide a description of how core administrative functions will be carried out, including planning to ensure the provision of services, ensuring available,

qualified providers to deliver services, service management, financial management, service monitoring, evaluation, and collaboration with other local service systems. Business plans are effective for three State fiscal years.

Involuntary Commitment: Anyone who has knowledge that a person who is mentally ill or is a substance abuser and who is dangerous to self or dangerous to others may petition the court for issuance of an order to take the respondent into custody for examination by a physician or eligible psychologist. If the clerk finds reasonable grounds to believe that the facts in the petition are true and the respondent is dangerous to self or others, the clerk may order the respondent to be taken into custody for an initial examination by a physician or eligible psychologist. If the physician or eligible psychologist recommends inpatient commitment, then a *physician* is required to perform an examination of the respondent within 24 hours after the respondent is admitted into a facility. This examination would determine whether the respondent is mentally ill or a substance abuser and is dangerous to self or dangerous to others, and the results of this examination are considered by the court at the hearing to determine whether the respondent should be involuntarily committed.

Licensed Clinical Social Workers (LCSW): Social workers are licensed under Chapter 90B of the General Statutes. G.S. 90B-3 defines a LCSW to mean a person who is competent to function independently, who holds himself or herself out to the public as a social worker, and who offers or provides clinical social work services or supervises others engaging in clinical social work practice. According to the North Carolina Social Work Board website, the requirements for becoming a LCSW include the following:

- A Masters in Social Work (MSW), a Doctorate in Social Work (DSW), or a Doctorate in Philosophy (PhD) from a Council on Social Work Education (CSWE) accredited program.
- 3,000 hours of paid employment accumulated in no less than two years nor more than six years. (No more than 1500 hours accumulated in one year.)
- 100 hours of clinical supervision from a LCSW with a graduate degree in Social Work and two years of supervised clinical experience. Of these 100 hours at least 75 hours must have been individual supervision.
- Take and pass the American Association of Social Work Boards "Clinical level" examination.

Psychiatric Nurses: 10-3C.5202 of the NC Administrative Code defines a psychiatric nurse to mean an individual who is licensed to practice as a registered nurse in the State by the NC Board of Nursing; and has the following:

- A graduate degree from an accredited master's level program in psychiatric mental health nursing with two years of experience; or
- A master's degree in behavioral science with two years of supervised clinical experience in psychiatric mental health nursing; or
- A baccalaureate degree in behavioral science with four years of supervised clinical experience in psychiatric mental health nursing.

According to the NC Board of Nursing, a masters level psychiatric nurse is an advanced practice registered nurse generally referred to as a psychiatric-mental health clinical nurse specialist. A masters level psychiatric nurse would be eligible for direct reimbursement of services.

Certified Clinical Addictions Specialists: G.S. 90-113.31 defines a certified clinical addictions specialist to be a person certified by the NC Substance Abuse Professional Certification Board to practice as a clinical addictions specialist in accordance with the provisions of Article 5C of the General Statutes. G.S. 90-113.40 requires the Board to issue a certificate certifying an applicant as a certified clinical addictions specialist if it meets certain requirements for a certified substance abuse counselor or a certified substance abuse prevention consultant and meets one of four sets of criteria specified in statute.

BILL ANALYSIS: The proposed committee substitute for House Bill 883 would authorize the Secretary, upon request of a phase-one LME, to waive temporarily the requirements of the involuntary commitment statutes regarding who can conduct the initial examination to permit LCSWs, masters level psychiatric nurses, or masters level certified clinical addictions specialists to conduct the examination. In order to obtain this waiver, the LME must, as part of its business plan, describe how the purpose of the statutory requirement would be better served by waiving the requirement, how the waiver will enable the LME to improve the delivery or management of services, how the services to be provided by the LCSWs, masters level psychiatric nurses, and masters level certified clinical addictions specialists are within the scope of practice for those professions, and how the health, safety, and welfare of persons will be protected. In order to approve the LME's request for the waiver, the Secretary must find that: (1) the request meets the requirements of the bill, (2) the request furthers the purposes of State policy, and MH/DD/SA services reform, (3) the request improves the delivery of MH/DD/SA services in the counties affected by the waiver and protects the health, safety, and welfare of individuals receiving these services, and (4) the duties and responsibilities performed by the LCSWs, masters level psychiatric nurses, or the masters level certified clinical addictions specialists are within the scope of practice for these professions. The Secretary shall evaluate the services and the protection of health, safety, and welfare under the waiver. Waivers could be in effect for a period not to exceed three years or the period, for which the business plan is approved, whichever is shorter. The Secretary may grant a waiver under this section only to those LMEs that have been designated as phase-one entities as of July 1, 2003. **According to the Division of MH/DD/SA services, there are currently 13 LMEs that have been designated as phase-one entities.** The Department would have to ensure that staff performing the duties are trained and privileged to perform the functions identified in the waiver, and the LME would have to ensure that a psychiatrist is available at all times to provide back-up services.

The act would become effective July 1, 2003 and expire July 1, 2006.

Amy Compeau, Research Assistant, contributed to this summary.

H883-SMSW-001

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2003

HOUSE BILL 815

Short Title:	Detox Facilities Not Subject to CON.	(Public)
Sponsors:	Representatives Alexander; and Insko.	
Referred to:	Health.	

April 1, 2003

A BILL TO BE ENTITLED

AN ACT TO AMEND THE DEFINITION OF CHEMICAL DEPENDENCY TREATMENT FACILITY TO PROVIDE THAT SOCIAL SETTING DETOXIFICATION FACILITIES AND MEDICAL DETOXIFICATION FACILITIES ARE NOT CHEMICAL DEPENDENCY TREATMENT FACILITIES FOR THE PURPOSES OF CERTIFICATE OF NEED REQUIREMENTS AND TO AMEND THE DEFINITION OF CHEMICAL DEPENDENCY TREATMENT BED TO PROVIDE THAT BEDS LICENSED FOR DETOXIFICATION ARE NOT CHEMICAL DEPENDENCY TREATMENT BEDS FOR THE PURPOSES OF CERTIFICATE OF NEED REQUIREMENTS.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 131E-176(5a) reads as rewritten:

"(5a) "Chemical dependency treatment facility" means a public or private facility, or unit in a facility, which is engaged in providing 24-hour a day treatment for chemical dependency or substance abuse. This treatment may include detoxification, administration of a therapeutic regimen for the treatment of chemically dependent or substance abusing persons and related services. The facility or unit may be:

a. A unit within a general hospital or an attached or freestanding unit of a general hospital licensed under Article 5, Chapter 131E, of the General Statutes,

b. A unit within a psychiatric hospital or an attached or freestanding unit of a psychiatric hospital licensed under Article 1A of General Statutes Chapter 122 or Article 2 of General Statutes Chapter 122C,

c. A freestanding facility specializing in treatment of persons who are substance abusers or chemically dependent licensed under Article 1A of General Statutes Chapter 122 or Article 2 of General Statutes Chapter 122C; and may be identified as

"chemical dependency, substance abuse, alcoholism, or drug abuse treatment units," "residential chemical dependency, substance abuse, alcoholism or drug abuse facilities," ~~"social setting detoxification facilities" and "medical detoxification facilities,"~~ or by other names if the purpose is to provide treatment of chemically dependent or substance abusing persons, but shall not include social setting detoxification facilities, medical detoxification facilities, halfway houses or recovery farms."

SECTION 2. G.S. 131E-176(5b) reads as rewritten:

"(5b) "Chemical dependency treatment beds" means beds that are licensed ~~for detoxification or~~ for the inpatient treatment of chemical dependency. Residential treatment beds for the treatment of chemical dependency or substance abuse are chemical dependency treatment beds. Chemical dependency treatment beds shall not include beds licensed for detoxification."

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

HOUSE BILL 815:
Detox Facilities Not Subject to CON

BILL ANALYSIS

Committee:	House Health	**Introduced by:**	Rep. Alexander
Date:	April 15, 2003	**Summary by:**	Dianna Jessup
Version:	First Edition		Committee Counsel

SUMMARY: House Bill 815 would exempt social setting detoxification facilities and medical detoxification facilities from Certificate of Need requirements. The act would become effective when it becomes law.

CURRENT LAW:

Certificate of Need: State law prohibits health care providers from acquiring, replacing, or adding to their facilities and equipment unless the provider obtains a Certificate of Need from the Department of Health and Human Services (DHHS). A Certificate of Need is also required before beginning to offer certain health services. The purpose of the CON is to control health care costs by preventing the unnecessary duplication of medical facilities and services and to help ensure the geographic distribution of health care facilities and services. All new hospitals, psychiatric facilities, chemical dependency treatment facilities, nursing homes, adult care homes, kidney disease treatment centers, intermediate care facilities for the mentally retarded, rehabilitation facilities, home health agencies hospices, diagnostic centers, oncology treatment centers, and ambulatory surgical facilities must first obtain a CON before developing new facilities or offering new services.

Chemical Dependency Treatment Facilities: Chemical dependency treatment facilities are currently subject to CON requirements. G.S. 131E-176 defines a "chemical dependency treatment facility" to be a public or private facility, or unit in a facility, which is engaged in providing 24-hour a day treatment for chemical dependency or substance abuse. This treatment may include detoxification, therapy, and related services. "Halfway houses" and "recovery farms" are not considered "chemical dependency treatment facilities" for CON purposes.

Social Setting Detoxification Facilities and Medical Detoxification Facilities: Social setting detoxification facilities and medical detoxification facilities are considered "chemical dependency treatment facilities" under G.S. 131E-176. They are licensed under Article 2 of Chapter 122C of the General Statutes. Services provided by social setting detoxification facilities are not eligible for reimbursement under Medicaid. Medicaid does cover medical detoxification if provided at an acute care hospital. These facilities do not engage in treatment for substance abuse.

BILL ANALYSIS: House Bill 815 would exempt social setting detoxification facilities and medical detoxification facilities from CON requirements, the same as halfway houses and recovery farms. Persons who want to offer or develop these facilities would not have to seek the prior approval of DHHS. Licensing requirements would still apply. The act would become effective when it becomes law.

H815-SMSW-001

Amy Compeau, Research Assistant, contributed to this summary.

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2003

HOUSE BILL 886

Short Title:	Due Process for Physicians.	(Public)
Sponsors:	Representatives Wright and Howard (Primary Sponsors).	
Referred to:	Health.	

April 7, 2003

A BILL TO BE ENTITLED

AN ACT TO AMEND VARIOUS PROVISIONS RELATING TO THE NORTH CAROLINA MEDICAL BOARD UNDER THE LAWS REGULATING THE PRACTICE OF MEDICINE.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 90-2 reads as rewritten:

"**§ 90-2. Medical Board.**

(a) In order to properly regulate the practice of medicine and surgery for the benefit and protection of the people of North Carolina, there is established the North Carolina Medical Board. The Board shall consist of 12 members.

(1) Seven of the members shall be duly licensed physicians elected and nominated ~~to~~ by the ~~Governor by the North Carolina Medical Society.~~ Governor. Of the seven members appointed by the Governor, one member shall be a faculty member at one of the medical schools in North Carolina.

(2) Of the remaining five members, all to be appointed by the Governor, at least three shall be public members and at least one shall be a physician assistant as defined in G.S. 90-18.1 or a nurse practitioner as defined in G.S. 90-18.2. A public member shall not be a health care provider nor the spouse of a health care provider. For purposes of board membership, "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 section, a person enrolled in a program to prepare him to be a licensed health care professional or an allied health professional shall be deemed a health care provider. For purposes of this section, any person with significant financial interest in a health service or profession is not a public member.

(b) No member appointed to the Board on or after November 1, 1981, shall serve more than two complete consecutive three-year terms, except that each member shall serve until his successor is chosen and qualifies.

(c) In order to establish regularly overlapping terms, the terms of office of the members shall expire as follows: two on October 31, 1993; four on October 31, 1994; four on October 31, 1995; and two on October 31, 1996.

(d) ~~Any~~A member of the Board ~~may~~ shall be removed from office by the Governor for good cause ~~shown.~~shown, including malicious prosecution or abuse of power. Any vacancy in the physician membership of the Board shall be filled for the period of the unexpired term by the ~~Governor from a list of physicians submitted by the North Carolina Medical Society Executive Council.~~Governor. Any vacancy in the public, physician assistant, or nurse practitioner membership of the Board shall be filled by the Governor for the unexpired term.

(e) The North Carolina Medical Board shall have the power to acquire, hold, rent, encumber, alienate, and otherwise deal with real property in the same manner as any 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."

SECTION 2. G.S. 90-8 reads as rewritten:

"**§ 90-8. Officers may administer oaths, and subpoena witnesses, records and other materials.**

The president and secretary of the Board may administer oaths to all persons appearing before it as the Board may deem necessary to perform its duties, and may summon and issue subpoenas for the appearance of any witnesses deemed necessary to testify concerning any matter to be heard before or inquired into by the Board. The power of the Board to subpoena is limited to persons with knowledge related to a matter before the Board. Medical expert witnesses, including medical practitioners licensed in the United States, must routinely and actively practice in the specialty that is under investigation by the Board. Each party must disclose the identity of an expert, the subjects on which the expert is expected to testify, the substance of the facts and opinions on which the expert is expected to rely, and the qualifications of the expert. Statements contained in medical or scientific literature may be relied upon in direct and cross-examination and admitted into evidence. The Board may order that any patient records, documents or other material concerning any matter to be heard before or inquired into by the Board shall be produced before the Board or made available for inspection, notwithstanding any other provisions of law providing for the application of any physician-patient privilege with respect to such records, documents or other material. All records, documents, or other material compiled by the Board are subject to the provisions of G.S. 90-16. Notwithstanding the provisions of G.S. 90-16, in any proceeding before the Board, in any record of any hearing before the Board, and in the notice of charges against any licensee, the Board shall withhold from public disclosure the identity of a patient including information relating to dates and places of treatment, or any other information that would tend to identify the patient, unless the patient or the

representative of the patient expressly consents to the disclosure. Upon written request, the Board shall revoke a subpoena if, upon a hearing, it finds that the evidence the production of which is required does not relate to a matter in issue, or if the subpoena does not describe with sufficient particularity the evidence the production of which is required, or if for any other reason in law the subpoena is invalid."

SECTION 3. G.S. 90-14(a) reads as rewritten:

"(a) The Board shall have the power to deny, annul, suspend, or revoke a license, or other authority to practice medicine in this State, issued by the Board to any person who has been found by the Board to have committed any of the following acts or conduct, or for any of the following reasons:

(1) Immoral or dishonorable conduct.

(2) Producing or attempting to produce an abortion contrary to law.

(3) Made false statements or representations to the Board, or who has willfully concealed from the Board material information in connection with an application for a license.

(4) Repealed by Session Laws 1977, c. 838, s. 3.

(5) Being unable to practice medicine with reasonable skill and safety to patients by reason of illness, drunkenness, excessive use of alcohol, drugs, chemicals, or any other type of material or by reason of any physical or mental abnormality. The Board is empowered and authorized to require a physician licensed by it to submit to a mental or physical examination by physicians designated by the Board before or after charges may be presented against the physician, and the results of the examination shall be admissible in evidence in a hearing before the Board.

(6) Unprofessional conduct, including, but not limited to, departure from, or the failure to conform to, the standards of acceptable and prevailing medical practice, or the ethics of the medical profession, irrespective of whether or not a patient is injured thereby, or the committing of any act contrary to honesty, justice, or good morals, whether the same is committed in the course of the physician's practice or otherwise, and whether committed within or without North Carolina. The standards of practice in any specialty, including complementary treatments, shall be defined by specialists in that field. The Board shall not annul, suspend, revoke the license of or deny a license to a ~~person~~ person, harass, or initiate an investigation solely because of that person's practice of a therapy that is experimental, nontraditional, or that departs from acceptable and prevailing medical practices unless, by ~~competent~~ a preponderance of the evidence, the Board can establish that the treatment has a ~~safety~~ risk of harm to the patient greater than the prevailing treatment or that the treatment is generally not ~~effective.~~as effective in comparison to the effective rates of other prevailing treatments.

(7) Conviction in any court of a crime involving moral turpitude, or the violation of a law involving the practice of medicine, or a conviction of a felony; provided that a felony conviction shall be treated as provided in subsection (c) of this section.

(8) By false representations has obtained or attempted to obtain practice, money or anything of value.

(9) Has advertised or publicly professed to treat human ailments under a system or school of treatment or practice other than that for which the physician has been educated. A duly licensed physician shall not be prohibited from displaying all of his or her certifications in public documents.

(10) Adjudication of mental incompetency, which shall automatically suspend a license unless the Board orders otherwise.

(11) Lack of professional competence to practice medicine with a reasonable degree of skill and safety for patients. In this connection the Board may consider repeated acts of a physician indicating the physician's failure to properly treat a patient. The Board may, upon reasonable grounds, require a physician to submit to inquiries or examinations, written or oral, by members of the Board or by other physicians licensed to practice medicine in this State, as the Board deems necessary to determine the professional qualifications of such licensee.

(12) Promotion of the sale of drugs, devices, appliances or goods for a patient, or providing services to a patient, in such a manner as to exploit the patient, and upon a finding of the exploitation, the Board may order restitution be made to the payer of the bill, whether the patient or the insurer, by the physician; provided that a determination of the amount of restitution shall be based on credible testimony in the record. Selling nutritional supplements or vitamins shall have the same financial disclosures as those required with drugs, devices, appliances, or goods. Nothing in this subdivision shall restrain free trade or limit the legitimate trade activities involved in the course of the practice of medicine.

(13) Having a license to practice medicine or the authority to practice medicine revoked, suspended, restricted, or acted against or having a license to practice medicine denied by the licensing authority of any jurisdiction. For purposes of this subdivision, the licensing authority's acceptance of a license to practice medicine voluntarily relinquished by a physician or relinquished by stipulation, consent order, or other settlement in response to or in anticipation of the filing of administrative charges against the physician's license, is an action against a license to practice medicine.

(14) The failure to respond, within a reasonable period of time and in a reasonable manner as determined by the Board, to inquiries from the

Board concerning any matter affecting the license to practice medicine. However, the Board shall conclude an investigation pursuant to a violation of this subdivision within 18 months from the date the incident was initially reported.

(15) The failure to complete an amount not to exceed 150 hours of continuing medical education during any three consecutive calendar years pursuant to rules adopted by the Board.

For any of the foregoing reasons, the Board may deny the issuance of a license to an applicant or revoke a license issued to a physician, may suspend such a license for a period of time, and may impose conditions upon the continued practice after such period of suspension as the Board may deem advisable, may limit the accused physician's practice of medicine with respect to the extent, nature or location of the physician's practice as the Board deems advisable. The Board may, in its discretion and upon such terms and conditions and for such period of time as it may prescribe, restore a license so revoked or rescinded, except that no license that has been revoked shall be restored for a period of two years following the date of revocation."

SECTION 4. G.S. 90-14 is amended by adding a new subsection to read:

"(g) In order to annul, suspend, deny, or revoke a license of an accused physician, the Board must find that the facts satisfy, by the greater weight of the evidence, that there is a pattern of incompetence and that the care provided was not in accordance with the standards of practice for the procedures or treatments administered."

SECTION 5. G.S. 90-14.2 reads as rewritten:

"**§ 90-14.2. Hearing before revocation or suspension of a license.**

Before the Board shall revoke, restrict or suspend any license granted by it, the licensee shall be given a written notice indicating the general nature of the charges, accusation, or complaint made against him, which notice may be prepared by a committee or one or more members of the Board designated by the Board, and stating that such licensee will be given an opportunity to be heard concerning such charges or complaint at a time and place stated in such notice, or at a time and place to be thereafter designated by the Board, and the Board shall hold a public hearing not less than 30 days from the date of the service of such notice upon such licensee, at which such licensee may appear personally and through counsel, may cross examine witnesses and present evidence in his own behalf. A physician who is mentally incompetent shall be represented at such hearing and shall be served with notice as herein provided by and through a guardian ad litem appointed by the clerk of the court of the county in which the physician has his residence. Such licensee or physician may, if he desires, file written answers to the charges or complaints preferred against him within 30 days after the service of such notice, which answer shall become a part of the record but shall not constitute evidence in the case. Members of the Board participating on the hearing committee shall not have been involved in any part of the investigation."

SECTION 6. G.S. 90-14.5 reads as rewritten:

"**§ 90-14.5. Use of trial examiner or depositions.**

~~Where the licensee requests~~The licensee may request that the hearing herein provided for be held by the Board in a county other than the county designated for the

holding of the meeting of the Board at which the matter is to be heard, the Board may designate in writing one or more of its members to conduct the hearing as a trial examiner or trial committee, to take evidence and report a written transcript thereof to the Board at a meeting where a majority of the members are present and participating in the decision. Evidence and testimony may also be presented at such hearings and to the Board in the form of depositions taken before any person designated in writing by the Board for such purpose or before any person authorized to administer oaths, in accordance with the procedure for the taking of depositions in civil actions in the superior court. When a trial examiner or trial committee recommends license revocation, suspension, or retraction, the licensee shall be granted a full Board hearing at the licensee's request if the request is made in a timely manner as determined by the Board."

SECTION 7. G.S. 90-14.6 reads as rewritten:

"**§ 90-14.6. Evidence admissible.**

In proceedings held pursuant to this Article the Board shall admit and hear evidence in the same manner and form as prescribed by law for civil actions. A complete record of such evidence shall be made, together with the other proceedings incident to such hearing. The physician under investigation may call witnesses, including medical practitioners licensed in the United States, with expertise in the same field of practice as the physician under investigation. Witnesses shall not be restricted to experts certified by the American Board of Medical Specialties. In an investigative meeting, the physician being investigated may present testimony from medical practitioners licensed in the United States with expertise in the same field of practice as the physician under investigation. Members of the Board shall not be immune from civil or criminal liability for failing to exercise, in good faith, its powers and duties authorized by law."

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

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2003

H 1

HOUSE BILL 907*

Short Title:	Deaf/Hard of Hearing Advisory Council.	(Public)
Sponsors:	Representative Alexander.	
Referred to:	Health.	

April 7, 2003

A BILL TO BE ENTITLED

AN ACT TO AMEND THE LAWS RELATING TO THE COUNCIL FOR THE DEAF AND HARD OF HEARING AND TO CHANGE THE APPOINTING AUTHORITY AND MEMBERSHIP COMPOSITION OF TWO OF THE MEMBERS APPOINTED TO THE COUNCIL.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 143B-216.31 reads as rewritten:

"**§ 143B-216.31. Council for the Deaf and the Hard of Hearing – creation and duties.**

There is hereby created the Council for the Deaf and the Hard of Hearing of the Department of Health and Human Services. The Council shall have duties including the following:

(1) To make recommendations to the Secretary of the Department of Health and Human Services ~~regarding improvement of human services to the deaf and the hard of hearing;~~for cost-effective provision, coordination, and improvement of services;

(2) To ~~study ways to promote public understanding of the problems of the deaf and the hard of hearing and to consider the need for new State programs concerning deafness;~~create public awareness of the specific needs and abilities of people who are deaf, hard of hearing, or deaf-blind and to consider the need for new State programs concerning the deaf, hard of hearing, and deaf-blind;

(3) To advise the Secretary of the Department of Health and Human Services ~~in the preparation of a plan describing the quality, extent and scope of services provided or to be provided, to deaf and hard of hearing persons in this State;~~during planning and implementation of services being provided to North Carolina citizens who are deaf, hard of hearing, or deaf-blind with respect to the quality, extent, and scope of those services;

(4) To ~~study any State programs that provide educational services for deaf and hard of hearing persons and to advise the Secretary of the Department of Health and Human Services and the Superintendent of Public Instruction concerning coordination of these programs to prevent duplication of services; and~~advise the Secretary of the Department of Health and Human Services and the Superintendent of the Department of Public Instruction regarding planning, implementation, and cost-effective coordination of State programs providing educational services for persons who are deaf, hard of hearing, or deaf-blind; and

(5) To ~~advise and make recommendations to the Secretary of the Department of Health and Human Services upon any matter as requested by the Secretary.~~respond to the Secretary of the Department of Health and Human Services' requests for advice or recommendations pertaining to any matter affecting deaf, hard of hearing, or deaf-blind citizens of North Carolina."

SECTION 2. G.S. 143B-216.32 reads as rewritten:

"**§ 143B-216.32. Council for the Deaf and the Hard of Hearing – membership; quorum; compensation.**

(a) The Council for the Deaf and the Hard of Hearing shall consist of 25 members. ~~Fifteen~~ Seventeen members shall be members appointed by the Governor. Three members appointed by the Governor shall be persons who are ~~deaf and~~deaf, three members shall be persons who are hard of hearing. One appointment shall be an educator who trains deaf education teachers and one appointment shall be an audiologist licensed under Article 22 of Chapter 90 of the General Statutes. Three appointments shall be parents of deaf or hard of hearing children including one parent of a student in a residential school; one parent of a student in a preschool program; and one parent of a student in a mainstream education program, with at least one parent coming from each region of the North Carolina schools for the deaf regions. One member appointed by the Governor shall be recommended by the President of the North Carolina Association of the Deaf; one member shall be recommended by the President of the North Carolina Deaf-Blind Associates; one member shall be recommended by the President of the North Carolina Pediatric Society; one member shall be recommended by the President of the North Carolina Registry of Interpreters for the Deaf; one member shall be recommended by a local education agency; and one member shall be nominated by the Superintendent of Public Instruction. ~~Two members~~One member shall be appointed from the House of Representatives by the Speaker of the House of Representatives and ~~two members~~one member shall be appointed from the Senate by the President Pro Tempore of the Senate. The Secretary of Health and Human Services shall appoint six members as follows: one from the Division of Vocational Rehabilitation, one from the Division of Aging, one from the Division of Mental Health, Developmental Disabilities, and Substance Abuse Services, one from the Division of Social Services, ~~one from a North Carolina Chapter of SHHH (Self Help for the Hard of Hearing), and one from SPEAK (Statewide Parents' Education and Advocacy for Kids).~~one member upon the

recommendation of the North Carolina Chapter of Self Help for the Hard of Hearing (SHHH), and one upon the recommendation of the North Carolina Black Deaf Advocates (NCBDA).

(b) The terms of the initial members of the Council shall commence July 1, 1989. In his initial appointments, the Governor shall designate four members who shall serve terms of five years, four who shall serve terms of four years, four who shall serve terms of three years, and three who shall serve terms of two years. After the initial appointees' terms have expired, all members shall be appointed for a term of four years. No member ~~appointed by the Governor~~ shall serve more than two successive ~~terms.~~terms unless the member is an employee of the Department of Health and Human Services or the Department of Public Instruction representing his or her agency as a specialist in the field of service.

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.

(c) The chairman of the Council shall be designated by the Secretary of the Department of Health and Human Services from the Council members. The chairman shall hold this office for not more than four years.

(d) The Council shall meet quarterly and at other times at the call of the chairman. A majority of the Council shall constitute a quorum.

(e) Council members shall be reimbursed for expenses incurred in the performance of their duties in accordance with G.S. 138-5.

(f) The Secretary of the Department of Health and Human Services shall provide clerical and other assistance as needed."

SECTION 3. Pursuant to G.S. 143B-216.32(a), as enacted in Section 2 of this act, when the term of the member appointed by the Secretary of Health and Human Services who is a representative from Statewide Parents' Education and Advocacy for Kids (SPEAK) expires, the Secretary of Health and Human Services shall appoint one member upon the recommendation of the North Carolina Black Deaf Advocates to serve a four-year term to commence when this act becomes effective.

Pursuant to G.S. 143B-216.32(a), as enacted in Section 2 of this act, the member appointed by the Governor as recommended by the President of the North Carolina Deaf-Blind Associates shall be appointed for a four-year term to commence when this act becomes effective and the member appointed by the Governor as recommended by a local education agency shall be appointed for a four-year term to commence when this act becomes effective. Members described in this section shall serve for the terms for which they were appointed and until their successors are appointed and qualified.

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

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2003

H D

HOUSE BILL 907*
PROPOSED COMMITTEE SUBSTITUTE H907-CSLU-3 [v.2]

4/13/2003 7:17:19 PM

Short Title: Deaf/Hard of Hearing Advisory Council. (Public)

Sponsors:

Referred to:

April 7, 2003

A BILL TO BE ENTITLED

AN ACT TO AMEND THE LAWS RELATING TO THE COUNCIL FOR THE DEAF AND HARD OF HEARING, TO INCREASE THE MEMBERS ON THE COUNCIL, AND TO CHANGE THE APPOINTING AUTHORITY FOR TWO OF THE MEMBERS APPOINTED TO THE COUNCIL.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 143B-216.31 reads as rewritten:

"**§ 143B-216.31. Council for the Deaf and the Hard of Hearing – creation and duties.**

There is hereby created the Council for the Deaf and the Hard of Hearing of the Department of Health and Human Services. The Council shall have duties including the following:

(1) To make recommendations to the Secretary of the Department of Health and Human Services ~~regarding improvement of human services to the deaf and the hard of hearing;~~for cost-effective provision, coordination, and improvement of services;

(2) To ~~study ways to promote public understanding of the problems of the deaf and the hard of hearing and to consider the need for new State programs concerning deafness;~~create public awareness of the specific needs and abilities of people who are deaf, hard of hearing, or deaf-blind and to consider the need for new State programs concerning the deaf, hard of hearing, and deaf-blind;

(3) To advise the Secretary of the Department of Health and Human Services ~~in the preparation of a plan describing the quality, extent and scope of services provided or to be provided, to deaf and hard of hearing persons in this State;~~during planning and implementation of services being provided to North Carolina citizens who are deaf, hard

of hearing, or deaf-blind with respect to the quality, extent, and scope of those services;

(4) To ~~study any State programs that provide educational services for deaf and hard of hearing persons and to advise the Secretary of the Department of Health and Human Services and the Superintendent of Public Instruction concerning coordination of these programs to prevent duplication of services; and~~advise the Secretary of the Department of Health and Human Services and the Superintendent of the Department of Public Instruction regarding planning, implementation, and cost-effective coordination of State programs providing educational services for persons who are deaf, hard of hearing, or deaf-blind; and

(5) To ~~advise and make recommendations to the Secretary of the Department of Health and Human Services upon any matter as requested by the Secretary.~~respond to the Secretary of the Department of Health and Human Services' requests for advice or recommendations pertaining to any matter affecting deaf, hard of hearing, or deaf-blind citizens of North Carolina."

SECTION 2. G.S. 143B-216.32 reads as rewritten:

"**§ 143B-216.32. Council for the Deaf and the Hard of Hearing – membership; quorum; compensation.**

(a) The Council for the Deaf and the Hard of Hearing shall consist of ~~25~~ 27 members. ~~Fifteen~~ Nineteen members shall be members appointed by the Governor. Three members appointed by the Governor shall be persons who are ~~deaf and~~deaf, three members shall be persons who are hard of hearing. One appointment shall be an educator who trains deaf education teachers and one appointment shall be an audiologist licensed under Article 22 of Chapter 90 of the General Statutes. Three appointments shall be parents of deaf or hard of hearing children including one parent of a student in a residential school; one parent of a student in a preschool program; and one parent of a student in a mainstream education program, with at least one parent coming from each region of the North Carolina schools for the deaf regions. One member appointed by the Governor shall be recommended by the President of the North Carolina Association of the Deaf; one member shall be recommended by the President of the North Carolina Deaf-Blind Associates; one member shall be recommended by the North Carolina Chapter of Self Help for the Hard of Hearing (SHHH); one member shall be recommended by the North Carolina Black Deaf Advocates (NCBDA); one member shall be recommended by the President of the North Carolina Pediatric Society; one member shall be recommended by the President of the North Carolina Registry of Interpreters for the Deaf; one member shall be recommended by a local education agency; and one member shall be ~~nominated~~ recommended by the Superintendent of Public Instruction. Two members shall be appointed from the House of Representatives by the Speaker of the House of Representatives and two members shall be appointed from the Senate by the President Pro Tempore of the Senate. The Secretary of Health and Human Services shall appoint ~~six~~ four members as follows: one from the Division

of Vocational Rehabilitation, one from the Division of Aging, one from the Division of Mental Health, Developmental Disabilities, and Substance Abuse Services, and one from the Division of Social ~~Services, one from a North Carolina Chapter of SHHH (Self Help for the Hard of Hearing), and one from SPEAK (Statewide Parents' Education and Advocacy for Kids).~~Services.

(b) The terms of the initial members of the Council shall commence July 1, 1989. In his initial appointments, the Governor shall designate four members who shall serve terms of five years, four who shall serve terms of four years, four who shall serve terms of three years, and three who shall serve terms of two years. After the initial appointees' terms have expired, all members shall be appointed for a term of four years. No member ~~appointed by the Governor~~ shall serve more than two successive ~~terms.~~terms unless the member is an employee of the Department of Health and Human Services or the Department of Public Instruction representing his or her agency as a specialist in the field of service.

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.

(c) The chairman of the Council shall be designated by the Secretary of the Department of Health and Human Services from the Council members. The chairman shall hold this office for not more than four years.

(d) The Council shall meet quarterly and at other times at the call of the chairman. A majority of the Council shall constitute a quorum.

(e) Council members shall be reimbursed for expenses incurred in the performance of their duties in accordance with G.S. 138-5.

(f) The Secretary of the Department of Health and Human Services shall provide clerical and other assistance as needed."

SECTION 3. Pursuant to G.S. 143B-216.32(a), as enacted in Section 2 of this act, when the term of the member appointed by the Secretary of Health and Human Services who is a representative from the North Carolina Chapter of Self Help for the Hard of Hearing (SHHH) expires, the Governor shall appoint one member upon the recommendation of the North Carolina Chapter of Self Help for the Hard of Hearing to a serve a four-year term to commence when this act becomes effective. When the term of the member appointed by the Secretary of Health and Human Services who is a representative from Statewide Parents' Education and Advocacy for Kids (SPEAK) expires, the Governor shall appoint one member upon the recommendation of the North Carolina Black Deaf Advocates to serve a four-year term to commence when this act becomes effective.

Pursuant to G.S. 143B-216.32(a), as enacted in Section 2 of this act, the member appointed by the Governor as recommended by the President of the North Carolina Deaf-Blind Associates shall be appointed for a four-year term to commence when this act becomes effective and the member appointed by the Governor as recommended by a local education agency shall be appointed for a four-year term to commence when this act becomes effective. Members described in this section shall

serve for the terms for which they were appointed and until their successors are appointed and qualified.

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

FISCAL ANALYSIS MEMORANDUM

[This confidential fiscal memorandum is a fiscal analysis of a draft bill, amendment, committee substitute, or conference committee report that has not been formally introduced or adopted on the chamber floor or in committee. This is not an official fiscal note. If upon introduction of the bill you determine that a formal fiscal note is needed, please make a fiscal note request to the Fiscal Research Division, and one will be provided under the rules of the House and the Senate.]

DATE: **April 16, 2003**

TO: Representative Verla Insko

FROM: Susan Morgan
Fiscal Research Division

RE: House Bill 170-(Proposed Committee Substitute)
"Special Assistance In-Home Option"

FISCAL IMPACT

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

	FY 2003-04	FY 2004-05	FY 2005-06	FY 2006-07	FY 2007-08
EXPENDITURES	See Assumptions				

PRINCIPAL DEPARTMENT(S) & PROGRAM(S) AFFECTED: Department of Health and Human Services – Division of Social Services

EFFECTIVE DATE: July 1, 2003

ISSUE BACKGROUND:

State/County Special Assistance (SA) provides payments to eligible individuals who live in the following types of facilities that are licensed under state law by the Division of Facility Services: adult care homes, family care homes, group homes for developmentally disabled adults, group homes for mentally ill adults, and adult care homes that are located in nursing homes (known as combination facilities). SA is funded 50% by the state and 50% by the county. In 1999, the General Assembly authorized the Department of Health and Human

Services to implement a demonstration project that would provide SA payments to individuals who qualified for SA, but chose to remain in their home. Individuals were identified as potential participants in the demonstration project upon applying for SA and seeking placement in an adult care home or other facility. Participants were allowed to receive an SA payment (50% of the standard SA payment) and remain in their home while receiving additional community-based services determined necessary by a social services case manager at the local level. The number of participants in the demonstration project was capped at 400 participants, and 22 counties participated in the project.

BILL SUMMARY:

The bill will allow all North Carolina counties to participate in a Special Assistance In-Home Program, and increases the maximum number of participants from 400 to 2,000. Counties are not required to participate in the In-Home Program. The bill maintains the stipulation that participants shall receive 50% of the payment they would have received in entering a facility, unless a lesser amount is determined appropriate as determined by a local case manager. The Department is directed to implement policies to assure that the participants in the In-Home Program would have required placement in a facility had this option not been available. The bill requires the In-Home Program to be funded within existing resources allocated for State/County Special Assistance.

ASSUMPTIONS AND METHODOLOGY:

The impact of this bill on the general fund and on local budgets is based on a basic analysis of allowing a maximum of 50% of the standard SA payment for participants in the In-Home Program. This analysis considers *only* the impact to the SA budget and does not address the potential impact on other services such as Medicaid and other community-based services, such as the Home and Community Care Block Grant.

A comparison of Standard State/County Special Assistance, and the proposed In-Home Program follows:

	Standard SA	**In-Home Program**
Number of Participants	2000[1]	2000
Average Monthly Payment/Person	$426	$184
Average Annual Payment/Person	$5,112	$2,208
Total Expenditures	$10,224,000	$4,416,000
Total *State* Expenditures (50%)	$$5,112,000	$2,208,000
Projected Savings/Year	N/A	$2,904,000
Cumulative Savings/ 5 Years[2]		$14,520,000

[1]SA is an entitlement program and anyone determined to be eligible is entitled to benefits, including Medicaid Benefits.
[2]Assumes SA rates would remain at current rate of $1,091/month/person.

SOURCES OF DATA: Special Assistance Demonstration Project Final Report, January 2003 – Average payment data based on 377 participants.

TECHNICAL CONSIDERATIONS:

The projected savings identified are calculated with the assumption that the Department will be successful in assuring that participants would have been placed in a facility and received standard SA payments had this program not been available. If any of the 2000 participants in the In-Home Program would not have entered a facility had this program not been offered, then the projected savings would be decreased by the average annual per person expenditure ($2,208).

This analysis is also based on the continued "cap" of the program at 2,000 participants, and does not included the impact to other programs at the local level.

HOUSE BILL 907:
Deaf/Hard of Hearing Advisory Council

BILL ANALYSIS

Committee:	House Health	**Introduced by:**	Rep. Alexander
Date:	April 17, 2003	**Summary by:**	Amy Compeau
Version:	H907-CSLU-3 [v.2]		Research Division Staff

SUMMARY: ***House Bill 907 would amend the laws relating to the Council for the Deaf and the Hard of Hearing (Council) and would change the appointing authority and membership composition of two of the members appointed to the Council. The act would become effective when it becomes law.***

The PCS to House Bill 907 would increase the members on the Council from 25 to 27 and would make additional changes described below.

CURRENT LAW: S.L. 1989-533 established the Council for the Deaf and the Hard of Hearing of the Department of Health and Human Services (DHHS). The North Carolina General Assembly established the Council to advise the Secretary of DHHS (Secretary) on matters pertaining to the services for deaf and hard of hearing people.

BILL ANALYSIS:

Section 1 would amend the duties of the Council as follows:

1. The bill clarifies that the Council would make recommendations to the Secretary for cost-effective provision, coordination, and improvement of services. (Current law requires the Council to make recommendations regarding improvement of human services to the deaf and hard of hearing.)
2. The bill would require the Council to create public awareness of the specific needs and abilities of people who are deaf, hard of hearing, or deaf-blind. (Current law requires the Council to study ways to promote public understanding.)
3. The bill would specify that the Council would advise the Secretary during planning and implementation of services being provided with respect to the quality, extent, and scope of those services. (Current law requires the Council to advise the Secretary in the preparation of a plan for services to be provided).
4. The Council would advise the Secretary and the Superintendent of the Department of Public Instruction regarding planning, implementation and cost effective coordination of State programs providing educational services for persons who are deaf, hard of hearing, or deaf-blind. (This section of the bill makes clarifying changes to the law.)
5. The Council would respond to the Secretary's requests for advice or recommendations pertaining to any matter affecting deaf, hard of hearing or deaf-blind citizens. (Current law requires the Council to advise the Secretary on any matter requested.)

Section 2 would change the membership, appointing authority, member qualification and term limits of certain Council members. HB 907 would increase the number of members to the Council appointed by the Governor from 15 members to 17 members. The two additional members would be appointed by the Governor as follows: (1) member recommended by the President of the NC Deaf-Blind Associates and (1) member recommended by a local education agency.

The PCS would increase membership to the Council from 25 to 27 members. The two additional members would be appointed by the Governor as follows: (1) member recommended by the North Carolina Chapter of Self Help for the Hard of Hearing (SHHH) and (1) member recommended by the North Carolina Black Deaf Advocates (NCBDA). The PCS, then, would increase the number of Council members appointed by the Governor from 15 members to 19 members.

HB 907 would have taken away one appointee each from the Speaker and President Pro Tempore. *The PCS would maintain current law so that the Speaker and President Pro Tempore could continue making two appointees each to the Council.*

HB 907 changes the recommendations from which the Secretary could make her six appointees to the Council. It would specify that one member would be appointed based upon the recommendation of SHHH (Current law specifies a member of SHHH) and one member would be appointed based upon the recommendation of NCBDA (Current law specifies a member of Statewide Parents' Education and Advocacy for Kids (SPEAK). *The PCS would decrease the number of the Secretary's appointees from six members to four members. The Secretary would no longer appoint a member from SHHH and a member from SPEAK.*

HB 907 would clarify that no member could serve more than two successive terms unless the member is an employee of DHHS or the Department of Public Instruction representing the agency as a specialist in the field of service.

Section 3 would specify staggered terms for the four new appointees of the Governor to the Council.

BACKGROUND: According to Division of Services for the Deaf and Hard of Hearing, DHHS, the bill is deleting an outdated reference in statute, and it adds representation to the Council from two organizations. Current law requires the Secretary to appoint a member from SPEAK, and this organization no longer exists so the bill would delete the reference. The bill would add members to the Council based upon the recommendation of NCBDA and of the President of the North Carolina Deaf-Blind Associates. Current law requires the Secretary to appoint two members to the Council from organizations representing the deaf community. These members do not have term limits. Current law requires the Governor to appoint members to the Council from organizations representing the deaf community as well as other individuals who are deaf or hard of hearing or who are parents of deaf or hard of hearing children. The members appointed by the Governor cannot serve more than two consecutive four-year terms. The bill would require the Governor to make all appointments from the deaf and hard of hearing community to the Council so they would all have the same term limits.

H907-SMRP-001

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2003

H D

HOUSE BILL 886
PROPOSED COMMITTEE SUBSTITUTE H886-CSSW-14 [v.6]

4/22/2003 5:53:00 PM

Short Title: Due Process for Physicians. (Public)

Sponsors:

Referred to:

April 7, 2003

A BILL TO BE ENTITLED

AN ACT TO AMEND VARIOUS PROVISIONS RELATING TO THE NORTH CAROLINA MEDICAL BOARD UNDER THE LAWS REGULATING THE PRACTICE OF MEDICINE.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 90-2 reads as rewritten:

"**§ 90-2. Medical Board.**

(a) ~~In order to properly regulate the practice of medicine and surgery for the benefit and protection of the people of North Carolina, there is established the North Carolina Medical Board.~~ There is established the North Carolina Medical Board to regulate the practice of medicine and surgery for the benefit and protection of the people of North Carolina. The Board shall consist of 12 members.

(1) Seven of the members shall be duly licensed physicians ~~elected and nominated to~~ appointed by the ~~Governor by the North Carolina Medical Society.~~ Governor. Of the seven members appointed by the Governor, one member shall be a faculty member at one of the medical schools in North Carolina. In addition, of these seven members, three shall be duly licensed physicians nominated by the North Carolina Medical Society, three shall be duly licensed physicians nominated by The Old North State Medical Society, and one shall be a duly licensed physician nominated by the North Carolina Osteopathic Medical Association.

(2) Of the remaining five members, all to be appointed by the Governor, ~~at least three~~ four shall be public members and ~~at least~~ one shall be either a physician assistant as defined in G.S. 90-18.1 or a nurse practitioner as defined in G.S. 90-18.2. A public member shall not be a health care provider ~~nor~~ or the spouse of a health care provider. For purposes of board membership, "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 section, a person enrolled in a program to prepare ~~him~~ that person to be a licensed health care professional or an allied health professional shall be deemed a health care provider. For purposes of this section, any person with significant financial interest in a health service or profession is not a public member.

(a1) Each appointing and nominating authority shall ensure, insofar as possible, that its appointees and nominees to the Board reflect the composition of the State with regard to ethnic, racial, age, and religious composition.

(b) No member ~~appointed to the Board on or after November 1, 1981,~~ shall serve more than two complete consecutive three-year terms, except that each member shall serve until ~~his~~ a successor is chosen and qualifies.

~~(c) In order to establish regularly overlapping terms, the terms of office of the members shall expire as follows: two on October 31, 1993; four on October 31, 1994; four on October 31, 1995; and two on October 31, 1996.~~

(d) ~~Any~~A member of the Board ~~may~~ shall be removed from office by the Governor for good cause ~~shown.~~shown, including malicious prosecution or abuse of power. Any vacancy in the physician membership of the Board shall be filled for the period of the unexpired term by the ~~Governor from a list of physicians submitted by the North Carolina Medical Society Executive Council.~~Governor from nominees provided by the applicable professional organization. Any vacancy in the public, physician assistant, or nurse practitioner membership of the Board shall be filled by the Governor for the unexpired term.

(e) The North Carolina Medical Board shall have the power to acquire, hold, rent, encumber, alienate, and otherwise deal with real property in the same manner as any 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."

SECTION 1.(a). G.S. 90-3 is repealed.

SECTION 2. G.S. 90-8 reads as rewritten:

"**§ 90-8. Officers may administer oaths, and subpoena witnesses, records and other materials.**

The president and secretary of the Board may administer oaths to all persons appearing before it as the Board may deem necessary to perform its duties, and may summon and issue subpoenas for the appearance of any witnesses deemed necessary to testify concerning any matter to be heard before or inquired into by the Board. The power of the Board to subpoena is limited to persons with knowledge related to a matter before the Board. The Board may order that any patient records, documents or other material concerning any matter to be heard before or inquired into by the Board shall be produced before the Board or made available for inspection, notwithstanding any other provisions of law providing for the application of any physician-patient privilege with

respect to such records, documents or other material. All records, documents, or other material compiled by the Board are subject to the provisions of G.S. 90-16. Notwithstanding the provisions of G.S. 90-16, in any proceeding before the Board, in any record of any hearing before the Board, and in the notice of charges against any licensee, the Board shall withhold from public disclosure the identity of a patient including information relating to dates and places of treatment, or any other information that would tend to identify the patient, unless the patient or the representative of the patient expressly consents to the disclosure. Upon written request, the Board shall revoke a subpoena if, upon a hearing, it finds that the evidence the production of which is required does not relate to a matter in issue, or if the subpoena does not describe with sufficient particularity the evidence the production of which is required, or if for any other reason in law the subpoena is invalid."

SECTION 3. G.S. 90-14(a) reads as rewritten:

"(a) The Board shall have the power to deny, annul, suspend, or revoke a license, or other authority to practice medicine in this State, issued by the Board to any person who has been found by the Board to have committed any of the following acts or conduct, or for any of the following reasons:

(1) Immoral or dishonorable conduct.

(2) Producing or attempting to produce an abortion contrary to law.

(3) Made false statements or representations to the Board, or who has willfully concealed from the Board material information in connection with an application for a license.

(4) Repealed by Session Laws 1977, c. 838, s. 3.

(5) Being unable to practice medicine with reasonable skill and safety to patients by reason of illness, drunkenness, excessive use of alcohol, drugs, chemicals, or any other type of material or by reason of any physical or mental abnormality. The Board is empowered and authorized to require a physician licensed by it to submit to a mental or physical examination by physicians designated by the Board before or after charges may be presented against the physician, and the results of the examination shall be admissible in evidence in a hearing before the Board.

(6) Unprofessional conduct, including, but not limited to, departure from, or the failure to conform to, the standards of acceptable and prevailing medical practice, or the ethics of the medical profession, irrespective of whether or not a patient is injured thereby, or the committing of any act contrary to honesty, justice, or good morals, whether the same is committed in the course of the physician's practice or otherwise, and whether committed within or without North Carolina. The standards of practice in any specialty, including integrative, complementary and alternative medical treatments, shall be defined by specialists that have met the national certification standards for that specific medical treatment. The Board shall not annul, suspend, revoke the license of or deny a license to a ~~person~~ person, or harass a person, solely because of

that person's practice of a therapy that is experimental, nontraditional, or that departs from acceptable and prevailing medical practices unless, by ~~competent~~ a greater weight of the evidence, the Board can establish that the treatment has a ~~safety~~ risk of harm to the patient greater than the prevailing treatment or that the treatment is generally not ~~effective.~~ as effective in comparison to the effective rates of other prevailing treatments.

(7) Conviction in any court of a crime involving moral turpitude, or the violation of a law involving the practice of medicine, or a conviction of a felony; provided that a felony conviction shall be treated as provided in subsection (c) of this section.

(8) By false representations has obtained or attempted to obtain practice, money or anything of value.

(9) Has advertised or publicly professed to treat human ailments under a system or school of treatment or practice other than that for which the physician has been educated. A duly licensed physician shall not be prohibited from displaying all of the physician's certifications in public documents so long as the certifications displayed are not misleading as determined by the Board.

(10) Adjudication of mental incompetency, which shall automatically suspend a license unless the Board orders otherwise.

(11) Lack of professional competence to practice medicine with a reasonable degree of skill and safety for patients. In this connection the Board may consider repeated acts of a physician indicating the physician's failure to properly treat a patient. The Board may, upon reasonable grounds, require a physician to submit to inquiries or examinations, written or oral, by members of the Board or by other physicians licensed to practice medicine in this State, as the Board deems necessary to determine the professional qualifications of such licensee.

(12) Promotion of the sale of drugs, devices, appliances or goods for a patient, or providing services to a patient, in such a manner as to exploit the patient, and upon a finding of the exploitation, the Board may order restitution be made to the payer of the bill, whether the patient or the insurer, by the physician; provided that a determination of the amount of restitution shall be based on credible testimony in the record. The Board shall not deny, annul, suspend, or revoke a license for selling nutritional supplements or vitamins so long as the physician provides the financial disclosures recommended by the Board for drugs, devices, appliances, or goods.

(13) Having a license to practice medicine or the authority to practice medicine revoked, suspended, restricted, or acted against or having a license to practice medicine denied by the licensing authority of any jurisdiction. For purposes of this subdivision, the licensing authority's

acceptance of a license to practice medicine voluntarily relinquished by a physician or relinquished by stipulation, consent order, or other settlement in response to or in anticipation of the filing of administrative charges against the physician's license, is an action against a license to practice medicine.

(14) The failure to respond, within a reasonable period of time and in a reasonable manner as determined by the Board, to inquiries from the Board concerning any matter affecting the license to practice medicine.

(15) The failure to complete an amount not to exceed 150 hours of continuing medical education during any three consecutive calendar years pursuant to rules adopted by the Board.

For any of the foregoing reasons, the Board may deny the issuance of a license to an applicant or revoke a license issued to a physician, may suspend such a license for a period of time, and may impose conditions upon the continued practice after such period of suspension as the Board may deem advisable, may limit the accused physician's practice of medicine with respect to the extent, nature or location of the physician's practice as the Board deems advisable. The Board may, in its discretion and upon such terms and conditions and for such period of time as it may prescribe, restore a license so revoked or rescinded, except that no license that has been revoked shall be restored for a period of two years following the date of revocation. Unless the person under investigation has obstructed a Board investigation by not responding or providing documents requested by the Board, the Board shall conclude an investigation of a violation of this section within 18 months from the date the investigation is initiated and shall notify the person under investigation when the investigation is concluded."

SECTION 4. G.S. 90-14 is amended by adding a new subsection to read:

"(g) In order to annul, suspend, deny, or revoke a license of an accused person, the Board shall find that the facts satisfy, by the greater weight of the evidence, that the care provided was not in accordance with the standards of practice for the procedures or treatments administered.

(h) The Board shall establish an expert review panel on integrative medicine to review cases involving licensees who practice integrative medicine and make recommendations to the Board prior to the Board taking action against any licensee who practices integrative medicine."

SECTION 5. G.S. 90-14.2 reads as rewritten:

"**§ 90-14.2. Hearing before revocation or suspension of a license.**

(a) Before the Board shall revoke, restrict or suspend any license granted by it, the Board shall give the licensee ~~shall be given a~~ written notice indicating the general nature of the charges, accusation, or complaint made against ~~him,~~the licensee. The ~~which~~ notice may be prepared by a committee or one or more members of the Board designated by the ~~Board,~~ Board. ~~and stating~~The notice shall provide that ~~such~~ the licensee ~~will~~ shall be given an opportunity to be heard concerning ~~such~~ the charges or complaint at a time and place stated in ~~such~~ the notice, or at a time and place to be ~~thereafter~~ at some other time designated by the ~~Board, and the~~ Board. The Board shall

hold a public hearing not less than 30 days from the date of the service of ~~such~~ the notice upon ~~such~~ the ~~licensee, at which such~~ licensee.

(b) At the hearing, the licensee may appear personally and through counsel, may cross examine witnesses and present evidence in ~~his~~the licensee's own behalf. A ~~physician~~ licensee who is mentally incompetent shall be represented at ~~such~~ the hearing and shall be served with notice as ~~herein~~ provided in this section by and through a guardian ad litem appointed by the clerk of the court of the county in which the ~~physician has his residence.~~ licensee resides.

(c) At least 15 days prior to any hearing, each party shall disclose the identity of an expert, the subjects on which the expert is expected to testify, the substance of the facts and opinions on which the expert is expected to rely, and the qualifications of the expert.

(d) ~~Such~~ The licensee ~~or physician may, if he desires,~~ may file written answers to the charges or complaints ~~preferred against him~~ within 30 days after the service of ~~such~~ the ~~notice, which~~ notice. The answer shall become a part of the record but shall not constitute evidence in the case."

SECTION 6. G.S. 90-14.6 reads as rewritten:

"**§ 90-14.6. Evidence admissible.**

(a) In proceedings held pursuant to this Article the Board shall admit and hear evidence in the same manner and form as prescribed by law for civil actions. A complete record of such evidence shall be made, together with the other proceedings incident to such hearing.

(b) In proceedings held pursuant to this Article, the licensee under investigation may call witnesses, including medical practitioners licensed in the United States, with expertise in the same field of practice as the licensee under investigation, and the Board shall consider this testimony. Witnesses shall not be restricted to experts certified by the American Board of Medical Specialties.

(c) Statements contained in medical or scientific literature shall be competent evidence in proceedings held pursuant to this Article.

(d) In an investigative meeting, the Board shall hear and consider testimony of medical practitioners licensed in the United States with expertise in the same field of practice as the licensee under investigation."

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

House Committee on Health

April 23, 2003

Minutes

The House Committee on Health met onWednesday, April 23, 2003 at 12:00 noon in Room 544 of the Legislative Office Building. A silent roll was taken. A copy of the roll denoting members present is attached to the minutes (Attachment I) along with a copy of the agenda and Visitor Registration Sheet (Attachments II and III).

Chair Insko welcomed members and visitors. Dusty Rhodes, Francis Poole and Jackson Stancil were recognized as the sergeant-at-arms. (Note: no pages were present.) She then turned the meeting over to Chair Justus.

Chair Justus then recognized Rep. Insko to explain her bill, HB 883 A BILL TO BE ENTITLED AN ACT TO AUTHORIZE THE SECRETARY OF HEALTH AND HUMAN SERVICES TO TEMPORARILY WAIVE CERTAIN REQUIREMENTS OF THE MENTAL HEALTH COMMITMENT STATUTES TO FURTHER MENTAL HEALTH REFORM EFFORTS. (Attachment IV) Motion was made to adopt the new committee substitute for discussion and same was adopted. (Attachment V) A bill analysis was provided (Attachment VI) The proposed committee substitute authorized the Secretary of the Department of Health and Human Services to permit phase one, mental health local management entities to substitute for a physician or eligible psychologist, a licensed clinical social workers, a masters level psychiatric nurse, or a masters level certified clinical addictions specialist to conduct the initial (first –level) examination of individuals in involuntary commitment proceedings. This proposed bill would not expand the scope of practice for licensed clinical social workers, masters level psychiatric nurses, or masters level certified clinical addictions specialists. Tara Larson of the Department of MH/DD/SAS explained that only change is who does first level of examination. That all due process rights will remain the same.

Rep. Munford was recognized by the Chair and spoke in opposition of the bill. He felt that the phase one level was most critical phase. Rep. Munford referred to his own personal experience with a family member, the difficulties encountered in obtaining a person's release and how "lives are always changed" by procedure.

Rep. Bowie made motion for favorable report as to the committee substitute, unfavorable as to the original and recommended that committee substitute be re-referred to a Judiciary committee. Rep. Culpepper was consulted as to what Judiciary committee bill should be referred - Judiciary IV. Motion made to give the committee substitute a favorable report, unfavorable as to the original bill and recommended that it be re-referred to the Judiciary IV Committee. Motion adopted with Rep. Munford and Rep. Setzer voting against the motion.

Rep. Insko resumes as Chair.

The Chair then recognized Rep. Tom Wright and Rep. Julia Howard to explain their bill, HB 886 A BILL ENTITLED TO ACT TO AMEND VARIOUS PROVISIONS RELATING TO THE NORTH CAROLINA MEDICAL BOARD UNDER THE LAWS REGULATING THE PRACTICE OF MEDICINE. (Attachment VII) Rep. Wright offered a proposed Committee Substitute, which was adopted without objection. Rep Howard explained that a number of people had worked on this bill and the new committee substitute addressed their concerns. The bill would amend various provisions relating to the North Carolina Medical Board under the laws regulating the practice of medicine. (Attachment VIII). Dianna Jessup, staff, provided an analysis on the bill (Attachment IX). Under Section 1, the bill would amend the provisions of the statute relating to the appointment and removal of members of the North Carolina Medical Board. The board shall consist of twelve members appointed by the Governor. Seven members shall be duly licensed physicians -- three physicians nominated by the North Carolina Medical Society, three physicians nominated by the Old North State Medical Society and one physician nominated by the North Carolina Osteopathic Medical Association with vacancies filled from nominees provided by the applicable professional organization. Of the remaining five members appointed by the Governor, four shall be public members and one shall be either a physician assistant (defined in G.S. 90-18.1) or nurse practitioner. Each appointing or nominating authority shall ensure, insofar as possible, that its appointees and nominees reflect the composition of the state with regard to ethnic, racial, age, and religious composition. Section 2 would amend the provisions relating to Board's power to administer oaths and subpoena witnesses to specify that the Board's power to subpoena would be limited to persons with knowledge related to matter before the Board. Section 3 would amend laws relating to denying, suspending or revoking license. Section 4 adds new language that requires the Board to find, by a greater weight of the evidence, that the care provided was not in accordance with the standards of practice for the procedures or treatments administered. It also requires the Board to establish an expert review panel on integrative medicine to review cases involving licensees who practice integrative medicine and to make recommendations to the Board prior to the Board taking action against any licensee who practices integrative medicine. Addition language specifies that medical expert witnesses must practice in the specialty under investigation by the Board, and that the parties must disclose expert witnesses, the substance of the facts and opinion on which the expert is expected to rely, and the qualifications of the expert.

Chair Insko then calls for testimony for and against the bill.

Dr. Rashid Buttar, President of the NC Integrative Medical Society spoke of doctors using alternative medicine as practicing quackery. Rep. Setzer asks how many doctors fined for using alternate medicine – has no one been fined? Dr. Buttar responds yes they have and doctors have lost licenses. Several concerns are raised by Reps. Allred and England regarding kidney disease and by Rep. Insko regarding nutrition therapy for cancer patients. Rep. Munford asks if Dr. Buttar supports Section 1. Dr. Buttar responds in the affirmative. Rep. Barnhart wants to know the kinds of integrative, complementary

and alternative medical treatments available and Rep. Insko requests a list of organizations. Rep. Glazier asks if any physician has been had their license revoke. Dr. Buttar responds not for treatment but for method.

Chair Insko advises that time had run out and meeting is adjourned at 1:01 p.m.

Verla Insko
Rep. Verla Insko, Chair

Pamela J Evans
Pamela Evans, Committee Clerk

Carolyn Justus
Rep. Carolyn Justus, Chair

ATTENDANCE

HOUSE COMMITTEE ON HEALTH

DATES	4/23/03														
INSKO, Verla CHAIR	✓														
JUSTUS, Carolyn CHAIR	✓														
ENGLAND, Bob VICE-CHAIR	✓														
ADAMS, Alma															
ALLEN, Bernard	✓														
ALLEN, Gordon	✓														
ALLRED, Cary	✓														
BARNHART, Jeff	✓														
BOWIE, Joni	✓														
CLARY, Debbie															
EARLE, Beverly	✓														
GLAZIER, Rick	✓														
HILTON, Mark	✓														
McALLISTER, Mary															
MUNFORD, Don	✓														
SETZER, Mitchell	✓														
SHERRILL, Wilma															
WAINWRIGHT, William	✓														
WILSON, Connie	✓														
WRIGHT, Tom	✓														
Ex officio Members															
Brubaker, Bru															
Culpepper, Bill	✓														
Cunningham, Pete															
Eddins, Rick															

ATTACHMENT II

AGENDA

HOUSE COMMITTEE ON HEALTH

April 23, 2003
Room 643 LOB
12:00 Noon

Representative Carolyn Justus, Chair **Representative Verla Insko, Chair**

CALL TO ORDER

INTRODUCTION OF PAGES

BILLS TO BE HEARD

HB 883 MH Reform Waiver – Rep. Insko

HB 886 Due Process for Physicians – Reps. Wright and Howard

ADJOURNMENT

ATTACHMENT III

VISITOR REGISTRATION SHEET

HOUSE COMMITTEE ON HEALTH — APRIL 23, 2003

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Debra Hayes	citizen
Benita Davis	JMSW Program
Sheila Johnson	JMSW/ Mecklenburg
Jamillah Bynum	JMSW Program
Lora McDowell-Landrum	JMSW/Meck.
Susan Parrish	citizen
Jeff Hickman	citizen
Sandy L. O'Daniel	Citizen - Franklin Cty Resident
Joanne stevens	Nursing
Bill Wilson	NC Academy of Trial Lawyers
Dana Simpson	Smith Anderson

VISITOR REGISTRATION SHEET

HOUSE COMMITTEE ON HEALTH — APRIL 23, 2003

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
M Lewis	NCSA
W N Hilliard	NCSA
Stacy Flannery	NCHCFA
Lucy Ball	Wake Forest Medical School
Evelyn Hawthorne	DTOR
Joyce Pickens	JP Broadmeuse
Lu-Ann Coe	NC Psychiatric Assoc
Christine A. Mills	Joint Master of Social Work/Child welfare Scholar NC A+T and UNCG
Elizabeth Roman	Raleigh, NC (self)
RASHID BUTTAR	NC Integrative Medical Society
Oniqua Williams	JMSW program

VISITOR REGISTRATION SHEET

HOUSE COMMITTEE ON HEALTH — APRIL 23, 2003

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Shonny Williams	JMSW Program UNCG NCA+TSU
Gloria Brown	2200 Old Forest Dr. Hills NC 27278 Johnson C. MSW
Alicia Kaplan	JMSW Program NCA&T SU & UNC-G Child Welfare Collaborative
Ginger Stewart	JMSW Program " "
Carol Lawen	EGLS
Rodney S. Clark	OCPA
Robin Huffman	NC Psychiatric Assn
Sally Cameron	NC Psychological Assoc
Beth Melcher	NAMI NC
Jennifer McGuinn	NASW-NC
Margaret Bennett	2707 Anderson Dr Raleigh NC

VISITOR REGISTRATION SHEET

HOUSE COMMITTEE ON HEALTH — APRIL 23, 2003

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
T-B Kee	NCMS
Horne	NCMS
Paul Pulley	Pulley Watson
Marc Lewis	JMSW Program
Heidi Dohnert	JMSW Program
Emily Liddle	JMSW Program
Melody Moore	JMSW Child Welfare Scholar
Ernestine Durham	EXE. INTERN
Melanie Phelps	NCMS
David Henderson	NC Medical Board
Carolyn Ellis	Citizen

VISITOR REGISTRATION SHEET

HOUSE COMMITTEE ON HEALTH — APRIL 23, 2003

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Diana Spinks	JMSW Program
Joe Donovan	MH Consumer
Dan Beeman	JMSW Program
Maura Nsonwu	JMSW Program
Natasha Johnson	JMSW
Evette R. Bethea	JMSW Program NCA&TSU and UNC-G
Dony Baker	DMH/DD/SAS
Jane Rehm	DMH/DD/SAS
Thomas Mansfield	NC Medical Board
LIZ KANOF	NCMB NCMS
J. Craig Jones	DHHS

VISITOR REGISTRATION SHEET

HOUSE COMMITTEE ON HEALTH — APRIL 23, 2003

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Wilson Ellis	SEIF
Colleen Kochanek	Hafer & Caldwell, P.A.
PERRI MORGAN	NFIB
Audrey Galloway	Strategic Influences
Victor Galloway	FCB
Paul Hicks	Cape Fear COG
Jamie Ramquist	NCIMS
BILL RUSTIA	AHP
Steve Mitchell	Novartis

ATTACHMENT IV Health
524
4/23/03

House Pages

1. Name: _____

   County: _____

   Sponsor: _____

2. Name: _____

   County: _____

   Sponsor: _____

3. Name: _____

   County: _____

   Sponsor: _____

4. Name: _____

   County: _____

   Sponsor: _____

5. Name: _____

   County: _____

   Sponsor: _____

Sgt-At-Arms

1. Name: Dusty Rhodes
2. Name: Francis Poole
3. Name: Jackson Stancil
4. Name: _____

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2003

HOUSE BILL 883

Short Title:	MH Reform Waiver.	(Public)
Sponsors:	Representative Insko.	
Referred to:	Health.	

April 7, 2003

A BILL TO BE ENTITLED

AN ACT TO AUTHORIZE THE SECRETARY OF HEALTH AND HUMAN SERVICES TO TEMPORARILY WAIVE CERTAIN REQUIREMENTS OF THE MENTAL HEALTH COMMITMENT STATUTES TO FURTHER MENTAL HEALTH REFORM EFFORTS.

The General Assembly of North Carolina enacts:

SECTION 1. The Secretary of Health and Human Services may, upon request of a phase-one local management entity, waive temporarily the requirements of G.S. 122C-261 through G.S. 122C-263 and G.S. 122C-281 through G.S. 122C-283 pertaining to initial (first-level) examinations by a physician or eligible psychologist of individuals meeting the criteria of G.S. 122C-261(a) or G.S. 122C-281(a), as applicable, as follows:

(1) The Secretary has received a request from a phase-one local management entity to substitute for a physician or eligible psychologist, a licensed clinical social worker, a masters level psychiatric nurse, or a masters level certified clinical addiction specialist to conduct the initial (first-level) examinations of individuals meeting the criteria of G.S. 122C-261(a) or G.S. 122C-281(a). The waiver shall be implemented on a pilot-program basis. The request from the local management entity shall be submitted as part of the entity's local business plan and shall specifically describe:

a. How the purpose of the statutory requirement would be better served by waiving the requirement and substituting the proposed change under the waiver.

b. How the waiver will enable the local management entity to improve the delivery or management of mental health, developmental disabilities, and substance abuse services.

c. How the services to be provided by the licensed clinical social worker, the masters level psychiatric nurse, or the masters level

certified clinical addiction specialist under the waiver are within each of these professional's scope of practice.

d. How the health, safety, and welfare of individuals will continue to be at least as well protected under the waiver as under the statutory requirement.

e. The method to be used to evaluate the effectiveness and efficiency of mental health, developmental disabilities, and substance abuse services and protection of health, safety, and welfare under the waiver.

(2) The Secretary shall review the request and may approve it upon finding that:

a. The request meets the requirements of this section.

b. The request furthers the purposes of State policy under G.S. 122C-2, and mental health, developmental disabilities, and substance abuse services reform.

c. The request improves the delivery of mental health, developmental disabilities, and substance abuse services in the counties affected by the waiver and also protects the health, safety, and welfare of individuals receiving these services.

d. The duties and responsibilities performed by the licensed clinical social worker, the masters level psychiatric nurse, or the masters level certified clinical addiction specialist are within the individual's scope of practice.

(3) The waiver granted by the Secretary under this section shall be in effect for a period not to exceed three years, or the period for which the requesting local management entity's business plan is approved, whichever is shorter.

(4) The Secretary may grant a waiver under this section only to those local management entities that have been designated as phase-one entities as of July 1, 2003.

(5) In no event shall the substitution of a licensed clinical social worker, masters level psychiatric nurse, or masters level certified clinical addiction specialist under a waiver granted under this section be construed as authorization to expand the scope of practice of the licensed clinical social worker, the masters level psychiatric nurse, or the masters level certified clinical addiction specialist.

(6) The Department shall assure that staff performing the duties are trained and privileged to perform the functions identified in the waiver.

(7) The local management entity shall assure that a psychiatrist is available at all times to provide back-up services.

SECTION 2. This act becomes effective July 1, 2003, and expires July 1, 2006.

HOUSE BILL 883: MH Reform Waiver

BILL ANALYSIS

Committee:	House Health	**Introduced by:**	Rep. Insko
Date:	April 15, 2003	**Summary by:**	Dianna Jessup
Version:	PCS for First Edition H883-CSSW-13[v.3]		Committee Counsel

SUMMARY: ***The proposed committee substitute for House Bill 883 would authorize the Secretary of the Department of Health and Human Services (Secretary) to permit phase one, mental health local management entities (LMEs) to substitute for a physician or eligible psychologist, a licensed clinical social worker, a masters level psychiatric nurse, or a masters level certified clinical addictions specialist to conduct the initial (first-level) examination of individuals in involuntary commitment proceedings. Any waiver could only be in effect for a period not to exceed three years. The proposed bill would not expand the scope of practice for licensed clinical social workers, masters level psychiatric nurses, or masters level certified clinical addictions specialists. The act would become effective July 1, 2003 and expire July 1, 2006.***

Differences between the First Edition and the PCS

1. The PCS shifted the responsibility for an evaluation of the effectiveness, quality and efficiency of services under the waiver from the phase-one local management entity to the Secretary of Health and Human Services.

2. The PCS also changes the local management entities that the Secretary may grant a waiver to under the provisions of the bill. Originally, the Secretary could grant a waiver only to the local management entities that have been designated as phase-one entities by July 1, 2003. The proposed committee substitute limits the number of waivers to only three local management entities that have been designated as phase-one entities by July 1, 2003.

CURRENT LAW:

Mental Health Reform: As enacted by the 2001 General Assembly, S.L. 2001-437 (HB 381), amended the mental health statutes to provide counties an alternative to establishing area authorities to ensure the provision of public mental health, developmentally disabled and substance abuse (MH/DD/SA) services to consumers. Counties were authorized to withdraw from existing area authorities and to ensure the delivery of public MH/DD/SA services through a single county program or jointly with one or more counties through a joint agency established pursuant to the terms of an interlocal agreement. (County programs and area authorities are known as LMEs). By October 1, 2002, each county was to have sent a letter of intent to the Secretary indicating the intent of the county or counties to provide services through an existing area authority or through a county program. The bill provided for phased-in implementation of reform, requiring the Secretary to certify the business plans of one-third of the area authorities and county programs by July 1, 2003; two-thirds of the area authorities and county programs by January 1, 2004; and complete certification of all area authorities and county programs by July 1, 2004.

Under the new governance scheme, LMEs are required to develop "business plans" to guide the management and delivery of services. These business plans are required to be submitted to the Secretary for review and certification. The business plans must provide a description of how core administrative functions will be carried out, including planning to ensure the provision of services, ensuring available,

qualified providers to deliver services, service management, financial management, service monitorin evaluation, and collaboration with other local service systems. Business plans are effective for three Sta fiscal years.

Involuntary Commitment: Anyone who has knowledge that a person who is mentally ill or is a substance abuser and who is dangerous to self or dangerous to others may petition the court for issuance of an order to take the respondent into custody for examination by a physician or eligible psychologist. If the clerk finds reasonable grounds to believe that the facts in the petition are true and the respondent is dangerous to self or others, the clerk may order the respondent to be taken into custody for an initial examination by a physician or eligible psychologist. If the physician or eligible psychologist recommends inpatient commitment, then a *physician* is required to perform an examination of the respondent within 24 hours after the respondent is admitted into a facility. This examination would determine whether the respondent is mentally ill or a substance abuser and is dangerous to self or dangerous to others, and the results of this examination are considered by the court at the hearing to determine whether the respondent should be involuntarily committed.

Licensed Clinical Social Workers (LCSW): Social workers are licensed under Chapter 90B of the General Statutes. G.S. 90B-3 defines a LCSW to mean a person who is competent to function independently, who holds himself or herself out to the public as a social worker, and who offers or provides clinical social work services or supervises others engaging in clinical social work practice. According to the North Carolina Social Work Board website, the requirements for becoming a LCSW include the following:

- A Masters in Social Work (MSW), a Doctorate in Social Work (DSW), or a Doctorate in Philosophy (PhD) from a Council on Social Work Education (CSWE) accredited program.
- 3,000 hours of paid employment accumulated in no less than two years nor more than six years. (No more than 1500 hours accumulated in one year.)
- 100 hours of clinical supervision from a LCSW with a graduate degree in Social Work and two years of supervised clinical experience. Of these 100 hours at least 75 hours must have been individual supervision.
- Take and pass the American Association of Social Work Boards "Clinical level" examination.

Psychiatric Nurses: 10-3C.5202 of the NC Administrative Code defines a psychiatric nurse to mean an individual who is licensed to practice as a registered nurse in the State by the NC Board of Nursing; and has the following:

- A graduate degree from an accredited master's level program in psychiatric mental health nursing with two years of experience; or
- A master's degree in behavioral science with two years of supervised clinical experience in psychiatric mental health nursing; or
- A baccalaureate degree in behavioral science with four years of supervised clinical experience in psychiatric mental health nursing.

According to the NC Board of Nursing, a masters level psychiatric nurse is an advanced practice registered nurse generally referred to as a psychiatric-mental health clinical nurse specialist. A masters level psychiatric nurse would be eligible for direct reimbursement of services.

Certified Clinical Addictions Specialists: G.S. 90-113.31 defines a certified clinical addictions specialist to be a person certified by the NC Substance Abuse Professional Certification Board to practice as a clinical addictions specialist in accordance with the provisions of Article 5C of the General Statutes. G.S. 90-113.40 requires the Board to issue a certificate certifying an applicant as a certified clinical addictions specialist if it meets certain requirements for a certified substance abuse counselor or a certified substance abuse prevention consultant and meets one of four sets of criteria specified in statute.

BILL ANALYSIS: The proposed committee substitute for House Bill 883 would authorize the Secretary, upon request of a phase-one LME, to waive temporarily the requirements of the involuntary commitment statutes regarding who can conduct the initial examination to permit LCSWs, masters level psychiatric nurses, or masters level certified clinical addictions specialists to conduct the examination. In order to obtain this waiver, the LME must, as part of its business plan, describe how the purpose of the statutory requirement would be better served by waiving the requirement, how the waiver will enable the LME to improve the delivery or management of services, how the services to be provided by the LCSWs, masters level psychiatric nurses, and masters level certified clinical addictions specialists are within the scope of practice for those professions, and how the health, safety, and welfare of persons will be protected. In order to approve the LME's request for the waiver, the Secretary must find that: (1) the request meets the requirements of the bill, (2) the request furthers the purposes of State policy, and MH/DD/SA services reform, (3) the request improves the delivery of MH/DD/SA services in the counties affected by the waiver and protects the health, safety, and welfare of individuals receiving these services, and (4) the duties and responsibilities performed by the LCSWs, masters level psychiatric nurses, or the masters level certified clinical addictions specialists are within the scope of practice for these professions. The Secretary shall evaluate the services and the protection of health, safety, and welfare under the waiver. Waivers could be in effect for a period not to exceed three years or the period, for which the business plan is approved, whichever is shorter. The Secretary may grant a waiver under this section only to those LMEs that have been designated as phase-one entities as of July 1, 2003. **According to the Division of MH/DD/SA services, there are currently 13 LMEs that have been designated as phase-one entities.** The Department would have to ensure that staff performing the duties are trained and privileged to perform the functions identified in the waiver, and the LME would have to ensure that a psychiatrist is available at all times to provide back-up services.

The act would become effective July 1, 2003 and expire July 1, 2006.

Amy Compeau, Research Assistant, contributed to this summary.

H883-SMSW-001

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2003

H D

HOUSE BILL 883
PROPOSED COMMITTEE SUBSTITUTE H883-CSSW-13 [v.3]

4/15/2003 10:07:47 PM

Short Title: MH Reform Waiver. (Public)

Sponsors:

Referred to:

April 7, 2003

A BILL TO BE ENTITLED

AN ACT TO AUTHORIZE THE SECRETARY OF HEALTH AND HUMAN SERVICES TO TEMPORARILY WAIVE CERTAIN REQUIREMENTS OF THE MENTAL HEALTH COMMITMENT STATUTES TO FURTHER MENTAL HEALTH REFORM EFFORTS.

The General Assembly of North Carolina enacts:

SECTION 1. The Secretary of Health and Human Services may, upon request of a phase-one local management entity, waive temporarily the requirements of G.S. 122C-261 through G.S. 122C-263 and G.S. 122C-281 through G.S. 122C-283 pertaining to initial (first-level) examinations by a physician or eligible psychologist of individuals meeting the criteria of G.S. 122C-261(a) or G.S. 122C-281(a), as applicable, as follows:

(1) The Secretary has received a request from a phase-one local management entity to substitute for a physician or eligible psychologist, a licensed clinical social worker, a masters level psychiatric nurse, or a masters level certified clinical addictions specialist to conduct the initial (first-level) examinations of individuals meeting the criteria of G.S. 122C-261(a) or G.S. 122C-281(a). The waiver shall be implemented on a pilot-program basis. The request from the local management entity shall be submitted as part of the entity's local business plan and shall specifically describe:

a. How the purpose of the statutory requirement would be better served by waiving the requirement and substituting the proposed change under the waiver.

b. How the waiver will enable the local management entity to improve the delivery or management of mental health, developmental disabilities, and substance abuse services.

c. How the services to be provided by the licensed clinical social worker, the masters level psychiatric nurse, or the masters level certified clinical addictions specialist under the waiver are within each of these professional's scope of practice.

d. How the health, safety, and welfare of individuals will continue to be at least as well protected under the waiver as under the statutory requirement.

(2) The Secretary shall review the request and may approve it upon finding that:

a. The request meets the requirements of this section.

b. The request furthers the purposes of State policy under G.S. 122C-2, and mental health, developmental disabilities, and substance abuse services reform.

c. The request improves the delivery of mental health, developmental disabilities, and substance abuse services in the counties affected by the waiver and also protects the health, safety, and welfare of individuals receiving these services.

d. The duties and responsibilities performed by the licensed clinical social worker, the masters level psychiatric nurse, or the masters level certified clinical addictions specialist are within the individual's scope of practice.

(3) The Secretary shall evaluate the effectiveness, quality, and efficiency of mental health, developmental disabilities, and substance abuse services and protection of health, safety, and welfare under the waiver.

(4) The waiver granted by the Secretary under this section shall be in effect for a period not to exceed three years, or the period for which the requesting local management entity's business plan is approved, whichever is shorter.

(5) The Secretary may grant a waiver under this section only to three local management entities that have been designated as phase-one entities as of July 1, 2003.

(6) In no event shall the substitution of a licensed clinical social worker, masters level psychiatric nurse, or masters level certified clinical addictions specialist under a waiver granted under this section be construed as authorization to expand the scope of practice of the licensed clinical social worker, the masters level psychiatric nurse, or the masters level certified clinical addictions specialist.

(7) The Department shall assure that staff performing the duties are trained and privileged to perform the functions identified in the waiver.

(8) The local management entity shall assure that a psychiatrist is available at all times to provide back-up services.

SECTION 2. This act becomes effective July 1, 2003, and expires July 1, 2006.

2003 COMMITTEE REPORT
HOUSE OF REPRESENTATIVES

The following report(s) from standing committee(s) is/are presented:
By Representatives **Verla Insko and Carolyn Justus,** Chairs for the Committee on **HEALTH.**

☐ Committee Substitute for
H.B. 883 A BILL TO BE ENTITLED AN ACT TO AUTHORIZE THE SECRETARY OF HEALTH AND HUMAN SERVICES TO TEMPORARILY WAIVE CERTAIN REQUIREMENTS OF THE MENTAL HEALTH COMMITMENT STATUTES TO FURTHER MENTAL HEALTH REFORM EFFORTS.

☐ 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 ~~(# H.B.), ☐ 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 Judiciary IV

☐ 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)

3/06/03

FOR JOURNAL USE ONLY

____ Pursuant to Rule 36(b), the bill/resolution is placed on the Calendar of _____.

____ The (committee substitute) bill/resolution (, as amended,) is (ordered engrossed and) re-referred to the Committee on _____.

____ The bill/resolution is re-referred to the Committee on _____.

____ On motion of (Rep. _____,) (the Chair,) the (committee substitute) bill/resolution is (ordered engrossed and) re-referred to the Committee on _____.

____ Pursuant to Rule 36(b), the (House)committee substitute bill (No. ____)/resolution is placed on the Calendar of _____. (The original bill) (House Committee Substitute Bill No. ____)/resolution is placed on the Unfavorable Calendar.

____ On motion of Rep. _____, (the rules are suspended) (Rule ____ is suspended) and the bill/resolution is placed on today's calendar. (for immediate consideration.)

____ On motion of Rep. _____, Committee Amendment No.(s) _____ is/are adopted (by EV____ ____).

____ On motion of Rep. _____, Committee Amendment No.(s) _____ is/are adopted (by EV____ ____).

____ Rep. _____ offers Amendment No. _____ which (is adopted.) (fails of adoption.) (by EV ____ ____.) ( ) This amendment changes the title.

____ The bill/resolution (, as amended,) passes its second reading (by following vote, ____ ____ RC) (, by EV ____ ____,) and (remains on the Calendar,) (and there being no objection is read a third time).

____ The bill/resolution (, as amended,) passes its third reading (by the following vote, ____ ____ RC) (, by EV ____ ____,) and is ordered
____ sent to the Senate.
____ without engrossment. ____ by Special message.
____ sent to the Senate for concurrence in
_____ the House amendment (s).
_____the House committee substitute bill.
____ enrolled.

____ On motion of Rep. _____, the House concurs in the (material) Senate _____ (by the following vote, ____ ____ RC) (, by EV ____ ____,) and the bill is ordered enrolled.

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2003

HOUSE BILL 886

Short Title:	Due Process for Physicians.	(Public)
Sponsors:	Representatives Wright and Howard (Primary Sponsors).	
Referred to:	Health.	

April 7, 2003

A BILL TO BE ENTITLED

AN ACT TO AMEND VARIOUS PROVISIONS RELATING TO THE NORTH CAROLINA MEDICAL BOARD UNDER THE LAWS REGULATING THE PRACTICE OF MEDICINE.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 90-2 reads as rewritten:

"**§ 90-2. Medical Board.**

(a) In order to properly regulate the practice of medicine and surgery for the benefit and protection of the people of North Carolina, there is established the North Carolina Medical Board. The Board shall consist of 12 members.

(1) Seven of the members shall be duly licensed physicians elected and nominated ~~to~~ by the ~~Governor by the North Carolina Medical Society.~~ Governor. Of the seven members appointed by the Governor, one member shall be a faculty member at one of the medical schools in North Carolina.

(2) Of the remaining five members, all to be appointed by the Governor, at least three shall be public members and at least one shall be a physician assistant as defined in G.S. 90-18.1 or a nurse practitioner as defined in G.S. 90-18.2. A public member shall not be a health care provider nor the spouse of a health care provider. For purposes of board membership, "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 section, a person enrolled in a program to prepare him to be a licensed health care professional or an allied health professional shall be deemed a health care provider. For purposes of this section, any person with significant financial interest in a health service or profession is not a public member.

(b) No member appointed to the Board on or after November 1, 1981, shall serve more than two complete consecutive three-year terms, except that each member shall serve until his successor is chosen and qualifies.

(c) In order to establish regularly overlapping terms, the terms of office of the members shall expire as follows: two on October 31, 1993; four on October 31, 1994; four on October 31, 1995; and two on October 31, 1996.

(d) ~~Any~~A member of the Board ~~may~~ shall be removed from office by the Governor for good cause ~~shown.~~shown, including malicious prosecution or abuse of power. Any vacancy in the physician membership of the Board shall be filled for the period of the unexpired term by the ~~Governor from a list of physicians submitted by the North Carolina Medical Society Executive Council.~~Governor. Any vacancy in the public, physician assistant, or nurse practitioner membership of the Board shall be filled by the Governor for the unexpired term.

(e) The North Carolina Medical Board shall have the power to acquire, hold, rent, encumber, alienate, and otherwise deal with real property in the same manner as any 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."

SECTION 2. G.S. 90-8 reads as rewritten:

"**§ 90-8. Officers may administer oaths, and subpoena witnesses, records and other materials.**

The president and secretary of the Board may administer oaths to all persons appearing before it as the Board may deem necessary to perform its duties, and may summon and issue subpoenas for the appearance of any witnesses deemed necessary to testify concerning any matter to be heard before or inquired into by the Board. The power of the Board to subpoena is limited to persons with knowledge related to a matter before the Board. Medical expert witnesses, including medical practitioners licensed in the United States, must routinely and actively practice in the specialty that is under investigation by the Board. Each party must disclose the identity of an expert, the subjects on which the expert is expected to testify, the substance of the facts and opinions on which the expert is expected to rely, and the qualifications of the expert. Statements contained in medical or scientific literature may be relied upon in direct and cross-examination and admitted into evidence. The Board may order that any patient records, documents or other material concerning any matter to be heard before or inquired into by the Board shall be produced before the Board or made available for inspection, notwithstanding any other provisions of law providing for the application of any physician-patient privilege with respect to such records, documents or other material. All records, documents, or other material compiled by the Board are subject to the provisions of G.S. 90-16. Notwithstanding the provisions of G.S. 90-16, in any proceeding before the Board, in any record of any hearing before the Board, and in the notice of charges against any licensee, the Board shall withhold from public disclosure the identity of a patient including information relating to dates and places of treatment, or any other information that would tend to identify the patient, unless the patient or the

representative of the patient expressly consents to the disclosure. Upon written request, the Board shall revoke a subpoena if, upon a hearing, it finds that the evidence the production of which is required does not relate to a matter in issue, or if the subpoena does not describe with sufficient particularity the evidence the production of which is required, or if for any other reason in law the subpoena is invalid."

SECTION 3. G.S. 90-14(a) reads as rewritten:

"(a) The Board shall have the power to deny, annul, suspend, or revoke a license, or other authority to practice medicine in this State, issued by the Board to any person who has been found by the Board to have committed any of the following acts or conduct, or for any of the following reasons:

(1) Immoral or dishonorable conduct.

(2) Producing or attempting to produce an abortion contrary to law.

(3) Made false statements or representations to the Board, or who has willfully concealed from the Board material information in connection with an application for a license.

(4) Repealed by Session Laws 1977, c. 838, s. 3.

(5) Being unable to practice medicine with reasonable skill and safety to patients by reason of illness, drunkenness, excessive use of alcohol, drugs, chemicals, or any other type of material or by reason of any physical or mental abnormality. The Board is empowered and authorized to require a physician licensed by it to submit to a mental or physical examination by physicians designated by the Board before or after charges may be presented against the physician, and the results of the examination shall be admissible in evidence in a hearing before the Board.

(6) Unprofessional conduct, including, but not limited to, departure from, or the failure to conform to, the standards of acceptable and prevailing medical practice, or the ethics of the medical profession, irrespective of whether or not a patient is injured thereby, or the committing of any act contrary to honesty, justice, or good morals, whether the same is committed in the course of the physician's practice or otherwise, and whether committed within or without North Carolina. The standards of practice in any specialty, including complementary treatments, shall be defined by specialists in that field. The Board shall not annul, suspend, revoke the license of or deny a license to a ~~person~~ person, harass, or initiate an investigation solely because of that person's practice of a therapy that is experimental, nontraditional, or that departs from acceptable and prevailing medical practices unless, by ~~competent~~ a preponderance of the evidence, the Board can establish that the treatment has a ~~safety~~ risk of harm to the patient greater than the prevailing treatment or that the treatment is generally not ~~effective.~~as effective in comparison to the effective rates of other prevailing treatments.

(7) Conviction in any court of a crime involving moral turpitude, or the violation of a law involving the practice of medicine, or a conviction of a felony; provided that a felony conviction shall be treated as provided in subsection (c) of this section.

(8) By false representations has obtained or attempted to obtain practice, money or anything of value.

(9) Has advertised or publicly professed to treat human ailments under a system or school of treatment or practice other than that for which the physician has been educated. A duly licensed physician shall not be prohibited from displaying all of his or her certifications in public documents.

(10) Adjudication of mental incompetency, which shall automatically suspend a license unless the Board orders otherwise.

(11) Lack of professional competence to practice medicine with a reasonable degree of skill and safety for patients. In this connection the Board may consider repeated acts of a physician indicating the physician's failure to properly treat a patient. The Board may, upon reasonable grounds, require a physician to submit to inquiries or examinations, written or oral, by members of the Board or by other physicians licensed to practice medicine in this State, as the Board deems necessary to determine the professional qualifications of such licensee.

(12) Promotion of the sale of drugs, devices, appliances or goods for a patient, or providing services to a patient, in such a manner as to exploit the patient, and upon a finding of the exploitation, the Board may order restitution be made to the payer of the bill, whether the patient or the insurer, by the physician; provided that a determination of the amount of restitution shall be based on credible testimony in the record. Selling nutritional supplements or vitamins shall have the same financial disclosures as those required with drugs, devices, appliances, or goods. Nothing in this subdivision shall restrain free trade or limit the legitimate trade activities involved in the course of the practice of medicine.

(13) Having a license to practice medicine or the authority to practice medicine revoked, suspended, restricted, or acted against or having a license to practice medicine denied by the licensing authority of any jurisdiction. For purposes of this subdivision, the licensing authority's acceptance of a license to practice medicine voluntarily relinquished by a physician or relinquished by stipulation, consent order, or other settlement in response to or in anticipation of the filing of administrative charges against the physician's license, is an action against a license to practice medicine.

(14) The failure to respond, within a reasonable period of time and in a reasonable manner as determined by the Board, to inquiries from the

Board concerning any matter affecting the license to practice medicine. However, the Board shall conclude an investigation pursuant to a violation of this subdivision within 18 months from the date the incident was initially reported.

(15) The failure to complete an amount not to exceed 150 hours of continuing medical education during any three consecutive calendar years pursuant to rules adopted by the Board.

For any of the foregoing reasons, the Board may deny the issuance of a license to an applicant or revoke a license issued to a physician, may suspend such a license for a period of time, and may impose conditions upon the continued practice after such period of suspension as the Board may deem advisable, may limit the accused physician's practice of medicine with respect to the extent, nature or location of the physician's practice as the Board deems advisable. The Board may, in its discretion and upon such terms and conditions and for such period of time as it may prescribe, restore a license so revoked or rescinded, except that no license that has been revoked shall be restored for a period of two years following the date of revocation."

SECTION 4. G.S. 90-14 is amended by adding a new subsection to read:

"(g) In order to annul, suspend, deny, or revoke a license of an accused physician, the Board must find that the facts satisfy, by the greater weight of the evidence, that there is a pattern of incompetence and that the care provided was not in accordance with the standards of practice for the procedures or treatments administered."

SECTION 5. G.S. 90-14.2 reads as rewritten:

"**§ 90-14.2. Hearing before revocation or suspension of a license.**

Before the Board shall revoke, restrict or suspend any license granted by it, the licensee shall be given a written notice indicating the general nature of the charges, accusation, or complaint made against him, which notice may be prepared by a committee or one or more members of the Board designated by the Board, and stating that such licensee will be given an opportunity to be heard concerning such charges or complaint at a time and place stated in such notice, or at a time and place to be thereafter designated by the Board, and the Board shall hold a public hearing not less than 30 days from the date of the service of such notice upon such licensee, at which such licensee may appear personally and through counsel, may cross examine witnesses and present evidence in his own behalf. A physician who is mentally incompetent shall be represented at such hearing and shall be served with notice as herein provided by and through a guardian ad litem appointed by the clerk of the court of the county in which the physician has his residence. Such licensee or physician may, if he desires, file written answers to the charges or complaints preferred against him within 30 days after the service of such notice, which answer shall become a part of the record but shall not constitute evidence in the case. Members of the Board participating on the hearing committee shall not have been involved in any part of the investigation."

SECTION 6. G.S. 90-14.5 reads as rewritten:

"**§ 90-14.5. Use of trial examiner or depositions.**

~~Where the licensee requests~~The licensee may request that the hearing herein provided for be held by the Board in a county other than the county designated for the

holding of the meeting of the Board at which the matter is to be heard, the Board may designate in writing one or more of its members to conduct the hearing as a trial examiner or trial committee, to take evidence and report a written transcript thereof to the Board at a meeting where a majority of the members are present and participating in the decision. Evidence and testimony may also be presented at such hearings and to the Board in the form of depositions taken before any person designated in writing by the Board for such purpose or before any person authorized to administer oaths, in accordance with the procedure for the taking of depositions in civil actions in the superior court. When a trial examiner or trial committee recommends license revocation, suspension, or retraction, the licensee shall be granted a full Board hearing at the licensee's request if the request is made in a timely manner as determined by the Board."

SECTION 7. G.S. 90-14.6 reads as rewritten:

"**§ 90-14.6. Evidence admissible.**

In proceedings held pursuant to this Article the Board shall admit and hear evidence in the same manner and form as prescribed by law for civil actions. A complete record of such evidence shall be made, together with the other proceedings incident to such hearing. The physician under investigation may call witnesses, including medical practitioners licensed in the United States, with expertise in the same field of practice as the physician under investigation. Witnesses shall not be restricted to experts certified by the American Board of Medical Specialties. In an investigative meeting, the physician being investigated may present testimony from medical practitioners licensed in the United States with expertise in the same field of practice as the physician under investigation. Members of the Board shall not be immune from civil or criminal liability for failing to exercise, in good faith, its powers and duties authorized by law."

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

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2003

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HOUSE BILL 886
PROPOSED COMMITTEE SUBSTITUTE H886-CSSW-14 [v.6]

4/22/2003 5:53:00 PM

Short Title: Due Process for Physicians. (Public)

Sponsors:

Referred to:

April 7, 2003

A BILL TO BE ENTITLED

AN ACT TO AMEND VARIOUS PROVISIONS RELATING TO THE NORTH CAROLINA MEDICAL BOARD UNDER THE LAWS REGULATING THE PRACTICE OF MEDICINE.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 90-2 reads as rewritten:

"**§ 90-2. Medical Board.**

(a) ~~In order to properly regulate the practice of medicine and surgery for the benefit and protection of the people of North Carolina, there is established the North Carolina Medical Board.~~ There is established the North Carolina Medical Board to regulate the practice of medicine and surgery for the benefit and protection of the people of North Carolina. The Board shall consist of 12 members.

(1) Seven of the members shall be duly licensed physicians ~~elected and nominated to~~ appointed by the ~~Governor by the North Carolina Medical Society.~~ Governor. Of the seven members appointed by the Governor, one member shall be a faculty member at one of the medical schools in North Carolina. In addition, of these seven members, three shall be duly licensed physicians nominated by the North Carolina Medical Society, three shall be duly licensed physicians nominated by The Old North State Medical Society, and one shall be a duly licensed physician nominated by the North Carolina Osteopathic Medical Association.

(2) Of the remaining five members, all to be appointed by the Governor, ~~at least three~~ four shall be public members and ~~at least~~ one shall be either a physician assistant as defined in G.S. 90-18.1 or a nurse practitioner as defined in G.S. 90-18.2. A public member shall not be a health care provider ~~nor~~ or the spouse of a health care provider. For purposes of board membership, "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 section, a person enrolled in a program to prepare ~~him~~ that person to be a licensed health care professional or an allied health professional shall be deemed a health care provider. For purposes of this section, any person with significant financial interest in a health service or profession is not a public member.

(a1) Each appointing and nominating authority shall ensure, insofar as possible, that its appointees and nominees to the Board reflect the composition of the State with regard to ethnic, racial, age, and religious composition.

(b) No member ~~appointed to the Board on or after November 1, 1981,~~ shall serve more than two complete consecutive three-year terms, except that each member shall serve until ~~his~~ a successor is chosen and qualifies.

~~(c) In order to establish regularly overlapping terms, the terms of office of the members shall expire as follows: two on October 31, 1993; four on October 31, 1994; four on October 31, 1995; and two on October 31, 1996.~~

(d) ~~Any~~A member of the Board ~~may~~ shall be removed from office by the Governor for good cause ~~shown.~~shown, including malicious prosecution or abuse of power. Any vacancy in the physician membership of the Board shall be filled for the period of the unexpired term by the ~~Governor from a list of physicians submitted by the North Carolina Medical Society Executive Council.~~Governor from nominees provided by the applicable professional organization. Any vacancy in the public, physician assistant, or nurse practitioner membership of the Board shall be filled by the Governor for the unexpired term.

(e) The North Carolina Medical Board shall have the power to acquire, hold, rent, encumber, alienate, and otherwise deal with real property in the same manner as any 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."

SECTION 1.(a). G.S. 90-3 is repealed.

SECTION 2. G.S. 90-8 reads as rewritten:

"**§ 90-8. Officers may administer oaths, and subpoena witnesses, records and other materials.**

The president and secretary of the Board may administer oaths to all persons appearing before it as the Board may deem necessary to perform its duties, and may summon and issue subpoenas for the appearance of any witnesses deemed necessary to testify concerning any matter to be heard before or inquired into by the Board. The power of the Board to subpoena is limited to persons with knowledge related to a matter before the Board. The Board may order that any patient records, documents or other material concerning any matter to be heard before or inquired into by the Board shall be produced before the Board or made available for inspection, notwithstanding any other provisions of law providing for the application of any physician-patient privilege with

respect to such records, documents or other material. All records, documents, or other material compiled by the Board are subject to the provisions of G.S. 90-16. Notwithstanding the provisions of G.S. 90-16, in any proceeding before the Board, in any record of any hearing before the Board, and in the notice of charges against any licensee, the Board shall withhold from public disclosure the identity of a patient including information relating to dates and places of treatment, or any other information that would tend to identify the patient, unless the patient or the representative of the patient expressly consents to the disclosure. Upon written request, the Board shall revoke a subpoena if, upon a hearing, it finds that the evidence the production of which is required does not relate to a matter in issue, or if the subpoena does not describe with sufficient particularity the evidence the production of which is required, or if for any other reason in law the subpoena is invalid."

SECTION 3. G.S. 90-14(a) reads as rewritten:

"(a) The Board shall have the power to deny, annul, suspend, or revoke a license, or other authority to practice medicine in this State, issued by the Board to any person who has been found by the Board to have committed any of the following acts or conduct, or for any of the following reasons:

(1) Immoral or dishonorable conduct.

(2) Producing or attempting to produce an abortion contrary to law.

(3) Made false statements or representations to the Board, or who has willfully concealed from the Board material information in connection with an application for a license.

(4) Repealed by Session Laws 1977, c. 838, s. 3.

(5) Being unable to practice medicine with reasonable skill and safety to patients by reason of illness, drunkenness, excessive use of alcohol, drugs, chemicals, or any other type of material or by reason of any physical or mental abnormality. The Board is empowered and authorized to require a physician licensed by it to submit to a mental or physical examination by physicians designated by the Board before or after charges may be presented against the physician, and the results of the examination shall be admissible in evidence in a hearing before the Board.

(6) Unprofessional conduct, including, but not limited to, departure from, or the failure to conform to, the standards of acceptable and prevailing medical practice, or the ethics of the medical profession, irrespective of whether or not a patient is injured thereby, or the committing of any act contrary to honesty, justice, or good morals, whether the same is committed in the course of the physician's practice or otherwise, and whether committed within or without North Carolina. The standards of practice in any specialty, including integrative, complementary and alternative medical treatments, shall be defined by specialists that have met the national certification standards for that specific medical treatment. The Board shall not annul, suspend, revoke the license of or deny a license to a ~~person~~ person, or harass a person, solely because of

that person's practice of a therapy that is experimental, nontraditional, or that departs from acceptable and prevailing medical practices unless, by ~~competent~~ a greater weight of the evidence, the Board can establish that the treatment has a ~~safety~~ risk of harm to the patient greater than the prevailing treatment or that the treatment is generally not ~~effective.~~as effective in comparison to the effective rates of other prevailing treatments.

(7) Conviction in any court of a crime involving moral turpitude, or the violation of a law involving the practice of medicine, or a conviction of a felony; provided that a felony conviction shall be treated as provided in subsection (c) of this section.

(8) By false representations has obtained or attempted to obtain practice, money or anything of value.

(9) Has advertised or publicly professed to treat human ailments under a system or school of treatment or practice other than that for which the physician has been educated. A duly licensed physician shall not be prohibited from displaying all of the physician's certifications in public documents so long as the certifications displayed are not misleading,as determined by the Board.

(10) Adjudication of mental incompetency, which shall automatically suspend a license unless the Board orders otherwise.

(11) Lack of professional competence to practice medicine with a reasonable degree of skill and safety for patients. In this connection the Board may consider repeated acts of a physician indicating the physician's failure to properly treat a patient. The Board may, upon reasonable grounds, require a physician to submit to inquiries or examinations, written or oral, by members of the Board or by other physicians licensed to practice medicine in this State, as the Board deems necessary to determine the professional qualifications of such licensee.

(12) Promotion of the sale of drugs, devices, appliances or goods for a patient, or providing services to a patient, in such a manner as to exploit the patient, and upon a finding of the exploitation, the Board may order restitution be made to the payer of the bill, whether the patient or the insurer, by the physician; provided that a determination of the amount of restitution shall be based on credible testimony in the record. The Board shall not deny, annul, suspend, or revoke a license for selling nutritional supplements or vitamins so long as the physician provides the financial disclosures recommended by the Board for drugs, devices, appliances, or goods.

(13) Having a license to practice medicine or the authority to practice medicine revoked, suspended, restricted, or acted against or having a license to practice medicine denied by the licensing authority of any jurisdiction. For purposes of this subdivision, the licensing authority's

acceptance of a license to practice medicine voluntarily relinquished by a physician or relinquished by stipulation, consent order, or other settlement in response to or in anticipation of the filing of administrative charges against the physician's license, is an action against a license to practice medicine.

(14) The failure to respond, within a reasonable period of time and in a reasonable manner as determined by the Board, to inquiries from the Board concerning any matter affecting the license to practice medicine.

(15) The failure to complete an amount not to exceed 150 hours of continuing medical education during any three consecutive calendar years pursuant to rules adopted by the Board.

For any of the foregoing reasons, the Board may deny the issuance of a license to an applicant or revoke a license issued to a physician, may suspend such a license for a period of time, and may impose conditions upon the continued practice after such period of suspension as the Board may deem advisable, may limit the accused physician's practice of medicine with respect to the extent, nature or location of the physician's practice as the Board deems advisable. The Board may, in its discretion and upon such terms and conditions and for such period of time as it may prescribe, restore a license so revoked or rescinded, except that no license that has been revoked shall be restored for a period of two years following the date of revocation. Unless the person under investigation has obstructed a Board investigation by not responding or providing documents requested by the Board, the Board shall conclude an investigation of a violation of this section within 18 months from the date the investigation is initiated and shall notify the person under investigation when the investigation is concluded."

SECTION 4. G.S. 90-14 is amended by adding a new subsection to read:

"(g) In order to annul, suspend, deny, or revoke a license of an accused person, the Board shall find that the facts satisfy, by the greater weight of the evidence, that the care provided was not in accordance with the standards of practice for the procedures or treatments administered.

(h) The Board shall establish an expert review panel on integrative medicine to review cases involving licensees who practice integrative medicine and make recommendations to the Board prior to the Board taking action against any licensee who practices integrative medicine."

SECTION 5. G.S. 90-14.2 reads as rewritten:

"**§ 90-14.2. Hearing before revocation or suspension of a license.**

(a) Before the Board shall revoke, restrict or suspend any license granted by it, the Board shall give the licensee ~~shall be given a~~ written notice indicating the general nature of the charges, accusation, or complaint made against ~~him,~~the licensee. The ~~which~~ notice may be prepared by a committee or one or more members of the Board designated by the ~~Board,~~ Board. ~~and stating~~The notice shall provide that ~~such~~ the licensee ~~will~~ shall be given an opportunity to be heard concerning ~~such~~ the charges or complaint at a time and place stated in ~~such~~ the notice, or at a time and place to be ~~thereafter~~ at some other time designated by the ~~Board, and the~~ Board. The Board shall

hold a public hearing not less than 30 days from the date of the service of ~~such~~ the notice upon ~~such~~ the ~~licensee, at which such~~ licensee.

(b) At the hearing, the licensee may appear personally and through counsel, may cross examine witnesses and present evidence in ~~his~~the licensee's own behalf. A ~~physician~~ licensee who is mentally incompetent shall be represented at ~~such~~ the hearing and shall be served with notice as ~~herein~~ provided in this section by and through a guardian ad litem appointed by the clerk of the court of the county in which the ~~physician has his residence.~~ licensee resides.

(c) At least 15 days prior to any hearing, each party shall disclose the identity of an expert, the subjects on which the expert is expected to testify, the substance of the facts and opinions on which the expert is expected to rely, and the qualifications of the expert.

(d) ~~Such~~ The licensee ~~or physician may, if he desires,~~ may file written answers to the charges or complaints ~~preferred against him~~ within 30 days after the service of ~~such~~ the ~~notice, which~~ notice. The answer shall become a part of the record but shall not constitute evidence in the case."

SECTION 6. G.S. 90-14.6 reads as rewritten:

"**§ 90-14.6. Evidence admissible.**

(a) In proceedings held pursuant to this Article the Board shall admit and hear evidence in the same manner and form as prescribed by law for civil actions. A complete record of such evidence shall be made, together with the other proceedings incident to such hearing.

(b) In proceedings held pursuant to this Article, the licensee under investigation may call witnesses, including medical practitioners licensed in the United States, with expertise in the same field of practice as the licensee under investigation, and the Board shall consider this testimony. Witnesses shall not be restricted to experts certified by the American Board of Medical Specialties.

(c) Statements contained in medical or scientific literature shall be competent evidence in proceedings held pursuant to this Article.

(d) In an investigative meeting, the Board shall hear and consider testimony of medical practitioners licensed in the United States with expertise in the same field of practice as the licensee under investigation."

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

ATTACHMENT XI

HOUSE BILL 886:
Due Process for Physicians

BILL ANALYSIS

Committee:	House Health	**Introduced by:**	Rep. Wright and Howard
Date:	April 23, 2003	**Summary by:**	Dianna Jessup
Version:	PCS H886-CSSW-14		Committee Counsel

SUMMARY: ***House Bill 886 would amend various provisions relating to the North Carolina Medical Board under the laws regulating the practice of medicine. The act would become effective when it becomes law.***

The PCS makes the changes described more fully below.

CURRENT LAW: The North Carolina Medical Board (Board) is charged with regulating the practice of medicine and surgery in this State. The Board is comprised of 12 members who serve for three-year terms. Of the terms of the current members, four are due to expire in October 2003.

Currently, the North Carolina Medical Society (an association of physicians) nominates seven members for appointment to the Board by the Governor. Nominees from the Society's Executive Council fill any vacancies in these positions.

The Board is authorized to adopt rules governing applicants for licensure, admission, and the conduct of examinations for licensure and admission and to deny, annul, suspend, or revoke the license or other authority to practice medicine in this State. The Board conducts both informal meetings to inquire into matters (called investigative meetings) and formal hearings.

The president and the secretary of the Board may administer oaths and issue subpoenas for the appearance of witnesses to testify concerning any matter before the Board. The Board may also order pertinent documents, including patient records, to be produced for inspection.

The Board can deny, annul, suspend, or revoke a license for a variety of reasons enumerated by statute. Reasons pertinent to this bill include:

1. Unprofessional conduct that departs from the standard of acceptable and prevailing medical practice. The Board cannot, however, revoke the license of or deny a license to a person solely because that person's practice of an experimental or nontraditional therapy unless, by competent evidence, the Board can establish a safety risk greater than the prevailing treatment.
2. Advertising or publicly professing to treat ailments under a system or school of treatment or practice other than that for which the physician has been educated.
3. Promoting the sale of drugs, devices, appliances or goods for a patient or providing services to a patient, in a manner to exploit the patient. There are ethical guidelines from the Board and the American Medical Society relating to the sale of goods from physicians' offices.

Before the Board can revoke, restrict or suspend a license, the licensee must be given notice and an opportunity to be heard. At the hearing, the licensee may cross-examine witnesses and present evidence. The rules of procedure and evidence for civil actions apply. If the licensee requests that the hearing be held in a county other than where the full Board meets, the Board may designate a committee of its members to conduct the hearing.

BILL ANALYSIS:

Section 1 would amend the provisions of the statute related to the appointment and removal of members of the North Carolina Medical Board as follows:

- The original bill provided that the Governor's physician appointees would not be appointed from nominees provided by the North Carolina Medical Society. *The PCS provides that of the physician appointments, three shall be physicians nominated by the North Carolina Medical Society, three shall be physicians nominated by The Old North State Medical Society, and one shall be a physician nominated by the North Carolina Osteopathic Medical Association. Vacancies would be filled from nominees provided by the applicable professional organization.*
- One of the physician appointees would have to be a faculty member at one of the State's medical schools.
- The Governor would be required to remove a member of the Board for "good cause shown", including malicious prosecution or abuse of power.
- *The PCS adds language that would provide that each appointing and nominating authority shall ensure, insofar as possible, that its appointees and nominees reflect the composition of the State with regard to ethnic, racial, age, and religious composition.*

Section 2 would amend the provisions relating to the Board's power to administer oaths and subpoena witnesses to specify that the Board's power to subpoena would be limited to persons with knowledge related to a matter before the Board. *The PCS moves the following language to Sections 5 and 7 of the bill:* Language in this section would specify that medical expert witnesses must routinely and actively practice in the specialty under investigation by the Board, and that for expert witnesses, the parties must disclose *(at least 15 days prior to any hearing)* the expert's identity, the subjects on which the expert is expected to testify, the substance of the facts and opinion on which the expert is expected to rely, and the qualifications of the expert. Statements contained in medical or scientific literature would be competent evidence.

Section 3 would amend the law relating to the grounds for denying, annulling, suspending, or revoking a license to provide as follows:

- The standards of practice in any specialty, including complementary treatments, shall be defined by specialists in that field. *The PCS clarifies that the specialists must meet the national certification standards for that specific medical treatment.*
- The Board cannot annul or suspend a license, and the Board cannot initiate an investigation solely because a person's practice is experimental, nontraditional, or departs from acceptable and prevailing medical practice unless by a preponderance of the evidence, the Board can establish that the treatment has a risk of harm to the patient greater than the prevailing treatment or that the treatment is generally not as effective in comparison to the effective rates of other prevailing treatments.
- A duly licensed physician cannot be prohibited from displaying the physician's certifications in public documents. *The PCS clarifies that the certifications displayed may not be misleading, as determined by the Board.*
- Selling nutritional supplements or vitamins shall have the same financial disclosures as those required with drugs, devices, appliances, or goods. *The PCS clarifies that the Board shall not*

deny, annul, suspend, or revoke a license for selling nutritional supplements or vitamins so long as the physician provides the financial disclosures recommended by the Board for drugs, devices, appliances, or goods.

- The Board must conclude an investigation into a failure to respond to a Board inquiry within 18 months from the date the incident was initially reported. *The PCS makes this provision generally applicable to all investigations unless the person under investigation has obstructed a Board investigation by not responding or providing documents requested by the Board. In addition, the PCS would provide that the Board must notify the accused person of the conclusion of the investigation.*

Section 4 would require the Board to find, by a greater weight of the evidence, a pattern of incompetence and a deviation from the standard of practice in order to be able to annul, suspend, deny, or revoke the license of an accused physician. *The PCS would require the Board to find, by a greater weight of the evidence, that the care provided was not in accordance with the standards of practice for the procedures or treatments administered. In addition, The PCS adds a new subsection that would require the Board to establish an expert review panel on integrative medicine to review cases involving licensees who practice integrative medicine and to make recommendations to the Board prior to the Board taking action against any licensee who practices integrative medicine.*

Section 5 would prohibit members of the Board who investigated a licensee from serving on the hearing committee that conducts the hearing concerning that licensee. *See Section 2 for the changes made by the PCS.*

Formerly Section 6 of the bill would require a full Board hearing in cases where a trial examiner or trial committee recommends license revocation, suspension, or retraction, if the licensee requests one in a timely manner (to be determined by the Board). *The PCS removes this section.*

Formerly Section 7 of the bill would specify that for Board proceedings, a physician under investigation may call witnesses, including medical practitioners, with expertise in the same field of practice as the physician under investigation. Witnesses would not be restricted to experts certified by the American Board of Medical Specialties. In an investigative meeting (a non-public, informal meeting), the physician being investigated may present testimony from licensed medical practitioners with expertise in the same field of practice as the physician. *The PCS makes this Section 6. See Section 2 of the bill summary for other changes made by the PCS.*

This section also adds language that prevents Board members from being immune from civil or criminal liability for failing to exercise, in good faith, its powers and duties authorized by law. *The PCS removes this language.*

Formerly Section 8 of the bill makes the act effective when it becomes law. *The PCS makes this Section 7.*

H866-SMSW-001

ATTACHMENT VI

SENATE BILL 704:
Traumatic Brain Injury Advisory Council

BILL ANALYSIS

Committee:	House Health	**Introduced by:**	Sen. Kerr
Date:	May 13, 2003	**Summary by:**	Amy Compeau
Version:	Second Edition		Research Division Staff

SUMMARY: ***Senate Bill 704, Second Edition, would establish the Traumatic Brain Injury Advisory Council (Council) in the Department of Health and Human Services (DHHS). The Council would review definitions of traumatic brain injuries (TBI), promote interagency coordination, study the needs of individuals with TBI and their families, make recommendations on comprehensive statewide service delivery, and promote injury prevention. The act would become effective when it becomes law.***

BILL ANALYSIS:

Duties of the Council

SB 704 would establish a Council within DHHS that would have the following duties:

1. Review definitions of "traumatic brain injury" as defined by State and federal regulations to determine whether changes should be made to the State definition.
2. Promote interagency coordination among State agencies responsible for services and support of individuals that have sustained TBI.
3. Study the needs of individuals with TBI and their families.
4. Make recommendations to the Governor, the General Assembly, and the Secretary of DHHS regarding the planning, development, funding, and implementation of a comprehensive statewide service delivery system.
5. Promote and implement injury prevention strategies across the State.

Council Membership

Number	Member Qualification
	(2) APPOINTEES OF THE PRESIDENT PRO TEMPORE
1	Executive Director of the Brain Injury Association of NC, or a designee
1	A physician, nurse, or other professional coordinator with expertise in trauma, neurosurgery, neuropsychology, physical medicine and rehabilitation, or emergency medicine
	(2) APPOINTEES OF THE SPEAKER
1	Chair of the Board of the Brain Injury Association of NC, or a designee
1	A physician, nurse, or other professional coordinator with expertise in trauma, neurosurgery, neuropsychology, physical medicine and rehabilitation, or emergency medicine
	(9) APPOINTEES OF THE GOVERNOR
3	Survivors of brain injury, from the eastern, central, and western regions of the State
3	Family members of persons with brain injury
1	A brain injury service provider in private practice
1	The director of an area program or county program of MH/DD/SA* services
1	The Executive Director of the NC Carolina Trial Lawyers Association, or a designee
	(8) APPOINTEES OF THE SECRETARY OF DHHS
1	Representative from the Division of MH/DD/SA* services
1	Representative from the Division of Vocational Rehabilitation

1	Representative from the Council on Developmental Disabilities
1	Representative from the Division of Medical Assistance
1	Representative from the Division of Facility Services
1	Representative from the Division of Social Services
1	Representative from the Office of Emergency Medical Services
1	Representative from the Division of Public Health
(2) APPOINTEES OF THE SUPERINTENDENT OF PUBLIC INSTRUCTION	
2	At least one appointee shall be from the Division of Exceptional Children
(1) APPOINTEE OF THE COMMISSIONER INSURANCE	
1	N/A
(1) APPOINTEE OF THE SECRETARY OF ADMINISTRATION	
1	Appointee represents veterans affairs
25	**Total Members**

* MH/DD/SA stands for Mental Health, Developmental Disabilities, and Substance Abuse.

Council Terms and Structure

TERMS: The terms of the initial members of the Council would commence October 1, 2003. The Governor's initial 9 appointees would have staggered terms. After the initial appointees' terms expire, all members would be appointed for 4-year terms. No member appointed by the Governor would serve more than 2 successive terms.

STRUCTURE: The chair of the Council would be designated by the Secretary and would not hold the office for more than four years. The Council would meet quarterly and at other times at the call of the chair. A majority of the Council would constitute a quorum. FUNDS: Members would be reimbursed for expenses incurred in the performance of their duties in accordance with G.S. 138-5 and G.S. 138-6, as applicable. In addition, the Secretary would provide clerical and other assistance as needed.

BACKGROUND: The Health Resources and Services Administration (HRSA) recommends that each state create, through statute, a TBI Advisory Council. According to HRSA, 20 states have established such Councils.

The below data was compiled by staff from the Division of MH/DD/SA services, DHHS.

National Statistics

A TBI may be classified as severe, moderate or mild. National estimates from the Centers for Disease Control and Prevention (CDC) suggest there are as many as 1.5 million persons with mild to severe TBI per year in the U.S. Putting this in perspective of other well-known chronic diseases, TBI occurs 8 times more often than the number of people diagnosed with breast cancer and 34 times the number of new cases of HIV/AIDS. CDC estimates that annually approximately 230,000 people with TBI are hospitalized and survived; over 1 million are treated in an Emergency Department.

State Statistics

The injury surveillance systems in the State for TBI can only identify the most severe cases of TBI, i.e., the number of residents who died or were hospitalized from a brain injury. The NC State Center for Health Statistics reports that in 2001, 1,800 State residents died from TBI (a rate of 22.1 per 100,000 population). Also in 2001, there were 4,600 TBI hospitalizations (a rate of 56.4 per 100,000 population). The highest *number* of TBI deaths and hospitalizations occur to adolescents and young adults, primarily from motor vehicle crashes (MVC) and firearms in homicides and suicides. In contrast, the highest *rates* of TBI deaths and hospitalizations occur in people age 85 and older, primarily as the consequences of falls. According to the NC Medical Journal, the risk for TBI, overall, is twice as great in men than women.

S704-SMRP-002

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2003

S 3

SENATE BILL 522
Health & Human Resources Committee Substitute Adopted 4/7/03
Third Edition Engrossed 4/15/03

Short Title: Board of Nursing. (Public)

Sponsors:

Referred to:

March 25, 2003

A BILL TO BE ENTITLED

AN ACT TO CHANGE THE METHOD BY WHICH CERTAIN MEMBERS ON THE NORTH CAROLINA BOARD OF NURSING ARE ELECTED OR APPOINTED, TO MAKE TECHNICAL CHANGES TO THE NURSING PRACTICE ACT, AND TO REQUIRE THAT HEALTH CARE FACILITIES VERIFY THE LICENSURE STATUS OF APPLICANTS SEEKING EMPLOYMENT AS NURSES.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 90-171.21 reads as rewritten:

"**§ 90-171.21. Board of Nursing; composition; selection; vacancies; qualifications; term of office; compensation.**

(a) The Board shall consist of 15 members. Nine members shall be registered nurses. ~~Four~~ Three members shall be licensed practical nurses. ~~Two~~ Three members shall be representatives of the public.

(b) Selection. – The North Carolina Board of Nursing shall conduct an election each year to fill vacancies of nurse members of the Board scheduled to occur during the next year. Nominations of candidates for election of registered nurse members shall be made by written petition signed by not less than 10 registered nurses eligible to vote in the election. Nominations of candidates for election of licensed practical nurse members shall be made by written petition signed by not less than 10 licensed practical nurses eligible to vote in the election. Every licensed registered nurse holding an active license shall be eligible to vote in the election of registered nurse board members. Every licensed practical nurse holding an active license shall be eligible to vote in the election of licensed practical nurse board members. The list of nominations shall be filed with the Board after January 1 of the year in which the election is to be held and no later than midnight of the first day of April of such year. Before preparing ballots, the Board shall notify each person who has been duly nominated of ~~his~~ the person's nomination and request permission to enter ~~his~~ the person's name on the ballot. A member of the Board who is nominated ~~to succeed himself~~ for reelection and who does not withdraw ~~his~~ the

member's name from the ballot is disqualified to participate in conducting the election. Elected members shall begin their term of office on January 1 of the year following their election.

Nominations of persons to serve as public members of the Board may be made to the Governor or the General Assembly by any citizen or group within the State. The Governor shall appoint ~~the two public members~~one public member to the ~~Board.~~Board, and the General Assembly shall appoint two public members to the Board. Of the public members appointed by the General Assembly, one shall be appointed by the General Assembly upon the recommendation of the President Pro Tempore of the Senate, and one shall be appointed by the General Assembly upon the recommendation of the Speaker of the House of Representatives.

Board members shall be commissioned by the Governor upon their election or appointment.

(c) Vacancies. – All unexpired terms of Board members appointed by the General Assembly shall be filled within 45 days after the term is vacated. The Governor shall fill all other unexpired terms on the Board within 30 days after the term is vacated. For vacancies of registered nurse or licensed practical nurse members, the Governor shall appoint the person who received the next highest number of votes to those elected members at the most recent election for board members. ~~The Governor shall select the public member to fill any vacancy of a public member.~~ Appointees shall serve the remainder of the unexpired term and until their successors have been duly elected or appointed and qualified.

(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 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.~~Of the nine registered nurse members on the Board, two shall be nurse administrators, one employed by a hospital or a hospital system and one employed by any other type of nursing care delivery system, both of whom shall be accountable for the administration of nursing services and not directly involved in patient care; one shall be an individual who meets the requirements to practice as a certified registered nurse anesthetist, a certified nurse midwife, a clinical nurse specialist, or a nurse practitioner; two shall be staff nurses, defined as individuals who are primarily involved in direct patient care regardless of practice setting; one shall be an at-large registered nurse who meets the requirements of sub-subdivisions (1)a. and b. of this subsection, but is not currently an educator in a program leading to licensure or any other degree-granting program; and three shall be nurse educators. Of the three nurse educators, one shall be a practical

nurse educator, one shall be an associate degree or diploma nurse educator, and one shall be a baccalaureate or higher degree nurse educator. All nurse educators shall meet the minimum education requirement as established by the Board's education program standards for nurse faculty. Candidates eligible for election to the Board as nurse educators are not eligible for election as the at-large member.

(1) ~~All~~ Except for the at-large member, every registered nurse ~~members~~member shall meet the following criteria:

a. Hold a ~~current~~ current, unencumbered license to practice as a registered nurse in North Carolina.

a1. Be a resident of North Carolina.

b. Have ~~at least~~a minimum of five ~~years'~~ years of experience ~~in nursing practice, nursing administration, and/or nursing education.~~as a registered nurse.

c. Have been engaged continuously in ~~nursing practice, nursing administration, or nursing education~~a position that meets the criteria for the specified Board position for at least three years immediately preceding election.

d. Show evidence that the employer of the registered nurse is aware that the nurse intends to serve on the Board.

(2) ~~Licensed~~ Every licensed practical nurse ~~members~~ member shall meet the following criteria:

a. Hold a ~~current~~ current, unencumbered license to practice as a licensed practical nurse in North Carolina.

a1. Be a resident of North Carolina.

~~b. Be a graduate of a board approved program for the preparation of practical nurses.~~

c. Have ~~at least~~a minimum of five ~~years'~~ years of experience as a licensed practical nurse.

d. Have been engaged continuously in the position of a licensed practical ~~nursing~~ nurse for at least three years immediately preceding election.

e. Show evidence that the employer of the licensed practical nurse is aware that the nurse intends to serve on the Board.

(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.~~of health services, employed in the health services field, or hold a vested interest at any level in the provision of health services as defined by the North Carolina Board of Ethics. No public member or person in the public member's immediate family as defined by G.S. 90-405(8) shall be currently employed as a licensed nurse or been previously employed as a licensed nurse.

(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.

(e) Term. – ~~The term of office for board members shall be three years.~~Members of the Board shall serve four-year staggered terms. No member shall serve more than two consecutive ~~three-year terms after July 1, 1981.~~four-year terms or eight consecutive years after January 1, 2005.

(f) Removal. – The Board may remove any of its members for neglect of duty, incompetence, or unprofessional conduct. A member subject to disciplinary proceedings shall be disqualified from Board business until the charges are resolved.

(g) Reimbursement. – Board members are entitled to receive compensation and reimbursement as authorized by G.S. 93B-5."

SECTION 2. G.S. 90-171.22 reads as rewritten:

"**§ 90-171.22. Officers.**

The officers of the Board shall be a ~~chairman,~~ chair, ~~who shall be a registered nurse,~~ a ~~vice-chairman,~~ vice-chair, and ~~such~~ any other officers ~~as~~ the Board ~~may deem~~ considers necessary. All officers shall be elected annually by the Board for terms of one year and shall serve until their successors have been elected and qualified."

SECTION 3. G.S. 90-171.23(b) reads as rewritten:

"(b) Duties, powers. The Board is empowered to:

...

(8) ~~Prescribe~~ Establish 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.

(9) ~~Survey~~ Review all nursing programs at least every ~~five~~ eight years or more often as ~~deemed~~ considered necessary by the Board or program director.

...."

SECTION 4. G.S. 90-171.38(a) reads as rewritten:

"(a) A nursing program may be operated under the authority of a general hospital, or an approved post-secondary educational institution. The Board shall establish, revise, or repeal standards for nursing programs. These standards shall specify program requirements, curricula, faculty, students, facilities, resources, administration, and describe the approval process. Any institution desiring to establish a nursing program shall apply to the Board and submit satisfactory evidence that it will meet the standards ~~prescribed~~ established by the Board. Those standards shall be designed to ensure that graduates of those programs have the education necessary to safely and competently practice nursing. ~~The Board shall encourage the continued operation of all present programs that meet the standards approved by the Board.~~"

SECTION 5. G.S. 90-171.40 reads as rewritten:

"**§ 90-171.40. ~~Periodic surveys.~~Ongoing approval.**

The Board shall ~~designate persons to survey~~review all nursing programs in the State at least every ~~five~~ eight years or more often as ~~deemed~~ considered necessary. ~~Written reports of such surveys shall be submitted to the Board.~~ If the Board determines that any approved nursing program does not meet or maintain the standards required by the Board, the Board shall give written notice ~~thereof in writing~~ specifying the deficiencies ~~shall be given immediately~~ to the institution responsible for the program. The Board shall withdraw approval from a program ~~which~~ that fails to correct deficiencies within a reasonable time. The Board shall publish annually a list of nursing programs in this State showing their approval status."

SECTION 6. Article 9A of Chapter 90 of the General Statutes is amended by adding a new section to read:

"**§ 90-171.43A. Mandatory employer verification of licensure status.**

(a) Before hiring a registered nurse or a licensed practical nurse in North Carolina, a health care facility shall verify that the applicant has a current, valid license to practice nursing pursuant to G.S. 90-171.43.

(b) For purposes of this section, 'health care facility' means:

(1) Facilities described in G.S. 131E-256(b).

(2) Public health departments, physicians' offices, ambulatory care facilities, and rural health clinics."

SECTION 7. Members serving on the Board of Nursing on the effective date of this act shall continue to serve until December 31, 2004. To establish staggered terms for the appointments of public members made pursuant to G.S. 90-171.21(b), as enacted in Section 1 of this act, the Governor shall appoint one member for a four-year term, the General Assembly, upon the recommendation of the President Pro Tempore of the Senate, shall appoint one member for a three-year term, and the General Assembly, upon the recommendation of the Speaker of the House of Representatives, shall appoint one member for a two-year term.

To stagger terms for members elected to the Board, the Board shall conduct an election in 2004 pursuant to G.S. 90-171.21(b) to elect members as follows:

(1) A registered nurse administrator employed by a hospital or hospital system, an at-large registered nurse, and a licensed practical nurse, each to serve for a one-year term.

(2) A staff registered nurse, a registered nurse who is an associate degree or diploma nurse educator, and a licensed practical nurse, each to serve for a two-year term.

(3) A registered nurse who is a baccalaureate or higher degree nurse educator, a registered nurse administrator employed by a nursing care delivery system other than a hospital system, and a licensed practical nurse, each to serve for a three-year term.

(4) A staff registered nurse, a registered nurse who is a practical nurse educator, and either a certified registered nurse anesthetist, a certified

nurse midwife, a clinical nurse specialist, or a nurse practitioner, each to serve for a four-year term.

All members appointed and elected to the Board pursuant to this section shall begin serving their terms on January 1, 2005. After staggered terms have been established, all subsequent appointments and elections to the Board shall be for four-year terms.

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

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2003

S D

SENATE BILL 522
Health & Human Resources Committee Substitute Adopted 4/7/03
Third Edition Engrossed 4/15/03
PROPOSED HOUSE COMMITTEE SUBSTITUTE S522-PCS35280-LB-50

Short Title: Board of Nursing. (Public)

Sponsors:

Referred to:

March 25, 2003

A BILL TO BE ENTITLED

AN ACT TO CHANGE THE METHOD BY WHICH CERTAIN MEMBERS ON THE NORTH CAROLINA BOARD OF NURSING ARE ELECTED OR APPOINTED, TO MAKE TECHNICAL CHANGES TO THE NURSING PRACTICE ACT, AND TO REQUIRE THAT HEALTH CARE FACILITIES VERIFY THE LICENSURE STATUS OF APPLICANTS SEEKING EMPLOYMENT AS NURSES.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 90-171.21 reads as rewritten:

"**§ 90-171.21. Board of Nursing; composition; selection; vacancies; qualifications; term of office; compensation.**

(a) The Board shall consist of ~~15~~ 14 members. ~~Nine~~ Eight members shall be registered nurses. ~~Four~~ Three members shall be licensed practical nurses. ~~Two~~ Three members shall be representatives of the public.

(b) Selection. – The North Carolina Board of Nursing shall conduct an election each year to fill vacancies of nurse members of the Board scheduled to occur during the next year. Nominations of candidates for election of registered nurse members shall be made by written petition signed by not less than 10 registered nurses eligible to vote in the election. Nominations of candidates for election of licensed practical nurse members shall be made by written petition signed by not less than 10 licensed practical nurses eligible to vote in the election. Every licensed registered nurse holding an active license shall be eligible to vote in the election of registered nurse board members. Every licensed practical nurse holding an active license shall be eligible to vote in the election of licensed practical nurse board members. The list of nominations shall be filed with the Board after January 1 of the year in which the election is to be held and no later than midnight of the first day of April of such year. Before preparing ballots, the Board shall notify each person who has been duly nominated of ~~his~~ the person's nomination and

request permission to enter ~~his~~ the person's name on the ballot. A member of the Board who is nominated ~~to succeed himself~~ for reelection and who does not withdraw ~~his~~ the member's name from the ballot is disqualified to participate in conducting the election. Elected members shall begin their term of office on January 1 of the year following their election.

Nominations of persons to serve as public members of the Board may be made to the Governor or the General Assembly by any citizen or group within the State. The Governor shall appoint ~~the two public members~~one public member to the ~~Board.~~Board, and the General Assembly shall appoint two public members to the Board. Of the public members appointed by the General Assembly, one shall be appointed by the General Assembly upon the recommendation of the President Pro Tempore of the Senate, and one shall be appointed by the General Assembly upon the recommendation of the Speaker of the House of Representatives.

Board members shall be commissioned by the Governor upon their election or appointment.

(c) Vacancies. – All unexpired terms of Board members appointed by the General Assembly shall be filled within 45 days after the term is vacated. The Governor shall fill all other unexpired terms on the Board within 30 days after the term is vacated. For vacancies of registered nurse or licensed practical nurse members, the Governor shall appoint the person who received the next highest number of votes to those elected members at the most recent election for board members. ~~The Governor shall select the public member to fill any vacancy of a public member.~~ Appointees shall serve the remainder of the unexpired term and until their successors have been duly elected or appointed and qualified.

(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 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.~~ Of the eight registered nurse members on the Board, one shall be a nurse administrator employed by a hospital or a hospital system, who shall be accountable for the administration of nursing services and not directly involved in patient care; one shall be an individual who meets the requirements to practice as a certified registered nurse anesthetist, a certified nurse midwife, a clinical nurse specialist, or a nurse practitioner; two shall be staff nurses, defined as individuals who are primarily involved in direct patient care regardless of practice setting; one shall be an at-large registered nurse who meets the requirements of sub-subdivisions (1)a. and b. of this subsection, but is not currently an educator in a program leading to licensure or any other degree-granting program; and

three shall be nurse educators. Of the three nurse educators, one shall be a practical nurse educator, one shall be an associate degree or diploma nurse educator, and one shall be a baccalaureate or higher degree nurse educator. All nurse educators shall meet the minimum education requirement as established by the Board's education program standards for nurse faculty. Candidates eligible for election to the Board as nurse educators are not eligible for election as the at-large member.

(1) ~~All~~ Except for the at-large member, every registered nurse ~~members~~member shall meet the following criteria:

a. Hold a ~~current~~ current, unencumbered license to practice as a registered nurse in North Carolina.

a1. Be a resident of North Carolina.

b. Have ~~at least~~a minimum of five ~~years'~~ years of experience ~~in nursing practice, nursing administration, and/or nursing education.~~as a registered nurse.

c. Have been engaged continuously in ~~nursing practice, nursing administration, or nursing educationa~~ position that meets the criteria for the specified Board position for at least three years immediately preceding election.

d. Show evidence that the employer of the registered nurse is aware that the nurse intends to serve on the Board.

(2) ~~Licensed~~ Every licensed practical nurse ~~members~~ member shall meet the following criteria:

a. Hold a ~~current~~ current, unencumbered license to practice as a licensed practical nurse in North Carolina.

a1. Be a resident of North Carolina.

~~b. Be a graduate of a board-approved program for the preparation of practical nurses.~~

c. Have ~~at least~~a minimum of five ~~years'~~ years of experience as a licensed practical nurse.

d. Have been engaged continuously in the position of a licensed practical ~~nursing~~ nurse for at least three years immediately preceding election.

e. Show evidence that the employer of the licensed practical nurse is aware that the nurse intends to serve on the Board.

(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.~~of health services, employed in the health services field, or hold a vested interest at any level in the provision of health services as defined by the North Carolina Board of Ethics. No public member or person in the public member's immediate family as defined by G.S. 90-405(8) shall be currently employed as a licensed nurse or been previously employed as a licensed nurse.

(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.

(e) Term. – ~~The term of office for board members shall be three years.~~Members of the Board shall serve four-year staggered terms. No member shall serve more than two consecutive ~~three-year terms after July 1, 1981.~~four-year terms or eight consecutive years after January 1, 2005.

(f) Removal. – The Board may remove any of its members for neglect of duty, incompetence, or unprofessional conduct. A member subject to disciplinary proceedings shall be disqualified from Board business until the charges are resolved.

(g) Reimbursement. – Board members are entitled to receive compensation and reimbursement as authorized by G.S. 93B-5."

SECTION 2. G.S. 90-171.22 reads as rewritten:

"**§ 90-171.22. Officers.**

The officers of the Board shall be a ~~chairman,~~ chair, ~~who shall be a registered nurse,~~ a ~~vice-chairman,~~ vice-chair, and ~~such~~ any other officers ~~as~~ the Board ~~may deem~~ considers necessary. All officers shall be elected annually by the Board for terms of one year and shall serve until their successors have been elected and qualified."

SECTION 3. G.S. 90-171.23(b) reads as rewritten:

"(b) Duties, powers. The Board is empowered to:

...

(8) ~~Prescribe~~ Establish 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.

(9) ~~Survey~~ Review all nursing programs at least every ~~five~~ eight years or more often as ~~deemed~~ considered necessary by the Board or program director.

...."

SECTION 4. G.S. 90-171.38(a) reads as rewritten:

"(a) A nursing program may be operated under the authority of a general hospital, or an approved post-secondary educational institution. The Board shall establish, revise, or repeal standards for nursing programs. These standards shall specify program requirements, curricula, faculty, students, facilities, resources, administration, and describe the approval process. Any institution desiring to establish a nursing program shall apply to the Board and submit satisfactory evidence that it will meet the standards ~~prescribed~~ established by the Board. Those standards shall be designed to ensure that

graduates of those programs have the education necessary to safely and competently practice nursing. ~~The Board shall encourage the continued operation of all present programs that meet the standards approved by the Board.~~"

SECTION 5. G.S. 90-171.40 reads as rewritten:

"**§ 90-171.40. ~~Periodic surveys.~~Ongoing approval.**

The Board shall ~~designate persons to survey~~review all nursing programs in the State at least every ~~five~~ eight years or more often as ~~deemed~~ considered necessary. ~~Written reports of such surveys shall be submitted to the Board.~~ If the Board determines that any approved nursing program does not meet or maintain the standards required by the Board, the Board shall give written notice ~~thereof in writing~~ specifying the deficiencies ~~shall be given immediately~~ to the institution responsible for the program. The Board shall withdraw approval from a program ~~which~~ that fails to correct deficiencies within a reasonable time. The Board shall publish annually a list of nursing programs in this State showing their approval status."

SECTION 6. Article 9A of Chapter 90 of the General Statutes is amended by adding a new section to read:

"**§ 90-171.43A. Mandatory employer verification of licensure status.**

(a) Before hiring a registered nurse or a licensed practical nurse in North Carolina, a health care facility shall verify that the applicant has a current, valid license to practice nursing pursuant to G.S. 90-171.43.

(b) For purposes of this section, 'health care facility' means:

(1) Facilities described in G.S. 131E-256(b).

(2) Public health departments, physicians' offices, ambulatory care facilities, and rural health clinics."

SECTION 7. The terms of members serving on the Board of Nursing on December 31, 2004, expire on that date. To establish staggered terms for the appointments of public members made pursuant to G.S. 90-171.21(b), as enacted in Section 1 of this act, the Governor shall appoint one member for a four-year term, the General Assembly, upon the recommendation of the President Pro Tempore of the Senate, shall appoint one member for a three-year term, and the General Assembly, upon the recommendation of the Speaker of the House of Representatives, shall appoint one member for a two-year term.

To stagger terms for members elected to the Board, the Board shall conduct an election in 2004 pursuant to G.S. 90-171.21(b) to elect members as follows:

(1) An at-large registered nurse and a licensed practical nurse, to serve for a one-year term.

(2) A staff registered nurse, a registered nurse who is an associate degree or diploma nurse educator, and a licensed practical nurse, each to serve for a two-year term.

(3) A registered nurse who is a baccalaureate or higher degree nurse educator, a registered nurse administrator employed by a hospital or a hospital system, and a licensed practical nurse, each to serve for a three-year term.

(4) A staff registered nurse, a registered nurse who is a practical nurse educator, and either a certified registered nurse anesthetist, a certified nurse midwife, a clinical nurse specialist, or a nurse practitioner, each to serve for a four-year term.

All members appointed and elected to the Board pursuant to this section shall begin serving their terms on January 1, 2005. After staggered terms have been established, all subsequent appointments and elections to the Board shall be for four-year terms. For the purpose of initial application of the provisions of G.S. 90-171.21(e) that limit members to eight consecutive years of service, consecutive service as of December 31, 2004, shall count, and if the member reaches the eight-year maximum during a term of office, that person is not eligible to continue in office and a vacancy is created to be filled for the remainder of the unexpired term.

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

SENATE BILL 522: Board of Nursing

BILL ANALYSIS

Committee:	House Health	**Introduced by:**	Sen. Rand
Date:	May 13, 2003	**Summary by:**	Amy Compeau
Version:	S522-PCS35280-LB-50		Research Division Staff

SUMMARY: ***Senate Bill 522, Third Edition, would: (1) require health care facilities to verify the licensure status of applicants seeking employment as nurses, (2) change the method by which certain members are elected or appointed, and (3) make other technical changes to the Nursing Practice Act. The act would become effective when it becomes law.***

The PCS to SB 522 would decrease the number of members on the NC Board of Nursing (Board) from 15 to 14 members by reducing the number of registered nurse members from 9 to 8 members. The PCS also clarifies limitations regarding the number of consecutive years a member could serve on the Board during transition.

BACKGROUND AND BILL ANALYSIS:

Mandatory Employer Verification of Licensure Status (Sec. 6)

According to the Board, it maintains a licensure database that is updated every 24 hours. Free access is available to the database via a web-based or automated telephone verification system. The bill would require employers in health care facilities to verify the licensure status of a registered nurse (RN) or a licensed practical nurse (LPN) before hiring the applicant. The employers could access the Board's licensure database to verify licensure as required under this section.

DEFINITION OF "HEALTH CARE FACILITY": G.S. 131E-256(b) defines the term, "health care facility" to include: (1) adult care homes, (2) hospitals, (3) home care agencies, (4) nursing pools, (5) hospices, (6) nursing facilities, (7) State-operated facilities, (8) residential facilities, and (9) 24-hour facilities. In addition, SB 522 would consider the following to be a "health care facility": (1) public health departments, (2) physicians' offices, (3) ambulatory care facilities, and (4) rural health clinics.

Currently, Article 15 of Chapter 131E of the General Statutes requires health care facilities to access the Health Care Personnel Registry (Registry) before hiring certain health care personnel including nurse aides, in-home aides, adult care personal aides, and unlicensed assistant personnel. The Registry contains the names of personnel who were subject to findings of neglect or abuse, misappropriation of resident or facility property and other offenses.

Changes to Board Membership and Terms (Sec. 1)

Changes to Board Membership			
	Current Law	**SB 522 (3rd Ed.)**	**PCS**
# of RNs on Board	**9**	**9**	**8**
# of LPNs on Board	**4**	**3**	**3**
# of Public Members on Board	**2**	**3**	**3**
Total Board Membership	**15**	**15**	**14**
Changes to Appointment and Selection of Board Members			
# of Public Members Appointed by the Governor	**2**	**1**	**1**
# of Public Members Appointed by the General Assembly	**0**	**2** (1 upon rec. of Pres. Pro. Tem and 1 upon rec. of Speaker)	**2** (1 upon rec. of Pres. Pro. Tem and 1 upon rec. of Speaker)

Changes to Terms and Term Limits			
	Current Law	**SB 522 (3rd Ed.)**	**PCS**
Length of Terms	3 years	4-year staggered	***Same as 3rd Ed.***
Term Limits	No more than two consecutive 3-year terms	No more than two consecutive 4-year terms or 8 consecutive years	***Same as 3rd Ed.***

Changes to Qualifications for RN Board Members (Sec. 1)

Changes to Qualification Criteria for RN Board Members		
Current Law*	**SB 522 (3rd Ed.)**	PCS
3 Nurse Educators who hold baccalaureate or advanced degrees	3 Nurse Educators as follows: (1) practical nurse educator, (1) associate degree or diploma nurse educator, and (1) baccalaureate or higher degree nurse educator	***Same as 3rd Ed.*** 3 Nurse Educators
2 RNs employed by a hospital, with at least one being a hospital nursing service director	2 Staff Nurses	***Same as 3rd Ed.*** 2 Staff Nurses
1 employed by a licensed physician in private practice	2 Nurse Administrators as follows: (1) employed by a hospital or a hospital system and (1) employed by any other type of nursing care delivery system	1 Nurse Administrator employed by a hospital or a hospital system
1 employed by a skilled or intermediate care facility	1 At-Large Member	***Same as 3rd Ed.*** 1 At-Large Member
1 shall be either a (1) nurse practitioner, (2) nurse anesthetist, (3) nurse midwife, or (4) clinical nurse specialist	1 shall meet the requirements to practice as either a (1) certified registered nurse anesthetist, (2) certified nurse midwife, (3) clinical nurse specialist, or (4) nurse practitioner	***Same as 3rd Ed.*** 1 member who meets one of the four specified requirements
1 community health nurse		
Total of 9 RN Members	**Total of 9 RN Members**	**Total of 8 RN Members**

* Current law does allow for an at-large registered nursing position on the Board, if no nurse is nominated in one of the existing categories.

Other Changes Affecting Board Membership (Secs. 1 and 2)

SB522 would require the RN members of the Board, except for the at-large member, and the LPN members of the Board to be residents of the state of North Carolina and to show evidence of the employer's awareness of the nurse's intent to serve on the Board. In addition, these Board members must hold a current, *unencumbered* NC license and must have been engaged *continuously* in a position in their respective fields for at least three years immediately preceding election.

The bill would clarify that a public member shall not be: (1) a provider of health services, (2) employed in the health services field, or (3) hold a vested interest at any level in the provision of health services. Furthermore, no public member or person in the public member's immediate family shall be currently employed as a licensed nurse or been previously employed as a licensed nurse.

The bill would delete limitations by which Board members may serve as officers of the Board. Under current law, only a RN may serve as chair.

Board's Review of Nursing Programs (Secs. 3, 4 and 5)

According to the Board, there are 95 approved education programs for initial licensure of registered nurses or licensed practical nurses in the State. Current law requires all nursing programs to be reviewed by the Board for approval status at least every 5 years. Secs. 3 and 5 of SB 522 would change the requirement for review to at least every 8 years.

Sec. 4 of the bill would delete the requirement that the Board must encourage the continued operation of all present nursing programs that meet standards approved by the Board.

Transition from Current Board Status and Membership (Sec. 7)

Members serving on the Board on the effective date of this act would continue to serve until December 31, 2004. SB 522 would establish methods for staggered terms for the appointments of public members and for the election of elected members. All members appointed and elected to the Board would begin serving their terms on January 1, 2005.

The PCS clarifies that the terms of members serving on the Board of Nursing on December 31, 2004, would expire on that date.

For the purposes of initial application of term limits proposed by the bill (maximum of 8 consecutive years), the PCS to SB 522 would clarify that consecutive service as of December 31, 2004 would count towards the eight-year maximum. In addition, a person who reaches the eight-year maximum during office would not be eligible to continue in office. The vacancy would need to be filled for the remainder of the unexpired term.

S522-SMRP-003

SENATE BILL 522: Board of Nursing

BILL ANALYSIS

Committee:	House Health	**Introduced by:**	Sen. Rand
Date:	May 13, 2003	**Summary by:**	Amy Compeau
Version:	Third Edition		Research Division Staff

SUMMARY: ***Senate Bill 522, Third Edition, would: (1) require health care facilities to verify the licensure status of applicants seeking employment as nurses, (2) change the method by which certain members are elected or appointed, and (3) make other technical changes to the Nursing Practice Act. The act would become effective when it becomes law.***

BACKGROUND AND BILL ANALYSIS:

Mandatory Employer Verification of Licensure Status (Sec. 6 of SB 522)

According to the NC Board of Nursing (Board), the Board maintains a licensure database that is updated every 24 hours. Free access is available to the database via a web-based or automated telephone verification system. The bill would require employers in health care facilities to verify the licensure status of a registered nurse (RN) or a licensed practical nurse (LPN) before hiring the applicant. The employers could access the Board's licensure database to verify licensure as required under this section.

DEFINITION OF "HEALTH CARE FACILITY": G.S. 131E-256(b) defines the term, "health care facility" to include: (1) adult care homes, (2) hospitals, (3) home care agencies, (4) nursing pools, (5) hospices, (6) nursing facilities, (7) State-operated facilities, (8) residential facilities, and (9) 24-hour facilities. In addition, SB 522 would consider the following to be a "health care facility": (1) public health departments, (2) physicians' offices, (3) ambulatory care facilities, and (4) rural health clinics.

Currently, Article 15 of Chapter 131E of the General Statutes requires health care facilities to access the Health Care Personnel Registry (Registry) before hiring certain health care personnel including nurse aides, in-home aides, adult care personal aides, and unlicensed assistant personnel. The Registry contains the names of personnel who were subject to findings of neglect or abuse, misappropriation of resident or facility property and other offenses.

Changes to Board Membership and Terms (Sec. 1 of SB 522)

Changes to Board Membership		
	Current Law	**SB 522**
# of RNs on Board	9	9
# of LPNs on Board	4	3
# of Public Members on Board	2	3
Total Board Membership	**15**	**15**
Changes to Appointment and Selection of Board Members		
# of Public Members Appointed by the Governor	2	1
# of Public Members Appointed by the General Assembly	0	2 (1 upon rec. of Pres. Pro. Tem and 1 upon rec. of Speaker)
Changes to Terms and Term Limits		
Length of Terms	3 years	4-year staggered
Term Limits	No more than two consecutive 3-year terms	No more than two consecutive 4-year terms or 8 consecutive years

Changes to Qualifications for RN Board Members (Sec. 1 of SB 522)

Changes to Qualification Criteria for RN Board Members	
Current Law*	**SB 522**
3 Nurse Educators who hold baccalaureate or advanced degrees	3 Nurse Educators as follows: (1) practical nurse educator, (1) associate degree or diploma nurse educator, and (1) baccalaureate or higher degree nurse educator
2 RNs employed by a hospital, with at least one being a hospital nursing service director	2 Staff Nurses
1 employed by a licensed physician in private practice	2 Nurse Administrators
1 employed by a skilled or intermediate care facility	1 At-Large Member
1 shall be either a (1) nurse practitioner, (2) nurse anesthetist, (3) nurse midwife, or (4) clinical nurse specialist	1 shall meet the requirements to practices as either a (1) certified registered nurse anesthetist, (2) certified nurse midwife, (3) clinical nurse specialist, or (4) nurse practitioner
1 community health nurse	
Total of 9 RN Members	**Total of 9 RN Members**

* Current law does allow for an at-large registered nursing position on the Board, if no nurse is nominated in one of the existing categories.

Other Changes Affecting Board Membership (Secs. 1 and 2 of SB 522)

SB522 would require the RN members of the Board, except for the at-large member, and the LPN members of the Board to be residents of the state of North Carolina and to show evidence of the employer's awareness of the nurse's intent to serve on the Board. In addition, these Board members must hold a current, *unencumbered* NC license and must have been engaged *continuously* in a position in their respective fields for at least three years immediately preceding election.

The bill would clarify that a public member shall not be: (1) a provider of health services, (2) employed in the health services field, or (3) hold a vested interest at any level in the provision of health services. Furthermore, no public member or person in the public member's immediate family shall be currently employed as a licensed nurse or been previously employed as a licensed nurse.

The bill would delete limitations by which Board members may serve as officers of the Board. Under current law, only a RN may serve as chair.

Board's Review of Nursing Programs (Secs. 3, 4 and 5 of SB 522)

According to the Board, there are 95 approved education programs for initial licensure of registered nurses or licensed practical nurses in the State. Current law requires all nursing programs to be reviewed by the Board for approval status at least every 5 years. Secs. 3 and 5 of SB 522 would change the requirement for review to at least every 8 years.

Sec. 4 of the bill deletes the requirement that the Board must encourage the continued operation of all present nursing programs that meet standards approved by the Board.

Transition from Current Board Status and Membership (Sec. 7 of SB 522)

Members serving on the Board on the effective date of this act would continue to serve until December 31, 2004. SB 522 would establish methods for staggered terms for the appointments of public members and for the election of elected members. All members appointed and elected to the Board would begin serving their terms on January 1, 2005.

S522-SMRP-002

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2003

S 3

SENATE BILL 648
Health & Human Resources Committee Substitute Adopted 4/21/03
Third Edition Engrossed 4/30/03

Short Title: Cervical Cancer Elimination Task Force. (Public)

Sponsors:

Referred to:

April 1, 2003

A BILL TO BE ENTITLED

AN ACT TO ESTABLISH AN AD HOC CERVICAL CANCER ELIMINATION TASK FORCE TO THE ADVISORY COMMITTEE ON CANCER COORDINATION AND CONTROL.

The General Assembly of North Carolina enacts:

SECTION 1.(a) A standing ad hoc task force on cervical cancer elimination is established pursuant to this act to serve the Advisory Committee on Cancer Coordination and Control. The ad hoc task force shall be called the Cervical Cancer Elimination Task Force (Task Force). The task force shall perform the duties specified in subsection (j) of this section.

SECTION 1.(b) The Task Force shall have 22 members. The Director of the Division of Public Health in the Department of Health and Human Services, the Director of the Division of Medical Assistance in the Department of Health and Human Services, the Chair and Vice-Chair of the North Carolina's Legislative Women's Caucus, or their designees, shall be members of the Task Force. The following additional members shall be appointed as follows:

(1) By the President Pro Tempore of the Senate, as follows:
   a. One member of the Senate;
   b. Two representatives from the North Carolina's Legislative Women's Caucus;
   c. A representative of a women's health organization;
   d. A representative from the American Academy of Pediatrics; and
   e. A certified schoolteacher.

(2) By the Speaker(s) of the House of Representatives:
   a. One member of the House;
   b. Two representatives from the North Carolina's Legislative Women's Caucus;

c. A member of the North Carolina Cancer Society;
d. A member of the health insurance industry; and
e. A member from the American College of Obstetrics and Gynecology.

(3) By the Governor, as follows:
a. A member of the American Academy of Family Physicians;
b. The State Epidemiologist;
c. Two members at large;
d. A news director of a newspaper or television or radio station; and
e. A licensed registered nurse.

The Governor shall choose a Chair from among the members of the Task Force. The Task Force shall elect a Vice-Chair from its members.

SECTION 1.(c) Each appointing authority shall assure, insofar as possible, that its appointees to the Task Force reflect the composition of the North Carolina population with regard to ethnic, racial, age, and religious composition.

SECTION 1.(d) The General Assembly and the Governor shall make their appointments to the Task Force not later than 30 days after the adjournment of the 2003 Regular Session of the 2003 General Assembly. The original appointing authority, using the criteria set out in this section for the original appointment, shall fill a vacancy on the Task Force.

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

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

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

SECTION 1.(h) A majority of the Task Force shall constitute a quorum for the transaction of its business.

SECTION 1.(i) The Task Force shall have the following duties:

(1) To undertake a statistical and qualitative examination of the prevalence and burden of cervical cancer.

(2) To raise public awareness on the causes and nature of cervical cancer, personal risk factors, value of prevention, early detection, options for testing, treatment costs, new technology, medical care reimbursement, and physician education.

(3) To identify priority strategies, new technologies or newly introduced vaccines which are effective in preventing and controlling the risk of cervical cancer.

(4) To identify and examine the limitations of existing laws, regulations, programs, services with regard to coverage and awareness issues for cervical cancer, including amending G.S. 58-51-57 to require every policy or contract of accident or health insurance, and every preferred provider benefit plan under G.S. 58-50-56, that is issued or renewed, or amended on or after January 1, 2004, to provide coverage for PAP smears and mammograms in accordance with the most recently published American Cancer Society Guidelines.

(5) To develop a statewide comprehensive Cervical Cancer Prevention Plan, and strategies for Plan implementation and for promoting the Plan to the general public, State and local elected officials, various public and private organizations and associations, businesses, industries, and agencies.

(6) To identify strategies to facilitate specific commitments to help implement the Plan from the entities listed in subdivision (8) of this subsection.

(7) To facilitate coordination of and communication among State and local agencies and organizations regarding current or future involvement in achieving the aims of the Cervical Cancer Task Force Plan.

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

SECTION 1.(j) Beginning April 1, 2004, and on April 1 each year thereafter, the Task Force shall submit a report to the Advisory Committee on Cancer Coordination and Control. At the time the Task Force submits its report to the Advisory Committee, the Task Force shall also present its report to the North Carolina's Legislative Women's Caucus, the Governor, and the Joint Legislative Commission on Governmental Operations. Each annual report shall address:

(1) Progress being made in fulfilling the duties of the Task Force and in developing the Cervical Cancer Plan.

(2) The anticipated time frame for completion of the Prevention Plan.

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

SECTION 1.(k) Upon submission of the Task Force's final report to the Advisory Committee on Cancer Coordination and Control, to the Governor, and to the 2008 Regular Session of the 2007 General Assembly, the Task Force shall expire.

SECTION 2. The Department of Health and Human Services, Division of Public Health, shall use funds appropriated to it for the 2003-2004 fiscal year to implement this act.

SECTION 3. This act becomes effective July 1, 2003.

ATTACHMENT XIII

SENATE BILL 648:
Cervical Cancer Elimination Task Force

BILL ANALYSIS

Committee:	House Health	**Introduced by:**	Sen. Foxx
Date:	May 13, 2003	**Summary by:**	Dianna Jessup
Version:	Third Edition		Committee Counsel

SUMMARY: ***Senate Bill 648 would establish an ad hoc cervical cancer elimination task force to the Advisory Committee on Cancer Coordination and Control. The act would become effective July 1, 2003.***

CURRENT LAW:

The Advisory Committee on Cancer Coordination and Control

The Advisory Committee on Cancer Coordination and Control (ACCCC) was established by the North Carolina General Assembly in S.L. 1993-321, Sec. 288. ACCCC is housed within the Department of Health and Human Services (DHHS) and currently consists of 34 members, including the Secretary of DHHS or the Secretary's designee. ACCCC is charged with recommending to the Secretary a coordinated, comprehensive cancer control plan for the State. ACCCC submits annual reports on the progress in implementing a cancer control program to the Governor and to the Joint Legislative Commission on Governmental Operations.

BILL ANALYSIS: SB 648 would establish a standing ad hoc task force, called the Cervical Cancer Elimination Task Force (Task Force) that would serve ACCCC.

Task Force Membership

The President Pro Tempore of the Senate, the Speaker of the House of Representatives and the Governor would each appoint 6 members to the Task Force. The table below describes Task Force membership.

Number	Member Qualification	Appointing Authority
1	Director of the Division of Public Health, DHHS	N/A
1	Director of the Division of Medical Assistance in DHHS	N/A
2	Chair and Vice-Chair of the NC Legislative Women's Caucus or their designees	N/A
1	Member of the Senate	President Pro Tempore
2	Representatives of the NC Legislative Women's Caucus	President Pro Tempore
1	Representative of a women's health organization	President Pro Tempore
1	Representative from the American Academy of Pediatrics	President Pro Tempore
1	Certified school teacher	President Pro Tempore
1	Member of the House	Speaker
2	Representatives of the NC Legislative Women's Caucus	Speaker
1	Member of the NC Cancer Society	Speaker
1	Member of the health insurance industry	Speaker
1	Member of the American College of Obstetrics and Gynecology	Speaker
1	Member of the American Academy of Family Physicians	Governor
1	The State Epidemiologist	Governor
2	At-large members	Governor
1	News director of a newspaper or television or radio station	Governor
1	Licensed registered nurse	Governor
Total: 22		

Task Force Structure

Appointees to the Task Force would represent the North Carolina population in regards to ethnic, racial, age, and religious composition. The Governor would appoint the Chair and the Task Force would elect the Vice-Chair. A majority of the Task Force would constitute a quorum for the transaction of its business. The Task Force would meet at least quarterly and at other times at the call of the Chair. The Chair would be permitted to establish committees for the purpose of making special studies pursuant to its duties and could appoint non-Task Force members to serve on each committee as resource persons. Members of the Task Force would receive per diem and necessary travel and subsistence expenses. FUNDS: The Division of Public Health, DHHS, would use funds appropriated to it for FY 2003-2004 to implement the act.

Task Force Duties

The Task Force would have the following duties:

- To undertake a statistical and qualitative examination of the prevalence and burden of cervical cancer.
- To raise public awareness on the causes and nature of cervical cancer.
- To identify priority strategies, new technologies, or newly introduced vaccines effective in preventing and controlling cervical cancer.
- To identify and examine the limitations of existing laws, regulations, programs, and services with regard to coverage and awareness issues for cervical cancer. As part of this duty, the Task Force will examine whether to amend existing law to require coverage for PAP smears and mammograms.
- To develop a statewide comprehensive Cervical Cancer Prevention Plan (Plan) and strategies for Plan implementation and promotion.
- To facilitate coordination of and communication among State and local agencies and organizations regarding current or future involvement in achieving the aims of the Plan.
- To receive and consider testimony from various individuals, organizations, and agencies to learn their ideas for improving cervical cancer prevention, diagnosis, and treatment. The Task Force would also identify commitments to help implement the Plan from these entities.

Task Force Reports

The bill would require the Task Force to submit an annual report to ACCCC. The annual report would also be submitted to the NC Legislative Women's Caucus, the Governor, and the Joint Legislative Commission on Governmental Operations by April 1, 2004 and on April 1 of each year thereafter. A final report would be submitted to the Committee, Governor, and the 2008 Regular Session of the 2007 General Assembly. Upon submission of the final report, the Task Force would expire.

BACKGROUND:

Incidence and Mortality Rates – North Carolina

According to the NC Central Cancer Registry, State Center for Health Statistics, DHHS, the projected number of new invasive cervical cancer cases in the State for 2003 is 400 females. The projected number of deaths is 145 females. Cervical cancer was the 7th most frequently diagnosed cancer for females in North Carolina from 1994-1998. The American Cancer Society produced cancer incidence and mortality rates for cervical cancer in North Carolina covering 1993-1997. The rates are per 100,000. The incidence rate was 8.3% of women and the mortality rate was 3.0% of women compared to a national incidence rate of 7.8% and a national mortality rate of 2.7%.

Incidence and Mortality Rates – National

According to the American Cancer Society's Cancer Facts & Figures 2002, it was predicted that about 13,000 cases of invasive cervical cancer would be diagnosed in 2002, and an estimated 4,100 cervical cancer deaths would occur in 2002. The report also noted that mortality rates have declined. Since 1982, cervical cancer mortality rates have declined on average by about 1.6% per year. The report found that as pap screening has become more prevalent, preinvasive lesions of the cervix are detected far more frequently than invasive cancer.

Cervical Cancer Disparities between African-American Women and White Women

Nationally, the American Cancer Society reported that from 1994-1998, the incidence rate in black women (11.3 per 100,000) was higher than the rate in white women (7.0 per 100,000). In addition, the State Center for Health Statistics submitted a report in August 2002 regarding cervical cancer disparities in North Carolina from 1995 to 1998. The report found that African-American women have a much higher cervical cancer incidence rate than white women at ages 45 and older. In fact, the disparity is most pronounced among women ages 65 and older, where the incidence rate for African-American women was found to be three times that for white women. The report found that cervical cancer mortality rates were also much higher among African-American women. The report found that African-American women have their cervical cancer diagnosed at a later stage than white women, and that African-American women received less treatment for their cervical cancer.

Survival Rate

According to the American Cancer Society's Cancer Facts & Figures 2002, the survival for patients with preinvasive lesions is nearly 100%. When detected early, invasive cervical cancer is one of the most successfully treatable cancers with a 5-year relative survival rate of 92% for localized cancers. Whites are more likely than African-Americans to have their cancers diagnosed at an early stage. 56% of invasive cervical cancers among white women and 44% of cancers among African-American women are diagnosed at a localized stage.

S648-SMSW-001

Amy Compeau, Research Assistant, and Linda Attarian contributed to this summary.

ATTACHMENT XIV

NORTH CAROLINA GENERAL ASSEMBLY
AMENDMENT
Senate Bill 648

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

S648-ASW-17 [v.3]

Date _____,2003

Comm. Sub. [YES]
Amends Title [NO]
Third Edition

Representative Glazier

moves to amend the bill on page 2, line 1, by deleting "North Carolina" and substituting "American";

and on page 3, lines 38-40, by rewriting the lines to read:

"**SECTION 1.(k).** The Task Force shall expire on April 1, 2008 or upon submission of the Task Force's final report to the Advisory Committee on Cancer Coordination and Control, to the Governor, and to the 2008 Regular Session of the 2007 General Assembly, whichever occurs earlier.".

SIGNED _____
Amendment Sponsor

SIGNED _____
Committee Chair if Senate Committee Amendment

ADOPTED _____ FAILED _____ TABLED _____

NORTH CAROLINA GENERAL ASSEMBLY

LEGISLATIVE FISCAL NOTE

BILL NUMBER: SB 648 (3rd Edition)

SHORT TITLE: Cervical Cancer Elimination Task Force

SPONSOR(S): Sen. Virginia Foxx

FISCAL IMPACT

Yes (x) **No ( )** **No Estimate Available ( )**

	FY 2003-04	FY 2004-05	FY 2005-06	FY 2006-07	FY 2007-08
REVENUES	0	0	0	0	0
EXPENDITURES	$53,000	$28,000	$28,000	$28,000	$28,000
POSITIONS:	0	0	0	0	0

PRINCIPAL DEPARTMENT(S) & PROGRAM(S) AFFECTED: Department of Health and Human Services
Division of Public Health

EFFECTIVE DATE: July 1, 2003

BILL SUMMARY: Establishes an ad hoc cervical cancer elimination task force to the advisory committee on Cancer Coordination and Control. The Task Force will have 22 members including Legislators, Department of Health and Human Services officials, and other individuals appointed by the President Pre Tempore of the Senate and Speakers of the House.

The Task Force shall develop a statewide comprehensive cervical cancer prevention plan and strategies for plan implementation. Other activities will include raising public awareness on the causes and nature of cervical cancer, examining existing laws, regulations, programs and services and making recommendations to the General Assembly.

The Task Force will meet at least quarterly and more frequently at the request of the chair and receive per diem and necessary travel and subsistence expenses in accordance with G.S. 120-3.1, 138-5, and 138-6, as applicable. The Task Force will expire in FY2008.

ASSUMPTIONS AND METHODOLOGY:

1. The budget assumes members of the Task Force will receive per diem and necessary travel and subsistence expenses for four meetings annually, totaling $7,000.
2. The Task Force would be staffed through existing resources within Division of Public Health; therefore, no additional cost for personnel is needed.
3. It is estimated that approximately $20,000 would be needed to develop and distribute materials for education and awareness and any activities related to these efforts.
4. It is further estimated that an additional $25,000 would be needed to contract with a consulting firm to undertake a statistical and qualitative examination of the prevalence and burden of cervical cancer and develop a plan for the elimination of cervical cancer in North Carolina, as prescribed by the bill. This amount will be one-time funds for the planning activities during FY04; therefore, the total requirements will decrease beginning FY05.
5. The budget assumes no inflationary increases for the Task Force.

SOURCES OF DATA:
General Assembly Administrative Division
North Carolina Office of State Personnel

TECHNICAL CONSIDERATIONS: None.

FISCAL RESEARCH DIVISION: (919) 733-4910

Lisa Hollowell

PREPARED BY: Lisa Hollowell, Fiscal Analyst II, Fiscal Research Division

APPROVED BY: James D. Johnson, Director, Fiscal Research Division

James D. Johnson

DATE: May 5, 2003

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2003

S 2

SENATE BILL 388

Health and Human Resources Committee Substitute Adopted 4/28/03

Short Title: Update Cervical Cancer Screening Coverage. (Public)

Sponsors:

Referred to:

March 12, 2003

A BILL TO BE ENTITLED

AN ACT TO UPDATE NORTH CAROLINA GENERAL STATUTES IN RESPONSE TO RECENT MEDICAL ADVANCES IN SCREENING FOR THE EARLY DETECTION OF CERVICAL CANCER.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 58-50-155 reads as rewritten:

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

(a) Notwithstanding G.S. 58-50-125(c), the standard health plan developed and approved under G.S. 58-50-125 shall provide coverage for all of the following:

(1) Mammograms and ~~pap smears~~ examinations and laboratory tests for the screening for the early detection of cervical cancer at least equal to the coverage required by G.S. 58-51-57.

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

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

(4) For a qualified individual, scientifically proven bone mass measurement for the diagnosis and evaluation of osteoporosis or low bone mass at least equal to the coverage required by G.S. 58-3-174.

(5) Prescribed contraceptive drugs or devices that prevent pregnancy and that are approved by the United States Food and Drug Administration for use as contraceptives, or outpatient contraceptive services at least equal to the coverage required by G.S. 58-3-178, if the plan covers prescription drugs or devices, or outpatient services, as applicable. The same exceptions and exclusions as are provided under G.S. 58-3-178 apply to standard plans developed and approved under G.S. 58-50-125.

(6) Colorectal cancer examinations and laboratory tests at least equal to the coverage required by G.S. 58-3-179.

(a1), (a2) Repealed by Session Laws 1999-197, s. 2.

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

SECTION 2. G.S. 58-51-57 reads as rewritten:

"**§ 58-51-57. Coverage for mammograms and ~~pap smears.~~ cervical cancer screening.**

(a) Every policy or contract of accident or health insurance, and every preferred provider benefit plan under G.S. 58-50-56, that is issued, renewed, or amended on or after January 1, 1992, shall provide coverage for ~~pap smears~~ examinations and laboratory tests for the screening for the early detection of cervical cancer and for low-dose screening mammography. The same deductibles, coinsurance, and other limitations as apply to similar services covered under the policy, contract, or plan shall apply to coverage for ~~pap smears~~ examinations and laboratory tests for the screening for the early detection of cervical cancer and low-dose screening mammography.

(a1) As used in this section, "examinations and laboratory tests for the screening for the early detection of cervical cancer" means conventional PAP smear screening, liquid-based cytology, and human papilloma virus (HPV) detection methods for women with equivocal findings on cervical cytologic analysis.

(b) As used in this section, "low-dose screening mammography" means a radiologic procedure for the early detection of breast cancer provided to an asymptomatic woman using equipment dedicated specifically for mammography, including a physician's interpretation of the results of the procedure.

(c) Coverage for low-dose screening mammography shall be provided as follows:

(1) One or more mammograms a year, as recommended by a physician, for any woman who is at risk for breast cancer. For purposes of this subdivision, a woman is at risk for breast cancer if any one or more of the following is true:
   a. The woman has a personal history of breast cancer;
   b. The woman has a personal history of biopsy-proven benign breast disease;
   c. The woman's mother, sister, or daughter has or has had breast cancer; or
   d. The woman has not given birth prior to the age of 30;

(2) One baseline mammogram for any woman 35 through 39 years of age, inclusive;

(3) A mammogram every other year for any woman 40 through 49 years of age, inclusive, or more frequently upon recommendation of a physician; and

(4) A mammogram every year for any woman 50 years of age or older.

(d) Reimbursement for a mammogram authorized under this section shall be made only if the facility in which the mammogram was performed meets

mammography accreditation ~~standards. Mammography accreditation standards shall be those~~ standards established by the North Carolina Medical Care ~~Commission unless such standards are not in effect, in which case standards established by the United States Department of Health and Human Services for Medicare/Medicaid coverage of screening mammography shall apply until Medical Care Commission standards become effective.~~Commission. ~~Facilities that do not meet required mammography accreditation standards shall so inform the patient or the patient's legally responsible person prior to performing the mammogram.~~

(e) ~~Coverage for pap smears shall be provided for pap smears obtained once a year, or more frequently if recommended by a physician.~~ Coverage for the screening for the early detection of cervical cancer shall be in accordance with the most recently published American Cancer Society guidelines or guidelines adopted by the North Carolina Advisory Committee on Cancer Coordination and Control. Coverage shall include the examination, the laboratory fee, and the physician's interpretation of the laboratory results. Reimbursements for laboratory fees shall be made only if the laboratory meets accreditation standards adopted by the North Carolina Medical Care Commission.~~When the screening pap smear accreditation standards adopted by the North Carolina Medical Care Commission become effective, reimbursement for laboratory fees shall be made only if the laboratory meets those standards. Facilities utilizing services of laboratories that do not meet accreditation standards for screening pap smears shall, prior to performing the pap smear examination, inform the patient or the patient's legally responsible person that such laboratory fees will not be covered.~~"

SECTION 3. G.S. 58-65-92 reads as rewritten:

"**§ 58-65-92. Coverage for mammograms and ~~pap smears.~~ cervical cancer screening.**

(a) Every insurance certificate or subscriber contract under any hospital service plan or medical service plan governed by this Article and Article 66 of this Chapter, and every preferred provider benefit plan under G.S. 58-50-56, that is issued, renewed, or amended on or after January 1, 1992, shall provide coverage for ~~pap smears~~ examinations and laboratory tests for the screening for the early detection of cervical cancer and for low-dose screening mammography. The same deductibles, coinsurance, and other limitations as apply to similar services covered under the certificate or contract shall apply to coverage for ~~pap smears~~ examinations and laboratory tests for the screening for the early detection of cervical cancer and low-dose screening mammography.

(a1) As used in this section, "examinations and laboratory tests for the screening for the early detection of cervical cancer" means conventional PAP smear screening, liquid-based cytology, and human papilloma virus (HPV) detection methods for women with equivocal findings on cervical cytologic analysis.

(b) As used in this section, "low-dose screening mammography" means a radiologic procedure for the early detection of breast cancer provided to an asymptomatic woman using equipment dedicated specifically for mammography, including a physician's interpretation of the results of the procedure.

(c) Coverage for low-dose screening mammography shall be provided as follows:

(1) One or more mammograms a year, as recommended by a physician, for any woman who is at risk for breast cancer. For purposes of this subdivision, a woman is at risk for breast cancer if any one or more of the following is true:

a. The woman has a personal history of breast cancer;

b. The woman has a personal history of biopsy-proven benign breast disease;

c. The woman's mother, sister, or daughter has or has had breast cancer; or

d. The woman has not given birth prior to the age of 30;

(2) One baseline mammogram for any woman 35 through 39 years of age, inclusive;

(3) A mammogram every other year for any woman 40 through 49 years of age, inclusive, or more frequently upon recommendation of a physician; and

(4) A mammogram every year for any woman 50 years of age or older.

(d) Reimbursement for a mammogram authorized under this section shall be made only if the facility in which the mammogram was performed meets mammography accreditation ~~standards. Mammography accreditation standards shall be those~~ standards established by the North Carolina Medical Care ~~Commission unless such standards are not in effect, in which case standards established by the United States Department of Health and Human Services for Medicare/Medicaid coverage of screening mammography shall apply until Medical Care Commission standards become effective.~~Commission. ~~Facilities that do not meet required mammography accreditation standards shall so inform the patient or the patient's legally responsible person prior to performing the mammogram.~~

(e) ~~Coverage for pap smears shall be provided for pap smears obtained once a year, or more frequently if recommended by a physician.~~ Coverage for the screening for the early detection of cervical cancer shall be in accordance with the most recently published American Cancer Society guidelines or guidelines adopted by the North Carolina Advisory Committee on Cancer Coordination and Control. Coverage shall include the examination, the laboratory fee, and the physician's interpretation of the laboratory results. Reimbursements for laboratory fees shall be made only if the laboratory meets accreditation standards adopted by the North Carolina Medical Care Commission.~~When the screening pap smear accreditation standards adopted by the North Carolina Medical Care Commission become effective, reimbursement for laboratory fees shall be made only if the laboratory meets those standards. Facilities utilizing services of laboratories that do not meet accreditation standards for screening pap smears shall, prior to performing the pap smear examination, inform the patient or the patient's legally responsible person that such laboratory fees will not be covered.~~"

SECTION 4. G.S. 59-67-76 reads as rewritten:

"(a) Every health care plan written by a health maintenance organization and in force, issued, renewed, or amended on or after January 1, 1992, that is subject to this Article, shall provide coverage for ~~pap smears~~ examinations and laboratory tests for the screening for the early detection of cervical cancer and for low-dose screening mammography. The same deductibles, coinsurance, and other limitations as apply to similar services covered under the plan shall apply to coverage for ~~pap smears~~ examinations and laboratory tests for the screening for the early detection of cervical cancer and low-dose screening mammography.

(a1) As used in this section, "examinations and laboratory tests for the screening for the early detection of cervical cancer" means conventional PAP smear screening, liquid-based cytology, and human papilloma virus (HPV) detection methods for women with equivocal findings on cervical cytologic analysis.

(b) As used in this section, "low-dose screening mammography" means a radiologic procedure for the early detection of breast cancer provided to an asymptomatic woman using equipment dedicated specifically for mammography, including a physician's interpretation of the results of the procedure.

(c) Coverage for low-dose screening mammography shall be provided as follows:

(1) One or more mammograms a year, as recommended by a physician, for any woman who is determined to be at risk for breast cancer. For purposes of this subdivision, a woman is at risk for breast cancer if any one or more of the following is true:
   a. The woman has a personal history of breast cancer;
   b. The woman has a personal history of biopsy-proven benign breast disease;
   c. The woman's mother, sister, or daughter has or has had breast cancer; or
   d. The woman has not given birth prior to the age of 30;

(2) One baseline mammogram for any woman 35 through 39 years of age, inclusive;

(3) A mammogram every other year for any woman 40 through 49 years of age, inclusive, or more frequently upon recommendation of a physician; and

(4) A mammogram every year for any woman 50 years of age or older.

(d) Reimbursement for a mammogram authorized under this section shall be made only if the facility in which the mammogram was performed meets mammography accreditation ~~standards. Mammography accreditation standards shall be those~~ standards established by the North Carolina Medical Care ~~Commission unless such standards are not in effect, in which case standards established by the United States Department of Health and Human Services for Medicare/Medicaid coverage of screening mammography shall apply until Medical Care Commission standards become effective.~~Commission. ~~Facilities that do not meet required mammography accreditation standards shall so inform the patient or the patient's legally responsible person prior to performing the mammogram.~~

(e) ~~Coverage for pap smears shall be provided for pap smears obtained once a year, or more frequently if recommended by a physician.~~ Coverage for the screening for the early detection of cervical cancer shall be in accordance with the most recently published American Cancer Society guidelines or guidelines adopted by the North Carolina Advisory Committee on Cancer Coordination and Control. Coverage shall include the examination, the laboratory fee, and the physician's interpretation of the laboratory results. Reimbursements for laboratory fees shall be made only if the laboratory meets accreditation standards adopted by the North Carolina Medical Care Commission.~~When the screening pap smear accreditation standards adopted by the North Carolina Medical Care Commission become effective, reimbursement for laboratory fees shall be made only if the laboratory meets those standards. Facilities utilizing services of laboratories that do not meet accreditation standards for screening pap smears shall, prior to performing the pap smear examination, inform the patient or the patient's legally responsible person that such laboratory fees will not be covered.~~"

SECTION 5.(a) G.S. 135-40.5(e) reads as rewritten:

"(e) Routine Diagnostic Examinations. – The Plan will pay one hundred percent (100%) of allowable charges for routine diagnostic examinations and tests, including breast, colon, rectal, and prostate exams, X rays, mammograms, blood and blood pressure checks, urine tests, tuberculosis tests, and general health checkups that are medically necessary for the maintenance and improvement of individual health but no more often than once every three years for covered individuals to age 40 years, once every two years for covered individuals to age 50 years, and once a year for covered individuals age 50 years and older, unless a more frequent occurrence is warranted by a medical condition when such charges are incurred in a medically supervised facility. Routine diagnostic examinations and tests covered under this subsection also include ~~one Pap smear per year~~ examinations and tests for the screening for the early detection of cervical cancer. The coverage shall be in accordance with the most recently published American Cancer Society guidelines or guidelines adopted by the North Carolina Advisory Committee on Cancer Coordination and Control for any covered female. For the purposes of this subsection, "examinations and laboratory tests for the screening for the early detection of cervical cancer" means conventional PAP smear screening, liquid-based cytology, and human papilloma virus (HPV) detection methods for women with equivocal findings on cervical cytologic analysis. Provided, however, that charges for such examinations and tests are not covered by the Plan when they are incurred to obtain or continue employment, to secure insurance coverage, to comply with legal proceedings, to attend schools or camps, to meet travel requirements, to participate in athletic and related activities, or to comply with governmental licensing requirements. The maximum amount payable under this subsection for a covered individual is one hundred fifty dollars ($150.00) per fiscal year."

SECTION 5.(b) G.S. 135-40.6(8)s. reads as rewritten:

...

s. Routine Diagnostic Examinations: Allowable charges for routine diagnostic examinations and tests, including ~~Pap smears,~~ examinations and tests for the screening for the early

detection of cervical cancer, breast, colon, rectal, and prostate exams, X rays, mammograms, blood and blood pressure checks, urine tests, tuberculosis tests, and general health checkups that are medically necessary for the maintenance and improvement of individual health but no more often than once every three years for covered individuals to age 40 years, once every two years for covered individuals to age 50 years, and once a year for covered individuals age 50 years and older, and, for examinations and tests for the screening for the early detection of cervical cancer, in accordance with the most recently published American Cancer Society guidelines or guidelines adopted by the North Carolina Advisory Committee on Cancer Coordination and Control, unless a more frequent occurrence is warranted by a medical condition when such charges are incurred in a medically supervised facility. Provided, however, that charges for such examinations and tests are not covered by the Plan when they are incurred to obtain or continue employment, to secure insurance coverage, to comply with legal proceedings, to attend schools or camps, to meet travel requirements, to participate in athletic and related activities or to comply with governmental licensing requirements. For purposes of this subdivision, "examinations and laboratory tests for the screening for the early detection of cervical cancer" means conventional PAP smear screening, liquid-based cytology, and human papilloma virus (HPV) detection methods for women with equivocal findings on cervical cytologic analysis.

..."

SECTION 6. This act becomes effective January 1, 2004, and applies to all health benefit plans that are delivered, issued for delivery, or renewed on and after that date. For the purposes of this act, renewal of a health benefit plan is presumed to occur on each anniversary of the date on which coverage was first effective on the person or persons covered by the health benefit plan.

ATTACHMENT
XVIII

SENATE BILL 388:
Update Cervical Cancer Screening Coverage

BILL ANALYSIS

Committee:	House Health	**Introduced by:**	Sen. Foxx
Date:	May 13, 2003	**Summary by:**	Dianna Jessup
Version:	Second Edition		Committee Counsel

SUMMARY: ***Senate Bill 388 would specify that laboratory tests for cervical cancer screening must be covered under health benefit plans, replacing the term "pap smear". The act would become effective January 1, 2004 and apply to all new health benefit plans and renewals of plans on or after that date. For purposes of the act, renewal of a health benefit plan would be presumed to occur on the anniversary date of the policy.***

CURRENT LAW: Currently, small employer group insurance plans, health policy and preferred provider benefit plans, hospital service plans, medical service plans, HMO plans, and the State Health Plan cover pap smears, generally once a year. These plans are also required to cover mammograms. Reimbursement for mammograms and pap smears are made only if the facility in which the mammogram or pap smear was performed meets accreditation standards established by the North Carolina Medical Care Commission. The statutes provide for what standards apply for reimbursement if the Medical Care Commission has not adopted standards.

BILL ANALYSIS: Generally, the bill would delete "pap smear" and substitute "examinations and laboratory tests for the screening for the early detection of cervical cancer" throughout the health benefit plan statutes. The bill would define "examinations and laboratory tests for the screening for the early detection of cervical cancer" to mean conventional PAP smear screening, liquid-based cytology, and human papilloma virus (HPV) detection methods for women with equivocal findings on cervical cytologic analysis. The bill would also provide that coverage for the screening shall be in accordance with the most recently published American Cancer Society guidelines or guidelines adopted by the North Carolina Advisory Committee on Cancer Coordination and Control. Reimbursement would be made only if the facility or the laboratory meets accreditation standards adopted by the Medical Care Commission.

Section 1 would make these changes to small employer group health insurance plans.

Section 2 would make these changes to health policy and preferred provider benefit plans.

Section 3 would make these changes to the hospital service plans and medical service plans.

Section 4 would make these changes to HMO health care plans.

Section 5 would make these changes to the State Health Plan.

Section 6 would make these changes effective January 1, 2004 and apply to all health benefit plans delivered, issued for delivered, or renewed on and after that date. For the purposes of the act, renewal of a health benefit plan would be presumed to occur on the anniversary date of the plan.

S388-SMSW-002

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ATTACHMENT XIX

NORTH CAROLINA GENERAL ASSEMBLY AMENDMENT

(Please type or use ballpoint pen)

EDITION No. _____

H. B. No. _____ DATE _____

S. B. No. 388 Amendment No. _____
(to be filled in by Principal Clerk)

COMMITTEE SUBSTITUTE ✓

(Rep.) _____
Sen.)

moves to amend the bill on page 2, line 20;

( ) ~~WHICH CHANGES THE TITLE~~

~~by~~ on page 3, line 35; page 5, line 12; page 6, line 33; and page 7, line 27 by adding after the word "analysis" the phrase "that are subject to the approval of and have been approved by the Federal Drug Administration"

SIGNED _____

ADOPTED _____ FAILED _____ TABLED _____

ATTACHMENT XX

NORTH CAROLINA GENERAL ASSEMBLY
LEGISLATIVE ACTUARIAL NOTE

BILL NUMBER: Senate Bill 388, Second Edition, Sections 5, 5(a), & 6

SHORT TITLE: Update Cervical Cancer Screening Coverage

SPONSOR(S): Sen. Foxx

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, premium payments for coverages selected by eligible former teachers and State employees and premium payments for coverages selected by firefighters, rescue squad workers, and members of the National Guard.

BILL SUMMARY: The bill replaces the Plan's coverage of one Pap smear per year in its coverage for routine diagnostic examinations with whatever guidelines are published by the American Cancer Society or the North Carolina Advisory Committee on Cancer Coordination and Control for examinations and laboratory tests for screening for the early detection of cervical cancer. The phrase "examinations and laboratory tests for the screening for the early detection of cervical cancer" is defined as conventional Pap smear screening, liquid-based cytology, and human papilloma virus detection methods for women with equivocal findings on cervical cytologic analysis.

EFFECTIVE DATE: January 1, 2004

ESTIMATED IMPACT ON STATE: Based upon information provided by the Plan, both Aon Consulting, consulting actuary for the Plan, and Hartman & Associates, consulting actuary for the General Assembly's Fiscal Research Division, estimate the bill will result in cost savings to the Plan. These estimates are based upon the American Cancer Society's current guidelines on examinations and tests for the early detection of cervical cancer. Aon consulting projects a cost savings to the Plan of $70,000 for fiscal year 2003-04 and a cost savings of $300,000 for fiscal year 2004-05. Hartman & Associates estimates a cost savings to the Plan of $117,000 for fiscal year 2003-04 and a cost savings of $394,000 for fiscal year 2004-05.

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 premiums in the indemnity program are fully contributory, except for job-sharing public school teachers who are authorized partially contributory premiums at 50% of non-contributory rates. 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 20% 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; however none of the HMOs with certificates of authority to transact business in North Carolina have offered to participate in the Plan since September 30, 2001. 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, 2002, include:

	Self-Insured Indemnity Program	Alternative HMOs	Plan Total
Number of Participants			
Active Employees	280,065	-0-	280,065
Active Employee Dependents	137,841	-0-	137,841
Retired Employees	117,225	-0-	117,225
Retired Employee Dependents	18,999	-0-	18,999
Former Employees & Dependents with Continued Coverage	2,535	-0-	2,535
Firefighters, Rescue Squad Workers, National Guard Members & Dependents	7	-0-	7
Total Enrollments	556,672	-0-	556,672
Number of Contracts			
Employee Only	313,439	-0-	313,439
Employee & Child(ren)	40,978	-0-	40,978
Employee & Family	44,710	-0-	44,710
Total Contracts	399,127	-0-	399,127
Percentage of Enrollment by Age			
29 & Under	26.9%	-0-%	26.9%
30-44	20.9	-0-	20.9
45-54	20.9	-0-	20.9
55-64	16.2	-0-	16.2
65 & Over	15.1	-0-	15.1
Percentage of Enrollment by Sex			
Male	38.3%	-0-%	38.3%
Female	61.7	-0-	61.7

Assumptions for the Self-Insured Indemnity Program: For the fiscal year beginning July 1, 2002, the self-insured program started its operations with a beginning cash balance of $91.6 million. Receipts for the year are estimated to be $1.371 billion from premium collections and $7 million from investment earnings for a total of $1.378 billion in receipts for the year. Disbursements from the self-insured program are expected to be $1.335 billion in claim payments and $38 million in administration and claims processing expenses for a total of $1.373 billion for the year beginning July 1, 2002. For the fiscal year beginning July 1, 2002, the self-insured indemnity program is expected to have a net operating gain of approximately $14 million for the year. Without reserving an additional $15 million for implementation of the claims data and privacy requirements of the federal Health Insurance Portability and Accountability Act (HIPPA) that take effect on and after April 14, 2003, the Plan's self-insured indemnity program is expected to have an available beginning cash balance of $96 million for the fiscal year beginning July 1, 2003. The self-insured indemnity program is nonetheless assumed to be unable to carry out its operations for the 2003-2005 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, discounts on hospital outpatient services, pre-admission hospital testing, pre-admission hospital inpatient certification with length-of-stay approval, hospital bill audits, case and disease management for selected medical conditions, mental health case management, coordination of benefits with other payers, Medicare benefit "carve-outs", cost reduction contracts with participating physicians and other providers, a prescription drug benefit manager with manufacturer rebates from formularies, and fraud detection) are maintained and improved where possible. Current non-contributory premium rates are $186.04 monthly for employees whose primary payer of health benefits is Medicare and $244.38 per month for employees whose primary payer of health benefits is not Medicare. Fully contributory premium amounts for employee and child(ren) contracts are $115.78 monthly for children whose primary payer of health benefits is Medicare and $152.32 monthly for other covered children, and $277.68 per month for family contracts whose dependents have Medicare as the primary payer of health benefits and $365.36 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 less than 1% annually over the next two years. The number of enrolled active employees is expected to show no increase 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 a 2% decrease in the number of active employee dependents per year whereas the number of retiree dependents is expected to increase 2% per year. Investment earnings are based upon a 4.5% 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 the Indemnity Plan's Coverage of Screening for Cervical Cancer: New guidelines addressing when and how often women should get early detection tests for cervical cancer and pre-cancer were issued November 14, 2002, by the American Cancer Society. Based on the new recommendations, most women would begin cervical cancer screening later, have an option to stop at a certain age, and be exempt from screening entirely if they have had a hysterectomy. The new guidelines are expected to have a major impact on the number of women who are over-screened and over-treated. Because most cervical pre-cancers grow slowly, having a test every two to three years will find almost all cervical pre-cancers, and cancers while they can be removed or treated successfully according to medical experts with the American Cancer Society. The Society, however, notes that the biggest gain in reducing cervical cancer incidence and mortality would be achieved by increasing screening rates among women who have not been screened or who have not been screened regularly.

The new guidelines, in summary form, are:

- Cervical cancer screening should begin about three years after a woman begins having vaginal intercourse, but no later than 21 years of age.
- Cervical screening should be done every year with regular Pap tests or every two years using liquid-based Pap tests. At or after age 30, women who have had three normal test results in a row may get screened every two to three years. A doctor may suggest getting the test more often if a woman has certain risk factors such as human immunodeficiency virus (HIV) infection or a weakened immune system.
- Women 70 years of age and older who have had three or more normal Pap test results and no abnormal results in the last 10 years may choose to stop cervical cancer screening.
- Screening after a total hysterectomy (with removal of the cervix) is not necessary unless the surgery was done as a treatment for cervical cancer or pre-cancer. Some other special conditions may require continued screening. Women who have had a hysterectomy without removal of the cervix should continue cervical cancer screening at least until age 70. In addition, a promising new test for human papilloma virus (HPV), not yet approved for screening by the FDA, may be useful in detecting early cervical cancer in women over 30 years of age. If the test is approved, it may be added to the guidelines.

The American Cancer Society estimates that 13,000 women will develop invasive cervical cancer this year, and about 4,100 women will die of the disease..

The guidelines of the North Carolina Advisory Committee on Cancer Coordination and Control for cervical cancer screening include those endorsed by the American Cancer Society, the National Cancer Institute, and American College of Obstetrics and Gynecology. These recommendations include an annual Pap smear with a pelvic examination for women who are, or have been, sexually active or who are 18 years or older. After three or more consecutive normal annual examinations, the Pap smear may be performed less frequently at the discretion of the physician.

For the last two fiscal years, the Plan's claims experience for cervical cancer screenings has been:

		Member Ages			
Group	Up to 17	18-34	35-54	55 & Over	Total
FY2002					
No. of Screenings					
Active	771	23,811	49,088	10,748	84,418
Retired (Non-Medicare)	37	383	2,313	8,071	10,804
Total	808	24,194	51,401	18,819	95,222
Cost of Screenings					
Active - Charge	$22,421	$697,424	$1,421,588	$304,383	$2,445,817
Active - Paid	$19,190	$597,894	$1,115,279	$231,512	$1,963,876
Retired - Charge	$1,214	$10,923	$66,198	$227,199	$305,533
Retired - Paid	$971	$9,154	$49,984	$175,302	$235,410
Total - Charge	$23,634	$708,347	$1,487,787	$531,582	$2,751,350
Total - Paid	$20,161	$607,048	$1,165,263	$406,814	$2,199,286
FY2001					
No. of Screenings					
Active	632	19,344	42,874	9,007	71,857
Retired (Non-Medicare)	26	308	1,994	6,935	9,263
Total	658	19,652	44,868	15,942	81,120
Cost of Screenings					
Active - Charge	$21,425	$664,273	$1,434,993	$297,321	$2,418,012
Active - Paid	$17,159	$509,134	$1,043,982	$217,789	$1,788,064

Retired - Charge	$986	$10,632	$66,261	$225,665	$303,544
Retired - Paid	$824	$8,091	$48,614	$166,856	$224,385
Total - Charge	$22,411	$674,905	$1,501,253	$522,986	$2,721,556
Total - Paid	$17,982	$517,225	$1,092,596	$384,645	$2,012,449

Over the last two fiscal years, the Plan had has the following number of cervical cancer cases with the amount of allowable charges and paid claims:

	FY2002				FY2001			
Member Age (Years)	No. of Cases	% of Cases	Claim Payments	% of Claims	No. of Cases	% of Cases	Claim Payments	% of Claims
6-10	1	0.1%	$0	0.0%	1	0.1%	$0	0.0%
11-15	0	0.0%	$0	0.0%	1	0.1%	$28	0.0%
16-20	6	0.4%	$696	0.1%	13	1.0%	$3,293	0.4%
21-25	4	0.3%	$177	0.0%	8	0.6%	$1,952	0.2%
26-30	12	0.8%	$1,295	0.1%	14	1.0%	$5,941	0.7%
31-35	67	4.6%	$37,845	4.3%	29	2.1%	$1,887	0.2%
36-40	39	2.7%	$23,451	2.7%	168	12.3%	$121,753	14.6%
41-45	295	20.1%	$274,318	31.3%	217	15.9%	$185,411	22.2%
46-50	165	11.2%	$79,264	9.0%	81	5.9%	$44,724	5.3%
51-55	140	9.5%	$126,953	14.5%	186	13.6%	$160,180	19.2%
56-60	228	15.5%	$77,233	8.8%	196	14.4%	$161,961	19.4%
61-65	154	10.5%	$203,359	23.2%	148	10.9%	$98,641	11.8%
66-70	147	10.0%	$35,276	4.0%	125	9.2%	$37,794	4.5%
71-75	44	3.0%	$2,165	0.2%	27	2.0%	$194	0.0%
76 & Over	166	11.3%	$15,736	1.8%	149	10.9%	$12,304	1.5%
Total	1,468	100.0%	$877,768	100.0%	1,363	100.0%	$836,063	100.0%

For the last three fiscal years, the Plan has had the following average quarterly number of females, aged 15 and older, enrolled:

	Female Enrollees Aged 15 & Older		
Age (Years)	FY2002	FY2001	FY2000
15-19	15,025	13,839	11,994
20-24	16,112	14,090	11,224
25-29	18,791	16,070	12,687
30-34	22,167	18,204	13,730
35-39	23,451	20,791	17,466
40-44	29,600	26,948	23,565
45-49	36,444	33,156	28,959
50-54	38,011	33,786	28,265
55-59	29,087	24,391	21,220
60-64	21,317	19,097	17,343
65-69	16,180	15,292	14,289
70-74	13,262	12,745	12,239
75-79	10,172	9,850	9,516
80 & Over	13,724	13,064	12,480
Total	303,341	271,321	234,976

SOURCES OF DATA:

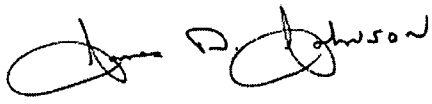
- Actuarial Note, Hartman & Associates, Senate Bill 388, Senate Committee Substitute, April 25, 2003, original of which is on file in the General Assembly's Fiscal Research Division.
- Actuarial Note, Aon Consulting, Senate Bill 388, Senate Committee Substitute, April 25, 2003, original of which is on 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: (919) 733-4910

PREPARED BY: Sam Byrd

APPROVED BY: James D. Johnson



DATE: April 25, 2003.

2003 COMMITTEE REPORT
HOUSE OF REPRESENTATIVES

The following report(s) from standing committee(s) is/are presented:
By Representatives **Verla Insko and Carolyn Justus,** Chairs for the Committee on **HEALTH**.

☒ Committee Substitute for
S.B. 388 A BILL TO BE ENTITLED AN ACT TO UPDATE NORTH CAROLINA GENERAL STATUTES IN RESPONSE TO RECENT MEDICAL ADVANCES IN SCREENING FOR THE EARLY DETECTION OF CERVICAL CANCER.

☐ 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 (# H.B.), ☐ 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)

3/06/03

FOR JOURNAL USE ONLY

____ Pursuant to Rule 36(b), the bill/resolution is placed on the Calendar of _____.

____ The (committee substitute) bill/resolution (, as amended,) is (ordered engrossed and) re-referred to the Committee on _____.

____ The bill/resolution is re-referred to the Committee on _____.

____ On motion of (Rep. _____,) (the Chair,) the (committee substitute) bill/resolution is (ordered engrossed and) re-referred to the Committee on _____.

____ Pursuant to Rule 36(b), the (House)committee substitute bill (No. ____)/resolution is placed on the Calendar of _____. (The original bill) (House Committee Substitute Bill No. ____)/resolution is placed on the Unfavorable Calendar.

____ On motion of Rep. _____, (the rules are suspended) (Rule ____ is suspended) and the bill/resolution is placed on today's calendar. (for immediate consideration.)

____ On motion of Rep. _____, Committee Amendment No.(s) _____ is/are adopted (by EV____ ____).

____ On motion of Rep. _____, Committee Amendment No.(s) _____ is/are adopted (by EV____ ____).

____ Rep. _____ offers Amendment No. _____ which (is adopted.) (fails of adoption.) (by EV ____ ____.) ( ) This amendment changes the title.

____ The bill/resolution (, as amended,) passes its second reading (by following vote, ____ ____ RC) (, by EV ____ ____,) and (remains on the Calendar,) (and there being no objection is read a third time).

____ The bill/resolution (, as amended,) passes its third reading (by the following vote, ____ ____ RC) (, by EV ____ ____,) and is ordered
____ sent to the Senate.
____ without engrossment. ____ by Special message.
____ sent to the Senate for concurrence in
_____ the House amendment (s).
_____the House committee substitute bill.
____ enrolled.

____ On motion of Rep. _____, the House concurs in the (material) Senate _____ (by the following vote, ____ ____ RC) (, by EV ____ ____,) and the bill is ordered enrolled.

House Committee on Health

May 20, 2003

Minutes

The House Committee on Health met on Tuesday, May 20, 2003 at 12:00 noon in Room 544 of the Legislative Office Building. A silent roll was taken. A copy of the roll denoting members present is attached to the minutes (Attachment I) along with a copy of the agenda and Visitor Registration Sheet (Attachments II and III).

Chair Insko welcomed visitors and members and recognized the pages: Katie Adcock from Cumberland County sponsored by Rep. Glazier, Christina Pate from Wayne County sponsored by Rep. Pate, Lauren Cottle from Pender County sponsored by Rep. Wright and Lauren Everett from Cumberland County sponsored by Rep. Glazier. Dusty Rhodes, Earl Tharrington, Jackson Stancil and Frances Poole were recognized as the sergeant-at-arms. (Attachment IV)

Senator Purcell was called to explain his bill, SB 582 A BILL TO BE ENTITLED AN ACT TO ESTABLISH COMMISSION ON CHILDHOOD OBESITY. (Attachment V) This bill creates a 27-member Commission on Childhood Obesity. The Commission shall study various issues relating to childhood obesity including the cause of obesity in North Carolina children, socioeconomic issues associated with childhood obesity, how the state should deal with childhood obesity, and how to prevent obesity in North Carolina. The Commission will make recommendations on nutritional guidelines for food served in the public schools, physical education and physical activities in the public schools, healthy and nutritional behavior by North Carolina students and their families. The Commission will subject a final written report to the Joint Legislative Care Oversight Committee, the Joint Legislative Education Oversight Committee and the Health and Wellness Trust Fund Commission by May 7, 2004, at which time the Commission will terminate. No new State funds shall be used for the Commission. (Bill Analysis – Attachment VI)

Rep. McAllister questioned why so many members on commission and could membership be reduced. Senator Purcell responded that large committees work pretty well and that size should give commission a broad base. Rep. Sherrill expressed concern about funding, staff to send of notices, make reports, transcribe minutes, etc.

Chair Insko then indicated that no vote would be taken on bill today as issues needed to be worked out. Rep. Sherrill recommended that bill be sent to subcommittee. Chair Insko indicated that subcommittee would be appointed.

Meeting was adjourned at 12:21 p.m.*

Verla Insko
Rep. Verla Insko, Chair

Pamela J Evans
Pamela Evans, Committee Clerk

(*Note: Due to time, SB 657 Tanning Salons/Restrictions on Use was not considered. Bill and Analysis – Attachment VII)

ATTENDANCE

HOUSE COMMITTEE ON HEALTH

DATES	5/22/03														
INSKO, Verla CHAIR	✓														
JUSTUS, Carolyn CHAIR	✓														
ENGLAND, Bob VICE-CHAIR	✓														
ADAMS, Alma	✓														
ALLEN, Bernard	✓														
ALLEN, Gordon	✓														
ALLRED, Cary															
BARNHART, Jeff															
BOWIE, Joni	✓														
CLARY, Debbie															
EARLE, Beverly															
GLAZIER, Rick	✓														
HILTON, Mark	✓														
McALLISTER, Mary	✓														
MUNFORD, Don	✓														
SETZER, Mitchell															
SHERRILL, Wilma	✓														
WAINWRIGHT, William															
WILSON, Connie															
WRIGHT, Tom															
Ex officio Members															
Brubaker, Bru															
Culpepper, Bill															
Cunningham, Pete															
Eddins, Rick															

ATTACHMENT II

AGENDA

HOUSE COMMITTEE ON HEALTH

May 20, 2003
Room 544 LOB
12:00 Noon

OPENING REMARKS

Representative Verla Insko, Chair
Representative Carolyn Justus, Chair

AGENDA ITEMS

SB 582 Establish Commission on Childhood Obesity – Senator William Purcell

SB 657 Tanning Salons/Restrictions on Use – Senator James Forrester

ADJOURNMENT

VISITOR REGISTRATION SHEET

HOUSE COMMITTEE ON HEALTH — MAY 20, 2003

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Jim Hyde	SBE
Katherine Joyce	NCASA
Theresa K.	CAA
Gordon Payne	McGuireWoods
Brian Shank	AstraZeneca
John Boadish	AstraZeneca
George Judelat	NCSJA
Brian Lewis	Planned Parenthood
Peg Johnson	Planned Parenthood
Marion Deerhake	Self + NC Rad. Protection Cmsn.
Liz Kanof MD	NC Dermatology Assoc
Leanne Winner	NCSBA

VISITOR REGISTRATION SHEET

HOUSE COMMITTEE ON HEALTH — MAY 20, 2003

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Steven Stuhl	NCSOA
Harry Kaplan	AHA
Joanne Stevens	nursing
Steven McClenny	NCDHHS
Alan Skipper	NC Med. Soc NC Derm. Assoc.

House Pages

1. Name: Katie Adcock
   County: Cumberland
   Sponsor: Glazier
2. Name: Christina Pate
   County: Wayne
   Sponsor: Pate
3. Name: Lauren ~~Cottle~~ Cottle
   County: Pender
   Sponsor: Wright
4. Name: Lauren Everett
   County: Cumberland
   Sponsor: Glazier
5. Name:
   County:
   Sponsor:

Sgt-At-Arms

1. Name: Dusty Rhodes
2. Name: Earl Tharrington
3. Name: Jackson Stancil
4. Name: Francis Poole

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2003

S 2

SENATE BILL 582*

Health & Human Resources Committee Substitute Adopted 4/30/03

Short Title: Establish Commission on Childhood Obesity. (Public)

Sponsors:

Referred to:

March 31, 2003

A BILL TO BE ENTITLED

AN ACT TO ESTABLISH THE COMMISSION ON CHILDHOOD OBESITY.

Whereas, the four leading causes of death in North Carolina are stroke, heart disease, cancer, and diabetes, all of which are associated with overweight and obesity; and

Whereas, the prevalence of obesity has doubled in children and tripled in adolescents in the last two decades, bringing with it increased risk for future disease, as well as pediatric diagnoses of sleep apnea, orthopedic problems, psychological stress, and type 2 diabetes (formerly termed adult onset diabetes as it was rarely seen in persons under 30); and

Whereas, overweight teens have a 70% chance of becoming overweight or obese adults, making the next generation likely to have more adults with chronic diseases related to obesity at earlier ages than past generations; and

Whereas, the cost attributed to obesity and associated chronic diseases in the United States is more than $100 billion and these costs are spiraling upward; and

Whereas, children and adolescents are not meeting the recommendations of the Dietary Guidelines for Americans, including fruits and vegetables, but are consuming increasing amounts of foods high in fat and sugar; and

Whereas, standards were adopted in 1995 for meals served in the National School Lunch and School Breakfast Programs, but no standards exist for foods and beverages served a la carte in the cafeteria or in other venues during the school day; and

Whereas, regular physical activity substantially reduces the risk of dying of coronary heart disease and decreases the risk for stroke, colon cancer, diabetes, and high blood pressure. It also helps to control weight; contributes to healthy bones, muscles, and joints; reduces symptoms of anxiety and depression; and is associated with fewer hospitalizations, physician visits, and medications; Now, therefore,

The General Assembly of North Carolina enacts:

SECTION 1. There is established the Commission on Childhood Obesity.

SECTION 2. The Commission on Childhood Obesity shall be composed of 27 members who have knowledge and interest in reversing the epidemic of childhood obesity and taking steps to prevent obesity. The members shall be appointed as follows:

(1) The Superintendent of Public Instruction or his or her designee.

(2) One member of the Health and Wellness Trust Fund appointed by the chair of the Health and Wellness Trust Fund.

(3) Two parents of public school children and one public high school student appointed by the Governor after receiving recommendations from the North Carolina State Parent Teacher Association.

(4) Two members of the Senate appointed by the President Pro Tempore of the Senate.

(5) Two members of the House of Representatives appointed by the Speaker of the House of Representatives.

(6) Two members of a local board of education appointed by the Governor, after receiving recommendations from the North Carolina School Boards Association.

(7) One public school child nutrition director appointed by the Governor, after receiving recommendations from the Superintendent of Public Instruction.

(8) One public school nutrition education specialist appointed by the Governor, after receiving recommendations from the Superintendent of Public Instruction.

(9) One at-large member appointed by the Governor.

(10) Five members appointed by the President Pro Tempore of the Senate. In making these appointments, the President Pro Tempore shall appoint the following:

a. One public school health education teacher.
b. One representative from the Smart Start Program.
c. One pediatrician.
d. One psychiatrist, specializing in obesity.
e. One school administrator.

Professional associations representing teachers, school administrators, and the medical community may recommend appointees to the President Pro Tempore of the Senate.

(11) Five members appointed by the Speaker of the House of Representatives. In making these appointments, the Speaker of the House of Representatives shall appoint the following:

a. One public school physical education specialist.
b. One representative from the More At Four Program.
c. One dentist.
d. One member of the research community addressing the obesity epidemic.
e. One school administrator.

Professional associations representing teachers, school administrators, and dentists may recommend appointees to the Speaker of the House of Representatives.

(12) One representative of the vending machine industry, who is appointed by the Health and Wellness Trust Fund Commission, after receiving recommendations from the North Carolina Citizens for Business and Industry.

(13) One nutritionist, who is appointed by the Health and Wellness Trust Fund Commission, after receiving recommendations from professional associations.

(14) One economist, with expertise in the socioeconomic issues associated with obesity, who is appointed by the Health and Wellness Trust Fund Commission, after receiving recommendations from the research community.

Each of the following organizations or agencies may select a representative from its organization or agency to advise the Commission. These members shall provide information to the Commission about the obesity epidemic in North Carolina: North Carolina Department of Health and Human Services, Division of Public Health; North Carolina Department of Public Instruction, Child Nutrition Services; Be Active North Carolina, Inc., Prevention Partners; American Cancer Society; American Heart Association; Action for Healthy Kids NC; Healthy Weight Initiative; and the Office of the Governor.

SECTION 3. The member of the Health and Wellness Trust Fund Commission appointed by the chair of the Health and Wellness Trust Fund Commission shall serve as the chair of the Commission. Vacancies on the Commission shall be filled by the same appointing authority as made the initial appointment.

SECTION 4. The study shall include the following:

(1) The causes of obesity in North Carolina's children.

(2) The socioeconomic issues associated with childhood obesity.

(3) How the State should deal with childhood obesity.

(4) The steps that should be taken to prevent obesity in North Carolina.

SECTION 5. The Commission shall make recommendations that include the following:

(1) Nutritional guidelines for food served in public schools outside of the National School Lunch and School Breakfast Programs.

(2) Physical education in public schools.

(3) Physical activities in public schools.

(4) Healthy and nutritional behavior by North Carolina students and, when possible, their families.

The Commission is encouraged to explore different settings for its recommendations, including families, schools/child care, communities, health care, media/communication/social marketing, and surveillance/research.

SECTION 6. The Commission shall submit a final written report of its findings and recommendations to the Joint Legislative Health Care Oversight

Committee, the Joint Legislative Education Oversight Committee, and the Health and Wellness Trust Fund Commission no later than Friday, May 7, 2004. The final report may contain a summary of recommendations for changes to any law, rule, and policy that would lower or eradicate the obesity rates in North Carolina and our schools. Upon filing its final report, the Commission shall terminate.

SECTION 7. Members of the Commission shall be paid per diem, subsistence, and travel allowances in accordance with G.S. 120-3.1, 138-5, and 138-6, as appropriate.

SECTION 8. Federal funds, private funds, and existing State funds may be used to support the Commission. No new State funds shall be used to support the Commission.

SECTION 9. This act is effective when it becomes law.

SENATE BILL 582:
Establish Commission on Childhood Obesity.

BILL ANALYSIS

Committee: House Health
Date: May 20, 2003
Version: Second Edition

Introduced by: Sen. Purcell
Summary by: Sara Kamprath
Committee Analyst

SUMMARY: ***Senate Bill 582 creates the 27-member Commission on Childhood Obesity. The Commission shall study various issues relating to childhood obesity and may make recommendations to change any law, rule or policy in order to lower obesity rates in the State. The final written report shall be made by Friday, May 7, 2004. The Commission shall terminate upon filing its final report. No new State funds shall be used for the Commission. The bill becomes effective when it becomes law.***

BILL ANALYSIS:

Commission Membership -- There is created a 27-member Commission on Childhood Obesity.

Number	Member Qualification
1	Superintendent of Public Instruction or designee
	(4) APPOINTEES OF THE HEALTH AND WELLNESS TRUST FUND
1	Member of the Health and Wellness Trust Fund appointed by the chair of the Fund
1	Representative of the vending machine industry based on recommendations by the NC Citizens for Business and Industry
1	Nutritionist based on recommendations by professional associations
1	Economist, with expertise in socioeconomic issues associated with obesity, based on recommendations by the research community
	(8) APPOINTEES OF THE GOVERNOR
3	2 parents of public school children and 1 public high school student based on recommendations by the NC PTA
2	Members of a local board of education based on recommendations by the NC School Boards Association
1	Public school child nutrition director based on recommendations by the Superintendent of Public Instruction
1	Public school nutrition education specialist based on recommendations by the Superintendent of Public Instruction
1	At-large member
	(7) APPOINTEES OF THE PRESIDENT PRO TEMPORE
2	Members of the Senate
1	Public school health education teacher
1	Representative from Smart Start
1	Pediatrician
1	Psychiatrist, specializing in obesity
1	School administrator
For the 5 non-Senator members, professional organizations representing teachers, school administrators, and the medical community may recommend appointees	

(7) APPOINTEES OF THE SPEAKER	
2	Members of the House of Representatives
1	Public school physical education specialist
1	Representative from the More at Four Program
1	Dentist
1	Member of the research community addressing the obesity epidemic
1	School administrator
For the 5 non-House members, professional associations representing teachers, school administrators, and dentists may recommend appointees	

Commission Structure and Terms of Members

The chair of the Commission shall be the member appointed by the chair of the Health and Wellness Trust Fund Commission. The appointing authority that made the original appointment shall fill any vacancy on the Commission. The members of the Commission shall be paid the appropriate per diem, subsistence and travel allowances.

Study

The study shall examine the causes of obesity in North Carolina's children, the socio-economic issues associated with childhood obesity, how the State should deal with childhood obesity and the steps that should be taken to prevent obesity in North Carolina.

Duties of the Commission

The Commission shall make recommendations that include the following:

(1) Nutritional guidelines for food served in public schools outside of the National School Lunch and School Breakfast Program.
(2) Physical education in public schools.
(3) Physical activities in public schools.
(4) Healthy and nutritional behavior by North Carolina students and when possible their families.

Reports

The Commission shall submit a final written report with its findings and recommendations to the Joint Legislative Health Care Oversight Committee, the Joint Legislative Education Oversight Committee and the Health and Wellness Trust Fund Commission by Friday, May 7, 2004. The Commission shall terminate when the final report is filed.

Funding

No new State funds shall be used for the Commission but only federal funds, private funds and existing State funds.

BACKGROUND:

Increased body weight is a factor in the onset and severity of many diseases such as adult-onset diabetes, hypertension, coronary heart disease, and some cancers. It is important to teach healthy behaviors at an early age because making changes is more difficult later in life.

Body Mass Index (BMI) is an index of a person's weight in relation to their height. BMI is commonly used to classify overweight and obesity among adults as well as helps to identify children who are overweight or at risk of becoming overweight. The following table shows data gathered on children seen in public health settings in 2000.

Percent of NC Children who are Overweight

	1995	2000	Increase
Ages 2-4	9.0%	12.2%	36.6%
Ages 5-11	14.7%	20.6%	40.1%
Ages 12-18	22.7%	26.0%	14.5%

S582-SMRJ-003

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2003

S 2

SENATE BILL 657
Health & Human Resources Committee Substitute Adopted 4/10/03

Short Title: Tanning Salons/Restrictions on Use. (Public)

Sponsors:

Referred to:

April 1, 2003

A BILL TO BE ENTITLED

AN ACT IMPOSING RESTRICTIONS ON THE USE AND OPERATION OF TANNING FACILITIES AND EQUIPMENT.

Whereas, on an average day in the United States, more than one million people visit indoor tanning salons for the purpose of tanning the skin; and

Whereas, studies have found that indoor tanning may be just as harmful to the skin as outdoor sun exposure; and

Whereas, most indoor tanning salon bulbs provide a significant amount of UVA and UVB radiation, both types of which are found in the outdoor sun and cause various types of damage to the skin that may lead to skin cancer; and

Whereas, past studies have suggested that tanning beds contribute to the incidence of melanoma, and a recent study in the Journal of the National Cancer Institute indicates that the use of tanning devices may also contribute to the incidence of nonmelanoma skin cancers; and

Whereas, dermatologists across the country are alarmed with the number of teenagers and young adults who continue to patronize tanning salons regardless of studies reporting the link between sun exposure and a wide array of skin cancers; and

Whereas, the Centers for Disease Control and Prevention reports an estimated 700 emergency department visits per year related to tanning salon exposure; Now, therefore,

The General Assembly of North Carolina enacts:

SECTION 1. Chapter 104E of the General Statutes is amended by adding the following new section to read:

"**§ 104E-9.1. Restrictions on use and operation of tanning equipment.**

(a) Operators of tanning equipment and owners of tanning facilities subject to rules adopted pursuant to this Chapter shall comply with or ensure compliance with the following:

(1) The operator shall provide to each consumer a warning statement that defines the potential hazards and consequences of exposure to

ultraviolet radiation. Before allowing the consumer's initial use of the tanning equipment, the operator shall obtain the signature of the consumer on the warning statement acknowledging receipt of the warning.

(2) The operator shall not allow a person younger than the age of 18 years to use tanning equipment unless the person gives the operator a written informed consent statement signed and dated by the person's parent or legal guardian and sworn before a notary public stating that the parent or legal guardian has read and understands the warnings given by the tanning facility, consents to the minor's use of the tanning equipment, and agrees that the minor shall use protective eyewear.

(3) The operator shall not allow a person younger than the age of 13 years to use tanning equipment unless:

a. The tanning facility receives written permission from the person's physician allowing the person to use the tanning equipment, and

b. The person's parent or legal guardian remains at the tanning facility while the person uses the tanning equipment.

(4) The operator shall not allow a person 13, 14, or 15 years of age to use tanning equipment unless the person's parent or legal guardian remains at the tanning facility while the person uses the tanning equipment.

(5) Neither an operator nor an owner shall claim or distribute promotional materials that claim that using tanning equipment is safe or free from risk or that using tanning equipment will result in medical or health benefits.

(6) The operator shall not allow a person to use tanning equipment longer than the recommended exposure time provided by the manufacturer of the tanning equipment as shown on the label of the tanning equipment.

(b) The Commission may adopt and the Department shall enforce rules to implement this section. The requirements of this section are in addition to other rules adopted pursuant to this Chapter that are applicable to tanning facilities and do not conflict with this section.

(c) As used in this section, unless the context requires otherwise, the term:

(1) 'Consumer' means any individual who is provided access to a tanning facility that is subject to registration and regulation under this Chapter.

(2) 'Tanning facility' means any location, place, area, structure, or business that provides consumers access to tanning equipment. For the purpose of this definition, tanning equipment registered to different persons at the same location and tanning equipment registered to the same person, but at separate locations, shall constitute separate tanning facilities.

(3) 'Tanning equipment' means ultraviolet or other lamps and equipment containing such lamps intended to induce skin tanning through the

irradiation of any part of the living human body with ultraviolet radiation."

SECTION 2. This act becomes effective October 1, 2003.

SENATE BILL 657:
Tanning Salons/Restrictions on Use

BILL ANALYSIS

Committee:	House Health	**Introduced by:**	Sen. Forrester
Date:	May 20, 2003	**Summary by:**	Dianna Jessup
Version:	PCS S657-CSSW-39		Committee Counsel

SUMMARY: ***Senate Bill 657 would impose restrictions on the use of tanning equipment by minors, prohibit operators in tanning facilities from claiming that tanning equipment is safe, and prohibit operators from allowing persons to use tanning equipment longer than the recommended exposure time by the manufacturer of the equipment. Violations could result in administrative penalties. The act would become effective October 1, 2003.***

The second edition clarified the language as it relates to the use of tanning equipment by minors and added provision prohibiting an operator from allowing a person to use tanning equipment longer than the recommended exposure time provided by the manufacturer and requiring parental consents to be notarized.

The PCS would add a provision that would require operators to inform consumers of the recommended exposure time and delete the provision added in the second edition that prohibited an operator from allowing a person to use tanning equipment longer than the recommended exposure time. The PCS would also add that the written informed consent could either notarized (as provided in the second edition) or signed in the operator's presence.

CURRENT LAW: The Radiation Protection Commission is a statutorily-created commission within the Department of Environment and Natural Resources (Department) charged with adopting rules providing for a program to regulate and inspect sources of nonionizing radiation, which includes tanning equipment. Current rules require tanning facilities to register with the Department and renew their registration annually and also address the posting of warning signs, equipment requirements, the wearing of protective eyewear, what records must be maintained, registration of persons who service tanning equipment, and fees for registration. Operators of tanning equipment must be trained and certified.

Specific to this bill, the rules require operators to provide consumers the opportunity to read a copy of the warning concerning exposure to radiation and to request that the consumer sign the statement, prohibit registrants from allowing a person under age 18 to use tanning equipment unless the person provides a consent form signed by that person's parent, and require remote timers on tanning equipment with a maximum timer interval that does not exceed the manufacturer's maximum recommended exposure time.

The Department may impose an administrative penalty on any person who fails to comply with the rules. Each day of a continuing violation constitutes a separate violation. An administrative penalty may not exceed $10,000 per day. Penalties may be contested.

BILL ANALYSIS: In addition to the rules prescribed for tanning facilities, operators must comply with the following:

- Provide a warning statement to the consumer and obtain the consumer's signature acknowledging receipt of the statement before allowing the consumer to use the tanning equipment for the first time. The warning must inform the consumer of the recommended exposure time provided by the manufacturer of the tanning eqipment. Current rules require operators to provide the consumer the

"opportunity" to read the warning and to "request" the consumer to sign the statement and require timers with a maximum timer interval that does not exceed the manufacturer's maximum recommended exposure time.

- Operators would be prohibited from claiming or distributing promotional materials that claim that using tanning equipment is safe or free from risk or that using tanning equipment will result in medical or health benefits. Current rules do not address this issue.
- Operators could only allow persons under 18 to use tanning equipment subject to the following restrictions:
    - *16 and 17 year olds* would be required to provide a written consent from the person's parent or guardian. The consent either would have to be notarized or signed by the parent or guardian in the operator's presence.
    - *13, 14, and 15 year olds* would be required to provide the signed parental consent form and a parent must be present at the tanning facility in order for the person to use the tanning equipment.
    - *Persons under 13* would be required to provide the signed parental consent form, written permission from the person's physician to use the tanning equipment, and a parent must be present at the tanning facility in order for the person to use the tanning equipment.

The Commission would be permitted to adopt rules to implement the requirements described above. The Department, as in other matters relating to tanning equipment, would enforce the rules.

Finally, the bill defines the terms "consumer", "tanning facility", and "tanning equipment". These definitions are consistent with the definitions for these terms currently in the rules.

S657-SMSW-003

House Committee on Health

May 27, 2003

Minutes

The House Committee on Health met on Tuesday, May 27, 2003 at 12:00 noon in Room 544 of the Legislative Office Building. A silent roll was taken. A copy of the roll denoting members present is attached to the minutes (Attachment I) along with a copy of the agenda and Visitor Registration Sheet (Attachments II and III).

Rep. Carolyn Justus, Chair welcomed visitors and members and recognized the pages: Charlotte Saunders from Rowan County sponsored by Rep. McCombs, Katie Gardner from Rowan County sponsored by Rep. Howard, Martin Dalton from Gaston County sponsored by Rep. Patrick McHenry, Tiffany Cornell from Forsyth County sponsored by Rep. Parmon and Kolenya Stanley from Cherokee County sponsored by Rep. West. Dusty Rhodes, Walter Spell and Jim Brewer were recognized as the sergeant-at-arms. (Attachment IV)

Senator Queen was recognized to explain his bill SB 897 A BILL TO BE ENTITLED AN ACT TO EXEMPT FROM PRIOR AUTHORIZATION REQUIREMENTS FOR PRESCRIPTION DRUGS UNDER THE MEDICAID PROGRAM ANTIHEMPHILIC DRUGS PRESCRIBED FOR THE TREATMENT OF HEMOPHILIA AND BLOOD DISORDERS. (Attachment V) He explains that his bill would statutorily exempt prescription drugs for hemophilia and blood disorders from prior authorization requirements under Medicaid where there is no generically equivalent drug available. The bill does not change current practice, has no fiscal impact and drugs are generally processed within 24 hours. Rep. Gillespie is then recognized and states that there are no generically equivalent drugs available for antihemophilic drugs at this time. (Bill Analysis and Fiscal Note – Attachment VI and VII) He also references a miracle drug developed from ovaries taken from Chinese hampsters. Rep. McAllister expresses interested in "miracle drug". Adams questions why drugs could not be put on approved list. Rep. Queen explains that it is a family of drugs specific to hemphilia community. Vice-Chair England makes motion for a favorable report. Motion is adopted. (Committee Report – Attachment VIII)

Chair Justus then calls upon Sen. Swindell to explain his bill S503 A BILL TO BE ENTITLED AN ACT TO UPDATE THE LAWS RELATING TO THE ATTENDANCE AGES AND ELIGIBILITY OF STUDENTS FOR NORTH CAROLINA SCHOOLS FOR THE DEAF. (Attachment X) This bill conforms NC law governing the eligibility and admission of deaf children to the NC Schools for the Deaf to current admission policies and practices and makes other technical and clarifying changes. (Bill Analysis – Attachment XI) Rep. B. Allen offers an amendment, which is adopted. (Attachment XII) Rep. Bowies makes motion to roll the bill into a committee

substitute and give the bill a favorable report and unfavorable as to the original bill. Motion adopted. (Committee Report – Attachment XIII)

Senator Purcell is called to explain his bill SB 519 AN ACT TO AMEND THE LAW REGARDING THE PREVENTION AND CONTROL OF LEAD POISONING IN CHILDREN. (Attachment XIX) (Bill Analysis – Attachment XX) Rep. Bowie is recognized and states that since bill is identical to the house bill already heard in committee, she makes motion for a favorable report. Motion adopted. (Committee Report – Attachment XXI)

Carolyn Justus then adjourns meeting at 12:26 p.m.

Carolyn Justus, Chair

Pamela J. Evans, Committee Clerk

ATTENDANCE

HOUSE COMMITTEE ON HEALTH

DATES	5/27/03														
INSKO, Verla CHAIR	✓														
JUSTUS, Carolyn CHAIR	✓														
ENGLAND, Bob VICE-CHAIR	✓														
ADAMS, Alma	✓														
ALLEN, Bernard	✓														
ALLEN, Gordon	✓														
ALLRED, Cary															
BARNHART, Jeff															
BOWIE, Joni	✓														
CLARY, Debbie															
EARLE, Beverly															
GLAZIER, Rick	✓														
HILTON, Mark															
McALLISTER, Mary	✓														
MUNFORD, Don	✓														
SETZER, Mitchell	✓														
SHERRILL, Wilma															
WAINWRIGHT, William															
WILSON, Connie															
WRIGHT, Tom															
Ex officio Members															
Brubaker, Bru															
Culpepper, Bill															
Cunningham, Pete															
Eddins, Rick															

ATTACHMENT II

AGENDA

HOUSE COMMITTEE ON HEALTH

May 27, 2003
Room 544 LOB
12:00 Noon

OPENING REMARKS

Representative Verla Insko, Chair
Representative Carolyn Justus, Chair

AGENDA ITEMS

SB 503 Age/Eligibility/NC Schools for the Deaf-Senator Swindell

SB 897 Medicaid Prior Authorization-Senator Queen

SB 519 Child Lead Poisoning Prevention Prgm Amends.-AB-Senator Purcell

ADJOURNMENT

ATTACHMENT III

VISITOR REGISTRATION SHEET

HOUSE COMMITTEE ON HEALTH — MAY 27, 2003

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Lyn Ryan	Beloved Community Ctr.
Rosemarie Waddell	Beloved Community Center 417 Arlington St GSO 27406
Camille Stell	Kcott
Paige Johnson	Planned Parenthood
Brian Lewis	Planned Parenthood
Martha Downing	DPI
Matt Igelman	Hemophilia of NC
Judy Igelman	Hemophilia of NC
Elizabeth Fuller	Baxter
Katy Rhoads	Office of Education Services
Sheila McKenney	NC DHHS
Wm H Potter	NCDS / NCPTA

VISITOR REGISTRATION SHEET

HOUSE COMMITTEE ON HEALTH — MAY 27, 2003

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
John McMillan	MFAS
GARY SIMMONS	GPA
Jeremy Cooper	NCACIA
PAYTON MAYNARD	
Mari Luis	BSK
John Bowdish	AstraZeneca
Bill Rustin	ACP
Steve Mitchell	NPC
Terry Haggerty	NCPC
Elizabeth Dalton	Bone & Associates

VISITOR REGISTRATION SHEET

HOUSE COMMITTEE ON HEALTH — MAY 27, 2003

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
	NASW
	HHS
Amy Dobson	NC Statewatch.
Ed Norman	DENR
TED KAPLAN	K.E.L.
	Moore & VanAllen
	NCAHP
Joanne Stevens	Nursing + NCCHSA
	Capitol Group

House Pages

1. Name: Charlotte Saunders
   County: Rowan
   Sponsor: Eugene McCombs
2. Name: Katie Gardner
   County: Rowan
   Sponsor: Julia Howard
3. Name: MARTIN DALTON
   County: GASTON
   Sponsor: McHenry
4. Name: Tiffany Correll
   County: Forsyth
   Sponsor: Parmon
5. Name: Kalenya Stanley
   County: Cherokee
   Sponsor: West

Sgt-At-Arms

1. Name: Dusty Rhodes
2. Name: WALTER SPELL
3. Name: Jim Brewer
4. Name:

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2003

S 2

SENATE BILL 897
Health & Human Resources Committee Substitute Adopted 4/21/03

Short Title: Medicaid Prior Authorization. (Public)

Sponsors:

Referred to:

April 3, 2003

A BILL TO BE ENTITLED

AN ACT TO EXEMPT FROM PRIOR AUTHORIZATION REQUIREMENTS FOR PRESCRIPTION DRUGS UNDER THE MEDICAID PROGRAM ANTIHEMOPHILIC DRUGS PRESCRIBED FOR THE TREATMENT OF HEMOPHILIA AND BLOOD DISORDERS.

The General Assembly of North Carolina enacts:

SECTION 1. Part 6 of Article 2 of Chapter 108A of the General Statutes is amended by adding the following new section to read:

"**§ 108A-68.1. Certain prescription drugs exempt from prior authorization requirements.**

Prior authorization shall not be required or utilized for any antihemophilic factor drugs prescribed for the treatment of hemophilia and blood disorders where there is no generically equivalent drug available. Nothing in this section shall prohibit the Secretary from implementing a disease management program."

SECTION 2. This act is effective when it becomes law and expires July 1, 2006.

SENATE BILL 897:
Medicaid Prior Authorization

BILL ANALYSIS

Committee:	House Health	**Introduced by:**	Sen. Queen
Date:	May 27, 2003	**Summary by:**	Dianna Jessup
Version:	Second Edition		Committee Counsel

SUMMARY: ***Senate Bill 897 would statutorily exempt prescription drugs for hemophilia and blood disorders from prior authorization requirements under Medicaid where there is no generically equivalent drug available. The Secretary of HHS would continue to be able to implement a disease management program. The act would become effective when it becomes law.***

CURRENT LAW: According to the Division of Medical Assistance, Department of Health and Human Services, during fiscal year 2002, the Medicaid program spent $1,056,158,750 on outpatient pharmacy benefits for Medicaid recipients, a 13.9% increase from the previous fiscal year. The pharmacy benefit is one of the most costly components of the Medicaid budget. To help control costs, a prescriber is required to obtain prior authorization for certain designated drugs. The list of these drugs is not in statute, but is maintained by DMA and communicated to providers. Currently, prior authorization is required for the following prescription drugs:

Medicaid Prior Authorization List

- Drugs used to treat ADHD
- Procrit/Epogen
- Neopogen
- OxyContin
- Growth Hormones
- Provigil
- Rebetron
- Vioxx, Celebrex, Bextra
- Enbrel, Betaseron, Copaxone
- Botox, Myobloc, Zyban, Nicotrol, Habitrol
- Synagis, RespiGam

Generally, these drugs were chosen because of their high cost or because of the potential for overutilizaton or abuse. Prior approval is administered by ACS (Affiliated Computer Systems) in Atlanta. The prescriber contacts ACS directly for prior approval by telephone, fax, email, or mail. Prior approval requests are generally processed within 24 hours.

Should a pharmacy need to dispense medication to a recipient in an emergency, the pharmacist can call ACS for approval. If it is after ACS hours, the pharmacist can dispense a 72-hour supply.

Blood disorders and hemophilia: Bleeding disorders, characterized by a tendency to bleed easily, may result from defects in the blood vessels or from abnormalities in the blood itself. The abnormalities may

be in the blood clotting factors or the platelets. Hemophilia is an inherited bleeding disorder that affects 18,000 persons (primarily males) in the United States. The disorder results from deficiencies in blood clotting factors and can lead to spontaneous internal bleeding and bleeding following injuries or surgery. Antihemophilic factor drugs are used to help the blood form clots and are administered by IV or injection. Currently, there are no generic equivalents for these drugs.

BILL ANALYSIS: If Senate Bill 897 were enacted, prior authorization could not be required or utilized for any antihemophilic factor drugs prescribed for the treatment of hemophilia and blood disorders where there is no generically equivalent drug available.

BACKGROUND: A similar provision appears in both versions of the proposed budget bill, which if enacted would be uncodified.

S897-SMSW-002

NORTH CAROLINA GENERAL ASSEMBLY

LEGISLATIVE FISCAL NOTE

BILL NUMBER: Senate Bill 897 (2nd Edition)

SHORT TITLE: Medicaid Prior Authorization

SPONSOR(S): Senator Joe Sam Queen

FISCAL IMPACT

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

	FY 2003-04	FY 2004-05	FY 2005-06	FY 2006-07	FY 2007-08
REVENUES					
EXPENDITURES					
POSITIONS: (cumulative)					

PRINCIPAL DEPARTMENT(S) & PROGRAM(S) AFFECTED: Department of Health and Human Services –Division of Medical Assistance

EFFECTIVE DATE: When it becomes law and it expires July 1, 2006

BILL SUMMARY: The proposed legislation exempts from prior authorization under the Medicaid Program any antihemophilic drugs prescribed for the treatment of hemophilia and blood disorders where there is no generically equivalent drug available.

ASSUMPTIONS AND METHODOLOGY: This legislation has no fiscal impact because the Division of Medical Assistance does not currently require any antihemophilic drugs prescribed for the treatment of hemophilia and blood disorders to be subject to prior authorization under the Medicaid Program. In addition, the proposed legislation allows for prior authorization when a generically equivalent drug becomes available. There are no generically equivalent drugs available for antihemophilic drugs at this time.

SOURCES OF DATA: Department of Health and Human Services – Division of Medical Assistance
TECHNICAL CONSIDERATIONS:

FISCAL RESEARCH DIVISION: (919) 733-4910

PREPARED BY: L. Carol Shaw L Carol Shaw

APPROVED BY: James D. Johnson, Director Fiscal Research Division

James D. Johnson

DATE: April 22, 2003

2003 COMMITTEE REPORT
HOUSE OF REPRESENTATIVES

The following report(s) from standing committee(s) is/are presented:
By Representatives **Verla Insko and Carolyn Justus,** Chairs for the Committee on **HEALTH**.

☒ Committee Substitute for
S.B. 897 A BILL TO BE ENTITLED AN ACT TO EXEMPT FROM PRIOR AUTHORIZATION REQUIREMENTS FOR PRESCRIPTION DRUGS UNDER THE MEDICAID PROGRAM ANTIHEMOPHILIC DRUGS PRESCRIBED FOR THE TREATMENT OF HEMOPHILIA AND BLOOD DISORDERS.

☒ 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 (# H.B.), ☐ 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)

3/06/03

FOR JOURNAL USE ONLY

____ Pursuant to Rule 36(b), the bill/resolution is placed on the Calendar of _____.

____ The (committee substitute) bill/resolution (, as amended,) is (ordered engrossed and) re-referred to the Committee on _____.

____ The bill/resolution is re-referred to the Committee on _____.

____ On motion of (Rep. _____,) (the Chair,) the (committee substitute) bill/resolution is (ordered engrossed and) re-referred to the Committee on _____.

____ Pursuant to Rule 36(b), the (House)committee substitute bill (No. ____)/resolution is placed on the Calendar of _____. (The original bill) (House Committee Substitute Bill No. ____)/resolution is placed on the Unfavorable Calendar.

____ On motion of Rep. _____, (the rules are suspended) (Rule ____ is suspended) and the bill/resolution is placed on today's calendar. (for immediate consideration.)

____ On motion of Rep. _____, Committee Amendment No.(s) _____ is/are adopted (by EV____ ____).

____ On motion of Rep. _____, Committee Amendment No.(s) _____ is/are adopted (by EV____ ____).

____ Rep. _____ offers Amendment No. _____ which (is adopted.) (fails of adoption.) (by EV ____ ____.) ( ) This amendment changes the title.

____ The bill/resolution (, as amended,) passes its second reading (by following vote, ____ ____ RC) (, by EV ____ ____,) and (remains on the Calendar,) (and there being no objection is read a third time).

____ The bill/resolution (, as amended,) passes its third reading (by the following vote, ____ ____ RC) (, by EV ____ ____,) and is ordered
____ sent to the Senate.
____ without engrossment. ____ by Special message.
____ sent to the Senate for concurrence in
_____ the House amendment (s).
_____the House committee substitute bill.
____ enrolled.

____ On motion of Rep. _____, the House concurs in the (material) Senate _____ (by the following vote, ____ ____ RC) (, by EV ____ ____,) and the bill is ordered enrolled.

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2003

S 2

SENATE BILL 503
Education/Higher Education Committee Substitute Adopted 4/17/03

Short Title: Age/Eligibility/NC Schools for the Deaf. (Public)

Sponsors:

Referred to:

March 24, 2003

A BILL TO BE ENTITLED

AN ACT TO UPDATE THE LAWS RELATING TO THE ATTENDANCE AGES AND ELIGIBILITY OF STUDENTS FOR NORTH CAROLINA SCHOOLS FOR THE DEAF.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 143B-216.41 reads as rewritten:

"**§ 143B-216.41. Pupils admitted; education.**

~~The Department of Health and Human Services shall according to such reasonable regulations as the Board of Directors may prescribe, on application, receive into the schools for the purposes of education all deaf children resident of the State who are from age five through age 20 years: Provided, that the Department of Health and Human Services may admit students who are not within the age limits set forth above when in its judgment, such admission will be in the best interests of the applicant and the facilities of the school permit such admission. Only those who are bona fide citizens or residents of North Carolina shall be eligible to and entitled to receive free tuition and maintenance. The Department may fix charges and the Board of Directors may prescribe rules whereby nonresident deaf children may be admitted, but in no event shall the admission of nonresidents in any way prevent the attendance of any eligible deaf child, resident of North Carolina. The Department shall provide for the instruction of all pupils in the branches of study now prescribed by law for the public schools of the State and in such other branches as may be of special benefit to the deaf.~~

~~The Department shall encourage the State to provide the classrooms with modern auditory training equipment, audiovisual media equipment, and any other special equipment to provide the best educational conditions for the deaf. The Department shall provide a teacher training program in the State. The Department shall provide for a comprehensive vocational and technical training program for boys and girls as may be useful to them in making themselves self-supporting.~~

(a) The Department of Health and Human Services shall admit all deaf and deaf/multidisabled children into the schools for the deaf who meet the following criteria

and in accordance with federal and State law and rules adopted by the Office of Education Services:

(1) The child has been referred by the child's local education agency and deemed appropriate by the child's Individualized Education Program (IEP) Team.

(2) The child is a resident of this State, except as provided in subsection (b) of this section.

(3) The child is at least five years of age but not older than 21 years of age.

(b) Nonresident deaf or deaf/multidisabled children may be admitted to the schools for the deaf in accordance with rules adopted by the Office of Education Services if the admission does not prevent the attendance of any deaf or deaf/multidisabled child who is a resident of the State. Only children who are residents of North Carolina are entitled to free tuition and room and board.

(c) The Department, through the Office of Education Services, shall provide unique instructional programs to meet the needs of all students admitted to the schools for the deaf. The Department shall encourage the State to provide classrooms with modern auditory training equipment, audiovisual media equipment, and any other special equipment to provide the best educational conditions for the deaf and deaf/multidisabled.

(d) The Department, through the Office of Education Services, shall do the following:

(1) Maintain a collaborative relationship with institutions of higher education to provide teacher-training opportunities.

(2) Provide for a comprehensive vocational and technical training program as directed in the transition component of the Individualized Education Programs of students."

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

SENATE BILL 503:
Age/Eligibility/NC Schools for the Deaf

BILL ANALYSIS

Committee:	House Health	**Introduced by:**	Senator Swindell
Date:	May 23, 2003	**Summary by:**	Sara Kamprath*
Version:	Second Edition		Committee Counsel

SUMMARY: ***Senate Bill 503 conforms NC law governing the eligibility and admission of deaf children to the NC Schools for the Deaf to current admission policies and practices and makes other technical and clarifying changes. The bill is effective when it becomes law.***

CURRENT LAW: In accordance with G.S. 143B-216.41, a statute enacted in 1961, all hearing impaired children between the ages of 5 and 20 are eligible for admission to either the Eastern North Carolina School for the Deaf at Wilson (K-12) or the North Carolina School for the Deaf in Morganton (K-12). The Department of Health and Human Services (DHHS) is responsible for the operation and maintenance of the schools. Current law authorizes the Board of Directors of each of the Schools to adopt rules governing the admission of students. Children under the age of six may be admitted if admission is in the best interests of the applicant and the school. Non-residents may be admitted if space is available, but only residents of North Carolina may receive free tuition and maintenance. Non-residents must pay the per capita costs.

G.S. 143B-216.41 also requires the NC Schools for the Deaf to provide instruction in all branches of study as required by law for the public schools and in other branches of study that may be beneficial to deaf or hard-of-hearing students. The DHHS is required to encourage the State to ensure that classrooms in the Schools for the Deaf are equipped with the necessary tools and media equipment to ensure the best educational conditions for deaf or head-of-hearing students attending the schools. DHHS is also required to provide a teacher training program to train teachers in public schools.

BILL ANALYSIS: The bill makes the following changes to the statute governing the eligibility and admission to the NC Schools for the Deaf:

1. Shifts rule-making authority over admission policies from the Board of Directors of the Schools for the Deaf to the Superintendent of the Office of Education Services in DHHS. *This change is made because the Schools for the Deaf no longer have Boards of Directors.*
2. Adds a provision stating that all applicants for admission to a School for the Deaf must be referred by their local education agencies. (DHHS is a local education agency).
3. Adds a provision stating that applicants must meet certain criteria for admission. *Currently, it is unclear what the criteria for admission is or what entity is responsible for defining the criteria.*
4. Clarifies that children who are deaf, hard-of-hearing or deaf and blind are eligible for admission, not *just* deaf children. *This is the current policy.*
5. Clarifies that children between the ages of 5 and 21 are eligible for admission and deletes language that gave DHHS discretion to admit students outside the age range of 5 and 20. *This is the current policy.*

6. Changes current law regarding the scope of instruction that the Department must provide students enrolled in the schools for the deaf to limit the scope of instruction to programs to meet the unique needs of the students.
7. Changes current law to provide that the Department, through the Office of Education Services, must maintain a collaborative relationship with institutions of higher education to provide teacher training opportunities instead of the Department providing a teacher training program.
8. Changes current law to provide that the Department, through the Office of Education Services, must provide a comprehensive vocational and technical training program as directed by the child's IEP plan instead of "as may be useful to make the child self-supporting".

BACKGROUND:

Prevalence of deafness: In the United States, hearing loss is the leading birth defect. Since 2001, North Carolina has implemented an infant screening program and from that data, it is estimated that the number of children who are born deaf or hard of hearing range between 3 and 6 per 100,000. It is expected that approximately 75 children will be born profoundly deaf in North Carolina each year. This number will gradually rise with the birthrate and is expected to reach 82 in 2011.

Residency of students attending NC Schools for the Deaf: All children attending the NC Schools for the Deaf are residents of North Carolina. According to DHHS, no non-resident students have attended the NC Schools for the Deaf for at least the last five years. However, there are currently 8 students enrolled who are NC residents, but who are not US citizens.

The following Tables provide comparison data regarding enrollment, staffing and costs related to the education of deaf students attending the NC Schools for the Deaf and students enrolled in non-residential public schools. The data is provided by DPI.

Table 1 is the number of students in public schools vs. the schools for the deaf.

Category	Num. In Public Schools	Num. in Schools for Deaf
Hearing Impaired	2,031	218

Table 2 contains the number of teachers in public schools vs. the schools for the deaf.

Category	Employed Fully Certified	Employed Not Fully Certified	Vacant Position	Total Employed
LEA - 6-21	155.16	20	6	181.16
LEA - Preschool	26.77	3.80	0.24	30.81
Schools for Deaf - 6-21	64.26	0	7	71.26
Schools for Deaf - PreSchool	0	0	0	0

Table 3 contains the State and federal funding that the public schools receive for each student who is deaf.

Allotment	State	Federal
Ages 6-20	$2,670.28	
PreSchool	$2,124.73	
Ages 6-21		$942.77 - Base Amount
PreSchool		$486.19 - Formula-Based

*Drupti Chauhan, Robin Johnson, Linda Attarian, Staff Attorneys, Research Division contributed significantly to this summary.

NORTH CAROLINA GENERAL ASSEMBLY AMENDMENT

(Please type or use ballpoint pen)

ATTACHMENT XII

EDITION No. _____

H. B. No. _____ DATE 5/27/03

S. B. No. 503 Amendment No. _____
(to be filled in by Principal Clerk)

COMMITTEE SUBSTITUTE _____

Rep.)
) B
Sen.)

moves to amend the bill on page 2, lines 3-5

( ) WHICH CHANGES THE TITLE

by rewriting the lines to read:

"(1) The child has been referred by the child's local education agency and an admission is deemed appropriate by the child's Individualized Education Program (IEP) Team."

SIGNED Bernard Allen

ADOPTED _____ FAILED _____ TABLED _____

GA-33-A

PRINCIPAL CLERK'S OFFICE (FOR ENGROSSMENT)

ATTACHMENT XIII

2003 COMMITTEE REPORT
HOUSE OF REPRESENTATIVES

The following report(s) from standing committee(s) is/are presented:
By Representatives **Verla Insko and Carolyn Justus,** Chairs for the Committee on **HEALTH**.

☒ Committee Substitute for
S.B. 503 A BILL TO BE ENTITLED AN ACT TO UPDATE THE LAWS RELATING TO THE ATTENDANCE AGES AND ELIGIBILITY OF STUDENTS FOR NORTH CAROLINA SCHOOLS FOR THE DEAF.

☐ 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 (# H.B.), ☐ 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)

3/06/03

FOR JOURNAL USE ONLY

____ Pursuant to Rule 36(b), the bill/resolution is placed on the Calendar of _____.

____ The (committee substitute) bill/resolution (, as amended,) is (ordered engrossed and) re-referred to the Committee on _____.

____ The bill/resolution is re-referred to the Committee on _____.

____ On motion of (Rep. _____,) (the Chair,) the (committee substitute) bill/resolution is (ordered engrossed and) re-referred to the Committee on _____.

____ Pursuant to Rule 36(b), the (House)committee substitute bill (No. ____)/resolution is placed on the Calendar of _____. (The original bill) (House Committee Substitute Bill No. ____)/resolution is placed on the Unfavorable Calendar.

____ On motion of Rep. _____, (the rules are suspended) (Rule ____ is suspended) and the bill/resolution is placed on today's calendar. (for immediate consideration.)

____ On motion of Rep. _____, Committee Amendment No.(s) _____ is/are adopted (by EV____ ____).

____ On motion of Rep. _____, Committee Amendment No.(s) _____ is/are adopted (by EV____ ____).

____ Rep. _____ offers Amendment No. _____ which (is adopted.) (fails of adoption.) (by EV ____ ____.) ( ) This amendment changes the title.

____ The bill/resolution (, as amended,) passes its second reading (by following vote, ____ ____ RC) (, by EV ____ ____,) and (remains on the Calendar,) (and there being no objection is read a third time).

____ The bill/resolution (, as amended,) passes its third reading (by the following vote, ____ ____ RC) (, by EV ____ ____,) and is ordered
____ sent to the Senate.
____ without engrossment. ____ by Special message.
____ sent to the Senate for concurrence in
_____ the House amendment (s).
_____the House committee substitute bill.
____ enrolled.

____ On motion of Rep. _____, the House concurs in the (material) Senate _____ (by the following vote, ____ ____ RC) (, by EV ____ ____,) and the bill is ordered enrolled.

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2003

S 3

SENATE BILL 519*
Health & Human Resources Committee Substitute Adopted 4/14/03
Third Edition Engrossed 4/16/03

Short Title: Child Lead Poisoning Prevention Prgm Amends.-AB (Public)

Sponsors:

Referred to:

March 24, 2003

A BILL TO BE ENTITLED

AN ACT TO AMEND THE LAW REGARDING THE PREVENTION AND CONTROL OF LEAD POISONING IN CHILDREN.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 130A-131.7 reads as rewritten:

"**§ 130A-131.7. Definitions.**

~~As used in this Part, unless the context requires otherwise, the term:~~The following definitions apply in this Part:

(1) "Abatement" means undertaking any of the following measures to eliminate a lead-based paint hazard:
   a. Removing lead-based paint from a surface and repainting the surface.
   b. Removing a component, such as a windowsill, painted with lead-based paint and replacing the component.
   c. Enclosing a surface painted with lead-based paint with paneling, vinyl siding, or another approved material.
   d. Encapsulating a surface painted with lead-based paint with a sealant.
   e. Any other measure approved by the Commission.

(2) "Child-occupied facility" means a building, or portion of a building, constructed ~~prior to~~before 1978, regularly visited by a child who is less than ~~6~~ six years of age. Child-occupied facilities may include, but are not limited to, child care facilities, preschools, nurseries, kindergarten classrooms, schools, clinics, or treatment centers including the common areas, the grounds, any outbuildings, or other structures appurtenant to the facility.

(3) "Confirmed lead poisoning" means a blood lead concentration of 20 micrograms per deciliter or greater determined by the lower of two consecutive blood tests within a six-month period.

(4) "Department" means the Department of Environment and Natural Resources or its authorized agent.

(5) "Elevated blood lead level" means a blood lead concentration of 10 micrograms per deciliter or greater determined by the lower of two consecutive blood tests within a six-month period.

(6) "Lead-based paint hazard" means a condition that is likely to ~~cause adverse health effects as a~~ result ~~of~~ in exposure to lead-based paint or to soil or dust that contains lead ~~derived from lead-based paint.~~at a concentration that constitutes a lead poisoning hazard.

(7) "Lead poisoning hazard" means any of the ~~presence of readily accessible or mouthable lead-bearing substances, including lead-based paint, measuring 1.0 milligram per square centimeter or greater by X-ray fluorescence or five-tenths of one percent (0.5%) or greater by chemical analysis; or 15 parts per billion or greater in drinking water; or 100 micrograms per square foot or greater for dust on floors; or 500 micrograms per square foot or greater for dust on windowsills; or 800 micrograms per square foot or greater for dust in window troughs, or soil lead concentrations in an amount greater than or equal to 400 parts per million that is determined by the Department to present a hazard in light of (i) the condition and use of the land and (ii) other relevant factors.~~following:

a. Any lead-based paint or other substance that contains lead in an amount equal to or greater than 1.0 milligrams lead per square centimeter as determined by X-ray fluorescence or five-tenths of a percent (0.5%) lead by weight as determined by chemical analysis: (i) on any readily accessible substance or chewable surface on which there is evidence of teeth marks or mouthing; or (ii) on any other deteriorated or otherwise damaged interior or exterior surface.

b. Any substance that contains lead intended for use by children less than six years of age in an amount equal to or greater than 0.06 percent (0.06%) lead by weight as determined by chemical analysis.

c. Any concentration of lead dust that is equal to or greater than 40 micrograms per square foot on floors or 250 micrograms per square foot on interior windowsills, vinyl miniblinds, bathtubs, kitchen sinks, or lavatories.

d. Any lead-based paint or other substance that contains lead on a friction or impact surface that is subject to abrasion, rubbing, binding, or damage by repeated contact and where the lead dust concentrations on the nearest horizontal surface underneath the

friction or impact surface are equal to or greater than 40 micrograms per square foot on floors or 250 micrograms per square foot on interior windowsills.

e. Any concentration of lead in bare soil in play areas, gardens, pet sleeping areas, and areas within three feet of a residential housing unit or child-occupied facility equal to or greater than 400 parts per million. Any concentration of lead in bare soil in other locations of the yard equal to or greater than 1,200 parts per million.

f. Any ceramic ware generating equal to or greater than three micrograms of lead per milliliter of leaching solution for flatware or 0.5 micrograms of lead per milliliter for cups, mugs, and pitchers as determined by Method 973.32 of the Association of Official Analytical Chemists.

g. Any concentration of lead in drinking water equal to or greater than 15 parts per billion.

(8) "Lead-safe housing" is housing that was built since 1978 or has been tested by a person that has been certified to perform risk assessments and found to have no lead-based paint hazard within the meaning of the Residential Lead-Based Paint Reduction Act of 1992, 42 U.S.C. § 4851b(15).

(9) "Maintenance standard" means the following:

a. Using safe work practices, repairing and repainting areas of deteriorated paint inside a residential housing unit and for single-family and duplex residential dwelling built ~~prior to~~before 1950, repairing and repainting areas of deteriorated paint on interior and exterior surfaces;

b. Cleaning the interior of the unit to remove dust that constitutes a lead poisoning hazard;

c. Adjusting doors and windows to minimize friction or impact on surfaces;

d. Subject to the occupant's approval, appropriately cleaning any carpets;

e. Taking such steps as are necessary to ensure that all interior surfaces on which dust might collect are readily cleanable; and

f. Providing the occupant or occupants all information required to be provided under the Residential Lead-Based Paint Hazard Reduction Act of 1992, and amendments thereto.

(10) "Managing agent" means any person who has charge, care, or control of a building or part thereof in which dwelling units or rooming units are leased.

(11) ~~"Mouthable lead-bearing substance" means any substance on surfaces or fixtures five feet or less from the floor or ground that form a protruding corner or similar edge, or protrude one-half inch or more~~

~~from a flat wall surface, or are freestanding, containing lead-contaminated dust at a level that constitutes a lead poisoning hazard. Mouthable surfaces or fixtures include toys, vinyl miniblinds, doors, door jambs, stairs, stair rails, windows, windowsills, and baseboards.~~

(12) ~~"Persistent elevated blood lead level" means a blood lead concentration of 15-19 micrograms per deciliter determined by the lowest of three consecutive blood tests. The first two blood tests shall be performed within a six-month period, and the third blood test shall be performed at least 12 weeks and not more than six months after the second blood test.~~

(13) "Readily accessible ~~lead-bearing~~ substance" means any substance ~~containing lead at a level that constitutes a lead poisoning hazard which~~that can be ingested or inhaled by a child ~~under 6~~less than six years of age. Readily accessible substances include deteriorated paint that is peeling, chipping, cracking, flaking, or blistering to the extent that the paint has separated from the substrate. Readily accessible substances also include soil, ~~water,~~water, toys, vinyl miniblinds, bathtubs, lavatories, doors, door jambs, stairs, stair rails, windows, interior windowsills, baseboards, and paint that is chalking.

(14) "Regularly visits" means the presence at a residential housing unit or child-occupied facility on at least two different days within any week, provided that each day's visit lasts at least three hours and the combined weekly visits last at least six hours, and the combined annual visits last at least 60 hours.

(15) "Remediation" means the elimination or control of lead poisoning hazards by methods approved by the Department.

(16) "Residential housing unit" means a dwelling, dwelling unit, or other structure, all or part of which is designed or used for human habitation, including the common areas, the grounds, any outbuildings, or other structures appurtenant to the residential housing unit.

(17) "Supplemental address" means a residential housing unit or child-occupied facility where a child with ~~a persistent elevated blood lead level or a~~ confirmed lead poisoning regularly visits or attends. Supplemental address also means a residential housing unit or child-occupied facility where a child resided, regularly visited, or attended within the six months immediately preceding the determination of ~~a persistent elevated blood lead level or a~~ confirmed lead poisoning."

SECTION 2. G.S. 130A-131.8 reads as rewritten:

"**§ 130A-131.8. Reports of blood levels in children.**

All laboratories doing business in this State shall report to the Department all blood lead ~~levels of one microgram per deciliter or greater~~test results for children less than ~~6~~ six years of age and for individuals whose ages are unknown at the time of testing.

Reports shall be made within five working days after test completion on forms provided by the Department or on self-generated forms containing: the child's full name, date of birth, sex, race, address, and Medicaid number, if any; the name, address, and telephone number of the requesting health care provider; the name, address, and telephone number of the testing laboratory; the laboratory results, the specimen type – venous or capillary; the laboratory sample number, and the dates the sample was collected and analyzed. ~~Such~~The reports may be made by electronic submissions."

SECTION 3. G.S. 130A-131.9 reads as rewritten:

"**§ 130A-131.9. Examination and testing.**

When the Department has a reasonable suspicion that a child less than ~~6~~ six years of age has ~~a persistent~~ an elevated blood lead level or a confirmed lead poisoning, the Department may require that child to be examined and tested within 30 days. The Department shall require from the owner, managing agent, or tenant of the residential housing unit or child-occupied facility information on each child who resides in, regularly visits, or attends, or, who has within the past six months, resided in, regularly visited, or attended the unit or facility. The information required shall include each child's name and date of birth, the names and addresses of each child's parents, legal guardian, or full-time custodian. The owner, managing agent, or tenant shall submit the required information within 10 days of receipt of the request from the Department."

SECTION 4. G.S. 130A-131.9A reads as rewritten:

"**§ 130A-131.9A. Investigation to identify lead poisoning hazards.**

(a) When the Department learns of ~~a persistent elevated blood lead level or a~~ confirmed lead poisoning, the Department shall conduct an investigation to identify the lead poisoning hazards to children. The Department shall investigate the residential housing unit ~~or child-occupied facility~~ where the child with ~~the persistent elevated blood lead level or the~~ confirmed lead poisoning ~~resides, regularly visits, or attends.~~resides. The Department shall also investigate the supplemental addresses of the child who has ~~a persistent elevated blood lead or a~~ confirmed lead poisoning.

(a1) When the Department learns of an elevated blood lead level, the Department shall, upon informed consent, investigate the residential housing unit where the child with the elevated blood level resides. When consent to investigate is denied, the child with the elevated blood lead level cannot be located, or the child's parent or guardian fails to respond, the Department shall document the denial of consent, inability to locate, or failure to respond.

(b) The Department shall also conduct an investigation when it reasonably suspects that a lead poisoning hazard to children exists in a residential housing unit or child-occupied facility occupied, regularly visited, or attended by a child less than ~~6~~ six years of age.

(c) In conducting an investigation, the Department may take samples of surface materials, or other materials suspected of containing lead, for analysis and testing. If samples are taken, chemical determination of the lead content of the samples shall be by atomic absorption spectroscopy or equivalent methods approved by the Department."

SECTION 5. G.S. 130A-131.9B reads as rewritten:

"**§ 130A-131.9B. Notification.**

Upon determination that a lead poisoning hazard exists, the Department shall give written notice of the lead poisoning hazard to the owner or managing agent of the residential housing unit or child-occupied facility and to all persons residing in, attending, or regularly visiting the unit or facility. The written notice to the owner or managing agent shall include a list of possible methods of ~~abatement of the lead-based paint hazards and of possible methods of remediation of any other lead poisoning hazard~~. remediation."

SECTION 6. G.S. 130A-131.9C reads as rewritten:

"**§ 130A-131.9C. ~~Abatement and remediation.~~Remediation.**

(a) Upon determination that a child less than ~~6~~ six years of age has a confirmed lead poisoning of 20 micrograms per deciliter or greater and that child resides ~~in, attends, or regularly visits,~~in a residential housing unit ~~or child-occupied facility~~ containing lead poisoning hazards, the Department shall require ~~abatement of the lead-based paint hazards and the~~ remediation of ~~other~~ the lead poisoning hazards. The Department shall also require ~~the abatement of the lead-based paint hazards and the~~ remediation of ~~other~~ the lead poisoning hazards identified at the supplemental addresses of a child less than ~~6~~ six years of age with a confirmed lead poisoning of 20 micrograms per deciliter or greater.

(b) When ~~abatement of lead-based paint hazards or~~ remediation of ~~other~~ lead poisoning hazards is required under subsection (a) of this section, the owner or managing agent shall submit a written remediation plan to the Department within 14 days of receipt of the lead poisoning hazard notification and shall obtain written approval of the plan ~~prior to~~before initiating ~~abatement of lead-based paint hazards or~~ remediation ~~of other lead poisoning hazards.~~activities. The remediation plan shall comply with subsections (g), (h), and (i) of this section.

(c) If the remediation plan submitted fails to meet the requirements of this section, the Department shall issue an order requiring submission of a modified plan. The order shall indicate the modifications ~~which~~ that shall be made to the remediation plan and the date ~~by which~~that the plan as modified shall be submitted to the Department.

(d) If the owner or managing agent does not submit a remediation plan within 14 days, the Department shall issue an order requiring submission of a remediation plan within five days of receipt of the order.

(e) The owner or managing agent shall notify the Department and the occupants of the dates of remediation activities at least three days ~~prior to the~~before commencement of the activities.

(f) ~~Abatement of lead-based paint hazards and remediation~~Remediation of ~~other~~ the lead poisoning hazards shall be completed within 60 days of the Department's approval of the remediation plan. If ~~these~~ the remediation activities are not completed within 60 ~~days as required,~~days, the Department shall issue an order requiring completion of the activities. An owner or managing agent may apply to the Department for an extension of the deadline. The Department may issue an order extending the deadline for 30 days upon proper written application by the owner or managing agent.

(g) ~~The~~ All of the following methods of ~~abatement~~ remediation of lead-based paint hazards are prohibited:

(1) Stripping paint on-site with methylene chloride-based ~~solutions;~~solutions.

(2) Torch or flame ~~burning;~~burning.

(3) Heating paint with a heat gun above 1,100 degrees ~~Fahrenheit;~~Fahrenheit.

(4) Covering with new paint or wallpaper unless all readily accessible lead-based paint has been ~~removed;~~removed.

(5) Uncontrolled abrasive ~~blasting; or~~ blasting, machine sanding, or grinding, except when used with High Efficiency Particulate Air (HEPA) exhaust control that removes particles of 0.3 microns or larger from the air at ninety-nine and seven-tenths percent (99.7%) or greater efficiency.

(6) Uncontrolled waterblasting.

(7) Dry scraping, unless used in conjunction with heat guns, or around electrical outlets, or when treating no more than two square feet on interior surfaces, or no more than 20 square feet on exterior surfaces.

(h) All lead-containing waste and residue shall be removed and disposed of in accordance with applicable federal, State, and local laws and rules. Other substances containing lead that are intended for use by children less than six years of age and vinyl miniblinds that constitute a lead poisoning hazard shall be removed and disposed of in accordance with applicable federal, State, and local laws and rules.

(i) All remediation plans shall require that the lead poisoning hazards be reduced to ~~below~~ the following levels:

(1) ~~Floor lead dust levels~~Fewer ~~are less~~ than ~~100~~ 40 micrograms per square ~~foot;~~foot for lead dust on floors.

(2) ~~Windowsill lead dust levels are less~~Fewer than ~~500~~ 250 micrograms per square ~~foot;~~foot for lead dust on interior windowsills, bathtubs, kitchen sinks, and lavatories.

(3) ~~Window trough lead dust levels are less~~Fewer than ~~800~~ 400 micrograms per square ~~foot;~~foot for lead dust on window troughs.

(4) ~~Soil lead levels are less~~Fewer than 400 parts per million ~~or such other level higher than 400 parts per million as determined by the Department to prevent a hazard in light of the condition and use of the land and in light of other relevant factors; and~~for lead in bare soil in play areas, gardens, pet sleeping areas, and areas within three feet of the residential housing unit or child-occupied facility. Lead in bare soil in other locations of the yard shall be reduced to less than 1,200 parts per million.

(5) ~~Drinking water lead levels less~~ Fewer than 15 parts per ~~billion.~~ billion for lead in drinking water.

(j) The Department shall verify by visual inspection that the approved remediation plan has been completed. The Department may also verify plan completion by residual lead dust monitoring and soil or drinking water lead level measurement.

(j1) Compliance with the maintenance standard satisfies the remediation requirements for confirmed lead poisoning cases identified on or after 1 October 1990 as long as all lead poisoning hazards identified on interior and exterior surfaces are addressed by remediation. Except for owner-occupied residential housing units, continued compliance shall be verified by means of an annual monitoring inspection conducted by the Department. For owner-occupied residential housing units, continued compliance shall be verified (i) by means of an annual monitoring inspection, (ii) by documentation that no child less than six years of age has resided in or regularly visited the residential housing unit within the past year, or (iii) by documentation that no child less than six years of age residing in or regularly visiting the unit has an elevated blood lead level.

(k) Removal of children from the residential housing unit or child-occupied facility shall not constitute ~~abatement or~~ remediation if the property continues to be used for a residential housing unit or child-occupied ~~facility.~~facility. The remediation requirements imposed in subsection (a) of this section apply so long as the property continues to be used as a residential housing unit or child-occupied facility."

SECTION 7. G.S. 130A-131.9G reads as rewritten:

"**§ 130A-131.9G. Resident responsibilities.**

In any residential housing unit occupied by a child less than ~~6~~ six years ~~old~~ of age who has an elevated blood lead level of 10 micrograms per deciliter or greater, the Department shall advise, in writing, the owner or managing agent and the child's parents or legal guardian ~~as to~~of the importance of carrying out routine cleaning activities in the units they occupy, own, or manage. ~~Such~~ The cleaning activities shall ~~include:~~include all of the following:

(1) Wiping clean all windowsills with a damp cloth or sponge at least ~~weekly;~~weekly.

(2) Regularly washing all surfaces accessible to ~~children;~~children.

(3) In the case of a leased residential housing unit, identifying any deteriorated paint in the unit and notifying the owner or managing agent of ~~such~~ the conditions within 72 hours of ~~discovery;~~ ~~and~~discovery.

(4) Identifying and understanding potential lead poisoning hazards in the environment of each child ~~under the age of 6~~ less than six years of age in the unit (including toys, vinyl miniblinds, playground equipment, drinking water, soil, and painted surfaces), and taking steps to prevent children from ingesting lead such as encouraging children to wash their faces and hands frequently and especially after playing outdoors."

SECTION 8. This act becomes effective 1 July 2003.

SENATE BILL 519:
Child Lead Poisoning Prevention Pgrm. Amends

BILL ANALYSIS

Committee:	House Health	**Introduced by:**	Senator Purcell
Date:	May 23, 2003	**Summary by:**	Sandra Alley
Version:	Third Edition		Committee Counsel

SUMMARY: ***Senate Bill 519 amends the law governing the Childhood Lead Poisoning Prevention Program within the Division of Environmental Health (Department) to revise the Program's environmental lead hazard and clean-up standards so that they are consistent with revised federal standards and guidelines; and to codify programmatic procedures currently in place with respect to investigations and remedial actions when a child is suspected or confirmed to have been exposed an environmental lead hazard. The bill is recommended by the Department as an agency bill and becomes effective July 1, 2003***

CURRENT LAW: The statutes governing the environmental lead hazard detection and remediation aspects of the North Carolina Childhood Lead Poisoning Prevention Program (NC CLPPP) are set forth in Part 4 of Article 5 of Chapter 130A.

Screening: Childhood lead poisoning has been a reportable condition under NC state law since 1990. Laboratories are required to report any test with a lead blood level of 1 microgram per deciliter (*u*g/dL) or greater to the Department. When the Department has a reasonable suspicion that a child less than 6 years old has a blood lead level of 15 *u*g/dL, the Department is authorized to require that the child be examined and tested for lead. Since 1994 the State Laboratory provides blood lead analysis at no charge for children who are uninsured.

Since 1998 NC CLPPP has implemented a statewide screening program targeting children between the ages of 12 and 24 months who are participating in the Medicaid, WIC, or Health Choice programs. Children under 6 years with lead poisoning (blood lead level of 20 *u*g/dL or higher) are provided with medical follow-up and health education as recommended by the National Centers for Disease Control (CDC) at the clinic where the child was screened.

Investigations: Under current law, when a child less than 6 years old has been screened and is found to have blood lead levels of 10 *u*g/dL or higher, the Department must advise the owner or manager of any residential housing unit occupied by the child about the importance of routine cleaning to prevent potential lead hazards.

When a child less than 6 years old has been identified with a blood lead levels of 15 *u*g/dL or higher, the Department is required to conduct an environmental investigation of residential housing unit or child care facility where the child resides, regularly visits, or attends. If the child has a blood lead level of 20 *u*g/dL or greater, the Department must also conduct an investigation of any supplemental addresses the child may have. During such an investigation, the family is interviewed and environmental samples are collected for laboratory analysis. Once the sources of lead exposure are identified, the owners of the residence or facility are notified. The costs associated with the investigation are reimbursable under Medicaid (up to $438 per child).

Note: Childcare facilities are routinely inspected as a condition of licensure for lead hazards. If an inspector has a reasonable suspicion that a lead hazard exists the Department is notified and an investigation is initiated for the presence of lead hazards.

Abatement and remediation: Owners who have been notified that a lead hazard exists are required to abate lead-based *paint* hazards (i.e., permanently remove, enclose or encapsulate) and remediate all other lead poisoning hazards. The owner must submit a written remediation plan to the local health department for approval prior to commencing. The plan must include specific information as required by rules adopted by the Commission for Health Services, including time frames for completion, methods, and clearance procedures to be performed. Local health departments receive $2,000 per child from State appropriations for each child requiring an environmental investigation. This funding supports childhood screening and follow-up medical services as well as costs related to conducting environmental investigations.

BILL ANALYSIS:

Programmatic changes:

Sections 2 through 4 codify current environmental intervention policies in place pursuant to recommendations issued by the State Health Director in 1999. These policies include:

1. All blood lead level test results from screenings conducted on children less than 6 years of age must be reported to the Department, including tests that are negative for lead. See Section 2.
2. A reasonable suspicion that a child has a blood lead level of 10 *u*g/dL or greater will trigger an intervention by the Department. The current law's threshold is 15 *u*g/dL. See Section 3 and 4.
3. The Department is given new authority to investigate the residential housing unit where a child with a blood lead level of 10 *u*g/dL or greater IF the Department obtains informed consent of the owner or tenant of the property. See Section 4.

Sections 5 and 6 delete all references to "*abatement of lead-based paint hazards*" from the statutes governing the clean up lead hazards. The reason for the deletions is that "abatement" (see definition, page 1, lines 9-19), falls within the definition of "remediation" (see definition, page 2, lines 23-24), and therefore it is redundant to use both terms.

Section 6 also:

1. Updates the law to conform to revised environmental lead hazard standards (see explanation below);
2. Requires the removal of vinyl miniblinds that constitute a lead hazard and any substances containing lead that intended for use by children less than 6 years old. (See page 7, lines 17-19); and
3. Provides that remediation is only necessary so long as the property continues to be used as a residential housing unit or child occupied facility. (See page 8, lines 11-13.)

Changes to environmental lead hazard and clean-up standards:

The bill makes significant changes to the definition of "*lead poisoning hazard*". Briefly, under the new definition, lead is considered to be a hazard if there are greater than 40 micrograms of lead in dust per square foot on floors; 250 micrograms of lead in dust per square foot on interior window sills and 400 parts per million of lead in bare soil in children's play area or 1200 parts per million average for bare soil in the rest of the yard. To compare current statutory thresholds with the proposed thresholds, see the table on the next page.

Substance/Surface	Current Standard	Revised Standard	Other Changes Proposed
Lead-based paint	1 milligram per square centimeter or greater measured by x-ray fluorescence or 0.5% by chemical analysis and on "a readily accessible substance or mouthable lead bearing substance"	Same	Lead-based paint will meet the definition of "lead poisoning hazard" only if it is on either a readily accessible or chewable surface (must see evidence of teeth marks) OR a deteriorated or damaged interior or exterior surface
Dust on floors	100 micrograms per square foot or greater	40 micrograms per square foot or greater	
Dust on interior windowsills	500 micrograms per square foot or greater	250 micrograms per square foot or greater	Bill adds the following surfaces to this standard: *vinyl miniblinds, bathtubs, kitchen sinks, and lavatories*
Bare soil in children's play areas	400 parts per million (ppm) or greater	400 ppm or greater	Allows 1200 ppm in any other part of a yard
Drinking water	Less than 15 parts per billion	Same	
Any substance that contains lead and is intended for use by children less than 6 years of age.	No existing standard	0.06% lead by weight as determined by chemical analysis -- a standard allowed by the Consumer Products Safety Center	
Ceramic ware	No existing standard	3 micrograms of lead per milliliter of leaching solution for flatware or 0.5 micrograms per milliliter for cups, mugs and pitchers	Standard allows measurements of leaching potential of lead, rather than total lead content
Window trough	800 micrograms per square foot or greater	400 micrograms per square foot or greater	

The bill makes conforming amendments to other definitions.

BACKGROUND:

The health effects of lead exposure: Health problems from exposure to lead can include profound developmental and neurological impairment in children. The Environmental Protection Agency (EPA) estimates that nearly 1 million children in the US have dangerously elevated levels of lead in their blood. The CDC defines an elevated blood lead level as 10 *u*g/dL or greater. According to CDC survey data, elevated blood lead levels are more common among low-income children, urban children, and those living in subsidized housing.

Revised EPA standards: The EPA adopted new, more protective environmental lead hazard standards in 2001. The standards are intended to guide state and local governments and the federal Housing and Urban Development (HUD) in adopting benchmarks upon which to base remedial actions to safeguard children and the public from the dangers of lead. Landlords, parents, and childcare providers use these standards to make informed decisions regarding lead found in their homes, yards or play areas. The standards proposed in this legislation will bring NC laws in line with the current EPA standards.

North Carolina Childhood Lead Surveillance Data: In the most recent year that data is available (2002), over 120,000 children under 6 years old were screened for lead and 528 children had blood lead levels of 10 *u*g/dL or greater. Of those 528 children, 68 children had blood lead levels of 20 *u*g/dL or greater.

Linda Attarian, former Staff Attorney, contributed significantly to this report.

S519-SMSP-001

ATTACHMENT XXI

2003 COMMITTEE REPORT
HOUSE OF REPRESENTATIVES

The following report(s) from standing committee(s) is/are presented:
By Representatives **Verla Insko and Carolyn Justus,** Chairs for the Committee on **HEALTH**.

☒ Committee Substitute for
S.B. 519 A BILL TO BE ENTITLED AN ACT TO AMEND THE LAW REGARDING THE PREVENTION AND CONTROL OF LEAD POISONING IN CHILDREN.

☒ With a favorable report.

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

☐ With a favorable report, as amended.

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

☐ With a favorable report as to the committee substitute bill (# H.B.), ☐ 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)

3/06/03

FOR JOURNAL USE ONLY

____ Pursuant to Rule 36(b), the bill/resolution is placed on the Calendar of _____.

____ The (committee substitute) bill/resolution (, as amended,) is (ordered engrossed and) re-referred to the Committee on _____.

____ The bill/resolution is re-referred to the Committee on _____.

____ On motion of (Rep. _____,) (the Chair,) the (committee substitute) bill/resolution is (ordered engrossed and) re-referred to the Committee on _____.

____ Pursuant to Rule 36(b), the (House)committee substitute bill (No. ____)/resolution is placed on the Calendar of _____. (The original bill) (House Committee Substitute Bill No. ____)/resolution is placed on the Unfavorable Calendar.

____ On motion of Rep. _____, (the rules are suspended) (Rule ____ is suspended) and the bill/resolution is placed on today's calendar. (for immediate consideration.)

____ On motion of Rep. _____, Committee Amendment No.(s) _____ is/are adopted (by EV____ ____).

____ On motion of Rep. _____, Committee Amendment No.(s) _____ is/are adopted (by EV____ ____).

____ Rep. _____ offers Amendment No. _____ which (is adopted.) (fails of adoption.) (by EV ____ ____.) ( ) This amendment changes the title.

____ The bill/resolution (, as amended,) passes its second reading (by following vote, ____ ____ RC) (, by EV ____ ____,) and (remains on the Calendar,) (and there being no objection is read a third time).

____ The bill/resolution (, as amended,) passes its third reading (by the following vote, ____ ____ RC) (, by EV ____ ____,) and is ordered
____ sent to the Senate.
____ without engrossment. ____ by Special message.
____ sent to the Senate for concurrence in
_____ the House amendment (s).
_____the House committee substitute bill.
____ enrolled.

____ On motion of Rep. _____, the House concurs in the (material) Senate _____ (by the following vote, ____ ____ RC) (, by EV ____ ____,) and the bill is ordered enrolled.

House Committee on Health

April 24, 2003

Minutes

The House Committee on Health met on Thursday, April 24, 2003, 2003 at 12:00 noon in Room 544 of the Legislative Office Building. A silent roll was taken. A copy of the roll denoting members present is attached to the minutes (Attachment I) along with a copy of the agenda and Visitor Registration Sheet (Attachments II and III).

Chair Justus welcomed visitors and members and recognized the pages: Austin Branch of Pitt County sponsored by Rep. Tolson and Joy Hawley of Harnett County sponsored by Rep. Lewis. Dusty Rhodes, Charles Williams and Aaron Woodlief were recognized as the sergeant-at-arms. (Attachment IV)

Chair Justus advised that bills would be heard out of order.

Chair Justus called upon Rep. Brubaker to explain his bill HB 1177 A BILL TO BE ENTITLED AN ACT TO PROVIDE THAT PHYSICIANS IN GOOD STANDING TO PRACTICE MEDICINE IN ANOTHER STATE MAY PRACTICE MEDICINE OR SURGERY AT A CAMP FOR THERAPEUTIC RECREATION FOR INDIVIDUALS WITH CHRONIC ILLNESSES UNDER CERTAIN RESTRICTED CONDITIONS. (Attachment V) This bill allows physicians who are licensed and in good standing in another state to come to North Carolina to practice medicine or surgery at therapeutic recreational camps without being subject to the state law that bars the practice of medicine without a license. (Bill Analysis as Attachment VI). Rep. Brubaker referred to the Kyle Petty Camp in North Carolina for disabled children and would allow visiting physicians to such camps to practice without charge. Rep. Wright makes motion that the bill receive a favorable report. Motion adopted. (Committee Report - Attachment VII)

Chair Justus then calls upon Rep. Brubaker to explain his next bill HB 916 A BILL TO BE ENTITLED AN ACT TO ESTABLISH A VACCINATION PROGRAM FOR FIRST RESPONDERS TO TERRORIST INCIDENTS, CATASTROPHIC OR NATURAL DISASTERS, OR EMERGENCIES. (Attachment VIII) Proposed committee substituted offered and Rep. Insko makes motion that the proposed committee substituted be adopted for discussion. (Attachment IX) Motion adopted. This bill establishes a first responders vaccination program for first responders who may be exposed to infectious diseases when deployed to disaster locations. Vaccinations will be available to first responders when recommended by the US Public Health Service. (Bill Analysis Attachment X). Rep. Sherrill makes motion for a favorable report as to the committee substitute and unfavorable as to the original bill. Motion adopted. (Committee Report –Attachment XI)

Rep. Justus advises that a fiscal note has now been prepared for the next bill and calls upon Rep. Alexander to continue her explanation of HB 815 A BILL TO BE ENTITLED AN ACT TO AMEND THE DEFINITION OF CHEMICAL DEPENDENCY TREATMENT FACILITY TO PROVIDE THAT SOCIAL SETTING DETOXIFICATION FACILITIES AND MEDICAL DETOXIFICATION FACILITIES ARE NOT CHEMICAL DEPENDENCY TREATMENT FACILITIES FOR THE PURPOSES OF CERTIFICATE OF NEED REQUIREMENTS AND TO AMEND THE DEFINITION OF CHEMICAL DEPENDENCY TREATMENT BED TO PROVIDE THAT BEDS LICENSED FOR DETOXIFICATION ARE NOT CHEMICAL DEPENDENCY TREATMENT BEDS FOR THE PURPOSES OF CERTIFICATE OF NEED REQUIREMENTS. (Attachment XII) (Bill Analysis attached as Attachment XIII) Rep. Alexander restates that bill amends GS 131E-176 to exempt social setting detoxification facilities and medical detoxification facilities from Certificate of Need requirements. Rep. Alexander then requests staff review the fiscal note (Attachment XIV) for members. Staff states that for fiscal year 2003-04 that the projected number of Medicaid eligible clients to be served (10% of 2,401) will be 240 at a cost per day of $315 for an average of 5 days. Thus, the projected increased Medicaid expenditure per year is $378,000. The Federal Revenue Share is @62.56% ($236,477) with expenditures of the state's Medicaid share @85% of non-federal funds ($120,295) and the county's Medicaid share @15% of non-federal or $21,228. The Division of Mental Health, Developmental Disabilities, and Substance Abuse Services advised that it would cover the fiscal impact to the Medicaid budget in the Division of Medical Assistance through cost savings associated with the downsizing of the state psychiatric hospitals. Rep. Sherrill expressed concerned about local shares. Tara Larson of the Department of MH/DD/SAS stated that counties are required to put up matching funds. Rep. Sherrill then moves bill be referred to Appropriations. Rep. Insko suggests the fiscal note needs to be fixed for division to cover local match and could this be done in appropriations. Rep. Sherrill responded that there was a 9:00 a.m. Appropriations meeting on Tuesday to adjust these bills. Rep. Sherrill then moves that the bill be given a favorable report and recommends that bill be re-referred to the Committee on Appropriations. Motion adopted. (Committee Report – Attachment XV)

Chair Justus asked Rep. Alexander to explain her bill HB 907 A BILL TO BE ENTITLED AN ACT TO AMEND THE LAWS RELATING TO THE COUNCIL FOR THE DEAF AND HARD OF HEARING, TO INCREASE THE MEMBERS ON THE COUNCIL, AND TO CHANGE THE APPOINTING AUTHORITY FOR TWO OF THE MEMBERS APPOINTED TO THE COUNCIL. (Attachment XVI) Rep. Alexander offers a proposed committee substitute. (Attachment XVII) Rep. Sherrill moves to adopt the proposed committee substitute for discussion and motion is adopted. Rep. Alexander explains the bill will amend the laws relating to the Council for the Deaf and the Hard of Hearing and will change the appointing authority and membership composition of two of the members appointed to the Council. In addition, the proposed committee substitute increases the members on the Council from 25 to 27. (Bill Analysis – Attachment XVIII) Rep. Wilson makes motion for a favorable report as to the committee substitute which changes the title and unfavorable as to the original bill. Motion adopted. (Committee Report – Attachment XIX)

Chair then calls upon Reps. Wright and Howard to continue with their bill HB 886 A BILL TO BE ENTITLED AN ACT TO AMEND VARIOUS PROVISIONS RELATING OT THE NORTH CAROLINA MEDICAL BOARD UNDER THE LAWS REGULATING THE PRACTICE OF MEDICINE. (Attachment XX) Rep. Wright offers a new proposed committee substitute. Rep. Wilson makes motion to adopt the proposed committee substitute for discussion purposes and it is adopted. (Attachment XXI) Rep. Wright advises that bill has changed substantially and Dianna Jessup, staff, explains that long title has changed to reflect changes in bill and refers members to the bill analysis (Attachment XXII).

Representative McAllister moves that the bill be given a favorable report as to the committee substitute, which changes the title, and unfavorable as to the original bill.

Questions arise concerning language in bill that refers to each appointing and nominating authority to ensure, insofar as possible, that its appointees and nominees to the Board reflect the composition of the State with regard to ethnic, racial, age and religious but then states that three members must be nominated from a specific group, the Old North State Medical Society. After some discussion about adding more women and naming a specific group, the members agree that representation on board should be integrated, but to designate one group is the wrong approach. Rep. Wright offers amendment that of the remaining five members, all to be appointed by the Governor, one shall be duly licensed physicians who is a doctor of osteopathy or a full-time faculty member of one of the medical school in North Carolina who utilizes integrative medicine in their clinical practice or a member of The Old North State Medical Society. Rep Sherrill offers technical amendment to add the word "gender" on page 2, line 24 to read "Each appointing and nominating authority shall ensure, insofar as possible, that its appointees and nominees to the Board reflect the composition of the State with regard to gender, ethnic, racial, age, and religious composition".

Representative McAllister makes motion to roll the amendments into a committee substitute, favorable as to the committee substitute, which changes the title, unfavorable as to the original bill. Motion is adopted. (Committee Report - Attachment XXIII)

Meeting adjourned at 1:01 p.m.*

Carolyn Justus, Chair

Pamela Evans, Committee Clerk

(Note: Due to time, HB 923 Exempt Alt. Medicine/Practice of Medicine and HB 1043 Health Provider Immunity/Terrorist Incidents was not heard. For the record, bills are attached as Attachment XXIV.)

ATTACHMENT I

ATTENDANCE

HOUSE COMMITTEE ON HEALTH

DATES	4/24/03														
INSKO, Verla CHAIR	✓														
JUSTUS, Carolyn CHAIR	✓														
ENGLAND, Bob VICE-CHAIR															
ADAMS, Alma															
ALLEN, Bernard	✓														
ALLEN, Gordon	✓														
ALLRED, Cary	✓														
BARNHART, Jeff	✓														
BOWIE, Joni	✓														
CLARY, Debbie															
EARLE, Beverly															
GLAZIER, Rick															
HILTON, Mark	✓														
McALLISTER, Mary	✓														
MUNFORD, Don	✓														
SETZER, Mitchell	✓														
SHERRILL, Wilma	✓														
WAINWRIGHT, William	✓														
WILSON, Connie	✓														
WRIGHT, Tom	✓														
Ex officio Members															
Brubaker, Bru	✓														
Culpepper, Bill															
Cunningham, Pete															
Eddins, Rick															

ATTACHMENT II

AGENDA

HOUSE COMMITTEE ON HEALTH

April 24, 2003
Room 544 LOB
12:00 Noon

OPENING REMARKS

Representative Verla Insko, Chair
Representative Carolyn Justus, Chair

AGENDA ITEMS

HB 815 Detox Facilities Not Subject to CON-Rep. Alexander

HB 907 Deaf/Hard of Hearing Advisory Council – Rep. Alexander

HB 916 First-Responders Vaccination Program – Rep. Brubaker

HB1177 Volunteer M.D.s at Therapeutic Rec. Camps – Rep. Brubaker

HB 886 Due Process for Physicians – Reps. Wright and Howard

HB 923 Exempt Alt. Medicine/Practice of Medicine-Rep. Luebke

HB1043 Health Provider Immunity/Terrorist Incidents-Rep. Harrell

ADJOURNMENT

ATTACHMENT III

VISITOR REGISTRATION SHEET

HOUSE COMMITTEE ON HEALTH — APRIL 24, 2003

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
S. Norton	62 Fernwood CH
Mark Smith	NCSA
John McMillan	NF+S
Ann Cole	DVHS
Lee-Ann Coe	NCPA
Joanne Stevens	Nursing
Amy Martin	Interpreters Incorporated
Linda Harrington	DHHS
Angela Tull	DHHS
Cam Cain	BPM/L
Julie Ingle	Durham

VISITOR REGISTRATION SHEET

HOUSE COMMITTEE ON HEALTH — APRIL 24, 2003

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Susan Gaylord	2307 Bedford St. Durham, NC
Dana Simpson	Smith Anderson
Bob Seligson	NCMS
Lori Ann Harris	LA Harris & Assoc Inc

VISITOR REGISTRATION SHEET

Name of Committee

Date

VISITORS: PLEASE SIGN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Barbara Zelter	Citizens for Healthcare Freedom 1903 Craig St. Raleigh, NC
Bobby Riddle	PFFPNC
Greg Sudamito	G&L
[illegible]	GSK
Margaret Bennett	self - 2707 Anderson Drive, Raleigh NC
Carolyn Ellis	citizen
[illegible]	citizen
[illegible]	
Julie Allen	NC Statewatch
Ken Melton	Alley Associates
E. Sonny Dalton	Bové & Associates
[illegible]	EJ&R
[illegible]	Smith Anderson
[illegible]	Pfizer Inc
[illegible]	Eli Lilly
[illegible]	Bowe & Assoc
Hugh Tilson	NCHA
Susan Siegel	UNC School of Medicine
[illegible]	ADCNC
[illegible]	Piedmont BHC
[illegible]	NC Council
[illegible]	Piedmont BHC
Melanie Phelps	NCMS
Thomas Mansfield	NC Med Board
Liz Knauf	NC Med Board/NCMS
[illegible]	AGO
[illegible]	"
[illegible]	"

House Pages

1. Name: Austin Branch
   County: Pitt
   Sponsor: Tolson
2. Name: Jay Hawley
   County: Harnett
   Sponsor: Lewis
3. Name: _____
   County: _____
   Sponsor: _____
4. Name: _____
   County: _____
   Sponsor: _____
5. Name: _____
   County: _____
   Sponsor: _____

Sgt-At-Arms

1. Name: Dusty Rhodes
2. Name: Charles Williams
3. Name: Aaron Woodlief
4. Name: _____

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2003

H 1

HOUSE BILL 1177

Short Title:	Volunteer M.D.s at Therapeutic Rec. Camps.	(Public)
Sponsors:	Representative Brubaker.	
Referred to:	Health.	

April 10, 2003

A BILL TO BE ENTITLED

AN ACT TO PROVIDE THAT PHYSICIANS IN GOOD STANDING TO PRACTICE MEDICINE IN ANOTHER STATE MAY PRACTICE MEDICINE OR SURGERY AT A CAMP FOR THERAPEUTIC RECREATION FOR INDIVIDUALS WITH CHRONIC ILLNESSES UNDER CERTAIN RESTRICTED CONDITIONS.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 90-18(c) reads as rewritten:

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

. . .

(19) The practice of medicine or surgery by any physician who comes into this State to practice medicine or surgery at a camp that specializes in providing therapeutic recreation for individuals with chronic illnesses, as long as all the following conditions are satisfied:

a. The physician is licensed and in good standing to practice medicine in another state.

b. The physician provides services only at the camp or in connection with camp events or camp activities that occur off the grounds of the camp.

c. The physician receives no compensation for the services.

d. The physician provides those services within this State for no more than 14 days per calendar year.

e. The camp has a medical director who holds an unrestricted license to practice medicine and surgery issued under this Article."

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

VOLUNTEER M.D.S AT THERAPEUTIC RECREATION CAMPS: House Bill 1177

BILL ANALYSIS

Committee:	House Health	**Introduced by:**	Rep. Brubaker
Date:	April 23, 2003	**Summary by:**	Sandra Alley
Version:	First Edition		Committee Counsel

SUMMARY: ***House Bill 1177 allows physicians who are licensed and in good standing in another state to come to this state to practice medicine or surgery at therapeutic recreational camps without being subject to the state law that bars the practice of medicine without a license. This act is effective when it becomes law.***

CURRENT LAW: North Carolina law restricts the practice of medicine or surgery to persons licensed under North Carolina law. The definition of "practicing medicine or surgery" in the statute is very broad:

"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, 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." N.C.G.S. §90-18(b).

The list of activities deemed not to constitute practicing medicine or surgery is extensive, including domestic and family emergencies, dentistry, nursing and the practice of medicine or surgery by any surgeon or physician in the U.S. army, navy or public health service in the discharge of his official duties. Current law does not, however, provide an exception for out-of-state physicians who volunteer at therapeutic camps in North Carolina.

BILL ANALYSIS: House Bill 1177 would add another exception to the list of exceptions contained in §90-18(c)(1)-(18). The exception would encompass the practice of medicine or surgery by any physician who comes to a therapeutic recreation camp form individuals with chronic illness as long as they meet certain conditions. The physician must be: licensed and in good standing to practice medicine in another state; provide services only at the camp or in connection with the camp; provide services as a volunteer; provide services for no more than 14 days a year; and the camp must have a medical director with an unrestricted license to practice medicine or surgery in North Carolina.

This act is effective when it becomes law.

2003 COMMITTEE REPORT
HOUSE OF REPRESENTATIVES

The following report(s) from standing committee(s) is/are presented:
By Representatives **Verla Insko and Carolyn Justus,** Chairs for the Committee on **HEALTH**.

☐ Committee Substitute for
H.B. 1177 A BILL TO BE ENTITLED AN ACT TO PROVIDE THAT PHYSICIANS IN GOOD STANDING TO PRACTICE MEDICINE IN ANOTHER STATE MAY PRACTICE MEDICINE OR SURGERY AT A CAMP FOR THERAPEUTIC RECREATION FOR INDIVIDUALS WITH CHRONIC ILLNESSES UNDER CERTAIN RESTRICTED CONDITIONS.

☒ 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 (# H.B.), ☐ 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)

3/06/03

FOR JOURNAL USE ONLY

____ Pursuant to Rule 36(b), the bill/resolution is placed on the Calendar of _____.

____ The (committee substitute) bill/resolution (, as amended,) is (ordered engrossed and) re-referred to the Committee on _____.

____ The bill/resolution is re-referred to the Committee on _____.

____ On motion of (Rep. _____,) (the Chair,) the (committee substitute) bill/resolution is (ordered engrossed and) re-referred to the Committee on _____.

____ Pursuant to Rule 36(b), the (House)committee substitute bill (No. ____)/resolution is placed on the Calendar of _____. (The original bill) (House Committee Substitute Bill No. ____)/resolution is placed on the Unfavorable Calendar.

____ On motion of Rep. _____, (the rules are suspended) (Rule ____ is suspended) and the bill/resolution is placed on today's calendar. (for immediate consideration.)

____ On motion of Rep. _____, Committee Amendment No.(s) _____ is/are adopted (by EV____ ____).

____ On motion of Rep. _____, Committee Amendment No.(s) _____ is/are adopted (by EV____ ____).

____ Rep. _____ offers Amendment No. _____ which (is adopted.) (fails of adoption.) (by EV ____ ____.) ( ) This amendment changes the title.

____ The bill/resolution (, as amended,) passes its second reading (by following vote, ____ ____ RC) (, by EV ____ ____,) and (remains on the Calendar,) (and there being no objection is read a third time).

____ The bill/resolution (, as amended,) passes its third reading (by the following vote, ____ ____ RC) (, by EV ____ ____,) and is ordered
____ sent to the Senate.
____ without engrossment. ____ by Special message.
____ sent to the Senate for concurrence in
_____ the House amendment (s).
_____ the House committee substitute bill.
____ enrolled.

____ On motion of Rep. _____, the House concurs in the (material) Senate _____ (by the following vote, ____ ____ RC) (, by EV ____ ____,) and the bill is ordered enrolled.

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2003

HOUSE BILL 916

Short Title:	First-Responders Vaccination Program.	(Public)
Sponsors:	Representatives Brubaker; and Insko.	
Referred to:	Health.	

April 8, 2003

A BILL TO BE ENTITLED

AN ACT TO ESTABLISH A VACCINATION PROGRAM FOR FIRST RESPONDERS TO TERRORIST INCIDENTS, CATASTROPHIC OR NATURAL DISASTERS, OR EMERGENCIES.

The General Assembly of North Carolina enacts:

SECTION 1. Article 22 of Chapter 130A of the General Statutes is amended by adding the following new section to read:

"**§ 130A-485. Vaccination program established; definitions.**

(a) The Department shall offer a vaccination program for first responders who may be exposed to infectious diseases when deployed to disaster locations. The vaccinations shall include, but are not limited to, hepatitis A vaccination, hepatitis B vaccination, diptheria-tetanus vaccination, influenza vaccination, pneumococcal vaccination, and other vaccinations when recommended by the United States Public Health Service and in accordance with Federal Emergency Management Directors Policy. Immune globulin will be made available when necessary, as determined by the State Health Director.

(b) Participation in the vaccination program is voluntary by the first responders, except for first responders who are classified as having "occupational exposure" to bloodborne pathogens as defined by the Occupational Safety and Health Administration Standard contained at 29 C.F.R. § 1910.10300 who shall be required to take the designated vaccinations or otherwise required by law.

(c) The Department shall exempt from vaccinations first responders who present a written statement from a licensed physician indicating that a vaccine is medically contraindicated for the first responder or the first responder signs a written statement that the administration of a vaccination conflicts with the first responder's religious tenets.

(d) In the event of a vaccine shortage, the State Public Health Director, in consultation with the Centers for Disease Control and Prevention, shall give priority for vaccination to first responders.

(e) The Department shall notify first responders of the availability of the vaccination program and shall provide educational materials on ways to prevent exposure to infectious diseases.

(f) The Department may contract with local and district health departments, not-for-profit home health care agencies, hospitals, and physicians to administer a vaccination program for first responders.

(g) As used in this section, unless the context clearly requires otherwise, the term:

(1) 'Bioterrorism' means the intentional use of any microorganism, virus, infectious substance, biological product, or biological agent as defined in G.S. 130A-479 that may be engineered as a result of biotechnology or any naturally occurring or bioengineered component of any microorganism, virus, infectious substance, or biological product to cause or attempt to cause death, disease, or other biological malfunction in any living organism.

(2) 'Disaster locations' means any geographical location where a bioterrorism attack, terrorist incident, catastrophic or natural disaster, or emergency occurs.

(3) 'First responders' means State and local law enforcement personnel, fire department personnel, and emergency medical personnel who will be deployed to bioterrorism attacks, terrorist attacks, catastrophic or natural disasters, or emergencies."

SECTION 2. Nothing in this act obligates the General Assembly to appropriate State funds for the implementation of this act. The Department of Health and Human Services shall apply for federal funds available to implement a vaccination program for first responders as enacted in Section 1 of this act and, upon receipt of federal funds, shall implement the vaccination program established by this act.

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

ATTACHMENT IX

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2003

H D

HOUSE BILL 916
PROPOSED COMMITTEE SUBSTITUTE H916-CSSP-3 [v.1]

4/23/2003 5:12:01 PM

Short Title: First-Responders Vaccination Program. (Public)

Sponsors:

Referred to:

April 8, 2003

A BILL TO BE ENTITLED

AN ACT TO ESTABLISH A VACCINATION PROGRAM FOR FIRST RESPONDERS TO TERRORIST INCIDENTS, CATASTROPHIC OR NATURAL DISASTERS, OR EMERGENCIES.

The General Assembly of North Carolina enacts:

SECTION 1. Article 22 of Chapter 130A of the General Statutes is amended by adding the following new section to read:

"**§ 130A-485. Vaccination program established; definitions.**

(a) The Department and local health departments shall offer a vaccination program for first responders who may be exposed to infectious diseases when deployed to disaster locations. The vaccinations shall include, but are not limited to, hepatitis A vaccination, hepatitis B vaccination, diptheria-tetanus vaccination, influenza vaccination, pneumococcal vaccination, and other vaccinations when recommended by the United States Public Health Service and in accordance with Federal Emergency Management Directors Policy. Immune globulin will be made available when necessary, as determined by the State Health Director.

(b) Participation in the vaccination program is voluntary by the first responders, except for first responders who are classified as having "occupational exposure" to bloodborne pathogens as defined by the Occupational Safety and Health Administration Standard contained at 29 C.F.R. § 1910.10300 who shall be required to take the designated vaccinations or otherwise required by law.

(c) The Department shall exempt from vaccinations first responders who present a written statement from a licensed physician indicating that a vaccine is medically contraindicated for the first responder or the first responder signs a written statement that the administration of a vaccination conflicts with the first responder's religious tenets.

(d) In the event of a vaccine shortage, the State Public Health Director, in consultation with the Centers for Disease Control and Prevention, shall give priority for vaccination to first responders deployed to a disaster location.

(e) The Department shall notify first responders of the availability of the vaccination program and shall provide educational materials on ways to prevent exposure to infectious diseases.

(f) As used in this section, unless the context clearly requires otherwise, the term:

(1) 'Bioterrorism' means the intentional use of any microorganism, virus, infectious substance, biological product, or biological agent as defined in G.S. 130A-479 that may be engineered as a result of biotechnology or any naturally occurring or bioengineered component of any microorganism, virus, infectious substance, or biological product to cause or attempt to cause death, disease, or other biological malfunction in any living organism.

(2) 'Disaster locations' means any geographical location where a bioterrorism attack, terrorist incident, catastrophic or natural disaster, or emergency occurs.

(3) 'First responders' means State and local law enforcement personnel, fire department personnel, and emergency medical personnel who will be deployed to bioterrorism attacks, terrorist attacks, catastrophic or natural disasters, or emergencies."

SECTION 2. Nothing in this act obligates the General Assembly to appropriate State funds for the implementation of this act. The Department of Health and Human Services shall work with local employers to access, when available, federal funds to implement a vaccination program for first responders as enacted in Section 1 of this act.

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

FIRST-RESPONDERS VACCINATION PROGRAM: House Bill 916

BILL ANALYSIS

Committee:	House Health	**Introduced by:**	Reps. Brubaker and Insko
Date:	April 23, 2003	**Summary by:**	Sandra Alley
Version:	First Edition		Committee Counsel

SUMMARY: ***House Bill 916 establishes a first responders vaccination program for first responders who may be exposed to infectious diseases when deployed to disaster locations. Vaccinations will be available to first responders when recommended by the United States Public Health Service. This act is effective when it becomes law.***

BILL ANALYSIS: House Bill 916 establishes a vaccination program in the Department of Health and Human Services and local health departments for first responders who may be exposed to infectious diseases when deployed to disaster locations. Under the bill "first responders" are State and local law enforcement personnel and emergency medical personnel who would be deployed to such locations. Participation in the program is voluntary for most first responders. The program would be mandatory for first responders who are exposed to bloodborne pathogens including but not limited to hepatitis B virus and HIV. A first responder may be exempt from vaccinations for medical or religious reasons. Under the bill the State Public Health Director must give priority to first responders deployed to a disaster location if there is a shortage of vaccine. The Department shall notify first responders about the availability of the program and shall provide educational materials about how to prevent exposure to infectious diseases. The Department and local health departments will implement the vaccination program upon the application for and receipt of federal funds.

BACKGROUND: The state legislatures of Oklahoma and Mississipi have passed similar legislation but the bills have yet to be signed into law. In addition, Kentucky and Missouri state legislatures have considered similar legislation.

Amy Compeau, Research Assistant, contributed to this summary.

2003 COMMITTEE REPORT
HOUSE OF REPRESENTATIVES

The following report(s) from standing committee(s) is/are presented:
By Representatives **Verla Insko and Carolyn Justus,** Chairs for the Committee on **HEALTH**.

☐ Committee Substitute for
H.B. 916 A BILL TO BE ENTITLED AN ACT TO ESTABLISH A VACCINATION PROGRAM FOR FIRST RESPONDERS TO TERRORIST INCIDENTS, CATASTROPHIC OR NATURAL DISASTERS , OR EMERGENCIES.

☐ 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 (~~# H.B.);~~ ☐ ~~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)

3/06/03

FOR JOURNAL USE ONLY

____ Pursuant to Rule 36(b), the bill/resolution is placed on the Calendar of _____.

____ The (committee substitute) bill/resolution (, as amended,) is (ordered engrossed and) re-referred to the Committee on _____.

____ The bill/resolution is re-referred to the Committee on _____.

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____ On motion of Rep. _____, Committee Amendment No.(s) _____ is/are adopted (by EV____ ____).

____ On motion of Rep. _____, Committee Amendment No.(s) _____ is/are adopted (by EV____ ____).

____ Rep. _____ offers Amendment No. _____ which (is adopted.) (fails of adoption.) (by EV ____ ____.) ( ) This amendment changes the title.

____ The bill/resolution (, as amended,) passes its second reading (by following vote, ____ ____ RC) (, by EV ____ ____,) and (remains on the Calendar,) (and there being no objection is read a third time).

____ The bill/resolution (, as amended,) passes its third reading (by the following vote, ____ ____ RC) (, by EV ____ ____,) and is ordered
____ sent to the Senate.
____ without engrossment. ____ by Special message.
____ sent to the Senate for concurrence in
_____ the House amendment (s).
_____the House committee substitute bill.
____ enrolled.

____ On motion of Rep. _____, the House concurs in the (material) Senate _____ (by the following vote, ____ ____ RC) (, by EV ____ ____,) and the bill is ordered enrolled.

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2003

HOUSE BILL 815

Short Title:	Detox Facilities Not Subject to CON.	(Public)
Sponsors:	Representatives Alexander; and Insko.	
Referred to:	Health.	

April 1, 2003

A BILL TO BE ENTITLED

AN ACT TO AMEND THE DEFINITION OF CHEMICAL DEPENDENCY TREATMENT FACILITY TO PROVIDE THAT SOCIAL SETTING DETOXIFICATION FACILITIES AND MEDICAL DETOXIFICATION FACILITIES ARE NOT CHEMICAL DEPENDENCY TREATMENT FACILITIES FOR THE PURPOSES OF CERTIFICATE OF NEED REQUIREMENTS AND TO AMEND THE DEFINITION OF CHEMICAL DEPENDENCY TREATMENT BED TO PROVIDE THAT BEDS LICENSED FOR DETOXIFICATION ARE NOT CHEMICAL DEPENDENCY TREATMENT BEDS FOR THE PURPOSES OF CERTIFICATE OF NEED REQUIREMENTS.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 131E-176(5a) reads as rewritten:

"(5a) "Chemical dependency treatment facility" means a public or private facility, or unit in a facility, which is engaged in providing 24-hour a day treatment for chemical dependency or substance abuse. This treatment may include detoxification, administration of a therapeutic regimen for the treatment of chemically dependent or substance abusing persons and related services. The facility or unit may be:

a. A unit within a general hospital or an attached or freestanding unit of a general hospital licensed under Article 5, Chapter 131E, of the General Statutes,

b. A unit within a psychiatric hospital or an attached or freestanding unit of a psychiatric hospital licensed under Article 1A of General Statutes Chapter 122 or Article 2 of General Statutes Chapter 122C,

c. A freestanding facility specializing in treatment of persons who are substance abusers or chemically dependent licensed under Article 1A of General Statutes Chapter 122 or Article 2 of General Statutes Chapter 122C; and may be identified as

"chemical dependency, substance abuse, alcoholism, or drug abuse treatment units," "residential chemical dependency, substance abuse, alcoholism or drug abuse facilities," ~~"social setting detoxification facilities" and "medical detoxification facilities,"~~ or by other names if the purpose is to provide treatment of chemically dependent or substance abusing persons, but shall not include social setting detoxification facilities, medical detoxification facilities, halfway houses or recovery farms."

SECTION 2. G.S. 131E-176(5b) reads as rewritten:

"(5b) "Chemical dependency treatment beds" means beds that are licensed ~~for detoxification or~~ for the inpatient treatment of chemical dependency. Residential treatment beds for the treatment of chemical dependency or substance abuse are chemical dependency treatment beds. Chemical dependency treatment beds shall not include beds licensed for detoxification."

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

HOUSE BILL 815:
Detox Facilities Not Subject to CON

BILL ANALYSIS

Committee:	House Health	**Introduced by:**	Rep. Alexander
Date:	April 15, 2003	**Summary by:**	Dianna Jessup
Version:	First Edition		Committee Counsel

SUMMARY: ***House Bill 815 would exempt social setting detoxification facilities and medical detoxification facilities from Certificate of Need requirements. The act would become effective when it becomes law.***

CURRENT LAW:

Certificate of Need: State law prohibits health care providers from acquiring, replacing, or adding to their facilities and equipment unless the provider obtains a Certificate of Need from the Department of Health and Human Services (DHHS). A Certificate of Need is also required before beginning to offer certain health services. The purpose of the CON is to control health care costs by preventing the unnecessary duplication of medical facilities and services and to help ensure the geographic distribution of health care facilities and services. All new hospitals, psychiatric facilities, chemical dependency treatment facilities, nursing homes, adult care homes, kidney disease treatment centers, intermediate care facilities for the mentally retarded, rehabilitation facilities, home health agencies hospices, diagnostic centers, oncology treatment centers, and ambulatory surgical facilities must first obtain a CON before developing new facilities or offering new services.

Chemical Dependency Treatment Facilities: Chemical dependency treatment facilities are currently subject to CON requirements. G.S. 131E-176 defines a "chemical dependency treatment facility" to be a public or private facility, or unit in a facility, which is engaged in providing 24-hour a day treatment for chemical dependency or substance abuse. This treatment may include detoxification, therapy, and related services. "Halfway houses" and "recovery farms" are not considered "chemical dependency treatment facilities" for CON purposes.

Social Setting Detoxification Facilities and Medical Detoxification Facilities: Social setting detoxification facilities and medical detoxification facilities are considered "chemical dependency treatment facilities" under G.S. 131E-176. They are licensed under Article 2 of Chapter 122C of the General Statutes. Services provided by social setting detoxification facilities are not eligible for reimbursement under Medicaid. Medicaid does cover medical detoxification if provided at an acute care hospital. These facilities do not engage in treatment for substance abuse.

BILL ANALYSIS: House Bill 815 would exempt social setting detoxification facilities and medical detoxification facilities from CON requirements, the same as halfway houses and recovery farms. Persons who want to offer or develop these facilities would not have to seek the prior approval of DHHS. Licensing requirements would still apply. The act would become effective when it becomes law.

H815-SMSW-001

Amy Compeau, Research Assistant, contributed to this summary.

NORTH CAROLINA GENERAL ASSEMBLY

LEGISLATIVE FISCAL NOTE

BILL NUMBER: House Bill 815 (First Edition)

SHORT TITLE: Detox Facilities Not Subject to CON

SPONSOR(S): Representatives Alexander and Insko

FISCAL IMPACT

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

	FY 2003-04	FY 2004-05	FY 2005-06	FY 2006-07	FY 2007-08
REVENUES					
Federal Medicaid	$236,477	$236,477	$236,477	$236,477	$236,477
EXPENDITURES					
State Medicaid Share	$120,295	$120,295	$120,295	$120,295	$120,295
Local					
County Medicaid Share	$21,228	$21,228	$21,228	$21,228	$21,228

PRINCIPAL DEPARTMENT(S) & PROGRAM(S) AFFECTED: Department of Health and Human Services

The Division of Mental Health, Developmental Disabilities, and Substance Abuse Services has stated that it will cover the fiscal impact to the Medicaid budget in the Division of Medical Assistance through cost savings associated with the downsizing of the state psychiatric hospitals. The necessary amount would be transferred from the Division of Mental Health, Developmental Disabilities, and Substance Abuse Services budget to the Division of Medical Assistance budget.

EFFECTIVE DATE: When the bill becomes law.

BILL SUMMARY: House Bill 815 amends G.S. 131E-176 to exclude social-setting detoxification and medical detoxification facilities from certificate of need requirements.

By removing these two types of facilities, the development of detoxification facilities that are independent of general and psychiatric hospitals would no longer require certificates of need from the Department of Health and Human Services (DHHS). As a result, there would be no state regulation of the number of freestanding detoxification facilities in the State, but DHHS would continue to license and regulate the operation of such facilities.

Residential treatment facilities for chemical dependent persons would still be subject to certificates of need.

ASSUMPTIONS AND METHODOLOGY: In developing the fiscal impact of the proposed bill, three general issues were considered: (1) the anticipated increase in the Medicaid program; (2) the net fiscal impact to the State's Alcohol and Drug Abuse Treatment Centers (ADATC's), and; (3) the net fiscal impact to Division of Facility Services.

Medicaid

Non-hospital medical detoxification is a reimbursable service for persons eligible for Medicaid. The removal of the certificate of need requirement is expected to increase the availability of detoxification beds throughout the State. According to DHHS, these additional beds coupled with the existing need for services should result in increased Medicaid expenditures.

In calculating the impact to the Medicaid budget, DHHS developed the following assumptions:

- The number of individuals who have unmet detoxification needs is 3,600 per year.
- 33.3% of these individuals would use social setting detoxification services.
- 66.7% of these individuals would use non-hospital medical detoxification services.
- 10% of individuals needing non-hospital detoxification services are eligible for Medicaid.
- The average cost per day for non-hospital medical detoxification services is $315.
- The cost per day of detoxification services will not inflate over the next five years.
- The average length of stay is 5 days.
- The increase in new detoxification beds will equal the unmet need for services.

Using these assumptions, DHHS calculated the following:

Projected Fiscal Impact (DMA Budget):	**Non-Hospital Medical Detox**
Projected Number of **Medicaid Eligible** Clients to be Served per Year (10% of 2,401 individuals)	240
Cost per Day	$315
Average Number of Days	5
Projected Increased Medicaid Expenditure per Year	**$378,000**
Federal Share @ 62.56%	$236,477
State Share @ 85% of Non-federal	$120,295
County Share @ 15% of Non-federal	$ 21,228

Alcohol and Drug Abuse Treatment Centers (ADATC's)

DHHS is currently developing detoxification service capacity in the State's ADATC's. Without certificate of need requirements for freestanding detoxification activities, the increased capacity for detoxification services across the State could reduce the demand for detoxification beds in the ADATC's.

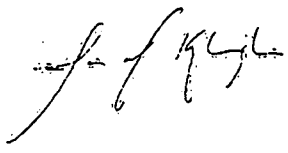
DHHS anticipates that the ADATC detoxification beds will operate at capacity, serving roughly 3.600 persons per year. *These 3,600 persons are not included in the assumption mentioned in the previous section regarding persons with unmet detoxification needs.* According to DHHS,

the 3,600 persons to be served in the ADATC's will be served within existing budget for DHHS. All other impacts addressed in this fiscal note assume that there is an unmet need for detoxification services over and above services provided at the ADATC's. This new detoxification capacity at the ADACT's is not expected to impact the assumed demand for new community detoxification services. **As a result, no net fiscal impact is expected in the DHHS regarding the statewide increase in detoxification beds.**

Division of Facility Services (DFS)
DFS is current responsible for issuing certificates of need to freestanding detoxification facilities. By excluding freestanding detoxification facilities from certificates of need requirements, DFS is expecting a small cost savings associated with reduced workload in issuing certificates of need. This cost savings is balanced by increased costs associated with licensing and regulating an increased number of freestanding detoxification facilities. According to DHHS, the savings and costs should balance out in the end. **As a result, no net fiscal impact is expected to DFS.**

FISCAL RESEARCH DIVISION: (919) 733-4910

PREPARED BY: Jim Klingler, Fiscal Analyst



APPROVED BY: James D. Johnson, Director Fiscal Research Division

DATE: April 23, 2003

ATTACHMENT XV

2003 COMMITTEE REPORT
HOUSE OF REPRESENTATIVES

The following report(s) from standing committee(s) is/are presented:
By Representatives **Verla Insko and Carolyn Justus,** Chairs for the Committee on **HEALTH**.

☐ Committee Substitute for
H.B. 815 A BILL TO BE ENTITLED AN ACT TO AMEND THE DEFINITION OF CHEMICAL DEPENDENCY TREATMENT FACILITY TO PROVIDE THAT SOCIAL SETTING DETOXIFICATION FACILITIES AND MEDICAL DETOXIFICATION FACILITIES ARE NOT CHEMICAL DEPENDENCY TREATMENT FACILITIES FOR THE PURPOSES OF CERTIFICATE OF NEED REQUIREMENTS AND TO AMEND THE DEFINITION OF CHEMICAL DEPENDENCY TREATMENT BED TO PROVIDE THAT BEDS LICENSED FOR DETOXIFICATION ARE NOT CHEMICAL DEPENDENCY TREATMENT BEDS FOR THE PURPOSES OF CERTIFICATE OF NEED 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 the committee substitute bill (# H.B.), ☐ 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)

3/06/03

FOR JOURNAL USE ONLY

____ Pursuant to Rule 36(b), the bill/resolution is placed on the Calendar of _____.

____ The (committee substitute) bill/resolution (, as amended,) is (ordered engrossed and) re-referred to the Committee on _____.

____ The bill/resolution is re-referred to the Committee on _____.

____ On motion of (Rep. _____,) (the Chair,) the (committee substitute) bill/resolution is (ordered engrossed and) re-referred to the Committee on _____.

____ Pursuant to Rule 36(b), the (House)committee substitute bill (No. ____)/resolution is placed on the Calendar of _____. (The original bill) (House Committee Substitute Bill No. ____)/resolution is placed on the Unfavorable Calendar.

____ On motion of Rep. _____, (the rules are suspended) (Rule ____ is suspended) and the bill/resolution is placed on today's calendar. (for immediate consideration.)

____ On motion of Rep. _____, Committee Amendment No.(s) _____ is/are adopted (by EV____ ____).

____ On motion of Rep. _____, Committee Amendment No.(s) _____ is/are adopted (by EV____ ____).

____ Rep. _____ offers Amendment No. _____ which (is adopted.) (fails of adoption.) (by EV ____ ____.) ( ) This amendment changes the title.

____ The bill/resolution (, as amended,) passes its second reading (by following vote, ____ ____ RC) (, by EV ____ ____,) and (remains on the Calendar,) (and there being no objection is read a third time).

____ The bill/resolution (, as amended,) passes its third reading (by the following vote, ____ ____ RC) (, by EV ____ ____,) and is ordered
____ sent to the Senate.
____ without engrossment. ____ by Special message.
____ sent to the Senate for concurrence in
_____ the House amendment (s).
_____the House committee substitute bill.
____ enrolled.

____ On motion of Rep. _____, the House concurs in the (material) Senate _____ (by the following vote, ____ ____ RC) (, by EV ____ ____,) and the bill is ordered enrolled.

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2003

HOUSE BILL 907*

Short Title:	Deaf/Hard of Hearing Advisory Council.	(Public)
Sponsors:	Representative Alexander.	
Referred to:	Health.	

April 7, 2003

A BILL TO BE ENTITLED

AN ACT TO AMEND THE LAWS RELATING TO THE COUNCIL FOR THE DEAF AND HARD OF HEARING AND TO CHANGE THE APPOINTING AUTHORITY AND MEMBERSHIP COMPOSITION OF TWO OF THE MEMBERS APPOINTED TO THE COUNCIL.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 143B-216.31 reads as rewritten:

"**§ 143B-216.31. Council for the Deaf and the Hard of Hearing – creation and duties.**

There is hereby created the Council for the Deaf and the Hard of Hearing of the Department of Health and Human Services. The Council shall have duties including the following:

(1) To make recommendations to the Secretary of the Department of Health and Human Services ~~regarding improvement of human services to the deaf and the hard of hearing;~~for cost-effective provision, coordination, and improvement of services;

(2) To ~~study ways to promote public understanding of the problems of the deaf and the hard of hearing and to consider the need for new State programs concerning deafness;~~create public awareness of the specific needs and abilities of people who are deaf, hard of hearing, or deaf-blind and to consider the need for new State programs concerning the deaf, hard of hearing, and deaf-blind;

(3) To advise the Secretary of the Department of Health and Human Services ~~in the preparation of a plan describing the quality, extent and scope of services provided or to be provided, to deaf and hard of hearing persons in this State;~~during planning and implementation of services being provided to North Carolina citizens who are deaf, hard of hearing, or deaf-blind with respect to the quality, extent, and scope of those services;

(4) To ~~study any State programs that provide educational services for deaf and hard of hearing persons and to advise the Secretary of the Department of Health and Human Services and the Superintendent of Public Instruction concerning coordination of these programs to prevent duplication of services; and~~advise the Secretary of the Department of Health and Human Services and the Superintendent of the Department of Public Instruction regarding planning, implementation, and cost-effective coordination of State programs providing educational services for persons who are deaf, hard of hearing, or deaf-blind; and

(5) To ~~advise and make recommendations to the Secretary of the Department of Health and Human Services upon any matter as requested by the Secretary.~~respond to the Secretary of the Department of Health and Human Services' requests for advice or recommendations pertaining to any matter affecting deaf, hard of hearing, or deaf-blind citizens of North Carolina."

SECTION 2. G.S. 143B-216.32 reads as rewritten:

"**§ 143B-216.32. Council for the Deaf and the Hard of Hearing – membership; quorum; compensation.**

(a) The Council for the Deaf and the Hard of Hearing shall consist of 25 members. ~~Fifteen~~ Seventeen members shall be members appointed by the Governor. Three members appointed by the Governor shall be persons who are ~~deaf and~~deaf, three members shall be persons who are hard of hearing. One appointment shall be an educator who trains deaf education teachers and one appointment shall be an audiologist licensed under Article 22 of Chapter 90 of the General Statutes. Three appointments shall be parents of deaf or hard of hearing children including one parent of a student in a residential school; one parent of a student in a preschool program; and one parent of a student in a mainstream education program, with at least one parent coming from each region of the North Carolina schools for the deaf regions. One member appointed by the Governor shall be recommended by the President of the North Carolina Association of the Deaf; one member shall be recommended by the President of the North Carolina Deaf-Blind Associates; one member shall be recommended by the President of the North Carolina Pediatric Society; one member shall be recommended by the President of the North Carolina Registry of Interpreters for the Deaf; one member shall be recommended by a local education agency; and one member shall be nominated by the Superintendent of Public Instruction. ~~Two members~~One member shall be appointed from the House of Representatives by the Speaker of the House of Representatives and ~~two members~~one member shall be appointed from the Senate by the President Pro Tempore of the Senate. The Secretary of Health and Human Services shall appoint six members as follows: one from the Division of Vocational Rehabilitation, one from the Division of Aging, one from the Division of Mental Health, Developmental Disabilities, and Substance Abuse Services, one from the Division of Social Services, ~~one from a North Carolina Chapter of SHHH (Self Help for the Hard of Hearing), and one from SPEAK (Statewide Parents' Education and Advocacy for Kids).~~one member upon the

recommendation of the North Carolina Chapter of Self Help for the Hard of Hearing (SHHH), and one upon the recommendation of the North Carolina Black Deaf Advocates (NCBDA).

(b) The terms of the initial members of the Council shall commence July 1, 1989. In his initial appointments, the Governor shall designate four members who shall serve terms of five years, four who shall serve terms of four years, four who shall serve terms of three years, and three who shall serve terms of two years. After the initial appointees' terms have expired, all members shall be appointed for a term of four years. No member ~~appointed by the Governor~~ shall serve more than two successive ~~terms.~~terms unless the member is an employee of the Department of Health and Human Services or the Department of Public Instruction representing his or her agency as a specialist in the field of service.

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.

(c) The chairman of the Council shall be designated by the Secretary of the Department of Health and Human Services from the Council members. The chairman shall hold this office for not more than four years.

(d) The Council shall meet quarterly and at other times at the call of the chairman. A majority of the Council shall constitute a quorum.

(e) Council members shall be reimbursed for expenses incurred in the performance of their duties in accordance with G.S. 138-5.

(f) The Secretary of the Department of Health and Human Services shall provide clerical and other assistance as needed."

SECTION 3. Pursuant to G.S. 143B-216.32(a), as enacted in Section 2 of this act, when the term of the member appointed by the Secretary of Health and Human Services who is a representative from Statewide Parents' Education and Advocacy for Kids (SPEAK) expires, the Secretary of Health and Human Services shall appoint one member upon the recommendation of the North Carolina Black Deaf Advocates to serve a four-year term to commence when this act becomes effective.

Pursuant to G.S. 143B-216.32(a), as enacted in Section 2 of this act, the member appointed by the Governor as recommended by the President of the North Carolina Deaf-Blind Associates shall be appointed for a four-year term to commence when this act becomes effective and the member appointed by the Governor as recommended by a local education agency shall be appointed for a four-year term to commence when this act becomes effective. Members described in this section shall serve for the terms for which they were appointed and until their successors are appointed and qualified.

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

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2003

H D

HOUSE BILL 907*
PROPOSED COMMITTEE SUBSTITUTE H907-CSLU-3 [v.2]

4/13/2003 7:17:19 PM

Short Title: Deaf/Hard of Hearing Advisory Council. (Public)

Sponsors:

Referred to:

April 7, 2003

A BILL TO BE ENTITLED

AN ACT TO AMEND THE LAWS RELATING TO THE COUNCIL FOR THE DEAF AND HARD OF HEARING, TO INCREASE THE MEMBERS ON THE COUNCIL, AND TO CHANGE THE APPOINTING AUTHORITY FOR TWO OF THE MEMBERS APPOINTED TO THE COUNCIL.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 143B-216.31 reads as rewritten:

"**§ 143B-216.31. Council for the Deaf and the Hard of Hearing – creation and duties.**

There is hereby created the Council for the Deaf and the Hard of Hearing of the Department of Health and Human Services. The Council shall have duties including the following:

(1) To make recommendations to the Secretary of the Department of Health and Human Services ~~regarding improvement of human services to the deaf and the hard of hearing;~~for cost-effective provision, coordination, and improvement of services;

(2) To ~~study ways to promote public understanding of the problems of the deaf and the hard of hearing and to consider the need for new State programs concerning deafness;~~create public awareness of the specific needs and abilities of people who are deaf, hard of hearing, or deaf-blind and to consider the need for new State programs concerning the deaf, hard of hearing, and deaf-blind;

(3) To advise the Secretary of the Department of Health and Human Services ~~in the preparation of a plan describing the quality, extent and scope of services provided or to be provided, to deaf and hard of hearing persons in this State;~~during planning and implementation of services being provided to North Carolina citizens who are deaf, hard

of hearing, or deaf-blind with respect to the quality, extent, and scope of those services;

(4) To ~~study any State programs that provide educational services for deaf and hard of hearing persons and to advise the Secretary of the Department of Health and Human Services and the Superintendent of Public Instruction concerning coordination of these programs to prevent duplication of services; and~~advise the Secretary of the Department of Health and Human Services and the Superintendent of the Department of Public Instruction regarding planning, implementation, and cost-effective coordination of State programs providing educational services for persons who are deaf, hard of hearing, or deaf-blind; and

(5) To ~~advise and make recommendations to the Secretary of the Department of Health and Human Services upon any matter as requested by the Secretary.~~respond to the Secretary of the Department of Health and Human Services' requests for advice or recommendations pertaining to any matter affecting deaf, hard of hearing, or deaf-blind citizens of North Carolina."

SECTION 2. G.S. 143B-216.32 reads as rewritten:

"**§ 143B-216.32. Council for the Deaf and the Hard of Hearing – membership; quorum; compensation.**

(a) The Council for the Deaf and the Hard of Hearing shall consist of ~~25~~ 27 members. ~~Fifteen~~ Nineteen members shall be members appointed by the Governor. Three members appointed by the Governor shall be persons who are ~~deaf and~~deaf, three members shall be persons who are hard of hearing. One appointment shall be an educator who trains deaf education teachers and one appointment shall be an audiologist licensed under Article 22 of Chapter 90 of the General Statutes. Three appointments shall be parents of deaf or hard of hearing children including one parent of a student in a residential school; one parent of a student in a preschool program; and one parent of a student in a mainstream education program, with at least one parent coming from each region of the North Carolina schools for the deaf regions. One member appointed by the Governor shall be recommended by the President of the North Carolina Association of the Deaf; one member shall be recommended by the President of the North Carolina Deaf-Blind Associates; one member shall be recommended by the North Carolina Chapter of Self Help for the Hard of Hearing (SHHH); one member shall be recommended by the North Carolina Black Deaf Advocates (NCBDA); one member shall be recommended by the President of the North Carolina Pediatric Society; one member shall be recommended by the President of the North Carolina Registry of Interpreters for the Deaf; one member shall be recommended by a local education agency; and one member shall be ~~nominated~~ recommended by the Superintendent of Public Instruction. Two members shall be appointed from the House of Representatives by the Speaker of the House of Representatives and two members shall be appointed from the Senate by the President Pro Tempore of the Senate. The Secretary of Health and Human Services shall appoint ~~six~~ four members as follows: one from the Division

of Vocational Rehabilitation, one from the Division of Aging, one from the Division of Mental Health, Developmental Disabilities, and Substance Abuse Services, and one from the Division of Social ~~Services, one from a North Carolina Chapter of SHHH (Self Help for the Hard of Hearing), and one from SPEAK (Statewide Parents' Education and Advocacy for Kids).~~Services.

(b) The terms of the initial members of the Council shall commence July 1, 1989. In his initial appointments, the Governor shall designate four members who shall serve terms of five years, four who shall serve terms of four years, four who shall serve terms of three years, and three who shall serve terms of two years. After the initial appointees' terms have expired, all members shall be appointed for a term of four years. No member ~~appointed by the Governor~~ shall serve more than two successive ~~terms.~~terms unless the member is an employee of the Department of Health and Human Services or the Department of Public Instruction representing his or her agency as a specialist in the field of service.

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.

(c) The chairman of the Council shall be designated by the Secretary of the Department of Health and Human Services from the Council members. The chairman shall hold this office for not more than four years.

(d) The Council shall meet quarterly and at other times at the call of the chairman. A majority of the Council shall constitute a quorum.

(e) Council members shall be reimbursed for expenses incurred in the performance of their duties in accordance with G.S. 138-5.

(f) The Secretary of the Department of Health and Human Services shall provide clerical and other assistance as needed."

SECTION 3. Pursuant to G.S. 143B-216.32(a), as enacted in Section 2 of this act, when the term of the member appointed by the Secretary of Health and Human Services who is a representative from the North Carolina Chapter of Self Help for the Hard of Hearing (SHHH) expires, the Governor shall appoint one member upon the recommendation of the North Carolina Chapter of Self Help for the Hard of Hearing to a serve a four-year term to commence when this act becomes effective. When the term of the member appointed by the Secretary of Health and Human Services who is a representative from Statewide Parents' Education and Advocacy for Kids (SPEAK) expires, the Governor shall appoint one member upon the recommendation of the North Carolina Black Deaf Advocates to serve a four-year term to commence when this act becomes effective.

Pursuant to G.S. 143B-216.32(a), as enacted in Section 2 of this act, the member appointed by the Governor as recommended by the President of the North Carolina Deaf-Blind Associates shall be appointed for a four-year term to commence when this act becomes effective and the member appointed by the Governor as recommended by a local education agency shall be appointed for a four-year term to commence when this act becomes effective. Members described in this section shall

serve for the terms for which they were appointed and until their successors are appointed and qualified.

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

HOUSE BILL 907:
Deaf/Hard of Hearing Advisory Council

BILL ANALYSIS

Committee:	House Health	**Introduced by:**	Rep. Alexander
Date:	April 17, 2003	**Summary by:**	Amy Compeau
Version:	H907-CSLU-3 [v.2]		Research Division Staff

SUMMARY: House Bill 907 would amend the laws relating to the Council for the Deaf and the Hard of Hearing (Council) and would change the appointing authority and membership composition of two of the members appointed to the Council. The act would become effective when it becomes law.

The PCS to House Bill 907 would increase the members on the Council from 25 to 27 and would make additional changes described below.

CURRENT LAW: S.L. 1989-533 established the Council for the Deaf and the Hard of Hearing of the Department of Health and Human Services (DHHS). The North Carolina General Assembly established the Council to advise the Secretary of DHHS (Secretary) on matters pertaining to the services for deaf and hard of hearing people.

BILL ANALYSIS:

Section 1 would amend the duties of the Council as follows:

1. The bill clarifies that the Council would make recommendations to the Secretary for cost-effective provision, coordination, and improvement of services. (Current law requires the Council to make recommendations regarding improvement of human services to the deaf and hard of hearing.)
2. The bill would require the Council to create public awareness of the specific needs and abilities of people who are deaf, hard of hearing, or deaf-blind. (Current law requires the Council to study ways to promote public understanding.)
3. The bill would specify that the Council would advise the Secretary during planning and implementation of services being provided with respect to the quality, extent, and scope of those services. (Current law requires the Council to advise the Secretary in the preparation of a plan for services to be provided).
4. The Council would advise the Secretary and the Superintendent of the Department of Public Instruction regarding planning, implementation and cost effective coordination of State programs providing educational services for persons who are deaf, hard of hearing, or deaf-blind. (This section of the bill makes clarifying changes to the law.)
5. The Council would respond to the Secretary's requests for advice or recommendations pertaining to any matter affecting deaf, hard of hearing or deaf-blind citizens. (Current law requires the Council to advise the Secretary on any matter requested.)

Section 2 would change the membership, appointing authority, member qualification and term limits of certain Council members. HB 907 would increase the number of members to the Council appointed by the Governor from 15 members to 17 members. The two additional members would be appointed by the Governor as follows: (1) member recommended by the President of the NC Deaf-Blind Associates and (1) member recommended by a local education agency.

The PCS would increase membership to the Council from 25 to 27 members. The two additional members would be appointed by the Governor as follows: (1) member recommended by the North Carolina Chapter of Self Help for the Hard of Hearing (SHHH) and (1) member recommended by the North Carolina Black Deaf Advocates (NCBDA). The PCS, then, would increase the number of Council members appointed by the Governor from 15 members to 19 members.

HB 907 would have taken away one appointee each from the Speaker and President Pro Tempore. *The PCS would maintain current law so that the Speaker and President Pro Tempore could continue making two appointees each to the Council.*

HB 907 changes the recommendations from which the Secretary could make her six appointees to the Council. It would specify that one member would be appointed based upon the recommendation of SHHH (Current law specifies a member of SHHH) and one member would be appointed based upon the recommendation of NCBDA (Current law specifies a member of Statewide Parents' Education and Advocacy for Kids (SPEAK). *The PCS would decrease the number of the Secretary's appointees from six members to four members. The Secretary would no longer appoint a member from SHHH and a member from SPEAK.*

HB 907 would clarify that no member could serve more than two successive terms unless the member is an employee of DHHS or the Department of Public Instruction representing the agency as a specialist in the field of service.

Section 3 would specify staggered terms for the four new appointees of the Governor to the Council.

BACKGROUND: According to Division of Services for the Deaf and Hard of Hearing, DHHS, the bill is deleting an outdated reference in statute, and it adds representation to the Council from two organizations. Current law requires the Secretary to appoint a member from SPEAK, and this organization no longer exists so the bill would delete the reference. The bill would add members to the Council based upon the recommendation of NCBDA and of the President of the North Carolina Deaf-Blind Associates. Current law requires the Secretary to appoint two members to the Council from organizations representing the deaf community. These members do not have term limits. Current law requires the Governor to appoint members to the Council from organizations representing the deaf community as well as other individuals who are deaf or hard of hearing or who are parents of deaf or hard of hearing children. The members appointed by the Governor cannot serve more than two consecutive four-year terms. The bill would require the Governor to make all appointments from the deaf and hard of hearing community to the Council so they would all have the same term limits.

2003 COMMITTEE REPORT
HOUSE OF REPRESENTATIVES

The following report(s) from standing committee(s) is/are presented:
By Representatives **Verla Insko and Carolyn Justus,** Chairs for the Committee on **HEALTH**.

☐ Committee Substitute for
H.B. 907 A BILL TO BE ENTITLED AN ACT TO AMEND THE LAWS RELATING TO THE COUNCIL FOR THE DEAF AND HARD OF HEARING AND TO CHANGE THE APPOINTING AUTHORITY AND MEMBERSHIP COMPOSITION OF TWO OF THE MEMBERS APPOINTED TO THE COUNCIL.

☐ 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 ~~(# H.B.)~~, ☒ 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)

3/06/03

FOR JOURNAL USE ONLY

____ Pursuant to Rule 36(b), the bill/resolution is placed on the Calendar of _____.

____ The (committee substitute) bill/resolution (, as amended,) is (ordered engrossed and) re-referred to the Committee on _____.

____ The bill/resolution is re-referred to the Committee on _____.

____ On motion of (Rep. _____,) (the Chair,) the (committee substitute) bill/resolution is (ordered engrossed and) re-referred to the Committee on _____.

____ Pursuant to Rule 36(b), the (House)committee substitute bill (No. ____)/resolution is placed on the Calendar of _____. (The original bill) (House Committee Substitute Bill No. ____)/resolution is placed on the Unfavorable Calendar.

____ On motion of Rep. _____, (the rules are suspended) (Rule ____ is suspended) and the bill/resolution is placed on today's calendar. (for immediate consideration.)

____ On motion of Rep. _____, Committee Amendment No.(s) _____ is/are adopted (by EV____ ____).

____ On motion of Rep. _____, Committee Amendment No.(s) _____ is/are adopted (by EV____ ____).

____ Rep. _____ offers Amendment No. _____ which (is adopted.) (fails of adoption.) (by EV ____ ____.) ( ) This amendment changes the title.

____ The bill/resolution (, as amended,) passes its second reading (by following vote, ____ ____ RC) (, by EV ____ ____,) and (remains on the Calendar,) (and there being no objection is read a third time).

____ The bill/resolution (, as amended,) passes its third reading (by the following vote, ____ ____ RC) (, by EV ____ ____,) and is ordered
____ sent to the Senate.
____ without engrossment. ____ by Special message.
____ sent to the Senate for concurrence in
_____ the House amendment (s).
_____the House committee substitute bill.
____ enrolled.

____ On motion of Rep. _____, the House concurs in the (material) Senate _____ (by the following vote, ____ ____ RC) (, by EV ____ ____,) and the bill is ordered enrolled.

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2003

HOUSE BILL 886

Short Title:	Due Process for Physicians.	(Public)
Sponsors:	Representatives Wright and Howard (Primary Sponsors).	
Referred to:	Health.	

April 7, 2003

A BILL TO BE ENTITLED

AN ACT TO AMEND VARIOUS PROVISIONS RELATING TO THE NORTH CAROLINA MEDICAL BOARD UNDER THE LAWS REGULATING THE PRACTICE OF MEDICINE.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 90-2 reads as rewritten:

"**§ 90-2. Medical Board.**

(a) In order to properly regulate the practice of medicine and surgery for the benefit and protection of the people of North Carolina, there is established the North Carolina Medical Board. The Board shall consist of 12 members.

(1) Seven of the members shall be duly licensed physicians elected and nominated ~~to~~ by the ~~Governor by the North Carolina Medical Society.~~ Governor. Of the seven members appointed by the Governor, one member shall be a faculty member at one of the medical schools in North Carolina.

(2) Of the remaining five members, all to be appointed by the Governor, at least three shall be public members and at least one shall be a physician assistant as defined in G.S. 90-18.1 or a nurse practitioner as defined in G.S. 90-18.2. A public member shall not be a health care provider nor the spouse of a health care provider. For purposes of board membership, "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 section, a person enrolled in a program to prepare him to be a licensed health care professional or an allied health professional shall be deemed a health care provider. For purposes of this section, any person with significant financial interest in a health service or profession is not a public member.

(b) No member appointed to the Board on or after November 1, 1981, shall serve more than two complete consecutive three-year terms, except that each member shall serve until his successor is chosen and qualifies.

(c) In order to establish regularly overlapping terms, the terms of office of the members shall expire as follows: two on October 31, 1993; four on October 31, 1994; four on October 31, 1995; and two on October 31, 1996.

(d) ~~Any~~A member of the Board ~~may~~ shall be removed from office by the Governor for good cause ~~shown.~~shown, including malicious prosecution or abuse of power. Any vacancy in the physician membership of the Board shall be filled for the period of the unexpired term by the ~~Governor from a list of physicians submitted by the North Carolina Medical Society Executive Council.~~Governor. Any vacancy in the public, physician assistant, or nurse practitioner membership of the Board shall be filled by the Governor for the unexpired term.

(e) The North Carolina Medical Board shall have the power to acquire, hold, rent, encumber, alienate, and otherwise deal with real property in the same manner as any 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."

SECTION 2. G.S. 90-8 reads as rewritten:

"**§ 90-8. Officers may administer oaths, and subpoena witnesses, records and other materials.**

The president and secretary of the Board may administer oaths to all persons appearing before it as the Board may deem necessary to perform its duties, and may summon and issue subpoenas for the appearance of any witnesses deemed necessary to testify concerning any matter to be heard before or inquired into by the Board. The power of the Board to subpoena is limited to persons with knowledge related to a matter before the Board. Medical expert witnesses, including medical practitioners licensed in the United States, must routinely and actively practice in the specialty that is under investigation by the Board. Each party must disclose the identity of an expert, the subjects on which the expert is expected to testify, the substance of the facts and opinions on which the expert is expected to rely, and the qualifications of the expert. Statements contained in medical or scientific literature may be relied upon in direct and cross-examination and admitted into evidence. The Board may order that any patient records, documents or other material concerning any matter to be heard before or inquired into by the Board shall be produced before the Board or made available for inspection, notwithstanding any other provisions of law providing for the application of any physician-patient privilege with respect to such records, documents or other material. All records, documents, or other material compiled by the Board are subject to the provisions of G.S. 90-16. Notwithstanding the provisions of G.S. 90-16, in any proceeding before the Board, in any record of any hearing before the Board, and in the notice of charges against any licensee, the Board shall withhold from public disclosure the identity of a patient including information relating to dates and places of treatment, or any other information that would tend to identify the patient, unless the patient or the

representative of the patient expressly consents to the disclosure. Upon written request, the Board shall revoke a subpoena if, upon a hearing, it finds that the evidence the production of which is required does not relate to a matter in issue, or if the subpoena does not describe with sufficient particularity the evidence the production of which is required, or if for any other reason in law the subpoena is invalid."

SECTION 3. G.S. 90-14(a) reads as rewritten:

"(a) The Board shall have the power to deny, annul, suspend, or revoke a license, or other authority to practice medicine in this State, issued by the Board to any person who has been found by the Board to have committed any of the following acts or conduct, or for any of the following reasons:

(1) Immoral or dishonorable conduct.

(2) Producing or attempting to produce an abortion contrary to law.

(3) Made false statements or representations to the Board, or who has willfully concealed from the Board material information in connection with an application for a license.

(4) Repealed by Session Laws 1977, c. 838, s. 3.

(5) Being unable to practice medicine with reasonable skill and safety to patients by reason of illness, drunkenness, excessive use of alcohol, drugs, chemicals, or any other type of material or by reason of any physical or mental abnormality. The Board is empowered and authorized to require a physician licensed by it to submit to a mental or physical examination by physicians designated by the Board before or after charges may be presented against the physician, and the results of the examination shall be admissible in evidence in a hearing before the Board.

(6) Unprofessional conduct, including, but not limited to, departure from, or the failure to conform to, the standards of acceptable and prevailing medical practice, or the ethics of the medical profession, irrespective of whether or not a patient is injured thereby, or the committing of any act contrary to honesty, justice, or good morals, whether the same is committed in the course of the physician's practice or otherwise, and whether committed within or without North Carolina. The standards of practice in any specialty, including complementary treatments, shall be defined by specialists in that field. The Board shall not annul, suspend, revoke the license of or deny a license to a ~~person~~ person, harass, or initiate an investigation solely because of that person's practice of a therapy that is experimental, nontraditional, or that departs from acceptable and prevailing medical practices unless, by ~~competent~~ a preponderance of the evidence, the Board can establish that the treatment has a ~~safety~~ risk of harm to the patient greater than the prevailing treatment or that the treatment is generally not ~~effective.~~as effective in comparison to the effective rates of other prevailing treatments.

(7) Conviction in any court of a crime involving moral turpitude, or the violation of a law involving the practice of medicine, or a conviction of a felony; provided that a felony conviction shall be treated as provided in subsection (c) of this section.

(8) By false representations has obtained or attempted to obtain practice, money or anything of value.

(9) Has advertised or publicly professed to treat human ailments under a system or school of treatment or practice other than that for which the physician has been educated. A duly licensed physician shall not be prohibited from displaying all of his or her certifications in public documents.

(10) Adjudication of mental incompetency, which shall automatically suspend a license unless the Board orders otherwise.

(11) Lack of professional competence to practice medicine with a reasonable degree of skill and safety for patients. In this connection the Board may consider repeated acts of a physician indicating the physician's failure to properly treat a patient. The Board may, upon reasonable grounds, require a physician to submit to inquiries or examinations, written or oral, by members of the Board or by other physicians licensed to practice medicine in this State, as the Board deems necessary to determine the professional qualifications of such licensee.

(12) Promotion of the sale of drugs, devices, appliances or goods for a patient, or providing services to a patient, in such a manner as to exploit the patient, and upon a finding of the exploitation, the Board may order restitution be made to the payer of the bill, whether the patient or the insurer, by the physician; provided that a determination of the amount of restitution shall be based on credible testimony in the record. Selling nutritional supplements or vitamins shall have the same financial disclosures as those required with drugs, devices, appliances, or goods. Nothing in this subdivision shall restrain free trade or limit the legitimate trade activities involved in the course of the practice of medicine.

(13) Having a license to practice medicine or the authority to practice medicine revoked, suspended, restricted, or acted against or having a license to practice medicine denied by the licensing authority of any jurisdiction. For purposes of this subdivision, the licensing authority's acceptance of a license to practice medicine voluntarily relinquished by a physician or relinquished by stipulation, consent order, or other settlement in response to or in anticipation of the filing of administrative charges against the physician's license, is an action against a license to practice medicine.

(14) The failure to respond, within a reasonable period of time and in a reasonable manner as determined by the Board, to inquiries from the

Board concerning any matter affecting the license to practice medicine. However, the Board shall conclude an investigation pursuant to a violation of this subdivision within 18 months from the date the incident was initially reported.

(15) The failure to complete an amount not to exceed 150 hours of continuing medical education during any three consecutive calendar years pursuant to rules adopted by the Board.

For any of the foregoing reasons, the Board may deny the issuance of a license to an applicant or revoke a license issued to a physician, may suspend such a license for a period of time, and may impose conditions upon the continued practice after such period of suspension as the Board may deem advisable, may limit the accused physician's practice of medicine with respect to the extent, nature or location of the physician's practice as the Board deems advisable. The Board may, in its discretion and upon such terms and conditions and for such period of time as it may prescribe, restore a license so revoked or rescinded, except that no license that has been revoked shall be restored for a period of two years following the date of revocation."

SECTION 4. G.S. 90-14 is amended by adding a new subsection to read:

"(g) In order to annul, suspend, deny, or revoke a license of an accused physician, the Board must find that the facts satisfy, by the greater weight of the evidence, that there is a pattern of incompetence and that the care provided was not in accordance with the standards of practice for the procedures or treatments administered."

SECTION 5. G.S. 90-14.2 reads as rewritten:

"**§ 90-14.2. Hearing before revocation or suspension of a license.**

Before the Board shall revoke, restrict or suspend any license granted by it, the licensee shall be given a written notice indicating the general nature of the charges, accusation, or complaint made against him, which notice may be prepared by a committee or one or more members of the Board designated by the Board, and stating that such licensee will be given an opportunity to be heard concerning such charges or complaint at a time and place stated in such notice, or at a time and place to be thereafter designated by the Board, and the Board shall hold a public hearing not less than 30 days from the date of the service of such notice upon such licensee, at which such licensee may appear personally and through counsel, may cross examine witnesses and present evidence in his own behalf. A physician who is mentally incompetent shall be represented at such hearing and shall be served with notice as herein provided by and through a guardian ad litem appointed by the clerk of the court of the county in which the physician has his residence. Such licensee or physician may, if he desires, file written answers to the charges or complaints preferred against him within 30 days after the service of such notice, which answer shall become a part of the record but shall not constitute evidence in the case. Members of the Board participating on the hearing committee shall not have been involved in any part of the investigation."

SECTION 6. G.S. 90-14.5 reads as rewritten:

"**§ 90-14.5. Use of trial examiner or depositions.**

~~Where the licensee requests~~The licensee may request that the hearing herein provided for be held by the Board in a county other than the county designated for the

holding of the meeting of the Board at which the matter is to be heard, the Board may designate in writing one or more of its members to conduct the hearing as a trial examiner or trial committee, to take evidence and report a written transcript thereof to the Board at a meeting where a majority of the members are present and participating in the decision. Evidence and testimony may also be presented at such hearings and to the Board in the form of depositions taken before any person designated in writing by the Board for such purpose or before any person authorized to administer oaths, in accordance with the procedure for the taking of depositions in civil actions in the superior court. When a trial examiner or trial committee recommends license revocation, suspension, or retraction, the licensee shall be granted a full Board hearing at the licensee's request if the request is made in a timely manner as determined by the Board."

SECTION 7. G.S. 90-14.6 reads as rewritten:

"**§ 90-14.6. Evidence admissible.**

In proceedings held pursuant to this Article the Board shall admit and hear evidence in the same manner and form as prescribed by law for civil actions. A complete record of such evidence shall be made, together with the other proceedings incident to such hearing. The physician under investigation may call witnesses, including medical practitioners licensed in the United States, with expertise in the same field of practice as the physician under investigation. Witnesses shall not be restricted to experts certified by the American Board of Medical Specialties. In an investigative meeting, the physician being investigated may present testimony from medical practitioners licensed in the United States with expertise in the same field of practice as the physician under investigation. Members of the Board shall not be immune from civil or criminal liability for failing to exercise, in good faith, its powers and duties authorized by law."

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

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2003

H D

HOUSE BILL 886
PROPOSED COMMITTEE SUBSTITUTE H886-CSSW-14 [v.6]

4/22/2003 5:53:00 PM

Short Title: Due Process for Physicians. (Public)

Sponsors:

Referred to:

April 7, 2003

A BILL TO BE ENTITLED

AN ACT TO AMEND VARIOUS PROVISIONS RELATING TO THE NORTH CAROLINA MEDICAL BOARD UNDER THE LAWS REGULATING THE PRACTICE OF MEDICINE.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 90-2 reads as rewritten:

"**§ 90-2. Medical Board.**

(a) ~~In order to properly regulate the practice of medicine and surgery for the benefit and protection of the people of North Carolina, there is established the North Carolina Medical Board.~~ There is established the North Carolina Medical Board to regulate the practice of medicine and surgery for the benefit and protection of the people of North Carolina. The Board shall consist of 12 members.

(1) Seven of the members shall be duly licensed physicians ~~elected and nominated to~~ appointed by the ~~Governor by the North Carolina Medical Society.~~ Governor. Of the seven members appointed by the Governor, one member shall be a faculty member at one of the medical schools in North Carolina. In addition, of these seven members, three shall be duly licensed physicians nominated by the North Carolina Medical Society, three shall be duly licensed physicians nominated by The Old North State Medical Society, and one shall be a duly licensed physician nominated by the North Carolina Osteopathic Medical Association.

(2) Of the remaining five members, all to be appointed by the Governor, ~~at least three~~ four shall be public members and ~~at least~~ one shall be either a physician assistant as defined in G.S. 90-18.1 or a nurse practitioner as defined in G.S. 90-18.2. A public member shall not be a health care provider ~~nor~~ or the spouse of a health care provider. For purposes of board membership, "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 section, a person enrolled in a program to prepare ~~him~~ that person to be a licensed health care professional or an allied health professional shall be deemed a health care provider. For purposes of this section, any person with significant financial interest in a health service or profession is not a public member.

(a1) Each appointing and nominating authority shall ensure, insofar as possible, that its appointees and nominees to the Board reflect the composition of the State with regard to ethnic, racial, age, and religious composition.

(b) No member ~~appointed to the Board on or after November 1, 1981,~~ shall serve more than two complete consecutive three-year terms, except that each member shall serve until ~~his~~ a successor is chosen and qualifies.

~~(c) In order to establish regularly overlapping terms, the terms of office of the members shall expire as follows: two on October 31, 1993; four on October 31, 1994; four on October 31, 1995; and two on October 31, 1996.~~

(d) ~~Any~~A member of the Board ~~may~~ shall be removed from office by the Governor for good cause ~~shown.~~shown, including malicious prosecution or abuse of power. Any vacancy in the physician membership of the Board shall be filled for the period of the unexpired term by the ~~Governor from a list of physicians submitted by the North Carolina Medical Society Executive Council.~~Governor from nominees provided by the applicable professional organization. Any vacancy in the public, physician assistant, or nurse practitioner membership of the Board shall be filled by the Governor for the unexpired term.

(e) The North Carolina Medical Board shall have the power to acquire, hold, rent, encumber, alienate, and otherwise deal with real property in the same manner as any 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."

SECTION 1.(a). G.S. 90-3 is repealed.

SECTION 2. G.S. 90-8 reads as rewritten:

"**§ 90-8. Officers may administer oaths, and subpoena witnesses, records and other materials.**

The president and secretary of the Board may administer oaths to all persons appearing before it as the Board may deem necessary to perform its duties, and may summon and issue subpoenas for the appearance of any witnesses deemed necessary to testify concerning any matter to be heard before or inquired into by the Board. The power of the Board to subpoena is limited to persons with knowledge related to a matter before the Board. The Board may order that any patient records, documents or other material concerning any matter to be heard before or inquired into by the Board shall be produced before the Board or made available for inspection, notwithstanding any other provisions of law providing for the application of any physician-patient privilege with

respect to such records, documents or other material. All records, documents, or other material compiled by the Board are subject to the provisions of G.S. 90-16. Notwithstanding the provisions of G.S. 90-16, in any proceeding before the Board, in any record of any hearing before the Board, and in the notice of charges against any licensee, the Board shall withhold from public disclosure the identity of a patient including information relating to dates and places of treatment, or any other information that would tend to identify the patient, unless the patient or the representative of the patient expressly consents to the disclosure. Upon written request, the Board shall revoke a subpoena if, upon a hearing, it finds that the evidence the production of which is required does not relate to a matter in issue, or if the subpoena does not describe with sufficient particularity the evidence the production of which is required, or if for any other reason in law the subpoena is invalid."

SECTION 3. G.S. 90-14(a) reads as rewritten:

"(a) The Board shall have the power to deny, annul, suspend, or revoke a license, or other authority to practice medicine in this State, issued by the Board to any person who has been found by the Board to have committed any of the following acts or conduct, or for any of the following reasons:

(1) Immoral or dishonorable conduct.

(2) Producing or attempting to produce an abortion contrary to law.

(3) Made false statements or representations to the Board, or who has willfully concealed from the Board material information in connection with an application for a license.

(4) Repealed by Session Laws 1977, c. 838, s. 3.

(5) Being unable to practice medicine with reasonable skill and safety to patients by reason of illness, drunkenness, excessive use of alcohol, drugs, chemicals, or any other type of material or by reason of any physical or mental abnormality. The Board is empowered and authorized to require a physician licensed by it to submit to a mental or physical examination by physicians designated by the Board before or after charges may be presented against the physician, and the results of the examination shall be admissible in evidence in a hearing before the Board.

(6) Unprofessional conduct, including, but not limited to, departure from, or the failure to conform to, the standards of acceptable and prevailing medical practice, or the ethics of the medical profession, irrespective of whether or not a patient is injured thereby, or the committing of any act contrary to honesty, justice, or good morals, whether the same is committed in the course of the physician's practice or otherwise, and whether committed within or without North Carolina. The standards of practice in any specialty, including integrative, complementary and alternative medical treatments, shall be defined by specialists that have met the national certification standards for that specific medical treatment. The Board shall not annul, suspend, revoke the license of or deny a license to a ~~person~~ person, or harass a person, solely because of

that person's practice of a therapy that is experimental, nontraditional, or that departs from acceptable and prevailing medical practices unless, by ~~competent~~ a greater weight of the evidence, the Board can establish that the treatment has a ~~safety~~ risk of harm to the patient greater than the prevailing treatment or that the treatment is generally not ~~effective.~~ as effective in comparison to the effective rates of other prevailing treatments.

(7) Conviction in any court of a crime involving moral turpitude, or the violation of a law involving the practice of medicine, or a conviction of a felony; provided that a felony conviction shall be treated as provided in subsection (c) of this section.

(8) By false representations has obtained or attempted to obtain practice, money or anything of value.

(9) Has advertised or publicly professed to treat human ailments under a system or school of treatment or practice other than that for which the physician has been educated. A duly licensed physician shall not be prohibited from displaying all of the physician's certifications in public documents so long as the certifications displayed are not misleading as determined by the Board.

(10) Adjudication of mental incompetency, which shall automatically suspend a license unless the Board orders otherwise.

(11) Lack of professional competence to practice medicine with a reasonable degree of skill and safety for patients. In this connection the Board may consider repeated acts of a physician indicating the physician's failure to properly treat a patient. The Board may, upon reasonable grounds, require a physician to submit to inquiries or examinations, written or oral, by members of the Board or by other physicians licensed to practice medicine in this State, as the Board deems necessary to determine the professional qualifications of such licensee.

(12) Promotion of the sale of drugs, devices, appliances or goods for a patient, or providing services to a patient, in such a manner as to exploit the patient, and upon a finding of the exploitation, the Board may order restitution be made to the payer of the bill, whether the patient or the insurer, by the physician; provided that a determination of the amount of restitution shall be based on credible testimony in the record. The Board shall not deny, annul, suspend, or revoke a license for selling nutritional supplements or vitamins so long as the physician provides the financial disclosures recommended by the Board for drugs, devices, appliances, or goods.

(13) Having a license to practice medicine or the authority to practice medicine revoked, suspended, restricted, or acted against or having a license to practice medicine denied by the licensing authority of any jurisdiction. For purposes of this subdivision, the licensing authority's

acceptance of a license to practice medicine voluntarily relinquished by a physician or relinquished by stipulation, consent order, or other settlement in response to or in anticipation of the filing of administrative charges against the physician's license, is an action against a license to practice medicine.

(14) The failure to respond, within a reasonable period of time and in a reasonable manner as determined by the Board, to inquiries from the Board concerning any matter affecting the license to practice medicine.

(15) The failure to complete an amount not to exceed 150 hours of continuing medical education during any three consecutive calendar years pursuant to rules adopted by the Board.

For any of the foregoing reasons, the Board may deny the issuance of a license to an applicant or revoke a license issued to a physician, may suspend such a license for a period of time, and may impose conditions upon the continued practice after such period of suspension as the Board may deem advisable, may limit the accused physician's practice of medicine with respect to the extent, nature or location of the physician's practice as the Board deems advisable. The Board may, in its discretion and upon such terms and conditions and for such period of time as it may prescribe, restore a license so revoked or rescinded, except that no license that has been revoked shall be restored for a period of two years following the date of revocation. Unless the person under investigation has obstructed a Board investigation by not responding or providing documents requested by the Board, the Board shall conclude an investigation of a violation of this section within 18 months from the date the investigation is initiated and shall notify the person under investigation when the investigation is concluded."

SECTION 4. G.S. 90-14 is amended by adding a new subsection to read:

"(g) In order to annul, suspend, deny, or revoke a license of an accused person, the Board shall find that the facts satisfy, by the greater weight of the evidence, that the care provided was not in accordance with the standards of practice for the procedures or treatments administered.

(h) The Board shall establish an expert review panel on integrative medicine to review cases involving licensees who practice integrative medicine and make recommendations to the Board prior to the Board taking action against any licensee who practices integrative medicine."

SECTION 5. G.S. 90-14.2 reads as rewritten:

"**§ 90-14.2. Hearing before revocation or suspension of a license.**

(a) Before the Board shall revoke, restrict or suspend any license granted by it, the Board shall give the licensee ~~shall be given a~~ written notice indicating the general nature of the charges, accusation, or complaint made against ~~him,~~the licensee. The ~~which~~ notice may be prepared by a committee or one or more members of the Board designated by the ~~Board,~~ Board. ~~and stating~~The notice shall provide that ~~such~~ the licensee ~~will~~ shall be given an opportunity to be heard concerning ~~such~~ the charges or complaint at a time and place stated in ~~such~~ the notice, or at a time and place to be ~~thereafter~~ at some other time designated by the ~~Board, and the~~ Board. The Board shall

hold a public hearing not less than 30 days from the date of the service of ~~such~~ the notice upon ~~such~~ the ~~licensee, at which such~~ licensee.

(b) At the hearing, the licensee may appear personally and through counsel, may cross examine witnesses and present evidence in ~~his~~the licensee's own behalf. A ~~physician~~ licensee who is mentally incompetent shall be represented at ~~such~~ the hearing and shall be served with notice as ~~herein~~ provided in this section by and through a guardian ad litem appointed by the clerk of the court of the county in which the ~~physician has his residence.~~ licensee resides.

(c) At least 15 days prior to any hearing, each party shall disclose the identity of an expert, the subjects on which the expert is expected to testify, the substance of the facts and opinions on which the expert is expected to rely, and the qualifications of the expert.

(d) ~~Such~~ The licensee ~~or physician may, if he desires,~~ may file written answers to the charges or complaints ~~preferred against him~~ within 30 days after the service of ~~such~~ the ~~notice, which~~ notice. The answer shall become a part of the record but shall not constitute evidence in the case."

SECTION 6. G.S. 90-14.6 reads as rewritten:

"**§ 90-14.6. Evidence admissible.**

(a) In proceedings held pursuant to this Article the Board shall admit and hear evidence in the same manner and form as prescribed by law for civil actions. A complete record of such evidence shall be made, together with the other proceedings incident to such hearing.

(b) In proceedings held pursuant to this Article, the licensee under investigation may call witnesses, including medical practitioners licensed in the United States, with expertise in the same field of practice as the licensee under investigation, and the Board shall consider this testimony. Witnesses shall not be restricted to experts certified by the American Board of Medical Specialties.

(c) Statements contained in medical or scientific literature shall be competent evidence in proceedings held pursuant to this Article.

(d) In an investigative meeting, the Board shall hear and consider testimony of medical practitioners licensed in the United States with expertise in the same field of practice as the licensee under investigation."

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

HOUSE BILL 886:
Due Process for Physicians

BILL ANALYSIS

Committee:	House Health	**Introduced by:**	Rep. Wright and Howard
Date:	April 23, 2003	**Summary by:**	Dianna Jessup
Version:	PCS H886-CSSW-14		Committee Counsel

SUMMARY: ***House Bill 886 would amend various provisions relating to the North Carolina Medical Board under the laws regulating the practice of medicine. The act would become effective when it becomes law.***

The PCS makes the changes described more fully below.

CURRENT LAW: The North Carolina Medical Board (Board) is charged with regulating the practice of medicine and surgery in this State. The Board is comprised of 12 members who serve for three-year terms. Of the terms of the current members, four are due to expire in October 2003.

Currently, the North Carolina Medical Society (an association of physicians) nominates seven members for appointment to the Board by the Governor. Nominees from the Society's Executive Council fill any vacancies in these positions.

The Board is authorized to adopt rules governing applicants for licensure, admission, and the conduct of examinations for licensure and admission and to deny, annul, suspend, or revoke the license or other authority to practice medicine in this State. The Board conducts both informal meetings to inquire into matters (called investigative meetings) and formal hearings.

The president and the secretary of the Board may administer oaths and issue subpoenas for the appearance of witnesses to testify concerning any matter before the Board. The Board may also order pertinent documents, including patient records, to be produced for inspection.

The Board can deny, annul, suspend, or revoke a license for a variety of reasons enumerated by statute. Reasons pertinent to this bill include:

1. Unprofessional conduct that departs from the standard of acceptable and prevailing medical practice. The Board cannot, however, revoke the license of or deny a license to a person solely because that person's practice of an experimental or nontraditional therapy unless, by competent evidence, the Board can establish a safety risk greater than the prevailing treatment.
2. Advertising or publicly professing to treat ailments under a system or school of treatment or practice other than that for which the physician has been educated.
3. Promoting the sale of drugs, devices, appliances or goods for a patient or providing services to a patient, in a manner to exploit the patient. There are ethical guidelines from the Board and the American Medical Society relating to the sale of goods from physicians' offices.

Before the Board can revoke, restrict or suspend a license, the licensee must be given notice and an opportunity to be heard. At the hearing, the licensee may cross-examine witnesses and present evidence. The rules of procedure and evidence for civil actions apply. If the licensee requests that the hearing be held in a county other than where the full Board meets, the Board may designate a committee of its members to conduct the hearing.

BILL ANALYSIS:

Section 1 would amend the provisions of the statute related to the appointment and removal of members of the North Carolina Medical Board as follows:

- The original bill provided that the Governor's physician appointees would not be appointed from nominees provided by the North Carolina Medical Society. *The PCS provides that of the physician appointments, three shall be physicians nominated by the North Carolina Medical Society, three shall be physicians nominated by The Old North State Medical Society, and one shall be a physician nominated by the North Carolina Osteopathic Medical Association. Vacancies would be filled from nominees provided by the applicable professional organization.*
- One of the physician appointees would have to be a faculty member at one of the State's medical schools.
- The Governor would be required to remove a member of the Board for "good cause shown", including malicious prosecution or abuse of power.
- *The PCS adds language that would provide that each appointing and nominating authority shall ensure, insofar as possible, that its appointees and nominees reflect the composition of the State with regard to ethnic, racial, age, and religious composition.*

Section 2 would amend the provisions relating to the Board's power to administer oaths and subpoena witnesses to specify that the Board's power to subpoena would be limited to persons with knowledge related to a matter before the Board. *The PCS moves the following language to Sections 5 and 7 of the bill:* Language in this section would specify that medical expert witnesses must routinely and actively practice in the specialty under investigation by the Board, and that for expert witnesses, the parties must disclose *(at least 15 days prior to any hearing)* the expert's identity, the subjects on which the expert is expected to testify, the substance of the facts and opinion on which the expert is expected to rely, and the qualifications of the expert. Statements contained in medical or scientific literature would be competent evidence.

Section 3 would amend the law relating to the grounds for denying, annulling, suspending, or revoking a license to provide as follows:

- The standards of practice in any specialty, including complementary treatments, shall be defined by specialists in that field. *The PCS clarifies that the specialists must meet the national certification standards for that specific medical treatment.*
- The Board cannot annul or suspend a license, and the Board cannot initiate an investigation solely because a person's practice is experimental, nontraditional, or departs from acceptable and prevailing medical practice unless by a preponderance of the evidence, the Board can establish that the treatment has a risk of harm to the patient greater than the prevailing treatment or that the treatment is generally not as effective in comparison to the effective rates of other prevailing treatments.
- A duly licensed physician cannot be prohibited from displaying the physician's certifications in public documents. *The PCS clarifies that the certifications displayed may not be misleading, as determined by the Board.*
- Selling nutritional supplements or vitamins shall have the same financial disclosures as those required with drugs, devices, appliances, or goods. *The PCS clarifies that the Board shall not*

deny, annul, suspend, or revoke a license for selling nutritional supplements or vitamins so long as the physician provides the financial disclosures recommended by the Board for drugs, devices, appliances, or goods.

- The Board must conclude an investigation into a failure to respond to a Board inquiry within 18 months from the date the incident was initially reported. *The PCS makes this provision generally applicable to all investigations unless the person under investigation has obstructed a Board investigation by not responding or providing documents requested by the Board. In addition, the PCS would provide that the Board must notify the accused person of the conclusion of the investigation.*

Section 4 would require the Board to find, by a greater weight of the evidence, a pattern of incompetence and a deviation from the standard of practice in order to be able to annul, suspend, deny, or revoke the license of an accused physician. *The PCS would require the Board to find, by a greater weight of the evidence, that the care provided was not in accordance with the standards of practice for the procedures or treatments administered. In addition, The PCS adds a new subsection that would require the Board to establish an expert review panel on integrative medicine to review cases involving licensees who practice integrative medicine and to make recommendations to the Board prior to the Board taking action against any licensee who practices integrative medicine.*

Section 5 would prohibit members of the Board who investigated a licensee from serving on the hearing committee that conducts the hearing concerning that licensee. *See Section 2 for the changes made by the PCS.*

Formerly Section 6 of the bill would require a full Board hearing in cases where a trial examiner or trial committee recommends license revocation, suspension, or retraction, if the licensee requests one in a timely manner (to be determined by the Board). *The PCS removes this section.*

Formerly Section 7 of the bill would specify that for Board proceedings, a physician under investigation may call witnesses, including medical practitioners, with expertise in the same field of practice as the physician under investigation. Witnesses would not be restricted to experts certified by the American Board of Medical Specialties. In an investigative meeting (a non-public, informal meeting), the physician being investigated may present testimony from licensed medical practitioners with expertise in the same field of practice as the physician. *The PCS makes this Section 6. See Section 2 of the bill summary for other changes made by the PCS.*

This section also adds language that prevents Board members from being immune from civil or criminal liability for failing to exercise, in good faith, its powers and duties authorized by law. *The PCS removes this language.*

Formerly Section 8 of the bill makes the act effective when it becomes law. *The PCS makes this Section 7.*

H866-SMSW-001

ATTACHMENT XXIII

2003 COMMITTEE REPORT
HOUSE OF REPRESENTATIVES

The following report(s) from standing committee(s) is/are presented:
By Representatives **Verla Insko and Carolyn Justus,** Chairs for the Committee on **HEALTH**.

☐ Committee Substitute for
H.B. 886 A BILL TO BE ENTITLED AN ACT TO AMEND VARIOUS PROVISIONS RELATING TO THE NORTH CAROLINA MEDICAL BOARD UNDER THE LAWS REGULATING THE PRACTICE OF MEDICINE.

☐ 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 ~~(# H.B.)~~, ☒ 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)

3/06/03

FOR JOURNAL USE ONLY

____ Pursuant to Rule 36(b), the bill/resolution is placed on the Calendar of _____.

____ The (committee substitute) bill/resolution (, as amended,) is (ordered engrossed and) re-referred to the Committee on _____.

____ The bill/resolution is re-referred to the Committee on _____.

____ On motion of (Rep. _____,) (the Chair,) the (committee substitute) bill/resolution is (ordered engrossed and) re-referred to the Committee on _____.

____ Pursuant to Rule 36(b), the (House)committee substitute bill (No. ____)/resolution is placed on the Calendar of _____. (The original bill) (House Committee Substitute Bill No. ____)/resolution is placed on the Unfavorable Calendar.

____ On motion of Rep. _____, (the rules are suspended) (Rule ____ is suspended) and the bill/resolution is placed on today's calendar. (for immediate consideration.)

____ On motion of Rep. _____, Committee Amendment No.(s) _____ is/are adopted (by EV____ ____).

____ On motion of Rep. _____, Committee Amendment No.(s) _____ is/are adopted (by EV____ ____).

____ Rep. _____ offers Amendment No. _____ which (is adopted.) (fails of adoption.) (by EV ____ ____.) ( ) This amendment changes the title.

____ The bill/resolution (, as amended,) passes its second reading (by following vote, ____ ____ RC) (, by EV ____ ____,) and (remains on the Calendar,) (and there being no objection is read a third time).

____ The bill/resolution (, as amended,) passes its third reading (by the following vote, ____ ____ RC) (, by EV ____ ____,) and is ordered
____ sent to the Senate.
____ without engrossment. ____ by Special message.
____ sent to the Senate for concurrence in
_____ the House amendment (s).
_____ the House committee substitute bill.
____ enrolled.

____ On motion of Rep. _____, the House concurs in the (material) Senate _____ (by the following vote, ____ ____ RC) (, by EV ____ ____,) and the bill is ordered enrolled.

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2003

HOUSE BILL 923

Short Title:	Exempt Alt. Medicine/Practice of Medicine.	(Public)
Sponsors:	Representative Luebke.	
Referred to:	Health.	

April 8, 2003

A BILL TO BE ENTITLED

AN ACT TO EXEMPT THE PRACTICE OF COMPLEMENTARY OR ALTERNATIVE FORMS OF HEALTH CARE FROM THE PRACTICE OF MEDICINE.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 90-18(c) reads as rewritten:

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

(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.

(19) The practice of a complementary or an alternative form of health care, so long as the practitioner discloses to a client his or her professional training and qualifications and discloses to a client that he or she is not a licensed medical doctor. For purposes of this subdivision, complementary or alternative forms of health care shall include the healing modalities, therapies, and health care systems as defined by the National Institutes of Health's National Center for Complementary and Alternative Medicine (NCCAM), the World Health Organization-Traditional or Complementary/Alternative Medicine (WHO CAM), and the White House Commission on Complementary and Alternative Medicine Policy (WHCCAMP)."

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

HOUSE BILL 923:
Exempt Alt. Medicine/Practice of Medicine

BILL ANALYSIS

Committee:	House Health	**Introduced by:**	Rep. Luebke
Date:	April 23, 2003	**Summary by:**	Amy Compeau
Version:	First Edition		Research Division Staff

SUMMARY: ***House Bill 923 would exempt from the definition of the practice of medicine, the practice of a complementary or an alternative form of health care, so long as the practitioner discloses to a client the practitioner's professional training and qualifications and discloses that the practitioner is not a licensed medical doctor. The act would become effective when it becomes law.***

CURRENT LAW: Article 1 of Chapter 90 of the General Statutes regulates the practice of medicine. G.S. 90-18 defines the practice of medicine and establishes penalties for practicing medicine without a license. A person shall be regarded as practicing medicine when he or she 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 practicing medicine without a license shall not be allowed to maintain any action to collect fees for such services and shall be guilty of a Class 1 misdemeanor. 18 exemptions currently exist from the definition of the practice of medicine.

BILL ANALYSIS: House Bill 923 would exempt the practice of a complementary or an alternative form of health care from the definition of the practice of medicine. In order for the treatment to be exempt, the practitioner must disclose to a client his or her professional training and qualifications and that he or she is not a licensed medical doctor. Complementary or alternative forms of health care shall include the healing modalities, therapies, and health care systems as defined by:

1. The National Institutes of Health's National Center for Complementary and Alternative Medicine (NCCAM);
2. The World Health Organization-Traditional or Complementary/Alternative Medicine (WHO CAM); and
3. The White House Commission on Complementary and Alternative Medicine Policy (WHCCAMP).

BACKGROUND:

NCCAM: The NCCAM is one of the 27 institutes and centers that make up the National Institutes of Health (NIH). The NIH is one of eight agencies under the Public Health Service in the Department of Health and Human Services. The NCCAM supports rigorous research on complementary and alternative medicine (CAM), trains researchers in CAM, and disseminates information to the public and professionals on which CAM modalities work, which do not, and why. The NCCAM defines CAM as a group of diverse medical and health care systems, practices, and products that are not presently considered to be a part of conventional medicine. The list of what is considered to be CAM changes continually. NCCAM classifies CAM therapies into five categories: (1) alternative medical systems that are built upon complete systems of theory and practice, i.e. naturopathic medicine, (2) mind-body interventions that use a variety of techniques designed to enhance the mind's capacity to affect bodily function and symptoms, i.e. meditation, (3) biologically based therapies that use substances found in

nature such as herbs, foods, and vitamins, (4) manipulative and body-based methods that are based on manipulation and/or movement of one or more parts of the body, i.e. massage, and (5) energy therapies that involve the use of energy fields that purportedly surround and penetrate the human body or that use electromagnetic fields.

World Health Organization (WHO): The WHO is the United Nations specialized agency for health and was established on April 7, 1948. The WHO's objective, as set out in its Constitution, is the attainment by all people of the highest possible level of health. The WHO defines CAM to mean a broad set of health care practices that are not part of that country's own tradition and are not integrated into the dominant health care system. CAM is used inter-changeably with traditional medicine in some countries. The WHO defines traditional medicine to mean the sum total of the knowledge, skills, and practices based on the theories, beliefs, and experiences indigenous to different cultures, whether explicable or not, used in the maintenance of health as well as in the prevention, diagnosis, improvement or treatment of physical and mental illness.

WHCCAMP: President Clinton issued Executive Order 13147 establishing the White House Commission on Complementary and Alternative Medicine Policy on March 7, 2000 because of the public interest in and use of unconventional health care. The WHCCAMP made recommendations on public policy and legislation to the President through the Secretary of Health and Human Services in March 2002. In the final report, the WHCCAMP defines CAM as a heterogeneous group of medical, health care, and healing systems other than those intrinsic to mainstream health care in the United States. The report noted that most CAM modalities have not yet been scientifically studied and found to be safe and effective. The report also noted the lack of an appropriate definition of CAM and the need to differentiate between interventions that have been, or have the potential to be, found safe and effective and those that lack any scientific evidence of safety or effectiveness.

Utilization of CAM: According to Citizens for Healthcare Freedom, Inc., as many as 3.3 million North Carolina citizens use CAM for a large portion of their health care.

Americans made more visits to CAM providers than to all primary care physicians in 1997. Nationwide, the total number of visits to CAM providers increased from 427 million in 1990 to 629 million in 1997 (47% increase). In 1997, Americans made 386 million visits to primary care physicians compared to 629 million visits to CAM providers. Out of pocket expenses associated with CAM therapies received in 1997, are estimated at $27 billion.

H923-SMRP-001

HOUSE BILL 1043

Short Title: Health Provider Immunity/Terrorist Incidents. (Public)

Sponsors: Representatives Harrell; and Glazier.

Referred to: Health.

April 10, 2003

A BILL TO BE ENTITLED

AN ACT TO PROVIDE IMMUNITY FROM LIABILITY FOR HEALTH CARE PROVIDERS PROVIDING HEALTH CARE TREATMENT TO PERSONS INJURED BY A TERRORIST INCIDENT.

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:

"**§ 90-21.17. Health care treatment of persons injured by a terrorist incident; immunity.**

(a) A health care provider or emergency medical care provider who renders medical, dental, or other health care treatment to a person who is unconscious, ill, or injured by a terrorist incident shall not be liable for damages for injuries alleged to have been sustained by the person or for damages for the death of the person alleged to have occurred by reason of an act or omission in the rendering of the treatment unless it is established that the injuries were or the death was caused by gross negligence, wanton conduct, or intentional wrongdoing on the part of the person rendering the treatment.

(b) The immunity conferred by this section applies only to the extent that professional liability insurance covering the health care provider or emergency medical care provider excludes coverage for treatment rendered during acts of war or terrorist incidents. The immunity conferred by this section applies whether or not the health care provider or emergency medical care provider rendering the treatment is compensated for the treatment.

(c) As used in this section, 'terrorist incident' means activities that occur within the territorial jurisdiction of the United States, involve acts dangerous to human life that are a violation of the criminal laws of the United States or of any state, and are intended to do one of the following:

(1) Intimidate or coerce a civilian population.

(2) Influence the policy of a government by intimidation or coercion.

(3) Affect the conduct of a government by mass destruction, assassination, or kidnapping."

SECTION 2. This act is effective when it becomes law and applies to illness or injury resulting from terrorist incidents occurring on and after that date.

House Committee on Health

April 29, 2003

Minutes

The House Committee on Health met on Tuesday, April 29, 2003 at 12:00 noon in Room 544 of the Legislative Office Building. A silent roll was taken. A copy of the roll denoting members present is attached to the minutes (Attachment I) along with a copy of the agenda and Visitor Registration Sheet (Attachments II and III).

Rep. Verla Insko, Chair welcomed members and visitors and recognized the page: Precious Clements from Wake County sponsored by Rep. Bernard Allen. Dusty Rhodes and Brian Doherty were recognized as Sergeant-in-Arms.

Chair Insko advised that only Rep. Harrell's HB 1043 A BILL TO BE ENTITLED AN ACT TO PROVIDE IMMUNITY FROM LIABILITY FOR HEALTH CARE PROVIDERS PROVIDING HEALTH CARE TREATMENT TO PERSONS INJURED BY A TERRORIST INCIDENT bill is on the agenda and that the bill sponsor was not present, but had been called. (Attachment IV) Chair Insko requested staff walk through bill. (Bill Analysis – Attachment V)

Rep. Sherrill calls for a quorum. Chair Insko states that a quorum is present.

Rep. Wright then states that it is the responsibility of bill sponsor to be present and bill should not be heard.

Chair Insko agrees and adjourns meeting at 12:08. Chair Insko states that she will advise Rep. Harrell.

Verla Insko
Rep .Verla Insko, Chair

Pamela J. Evans
Pamela J. Evans, Committee Assistant

ATTENDANCE

HOUSE COMMITTEE ON HEALTH

DATES	4/29/08														
INSKO, Verla CHAIR	✓														
JUSTUS, Carolyn CHAIR	✓														
ENGLAND, Bob VICE-CHAIR	✓														
ADAMS, Alma															
ALLEN, Bernard	✓														
ALLEN, Gordon															
ALLRED, Cary															
BARNHART, Jeff															
BOWIE, Joni															
CLARY, Debbie															
EARLE, Beverly															
GLAZIER, Rick															
HILTON, Mark															
McALLISTER, Mary															
MUNFORD, Don															
SETZER, Mitchell	✓														
SHERRILL, Wilma	✓														
WAINWRIGHT, William															
WILSON, Connie															
WRIGHT, Tom	✓														
Ex officio Members															
Brubaker, Bru															
Culpepper, Bill															
Cunningham, Pete															
Eddins, Rick															

ATTACHMENT II

AGENDA

HOUSE COMMITTEE ON HEALTH

April 29, 2003
Room 544 LOB
12:00 Noon

OPENING REMARKS

Representative Verla Insko, Chair
Representative Carolyn Justus, Chair

AGENDA ITEMS

HB1043 Health Provider Immunity/Terrorist Incidents-Rep. Harrell

ADJOURNMENT

VISITOR REGISTRATION SHEET

HOUSE COMMITTEE ON HEALTH — APRIL 29, 2003

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2003

HOUSE BILL 1043

Short Title:	Health Provider Immunity/Terrorist Incidents.	(Public)
Sponsors:	Representatives Harrell; and Glazier.	
Referred to:	Health.	

April 10, 2003

A BILL TO BE ENTITLED

AN ACT TO PROVIDE IMMUNITY FROM LIABILITY FOR HEALTH CARE PROVIDERS PROVIDING HEALTH CARE TREATMENT TO PERSONS INJURED BY A TERRORIST INCIDENT.

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:

"**§ 90-21.17. Health care treatment of persons injured by a terrorist incident; immunity.**

(a) A health care provider or emergency medical care provider who renders medical, dental, or other health care treatment to a person who is unconscious, ill, or injured by a terrorist incident shall not be liable for damages for injuries alleged to have been sustained by the person or for damages for the death of the person alleged to have occurred by reason of an act or omission in the rendering of the treatment unless it is established that the injuries were or the death was caused by gross negligence, wanton conduct, or intentional wrongdoing on the part of the person rendering the treatment.

(b) The immunity conferred by this section applies only to the extent that professional liability insurance covering the health care provider or emergency medical care provider excludes coverage for treatment rendered during acts of war or terrorist incidents. The immunity conferred by this section applies whether or not the health care provider or emergency medical care provider rendering the treatment is compensated for the treatment.

(c) As used in this section, 'terrorist incident' means activities that occur within the territorial jurisdiction of the United States, involve acts dangerous to human life that are a violation of the criminal laws of the United States or of any state, and are intended to do one of the following:

(1) Intimidate or coerce a civilian population.

(2) Influence the policy of a government by intimidation or coercion.

(3) Affect the conduct of a government by mass destruction, assassination, or kidnapping."

SECTION 2. This act is effective when it becomes law and applies to illness or injury resulting from terrorist incidents occurring on and after that date.

ATTACHMENT V

HOUSE BILL 1043:
Health Provider Immunity/Terrorist Incidents

BILL ANALYSIS

Committee:	House Health	**Introduced by:**	Rep. Harrell
Date:	April 24, 2003	**Summary by:**	Dianna Jessup
Version:	First Edition		Committee Counsel

SUMMARY: ***House Bill 1043 would provide immunity from liability for a health care provider or emergency medical care provider who renders medical, dental, or other health care treatment to a person injured by a terrorist incident, unless the person was injured by the provider's gross negligence, wanton conduct, or intentional wrongdoing. This immunity would apply only to the extent that the provider's professional liability insurance excludes coverage for treatment rendered during acts of war or terrorist incidents. The act would become effective when it becomes law and would apply to illness or injury resulting from terrorist incidents occurring on and after that date.***

CURRENT LAW: Generally, a person may be liable for damages in a malpractice action for personal injury or death arising out of the furnishing or failing to furnish professional services in the performance of medical, dental, or other health care if the care provided was not in accordance with the standards of practice among members of the same health care profession with similar training and experience situated in the same or similar communities at the time of the alleged act. There are circumstances, however, in which the law provides for limitations to this general rule of liability, including the following statutes:

G.S. 90-21.14 First aid or emergency treatment: This statute provides immunity to persons, including volunteer medical or health care providers at local health departments or nonprofit community health centers or to volunteer members of rescue squads *who receive no compensation for their services*, who render first aid or emergency treatment when it is apparent that immediate treatment is needed, unless it is established that the injuries were or death was caused by *gross negligence*.

G.S. 90-21.15 Emergency treatment using automated external defibrillator: This statute provides immunity to persons who use an automated external defibrillator to attempt to save or to save a life when they do so *without receiving compensation* when it is apparent that immediate treatment is needed, unless it is established that the injuries were or death was caused by *gross negligence*. This statute also provides immunity to persons who provide the cardiopulmonary resuscitation and automated external defibrillator training to a person using an automated external defibrillator, persons responsible for the site where the automated external defibrillator is located when the person has provided for a program of training, and North Carolina licensed physicians writing a prescription without compensation for an automated external defibrillator.

G.S. 90-21.16 Volunteer health care professionals: This statute provides that certain volunteer health care providers *who receive 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.

Generally, under statutes providing for immunity, only health care providers who receive no compensation are immune, and the immunity does not apply to acts of gross negligence.

BILL ANALYSIS: House Bill 1043 would provide immunity to a health care provider or emergency care provider who renders treatment to a person who is unconscious, ill, or injured by a "terrorist incident" except in the case of gross negligence on the part of the provider. This immunity would apply whether or not the provider is compensated for the treatment, but applies only to the extent that the provider's professional liability insurance excludes coverage for treatment rendered during acts of war or terrorist incidents.

"Terrorist incident" would be defined to mean activities that occur within the territorial jurisdiction of the United States, involve acts dangerous to human life that are a violation of the criminal laws of the United States or any state, and are intended to do one of the following:

- Intimidate or coerce a civilian population
- Influence the policy of a government by intimidation or coercion
- Affect the conduct of a government by mass destruction, assassination, or kidnapping

The act would become effective when it becomes law and apply to illness or injury resulting from terrorist incidents occurring from and after when the act becomes law.

BACKGROUND: Virginia has recently enacted similar legislation. The legislation provides, in the absence of gross negligence or willful misconduct, any health care provider who responds to a man-made disaster by delivering health care to persons injured in the man-made disaster immunity from civil liability for any injury or wrongful death arising from abandonment by such health care provider of any person to whom such health care provider owes a duty to provide health care when: (1) a state or local emergency has been or is subsequently declared relating to the man-made disaster; and (2) the provider was unable to provide the requisite health care to the person to whom he owed such duty of care as a result of the provider's voluntary or mandatory response to the relevant man-made disaster. This provision also provides, in the absence of gross negligence or willful misconduct, any hospital or other entity credentialing health care providers to deliver health care in response to a man-made disaster immunity from civil liability for any cause of action arising out of such credentialing or granting of practice privileges if (1) a state or local emergency has been or is subsequently declared relating to such man-made disaster; and (2) the hospital has followed procedures for such credentialing and granting of practice privileges that are consistent with the Joint Commission on Accreditation of Healthcare Organizations' standards for granting emergency practice privileges. Further, the immunity provided by the new section in this bill will be in addition to, and, not be in lieu of, any immunities provided in other state or federal law, including, but not limited to, Virginia's Good Samaritan law and emergency services and disaster law.

H1043-SMSW-001

Amy Compeau, Research Assistant, contributed to this summary.

House Committee on Health

April 30, 2003

Minutes

The House Committee on Health met on Wednesday, April 30, 2003 at 12:00 noon in Room 544 of the Legislative Office Building. A silent roll was taken. A copy of the roll denoting members present is attached to the minutes (Attachment I) along with a copy of the agenda and Visitor Registration Sheet (Attachments II and III).

Rep. Insko, Chair states that this will be short meeting and asks Rep. Harrell to explain his bill.

Rep. Harrell was called to explain his bill, HB 1043 A BILL TO BE ENTITLED AN ACT TO PROVIDE IMMUNITY FROM LIABILITY FOR HEALTH CARE PROVIDERS PROVIDING HEALTH CARE TREATMENT TO PERSONS INJURED BY A TERRORIST INCIDENT. (Attachment IV) This bill provides immunity to a health care provider or emergency care provider who renders treatment to a person who is unconscious, ill, or injured by a "terrorist incident" except in the case of gross negligence on the part of the provider. This immunity would apply whether or not the provider is compensated for the treatment, but applies only to the extent that the provider's professional liability insurance excludes coverage for treatment rendered during acts of war or terrorist incidents. (Bill Analysis – Attachment V)

Rep. Harrell offers a proposed committee substitute and motion is made to accept the proposed committee substitute for discussion purposes. (Attachment VI)

Rep. Wright asks for background as to need, what is difference from natural disasters, and is a "Good Samaritan" clause included? Staff and Rep. Harrell explain that the main issue is compensation due to physicians being called upon to help for extended periods of time. Rep. Sherrill asks what is legal definition of a terrorist. Rep. Earle suggests that bill needs to pass and be amended on floor, if needed. After discussion among the committee members, Rep. Bernard Allen makes motion for a favorable report as to the committee substitute and unfavorable as to the original bill. Motion adopted. (Committee Report – Attachment VII)

Meeting adjourned at 12:55 p.m.

Verla C. Insko, Chair

Pamela Evans, Committee Clerk

ATTENDANCE

HOUSE COMMITTEE ON HEALTH

DATES	4/30/03														
INSKO, Verla CHAIR	✓														
JUSTUS, Carolyn CHAIR	✓														
ENGLAND, Bob VICE-CHAIR	✓														
ADAMS, Alma	✓														
ALLEN, Bernard	✓														
ALLEN, Gordon	✓														
ALLRED, Cary	✓														
BARNHART, Jeff	✓														
BOWIE, Joni															
CLARY, Debbie															
EARLE, Beverly	✓														
GLAZIER, Rick	✓														
HILTON, Mark															
McALLISTER, Mary															
MUNFORD, Don	✓														
SETZER, Mitchell	✓														
SHERRILL, Wilma	✓														
WAINWRIGHT, William															
WILSON, Connie															
WRIGHT, Tom	✓														
Ex officio Members															
Brubaker, Bru															
Culpepper, Bill															
Cunningham, Pete															
Eddins, Rick															

ATTACHMENT II

AGENDA

HOUSE COMMITTEE ON HEALTH

April 30, 2003
Room 544 LOB
12:00 Noon

OPENING REMARKS

Representative Verla Insko, Chair
Representative Carolyn Justus, Chair

AGENDA ITEMS

HB1043 Health Provider Immunity/Terrorist Incidents-Rep. Harrell

ADJOURNMENT

ATTACHMENT III

VISITOR REGISTRATION SHEET

HOUSE COMMITTEE ON HEALTH — APRIL 30, 2003

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Joanne Stevens	nursing
J Cauley	UHS
Camille Hall	KCH
Stacy Flannery	NCHCFA
Amy Jo Horne	NCMS
George Lewis	Johnson & Johnson
Rob Hamm	
Stana McKenney	NC DHHS
Ann Lucas	DUHS
Amy Dixon	NC State Health

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2003

HOUSE BILL 1043

Short Title:	Health Provider Immunity/Terrorist Incidents.	(Public)
Sponsors:	Representatives Harrell; and Glazier.	
Referred to:	Health.	

April 10, 2003

A BILL TO BE ENTITLED

AN ACT TO PROVIDE IMMUNITY FROM LIABILITY FOR HEALTH CARE PROVIDERS PROVIDING HEALTH CARE TREATMENT TO PERSONS INJURED BY A TERRORIST INCIDENT.

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:

"**§ 90-21.17. Health care treatment of persons injured by a terrorist incident; immunity.**

(a) A health care provider or emergency medical care provider who renders medical, dental, or other health care treatment to a person who is unconscious, ill, or injured by a terrorist incident shall not be liable for damages for injuries alleged to have been sustained by the person or for damages for the death of the person alleged to have occurred by reason of an act or omission in the rendering of the treatment unless it is established that the injuries were or the death was caused by gross negligence, wanton conduct, or intentional wrongdoing on the part of the person rendering the treatment.

(b) The immunity conferred by this section applies only to the extent that professional liability insurance covering the health care provider or emergency medical care provider excludes coverage for treatment rendered during acts of war or terrorist incidents. The immunity conferred by this section applies whether or not the health care provider or emergency medical care provider rendering the treatment is compensated for the treatment.

(c) As used in this section, 'terrorist incident' means activities that occur within the territorial jurisdiction of the United States, involve acts dangerous to human life that are a violation of the criminal laws of the United States or of any state, and are intended to do one of the following:

(1) Intimidate or coerce a civilian population.

(2) Influence the policy of a government by intimidation or coercion.

(3) Affect the conduct of a government by mass destruction, assassination, or kidnapping."

SECTION 2. This act is effective when it becomes law and applies to illness or injury resulting from terrorist incidents occurring on and after that date.

ATTACHMENT V

HOUSE BILL 1043:
Health Provider Immunity/Terrorist Incidents

BILL ANALYSIS

Committee:	House Health	**Introduced by:**	Rep. Harrell
Date:	April 24, 2003	**Summary by:**	Dianna Jessup
Version:	First Edition		Committee Counsel

SUMMARY: ***House Bill 1043 would provide immunity from liability for a health care provider or emergency medical care provider who renders medical, dental, or other health care treatment to a person injured by a terrorist incident, unless the person was injured by the provider's gross negligence, wanton conduct, or intentional wrongdoing. This immunity would apply only to the extent that the provider's professional liability insurance excludes coverage for treatment rendered during acts of war or terrorist incidents. The act would become effective when it becomes law and would apply to illness or injury resulting from terrorist incidents occurring on and after that date.***

CURRENT LAW: Generally, a person may be liable for damages in a malpractice action for personal injury or death arising out of the furnishing or failing to furnish professional services in the performance of medical, dental, or other health care if the care provided was not in accordance with the standards of practice among members of the same health care profession with similar training and experience situated in the same or similar communities at the time of the alleged act. There are circumstances, however, in which the law provides for limitations to this general rule of liability, including the following statutes:

G.S. 90-21.14 First aid or emergency treatment: This statute provides immunity to persons, including volunteer medical or health care providers at local health departments or nonprofit community health centers or to volunteer members of rescue squads *who receive no compensation for their services*, who render first aid or emergency treatment when it is apparent that immediate treatment is needed, unless it is established that the injuries were or death was caused by *gross negligence*.

G.S. 90-21.15 Emergency treatment using automated external defibrillator: This statute provides immunity to persons who use an automated external defibrillator to attempt to save or to save a life when they do so *without receiving compensation* when it is apparent that immediate treatment is needed, unless it is established that the injuries were or death was caused by *gross negligence*. This statute also provides immunity to persons who provide the cardiopulmonary resuscitation and automated external defibrillator training to a person using an automated external defibrillator, persons responsible for the site where the automated external defibrillator is located when the person has provided for a program of training, and North Carolina licensed physicians writing a prescription without compensation for an automated external defibrillator.

G.S. 90-21.16 Volunteer health care professionals: This statute provides that certain volunteer health care providers *who receive 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.

Generally, under statutes providing for immunity, only health care providers who receive no compensation are immune, and the immunity does not apply to acts of gross negligence.

BILL ANALYSIS: House Bill 1043 would provide immunity to a health care provider or emergency care provider who renders treatment to a person who is unconscious, ill, or injured by a "terrorist incident" except in the case of gross negligence on the part of the provider. This immunity would apply whether or not the provider is compensated for the treatment, but applies only to the extent that the provider's professional liability insurance excludes coverage for treatment rendered during acts of war or terrorist incidents.

"Terrorist incident" would be defined to mean activities that occur within the territorial jurisdiction of the United States, involve acts dangerous to human life that are a violation of the criminal laws of the United States or any state, and are intended to do one of the following:

- Intimidate or coerce a civilian population
- Influence the policy of a government by intimidation or coercion
- Affect the conduct of a government by mass destruction, assassination, or kidnapping

The act would become effective when it becomes law and apply to illness or injury resulting from terrorist incidents occurring from and after when the act becomes law.

BACKGROUND: Virginia has recently enacted similar legislation. The legislation provides, in the absence of gross negligence or willful misconduct, any health care provider who responds to a man-made disaster by delivering health care to persons injured in the man-made disaster immunity from civil liability for any injury or wrongful death arising from abandonment by such health care provider of any person to whom such health care provider owes a duty to provide health care when: (1) a state or local emergency has been or is subsequently declared relating to the man-made disaster; and (2) the provider was unable to provide the requisite health care to the person to whom he owed such duty of care as a result of the provider's voluntary or mandatory response to the relevant man-made disaster. This provision also provides, in the absence of gross negligence or willful misconduct, any hospital or other entity credentialing health care providers to deliver health care in response to a man-made disaster immunity from civil liability for any cause of action arising out of such credentialing or granting of practice privileges if (1) a state or local emergency has been or is subsequently declared relating to such man-made disaster; and (2) the hospital has followed procedures for such credentialing and granting of practice privileges that are consistent with the Joint Commission on Accreditation of Healthcare Organizations' standards for granting emergency practice privileges. Further, the immunity provided by the new section in this bill will be in addition to, and, not be in lieu of, any immunities provided in other state or federal law, including, but not limited to, Virginia's Good Samaritan law and emergency services and disaster law.

H1043-SMSW-001

Amy Compeau, Research Assistant, contributed to this summary.

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2003

H D

HOUSE BILL 1043
PROPOSED COMMITTEE SUBSTITUTE H1043-CSSW-21 [v.1]

4/24/2003 8:16:30 AM

Short Title: Health Provider Immunity/Terrorist Incidents. (Public)

Sponsors:

Referred to:

April 10, 2003

A BILL TO BE ENTITLED

AN ACT TO PROVIDE IMMUNITY FROM LIABILITY FOR HEALTH CARE PROVIDERS PROVIDING HEALTH CARE TREATMENT TO PERSONS INJURED BY A TERRORIST INCIDENT.

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:

"**§ 90-21.18. Health care treatment of persons injured by a terrorist incident; immunity.**

(a) A health care provider or emergency medical care provider who renders medical, dental, or other health care treatment to a person who is unconscious, ill, or injured by a terrorist incident shall not be liable for damages for injuries alleged to have been sustained by the person or for damages for the death of the person alleged to have occurred by reason of an act or omission in the rendering of the treatment unless it is established that the injuries were or the death was caused by gross negligence, wanton conduct, or intentional wrongdoing on the part of the person rendering the treatment.

(b) The immunity conferred by this section applies only to the extent that professional liability insurance covering the health care provider or emergency medical care provider excludes coverage for treatment rendered during acts of war or terrorist incidents. The immunity conferred by this section applies whether or not the health care provider or emergency medical care provider rendering the treatment is compensated for the treatment.

(c) As used in this section, 'terrorist incident' means activities that occur within the territorial jurisdiction of the United States, involve acts dangerous to human life that are a violation of the criminal laws of the United States or of any state, and are intended to do one of the following:

(1) Intimidate or coerce a civilian population.

(2) Influence the policy of a government by intimidation or coercion.

(3) Affect the conduct of a government by mass destruction, assassination, or kidnapping."

SECTION 2. This act is effective when it becomes law and applies to illness or injury resulting from terrorist incidents occurring on and after that date.

House Committee on Health

May 13, 2003

Minutes

The House Committee on Health met on Tuesday, May 13, 2003 at 12:00 noon in Room 544 of the Legislative Office Building. A silent roll was taken. A copy of the roll denoting members present is attached to the minutes (Attachment I) along with a copy of the agenda and Visitor Registration Sheet (Attachments II and III).

Chair Justus recognizes Pages: Jennifer Leigh Walker from Cumberland Co. sponsored by Rep. Lucas, Jocelyn Monroe from Cumberland Co. sponsored by Rep. Dickson, Oliver Buckamster from Cumberland County sponsored by Rep. Glazier, Vernon Robinson from Cumberland County sponsored by Rep. Glazier, Jamal Valentine and Raejhael La-ty from Pender County sponsored by Rep. Wright and Antwoine Viston from Sampson County sponsored by Rep. Bell and the Sergeant-at-Arms, Dusty Rhodes, Jim Womack, Jim Brewer and Francis Poole. (Attachment IV)

Chair Justus advises that bills will be heard out of order and calls upon Sen. Kerr to explain his bill SB 704 A BILL TO BE ENTITLED AN ACT TO ESTABLISH THE TRAUMATIC BRAIN INJURY ADVISORY COUNCIL. (Attachment V) This bill would establish the traumatic brain injury advisory council in the Department of Health and Human Services. The Council will review definitions of brain injuries, promote interagency coordination, study needs of injured and their families, provide advice on comprehensive statewide service delivery, and promote injury prevention. It provides for a 29 member advisory council with two members to be appointed by Pres. Pro Tem., three members by Speaker, 9 members appointed by the Governor, 8 members appointed by the Secretary of Health and Human Resources, two members by the Superintendent of Public Instruction, One member by the Commissioner of Insurance and One member by the Secretary of Administration. (Bill Analysis – Attachment VI).

Chair Justus then recognizes Chuck Stone, Goldsboro, NC, who works with families and survivors of Traumatic Brain Injury and Tanya Harrison, Goldsboro, NC, a survivor of a traumatic brain injury to speak briefly.

Rep. Munford questions name on bill "North Carolina Trial Lawyers Association" and Rep. Barnhard offers amendment to change correct name to "North Carolina Academy of Trial Lawyers". Rep. Bernard Allen makes motion that amendment be rolled into a proposed committee substitute and favorable as to the proposed committee substitute and unfavorable as to the original bill. Motion carried. (Committee Report – Attachment VII)

Sen. Rand comes forward to explain his bill SB 522 A BILL TO BE ENTITLED AN ACT TO CHANGE THE METHOD BY WHICH CERTAIN MEMBERS ON THE NORTH CAROLINA BOARD OF NURSING ARE ELECTED OR APPOINTED, TO MAKE TECHNICAL CHANGES TO THE NURSING PRACTICE ACT, AND TO REQUIRE THAT HEALTH CARE FACILITIES VERIFY THE LICENSURE STATUS OF APPLICANTS SEEKING EMPLOYMENT AS NURSES. (Attachment VIII) A Proposed

Committee Substitute is passed out and Rep. B. Allen makes motion to adopt the proposed committee substitute. (Attachment IX) Motion is adopted. The bill requires health care facilities to verify the licensure status of applicants seeking employment as nurses, changes the method by which certain members are elected or appointed, and makes other technical changes to the Nursing Practice Act. In addition it provides that the Board shall decrease the number of member on the NC Board of Nursing from 15 to 14 members by reducing the number of registered nurse members from 9 to 8 members as well as other clarifying changes. (Bill Analysis – Attachment X)

Rep. McAllister asks why reduction in number. Rep. Rand responds that the measure was agreed on at the request from the Board of Nursing. Rep. Wright then makes motion to give the proposed committee substitute as favor report and unfavorable as to the original bill. Motion carried. (Committee Report – Attachment XI)

Sen. Foxx is recognized to speak on her bill SB 648AN BILL ENTITLED AN ACT TO ESTABLISH AN AD HOC CERVICAL CANCER ELIMINATION TASK FORCE TO THE ADVISORY COMMITTEE ON CANCER COORDINATION AND CONTROL. (Attachment XII) It establishes a standing ad hoc task force, the Cervical Cancer Elimination Task Force that would serve the Advisory Committee on Cancer Coordination and Control. (Bill Analysis – Attachment XIII) Rep. Glazier offers an amendment, which is adopted for discussion. (Attachment XIV) Rep. Sherrill is concerned about fiscal impact. (Fiscal Note – Attachment XV) Rep. McAllister makes motion that amendments be rolled into a committee substitute, favorable report as to the committee substitute and unfavorable as to the original bill. Motion carried. (Committee Report – Attachment XVI)

Reps. Wright and Sherrill after motion approved reiterate their feelings that bill should be sent to Appropriations.

Rep. Foxx is called upon to explain her bill SB 388 A BILL ENTITLED AN ACT TO UPDATE NORTH CAROLINA GENERAL STATUTES IN RESPONSE TO RECENT MEDICAL ADVANCES IN SCREENING FOR THE EARLY DETECTION OF CERVICAL CANCER. (Attachment XVII) The bill specifies that laboratory tests for cervical cancer screening must be covered under health benefit plans, replacing the term "pap smear". (Bill Analysis – Attachment XVIII) Rep. Barnhart offers amendment by adding after the word "analysis" the phrase "that are subject to the approval of and have been approved by the Federal Drug Administration." (Attachment XIX) Amendment is adopted. (Fiscal Note – Attachment XX) Rep. Setzer makes motion that amendments be rolled into a committee substitute, given a favorable report and unfavorable as to the original bill. Motion is adopted. (Committee Report – Attachment XXI)

Meeting was adjourned at 12:57 p.m.

Carolyn Justus
Rep. Carolyn Justus, Chair

Pamela J. Evans
Pamela J. Evans, Committee Assistant

ATTENDANCE

HOUSE COMMITTEE ON HEALTH

DATES	5/13/03														
INSKO, Verla CHAIR	✓														
JUSTUS, Carolyn CHAIR	✓														
ENGLAND, Bob VICE-CHAIR	✓														
ADAMS, Alma															
ALLEN, Bernard	✓														
ALLEN, Gordon	✓														
ALLRED, Cary															
BARNHART, Jeff	✓														
BOWIE, Joni	✓														
CLARY, Debbie															
EARLE, Beverly															
GLAZIER, Rick	✓														
HILTON, Mark	✓														
McALLISTER, Mary	✓														
MUNFORD, Don	✓														
SETZER, Mitchell	✓														
SHERRILL, Wilma	✓														
WAINWRIGHT, William															
WILSON, Connie															
WRIGHT, Tom	✓														
Ex officio Members															
Brubaker, Bru															
Culpepper, Bill															
Cunningham, Pete															
Eddins, Rick															

ATTACHMENT II

AGENDA

HOUSE COMMITTEE ON HEALTH

May 13, 2003
Room 544 LOB
12:00 Noon

OPENING REMARKS

Representative Verla Insko, Chair
Representative Carolyn Justus, Chair

AGENDA ITEMS

SB 648 Cervical Cancer Elimination Task Force-Senator Virginia Foxx

SB 388 Update Cervical Cancer Screening Coverage-Senator Virginia Foxx

SB 522 Board of Nursing-Senator Tony Rand

SB 704 Traumatic Brain Injury Advisory Council-Senator John Kerr

ADJOURNMENT

ATTACHMENT III

VISITOR REGISTRATION SHEET

HOUSE COMMITTEE ON HEALTH — MAY 13, 2003

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
John Thomas	dhcs
John Bowdish	Astra Zeneca
Joyce Peters	NCAHSA | MANRT
Lee Dawson	NCAHP
Barry Delaney	BSK
Mollie Smith	NCSA
Howard Kramer	N.C. Bd. of NURSING
Patsy Johnson	NC Board of Nursing
Joanne Stevens	NURSING
Dick Carlton	Carlton & Alexander PLLC
HUGH TILSON	NCHA

VISITOR REGISTRATION SHEET

HOUSE COMMITTEE ON HEALTH — MAY 13, 2003

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Amy Jo Horne	NCMS
Jessy Ford	Smith Anderson
John Mattox	GOV OFFICE
Kacky Hammond	Brain Injury Assoc of NC 500 Todd Drive, Goldsboro, NC 27534
Charles "Chuck" Stone	Brain Injury Association of NC (Christopher Voorhees)
Linda Allen-Sink	Parent (mother) of TBI Goldsboro, NC
Odell Ingram	Re Nu Life TBI Family
Anne King	Retired, Division of Mental Health + Re Nu Life Advisory Council
Tonia M. Harrison	
Tony Rogers	
Lisa Dawkins	DHHS

1) Rashael Laty
Pender
Wright

(2.) Antwine Vinston
Sampson
Bell

House Pages

1. Name: Jennifer Leigh Walker
   County: Cumberland
   Sponsor: Lucas
2. Name: Jarvin Monroe
   County: Cumberland
   Sponsor: Dickinson
3. Name: Oliver Buchanstor
   County: Cumberland
   Sponsor: Glazier
4. Name: Vernon Robinson
   County: Cumberland
   Sponsor:
5. Name: Jamal Valentine
   County:
   Sponsor:

Sgt-At-Arms

1. Name: Dusty Rhodes
2. Name: Jim Womack
3. Name: Francis Poole
4. Name: Jim Brewer

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2003

S 2

SENATE BILL 704
Health & Human Resources Committee Substitute Adopted 4/21/03

Short Title: Traumatic Brain Injury Advisory Council. (Public)

Sponsors:

Referred to:

April 2, 2003

A BILL TO BE ENTITLED

AN ACT TO ESTABLISH THE TRAUMATIC BRAIN INJURY ADVISORY COUNCIL.

The General Assembly of North Carolina enacts:

SECTION 1. Article 3 of Chapter 143B of the General Statutes is amended by adding the following new Part to read:

"Part 33. North Carolina Traumatic Brain Injury Advisory Council.

"**§ 143B-216.65. North Carolina Traumatic Brain Injury Advisory Council – creation and duties.**

There is established the North Carolina Traumatic Brain Injury Advisory Council in the Department of Health and Human Services. The Council shall have duties including the following:

(1) Review how the term 'traumatic brain injury' is defined by State and federal regulations and to determine whether changes should be made to the State definition to include 'acquired brain injury' or other appropriate conditions.

(2) Promote interagency coordination among State agencies responsible for services and support of individuals that have sustained traumatic brain injury.

(3) Study the needs of individuals with traumatic brain injury and their families.

(4) Make recommendations to the Governor, the General Assembly, and the Secretary of Health and Human Services regarding the planning, development, funding, and implementation of a comprehensive statewide service delivery system.

(5) Promote and implement injury prevention strategies across the State.

"**§ 143B-216.66. North Carolina Traumatic Brain Injury Advisory Council – membership; quorum; compensation.**

(a) The Council shall consist of 25 members, appointed as follows:

(1) Two members by the General Assembly, upon the recommendation of the President Pro Tempore of the Senate, as follows:
  a. The Executive Director, or designee thereof, of the Brain Injury Association of North Carolina.
  b. A physician, nurse, or other professional coordinator with expertise in trauma, neurosurgery, neuropsychology, physical medicine and rehabilitation, or emergency medicine.
(2) Two members by the General Assembly, upon the recommendation of the Speaker of the House of Representatives, as follows:
  a. The Chair of the Board, or designee thereof, of the Brain Injury Association of North Carolina.
  b. A physician, nurse, or other professional coordinator with expertise in trauma, neurosurgery, neuropsychology, physical medicine and rehabilitation, or emergency medicine.
(3) Nine members by the Governor, as follows:
  a. Three survivors of brain injury, one each representing the eastern, central, and western regions of the State.
  b. Three family members of persons with brain injury.
  c. A brain injury service provider in private practice.
  d. The director of an area program or county program of mental health, developmental disabilities, and substance abuse services.
  e. The Executive Director, or designee thereof, of the North Carolina Trial Lawyers Association.
(4) Eight members by the Secretary of Health and Human Services, one from each of the following:
  a. The Division of Mental Health, Developmental Disabilities, and Substance Abuse Services.
  b. The Division of Vocational Rehabilitation.
  c. The Council on Developmental Disabilities.
  d. The Division of Medical Assistance.
  e. The Division of Facility Services.
  f. The Division of Social Services.
  g. The Office of Emergency Medical Services.
  h. The Division of Public Health.
(5) Two members by the Superintendent of Public Instruction, at least one of whom is from the Division of Exceptional Children.
(6) One member by the Commissioner of Insurance.
(7) One member by the Secretary of Administration representing veterans affairs.

(b) The terms of the initial members of the Council shall commence October 1, 2003. In his initial appointments, the Governor shall designate three members who shall serve terms of four years, three members who shall serve terms of three years, and three members who shall serve terms of two years. After the initial appointees' terms have

expired, all members shall be appointed for a term of four years. No member appointed by the Governor shall serve more than two successive terms.

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.

(c) The chair of the Council shall be designated by the Secretary of the Department of Health and Human Services from the Council members. The chair shall hold this office for not more than four years.

(d) The Council shall meet quarterly and at other times at the call of the chair. A majority of the Council shall constitute a quorum.

(e) Council members shall be reimbursed for expenses incurred in the performance of their duties in accordance with G.S. 138-5 and G.S. 138-6, as applicable.

(f) The Secretary of the Department of Health and Human Services shall provide clerical and other assistance as needed."

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

House Committee on Health

June 3, 2003

Minutes

The House Committee on Health met on Tuesday, June 3, 2003 at 12:00 noon in Room 544 of the Legislative Office Building. A silent roll was taken. A copy of the roll denoting members present is attached to the minutes (Attachment I) along with a copy of the agenda and Visitor Registration Sheet (Attachments II and III).

Rep. Verla Insko, Chair calls meeting to order and recognizes Pages: Allison Clark from Pitt County sponsored by Rep. McLawhorn, Hannah Skinner also from Pitt County sponsored by Rep. McLawhorn and Emily Wilborn from Hiatt County sponsored by Rep. Dickson. The sergeant-in-arms are Earl Tharrington, Dusty Rhodes and Walter Spell.

Chair Insko calls upon Rep. Justice to explain her bill HB 1094 A BILL TO BE ENTITLED AN ACT AUTHORIZING LOCAL BOARDS OF HEALTH TO ADOPT RULES. (Attachment IV) A proposed committee substitute is introduced and Rep. B. Allen made motion to adopt it for discussion purposes. (Attachment V). Motion adopted. Rep. Justice explains her bill would allow local boards of health, when required to protect the public health, to adopt more stringent rules than the Commission of Health Services or the Environmental Management Commission with respect to animal operations as defined by G.S. 143-215.10B. (Bill Analysis – Attachment VI)

Chair Insko advises that staff would speak next, followed by public and then clarifying questions. Rep. Allred requests if committee is going to vote today. Chair Insko states that no motions will be heard today as there are 20 people requesting to speak.

Chair Insko then calls upon Glenn Jernigan of the Agricultural Alliance, Crop Protection Association. Mr. Jernigan speaks against bill. Dr. Edward Ellis of the NC Citizens for Public Health speaks next (Attachment VII) in support of bill. Erica Peterson of the NC Agribusiness Council is next to speak in opposition of bill. Deborah Rowe of the Public Health Practitioners speaks next in support of bill. She is followed by Tommy Emerson, David Meredith and Bill Smith who all spoke in opposition to bill. (Handouts attached as Attachment VIII)

Rep. Wainwright asks staff to point out to him where is the language in the bill that leads people to believe this bill would give local health boards the authority to do what the Courts have ruled that they should not be doing. Staff responds that bill would amend Section 130A-39(b) to allow local boards of health to adopt rules governing animal operations. Local authority regarding swine farms were limited by the decision of the Supreme Court in Craig v. Chatham where rules passed by the Chatham County

Board of Health were more stringent than rules set out by the Environmental Management Commission where the permitting, inspection and waste management systems of swine farms in Chatham County were found invalid. It also allows local boards of health to impose a fee for health inspections of animal waste management systems.

Chair Insko advises that bill will be continued on Thursday, June 5, 2003.

Meeting was adjourned at 11:58 a.m.

Rep. Verla Insko, Chair

Pamela J. Evans, Committee Clerk

ATTENDANCE

HOUSE COMMITTEE ON HEALTH

DATES	6/5/03														
INSKO, Verla CHAIR	✓														
JUSTUS, Carolyn CHAIR	✓														
ENGLAND, Bob VICE-CHAIR	✓														
ADAMS, Alma	✓														
ALLEN, Bernard	✓														
ALLEN, Gordon	✓														
ALLRED, Cary	✓														
BARNHART, Jeff	✓														
BOWIE, Joni	✓														
CLARY, Debbie	✓														
EARLE, Beverly	✓														
GLAZIER, Rick	✓														
HILTON, Mark	✓														
McALLISTER, Mary	✓														
MUNFORD, Don	✓														
SETZER, Mitchell	✓														
SHERRILL, Wilma	✓														
WAINWRIGHT, William	✓														
WILSON, Connie	✓														
WRIGHT, Tom	✓														
Ex officio Members															
Brubaker, Bru															
Culpepper, Bill															
Cunningham, Pete															
Eddins, Rick															

ATTACHMENT II

AGENDA

HOUSE COMMITTEE ON HEALTH

June 5, 2003
Room 544 LOB
12:00 Noon

OPENING REMARKS

Representative Verla Insko, Chair
Representative Carolyn Justus, Chair

AGENDA ITEMS

SB 926 Clarify Group Homes Licensure & LEA Reimburs. – Sen. Rand

HB 1094 Local Health Departments – Rep. Justice

ADJOURNMENT

ATTACHMENT III

VISITOR REGISTRATION SHEET

HOUSE COMMITTEE ON HEALTH — **Name of Committee**

JUNE 3, 2003 — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Jeremy Rechmeyer	NCPIRG
Wayne Raynor	N.C. Health Directors Assoc.
Tim Green	NC Assoc Local Health D.T. Alamance Co Health Dept
Eugene C. Hines Jr.	NC Health Directors Assoc Cumberland Co. Health Depart.
John Lasky	Rep Glazier
Jim Blackburn	NC Association of County Commissioners
Paige Johnson	Planned Parenthood of Central NC
David Knight	NC Sierra Club
Price Harrison	Beaufort NC
Elizabeth Ouzts	NCPIRG
Lauren Sloss	Sierra Club
Tom Beason	NC EHU Dept
Glenn R. Jones	Crop Protection Assn of N. Agricultural Alliance of N.

VISITOR REGISTRATION SHEET

HOUSE COMMITTEE ON HEALTH — JUNE 3, 2003

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Kelly Mance	NC Conservation Network
Angie Williams	TNC
Katie Hoover	TNC
Wendy Rutter	TNC
Courtney Washburn	NC Sierra Club
DAN WHITTLE	ENVIRONMENTAL DEFENSE
Mindy Hilgeman	NC Conservation Network
Heather Yandow	NC Conservation Network
HANK GILBERT	DAVID KNIGHT
Lisa Page	NC Conservation Council
Sabina Jang	David Knight
Tyler Mansfield	NC Env. Def.

VISITOR REGISTRATION SHEET

HOUSE COMMITTEE ON HEALTH — JUNE 3, 2003

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Colleen Kochanek	Hafer & Caldwell, P.A.
DAO.A Mickey	BLUE RIDGE ENVIRONMENTAL DEFENSE LEAGUE
Stacey Tsougas	Blue Ridge Environmental Defense League
Karina Chapman	planned parenthood intern
Erica Upton Peterson	NC Agribusiness Council
George Upton	SAMPSON CO. EXT SERVICE
RONNIE JACKSON	SAMPSON County Farmer of AG
Molly Diggins	NC Sierra Club

VISITOR REGISTRATION SHEET

HOUSE COMMITTEE ON HEALTH — JUNE 3, 2003

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Fran Piercy	Capitol Group
Joanne Stevens	nursing / NCCASK
Dustin Taylor	Southern Environmental Law Center
R. Paul Wilms	NCHBA
Gabriella Kostrzewa	
Theresa K	CAS
John Long	Martin Marietta
Leslie Bevacqua	NCCBI
Michelle Nowlin	SELC
Preston Howard	NCJC
Nancy Thompson,	LMCIC

VISITOR REGISTRATION SHEET

HOUSE COMMITTEE ON HEALTH — JUNE 3, 2003

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Bob Sloan	NC Forestry Assoc
Steve Woodson	NC Farm Bureau
Alan Briggs	Save Our State
Jerry Schill	NC Fisheries Association
David Meredith	N C State Grange
John Cyrus	N C State Grange
Terry Hardesty	N.C. Park Council
Michael Edwards	Southern Environmental Law Center
Roberta Best	Pender County Board of Health
Jack Griffith	Pender Co. Health Dept.
Don Yousey	Health Director, Brunswick Co.

VISITOR REGISTRATION SHEET

HOUSE COMMITTEE ON HEALTH — JUNE 3, 2003

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Louis Latour	Wilson Co. Dept. of Public Health
Kris Thornburg	Environmental Defense
Dylan Fuge	Environmental Defense
Christopher Brook	Environmental Defense
Ivan Urlaub	Environmental Defense
Paula Gupton	Page NC Team Bureau
Deborah Rowe	NC Public Health Association
Frank Sheffield	Chatham Cty Ag Council
Amy Dobson	NC Statewatch
Steve Slott	Assoc. NC Boards of Health
Grady McKellar	N.C. Conservation Network.

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2003

H 2

HOUSE BILL 1094
Committee Substitute Favorable 5/14/03

Short Title: Local Health Departments. (Public)

Sponsors:

Referred to:

April 10, 2003

A BILL TO BE ENTITLED

AN ACT AUTHORIZING LOCAL BOARDS OF HEALTH TO ADOPT RULES.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 130A-39 reads as rewritten:

"**§ 130A-39. Powers and duties of a local board of health.**

(a) A local board of health shall have the responsibility to protect and promote the public health. The board shall have the authority to adopt rules necessary for that purpose.

(b) A local board of health may adopt a more stringent rule in an area regulated by the Commission for Health Services or the Environmental Management Commission where, in the opinion of the local board of health, a more stringent rule is required to protect the public health; otherwise, the rules of the Commission for Health Services or the rules of the Environmental Management Commission shall prevail over local board of health rules. However, a local board of health may not adopt a rule concerning the grading, operating, and permitting of food and lodging facilities as listed in Part 6 of Article 8 of this Chapter and as defined in G.S. 130A-247(1), and a local board of health may adopt rules concerning wastewater collection, treatment and disposal systems which are not designed to discharge effluent to the land surface or surface waters only in accordance with G.S. 130A-335(c). A local board of health may adopt rules governing animal operations, as defined by G.S. 143-215.10B.

(b1) For purposes of subsection (b) of this section, a showing by a local board of health that a more stringent rule is required to protect the public health may be based on published scientific studies, testimony from experts in health-related professions, or documentation of gaps in State regulatory programs that may threaten public health. These studies and testimony must be related to the general subject matter of the rule but need not be based on county-specific considerations.

(c) The rules of a local board of health shall apply to all municipalities within the local board's jurisdiction.

(d) Not less than 10 days before the adoption, amendment or repeal of any local board of health rule, the proposed rule shall be made available at the office of each county clerk within the board's jurisdiction, and a notice shall be published in a newspaper having general circulation within the area of the board's jurisdiction. The notice shall contain a statement of the substance of the proposed rule or a description of the subjects and issues involved, the proposed effective date of the rule and a statement that copies of the proposed rule are available at the local health department. A local board of health rule shall become effective upon adoption unless a later effective date is specified in the rule.

(e) Copies of all rules shall be filed with the secretary of the local board of health.

(f) A local board of health may, in its rules, adopt by reference any code, standard, rule or regulation which has been adopted by any agency of this State, another state, any agency of the United States or by a generally recognized association. Copies of any material adopted by reference shall be filed with the rules.

(g) A local board of health may impose a fee for services to be rendered by a local health department, except where the imposition of a fee is prohibited by statute or where an employee of the local health department is performing the services as an agent of the State. Notwithstanding any other provisions of law, a local board of health may impose cost-related fees for services performed pursuant to Article 11 of this Chapter, "Wastewater Systems," for services performed pursuant to Part 10, Article 8 of this Chapter, "Public Swimming Pools", and for services performed pursuant to Part 11, Article 8 of this Chapter, "Tattooing". Fees shall be based upon a plan recommended by the local health director and approved by the local board of health and the appropriate county board or boards of commissioners. The fees collected under the authority of this subsection are to be deposited to the account of the local health department so that they may be expended for public health purposes in accordance with the provisions of the Local Government Budget and Fiscal Control Act."

SECTION 2. G.S. 130A-39(g) reads as rewritten:

"(g) A local board of health may impose a fee for services to be rendered by a local health department, except where the imposition of a fee is prohibited by statute or where an employee of the local health department is performing the services as an agent of the State. Notwithstanding any other provisions of law, a local board of health may impose cost-related fees for services performed pursuant to Article 11 of this Chapter, "Wastewater Systems," for services performed pursuant to Part 10, Article 8 of this Chapter, "Public Swimming Pools", ~~and~~ for services performed pursuant to Part 11, Article 8 of this Chapter, ~~"Tattooing".~~ "Tattooing", and for health inspections of animal waste management systems, as defined in G.S. 143-215.10B. Fees shall be based upon a plan recommended by the local health director and approved by the local board of health and the appropriate county board or boards of commissioners. The fees collected under the authority of this subsection are to be deposited to the account of the local health department so that they may be expended for public health purposes in accordance with the provisions of the Local Government Budget and Fiscal Control Act."

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

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2003

H D

HOUSE BILL 1094
Committee Substitute Favorable 5/14/03
PROPOSED COMMITTEE SUBSTITUTE H1094-PCS30356-RTf-37

Short Title: Local Health Departments. (Public)

Sponsors:

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SECTION 1. G.S. 130A-39 reads as rewritten:

"**§ 130A-39. Powers and duties of a local board of health.**

(a) A local board of health shall have the responsibility to protect and promote the public health. The board shall have the authority to adopt rules necessary for that ~~purpose.~~purpose, unless expressly prohibited by statute.

(b) A local board of health may adopt a more stringent rule in an area regulated by the Commission for Health Services or the Environmental Management Commission where, in the opinion of the local board of health, a more stringent rule is required to protect the public health; otherwise, the rules of the Commission for Health Services or the rules of the Environmental Management Commission shall prevail over local board of health rules. However, a local board of health may not adopt a rule concerning the grading, operating, and permitting of food and lodging facilities as listed in Part 6 of Article 8 of this Chapter and as defined in G.S. 130A-247(1), and a local board of health may adopt rules concerning wastewater collection, treatment and disposal systems which are not designed to discharge effluent to the land surface or surface waters only in accordance with G.S. 130A-335(c). A local board of health may adopt rules governing animal operations, as defined in G.S. 143-215.10B.

(b1) For purposes of subsection (b) of this section, a showing by a local board of health that a more stringent rule is required to protect the public health may be based on published scientific studies, testimony from experts in health-related professions, or documentation of gaps in State regulatory programs that may threaten public health. These studies and testimony must be related to the general subject matter of the rule but need not be based on county-specific considerations.

(c) The rules of a local board of health shall apply to all municipalities within the local board's jurisdiction.

(d) Not less than 10 days before the adoption, amendment or repeal of any local board of health rule, the proposed rule shall be made available at the office of each county clerk within the board's jurisdiction, and a notice shall be published in a newspaper having general circulation within the area of the board's jurisdiction. The notice shall contain a statement of the substance of the proposed rule or a description of the subjects and issues involved, the proposed effective date of the rule and a statement that copies of the proposed rule are available at the local health department. A local board of health rule shall become effective upon adoption unless a later effective date is specified in the rule.

(e) Copies of all rules shall be filed with the secretary of the local board of health.

(f) A local board of health may, in its rules, adopt by reference any code, standard, rule or regulation which has been adopted by any agency of this State, another state, any agency of the United States or by a generally recognized association. Copies of any material adopted by reference shall be filed with the rules.

(g) A local board of health may impose a fee for services to be rendered by a local health department, except where the imposition of a fee is prohibited by statute or where an employee of the local health department is performing the services as an agent of the State. Notwithstanding any other provisions of law, a local board of health may impose cost-related fees for services performed pursuant to Article 11 of this Chapter, 'Wastewater Systems,' for services performed pursuant to Part 10, Article 8 of this Chapter, 'Public Swimming Pools', ~~and~~ for services performed pursuant to Part 11, Article 8 of this Chapter, ~~'Tattooing'.~~ 'Tattooing', and for health inspections of animal waste management systems, as defined in G.S. 143-215.10B. Fees shall be based upon a plan recommended by the local health director and approved by the local board of health and the appropriate county board or boards of commissioners. The fees collected under the authority of this subsection are to be deposited to the account of the local health department so that they may be expended for public health purposes in accordance with the provisions of the Local Government Budget and Fiscal Control Act."

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

ATTACHMENT VI

HOUSE BILL 1094:
Local Health Departments

BILL ANALYSIS

Committee:	House Health	**Introduced by:**	Rep. Justice
Date:	June 2, 2003	**Summary by:**	Sandra Alley
Version:	Second Edition		Committee Counsel

SUMMARY: ***HB 1094 would allow local boards of health, when required to protect the public health, to adopt more stringent rules than the Commission of Health Services or the Environmental Management Commission with respect to animal operations as defined by G.S. 143-215.10B. The Act would become effective when it becomes law.***

CURRENT LAW: G.S. 130A-39 delegates power to local boards of health to adopt a more stringent rule in an area regulated by the Commission for Health Services or the Environmental Management Commission (EMC), where, in the opinion of the local board of health, a more stringent rule is required to protect the public health. A local health board is limited in its rule-making powers in that the regulation must be "related to the promotion or protection of public health." City of Roanoke Rapids, v. Peedin, 124 N.C. App. 578 (1996).

Local rulemaking authority with respect to swine farms was limited by the decision of the Supreme Court in Craig v. Chatham, 356 N.C. 40 (2002), where rules passed by the Chatham County Board of Health, that were more stringent than rules set out by the EMC regarding the permitting, inspection and waste management systems of swine farms in Chatham County, were found invalid. The Supreme Court held that the system set up by the EMC at the direction of the General Assembly, in conjunction with the State Swine Farm Citing Act (G.S. 106-800 through 805) and G.S. 143-215.10A through 215.10M ("Animal Waste Management Systems"), established a "complete and integrated regulatory scheme" so as to leave no room for further local regulation, without specific reasons applicable to a local health need.

BILL ANALYSIS: HB 1094 amends G.S. 130A-39(b) to allow local boards of health to adopt rules governing animal operations. "Animal operations" are defined in G.S. 143-215.10B as "any agricultural farming activity involving 250 or more swine, 100 or more confined cattle, 75 or more horses, 1,000 or more sheep, or 30,000 or more confined poultry with a liquid animal waste management system. A public livestock market regulated under Article 35 of Chapter 106 of the General Statutes" is also considered an animal operation under the definition.

HB 1094 adds a new subsection G.S. 130A-39(b1) which allows local boards of health to use scientific studies, expert testimony and documentation of gaps in the State regulatory scheme to establish that a more stringent regulation is necessary to protect the public health. Studies, testimony and documentation need not be based on the specific county seeking the more stringent regulation.

Also, HB 1094 rewrites G.S. 130A-39(g) to allow local boards of health to impose a fee for health inspections of animal waste management systems, as defined in G.S. 143-215.10B.

BACKGROUND: This legislation is in response to Craig v. County of Chatham, where the NC Supreme Court held that state law preempts the regulation of swine farms and therefore, under G.S. 130A-39(b), local boards of health cannot adopt ordinances regulating swine farms without specific reasons applicable to a local health need.

H1094-SMSP-002

North Carolina Legislature
House of Representatives
House Health Committee-House Bill 1094
Tuesday, June 3, 2003
Testimony Presented For The North Carolina Citizens For Public Health
by Edward V. Ellis, Ph.D., President

Public Health in North Carolina is a valuable resource and service for our citizens. Local Boards of Health, for over 100 years, have been and continue to be a key element of our total state public health structure. It enjoys a reputation that is the envy of other states in our country and most important it is close to the citizens whose health it must protect. It is, therefore, mandatory rather than optional that there should not be any confusion with respect to the authority of local Boards of Health to adopt and promulgate rules necessary for the purpose of promoting and protecting the health of our citizens.

Since 1976, the North Carolina Citizens For Public Health has devoted it's time, talents and resources to increasing the involvement of citizens in public and community health. This effort is fueled by volunteers from across our state. Some of our accomplishments include:

- **Initiating and supporting North Carolina Public Health Month, the first such observance in the country;**
- **Representing citizens on public health issues with policy makers;and,**
- **Serving as the catalyst for the organization of the Association of North Carolina Boards of Health.**

We support House Bill 1094. This bill will clear the air and reaffirm the Legislature's intent to keep in place the authority of local Boards of Health to address local health concerns. This action would speak to the very essence of citizen involvement--citizens having input into the policy/decision making process of health at the local level.

HOUSE BILL 1094
QUESTIONS AND ANSWERS

QUESTION: Does passage of House Bill 1094 create a "dangerous precedent" giving local boards broad new regulatory authority?

ANSWER: No. H 1094 merely restores the authority of local health boards to protect local public health from a wide range of activities--authority that state law explicitly granted to local heath boards for many years prior to the Supreme Court ruling in *Craig v. Chatham County*. Before the court handed down the *Chatham County* decision, local health boards were empowered to protect the public health via the adoption of more stringent rules by North Carolina General Statute §130A-39. H 1094 is intended to address the broad effects of the *Chatham County* decision that have resulted in paralyzing local boards of health from acting to address new health issues in their communities.

QUESTION: Does good public policy demand uniform regulations statewide?

ANSWER: No. Washington doesn't always know best, and neither does Raleigh. Good public policy provides flexibility to local governments to adopt more stringent controls if federal and/or state standards are not sufficient to address local health problems or concerns. There is a long tradition of government, at the federal, state, and local levels, sharing regulatory power over activities that impact public health and the environment. A perfect example is the recent passage of the Clean Smokestacks legislation. The one-size-fits-all federal standards for air, determined by the U.S. Environmental Protection Agency were not good enough for North Carolina and, therefore, were supplemented by the North Carolina General Assembly. Similarly, in the case of H 1094, county officials are better equipped than state policymakers and officials to address the unique public health challenges in their counties (fostered by local differences in climate, topography, soils, groundwater tables, population densities, etc.).

QUESTION: Will passage of H 1094 result in the adoption of a hodge-podge of 100 different local health ordinances burdening farmers and others whose activities are already subject to some state regulation?

ANSWER: Absolutely not. Prior to the *Chatham County* decision, only eight local health boards had adopted rules governing swine and other livestock operations.These ordinances imposed modest requirements on farmers that did not interfere with their operations, but rather helped to alleviate community concerns and foster better relationships between the farmers and the community. H 1094 does not require counties to regulate livestock operations or any other activity. It simply restores their authority to do so if public health concerns warrant their attention.

QUESTION: Will passage of H 1094 encourage the adoption of onerous requirements?

ANSWER: No. Clarifying the authority of local boards of health by passing this bill would simply enable them to continue to make the reasoned and measured responses to the unique public health concerns facing their counties. Health boards are funded and appointed by the county commissions, and there is sufficient oversight and interaction between the two bodies to assure accountability.

QUESTION: Is there precedent for the General Assembly's adoption of legislation that reverses the effects of a court decision?

ANSWER: Yes. The legislative branch and the judicial branch of our state's government work separately but with an eye on one another's actions. The courts are frequently asked to interpret the effect and intent of laws enacted by the General Assembly. When the courts have misinterpreted state statutes, the General Assembly has used its legislative authority to clarify its intention and reverse the effects of the courts' misinterpretation.

Most recently, this occurred in the case *Smith Chapel Baptist Church v. City of Durham*, 350 N.C. 805, 517 S.E.2d 874 (1999). That case concerned the authority of the City to establish a stormwater utility as a mechanism for complying with the federal Clean Water Act's requirements for controlling stormwater runoff. The court held that the City had exceeded its authority and nullified the ordinance. In response to this decision, in 2000, the General Assembly amended the statutes in question (G.S. §§ 160A-311 and 314) to clarify that local governments had the authority to create stormwater management plans and programs and to impose fees for the financing of those programs.

QUESTION: Don't local health departments lack the requisite expertise to address health impacts from livestock operations?

ANSWER: No. Since 1879 local health departments have been at the vanguard of addressing public health problems. These bodies have a proven track record of effectively addressing the health care concerns of North Carolinians. Local health officials have significantly more expertise in addressing health impacts from livestock operations and other activities than do lawmakers or state water quality and agricultural officials. These state officials address the environmental impacts of livestock operations and generally do not possess expertise or jurisdiction over health concerns.

QUESTION: Wouldn't H 1094 be detrimental to farms and other businesses operations active in more than one county due to multiple local health rules?

ANSWER: No. Many businesses already operate in multiple counties and, as such, are subject to different taxation and zoning ordinances. There is no evidence that different local zoning of health ordinances have had any negative impact on these businesses.

Prepared by Michelle Nowlin, Southern Environmental Law Center, and Daniel Whittle, Environmental Defense, Attorneys for *Amicus Curiae* in *Craig v. County of Chatham*.

STATE OF NORTH CAROLINA

COUNTY OF DUPLIN

RESOLUTION OPPOSING HOUSE BILL 1094
(AN ACT AUTHORIZING LOCAL BOARD OF HEALTH TO ADOPT RULES)

WHEREAS, the North Carolina House of Representatives is considering adoption of House Bill 1094 which seeks to expand the authorities of local boards of health to include authority to adopt rules governing animal operations as defined by GS 143-215.10B; and

WHEREAS, the State of North Carolina already has in place stringent rules and regulations governing the articles addressed in the bill; and

WHEREAS, the enforcement of additional rules promulgated by boards of health would burden the already strained finances of counties; and

WHEREAS, rules of the nature addressed in the bill need to be consistent across the State rather than have 100 different sets of rules adopted by each of the state's 100 county health departments, should they decide to set such additional rules; and

WHEREAS, additional rules would stagnate the growth of already over-taxed and over-governed industries within our County.

NOW, THEREFORE BE IT RESOLVED, that the Board of Commissioners of Duplin County oppose the adoption of House Bill 1094 and urges their legislative delegates to consider the impact said legislation could have on the economy of Duplin County and other rural counties and vote against the bill.

Adopted this the 2nd day of June, 2003.

Larry Howard
Chairman

ATTEST: Judy Brown
Clerk

03-06-03 08:08 FROM-FINANCE 8102862107 T-418 P.03/03 F-357

RESOLUTION OPPOSING HOUSE BILL 1094
(AN ACT AUTHORIZING LOCAL BOARDS OF HEALTH TO ADOPT RULES)

WHEREAS, the North Carolina House of Representatives is considering adoption of House Bill 1094 which seeks to expand the authorities of local boards of health to include authority to adopt rules governing animal operations as defined by GS 143-215.10B; and

WHEREAS, the State of North Carolina already has in place stringent rules and regulation governing the articles addressed in the bill; and

WHEREAS, the enforcement of additional rules promulgated by boards of health would burden the already strained finances of counties; and

WHEREAS, rules of the nature addressed in the bill need to be consistent across the State rather than have 100 different sets of rules adopting by each of the state's 100 county health departments, should they decide to set such additional rules; and

WHEREAS, additional rules would stagnate the growth of already over-taxed and over-governed industries within our County.

NOW, THEREFORE, BE IT RESOLVED, that the Board of Commissioners of the County of opposes the adoption of House Bill 1094 and urges their legislation delegate to consider the impact said legislation could have on the economy of *Simpson County* and other rural counties and vote against the bill.

ADOPTED this 4th day of June, in the year 2003.

Jarvis H. McLamb, Chairman

ATTEST:

Jerry D. Hobbs, Clerk to the Board

THE NORTH CAROLINA STATE GRANGE

May 29, 2003

Dear House Health Committee Member,

I am writing you on behalf of the North Carolina State Grange to voice our opposition HB1094.

We feel that regulations that govern animal agriculture should be only under the jurisdiction of the state. HB 1094 would set a dangerous precedent of giving local health departments more stringent regulatory powers than state regulatory agencies. Many of our family farms straddle county lines or have property in more than one county. Laws governing Agriculture across the state should be uniform. With 100 counties in the state we could end up 100 different sets of regulations governing livestock production. We fear that the loss of uniformity in the laws that govern livestock production and allowing local health departments the ability to regulate animal agriculture could force many of the state's livestock producers out of business.

Dr. Mike Walden of NC State University state's Agribusiness accounts for more than 22 percent of North Carolina's economy, with 780,000 of the state's 3.6 million workers having jobs that are related to Agriculture. North Carolina Agribusiness Council figures state that Agribusiness contributes over $62 billion to the state's economy far outpacing second place tourism which contributes about $12 Billion. Livestock production contributes more to our state's economy than any other segment of Agriculture.

Many of North Carolina's farm families have already had to sell their farms and seek employment off the farm. When these farms are sold off and developed, this open space is lost forever. As development destroys what makes our state such a desirable place to live it is also the primary factor in polluting our environment. North Carolina is losing 2,000 farms and 150,000 acres each year. Since 1985 we have lost over half of our farms. With the loss of these farms local economies will suffer most. Farmers spend about 80 cents out of every dollar they earn locally. Keeping these local economies healthy is of vital importance to the whole economy of our state.

The Grange represents over 50,000 North Carolina citizens. The Grange is the oldest organization in the country that represents families who live in rural areas and are involved in Agriculture. Our member ship is made up primarily of people who's income is tied to what what happens in Agriculture. Again we urge you to vote no to HB 1094.

Sincerely:

David Meredith

David Meredith
Director of Legislative Affairs

CC: Other Interested Members of the General Assembly

PO BOX 9965 ◆ GREENSBORO, NC 27429-9965 ◆ 336/854-9000 ◆ 800/432-4857 ◆ FAX 336/292-1923 ◆ www.ncgrange.com

County of Bladen

Board of Commissioners

Resolution

Opposing House Bill 1094
(An Act Authorizing Local Boards of Health to Adopt Rules)

WHEREAS; the North Carolina House of Representatives is considering adoption of House Bill 1094 which seeks to expand the authorities of local boards of health to include authority to adopt rules governing animal operations as defined by N.C.G.S. 143-215.10B; and

WHEREAS, the State of North Carolina already has in place stringent rules and regulation governing the articles addressed in the bill; and

WHEREAS, the enforcement of additional rules promulgated by boards of health would burden the already strained finances of counties; and

WHEREAS, rules of the nature addressed in the bill need to be consistent across the State rather than have 100 different sets of rules adopting by each of the state's 100 county health departments, should they decide to set such additional rules; and

WHEREAS, additional rules would stagnate the growth of already over-taxed and over-governed industries within our County.

NOW, THEREFORE, BE IT RESOLVED, that the Bladen County Board of Commissioners opposes the adoption of House Bill 1094 and urges its legislation delegate to consider the impact said legislation could have on the economy of Bladen County and other rural counties and vote against the bill.

ADOPTED this 2nd day of June, 2003.

W. D. Neill, Jr.

W. D. Neill, Jr., Chairman
Bladen County Board of Commissioners

ATTEST:

Kathy P. Britt

Kathy P. Britt, Clerk

House Committee on Health

June 5, 2003

Minutes

The House Committee on Health met on Thursday, June 5, 2003 at 12:00 noon in Room 544 of the Legislative Office Building. A silent roll was taken. A copy of the roll denoting members present is attached to the minutes (Attachment I) along with a copy of the agenda and Visitor Registration Sheet (Attachments II and III).

Rep. Carolyn Justus, Chair calls meeting to order and recognizes Pages: Tim Curtis sponsored by Speaker Black, Clint Starnes from Cumberland sponsored by Rep. Starnes and Bobby Ruffin from Alamance County sponsored by Rep. Bordsen. The sergeant-in-arms are Dusty Rhodes and Charles Williams.

Chair Justus advises first bill to be heard will be SB 926 and calls upon Rep. Glazier to explain Sen. Rand's SB 926 A BILL TO BE ENTITLED AN ACT TO CLARIFY THE LICENSING PROCESS FOR NEW GROUP HOME FACILITIES AND FOR THE REIMBURSEMENT OF EDUCATIONAL COSTS BY THE HOME COUNTY TO THE HOST COUNTY. (Attachment IV) A proposed Committee Substitute is introduced and adopted for discussion purposes. (Attachment V) The propose committee substitute makes various clarifying amendments to the licensure statutes for group homes and to the statutes governing reimbursement for the educational costs of children placed in group homes. (Bill Analysis – Attachment VI) Rep. Sherrill makes motion to give proposed committee substitute a favorable report and unfavorable as to the original bill. Motion is adopted. (Committee Report-Attachment VII).

Chair Justus advises that next bill will to be heard will be HB 1094, which was carried over from Tuesday's meeting. Chair Justus then calls upon Rep. Justice to briefly explain her bill HB 1094 A BILL TO BE ENTITLED AN ACT AUTHORIZING LOCAL BOARDS OF HEALTH TO ADOPT RULES. (Bill and Bill Analysis - Attachments VIII and IX) A proposed committee substitute is introduced and adopted for discussion purposes (Attachment X) Rep. Justice explains changes in bill that includes removing the language relating to rules for animal operations Instead local boards of health would have authority to adopt rules necessary to protect and promote the public health unless expressly prohibited by statute. The title is also amended to conform with the language in the bill. (Bill Analysis – Attachment XI)

Rep. Hilton expresses concerns that the proposed committee substitute gives local health boards more authority than the original bill in allowing boards to make regulations. He feels that it is not a good bill and requests the Chair at appropriate time to recognize his motion for an unfavorable report.

Rep. Glazier also expresses concerns of whether bill will preempt state statutes. Paul Myers of the Association of County Commissioners responds that this is a confusing area of law and there is nothing straightforward about it. There is case law and constitutional law and to answer Rep. Glazier's question he believes it would change law. George Givens, staff also addresses issue of implied preemption.

Rep. Barnhart asks about impact on court case. George Givens, staff, states in his opinion it would reverse the decision in Craig v. Chatham. Rep. Barnhart states he is greatly concerned with the wording itself "unless expressly prohibited by statute". He feels this implies that unless the Board of Health is expressly prohibited by statute they could basically go out and do anything. Rep. Barnhart states that Boards of Health across the state are appointed as 11-member boards and of those members only six are needed for a quorum. He reiterates that he believes this is dangerous territory to allow six people to go out and do whatever they want to do unless it is expressly prohibited.

Rep. B. Allen is recognized and states he wants to make a motion for a favorable report. He feels that local health department should have that kind of control.

Chair Justus advises that the committee will now hear from people who wish to speak in support or opposition to bill. She calls on Dr. Steven Slott, President of NC Association Boards of Health who speaks in support of bill. Steve Woodson, Associate General Council with NC Farm Bureau speaks next in opposition to bill. Michelle Nolan, an attorney then speaks regarding the Supreme Court ruling in Craig v. Chatham Co.

Rep. Allred states he wants to amend bill to require Boards of Commissioners to approve the regulations adopted or give Boards of Commissioners the right to review or reject regulations. Before he is allowed to offer his amendment, questions arise from committee members concerning rules of committee and motions made.

Reps. Sherrill and Bowie call for a vote. There is then more discussion as to what motion has precedent among members and the rules of committee. Rep. Allred moves motion to adjourn, which is voted against by members.

Rep. Hilton again makes motion for proposed committee substitute to receive an unfavorable report. After discussion among members, motion is adopted. (Committee Report – Attachment XII)

Meeting is adjourned at 12:43 a.m.

Carolyn Justus
Rep. Carolyn Justus, Chair

Pamela J. Evans
Pamela J. Evans, Committee Clerk

ATTACHMENT I

ATTENDANCE

HOUSE COMMITTEE ON HEALTH

DATES	6/5/13														
INSKO, Verla CHAIR	✓														
JUSTUS, Carolyn CHAIR	✓														
ENGLAND, Bob VICE-CHAIR	✓														
ADAMS, Alma	✓														
ALLEN, Bernard	✓														
ALLEN, Gordon	✓														
ALLRED, Cary	✓														
BARNHART, Jeff	✓														
BOWIE, Joni	✓														
CLARY, Debbie															
EARLE, Beverly	✓														
GLAZIER, Rick	✓														
HILTON, Mark	✓														
McALLISTER, Mary	✓														
MUNFORD, Don	✓														
SETZER, Mitchell	✓														
SHERRILL, Wilma	✓														
WAINWRIGHT, William	✓														
WILSON, Connie															
WRIGHT, Tom	✓														
Ex officio Members															
Brubaker, Bru															
Culpepper, Bill															
Cunningham, Pete															
Eddins, Rick															

AGENDA

HOUSE COMMITTEE ON HEALTH

June 5, 2003
Room 544 LOB
12:00 Noon

OPENING REMARKS

Representative Verla Insko, Chair
Representative Carolyn Justus, Chair

AGENDA ITEMS

SB 926 Clarify Group Homes Licensure & LEA Reimburs. – Sen. Rand

HB 1094 Local Health Departments – Rep. Justice

ADJOURNMENT

ATTACHMENT III

VISITOR REGISTRATION SHEET

HOUSE COMMITTEE ON HEALTH — JUNE 5, 2003

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Patty Harrison	Beaufort NC
Molly Diggins	NC Sierra Club
Deborah Ramos	NCPAA
Bill Smith	NCALHD
Tim Minton	NC Home Builders Association
David Knight	NC Sierra
Rob Lamm	HHS
[illegible]	[illegible]
Henry Jones	Attorney Raleigh
Chad Essick	Edwards & Webb
[illegible]	CNC/Press

VISITOR REGISTRATION SHEET

HOUSE COMMITTEE ON HEALTH — JUNE 5, 2003

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Courtney Washburn	NC Sierra Club
DAVID PRESTWOOD	NCPIRG
Jeremy Packamayer	" "
Jeremy Kleyn	NC CONNECT
Jim Blackburn	NC Association of County Commissioners
Joanne Stevens	nursing
Katherine Joyce	NCASA
Stan Wall	Conservation Council
TOM BEAN	NC ENV DEF
Tyler Mansfield	NC Env. Def.
HALEY GILBERT	DAVID KNIGHT
Lauren Hoers	Sierra Club

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HOUSE COMMITTEE ON HEALTH — JUNE 5, 2003

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NAME	FIRM OR AGENCY AND ADDRESS
David Meeker	NC State Grange
Gregg K	CA
Edwin Jernigan	Agricultural Alliance of N.C.
Karen Carpenter	NCPC
Christopher Brooke	Environmental Defense
Dylan Fuge	Environmental Defense
Michelle Nowlin	SELC
CHARLOTTE MITCHELL	SELC
Michael Edwards	SELC
FRANK Sheffield	Chatham Cty. Ag. Council
S. Henri McClees	McClees Consulting, Inc.
Steve SLOTT	Association NC Boards of Health

VISITOR REGISTRATION SHEET

HOUSE COMMITTEE ON HEALTH — JUNE 5, 2003

Name of Committee — **Date**

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NAME	FIRM OR AGENCY AND ADDRESS
Fran Cockman	NC StateWatch
John O'Hale	Governor's Office
[illegible]	CSA
Steve Woodson	NC Farm Bureau
John Long	Martin Marietta
Lu-Ann Coe	NCPA
[illegible]	Smith Anderson
[illegible]	NC Forestry Assn
[illegible]	NCRA
[illegible]	Bone & Associates
BethAnne Mumford	NCPC

VISITOR REGISTRATION SHEET

HOUSE COMMITTEE ON HEALTH — JUNE 5, 2003

Name of Committee — **Date**

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NAME	FIRM OR AGENCY AND ADDRESS
Nancy Thompson	NCIC
Gene Ainsworth	RJR
Jimmy Randolph	NC Poultry Federation
John Cyrus	N C State Grange
Paul Meyer	NCAA
Karen Kelley	VNC
Kim Hibbard	NCLM
Ed Regan	N.C.A.C.C.
Leanne Winner	NCSBA
NAN Freeland	North Carolina Environmental Justice Network
Sarah Horne	
Valerie A. Hendrick	DPI

VISITOR REGISTRATION SHEET

HOUSE COMMITTEE ON HEALTH — JUNE 5, 2003

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Paul Woolworth	Fayetteville Observer
Stana McKinney	NC DHHS
Angie McMillan	TNC

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2003

S 2

SENATE BILL 926
Health & Human Resources Committee Substitute Adopted 4/21/03

Short Title: Clarify Group Homes Licensure & LEA Reimburs. (Public)

Sponsors:

Referred to:

April 3, 2003

A BILL TO BE ENTITLED

AN ACT TO CLARIFY THE LICENSING PROCESS FOR NEW GROUP HOME FACILITIES AND FOR THE REIMBURSEMENT OF EDUCATIONAL COSTS BY THE HOME COUNTY TO THE HOST COUNTY.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 115C-140.1 reads as rewritten:

"**§ 115C-140.1. Cost of education of children in group homes, foster homes, etc.**

(a) **(Effective until July 1, 2003)** Notwithstanding the provisions of any other statute and without regard for the place of domicile of a parent or guardian, the cost of a free appropriate public education for a child with special needs who is placed in or assigned to a group home, foster home or other similar facility, pursuant to State and federal law, shall be borne by the local board of education in which the group home, foster home or other similar facility is located. Nothing in this section obligates any local board of education to bear any cost for the care and maintenance of a child with special needs in a group home, foster home or other similar facility.

(a) **(Effective July 1, 2003)** Notwithstanding the provisions of any other statute and without regard for the place of domicile of a parent or guardian, the cost of a free appropriate public education for a child with ~~special needs~~ disabilities who is placed in or assigned to a group ~~home,~~ home or foster ~~home or other similar facility,~~ home, pursuant to State and federal law, shall be borne by the local board of education in which the group ~~home,~~ home or foster home ~~or other similar facility~~ is located. However, the local school administrative unit in which a child is domiciled shall transfer to the local school administrative unit in which the institution is located an amount equal to the actual local cost in excess of State and federal funding required to educate that child in the local school administrative unit for the fiscal ~~year.~~ year after all State and federal funding has been exhausted. ~~Nothing in this section obligates any local board of education to bear any cost for the care and maintenance of a child with special needs in a group home, foster home or other similar facility.~~

(b) The State Board of Education shall use State and federal funds appropriated for children with special needs to establish a reserve fund to reimburse local boards of education for the education costs of children assigned to group homes or other facilities as provided in subsection (a) of this section. Local school administrative units may submit a Special State Reserve Program application for foster home or group home children whose special education and related services costs exceed the per child group home allocation.

(c) The Department shall review the current cost of children with disabilities served in the local school administrative units with group homes or foster homes to determine the actual cost of services."

SECTION 2. G.S. 122C-23 reads as rewritten:

"**§ 122C-23. Licensure.**

(a) No person shall establish, maintain, or operate a licensable facility for the mentally ill, developmentally disabled, or substance abusers without a current license issued by the Secretary.

(b) Each license is issued to the person only for the premises named in the application and shall not be transferable or assignable except with prior written approval of the Secretary.

(c) Any person who intends to establish, maintain, or operate a licensable facility shall apply to the Secretary for a license. The Secretary shall prescribe by rule the contents of the application forms.

(d) The Secretary shall issue a license if the Secretary finds that the person complies with this Article and the rules of the Commission and Secretary.

(e) Unless a license is provisional or has been suspended or revoked, it shall be valid for a period not to exceed two years from the date of issue. The expiration date of a license shall be specified on the license when issued. Renewal of a regular license is contingent upon receipt of information required by the Secretary for renewal and continued compliance with this Article and the rules of the Commission and the Secretary.

A provisional license for a period not to exceed six months may be granted by the Secretary to a person who is temporarily unable to comply with a rule or rules. During this period the licensable facility shall correct the noncompliance based on a plan submitted to and approved by the Secretary. The noncompliance may not present an immediate threat to the health and safety of the individuals in the licensable facility. A provisional license for an additional period of time to meet the noncompliance may not be issued.

(e1) Except as provided in subsection (e2) of this section, ~~The Department~~ the Secretary shall not enroll any new provider for Medicaid Home or Community Based services or other Medicaid services, as defined in 42 C.F.R. 440.90, 42 C.F.R. 440.130(d), and 42 C.F.R. 440.180, or issue a license for a new facility or a new service to any applicant meeting any of the following criteria:

(1) ~~Was~~ The applicant was the owner, principal, or affiliate of a licensable facility under Chapter ~~122C~~122C, ~~or~~ Chapter ~~131D~~131D, or Article 7

of Chapter 110 that had its license revoked until 60 months after the date of the revocation.

(2) ~~Is~~ The applicant is the owner, principal, or affiliate of a licensable facility that was assessed a penalty for a Type A or Type B violation under Article 3 of this ~~Chapter until 60 months after the date of the violation.~~ Chapter, or any combination thereof, and any one of the following conditions exist:

a. A single violation has been assessed in the six months prior to the application.

b. Two violations have been assessed in the 18 months prior to the application and 18 months have not passed from the date of the most recent violation.

c. Three violations have been assessed in the 36 months prior to the application and 36 months have not passed from the date of the most recent violation.

d. Four or more violations have been assessed in the 60 months prior to application and 60 months have not passed from the date of the most recent violation.

(3) ~~Is~~ The applicant is the owner, principal, or affiliate of a licensable facility that had its license summarily suspended or downgraded to provisional status as a result of violations under G.S. 122C-24.1(a) until 60 months after the date of reinstatement or restoration of the license.

(4) ~~Is~~ The applicant is the owner, principal, or affiliate of a licensable facility that had its license summarily suspended or downgraded to provisional status as a result of violations under Article 1A of Chapter 131D until 60 months after the date of reinstatement or restoration of the license.

(5) The applicant is found by the Secretary to have a prior history as a provider under Chapter 122C, Chapter 131D, or Article 7 of Chapter 110 that indicates the applicant will not be able to comply with licensing or enrollment statutes and rules promulgated under those statutes.

(e2) The Secretary may enroll a provider described in subsection (e1) of this section if any of the following circumstances apply:

(1) The applicant is an area program or county program providing services under G.S. 122C-141, and there is no other provider of the service in the catchment area.

(2) The Secretary finds that the area program or county program has shown good cause by clear and convincing evidence why the enrollment should be allowed.

(f) Upon written application and in accordance with rules of the Commission, the Secretary may for good cause waive any of the rules implementing this Article, provided those rules do not affect the health, safety, or welfare of the individuals within

the licensable facility. Decisions made pursuant to this subsection may be appealed to the Commission for a hearing in accordance with Chapter 150B of the General Statutes.

(g) The Secretary may suspend the admission of any new clients to a facility licensed under this Article where the conditions of the facility are detrimental to the health or safety of the clients. This suspension shall be for the period determined by the Secretary and shall remain in effect until the Secretary is satisfied that conditions or circumstances merit removal of the suspension. In suspending admissions under this subsection, the Secretary shall consider the following factors:

(1) The degree of sanctions necessary to ensure compliance with this section and rules adopted to implement this subsection, and

(2) The character and degree of impact of the conditions at the facility on the health or safety of its clients.

A facility may contest a suspension of admissions under this subsection in accordance with Chapter 150B of the General Statutes. In contesting the suspension of admissions, the facility must file a petition for a contested case within 20 days after the Department mails notice of suspension of admissions to the licensee."

SECTION 3. G.S. 131D-2(b)(1b) reads as rewritten:

"(1b) No new license shall be issued for any adult care home to an applicant for licensure who:

a. Was the owner, principal, or affiliate of ~~an adult care home~~ a licensable facility under Chapter 122C, Chapter 131D, or Article 7 of Chapter 110 that had its license revoked until one full year after the date of revocation;

b. Is the owner, principal, or affiliate of an adult care home that was assessed a penalty for a Type A or Type B violation until the earlier of one year from the date the penalty was assessed or until the home has substantially complied with the correction plan established pursuant to G.S. 131D-34 and substantial compliance has been certified by the Department; or

c. Is the owner, principal, or affiliate of an adult care home that had its license summarily suspended or downgraded to provisional status as a result of Type A or B violations until six months from the date of reinstatement of the license, restoration from provisional to full licensure, or termination of the provisional license, as applicable.

d. Is the owner, principal, or affiliate of a licensable facility that had its license summarily suspended or downgraded to provisional status as a result of violations under Chapter 122C, or Article 1 of Chapter 131D, or had its license summarily suspended or denied under Article 7 of Chapter 110 until six months from the date of the reinstatement of the license, restoration from provisional to full licensure, or termination of the provisional license, as applicable.

An applicant for new licensure may appeal a denial of certification of substantial compliance under subparagraph b. of this subdivision by filing with the Department a request for review by the Secretary within 10 days of the date of denial of the certification. Within 10 days of receipt of the request for review the Secretary shall issue to the applicant a written determination that either denies certification of substantial compliance or certifies substantial compliance. The decision of the Secretary is final."

SECTION 4. G.S. 131D-10.3 reads as rewritten:

"**§ 131D-10.3. Licensure required.**

(a) No person shall operate, establish or provide foster care for children or receive and place children in residential care facilities, family foster homes, or adoptive homes without first applying for a license to the Department and submitting the required information on application forms provided by the Department.

(b) Persons licensed or seeking a license under this Article shall permit the Department access to premises and information required to determine whether the person is in compliance with licensing rules of the Commission.

(c) Persons licensed pursuant to this Article shall be periodically reviewed by the Department to determine whether they comply with Commission rules and whether licensure shall continue.

(d) This Article shall apply to all persons intending to organize, develop or provide foster care for children or receive and place children in residential child-care facilities, family foster homes or adoptive homes irrespective of such persons having applied for or obtained a certification, registration or permit to carry on work not controlled by this Article except persons exempted in G.S. 131D-10.4.

(e) Unless revoked or modified to a provisional or suspended status, the terms of a license issued by the Department shall be in force for a period not to exceed 24 months from the date of issuance under rules adopted by the Commission.

(f) Persons licensed or seeking a license who are temporarily unable to comply with a rule or rules may be granted a provisional license. The provisional license can be issued for a period not to exceed six months. The noncompliance with a rule or rules shall not present an immediate threat to the health and safety of the children, and the person shall have a plan approved by the Department to correct the area(s) of noncompliance within the provisional period. A provisional license for an additional period of time to meet the same area(s) of noncompliance shall not be issued.

(g) In accordance with Commission rules, a person may submit to the Department documentation of compliance with the standards of a nationally recognized accrediting body, and the Department on the basis of such accreditation may deem the person in compliance with one or more Commission licensing rules.

(h) Except as provided in subsection (i) of this section, the Secretary ~~The Department~~ shall not enroll any new provider for Medicaid Home or Community Based services or other Medicaid services, as defined in 42 C.F.R. 440.90, 42 C.F.R. 440.130(d), and 42 C.F.R. 440.180, or issue a license for a new facility or a new service to any applicant meeting any of the following criteria:

(1) ~~Was~~ The applicant was the owner, principal, or affiliate of a licensable facility under Chapter ~~122C or~~ 122C, Chapter ~~131D~~131D, or Article 7 of Chapter 110 that had its license revoked until 60 months after the date of the revocation.

(2) ~~Is~~ The applicant is the owner, principal, or affiliate of a licensable facility that was assessed a penalty for a Type A or Type B violation under Article 3 of ~~Chapter 122C until 60 months after the date of the violation.~~Chapter122C, or any combination thereof, and any one of the following conditions exist:

a. A single violation has been assessed in the six months prior to the application.

b. Two violations have been assessed in the 18 months prior to the application and 18 months have not passed from the date of the most recent violation.

c. Three violations have been assessed in the 36 months prior to the application and 36 months have not passed from the date of the most recent violation.

d. Four or more violations have been assessed in the 60 months prior to application and 60 months have not passed from the date of the most recent violation.

(3) ~~Is~~ The applicant is the owner, principal, or affiliate of a licensable facility that had its license summarily suspended or downgraded to provisional status as a result of violations under G.S. 122C- 24.1(a) until 60 months after the date of reinstatement or restoration of the license.

(4) ~~Is~~ The applicant is the owner, principal, or affiliate of a licensable facility that had its license summarily suspended or downgraded to provisional status as a result of violations under Article 1A of Chapter ~~131D~~131D, or had its license summarily suspended or denied under Article 7 of Chapter 110 until 60 months after the date of reinstatement or restoration of the license.

(5) The applicant is found by the Secretary to have a prior history as a provider under Chapter 122C, Chapter 131D, or Article 7 of Chapter 110 that indicates the applicant will not be able to comply with licensing or enrollment statutes and rules promulgated.

(i) The Secretary may enroll a provider described in subsection (h) of this section if any of the following circumstances apply:

(1) The applicant is an area program or county program providing services under G.S. 122C-141, and there is no other provider of the service in the catchment area.

(2) The Secretary finds that the area program or county program has shown good cause by clear and convincing evidence why the enrollment should be allowed."

SECTION 5. Section 3 of S.L. 2002-164 reads as rewritten:

"**SECTION 3.** The State Board of Education shall provide for a local school administrative unit to request funds from the Group Homes Program for Children with Disabilities if a child assigned to that unit was not in that unit's April ~~headcount~~ child count for ~~exceptional~~ children with disabilities or the average daily membership for the previous school ~~year, even if the local school administrative unit received Group Homes Program funds for that child for a portion of the preceding school year~~year. The local school administrative unit shall receive full school year funding upon the local school unit's request for group home or foster home program funds. These funds may not be requested except by a local school administrative unit."

SECTION 6.(a) The Department of Health and Human Services, in conjunction with the Department of Juvenile Justice and Delinquency Prevention, and the Department of Public Instruction shall report on the following Program information:

(1) The number and other demographic information of children served utilizing Comprehensive Treatment Services Program funds or who are placed out of their home under the auspices of one of the referenced agencies.

(2) The amount and source of funds expended to implement the Program.

(3) Information regarding the number of children screened for mental health, developmental disabilities, or substance abuse; specific placement of children including the placement of children in programs or facilities outside of the child's home county; and treatment needs of children served.

(4) The average length of stay in residential treatment, transition, and return to home.

(5) The number of children diverted from institutions or other out-of-home placements such as training schools and State psychiatric hospitals and a description of the services provided.

(6) Recommendations on other areas that need to be improved.

(7) Other information relevant to successfully maintaining children in their county of residence.

(8) A method of identifying and reporting child placements outside of the family unit in group homes or therapeutic foster care home settings.

SECTION 6.(b) The Department of Health and Human Services, in conjunction with the Department of Juvenile Justice and Delinquency Prevention, and the Department of Public Instruction shall submit a report by April 1, 2004, on the method of identifying and reporting child placements outside of the family unit in group homes or therapeutic foster care home settings to the House of Representatives Appropriations Subcommittee on Health and Human Services, the Senate Appropriations Committee on Health and Human Services, and the Fiscal Research Division.

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

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2003

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SENATE BILL 926

Health & Human Resources Committee Substitute Adopted 4/21/03
PROPOSED HOUSE COMMITTEE SUBSTITUTE S926-CSST-48 [v.3]

6/3/2003 9:02:48 AM

Short Title: Clarify Group Homes Licensure & LEA Reimburs. (Public)

Sponsors:

Referred to:

April 3, 2003

A BILL TO BE ENTITLED

AN ACT TO CLARIFY THE LICENSING PROCESS FOR NEW GROUP HOME FACILITIES AND FOR THE REIMBURSEMENT OF EDUCATIONAL COSTS BY THE HOME COUNTY TO THE HOST COUNTY.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 115C-140.1 reads as rewritten:

"**§ 115C-140.1. Cost of education of children in group homes, foster homes, etc.**

(a) **(Effective until July 1, 2003)** Notwithstanding the provisions of any other statute and without regard for the place of domicile of a parent or guardian, the cost of a free appropriate public education for a child with special needs who is placed in or assigned to a group home, foster home or other similar facility, pursuant to State and federal law, shall be borne by the local board of education in which the group home, foster home or other similar facility is located. Nothing in this section obligates any local board of education to bear any cost for the care and maintenance of a child with special needs in a group home, foster home or other similar facility.

(a) **(Effective July 1, 2003)** Notwithstanding the provisions of any other statute and without regard for the place of domicile of a parent or guardian, the cost of a free appropriate public education for a child with ~~special needs~~ disabilities who is placed in or assigned to a group ~~home,~~ home or foster ~~home or other similar facility,~~ home, pursuant to State and federal law, shall be borne by the local board of education in which the group ~~home,~~ home or foster home ~~or other similar facility~~ is located. However, the local school administrative unit in which a child is domiciled shall transfer to the local school administrative unit in which the institution is located an amount equal to the actual local cost in excess of State and federal funding required to educate that child in the local school administrative unit for the fiscal ~~year.~~ year after all State and federal funding has been exhausted. ~~Nothing in this section obligates any local~~

~~board of education to bear any cost for the care and maintenance of a child with special needs in a group home, foster home or other similar facility.~~

(b) The State Board of Education shall use State and federal funds appropriated for children with special needs to establish a reserve fund to reimburse local boards of education for the education costs of children assigned to group homes or other facilities as provided in subsection (a) of this section. Local school administrative units may submit a Special State Reserve Program application for foster home or group home children whose special education and related services costs exceed the per child group home allocation.

(c) The Department shall review the current cost of children with disabilities served in the local school administrative units with group homes or foster homes to determine the actual cost of services."

SECTION 2. G.S. 122C-23 reads as rewritten:

"**§ 122C-23. Licensure.**

(a) No person shall establish, maintain, or operate a licensable facility for the mentally ill, developmentally disabled, or substance abusers without a current license issued by the Secretary.

(b) Each license is issued to the person only for the premises named in the application and shall not be transferable or assignable except with prior written approval of the Secretary.

(c) Any person who intends to establish, maintain, or operate a licensable facility shall apply to the Secretary for a license. The Secretary shall prescribe by rule the contents of the application forms.

(d) The Secretary shall issue a license if the Secretary finds that the person complies with this Article and the rules of the Commission and Secretary.

(e) Unless a license is provisional or has been suspended or revoked, it shall be valid for a period not to exceed two years from the date of issue. The expiration date of a license shall be specified on the license when issued. Renewal of a regular license is contingent upon receipt of information required by the Secretary for renewal and continued compliance with this Article and the rules of the Commission and the Secretary.

A provisional license for a period not to exceed six months may be granted by the Secretary to a person who is temporarily unable to comply with a rule or rules. During this period the licensable facility shall correct the noncompliance based on a plan submitted to and approved by the Secretary. The noncompliance may not present an immediate threat to the health and safety of the individuals in the licensable facility. A provisional license for an additional period of time to meet the noncompliance may not be issued.

(e1) Except as provided in subsection (e2) of this section, ~~The Department~~ the Secretary shall not enroll any new provider for Medicaid Home or Community Based services or other Medicaid services, as defined in 42 C.F.R. 440.90, 42 C.F.R. 440.130(d), and 42 C.F.R. 440.180, or issue a license for a new facility or a new service to any applicant meeting any of the following criteria:

(1) ~~Was~~ The applicant was the owner, principal, or affiliate of a licensable facility under Chapter ~~122C~~122C, ~~or~~ Chapter ~~131D~~131D, or Article 7 of Chapter 110 that had its license revoked until 60 months after the date of the revocation.

(2) ~~Is~~ The applicant is the owner, principal, or affiliate of a licensable facility that was assessed a penalty for a Type A or Type B violation under Article 3 of this ~~Chapter until 60 months after the date of the violation.~~Chapter, or any combination thereof, and any one of the following conditions exist:

a. A single violation has been assessed in the six months prior to the application.

b. Two violations have been assessed in the 18 months prior to the application and 18 months have not passed from the date of the most recent violation.

c. Three violations have been assessed in the 36 months prior to the application and 36 months have not passed from the date of the most recent violation.

d. Four or more violations have been assessed in the 60 months prior to application and 60 months have not passed from the date of the most recent violation.

(3) ~~Is~~The applicant is the owner, principal, or affiliate of a licensable facility that had its license summarily suspended or downgraded to provisional status as a result of violations under G.S. 122C-24.1(a) until 60 months after the date of reinstatement or restoration of the license.

(4) ~~Is~~ The applicant is the owner, principal, or affiliate of a licensable facility that had its license summarily suspended or downgraded to provisional status as a result of violations under Article 1A of Chapter 131D until 60 months after the date of reinstatement or restoration of the license.

(e2) The Secretary may enroll a provider described in subsection (e1) of this section if any of the following circumstances apply:

(1) The applicant is an area program or county program providing services under G.S. 122C-141, and there is no other provider of the service in the catchment area.

(2) The Secretary finds that the area program or county program has shown good cause by clear and convincing evidence why the enrollment should be allowed.

(e3) For purposes of (e1)(2), fines assessed prior to October 23, 2002, are not applicable to this provision. However, licensure or enrollment shall be denied if an applicant's history as a provider under Chapter 131D, Chapter 122C or Article 7 of Chapter110 is such that the Secretary has concluded the applicant will likely be unable to comply with licensing or enrollment statutes, rules, or regulations. In the event the Secretary denies licensure or enrollment under this subsection, the reasons for the denial

and appeal rights pursuant to Article 3 of Chapter 150B shall be given to the provider in writing.

(f) Upon written application and in accordance with rules of the Commission, the Secretary may for good cause waive any of the rules implementing this Article, provided those rules do not affect the health, safety, or welfare of the individuals within the licensable facility. Decisions made pursuant to this subsection may be appealed to the Commission for a hearing in accordance with Chapter 150B of the General Statutes.

(g) The Secretary may suspend the admission of any new clients to a facility licensed under this Article where the conditions of the facility are detrimental to the health or safety of the clients. This suspension shall be for the period determined by the Secretary and shall remain in effect until the Secretary is satisfied that conditions or circumstances merit removal of the suspension. In suspending admissions under this subsection, the Secretary shall consider the following factors:

(1) The degree of sanctions necessary to ensure compliance with this section and rules adopted to implement this subsection, and

(2) The character and degree of impact of the conditions at the facility on the health or safety of its clients.

A facility may contest a suspension of admissions under this subsection in accordance with Chapter 150B of the General Statutes. In contesting the suspension of admissions, the facility must file a petition for a contested case within 20 days after the Department mails notice of suspension of admissions to the licensee."

SECTION 3. G.S. 131D-2(b)(1b) reads as rewritten:

"(1b) No new license shall be issued for any adult care home to an applicant for licensure who:

a. Was the owner, principal, or affiliate of ~~an adult care home~~ a licensable facility under Chapter 122C, Chapter 131D, or Article 7 of Chapter 110 that had its license revoked until one full year after the date of revocation;

b. Is the owner, principal, or affiliate of an adult care home that was assessed a penalty for a Type A or Type B violation until the earlier of one year from the date the penalty was assessed or until the home has substantially complied with the correction plan established pursuant to G.S. 131D-34 and substantial compliance has been certified by the Department; or

c. Is the owner, principal, or affiliate of an adult care home that had its license summarily suspended or downgraded to provisional status as a result of Type A or B violations until six months from the date of reinstatement of the license, restoration from provisional to full licensure, or termination of the provisional license, as applicable.

d. Is the owner, principal, or affiliate of a licensable facility that had its license summarily suspended or downgraded to provisional status as a result of violations under Chapter 122C, or Article 1 of Chapter 131D, or had its license summarily

suspended or denied under Article 7 of Chapter 110 until six months from the date of the reinstatement of the license, restoration from provisional to full licensure, or termination of the provisional license, as applicable.

An applicant for new licensure may appeal a denial of certification of substantial compliance under subparagraph b. of this subdivision by filing with the Department a request for review by the Secretary within 10 days of the date of denial of the certification. Within 10 days of receipt of the request for review the Secretary shall issue to the applicant a written determination that either denies certification of substantial compliance or certifies substantial compliance. The decision of the Secretary is final."

SECTION 4. G.S. 131D-10.3 reads as rewritten:

"**§ 131D-10.3. Licensure required.**

(a) No person shall operate, establish or provide foster care for children or receive and place children in residential care facilities, family foster homes, or adoptive homes without first applying for a license to the Department and submitting the required information on application forms provided by the Department.

(b) Persons licensed or seeking a license under this Article shall permit the Department access to premises and information required to determine whether the person is in compliance with licensing rules of the Commission.

(c) Persons licensed pursuant to this Article shall be periodically reviewed by the Department to determine whether they comply with Commission rules and whether licensure shall continue.

(d) This Article shall apply to all persons intending to organize, develop or provide foster care for children or receive and place children in residential child-care facilities, family foster homes or adoptive homes irrespective of such persons having applied for or obtained a certification, registration or permit to carry on work not controlled by this Article except persons exempted in G.S. 131D-10.4.

(e) Unless revoked or modified to a provisional or suspended status, the terms of a license issued by the Department shall be in force for a period not to exceed 24 months from the date of issuance under rules adopted by the Commission.

(f) Persons licensed or seeking a license who are temporarily unable to comply with a rule or rules may be granted a provisional license. The provisional license can be issued for a period not to exceed six months. The noncompliance with a rule or rules shall not present an immediate threat to the health and safety of the children, and the person shall have a plan approved by the Department to correct the area(s) of noncompliance within the provisional period. A provisional license for an additional period of time to meet the same area(s) of noncompliance shall not be issued.

(g) In accordance with Commission rules, a person may submit to the Department documentation of compliance with the standards of a nationally recognized accrediting body, and the Department on the basis of such accreditation may deem the person in compliance with one or more Commission licensing rules.

(h) Except as provided in subsection (i) of this section, the Secretary ~~The Department~~ shall not enroll any new provider for Medicaid Home or Community Based services or other Medicaid services, as defined in 42 C.F.R. 440.90, 42 C.F.R. 440.130(d), and 42 C.F.R. 440.180, or issue a license for a new facility or a new service to any applicant meeting any of the following criteria:

(1) ~~Was~~ The applicant was the owner, principal, or affiliate of a licensable facility under Chapter ~~122C or~~ 122C, Chapter ~~131D~~131D, or Article 7 of Chapter 110 that had its license revoked until 60 months after the date of the revocation.

(2) ~~Is~~ The applicant is the owner, principal, or affiliate of a licensable facility that was assessed a penalty for a Type A or Type B violation under Article 3 of ~~Chapter 122C until 60 months after the date of the violation.~~Chapter122C, or any combination thereof, and any one of the following conditions exist:

a. A single violation has been assessed in the six months prior to the application.

b. Two violations have been assessed in the 18 months prior to the application and 18 months have not passed from the date of the most recent violation.

c. Three violations have been assessed in the 36 months prior to the application and 36 months have not passed from the date of the most recent violation.

d. Four or more violations have been assessed in the 60 months prior to application and 60 months have not passed from the date of the most recent violation.

(3) ~~Is~~ The applicant is the owner, principal, or affiliate of a licensable facility that had its license summarily suspended or downgraded to provisional status as a result of violations under G.S. 122C- 24.1(a) until 60 months after the date of reinstatement or restoration of the license.

(4) ~~Is~~ The applicant is the owner, principal, or affiliate of a licensable facility that had its license summarily suspended or downgraded to provisional status as a result of violations under Article 1A of Chapter ~~131D~~131D, or had its license summarily suspended or denied under Article 7 of Chapter 110 until 60 months after the date of reinstatement or restoration of the license.

(i) The Secretary may enroll a provider described in subsection (h) of this section if any of the following circumstances apply:

(1) The applicant is an area program or county program providing services under G.S. 122C-141, and there is no other provider of the service in the catchment area.

(2) The Secretary finds that the area program or county program has shown good cause by clear and convincing evidence why the enrollment should be allowed.

(j) For purposes of (h)(2) of this section, fines assessed prior to October 23, 2002, are not applicable to this provision. However, licensure or enrollment shall be denied if an applicant's history as a provider under Chapter 131D, Chapter 122C, or Article 7 of Chapter 110 is such that the Secretary has concluded the applicant will likely be unable to comply with licensing or enrollment statutes, rules, or regulations. In the event the Secretary denies licensure or enrollment under this subsection, the reasons for the denial and appeal rights pursuant to Article 3 of Chapter 150B shall be given to the provider in writing."

SECTION 5. Section 3 of S.L. 2002-164 reads as rewritten:

"**SECTION 3.** The State Board of Education shall provide for a local school administrative unit to request funds from the Group Homes Program for Children with Disabilities if a child assigned to that unit was not in that unit's April ~~headcount~~ child count for ~~exceptional~~ children with disabilities or the average daily membership for the previous school ~~year, even if the local school administrative unit received Group Homes Program funds for that child for a portion of the preceding school year~~year. The local school administrative unit shall receive full school year funding upon the local school unit's request for group home or foster home program funds. These funds may not be requested except by a local school administrative unit."

SECTION 6.(a) The Department of Health and Human Services, in conjunction with the Department of Juvenile Justice and Delinquency Prevention, and the Department of Public Instruction shall report on the following Program information:

(1) The number and other demographic information of children served utilizing Comprehensive Treatment Services Program funds or who are placed out of their home under the auspices of one of the referenced agencies.

(2) The amount and source of funds expended to implement the Program.

(3) Information regarding the number of children screened for mental health, developmental disabilities, or substance abuse; specific placement of children including the placement of children in programs or facilities outside of the child's home county; and treatment needs of children served.

(4) The average length of stay in residential treatment, transition, and return to home.

(5) The number of children diverted from institutions or other out-of-home placements such as training schools and State psychiatric hospitals and a description of the services provided.

(6) Recommendations on other areas that need to be improved.

(7) Other information relevant to successfully maintaining children in their county of residence.

(8) A method of identifying and reporting child placements outside of the family unit in group homes or therapeutic foster care home settings.

SECTION 6.(b) The Department of Health and Human Services, in conjunction with the Department of Juvenile Justice and Delinquency Prevention, and the Department of Public Instruction shall submit a report by April 1, 2004, on the

method of identifying and reporting child placements outside of the family unit in group homes or therapeutic foster care home settings to the House of Representatives Appropriations Subcommittee on Health and Human Services, the Senate Appropriations Committee on Health and Human Services, and the Fiscal Research Division.

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

SENATE BILL 926:
Clarify Group Homes Licensure & LEA reimburs

BILL ANALYSIS

Committee:	Senate Health and Human Resources	**Introduced by:**	Senator Rand
		Summary by:	R. Erika Churchill Staff Counsel
Date:	June 5, 2003		
Version:	S926-CSST-48 v.3		

SUMMARY: ***The proposed committee substitute for Senate Bill 926 would make various clarifying amendments to the licensure statutes for group homes and to the statutes governing reimbursement for the educational costs of children placed in group homes.***

CURRENT LAW AND BILL ANALYSIS:

Section 1.

Current Law. Payment for the cost of educating children placed in group homes. G.S. 115C-140.1(a), effective July 1, 2003, provides that the local board of education in which the group home is located is responsible for the cost of a free appropriate public education for a child with special needs residing in a group home or foster home. However, the local school administrative unit where that child is domiciled is to transfer to the local school administrative unit where the group or foster home is located an amount equal to the actual local cost in excess of the State and federal funding.

Bill Analysis.

The proposed committee substitute clarifies that:

- State and federal funds for the cost of a free appropriate public education for a child with disabilities in group and foster home are to be exhausted before the "home county" LEA is to reimburse the "host county" LEA.
- a local school administrative unit providing an education to a child with disabilities to submit an application for funds to the Special State Reserve Program when the costs exceed the per child group home allocation.

Additionally, the Department of Public Instruction is required to review the current costs to determine the actual local cost of services to children with disabilities. The proposed committee substitute would also change the description of 'child with special needs' to 'child with disabilities.'

Sections 2 and 4.

Current Law. G.S. 122-23 governs licensure for facilities for the mentally ill, the developmentally disabled and substance abusers. G.S. 131D-10.3 governs licensure for foster homes. With the intent to prevent a provider from gaining licensure or Medicaid provider status under one chapter after having lost licensure or provider status under the other chapter, both chapters were amended in 2002 to provide that licensure or enrollment for Medicaid was to be denied to any of the following person(s) within the stated time-frames:

- Someone who was the owner, principal, or affiliate of a licensable facility under Chapter 122C or Chapter 131D that had its license revoked until 60 months after the date of the revocation.
- Someone who is the owner, principal, or affiliate of a licensable facility that was assessed a penalty for a violation of client's rights until 60 months after the date of the violation.
- Someone who is the owner, principal, or affiliate of a licensable facility that had its license summarily suspended or downgraded to provisional status as a result of violations under G.S. 122C-24.1(a) until 60 months after the date of reinstatement or restoration of the license.

Someone who is the owner, principal, or affiliate of a licensable facility that had its license summarily suspended or downgraded to provisional status as a result of violations under Article 1A of Chapter 131D until 60 months after the date of reinstatement or restoration of the license.

Bill Analysis. The proposed committee substitute would make changes to the ability of the Secretary of Health and Human Services to issue licenses and enroll providers for Medicaid services. The changes would add child day care centers to those facilities that licensure discipline affects further licensure. Also the proposed committee substitute would amend the licensure statutes to provide that licensure or enrollment for Medicaid must be denied to someone who is the owner, principal, or affiliate of a licensable facility that had its license summarily suspended or downgraded to provisional status as a result of violations under G.S. 122C-24.1(a) until 60 months after the date of reinstatement or restoration of the license. The proposed committee substitute provides that licensure or new Medicaid enrollment is to be denied to:

(1) Someone who is the owner, principal, or affiliate of a licensable facility that was assessed a penalty for a client's rights violation after October 23, 2002, and any one of the following conditions exist:
   a. A single violation has been assessed in the **six months** prior to the application.
   b. Two violations have been assessed in the 18 months prior to the application and **18 months** have not passed from the date of the most recent violation.
   c. Three violations have been assessed in the 36 months prior to the application and **36 months** have not passed from the date of the most recent violation.
   d. Four or more violations have been assessed in the 60 months prior to application and **60 months** have not passed from the date of the most recent violation.

(2) Someone found by the Secretary to have a prior history as a provider under Chapter 122C, Chapter 131D, or Article 7 of Chapter 110 that indicates the applicant will not be able to comply with licensing or enrollment statutes, rules, or regulations promulgated under those statutes. If licensure is denied for this reason, the Secretary must notify the applicant of the reasons why and give notice to the applicant that the applicant can appeal the decision in accordance with Article 3 of Chapter 150B.

The sections also provide that the Secretary may issue a license or enroll a provider in the both of the following:

(1) The applicant is an area program or county program providing services under G.S. 122C-141, and there is no other provider of the service in the catchment area.
(2) The Secretary finds that the area program or county program has shown good cause by clear and convincing evidence why the enrollment should be allowed.

Section 3. The proposed committee substitute would require licensure to be denied to an applicant for an adult care home who is the owner, principal, or affiliate of a licensable facility that had its license summarily suspended or downgraded to provisional status as a result of violations under Chapter 122C or Article 1 of Chapter 131D or had its license summarily suspended or denied under Article 7 of Chapter 110 until **six months** from the date of the reinstatement of the license, restoration from provisional to full licensure, or termination of the provisional license, as applicable.

Section 5. The proposed committee substitute conforms language in S.L. 2002-164 to the current terminology used by the Department of Public Instruction. The proposed committee substitute would

also clarify that the local school administrative unit requesting funding from the Group Homes Program for Children with Disabilities shall receive full school year funding.

Section 6.

Current Law. The Department of Health and Human Services, in conjunction with the Department of Juvenile Justice and Delinquency Prevention, the Department of Public Instruction, and other affected agencies, shall report on the following Program information:

- The number and other demographic information of children served.
- The amount and source of funds expended to implement the Program.
- Information regarding the number of children screened, specific placement of children including the placement of children in programs or facilities outside of the child's home county, and treatment needs of children served.
- The average length of stay in residential treatment, transition, and return to home.
- The number of children diverted from institutions or other out-of-home placements such as training schools and State psychiatric hospitals and a description of the services provided.
- Recommendations on other areas of the Program that need to be improved.
- Other information relevant to successful implementation of the Program.
- A method of identifying and tracking children placed outside of the family unit in group homes or therapeutic foster care home settings.

Bill Analysis. The proposed committee substitute would require the Department of Health and Human Services, together with the Department of Juvenile Justice and Delinquency Prevention and the Department of Public Instruction, to determine a method of identifying and ***reporting*** child placements outside the family unit group home and therapeutic foster care home settings. This is in addition to several other reporting requirements included in S.L. 2002-164 as stated above.

EFFECTIVE DATE: The proposed committee substitute would become effective when it becomes law.

2003 COMMITTEE REPORT
HOUSE OF REPRESENTATIVES

The following report(s) from standing committee(s) is/are presented:
By Representative(s) **Carolyn Justus and Verla Insko,** (Chair/Chairs) for the Committee on **HEALTH**.

☒ Senate Committee Substitute for
S.B. 926 A BILL TO BE ENTITLED AN ACT TO CLARIFY THE LICENSING PROCESS FOR NEW GROUP HOME FACILITIES AND FOR THE REIMBURSEMENT OF EDUCATIONAL COSTS BY THE HOME COUNTY TO THE HOST COUNTY.

☐ 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)

3/06/03

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2003

H 2

HOUSE BILL 1094
Committee Substitute Favorable 5/14/03

Short Title: Local Health Departments. (Public)

Sponsors:

Referred to:

April 10, 2003

A BILL TO BE ENTITLED

AN ACT AUTHORIZING LOCAL BOARDS OF HEALTH TO ADOPT RULES.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 130A-39 reads as rewritten:

"**§ 130A-39. Powers and duties of a local board of health.**

(a) A local board of health shall have the responsibility to protect and promote the public health. The board shall have the authority to adopt rules necessary for that purpose.

(b) A local board of health may adopt a more stringent rule in an area regulated by the Commission for Health Services or the Environmental Management Commission where, in the opinion of the local board of health, a more stringent rule is required to protect the public health; otherwise, the rules of the Commission for Health Services or the rules of the Environmental Management Commission shall prevail over local board of health rules. However, a local board of health may not adopt a rule concerning the grading, operating, and permitting of food and lodging facilities as listed in Part 6 of Article 8 of this Chapter and as defined in G.S. 130A-247(1), and a local board of health may adopt rules concerning wastewater collection, treatment and disposal systems which are not designed to discharge effluent to the land surface or surface waters only in accordance with G.S. 130A-335(c). A local board of health may adopt rules governing animal operations, as defined by G.S. 143-215.10B.

(b1) For purposes of subsection (b) of this section, a showing by a local board of health that a more stringent rule is required to protect the public health may be based on published scientific studies, testimony from experts in health-related professions, or documentation of gaps in State regulatory programs that may threaten public health. These studies and testimony must be related to the general subject matter of the rule but need not be based on county-specific considerations.

(c) The rules of a local board of health shall apply to all municipalities within the local board's jurisdiction.

(d) Not less than 10 days before the adoption, amendment or repeal of any local board of health rule, the proposed rule shall be made available at the office of each county clerk within the board's jurisdiction, and a notice shall be published in a newspaper having general circulation within the area of the board's jurisdiction. The notice shall contain a statement of the substance of the proposed rule or a description of the subjects and issues involved, the proposed effective date of the rule and a statement that copies of the proposed rule are available at the local health department. A local board of health rule shall become effective upon adoption unless a later effective date is specified in the rule.

(e) Copies of all rules shall be filed with the secretary of the local board of health.

(f) A local board of health may, in its rules, adopt by reference any code, standard, rule or regulation which has been adopted by any agency of this State, another state, any agency of the United States or by a generally recognized association. Copies of any material adopted by reference shall be filed with the rules.

(g) A local board of health may impose a fee for services to be rendered by a local health department, except where the imposition of a fee is prohibited by statute or where an employee of the local health department is performing the services as an agent of the State. Notwithstanding any other provisions of law, a local board of health may impose cost-related fees for services performed pursuant to Article 11 of this Chapter, "Wastewater Systems," for services performed pursuant to Part 10, Article 8 of this Chapter, "Public Swimming Pools", and for services performed pursuant to Part 11, Article 8 of this Chapter, "Tattooing". Fees shall be based upon a plan recommended by the local health director and approved by the local board of health and the appropriate county board or boards of commissioners. The fees collected under the authority of this subsection are to be deposited to the account of the local health department so that they may be expended for public health purposes in accordance with the provisions of the Local Government Budget and Fiscal Control Act."

SECTION 2. G.S. 130A-39(g) reads as rewritten:

"(g) A local board of health may impose a fee for services to be rendered by a local health department, except where the imposition of a fee is prohibited by statute or where an employee of the local health department is performing the services as an agent of the State. Notwithstanding any other provisions of law, a local board of health may impose cost-related fees for services performed pursuant to Article 11 of this Chapter, "Wastewater Systems," for services performed pursuant to Part 10, Article 8 of this Chapter, "Public Swimming Pools", ~~and~~ for services performed pursuant to Part 11, Article 8 of this Chapter, ~~"Tattooing".~~ "Tattooing", and for health inspections of animal waste management systems, as defined in G.S. 143-215.10B. Fees shall be based upon a plan recommended by the local health director and approved by the local board of health and the appropriate county board or boards of commissioners. The fees collected under the authority of this subsection are to be deposited to the account of the local health department so that they may be expended for public health purposes in accordance with the provisions of the Local Government Budget and Fiscal Control Act."

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

HOUSE BILL 1094:
Local Health Departments

BILL ANALYSIS

Committee:	House Health	**Introduced by:**	Rep. Justice
Date:	June 2, 2003	**Summary by:**	Sandra Alley
Version:	Second Edition		Committee Counsel

SUMMARY: ***HB 1094 would allow local boards of health, when required to protect the public health, to adopt more stringent rules than the Commission of Health Services or the Environmental Management Commission with respect to animal operations as defined by G.S. 143-215.10B. The Act would become effective when it becomes law.***

CURRENT LAW: G.S. 130A-39 delegates power to local boards of health to adopt a more stringent rule in an area regulated by the Commission for Health Services or the Environmental Management Commission (EMC), where, in the opinion of the local board of health, a more stringent rule is required to protect the public health. A local health board is limited in its rule-making powers in that the regulation must be "related to the promotion or protection of public health." City of Roanoke Rapids, v. Peedin, 124 N.C. App. 578 (1996).

Local rulemaking authority with respect to swine farms was limited by the decision of the Supreme Court in Craig v. Chatham, 356 N.C. 40 (2002), where rules passed by the Chatham County Board of Health, that were more stringent than rules set out by the EMC regarding the permitting, inspection and waste management systems of swine farms in Chatham County, were found invalid. The Supreme Court held that the system set up by the EMC at the direction of the General Assembly, in conjunction with the State Swine Farm Citing Act (G.S. 106-800 through 805) and G.S. 143-215.10A through 215.10M ("Animal Waste Management Systems"), established a "complete and integrated regulatory scheme" so as to leave no room for further local regulation, without specific reasons applicable to a local health need.

BILL ANALYSIS: HB 1094 amends G.S. 130A-39(b) to allow local boards of health to adopt rules governing animal operations. "Animal operations" are defined in G.S. 143-215.10B as "any agricultural farming activity involving 250 or more swine, 100 or more confined cattle, 75 or more horses, 1,000 or more sheep, or 30,000 or more confined poultry with a liquid animal waste management system. A public livestock market regulated under Article 35 of Chapter 106 of the General Statutes" is also considered an animal operation under the definition.

HB 1094 adds a new subsection G.S. 130A-39(b1) which allows local boards of health to use scientific studies, expert testimony and documentation of gaps in the State regulatory scheme to establish that a more stringent regulation is necessary to protect the public health. Studies, testimony and documentation need not be based on the specific county seeking the more stringent regulation.

Also, HB 1094 rewrites G.S. 130A-39(g) to allow local boards of health to impose a fee for health inspections of animal waste management systems, as defined in G.S. 143-215.10B.

BACKGROUND: This legislation is in response to Craig v. County of Chatham, where the NC Supreme Court held that state law preempts the regulation of swine farms and therefore, under G.S. 130A-39(b), local boards of health cannot adopt ordinances regulating swine farms without specific reasons applicable to a local health need.

H1094-SMSP-002

ATTACHMENT X

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2003

H D

HOUSE BILL 1094
Committee Substitute Favorable 5/14/03
PROPOSED COMMITTEE SUBSTITUTE H1094-PCS70339-RT-45

Short Title: Local Boards of Health. (Public)

Sponsors:

Referred to:

April 10, 2003

A BILL TO BE ENTITLED

AN ACT TO CLARIFY THE AUTHORITY OF LOCAL BOARDS OF HEALTH TO ADOPT RULES TO PROTECT PUBLIC HEALTH.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 130A-39 reads as rewritten:

"**§ 130A-39. Powers and duties of a local board of health.**

(a) A local board of health shall have the responsibility to protect and promote the public health. The board shall have the authority to adopt rules necessary for that ~~purpose.~~purpose, unless expressly prohibited by statute.

(b) A local board of health may adopt a more stringent rule in an area regulated by the Commission for Health Services or the Environmental Management Commission where, in the opinion of the local board of health, a more stringent rule is required to protect the public health; otherwise, the rules of the Commission for Health Services or the rules of the Environmental Management Commission shall prevail over local board of health rules. However, a local board of health may not adopt a rule concerning the grading, operating, and permitting of food and lodging facilities as listed in Part 6 of Article 8 of this Chapter and as defined in G.S. 130A-247(1), and a local board of health may adopt rules concerning wastewater collection, treatment and disposal systems which are not designed to discharge effluent to the land surface or surface waters only in accordance with G.S. 130A-335(c).

(c) The rules of a local board of health shall apply to all municipalities within the local board's jurisdiction.

(d) Not less than 10 days before the adoption, amendment or repeal of any local board of health rule, the proposed rule shall be made available at the office of each county clerk within the board's jurisdiction, and a notice shall be published in a newspaper having general circulation within the area of the board's jurisdiction. The notice shall contain a statement of the substance of the proposed rule or a description of

the subjects and issues involved, the proposed effective date of the rule and a statement that copies of the proposed rule are available at the local health department. A local board of health rule shall become effective upon adoption unless a later effective date is specified in the rule.

(e) Copies of all rules shall be filed with the secretary of the local board of health.

(f) A local board of health may, in its rules, adopt by reference any code, standard, rule or regulation which has been adopted by any agency of this State, another state, any agency of the United States or by a generally recognized association. Copies of any material adopted by reference shall be filed with the rules.

(g) A local board of health may impose a fee for services to be rendered by a local health department, except where the imposition of a fee is prohibited by statute or where an employee of the local health department is performing the services as an agent of the State. Notwithstanding any other provisions of law, a local board of health may impose cost-related fees for services performed pursuant to Article 11 of this Chapter, 'Wastewater Systems,' for services performed pursuant to Part 10, Article 8 of this Chapter, 'Public Swimming Pools', ~~and~~ for services performed pursuant to Part 11, Article 8 of this Chapter, ~~'Tattooing'.~~ 'Tattooing', and for health inspections of animal waste management systems, as defined in G.S. 143-215.10B. Fees shall be based upon a plan recommended by the local health director and approved by the local board of health and the appropriate county board or boards of commissioners. The fees collected under the authority of this subsection are to be deposited to the account of the local health department so that they may be expended for public health purposes in accordance with the provisions of the Local Government Budget and Fiscal Control Act."

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

HOUSE BILL 1094:
Local Health Departments

BILL ANALYSIS

Committee:	House Health	**Introduced by:**	Rep. Justice
Date:	June 5, 2003	**Summary by:**	Sandra Alley
Version:	H1094-PCS70339-RT-45		Committee Counsel

SUMMARY: ***HB 1094 would allow local boards of health, when required to protect the public health, to adopt more stringent rules than the Commission of Health Services or the Environmental Management Commission with respect to animal operations as defined by G.S. 143-215.10B. The Act would become effective when it becomes law.***

Under the PCS to HB 1094 the language relating to rules for animal operations is removed. Instead, local boards of health would have authority to adopt rules necessary to protect and promote the public health unless expressly prohibited by statute.

The PCS also amends the title and short title to conform with the language in the bill.

CURRENT LAW: G.S. 130A-39 delegates power to local boards of health to adopt a more stringent rule in an area regulated by the Commission for Health Services or the Environmental Management Commission (EMC), where, in the opinion of the local board of health, a more stringent rule is required to protect the public health. A local health board is limited in its rule-making powers in that the regulation must be "related to the promotion or protection of public health." City of Roanoke Rapids, v. Peedin, 124 N.C. App. 578 (1996).

Local rulemaking authority was limited by the decision of the Supreme Court in Craig v. Chatham, 356 N.C. 40 (2002). In Craig, the local board of health passed more stringent rules than those set out by the EMC regarding the permitting, inspection and waste management systems of swine farms in Chatham County. The Supreme Court held that the local rules were invalid because the system set up by the EMC at the direction of the General Assembly, in conjunction with the State Swine Farm Citing Act (G.S. 106-800 through 805) and G.S. 143-215.10A through 215.10M ("Animal Waste Management Systems"), established a "complete and integrated regulatory scheme" so as to leave no room for further local regulation, without specific reasons applicable to a local health need.

BILL ANALYSIS: HB 1094 amends G.S. 130A-39(b) to allow local boards of health to adopt rules for animal operations. "Animal operations" are defined in G.S. 143-215.10B as "any agricultural farming activity involving 250 or more swine, 100 or more confined cattle, 75 or more horses, 1,000 or more sheep, or 30,000 or more confined poultry with a liquid animal waste management system. A public livestock market regulated under Article 35 of Chapter 106 of the General Statutes" is also considered an animal operation under the definition.

Also, HB 1094 rewrites G.S. 130A-39(g) to allow local boards of health to impose a fee for health inspections of animal waste management systems, as defined in G.S. 143-215.10B.

The PCS to HB 1094 removes the language allowing local health boards to pass more stringent rules than the State to regulate animal operations. Instead, the under the PCS, G.S. 130A-39(a) is rewritten to limit local boards of health authority to adopt more stringent rules necessary to protect and promote public health where *expressly* prohibited by statute.

The PCS also:

- rewrites the title of the bill from **"An Act Authorizing Local Boards of Health to Adopt Rules"** to **"An Act to Clarify the Authority of Local Boards of Health to Adopt Rules to Protect Public Health"**
- rewrites the short title from **"Local Health Departments"** to **"Local Boards of Health"**.

BACKGROUND: This legislation is in response to Craig v. County of Chatham, where the NC Supreme Court held that state law preempts the regulation of swine farms and therefore, under G.S. 130A-39(b), local boards of health cannot adopt ordinances regulating swine farms without specific reasons applicable to a local health need. In Craig the court held that local boards do not have the authority to pass rules more stringent than the State where the State has provided a "complete and integrated regulatory scheme" to the exclusion of local regulation.

H1094-SMSP-003

ATTACHMENT XII

2003 COMMITTEE REPORT
HOUSE OF REPRESENTATIVES

The following report(s) from standing committee(s) is/are presented:
By Representatives **Verla Insko and Carolyn Justus,** Chairs for the Committee on **HEALTH**.

☐ Committee Substitute for
H.B.1094 A BILL TO BE ENTITLED AN ACT AUTHORIZING LOCAL BOARDS OF HEALTH TO ADOPT RULES.

☐ 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 (# H.B.), ☐ 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)

3/06/03

FOR JOURNAL USE ONLY

____ Pursuant to Rule 36(b), the bill/resolution is placed on the Calendar of _____.

____ The (committee substitute) bill/resolution (, as amended,) is (ordered engrossed and) re-referred to the Committee on _____.

____ The bill/resolution is re-referred to the Committee on _____.

____ On motion of (Rep. _____,) (the Chair,) the (committee substitute) bill/resolution is (ordered engrossed and) re-referred to the Committee on _____.

____ Pursuant to Rule 36(b), the (House)committee substitute bill (No. ____)/resolution is placed on the Calendar of _____. (The original bill) (House Committee Substitute Bill No. ____)/resolution is placed on the Unfavorable Calendar.

____ On motion of Rep. _____, (the rules are suspended) (Rule ____ is suspended) and the bill/resolution is placed on today's calendar. (for immediate consideration.)

____ On motion of Rep. _____, Committee Amendment No.(s) _____ is/are adopted (by EV____ ____).

____ On motion of Rep. _____, Committee Amendment No.(s) _____ is/are adopted (by EV____ ____).

____ Rep. _____ offers Amendment No. _____ which (is adopted.) (fails of adoption.) (by EV ____ ____.) ( ) This amendment changes the title.

____ The bill/resolution (, as amended,) passes its second reading (by following vote, ____ ____ RC) (, by EV ____ ____,) and (remains on the Calendar,) (and there being no objection is read a third time).

____ The bill/resolution (, as amended,) passes its third reading (by the following vote, ____ ____ RC) (, by EV ____ ____,) and is ordered
____ sent to the Senate.
____ without engrossment. ____ by Special message.
____ sent to the Senate for concurrence in
_____ the House amendment (s).
_____the House committee substitute bill.
____ enrolled.

____ On motion of Rep. _____, the House concurs in the (material) Senate _____ (by the following vote, ____ ____ RC) (, by EV ____ ____,) and the bill is ordered enrolled.

House Committee on Health

June 10, 2003

Minutes

The House Committee on Health met on Tuesday, June 10, 2003 at 12:00 noon in Room 544 of the Legislative Office Building. A silent roll was taken. A copy of the roll denoting members present is attached to the minutes (Attachment I) along with a copy of the agenda and Visitor Registration Sheet (Attachments II and III).

Rep. Verla Insko calls meeting to order and introduces Pages: Lucy Rogers and Elise Dorsett from Wake County sponsored by Rep. Munford and Laura Fox from Wake County sponsored by Rep .Fox, Denise Peeples also from Wake County sponsored by Rep. Ross and Kesa Frederick who is sponsored by Rep. Wainwright. The Sergeant-in-Arms Dusty Rhodes, Paul and Frances Poole.

Chair Insko takes a minute of personal privilege and calls attention to the Session Rules of 2003. Rule 28(d) states: "Procedure in the standing committees and permanent subcommittees shall be governed by the rules of the House . . . ". Chair Insko advises members that she will appreciate their following the Rules of House in Health Committee meetings and then thanks the members for their attention.

Chair Insko calls the meeting to order and calls upon Sen. Berger to explain his bill SB 1016 A BILL TO BE ENTITLED AN ACT REQUIRING NURSING HOMES TO ESTABLISH A MEDICATION MANAGEMENT ADVISORY COMMITTEE AND SPECIFYING THE DUTIES OF THE COMMITTEE, AND TO REQUIRE NURSING HOMES TO DO CERTAIN THINGS PERTAINING TO THE REDUCTION OF MEDICATION-RELATED ERRORS TO INCREASE PATIENT SAFETY. (Attachment IV). Bill requires nursing homes to establish medication management advisory committees and for every nursing home administrator to ensure that the nursing home quality assurance committee implements measures to minimize risk of medication-related errors. Imposes additional duties on consultant pharmacist. Requires that Secretary of Health and Human Services contract with a public or private entity to develop and implement a Medication Error Quality Initiative rather than doing it within the Department. (Bill Analysis – Attachment V)

Rep. Adams asks if there is no current oversight for nursing homes. Sen. Berger responds in-house only – no centralized system. Each nursing home handles medication errors in a different way. Rep. Adams then requests outline of who would make up group and when they would meet. Sen. Berger advises nursing home administrator, director of nursing, consultant pharmacist, physician designed at nursing home administrator and at least three other members of nursing home staff who will met as needed, but no less than quarterly.

Proposed Committee Substitute is passed out and adopted for discussion purposes. (Attachment VI). Rep. Barnhart wants to know how industry feels about bill. Sen. Berger responds that the industry favors bill. Rep. Hill then offers an amendment – a technical correction. Amendment is adopted. Rep. Bowie moves to roll amendment into a proposed committee substitute, favorable as to the committee substitute and unfavorable as to the original bill. Motion adopted. (Committee Report – Attachment VII)

Rep. Luebke is then called to explain his bill HB 923 A BILL TO BE ENTITLED AN ACT TO EXEMPT THE PRACTICE OF COMPLEMENTARY OR ALTERNATIVE FORMS OF HEALTH CARE FROM THE PRACTICE OF MEDICINE. (Attachment VIII) Rep. Adams makes motion to adopt proposed committee substitute for discussion purposes. (Attachment IX) Motion adopted. (Bill Analysis – Attachment X) Rep. Bowie inquires about time restricts on bill. Chair Insko advises committee will hear from four speakers opposing bill and four for bill. Rep. Luekbe has requested speakers limit time to two minutes each.

Rep. Luebke explains this is a consumer choice bill that some of his constitutes in Durham ask him to run. The bill would exempt the practice of alternative or complementary medicine from licensure by the NC Medical Board and would require those persons to register with the Secretary of State. The practitioner would be required to disclose to a client his or her professional training and qualifications and that he or she is not a licensed medical doctor. The practitioner could not performance surgery, administer x-ray radiation or prescribed prescription drugs. Rep. Luebke states that it is an alterative way to provide health case.

Barbara Zelter is recognized and spoke.(Attachment XI). She is followed by Dr. Doug Mann, Professor of Neurology at UNC. Dr. Mann states that he is involved in a five-year study through a NIH grant to teach alternative medicine to students. His study deals with how alternative medicine works, what population it works on and safety. Next to speak is Julie Insley, Vice President and who is on the board of the Carolina Health Coalition. She states Coalition is a grass root organization that brought bill to Rep. Luebke. Finally, Boyd Landry, Executive Director for National Health in Washington spoke voicing his opinion for the bill.

Dr. Liz Kanoff, Past President of the Medical Society and Medical Board advised that their members strongly oppose bill. She spoke about the dangers of alternative medicine and that enforcement by the Secretary of State would be impossible. Charles Wilkins, Council to the NC Board of Message and Body Work Therapy spoke. His organization had no concerns with the original bill, but now sees several conflicts with the committee substitute. Rep. Luebke agreed to work with group about their concerns. Mr. Thomas Mansfield, Director of the Legal Department for the Medical Board felt that the Secretary of State's Office could not regulate the bill and spoke in opposition to it. As chief prosecutor for the medical board he is concerned as to who will protect the public from unsafe practitioners of alternative medicine and how does this bill affects the medical board's ability to regulate its licensees. The medical board was created to protect

the public against unsafe practitioners. He feels that the Secretary of State's Office is not an adequate agency to practice oversight of these practitioners. Further, he states that he can provide the members with real cases where people have been submitted to hospitals or died as a result of alternative medicine such as those under this bill.

Mr. Hubner was the last speaker. He spoke in favor of the bill. He was a consumer user of alternative medicine. He started using alternative medicine about three years ago and has not been seen by a medical doctor during that time. He states that he has cured himself using alternative medicine for bronchitis, pneumonia, and allergies. He spoke about right to choose his own health care. He felt this was an issue of control and not who gets the health care dollars that are spent.

Rep. Allred was recognized and spoke in opposition to bill referring to his own experience of being in the pharmaceutical business for 33 years. He expresses concern about lack of training for people who will be allowed to prescribe products, which have not been proven to be safe and effective for specific illnesses and personally find that quite offensive. He questioned if this bill required any training for these people and would it allow people who have no training to prescribe products that are not proven safe and effective. Rep. Luebke advised that the bill does not have anything to do with prescriptions.

Chair Inkso reiterates Rep. Alllred's question for Rep. Luebke. Is there any language in this bill that relates to training? Rep. Luebke then advised there was no formal training with regards to degrees and the reason is that the bill includes traditional healers. An herbalist does not necessarily have to have a Ph.D. in order to understand herbs and their healing potentials.

Rep. Allred asked a follow-up question concerning if there are people here today that received treatment in North Carolina already. The reply was yes.

Rep. Justus asked Dr. Mann if one of the things his study looked at was safety and if so, had any problems been found. Dr. Mann replied there was always the possibility of problems. One of the problems is a lack of communication between the patient who is using alternative medicine and their medical provider. (Note: Handouts from various sources are attached as Attachment XII for the record)

Chair Insko advised time was up and advised members to watch their email as to how bill will be handled.

Meeting was adjourned at 12:54 p.m.

Verla Insko

Representative Verla Insko, Chair

Pamela J. Evans

Pamela J. Evans, Committee Clerk

ATTENDANCE

HOUSE COMMITTEE ON HEALTH

DATES	6/18/03														
INSKO, Verla CHAIR	✓														
JUSTUS, Carolyn CHAIR	✓														
ENGLAND, Bob VICE-CHAIR	✓														
ADAMS, Alma	✓														
ALLEN, Bernard	✓														
ALLEN, Gordon	✓														
ALLRED, Cary	✓														
BARNHART, Jeff	✓														
BOWIE, Joni	✓														
CLARY, Debbie	✓														
EARLE, Beverly	✓														
GLAZIER, Rick	✓														
HILTON, Mark	✓														
McALLISTER, Mary	✓														
MUNFORD, Don	✓														
SETZER, Mitchell	✓														
SHERRILL, Wilma	✓														
WAINWRIGHT, William															
WILSON, Connie	✓														
WRIGHT, Tom	✓														
Ex officio Members															
Brubaker, Bru															
Culpepper, Bill															
Cunningham, Pete															
Eddins, Rick															

ATTACHMENT II

AGENDA

HOUSE COMMITTEE ON HEALTH

June 10, 2003
Room 544 LOB
12:00 Noon

OPENING REMARKS

Representative Verla Insko, Chair
Representative Carolyn Justus, Chair

AGENDA ITEMS

SB 1016 Nursing Home/Medication Errors – Sen. Berger

HB 923 Exempt Alt. Medicine/Practice of Medicine - Rep. Luebke

ADJOURNMENT

ATTACHMENT II

VISITOR REGISTRATION SHEET

HOUSE COMMITTEE ON HEALTH — JUNE 10, 2003

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Lee-Ann Coe	NC Psychiatric Assoc.
Peggy Myers	
Mike Causey	Causey & Assoc.
Thomas Mansfield	NC Medical Board
Amy Jo Horne	NCMS
C. Pardue	
DB Lee	NCMS
Amy Dobson	NC State Watch
Rose McCreery	Concerned Citizen
Judith Scalia	cured by homeopathy
[illegible]	NC Board of Massage & Bodywork Therapy Raleigh NC

ATTACHMENT III

VISITOR REGISTRATION SHEET

HOUSE COMMITTEE ON HEALTH — JUNE 10, 2003

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Elene G. Terry	CHF 3426 Medford Rd. Durham NC
Cara Benedetto	CHCH 110 Hilton Ave Durham NC 27707
Jonathan Pottinger	4908 Forestville Rd. Raleigh, NC 27616
Mrs. Nora Pottinger	4908 Forestville Rd, Rd. NC 27616
Boyd Landay	1220 L St NW PMB 100-409 Washington, DC 20005
John Ivey	Durham NC 27712
Arlene Green	Chapel Hill 27516
[illegible]	Wilmington 28403
Larry Green	7121 New Light Trail Chapel Hill NC 27516
Robert E. Bacon Jr	204 Ginkgo Rd Chapel Hill, NC 27514
BRIAN KRAMER	3569 HANORTH DR. SUITE 402 RALEIGH. NC 27615

VISITOR REGISTRATION SHEET

HOUSE COMMITTEE ON HEALTH — JUNE 10, 2003

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
[signature]	NASW
[signature]	2745 Dogwood Rd, Durham, NC 27705
Charlie Chrisawn	Poyner & Spruill
Hart Matthews	Citizens for Health Care Freedom 1607 Maryland Ave, Durham, NC 27705
Tracy Triggs-Matthews	Citizens 4 Healthcare Freedom 1607 Maryland Ave. Durham 2770[illegible]
Holly Cruickshank	Citizens for Health Care Freedom 1703 Woodburn Road Durham, NC 27705
Blade Cruickshank	" " "
Sonya Pailes	104 Julio Lane Garner NC NCFOM / NCMA
Diane Cordova	Independent Weekly 2810 Hillsborough Rd. Durham, 27715
Audrey Galloway	Strategic Influences
Michelle Frazier	NC Bar Ass'n
Amy Darden	NC Bar Assn

VISITOR REGISTRATION SHEET

HOUSE COMMITTEE ON HEALTH — JUNE 10, 2003

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Susan Gaylord	2330 Bedford St, Durham, NC
DOUG MANN	132 CAROLINA FOREST CT. C.Hill
KENNETH G. JAMES	2306 Shallowford Lane Chapel Hill
Gail Zurowski	1221 Coldstream Court Raleigh, NC 27615
Brooke Ferguson	3916 - J Knickerbocker Pkwy Raleigh NC 27612
Margaret Bennett	2707 Anderson Dr, Raleigh NC 27608
David Black	Beaver Huff 230 Green St. Fayetteville, NC 28305
J. M Radford	11
Ed King	118 Baldwin Farm Rd Pittsboro, NC 27312
Mark Huebner	200-3 Mahone St. Durham, NC 27713
Barbara Howe	Libertarian Party of NC
Paul Reddino	1987 Ferncliff Rd CLT. NC 28211

VISITOR REGISTRATION SHEET

HOUSE COMMITTEE ON HEALTH — JUNE 10, 2003

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Christian L. Lanier	Constituent
Wanda B. Lanier	Constituent
Douglas L. Lanier	Constituent
Mark Faggion	Constituent
Annie Roach	Constituent
Rebecca Walton	constituent
Amy Yonowitz	NC Med Board
Liz Knox MD	NC Med Society
Susan R. DeLaney	— NCANP —
Jan Ramquist	NCNP
Evelyn Hausmann	OAGR

VISITOR REGISTRATION SHEET

HOUSE COMMITTEE ON HEALTH — JUNE 10, 2003

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
WAYNE SAVILLE	NC BOARD OF MASSAGE & BODYWORK THERAPY MEMBER
Charles P. Wilkins	NC Board of Massage & Bodywork Therapy - Council
Julie N. Hollister	14001 Eggleston Dr, Pineville NC 28134-6326 Recovered patient from pancreatic cancer
Barbara Zelter	Citizens for Healthcare Freedom
Wanda Webb-Schrader	Wellness Consultant
Karina Chapman	PPAS intern
Sharon Ryan	HB 923 proponent
Gwendoline Y. Fortune, Ed.D.	Consumer of Complementary Health Care Pro's

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2003

S 2

SENATE BILL 1016
Health & Human Resources Committee Substitute Adopted 4/30/03

Short Title: Nursing Home/Medication Errors. (Public)

Sponsors:

Referred to:

April 3, 2003

A BILL TO BE ENTITLED

AN ACT REQUIRING NURSING HOMES TO ESTABLISH A MEDICATION MANAGEMENT ADVISORY COMMITTEE AND SPECIFYING THE DUTIES OF THE COMMITTEE, AND TO REQUIRE NURSING HOMES TO DO CERTAIN THINGS PERTAINING TO THE REDUCTION OF MEDICATION-RELATED ERRORS TO INCREASE PATIENT SAFETY.

The General Assembly of North Carolina enacts:

SECTION 1. Part 2 of Article 6 of Chapter 131E of the General Statutes is amended by adding the following new sections to read:

"**§ 131E-128.1. Nursing home medication management advisory committee.**

(a) Definitions. – As used in this section, unless the context requires otherwise, the term:

(1) 'Advisory committee' means a medication management committee established under this section to advise the quality assurance committee.

(2) 'Medication-related error' means any preventable medication-related event that adversely affects a patient in a nursing home and that is related to professional practice, or health care products, procedures, and systems, including, but not limited to, prescribing, prescription order communications, product labeling, packaging and nomenclature, compounding, dispensing, distribution, administration, education, monitoring, and use.

(3) 'Nursing home' means a nursing home licensed under this Chapter and includes an adult care home operated as part of a nursing home.

(4) 'Potential medication-related error' means a medication-related error that has not yet adversely affected a patient in a nursing home, but that has the potential to if not anticipated or prevented or if left unnoticed.

(5) 'Quality assurance committee' means a quality assurance committee established in accordance with federal and State regulations to identify

issues with respect to which quality assessment and assurance activities are necessary and to develop and implement appropriate plans of action to correct deficiencies in quality of care.

(b) Purpose. – It is the purpose of the General Assembly to enhance compliance with this Part through the establishment of medication management advisory committees in nursing homes. The purpose of these committees is to assist nursing homes in identifying medication-related errors, evaluate the causes of those errors, and take appropriate actions to ensure the safe prescribing, dispensing, and administration of medications to nursing home patients.

(c) Advisory Committee Established; Membership. – Every nursing home shall establish a medication management advisory committee to advise the quality assurance committee on quality of care issues related to pharmaceutical and medication management and use in the nursing home. The nursing home shall maintain the advisory committee as part of its administrative duties. The advisory committee shall be interdisciplinary and consist of the nursing home administrator and at least the following members appointed by the nursing home administrator:

(1) The director of nursing.

(2) The consultant pharmacist.

(3) A physician designated by the nursing home administrator.

(4) At least three other members of the nursing home staff.

(d) Meetings. – The advisory committee shall meet as needed but not less frequently than quarterly. The Director of Nursing or Staff Development Coordinator shall chair the advisory committee. The nursing home administrator shall ensure that a record is maintained of each meeting.

(e) Confidentiality. – The meetings or proceedings of the advisory committee, the records and materials it produces and the materials it considers, including analyses and reports pertaining to medication-related error reporting under G.S. 131E-128.2 and G.S. 131E-128.5 and pharmacy reports on drug defects and adverse reactions under G.S. 131E-128.4, shall be confidential and not considered public records within the meaning of G.S. 132-1, "Public records defined". The meetings or proceedings and records and materials also shall not be subject to discovery or introduction into evidence in any civil action against a nursing home licensed under this Article, or a provider of professional health services which results from matters which are the subject of evaluation and review by the committee. No person who was in attendance at a meeting of the committee may testify in any civil action as to any evidence or other matters produced or presented during the meetings or proceedings of the committee or as to any findings, recommendations, evaluations, opinions, or other actions of the committee or its members. Notwithstanding the foregoing:

(1) Information, documents, or records otherwise available, including any deficiencies found in the course of an inspection conducted under G.S. 131E-105, shall not be immune from discovery or used in a civil action merely because they were presented during meetings or proceedings of the advisory committee. A member of the advisory committee or a person who testifies before the committee may testify in a civil action

but cannot be asked about that person's testimony before the committee or any opinion formed as a result of the committee meetings or proceedings.

(2) Information that is confidential and is not subject to discovery or use in civil actions under this subsection may be released to a professional standards review organization that performs any accreditation or certification function. Information released to the professional standards review organization shall be limited to that which is reasonably necessary and relevant to the standards review organizations' determination to grant or continue accreditation or certification. Information released to the standards review organization retains its confidentiality and is not subject to discovery or use in any civil action as provided under this subsection, and the standards review organization shall keep the information confidential subject to this subsection.

(3) Information that is confidential and is not subject to discovery or use in civil actions under this subsection may be released to the Department of Health and Human Services pursuant to its investigative authority under G.S. 131E-105. Information released to the Department shall be limited to that which is reasonably necessary and relevant to the Department's investigation of compliance with Part 1 of Article 6 of this Chapter. Information released to the Department retains its confidentiality and is not subject to discovery or use in any civil action as provided in this subsection, and the Department shall keep the information confidential subject to this subsection.

(4) Information that is confidential and is not subject to discovery or use in civil actions under this subsection may be released to an occupational licensing board having jurisdiction over the license of an individual involved in an incident that is under review or investigation by the advisory committee. Information released to the occupational licensing board shall be limited to that which is reasonably necessary and relevant to an investigation being conducted by the licensing board pertaining to the individual's involvement in the incident under review by the advisory committee. Information released to an occupational licensing board retains its confidentiality and is not subject to discovery or use in any civil action as provided in this subsection, and the occupational licensing board shall keep the information confidential subject to this subsection.

(f) Duties. – The advisory committee shall do the following:

(1) Assess the nursing home's pharmaceutical management system, including prescribing, distribution, administration policies, procedures, and practices and identify areas at high risk for medication-related errors.

(2) Review the nursing home's pharmaceutical management goals and respond accordingly to ensure that these goals are being met.

(3) Review, investigate, and respond to nursing home incident reports, deficiencies cited by licensing or credentialing agencies, and resident grievances that involve actual or potential medication-related errors.

(4) Identify goals and recommendations for the implementation of best practices and procedures, including risk reduction technology, to improve patient safety by reducing the risk of medication-related errors.

(5) Develop recommendations for the establishment of a mandatory, nonpunitive, confidential reporting system within the nursing home of actual and potential medication-related errors.

(6) Develop specifications for drug dispensing and administration documentation procedures to ensure compliance with federal and State law, including the North Carolina Nursing Practice Act.

(7) Develop specifications for self-administration of drugs by qualified patients in accordance with law, including recommendations for assessment procedures as to which patients may be qualified to self-administer their medications.

(g) Penalty. – The Department may take adverse action against the license of a nursing home upon a finding that the nursing home has failed to comply with this section, G.S. 131E-128.2, 131E-128.3, 131E-128.4, or 131E-128.5.

"**§ 131E-128.2. Nursing home quality assurance committee; duties related to medication error prevention.**

(a) Every nursing home administrator shall ensure that the nursing home quality assurance committee develops and implements appropriate measures to minimize the risk of actual and potential medication-related errors, including the measures listed in this subsection. The design and implementation of the measures shall be based upon recommendations of the medication management advisory committee and shall:

(1) Increase awareness and education of the patient and family members about all medications that the patient is using, both prescription and over-the-counter, including dietary supplements.

(2) Increase prescription legibility.

(3) Minimize confusion in prescription drug labeling and packaging, including unit dose packaging.

(4) Develop a confidential and nonpunitive process for internal reporting of actual and potential medication-related errors.

(5) To the extent practicable, implement proven medication safety practices, including the use of automated drug ordering and dispensing systems.

(6) Educate facility staff engaged in medication administration activities on similar-sounding drug names.

(7) Implement a system to accurately identify recipients before any drug is administered.

(8) Implement policies and procedures designed to improve accuracy in medication administration and in documentation by properly authorized individuals, in accordance with prescribed orders and stop order policies.

(9) Implement policies and procedures for the self-administration of medication.

(10) Investigate and analyze the frequency and root causes of general categories and specific types of actual or potential medication-related errors.

(11) Develop recommendations for plans of action to correct identified deficiencies in the facility's pharmaceutical management practices.

"**§ 131E-128.3. Staff orientation on medication error prevention.**

The nursing home administrator shall ensure that the nursing home provide a minimum of one hour of education and training in the prevention of actual or potential medication-related errors. This training shall be provided upon orientation and annually thereafter to all nonphysician personnel involved in direct patient care. The content of the training shall include at least the following:

(1) General information relevant to the administration of medications including terminology, procedures, and routes of medication administration, potential side effects and adverse reactions.

(2) Additional instruction on categories of medication pertaining to the specific needs of the patient receiving the medication.

(3) The facility's policy and procedures regarding its medication administration system.

(4) How to assist patients with safe and accurate self-administration, where appropriate.

(5) Identifying and reporting actual and potential medication-related errors.

"**§ 131E-128.4. Nursing home pharmacy reports; duties of consultant pharmacist.**

(a) The consultant pharmacist shall conduct a drug regimen review for actual and potential drug therapy problems and make remedial or preventive clinical recommendations into the medical record of every patient receiving medication. The consultant pharmacist shall conduct the review at least monthly in accordance with the nursing home's policies and procedures.

(b) The consultant pharmacist shall report and document any drug irregularities and clinical recommendations promptly to the attending physician or nurse-in-charge and the nursing home administrator. The reports shall include problems identified and recommendations concerning:

(1) Drug therapy which may be affected by biological agents, laboratory tests, special dietary requirements, and foods used or administered concomitantly with other medication to the same recipient.

(2) Monitoring for potential adverse effects.

(3) Allergies.

(4) Drug interactions, including interactions between prescription drugs and over-the-counter drugs, drugs and disease, and interactions between drugs and nutrients.
(5) Contraindications and precautions.
(6) Potential therapeutic duplication.
(7) Over-extended length of treatment of certain drugs typically prescribed for a short period of time.
(8) Beer's listed drugs which are potentially inappropriate for use by elderly persons.
(9) Under treatment or medical conditions that are suboptimally treated or not treated at all that warrant additional drug therapy to ensure quality of care.
(10) Other identified problems and recommendations.

(c) The consultant pharmacist shall report drug product defects and adverse drug reactions in accordance with the ASHSP-USP-FDA Drug Product Defect Reporting System and the USP Adverse Drug Reaction Reporting System. The term "ASHSP-USP-FDA" means American Society of Health System Pharmacists-United States Pharmacopoeia-Food and Drug Administration. Information released to the ASHSP-USP-FDA retains its confidentiality and is not subject to discovery or use in any civil actions as provided under G.S. 131E-128.1.

(d) The consultant pharmacist shall ensure that all known allergies and adverse effects are documented in plain view in the patient's medical record including the medication administration records and communicated to the dispensing pharmacy. The specific medications and the type of allergy or adverse reaction shall be specified in the documentation.

(e) The consultant pharmacist shall ensure that drugs that are not specifically limited as to duration of use or number of doses shall be controlled by automatic stop orders. The pharmacist consultant shall further ensure that the prescribing provider is notified of the automatic stop order prior to the dispensing of the last dose so that the provider may decide whether to continue to use the drug.

(f) The consultant pharmacist shall, on a quarterly basis, submit a summary of the reports submitted under subsections (a) and (b) of this section to the medication management advisory committee established under G.S. 131E-128.1. The summary shall not include any information that would identify a patient, a family member, or an employee of the nursing home. The purpose of the summary shall be to facilitate the identification and analysis of weaknesses in the nursing home's pharmaceutical care system that have an adverse impact on patient safety.

"**§ 131E-128.5. Medication-related error reports.**

(a) The Secretary of Health and Human Services shall contract with a public or private entity to develop and implement a Medication Error Quality Initiative. The Initiative would provide for, among other things, receipt and analysis by the contracting entity of annual reports from each nursing home on the nursing home's medication-related errors. The report submitted by the nursing home shall not contain information

that would identify the patient, individual reporting the error, or other persons involved in the occurrence. The report shall include the following:

(1) The total number of medication-related errors for the preceding year.

(2) A listing of the types of medication-related errors, the number of medication-related errors, the root cause analysis of each error, and the staff level involved.

(3) A listing of the types of injury caused and the number of injuries occurring.

(4) Types of liability claims filed based on an adverse incident or reportable injury.

(b) The contracting entity shall provide for analysis of the medication-related error reports to determine trends in the incidence of medication-related errors in nursing homes. Information released to the contractor retains its confidentiality and is not subject to discovery or use in any civil actions as provided under G.S. 131E-128.1, and the contractor shall keep the information confidential subject to that section."

SECTION 2. The Department shall use available grants and federal funds to implement G.S. 131E-182.5 as enacted in this act.

SECTION 3. This act becomes effective January 1, 2004.

ATTACHMENT V

SENATE BILL 1016:
Nursing Home/Medication Errors

BILL ANALYSIS

Committee:	House Health	**Introduced by:**	Sen. Berger
Date:	June 10, 2003	**Summary by:**	Dianna Jessup
Version:	Second Edition		Committee Counsel

SUMMARY: ***Senate Bill 1016 would require nursing homes to establish medication management advisory committees. The bill would also require every nursing home administrator to ensure that the nursing home quality assurance committee implements measures to minimize risk of medication-related errors. Staff training regarding prevention of medication errors would be required, and consultant pharmacists would be required to conduct certain drug regimen reviews and make certain reports. Finally, the Department of Health and Human Services would be required to contract with a third party to develop and implement a Medication Error Quality Initiative. The act would become effective January 1, 2004.***

CURRENT LAW: According to the Division of Facility Services of the Department of Health and Human Services, there are no requirements that make nursing homes report medication errors to a State regulatory agency. Each nursing home handles medication errors in a different way. Usually, nursing homes develop a form used to report medication errors that is processed by the nursing home administrator or the pharmacy committee.

Regulatory requirements regarding nursing homes and medication errors:

- Nursing homes must ensure that medications are administered in accordance with standards of professional practice and applicable occupational licensure regulations. (NCAC 10-3H.2306)
- The omission of a medication to a resident must be documented and reasons for the omission cited in the resident's medical record. (NCAC 10-3H.2306)
- Nursing homes must provide pharmaceutical services under the supervision of a pharmacist, including procedures that ensure the accurate acquiring, receiving and administering of all drugs and biologicals. (NCAC 10-3H.2601)
- Nursing homes must require the licensed pharmacist review each resident's drug regimen at least once a month to ensure that residents' drug use is safe and effective, and that facilities are in compliance with federal and State regulations. The pharmacist must report any irregularities to the attending physician and the director of nursing. (NCAC 10-3H.2601 and 10-3H.2603)
- Nursing homes must act to correct reported irregularities. (NCAC 10-3H.2603)
- Each resident's drug regimen must be free of any drugs used in excessive dose or duration, including duplicate drug therapy, or uses without adequate monitoring, or without adequate indications for its use. (NCAC 10-3H.2306)
- Nursing homes must reduce or discontinue drugs when there is an indication that the drug is causing adverse consequences. (NCAC 10-3H.2306)
- Nursing homes must ensure that antipsychotic drugs are administered only as part of a treatment plan, and may only be given if the antipsychotic drug therapy is necessary to treat a specific condition that is diagnosed and documented in the clinical record. (NCAC 10-3H.2306)

- Nursing homes must ensure that residents only self-administer medications when certain conditions are met to ensure the resident's safety. (NCAC 10-3H.2306)
- Nursing homes must maintain a quality assessment and assurance committee that must meet at least quarterly to identify deficiencies and develop plans of action to correct them. (NCAC 10-3H.2212) *The State cannot require disclosure of the records of these committees.
- The Board of Pharmacy has adopted rules applicable to drug distribution in nursing homes governing the following: (1) medication orders, (2) devices, (3) labeling, (4) automated dispensing, and (5) record keeping. Medication errors resulting from the administration of an incorrect medication or dose must be documented and reported to the pharmacist manager. These records must be maintained for three years.

BILL ANALYSIS:

Medication Management Advisory Committee

Senate Bill 1016 would require every nursing home to establish a medication management advisory committee to advise the quality assurance committee on quality of care issues related to pharmaceutical and medication management and use in the nursing home. The advisory committee would consist of the nursing home administrator and at least the following members appointed by the nursing home administrator:

1. The director of nursing.
2. The consultant pharmacist.
3. A physician designated by the nursing home administrator.
4. At least three other members of the nursing home staff.

The advisory committee would meet as needed but no less than quarterly. The Director of Nursing or Staff Development Coordinator would be the chair. The administrator must maintain a record of certain proceedings and information. The meetings and proceedings and records and materials produced by medication management advisory committees would be confidential and not subject to disclosure or use in a civil action.

DUTIES of the Advisory Committee: The Advisory Committee would have the following duties:

1. Assess the facility's pharmaceutical management system and practices and identify areas at high risk for medication-related errors.
2. Review the facility's pharmaceutical management goals and make sure goals are being met.
3. Review, investigate, and respond to facility incident reports and resident grievances.
4. Identify goals and recommendations for the implementation of best practices.
5. Develop recommendations for the establishment of a mandatory, nonpunitive, confidential reporting system.
6. Develop specifications for drug dispensing and administration documentation procedures to ensure compliance with federal and State law, including the NC Nursing Practice Act.
7. Develop specifications for self-administration of drugs by qualified patients in accordance with law.

Nursing Home Quality Assurance Committee

As part of its requirement to minimize risk of medication-related error, every nursing home quality assurance committee would have the following duties:

1. Educate and make the patient and the patient's family members aware of all the medications the patient is using.
2. Increase prescription legibility.
3. Minimize confusion in prescription drug labeling and packaging.
4. Develop a confidential and nonpunitive process for internal reporting of actual and potential medication-related errors.
5. To the extent practicable, implement proven medication safety practices.
6. Educate facility staff engaged in medication administration.
7. Implement a system to accurately identify recipients before any drug is administered.
8. Implement policies and procedures designed to improve accuracy in medication administration and in documentation.
9. Implement policies and procedures for the self-administration of medication.
10. Investigate and analyze the frequency and root causes of general categories and specific types of actual or potential medication-related errors.
11. Develop recommendations for plans of action to correct identified deficiencies in the facility's pharmaceutical management practices.

Staff Orientation on Medication Error Prevention

Upon orientation and annually thereafter, the nursing home must provide a minimum of one hour of education and training in the prevention of actual or potential medication-related errors for all nonphysician personnel involved in direct patient care.

Nursing Home Pharmacy Reports and Duties of Consultant Pharmacist

This new statute would require consultant pharmacists of nursing homes to undertake certain drug regimen reviews, make reports concerning drug irregularities, drug product defects and adverse drug reactions, ensure proper documentation of allergies and adverse effects, and ensure that drugs that are not specifically limited as to duration of use or number of doses shall be controlled by automatic stop orders.

Medication-Related Error Reports

The Secretary of Health and Human Services must contract with a public or private entity to develop and implement a Medication Error Quality Initiative. As part of the Initiative, each nursing home must report annually on the nursing home's medication-related errors. The report submitted by each nursing home would not contain information that would identify the patient, individual reporting the error, or other persons involved in the occurrence. The contracting entity would analyze the reports to determine trends in the incidence of medication-related errors in nursing homes. Information released to the contractor would retain its confidentiality and would not be subject to discovery or use in any civil action as provided under this act.

BACKGROUND: According to the Agency for Healthcare Research and Quality[1], about 7,000 people per year die from medication errors, about 16% more deaths than the number attributable to work-related injuries. The cost associated with these medical errors in lost income, disability, and health care is as much as $29 billion annually. The Harvard School of Public Health and the Henry J. Kaiser Family Foundation performed a survey examining the views of 831 physicians and 1,207 adults in April-July of 2002. The survey found that 42% of public respondents and more than one third of U.S. physicians said that they or one of their family members had experienced medical errors in receiving medical care. Physicians said that among the leading causes of errors are a shortage of nurses and overwork, stress or fatigue of health professionals. The Agency for Healthcare Research and Quality emphasized that medical errors can occur anywhere in the health care system including: (1) hospitals, (2) clinics, (3) outpatient surgery centers, (4) doctors' offices, (5) nursing homes, (6) pharmacies, and (7) patients' homes. The errors can involve: (1) medicines, (2) surgery, (3) diagnosis, (4) equipment, and (5) lab reports. In December 2000, the U.S. Pharmacopeia released its first national report on medication error data collected from *hospitals*. The report indicates that the three most frequently reported types of errors were:

1. Omission errors (failure to administer an ordered medication dose);
2. Improper dose or quantity errors (any medication dose, strength or quantity that differs from that prescribed); and
3. unauthorized drug errors (the medication dispensed and/or administered was not authorized by the prescriber; includes wrong drug errors).

Reporting Requirements: Mandatory versus Voluntary: Currently, 17 states have laws or regulations requiring mandatory reporting of medical errors or adverse events in *hospitals*. According to the National Academy of State Health Policy, five states (including North Carolina) and the District of Columbia have voluntary reporting systems in place.

Amy Compeau, Research Assistant, contributed to this summary.

S1016-SMSW-002

[1] The Agency for Healthcare Research and Quality is the Nation's lead Federal agency for research on health care quality, costs, outcomes, and patient safety. It is the research arm of the U.S. Department of Health and Human Services.

ATTACHMENT VI

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2003

S D

SENATE BILL 1016

Health & Human Resources Committee Substitute Adopted 4/30/03
PROPOSED HOUSE COMMITTEE SUBSTITUTE S1016-CSSW-47 [v.1]

6/9/2003 12:15:31 PM

Short Title: Nursing Home/Medication Errors. (Public)

Sponsors:

Referred to:

April 3, 2003

A BILL TO BE ENTITLED

AN ACT REQUIRING NURSING HOMES TO ESTABLISH A MEDICATION MANAGEMENT ADVISORY COMMITTEE AND SPECIFYING THE DUTIES OF THE COMMITTEE, AND TO REQUIRE NURSING HOMES TO DO CERTAIN THINGS PERTAINING TO THE REDUCTION OF MEDICATION-RELATED ERRORS TO INCREASE PATIENT SAFETY.

The General Assembly of North Carolina enacts:

SECTION 1. Part 2 of Article 6 of Chapter 131E of the General Statutes is amended by adding the following new sections to read:

"**§ 131E-128.1. Nursing home medication management advisory committee.**

(a) Definitions. – As used in this section, unless the context requires otherwise, the term:

(1) 'Advisory committee' means a medication management committee established under this section to advise the quality assurance committee.

(2) 'Medication-related error' means any preventable medication-related event that adversely affects a patient in a nursing home and that is related to professional practice, or health care products, procedures, and systems, including prescribing, prescription order communications, product labeling, packaging and nomenclature, compounding, dispensing, distribution, administration, education, monitoring, and use.

(3) 'Nursing home' means a nursing home licensed under this Chapter and includes an adult care home operated as part of a nursing home.

(4) 'Potential medication-related error' means a medication-related error that has not yet adversely affected a patient in a nursing home, but that has the potential to if not anticipated or prevented or if left unnoticed.

(5) 'Quality assurance committee' means a committee established in a nursing home in accordance with federal and State regulations to identify circumstances requiring quality assessment and assurance activities and to develop and implement appropriate plans of action to correct deficiencies in quality of care.

(b) Purpose. – It is the purpose of the General Assembly to enhance compliance with this Part through the establishment of medication management advisory committees in nursing homes. The purpose of these committees is to assist nursing homes in identifying medication-related errors, evaluate the causes of those errors, and take appropriate actions to ensure the safe prescribing, dispensing, and administration of medications to nursing home patients.

(c) Advisory Committee Established; Membership. – Every nursing home shall establish a medication management advisory committee to advise the quality assurance committee on quality of care issues related to pharmaceutical and medication management and use in the nursing home. The nursing home shall maintain the advisory committee as part of its administrative duties. The advisory committee shall be interdisciplinary and consist of the nursing home administrator and at least the following members appointed by the nursing home administrator:

(1) The director of nursing.

(2) The consultant pharmacist.

(3) A physician designated by the nursing home administrator.

(4) At least three other members of the nursing home staff.

(d) Meetings. – The advisory committee shall meet as needed but not less frequently than quarterly. The Director of Nursing or Staff Development Coordinator shall chair the advisory committee. The nursing home administrator shall ensure that a record is maintained of each meeting.

(e) Confidentiality. – The meetings or proceedings of the advisory committee, the records and materials it produces and the materials it considers, including analyses and reports pertaining to medication-related error reporting under G.S. 131E-128.2 and G.S. 131E-128.5 and pharmacy reports on drug defects and adverse reactions under G.S. 131E-128.4, shall be confidential and not considered public records within the meaning of G.S. 132-1. The meetings or proceedings and records and materials also shall not be subject to discovery or introduction into evidence in any civil action against a nursing home or a provider of professional health services resulting from matters that are the subject of evaluation and review by the committee. No person who was in attendance at a meeting of the committee shall testify in any civil action as to any evidence or other matters produced or presented during the meetings or proceedings of the committee or as to any findings, recommendations, evaluations, opinions, or other actions of the committee or its members. Notwithstanding the foregoing:

(1) Information, documents, or records otherwise available, including any deficiencies found in the course of an inspection conducted under G.S. 131E-105, shall not be immune from discovery or use in a civil action merely because they were presented during meetings or proceedings of the advisory committee. A member of the advisory committee or a

person who testifies before the committee may testify in a civil action but cannot be asked about that person's testimony before the committee or any opinion formed as a result of the committee meetings or proceedings.

(2) Information that is confidential and not subject to discovery or use in civil actions under this subsection may be released to a professional standards review organization that performs any accreditation or certification function. Information released to the professional standards review organization shall be limited to information reasonably necessary and relevant to the standards review organizations' determination to grant or continue accreditation or certification. Information released to the standards review organization retains its confidentiality and is not subject to discovery or use in any civil action as provided under this subsection. The standards review organization shall keep the information confidential subject to this subsection.

(3) Information that is confidential and not subject to discovery or use in civil actions under this subsection may be released to the Department of Health and Human Services pursuant to its investigative authority under G.S. 131E-105. Information released to the Department shall be limited to information reasonably necessary and relevant to the Department's investigation of compliance with Part 1 of Article 6 of this Chapter. Information released to the Department retains its confidentiality and is not subject to discovery or use in any civil action as provided in this subsection. The Department shall keep the information confidential subject to this subsection.

(4) Information that is confidential and is not subject to discovery or use in civil actions under this subsection may be released to an occupational licensing board having jurisdiction over the license of an individual involved in an incident that is under review or investigation by the advisory committee. Information released to the occupational licensing board shall be limited to information reasonably necessary and relevant to an investigation being conducted by the licensing board pertaining to the individual's involvement in the incident under review by the advisory committee. Information released to an occupational licensing board retains its confidentiality and is not subject to discovery or use in any civil action as provided in this subsection. The occupational licensing board shall keep the information confidential subject to this subsection.

(f) Duties. – The advisory committee shall do the following:

(1) Assess the nursing home's pharmaceutical management system, including its prescribing, distribution, administration policies, procedures, and practices, and identify areas at high risk for medication-related errors.

(2) Review the nursing home's pharmaceutical management goals and respond accordingly to ensure that these goals are being met.

(3) Review, investigate, and respond to nursing home incident reports, deficiencies cited by licensing or credentialing agencies, and resident grievances that involve actual or potential medication-related errors.

(4) Identify goals and recommendations to implement best practices and procedures, including risk reduction technology, to improve patient safety by reducing the risk of medication-related errors.

(5) Develop recommendations to establish a mandatory, nonpunitive, confidential reporting system within the nursing home of actual and potential medication-related errors.

(6) Develop specifications for drug dispensing and administration documentation procedures to ensure compliance with federal and State law, including the North Carolina Nursing Practice Act.

(7) Develop specifications for self-administration of drugs by qualified patients in accordance with law, including recommendations for assessment procedures that identify patients who may be qualified to self-administer their medications.

(g) Penalty. – The Department may take adverse action against the license of a nursing home upon a finding that the nursing home has failed to comply with this section, G.S. 131E-128.2, 131E-128.3, 131E-128.4, or 131E-128.5.

"**§ 131E-128.2. Nursing home quality assurance committee; duties related to medication error prevention.**

(a) Every nursing home administrator shall ensure that the nursing home quality assurance committee develops and implements appropriate measures to minimize the risk of actual and potential medication-related errors, including the measures listed in this subsection. The design and implementation of the measures shall be based upon recommendations of the medication management advisory committee and shall:

(1) Increase awareness and education of the patient and family members about all medications that the patient is using, both prescription and over-the-counter, including dietary supplements.

(2) Increase prescription legibility.

(3) Minimize confusion in prescription drug labeling and packaging, including unit dose packaging.

(4) Develop a confidential and nonpunitive process for internal reporting of actual and potential medication-related errors.

(5) To the extent practicable, implement proven medication safety practices, including the use of automated drug ordering and dispensing systems.

(6) Educate facility staff engaged in medication administration activities on similar-sounding drug names.

(7) Implement a system to accurately identify recipients before any drug is administered.

(8) Implement policies and procedures designed to improve accuracy in medication administration and in documentation by properly authorized individuals, in accordance with prescribed orders and stop order policies.

(9) Implement policies and procedures for patient self-administration of medication.

(10) Investigate and analyze the frequency and root causes of general categories and specific types of actual or potential medication-related errors.

(11) Develop recommendations for plans of action to correct identified deficiencies in the facility's pharmaceutical management practices.

"**§ 131E-128.3. Staff orientation on medication error prevention.**

The nursing home administrator shall ensure that the nursing home provide a minimum of one hour of education and training in the prevention of actual or potential medication-related errors. This training shall be provided upon orientation and annually thereafter to all nonphysician personnel involved in direct patient care. The content of the training shall include at least the following:

(1) General information relevant to the administration of medications including terminology, procedures, and routes of medication administration, potential side effects and adverse reactions.

(2) Additional instruction on categories of medication pertaining to the specific needs of the patient receiving the medication.

(3) The facility's policy and procedures regarding its medication administration system.

(4) How to assist patients with safe and accurate self-administration of medication, where appropriate.

(5) Identifying and reporting actual and potential medication-related errors.

"**§ 131E-128.4. Nursing home pharmacy reports; duties of consultant pharmacist.**

(a) The consultant pharmacist for a nursing home shall conduct a drug regimen review for actual and potential drug therapy problems in the nursing home and make remedial or preventive clinical recommendations into the medical record of every patient receiving medication. The consultant pharmacist shall conduct the review at least monthly in accordance with the nursing home's policies and procedures.

(b) The consultant pharmacist shall report and document any drug irregularities and clinical recommendations promptly to the attending physician or nurse-in-charge and the nursing home administrator. The reports shall include problems identified and recommendations concerning:

(1) Drug therapy that may be affected by biological agents, laboratory tests, special dietary requirements, and foods used or administered concomitantly with other medication to the same recipient.

(2) Monitoring for potential adverse effects.

(3) Allergies.

(4) Drug interactions, including interactions between prescription drugs and over-the-counter drugs, drugs and disease, and interactions between drugs and nutrients.
(5) Contraindications and precautions.
(6) Potential therapeutic duplication.
(7) Over-extended length of treatment of certain drugs typically prescribed for a short period of time.
(8) Beer's listed drugs that are potentially inappropriate for use by elderly persons.
(9) Under treatment or medical conditions that are suboptimally treated or not treated at all that warrant additional drug therapy to ensure quality of care.
(10) Other identified problems and recommendations.

(c) The consultant pharmacist shall report drug product defects and adverse drug reactions in accordance with the ASHSP-USP-FDA Drug Product Defect Reporting System and the USP Adverse Drug Reaction Reporting System. The term "ASHSP-USP-FDA" means American Society of Health System Pharmacists-United States Pharmacopoeia-Food and Drug Administration. Information released to the ASHSP-USP-FDA retains its confidentiality and is not subject to discovery or use in any civil actions as provided under G.S. 131E-128.1.

(d) The consultant pharmacist shall ensure that all known allergies and adverse effects are documented in plain view in the patient's medical record including the medication administration records and communicated to the dispensing pharmacy. The specific medications and the type of allergy or adverse reaction shall be specified in the documentation.

(e) The consultant pharmacist shall ensure that drugs that are not specifically limited as to duration of use or number of doses shall be controlled by automatic stop orders. The consultant pharmacist shall further ensure that the prescribing provider is notified of the automatic stop order prior to the dispensing of the last dose so that the provider may decide whether to continue to use the drug.

(f) The consultant pharmacist shall, on a quarterly basis, submit a summary of the reports submitted under subsections (a) and (b) of this section to the medication management advisory committee established under G.S. 131E-128.1. The summary shall not include any information that would identify a patient, a family member, or an employee of the nursing home. The purpose of the summary shall be to facilitate the identification and analysis of weaknesses in the nursing home's pharmaceutical care system that have an adverse impact on patient safety.

"**§ 131E-128.5. Medication-related error reports.**

(a) The Secretary of Health and Human Services shall contract with a public or private entity to develop and implement a Medication Error Quality Initiative. The Initiative would provide for, among other things, receipt and analysis by the contracting entity of annual reports from each nursing home on the nursing home's medication-related errors. The report submitted by the nursing home shall not contain information

that would identify the patient, individual reporting the error, or other persons involved in the occurrence. The report shall include the following:

(1) The total number of medication-related errors for the preceding year.

(2) A listing of the types of medication-related errors, the number of medication-related errors, the root cause analysis of each error, and the staff level involved.

(3) A listing of the types of injury caused and the number of injuries occurring.

(4) Types of liability claims filed based on an adverse incident or reportable injury.

(b) The contracting entity shall provide for analysis of the medication-related error reports to determine trends in the incidence of medication-related errors in nursing homes. Information released to the contractor retains its confidentiality and is not subject to discovery or use in any civil actions as provided under G.S. 131E-128.1, and the contractor shall keep the information confidential subject to that section."

SECTION 2. The Department shall use available grants and federal funds to implement G.S. 131E-182.5 as enacted in this act.

SECTION 3. This act becomes effective January 1, 2004.

2003 COMMITTEE REPORT
HOUSE OF REPRESENTATIVES

The following report(s) from standing committee(s) is/are presented:
By Representatives **Verla Insko and Carolyn Justus,** Chairs for the Committee on **HEALTH**.

☒ Committee Substitute for
S.B. 1016 A BILL TO BE ENTITLED AN ACT REQUIRING NURSING HOMES TO ESTABLISH A MEDICATION MANAGEMENT ADVISORY COMMITTEE AND SPECIFYING THE DUTIES OF THE COMMITTEE, AND TO REQUIRE NURSING HOMES TO DO CERTAIN THINGS PERTAINING TO THE REDUCTION OF MEDICATION-RELATED ERRORS TO INCREASE PATIENT SAFETY.

☐ 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 (# H.B.), ☐ 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)

3/06/03

FOR JOURNAL USE ONLY

____ Pursuant to Rule 36(b), the bill/resolution is placed on the Calendar of _____.

____ The (committee substitute) bill/resolution (, as amended,) is (ordered engrossed and) re-referred to the Committee on _____.

____ The bill/resolution is re-referred to the Committee on _____.

____ On motion of (Rep. _____,) (the Chair,) the (committee substitute) bill/resolution is (ordered engrossed and) re-referred to the Committee on _____.

____ Pursuant to Rule 36(b), the (House)committee substitute bill (No. ____)/resolution is placed on the Calendar of _____. (The original bill) (House Committee Substitute Bill No. ____)/resolution is placed on the Unfavorable Calendar.

____ On motion of Rep. _____, (the rules are suspended) (Rule ____ is suspended) and the bill/resolution is placed on today's calendar. (for immediate consideration.)

____ On motion of Rep. _____, Committee Amendment No.(s) _____ is/are adopted (by EV____ ____).

____ On motion of Rep. _____, Committee Amendment No.(s) _____ is/are adopted (by EV____ ____).

____ Rep. _____ offers Amendment No. _____ which (is adopted.) (fails of adoption.) (by EV ____ ____.) ( ) This amendment changes the title.

____ The bill/resolution (, as amended,) passes its second reading (by following vote, ____ ____ RC) (, by EV ____ ____,) and (remains on the Calendar,) (and there being no objection is read a third time).

____ The bill/resolution (, as amended,) passes its third reading (by the following vote, ____ ____ RC) (, by EV ____ ____,) and is ordered
____ sent to the Senate.
____ without engrossment. ____ by Special message.
____ sent to the Senate for concurrence in
_____ the House amendment (s).
_____the House committee substitute bill.
____ enrolled.

____ On motion of Rep. _____, the House concurs in the (material) Senate _____ (by the following vote, ____ ____ RC) (, by EV ____ ____,) and the bill is ordered enrolled.

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2003

HOUSE BILL 923

Short Title:	Exempt Alt. Medicine/Practice of Medicine.	(Public)
Sponsors:	Representative Luebke.	
Referred to:	Health.	

April 8, 2003

A BILL TO BE ENTITLED

AN ACT TO EXEMPT THE PRACTICE OF COMPLEMENTARY OR ALTERNATIVE FORMS OF HEALTH CARE FROM THE PRACTICE OF MEDICINE.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 90-18(c) reads as rewritten:

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

(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.

(19) The practice of a complementary or an alternative form of health care, so long as the practitioner discloses to a client his or her professional training and qualifications and discloses to a client that he or she is not a licensed medical doctor. For purposes of this subdivision, complementary or alternative forms of health care shall include the healing modalities, therapies, and health care systems as defined by the National Institutes of Health's National Center for Complementary and Alternative Medicine (NCCAM), the World Health Organization-Traditional or Complementary/Alternative Medicine (WHO CAM), and the White House Commission on Complementary and Alternative Medicine Policy (WHCCAMP)."

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

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2003

H D

HOUSE BILL 923
PROPOSED COMMITTEE SUBSTITUTE H923-CSSW-34 [v.9]

6/6/2003 10:24:44 AM

Short Title: Exempt Alt. Medicine/Practice of Medicine. (Public)

Sponsors:

Referred to:

April 8, 2003

A BILL TO BE ENTITLED

AN ACT TO EXEMPT THE PRACTICE OF COMPLEMENTARY OR ALTERNATIVE FORMS OF HEALTH CARE FROM THE PRACTICE OF MEDICINE UNDER CERTAIN CIRCUMSTANCES AND TO REQUIRE PERSONS WHO PRACTICE COMPLEMENTARY OR ALTERNATIVE FORMS OF HEALTH CARE TO REGISTER WITH THE SECRETARY OF STATE.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 90-18(c) reads as rewritten:

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

(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.

(19) The practice of performing or offering to perform a complementary or an alternative health care service as defined in G.S. 90E-2(2), so long as the practitioner discloses to a client the practitioner's professional training and qualifications and discloses to a client that the practitioner is not a licensed medical doctor. "

SECTION 2. The General Statutes is amended by adding a new chapter to read:

"CHAPTER 90E.

"The Consumer Health Freedom Act.

"§ 90E-1. Title.

This Chapter shall be known and may be cited as "The Consumer Health Freedom Act".

"§ 90E-2. Definitions.

In this Chapter:

(1) "Applicant" means a person applying for registration under this Chapter.

(2) "Complementary or alternative health care service" means a healing modality, therapy, or health care system that does not involve the performance of surgery, prescribing or administering x-ray radiation, or prescribing or administering legend drugs, controlled substances, medical devices, or anesthesia, performing chiropractic adjustment of

the joints or spine, massage therapy, or performing western allopathic bio-medical disease diagnosis. "Complementary or alternative health care service" includes acupressure; aromatherapy; ayurveda; biofield therapy; cranial sacral therapy; culturally-based traditional healing practices; dance, music and art therapy; energetic modalities; folk practices; practices utilizing food and dietary supplements; individual biological therapies such as bee pollen, nutrients, and the physical forces of heat, cold, water, touch, and light; herbology or herbalism; homeopathy; therapeutic touch or body work; mind-body therapeutic practices; Native American Medicine; naturopathy; polarity therapy; reiki; traditional Tibetan practices; and Qigong.

(3) "Secretary" means the Secretary of State.

"**§ 90E-3. The practice of complementary and alternative health care permitted; registration required; exemption for persons licensed under Chapter 90.**

(a) No person shall perform or offer to perform a complementary or alternative health care service in this State unless the person is registered with the Secretary under this Chapter. No person licensed under Chapter 90 of the General Statutes shall be required to comply with this Chapter for practicing within the scope of practice for which the person is licensed.

(b) An applicant for initial registration shall file with the Secretary the information required by subsection (c) of this section on a form prescribed by the Secretary accompanied by the registration fee. No application is complete until the Secretary has received all required information.

(c) The registration application shall be comprised of all of the following information:

(1) The name of the applicant and, if any, the name of the business and the business origination date, the addresses of the principal office and all offices in this State, the name of the contact person, and the taxpayer or employer identification number.

(2) A list by jurisdiction of each name under which the applicant has practiced in the preceding five years, including any alternative names, names of predecessors, and if know, successor business entities.

(3) Any other information the Secretary considers necessary.

(d) If the Secretary finds that the applicant has not fully met the requirements for registration, the Secretary shall refuse to register the applicant and shall notify the applicant in writing of the denial, stating the grounds for the denial. Within 30 days after service of the notification, the applicant may make a written demand upon the Secretary for a review to determine the reasonableness of the Secretary's action. The review shall be completed without undue delay, and the applicant shall be notified promptly in writing as to the outcome of the review. Within 30 days after services of the notification as to the outcome, the applicant may make a written demand upon the Secretary for a hearing under Article 3A of Chapter 150B of the General Statutes if the applicant disagrees with the outcome.

"**§ 90E-4. Fees.**

(a) Each applicant for registration shall pay to the Secretary, before the issuance of the registration, a nonrefundable application fee of fifty dollars ($50.00).

(b) Fees collected by the Secretary under this Article shall be used to pay the expenses of carrying out the duties of the Secretary prescribed in this Chapter.

"**§ 90E-5. Prohibited acts; criminal penalty.**

(a) No person shall perform or offer to perform a complementary or an alternative health service without being registered under this Chapter.

(b) A person who violates this section shall be guilty of a Class 3 misdemeanor."

SECTION 3. This act becomes effective December 1, 2003, and applies to offenses committed on or after that date.

ATTACHMENT X

HOUSE BILL 923: EXEMPT ALT. MEDICINE/PRACTICE OF MEDICINE

BILL ANALYSIS

Committee:	House Health	**Introduced by:**	Rep. Luebke
Date:	June 10, 2003	**Summary by:**	Dianna Jessup
Version:	PCS H923-CSSW-34		Committee Counsel

SUMMARY: ***House Bill 923 would exempt the practice of alternative or complementary health care from licensure by the North Carolina Medical Board and would require those persons to register with the Secretary of State. It would be a Class 3 misdemeanor, punishable by up to 20 days' community/intermediate/active punishment, to practice or offer to practice alternative or complementary health care without being registered. The act would become effective December 1, 2003 and apply to offenses committed on or after that date.***

The PCS adds the registration requirement.

CURRENT LAW:

State law governing the practice of medicine: Article 1 of Chapter 90 of the General Statutes regulates the practice of medicine. G.S. 90-18 defines the practice of medicine and establishes penalties for practicing medicine without a license. A person is regarded as practicing medicine if the person diagnoses or attempts to diagnose, treats or attempts to treat, operates or attempts to operate on, or prescribes for or administers to, or professes to treat any human ailment, physical or mental, or any physical injury to or deformity of another person. A person practicing medicine without a license is not allowed to maintain any action to collect fees for such services and is guilty of a Class 1 misdemeanor. Eighteen exemptions currently exist from the definition of the practice of medicine.

What is complementary/alternative medicine? The National Institutes of Health's National Center for Complementary and Alternative Medicine (NCCAM) is one of the 27 institutes and centers that make up the National Institutes of Health (NIH). The NIH is one of eight agencies under the Public Health Service in the Department of Health and Human Services. The NCCAM defines CAM as a group of diverse medical and health care systems, practices, and products that are not presently considered to be a part of conventional medicine. The list of what is considered to be CAM changes continually. NCCAM classifies CAM therapies into five categories: (1) alternative medical systems that are built upon complete systems of theory and practice, i.e. naturopathic medicine, (2) mind-body interventions that use a variety of techniques designed to enhance the mind's capacity to affect bodily function and symptoms, i.e. meditation, (3) biologically based therapies that use substances found in nature such as herbs, foods, and vitamins, (4) manipulative and body-based methods that are based on manipulation and/or movement of one or more parts of the body, i.e. massage, and (5) energy therapies that involve the use of energy fields that purportedly surround and penetrate the human body or that use electromagnetic fields.

BILL ANALYSIS: House Bill 923 would exempt the practice of a complementary or alternative health care service from the practice of medicine and would require those persons who practice CAM to register with the Secretary of State. CAM would be specifically defined to mean a healing modality, therapy, or health care system that does not involve the performance of surgery, prescribing or administering x-ray radiation, or prescribing or administering legend drugs, controlled substances, medical devices, or anesthesia, performing chiropractic adjustment of the joints or spine, massage

therapy, or performing western allopathic bio-medical disease diagnosis. Persons performing any of these services would continue to be considered as engaging in the practice of medicine. CAM would include certain therapies listed in the definition. A description of those therapies is attached. Registrants would have to provide certain information to the Secretary of State and pay a $50 fee. Failure to register would be a Class 3 misdemeanor.

BACKGROUND:

According to Citizens for Healthcare Freedom, Inc., as many as 3.3 million North Carolina citizens use CAM for a large portion of their health care.

Americans made more visits to CAM providers than to all primary care physicians in 1997. Nationwide, the total number of visits to CAM providers increased from 427 million in 1990 to 629 million in 1997 (47% increase). In 1997, Americans made 386 million visits to primary care physicians compared to 629 million visits to CAM providers. Out of pocket expenses associated with CAM therapies received in 1997, are estimated at $27 billion.

Amy Compeau, Research Assistant, contributed to this summary.

H923-SMSW-001

NCGA House Committee on Health: June 10, 2003, noon, 544 LOB

HB 923: EXEMPT ALTERNATIVE MEDICINE / PRACTICE OF MEDICINE

Testimony from the consumer's perspective

Barbara Zelter, 1903 Craig Street, Raleigh, NC 27608
919-755-9450, bzelter@nc.rr.com

Good afternoon, everyone. My name is Barbara Zelter and I am here to give you two minutes of the point of view of the healthcare consumer, the patient. I am also here to give quick voice to another patient, Haywood Hillier, the mother of my godchild in Asheville—I believe she has called Rep. Sherrill with her astounding story.

First, let me briefly thank the committee chairs for allowing this bill to be heard; I appreciate the open minds you all bring today. I especially want to recognize and thank Rep. Insko, for her long-time efforts for universal health care, as well as Rep. Wright for his advocacy for AIDS funding and many other heath areas.

Before my short personal story, let me make the three main points:

(1) **This issue of health care freedom is nonpartisan, and concerns the free market and our ability as patients to have the broadest possible selection of helpful remedies for what ails us.**

(2) **We patients need more information about the kind of effective alternate healthcare that saved me, and HB 923 is the way to bring the vast network of NC alternative practitioners more into the light of day, more visible and accountable, so we who need help can more easily find them and understand what they offer.**

(3) **Any time you have 3,000,000 people in a state, who are willing to pay out of pocket for healthcare services not covered by health insurance but which we find effective, you need to take note. The exponential rise of CAM (complementary and alternative medicine) is due to enormous patient satisfaction, and deserves to be legally supported.**

I am here personally to say that I have no grudge against regular medicine. But in 1998 and 1999, my internist and other MD's I saw could not cure me from a four-month solid stretch of debilitating flu and bronchitis. Their many antibiotics and other pharmaceuticals did nothing but get me sicker. By looking at a health-related newspaper, I was alerted to a kind of healer I had known nothing about, a homeopath. He assessed that I had mercury poisoning from the fillings in my teeth, a condition that basically had destroyed my immune system. His remedies led me to rapid and continuing perfect health. Under his care, I have not had a sick day of any sort, even a headache, since early 1999.

My godchild's mother's story is more startling than mine, and even more of a call for free access to the full range of alternative providers. Haywood Hillier is a woman in her fifties, a nationally ranked black belt karate instructor. In the span of one day two years ago, she fell bedridden with excruciating pain and weakness, totally disabled, to the horror of her three kids and husband. He took her to some of the best doctors in the state. They all alluded to some unspecified auto-immune condition, and gave her a variety of medicines, some of which did give her minor relief, but she was still in great pain and disabled.

Haywood went to experts at Bowman Gray in Winston. They were stumped and recommended the Mayo Clinic in Minnesota. She went there. Mayo doctors said they could not figure out what she had or what to do, and sent her home with only good wishes.

I had suggested alternative methods to her, but Haywood thought those sounded bogus and was not interested. After the Mayo failure, though, out of desperation, she tried some alternate practitioners in Asheville. The long and short of it is that a total of 17 of these CAM healers, who gave her nutritional therapy, massage, and some very arcane other treatments, healed her completely. She went from total invalid to her current return to teaching karate. Haywood and her family stress that it is critical for her to have all these non-conventional, effective remedies open to her.

My final point to you is that North Carolina and America are big enough to contain both the conventional western surgical and drug-based MD system, and the ancient and newer so-called alternate remedies. There is a place for both, and we need to end competition, and cooperate. We patients want to be able to have our docs and our other healers collaborate for our best interest.

In our state, acupuncturists, massage therapists, nurse-midwives and others have won exemption from the medical practices law. Chiropractors won exemption and I am glad they did, because as I stand before you, a vertebra in my back literally is broken, and a chiropractor is keeping me pain free without any drugs. The trend is that as we all learn more and more about the full range of healing arts and sciences, and become informed, we lose the kind of prejudice my mother, a nurse, had when she told me years ago that chiropractors were quacks. Most of them weren't, just as most MD's aren't, and most alternative healers are not. So let's open the door to all CAM practitioners who register with the Secretary of State and display to clients their complete credentials. Three million of us in NC who use alternative health care at our own pockets' expense are counting on you today. I ask you to report out favorably on HB 923. Thank you.

BRIEF DESCRIPTION OF COMPLEMENTARY OR ALTERNATIVE HEALTH CARE SERVICES IN HOUSE BILL 923

(FROM INTERNET RESOURCES ON THE SUBJECT)

Acupressure is a form of touch therapy that utilizes the principles of acupuncture and Chinese medicine. In acupressure, the same points on the body are used as in acupuncture, but are stimulated with finger pressure instead of with the insertion of needles. Acupressure is used to relieve a variety of symptoms and pain.

Aromatherapy is the therapeutic use of plant-derived, aromatic essential oils to promote physical and psychological well-being. It is sometimes used in combination with massage and other therapeutic techniques as part of a holistic treatment approach.

Ayurveda is a holistic system of healing which evolved among the Brahmin sages of ancient India some 3000-5000 years ago. There are several aspects of this system of medicine which distinguish it from other approaches to health care:

1. It focuses on establishing and maintaining balance of the life energies within us, rather than focusing on individual symptoms.
2. It recognizes the unique constitutional differences of all individuals and recommends different regimens for different types of people. Although two people may appear to have the same outward symptoms, their energetic constitutions may be very different and therefore call for very different remedies.
3. Ayurveda recognizes that all intelligence and wisdom flows from one Absolute source (*Paramatman*). Health is a result of the grace of the Absolute acting through the laws of Nature (*Prakriti*). Ayurveda promotes harmony between the individual and Nature by living a life of balance according to Nature's laws.
4. Ayurveda describes three fundamental energies that regulate all natural processes on both the macrocosmic and microcosmic levels. The same energies that produce effects in the various galaxies and star systems are also operating in your own physiology. These three universal energies are known as the *Tridosha*.
5. Finally, the ancient Ayurvedic physicians realized the need for preserving the alliance of the mind and body. Ayurveda seeks to heal the fragmentation and disorder of the mind-body complex and restore wholeness and harmony to all people.

Biofield therapies are intended to affect energy fields that purportedly surround and penetrate the human body. The existence of such fields has not yet been scientifically proven. Some forms of energy therapy manipulate biofields by applying pressure and/or manipulating the body by placing the hands in, or through, these fields. Examples include Qi gong, Reiki, and Therapeutic Touch.

Cranial Sacral Therapy (CST) is a gentle, hands-on method of evaluating and enhancing the functioning of a physiological body system called the craniosacral system - comprised of the membranes and cerebrospinal fluid that surround and protect the brain and spinal cord. Using a soft touch generally no greater than 5 grams, or about the weight of a nickel, practitioners release restrictions in the craniosacral system to improve the functioning of the central nervous system. CST is increasingly used as a preventive

health measure for its ability to bolster resistance to disease, and is effective for a wide range of medical problems associated with pain and dysfunction, including migraine headaches, autism, and traumatic brain and spinal cord injuries.

Culturally Based Traditional Healing Practices: Traditional medicine refers to ways of protecting and restoring health that existed before the arrival of modern medicine. As the term implies, these approaches to health belong to the traditions of each country, and have been handed down from generation to generation. In practice, the term "traditional medicine" refers to the following components: acupuncture, traditional birth attendants, mental healers and herbal medicine.

Dance, Music, and Art Therapy:

- **Dance Therapy** is the psychotherapeutic use of movement as a process that furthers the emotional, cognitive, social and physical integration of the individual. Dance/Movement therapists work with individuals who have social, emotional, cognitive and/or physical problems. They are employed in psychiatric hospitals, clinics, day care, community mental health centers, developmental centers, correctional facilities, special schools and rehabilitation facilities.

- **Music Therapy** is the prescribed use of music by a qualified person to effect positive changes in the psychological, physical, cognitive, or social functioning of individuals with health or educational problems.

- **Art Therapy** is defined as a human service profession that uses art media, images, the creative process, and patient/client responses to the created products as reflections of an individual's development, abilities, personality, interests, concerns, and conflicts. Art therapy practice is based on knowledge of human developmental and psychological theories which are implemented in the full spectrum of models of assessment and treatment including educational, psychodynamic, cognitive, transpersonal, and other therapeutic means of reconciling emotional conflicts, fostering self-awareness, developing social skills, managing behavior, solving problems, reducing anxiety, aiding reality orientation, and increasing self-esteem.

Energetic Modalities of therapy include acupuncture, homeopathy, and isopathy. All of these modalities are predicated on the idea that a life-force exists in the body, whose proper flow throughout the body is disturbed in a disease process. These energetic modalities of therapy rebalance and harmonize the flow of life-force to promote greater health in the body.

Folk Practices are a part of the culture of the specific group. They consist of preventive and remedial measures. Among the interventions frequently utilized include prayers, incantations, use of incense, herb-teas, BARIDAS (sweeping the body using special aromatic leaves and branches), use of various secretive remedies, burning of candles, use of ointments, etc. in ritualistic fashion, so as to produce a magical effect). Each type of illness or ailment generally requires a specific approach or treatment.

Practices Utilizing Food, Food and Dietary Supplements, Individual Biological Therapies such as Bee Pollen, Nutrients, and the Physical Forces of Heat, Cold, Water, Touch, and Light:

- **Diet and Nutrition:** The role of diet in the treatment of illness is extremely controversial in the medical profession. In complementary medicine, however, it is believed that modifying an individual patient's diet in specific ways according to his body requirements can reduce the inflammatory reactions of the body. Because all material traversing the intestinal lining is inspected by the immune system, it is felt that individuals with an abnormal immune system can develop an abnormal inflammatory response on exposure to antigens in the gut.

- **Dietary Supplement:** Congress defined the term "dietary supplement" in the Dietary Supplement Health and Education Act (DSHEA) of 1994. A dietary supplement is a product (other than tobacco) taken by mouth that contains a "dietary ingredient" intended to supplement the diet. Dietary ingredients may include vitamins, minerals, herbs or other botanicals, amino acids, and substances such as enzymes, organ tissues, and metabolites. Dietary supplements come in many forms, including extracts, concentrates, tablets, capsules, gelcaps, liquids, and powders. They have special requirements for labeling. Under DSHEA, dietary supplements are considered foods, not drugs.

- **Bee Pollen:** A Superfood is a rare occurrence in nature. It is when a food source is produced which is highly concentrated, with a complex supply of quality nutrients. Bee Pollen is the most famous Superfood. Because Bee Pollen is the reproductive spore of the plant, it is incredibly dense with plant nutrients. These nutrients fall into the category of Polyphenols, and they often function as antioxidants. Bee Pollen contains the highest antioxidant activity (ORAC results) and polyphenol content of any fruits and vegetables yet tested. Bee Pollen also contains enzymes, phytosterols, free amino acids, fatty acids with a good proportion of Omega 3 and 6 fatty acids, naturally chelated minerals, and whole vitamin complexes.

Herbology or Herbalism:
There are several types of herbal medicine systems that are used today; European, Native American, Chinese, Ayurvedic, and Western herbalism are the most prevalent systems. Despite differences in terminology and in the herbs used, there is a common thread that joins these systems: all of these systems treat the body as a 'whole', and they each utilize the energy of plants to 'work as needed' in synergy with the natural energy in each individual.

Homeopathy:
Homeopathic medicine is a CAM[1] alternative medical system. In homeopathic medicine, there is a belief that "like cures like" meaning that small, highly diluted quantities of medicinal substances are given to cure symptoms, when the same substances given at higher or more concentrated doses would actually cause those symptoms.

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[1] Complementary or alternative medicine.

Therapeutic Touch or Body Work:

- **Therapeutic Touch** is derived from an ancient technique called laying-on of hands. It is based on the premise that it is the healing force of the therapist that affects the patient's recovery; healing is promoted when the body's energies are in balance; and, by passing their hands over the patient, healers can identify energy imbalances.

- **Asian Bodywork Therapy** is the treatment of the human body/mind/spirit, including the electromagnetic or energetic field, which surrounds, infuses and brings that body to life, by pressure and/or manipulation. Asian Bodywork is based upon traditional Chinese Medical principles for assessing and evaluating the energetic system. It uses traditional Asian techniques and treatment strategies to primarily affect and balance the energetic system for the purpose of treating the human body, emotions, mind, energy field and spirit for the promotion, maintenance and restoration of health.

Mind-Body Therapeutic Practices: The basic principle of mind body therapy is that there are healing resources within the brain that can be used to help heal the body or its emotional state. Mind body therapy has several points of impact for the treatment and prevention of illnesses:

- Improved biological functioning (e.g., improved blood pressure);
- Reduced risks factors for disease; and
- Improved behavioral, psychological, and social functioning.

It is able to do so, in part, because of the mind's interconnectivity with (and influence over) key systems of the body: cardiovascular, immune, hormonal and metabolic, and reproductive. Practitioners of mind body therapy emphasize that it is more important to understand the person having the disease, rather than to understand the disease within the person. Mind body therapy is a tool that helps a patient gain control over the obstacles and effects of disease presented to the mind and body. Mind body therapy also can help a person live life with a greater measure of contentment and less vulnerability to the harmful effects of stress, anger, or frustration, so that they can live their lives more fully—whether or not they have a chronic disease.

Native American Medicine: Native American medicine is an umbrella term that encompasses the healing beliefs and practices of all the indigenous people of North America. Its therapeutic approach combines spirituality, herbalism, and magic in treating a wide range of physical and emotional ailments--from the common cold to depression. Because Native Americans believe that the health of an individual is inextricably linked to the people and objects surrounding that person, their healing practices promote harmony among everyone in a community--and with the physical environment and the spiritual world as well. Although there are variations in the specific healing methods of the different Native American nations (also called "tribes"), four practices are common to most. These practices include:

- The involvement of healers, also referred to as "medicine men," "medicine women," or "shamans" (although some Native Americans find the term "shaman" to be inappropriate because it is European in origin)
- The use of herbal remedies

- The employment of ritual purification or purging
- The observance of other symbolic rituals and ceremonies.

Naturopathy: Naturopathic medicine is a CAM alternative medical system in which practitioners work with natural healing forces within the body, with a goal of helping the body heal from disease and attain better health. Practices may include dietary modifications, massage, exercise, acupuncture, minor surgery, and various other interventions.

Polarity Therapy: is a comprehensive health system involving energy-based bodywork, diet, exercise and self- awareness. It works with the Human Energy Field, electro-magnetic patterns expressed in mental, emotional and physical experience. In Polarity Therapy, health is viewed as a reflection of the condition of the energy field, and therapeutic methods are designed to balance the field for health benefit.

Reiki: is a Japanese word representing Universal Life Energy. Reiki is based on the belief that when spiritual energy is channeled through a Reiki practitioner, the patient's spirit is healed, which in turn heals the physical body.

Traditional Tibetan Practices: The philosophical basis of Tibetan medicine is rooted in Buddhism. The historical Buddha Shakyamuni, sometimes called the Supreme Physician, is said to have first taught a healing system in India during the 6th century B.C. In many of his teachings, the Buddha used disease and healing as metaphors to illustrate his philosophy of the human condition. From the Buddhist perspective, physical illness is inextricably bound with mental, social and spiritual illness. Thus, the Buddhist medical system is more than studies of anatomy, physiopathology and pharmacopoeia. It is a guide to "right living" and involves the spiritual aspects of healing as well. When examining a patient, the practitioner begins by assessing the patient's constitution, which may be a combination of the three principles of energy. This examination includes observing the patient, making inquiries, and pulse-taking. Then, the practitioner determines a reason for the imbalance and implements a method of restoring balance.

Qigong: is a component of traditional Chinese medicine that combines movement, meditation, and regulation of breathing to enhance the flow of qi (an ancient term given to what is believed to be vital energy) in the body, improve blood circulation, and enhance immune function.

Joint House and Senate Health Committee Meeting

June 11, 2003

Minutes

The Joint House and Senate Committee on Health met on Wednesday, June 11, 2003 at 11:00 a.m. in Room 643 of the Legislative Office Building. A silent roll was taken. A copy of the roll denoting members present is attached to the minutes (Attachment I) along with a copy of the agenda (Attachment II).

Senate Chair Bingham calls meeting to order and introduces pages. House pages are Lucy Rogers and Elise Dorsett from Wake County sponsored by Rep. Munford, Laurie Fox sponsored by Rep. Fox, and Bill Gorman sponsored by Rep. Gorman. The Senate Pages are: Rebecca Gardner sponsored by Sen. Stevens and Sarah Riggins sponsored by Sen. Clodfelter.

Chair Bingham then recognizes Secretary Carmen Hooker Odom.

Secretary Carmen Hooker Odom spoke providing highlights from handout "The Health of North Carolinians: A Profile" (Attachment III) A copy of Secretary's speech is attached as Attachment IV

Senator Forrester spoke briefly concerning difficulty in getting handle on mental patients in North Carolina, the number of people in system state is treating and reform in North Carolina. He also stated that suicide deaths were twice as many as automobile accidents and he was particularly concerned with suicides among youth and senior citizens. Leah Devlin spoke to Senator Forrester's concerns about suicides specifically in youth. She indicated that the Department had a teen suicide prevention plan and they were working in partnership with mental health. Senator Forrester then indicated that the infant mortality rate had gone down and inquired about what caused decrease. Ms. Devlin stated that approximately 1,000 infants are lost each year; however, progress was being made especially where strong screening programs were in place.

Senator Queen and Representatives Wright, B. Allen and Glazier talked briefly about need for preventive health care resources and asked Secretary Hooker-Odom how General Assembly could help. Secretary Hooker-Odom stated one of the things was the removal of language regarding over 125% and need to expand eligibility. She also felt that the issue of planning was critical and indicated need for inter-departments to work together.

Chair Bingham indicated that time had elapsed and thanked Secretary Hooker-Odom.

Meeting was adjourned at 12:06 p.m.

Rep. Verla Insko, Chair

Pamela J. Evans, Committee Clerk

Rep. Carolyn Justus, Chair

Glenda Jones, Committee Clerk

ATTACHMENT I

ATTENDANCE

HOUSE COMMITTEE ON HEALTH

DATES		6/11/15														
INSKO, Verla	CHAIR	✓														
JUSTUS, Carolyn	CHAIR	✓														
ENGLAND, Bob	VICE-CHAIR	✓														
ADAMS, Alma		✓														
ALLEN, Bernard		✓														
ALLEN, Gordon																
ALLRED, Cary																
BARNHART, Jeff		✓														
BOWIE, Joni																
CLARY, Debbie		✓														
EARLE, Beverly																
GLAZIER, Rick		✓														
HILTON, Mark																
McALLISTER, Mary		✓														
MUNFORD, Don																
SETZER, Mitchell		✓														
SHERRILL, Wilma																
WAINWRIGHT, William																
WILSON, Connie																
WRIGHT, Tom		✓														
Ex officio Members																
Brubaker, Bru																
Culpepper, Bill																
Cunningham, Pete																
Eddins, Rick																

ATTENDANCE

Committee: **HEALTH & HUMAN RESOURCES**

DATES / NAMES	6/11/03															
William R. Purcell	✓															
Stan Bingham	✓															
Austin Allran																
Joe Sam Queen	✓															
James Forrester	✓															
Charlie Dannelly	✓															
John Garwood																
Fletcher Hartsell																
David Hoyle																
Ellie Kinnaird	✓															
Jeanne Lucas	✓															
Vernon Malone	✓															
Stephen Metcalf																
Eric Reeves	✓															

ATTACHMENT II

AGENDA

JOINT HEALTH AND HUMAN RESOURCES COMMITTEE
Wednesday, June 11, 2003 at 11:00 A.M.
Room 643, Legislative Office Building

I. **Welcome and Opening Remarks**

II. **Health and Human Services Secretary Carmen Hooker Odom will report to the Committees on the status of health in North Carolina.**

III. **Other Business**

IV. **Adjournment**

Carmen Hooker Odom
Remarks to the House Committee on Health and Senate Committee on Health and Human Resources
Wednesday, June 11, 2003

Good morning Chairman Purcell, Chairman Bingham, Madame Chair Insko and Madame Chair Justice and other members of the House and Senate committees:

More than 200 years ago, Benjamin Franklin wrote that for the "want of a nail" the horseshoe was lost, the horse went lame and the battle was lost. In other words, the key to victory lay in preventing problems before they occur rather than trying to solve them afterwards.

Franklin's lesson shouldn't be lost on us. North Carolina has made significant and fundamental strides in improving public health across the state in the past year. But even as we continue our efforts to reduce particular health problems . . . we must turn our attention and emphasis away from ***responding*** to health problems and toward ***preventing*** health problems.

In fact, the watchword for North Carolina's public health in the coming years must be prevention.

2002 proved to be a rewarding year for North Carolina public health. We made significant gains in public health preparedness while moving forward on other critical public health issues. The key to our success – as always – has rested on the strong partnership between the state Division of Public Health, local public health departments, health care providers, and other community health stakeholders.

While we have made great strides in addressing the threat of bioterrorism, this strengthened capacity is critical in enabling our public health system prepare for a wide variety of threats – ranging from hurricanes to the most recent worldwide public health threat involving SARS.

And while not neglecting those health issues that get most of the public and media attention, we need to build the same capacity to address the leading causes of death among our citizens, such as cardiovascular diseases, cancer, diabetes and stroke. We must also maintain and strengthen the major investments we have already made in maternal, infant and child health.

We are committed to major system improvements and accountability for outcomes that will assure that public health responds as effectively as possible as a state and local system. We must ensure that our society, its opinion leaders and decision-makers are not allowed to forget the importance of protecting and improving the public's health by ensuring a sound infrastructure.

As I stated at the outset, North Carolina must move from ***responding*** to health issues – which is costly in terms of dollars, pain and suffering, and premature death – toward preventive strategies with its lower cost and dramatic impact on improved quality of life for families and communities. We have much work to do in this area.

Health Behavior

In North Carolina, about 53 percent of deaths are preventable each year. Medical costs associated with tobacco use, physical inactivity, and poor nutrition are estimated to cost more than $6 billion per year in North Carolina. The obesity rate in North Carolina has increased 77 percent since 1990.

Poor health is highly associated with living in poverty. African Americans are 2.7 times as likely to live in poverty as whites.

Tobacco Use

Tobacco still leads as the number one cause of ***preventable*** deaths in North Carolina. Currently 34.5 percent of children in grades 9-12 indicate that they use tobacco. The addiction begins often by age 14 – if we can get people past age 21 tobacco free, they are not likely to be tobacco users. We know the science-based strategies that work – such as the creation of tobacco free environments, effective public awareness campaigns, and making more cessation services available.

Obesity

We have finally recognized and begun to address the problem of overweight and obesity adults and children in North Carolina. By 18 years of age approximately 25 percent of youth are overweight or obese and eventually 60 percent of adults are overweight. There was a 40 percent increase in overweight and obese children seen in local health departments aged 5-11 years between 1995-2000.

Overweight and obesity are major contributors to many preventable causes of death and raise the risk of developing high blood pressure, high cholesterol, diabetes, heart disease, stroke, cancer and other illnesses. In addition, Type II diabetes formerly seen only in adults is now being diagnosed in children. The underlying risk factors are often a combination of physical inactivity and poor diet.

Cardiovascular disease is the leading cause of death in North Carolina accounting for nearly 40 percent of all deaths, killing 26,000 people in the state annually. The *Eat Smart Move More Plan* and the *Moving Our Children to a Healthier Weight Initiative* were both launched in 2001, offering comprehensive recommendations for community action to prevent overweight and obesity.

Infant, Child, and Adolescent Health

The rate of child deaths has decreased 33 percent since 1987. Infant mortality has decreased 41 percent since 1980. Teen pregnancy has declined more than 30 percent in the last decade. On the other hand, the percentage of children with asthma has increased with 17 percent now diagnosed with the disease.

But children also face perils beyond disease. We have noted statewide increases in the number of child abuse and neglect cases. Many cases are in situations that couple domestic violence and substance abuse.

The Child Well-Being and Domestic Violence Task Force that Chief Justice I. Beverly Lake and I co-chaired looked at the effects on children raised in violent homes. The task force made recommendations to protect children who are exposed to domestic violence – as well as adopting shared principles and common protocols for the courts, public safety offices, child welfare protection agencies and domestic violence advocates.

In 2001, 7.5 percent of North Carolina children had no health insurance. Medicaid and Health Choice provide insurance coverage for many lower income children. NC Health Choice has offered health insurance to low-income children since 1998. Over 99,556 children were enrolled in NC Health Choice as of June 1, 2003.

Child immunization rates are high in North Carolina with 80 percent of children having appropriate immunizations in 2001 as compared to the national rate of 74 percent. This is due, in large part, to the General Assembly's support and championship of North Carolina as a universal vaccination state, where all of our children are provided vaccines.

As stated before, overweight and obesity has become a serious health problem among children in North Carolina. One-fourth of children ages 12-18 are overweight. Thirty-six percent of high school students reported no regular, vigorous physical activity each week and only 18 percent reported eating fruits and vegetables on a regular basis.

We must begin to teach children early about the importance of exercise through such programs as Governor Easley's More at Four Program and Smart Start. There is also a serious lack of school heath services in North Carolina.

While there are many aspects of a coordinated school health program that do well, one glaring example of our need to improve children's health services in school is in the ratio of school nurses to children. The national standard of nurses to students 1:750, however, in North Carolina the ratio is 1:2000. The lack of school health services represents a devastating missed opportunity to improve the health of children and help ensure their academic success.

Since 1990, adolescent pregnancy rates have declined by more than 30 percent in North Carolina. North Carolina has announced its lowest teen birth rate in more than two

decades. In 2001, the state's pregnancy rate for all 15-19 year old girls was 69.3 per 1,000, down 9 percent from the 2000 rate of 76.1 per 1,000.

Minority Health and Disparities

Minority males have the lowest life expectancy of any group, 68.0 years at birth. In spite of declines in infant mortality for all racial groups, African-American infants are still more than twice as likely to die at birth as white infants. African Americans are also more likely to suffer from a variety of illnesses, accounting for higher mortality than whites.

Between 1990 and 2000, North Carolina experienced the greatest percentage growth in Latino population of any state in the U.S. Nearly 50 percent of all Hispanic deaths are due to fatal injuries. Native Americans also suffer from higher death rates than whites and have a very high percentage of persons with no health insurance (25 percent).

I earnestly believe that we as a state must dedicate the necessary resources – both human and financial resources – in order to reduce and eventually eliminate health disparities among our minority populations. I urge and enjoin the membership of the General Assembly to do all within your power to move health disparities to a higher rung on the priority ladder.

Seniors

Chronic diseases are responsible for 65 percent of all deaths in North Carolina – resulting in approximately 45,000 deaths each year. While death itself is unavoidable, it may often be postponed if chronic health conditions and risky behaviors are prevented or controlled, especially among our senior population.

Many of the leading causes of death for North Carolinians – including heart disease and diabetes can be prevented.

North Carolina is also moving to meet the prescription needs of the state's senior population. The Senior Care Program was created to help low-income seniors who are coping with the rising costs of prescription medicine. Senior Care offers coverage for 60 percent of the first $1,000 worth of the costs for prescription drugs for the treatment of cardiovascular disease, chronic obstructive pulmonary disease and diabetes.

One or more of these diseases affects about 75 percent of North Carolina's elderly with about 150,000 seniors estimated to be eligible for this service. And the Division continues to promote awareness and education about arthritis and osteoporosis, which are leading causes of disability in the elderly.

As of June 6th, 16,752 Senior Care applications had been approved. The state's portion of cost per prescription is $44. Each utilizing member has received coverage for 2.2 prescriptions per month. We are preparing to send applications 24,000 dual eligibles

who are not already enrolled. Word of mouth is far and away the most frequent way that seniors report having heard about the program.

Mental Health

We continue to proceed with our effort to update the state's metal health delivery system. The *Blueprint for Change – North Carolina's State Reform Plan for Mental Health, Developmental Disabilities and Substance Abuse Services* constitutes the first substantial overhaul of the state's mental health system since 1974.

As you well know, the state spends more than $1.8 billion dollars every year to provide mental health, developmental disabilities and substance abuse services to over 300,000 citizens.

Each July, the state updates the plan reflecting changes and input it has received over the past year. We are in the process now of receiving and incorporating ideas, suggestions and comments concerning the state MH/DD/SAS plan from people across the state. We will continue to collect public comments through June 20, and then release an updated plan by July.

HIV/Sexually-Transmitted Disease and Communicable Diseases

North Carolina's syphilis rate is higher than the national rate, despite the fact that the syphilis rate in our state has been declining in the last few years. North Carolina's gonorrhea and chlamydia rates are also higher than the national average.

There was a 16 percent increase in new AIDS cases in North Carolina last year. This increase in new AIDS cases reflects a regional trend in which seven of the 10 states with the highest AIDS case rates are in the South. While the South represents a little more than 33 percent of the U.S. population, it now accounts for about 40 percent of the estimated people living with AIDS and 46 percent of the new AIDS cases.

Estimates are that currently at least 21,000 North Carolina residents are living with HIV/AIDS. Approximately 44 percent of new HIV cases were among African American males, 24.5 percent among African American females, and 19.5 percent were white, Non-Hispanic males. While many cases are reported without a transmission mode, about a third of all new cases indicate heterosexual transmission.

North Carolinians experience a much higher rate of sexually transmitted diseases compared with the rest of the country. North Carolinians have higher rates of congenital syphilis, primary and secondary syphilis, gonorrhea, chlamydia, and HIV/AIDS than other Americans.

Health Care Access

North Carolina has about the same percentage of people with no health insurance as the nation (14.2 percent versus 14.5 percent). Minorities are twice as likely as whites (26 percent versus 13 percent) to have no health insurance in North Carolina.

Medicaid has become a significant provider of health care for poor people in North Carolina. In 2002, the average monthly enrollment in Medicaid was 989,863, three times the number in 1989.

About 33 percent of all North Carolinians live in rural areas, compared with 20 percent nationally. There is an unequal distribution of health professionals in North Carolina. In 2001, 14 counties did not have any physicians attending births. North Carolina ranks 43rd in the nation in the number of Medicaid participation by dentists.

Public Health Preparedness

Since January of 2002 the strategic investments that have been made in partnership with local health departments, hospitals, the UNC School of Public Health and others include the establishment of the state Office of Public Health Preparedness and Response as well as the seven Public Health Regional Surveillance Teams.

The Division has also strengthened its epidemiology capacity recruiting additional experts and strengthening relationships with Department of Agriculture, universities and private labs. Because of its vital link in the state's ability to detect and respond to a natural or intended threat, the NC State Laboratory of Public Health is expanding its capacity centrally and regionally.

Also, the 2002 General Assembly passed the Public Health Readiness Act, which better defines the state's public health laws and ensures that state and local public health officials have the appropriate authority to protect the public's health. We are nearing completion of the first phase of the North Carolina smallpox plan. We are entering the West Nile season and are helping the public become aware of the risk of SARS in our community.

Summary

Chairman Purcell, Chairman Bingham, Madame Chair Insko and Madame Chair Justice and other members of the House and Senate committees – I appreciate the opportunity to talk about the overall state of public health in North Carolina in 2002.

While North Carolina continues to fall in the lower state rankings in most state health indicators, we have made significant strides in addressing health issues such as SARS and bioterrorism. We need, however, to build our capacity for responding to chronic diseases, the leading causes of death, and shore up our children and family services. We also must focus efforts on special populations – such as minorities, seniors,

and people living in rural areas – whom suffering from disproportionate number of health problems.

Most health issues facing North Carolina are preventable, if we make it our priority to invest in prevention and to deal with the socio-economic factors that impact health. You heard me speak today of what we've accomplished so far . . . think of the billions of dollars we could save in deferred medical costs as well as the lives saved if we learn the lesson that Benjamin Franklin tried to teach so long ago and "find the nail that saves the shoe that saves the horse and wins the battle."

Thank you.

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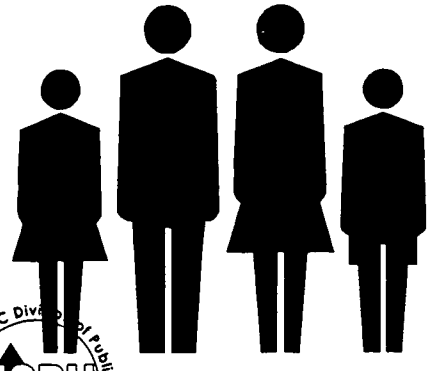
The Health of North Carolinians: A Profile



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April 2003

EXECUTIVE SUMMARY

North Carolina has a diverse population. More than 22 percent of its 8.2 million people are African-American, 5 percent are Latino, and 1 percent are American Indian. This diversity is represented in the health status of its citizens. North Carolina lags behind the nation in many key health indicators, including infant mortality, deaths from stroke and incidence of diabetes. Minorities almost always have worse health status indicators than whites. In this report we examine selected health indicators offering a profile of health in North Carolina. Two overarching goals of the Department of Health and Human Services are to increase quality years of life and eliminate health disparities.

CHRONIC DISEASES

- ✓ In 2001, almost one million citizens were 65 years or older. The population in North Carolina is growing older, increasing health care and related costs. Since 1980, life expectancy increased by more than 2 years, to 75.6 years. People who died lost an average of 8.4 years of expected life. Heart disease, cancer, and stroke accounted for more than 55 percent of all deaths in the state. The prevalence of diabetes increased in the population from 4.5 percent in 1995 to 6.7 percent in 2001. Hospital treatment for diabetic patients cost more than $2 billion in 2001. By 2001, osteoporosis had also become more prevalent with 6,409 hospital admissions having a primary diagnosis of hip fracture.

INFANT, CHILD, AND ADOLESCENT HEALTH

- ✓ The rate of child deaths has decreased 33 percent since 1987. Infant mortality has decreased 41 percent since 1980. Teen pregnancy has declined more than 30 percent in the last decade. On the other hand, the percentage of children with asthma has increased with 17 percent now diagnosed with the disease.

- ✓ In 2001, 7.5 percent of North Carolina children had no health insurance. Medicaid and Health Choice provide insurance coverage for many lower income children. NC Health Choice has offered health insurance to low-income children since 1998. Over 94,000 children were enrolled in NC Health Choice in January 2003.

- ✓ Child immunization rates are high in North Carolina with 80 percent of children having appropriate immunizations in 2001 as contrasted with a national rate of 74 percent. Overweight has become a serious health problem among children in North Carolina. One-fourth of children ages 12-18 are overweight. Thirty-six percent of high school students reported no regular, vigorous physical activity each week and only 18 percent reported eating fruits and vegetables on a regular basis.

MENTAL HEALTH

- ✓ Twenty-six percent of North Carolina adults responded in a random telephone survey that there were one or more days during the past month when their mental health was not good (due to stress, depression, or emotional problems).

- ✓ In 2001, 17,160 people were admitted to State Psychiatric Hospitals and 323,718 were served in Area Mental Health Centers. More than $300 million was spent on admissions to general hospitals for patients with mental illness or substance abuse as a primary diagnosis.

INJURY/VIOLENCE

- ✓ In 2001, 5,071 North Carolinians died from injury or violence with 1,606 deaths resulting from motor vehicles injuries, 985 from suicide, and 584 from homicide. All minority groups were more likely to die from homicide. American Indians and Hispanics were more likely to die from motor vehicles injuries, compared to whites. North Carolina survey data indicate that 2.8 percent of males and 10.4 percent of women had ever been sexually assaulted. Almost 10 percent of new mothers reported being physically abused around the time of pregnancy.

HIV/SEXUALLY-TRANSMITTED DISEASE & COMMUNICABLE DISEASES

- ✓ The rate of syphilis has declined almost 65 percent since 1990. Still, North Carolina's rate is higher than the national rate (3.3 versus 2.2 per 100,000 population). The HIV death rate in North Carolina has declined 60 percent since 1995. Of 1,014 new AIDS cases in 2002, 69 percent were African Americans. These 1,014 new AIDS cases represent a 16 percent increase from 2001, when 871 cases were reported.

MINORITY HEALTH

- ✓ Minority males have the lowest life expectancy of any group, 68.0 years at birth. In spite of declines in infant mortality for all racial groups, African-American infants are still more than twice as likely to die at birth as white infants. African Americans are also more likely to suffer from a variety of illnesses, accounting for higher mortality than whites.

- ✓ Between 1990 and 2000, North Carolina experienced the greatest percentage growth in Latino population of any state in the U.S. As a result of the young age of many Hispanics in North Carolina, about 50 percent of all Hispanic deaths are due to fatal injuries, with 22 percent of all Hispanic deaths caused by injuries sustained in motor vehicles crashes.

- ✓ Native Americans also suffer from higher death rates than whites and have a very high percentage of persons with no health insurance (25%).

HEALTH BEHAVIOR

- ✓ In North Carolina, about 53 percent of deaths are preventable each year. Medical costs associated with tobacco use, physical inactivity, and poor nutrition are estimated to cost more than $6 billion per year. The obesity rate in North Carolina has increased 77 percent since 1990.

- ✓ Poor health is highly associated with living in poverty. African Americans are 2.7 times as likely to live in poverty as whites.

HEALTH CARE ACCESS

- ✓ North Carolina has about the same percentage of people with no health insurance as the nation (14.2% versus 14.5%). Minorities are twice as likely as whites (26% versus 13%) to have no health insurance.

- ✓ Medicaid has become a significant provider of health care for poor people in North Carolina. In 2001, the average monthly enrollment in Medicaid was about 920,000, almost three times the number in 1989.

- ✓ About 33 percent of all North Carolinians live in rural areas, compared with 20 percent nationally. There is an unequal distribution of health professionals in North Carolina. In 2001, 14 counties did not have any physicians attending births. North Carolina ranks 43rd in the nation in the number of Medicaid participation by dentists.

SUMMARY

The health status of North Carolinians is varied and complex. The state has made progress in key areas but lags behind the nation in many other important aspects of health status and health care, including an enduring gap in health indicators when controlled by race or ethnicity.

THE HEALTH OF NORTH CAROLINIANS: A PROFILE

Since 1914, when deaths were first centrally recorded in North Carolina by the state Vital Records program, data obtained from birth and death certificates has been used to classify and determine the root causes behind public health threats such as birth defects, heart disease, SIDS, and cancer. Similarly, information regarding illness and injuries collected from hospital discharge data, registries, and health surveys can give us a more thorough idea of the prevalence and scope of public health problems such as asthma, osteoporosis, and mental illness. Through a combination of natality, mortality and morbidity data, a portrait of the overall health of North Carolinians can emerge.

The main objective of this report is to help policy makers, health, community, and business leaders identify trends in death, illness, and injury, as well as the factors that may lead to these events. In a rapidly changing health care environment, this information should facilitate the targeting of health programs to improve the health status of North Carolinians.

In 2001, there were nearly 8,200,000 residents of North Carolina. More than 980,000 of these people were age 65 or older, or 12 percent. This is an increase from 602,000, or 10 percent, of our population in this older age group in 1980. North Carolina's popularity as a retirement mecca and the aging of North Carolina's population have resulted in an increase in some health problems, particularly chronic diseases, and there has been an associated rise in deaths and medical care costs for these problems. North Carolina has a slightly higher unadjusted mortality rate than the rest of the country. In 2000 (the latest year of national data), 887 people died in North Carolina per 100,000 population compared to 873 nationally. North Carolina's overall age-adjusted death rate of 964 per 100,000 was significantly higher than the national rate of 872 per 100,000 population.

Life Expectancy & Years of Life Lost – The life expectancy at birth for North Carolinians is 75.6 years. This translates into about one year more than the life expectancy at birth in 1990 and two years more than the life expectancy in 1980. Due to the higher overall death rates in North Carolina compared to the nation, residents of our state live approximately one year less than the U.S. average. Premature mortality not only affects individuals and their families; it also impacts on the state's productivity. **Table 1** shows the total years of life lost and the average years of life lost for the leading causes of death. In 2001, North Carolinians who died lost an average of 8.4 years of life due to early death and a total of 592,326 total years of life. Motor vehicle injuries – which disproportionately involve younger people – had the highest average number of years of life lost per death (32.8 years).

Table 1: 2001 NC Ten Leading Causes of Death: Total Deaths and Years of Life Lost

Rank	Cause	Total Deaths	Average Years of Life Lost	Total Years of Life Lost
1	Heart disease	18,729	4.8	90,162
2	Cancer	16,047	7.9	126,494
3	Stroke	5,396	3.5	18,65
4	Chronic lung disease	3,511	4.4	15,421
5	Diabetes	2,180	6.5	14,125
6	Alzheimer's disease	1,785	0.7	1,221
7	Pneumonia & influenza	1,775	3.1	5,537
	Other unintentional injuries	1,775	19.3	34,211
9	Motor vehicle injuries	1,606	32.8	52,659
10	Nephritis, nephrotic syndrome, nephrosis	1,327	4.5	5,987
Total Deaths – All Causes		**70,738**	**8.4**	**592,326**

Chronic diseases are responsible for 65 percent of all deaths in North Carolina – resulting in approximately 45,000 deaths each year. While death itself is unavoidable, it may often be postponed if chronic health conditions and risky behaviors are prevented or controlled. Many of the leading causes of death for North Carolinians – including heart disease and diabetes can be prevented.

Chronic Diseases

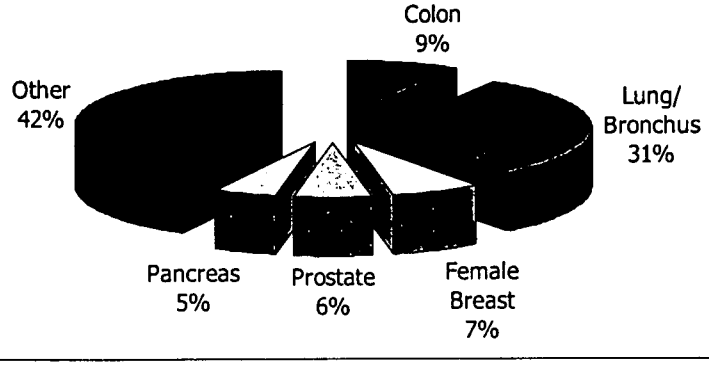
Cardiovascular Disease – In 2001, cardiovascular diseases (heart disease, stroke, and atherosclerosis) accounted for 35 percent of all deaths in the state. Over 24,000 North Carolina residents died of cardiovascular diseases in 2001. As shown in **Table 1**, heart disease was the leading cause of death in North Carolina in 2001, with almost 19,000 resident deaths (or approximately 1 in 4 deaths in the state). North Carolina's 2001 age-adjusted heart disease rate of 246 deaths per 100,000 population was below the national rate of 258 per 100,000 in 2000. However, the state's 2001 age-adjusted stroke death rate of 72.3 was higher than the national rate of 60.8. Cardiovascular diseases were also the leading cause of hospitalization in North Carolina in 2001, accounting for more than 174,000 hospitalizations and almost $3 billion in hospital charges.

A 2003 report from the Centers for Disease Control and Prevention (CDC) reveals that North Carolina has the nation's fourth-highest rate of stroke deaths among men and women ages 35 and older. Only South Carolina, Arkansas and Tennessee had higher stroke death rates than North Carolina. North Carolina is part of what is known as the "Stroke Belt", an area in the Southeastern part of the U.S. with the highest stroke rates. Within the Stroke Belt, North Carolina is one of three states (known as the "Stroke Buckle") with death rates two times higher than the rest of the nation.

According to the 2001 North Carolina Behavioral Risk Factor Surveillance System (BRFSS), 15 percent of North Carolinians between the ages of 55-64 report having been diagnosed with cardiovascular disease, and 25 percent of persons ages 65 and over. Among persons 18 and older, males were more likely (10.4%) to report being diagnosed with cardiovascular disease, heart attack, or stroke than females (7%). Those who reported having less than a high school education were almost five times as likely to have a history of cardiovascular diseases (19.4%) as college graduates (4.1%).

Cancer – The second leading cause of death in North Carolina is cancer, which resulted in more than 16,000 deaths in 2001 (see **Table 1**). The state's age-adjusted death rate for cancer of 207 was close to the national rate of 201 per 100,000 population in 2000. An estimated 40 percent of North Carolinians will develop cancer during their lifetime. More than 39,000 North Carolinians were projected to receive a cancer diagnosis in 2002. The leading causes of cancer death are lung cancer (4,900 deaths in 2001), cancer of the colon and rectum (1,537 deaths), breast cancer (1,171 deaths), prostate cancer (913 deaths), and cancer of the pancreas (857 deaths). 2001 cancer deaths by site are presented in **Chart 1**.

Chart 1: 2001 North Carolina Cancer Deaths, Percentages by Site



Deaths from many cancers can be reduced if the cancer is diagnosed at an early stage. Breast, cervical, and colon/rectum cancer deaths in particular could be reduced with regular screening. With the exception of colorectal screening, a larger percentage of North Carolinians receive cancer screenings than the national average. Colon/rectum cancer is 90 percent curable if detected early. However, according to the NC BRFSS survey, only about half of North Carolina adults over age 50 report ever having a colonoscopy. In contrast, the percentage of North Carolina women age 40 and older who reported having had a mammogram within the past two years was 78 percent, roughly similar to the U.S. rate of 76 percent.

Chronic Lung Diseases – Chronic lung diseases are the fourth leading cause of death in North Carolina, accounting for approximately 3,500 deaths each year (see **Table 1**). North Carolina's age-adjusted death rate due to chronic lung diseases during 1997-2001 was similar to that for the nation – 45.4 per 100,000 population compared with a rate of 44.3 nationally in 2000. 1997-2001 age-adjusted chronic lung disease death rates were highest among North Carolina's white (48.5) and American Indian (44.2) populations. African Americans, Asian-Americans, and Hispanics all had lower death rates from chronic lung diseases. During 1999-2001, North Carolina males had a much higher age-adjusted death rate from lung diseases (63.5 per 100,000 population) compared with females (37.0).

Diabetes – Diabetes is a major cause of death and disability in North Carolina and the nation. With a greater prevalence of obesity and an increasing number of older people, diabetes is increasing at epidemic proportions in North Carolina. The prevalence of diagnosed diabetes in North Carolina increased from 4.5 percent of the population in 1995 to 6.7 percent in 2001, an increase of 48 percent. The actual prevalence may be twice as high given that it is estimated that there is one undiagnosed case of diabetes for every case that is diagnosed.

In 2001, diabetes was the primary cause of nearly 2,200 deaths in North Carolina (**Table 1**), which represents a 30 percent increase in the number of deaths since 1994. North Carolina's age-adjusted diabetes death rate of 27.6 per 100,000 population is slightly higher than the rate of 25.2 found nationally. Diabetes also significantly contributes to other causes of death, such as heart disease, stroke, and kidney failure. In 2001, nearly 5,500 additional North Carolinians died with diabetes mentioned on the death certificate as a contributing condition.

Diabetes is the leading cause of non-traumatic lower limb amputation, kidney disease, and blindness in the state. In addition, people with diabetes are two to four times more likely to have cardiovascular disease. As presented in **Table 2**, in 2001 diabetes was directly responsible for more than 14,000 hospitalizations in North Carolina, and contributed to or complicated another 145,000. Diabetes was mentioned as a contributing condition in approximately 17 percent of all hospitalizations in 2001. The total cost in 2001 for hospitalizations involving diabetes was more than $2 billion. In addition, 2001 North Carolina hospital discharge data reveals that diabetes was associated with 8,830 hospitalizations involving renal dialysis or transplant, and more than 3,000 discharges involving amputations.

Table 2: 2001 NC Resident Hospital Discharges Related to Diabetes

	Total Discharges	Total Charges	Average Charge	Average Length of Stay
Principal Diagnosis of Diabetes	14,144	$143,155,833	$10,121	5.3
Any Diagnosis of Diabetes	159,127	$2,025,599,733	$12,729	5.5
Lower Limb Amputation	3,006	$70,227,513	$23,362	11.2
Cardiovascular disease and diabetes	45,842	$704,622,856	$15,371	5.1
Renal dialysis/transplant and diabetes	8,830	$147,164,709	$16,666	7.1

Osteoporosis – Osteoporosis is a condition characterized by thin, weak bones which can lead to fractures of the spine, wrist, hip, or other bones. Eighty percent of all cases occur among women. The debilitating effects of osteoporosis include hip, wrist, and vertebral fracture. National studies suggest that the consequences of hip fractures include long-term convalescent care, immobility, and, in 10-20 percent of cases, death. A recent report states that 1.27 million people in North Carolina had osteoporosis or low bone mass in 2002. As the population continues to grow older, it is likely that osteoporotic fractures will increase. The prevalence of osteoporosis is projected to grow 53 percent by the year 2020. The total medical costs for treatment of osteoporosis are estimated at $455 million per year. In 2001, there were 6,409 hospital admissions of North Carolinians age 65 and older with a primary diagnosis of hip fracture. Of those hospitalized with hip fractures, more than half were discharged to a long-term care facility.

Unfortunately, most people with osteoporosis have not been properly diagnosed and do not receive treatment, including high-risk patients who have already suffered fractures. Some people consider osteoporosis an inevitable consequence of aging and do not know that it can be prevented. Regular exercise and increasing intake of calcium (which builds up bone mass) are some ways to prevent osteoporosis. According to the 2001 NC BRFSS, among North Carolinians ages 45 and older, the majority (65%) indicated that their doctor had never spoken with them about preventing osteoporosis through lifestyle changes such as diet or exercise. Only 63 percent of North Carolina women ages 45 and older and 30 percent of men indicated that they are taking vitamin supplements that contain calcium to prevent or treat osteoporosis.

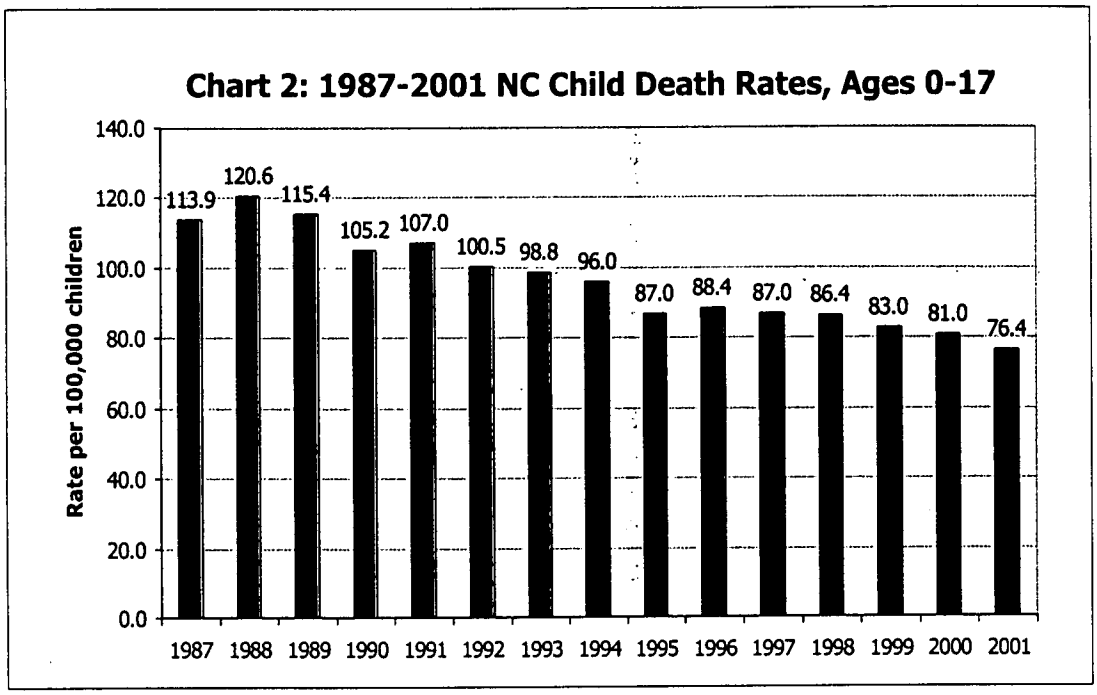
Arthritis/Chronic Joint Problems – Arthritis and chronic joint problems are among the most common chronic diseases and are the leading cause of disability in North Carolina and the United States. According to the 2002 BRFSS, more than a quarter (28.8%) of North Carolinians reported being told by a doctor that they had some form of arthritis or other chronic joint problems. The problem is more prevalent among the North Carolina's elderly population, with more than half (55%) of those ages 55 and older reporting diagnosed arthritis/joint problems. Of those with arthritis, 28 percent reported that arthritis adversely affected their usual activities and/or the nature and amount of work that they perform.

Infant, Child, and Adolescent Health

Child and Infant Mortality – As presented in **Chart 2**, the rate of child deaths (ages 0-17 years) has decreased significantly since 1987. Much of this can be attributed to a substantial decrease in infant mortality. The infant mortality rate in North Carolina has declined from 14.4 infant deaths per 1,000 live births in 1980 to 8.5 in 2001 – a reduction of 41 percent. Yet, despite this progress, North Carolina's infant mortality rate remains one of the five highest rates in the country. For the period 1998-2000, North Carolina had the fifth highest infant mortality rate in the country, with 9.0 deaths per 1,000 live births compared to 7.0 nationally. However, prenatal care appears to be improving. During 1987-91, the percentage of women receiving late or no prenatal care was 24 percent. By the 1997-2001 period, this percentage was down to 15 percent. Similarly, the number of women who reported smoking during pregnancy has also declined. During 1988-91, approximately 1 in 5 births (20%) involved a mother who had smoked during pregnancy, compared with 14 percent during 1997-2001.

Identifying Infants with Special Health Care Needs - Infants with special health care needs who are diagnosed early and have early treatment have markedly better outcomes than children who are diagnosed later in infancy or childhood. The state has three programs for identifying infants with special needs: newborn metabolic screening, newborn hearing screening, and birth defects monitoring.

North Carolina has been a pioneer in the screening of newborns. Every day, the State Laboratory for Public Health collects blood specimens from all newborns and screens them for up to 30 metabolic disorders – genetic defects that impair the way foods are digested or absorbed. Symptoms of metabolic



abnormalities are often subtle, but without proper diagnosis the disorders can result in mental retardation or even death. If an abnormality is found, the lab notifies the hospital and the hospital can then direct the parents to the appropriate doctors for treatment. With appropriate treatment these children can grow and live a long and healthy life. Since the program was first adopted in North Carolina in 1997, no babies have died as a result of metabolic disorders.

All 94 of the North Carolina's birthing facilities are now participating in Universal Newborn Hearing Screening. As a result, 99 percent of all newborns born in North Carolina hospitals are screened before discharge. Infants who do not receive hearing screening prior to discharge, who are not born in birthing facilities, or who require additional screening are identified so that screening services can be provided within 30 days of birth. As of April 1, 2003, the Newborn Hearing Screening Program identified 121 infants born in Year 2002 with hearing loss.

In 1995 the North Carolina General Assembly passed legislation creating the Birth Defects Monitoring Program (NCBDMP). With funds from the state, the March of Dimes, and the Centers for Disease Control and Prevention (CDC), this legislation allowed trained NCBDMP staff to access and review hospital medical records and discharge reports to ensure more complete, accurate, and timely information for active birth defects surveillance. The staff investigates all cases of North Carolina residents born with birth defects such as neural tube defects (approximately 200 cases a year), cleft lip and palate (130 cases per year), cardiovascular defects (1,000 cases per year), and chromosomal defects (180 infants per year). Some of these birth defects can be detected through prenatal testing, ultrasound, amniocentesis, and genetic testing. The NCBDMP has found that the risk of birth defects may be reduced through avoiding smoking, illicit drugs, and alcohol while pregnant; taking a multi-vitamin with folic acid prior to and during pregnancy; eating a healthy diet; and limiting exposure to environmental hazards.

Early Intervention – Early intervention is a system of services designed to support children ages birth through 5 who have or are at risk for disabilities. The Infant-Toddler Program is for children from birth to 3 years of age and their families. In Fiscal Year 2001-02, 9,841 children (2.9% of the population) were served in the program, which represents a 56 percent increase since Fiscal Year 1997-98. The Preschool Program addresses the needs of 3- to 5-year-olds that are not old enough for kindergarten. It served 19,010 children in the 2001-2002 school year.

The Development Evaluation Center (DEC) network serves young children with suspected or confirmed multiple and/or severe health problems and evaluates children for Early Intervention Services. During the 2001-2002 fiscal year, the network served a total of 23,774 children and delivered 61,175 evaluation services, 42,632 treatment services, and 79,713 other services. These services include tracking, provisional assessments, parent conferences, and consultation. The Child Service Coordination (CSC) Program, which works with families to obtain necessary preventive, specialized, and support services, served 51,458 children under the age of five years during Fiscal Year 2001-02 (9.2% of the population).

Asthma – While asthma does not cause many deaths among children in North Carolina, it is one of the most prevalent chronic diseases in our state, particularly among children. Approximately 7 percent of North Carolinians have asthma. An estimated 10 percent to 17 percent of children under age 18 have diagnosed asthma. The North Carolina School Asthma Survey suggests that another 17 percent of children may have undiagnosed asthma. Children with asthma are 37 times as likely to miss school as children without asthma symptoms.

School Health – A growing number of North Carolina students who have chronic illnesses and special health care needs, such as asthma and diabetes, attend public school. Students with chronic health conditions and disabilities often require special health care assistance during the school day. It is estimated that approximately 10 percent of all North Carolina students have at least one chronic health condition. For the 2001-02 school year, more than 2,300 children received insulin, 1,200 students required nebulizer treatments for asthma, and more than 3,300 students had epinephrine available for emergency injection due to severe allergies. More than 84,000 students (7%) received some medication at school and more than 35,000 (3%) required prescription medication at school on a daily basis.

Health Insurance – According to the Current Population Survey of the U.S. Census Bureau, 11 percent of North Carolina children ages 0-18 did not have health insurance during 2000-2001. For children at or below the poverty level during 1999-2001, 7.9 percent were without health insurance. Medicaid coverage is available to children in some families in poverty. According to the Division of Medical Assistance, in state fiscal year 2000-2001, more than half (56%) of all Medicaid recipients in the state were ages 0-20.

Beginning in October 1998, families who made too much money to qualify for Medicaid but too little to afford rising health insurance premiums were able to get free or reduced price comprehensive health care for their children (ages 0-18) through the "NC Health Choice for Children" program. While many states were unsuccessful in enrolling children, North Carolina was one of only 13 states to exceed its projected enrollment goals during its first years of operation. In fact, North Carolina surpassed its original projection by 64 percent. As a result, Health Choice was forced to freeze enrollments in 2001 due to inadequate funding to meet the unanticipated need. As of March 2003, there were almost 94,000 children enrolled in North Carolina's Health Choice program. Despite funding issues, a study by the University of North Carolina shows that the program has been successful in improving access to health care for low-income children. Parents of younger children said they had 25 percent fewer absences from work because their children were sick less often, and there was a 38 percent decrease in absenteeism for children in childcare.

Immunizations – North Carolina has made a concerted effort to ensure that all children receive age-appropriate immunizations. These efforts have paid off, with North Carolina recently recognized as having one of the top five highest percentages of immunized two-year-olds in the country. In 2001, 80 percent of North Carolina children ages 19-35 months were receiving the appropriate series of immunizations, compared to 74 percent nationally.

Overweight – In many ways, children mirror the behaviors of their parents. Like adults, a high percentage of North Carolina children are overweight. According to the North Carolina Nutrition and Physical Activity Surveillance System, 1 in 8 children ages 2-4, 1 in 5 children ages 5-11, and 1 in 4 children ages 12-18 are overweight based on their Body Mass Index. High rates of overweight can largely be attributed to physical inactivity and poor nutritional habits among North Carolina youth. According to the 2001 Youth Risk Behavior Survey, 36 percent of North Carolina high school students and 25 percent of middle

school students reported no regular, vigorous physical activity each week. Only 23 percent of North Carolina middle school students and 18 percent of high school students reported eating fruits and vegetables on a regular basis.

Child Abuse and Neglect – According to the North Carolina Department of Social Services, in state fiscal year 2001-2002, 107,218 children were assessed for child abuse and neglect, an increase of 5,060 children from the previous year. Of those cases, 32,883 children were found to be abused or neglected, an increase of 302 children from fiscal year 2000-2001.

Teen Pregnancy – North Carolina's teen pregnancy rates have declined significantly (34%) in the last decade. In 1990, 105.4 per 1,000 girls ages 15-19 became pregnant. In 2001, the teen pregnancy rate was 69 per 1000 girls ages 15-19. While teen pregnancy rates are down for both minorities and whites, racial disparities in teen pregnancy rates still persist. During 1997-2001, the minority teen pregnancy rate was 104.5 per 1,000 compared with a rate of 65 per 1,000 for white teenage girls. Of the more than 19,000 reported North Carolina resident teen pregnancies in 2001, 75 percent resulted in live births and 24 percent resulted in abortions.

Mental Health and Substance Abuse

The problems that North Carolina faces with regard to mental health are difficult to document due to inadequate data on the prevalence of mental disorders in the state. In 2001, 1,563 North Carolinians who died had a mental health or substance abuse diagnosis listed as the underlying cause of death. These figures included 1,131 deaths attributed to unspecified dementia (not including Alzheimer's, which is classified as a disease of the nervous system) and 288 deaths attributed to the use of alcohol (not including accidental alcohol overdose). This is just the tip of the iceberg. We currently have no way to document the prevalence of major mental diseases in the general population of North Carolina. According to one estimate, 10-12 percent of North Carolina's nine to 17 year-olds (170,000-208,000) have serious emotional disturbances. Nationally, about 40 million (22%) of non-elderly adults are estimated to have a diagnosed mental health disorder.

The North Carolina Behavioral Risk Factor Surveillance System (BRFSS) telephone survey asks a general question related to mental health. In 2001, 26 percent of adults who responded to this survey reported that there were one or more days during the past month when their mental health was not good (due to stress, depression, or emotional problems.) More women than men reported mental health disturbances, with 19 percent of males reporting that their mental health was not good, compared to 32 percent of females. In 2001, 18 percent of adults in the state reported having a physical or mental health problem that prevented them from doing their usual activities for one or more of the last 30 days.

The Division of Mental Health, Developmental Disabilities, and Substance Abuse Services has information on patients who receive mental health services in state-operated facilities. The Division reports that 17,160 people were served in Psychiatric Hospitals in the state during state fiscal year 2000-2001. Another 3,813 people were served in North Carolina Alcohol & Drug Treatment Centers and 323,718 people were treated in Area Mental Health Programs. Unfortunately, we cannot document the number of people receiving mental health treatment in the private sector, except for inpatient hospitalizations in non-federal hospitals. During 2001, there were more than 50,000 general inpatient hospitalizations in North Carolina with mental illness or substance abuse as the primary diagnosis, resulting in more than $330 million in hospital charges. Among NC BRFSS survey respondents, 5 percent reported having ever received treatment for an alcohol or substance abuse problem.

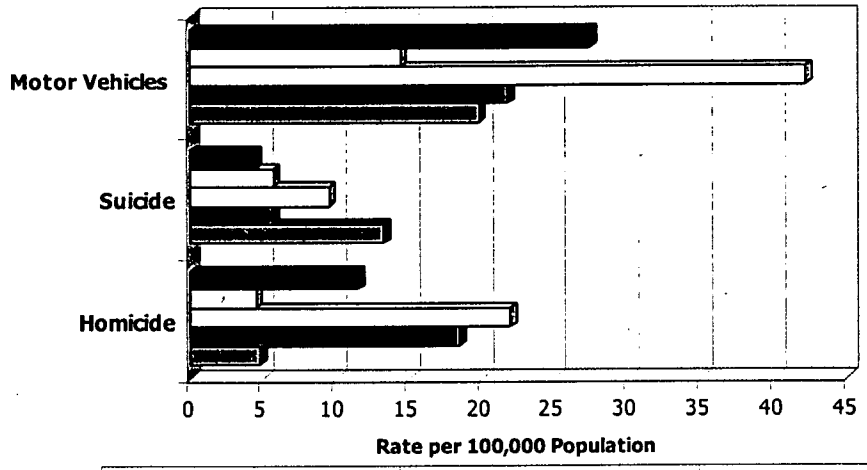
Alcohol also contributes significantly to premature deaths in North Carolina. The North Carolina Medical Examiners office measures blood alcohol levels for most deaths in the state due to injury and violence. Among the 12,612 suicide, homicide, motor vehicle, and other injury deaths occurring during 1996-1998, nearly one-third of the decedents (32.5%) tested positive for blood alcohol.

Illicit drug use is also a problem in North Carolina, especially among the young. According to the 1999-2000 National Household Survey on Drug Use, 10 percent of North Carolinians ages 12-17, 17 percent of 18-25 year olds, and 5 percent of those age 26 and older reported illicit drug use in the past month.

Injury and Violence

In 2001, 5,071 North Carolinians died from injury or violence, including 1,606 deaths from motor vehicle injuries, 1,775 deaths from other unintentional injuries, 985 deaths from suicide, and 584 deaths from homicide. In 2001, there were more than 71,000 hospitalizations with an injury (intentional or unintentional) listed as the primary diagnosis, resulting in $1,175,000,000 in hospital charges. **Chart 3** presents 1997-2001 age-adjusted death rates for three injury and violence categories by race and ethnicity.

Chart 3: 1997-2001 North Carolina Resident Age-Adjusted Death Rates for Injury and Violence by Race/Ethnicity



	Homicide	Suicide	Motor Vehicles
Latino/Hispanic	11.5	4.4	27.4
Asian/Pacific Islander	4.5	5.7	14.4
American Indian	21.9	9.5	42.1
African-American	18.4	5.6	21.8
White	4.8	13.3	19.8

Motor Vehicle – In 2001, for every motor vehicle injury death that occurred, there was a loss of approximately 32.8 years of life (see **Table 1**). This is the highest average years of life lost of any of the major causes of death. Motor vehicle injuries were the fifth leading cause of death for North Carolina males in 2001 (based on the number of deaths), but not one of the ten leading causes of death for females. American Indians have the highest age-adjusted rate of motor vehicle deaths – 42.1 per 100,000 population in 1997-2001. The American Indian motor vehicle death rate was double the rate for whites during this period (see **Chart 3**).

Homicide – In 2001, there were 584 homicides in North Carolina, which represents less than 1 percent of all deaths in the state. However, North Carolina's age-adjusted mortality rate for homicide is higher than the national rate. While homicide is not a leading cause of death in general, it was the second leading cause of death among persons ages 15-24 years in 2001 (163 deaths). North Carolina's African American and American Indian populations have higher age-adjusted homicide rates than other racial and ethnic groups.

Suicide – In 2001, suicide accounted for 1.4 percent of all deaths in North Carolina (985 deaths). Suicide was the 3rd leading cause of death to NC residents ages 15-24 years (134 deaths), and the 5th leading cause of death to residents ages 25-44 years (367 deaths). As shown in **Chart 3**, whites have the highest age-adjusted suicide death rate (13.3). North Carolina's age-adjusted suicide rate was significantly higher than the U.S. suicide rate in 2000. Data on suicide attempts is not available. However, information regarding the percentage of North Carolina youth experiencing suicidal thoughts or feelings is available. According to the 2001 Youth Risk Behavior Survey, 21 percent of North Carolina middle-school students and 18 percent of high school students have seriously considered attempting suicide.

Sexual/Physical Assault – According to the 2001 North Carolina BRFSS telephone survey, 6.8 percent of adult respondents reported that they had ever been sexually assaulted, 2.8 percent of males and 10.4 percent of females. 20.2 percent reported that they had ever been physically assaulted, defined as being pushed, hit, slapped, kicked, or physically hurt in any other way. In the majority of cases, the sexual or physical assault was perpetrated by an intimate partner or someone else known by the person who was assaulted. During 1997-1999, nearly 6 percent of new mothers responded to a North Carolina survey that they had been physically abused during their recent pregnancy.

Communicable Diseases

Sexually Transmitted Diseases – North Carolinians experience a much higher rate of sexually transmitted diseases compared with the rest of the country. North Carolinians have higher rates of congenital syphilis, primary and secondary syphilis, gonorrhea, chlamydia, and HIV/AIDS.

The syphilis rate in North Carolina has been steadily declining over the last few years. Since 1998, the syphilis rate has decreased 65 percent, from 9.3 per 100,000 population in 1998 to a rate of 3.3 in 2002. The number of syphilis cases has been cut in half for all race and ethnic groups in the state. However, North Carolina's syphilis rate was still higher than the national rate of 2.2 per 100,000 in 2001. Consistent with rates across the South, North Carolina's gonorrhea rate has been on the decline since 1998, with a rate of 246.5 in 1998 and 184.3 in 2002. Even with these declines, North Carolina's gonorrhea rate was still higher than the national average of 128.5 per 100,000 population in 2001. In contrast, after years of decline, chlamydia rates began to rise in the state in 2002 – from a rate of 270.8 in 2001 to 296.7 in 2002. The North Carolina rate was significantly higher than the national chlamydia rate of 278.3 in 2001. National chlamydia rates have also been rising recently. Both males and females, as well as nearly all racial/ethnic groups have seen an increase in chlamydia rates.

AIDS/HIV – For several years the number of new AIDS cases in North Carolina was on the decline. However, in 2002 1,014 new cases were reported. This represents an increase of 16 percent from 2001, when 871 new cases were reported. This increase in new AIDS cases reflects a regional trend in which seven of the ten states with the highest AIDS case rates in the nation are in the South. While the South represents a little more than 33 percent of the U.S. population, it now accounts for about 40 percent of the estimated people living with AIDS and 46 percent of the new AIDS cases. Estimates are that currently at least 21,000 North Carolina residents are living with HIV/AIDS. Approximately 44 percent of new HIV cases were among African American males, 24.5 percent among African American females, and 19.5 percent were white, Non-Hispanic males. While many cases are reported without a transmission mode, about a third of all new cases indicate heterosexual transmission.

North Carolina's HIV death rates have been steadily declining since 1996. In 1995, the HIV death rate was 14.1 per 100,000 population compared with a rate of 5.6 today. This mirrors national trends and is likely due to the use of improved drug treatments. HIV death rates are higher among African Americans, Hispanics, and American Indians in North Carolina. During the 1997-2001 period, the age-adjusted rate of HIV deaths was 21.2 for North Carolina's African Americans, 3.3 for American Indians, 4.1 for Hispanics, and 1.6 for whites.

Other Communicable Diseases – North Carolina also faces health threats related to other emerging and re-emerging communicable diseases. Some of these diseases have posed dangers for centuries, while others have surfaced only recently. North Carolina tuberculosis (TB) cases and rates have been declining for many years, although the disease has not been eliminated. In 1950, North Carolina had 89.9 cases of TB for every 100,000 people. By 2001, 398 cases of tuberculosis were reported to the state (the fewest number of cases ever reported) — resulting in an overall rate of 4.8 per 100,000 population. Cases of drug-resistant TB have also declined. Tuberculosis is more common among North Carolina's African-American population compared with whites. However, TB cases for African-Americans have declined 41.7% since 1994, compared with a decrease of only 11.4% for whites. Other emergent communicable diseases such as Severe Acute Respiratory Syndrome (SARS) and West Nile virus are being closely monitored by the North Carolina Department of Health and Human Services and the CDC in an effort to safeguard the public against infection from these viruses.

Food-borne Illness – Food-borne illness impacts the health of thousands of North Carolinians each year. It is well recognized that food-borne illness is vastly under-reported. Yet, during the 5-year period 1997-2001 there were more than 10,000 cases of food-borne illness and 60 outbreaks reported. For the year 2002 alone there were 3,023 cases and 15 outbreaks reported. The cost of a food-borne illness can be large because not only are there medical costs, but there can also be loss of work, hospitalization, or death. North Carolina must also be concerned about food security. The North Carolina Food Security and Safety Coalition was formed due to heightened concerns about bioterrorist attacks on food sources.

Minority Health & Health Disparities

One-quarter of North Carolinians reported in the 2000 Census that they were a minority race. This is approximately double the proportion for the United States as a whole. With many health status measures being worse for minority populations compared to whites, both in North Carolina and nationally, the higher proportion of minorities in North Carolina partly accounts for the relatively low national ranking of North Carolina on many health measures. A 2002 report based on mortality and NC BRFSS survey data indicates that while the life expectancy at birth for North Carolina's white population is 76.8 years, the life expectancy for minorities is only 72.1 years. Minority males fare even worse. Life expectancy is only 68.0 years for minority males, compared to 75.8 years for minority females.

African Americans – The 2000 Census reports that 22 percent of all North Carolinians are African American/Black. This compares with only 12 percent of the population nationally. North Carolina's African Americans are more likely to live in poverty (22.9%) and more likely to have no health insurance (20%) than whites. Poverty and a lack of access to health care are two main reasons why North Carolina's African Americans are generally in poorer health than whites based on mortality and disease incidence patterns. African Americans, for example, have a much higher infant mortality rate than do whites (15.1 deaths per 1,000 live births for African Americans compared to 6.4 for whites in 1997-2001). African Americans also have higher death rates from heart disease, cancer, AIDS, diabetes, homicide, and stroke, and a higher incidence of cancer, compared to whites. North Carolina's African American population also had the highest age-adjusted rates of HIV, gonorrhea, and chlamydia during 1997-2001. According to the NC BRFSS, North Carolina's African Americans are less likely to smoke and binge drink than most other racial/ethnic groups, but are more likely to be obese, have high blood pressure, and have inadequate fruit and vegetable consumption.

Hispanics – According to the 2000 Census, 4.7 percent of North Carolina residents are Hispanic. North Carolina's Hispanic population grew by almost 400 percent from 1990 to 2000, compared with an average national rate of growth for the Hispanic population of 58 percent. Moreover, because North Carolina's Hispanic population is disproportionately young and most of the female Hispanic newcomers are in their peak childbearing years, the potential for continued growth of the state's Hispanic population is great. Seventy-nine percent of North Carolina's Hispanic population is age 35 or younger whereas only 52 percent of the state's total population are in this age range. Given the younger age distribution of the Hispanic population, there are unique health issues for this group.

The leading causes of death among North Carolina Hispanics are consistent with the young age of the population. Approximately half of all North Carolina's 522 Hispanic deaths in 2001 were due to fatal injuries – either intentional or unintentional. Motor vehicle injuries topped the list of leading causes of death in 2001, representing 22 percent (115 deaths) of all Hispanic deaths. Homicide (67 deaths) and other unintentional injuries (53 deaths) were the 2nd and 3rd leading causes of death respectively and comprised another 23 percent of all Hispanic deaths in 2001. Suicide was the 7th leading cause of death among Hispanics in 2001 (23 deaths).

Despite relatively low socio-economic status and delayed prenatal care services, Latina women – especially first generation Latinas from Mexico – have birth outcomes as good as or better than non-Hispanic whites. A recent report by a statewide task force reveals that between 1996-2000, the rate of infant deaths per 1,000 live births to Mexican-born women was 6.1, compared to 6.6 for Whites and 15.0 for African Americans.

American Indians – North Carolina has one of the largest American Indian populations in the country. In 2000, American Indians numbered more than 95,000, or a little over 1 percent of the population in the state. As with other minority populations, North Carolina's American Indian population is generally in poorer health than Whites. North Carolina's American Indian population has higher death rates from diabetes, motor vehicle injuries, and homicide, as well as a substantially higher infant death rate. The rates for HIV, syphilis, and gonorrhea, and chlamydia are also high among the American Indian population in North Carolina. During 1997-2001, American Indians had higher percentages of women who smoked during pregnancy and women with late or no prenatal care. Much of the poor health outcomes for this population are likely related to the fact that they have one of the highest percentages of families living below the poverty level (21%) and one of the highest rates of adults ages 18-64 with no health insurance (25%). According to the NC BRFSS survey, American Indians have the highest percentage of adults who report being in fair or poor health (25.8%), compared with other racial/ethnic minorities.

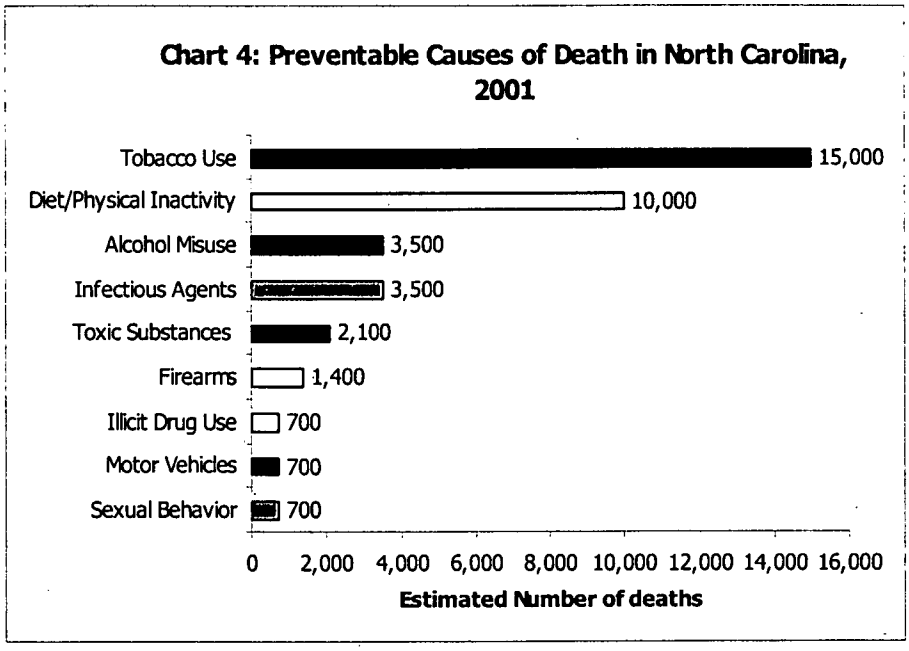
Table 3: NC Minority Mortality Rates and Risk Factor Percentages by Race and Ethnicity

	White	African American/ Black	American Indian	Asian/ Pacific Islander	Latino/ Hispanic	TOTAL
Mortality Rates[1] 1997-2001:						
Infant deaths per 1,000 live births	6.4	15.1	11.9	6.1	5.8	8.6
Heart disease	249.6	308.7	312.3	83.1	78.5	257.8
Cerebrovascular disease	70.1	98.9	74.6	42.2	31.4	74.5
Diabetes	78.1	169.5	154.6	41.6	41.2	93.0
Chronic obstructive lung disease	48.5	31.8	44.2	8.6	7.7	45.4
AIDS	1.6	21.2	3.3	0.7	4.1	5.6
Prostate cancer	28.2	79.6	52.0	11.0	7.6	35.7
Lung cancer	61.3	62.1	47.5	24.5	14.0	60.7
Colorectal cancer	18.6	27.0	16.1	8.0	9.3	19.8
Breast cancer	24.4	35.5	24.0	6.7	10.4	26.2
Homicide	4.8	18.4	21.9	4.5	11.5	7.8
Suicide	13.3	5.6	9.5	5.7	4.4	11.2
Motor vehicle injury	19.8	21.8	42.1	14.4	27.4	19.6
Behavioral Risk Factors[2] (percentages):						
Adults with high blood pressure	23.5	32.2	20.9	8.4	17.7	24.9
Adults who smoke	25.8	23.3	35.3	13.3	31.9	25.5
Adults who are overweight or obese	54.7	66.9	59.3	38.6	58.1	57.0
Adults w/ no leisure time physical acitivity	25.8	35.4	43.0	34.5	37.1	28.2
Inadequate daily fruit and vegetable intake	76.2	81.7	86.4	71.0	82.4	77.5
Percent of adults in fair/poor health	15.7	21.0	25.8	10.2	11.6	16.7

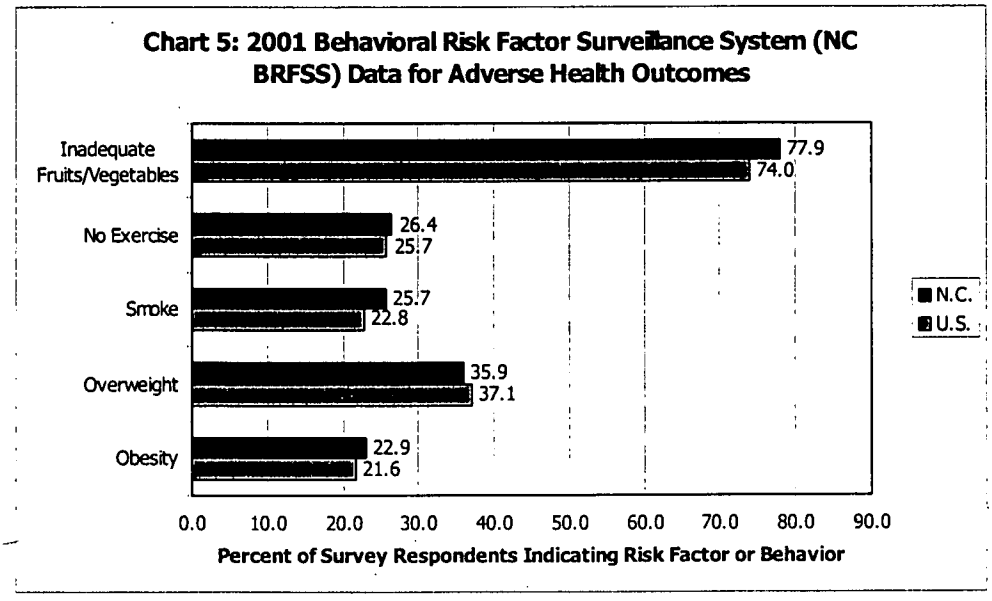
[1] Except for the infant death rate, mortality rates are age-adjusted and expressed per 100,000 population.
[2]Most of these data are for the period 1997-2001.

Health Behavior

According to a recent study, more than half (53%) of all deaths of North Carolinians in 2001 were preventable. Most of the leading causes of preventable deaths in North Carolina involved risky behavior or lifestyle choices. Among the leading causes of preventable death were tobacco use, unhealthy diet/ physical inactivity, alcohol misuse, firearms, sexual behavior, motor vehicles, and illicit drug use. The direct medical costs to North Carolina related to tobacco use, physical inactivity, and poor nutrition alone are estimated to be at least $6 billion per year. This does not include indirect costs such as lost productivity due to time off work or increased recruitment and hiring costs. **Chart 4** presents information on preventable deaths in 2001.

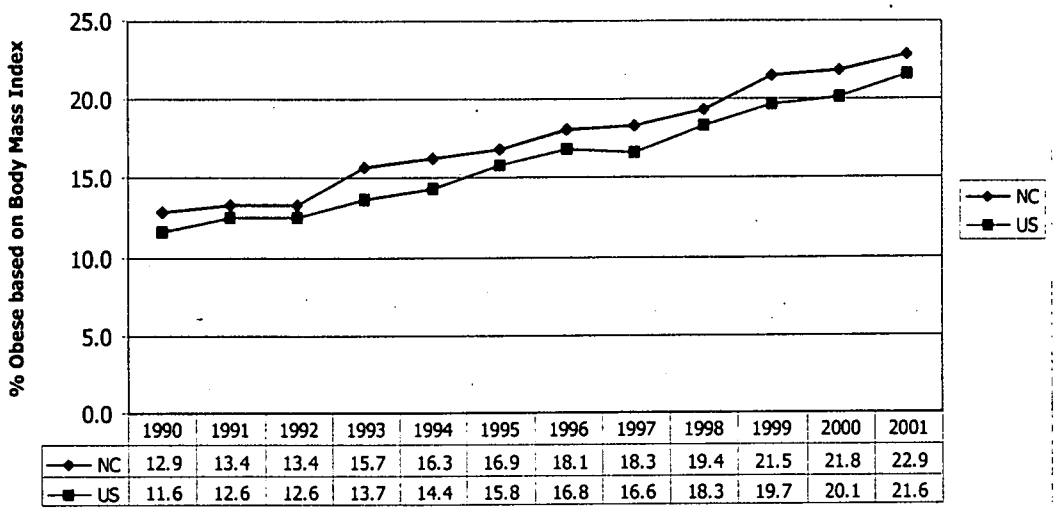


As shown below in **Chart 5**, North Carolina adults are more likely to smoke, lead sedentary lifestyles, be obese, and are less likely to eat healthy food than the national average. North Carolina adults are slightly more likely to be obese, but slightly less likely to be overweight than the U.S. averages. In all, approximately 6 in 10 NC BRFSS survey respondents (59%) indicated that they were overweight or obese based on their body mass index.



Since 1990, the obesity percentage in North Carolina has almost doubled, remaining slightly higher than the national average. **Chart 6** presents obesity percentages from 1990-2001 for North Carolina and the U.S.

Chart 6:
1990-2001 Prevalence of Obesity, North Carolina and U.S.



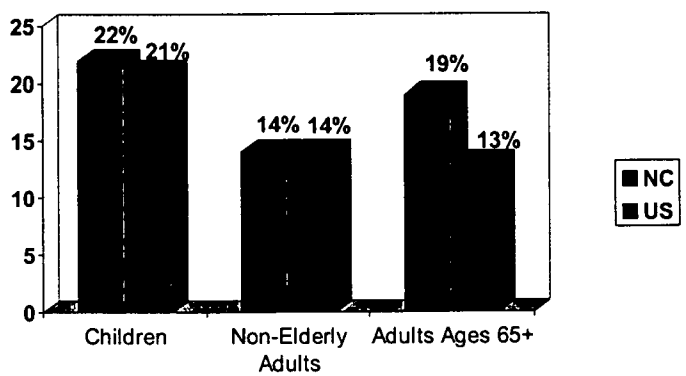
	1990	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000	2001
NC	12.9	13.4	13.4	15.7	16.3	16.9	18.1	18.3	19.4	21.5	21.8	22.9
US	11.6	12.6	12.6	13.7	14.4	15.8	16.8	16.6	18.3	19.7	20.1	21.6

Source: 1990-2001 Behavioral Risk Factor Surveillance System (BRFSS)

Health Care Access

Poverty – An individual's socioeconomic status has a strong link to overall health status. Poorer people have higher death rates and more health problems than individuals with higher socioeconomic status. As shown in **Chart 7**, North Carolina poverty rates were higher than the national average for all age groups in 2001. Based on the 2000 census, the poverty rate for North Carolina Blacks (22.9%) was more than twice that for whites (8.5%).

Chart 7: Percentage of Population Living Below Poverty by Age, 2001-2002

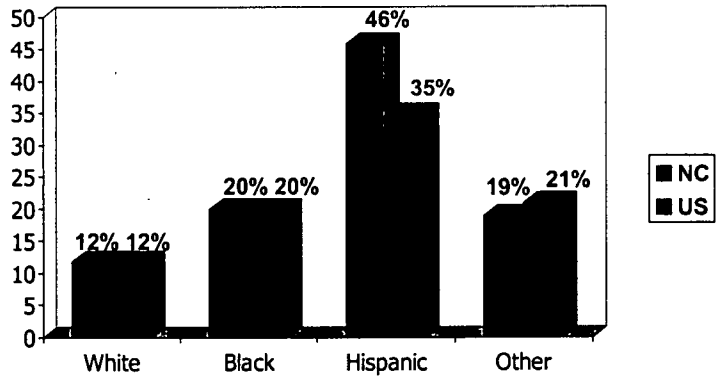


Source: Urban Institute and Kaiser Commission on Medicaid and the Uninsured based on pooled 2000 & 2001 Current Population Survey data.

Health Insurance Coverage – North Carolinians living in poverty and without health insurance experience greater difficulty gaining access to effective primary and specialized health care. When they do get treatment, they are typically in a later and more dangerous stage of their illness. It is not surprising, then, that we see more serious levels of chronic disease and illness among North Carolina's uninsured population. According to a recent study using NC BRFSS survey data, North Carolinians with chronic health conditions were more likely to report having limited access to health care.

More than 1 million (1,125,480) NC residents were without health insurance during 2000-2001. The percentage of North Carolinians without health insurance has been similar to the national average for at least two decades. According to the U.S. Census Bureau's Current Population Survey, the 1999-2001 percentage of North Carolinians without health insurance coverage for an entire year was 14.2 percent compared to 14.5 percent for the U.S. for this same time period. Persons of a minority race in North Carolina were much more likely to be uninsured in 2000-2001. As shown in **Chart 8**, while 12 percent of whites were without health insurance during 2000-2001, 1 in 5 Blacks (20%) and nearly half of all Hispanics (46%) lacked health insurance during this same time period. The percentage of uninsured children is 11 percent in North Carolina compared to 12 percent for children nationally. North Carolina may have a smaller percentage of uninsured children than many states because of its successful implementation of the State Child Health Insurance Program (SCHIP). This program is called "Health Choice" in North Carolina.

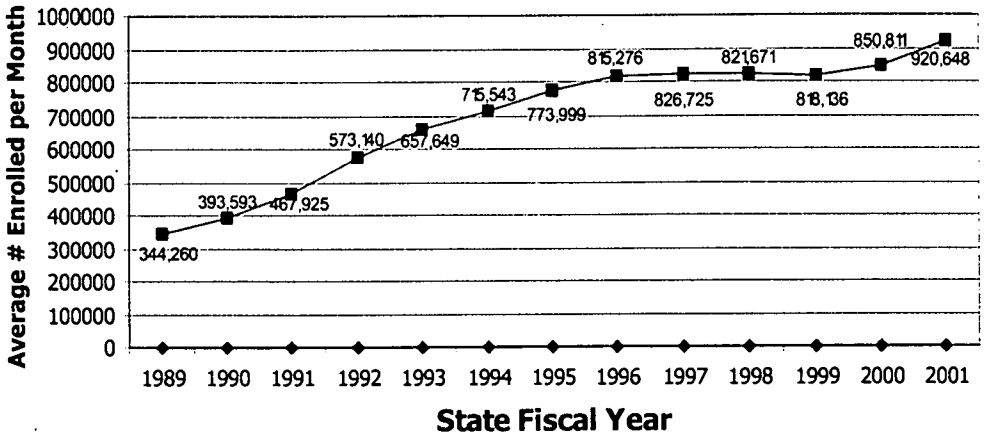
Chart 8: 2000-2001 Percentage of People Uninsured, US and NC



Source: Urban Institute and Kaiser Commission on Medicaid and the Uninsured based on pooled 2000 & 2001 Current Population Survey data.

North Carolina was one of the last states to initiate a Medicaid program, in 1970. Largely as a result of the Medicaid eligibility expansions for children and pregnant women adopted in the late 1980s, there has been a large increase in the number of Medicaid enrollees. As shown in **Chart 9**, between state fiscal year 1988-1989 (the first year of major expansions) and state fiscal year 2000-2001, the average monthly Medicaid enrollment climbed from 344,260 to 920,648 – an annual growth rate of 8.8 percent. The Division of Medical Assistance estimates that an average of 1 in 8 North Carolinians were enrolled in the state's Medicaid program in each month in state fiscal year 2000-2001.

Chart 9: Average Monthly Medicaid Enrollees in North Carolina, 1989-2001



Source: SFY2001 NC/DHHS Division of Medical Assistance Annual Report

Rural Health – Approximately 33 percent of North Carolina's population lives in rural areas, compared with 20 percent nationwide. Populations living in North Carolina's rural areas face more barriers to accessing health care due in part to a lack of health care providers in close proximity to their home.

North Carolinians living in rural areas are also more likely to be living in poverty, and thereby less likely to have access to transportation. This is particularly true for rural racial minority and Hispanic populations. The geographic availability of physicians and the distance to hospitals pose unique problems for North Carolina's rural residents. More than half of the state's population lives in a county with just one hospital, and there are 14 North Carolina counties without any hospital. Lack of access to obstetrical care in rural areas is also a growing problem. According to a study published by UNC's Sheps Center for Health Services Research in 1998, 14 North Carolina counties did not have a single physician who reported attending births.

Oral Health – According to the 2001 NC BRFSS survey, approximately 30 percent of North Carolina adults reported not having visited a dentist within the last year. The lack of dental care is especially acute among North Carolina's poor. Among those making less than $15,000 a year almost half reported not having an annual dental check-up, compared with less than 20 percent of those making more than $50,000 a year. Recent data for Medicaid recipients ages 5-14 show that only 34 percent had any dental services during the year. Younger children were the least likely to use dental services. One explanation for this is the low number of dentists who participate in the Medicaid program due to low reimbursement rates – an average of only 62 percent of their customary charges. Only six states have lower rates of dentist Medicaid participation.

The U.S. Surgeon General maintains that water fluoridation continues to be the most safe, effective, and inexpensive way to prevent tooth decay in a community. Fluoridation benefits North Carolinians of all ages and socioeconomic status. According to the Centers for Disease Control and Prevention, 83 percent of all North Carolina populations on public water systems were receiving optimally fluoridated water in 2000, compared to a 66 percent nationwide average.

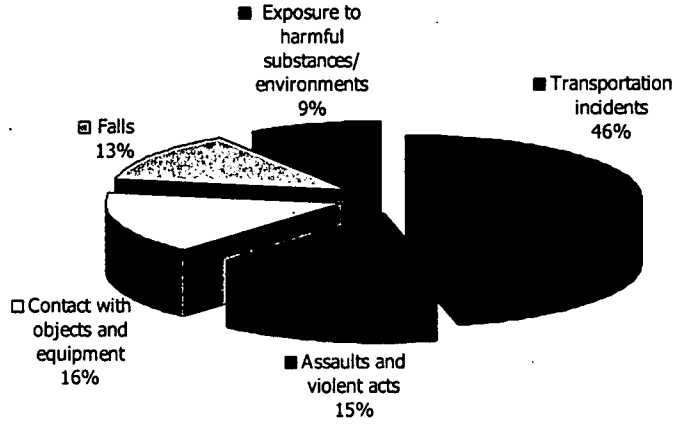
Occupational and Environmental Health

Environmental health concerns are gaining more attention in North Carolina and the nation. Baseline data are still being collected for most indicators such as air quality, water quality, and soil quality. According to the NC Department of Environment and Natural Resources, ozone levels have risen in recent years due to increased traffic, industry, and warmer weather. The state's air and water quality has also received increased attention due to concerns resulting from the fact that North Carolina is the second largest hog producing state in the nation. However, North Carolina data on adverse health effects associated with poor air and water quality are difficult to obtain.

A preliminary study from the North Carolina Division of Air Quality estimated that fine airborne particulate matter resulted in 2,400 premature deaths in North Carolina in 2000, including more than 1,700 deaths due to cardio-pulmonary causes and 335 deaths due to lung cancer. Achievement of the U.S. Environmental Protection Agency's standards for particulate matter could substantially reduce the number of premature deaths from these causes.

Occupational exposures and hazards also pose health threats to North Carolinians. Occupational health threats include traumatic injuries as well as exposure to toxic substances such as silica, asbestos, and lead. According to the U.S. Bureau of Labor Statistics, there were 203 fatal occupational injuries in North Carolina in 2001. As shown in **Chart 10**, almost half (46%) of these deaths were attributable to transportation accidents. Assaults, falls, exposure to harmful chemicals/environments, and fires account for the rest of these deaths. Interestingly, assault/violence in the workplace accounted for 15 percent of all occupational deaths in 2001. A recent study of 43,900 North Carolina death records revealed that construction workers face increased risks of falls, transportation injuries, respiratory tuberculosis, and electrocutions.

Chart 10: Fatal Occupational Injuries in North Carolina, 2001



Source: Bureau of Labor Statistics, U.S. Department of Labor Census of Fatal Occupational Injuries, 2001

Conclusion

North Carolina faces a myriad of health challenges. The health of North Carolinians is compromised by poverty, poor lifestyle choices, environmental problems, and insufficient access to adequate health care. There is very limited data in some areas, such as mental health and environmental health. Ensuring that its citizens have an equal opportunity to be healthy is a difficult, but attainable goal.

In 1988, North Carolina had the worst infant death rate in the nation. Since then, the state has reduced the infant death rate by one-third. In spite of this improvement, North Carolina still has the fifth highest infant mortality rate in the nation. North Carolina has also been tremendously successful in expanding insurance coverage to uninsured children with the implementation of NC Health Choice. While there is room for improvement, the success in these areas should reaffirm that with collaborative efforts we can work to tackle even our most complex health problems. Despite limited state resources, a strong commitment to the health improvement programs will result in better health for the citizens of our state.

House Committee on Health

June 12, 2003

Minutes

The House Committee on Health was cancelled for Tuesday, June 12, 2003 at 12:00 noon in Room 544 of the Legislative Office Building. (Agenda - Attachment I) Bills on the agenda were rescheduled for Tuesday, June 17, 2003.

For the record, the Bills and Bill Analysis are attached. (Attachment II)

ATTACHMENT I

AGENDA

HOUSE COMMITTEE ON HEALTH

June 12, 2003
Room 544 LOB
12:00 Noon

meeting cancelled due to Democratic Caucus

OPENING REMARKS

Representative Verla Insko, Chair
Representative Carolyn Justus, Chair

AGENDA ITEMS

HB 557 State Health Plan: Increase Wellness Benefit – Reps. Jeffus and Culp

HB 874 State Employees' Health Plan/Emergency Svces. – Reps. Frye and Dockham

SB 876 Meningitis Immunization – Sen. Purcell

ADJOURNMENT

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2003

H

HOUSE BILL 557

Short Title:	State Health Plan: Increase Wellness Benefit.	(Public)
Sponsors:	Representatives Jeffus, Culp (Primary Sponsors); Adams, B. Allen, Bowie, Capps, Coates, England, Fox, Howard, Hunter, C. Johnson, Lucas, Luebke, Munford, Preston, Rapp, Rayfield, Starnes, Weiss, C. Wilson, and Womble.	
Referred to:	Health.	

March 19, 2003

A BILL TO BE ENTITLED

AN ACT TO INCREASE THE WELLNESS BENEFIT UNDER THE TEACHERS' AND STATE EMPLOYEES' COMPREHENSIVE MAJOR MEDICAL PLAN.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 135-40.5(e) reads as rewritten:

"**§ 135-40.5. Benefits not subject to deductible or coinsurance.**

...

(e) Routine Diagnostic Examinations. – The Plan will pay one hundred percent (100%) of allowable charges for routine diagnostic examinations and tests, including breast, colon, rectal, and prostate exams, X rays, mammograms, blood and blood pressure checks, urine tests, tuberculosis tests, and general health checkups that are medically necessary for the maintenance and improvement of individual health but no more often than once every three years for covered individuals to age 40 years, once every two years for covered individuals to age 50 years, and once a year for covered individuals age 50 years and older, unless a more frequent occurrence is warranted by a medical condition when such charges are incurred in a medically supervised facility. Routine diagnostic examinations and tests covered under this subsection also include one Pap smear per year for any covered female. Provided, however, that charges for such examinations and tests are not covered by the Plan when they are incurred to obtain or continue employment, to secure insurance coverage, to comply with legal proceedings, to attend schools or camps, to meet travel requirements, to participate in athletic and related activities, or to comply with governmental licensing requirements. The maximum amount payable under this subsection for a covered individual is ~~one hundred fifty dollars ($150.00)~~ three hundred dollars ($300.00) per fiscal year."

SECTION 2. This act becomes effective July 1, 2003.

HOUSE BILL 557:
State Health Plan: Increase Wellness Benefit

BILL ANALYSIS

Committee:	House Health	**Introduced by:**	Reps. Jeffus and Culp
Date:	June 11, 2003	**Summary by:**	Sandra Alley
Version:	First Edition		Committee Counsel

SUMMARY: ***House Bill 557 would increase the maximum amount payable under routine wellness examinations for a covered individual of the Teachers' and State Employees' Comprehensive Major Medical Plan from $150 to $300 per fiscal year. The bill would become effective July 1, 2003.***

CURRENT LAW: The Teachers' and State Employees' Comprehensive Major Medical Plan (Plan) is divided into two programs. From October 1982, through June 1986, the Plan only had a self-funded indemnity program. A prepaid program of coverage by HMOs was offered in July 1986, as an alternative to the Plan's self-insured indemnity program. The benefits of the self-insured indemnity program are described in Part 3 of Article 3 of Chapter 135 of the General Statutes. HMOs are required to offer benefits comparable to those provided by the State's self-insured indemnity program. Both types of coverage continue to be available in the Plan; however, none of the HMOs with certificates of authority to transact business in North Carolina have offered to participate in the Plan since the Plan's contracts with Coventry, Prudential, and Wellpath expired on September 30, 2001.

BILL ANALYSIS: G.S. 135-40.5 specifies the benefits, including routine wellness examinations and tests that are not subject to a deductible or coinsurance under the Plan. Included are breast, colon, rectal, and prostate exams, x-rays, mammograms, blood and blood pressure checks, urine tests, tuberculosis tests, annual Pap smears and any medically necessary general health tests, subject to certain limitations. House Bill 557 would increase the maximum amount paid by the Plan per person for routine wellness examinations and tests from $150 to $300.

ACTUARIAL NOTE: Please see the Legislative Actuarial Note prepared by Sam Byrd of the Fiscal Research Division for an estimate of the financial and actuarial effect of the proposed change to the Plan.

Amy Compeau, Research Assistant, contributed to this summary.

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2003

HOUSE BILL 874

Short Title:	State Employees' Health Plan/Emergency Svces.	(Public)
Sponsors:	Representatives Frye, Dockham (Primary Sponsors); Barnhart, Bowie, Capps, Daughtry, Eddins, Gillespie, Gorman, Gulley, Hilton, McGee, McMahan, Mitchell, Munford, Pate, Rapp, Rayfield, Sauls, Stam, Walker, West, K. Williams, and G. Wilson.	
Referred to:	Health.	

April 7, 2003

A BILL TO BE ENTITLED

AN ACT PROVIDING FOR COVERAGE OF EMERGENCY SERVICES IN CERTAIN SITUATIONS UNDER THE TEACHERS' AND STATE EMPLOYEES' COMPREHENSIVE MAJOR MEDICAL PLAN.

The General Assembly of North Carolina enacts:

SECTION 1. 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 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) Repealed by Session Laws 2001-253, s. 1(m).

(c) Notwithstanding any other provision of this Article, on the first day of each confinement the Plan does not pay the first 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)i., j., k., n., r., and s., and G.S. 135-40.5(e). The co-payment 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, or to charges for injected medications. 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. The Plan then pays one hundred percent (100%) of the remaining covered expenses.

(e) Notwithstanding subsection (d) of this section, where qualified preferred providers of medical care are not reasonably available in medical emergencies, the Plan pays the amounts covered by subsection (a) of this section. Any amount of charges for services under this section that exceeds the amount allowed by the Plan for the services of qualified preferred providers under this section shall be negotiated between the Plan and the provider of medical services so that the Plan member is not held financially responsible for the amount of excess charges. As used in this section, a 'medical emergency' is the sudden and unexpected onset of a condition manifesting itself by acute symptoms of sufficient severity that, in the absence of immediate medical care, could imminently result in injury or danger to self or others."

SECTION 2. This act is effective when it becomes law and applies to medical emergency services received on and after January 1, 2000.

HOUSE BILL 874:
State Employees' Health Plan/Emergency Svces.

BILL ANALYSIS

Committee:	House Health	**Introduced by:**	Reps. Frye and Dockham
Date:	June 11, 2003	**Summary by:**	Sandra Alley
Version:	First Edition		Committee Counsel

SUMMARY: ***House Bill 874 would require the Teachers' and State Employees' Comprehensive Major Medical Plan (Plan) to provide coverage of medical emergencies where qualified preferred providers are unavailable. The bill would become effective when it becomes law and applies to services for medical emergencies received on and after January 1, 2000.***

CURRENT LAW: The Teachers' and State Employees' Comprehensive Major Medical Plan (Plan) is divided into two programs. From October 1982, through June 1986, the Plan only had a self-funded indemnity program. A prepaid program of coverage by HMOs was offered in July 1986, as an alternative to the Plan's self-insured indemnity program. The benefits of the self-insured indemnity program are described in Part 3 of Article 3 of Chapter 135 of the General Statutes. HMOs are required to offer benefits comparable to those provided by the State's self-insured indemnity program. Both types of coverage continue to be available in the Plan; however, none of the HMOs with certificates of authority to transact business in North Carolina have offered to participate in the Plan since the Plan's contracts with Coventry, Prudential, and Wellpath expired on September 30, 2001.

BILL ANALYSIS: House Bill 874 would make the following changes to the law relating to out-of-pocket expenditures under Part 3, Comprehensive Major Medical Plan, of Article 3 of Chapter 135 of the General Statutes:

1. The bill would clarify that after payment of specified out-of-network expenses, the Plan would pay 100% of the remaining covered expenses in a situation where qualified preferred providers are reasonably available, but a covered individual uses a provider outside of the preferred network.
2. The bill would require the Plan to cover expenses of medical emergencies in a situation where qualified preferred providers are *not* reasonably available, and a covered individual uses a provider outside of the preferred network. The bill would require the Plan and providers of medical services to negotiate any amount of charges for services provided that exceeds the amount allowed by the Plan so that the Plan member is not held financially responsible for the amount of excess charges. The bill defines a medical emergency as the sudden and unexpected onset of a condition manifesting itself by acute symptoms of sufficient severity that, in the absence of immediate medical care, could imminently result in injury or danger to self or others.

The bill would become effective when it becomes law and applies to medical emergency services received on and after January 1, 2000.

ACTUARIAL NOTE: Please see the Legislative Actuarial Note prepared by Sam Byrd of the Fiscal Research Division for an estimate of the financial and actuarial effect of the proposed changes to the Plan. The actuarial note indicates that the estimated impact on the State would be reduced if the Plan uses a contracted network of out-of-state preferred providers (PPO) of healthcare services. After reviewing proposals from five vendors, Aon Consulting, consulting actuary for the Plan, recommended a PPO for accessing health care services out-of-area. The Plan is currently in the process of completing contract negotiations with Private Healthcare Systems (PHCS).

Amy Compeau, Research Assistant, contributed to this summary.

H557-SMSP-001

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2003

S 3

SENATE BILL 876

Health & Human Resources Committee Substitute Adopted 4/21/03
Third Edition Engrossed 4/22/03

Short Title: Meningococcal Meningitis Immunization Info. (Public)

Sponsors:

Referred to:

April 3, 2003

A BILL TO BE ENTITLED

AN ACT TO REQUIRE ANY PRIVATE OR PUBLIC INSTITUTION THAT OFFERS A POSTSECONDARY DEGREE TO PROVIDE MENINGOCOCCAL DISEASE IMMUNIZATION INFORMATION TO STUDENTS IF THE INSTITUTION HAS A RESIDENTIAL CAMPUS.

The General Assembly of North Carolina enacts:

SECTION 1. Chapter 116 of the General Statutes is amended by adding a new Article to read:

"Article 32.

"Health Information.

"**§ 116-260. Information on meningococcal disease immunization.**

(a) Each public or private educational institution that offers a postsecondary degree as defined in G.S. 116-15 and that has a residential campus shall provide vaccination information on meningococcal disease to each student. The vaccination information shall be contained on student health forms provided to each student by the educational institution and shall include space for the student to indicate whether or not the student has received the vaccination against meningococcal disease. The vaccination information about meningococcal disease shall include any recommendations issued by the national Centers for Disease Control and Prevention regarding the disease.

(b) The vaccination information obtained under this section that is in the possession of the educational institution is confidential and shall not be a public record under G.S. 132-1.

(c) This section shall not be construed to require the educational institution to provide the meningococcal vaccination to students.

(d) This section shall not apply if the national Centers for Disease Control and Prevention no longer recommends the meningococcal vaccine.

(e) This section does not create a private right of action."

SECTION 2. This act is effective when it becomes law and applies to the 2003-2004 academic year and each subsequent year.

House Committee on Health

June 17, 2003

Minutes

The House Committee on Health met on Tuesday, June 17, 2003 at 12:00 noon in Room 544 of the Legislative Office Building. A silent roll was taken. A copy of the roll denoting members present is attached to the minutes (Attachment I) along with a copy of the agenda and Visitor Registration Sheet (Attachments II and III).

Rep. Carolyn Justus, Chair welcomed visitors and members and recognized the pages: Walter Wiggins from Forsyth County sponsored by Rep. Bill McGee, Scott Lassiter from Wake County sponsored by Rep. David Miner, Josh Barden also from Wake County sponsored by David Miner, Nicole Carpenter from Mecklenburg County sponsored by Speaker Black, and Nina Sewell from Mecklenburg County also sponsored by Speaker Black. Earl Tharrington, Martha Gadison, and Francis Poole were recognized as the sergeant-in-arms. (Attachment IV)

Representatives Jeffus and Culp were recognized to explain their bill HB 557 A BILL TO BE ENTITLED AN ACT TO INCREASE THE WELLNESS BENEFIT UNDER THE TEACHERS' AND STATE EMPLOYEES' COMPREHENSIVE MAJOR MEDICAL PLAN. (Attachment V) Rep. Jeffus explains that the bill will increase the maximum amount payable under routine wellness examinations for a covered individual of the Teachers' and State Employees' Comprehensive Major Medical Plan from $150 to $300 per fiscal year allowing more preventive measures and tests not subject to the Plan's annual deductible to take place. A bill analysis was provided. (Attachment VI). Rep. Jeffus also advised that if bill received favorable report that it will be referred to appropriations. Rep. Culp speaks concerning old saying "an ounce of prevention saves pound of cure".

Rep. Bernard Allen reminds committee members of Secretary Carmen Hooker Odom's speech last week and makes motion for a favorable report. Rep. Bowie supports and signed on to legislation but feels need for an explanation as to where they are going to get money. Sam Byrd refers to figures in Fiscal Note. (Attachment VII) Rep. Hilton asks why analysis for $300. Rep. Culp responses that this is the figure the retired teachers association came up with. Rep. Bowie again questions where money will come from. Rep. Jeffus suggests that maybe appropriations can deal with that question better. Rep. Adams states that teachers are not paid enough and feels bill can be adjusted by appropriations committee. Rep. Barnhart asks if someone from department could respond to status and if rates going up for state employees. Jack Walker, State Plan Executive, responds that over $54 million is needed to pay claims. How much to raise premiums and reduce benefits decided by General Assembly. He discusses need for increase for plan to "stay even". Rep. Barnhart suggests matter be delayed until we can afford it and not pass it along to appropriations when we don't have money. Several members then ask Jack

Walker and Sam Byrd various questions concerning rate increases needed and necessity of tests for people over 50 years of age every year.

Rep. Bernard Allen changes motion to report bill out without prejudice and it be re-referred to appropriations. Motion adopted. (Committee Report – Attachment VIII)

Representatives Frye and Dockham are called to explain their bill HB 874 A BILL TO BE ENTITLED AN ACT PROVIDING FOR COVERAGE OF EMERGENCY SERVICES IN CERTAIN SITUATIONS UNDER THE TEACHERS' AND STATE EMPLOYEES' COMPREHENSIVE MAJOR MEDICAL PLAN. (Attachment IX) Rep. Frye explains that bill requires the providers of medical services to negotiate any amounts of billed charges that are in excess of charges allowed by the plan for preferred providers of medical care in emergencies when preferred providers of care are not reasonably available. The purpose of the negotiations is for Plan members not to be financially responsible for amounts in excess of allowed changes. Medical emergencies are defined as the sudden and unexpected onset of a condition manifesting itself by acute symptoms of sufficient severity that, in the absence of immediate medical care, could imminently result in injury or danger to self or others. (Bill Analysis – Attachment X) Rep. Frye refers committee members to letter from State Employees Association (Attachment XI) endorsing proposed bill and letter from Sam Byrd to Speaker Morgan (Attachment XII) concerning a constituent of Rep. Frye's who was hospitalized while on vacation at a non-contracting hospital under the State's plan. There is some discussion among Reps. Earle, Hilton and Allred as to employee coverage in non-preferred or out-of-state hospitals and the costs associated with same. Sam Byrd refers to Fiscal Note (Attachment XIII).

Rep. Allred makes motion to give bill a favorable report and re-refer it to appropriations. Motion adopted. (Committee Report – Attachment XIV)

Senator Purcell is then called to explain his bill SB 876 A BILL ENTITLED AN ACT TO REQUIRE ANY PRIVATE OR PUBLIC INSTITUTION THAT OFFERS A POSTSECONDARY DEGREE TO PROVIDE MENINGOCOCCAL DISEASE IMMUNIZATION INFORMATION TO STUDENTS IF THE INSTITUTION HAS A RESIDENTIAL CAMPUS. (Attachment XV) A proposed Committee Substitute for Senate Bill 876 is passed out to members. (Attachment XVI). Motion is made and passed for the proposed committee substitute to be heard for discussion purposes. Senator Purcell explains that this bill substitutes the contents of Senate Bill 602 (currently in Senate Health and Human Resources) for the contents of Senate Bill 876 (the meningitis bill). The House version of the meningitis bill crossed and was passed by the Senate. The proposed committee substitute would require physicians who prescribe or dispense Buprenorphine (a Schedule IV controlled substance) for the treatment of opiate dependence to register with the Department of Health and Human Services annually and provide certain information in connection with the application. (Bill Analysis – Attachment XVII) Representative England moves for a favorable report as to the proposed committee substitute and unfavorable as to the original bill. Motion carried. (Committee Report – Attachment XVIII

Meeting was adjourned at 12:57 p.m.

Carolyn Justus, Chair

Pamela J. Evans, Committee Clerk

ATTACHMENT I

ATTENDANCE

HOUSE COMMITTEE ON HEALTH

DATES	4/15														
INSKO, Verla CHAIR															
JUSTUS, Carolyn CHAIR	✓														
ENGLAND, Bob VICE-CHAIR	✓														
ADAMS, Alma	✓														
ALLEN, Bernard	✓														
ALLEN, Gordon	✓														
ALLRED, Cary	✓														
BARNHART, Jeff	✓														
BOWIE, Joni	✓														
CLARY, Debbie															
EARLE, Beverly	✓														
GLAZIER, Rick															
HILTON, Mark	✓														
McALLISTER, Mary															
MUNFORD, Don	✓														
SETZER, Mitchell	✓														
SHERRILL, Wilma															
WAINWRIGHT, William															
WILSON, Connie															
WRIGHT, Tom															
Ex officio Members															
Brubaker, Bru															
Culpepper, Bill															
Cunningham, Pete															
Eddins, Rick															

ATTACHMENT II

AGENDA

HOUSE COMMITTEE ON HEALTH

June 17, 2003
Room 544 LOB
12:00 Noon

OPENING REMARKS

Representative Verla Insko, Chair
Representative Carolyn Justus, Chair

AGENDA ITEMS

HB 557 State Health Plan: Increase Wellness Benefit – Reps. Jeffus and Culp

HB 874 State Employees' Health Plan/Emergency Svces. – Reps. Frye and Dockham

SB 876 Meningococcal Meningitis Immunization Info. – Sen. Purcell

ADJOURNMENT

ATTACHMENT III

VISITOR REGISTRATION SHEET

HOUSE COMMITTEE ON HEALTH — JUNE 17, 2003

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
WES ROBINSON, MD	SAC
Mari Watt	NCSA
Lu-Ann Cox	NCPA
Peyton Mayworth	GR
John Bowdich	AstraZeneca
Tracy Presnell	NC Retired School Personnel
A. C Dawson	" " " "
Leigh H Hammond	NC Retired Govt Emp. Assn
Elizabeth D Wickham	Dyer Tree
Katherine Joyce	NCASA
Linda Kaye	SBE

VISITOR REGISTRATION SHEET

HOUSE COMMITTEE ON HEALTH — JUNE 17, 2003

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Paige Johnson	Planned Parenthood of Central NC
Anne Dinnen	
Donny Bryden	DMH/DD/SAS
Frank Lewis	OSBM
Marcus Davis	NCAE
Carolyn McKinney	NCAE
Starla McKenney	NC DHHS
John Wimbish	DMH/DD/SAS
Gordon Daughtry	State Health Plan
Jordan Walker	State Health Plan
Andrea McDonald	SEANC

VISITOR REGISTRATION SHEET

HOUSE COMMITTEE ON HEALTH — JUNE 17, 2003

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Ann Duncan	NCAHP
Buck Jernigan	Asheboro
Wendy Beam	Asheboro
Al Capehart	NC Rail-Trails, Inc Durham NC
Robert H. VanDine	NCAE
John O'Hale	Governor's Office
Brian Lewis	Planned Parenthood Health Sys.
Joyce Roberson	NC Assoc of Nurses

House Pages

1. Name: Walter Wiggins
   County: Forsyth
   Sponsor: Rep. Bill McGee
2. Name: _____
   County: _____
   Sponsor: _____
3. Name: _____
   County: _____
   Sponsor: _____
4. Name: _____
   County: _____
   Sponsor: _____
5. Name: _____
   County: _____
   Sponsor: _____

Sgt-At-Arms

1. Name: Dusty Rhodes
2. Name: Charles Williams
3. Name: Phillip Schreibman
4. Name: _____

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2003

H 1

HOUSE BILL 557

Short Title:	State Health Plan: Increase Wellness Benefit.	(Public)
Sponsors:	Representatives Jeffus, Culp (Primary Sponsors); Adams, B. Allen, Bowie, Capps, Coates, England, Fox, Howard, Hunter, C. Johnson, Lucas, Luebke, Munford, Preston, Rapp, Rayfield, Starnes, Weiss, C. Wilson, and Womble.	
Referred to:	Health.	

March 19, 2003

A BILL TO BE ENTITLED

AN ACT TO INCREASE THE WELLNESS BENEFIT UNDER THE TEACHERS' AND STATE EMPLOYEES' COMPREHENSIVE MAJOR MEDICAL PLAN.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 135-40.5(e) reads as rewritten:

"**§ 135-40.5. Benefits not subject to deductible or coinsurance.**

...

(e) Routine Diagnostic Examinations. – The Plan will pay one hundred percent (100%) of allowable charges for routine diagnostic examinations and tests, including breast, colon, rectal, and prostate exams, X rays, mammograms, blood and blood pressure checks, urine tests, tuberculosis tests, and general health checkups that are medically necessary for the maintenance and improvement of individual health but no more often than once every three years for covered individuals to age 40 years, once every two years for covered individuals to age 50 years, and once a year for covered individuals age 50 years and older, unless a more frequent occurrence is warranted by a medical condition when such charges are incurred in a medically supervised facility. Routine diagnostic examinations and tests covered under this subsection also include one Pap smear per year for any covered female. Provided, however, that charges for such examinations and tests are not covered by the Plan when they are incurred to obtain or continue employment, to secure insurance coverage, to comply with legal proceedings, to attend schools or camps, to meet travel requirements, to participate in athletic and related activities, or to comply with governmental licensing requirements. The maximum amount payable under this subsection for a covered individual is ~~one hundred fifty dollars ($150.00)~~ three hundred dollars ($300.00) per fiscal year."

SECTION 2. This act becomes effective July 1, 2003.

HOUSE BILL 557:
State Health Plan: Increase Wellness Benefit

BILL ANALYSIS

Committee:	House Health	**Introduced by:**	Reps. Jeffus and Culp
Date:	June 11, 2003	**Summary by:**	Sandra Alley
Version:	First Edition		Committee Counsel

SUMMARY: ***House Bill 557 would increase the maximum amount payable under routine wellness examinations for a covered individual of the Teachers' and State Employees' Comprehensive Major Medical Plan from $150 to $300 per fiscal year. The bill would become effective July 1, 2003.***

CURRENT LAW: The Teachers' and State Employees' Comprehensive Major Medical Plan (Plan) is divided into two programs. From October 1982, through June 1986, the Plan only had a self-funded indemnity program. A prepaid program of coverage by HMOs was offered in July 1986, as an alternative to the Plan's self-insured indemnity program. The benefits of the self-insured indemnity program are described in Part 3 of Article 3 of Chapter 135 of the General Statutes. HMOs are required to offer benefits comparable to those provided by the State's self-insured indemnity program. Both types of coverage continue to be available in the Plan; however, none of the HMOs with certificates of authority to transact business in North Carolina have offered to participate in the Plan since the Plan's contracts with Coventry, Prudential, and Wellpath expired on September 30, 2001.

BILL ANALYSIS: G.S. 135-40.5 specifies the benefits, including routine wellness examinations and tests that are not subject to a deductible or coinsurance under the Plan. Included are breast, colon, rectal, and prostate exams, x-rays, mammograms, blood and blood pressure checks, urine tests, tuberculosis tests, annual Pap smears and any medically necessary general health tests, subject to certain limitations. House Bill 557 would increase the maximum amount paid by the Plan per person for routine wellness examinations and tests from $150 to $300.

ACTUARIAL NOTE: Please see the Legislative Actuarial Note prepared by Sam Byrd of the Fiscal Research Division for an estimate of the financial and actuarial effect of the proposed change to the Plan.

Amy Compeau, Research Assistant, contributed to this summary.

NORTH CAROLINA GENERAL ASSEMBLY
LEGISLATIVE ACTUARIAL NOTE

BILL NUMBER: House Bill 557

SHORT TITLE: State Health Plan: Increase Wellness Benefit

SPONSOR(S): Reps. Jeffus and Culp

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, premium payments for coverages selected by eligible former teachers and State employees and premium payments for coverages selected by firefighters, rescue squad workers, and members of the National Guard.

BILL SUMMARY: The bill increases the maximum annual amount that the Plan will pay per person for routine wellness examinations and tests that are not subject to the Plan's annual deductible and coinsurance from $150 to $300. No change is made in the services covered under the Plan's wellness provisions.

EFFECTIVE DATE: July 1, 2003.

ESTIMATED IMPACT ON STATE: Based upon information provided by the Plan, Aon Consulting, the Plan's consulting actuary, projects that the bill will cost the Plan an additional $7,900,000 for 2003-04 and $10,600,000 for 2004-05. Also, based on information provided by the Plan, Hartman & Associates, the consulting actuary for the General Assembly's Fiscal Research Division, estimates that the Plan will incur additional costs of $4,014,000 for 2003-04 and $5,395,000 for 2003-05 if the bill is enacted. These additional costs would be expected to come from the following sources:

	Aon Consulting			Hartman & Associates		
	2003-04	2004-05	Biennium	2003-04	2004-05	Biennium
Employer Cost						
-General Fund	$5,119,000	$6,869,000	$11,988,000	$2,601,000	$3,496,000	$6,097,000
-Highway Fund	$ 256,000	$ 343,000	$ 599,000	$ 130,000	$ 175,000	$ 305,000
-Other Funds	$1,024,000	$1,374,000	$ 2,398,000	$ 520,000	$ 699,000	$1,219,000
-Total Employer	$6,399,000	$8,586,000	$14,985,000	$3,251,000	$4,370,000	$7,621,000
Employee Cost	$1,501,000	$2,014,000	$ 3,515,000	$ 763,000	$1,025,000	$1,788,000
Total Cost	$7,900,000	$10,600,000	$18,500,000	$4,014,000	$5,395,000	$9,409,000

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, except for job-sharing public school teachers who are authorized partially contributory premiums at 50% of non-contributory rates. 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 20% 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; however, none of the HMOs with certificates of authority to transact business in North Carolina have offered to participate in the Plan since September 30, 2001. 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, 2002, include:

	Self-Insured Indemnity Program	Alternative HMOs	Plan Total
Number of Participants			
Active Employees	280,065	-0-	280,065
Active Employee Dependents	137,841	-0-	137,841
Retired Employees	117,225	-0-	117,225
Retired Employee Dependents	18,999	-0-	18,999
Former Employees & Dependents with Continued Coverage	2,535	-0-	2,535
Firefighters, Rescue Squad Workers, National Guard Members & Dependents	7	-0-	7
Total Enrollments	556,672	-0-	556,672
Number of Contracts			
Employee Only	313,439	-0-	313,439
Employee & Child(ren)	40,978	-0-	40,978
Employee & Family	44,710	-0-	44,710
Total Contracts	399,127	-0-	399,1

Percentage of Enrollment by Age			
29 & Under	26.9%	-0-%	26.9%
30-44	20.9	-0-	20.9
45-54	20.9	-0-	20.9
55-64	16.2	-0-	16.2
65 & Over	15.1	-0-	15.1
Percentage of Enrollment by Sex			
Male	38.3%	-0-%	38.3%
Female	61.7	-0-	61.7

Assumptions for the Self-Insured Indemnity Program: For the fiscal year beginning July 1, 2002, the self-insured program started its operations with a beginning cash balance of $91.6 million. Receipts for the year are estimated to be $1.371 billion from premium collections and $7 million from investment earnings for a total of $1.378 billion in receipts for the year. Disbursements from the self-insured program are expected to be $1.335 billion in claim payments and $38 million in administration and claims processing expenses for a total of $1.373 billion for the year beginning July 1, 2002. For the fiscal year beginning July 1, 2002, the self-insured indemnity program is expected to have a net operating gain of approximately $5 million for the year. Without reserving an additional $15 million for implementation of the claims data and privacy requirements of the federal Health Insurance Portability and Accountability Act (HIPPA) that take effect on and after April 14, 2003, the Plan's self-insured indemnity program is expected to have an available beginning cash balance of $96 million for the fiscal year beginning July 1, 2003. The self-insured indemnity program is nonetheless assumed to be unable to carry out its operations for the 2003-2005 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, discounts on hospital outpatient services, pre-admission hospital testing, pre-admission hospital inpatient certification with length-of-stay approval, hospital bill audits, case and disease management for selected medical conditions, mental health case management, coordination of benefits with other payers, Medicare benefit "carve-outs", cost reduction contracts with participating physicians and other providers, a prescription drug benefit manager with manufacturer rebates from formularies, and fraud detection) are maintained and improved where possible. Current non-contributory premium rates are $186.04 monthly for employees whose primary payer of health benefits is Medicare and $244.38 per month for employees whose primary payer of health benefits is not Medicare. Fully contributory premium amounts for employee and child(ren) contracts are $115.78 monthly for children whose primary payer of health benefits is Medicare and $152.32 monthly for other covered children, and $277.68 per month for family contracts whose dependents have Medicare as the primary payer of health benefits and $365.36 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 less than 1% annually over the next two years. The number of enrolled active employees is expected to show no increase 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 a 2% decrease in the number of active employee dependents per year whereas the number of retiree dependents is expected to increase 2% per year. Investment earnings are based upon a 4.5% 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 the Indemnity Plan's Claims Experience for Wellness Benefits: For the last three fiscal years, the Plan's claims experience for wellness benefits has been:

Group	No. of Users	Charges	Allowed Charges	Copayments	Deductible	Coinsurance	Paid Claims
2001-02							
Employee Group							
No Deductible	169,814	$30,003,874	$20,108,668	$2,003,550	$0	$0	$18,105,118
Deductible	86,469	$15,506,678	$11,446,863	$500,190	$4,182,729	$874,381	$5,889,563
Total	256,283	$45,510,552	$31,555,531	$2,503,740	$4,182,729	$874,381	$23,994,681
Retiree Group							
No Deductible	50,461	$5,365,140	$3,850,404	$292,440	$0	$0	$3,557,964
Deductible	25,719	$3,552,447	$2,701,553	$98,205	$874,357	$224,721	$1,504,270
Total	76,180	$8,917,587	$6,551,957	$390,645	$874,357	$224,721	$5,062,234
Contin. Group							
No Deductible	1,147	$196,472	$149,326	$13,440	$0	$0	$121,507
Deductible	537	$111,135	$90,723	$3,225	$18,065	$7,341	$58,854
Total	1,684	$307,607	$240,049	$16,665	$18,065	$7,341	$180,361
Total Group							
No Deductible	221,422	$35,565,486	$24,094,019	$2,309,430	$0	$0	$21,784,589
Deductible	112,725	$19,170,260	$14,235,901	$601,620	$5,075,151	$1,106,443	$7,452,687
Total	334,147	$54,735,746	$38,329,920	$2,911,050	$5,075,151	$1,106,443	$29,237,276
2000-01							
Employee Group							
No Deductible	144,616	$23,254,002	$16,975,085	$273,550	$0	$0	$16,701,535
Deductible	78,811	$19,539,907	$16,585,874	$83,250	$3,677,993	$2,074,265	$10,750,366
Total	223,427	$42,793,909	$33,560,959	$356,800	$3,677,993	$2,074,265	$27,451,901
Retiree Group							
No Deductible	46,055	$4,842,453	$3,755,769	$46,330	$0	$0	$3,709,439
Deductible	21,549	$5,623,482	$4,939,010	$23,300	$962,751	$684,665	$3,268,294
Total	67,604	$10,465,935	$8,694,779	$69,630	$962,751	$684,665	$6,977,733
Contin. Group							
No Deductible	1,087	$186,820	$156,515	$1,870	$0	$0	$137,819
Deductible	601	$171,238	$152,693	$640	$19,261	$22,152	$107,821
Total	1,688	$358,058	$309,208	$2,510	$19,261	$22,152	$245,640
Total Group							
No Deductible	191,758	$28,283,275	$20,870,543	$321,750	$0	$0	$20,548,793
Deductible	100,961	$25,334,627	$21,674,758	$107,190	$4,660,005	$2,781,082	$14,126,481
Total	292,719	$53,617,902	$42,545,301	$428,940	$4,660,005	$2,781,082	$34,675,274
1999-2000							
Employee Group							
No Deductible	115,930	$16,283,190	$12,177,643	$276,610	$0	$0	$11,901,033
Deductible	49,311	$6,637,559	$5,500,408	$63,360	$1,536,710	$530,031	$3,370,307
Total	117,132	$22,920,749	$17,678,051	$339,970	$1,536,710	$530,031	$15,271,340
Retiree Group							
No Deductible	39,736	$3,376,868	$2,696,838	$46,220	$0	$0	$2,650,618
Deductible	11,767	$1,579,374	$1,321,208	$17,500	$257,681	$152,469	$893,558
Total	40,337	$4,956,242	$4,018,046	$63,720	$257,681	$152,469	$3,544,176
Contin. Group							
No Deductible	1,056	$144,191	$108,534	$2,300	$0	$0	$106,234

Deductible	382	$51,594	$40,973	$610	$9,828	$4,251	$26,284
Total	1,084	$195,785	$149,507	$2,910	$9,828	$4,251	$132,518
Total Group							
No Deductible	156,722	$19,804,249	$14,983,015	$325,130	$0	$0	$14,657,885
Deductible	61,460	$8,268,527	$6,862,589	$81,470	$1,804,219	$686,751	$4,290,149
Total	158,553	$28,072,776	$21,845,604	$406,600	$1,804,219	$686,751	$18,948,034

Groups include both employees and their enrolled spouses and dependent children. "No Deductible" refers to benefits paid without deductibles and coinsurance being assessed up to $150 per person per year.

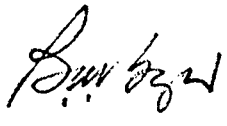
SOURCES OF DATA:

- Actuarial Note, Hartman & Associates, House Bill 557, April 26, 2003, original of which is on file in the General Assembly's Fiscal Research Division.
- Actuarial Note, Aon Consulting, House Bill 557, April 22, 2003, 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: (919) 733-4910

PREPARED BY: Sam Byrd



APPROVED BY: James D. Johnson, Director Fiscal Research Division

DATE: April 28, 2003

ATTACHMENT VIII
none

2003 COMMITTEE REPORT
HOUSE OF REPRESENTATIVES

The following report(s) from standing committee(s) is/are presented:
By Representatives **Carolyn Justus and Verla Insko** (Chairs) for the Committee on **HEALTH**.

☐ Committee Substitute for
H.B. 557 A BILL TO BE ENTITLED AN ACT TO INCREASE THE WELLNESS BENEFIT 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, and re-referred to 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)

03/19/03

FOR JOURNAL USE ONLY

____ Pursuant to Rule 36(b), the bill/resolution is placed on the Calendar of _____.

____ The (committee substitute) bill/resolution (, as amended,) is (ordered engrossed and) re-referred to the Committee on _____.

____ The bill/resolution is re-referred to the Committee on _____.

____ On motion of (Rep. _____,) (the Chair,) the (committee substitute) bill/resolution is (ordered engrossed and) re-referred to the Committee on _____.

____ Pursuant to Rule 36(b), the (House)committee substitute bill (No. ____)/resolution is placed on the Calendar of _____. (The original bill) (House Committee Substitute Bill No. ____)/resolution is placed on the Unfavorable Calendar.

____ On motion of Rep. _____, (the rules are suspended) (Rule ____ is suspended) and the bill/resolution is placed on today's calendar. (for immediate consideration.)

____ On motion of Rep. _____, Committee Amendment No.(s) _____ is/are adopted (by EV____ ____).

____ On motion of Rep. _____, Committee Amendment No.(s) _____ is/are adopted (by EV____ ____).

____ Rep. _____ offers Amendment No. _____ which (is adopted.) (fails of adoption.) (by EV ____ ____.) ( ) This amendment changes the title.

____ The bill/resolution (, as amended,) passes its second reading (by following vote, ____ ____ RC) (, by EV ____ ____,) and (remains on the Calendar,) (and there being no objection is read a third time).

____ The bill/resolution (, as amended,) passes its third reading (by the following vote, ____ ____ RC) (, by EV ____ ____,) and is ordered
____ sent to the Senate.
____ without engrossment. ____ by Special message.
____ sent to the Senate for concurrence in
_____ the House amendment (s).
_____the House committee substitute bill.
____ enrolled.

____ On motion of Rep. _____, the House concurs in the (material) Senate _____ (by the following vote, ____ ____ RC) (, by EV ____ ____,) and the bill is ordered enrolled.

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2003

HOUSE BILL 874

Short Title:	State Employees' Health Plan/Emergency Svces.	(Public)
Sponsors:	Representatives Frye, Dockham (Primary Sponsors); Barnhart, Bowie, Capps, Daughtry, Eddins, Gillespie, Gorman, Gulley, Hilton, McGee, McMahan, Mitchell, Munford, Pate, Rapp, Rayfield, Sauls, Stam, Walker, West, K. Williams, and G. Wilson.	
Referred to:	Health.	

April 7, 2003

A BILL TO BE ENTITLED

AN ACT PROVIDING FOR COVERAGE OF EMERGENCY SERVICES IN CERTAIN SITUATIONS UNDER THE TEACHERS' AND STATE EMPLOYEES' COMPREHENSIVE MAJOR MEDICAL PLAN.

The General Assembly of North Carolina enacts:

SECTION 1. 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 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) Repealed by Session Laws 2001-253, s. 1(m).

(c) Notwithstanding any other provision of this Article, on the first day of each confinement the Plan does not pay the first 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)i., j., k., n., r., and s., and G.S. 135-40.5(e). The co-payment 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, or to charges for injected medications. 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. The Plan then pays one hundred percent (100%) of the remaining covered expenses.

(e) Notwithstanding subsection (d) of this section, where qualified preferred providers of medical care are not reasonably available in medical emergencies, the Plan pays the amounts covered by subsection (a) of this section. Any amount of charges for services under this section that exceeds the amount allowed by the Plan for the services of qualified preferred providers under this section shall be negotiated between the Plan and the provider of medical services so that the Plan member is not held financially responsible for the amount of excess charges. As used in this section, a 'medical emergency' is the sudden and unexpected onset of a condition manifesting itself by acute symptoms of sufficient severity that, in the absence of immediate medical care, could imminently result in injury or danger to self or others."

SECTION 2. This act is effective when it becomes law and applies to medical emergency services received on and after January 1, 2000.

ATTACHMENT X

HOUSE BILL 874:
State Employees' Health Plan/Emergency Svces.

BILL ANALYSIS

Committee:	House Health	**Introduced by:**	Reps. Frye and Dockham
Date:	June 11, 2003	**Summary by:**	Sandra Alley
Version:	First Edition		Committee Counsel

SUMMARY: ***House Bill 874 would require the Teachers' and State Employees' Comprehensive Major Medical Plan (Plan) to provide coverage of medical emergencies where qualified preferred providers are unavailable. The bill would become effective when it becomes law and applies to services for medical emergencies received on and after January 1, 2000.***

CURRENT LAW: The Teachers' and State Employees' Comprehensive Major Medical Plan (Plan) is divided into two programs. From October 1982, through June 1986, the Plan only had a self-funded indemnity program. A prepaid program of coverage by HMOs was offered in July 1986, as an alternative to the Plan's self-insured indemnity program. The benefits of the self-insured indemnity program are described in Part 3 of Article 3 of Chapter 135 of the General Statutes. HMOs are required to offer benefits comparable to those provided by the State's self-insured indemnity program. Both types of coverage continue to be available in the Plan; however, none of the HMOs with certificates of authority to transact business in North Carolina have offered to participate in the Plan since the Plan's contracts with Coventry, Prudential, and Wellpath expired on September 30, 2001.

BILL ANALYSIS: House Bill 874 would make the following changes to the law relating to out-of-pocket expenditures under Part 3, Comprehensive Major Medical Plan, of Article 3 of Chapter 135 of the General Statutes:

1. The bill would clarify that after payment of specified out-of-network expenses, the Plan would pay 100% of the remaining covered expenses in a situation where qualified preferred providers are reasonably available, but a covered individual uses a provider outside of the preferred network.
2. The bill would require the Plan to cover expenses of medical emergencies in a situation where qualified preferred providers are *not* reasonably available, and a covered individual uses a provider outside of the preferred network. The bill would require the Plan and providers of medical services to negotiate any amount of charges for services provided that exceeds the amount allowed by the Plan so that the Plan member is not held financially responsible for the amount of excess charges. The bill defines a medical emergency as the sudden and unexpected onset of a condition manifesting itself by acute symptoms of sufficient severity that, in the absence of immediate medical care, could imminently result in injury or danger to self or others.

The bill would become effective when it becomes law and applies to medical emergency services received on and after January 1, 2000.

ACTUARIAL NOTE: Please see the Legislative Actuarial Note prepared by Sam Byrd of the Fiscal Research Division for an estimate of the financial and actuarial effect of the proposed changes to the Plan. The actuarial note indicates that the estimated impact on the State would be reduced if the Plan uses a contracted network of out-of-state preferred providers (PPO) of healthcare services. After reviewing proposals from five vendors, Aon Consulting, consulting actuary for the Plan, recommended a PPO for accessing health care services out-of-area. The Plan is currently in the process of completing contract negotiations with Private Healthcare Systems (PHCS).

Amy Compeau, Research Assistant, contributed to this summary.

H557-SMSP-001

State Employees Association of North Carolina – District 3
Serving the interests of Avery, Mitchell and Watauga Counties

MEMORANDUM

TO: Honorable Members of the House Committee on Health

FROM: Teresa S. Johnson, Chair, District 3
State Employees Association of North Carolina

DATE: June 17, 2003

SUBJECT: HOUSE BILL 874 (STATE EMPLOYEES' HEALTH PLAN/EMERGENCY SERVICES

The purpose of this memorandum is to respectively request your support of the original version of House Bill 874. This bill calls for the State Health Plan to negotiate payment with the health care provider for any charges that exceed the amount allowed by the State Health Plan when a State employee experiences a medical emergency out of state. This bill would assist State employees so that he/she is not held financially responsible for the amount of excess charges incurred as a result of not be treated by a preferred health care provider while out of state.

On behalf of my fellow state employees, I share with you our shock and disbelief that our State Health Plan would not provide the same level of coverage if we had a medical emergency out of state. It is not reasonable to expect we would receive medical care by a "preferred provider" when traveling out of state, and as such it is not reasonable to expect the State employee to incur the excess expenses of the services provided. On June 10, 2003, signature pages, with over 700 State employees' signatures indicating support of House Bill 874, were hand delivered to Representative Phillip Frye. I sincerely and earnestly urge you to support House Bill 874 in its original form.

Thank you for the opportunity to address this issue with you. As a fellow public servant, we thank you for your consideration and support of this very important request.

Cc: H874 Prime Sponsors Honorable Phillip D. Frye and Honorable Jerry C. Dockham
Honorable Virginia Foxx
Honorable Joe Sam Queen

Teresa S. Johnson, Veterans Affairs Coordinator, ASU, Boone, NC 28608 828-262-2583
147 Rivendell Court, Boone, NC 28607 828-268-1070 *teresaj@goboone.net* or *johnsonts@appstate.edu*

ATTACHMENT XII

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February 20, 2003

The Honorable Richard T. Morgan
Speaker of the House
House of Representatives
North Carolina General Assembly
Legislative Office Building
Raleigh, North Carolina 27603

Dear Mr. Speaker:

Representative Phillip D. Frye asked that we write to you concerning a mounting problem in the State Employee Health Benefit Plan. Representative Frye has a constituent state employee whose case mirrors a lot of others. From what Representative Frye has given to us, it appears that the state employee was in Pennsylvania on vacation when he suffered a severe heart attack. He was rushed to two hospitals, where he was admitted on an inpatient basis for three days. The hospital billed the State Employee Health Benefit Plan $54,277.32 for the stay. The Plan only allowed $18,814.42 of the charges based upon what hospitals contracting with the Plan in North Carolina are allowed for the same type of diagnosis and stay. Obviously, the Pennsylvania hospital was not a contracting hospital under the Plan. Of the $18,814.42 amount allowed, the Plan correctly assessed a $100.00 inpatient hospital deductible amount and, we assume to be correct, a $1,422.80 20% coinsurance amount against the Plan member to be paid by him. But unlike the same stay at a North Carolina hospital, the Plan member was balance-billed and is financially responsible for the $35,462.90 difference between the amount charged by the hospital and the amount allowed by the Plan. Ordinarily, we would verify individual claims information for individuals covered by the Plan with Blue Cross and Blue Shield of North Carolina. However, Tuesday, February 11, 2003, Dr. Jack Walker, Executive Administrator of the Plan, informed us that the Plan would no longer disclose an individual's personal health information to the Fiscal Research Division. This decision was apparently made under the privacy rules of the federal Health Insurance Portability and Accountability Act (HIPPA).

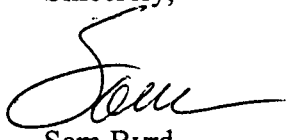
Mr. Speaker, here's what has caused the problem in Representative Frye's constituent's case. The State Employee Benefit Plan's self-insured indemnity program has not had reimbursement contracts with out-of-state hospitals simply because the case volume with a particular hospital was not sufficient for an out-of-state hospital to give the program the same discount that in-state hospitals have given the program. The Plan's former Executive Administrator prior to 2000 consistently directed Blue Cross and Blue Shield of North Carolina to negotiate rates of

reimbursement with out-of-state hospitals in individual cases in order to limit a Plan member's out-of-pocket expenses for use of these facilities, especially in emergency situations. The idea was to get out-of-state facilities to accept the Plan's payment as payment in full without balance billing the patient. Blue Cross tried to get an out-of-state hospital to accept the lower of what it accepted for treating a resident state employee or what the resident Blue Cross organization paid the hospital for the same services. If neither of these approaches was agreed upon, Blue Cross tried to get whatever discount off of charges that the out-of-state facility would agree to in order to keep the Plan member from being balance billed. Unfortunately, the Plan's current Executive Administrator changed what Blue Cross and Blue Shield was doing in this respect. Negotiations are still the rule from what we can gather, but Plan members are not being held harmless with respect to balance billing. Consequently, Plan members using out-of-state medical facilities are now facing large financial liabilities.

In order to remedy situations such as the one faced by Representative Frye's constituent, we have been working with our General Research and Bill Drafting staffs to come up with proposed legislation to prohibit balance billing in medical emergencies. Representative Frye is aware of these efforts. We hope to have something for Representative Frye's review by the end of next week.

We would be more than delighted to talk to you further on this case should you need any additional information.

Sincerely,



Sam Byrd
Principal Fiscal Analyst

SB/bt

Cc: Rep. Phillip Frye

NORTH CAROLINA GENERAL ASSEMBLY
LEGISLATIVE ACTUARIAL NOTE

BILL NUMBER: House Bill 874

SHORT TITLE: State Employees' Health Plan/Emergency Services

SPONSOR(S): Representatives Frye and Dockham

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, premium payments for coverages selected by eligible former teachers and State employees and premium payments for coverages selected by firefighters, rescue squad workers, and members of the National Guard.

BILL SUMMARY: The bill requires the Teachers' and State Employees' Comprehensive Major Medical Plan and the providers of medical services to negotiate any amounts that billed charges are in excess of charges allowed by the Plan for preferred providers of medical care in emergencies when preferred providers of care are not reasonably available. The purpose of the negotiations is for Plan members not to be financially responsible for the amounts in excess of allowed charges. Medical emergencies are defined as the sudden and unexpected onset of a condition manifesting itself by acute symptoms of sufficient severity that, in the absence of immediate medical care, could imminently result in injury or danger to self or others.

EFFECTIVE DATE: When the bill becomes law. The bill, however, applies to services for medical emergencies received on and after January 1, 2000.

ESTIMATED IMPACT ON STATE: Aon Consulting, consulting actuary for the Teachers' and State Employees' Comprehensive Major Medical Plan, projects the costs of the bill to be $29.1 million for fiscal year 2003-04 and $9.6 million for fiscal year 2004-05. The first year's cost includes $20.6 million in retroactive costs for the period January 1, 2000, through June 30, 2003. Aon Consulting notes that the bill's recurring costs of $8.5 million for 2003-04 and $9.6 million for 2004-05 does not assume the Plan's use of a contracted network of out-of-state preferred providers (PPO) of healthcare services. Use of an out-of-state PPO network would reduce the recurring costs of the bill to $1.3 million for 2003-04 and $1.4 million for 2004-05, according to Aon Consulting.

Hartman & Associates, consulting actuary for the General Assembly's Fiscal Research Division, estimates the costs of the bill to be $24,486,000 for fiscal year 2003-04 and $7,327,000 for fiscal year 2004-05. However, Hartman & Associates notes that use of a contracted network of preferred providers for services rendered out-of-state would reduce the costs of the bill by 85-90% of the otherwise estimated costs. Consequently, the recurring costs of the bill through use of an out-of-state PPO network would be estimated at $1 million for 2003-04 and $1.1 million for 2004-05.

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, except for job-sharing public school teachers who are authorized partially contributory premiums at 50% of non-contributory rates. 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 20% 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; however, none of the HMOs with certificates of authority to transact business in North Carolina have offered to participate in the Plan since September 30, 2001. 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, 2002, include:

	Self-Insured Indemnity Program	Alternative HMOs	Plan Total
Number of Participants			
Active Employees	280,065	-0-	280,065
Active Employee Dependents	137,841	-0-	137,841
Retired Employees	117,225	-0-	117,225
Retired Employee Dependents	18,999	-0-	18,999
Former Employees & Dependents with Continued Coverage	2,535	-0-	2,535
Firefighters, Rescue Squad Workers, National Guard Members & Dependents	7	-0-	7
Total Enrollments	556,672	-0-	556,672
Number of Contracts			
Employee Only	313,439	-0-	313,439
Employee & Child(ren)	40,978	-0-	40,978
Employee & Family	44,710	-0-	44,710
Total Contracts	399,127	-0-	399,1[illegible]
Percentage of			

Enrollment by Age			
29 & Under	26.9%	-0-%	26.9%
30-44	20.9	-0-	20.9
45-54	20.9	-0-	20.9
55-64	16.2	-0-	16.2
65 & Over	15.1	-0-	15.1
Percentage of Enrollment by Sex			
Male	38.3%	-0-%	38.3%
Female	61.7	-0-	61.7

Assumptions for the Self-Insured Indemnity Program: For the fiscal year beginning July 1, 2002, the self-insured program started its operations with a beginning cash balance of $91.6 million. Receipts for the year are estimated to be $1.371 billion from premium collections and $7 million from investment earnings for a total of $1.378 billion in receipts for the year. Disbursements from the self-insured program are expected to be $1.335 billion in claim payments and $38 million in administration and claims processing expenses for a total of $1.373 billion for the year beginning July 1, 2002. For the fiscal year beginning July 1, 2002, the self-insured indemnity program is expected to have a net operating gain of approximately $5 million for the year. Without reserving an additional $15 million for implementation of the claims data and privacy requirements of the federal Health Insurance Portability and Accountability Act (HIPPA) that take effect on and after April 14, 2003, the Plan's self-insured indemnity program is expected to have an available beginning cash balance of $96 million for the fiscal year beginning July 1, 2003. The self-insured indemnity program is nonetheless assumed to be unable to carry out its operations for the 2003-2005 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, discounts on hospital outpatient services, pre-admission hospital testing, pre-admission hospital inpatient certification with length-of-stay approval, hospital bill audits, case and disease management for selected medical conditions, mental health case management, coordination of benefits with other payers, Medicare benefit "carve-outs", cost reduction contracts with participating physicians and other providers, a prescription drug benefit manager with manufacturer rebates from formularies, and fraud detection) are maintained and improved where possible. Current non-contributory premium rates are $186.04 monthly for employees whose primary payer of health benefits is Medicare and $244.38 per month for employees whose primary payer of health benefits is not Medicare. Fully contributory premium amounts for employee and child(ren) contracts are $115.78 monthly for children whose primary payer of health benefits is Medicare and $152.32 monthly for other covered children, and $277.68 per month for family contracts whose dependents have Medicare as the primary payer of health benefits and $365.36 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 less than 1% annually over the next two years. The number of enrolled active employees is expected to show no increase 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 a 2% decrease in the number of active employee dependents per year whereas the number of retiree dependents is expected to increase 2% per year. Investment earnings are based upon a 4.5% 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 the Indemnity Program's Disallowed Claims in Medical Emergencies: For the last three calendar years, the Teachers' and State Employees' Comprehensive Major Medical Plan has disallowed the

following charges on professional health care claims for medical emergencies provided in-state and out-of-state. The "Average Disallowed Amount Per Case" is for each primary diagnosis. The "Cost Sharing" referred to in the following data refers to copayments, deductibles, and coinsurance paid by Plan members. Plan members would be financially responsible for "Disallowed Charges" as well.

Average Disallowed Amount Per Case	Professional Claims Disallowed							
	In-State Claims				Out-of-State Claims			
	No. of Cases	Total Charges	Disallowed Charges	Cost Sharing	No. of Cases	Total Charges	Disallowed Charges	Cost Sharing
Cal. Year 2002								
$0.01 & Over	43,947	$7,016,413	$1,760,844	$1,490,834	57,004	$9,914,085	$1,892,046	$2,063,643
$100.00 & Over	396	$554,927	$210,157	$26,923	3,171	$2,357,230	$723,569	$183,178
$500.00 & Over	123	$220,913	$110,116	$10,133	195	$717,518	$270,663	$10,401
$1,000.00 & Over	28	$80,345	$47,683	$1,839	114	$529,791	$208,149	$6,790
$1,500.00 & Over	26	$74,018	$44,915	$1,830	36	$376,099	$124,169	$5,024
$2,000.00 & Over	4	$20,366	$9,263	$15	36	$376,099	$124,169	$5,024
$2,500.00 & Over	4	$20,366	$9,263	$15	19	$324,729	$81,863	$2,679
$3,000.00 & Over	1	$4,875	$3,148	$0	19	$324,729	$81,863	$2,679
$4,000.00 & Over	0				19	$324,729	$81,863	$2,679
$5,000.00 & Over					0			
Cal. Year 2001								
$0.01 & Over	45,385	$7,261,134	$1,741,933	$1,436,968	53,229	$10,850,562	$1,396,560	$1,960,586
$100.00 & Over	4,174	$2,565,858	$800,156	$194,740	2,961	$2,870,490	$782,204	$153,461
$500.00 & Over	76	$173,988	$96,302	$3,372	210	$1,339,569	$387,653	$9,772
$1,000.00 & Over	55	$139,199	$81,955	$2,664	54	$1,063,412	$268,747	$3,476
$1,500.00 & Over	48	$115,495	$73,591	$1,839	38	$933,299	$250,415	$2,620
$2,000.00 & Over	0				38	$933,299	$250,415	$2,620
$2,500.00 & Over					38	$933,299	$250,415	$2,620
$3,000.00 & Over					37	$929,938	$248,060	$2,419
$4,000.00 & Over					1	$386,141	$112,353	$0
$5,000.00 & Over					1	$386,141	$112,353	$0
$120,000 & Over					0			
Cal. Year 2000								
$0.01 & Over	42,926	$6,340,461	$1,351,257	$1,126,691	43,461	$8,404,971	$1,065,442	$1,366,418
$100.00 & Over	2,208	$1,560,936	$420,354	$87,294	1,788	$1,814,943	$543,704	$94,966
$500.00 & Over	55	$136,360	$56,849	$2,010	149	$863,178	$294,210	$7,869
$1,000.00 & Over	20	$54,705	$33,396	$308	60	$710,415	$241,295	$1,197
$1,500.00 & Over	3	$9,235	$8,402	$13	46	$579,769	$224,045	$788
$2,000.00 & Over	3	$9,235	$8,402	$13	41	$561,280	$216,035	$560
$2,500.00 & Over	3	$9,235	$8,402	$13	40	$588,130	$213,790	$560
$3,000.00 & Over	0				34	$535,300	$197,232	$489
$4,000.00 & Over					17	$379,754	$131,882	$116
$5,000.00 & Over					17	$379,754	$131,882	$116
$10,000.00 & Over					1	$12,781	$12,539	$20
$15,000.00 & Over					0			

The diagnoses related to the larger disallowed amounts per case in the foregoing data include abdominal aortic aneurysm, acute myocardial infarction, antihemophilic globulin deficiency, arterial embolism & thrombosis, autoimmune disease, brain stem compression, cardiac tachycardia, cardiovascular disease, cervical

intevertebral disc displacement, chordae tendineae rupture, colon cancer, cornonary occlusion, epilepsy, gallbladder calculus, heat stroke, intestinal obstruction, lung, trachea & bronchus cancer, Meniere's disease, meningococcal meningitis, myasthenia gravis, precerebral occlusion, pulmonary collapse, retinal detachment, sickle-cell anemia, spina bifida, thoracic aortic aneurysm, and ventricular fibrillation.

The same type data for the last three calendar years for disallowed out-of-state hospital claims involving medical emergencies is as follows. The "Average Disallowed Amount Per Case" is for each primary diagnosis. The "Cost Sharing" referred to in the following data refers to copayments, deductibles, and coinsurance paid by Plan members. Plan members would also be financially responsible for "Disallowed Charges".

Average Disallowed Amount Per Case	Hospital Out-of-State Claims Disallowed							
	Inpatient Claims				Outpatient Claims			
	No. of Cases	Total Charges	Disallowed Charges	Cost Sharing	No. of Cases	Total Charges	Disallowed Charges	Cost Sharing
Cal. Year 2002								
$0.01 & Over	904	$6,910,946	$3,357,874	$366,595	982	$928,228	$1,947	$211,142
$100.00 & Over	870	$6,864,660	$3,356,672	$353,575	0			
$500.00 & Over	841	$6,772,458	$3,347,211	$338,833				
$1,000.00 & Over	745	$6,465,330	$3,275,894	$303,071				
$1,500.00 & Over	589	$5,869,744	$3,086,499	$250,582				
$2,000.00 & Over	520	$5,526,227	$2,973,919	$220,622				
$2,500.00 & Over	352	$4,727,502	$2,603,246	$153,324				
$3,000.00 & Over	287	$4,309,424	$2,422,396	$130,082				
$4,000.00 & Over	214	$3,683,714	$2,174,229	$105,166				
$5,000.00 & Over	166	$3,198,792	$1,952,663	$70,755				
$6,000.00 & Over	98	$2,404,558	$1,573,325	$43,921				
$7,000.00 & Over	90	$2,284,496	$1,521,576	$38,930				
$8,000.00 & Over	58	$1,765,045	$1,269,287	$23,761				
$9,000.00 & Over	41	$1,455,875	$1,120,803	$18,182				
$10,000.00 & Over	35	$1,351,717	$1,063,672	$15,523				
$15,000.00 & Over	25	$1,183,675	$946,907	$10,220				
$20,000.00 & Over	22	$1,110,391	$897,755	$8,117				
$25,000.00 & Over	8	$413,394	$384,220	$1,859				
$30,000.00 & Over	8	$413,394	$384,220	$1,859				
$35,000.00 & Over	8	$413,394	$384,220	$1,859				
$40,000.00 & Over	18	$984,173	$812,998	$7,365				
$45,000.00 & Over	8	$413,394	$384,220	$1,859				
$50,000.00 & Over	0							
Cal. Year 2001								
$0.01 & Over	914	$6,907,861	$2,527,880	$328,562	1,558	$912,065	$8,086	$181,484
$100.00 & Over	896	$6,859,962	$2,526,807	$318,982	0			
$500.00 & Over	706	$6,326,708	$2,474,039	$256,499				
$1,000.00 & Over	455	$5,523,591	$2,255,987	$164,595				
$1,500.00 & Over	403	$5,273,285	$2,193,135	$139,926				
$2,000.00 & Over	253	$4,224,202	$1,930,533	$86,796				
$2,500.00 & Over	212	$3,958,207	$1,845,691	$71,209				
$3,000.00 & Over	208	$3,872,849	$1,834,593	$68,064				
$4,000.00 & Over	168	$3,552,266	$1,693,685	$54,043				

$5,000.00 & Over	157	$3,457,371	$1,645,012	$49,401				
$6,000.00 & Over	107	$3,029,157	$1,367,053	$27,534				
$7,000.00 & Over	69	$2,471,562	$1,124,423	$17,806				
$8,000.00 & Over	58	$2,289,113	$1,045,164	$15,589				
$9,000.00 & Over	44	$2,059,705	$929,211	$12,990				
$10,000.00 & Over	39	$1,956,799	$880,322	$11,787				
$15,000.00 & Over	22	$1,601,468	$690,990	$7,900				
$20,000.00 & Over	9	$1,221,155	$468,665	$1,001				
$25,000.00 & Over	9	$1,221,155	$468,665	$1,001				
$30,000.00 & Over	8	$1,176,303	$440,525	$904				
$35,000.00 & Over	8	$1,176,303	$440,525	$904				
$40,000.00 & Over	2	$271,727	$212,801	$177				
$45,000.00 & Over	2	$271,727	$212,801	$177				
$50,000.00 & Over	2	$271,727	$212,801	$177				
$100,000 & Over	2	$271,727	$212,801	$177				
$110,000 & Over	0							
Cal. Year 2000								
$0.01 & Over	840	$5,039,133	$1,457,128	$244,129	1,384	$837,750	$9,283	$143,213
$100.00 & Over	727	$4,843,642	$1,451,475	$212,551	1	$1,643	$780	$172
$500.00 & Over	438	$4,117,016	$1,363,047	$134,640	1	$1,643	$780	$172
$1,000.00 & Over	267	$3,520,021	$1,228,386	$82,152	0			
$1,500.00 & Over	237	$3,345,708	$1,192,943	$75,880				
$2,000.00 & Over	160	$2,553,191	$1,062,455	$47,433				
$2,500.00 & Over	126	$2,062,107	$983,662	$33,710				
$3,000.00 & Over	113	$1,965,415	$949,885	$29,623				
$4,000.00 & Over	85	$1,744,888	$851,570	$21,751				
$5,000.00 & Over	70	$1,549,120	$786,756	$19,684				
$6,000.00 & Over	65	$1,501,406	$761,508	$17,158				
$7,000.00 & Over	59	$1,384,308	$721,363	$16,933				
$8,000.00 & Over	49	$1,189,988	$647,562	$12,526				
$9,000.00 & Over	49	$1,189,988	$647,562	$12,526				
$10,000.00 & Over	47	$1,164,907	$629,046	$11,587				
$15,000.00 & Over	5	$312,814	$141,088	$784				
$20,000.00 & Over	3	$168,911	$105,234	$634				
$25,000.00 & Over	2	$131,754	$80,617	$150				
$30,000.00 & Over	2	$131,754.00	$80,617.00	$150.00				
$35,000.00 & Over	2	$131,754.00	$80,617.00	$150.00				
$40,000.00 & Over	1	$55,086	$41,595	$75				
$45,000.00 & Over	0							

The diagnoses related to the larger disallowed amounts per case in the foregoing data include acute appendicitis, acute bronchitis, acute myocardial infarction, angina pectoris, asthma, atrial fibrillation, cardiac dysrhythmia, cerebral artery occlusion, cerebral ischemia, diabetes, diverticulosis, heart failure, hypertension, kidney & ureter calculus, pneumonia, precerebral artery occlusion, prostate cancer, respiratory failure, stroke, unconsciousness, and urethra & urinary tract obstruction.

On December 31, 2002, Aon Consulting issued a Request for Proposals (RFP) on behalf of the Plan to contract with a Preferred Provider Organization (PPO) for Accessing Health Care Services Out-of-Area. A contract was proposed to run through June 30, 2005. Proposals were to be received by the Plan no later than

January 31, 2003. Proposals were received from five vendors. Aon Consulting recommended that Private Healthcare Systems (PHCS), Waltham, Massachusetts, be awarded a contract to begin on or about July 1, 2003. PHCS' network of preferred providers includes institutional and professional providers of healthcare services on a nationwide basis. PHCS' fees are to be funded out of the claim cost savings to be realized by the Plan by use of the PPO, according to Aon Consulting. Contract negotiations between the Plan and PHCS are in the process of being completed as of the date of this note.

SOURCES OF DATA:

- Actuarial Note, Hartman & Associates, House Bill 874, May 14, 2003, original of which is on file in the General Assembly's Fiscal Research Division.
- Actuarial Note, Aon Consulting, House Bill 874, May 23, 2003, 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.

FISCAL RESEARCH DIVISION: (919) 733-4910

PREPARED BY: Sam Byrd

APPROVED BY: James D. Johnson, Director Fiscal Research Division

DATE: May 27, 2003

ATTACHMENT A
mine

2003 COMMITTEE REPORT
HOUSE OF REPRESENTATIVES

The following report(s) from standing committee(s) is/are presented:
By Representatives **Carolyn Justus and Verla Insko** (Chairs) for the Committee on **HEALTLH**.

☐ Committee Substitute for
H.B. 874 A BILL TO BE ENTITLED AN ACT PROVIDING FOR COVERAGE OF EMERGENCY SERVICES IN CERTAIN SITUATIONS 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)

03/19/03

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2003

S 3

SENATE BILL 876

Health & Human Resources Committee Substitute Adopted 4/21/03
Third Edition Engrossed 4/22/03

Short Title: Meningococcal Meningitis Immunization Info. (Public)

Sponsors:

Referred to:

April 3, 2003

A BILL TO BE ENTITLED

AN ACT TO REQUIRE ANY PRIVATE OR PUBLIC INSTITUTION THAT OFFERS A POSTSECONDARY DEGREE TO PROVIDE MENINGOCOCCAL DISEASE IMMUNIZATION INFORMATION TO STUDENTS IF THE INSTITUTION HAS A RESIDENTIAL CAMPUS.

The General Assembly of North Carolina enacts:

SECTION 1. Chapter 116 of the General Statutes is amended by adding a new Article to read:

"Article 32.

"Health Information.

"**§ 116-260. Information on meningococcal disease immunization.**

(a) Each public or private educational institution that offers a postsecondary degree as defined in G.S. 116-15 and that has a residential campus shall provide vaccination information on meningococcal disease to each student. The vaccination information shall be contained on student health forms provided to each student by the educational institution and shall include space for the student to indicate whether or not the student has received the vaccination against meningococcal disease. The vaccination information about meningococcal disease shall include any recommendations issued by the national Centers for Disease Control and Prevention regarding the disease.

(b) The vaccination information obtained under this section that is in the possession of the educational institution is confidential and shall not be a public record under G.S. 132-1.

(c) This section shall not be construed to require the educational institution to provide the meningococcal vaccination to students.

(d) This section shall not apply if the national Centers for Disease Control and Prevention no longer recommends the meningococcal vaccine.

(e) This section does not create a private right of action."

SECTION 2. This act is effective when it becomes law and applies to the 2003-2004 academic year and each subsequent year.

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2003

S D

SENATE BILL 876

Health & Human Resources Committee Substitute Adopted 4/21/03
Third Edition Engrossed 4/22/03
PROPOSED HOUSE COMMITTEE SUBSTITUTE S876-CSSW-44 [v.3]

6/6/2003 11:21:43 AM

Short Title: Controlled Substance/Physician Registration. (Public)

Sponsors:

Referred to:

April 3, 2003

A BILL TO BE ENTITLED

AN ACT TO REQUIRE PHYSICIANS WHO DISPENSE THE CONTROLLED SUBSTANCE BUPRENORPHINE FOR THE TREATMENT OF OPIATE DEPENDENCE TO REGISTER WITH THE DEPARTMENT OF HEALTH AND HUMAN SERVICES.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 90-101 is amended by adding a new subsection to read:

"(a1) Any physician who prescribes or dispenses Buprenorphine for the treatment of opiate dependence shall annually register with the Department, in accordance with rules adopted by the Commission. In the application for registration under this subsection, the applicant shall document plans to ensure that patients are directly engaged or referred to a qualified provider to receive counseling and case management, as appropriate, and shall acknowledge the application of federal confidentiality regulations to patient information. Applicant plans for referral to appropriate services shall be a written document and may include either an executed memorandum of agreement, contractual arrangement, or linkage agreement with qualified providers. The Department shall provide assistance upon request to physicians registered under this subsection to identify and establish linkages with qualified providers of counseling and case management. The Department shall provide the North Carolina Medical Board with any evidence of noncompliance with this subsection by a qualified physician prior to taking action to rescind the physician's registration to prescribe or dispense Buprenorphine for the treatment of opiate dependency."

SECTION 2. This act becomes effective October 1, 2003.

ATTACHMENT XVII

SENATE BILL 876:
Controlled Substance/Physician Registration

BILL ANALYSIS

Committee:	House Health	**Introduced by:**	Sen. Purcell
Date:	June 12, 2003	**Summary by:**	Dianna Jessup
Version:	PCS S876-CSSW-44		Committee Counsel

SUMMARY: ***The PCS for Senate Bill 876 would substitute the contents of Senate Bill 602 (currently in Senate Health and Human Resources) for the contents Senate Bill 876 (the meningitis bill). The House version of the meningitis bill crossed to the Senate and was passed in the Senate. The PCS would require physicians who prescribes or dispenses Buprenorphine (a Schedule IV controlled substance) for the treatment of opiate dependence to register with the Department of Health and Human Services annually and provide certain information in connection with the application to register. The act would become effective October 1, 2003.***

CURRENT LAW: Under the State's Controlled Substances Act, certain categories of persons who manufacture, distribute, dispense, or conduct research with any controlled substance within this State have to register with the North Carolina Department of Health and Human Services. Registrants may dispense these controlled substances to the extent authorized by their registration. Clinics, hospitals, nursing homes, teaching institutions, researcher, analytical laboratories, distributors, and manufacturers all are currently required to register. Practitioners (which include physicians) are exempt from this registration requirement. Under federal law, practitioners who dispense narcotic drugs to individuals for maintenance treatment or detoxification treatment are required to register annually with the Drug Enforcement Administration. In 2000, this law was amended to permit "qualified" physicians (defined in federal law) to dispense (including prescribe) schedule III, IV, or V narcotic drugs or combinations of these drugs approved by the FDA for the treatment of opiate addiction without having to register.

Buprenorphine is an opiate that has been marketed in the United States as a Schedule V parenteral analgesic. In 2002, the DEA reclassified buprenorphine from a Schedule V to a Schedule III narcotic. (In North Carolina, Buprenorphine is a Schedule IV controlled substance). In October 2002, Reckitt Benckiser received FDA approval to market two products containing burprenorphine, Subutex® and Suboxone®, for opiod addiction treatment. These are the first narcotic drugs available for the treatment of opiate dependence that can be prescribed in an office setting.

Thus, under current law, there are products available for the treatment of opiate dependence that can be prescribed or dispensed in an office setting, but qualified physicians who can prescribe or dispense them are not currently registered.

BILL ANALYSIS: The bill would require any physician who prescribes or dispenses Burprenorhine to treat opiate dependence would have to register with DHHS every year. No fee would be required to register. In the application for registration, the applicant would have to document plans to ensure that patients are directly engaged or referred to a qualified provider to receive counseling and case management and acknowledge the application of federal confidentiality regulations to patient information. DHHS would be required to provide assistance to physicians to identify and establish linkages with qualified providers of counseling and case management and to provide the NC Medical Board with any evidence of noncompliance with these requirements prior to rescinding the physician's registration. It is estimated that this would affect 25-30 physicians. *S876-SMSW-001*

2003 COMMITTEE REPORT
HOUSE OF REPRESENTATIVES

The following report(s) from standing committee(s) is/are presented:
By Representatives **Verla Insko and Carolyn Justus,** Chairs for the Committee on **HEALTH**.

☒ Committee Substitute for
S.B. 876 A BILL TO BE ENTITLED AN ACT TO REQUIRE ANY PRIVATE OR PUBLIC INSTITUTION THAT OFFERS A POSTSECONDARY DEGREE TO PROVIDE MENINGOCOCCAL DISEASE IMMUNIZATION INFORMATION TO STUDENTS IF THE INSTITUTION HAS A RESIDENTIAL CAMPUS.

☐ 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 (# H.B.), ☐ 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)

3/06/03

FOR JOURNAL USE ONLY

____ Pursuant to Rule 36(b), the bill/resolution is placed on the Calendar of _____.

____ The (committee substitute) bill/resolution (, as amended,) is (ordered engrossed and) re-referred to the Committee on _____.

____ The bill/resolution is re-referred to the Committee on _____.

____ On motion of (Rep. _____,) (the Chair,) the (committee substitute) bill/resolution is (ordered engrossed and) re-referred to the Committee on _____.

____ Pursuant to Rule 36(b), the (House)committee substitute bill (No. ____)/resolution is placed on the Calendar of _____. (The original bill) (House Committee Substitute Bill No. ____)/resolution is placed on the Unfavorable Calendar.

____ On motion of Rep. _____, (the rules are suspended) (Rule ____ is suspended) and the bill/resolution is placed on today's calendar. (for immediate consideration.)

____ On motion of Rep. _____, Committee Amendment No.(s) _____ is/are adopted (by EV____ ____).

____ On motion of Rep. _____, Committee Amendment No.(s) _____ is/are adopted (by EV____ ____).

____ Rep. _____ offers Amendment No. _____ which (is adopted.) (fails of adoption.) (by EV ____ ____.) ( ) This amendment changes the title.

____ The bill/resolution (, as amended,) passes its second reading (by following vote, ____ ____ RC) (, by EV ____ ____,) and (remains on the Calendar,) (and there being no objection is read a third time).

____ The bill/resolution (, as amended,) passes its third reading (by the following vote, ____ ____ RC) (, by EV ____ ____,) and is ordered
____ sent to the Senate.
____ without engrossment. ____ by Special message.
____ sent to the Senate for concurrence in
_____ the House amendment (s).
_____the House committee substitute bill.
____ enrolled.

____ On motion of Rep. _____, the House concurs in the (material) Senate _____ (by the following vote, ____ ____ RC) (, by EV ____ ____,) and the bill is ordered enrolled.

House Committee on Health

June 19, 2003

Minutes

The House Committee on Health met on Thursday, June 29, 2003 at 12:00 noon in Room 544 of the Legislative Office Building. A silent roll was taken. A copy of the roll denoting members present is attached to the minutes (Attachment I) along with a copy of the agenda and Visitor Registration Sheet (Attachments II and III).

Chair Insko advises that a subcommittee has been appointed to hear Rep. Blackwood's bill HB 835 A BILL TO BE ENTITLED AN ACT REQUIRING CERTAIN PHARMACIES TO PROVIDE PRESCRIPTION DRUG DISCOUNTS TO CERTAIN INDIVIDUALS dealing with prescription drugs for elderly. Rep. Barnhart, Rep. England and Chair Insko are appointed to subcommittee.

Chair Insko then recognizes Rep. Luebke to explain his bill HB 923 A BILL TO BE ENTITLED AN ACT TO EXEMPT THE PRACTICE OF COMPLEMENTARY OR ALTERNATIVE FORMS OF HEALTH CARE FROM THE PRACTICE OF MEDICINE UNDER CERTAIN CIRCUMSTANCES AND TO REQUIRE PERSONS WHO PRACTICE COMPLEMENTARY OR ALTERNATIVE FORMS OF HEALTH CARE TO REGISTER WITH THE SECRETARY OF STATE. (Attachment IV) The proposed Committee Substitute is adopted for discussion purposes (Attachment V) Rep. Luebke provides committee members with handouts pertaining to his bill. (Attachment VI)

Chair Insko recognizes Anthony Noto, Engineering Manager and President of Board Member & co-founder of Citizens for Healthcare Freedom. (Speech attached as Attachment VII) Rep. Luebke provides information to committee members for their review and consideration (Attachments VIII).

Chair Insko advises that bill will be sent to a subcommittee. Rep. Justus, Rep. Allen, Rep. Sherrill are appointed to subcommittee.

Meeting was adjourned at 12:26 p.m.

Verla Insko
Rep. Verla Insko, Chair

Pamela J. Evans
Pamela J. Evans, Committee Clerk

ATTENDANCE

HOUSE COMMITTEE ON HEALTH

DATES	6/19/03														
INSKO, Verla CHAIR	✓														
JUSTUS, Carolyn CHAIR	✓														
ENGLAND, Bob VICE-CHAIR															
ADAMS, Alma															
ALLEN, Bernard															
ALLEN, Gordon	✓														
ALLRED, Cary															
BARNHART, Jeff															
BOWIE, Joni															
CLARY, Debbie															
EARLE, Beverly															
GLAZIER, Rick															
HILTON, Mark															
McALLISTER, Mary															
MUNFORD, Don	✓														
SETZER, Mitchell	✓														
SHERRILL, Wilma															
WAINWRIGHT, William															
WILSON, Connie															
WRIGHT, Tom															
Ex officio Members															
Brubaker, Bru															
Culpepper, Bill															
Cunningham, Pete															
Eddins, Rick															

ATTACHMENT II

AGENDA

HOUSE COMMITTEE ON HEALTH

June 19, 2003
Room 544 LOB
12:00 Noon

OPENING REMARKS

Representative Verla Insko, Chair
Representative Carolyn Justus, Chair

AGENDA ITEMS

HB 923 Exempt Alt. Medicine/Practice of Medicine - Rep. Luebke

ADJOURNMENT

VISITOR REGISTRATION SHEET

HOUSE COMMITTEE ON HEALTH — JUNE 19, 2003

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
PAUL READING	Citizens for health care freedom Charlotte, NC 28211
Judith Davis	Citizens for health care freedom Matthews NC 28105
Barbara Zelter	Citizens for Healthcare Freedom Raleigh, NC.
Sharon Ryan	proponent 923
ANTHONY NOTO	CHF, KNIGHTDALE
JULIA INSLEY	CHF, DURHAM
Anne Wine	
Colette Rinkbank	CHF - Durham
Thomas Mansfield	NC Med Board
Amy Yonowitz	" " "

VISITOR REGISTRATION SHEET

HOUSE COMMITTEE ON HEALTH — JUNE 19, 2003

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Amy Jo Horne	NCMS
Crissy Forster	Smith Anderson
Mark Smith	NCAHP
John McMillan	MF&S
Amy Dobson	NC StateWatch
Karina Chapman	PPHS intern
Jonathan Gottlieb	4908 Forestville Rd. Raleigh, NC 27604
Julie Insley	Durham NC - CHF
Jane Dunbar	Health Care Freedom - Raleigh, NC
Margaret Bennett	2707 Anderson Dr Raleigh 27608
KAREN MARTELINO	WHOLE FOODS MARKET 621 BROAD ST. DURHAM, NC 27705

VISITOR REGISTRATION SHEET

HOUSE COMMITTEE ON HEALTH — JUNE 19, 2003

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Diane Cordova	Independent Weekly 2810 Hillsborough Road Durham, NC 27715
Cara Benedetto	Citizens for Health Care Freedom 110 Hilton Ave Durham NC 27707
Elena Terry	Citizens for HCF 3408 Medford Rd Durham NC 27705
Gail Zurowski	1221 Coldstream Court Raleigh NC 27615
MICHAEL (MAYO) MAHO	same as above
Rebecca Logan Walton	509 summit st Carthage NC 28327
Jeanie Britt	Ramseur NC
Elisabeth Brewer	Star, NC
Nora Gottlieb	

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2003

H 1

HOUSE BILL 923

Short Title:	Exempt Alt. Medicine/Practice of Medicine.	(Public)
Sponsors:	Representative Luebke.	
Referred to:	Health.	

April 8, 2003

A BILL TO BE ENTITLED

AN ACT TO EXEMPT THE PRACTICE OF COMPLEMENTARY OR ALTERNATIVE FORMS OF HEALTH CARE FROM THE PRACTICE OF MEDICINE.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 90-18(c) reads as rewritten:

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

(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.

(19) The practice of a complementary or an alternative form of health care, so long as the practitioner discloses to a client his or her professional training and qualifications and discloses to a client that he or she is not a licensed medical doctor. For purposes of this subdivision, complementary or alternative forms of health care shall include the healing modalities, therapies, and health care systems as defined by the National Institutes of Health's National Center for Complementary and Alternative Medicine (NCCAM), the World Health Organization-Traditional or Complementary/Alternative Medicine (WHO CAM), and the White House Commission on Complementary and Alternative Medicine Policy (WHCCAMP)."

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

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2003

H D

HOUSE BILL 923
PROPOSED COMMITTEE SUBSTITUTE H923-CSSW-34 [v.9]

6/6/2003 10:24:44 AM

Short Title: Exempt Alt. Medicine/Practice of Medicine. (Public)

Sponsors:

Referred to:

April 8, 2003

A BILL TO BE ENTITLED

AN ACT TO EXEMPT THE PRACTICE OF COMPLEMENTARY OR ALTERNATIVE FORMS OF HEALTH CARE FROM THE PRACTICE OF MEDICINE UNDER CERTAIN CIRCUMSTANCES AND TO REQUIRE PERSONS WHO PRACTICE COMPLEMENTARY OR ALTERNATIVE FORMS OF HEALTH CARE TO REGISTER WITH THE SECRETARY OF STATE.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 90-18(c) reads as rewritten:

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

(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.

(19) The practice of performing or offering to perform a complementary or an alternative health care service as defined in G.S. 90E-2(2), so long as the practitioner discloses to a client the practitioner's professional training and qualifications and discloses to a client that the practitioner is not a licensed medical doctor. "

SECTION 2. The General Statutes is amended by adding a new chapter to read:

"CHAPTER 90E.

"The Consumer Health Freedom Act.

"§ 90E-1. Title.

This Chapter shall be known and may be cited as "The Consumer Health Freedom Act".

"§ 90E-2. Definitions.

In this Chapter:

(1) "Applicant" means a person applying for registration under this Chapter.

(2) "Complementary or alternative health care service" means a healing modality, therapy, or health care system that does not involve the performance of surgery, prescribing or administering x-ray radiation, or prescribing or administering legend drugs, controlled substances, medical devices, or anesthesia, performing chiropractic adjustment of

the joints or spine, massage therapy, or performing western allopathic bio-medical disease diagnosis. "Complementary or alternative health care service" includes acupressure; aromatherapy; ayurveda; biofield therapy; cranial sacral therapy; culturally-based traditional healing practices; dance, music and art therapy; energetic modalities; folk practices; practices utilizing food and dietary supplements; individual biological therapies such as bee pollen, nutrients, and the physical forces of heat, cold, water, touch, and light; herbology or herbalism; homeopathy; therapeutic touch or body work; mind-body therapeutic practices; Native American Medicine; naturopathy; polarity therapy; reiki; traditional Tibetan practices; and Qigong.

(3) "Secretary" means the Secretary of State.

"**§ 90E-3. The practice of complementary and alternative health care permitted; registration required; exemption for persons licensed under Chapter 90.**

(a) No person shall perform or offer to perform a complementary or alternative health care service in this State unless the person is registered with the Secretary under this Chapter. No person licensed under Chapter 90 of the General Statutes shall be required to comply with this Chapter for practicing within the scope of practice for which the person is licensed.

(b) An applicant for initial registration shall file with the Secretary the information required by subsection (c) of this section on a form prescribed by the Secretary accompanied by the registration fee. No application is complete until the Secretary has received all required information.

(c) The registration application shall be comprised of all of the following information:

(1) The name of the applicant and, if any, the name of the business and the business origination date, the addresses of the principal office and all offices in this State, the name of the contact person, and the taxpayer or employer identification number.

(2) A list by jurisdiction of each name under which the applicant has practiced in the preceding five years, including any alternative names, names of predecessors, and if know, successor business entities.

(3) Any other information the Secretary considers necessary.

(d) If the Secretary finds that the applicant has not fully met the requirements for registration, the Secretary shall refuse to register the applicant and shall notify the applicant in writing of the denial, stating the grounds for the denial. Within 30 days after service of the notification, the applicant may make a written demand upon the Secretary for a review to determine the reasonableness of the Secretary's action. The review shall be completed without undue delay, and the applicant shall be notified promptly in writing as to the outcome of the review. Within 30 days after services of the notification as to the outcome, the applicant may make a written demand upon the Secretary for a hearing under Article 3A of Chapter 150B of the General Statutes if the applicant disagrees with the outcome.

"**§ 90E-4. Fees.**

(a) Each applicant for registration shall pay to the Secretary, before the issuance of the registration, a nonrefundable application fee of fifty dollars ($50.00).

(b) Fees collected by the Secretary under this Article shall be used to pay the expenses of carrying out the duties of the Secretary prescribed in this Chapter.

"**§ 90E-5. Prohibited acts; criminal penalty.**

(a) No person shall perform or offer to perform a complementary or an alternative health service without being registered under this Chapter.

(b) A person who violates this section shall be guilty of a Class 3 misdemeanor."

SECTION 3. This act becomes effective December 1, 2003, and applies to offenses committed on or after that date.

HOUSE BILL 923: EXEMPT ALT. MEDICINE/PRACTICE OF MEDICINE

BILL ANALYSIS

Committee:	House Health	**Introduced by:**	Rep. Luebke
Date:	June 10, 2003	**Summary by:**	Dianna Jessup
Version:	PCS H923-CSSW-34		Committee Counsel

SUMMARY: ***House Bill 923 would exempt the practice of alternative or complementary health care from licensure by the North Carolina Medical Board and would require those persons to register with the Secretary of State. It would be a Class 3 misdemeanor, punishable by up to 20 days' community/intermediate/active punishment, to practice or offer to practice alternative or complementary health care without being registered. The act would become effective December 1, 2003 and apply to offenses committed on or after that date.***

The PCS adds the registration requirement.

CURRENT LAW:

State law governing the practice of medicine: Article 1 of Chapter 90 of the General Statutes regulates the practice of medicine. G.S. 90-18 defines the practice of medicine and establishes penalties for practicing medicine without a license. A person is regarded as practicing medicine if the person diagnoses or attempts to diagnose, treats or attempts to treat, operates or attempts to operate on, or prescribes for or administers to, or professes to treat any human ailment, physical or mental, or any physical injury to or deformity of another person. A person practicing medicine without a license is not allowed to maintain any action to collect fees for such services and is guilty of a Class 1 misdemeanor. Eighteen exemptions currently exist from the definition of the practice of medicine.

What is complementary/alternative medicine? The National Institutes of Health's National Center for Complementary and Alternative Medicine (NCCAM) is one of the 27 institutes and centers that make up the National Institutes of Health (NIH). The NIH is one of eight agencies under the Public Health Service in the Department of Health and Human Services. The NCCAM defines CAM as a group of diverse medical and health care systems, practices, and products that are not presently considered to be a part of conventional medicine. The list of what is considered to be CAM changes continually. NCCAM classifies CAM therapies into five categories: (1) alternative medical systems that are built upon complete systems of theory and practice, i.e. naturopathic medicine, (2) mind-body interventions that use a variety of techniques designed to enhance the mind's capacity to affect bodily function and symptoms, i.e. meditation, (3) biologically based therapies that use substances found in nature such as herbs, foods, and vitamins, (4) manipulative and body-based methods that are based on manipulation and/or movement of one or more parts of the body, i.e. massage, and (5) energy therapies that involve the use of energy fields that purportedly surround and penetrate the human body or that use electromagnetic fields.

BILL ANALYSIS: House Bill 923 would exempt the practice of a complementary or alternative health care service from the practice of medicine and would require those persons who practice CAM to register with the Secretary of State. CAM would be specifically defined to mean a healing modality, therapy, or health care system that does not involve the performance of surgery, prescribing or administering x-ray radiation, or prescribing or administering legend drugs, controlled substances, medical devices, or anesthesia, performing chiropractic adjustment of the joints or spine, massage

therapy, or performing western allopathic bio-medical disease diagnosis. Persons performing any of these services would continue to be considered as engaging in the practice of medicine. CAM would include certain therapies listed in the definition. A description of those therapies is attached. Registrants would have to provide certain information to the Secretary of State and pay a $50 fee. Failure to register would be a Class 3 misdemeanor.

BACKGROUND:

According to Citizens for Healthcare Freedom, Inc., as many as 3.3 million North Carolina citizens use CAM for a large portion of their health care.

Americans made more visits to CAM providers than to all primary care physicians in 1997. Nationwide, the total number of visits to CAM providers increased from 427 million in 1990 to 629 million in 1997 (47% increase). In 1997, Americans made 386 million visits to primary care physicians compared to 629 million visits to CAM providers. Out of pocket expenses associated with CAM therapies received in 1997, are estimated at $27 billion.

Amy Compeau, Research Assistant, contributed to this summary.

H923-SMSW-001

Dear Representatives,
I am Anthony Noto, Engineering Manager by day and President, Board Member & Co-founder of Citizens for Healthcare Freedom by night... And husband & father of 3 by both...

I am an engineer & scientist, to me there is nothing that makes more sense & is more scientific than to realize a human must be treated as a whole.

There is nothing that makes more sense than the body being the only thing that can heal & reverse symptoms of disease when in fact it alone has created all of its symptoms.

There is nothing that makes more sense than the fact that treating the body to life enhancing, pro-life therapies is far safer than pharmaceuticals that attempt to control, manipulate, & many times kill life principles. It is pretty simple folks, just by their nature these therapies must be far safer.

These are the simple facts:
Millions of North Carolinians use alternative therapies every year. Many studies have been done to show their safety, as well as to prove they help promote & maintain health.

Safety is not an issue good people, despite the rhetoric you may hear from the medical industry, who happen to kill 250,000 (JAMA, July, 2000, "Is US Healthcare Really the Best in the World") Americans each year with properly prescribed medicines & seriously injures approx 2.4 Million more.

The problem is that 90% of these citizens don't tell their medical doctors about their alternative practitioner for three reasons. First they know that doing so could harm the practitioner due to the technicality in the medical licensing law. Second they don't want their MD accusing them of seeing a quack. And thirdly, the number 1 identified reason, they do not feel that their MD is knowledgeable about these therapies.

It is about time that we recognize these therapies in the open. Most of these practitioners are formally trained & certified, those that aren't are practicing culturally traditional therapies passed down through generations. These therapies do not belong under the jurisdiction of the medical doctor's licensing law!

We must allow open referrals back & forth as they do in other industrialized countries. The Allopathic medical machine has been at war with alternatives for hundreds of years. If the pharmaceutical model is such a great system of

medicine, why do they have to waste their time to discredit & malign other therapies? Chiropractors were only set free after winning several court battles against the AMA & other medical industry groups.

They claim to be the bastions of science, but the reality is that there is very little science in their practice of medicine. Need I remind everyone of the constant changes in their stance on almost all health issues? 30 years ago they would scoff at the idea of diet affecting your health. Operations for Stomach Ulcers, Tonsillectomies, and Hysterectomies were once the current rage. Wonder drugs such Thalidomide, Seldane, Cisapride, & soon possibly Paxil later ruled as harmful. One recent Harvard study showed that up to one fifth of all new prescription drugs may ultimately be recalled or produce potentially harmful side effects (JAMA May, 2002). "Side effect" what a great marketing term!

Eat butter, don't eat butter, eat butter again; don't eat salt, eat salt. Listen soon to what you'll here about for eggs & cholesterol containing foods...

The holistic community of practitioners has not changed their position once on any of these issues. Why, because their position is based on logic, they make sense. You don't need a study to prove what makes sense.

Dear representatives, speaking of sense, it makes no sense not to have this exemption in the medical licensing law, the benefits include:
-Allowing communication between conventional & non-conventional modalities, which can improve the overall health care of patients
-Allowing holistic professionals to advertise without fear of persecution, thereby making it easier for citizens to shop for the appropriate practitioner
-Attracting & encouraging more healers to stay in & move to NC
-Allowing patients to be honest with their conventional physicians about their alternative therapies
-Encouraging medical doctors to learn more about the alternatives
-Encouraging insurance coverage of these less expensive & preventative therapies

This bill carries zero cost to NC & its citizens, & has everything for us to gain.
Several states have already made the change to their medical licensing law, others are in process.
Please pass H 923 this session! The people want & deserve this ASAP!

Thank you for you time!

" Unless we put medical freedom into the Constitution, the time will come when medicine will organize into an underground dictatorship... To restrict the art of healing to one class of men and deny equal privileges to others will constitute the Bastille of medical science. All such laws are un-American and despotic and have no place in a republic... The Constitution of this republic should make special privilege for medical freedom as well as religious freedom."
Dr Benjamin Rush, signer of the Declaration of Independence

BRIEF DESCRIPTION OF COMPLEMENTARY OR ALTERNATIVE HEALTH CARE SERVICES IN HOUSE BILL 923

(FROM INTERNET RESOURCES ON THE SUBJECT)

Acupressure is a form of touch therapy that utilizes the principles of acupuncture and Chinese medicine. In acupressure, the same points on the body are used as in acupuncture, but are stimulated with finger pressure instead of with the insertion of needles. Acupressure is used to relieve a variety of symptoms and pain.

Aromatherapy is the therapeutic use of plant-derived, aromatic essential oils to promote physical and psychological well-being. It is sometimes used in combination with massage and other therapeutic techniques as part of a holistic treatment approach.

Ayurveda is a holistic system of healing which evolved among the Brahmin sages of ancient India some 3000-5000 years ago. There are several aspects of this system of medicine which distinguish it from other approaches to health care:

1. It focuses on establishing and maintaining balance of the life energies within us, rather than focusing on individual symptoms.
2. It recognizes the unique constitutional differences of all individuals and recommends different regimens for different types of people. Although two people may appear to have the same outward symptoms, their energetic constitutions may be very different and therefore call for very different remedies.
3. Ayurveda recognizes that all intelligence and wisdom flows from one Absolute source (*Paramatman*). Health is a result of the grace of the Absolute acting through the laws of Nature (*Prakriti*). Ayurveda promotes harmony between the individual and Nature by living a life of balance according to Nature's laws.
4. Ayurveda describes three fundamental energies that regulate all natural processes on both the macrocosmic and microcosmic levels. The same energies that produce effects in the various galaxies and star systems are also operating in your own physiology. These three universal energies are known as the *Tridosha*.
5. Finally, the ancient Ayurvedic physicians realized the need for preserving the alliance of the mind and body. Ayurveda seeks to heal the fragmentation and disorder of the mind-body complex and restore wholeness and harmony to all people.

Biofield therapies are intended to affect energy fields that purportedly surround and penetrate the human body. The existence of such fields has not yet been scientifically proven. Some forms of energy therapy manipulate biofields by applying pressure and/or manipulating the body by placing the hands in, or through, these fields. Examples include Qi gong, Reiki, and Therapeutic Touch.

Cranial Sacral Therapy (CST) is a gentle, hands-on method of evaluating and enhancing the functioning of a physiological body system called the craniosacral system - comprised of the membranes and cerebrospinal fluid that surround and protect the brain and spinal cord. Using a soft touch generally no greater than 5 grams, or about the weight of a nickel, practitioners release restrictions in the craniosacral system to improve the functioning of the central nervous system. CST is increasingly used as a preventive

health measure for its ability to bolster resistance to disease, and is effective for a wide range of medical problems associated with pain and dysfunction, including migraine headaches, autism, and traumatic brain and spinal cord injuries.

Culturally Based Traditional Healing Practices: Traditional medicine refers to ways of protecting and restoring health that existed before the arrival of modern medicine. As the term implies, these approaches to health belong to the traditions of each country, and have been handed down from generation to generation. In practice, the term "traditional medicine" refers to the following components: acupuncture, traditional birth attendants, mental healers and herbal medicine.

Dance, Music, and Art Therapy:

- **Dance Therapy** is the psychotherapeutic use of movement as a process that furthers the emotional, cognitive, social and physical integration of the individual. Dance/Movement therapists work with individuals who have social, emotional, cognitive and/or physical problems. They are employed in psychiatric hospitals, clinics, day care, community mental health centers, developmental centers, correctional facilities, special schools and rehabilitation facilities.

- **Music Therapy** is the prescribed use of music by a qualified person to effect positive changes in the psychological, physical, cognitive, or social functioning of individuals with health or educational problems.

- **Art Therapy** is defined as a human service profession that uses art media, images, the creative process, and patient/client responses to the created products as reflections of an individual's development, abilities, personality, interests, concerns, and conflicts. Art therapy practice is based on knowledge of human developmental and psychological theories which are implemented in the full spectrum of models of assessment and treatment including educational, psychodynamic, cognitive, transpersonal, and other therapeutic means of reconciling emotional conflicts, fostering self-awareness, developing social skills, managing behavior, solving problems, reducing anxiety, aiding reality orientation, and increasing self-esteem.

Energetic Modalities of therapy include acupuncture, homeopathy, and isopathy. All of these modalities are predicated on the idea that a life-force exists in the body, whose proper flow throughout the body is disturbed in a disease process. These energetic modalities of therapy rebalance and harmonize the flow of life-force to promote greater health in the body.

Folk Practices are a part of the culture of the specific group. They consist of preventive and remedial measures. Among the interventions frequently utilized include prayers, incantations, use of incense, herb-teas, BARIDAS (sweeping the body using special aromatic leaves and branches), use of various secretive remedies, burning of candles, use of ointments, etc. in ritualistic fashion, so as to produce a magical effect). Each type of illness or ailment generally requires a specific approach or treatment.

Practices Utilizing Food, Food and Dietary Supplements, Individual Biological Therapies such as Bee Pollen, Nutrients, and the Physical Forces of Heat, Cold, Water, Touch, and Light:

- **Diet and Nutrition:** The role of diet in the treatment of illness is extremely controversial in the medical profession. In complementary medicine, however, it is believed that modifying an individual patient's diet in specific ways according to his body requirements can reduce the inflammatory reactions of the body. Because all material traversing the intestinal lining is inspected by the immune system, it is felt that individuals with an abnormal immune system can develop an abnormal inflammatory response on exposure to antigens in the gut.

- **Dietary Supplement:** Congress defined the term "dietary supplement" in the Dietary Supplement Health and Education Act (DSHEA) of 1994. A dietary supplement is a product (other than tobacco) taken by mouth that contains a "dietary ingredient" intended to supplement the diet. Dietary ingredients may include vitamins, minerals, herbs or other botanicals, amino acids, and substances such as enzymes, organ tissues, and metabolites. Dietary supplements come in many forms, including extracts, concentrates, tablets, capsules, gelcaps, liquids, and powders. They have special requirements for labeling. Under DSHEA, dietary supplements are considered foods, not drugs.

- **Bee Pollen:** A Superfood is a rare occurrence in nature. It is when a food source is produced which is highly concentrated, with a complex supply of quality nutrients. Bee Pollen is the most famous Superfood. Because Bee Pollen is the reproductive spore of the plant, it is incredibly dense with plant nutrients. These nutrients fall into the category of Polyphenols, and they often function as antioxidants. Bee Pollen contains the highest antioxidant activity (ORAC results) and polyphenol content of any fruits and vegetables yet tested. Bee Pollen also contains enzymes, phytosterols, free amino acids, fatty acids with a good proportion of Omega 3 and 6 fatty acids, naturally chelated minerals, and whole vitamin complexes.

Herbology or Herbalism:
There are several types of herbal medicine systems that are used today; European, Native American, Chinese, Ayurvedic, and Western herbalism are the most prevalent systems. Despite differences in terminology and in the herbs used, there is a common thread that joins these systems: all of these systems treat the body as a 'whole', and they each utilize the energy of plants to 'work as needed' in synergy with the natural energy in each individual.

Homeopathy:
Homeopathic medicine is a CAM[1] alternative medical system. In homeopathic medicine, there is a belief that "like cures like" meaning that small, highly diluted quantities of medicinal substances are given to cure symptoms, when the same substances given at higher or more concentrated doses would actually cause those symptoms.

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[1] Complementary or alternative medicine.

Therapeutic Touch or Body Work:

- **Therapeutic Touch** is derived from an ancient technique called laying-on of hands. It is based on the premise that it is the healing force of the therapist that affects the patient's recovery; healing is promoted when the body's energies are in balance; and, by passing their hands over the patient, healers can identify energy imbalances.

- **Asian Bodywork Therapy** is the treatment of the human body/mind/spirit, including the electromagnetic or energetic field, which surrounds, infuses and brings that body to life, by pressure and/or manipulation. Asian Bodywork is based upon traditional Chinese Medical principles for assessing and evaluating the energetic system. It uses traditional Asian techniques and treatment strategies to primarily affect and balance the energetic system for the purpose of treating the human body, emotions, mind, energy field and spirit for the promotion, maintenance and restoration of health.

Mind-Body Therapeutic Practices: The basic principle of mind body therapy is that there are healing resources within the brain that can be used to help heal the body or its emotional state. Mind body therapy has several points of impact for the treatment and prevention of illnesses:

- Improved biological functioning (e.g., improved blood pressure);
- Reduced risks factors for disease; and
- Improved behavioral, psychological, and social functioning.

It is able to do so, in part, because of the mind's interconnectivity with (and influence over) key systems of the body: cardiovascular, immune, hormonal and metabolic, and reproductive. Practitioners of mind body therapy emphasize that it is more important to understand the person having the disease, rather than to understand the disease within the person. Mind body therapy is a tool that helps a patient gain control over the obstacles and effects of disease presented to the mind and body. Mind body therapy also can help a person live life with a greater measure of contentment and less vulnerability to the harmful effects of stress, anger, or frustration, so that they can live their lives more fully—whether or not they have a chronic disease.

Native American Medicine: Native American medicine is an umbrella term that encompasses the healing beliefs and practices of all the indigenous people of North America. Its therapeutic approach combines spirituality, herbalism, and magic in treating a wide range of physical and emotional ailments--from the common cold to depression. Because Native Americans believe that the health of an individual is inextricably linked to the people and objects surrounding that person, their healing practices promote harmony among everyone in a community--and with the physical environment and the spiritual world as well. Although there are variations in the specific healing methods of the different Native American nations (also called "tribes"), four practices are common to most. These practices include:

- The involvement of healers, also referred to as "medicine men," "medicine women," or "shamans" (although some Native Americans find the term "shaman" to be inappropriate because it is European in origin)
- The use of herbal remedies

- The employment of ritual purification or purging
- The observance of other symbolic rituals and ceremonies.

Naturopathy: Naturopathic medicine is a CAM alternative medical system in which practitioners work with natural healing forces within the body, with a goal of helping the body heal from disease and attain better health. Practices may include dietary modifications, massage, exercise, acupuncture, minor surgery, and various other interventions.

Polarity Therapy: is a comprehensive health system involving energy-based bodywork, diet, exercise and self- awareness. It works with the Human Energy Field, electro-magnetic patterns expressed in mental, emotional and physical experience. In Polarity Therapy, health is viewed as a reflection of the condition of the energy field, and therapeutic methods are designed to balance the field for health benefit.

Reiki: is a Japanese word representing Universal Life Energy. Reiki is based on the belief that when spiritual energy is channeled through a Reiki practitioner, the patient's spirit is healed, which in turn heals the physical body.

Traditional Tibetan Practices: The philosophical basis of Tibetan medicine is rooted in Buddhism. The historical Buddha Shakyamuni, sometimes called the Supreme Physician, is said to have first taught a healing system in India during the 6th century B.C. In many of his teachings, the Buddha used disease and healing as metaphors to illustrate his philosophy of the human condition. From the Buddhist perspective, physical illness is inextricably bound with mental, social and spiritual illness. Thus, the Buddhist medical system is more than studies of anatomy, physiopathology and pharmacopoeia. It is a guide to "right living" and involves the spiritual aspects of healing as well. When examining a patient, the practitioner begins by assessing the patient's constitution, which may be a combination of the three principles of energy. This examination includes observing the patient, making inquiries, and pulse-taking. Then, the practitioner determines a reason for the imbalance and implements a method of restoring balance.

Qigong: is a component of traditional Chinese medicine that combines movement, meditation, and regulation of breathing to enhance the flow of qi (an ancient term given to what is believed to be vital energy) in the body, improve blood circulation, and enhance immune function.

The Coalition for Natural Health

VIA ELECTRONIC MAIL AND U.S. MAIL

April 23, 2003

The Honorable Verla C. Insko
2121 Legislative Building
Raleigh, NC 27601-1096

RE: House Bill 923

Dear Representative Insko:

On behalf of the employees, members, and other stakeholders of the Coalition for Natural Health ("Coalition"), I am pleased to advise you of our complete and enthusiastic support of House Bill 923.

For your general information, the Coalition is a national, non-profit organization that works to protect and create natural health freedom for both practitioners of natural healing therapies and consumers. We have several thousand members nationwide and over 300 members live in North Carolina.

The merits of HB 923 are both numerous and substantial. By taking a number of natural, highly sought-after therapies – which present no risk of harm to consumers – out from under the medical practices act, natural healers can offer their services without fear of prosecution, thus greatly expediting the delivery of these therapies. As fear of criminal prosecution subsides, entry into the field by would-be practitioners and consumer confidence will increase, thus creating a stronger economy. Having more choices for their health care needs will also liberate consumers.

In our opinion, the most important reason for passing this bill is that this bill will get these valuable therapies into the marketplace. The result will be greatly improved health for the people of this state.

I respectfully encourage you and your fellow committee members to look favorably upon this bill. Thank you for your consideration.

Sincerely,

Executive Director
Coalition for Natural Health

cc: Representative Paul Luebke, Sponsor
Members of the House Health Committee

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Rep Paul
Luebke

HEALTH FREEDOM LEGISLATION:

States where Health Freedom legislation has been enacted:

Oklahoma	inherent
Minnesota	2000
Rhode Island	2001
California	2002
Idaho	2002

States where Health Freedom legislation has been introduced in the current session of the legislature:

Florida
Georgia
Iowa
New Jersey
New York

States where plans are underway to introduce Health Freedom legislation:

Arkansas
Kansas
Massachusetts
Wisconsin

RALEIGH
NEUROLOGY
ASSOCIATES, P.A.

June 18, 2003

Steve Keene
General Counsel
North Carolina Medical Society
Fax: 833-2023

Dear Mr. Keene:

It was a pleasure to speak with you today with regard to the issue of the safety of alternative medical therapies. As I explained to you it has been my experience that many patients are treated for a variety of neurological illnesses with alternative therapies. Let me provide you two examples in which these were not so harmless as the patients had been led to believe.

The first individual was a lady in her mid 60's who had a long history of sustained high blood pressure (hypertension). She had been treated by her internist with standard antihypertensive medications. She saw a practitioner of alternative health care methods here in our community who suggested that her blood pressure could be better controlled by chelation therapy. He recommended that she stop all of her blood pressure medicine and undergo chelation therapy. She did this. After several chelation treatments and after not being on her blood pressure medicine, she was admitted to the hospital with a massive intracerebral hemorrhage from which she subsequently died. Her family was quite distressed when they found out that she had stopped her medication without having notified either them or her internist. This is clearly an example of how an alternative form of therapy was presented to the patient without the patient having any clear explanation or understanding of the risks of cessation of a blood pressure medication. The patient was also given no understanding of the actual risks of chelation therapy. There is a well recognized standard of medical care that the most effective way of preventing intracerebral hemorrhage is to control blood pressure. This had been done effectively over the years with appropriate medication. I think her acute illness and death were directly attributable to poor advice.

A second example in my experience had a more favorable and less catastrophic outcome. Nonetheless the patient became acutely ill. This was a patient of mine that I had taken care of for many years who had migraine headaches. I provided a standard medication for her (Imitrex), which she took, but she did not like the way it made her feel. I switched her from Imitrex to a similar medication called Zomig. She called me shortly after taking a Zomig tablet with complaints of rapid heart beat, agitation, sweating and feelings of impending doom. I arranged for her to be brought to my office

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immediately. In the meantime I called the pharmaceutical company and described the reaction. They asked me if the patient concurrently was taking St. John's wort. This is an over-the-counter preparation for which there are absolutely no regulations. In fact, when the patient arrived and her symptoms were subsiding, she told me that she was taking this medication. What she has is what was called a Serotonin syndrome which was not a reaction to the medication, but was rather a reaction because of the interaction between a standard medicine and an over-the-counter alternative health preparation. My point is that the over-the-counter preparations are not entirely benign and there are potentially serious reactions between these preparations and standard medications. This patient received St. John's wort through an alterative health practitioner who led her to believe that the drug was perfectly safe.

It is certainly well within a patient's rights to be treated with alternative therapeutic measures, but it strikes me that those who hold themselves out to the public as being practitioners of healing arts should be subject to the same kinds of regulations that physicians, chiropractors, podiatrists, psychiatrists and psychologists are subjected to.

Sincerely,

S. Mitchell Freedman, MD
SMF:wr

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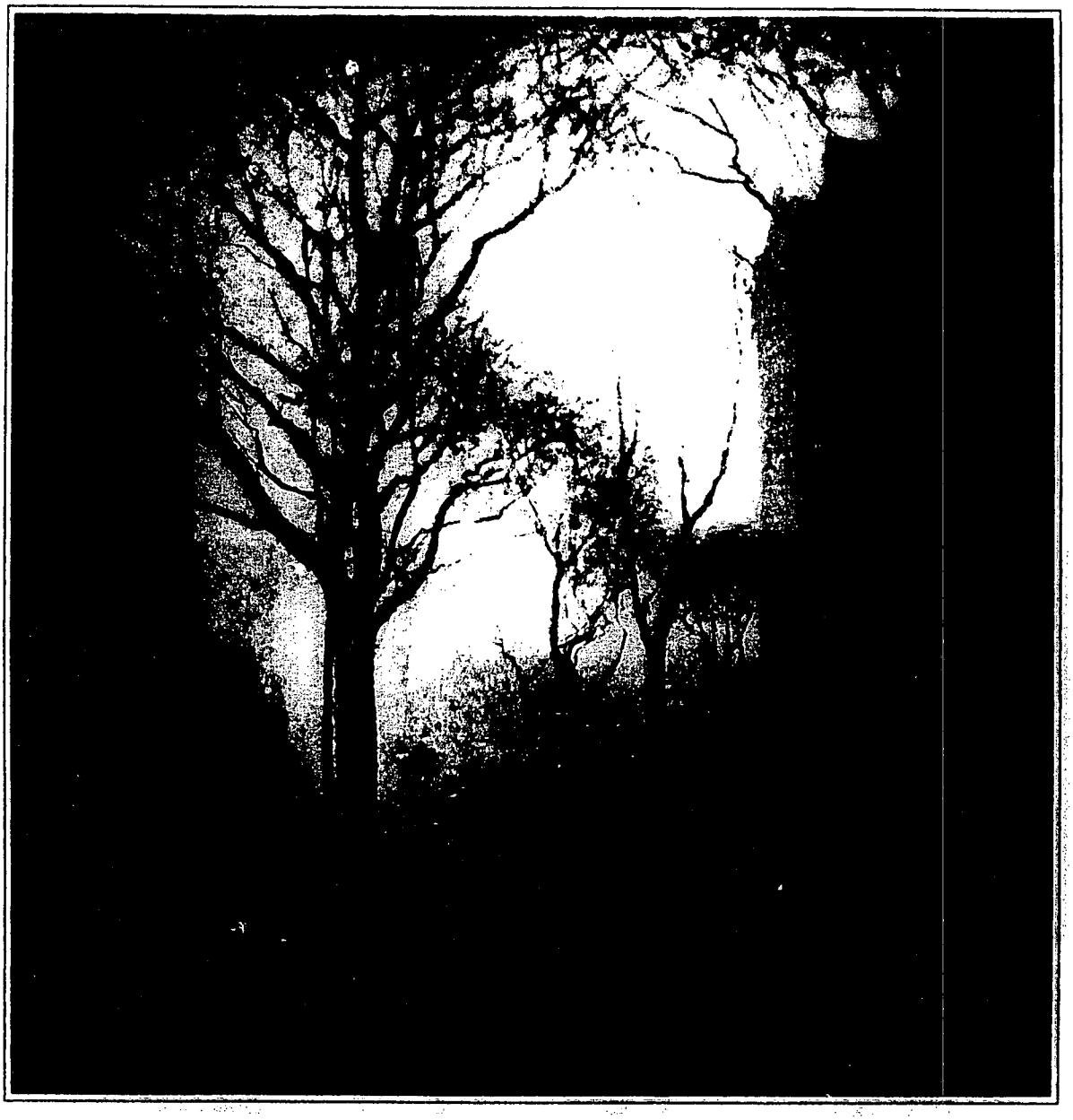
The Journal of the American Medical Association

April 15, 1998



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Rep. Luebke

Incidence of Adverse Drug Reactions in Hospitalized Patients

A Meta-analysis of Prospective Studies

Jason Lazarou, MSc; Bruce H. Pomeranz, MD, PhD; Paul N. Corey, PhD

Objective.—To estimate the incidence of serious and fatal adverse drug reactions (ADR) in hospital patients.

Data Sources.—Four electronic databases were searched from 1966 to 1996.

Study Selection.—Of 153, we selected 39 prospective studies from US hospitals.

Data Extraction.—Data extracted independently by 2 investigators were analyzed by a random-effects model. To obtain the overall incidence of ADRs in hospitalized patients, we combined the incidence of ADRs occurring while in the hospital plus the incidence of ADRs causing admission to hospital. We excluded errors in drug administration, noncompliance, overdose, drug abuse, therapeutic failures, and possible ADRs. Serious ADRs were defined as those that required hospitalization, were permanently disabling, or resulted in death.

Data Synthesis.—The overall incidence of serious ADRs was 6.7% (95% confidence interval [CI], 5.2%-8.2%) and of fatal ADRs was 0.32% (95% CI, 0.23%-0.41%) of hospitalized patients. We estimated that in 1994 overall 2 216 000 (1 721 000-2 711 000) hospitalized patients had serious ADRs and 106 000 (76 000-137 000) had fatal ADRs, making these reactions between the fourth and sixth leading cause of death.

Conclusions.—The incidence of serious and fatal ADRs in US hospitals was found to be extremely high. While our results must be viewed with circumspection because of heterogeneity among studies and small biases in the samples, these data nevertheless suggest that ADRs represent an important clinical issue.

JAMA. 1998;279:1200-1205

PUBLIC ATTENTION is currently focused on adverse drug reactions (ADR) as evidenced by a recent bill passed by the US Senate requiring pharmaceutical companies to provide ADR information to consumers.[1] Heightened interest in ADRs was stimulated by the thalidomide tragedy in the 1960s.[2] To obtain an accurate estimate of ADR incidence in hospital patients, prospective studies were done, beginning in the 1960s, in which a defined population could be kept under close observation by monitors who recorded all ADR occurrences.[3-5] These prospective studies have been done on 2 separate populations of patients; those admitted to the hospital due to an ADR (ADRAd),[6] and those experiencing an ADR while in the hospital (ADRIn).[7] We report here a meta-analysis of 39 of these prospective studies done in the United States over a period of 32 years from which we obtained ADR incidences for ADRIn and for ADRAd and an overall ADR incidence that combines these 2 groups. We focused mainly on serious and fatal ADRs since they represent the greatest impact of drug therapy. While recognizing the benefits of drug therapy, we chose not to compare benefits of drugs to the side effects of drugs.

From the Departments of Zoology (Mr Lazarou and Dr Pomeranz), Physiology (Dr Pomeranz) and Public Health Sciences (Dr Corey), University of Toronto, Toronto, Ontario.

Reprints: Bruce H. Pomeranz, MD, PhD, Departments of Physiology and Zoology, University of Toronto, 25 Harbord St, Toronto, Ontario, Canada M5S 3G5 (e-mail: pomeranz@zoo.utoronto.ca).

METHODS

Definitions

One step we took to reduce heterogeneity was to exclude any data that did not use the following specific definitions:

Adverse Drug Reaction (ADR).—According to the World Health Organization definition,[8] this is any noxious, unintended, and undesired effect of a drug, which occurs at doses used in humans for prophylaxis, diagnosis, or therapy. This definition excludes therapeutic failures, intentional and accidental poisoning (ie, overdose), and drug abuse.[8] Also, this does not include adverse events due to errors in drug administration or noncompliance (taking more or less of a drug than the prescribed amount).[8] Using this conservative definition avoids overestimating the ADR incidence.

For editorial comment see p 1216.

Recently, some authors prefer the term *adverse drug event* (ADE), which is an injury resulting from administration of a drug. In contrast to the World Health Organization definition of ADR, the definition of ADE includes errors in administration.[9] However, we have chosen the World Health Organization definition for ADR because of its frequent use in the studies that we analyzed, and because of our goal to estimate injuries incurred by drugs that were properly prescribed and administered. In those articles that did not use the World Health Organization definition (eg, ADE was used), we examined the raw data and removed adverse events due to errors in administration. However, this was not always feasible since a few articles may have included errors in administration but did not report them separately. Therefore, unfortunately, these latter articles added to the heterogeneity of our data.

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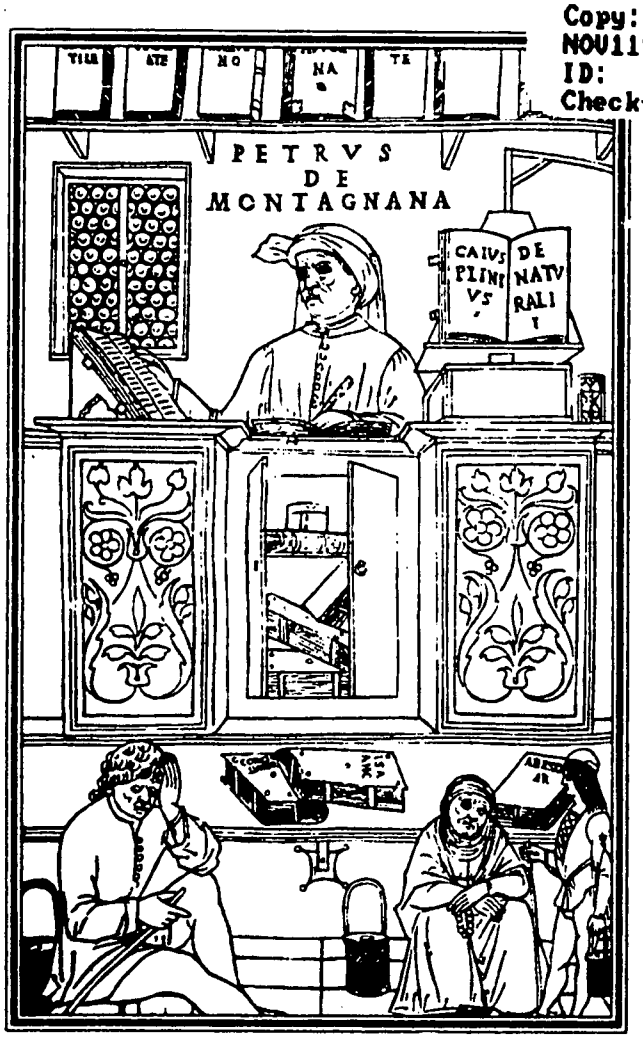

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Rep. Paul Wellstone

Trends in Alternative Medicine Use in the United States, 1990-1997

Results of a Follow-up National Survey

David M. Eisenberg, MD; Roger B. Davis, ScD; Susan L. Ettner, PhD; Scott Appel, MS; Sonja Wilkey; Maria Van Rompay; Ronald C. Kessler, PhD

Context.—A prior national survey documented the high prevalence and costs of alternative medicine use in the United States in 1990.

Objective.—To document trends in alternative medicine use in the United States between 1990 and 1997.

Design.—Nationally representative random household telephone surveys using comparable key questions were conducted in 1991 and 1997 measuring utilization in 1990 and 1997, respectively.

Participants.—A total of 1539 adults in 1991 and 2055 in 1997.

Main Outcomes Measures.—Prevalence, estimated costs, and disclosure of alternative therapies to physicians.

Results.—Use of at least 1 of 16 alternative therapies during the previous year increased from 33.8% in 1990 to 42.1% in 1997 ($P \leq .001$). The therapies increasing the most included herbal medicine, massage, megavitamins, self-help groups, folk remedies, energy healing, and homeopathy. The probability of users visiting an alternative medicine practitioner increased from 36.3% to 46.3% ($P = .002$). In both surveys alternative therapies were used most frequently for chronic conditions, including back problems, anxiety, depression, and headaches. There was no significant change in disclosure rates between the 2 survey years; 39.8% of alternative therapies were disclosed to physicians in 1990 vs 38.5% in 1997. The percentage of users paying entirely out-of-pocket for services provided by alternative medicine practitioners did not change significantly between 1990 (64.0%) and 1997 (58.3%) ($P = .36$). Extrapolations to the US population suggest a 47.3% increase in total visits to alternative medicine practitioners, from 427 million in 1990 to 629 million in 1997, thereby exceeding total visits to all US primary care physicians. An estimated 15 million adults in 1997 took prescription medications concurrently with herbal remedies and/or high-dose vitamins (18.4% of all prescription users). Estimated expenditures for alternative medicine professional services increased 45.2% between 1990 and 1997 and were conservatively estimated at $21.2 billion in 1997, with at least $12.2 billion paid out-of-pocket. This exceeds the 1997 out-of-pocket expenditures for all US hospitalizations. Total 1997 out-of-pocket expenditures relating to alternative therapies were conservatively estimated at $27.0 billion, which is comparable with the projected 1997 out-of-pocket expenditures for all US physician services.

Conclusions.—Alternative medicine use and expenditures increased substantially between 1990 and 1997, attributable primarily to an increase in the proportion of the population seeking alternative therapies, rather than increased visits per patient.

JAMA. 1998;280:1569-1575

From the Center for Alternative Medicine Research and Education, Department of Medicine, Beth Israel Deaconess Medical Center (Drs Eisenberg and Davis, Mr Appel, and Mss Wilkey and Van Rompay), and the Department of Health Care Policy, Harvard Medical School (Drs Ettner and Kessler), Boston, Mass.

Reprints: David M. Eisenberg, MD, Center for Alternative Medicine Research and Education, Beth Israel Deaconess Medical Center, 330 Brookline Ave, Boston, MA 02215

ALTERNATIVE medical therapies, functionally defined as interventions neither taught widely in medical schools nor generally available in US hospitals,[1] have attracted increased national attention from the media, the medical community, governmental agencies, and the public. A 1990 national survey of alternative medicine prevalence, costs, and patterns of use[1] demonstrated that alternative medicine has a substantial presence in the US health care system. Data from a survey in 1994[2] and a public opinion poll in 1997[3] confirmed the extensive use of alternative medical therapies in the United States. An increasing number of US insurers and managed care organizations now offer alternative medicine programs and benefits.[4] The majority of US medical schools now offer courses on alternative medicine.[5]

National surveys performed outside the United States suggest that alternative medicine is popular throughout the industrialized world.[6] The percentage of the population who used alternative therapies during the prior 12 months has been estimated to be 10% in Denmark (1987),[7] 33% in Finland (1982),[8] and 49% in Australia (1993).[9] Public opinion polls and consumers' association surveys suggest high prevalence rates throughout Europe and the United Kingdom.[10-13] The percentage of the Canadian population who saw an alternative therapy practitioner during the previous 12 months has been estimated at 15% (1995).[14] The wide range of utilization rates can be explained, in part, by the disparity in definitions of alternative therapy and the selection of therapies assessed.

The presumption is that alternative medicine use in the United States has increased at a considerable pace in recent years. The purpose of this follow-up national survey was to investigate this presumption and document trends in alternative medicine prevalence, costs, disclosure of use to physicians, and correlates of use since 1990.

METHODS

Sample

We conducted parallel nationally representative telephone surveys in 1991 and 1997. Survey methods were approved by the Beth Israel Deaconess Institutional Review Board, Boston, Mass.

The New York Times Magazine
MARCH 16, 2003 / SECTION 6

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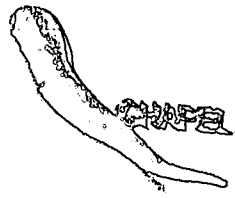

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Half of what doctors know is wrong

Can prevention kill you?

Is it ever O.K. for a doctor to refuse to treat a patient?

Are nurses expendable?

Should the results of an insidious experiment be ignored?

Are men the stronger sex?

What's really responsible for the malpractice morass?

Can old-fashioned treatments still work?

An issue exploring medicine and its myths.

Rep. Luebke

The New York Times Magazine / MARCH 16, 2003

Medicine's Progress, One Setback at a Time

The history of medicine is a long, serpentine narrative of the death of old ideas giving way to the birth of new ones. And this cycle is moving faster than ever. **BY LISA SANDERS, M.D.**

A decade ago, I stood alongside my 99 fellow freshmen as we were welcomed into the ranks of medicine in a "white coat ceremony." Here, on our first day of med school, we were presented with the short white coats that proclaimed us part of the mystery and the discipline of medicine. During that ceremony, the dean said something that was repeated throughout my education: half of what we teach you here is wrong — unfortunately, we don't know which half.

At the time it was hard to believe. Within those walls, in the anatomy lab, in the lecture hall, you feel that you are being shown the secrets of how the body is put together, how it lives, how it works, how it dies. It has the feel of authority and certainty. Like math, it has a feeling of inevitability.

But now, as a practicing doctor and teacher of residents, I relive that dean's aphorism daily. Medicine is, and always has been, an evolving discipline. And this necessarily means that what we know about medicine is constantly changing; that medicine is forever putting forth, and simultaneously upending, assumptions (as can be seen in the accompanying chart). This is particularly true at this moment. Virtually all of our

medical therapeutic options are being questioned, evaluated and re-evaluated by researchers across the globe. Certainly in this century there will be new genes discovered and inventions developed, but medical progress right now centers on the rapid displacement of old ideas to make room for new knowledge. Medicine, always a fluid and dynamic science, is in the midst of a major growth spurt.

This wave of research changes what we as doctors do almost daily. When I started on the wards as a third-year medical student, for example, we were taught that the use of beta blockers, a class of powerful medicines for the treatment of high blood pressure, could endanger the life of a patient with heart failure. The thinking was that beta blockers, which slow the heart rate, could make an already poorly performing heart perform even worse.

Now, less than eight years later, the opposite is thought to be true: beta blockers reduce the risk of death in patients who suffer heart failure. By slowing the heart, reducing its workload, a poorly performing heart improves. We know this now because researchers tested both theories, side by side, to see which was correct. One group of patients with heart failure was treated with beta blockers, another identical group was not. After several years the answer was clear. Beta blockers are now a widely accepted therapy for heart failure.

These rigorous studies, and their sometimes counterintuitive results, make up the headlines of medical journals — and sometimes daily papers — announcing essentially the death of one idea or the birth of another.

This is a relatively new phenomenon. Although the first randomized controlled trial was done more than half a century ago (in that study researchers tested the use of an early antibiotic against TB), it wasn't until the 70's that this sort of scientific examination came into widespread use. Therapies of all kinds had blossomed and so had the expectation that there needed to be a systematic way of evaluating their effectiveness.

By the late 90's, doctors had the appetite for this type of information, and researchers had the technique. Before the computer made its way into virtually every office, doctors often had filing cabinets where they kept articles on topics of interest. It was a reasonable way to keep track of a small amount of data but was easily overwhelmed by the new flood of research. It was technology — the computer, the Internet — that finally made it possible for the doctors in the trenches, doctors taking care of patients, to systematically practice what could be considered "evidence-based medicine." We all now have access to the newest and best in medical research right at our own desks. We can find out quickly, for example, that arthroscopic knee surgery for osteoarthritis and postmenopausal hormone replacement for the prevention of heart disease have lost their standing as effective therapies and even that certain techniques discarded long ago can serve a new purpose. (Leeches, for example, are now used on some patients to treat the pain of arthritis.)

How do you arrive at a treatment

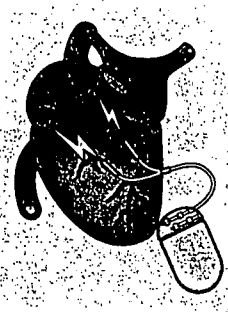
Pneumonia

In 1855, John Hughes Bennett made pioneering use of statistics to show that the common practice of bloodletting with leeches increased the mortality of pneumonia victims.

Mucolytica — medicines that promote expectoration — were key treatments up to the early 1900's. Iodide was given to make phlegm less sticky, but many were allergic to it.

Then came antibiotics. After World War II, penicillin nearly brought pneumonia to its knees. Fatalities from the great killer dropped from 200 per 100,000 cases in 1900 to 31 per 100,000 in 1949.

We may be victims of our own success: some strains of microbes are becoming multidrug resistant, and they require a new generation of antibiotics.



Irregular Heart Rhythms

The electrocardiogram (EKG) made its debut in 1895. Irregular heartbeats were corrected by dunking patients' heads in ice water or by vigorously massaging their necks. (In the right hands, both still work.)

In 1947, Claude Beck figured out how to short-circuit an errantly beating heart electrically, but the procedure could be performed only on an exposed heart in an operating room.

In 1956, Paul Zoll found a way to shock the heart into regular rhythms through the chest. In 1958, implantable pacemakers were invented. Doctors liberally prescribed new anti-arrhythmic drugs.

Studies show that anti-arrhythmic drugs were overprescribed and killed at least 50,000 patients. They are still used — cautiously. Sophisticated pacemakers called cardioverters read and treat arrhythmias on the spot.

RECENTLY, A PATIENT I took care of in the hospital brought that point home to me. She was a youngish woman, in her 40's, with honey-colored hair and bright blue eyes. She had come to this small Connecticut city from her farm in Maine to judge a local dog show, and on the way to the show she had fainted twice. In the E.R., she seemed a little winded, her heart was beating more rapidly than normal and the oxygen meter on her finger showed that despite her efforts she wasn't getting quite as much oxygen as she needed.

She had no fever, chills or cough, and a chest X-ray confirmed that she didn't have pneumonia. A lung scan showed that she had a pulmonary embolus, a clot from somewhere in her veins that had broken loose and traveled to her lungs. She was put on a blood thinner and admitted to the hospital. After a couple of days, she felt better and expressed her eagerness to go home: "I've got four collies and a husband, and they need me."

Most patients with a pulmonary embolus are started on blood thinners and sent home within a few days. But since our patient lived an eight-hour car ride away, I was worried. Travel is a risk factor for this disease. When you don't move — for example, when you're sitting in a car for a long stretch of time — your blood doesn't move, and whenever blood slows down, there is a chance of clots forming. When you start moving again, the clots can break free and travel to the vital organs.

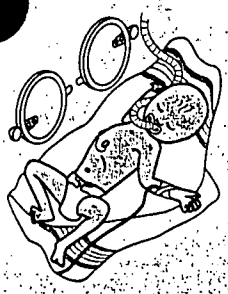
What if another piece of her clot broke off and went to her lungs again? The clot that brought her to the hospital had been a small one and she had tolerated its effect easily, but large pulmonary emboli are life-threatening. Just the isolation of highway driving might put her at risk. The old teaching was that you kept a person in the hospital for 72 to 96 hours while the clot "stabilized," though like most of the old teachings, that wasn't based so much on research as on reason. What was the real risk of a second clot, perhaps an even larger one, traveling to her lungs even when she was on a blood thinner?

I promised her an answer before lunch, and after completing my

Lisa Sanders, M.D., writes the Diagnosis column for the magazine.

nesses Stumbling Toward a Cure

ɛe misdiagnoses, erroneous detours and, with luck, great leaps forward. **BY MICHAEL SINGER, M.D.**



Pre-Term Labor

Inducing labor at seven months was the favored treatment for a "contracted pelvis" in the 1800's, despite the fact that it risked killing the fetus. Samuel Bard advised emptying the bowels, lying horizontal and taking opiates.

The link between premature birth and infant morbidity was clear in the 1930's, but treatment was limited: wheat-germ oil and progesterone were offered as labor stoppers but achieved little.

[redacted] in the 1970's, mothers got injections to mature fetal lungs faster. Bed rest, sedation and hydration were discredited by research but still widely practiced. Intravenous alcohol was also used.

Most neonatal deaths are caused by pre-term labor; many preventive efforts, like the use of intravenous alcohol, are ineffective or now discounted. Most early labors are caused by infection; antibiotics and steroids are now central to treatment.

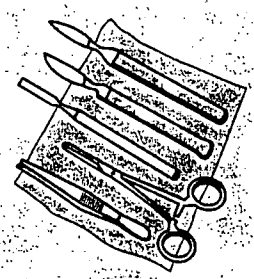
Ulcers (Peptic Ulcer Disease)

Up until the 1880's ulcers usually went untreated; they would bore through the sufferer's stomach, killing them. Doctors often tried to salvage an inflamed abdomen by cleaning out the corrosive discharge — to no avail.

In the 1880's, a patient's options included gastrectomy, removing part or all of the stomach. Vagotomy, severing the nerve that stimulates acid secretion from the stomach, was also used.

Anxiety was seen as the cause of ulcers in the 1920's. Endoscopy allowed ulcers to be sealed without surgery. But it was thought that ulcers caught early could be cured with a bland lifestyle and an even blander diet.

Stress is now ruled out as the cause. In the 1980's, 90 percent of ulcers were attributed to a bacterium and, less often, to heavy use of anti-inflammatories. "Triple therapy" — an acid suppressant, an antibiotic and Pepto-Bismol — cures most ulcers.



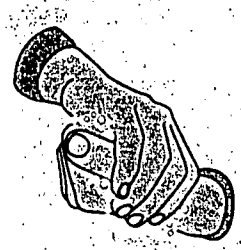
Melanoma

After World War I, working people began spending time indoors, and the wealthy saw more sun. Not coincidentally, melanoma captured the attention of clinicians. Despite the removal of large skin lesions, the disease mysteriously recurs.

The link between sun exposure, melanin formation and melanoma was identified by the 1960's. Chemotherapy and radiation took up the fight, but operations are still the standard.

In the 1970's, new staging systems allowed for better therapy and determination of prognosis. Sentinel-node biopsy — the injection of dye into a tumor to trace its metastatic movement in the lymphatic system — increased surgical accuracy.

Still one of the most vexing of malignancies, melanoma is unpredictable, often undetectable and frequently deadly. Its incidence rises as novel therapies are offered, including thalidomide, which deformed a generation of babies.



Obsessive-Compulsive Disorder

OCD was mistaken for demonic possession and treated with exorcism until the 19th century, when clinicians realized that this condition was a disease rather than the Devil's work.

In 1917, Sigmund Freud thought OCD sufferers were torn between guilty fear and defiant rage born of Draconian toilet training. He recommended psychoanalytic guidance to free them from their obsession.

After 1949, when leukotomy (what is now known as a prefrontal lobotomy) was developed to treat certain psychoses, OCD emerged as surprisingly responsive to operations. Outcry in the 1960's led surgical interventions to fall out of favor.

Genetic markers for OCD were discovered in lab animals in the early 1990's. Drugs like Prozac and Zoloft — selective serotonin reuptake inhibitors — became the cornerstone of treatment. Leukotomy is staging a quiet comeback.

rounds, I sat at my computer and called up the related research. A quick review of the literature showed that the average patient had a risk of recurrence of as little as 4 percent over the first six months, and a fraction of that in the first week. I went back to the patient with the good news. Her husband could take her home the next day, given the minimal possibility of a recurrence. Standing at this woman's bedside, explaining her illness and her risk, I felt once again the excitement that feels particular to medicine at this time in history. And yet, even as I rattled off statistics, I had to acknowledge that what feels definitive now may change, as have so many certainties of the past.

From a distance, medicine looks like a complete and beautiful body of knowledge. You get sick, and your doctor examines the sick part and figures out how to make it well. You live happily ever after. And there [redacted]ects of medicine that work that way. But here, up close, where [redacted]ne is practiced, it's clear that our body of knowledge is growing rapidly, changing constantly. Every week's journals and patients challenge the old knowledge and sometimes provide the new. It's how progress is made in medicine, one answer at a time.

A PATIENT of mine who came to the office recently was in the hospital a week earlier for an irregular heartbeat. In the hospital, his cardiologis started him on medicine to make his heart beat regularly again, and h was discharged on that medication. When he came to see me, he wa still taking it, but his heart had started to beat irregularly once more. H was supposed to see his cardiologist the next week but wanted to kno if he would have to keep taking the rhythm medicine. It made him fee tired, and he didn't like it.

Not that long ago, on hearing this story, I would have tried to convinc the patient that keeping his heart in a regular rhythm was the best optio and that if this drug wasn't working and made him tired, well, there wer others we could try. Now I had a different option. A recent study showe that patients who were allowed to remain in an irregular rhythm did just a well as patients who took medicine to control the rhythm, as long as thei heart rates — the number of beats per minute — were controlled. Now could tell him that it was probably going to be O.K. for him to stay in tha rhythm. He probably wouldn't have to take that medicine anymore.

That study? It was published just three months ago. ■

Carolina Health Freedom Coalition

A statewide alliance of concerned North Carolina citizens

P.O. Box 62282, Durham, NC 27715-2282

www.CitizensforHealthCareFreedom.org - CHF@nc.rr.com

- The Complementary and Alternative Health Care Exemption Act clarifies the legal status of complementary and alternative health care services.

- Almost fifty percent of North Carolina citizens currently use safe and non-invasive treatments known in the scientific literature as complementary and alternative medicine (CAM).

- Current law that prevents unrestricted access to these services deprives citizens of access to effective health care methods of their choice.

- Because of a legal technicality the law currently restricts CAM professionals from offering their services and freely exercising their trade.

- Enacting an exemption for these services in the medical licensing law will eliminate these barriers and will support the growing complementary and alternative health care industry.

North Carolina Health Care Access Bill
To Allow Free Access to Complementary and Alternative Medicine (CAM)

Definition and Prevalence of Complementary and Alternative Medicine in NC

In addition to the services offered by standard licensed medical practice, the citizens of North Carolina use many health care methods, notably non-invasive natural and traditional therapies, treatments generally known in the scientific literature as complementary and alternative medicine (CAM)*.

The World Health Organization defines alternative health care as "all forms of health care provision, which usually lie outside the official health sector." Another definition of CAM is "a disparate array of techniques, approaches, and systems of health care that have in common their *exclusion or marginalization from mainstream medicine* and health professions education in the U.S. and Western countries. (1)

Several studies describe the demographics, prevalence, and patterns of CAM use in the United States. The most relevant findings are the following:

- Americans made approximately 629 million visits to providers of CAM therapies during 1997, far exceeding the 386 million visits to primary care physicians
- Out of pocket expenses associated with CAM therapies were an estimated $27 billion, exceeding non-reimbursed expenses incurred for all hospitalizations in the United States. (3,4)

People who use CAM are educated and intelligent, and capable of making informed health care choices. Fifty-one percent of CAM users have a college education and forty-eight percent have an income above $50,000. (4)

Based on these surveys, a substantial portion of Americans currently uses one or more CAM or natural therapies, by choice and at their own risk. Many users do not inform their doctors of this fact. The most frequently used therapies are relaxation techniques, herbal medicine, massage, chiropractic, folk remedies, energy healing, homeopathy, hypnosis, biofeedback, and acupuncture. (4)

These findings indicate that CAM occupies a larger role in the health care of U.S. citizens than was previously understood. These studies further indicate that individuals using CAM include a wide variety of age, ethnic, socioeconomic, and other demographic categories. (5)

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* For purposes of this document, we use the term CAM because it is commonly used in the scientific literature. The question whether the provision of services classified as CAM should legally be classified as the "practice of medicine" is the subject of this document and of our proposed legislation.

These findings warrant the conclusion that possibly as many as 3.3 million North Carolinians presently receive a substantial volume of health care services from CAM providers.

Legal Technicalities Now Restrict NC Patients' Access to CAM

In spite of the widespread utilization of complementary and alternative health care services by North Carolinians, the provisions of many of these services may be a technical violation of the medical practice law, specifically Chapter 90, Article 1, §90-18 of the NC General Statutes.

CAM practitioners could therefore be subject to fines, penalties and restrictions of their practices under the General Statutes *even though there is no evidence that their practices are harmful to the public.*

This legal technicality presently prevents a large number of CAM practitioners from freely practicing their trade and endangers free access to valuable and safe forms of treatment for North Carolina citizens.

We Propose CAM Exemption from the Medical Licensing Law

We propose legislation that allows access for North Carolinians to CAM therapies and to practitioners of CAM who provide services not requiring medical training and credentials.

General statutes Chapter 90-18(c) currently list 18 exemptions from the medical practice law. By adding CAM practices as an exemption under current law, expressly allowing the practice of CAM, medical licensing restrictions would no longer apply to CAM therapies.

This law would affirm patients' right to informed consent. It would allow the practice of CAM, provided that the practitioner fully discloses to the patient that he/she is not a licensed medical doctor.

An alternative solution would be to create multiple licensing boards for the various CAM modalities. There is no evidence that complementary and alternative health care is harmful to the public. However, the above law would not preclude such licensing for any particular modality should it be deemed appropriate.

Why We Need Access to CAM

✓ *CAM Is Recognized by Government and Educational Institutions*

Government and educational institutions have begun to respond to the rapidly increasing demand for CAM services.

The United States Congress moved to establish an Office for Complementary and Alternative Medicine at the National Institute of Health; it conducts research on many different CAM therapies.

The University of North Carolina School of Medicine at Chapel Hill, through its Program on Integrative Medicine, has offered an introductory course on CAM since 1995. It also offers clinical rotations for

medical students at the practices of community CAM providers to observe CAM treatments. Since 2000, the medical school conducts an educational project funded by a grant from the National Institutes of Health, involving the state's allied health system (AHEC), to educate medical residents, students, and faculty of the health professions across North Carolina about CAM.

Two additional NC medical schools (Duke University and Wake Forest University) have established centers for integrative medicine with introductory courses about CAM; they have applied for grants to expand these projects.

Four states (Minnesota, Rhode Island, California, and Idaho) have enacted Health Freedom laws that allow the practice of CAM without a license, as long as practitioners disclose to their clients their education and qualifications, and that they are not licensed medical doctors.

The North Carolina Legislature has acted in the past to recognize, regulate, license or exempt from licensure several CAM modalities such as spiritual healing, chiropractic, massage therapy and acupuncture.

✓ ***People Seek CAM Services***

Surveys conducted in the United States have found that people seek CAM treatments because:

a. They have limited access to conventional care for financial reasons. (6-10) Over 44,000 Americans do not have health insurance. According to one study, more than 70% of people living in poor or rural areas used folk remedies; (9)
b. They are members of domestic cultural minorities that consider certain CAM or traditional therapies the norm. This also applies to immigrants from many foreign cultures; (7)
c. They wish to maximize their health care, or are looking for effective treatments to chronic diseases; (11-16)
d. They have become dissatisfied with conventional practice settings, or have found conventional treatments to be ineffective or harmful; (17)
e. Their health beliefs differ from conventional medical dogma. (17, 18)

Types of CAM Therapies

CAM modalities may be classified into the following subgroups and include, but are not limited to, the following: (1,18)

1. Mind-Body Therapies

- Bio-Feedback
- Hypnosis
- Guided Imagery
- Meditation
- Art Therapy
- Alexander Technique
- Feldenkrais
- Music Therapy

2. Manual and Body-work Therapies

- Chiropractic
- Osteopathy/Cranial- Sacral Manipulation
- Therapeutic Massage
- Functional Integration
- Structural Integration (Rolfing)
- Applied Kinesiology
- Therapeutic Touch
- Laying on Hands
- Reiki
- Reflexology
- Polarity Therapy

3. **Acupuncture**

4. **Herbal Medicine**

5. **Aromatherapy/Essential Oils**

6. **Homeopathy**

7. **Magnetic and Electromagnetic Therapies**

    - Magnetotherapy
    - Rife Generator Treatment
    - Lakhovsky Oscillator Treatment
    - Radionics

8. **Spiritual Healing**

9. **Crystal Healing**

10. **Ayurvedic Medicine**

11. **Chinese Herbal Medicine**

The Safety of Complementary and Alternative Medicine

Studies found that CAM services as they are currently provided in the US *do not represent a risk to the public and contribute to improved safety of health care.* (19-26)

"The most recent Federal government report on the health status of the nation, Healthy People 2010, is designed to further two overarching goals: 1) increasing the quality and years of healthy life and 2) eliminating disparities in health." (19-21) According to the White House Commission on Complementary and Alternative Medicine Policy (WHCCAMP) report, the principles that underlie CAM practices *are consistent with the two overarching goals of Healthy People 2010.* (22)

The WHCCAMP report recommends "states should evaluate and review their regulation of CAM practitioners and ensure their accountability to the public. *States should, as appropriate, implement provisions for licensure, registration, and exemption"*(23)

Before the state of Minnesota passed the Complementary and Alternative Health Care Freedom of Access Act, the Minnesota Department of Health commissioned a study on CAM safety that concluded that these healing modalities *do not constitute a significant public health risk.* (24)

The states of Rhode Island, Idaho and California have come to similar conclusions about the safety of CAM and have passed Health Freedom legislation that *allows the practice of alternative therapies without a license.*

Specifically for homeopathy, Dr. X. Zangh, Medical Officer for Traditional Medicines of the World Health Organization, found that *"there is no doubt about the safety of homeopathy."* (25)

After analyzing all available data on CAM safety, Wayne B. Jonas, M.D., former director of the National Institutes of Health's Office of Complementary and Alternative Medicine, and Edzart Ernst, M.D., PhD. professor and director of the Department of Complementary Medicine, Exeter, U.K., concluded "the prevalence of adverse effects in homeopathy, acupuncture, and herbal treatments, *appears to be lower than comparable practices in conventional treatment."* (26)

Support Health Freedom

✓ ***White House Commission Endorses Individual's Right to Choose Treatment***

The White House Commission on Complementary and Alternative Medicine Policy report recommends *the legislature respect individuals' right to choose treatments.*

The WHCCAMP report recommends the creation of a federal office to integrate CAM into the nation's health care system. Established in March 2000, the 20-member Commission included representatives of both mainstream and alternative medicine.

In its March 22, 2002 report to the President, the Commission proposed steps to *ensure that "public policy maximizes the potential benefits of CAM to all citizens."*(27)

✓ ***Health Care is a Basic Human Right***

Access to health care and choosing health care options are an intrinsic part of the right to life, liberty and the pursuit of happiness. The People reserve the right to choose viable and safe treatments currently available under the name CAM.

The People propose that the North Carolina Legislature enact the Health Freedom Act to remove any restrictions that prevent practitioners of CAM from practicing, and any ambiguities in the law, by expressly *exempting CAM practices from medical licensing restrictions.*

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Citizens for Healthcare Freedom

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The Basics on HB 923 Exempt alternative medicine/practice of medicine

Sponsored by: Rep. Paul Luebke, introduced April 8, 2003.

Requested by: ***Citizens for Healthcare Freedom***, a statewide nonprofit organization of complementary and alternative health practitioners, clients, and supporters. CHF advocates freedom of access to a full range of available treatments, health care services and providers.

Contacts: **Anthony P. Noto, BSME, President/Board Member/Co-Founder of CHF,**
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Bill Purpose: Clarify the status of complementary and alternative health care practices (CAM) as it relates to the license to practice medicine by adding an exemption to the medical licensing law NCGS 90.18(c). This would become the 19th exemption from the practice of medicine. It would remove the threat to providers of these modalities of being prosecuted for "practicing medicine without a license." It would also mandate that CAM practitioners openly (a) disclose to clients that they are not medical doctors, and (b) disclose their training and qualifications.

Goals: (1) Remove current restrictions on the practice of complementary and alternative health care, so practitioners can freely advertise, practice openly, and are more accessible to patients.

(2) Encourage clients to tell their physicians about their use of complementary and alternative health services. This will result in increased communication between conventional and alternative healthcare practitioners and provide better treatment.

(3) Increase patients' access to CAM, by allowing practitioners to freely practice their trade. This will benefit the growing natural health industry in North Carolina and increase revenue to the state.

Facts:

- An estimated 3.3 million North Carolinians use CAM for a large portion of their health care. Americans made 629 million visits to providers of CAM in 1997 (Eisenberg et al.), far exceeding the 386 million visits to primary care physicians.
- The U.S. government established an Office for Complementary and Alternative Medicine at the National Institutes of Health, in response to increased interest in CAM therapies and products.
- In 1995 the UNC Medical School at Chapel Hill established the Program for Integrative Medicine where CAM providers teach and precept students for clinical rotations. Duke University and Wake Forest University Schools of Medicine also have courses on CAM and are expanding this field of instruction. These initiatives educate medical and allied health students about alternative health care professions and therapies.
- Currently the medical licensing law lists eighteen exemptions from the practice of medicine, such as nursing, chiropractic and acupuncture. Health freedom bills have been passed in four states (MN, RI, CA, ID) and are pending in four additional states (FL, GA, IA, NY).
- According to studies, patients use CAM treatment for many reasons, including: They wish to maximize their health care; they have found conventional medicine ineffective or harmful; they adhere to cultural traditions of folk remedies or come from areas where conventional health care is not accessible; their health beliefs differ from those of conventional medical dogma.

North Carolina Citizens Need
-- Health Care Access Legislation --
To Allow Unrestricted Access To
Complementary and Alternative Health Care

Objective

Protect North Carolina citizens' access to complementary and alternative health care by adding an exemption to the medical practices law, General Statutes 90.18, for complementary and alternative health care providers. The proposed amendment will allow the practice of complementary and alternative health care, provided the practitioner discloses to the patient that s/he is not a licensed medical doctor or health care provider.

Rationale

1. **Liberty** - Every citizen has the right to choose the path of his/her own healing.

2. **Free Market** - Broaden the availability of all natural healing modalities, consistent with worldwide trends.

3. **Cost Effectiveness and Efficacy** - Some citizens are facing health insurance cost increases of more than 12% a year. At least 40 million Americans do not have health insurance. Citizens want more healthcare options, particularly for chronic illness. Complementary and alternative health care can be used as preventive medicine. Several studies have found that complementary and alternative health care services, as they are currently provided, do not represent a substantial risk to the general public, and may even contribute to improved safety of health care.

4. **Legalization** - Eliminate the legal restrictions to practice alternative health care because of possible technical violations of the medical licensing law, that could result in fines and penalties. Four states (MN, CA, RI, ID) have passed similar health freedom bills. Groups in four additional states (FL, GA, IA, NY) are introducing Health freedom bills, and plans to do so are under way in at least eight other states

5. **Education** - Once legalized, the marketplace can more effectively provide citizens with detailed information about complementary and alternative medical services. Freer communication between patients and their conventional and alternative health care providers will benefit all. Three North Carolina medical schools (UNC-CH, Duke, and Wake Forest) have Integrative Medicine programs, actively promoting allied health education in complementary and alternative therapies.

Complementary and Alternative Healthcare in North Carolina

Extent of Current Practice - As many as 3.3 million North Carolina citizens receive a substantial volume of health care services from complementary and alternative health care practitioners.

Popularity among Patients - The usage of the broad domain of healing arts including complementary and alternative practices continues to grow even though the patient typically pays for the total cost of the service. Americans made more visits to complementary and alternative healthcare providers (629 mi) than to all primary care physicians (386 mi) in 1997. Total number of visits to complementary providers increased by 47% from 427 mi in 1990 to 629 mi in 1997 nationwide.

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For immediate release:
Wednesday, April 9, 2003

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NC Law Threatens 3.3 Million North Carolinians' Access To Their Alternative Healthcare Providers

Raleigh, NC: Most people are shocked to learn that their complementary and alternative (CAM) healthcare providers could be convicted of a crime just by practicing their trade. A technicality in the NC medical licensing law could lead to misdemeanor charges against professionals of a wide range of healing practices. These practitioners do not claim to be licensed medical doctors, yet they may be prosecuted for "practicing medicine without a license". Representative Paul Luebke, Durham, is introducing a bill today to ensure patient access to their alternative providers, allowing them to practice as long as they disclose their professional training and qualifications, and that they are not licensed medical doctors.

"Homeopathy cured me when all the talents of my doctors and all the pharmaceutical drugs they gave me could not. It is frightening to think that the option of finding effective treatment with no dangerous side effects could be taken from me and others who want access to alternative methods in addition to our standard care from medical doctors," said Barbara Zelter. She is a patient activist working with Citizens for Healthcare Freedom (CHF), a statewide organization of alternative health practitioners, their clients and supporters, aiming to change what they see as a threat to the entire spectrum of complementary healthcare in North Carolina.

National studies show increased use of complementary and alternative therapies. According to a 1997 study by Eisenberg, et al, Americans made more visits to CAM providers than to all primary care physicians. CAM practices include acupressure, ayurveda, biofeedback, Chinese medicine, herbal medicine, homeopathy, hypnosis, music therapy, Native American medicine, polarity therapy, and many other healing modalities. An estimated 3.3 million North Carolinians receive a substantial portion of their healthcare services from these practitioners. According to Eisenberg, in 1997 Americans spent between 27 and 34 billion out of pocket on complementary and alternative treatment. Most of these services are not covered by insurance.

Representative Luebke is sponsoring **House Bill 923**, which exempts the practice of complementary and alternative forms of health care from the medical practices law. He says, "Health care consumers need more choices. They should not be restricted to the limited definitions of the practice of health care that currently prevail." The bill amends the state's medical practices law by adding an exemption for complementary and alternative practices. Current law has 18 existing exemptions that include nurses, chiropractors and acupuncturists. The bill, if enacted, will eliminate the existing barrier preventing practitioners from freely exercise their trade.

Supporters of the Carolina Health Freedom Coalition, which includes CHF and other groups, say these therapies are already being practiced safely and effectively. They say current law is unfair. HB 923 will further protect consumers in at least three ways, according to the group's President, Anthony Noto, an engineer from Knightdale. "(1) It keeps practitioners from fleeing North Carolina due to the restrictive effect of current law; (2) it requires the practitioner to disclose their qualifications, and that she or he is not a licensed medical doctor; (3) and it indirectly supports collaboration with licensed medical doctors. Currently most patients do not tell their doctors about their use of complementary therapies because of the legal and informational cloud surrounding them. We need clarity in the law so conventional and other practitioners can openly work together for the benefit of their patients."

"We do not claim to be medical doctors," says Manfred Mueller, CCH (Certified Classical Homeopath) from representative Luebke's district in Durham. Mueller and colleague Julia Insley, CCH, qualified for their certification in a national board exam, after meeting educational and training standards. Says Insley, "Our clients know that we're not MD's and we have them sign a consent form that includes this statement. They come to us because they are pleased with our contribution to their health and that of their families. They deserve a choice. We all do."

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Citizens for Healthcare Freedom

Advocating Informed Choice in Health Care Decisions

CHF is a North Carolina grassroots organization dedicated to educating the public about health care issues. The CHF mission is to improve the health and well-being of North Carolinians by empowering individuals and families to make freer and more fully informed healthcare decisions. A singer-songwriter and a mechanical engineer, both seriously concerned about the indiscriminate enforcement of vaccinations in the US, founded CHF in 1997. They believed citizens needed informed choice regarding benefits versus risks, as well as more attention given to required vaccine health screening requirements. Early efforts of CHF involved educating the public about vaccination risks and lack of long-term safety studies. The reason many people now know about the use of Thimiserol (a mercury derivative) in vaccines is because of organizations like CHF. In the fall of 2002 CHF reorganized and invited founding members of the NC Homeopathic Society to join with them. This collaboration was aimed at improving the healthcare climate in NC, fostering consumer education, and ensuring access to complementary and alternative healthcare services. CHF is a 501(c)(3) nonprofit corporation and contributions to CHF are tax-deductible.

CHF-NC Fund, the lobbying arm of CHF, is our sister organization. CHF-NC Fund is a 501(c) (4) nonprofit organization dedicated to helping NC citizens have a voice in the legislature when there are legal or reform issues at stake. Contributions or gifts to CHF-NC Fund, Inc. are not tax-deductible.

CHF has recently embarked on a project to guarantee citizens' access to a wide range of healthcare modalities which are now legally threatened. This project, named Carolina Health Freedom Coalition, is aimed at allowing unlicensed alternative health providers to offer their valuable services legally. This will create a safer environment for the practice of alternative health care and ensure access for consumers. Millions of NC citizens visit alternative health care providers each year and studies show this number is increasing. CHF is part of the health freedom movement that is sweeping across America.

Ever alert, CHF broke the news about Senate Bill 144 which would make felons of those who 'practice medicine without a license'. Unfortunately, current medical licensing law has a highly restrictive definition of the practice of medicine. Many alternative health practices would come under that definition. Practitioners could be charged with the unauthorized practice of medicine, simply for practicing their trade. CHF supporters consider it unacceptable to make felons of honest and qualified practitioners. CHF-NC Fund board members explain, "Our hope is to work with the legislature to pass HB 923, an amendment to the medical licensing law that adds an exemption for the practice of complementary and alternative forms of health care. Our vision is to help facilitate a healthier environment for our North Carolina citizens."

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Even Mayo Clinic Couldn't Help, but Asheville Alternative Healers Did

I am a 54-year-old woman. Before I got sick, I was extremely healthy and vigorous--a married, traditional mother of three children, and a karate instructor with a second-degree black belt, teaching at a large martial arts school[1] in Asheville, NC. In 1994, I won the gold medal in the Executive Division at the U.S. Karate Federation's National Championship.

In early 2002 I became very ill. In one 12-hour period, I went from doing 220 pushups in a martial arts class, to entering the hospital with a multitude of extreme symptoms. The doctors assured me that I was not having a heart attack, even as I kept telling them that I had tingling from head to foot and a cold burning pain coursing throughout my body. My blood pressure was very elevated and I was having difficulty breathing. Three days later I left the hospital with a diagnosis of a bacterial infection and a prescription for Cipro.

Obviously this antibiotic did not help with my overall condition, as I spent the next eight weeks bedridden, in tremendous pain, going from one doctor to another, with no answer as to my health crisis. The internists, rheumatologists, and neurologists did, however, prescribe a variety of medications[2] to relieve my extreme symptoms, as they searched for an answer. None of the medications seemed to help. I was generally unable to move, from weakness and pain. My youngest daughter came to me and said: "Mom, do you have cancer? Are you going to die?" You can imagine how disruptive this was in our family's life, and how alarmed we all were with the continuing symptoms and no diagnosis or relief.

We spent the next few months seeking assistance from various traditional caregivers and a subsequent trip to The Mayo Clinic in Rochester, MN. The doctor at Bowman Gray said his best guess was a viral or auto-immune infection that attacked the nervous system, but he didn't really know. His only suggestion was to stay on Neurontin for pain (it didn't help much) and hope for improvement over time. At the Mayo Clinic, the doctors shook their heads and said they were so sorry that they did not have any answers. One of the doctors concluded by saying: "You should do whatever you can to get well."

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[1] Center for Martial Arts, Asheville, NC.

[2] Prednisone, Toprox, Echotrin, Mycelex Troche, Xanax, Ambien, Neurontin, and Zonagran.

Five or six months into this ordeal, I remained in severe cold burning pain, and was wearing long underwear in 90-degree weather. While I had resumed some basic daily activities, I was still unable to return to work, and my day was essentially over by 2 or 3 in the afternoon. My quality of life was poor, and I could not do my part to contribute to family life.

At this point, I encountered a woman who gave me the name of a practitioner of energetic medicine and said that this healer had saved her life. I called that day for an appointment with her, and three weeks later started on a journey that truly has saved my health and life.

This energy practitioner determined that my body was allergic to almost everything that I was eating—from carbohydrates to sugars, even to the insulin that my own body was making. Metals were a particular concern. My immune system was not functioning as it should. The good news was that with energetic medicine, you can be detoxified for most allergies. We began the detoxifying process; with every session I became a little stronger. Since the metal toxicity was a problem, the energy therapist referred me to another alternative healer, who specialized in electro-dermal screening.

He verified the heavy metal problem, caused by the metal in the crowns and fillings in my mouth. He affirmed and built on the first practitioner's food allergy diagnosis by giving me a battery of food allergy tests and suggesting specific dietary changes. I began these dietary changes and noticed improvement. While these two alternative practitioners were not covered by our health insurance plan, we accepted the personal financial burden because I was seeing positive results for the very first time since the onset of the illness.

The alternative practitioners each referred me onward to other specialists in complementary fields—from colon hydrotherapy, to structural integration (rolfing), iridology, cranial-sacral manipulation, acupuncture, and others. Each of these contributed in particular, effective ways, for a cumulative momentum toward great improvement.

The most dramatic improvement came when I had all the mercury and palladium removed from my mouth, 10 months into the process. According to several practitioners, the metals were causing an allergic auto-immune response in my body. Based on the fact that I experienced exceptional relief when the metals were removed, I believe this theory is correct. An interesting side observation was that when the metals came out, I was finally relieved of the severe constipation that had plagued me for years. (My colon hydrotherapy healer had told me that my case was the worse she had ever seen in her practice.)

Here is a very disturbing fact that came to light while I was benefiting from the dental amalgam removal. I was told that despite the effectiveness of this process, a dentist can have his or her dental license taken away in the state of North Carolina for even

suggesting that the metals in one's mouth should be removed. My husband, who is an attorney, and I both find this denial of the amalgam toxicity syndrome appalling. Fortunately, we had dental insurance, but this valuable, healing treatment was not covered, due to the national dental profession's refusal to publicly acknowledge amalgams' link to a vast range of human diseases. My family had to pay $15,000 out of pocket for the amalgam removal procedure. We were fortunate that we could do that. But the insurance blackout on coverage for amalgam removal means that thousands of sufferers from metal toxicity can get no treatment or relief.

On February 4, 2003, it was one full year since the onset of my illness. At this point, due to alternative health care, I have returned to a semblance of normalcy in my life. I now can attend my children's sporting events, cook meals, go for walks, and just recently I have returned to teaching a martial arts class once a week. I continue to see my alternative health care practitioners and follow the dietary and other regimens that they recommend. I am convinced that had I been seeing alternative health care practitioners over the years, my health would never have collapsed as it did in February 2002.

While I respect Western medicine, my personal life experience this past year has proven to me beyond a doubt that many of the complementary and alternative healthcare modalities (CAM) are effective and absolutely needed as an option for patients in North Carolina.

I wish the Western allopathic physicians I saw (February – June 2002) knew enough about CAM so they could have referred me to these practitioners when they could not help me. I wish all doctors would be more informed about CAM, and encourage patients to seek alternative healthcare when those specialties can help. I wish medical insurance would recognize the validity of CAM and insure these modalities, so all people could afford the wonderful healing that I have been so privileged to receive.

When Western medicine failed me, complementary and alternative healthcare gave me back my health and my life.

HEALTH CARE

License to Heal

A legislative showdown is brewing between supporters of alternative therapies and the state's medical establishment

BY BARBARA SOLOW

A few years ago, when she was running a Raleigh advocacy organization for low-income citizens, Barbara Zelter came down with a case of bronchitis that lasted for months. She went to several doctors, tried antibiotics and other medications, but instead of getting better, she just got worse.

Finally, after more than a year of persistent illness, she came across the name of a Durham homeopath in a health and wellness tabloid and made an appointment. Over the next year Zelter says she made a "miraculous" recovery through homeopathy, a healing system that uses tiny quantities of natural substances that, in larger doses, mimic effects of the disease being treated. "I've been perfectly fine since then," she says. "In fact, I can't seem to get sick."

But Zelter, who now works as a program associate for the North Carolina Council of Churches, is worried that state legislators are poised to shut off access by other patients to the type of treatments that cured her. A bill recently introduced in the General Assembly would increase penalties for practicing medicine without a license from a misdemeanor to a felony. Zelter is one of numerous citizens who've been calling, e-mailing and writing lawmakers over the past month with concerns that the bill unfairly targets alternative medicine—much of which is performed by unlicensed practitioners.

The measure's sponsor, state Sen. James Forrester (R-Gaston), says patient safety is at the heart of his proposal—not any particular form of medicine. "This isn't a witch hunt," says Forrester, an MD whose bill has the backing of the North Carolina Medical Society. "I'm just changing the penalties, not the definition of what practicing medicine is. Right now, if you steal a newspaper from my box, it's the same penalty as practicing medicine without a license."

But proponents of alternative therapies fear that whatever Forrester's intentions, his bill will mean more inspections and prosecutions of health care providers not covered by current medical licensing. Those include homeopaths, naturopaths, massage therapists, herbalists—even midwives in some cases.

The penalties are a technicality that can be used to discourage alternative practitioners, says Anthony Noto, co-founder of Citizens for Healthcare Freedom, a consumer network that's been organizing against Senate Bill 144.

"The medical industry is extremely powerful," he adds. "And they're going to do whatever they can to keep their monopoly."

This isn't the first time such "scope of practice" issues have come before the General Assembly. Three years ago, a bill identical to Forrester's drew overflow crowds to a legislative hearing room in protest. That bill died in committee—as did a study group that was supposed to explore less punitive ways to achieve quality provision of alternative medicine.

Already, outcry over Forrester's bill has been loud enough to discourage at least one legislator from signing on. State Sen. Austin Allran (R-Catawba) confirmed that he withdrew his initial sponsorship of the measure, though he did not respond to more detailed questions about why. On the House side, state Rep. Paul Luebke (D-Durham) says he'll introduce a bill next week that would exempt those practicing alternative medicine from penalties under existing licensing laws. The bill would require practitioners to fully disclose the type and extent of their training to patients.

Similar "health freedom" bills have become law in three states (Minnesota, California and Rhode Island), and are pending in at least four others. On the other hand, a measure recently passed by the Georgia Senate would make the unlicensed practice of dental hygiene, diet therapy and marriage counseling—among other treatments—a felony.

In North Carolina, the number of health care providers who've been cited under existing licensing laws is very small. Last year, the state Medical Board referred only one case of practicing without a license to the state Attorney General's office. In 2001, the board referred four cases, and in 2000 it referred three. In a fiscal note accompanying Forrester's bill, the state Administrative Office of the Courts reports there have been no convictions during the past three years for practicing without a license.

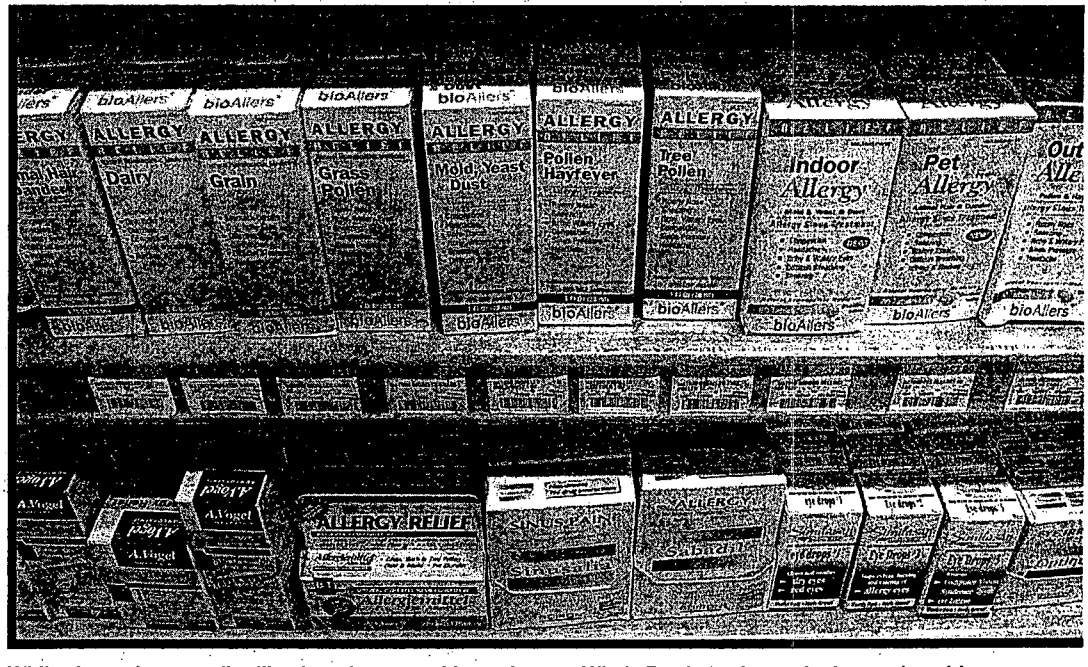
Backers of Forrester's bill insist that even if penalties are stiffened, those numbers are unlikely to rise. "Stepping it up to a felony gets the prosecutorial interest up," says Mike Edwards, a spokesman for the North Carolina Medical Society, which represents more than 10,000 doctors and physicians assistants statewide. "But it's not a significant number of people involved." Edwards says the "big picture" the Senate bill aims to address is accountability. "What we're trying to do is make sure there is competence," he says. "We feel like there is a standard of care that's been established and we want to maintain that."

But alternative practitioners say that's just the problem—those standards don't account for a host of treatments that lie outs mainstream. Licensing doesn't insure they say, so much as it reserves the stamp of approval solely for conventior apies. Some worry privately that after laissez-faire tolerance, the Medical B gearing up for a major assault on alt healers—a charge board officials dism

What can't be dismissed is the g popularity of non-traditional medi seminal Harvard Medical School found that in 1997, Americans mad visits to "complementary and alter health care providers than to all p care physicians. Out-of-pocket spen such therapies that year was $12.2 bi higher than expenditures for all U. pitalizations.

In North Carolina, Citizens for He Freedom estimates that as many as 3.3 people now receive a substantial por their health care from alternative pra ers—even though few have health in that will cover such services. Medical at the University of North Carolina, D Wake Forest have founded programs i grative medicine" designed to bridge tion in established and alternative th Even Blue Cross Blue Shield, the state' insurer, has created a discount prog therapies such as acupuncture, biof and massage. There are now 365 p under "Alt-Med Blue."

Zelter is one consumer who hop legislators will bow to such pock power by soundly rejecting Forrest and opting instead, for the "health fr approach. "It's hard times in the medi fession and somehow the popularity native medicine is threatening," she don't think legislators have evil int There's just a lot of ignorance out th



While alternative remedies like these homeopathic products at Whole Foods are increasingly popular with consumers, state legislators want to stiffen penalties for unlicensed medical practice—a category that includes therapies such as h opathy, naturopathy and herbal medicine. PHOTO BY ALEX MANESS

White House Commission on Complementary And Alternative Medicine Policy (WHCCAM) - DEFINITION OF CAM

Excerpted from WHCCAM Final Report, Chapter 2 (Overview)

Complementary and alternative medicine, or CAM, can be defined as a group of medical, health care, and healing systems other than those included in mainstream health care in the United States. CAM includes the worldviews, theories, modalities, products, and practices associated with these systems and their use to treat illness and promote health and well-being.

Although heterogeneous, the major CAM systems have many common characteristics, including a focus on individualizing treatments, treating the whole person, promoting self-care and self-healing, and recognizing the spiritual nature of each individual. In addition, many CAM systems have characteristics commonly found in mainstream health care, such as a focus on good nutrition and preventive practices. Unlike mainstream medicine, CAM often lacks or has only limited experimental and clinical study; however, scientific investigation of CAM is beginning to address this knowledge gap. Thus, boundaries between CAM and mainstream medicine, as well as among different CAM systems, are often blurred and are constantly changing.

Examples of the health care systems, practices, and products typically classified as CAM in the United States are listed in Table 1.

Table 1: CAM Systems of Health Care, Therapies, or Products

Major Domains of CAM	Examples Under Each Domain
Alternative health care systems	**Ayurvedic medicine** **Chiropractic** **Homeopathic medicine** **Native American medicine (e.g., sweat lodge, medicine wheel)** **Naturopathic medicine** **Traditional Chinese Medicine (e.g., acupuncture, Chinese herbal medicine)**
Mind-Body interventions	**Meditation** **Hypnosis** **Guided imagery** **Dance therapy** **Music therapy** **Art therapy** **Prayer and mental healing**
Biological based therapies	**Herbal therapies**

	Special diets (e.g. macrobiotics, extremely low-fat or high carbohydrate diets) **Orthomolecular medicine (e.g., megavitamin therapy)** **Individual biological therapies (e.g., shark cartilage, bee pollen)**
Therapeutic Massage, Body Work, and Somatic Movement Therapies	**Massage** **Feldenkrais** **Alexander Method**
Energy Therapies	**Qigong** **Reiki** **Therapeutic Touch**
Bioelectromagnetics	**Magnet therapy**

* In this report, "mainstream," "conventional," "allopathic," and "biomedical" are used synonymously to refer to the principal form of health care and medicine available in the United States.
** This table was adapted from the major domains of CAM and examples of each developed by the National Center for Complementary and Alternative Medicine, National Institutes of Health

Many of the CAM systems of health care listed in Table 1 have evolved from the collective clinical experiences of many practitioners over generations of practice, such as in Traditional Chinese Medicine. Others have evolved from the clinical experiences of a single practitioner or small groups of practitioners who have developed a particular intervention.

Despite their diversity, there are some common threads that run among many traditional systems of health care as well as systems that have emerged more recently. These similarities include an emphasis on whole systems, the promotion of self-care and the stimulation of self-healing processes, the integration of mind and body, the spiritual nature of illness and healing, and the prevention of illness by enhancing the vital energy, or subtle forces, in the body.[1]

References:

1. House of Lords. Science and Technology - Sixth Report. London: Science and Technology Committee Publications, 2000.

National Institutes of Health - National Center for Complementary and Alternative Medicine (NCCAM)

DEFINITION OF CAM

What is complementary and alternative medicine?

Complementary and alternative medicine, as defined by NCCAM, is a group of diverse medical and health care systems, practices, and products that are not presently considered to be part of conventional medicine.[1, 2] While some scientific evidence exists regarding some CAM therapies, for most there are key questions that are yet to be answered through well-designed scientific studies--questions such as whether they are safe and whether they work for the diseases or medical conditions for which they are used.

The list of what is considered to be CAM changes continually, as those therapies that are proven to be safe and effective become adopted into conventional health care and as new approaches to health care emerge.

Are complementary medicine and alternative medicine different from each other?

Yes, they are different.

- **Complementary** medicine is used **together with** conventional medicine. An example of a complementary therapy is using aromatherapy to help lessen a patient's discomfort following surgery.
- **Alternative** medicine is used **in place of** conventional medicine. An example of an alternative therapy is using a special diet to treat cancer instead of undergoing surgery, radiation, or chemotherapy that has been recommended by a conventional doctor.

What is integrative medicine?

Integrative medicine, as defined by NCCAM, combines mainstream medical therapies and CAM therapies for which there is some high-quality scientific evidence of safety and effectiveness.

What are the major types of complementary and alternative medicine?

NCCAM classifies CAM therapies into five categories, or domains:

1. Alternative Medical Systems

Alternative medical systems are built upon complete systems of theory and practice. Often, these systems have evolved apart from and earlier than the conventional medical approach used in the United States. Examples of alternative medical systems that have developed in Western cultures include homeopathic medicine and naturopathic medicine. Examples of systems that have developed in non-Western cultures include traditional Chinese medicine and Ayurveda.

2. Mind-Body Interventions

Mind-body medicine uses a variety of techniques designed to enhance the mind's capacity to affect bodily function and symptoms. Some techniques that were considered CAM in the past have become mainstream (for example, patient support groups and cognitive-behavioral therapy). Other mind-body techniques are still considered CAM, including meditation, prayer, mental healing, and therapies that use creative outlets such as art, music, or dance.

3. Biologically Based Therapies

Biologically based therapies in CAM use substances found in nature, such as herbs, foods, and vitamins. Some examples include dietary supplements, [3] herbal products, and the use of other so-called "natural" but as yet scientifically unproven therapies (for example, using shark cartilage to treat cancer).

4. Manipulative and Body-Based Methods

Manipulative and body-based methods in CAM are based on manipulation and/or movement of one or more parts of the body. Some examples include chiropractic or osteopathic manipulation, and massage.

5. Energy Therapies

Energy therapies involve the use of energy fields. They are of two types:

- **Biofield therapies** are intended to affect energy fields that purportedly surround and penetrate the human body. The existence of such fields has not yet been scientifically proven. Some forms of energy therapy manipulate biofields by applying pressure and/or manipulating the body by placing the hands in, or through, these fields. Examples include Qi gong, Reiki, and Therapeutic Touch.
- **Bioelectromagnetic-based therapies** involve the unconventional use of electromagnetic fields, such as pulsed fields, magnetic fields, or alternating current or direct current fields.

Notes

[1] Conventional medicine is medicine as practiced by holders of M.D. (medical doctor) or D.O. (doctor of osteopathy) degrees and by their allied health professionals, such as physical therapists, psychologists, and registered nurses. Other terms for conventional medicine include allopathy; Western, mainstream, orthodox, and regular medicine; and biomedicine. Some conventional medical practitioners are also practitioners of CAM.

[2] Other terms for complementary and alternative medicine include unconventional, non-conventional, unproven, and irregular medicine or health care.

[3] Some uses of dietary supplements have been incorporated into conventional medicine. For example, scientists have found that folic acid prevents certain birth defects, and a regimen of vitamins and zinc can slow the progression of an eye disease called age-related macular degeneration (AMD).

Dictionary of Terms

Aromatherapy ("ah-roam-uh-THER-ah-py"): Aromatherapy involves the use of essential oils (extracts or essences) from flowers, herbs, and trees to promote health and well-being.

Ayurveda ("ah-yur-VAY-dah") is a CAM alternative medical system that has been practiced primarily in the Indian subcontinent for 5,000 years. Ayurveda includes diet and herbal remedies and emphasizes the use of body, mind, and spirit in disease prevention and treatment.

Chiropractic ("ki-roh-PRAC-tic") is a CAM alternative medical system. It focuses on the relationship between bodily structure (primarily that of the spine) and function, and how that relationship affects the preservation and restoration of health. Chiropractors use manipulative therapy as an integral treatment tool.

Dietary supplements: Congress defined the term "dietary supplement" in the Dietary Supplement Health and Education Act (DSHEA) of 1994. A dietary supplement is a product (other than tobacco) taken by mouth that contains a "dietary ingredient" intended to supplement the diet. Dietary ingredients may include vitamins, minerals, herbs or other botanicals, amino acids, and substances such as enzymes, organ tissues, and metabolites. Dietary supplements come in many forms, including extracts, concentrates, tablets, capsules, gelcaps, liquids, and powders. They have special requirements for labeling. Under DSHEA, dietary supplements are considered foods, not drugs.

Electromagnetic fields: Electromagnetic fields (EMFs, also called electric and magnetic fields) are invisible lines of force that surround all electrical devices. The Earth also produces EMFs; electric fields are produced when there is thunderstorm activity, and magnetic fields are believed to be produced by electric currents flowing at the Earth's core.

Homeopathic ("home-ee-oh-PATH-ic") **medicine** is a CAM alternative medical system. In homeopathic medicine, there is a belief that "like cures like" meaning that small, highly diluted quantities of medicinal substances are given to cure symptoms, when the same substances given at higher or more concentrated doses would actually cause those symptoms.

Massage ("muh-SAHJ") therapists manipulate muscle and connective tissue to enhance function of those tissues and promote relaxation and well-being.

Naturopathic ("nay-chur-o-PATH-ic") **medicine** is a CAM alternative medical system in which practitioners work with natural healing forces within the body, with a goal of helping the body heal from disease and attain better health. Practices may include dietary modifications, massage, exercise, acupuncture, minor surgery, and various other interventions.

Osteopathic ("ahs-tee-oh-PATH-ic") **medicine** is a form of conventional medicine that, in part, emphasizes diseases arising in the musculoskeletal system. There is an underlying belief that all of the body's systems work together, and disturbances in one system may affect function elsewhere in the body. Some osteopathic physicians practice osteopathic manipulation, a full-body system of hands-on techniques to alleviate pain, restore function, and promote health and well-being.

Qi gong ("chee-GUNG") is a component of traditional Chinese medicine that combines movement, meditation, and regulation of breathing to enhance the flow of qi (an ancient term given to what is believed to be vital energy) in the body, improve blood circulation, and enhance immune function.

Reiki ("RAY-kee") is a Japanese word representing Universal Life Energy. Reiki is based on the belief that when spiritual energy is channeled through a Reiki practitioner, the patient's spirit is healed, which in turn heals the physical body.

Therapeutic Touch is derived from an ancient technique called laying-on of hands. It is based on the premise that it is the healing force of the therapist that affects the patient's recovery; healing is promoted when the body's energies are in balance; and, by passing their hands over the patient, healers can identify energy imbalances.

Resources

For more information on CAM or NCCAM, contact

NCCAM Clearinghouse

Toll-free: 1-888-644-6226
International: 301-519-3153
TTY (for deaf or hard-of-hearing callers): 1-866-464-3615

E-mail: info@nccam.nih.gov
Web site: nccam.nih.gov
Address: NCCAM Clearinghouse, P.O. Box 7923, Gaithersburg, MD 20898-7923

Fax: 1-866-464-3616
Fax-on-Demand Service: 1-888-644-6226

For more information on dietary supplements, contact

Office of Dietary Supplements
National Institutes of Health

Web site: ods.od.nih.gov

Center for Food Safety and Nutrition
U.S. Food and Drug Administration
5100 Paint Branch Parkway
College Park, MD 20740-3835
Web site: vm.cfsan.fda.gov

NCCAM has provided this material for your information. It is not intended to substitute for the medical expertise and advice of your primary health care provider. We encourage you to discuss any decisions about treatment or care with your health care provider. The mention of any product, service, or therapy in this information is not an endorsement by NCCAM.

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NCCAM Publication No. D156
May 2002

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Web: nccam.nih.gov
E-mail: info@nccam.nih.gov

World Health Organization (WHO) - Definition of CAM

Traditional Medicine (TRM)

Traditional medicine is the sum total of the knowledge, skills, and practices based on the theories, beliefs, and experiences indigenous to different cultures, whether explicable or not, used in the maintenance of health as well as in the prevention, diagnosis, improvement or treatment of physical and mental illness.

Complementary/Alternative Medicine (CAM)

The terms "complementary medicine" or "alternative medicine" are used inter-changeably with traditional medicine in some countries. They refer to a broad set of health care practices that are not part of that country's own tradition and are not integrated into the dominant health care system.

House Subcommittee on Health

April 9, 2003

Minutes

The House Subcommittee on Health appointed by the Chairs to consider Rep. Tim Moore's HB 346 Emerg. Generators/Nursing & Adult Care Homes met on Wednesday, April 9, 2003 at 10:00 a.m. in Room 424 of the Legislative Office Building. A copy of the roll denoting subcommittee members present is attached to the minutes (Attachment I).

Rep. Jeff Barnhart presided as Chair and welcomed visitors and members. Chair Barnhart then recognized Tom Wilder and Charles Williams as the sergeant-in-arms.

Chair Barnhart then called upon Rep. Moore to give subcommittee a brief recap of his bill HB 346 A BILL TO BE ENTITLED AN AT TO REQUIRE THAT NURSING HOMES AND ADULT CARE HOMES HAVE EMERGENCY GENERATORS FOR USE DURING POWER OUTAGES. (Attachment II) This bill requires all nursing homes and adult care homes to have emergency electrical service available for use during power outages sufficient to provide heat, lighting and other essential electrical services by January 1, 2004 in accordance with the rules to be adopted by the Medical Care Commission. Currently, only nursing homes are required to have emergency backup power. (Bill Analysis – Attachment III) A copy of 10 NCAC 03H.3402 Emergency Electrical Services was provided to subcommittee members. (Attachment IV)

Chair Barnhart expressed his concerns about the feasibility and costs involved in installing generators and rewiring facilities to make generators usable.

Chair Barnhart then called upon Lou Wilson of the Long-Term Care Association, Beverly Wheeler with Friends of Residents of Long-Term Care, and Jerry Cooper with the NCALA who provided subcommittee members with information on how nursing homes and adult care homes plan for emergencies and the potential impact costs would have on facilities. Costs were estimated between $5,000 and $8,000 for small adult care homes and up to $75,000 for larger facilities. Chair Barnhart then called upon Bill Warren with the Department of Health and Human Services, Division of Facility Services, Construction Section, who reported on process involved in rewiring facilities including sight reviews, obtaining bids, work involved and the inspection process. Bill Warren also reported on availability of funds.

While Reps. Glazier, Setzer and Wainwright felt bill was good in concept, they felt it merited further study. Rep. Wainwright made motion to turn the bill into a study bill and recommended it be referred to the NC Study Commission on Agency. Motion carried.

The meeting was adjourned at 10:53 a.m.

Rep. Jeff Barnhart, Chair

Pamela J. Evans, Committee Clerk

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ATTENDANCE

HOUSE SUBCOMMITTEE ON HEALTH

DATES	4/9/03														
BARNHART, Jeff – CHAIR	✓														
GLAZIER, Rick	✓														
SETZER, Mitchell	✓														
WAINWRIGHT, William	✓														

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2003

HOUSE BILL 346

Short Title:	Emerg. Generators/Nursing & Adlt Care Homes.	(Public)
Sponsors:	Representatives Moore; L. Allen, Bowie, Insko, Pate, and Setzer.	
Referred to:	Health.	

March 6, 2003

A BILL TO BE ENTITLED

AN ACT TO REQUIRE THAT NURSING HOMES AND ADULT CARE HOMES HAVE EMERGENCY GENERATORS FOR USE DURING POWER OUTAGES.

The General Assembly of North Carolina enacts:

SECTION 1. Effective January 1, 2004, Part 1 of Article 6 of Chapter 131E of the General Statutes is amended by adding the following new section to read:

"**§ 131E-114.2. Emergency electrical service required.**

Notwithstanding any other provision of law to the contrary, all nursing homes, combination homes, and adult care homes, as those terms are defined in G.S. 131E-101, licensed and operating in this State shall provide emergency electrical service for use in the event of failure of the normal electrical service. Emergency electrical service shall be sufficient to provide heat, lighting, and other essential electrical services as required by rules of the Medical Care Commission."

SECTION 2. Effective January 1, 2004, G.S. 131D-2(b)(1a) reads as rewritten:

"**§ 131D-2. Licensing of adult care homes for the aged and disabled.**

...

(b) Licensure; inspections. –

...

(1a) In addition to the licensing and inspection requirements mandated by subdivision (1) of this subsection, the Department shall ensure that adult care homes required to be licensed by this Article are monitored for licensure compliance on a regular basis. In carrying out this requirement, the Department shall work with county departments of social services to do the routine monitoring and to have the Division of Facility Services oversee this monitoring and perform any follow-up inspection called for. The Department shall monitor regularly the enforcement of rules pertaining to air circulation, ventilation, and room temperature in resident living quarters. These rules shall include the

requirement that air conditioning or at least one fan per resident bedroom and living and dining areas be provided when the temperature in the main center corridor exceeds 80 degrees Fahrenheit. The Department shall ensure that adult care homes required to be licensed by this Article provide emergency electrical service for use in the event of failure of the normal electrical service. The emergency electrical service shall be sufficient to provide heat, lighting, and other essential electrical services as required by rules adopted by the Medical Care Commission. The Department shall also keep an up-to-date directory of all persons who are administrators as defined in subdivision (1a) of subsection (a) of this section."

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

HOUSE BILL 346:
Emerg. Generators/Nursing & Adult Care Homes

BILL ANALYSIS

Committee:	House Health	**Introduced by:**	Rep. Moore
Date:	March 25, 2003	**Summary by:**	Dianna Jessup
Version:	First Edition		Committee Counsel

SUMMARY: ***House Bill 346 would require all nursing homes and adult care homes to have emergency electrical service available for use during power outages sufficient to provide heat, lighting and other essential electrical services by January 1, 2004 in accordance with rules to be adopted by the Medical Care Commission. Currently, only nursing homes are required to have emergency backup power. The act would become effective when it becomes law.***

CURRENT LAW: Nursing homes: Nursing homes, by statutory definition, are facilities that provide nursing or convalescent care for three or more persons. By rule, since the 1980's, newly constructed/converted nursing homes have been required to provide emergency electrical service, including the following:

- In existing facilities, emergency lights and a suitable source of emergency power for life-sustaining equipment to ensure continuous operation for a minimum of 72 hours.
- An emergency generating set, including a generator, located on the premises.
- Where electricity is the only source of power normally used for space heating, the emergency service must provide for heating of patient rooms.
- Sufficient fuel must be stored for the operation of the emergency generator for a period not less than 72 hours, on a 24-hour per day operational basis.

It is estimated that approximately 90-95% of nursing homes have generators capable of providing some heat.

Adult care homes: Adult care homes, by statutory definition, are assisted living residences in which the housing management provides 24-hour scheduled and unscheduled personal care services to two or more residents. Adult care homes that provide care to two to six unrelated residents are commonly called family care homes. Adult care homes are not required to provide emergency electrical service. It is estimated that approximately 10-15% of the 600 or more adult care homes currently are capable of providing some emergency electrical service.

Nursing homes and adult care homes have to submit plans for modifications to facilities to the Division of Facility Services, DHHS, for plan review and approval.

BILL ANALYSIS: Section 1 would amend the nursing home licensure act to require all nursing homes, combination homes, and facilities operated as part of nursing homes and which provide residential care for aged or disabled persons, by January 1, 2004, to provide emergency electrical service sufficient to provide heat, lighting, and other essential electrical services as required by rules of the Medical Care Commission. This would mostly affect combination homes and assisted living facilities operated as part of nursing homes, as nursing homes are already required to provide emergency electrical service. Section 2 would similarly amend the statutes regulating the licensure of adult care homes. This change would also affect family care homes. This would affect a large number of adult care homes and family care homes, which are currently not required to have emergency electrical service.

10 NCAC 03H .3402 EMERGENCY ELECTRICAL SERVICE

Emergency electrical service shall be provided for use in the event of failure of the normal electrical service. This emergency service shall consist of the following:

(1) In any existing facility, the following shall be provided:
   (a) type 1 or 2 emergency lights as required by the North Carolina State Building Code;
   (b) additional emergency lights for all nursing stations, drug preparation and storage areas, and for the telephone switchboard, if applicable;
   (c) one or more portable battery-powered lamps at each nursing station; and
   (d) a suitable source of emergency power for life-sustaining equipment, if the facility admits or cares for occupants needing such equipment, to ensure continuous operation for a minimum of 72 hours.

(2) Any new addition to an existing facility shall meet the same requirements as new construction.

(3) Any conversion of an existing building (hotel, motel, abandoned hospital, abandoned school, or other building) shall meet the same requirements for emergency electrical services as required for new construction.

(4) An emergency generating set, including the prime mover and generator, shall be located on the premises and shall be reserved exclusively for supplying the emergency electrical system.

(5) Emergency electrical services shall be provided as required by Rule .3101(b) of this Subchapter with the following modifications:
   (a) Exception No. 2 and Exception No. 3 contained in Section 517-10 of the North Carolina State Building Code, Volume IV shall not apply to new facilities.
   (b) Egress lighting shall be connected to the essential electrical system at exterior of exits.
   (c) Task illumination in the switchgear and boiler rooms shall be connected to the essential electrical system.

(6) The following equipment, devices, and systems which are essential to life, safety, and the protection of important equipment or vital materials shall be connected to the emergency electrical system as follows:
   (a) nurses' calling system;
   (b) fire pump if installed;
   (c) sewerage lift or sump pumps if installed;
   (d) one elevator, where elevators are used for vertical transportation of patients;
   (e) equipment such as burners and pumps necessary for operation of one or more boilers and their necessary auxiliaries and controls, required for heating and sterilization, if installed;
   (f) equipment necessary for maintaining telephone service.

(7) A minimum of one dedicated emergency branch circuit per bed for ventilator dependent patients is required in addition to the normal system receptacle at each bed location required by the North Carolina State Building Code, Volume IV. This emergency circuit shall be provided with a minimum of two duplex receptacles identified for emergency use. Additional emergency branch circuits/receptacles shall be provided where the electrical life support needs of the patient exceed the minimum requirements stated in this Paragraph. Each emergency circuit serving ventilator dependent patients shall be fed from the automatically transferred critical branch of the essential electrical system. This Paragraph shall apply to both new and existing facilities.

(8) Heating equipment provided for ventilator dependent patient bedrooms shall be connected to the critical branch of the essential electrical system and arranged for delayed automatic or manual connection to the emergency power source if the heating equipment depends upon electricity for proper operation. This Paragraph shall apply to both new and existing facilities.

(9) Task lighting connected to the automatically transferred critical branch of the essential electrical system shall be provided for each ventilator dependent patient bedroom. This Paragraph shall apply to both new and existing facilities.

(10) Where electricity is the only source of power normally used for space heating, the emergency service shall provide for heating of patient rooms. Emergency heating of patient rooms will not be required in areas where the facility is supplied by at least two separate generating sources, or a network distribution system with the facility feeders so routed, connected, and protected that a fault any place between the generators and the facility will not likely cause an interruption.

(11) The emergency electrical system shall be so controlled that after interruption of the normal electric power supply, the generator is brought to full voltage and frequency and connected with 10 seconds through one or more primary automatic transfer switches to all emergency lighting, alarms, nurses' call, and equipment necessary for maintaining telephone service. All other lighting and equipment required to be connected to the emergency system shall either be connected through the 10 second primary automatic transfer switching or shall be subsequently connected through other automatic or manual transfer switching. Receptacles connected to the emergency system shall be distinctively marked for identification.

(12) Sufficient fuel shall be stored for the operation of the emergency generator for a period not less than 72 hours, on a 24-hour per day operational basis. The generator system shall be tested and maintained per National Fire Protection Association (NFPA) code 99, current addition with all subsequent amendments, which is adopted by reference. Copies of this code may be obtained from the National Fire Protection Association, 1 Batterymarch Park, P.O. Box 9101, Quincy, MA 02269-9101 at a cost of thirty one dollars ($31.00). Records of running time shall be maintained and kept available for reference.

(13) Existing facilities shall have electrical systems that comply with licensure standards in effect at the time a license is first issued. Any remodeling that results in changes in service delivery shall comply with current licensure requirements to support the delivery of those services.

History Note: *Authority G.S. 131E-104;*
Eff. January 1, 1996.

House Subcommittee on Health

May 28, 2003

Minutes

The House Subcommittee on Health appointed by the Chairs to consider Sen. Purcell's SB 582 Establish Commission on Childhood Obesity met on Wednesday, May 28, 2003 at 10:00 a.m. in Room 415 of the Legislative Office Building. A copy of the roll denoting members present is attached to the minutes (Attachment I) along with the Visitor Registration Sheet. (Attachment II)

Rep. Insko presided as Chair and welcomed visitors and members. Chair Insko then recognized the pages: Courtney Curry and Qua'Shana Patterson from Gaston sponsored by Rep. Clary, Tiffany Correll from Forsyth County sponsored by Rep. Parmon and Shira Sutton from New Hanover sponsored by Rep. McComas. The Sergeant-in-Arts were Brian Doherty, Aaron Woodlief and Jim Brewer. Chair Insko also recognized Lisa Hollowell, Tamara Jones, Policy Director, from the Lt. Governor's Office and Jim Davis from the Health and Wellness Trust Fund.

Rep. Insko gave a brief explanation of Sen. Purcell's SB 582 A BILL TO BE ENTITLED AN ACT TO ESTABLISH THE COMMISSION ON CHILDHOOD OBESITY. (Attachment III). The bill creates a 27-member Commission to study various issues relating to childhood obesity and make recommendations to change any law, rule or policy in order to lower obesity rates in the State. (Bill Analysis - Attachment IV) A proposed committee substitute (Attachment V) is introduced and Rep. McAllister makes motion to accept it for discussion purposes. Motion carried. The proposed committee substitute makes several changes including revising the composition of commission members to 21 members and states how they are to be selected. Language is also added to reflect the purpose and function of the commission.

Jim Davis of the Health and Wellness Trust Fund Commission explains how the Health and Wellness Trust Fund grant money can be used since obesity has been identified as a health risk. Tamara Jones, Policy Director with the Lt. Governor's Office advises that approximately $250,000 will be need to conduct study and Lisa Hollowell reiterates that no state appropriated funds will be used as funds will come directly from the Health and Wellness Trust Fund.

Rep. Insko suggests final report date be made more flexible. Rep. Bowie expresses reluctant to end Commission and asks about commission submitting interim reports. Rep. McAllister moves to strike final report and suggests annual reports. Chair Insko instructs staff to work on language to this effect.

Meeting adjourned at 10:53 a.m.

Verla Insko

Rep. Verla Insko, Chair

Pamela J. Evans

Pamela J. Evans, Committee Assistant

ATTENDANCE

HOUSE SUBCOMMITTEE ON HEALTH

DATES	5/12/03														
INSKO, Verla CHAIR	✓														
BOWIE, Joni	✓														
EARLE, Beverly	✓														
HILTON, Mark															
McALLISTER, Mark	✓														

ATTACHMENT II

VISITOR REGISTRATION SHEET

HOUSE SUBCOMMITTEE ON HEALTH — MAY 28, 2003

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Jim DAVIS	Health & Wellness Trust Fund Commission

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2003

S 2

SENATE BILL 582*
Health & Human Resources Committee Substitute Adopted 4/30/03

Short Title: Establish Commission on Childhood Obesity. (Public)

Sponsors:

Referred to:

March 31, 2003

A BILL TO BE ENTITLED

AN ACT TO ESTABLISH THE COMMISSION ON CHILDHOOD OBESITY.

Whereas, the four leading causes of death in North Carolina are stroke, heart disease, cancer, and diabetes, all of which are associated with overweight and obesity; and

Whereas, the prevalence of obesity has doubled in children and tripled in adolescents in the last two decades, bringing with it increased risk for future disease, as well as pediatric diagnoses of sleep apnea, orthopedic problems, psychological stress, and type 2 diabetes (formerly termed adult onset diabetes as it was rarely seen in persons under 30); and

Whereas, overweight teens have a 70% chance of becoming overweight or obese adults, making the next generation likely to have more adults with chronic diseases related to obesity at earlier ages than past generations; and

Whereas, the cost attributed to obesity and associated chronic diseases in the United States is more than $100 billion and these costs are spiraling upward; and

Whereas, children and adolescents are not meeting the recommendations of the Dietary Guidelines for Americans, including fruits and vegetables, but are consuming increasing amounts of foods high in fat and sugar; and

Whereas, standards were adopted in 1995 for meals served in the National School Lunch and School Breakfast Programs, but no standards exist for foods and beverages served a la carte in the cafeteria or in other venues during the school day; and

Whereas, regular physical activity substantially reduces the risk of dying of coronary heart disease and decreases the risk for stroke, colon cancer, diabetes, and high blood pressure. It also helps to control weight; contributes to healthy bones, muscles, and joints; reduces symptoms of anxiety and depression; and is associated with fewer hospitalizations, physician visits, and medications; Now, therefore,

The General Assembly of North Carolina enacts:

SECTION 1. There is established the Commission on Childhood Obesity.

SECTION 2. The Commission on Childhood Obesity shall be composed of 27 members who have knowledge and interest in reversing the epidemic of childhood obesity and taking steps to prevent obesity. The members shall be appointed as follows:

(1) The Superintendent of Public Instruction or his or her designee.

(2) One member of the Health and Wellness Trust Fund appointed by the chair of the Health and Wellness Trust Fund.

(3) Two parents of public school children and one public high school student appointed by the Governor after receiving recommendations from the North Carolina State Parent Teacher Association.

(4) Two members of the Senate appointed by the President Pro Tempore of the Senate.

(5) Two members of the House of Representatives appointed by the Speaker of the House of Representatives.

(6) Two members of a local board of education appointed by the Governor, after receiving recommendations from the North Carolina School Boards Association.

(7) One public school child nutrition director appointed by the Governor, after receiving recommendations from the Superintendent of Public Instruction.

(8) One public school nutrition education specialist appointed by the Governor, after receiving recommendations from the Superintendent of Public Instruction.

(9) One at-large member appointed by the Governor.

(10) Five members appointed by the President Pro Tempore of the Senate. In making these appointments, the President Pro Tempore shall appoint the following:

a. One public school health education teacher.
b. One representative from the Smart Start Program.
c. One pediatrician.
d. One psychiatrist, specializing in obesity.
e. One school administrator.

Professional associations representing teachers, school administrators, and the medical community may recommend appointees to the President Pro Tempore of the Senate.

(11) Five members appointed by the Speaker of the House of Representatives. In making these appointments, the Speaker of the House of Representatives shall appoint the following:

a. One public school physical education specialist.
b. One representative from the More At Four Program.
c. One dentist.
d. One member of the research community addressing the obesity epidemic.
e. One school administrator.

Professional associations representing teachers, school administrators, and dentists may recommend appointees to the Speaker of the House of Representatives.

(12) One representative of the vending machine industry, who is appointed by the Health and Wellness Trust Fund Commission, after receiving recommendations from the North Carolina Citizens for Business and Industry.

(13) One nutritionist, who is appointed by the Health and Wellness Trust Fund Commission, after receiving recommendations from professional associations.

(14) One economist, with expertise in the socioeconomic issues associated with obesity, who is appointed by the Health and Wellness Trust Fund Commission, after receiving recommendations from the research community.

Each of the following organizations or agencies may select a representative from its organization or agency to advise the Commission. These members shall provide information to the Commission about the obesity epidemic in North Carolina: North Carolina Department of Health and Human Services, Division of Public Health; North Carolina Department of Public Instruction, Child Nutrition Services; Be Active North Carolina, Inc., Prevention Partners; American Cancer Society; American Heart Association; Action for Healthy Kids NC; Healthy Weight Initiative; and the Office of the Governor.

SECTION 3. The member of the Health and Wellness Trust Fund Commission appointed by the chair of the Health and Wellness Trust Fund Commission shall serve as the chair of the Commission. Vacancies on the Commission shall be filled by the same appointing authority as made the initial appointment.

SECTION 4. The study shall include the following:

(1) The causes of obesity in North Carolina's children.

(2) The socioeconomic issues associated with childhood obesity.

(3) How the State should deal with childhood obesity.

(4) The steps that should be taken to prevent obesity in North Carolina.

SECTION 5. The Commission shall make recommendations that include the following:

(1) Nutritional guidelines for food served in public schools outside of the National School Lunch and School Breakfast Programs.

(2) Physical education in public schools.

(3) Physical activities in public schools.

(4) Healthy and nutritional behavior by North Carolina students and, when possible, their families.

The Commission is encouraged to explore different settings for its recommendations, including families, schools/child care, communities, health care, media/communication/social marketing, and surveillance/research.

SECTION 6. The Commission shall submit a final written report of its findings and recommendations to the Joint Legislative Health Care Oversight

Committee, the Joint Legislative Education Oversight Committee, and the Health and Wellness Trust Fund Commission no later than Friday, May 7, 2004. The final report may contain a summary of recommendations for changes to any law, rule, and policy that would lower or eradicate the obesity rates in North Carolina and our schools. Upon filing its final report, the Commission shall terminate.

SECTION 7. Members of the Commission shall be paid per diem, subsistence, and travel allowances in accordance with G.S. 120-3.1, 138-5, and 138-6, as appropriate.

SECTION 8. Federal funds, private funds, and existing State funds may be used to support the Commission. No new State funds shall be used to support the Commission.

SECTION 9. This act is effective when it becomes law.

SENATE BILL 582:
Establish Commission on Childhood Obesity.

BILL ANALYSIS

Committee: House Health
Date: May 20, 2003
Version: Second Edition

Introduced by: Sen. Purcell
Summary by: Sara Kamprath
Committee Analyst

SUMMARY: ***Senate Bill 582 creates the 27-member Commission on Childhood Obesity. The Commission shall study various issues relating to childhood obesity and may make recommendations to change any law, rule or policy in order to lower obesity rates in the State. The final written report shall be made by Friday, May 7, 2004. The Commission shall terminate upon filing its final report. No new State funds shall be used for the Commission. The bill becomes effective when it becomes law.***

BILL ANALYSIS:

Commission Membership -- There is created a 27-member Commission on Childhood Obesity.

Number	Member Qualification
1	Superintendent of Public Instruction or designee
	(4) APPOINTEES OF THE HEALTH AND WELLNESS TRUST FUND
1	Member of the Health and Wellness Trust Fund appointed by the chair of the Fund
1	Representative of the vending machine industry based on recommendations by the NC Citizens for Business and Industry
1	Nutritionist based on recommendations by professional associations
1	Economist, with expertise in socioeconomic issues associated with obesity, based on recommendations by the research community
	(8) APPOINTEES OF THE GOVERNOR
3	2 parents of public school children and 1 public high school student based on recommendations by the NC PTA
2	Members of a local board of education based on recommendations by the NC School Boards Association
1	Public school child nutrition director based on recommendations by the Superintendent of Public Instruction
1	Public school nutrition education specialist based on recommendations by the Superintendent of Public Instruction
1	At-large member
	(7) APPOINTEES OF THE PRESIDENT PRO TEMPORE
2	Members of the Senate
1	Public school health education teacher
1	Representative from Smart Start
1	Pediatrician
1	Psychiatrist, specializing in obesity
1	School administrator
For the 5 non-Senator members, professional organizations representing teachers, school administrators, and the medical community may recommend appointees	

(7) APPOINTEES OF THE SPEAKER	
2	Members of the House of Representatives
1	Public school physical education specialist
1	Representative from the More at Four Program
1	Dentist
1	Member of the research community addressing the obesity epidemic
1	School administrator
For the 5 non-House members, professional associations representing teachers, school administrators, and dentists may recommend appointees	

Commission Structure and Terms of Members

The chair of the Commission shall be the member appointed by the chair of the Health and Wellness Trust Fund Commission. The appointing authority that made the original appointment shall fill any vacancy on the Commission. The members of the Commission shall be paid the appropriate per diem, subsistence and travel allowances.

Study

The study shall examine the causes of obesity in North Carolina's children, the socio-economic issues associated with childhood obesity, how the State should deal with childhood obesity and the steps that should be taken to prevent obesity in North Carolina.

Duties of the Commission

The Commission shall make recommendations that include the following:

(1) Nutritional guidelines for food served in public schools outside of the National School Lunch and School Breakfast Program.
(2) Physical education in public schools.
(3) Physical activities in public schools.
(4) Healthy and nutritional behavior by North Carolina students and when possible their families.

Reports

The Commission shall submit a final written report with its findings and recommendations to the Joint Legislative Health Care Oversight Committee, the Joint Legislative Education Oversight Committee and the Health and Wellness Trust Fund Commission by Friday, May 7, 2004. The Commission shall terminate when the final report is filed.

Funding

No new State funds shall be used for the Commission but only federal funds, private funds and existing State funds.

BACKGROUND:

Increased body weight is a factor in the onset and severity of many diseases such as adult-onset diabetes, hypertension, coronary heart disease, and some cancers. It is important to teach healthy behaviors at an early age because making changes is more difficult later in life.

Body Mass Index (BMI) is an index of a person's weight in relation to their height. BMI is commonly used to classify overweight and obesity among adults as well as helps to identify children who are overweight or at risk of becoming overweight. The following table shows data gathered on children seen in public health settings in 2000.

Percent of NC Children who are Overweight

	1995	2000	Increase
Ages 2-4	9.0%	12.2%	36.6%
Ages 5-11	14.7%	20.6%	40.1%
Ages 12-18	22.7%	26.0%	14.5%

S582-SMRJ-003

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2003

S D

SENATE BILL 582*
Health & Human Resources Committee Substitute Adopted 4/30/03
PROPOSED HOUSE COMMITTEE SUBSTITUTE S582-CSRJ-27 [v.3]

5/28/2003 9:12:09 AM

Short Title: Establish Commission on Childhood Obesity. (Public)

Sponsors:

Referred to:

March 31, 2003

A BILL TO BE ENTITLED

AN ACT TO ESTABLISH THE COMMISSION ON CHILDHOOD OBESITY.

Whereas, the four leading causes of death in North Carolina are stroke, heart disease, cancer, and diabetes, all of which are associated with overweight and obesity; and

Whereas, the prevalence of obesity has doubled in children and tripled in adolescents in the last two decades, bringing with it increased risk for future disease, as well as pediatric diagnoses of sleep apnea, orthopedic problems, psychological stress, and type 2 diabetes (formerly termed adult onset diabetes as it was rarely seen in persons under 30); and

Whereas, overweight teens have a 70% chance of becoming overweight or obese adults, making the next generation likely to have more adults with chronic diseases related to obesity at earlier ages than past generations; and

Whereas, the cost attributed to obesity and associated chronic diseases in the United States is more than $100 billion and these costs are spiraling upward; and

Whereas, children and adolescents are not meeting the recommendations of the Dietary Guidelines for Americans, including fruits and vegetables, but are consuming increasing amounts of foods high in fat and sugar; and

Whereas, standards were adopted in 1995 for meals served in the National School Lunch and School Breakfast Programs, but no standards exist for foods and beverages served a la carte in the cafeteria or in other venues during the school day; and

Whereas, regular physical activity substantially reduces the risk of dying of coronary heart disease and decreases the risk for stroke, colon cancer, diabetes, and high blood pressure. It also helps to control weight; contributes to healthy bones, muscles, and joints; reduces symptoms of anxiety and depression; and is associated with fewer hospitalizations, physician visits, and medications; Now, therefore,

The General Assembly of North Carolina enacts:

SECTION 1. There is established the Commission on Childhood Obesity, hereafter "Commission".

SECTION 2. The Commission on Childhood Obesity shall be composed of ~~27~~ 21 members who have knowledge and interest in reversing the epidemic of childhood obesity and taking steps to prevent obesity. The members shall be appointed as follows:

(1) The Superintendent of Public Instruction or his or her designee.

(2) One member of the Health and Wellness Trust Fund Commission appointed by the chair of the Health and Wellness Trust Fund Commission.

(3) ~~Two parents~~ One parent of a public school ~~children~~ child ~~and one public high school student~~ appointed by the Governor upon recommendation of the North Carolina State Parent Teacher Association.

(4) Two members of the Senate appointed by the President Pro Tempore of the Senate.

(5) Two members of the House of Representatives appointed by the Speaker of the House of Representatives.

(6) ~~Two members~~ One member of a local board of education appointed by the Governor, upon recommendation of the North Carolina School Boards Association.

~~(7) One public school child nutrition director appointed by the Governor, after receiving recommendations from the Superintendent of Public Instruction.~~

~~(8) One public school nutrition education specialist appointed by the Governor, after receiving recommendations from the Superintendent of Public Instruction.~~

~~(9) One at-large member appointed by the Governor.~~

(10) Five members appointed by the General Assembly upon the recommendation of the President Pro Tempore of the Senate, as follows:

a. One public school health education teacher.
b. One representative from the Smart Start Program.
c. One pediatrician.
d. One ~~psychiatrist~~psychologist, specializing in obesity.
e. One school administrator.

Professional associations representing teachers, school administrators, and the medical community may recommend appointees to the President Pro Tempore of the Senate.

(11) Five members appointed by the General Assembly upon the recommendation of the Speaker of the House of Representatives, as follows:

a. One public school physical education specialist.

b. One representative from the More At Four Program.
c. One dentist.
d. One member of the research community addressing the obesity epidemic.
e. One school ~~administrator~~nurse.

Professional associations representing teachers, school administrators, school nurses, and dentists may recommend appointees to the Speaker of the House of Representatives.

(12) One representative of ~~the vending machine~~ industry, who is appointed by the Health and Wellness Trust Fund Commission, after receiving recommendations from the North Carolina Citizens for Business and Industry.

(13) One nutritionist, who is appointed by the Health and Wellness Trust Fund Commission, after receiving recommendations from professional associations.

(14) One economist, with expertise in the socioeconomic issues associated with obesity, who is appointed by the Health and Wellness Trust Fund Commission, after receiving recommendations from the research community.

Each of the following organizations or agencies may select a representative from its organization or agency to advise the Commission. These members shall provide information to the Commission about the obesity epidemic in North Carolina: North Carolina Department of Health and Human Services, Division of Public Health; Health and Wellness Trust Fund Commission; North Carolina Department of Public Instruction, Child Nutrition Services; Be Active North Carolina, Inc., Prevention Partners; American Cancer Society; American Heart Association; Action for Healthy Kids NC; Healthy Weight Initiative; and the Office of the Governor.

SECTION 3. The member of the Health and Wellness Trust Fund Commission appointed by the chair of the Health and Wellness Trust Fund Commission shall serve as the chair of the Commission. Vacancies on the Commission shall be filled by the same appointing authority as made the initial appointment.

SECTION 4. The purpose of the Commission on Childhood Obesity is to evaluate the status of obesity among North Carolina's children and to recommend initiatives to the Department of Health and Human Services, Health and Wellness Trust Fund Commission, and Department of Public Instruction, and other interested parties and to suggest legislation as recommended by the Commission to intervene and combat the obesity.The study shall include the following:

(1) The causes of obesity in North Carolina's children.
(2) The socioeconomic issues associated with childhood obesity.
(3) How the State should deal with childhood obesity.
(4) The steps that should be taken to prevent obesity in North Carolina.
(5) Encourage parental involvement in education of children developing healthy eating and strong physical activity habits.

SECTION 5. The Commission ~~shall make recommendations that include the following~~recommendations shall address:

(1) Nutritional guidelines for food served in public schools outside of the National School Lunch and School Breakfast Programs.

(2) Physical education in public schools.

(3) Physical activities in public schools.

(4) Healthy and nutritional behavior by North Carolina students and, when possible, their families.

(5) Any other relevant matters at the discretion of the Commission.

The Commission is encouraged to explore different settings for its recommendations, including families, schools/child care, communities, faith-based organizations, health care, media/communication/social marketing, and surveillance/research.

SECTION 6. The Commission shall submit a final written report of its findings and recommendations to the Joint Legislative Health Care Oversight Committee, the Joint Legislative Education Oversight Committee, and the Health and Wellness Trust Fund Commission no later than Friday, May 7, 2004 and a final report no later than Friday, January 2005. The ~~final~~ reports may contain a summary of recommendations for changes to any law, rule, ~~and~~ or policy that would lower or eradicate the obesity rates in North Carolina and our schools. Upon filing its final report, the Commission shall terminate.

SECTION 7. Members of the Commission shall be paid per diem, subsistence, and travel allowances in accordance with G.S. 120-3.1, 138-5, and 138-6, as appropriate.

SECTION 8. Federal ~~funds, private funds, and existing State funds~~funds and private funds may be used to support the Commission. ~~No new State funds shall be used to support the Commission.~~No State appropriated funds shall be used to support the Commission.

SECTION 9. Subject to the prior approval of the Legislative Services Commission, the Commission may meet in the State Legislative Building or the Legislative Office Building.

SECTION 10. The Commission is authorized to hire staff or contract for other expertise to conduct its work.

SECTION 11. This act is effective when it becomes law.

House Subcommittee on Health

July 15, 2003

Minutes

The House Subcommittee on Health appointed by the Chairs at the last regular meeting of the Health Committee met on Tuesday, July 15, 2003 at 10:00 a.m. in Room 424 of the Legislative Office Building. A silent roll was taken. A copy of the roll denoting members present is attached to the minutes (Attachment I) along with a copy of Visitor Registration Sheet (Attachments II).

Rep. Verla Insko, Chair welcomed visitors and members and recognized the pages: Paul Natarajo from Wayne County sponsored by Rep. Louis Pate, Jordan Pittman from Brunswick County sponsored by Rep. Charles Johnson and William Council from Johnston County sponsored by Speaker Black. The sergeant-in-arms were Tom Wilder and Charles Williams. (Attachment III)

Rep. Insko called the Subcommittee to order and asks Rep. Blackwood and Dianna Jessup for an overview of Rep. Blackwood's HB 835 A BILL TO BE ENTITLED AN ACT REQUIRING CERTAIN PHARMACIES TO PROVIDE PRESCRIPTION DRUG DISCOUNTS TO CERTAIN INDIVIDUALS. (Attachment IV) The bill amends the Pharmacy Practice Act to require pharmacies that dispense prescriptions under the Medicaid program to charge the same rate it receives from Medicaid to individuals who are over 60 and who are not eligible for full Medicaid benefits and individuals not otherwise covered by prescription drugs under a health benefit plan or public or private prescription drug program. (Bill Analysis – Attachment V)

Rep. Barnhart questions whether bill includes everyone – rich or poor. Rep. Blackwell explains that yes the wealthy could potentially be covered, but most people in that tax bracket are covered under private insurance. Rep. Blackwood explains that the main purpose of his bill is to try to help older people. Rep. Barnhart also questions if bill is eligible, as crossover not met. Rep. Insko advises that subcommittee is meeting at request of Rep. Blackwood and that were is no impact on state budget. Reps. Barnhart and England are concerned about how pharmacies will handle pricing for those eligible. There was some discussion among members concerning how pharmacies will handle pricing and several pharmaceutical represents spoke about programs available to seniors.

Rep. Blackwood thanked the subcommittee members for their suggestions and feels he will be able to improve his bill.

Meeting adjourned at 10:43 a.m.

Verla Insko

Rep. Verla C. Insko, Chair

Pamela J. Evans

Pamela J. Evans, Committee Assistant

ATTENDANCE

HOUSE COMMITTEE ON HEALTH

DATES															
INSKO, Verla CHAIR	✓														
ENGLAND, Bob	✓														
BARNHART, Jeff	✓														

ATTACHMENT II

VISITOR REGISTRATION SHEET

HOUSE SUBCOMMITTEE ON HEALTH — JULY 15, 2003

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Bill Rustad	ACP
Mike James	NCMB
Zeb Alley	Alley Associates
Andy Ellen	NCRMA
Mitchell	NRC
Brian Shank	AZ
Glenn Wells	Hoffman-LaRoche
Tom Sri	NCDMB
Ken Melton	Alley Associates

House Pages

1. Name: Paul Nataraja
   County: Wayne
   Sponsor: Louis Pate
2. Name: Jordan Pittman
   County: Brunswick
   Sponsor: Charles Johnson
3. Name: William Council
   County: Johnston
   Sponsor: SPEAKER Black
4. Name:
   County:
   Sponsor:
5. Name:
   County:
   Sponsor:

Sgt-At-Arms

1. Name: Tom Wilder
2. Name: CHARLES WILLIAMS
3. Name:
4. Name:

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2003

HOUSE BILL 835

Short Title:	Presc. Drug Discounts/Uninsured Elderly.	(Public)
Sponsors:	Representatives Blackwood; Dockham, Frye, Gibson, Glazier, Insko, Justus, Kiser, Luebke, McMahan, C. Wilson, and Womble.	
Referred to:	Health.	

April 2, 2003

A BILL TO BE ENTITLED

AN ACT REQUIRING CERTAIN PHARMACIES TO PROVIDE PRESCRIPTION DRUG DISCOUNTS TO CERTAIN INDIVIDUALS.

The General Assembly of North Carolina enacts:

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

"**§ 90-85.42. Prescription drug discount required for certain individuals.**

(a) A pharmacy, by or through a pharmacist acting on its behalf as its employee, agent, or owner, that dispenses prescription drugs pursuant to reimbursement under the North Carolina Medical Assistance Program (Medicaid) shall comply with the requirements of this section.

(b) In dispensing prescription drugs to individuals who meet the requirements of this section, the pharmacy shall accept as payment in full from the individual the applicable rate for which the pharmacy is reimbursed from the North Carolina Medical Assistance Program (Medicaid). The discount required under this section shall be offered to individuals:

(1) Over the age of 60 and not eligible for full Medicaid benefits; and

(2) Not otherwise covered for prescription drugs under a health benefit plan or public or private prescription drug program.

(c) A pharmacy subject to this section shall display prominently at the point of service and at the point of sale, a sign reminding discount beneficiaries to ask that the charge for the beneficiary's prescription be the same amount as the fee charged to the North Carolina Medical Assistance Program (Medicaid)."

SECTION 2. This act becomes effective January 1, 2004.

ATTACHMENT V

HOUSE BILL 835:
Presc. Drug Discounts/Uninsured Elderly

BILL ANALYSIS

Committee:	House Health	**Introduced by:**	Rep. Blackwood
Date:	April 9, 2003	**Summary by:**	Dianna Jessup
Version:	First Edition		Committee Counsel

*SUMMARY: **House Bill 835 would amend the Pharmacy Practice Act to require pharmacies that dispense prescriptions under the Medicaid program to charge the same rate it receives from Medicaid to the following: (1) individuals who are over 60 and who are not eligible for full Medicaid benefits and (2) individuals not otherwise covered for prescription drugs under a health benefit plan or public or private prescription drug program. The act would become effective January 1, 2004.***

CURRENT LAW: State law does not currently regulate prices pharmacies can charge persons for prescriptions. *Medicaid* generally covers up to 6 prescriptions per month for elderly (over age 65), blind and disabled persons who have incomes equal to or less than 100% of the federal poverty guidelines, which currently is $8,980 annually for a family of one.

Reimbursement to Pharmacies under Medicaid: Under Medicaid, pharmacies are reimbursed under a two-tier system: (1) one price for generic drugs and (2) one price for brand name drugs. The reimbursements are as follows:

- GENERIC DRUGS: The Maximum Allowable Cost (MAC) List price plus a $5.60 dispensing fee. There is a federal MAC List maintained by the Centers for Medicare and Medicaid Services (CMS) and a State MAC List maintained by the Division of Medical Assistance (DMA), DHHS. Drugs are placed in different classes in the MAC List. For any drug dispensed by a pharmacist in a certain class such as acid indigestion, that pharmacist will receive a set reimbursement rate for all drugs in the acid indigestion class. Currently, there are over 400 drugs on the MAC List.
- BRAND NAME DRUGS: The Average Wholesale Price (AWP) minus 10% plus a $4.00 dispensing fee.

Medicaid recipients pay co pays for drugs as follows: a $1 co pay for generics and a $3 co pay for brand name drugs. DMA deducts this co pay from the price reimbursed to pharmacists. Most of the claims for reimbursement to pharmacies under Medicaid are handled electronically through a point of sale system. This software system is linked to Electronic Data Systems (EDS) who is the fiscal agent that handles all the claims for DMA. EDS calculates the Medicaid price and compares the Medicaid price with the pharmacy's cash price. EDS then transmits back to the pharmacy the lesser of the two prices as the pharmacist's reimbursement.

BILL ANALYSIS: House Bill 835 would require a pharmacy that dispenses prescriptions under the Medicaid Program to charge the same rate it receives from Medicaid to individuals: (1) over the age of 60 and not eligible for full Medicaid benefits **and** (2) not otherwise covered for prescription drugs under a health benefit plan or public or private prescription drug program. The bill would require the pharmacy to display a sign at the point of service and at the point of sale that would remind discount beneficiaries to ask to be charged the Medicaid rate. The bill does not require a pharmacy to charge the Medicaid rate automatically (see line 13 – "accept as payment").

BACKGROUND:

NC Medicaid Snapshots

The following information comes from a Fiscal Research Division publication entitled, Medicaid Program Overview, February 2003.

About $7.4 billion dollars was spent on the Medicaid program in SFY 2002. Today, Medicaid is 15.3% of the General Fund operating budget compared to 8.2% ten years ago. NC Medicaid covered 1.4 million state residents in SFY 2002 (17% of the State's population). 30.8% of recipients including the aged, blind, and disabled, consumed 71.1% of resources. Expenditures under Medicaid for prescription drugs exceeded one billion dollars in SFY 2002. Since 1995, drug expenditures have doubled from 8.2% to 17%.

National Prescription Drug Trends

The following information comes from The Henry J. Kaiser Family Foundation, Prescription Drug Trends, March 2003 report.

23% of Americans under age 65 in 1996 and 38% of Medicare beneficiaries in the fall of 1999 had no prescription coverage. Seniors lack drug coverage because Medicare does not cover outpatient prescription drugs, and because they do not have or cannot afford a private policy that supplements Medicare with drug coverage. Furthermore, U.S. spending for prescription drugs was $140.6 billion in 2001, more than tripling since 1990. Three main factors are driving the increases in prescription drug spending: (1) the increasing number of prescriptions (utilization), (2) changes in the types of drugs used (with newer, higher-priced drugs replacing older, less-expensive drugs), and (3) manufacturer price increases for existing drugs. U.S. spending for prescription drugs is expected to continue to rise rapidly, reaching $445.9 billion (17% of personal health care spending) by 2012.

A February 2002 Kaiser Family Foundation study found that 38% of non-institutionalized elderly are without prescription drug coverage. In addition, there has been an increase of 29% in Medicare beneficiaries' average annual out-of-pocket costs from $813 in 2000 to $1,051 in 2002. Furthermore, a Kaiser Family foundation 2001 Survey of Seniors in Eight States found that 35% of seniors without prescription coverage skipped doses or did not have prescriptions filled.

Amy Compeau, Research Assistant, contributed to this summary.

H835-SMSW-001

2004

HOUSE COMMITTEE
ON
HEALTH

2003-2004

Representative Verla Insko, Chair
Representative Carolyn Justus, Chair

Staff

Dianna Jessup
Sandra Alley
Sara Kamprath
Shawn Parker

Committee Assistants

Pamela Evans
Glenda Jones

HOUSE COMMITTEE ON HEALTH
MEMBERSHIP LIST
2003-2004 Session

MEMBER	ASSISTANT	PHONE	OFFICE	SEAT
INSKO, Verla Chair	Pamela Evans Committee Assistant	733-7208	2121	70
JUSTUS, Carolyn Chair	Glenda Jones Committee Assistant	733-5956	1023	27
ENGLAND, Bob Vice Chair	Lisa Brown	733-5749	2219	117
ADAMS, Alma	Beverlee Baker	733-5902	542	67
ALLEN, Bernard	Gloria Haywood	733-5772	1325	94
ALLEN, Gordon	Nancy Brantley	733-5662	534	10
ALLRED, Cary	Jean Allred	733-5905	606	38
BARNHART, Jeff	Pamela Ahlin	715-2009	608	76
BOWIE, Joni	Sharon Gaudette	733-5877	538	78
CLARY, Debbie	Shirley Winstead	715-2002	302B	14
EARLE, Beverly	Ann Raeford	715-2530	634	95
GLAZIER, Rick	Carin Savel	733-5601	2215	107
HILTON, Mark	Anne Soles	733-5988	1021	61
McALLISTER, Mary	Johnna Smith	733-5959	638	58
MUNFORD, Don	Carla Farmer	733-5809	539	41
SETZER, Mitchell	Joanna Mills	733-4948	1204	42
SHERRILL, Wilma	Rosa Kelley	715-3026	403	17
WAINWRIGHT, William	Blinda Edwards	715-3026	302D	8
WILSON, Connie	Chris Floyd	733-5849	503	37
WRIGHT, Tom	Clarestene Stewart	733-5754	528	19

Research Staff:				
Jessup, Dianna		733-2578	545	
Parker, Shawn		733-2578	545	
Kamprath, Sara		733-2578	545	
Alley, Sandra		733-2578	545	
Ex-Officio Members:				
Brubaker, Bru	Cindy Coley	715-4946	1229	2
Culpepper, Bill	Dot Crocker	715-3028	404	36
Cunningham, Pete	Valerie Rustin	733-5778	541	7
Eddins, Rick	Dorie Monroe	733-5800	1319	26

ATTENDANCE

HOUSE COMMITTEE ON HEALTH

DATES		5/25/04	6/1/04	6/15/04	7/15/04											
INSKO, Verla	CHAIR	✓	✓	✓	✓											
JUSTUS, Carolyn	CHAIR	✓	✓	✓	✓											
ENGLAND, Bob	VICE-CHAIR	✓	✓	✓	✓											
ADAMS, Alma		✓														
ALLEN, Bernard		✓	✓	✓												
ALLEN, Gordon		✓		✓	✓											
ALLRED, Cary		✓														
BARNHART, Jeff				✓												
BOWIE, Joni			✓		✓											
CLARY, Debbie																
EARLE, Beverly				✓												
GLAZIER, Rick		✓	✓		✓											
HILTON, Mark		✓	✓	✓	✓											
McALLISTER, Mary		✓		✓												
MUNFORD, Don		✓	✓	✓												
SETZER, Mitchell		✓	✓		✓											
SHERRILL, Wilma				✓												
WAINWRIGHT, William		✓														
WILSON, Connie			✓		✓											
WRIGHT, Tom				✓												
Ex officio Members																
Brubaker, Bru																
Culpepper, Bill																
Cunningham, Pete																
Eddins, Rick																

2003-2004 Biennium

Bill	Introducer	Short Title		Latest Action	In Date	Out Date
H0036=	Womble	REPEAL INVOLUNTARY STERILIZATION.	*HR	Ch. SL 2003-13	02-19-03	03-19-03
H0080	Insko	REPORTS TO MENTAL HEALTH OVERSIGHT COMM.	*HR	Ch. SL 2003-58	02-25-03	03-12-03
$ H0155	**Warren**	**LTC WORKFORCE IMPROVEMENT PROGRAM.**	**H**	**Re-ref Com On Appropriations**	**03-03-03**	**04-14-03**
H0170=	Insko	SPECIAL ASSISTANCE IN-HOME OPTION.	*H	Re-ref Com On Appropriations	03-03-03	04-23-03
$ H0171=	**Insko**	**DHHS/ENSURE NO FELONS EMP. IN LONG-TERM CARE.**	**H**	**Ref To Com On Health**	**03-03-03**	
$ H0172	**Insko**	**LOCAL LTC PLANNING PILOT PROJECT.**	***H**	**Re-ref Com On Appropriations**	**03-03-03**	**04-09-03**
H0180	Howard	STATE HEALTH PLAN/ DEPENDENT CHILD COVERAGE.	H	Ref To Com On Health	03-04-03	
H0208	Wright	MANAGED CARE/HLTH BENEFITS CLARIFYING-AB.	*H	Re-ref Com On Rules, Calendar, and Operations of the House	03-05-03	03-25-03
H0346	Moore	EMERG. GENERATORS/ AGING STUDY COMM. STUDY.	*H	Re-ref Com On Rules, Calendar, and Operations of the House	03-06-03	04-24-03
H0354=	Insko	AMEND DISABILITY LAWS	*HR	Ch. SL 2004-78	03-06-03	04-07-03
H0500	Hall	LEGISLATIVE FITNESS CENTER.	H	Ref To Com On Health	03-17-03	
H0551=	Tolson	ATTENDANCE AGE/ ELIGIBILITY/SCHOOLS FOR DEAF.	*H	Re-ref Com On Rules and Operations of the Senate	03-19-03	04-14-03
H0557	Jeffus	STATE HEALTH PLAN: INCREASE WELLNESS BENEFIT.	H	Re-ref Com On Appropriations	03-19-03	06-18-03
H0642=	Wood	CONSCIENCE PROTECTION/ CONTRACEPTIVES.	H	Ref To Com On Health	03-25-03	
H0669	Wright	HOSPITALS/LTC QUALITY ASSURANCE.	*H	Pres. To Gov. 7/ 16/2004	03-26-03	04-09-03
H0815	Alexander	DETOX FACILITIES NOT SUBJECT TO CON.	*HR	Ch. SL 2003-390	04-01-03	04-24-03
H0826=	Insko	AMEND MH CONFIDENTIALITY STATUTES.	*HR	Ch. SL 2003-313	04-01-03	04-09-03
H0835=	Blackwood	PRESC. DRUG DISCOUNTS/ UNINSURED ELDERLY.	H	Ref To Com On Health	04-02-03	
H0854=	Capps	NO ABORTIONS UNDER STATE HEALTH PLAN.	H	Re-ref Com On Rules, Calendar, and Operations of the House	04-03-03	05-19-04
H0870=	Gillespie	COMMUNITY BLDGS/ EXEMPT FROM FOOD RULES.	H	Ref To Com On Health	04-07-03	
H0874	Frye	STATE EMPLOYEES' HEALTH PLAN/EMERGENCY SVCES.	H	Re-ref Com On Appropriations	04-07-03	06-18-03
H0882=	Gillespie	MEDICAID PRIOR	H	Ref To Com On	04-07-03	

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2003-2004 Biennium

Bill	Introducer	Short Title		Latest Action	In Date	Out Date
		AUTHORIZATION.		Health		
H0883	Insko	MH REFORM WAIVER.	*HR	Ch. SL 2003-178	04-07-03	04-28-03
H0886	Wright	DUE PROCESS FOR PHYSICIANS.	*HR	Ch. SL 2003-366	04-07-03	04-28-03
H0889=	Eddins	ANALOGUES/SCHEDULE I CONTROLLED SUBSTANCE.	H	Re-ref Com On Judiciary IV	04-07-03	05-13-03
H0894	Clary	CLARIFY ADULT CARE HOME MORATORIUM.	H	Ref To Com On Health	04-07-03	
H0907=	Alexander	DEAF/HARD OF HEARING ADVISORY COUNCIL.	*HR	Ch. SL 2003-343	04-07-03	04-29-03
H0916	Brubaker	FIRST-RESPONDERS VACCINATION PROGRAM.	*HR	Ch. SL 2003-227	04-08-03	04-28-03
H0923	Luebke	EXEMPT ALT. MEDICINE/ PRACTICE OF MEDICINE.	H	Ref To Com On Health	04-08-03	
H0954=	Weiss	DISCHARGE FROM ADULT CARE HOMES.	H	Ref To Com On Health	04-08-03	
H0983	A. Williams	PRESCRIPTION CO-PAYMENTS/COUNTY PRISONERS.	H	Ref To Com On Health	04-09-03	
$ H1004=	**Barnhart**	**STRENGTHEN PUBLIC HEALTH INFRASTRUCTURE.**	**H**	**Ref to the Com on Health and, if favorable, to the Com on Appropriations**	**04-10-03**	
H1043	Harrell	HEALTH PROVIDER IMMUNITY/TERRORIST INCIDENTS.	*H	Ref To Com On Select Committee on Insurance and Civil Justice Reform	04-10-03	04-30-03
H1094	Justice	LOCAL HEALTH DEPARTMENTS.	*H	Re-ref Com On Health	05-14-03	
H1098	Insko	HEALTH CARE FUNDAMENTAL RIGHT.	H	Re-ref Com On Health	05-19-04	
H1177	Brubaker	VOLUNTEER M.D.S AT THERAPEUTIC REC. CAMPS.	*HR	Ch. SL 2003-109	04-10-03	04-24-03
$ H1178	**Wright**	**RAISE ADAP INCOME LIMIT.**	**H**	**Re-ref Com On Appropriations**	**04-10-03**	**04-22-03**
H1191	Wright	STATE HEALTH PLAN UNDER STATE TREASURER.	H	Ref To Com On Health	04-10-03	
H1468	Nye	DISEASE MGMT ACTIVITIES STATE HEALTH PLAN.	H	Ref To Com On Health	05-17-04	
H1469	Nye	DHHS DISEASE MGMT ACTIVITIES.	*HR	Ch. SL 2004-112	05-17-04	06-17-04
$ H1487=	**Clary**	**DHHS STUDY/MEDICAID INSTITUTIONAL BIAS.**	**H**	**Re-ref Com On Appropriations**	**05-17-04**	**06-01-04**
H1490	Clary	STUDY MENTALLY ILL LTC RESIDENT ISSUES.	H	Re-ref Com On Appropriations	05-17-04	06-01-04
H1498	Tolson	STUDY COMMITTEE ON HEALTH CARE WORKFORCE DEV.	H	Re-ref Com On Rules, Calendar, and Operations of the House	05-18-04	06-03-04
H1509=	Barnhart	CABARRUS MEMORIAL HOSPITAL ADVANCED DEGREES.	HR	Ch. SL 2004-67	05-19-04	06-15-04

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2003-2004 Biennium

Bill	Introducer	Short Title		Latest Action	In Date	Out Date
H1560=	Insko	OSTEOPOROSIS EDUCATION PROGRAM.	H	Ref To Com On Health	05-20-04	
H1568=	Hill	SEPTIC SYSTEM SETBACKS FOR PRE-1977 LOTS.	H	Ref To Com On Health	05-20-04	
H1572=	Insko	HORACE WILLIAMS AIRPORT.	H	Ref To Com On Health	05-20-04	
H1693	Allred	UNEMPL. INS. EXCEPT. FOR CERTAIN DOMESTIC SERV.	HF	Postponed Indefinitely	05-27-04	07-01-04
S0002	R. C. Soles, Jr.	DRIVERS LICENSE MEDICAL CERTIFICATION.	*HR	Ch. SL 2003-14	03-04-03	03-12-03
S0388	Virginia Foxx	UPDATE CERVICAL CANCER SCREENING COVERAGE.	*HR	Ch. SL 2003-186	05-01-03	05-21-03
S0503=	A. B Swindell	AGE/ELIGIBILITY/NC SCHOOLS FOR THE DEAF.	*HR	Ch. SL 2003-253	04-24-03	05-28-03
S0519=	William R. Purce	CHILD LEAD POISONING PREVENTION PRGM AMENDS.-AB	*HR	Ch. SL 2003-150	04-21-03	05-27-03
S0522	Tony Rand	BOARD OF NURSING.	*HR	Ch. SL 2003-146	04-17-03	05-19-03
S0582	William R. Purce	PUBLIC HEALTH PREPAREDNESS AND RESPONSE	*HR	Ch. SL 2004-80	05-01-03	06-02-04
S0648	Virginia Foxx	CERVICAL CANCER ELIMINATION TASK FORCE.	*HR	Ch. SL 2003-176	05-01-03	05-21-03
S0657	James Forrester	TANNING SALONS/ RESTRICTIONS ON USE.	*H	Pres. To Gov. 7/ 19/2004	04-17-03	05-29-03
S0657	James Forrester	TANNING SALONS/ RESTRICTIONS ON USE.	*H	Pres. To Gov. 7/ 19/2004	07-14-04	07-15-04
S0661	Eric Miller Reev	PRISONER HEALTH INFORMATION/EMS CHANGES.	*HR	Ch. SL 2003-392	05-05-03	07-16-03
S0694=	Scott Thomas	ANALOGUES/SCHEDULE I CONTROLLED SUBSTANCE.	*HR	Ch. SL 2003-249	05-01-03	05-13-03
S0704	John H. Kerr III	TRAUMATIC BRAIN INJURY ADVISORY COUNCIL.	*HR	Ch. SL 2003-114	04-24-03	05-13-03
S0876	William R. Purce	CONTROLLED SUBSTANCE/ PHYSICIAN REGISTRATION.	*HR	Ch. SL 2003-335	04-24-03	06-18-03
S0897=	Joe Sam Queen	MEDICAID PRIOR AUTHORIZATION.	*HR	Ch. SL 2003-179	04-28-03	05-28-03
$ S0926	**Tony Rand**	**CLARIFY GROUP HOMES LICENSURE & LEA REIMBURS.**	***HR**	**Ch. SL 2003-294**	**05-01-03**	**06-10-03**
S1016	Philip E. Berger	NURSING HOME/ MEDICATION ERRORS.	*HR	Ch. SL 2003-393	05-01-03	06-12-03
S1202=	R. C. Soles, Jr.	SEPTIC SYSTEM SETBACKS FOR PRE-1977 LOTS.	*H	Pres. To Gov. 7/ 12/2004	06-21-04	06-24-04

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DATES BILL WERE CONSIDERED

May 25, 2004	HB 1098 Health Care Fundamental Right
	SB 582 Establish Commission on Childhood Obesity
June 1, 2004	SB 582 Establish Commission on Childhood Obesity
	HB 1469 DHHS Disease Mgmt Activities
	HB 1487 DHHS Study/Medicaid Institutional Bias
	HB 1490 Study Mentally Ill LTC Resident Issues
June 15, 2004	HB 1469 DHHS Disease Mgmt Activities
	HB 1509 Cabarrus Memorial Hospital Advanced Degrees
July 15, 2004	SB 657 Tanning Salons/Restrictions on Use

DATES OF CONSIDERATION
BY BILL NUMBER

HB 1098	**Health Care Fundamental Right**	**May 25**
HB 1469	**DHHS Disease Mgmt Activities**	**June 1**
HB 1487	**DHHS Study/Medicaid Institutional Bias**	**June 1 and June 15**
HB 1490	**Study Mentally Il LTC Resident Issues**	**June 1**
HB 1509	**Cabarrus Memorial Hospital Advanced Degrees**	**June 15**
SB 582	**Establish Commission on Childhood Obesity**	**May 25 and June 1**
SB 657	**Tanning Salons/Restrictions on Use**	**July 15**

AGENDA

HOUSE COMMITTEE ON HEALTH

May 25, 2004
Room 544 LOB
12:00 Noon

OPENING REMARKS

Representative Verla Insko, Chair
Representative Carolyn Justus, Chair

AGENDA ITEMS

HB 1098 Health Care Fundamental Right - Rep. Insko, Rep. Alexander and Rep. Wright

SB 582 Establish Commission on Childhood Obesity – Sen. Purcell

ADJOURNMENT

AGENDA

HOUSE COMMITTEE ON HEALTH

June 1, 2004
Room 544 LOB
12:00 Noon

OPENING REMARKS

Representative Verla Insko, Chair
Representative Carolyn Justus, Chair

AGENDA ITEMS

SB	**582**	**Establish Commission on Childhood Obesity – Sen. Purcell**
HB	**1469**	**DHHS Disease Mgmt Activities – Reps. Nye, Barbee, Justus and Insko**
HB	**1487**	**DHHS Study/Medicaid Institutional Bias – Reps. Clary, Nye and Weiss**
HB	**1490**	**Study Mentally Ill LTC Resident Issues – Reps. Clary, Nye and Weiss**

ADJOURNMENT

AGENDA

HOUSE COMMITTEE ON HEALTH

June 15, 2004
Room 544 LOB
12:00 Noon

OPENING REMARKS

Representative Verla Insko, Chair
Representative Carolyn Justus, Chair

AGENDA ITEMS

HB 1469 **DHHS Disease Mgmt Activities – Reps. Nye, Barbee, Justus and Insko**

HB 1509 **Cabarrus Memorial Hospital Advanced Degrees – Reps. Barnhart and L. Johnson**

ADJOURNMENT

AGENDA

HOUSE COMMITTEE ON HEALTH

July 15, 2004
Room 544 LOB
10:00 a.m.

OPENING REMARKS

Representative Verla Insko, Chair
Representative Carolyn Justus, Chair

AGENDA ITEMS

SB 657 **Tanning Salons/Restrictions on Use – Senator James Forrester**

ADJOURNMENT

House Committee on Health

May 25, 2004

Minutes

The House Committee on Health met on Tuesday, May 25, 2004 at 12:00 noon in Room 544 of the Legislative Office Building. A silent roll was taken. A copy of the roll denoting members present is attached to the minutes (Attachment I) along with a copy of the agenda and Visitor Registration Sheet (Attachments II and III).

Rep. Carolyn Justus, Chair welcomed visitors and members and recognized the pages: Vivian Ariail from Richmond County sponsored by Margaret Dickson, Nikida Koraly from Carteret County sponsored by Jean Preston, Daniel Stevens from Wake County sponsored by Don Munford, and Lee Perry from Wake County sponsored by Speaker Black. Dusty Rhodes, Charles Williams, Phillip Schreibman and Bill Sullivan were recognized as the sergeant-in-arms. (Attachment IV)

Chair Justus advised that Rep. Insko's HB 1098 A BILL TO BE ENTITLED AN ACT TO AMEND THE NORTH CAROLINA CONSTITUTION TO RECOGNIZE THE RIGHT TO HEALTH CARE will be heard for information only and no vote will be taken. Rep. Insko is recognized to explain her bill (Attachment V)

Rep. Insko explains that the bill would amend the North Carolina Constitution to recognize the right to health care. The bill would be submitted to voters at the general election in November 2004 and includes a $25,000 appropriation from the General Fund to the State Board of Elections for 2004-05 to implement the act. Rep. Insko stated: "there is an obligation for the state to make sure that every resident is able to realize this fundamental right". The provision would give the General Assembly until 2010 to come up with a universal health-care plan for all North Carolinians. (Bill Analysis- Attachment VI and Handouts – Attachment VII)

The Chair then recognized Carol Kirshenbaum, M.D. an internist from Durham and President of the NC Committee to Defend Health Care, a statewide group of medical professionals and citizens advocating for a universal health care approach. She advised the committee that she was speaking on behalf of 70 different organizations that support the bill and spoke on the politics of health care in the state. Dr. Kirshenbaum told the committee that the number of uninsured people in the state grew by 200,000 from 2001 to 2002, that North Carolina is tied with Mississippi as the two states with the greatest percentage in uninsured persons, and that 45 percent of the state's residents are either uninsured or under-insured. She told about the cost of insurance coverage for health care will clearly be one of the most pressing issues in the state elections this year. Dr. Kirshenbaum then told the committee that she has had cancer since 1987 and is currently undergoing chemotherapy treatments.

Dr. Holly Biola, a family doctor practicing at Family Practice Center in Chapel Hill and Chatham County Hospital Emergency Department told the story of a 46-year-old home health aid for one of her office patients with severe lung disease. Dr. Biola had seen her several times when she was bringing per patient back and forth for his doctor's visits. The gentleman began to notice her losing weight so encouraged her to see a doctor while she was there with him at one of his visits, but she had not insurance, and felt she could not afford an office visit. Finally, when she had visibly deteriorated he insisted she come to the doctor and paid for it himself. This lady had not seen a doctor for 20 years. One look at her and Dr. Biola knew she was dying. A small breast lump was found and her first chest x-ray showed metastases throughout her chest. She was dead in six weeks. She was a mother, a sister, a friend, a taxpaying citizen and a caretaker...now she is gone. If there had been universal coverage she would have seen a doctor and been here today.

Chair Justus then recognized Robert Neal, a former Pillowtex employee. Mr. Neal was Vice President of Local 1501 of UNITED, which represented the Pillowtex workers. He had worked in the plant for 30 years and his wife had worked there for 20 years. They also have children who worked at the plant. They now have no health insurance. Mr. Neal told that the Trade Adjustment Act provided short-term payment of 65% of the health insurance costs for laid off workers. Unfortunately, very few of those who were unemployed could afford to pay the 35% remaining cost and the few who could have now lost the subsidy leaving them without insurance.

The next speaker recognized by Chair Justus was Stephanie Phillipi. Ms. Phillipi told about her husband, who had worked the same job for 20 years and had dental insurance, the best health care, life insurance and a 401K. He thought he had provided for his family until he was diagnosed with ALS. Now he is out of work, has used up all his benefits, and now she, her husband and their three children are struggling to survive.

Chair Justus next recognized Mary Mitchell to speak. Ms. Mitchell told about working all her life and being laid off in December, 2003 due to cutbacks in the Durham County Mental Health Substance Abuse Department. Due to the cost of COBRA she could not afford health insurance and sought care at Lincoln Health Center for her hypertension and depression. Because of limited medication choices at Lincoln her blood pressure is no longer controlled. Her previous doctor of ten years has been providing her with samples to control her depression.

Tomiba Lamb was then recognized to speak. Ms. Lamb told the committee that she was 25 years old, a wife and mother. She is also raising her sister's children. In 2003 she was diagnosed with diabetes and has been attending the Watch Mobile Unit for treatment of high blood pressure and obesity. She has no health insurance and her children are on Medicaid. She works at a $16,000 per year job and is not eligible for Medicaid as her income is too high. There are times when she has to stretch her pills until her next payday.

The Chair then recognizes the last speaker, Stephanie Newkirk. Ms. Newkirk ais from Bladen County and has three children who are on Medicaid. When the plant she

worked at closed she could no longer afford health insurance and has not been able to obtain treatment for carpel tunnel syndrome she developed while working.

Representative Insko thanked the speakers for sharing their stories. She then stated that elected officials have the authority and responsibly to make changes.

Chair Justus recognized Representative McAllister. Representative McAllister asked Representative Insko what the bill does? Representative Insko responded that she has run this bill every year since1999 and this bill allows the voters (taxpayers) the chance through the ballot to put in the constitution the right for health care.

Chair Justus then recognized Representative Adams who asked if the amendment appeared on the ballot would the $25,000 indicated in the bill be sufficient? Representative Insko responded that bill drafting put that figure in the bill. Representative Adams then asked what was the timeframe to develop the plan. Representative Insko advised it would take approximately 10 years.

Chair Justus then stated that she had requested a fiscal note regarding the cost to implement universal health care in North Carolina and was told by fiscal staff they could not prepare same, as there was no definition for health care.

Chair Justus advised the committee that time had lapsed and SB582 will be held at the next committee meeting.

Chair Justus adjourned the meeting at 11:48 a.m.

Carolyn Justus

Carolyn Justus, Chair

Pamela J. Evans

Pamela J. Evans, Committee Clerk

ATTENDANCE

HOUSE COMMITTEE ON HEALTH

DATES		5/25/04														
INSKO, Verla	CHAIR	✓														
JUSTUS, Carolyn	CHAIR	✓														
ENGLAND, Bob	VICE-CHAIR	✓														
ADAMS, Alma		✓														
ALLEN, Bernard		✓														
ALLEN, Gordon		✓														
ALLRED, Cary		✓														
BARNHART, Jeff																
BOWIE, Joni																
CLARY, Debbie																
EARLE, Beverly																
GLAZIER, Rick		✓														
HILTON, Mark		✓														
McALLISTER, Mary		✓														
MUNFORD, Don		✓														
SETZER, Mitchell		✓														
SHERRILL, Wilma																
WAINWRIGHT, William		✓														
WILSON, Connie																
WRIGHT, Tom																
Ex officio Members																
Brubaker, Bru																
Culpepper, Bill																
Cunningham, Pete																
Eddins, Rick																

AGENDA

HOUSE COMMITTEE ON HEALTH

May 25, 2004
Room 544 LOB
12:00 Noon

OPENING REMARKS

Representative Verla Insko, Chair
Representative Carolyn Justus, Chair

AGENDA ITEMS

HB 1098 Health Care Fundamental Right - Rep. Insko, Rep. Alexander and Rep. Wright

SB 582 Establish Commission on Childhood Obesity – Sen. Purcell

ADJOURNMENT

VISITOR REGISTRATION SHEET

HOUSE COMMITTEE ON HEALTH — May 25, 2009

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Joe Delk	Gov Office
John Mettrey	Gov office
Lor. Ann Harris	LAHA
Joanne Sheppard	NCNA
Gene Causby	NCSFSA
Susan Harrison	WCPSS
Michelle Kincaid	NCPIRG
Tom Coles, Jr.	W.A.T.C.H.
Shelley LaKes RN	W.A.T.C.H.
Gail Pruett, RN	NCNA
Pete MacDowell	NC Committee to Defend Reproductive Rights & Access

VISITOR REGISTRATION SHEET

HOUSE COMMITTEE ON HEALTH — May 25, 2005

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Sandra Bailey	Center for Community Action
Douglas Keith MD	Legislative Doctor Today
Lindsay Allen, RN, MSN	Nurse of the Day
Adam Searing	NC Justice Ctr. / NCHAC
Mac Legerton	Center For Community Action
Jonathan Kotch	UNC-CH
Matt Czajkowski	Chapel Hill
Butch Gunnells	Raleigh
Paula Hudson Collins	DPI - Raleigh
Joyce Peters	JPA Assoc

VISITOR REGISTRATION SHEET

HOUSE COMMITTEE ON HEALTH — May 25, 2004

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
ROBERT NEAL SR.	341 MELROSE DR SW CONCORD, N.C. 28025
MARY Mitchell	4412 Deerfield Street Durham N.C. 27704
Melissa Thacker	117 Hines Dr Lt#33 Goldsboro, NC 27534
Tometia McLamb	819 Maple St. Goldsboro, NC 27530
Steve Mitchell	Novartis
Ken Wright	BCBSNC
BRIAN SHANK	ASTRAZENECA
John Bowdish	AstraZeneca
JOHN GOODMAN	Alley Associates
Ann Jo Horne	NCMS
Marie Lewis	GSK

VISITOR REGISTRATION SHEET

HOUSE COMMITTEE ON HEALTH — May 25, 2009

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Allen Spaulding	300 James St., Carrboro
Steve Cline	DHHS - DPH
Lisa Gustin	~~DHHS - DPH~~
Nancy Beeco	SECA
Jerry Williams	TJERRY-JC
Deborah Rowe	NCPHA / NCALHD
Eddie Caldwell	NC College of Emergency Physicians
Hugh Tilson	NCHA
Kevin Leonard	WCSR
Jeanie Ramsey	NCIMS

VISITOR REGISTRATION SHEET

HOUSE COMMITTEE ON HEALTH — May 25, 2009

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Dana Simpson	Smith Anderson
Steve Shone	NC Pediatric Society
Rose Young	First Health of the Carolinas
Jacob Montgomery	
George Reed	NC Council of Churches
Jennifer Bumgarner	NC Alliance for Economic Justice
Melissa Reed	NARAL Pro-Choice North Carolina
Paige Johnson	Planned Parenthood of Central NC / NC Women United
Holly Biala MD	North Carolinia Committee to Defend Health Care

VISITOR REGISTRATION SHEET

HOUSE COMMITTEE ON HEALTH — May 25, 2009

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Brian Lewis	Planned Parenthood Health Sys, Inc.
Dems Lnzaf	NC - Committee to Defend Health Care
LIZ KAND=	NCMS Foundation
Carol Kirschenbaum MD	NC committee to defend Health Care
Lillie White	N.C. Fair Share / Disciples Inc.
Monica Nicholson	N.C Fair Share / Disples Inc.
Lynice R. Williams	NC Fair Share
[signature]	NCLHW
Jeff Engel	NC DHHS
Anna Wood	NC DHHS
[signature]	NCHBA

VISITOR REGISTRATION SHEET

HOUSE COMMITTEE ON HEALTH — May 25, 2009

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
[illegible]	NMRS
Lynn Bunce	N&O
[illegible]	UNC-TV
[illegible]	Capitol Broadcasting
[illegible]	NC Fair Share
Philip Schlossman	House Sgt. At Arms

House Pages

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   Sponsor: Margaret Dickson
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GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2003

H 1

HOUSE BILL 1098

Short Title:	Health Care Fundamental Right.	(Public)
Sponsors:	Representatives Insko, Alexander, Wright (Primary Sponsors); and Luebke.	
Referred to:	Rules, Calendar, and Operations of the House.	

April 10, 2003

A BILL TO BE ENTITLED

AN ACT TO AMEND THE NORTH CAROLINA CONSTITUTION TO RECOGNIZE THE RIGHT TO HEALTH CARE.

The General Assembly of North Carolina enacts:

SECTION 1. Article I of the North Carolina Constitution is amended by adding a new section to read:

"**Sec. 38. Health care.**

Health care is an essential safeguard of human life and dignity, and there is an obligation for the State to ensure that every resident is able to realize this fundamental right. Not later than July 1, 2006, the General Assembly shall provide by law a plan to ensure that by July 1, 2010, every resident of North Carolina has access to appropriate health care on a regular basis."

SECTION 2. The amendment set out in Section 1 of this act shall be submitted to the qualified voters of the State at the general election in November 2004, which election shall be conducted under the laws then governing elections in the State. Ballots, voting systems, or both may be used in accordance with Chapter 163 of the General Statutes. The question to be used in the voting systems and ballots shall be:

"[ ] FOR [ ] AGAINST

Constitutional amendment providing that health care is a fundamental right."

SECTION 3. If a majority of the votes cast on the question are in favor of the amendment set out in Section 1 of this act, the State Board of Elections shall certify the amendment to the Secretary of State. The Secretary of State shall enroll the amendment so certified among the permanent records of that office.

SECTION 4. There is appropriated from the General Fund to the State Board of Elections the sum of twenty-five thousand dollars ($25,000) for the 2004-2005 fiscal year to implement this act.

SECTION 5. Section 4 of this act becomes effective July 1, 2004. The remainder of this act is effective when it becomes law.

HOUSE BILL 1098:
Health Care Fundamental Right

BILL ANALYSIS

Committee:	House Health	**Introduced by:**	Reps. Insko, Alexander, Wright;and Luebke
Date:	May 24, 2004		
Version:	1st Edition	**Summary by:**	Shawn Parker Committee Staff

SUMMARY: ***House Bill 1098 would amend the North Carolina Constitution to recognize the right to health care.***

BILL ANALYSIS: House Bill 1098 would amend Article 1 of the North Carolina Constitution by adding a new section to read, "Health care is an essential safeguard of human life and dignity, and here is an obligation for the State to ensure that every resident is able to realize this fundamental right. Not later than July 1, 2006, the General Assembly shall provide by law a plan to ensure that by July 1, 2010, every resident of North Carolina has access to appropriate health care on a regular basis." The amendment would be submitted to qualified voters at the general election in November 2004. The bill would appropriate $25,000 from the General Fund to the State Board of Elections for the 2004-2005 fiscal year.

EFFECTIVE DATE: Section 4 of the bill would become effective July 1, 2004. The remainder of this act would become effective when it becomes law.

BACKGROUND: States that have considered similar measures include California and Oregon.

Attachment VII

North Carolina General Assembly
House of Representatives
State Legislative Building
16 W. Jones Street, Room 2121
Raleigh, NC 27601-1096

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EDUCATION
EDUCATION SUBCOMMITTEE ON UNIVERSITIES
ENVIRONMENT & NATURAL RESOURCES
HEALTH-CHAIR
JUDICIARY I

Press Release
Embargoed until May 25, 2004
Contact: Rep. Verla Insko, 919-733-7208

North Carolina Health Care in Crisis
It's Time for Political Accountability

Raleigh: "Since 2000, the percentage of people in North Carolina without health insurance has grown faster than in every other state except Mississippi," according to Rep. Verla Insko (D-Chapel Hill) "On top of this figure, several thousand former Pillowtex employees are losing their health insurance because their benefits are running out. From 2000 to 2001 this state added 200,000 people to the rolls of its uninsured, who now total of 1.3 million people. That is equal to the total population of our four biggest cities, Charlotte, Raleigh, Greensboro, and Durham, put together. Health care in this state is an impending disaster that is snowballing out of control. The costs of providing care to the uninsured are shifted to the insured. This cost-shifting makes health care increasingly unaffordable for everyone. There is no good news around the corner. The marketplace has not and will not correct this problem. It will only get worse, if left alone," she said.

Representative Insko introduced a number of people from across the state who testified about their personal experience with the health care crisis. (Brief synopses of their testimony and

their contact information can be found in the press package or is available from Rep. Insko's office.)

Dr. Carol Kirschenbaum, the President of the North Carolina Committee to Defend Health Care, a statewide group of medical professionals and citizens advocating for a universal health care approach, then addressed the politics of health care in the state.

"The North Carolina General Assembly's response to this health care crisis has been one of deep denial and business as usual. The cost of insurance coverage for health care will clearly be one of the most pressing issues in the state elections this year. We at the NC Committee to Defend Health Care will ask every candidate for state office the core question: Should access to health care be a right in North Carolina, or only a privilege for those who can afford it? Specifically, we will ask each incumbent and each candidate to go on record in support of Rep. Insko's HB 1098 which will be discussed in the House Health Committee at noon today. The bill is titled "An Act To Amend The North Carolina Constitution To Recognize The Right To Health Care." It calls for an amendment to the North Carolina Constitution to recognize health care as a right. If passed, the amendment would commit the General Assembly to coming up with a workable plan for ensuring access to affordable health care for all North Carolinians. Support for this bill will mark the clear distinction between political lip service and real commitment to addressing this impending health care disaster. The Committee to Defend Health Care will make a list those legislators who support or oppose this critical bill and publish the results. It will take political courage to sign on. It will take commitment to doing the right thing for our families and our businesses. Delay and indecision will create thousands of more victims of the health care system and make the problem ever harder to solve."

Footnotes:

City population: http://www.citypopulation.de/USA-NorthCarolina.html

NORTH CAROLINA COMMITTEE TO DEFEND HEALTH CARE

We ask only that all of us shall work together to make real a new ideal of democracy, the equal right of every person born on earth to needed medical care whenever and wherever he battles against disease and death.[1]

HB 1098 BRIEFING BULLETS

THE PROBLEM

- 16 % of North Carolina's population, in excess of 1.2 million North Carolinians, are without health insurance for an entire calendar year. Nearly as many lack coverage for part of a year and an additional million North Carolinians do not have adequate health insurance, including many of the state's elderly.
- Between 1991 and 2001 the number of uninsured North Carolinians has increased by more than 80% (from 700,000 in 1991). In the last few years our rate of increase in uninsurance is second only to that of Mississippi among the 50 states.
- While a majority of uninsured North Carolinians are white and employed, ethnic minorities, the working poor, young adults and children are disproportionately uninsured. Although the working poor shoulder the largest tax burden (proportional to income), they make up a larger number of uninsured than do the unemployed. This is so even while 65 cents of every health care dollar spent in our nation is paid out of public funds.
- The uninsured in North Carolina generate a cost to hospitals of $1.3 billion per year. Taxpayers share the burden of keeping the public hospitals we rely open, no matter the shortfall.

THE SOLUTION FOR NORTH CAROLINA

- To address this increasing need, Representative Verla Insko of Chapel Hill introduced HB 1098, the "Health Care Fundamental Right" in the North Carolina General Assembly on April 10, 2003.[2]
- If passed by both houses of the General Assembly, the voters of North Carolina would have the opportunity in November 2004 to decide by popular vote whether residents of our state should enjoy the right to health care with the state constitution being so amended.[3]
- If passed by the voters, the bill would require that, by July 2006, "the General Assembly shall provide by law a plan to ensure that ... every resident of North Carolina has access to appropriate health care on a regular basis."
- The amendment does *not* require that the state become a health care provider or insurer, *or* that any individual physician or other health provider offer care to any individual resident upon demand, *or* that the state provide health care to illegal aliens.
- The amendment does *not* prescribe any particular mechanism or mechanisms to meet the obligation of providing access to health care for all North Carolinians, only that the legislature develop a plan to assure access to needed medical care for all residents of our state.

NORTH CAROLINIANS SUPPORT THE RIGHT TO HEALTH CARE

- Of North Carolinians 83.1%, including 73% of Republicans, 81% of Democrats, and 86% of those not identifying with either party, either strongly agree or agree, that "the State Legislature should make a plan so that all NC Residents can get decent health care on a regular basis."[4]

---

[1] North Carolina Hospital and Medical Care Commission, Report to the Governor, 1945.

[2] Other state Representatives co-sponsoring the bill include Representatives Adams/Guilford; Alexander/Mecklenburg; Wright/Brunswick Columbus, New Hanover and Pender; Luebke/Durham; and Weiss/Wake.

[3] Groups endorsing the legislation include the NC Pediatric Society, NC Public Health Association, NC Nurses Association, NC College of Emergency Physicians, NC Council of Churches, North Carolina State AFL-CIO, and NC American Association of Retired Persons (NC-AARP), among many others.

[4] Poll by the School of Journalism and Mass Communications at UNC in 2000

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NORTH CAROLINA COMMITTEE TO DEFEND HEALTH CARE

Working to assure availability of quality health care, not only for those currently well-insured, but also for those who are uninsured and under-insured in our state.

HB 1098 BRIEFING PAPER
May 25, 2004

Background

HB 1098 is a bill to amend the state constitution to recognize the right to health care in North Carolina. It is patterned after a similar statement, the Bernardin Amendment, written by Joseph Cardinal Bernardin of Chicago shortly before his death. In North Carolina, HB 1098 was introduced in the General Assembly by Representative Verla Insko of Chapel Hill on April 10, 2004 with co-sponsorship from Representatives Adams (Guilford); Alexander (Mecklenburg); Wright (Brunswick, Columbus, New Hanover and Pender); Luebke (Durham); and Weiss (Wake).

Summary

HB 1098 would simply put a resolution on the November 2004 ballot, giving the voters of North Carolina the opportunity to decide whether residents of our state should enjoy the right to health care. In order to be placed on the ballot, both houses of the General Assembly must pass the resolution with a 60% majority. While establishing *in principle* the right to health care in North Carolina, the bill requires that, by July 31, 2006, the state develop "a plan to ensure that ... every resident of North Carolina has access to appropriate health care on a regular basis." The mechanism by which the state would implement the right to health care would be determined by the legislature and its commissions.

Rationale

Despite managed care, 16% of North Carolina's population, in excess of 1.2 million North Carolinians in 2001, were without health insurance for the entire year, compared to 700,000 in 1991 (more than 80% increase). Nationally, it is known that nearly twice as many are without health coverage for, at least, a portion of each year. On top of those numbers, another million or more North Carolinians do not have adequate health insurance, including many of the state's elderly, mentally ill and chronically ill, whose major health issue is excluded from their coverage. A majority of the uninsured are white and employed. Young adults, the poor, Hispanics and African-Americans are disproportionately uninsured (more than 3 times as likely to be uninsured than whites in the case of African-American women). Only 50% of North Carolina's poor were covered by Medicaid in 1996, ranging from 17.4% to 72.2% of those below poverty in individual counties. According to a report by Deloitte and Touche commissioned by the NC Hospital Association, the uninsured in North Carolina generate a cost to hospitals of $1.3 billion per year. Of 110 hospitals in North Carolina, 38 hospitals were running negative margins, and 11 hospitals were predicted to soon be out of cash.

Where we are headed is even more frightening, as public programs to assist the poor to obtain health insurance have not been able to keep pace with increasing rate of uninsurance among the working poor, as premiums rise and as employers increasingly shift costs to employees. Indeed more employers have ceased offering insurance, or offer it to fewer of their employees (by hiring fewer full-time employees for example). Our state's rate of increasing uninsurance during the last few years is second only to that of Mississippi. We also have sunk to a bottom rank in several quality measures such as "maternal mortality" (48th), "infant mortality" (45th) and "women's uninsurance" (41st) according to 2001 data from the National Women's Law Center. Nationally, it has been predicted that private health coverage for an average (basically healthy) family will rise above $20,000 annually by the year 2010, based on current trends, according to a May 2004 article in Health Affairs. Where will North Carolina stand in 2010, ranking near the bottom now, and with the most alarming rates of increasing uninsurance in the country?

NORTH CAROLINA COMMITTEE TO DEFEND HEALTH CARE

What HB 1098 would do

HB 1098 would do only one thing, put the "Right to Health Care" constitutional amendment on the ballot. Then it would be up to a majority of the voters in November to decide whether or not to amend the state constitution in this way. If passed by the voters, the amendment would require the state legislature to come up with a plan by July 1, 2006 for ensuring "appropriate health care on a regular basis" for all North Carolina residents to be implemented no later than July 1, 2010. The bill also prohibits anyone from suing the state, counties or municipalities, their agencies or employees for money damages. The state may provide for other mechanisms to enforce the amendment. The amendment specifically recognizes that all *residents*, not just all citizens, have a right to health care. In order to be a resident, a person must live in the state legally for 30 days.

What HB 1098 would *not* do

The amendment does *not* require that the state become a health care provider or insurer.

The amendment does *not* prescribe any particular mechanism or mechanisms to meet the obligation of providing access to health care for all North Carolina residents.

The amendment would *not* require that any individual physician or other health provider offer care to any individual resident upon demand. Under this amendment, the duty to provide appropriate health care for everyone becomes a responsibility of the state, *not* of individual doctors, just as the duty to provide free public education is a responsibility of the state, not of individual teachers. Therefore, the amendment would *not* expose health care providers to suits just because they refused to provide care for a specific individual who demanded it. The amendment would *not* require that the state provide health care to illegal aliens.

The amendment would *not necessarily* make medical care more expensive. In fact, the December 1994 Report of the North Carolina Health Planning Commission predicted the costs of three options for providing universal access to health care in our state. "The net change in health spending in North Carolina ranged from a **reduction** (emphasis added) of $1.13 billion under single payer to increases of $0.7 billion under employer mandate and $0.82 billion under individual mandate." (p. 29)

Public opinion in North Carolina supports the right to health care

A recent poll, conducted in Spring 2000 by the School of Journalism and Mass Communication at UNC-CH, showed that 83.1% of North Carolinians, including 73% of Republicans, 81% of Democrats, and 86% of those not identifying with either party, either strongly agree or agree that "the State Legislature should make a plan so that all North Carolina residents can get decent health care on a regular basis."

It is time to fulfill the wisdom and the promise of the North Carolina Hospital and Medical Care Commission, which 59 years ago said in its report to the Governor,

"We ask only that all of us shall work together to make real a new ideal of democracy, the equal right of every person born on earth to needed medical care whenever and wherever he battles against disease and death."

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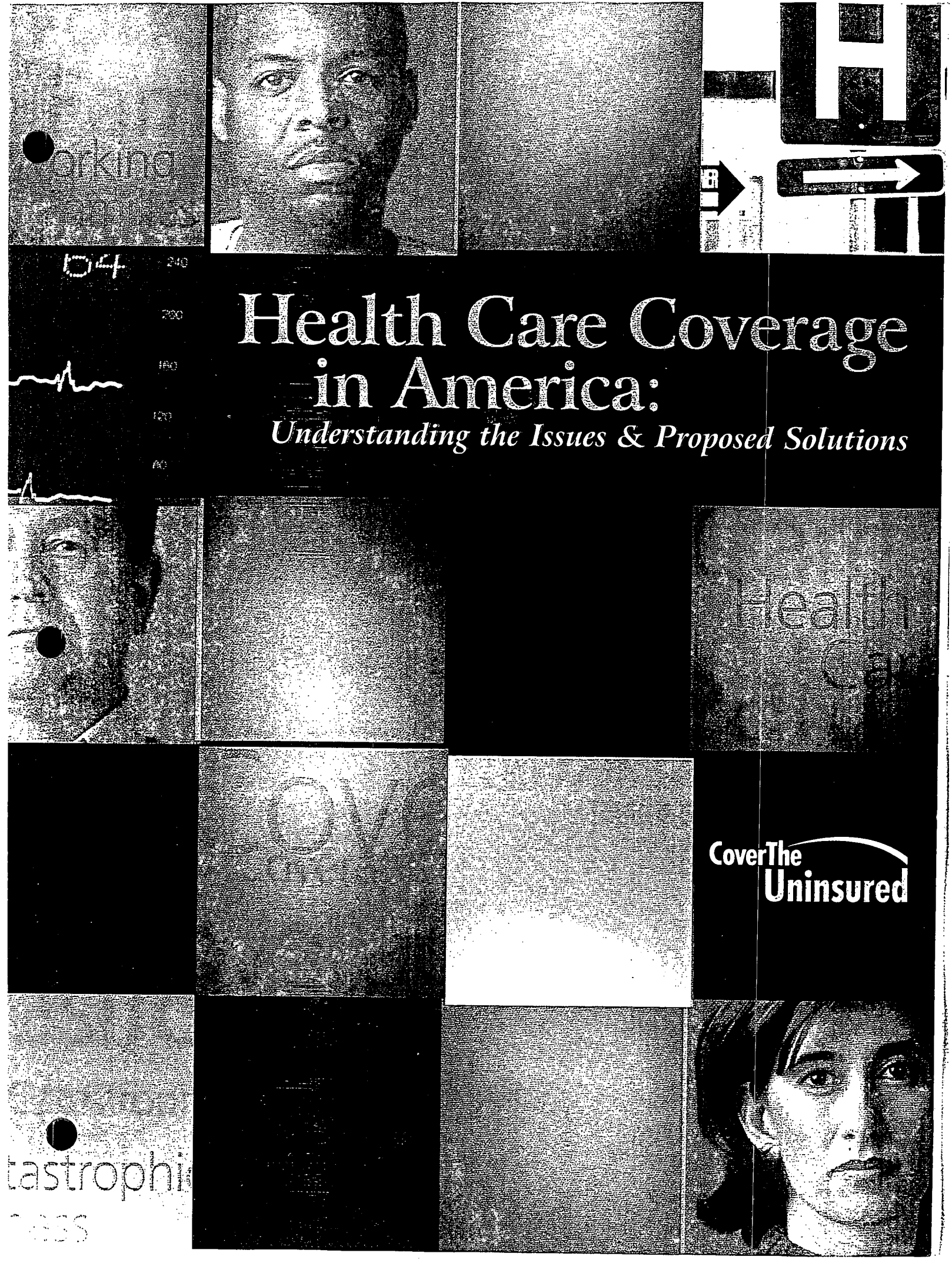

Health Care Coverage in America:

Understanding the Issues & Proposed Solutions

CoverThe Uninsured

ACKNOWLEDGMENTS

This guide was prepared by the Alliance for Health Reform with a grant from The Robert Wood Johnson Foundation, and designed by GMMB of Washington, DC. We trust that this publication will prove useful to a wide audience looking for reliable, up-to-date information on one of America's most pressing social problems during *Cover the Uninsured Week* 2004 and beyond.

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En Español
www.CoverTheUninsured.org/espanol

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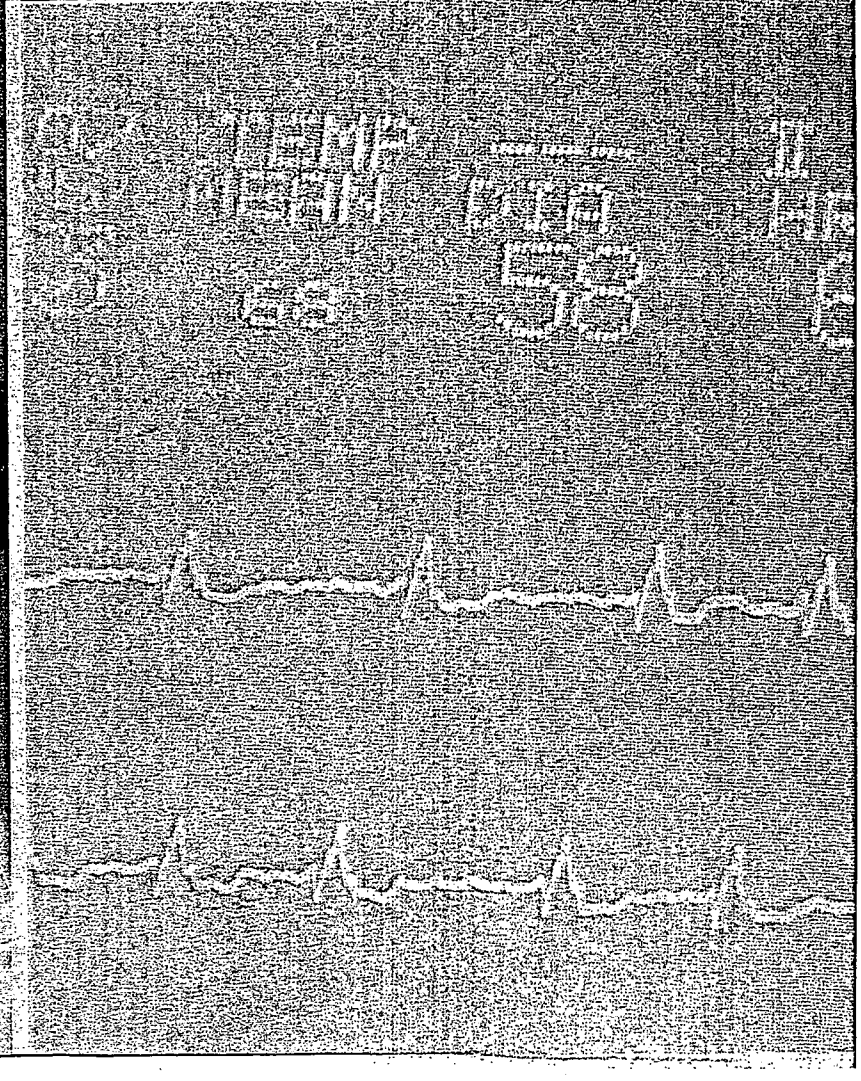
4 WHY THE RENEWED INTEREST IN THE UNINSURED?
6 WHY IS HEALTH COVERAGE SO IMPORTANT?
8 WHO IS UNINSURED?
10 HOW DO AMERICANS GET HEALTH COVERAGE?
19 APPROACHES TO COVERING THE UNINSURED
21 CONCLUSION
22 GLOSSARY
23 REFERENCES
26 END NOTES

Americans are known around the world for enjoying the simple things: a barbeque, a baseball game and rock n' roll.

But when it comes to health care, our attitude seems to be, "the more complicated, the better."



The United States has an incredibly complex and convoluted system for financing and delivering health care. Americans get coverage in many ways: through our employers, the federal government, the military, state programs, n our own, and by other means. At the same time, we pay ›r coverage out of pocket, through state and federal taxes, ıd through our employers.

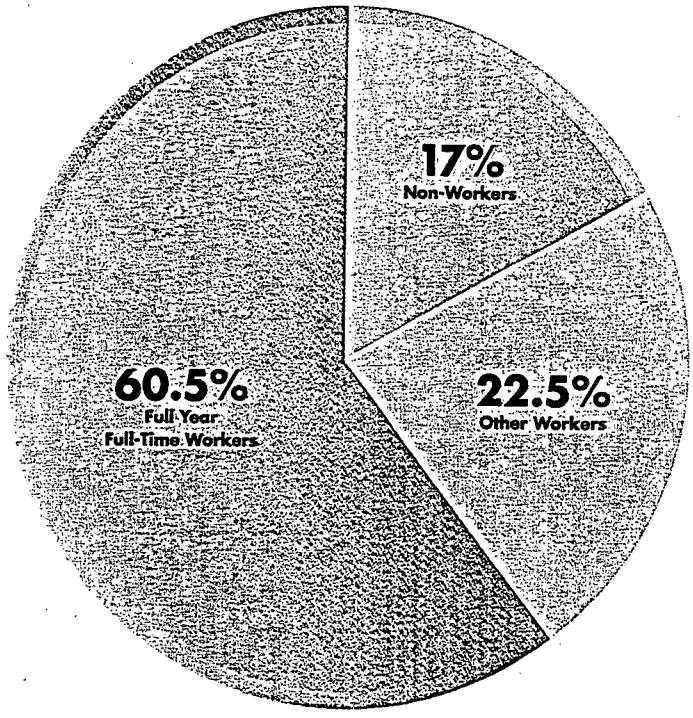
Several times during the past 60 years or so, Americans ave engaged in a nationwide discussion asking "How can e get health insurance for those who don't have it?" And st as important, "How can we help people keep their ealth insurance if they do have it?"

We are in the midst of another such discussion now. overnment officials, political candidates, employers, ıions, community leaders and ordinary citizens are pressing a desire for the nation's piecemeal system of ealth insurance—employment-based coverage for workers, der unded Medicare for the elderly, other public ograms for certain poor people—to cover the tens of illions of Americans who fall through the cracks each year.

Many say that we can do better and refer to the llowing facts:

- **Almost one in every six people in the U.S. lacks health insurance—43.6 million in 2002, according to the Census Bureau.[1]**
- **The percentage of the U.S. population without health coverage is growing, reaching 15.2 percent in 2002 vs. 14.2 percent in 2000.[2]**
- **Eight out of 10 of the uninsured are in working families (see Chart 1).[3]**
- **The uninsured don't fit any stereotype. They come from every community, every walk of life, every race and ethnic group, every income level.[4]**
- **People who have coverage can't necessarily count on k ping it. A person could have good coverage today, none at all six months from now, then regain coverage a few months later. Nearly 85 million people lacked coverage at some point between January 1, 1996 and December 31, 1999.[5]**

1. MOST UNINSURED AMERICANS ARE IN WORKING FAMILIES



Source: Employee Benefit Research Institute (2004). Estimates from the March Current Population Survey, 2003 Supplement.

This publication is designed to help you become an active participant in the national discussion about how we can secure health care coverage—private or public—for all Americans. In the pages to come, you will see evidence that a lack of health coverage has real consequences for a person's health and financial status. You will learn more about how people get health coverage now, and why so many don't have it. You will learn more about who is uninsured.

Finally, you will learn about several approaches to reducing the ranks of the uninsured. And you will learn how to make sense of proposals for reducing the number of people who go without health insurance in the U.S.

Cover The Uninsured

Why the Renewed Interest in the Uninsured?

Why the renewed interest in making sure all Americans have health care coverage? For one reason, we in the U.S. are growing increasingly concerned about the rising cost of health care and health coverage. We're justifiably afraid that as health coverage becomes more and more expensive, we may not be able to afford our share of coverage offered on the job—if we are offered coverage at all. We know that if we lose a job, we could also lose our access to affordable health coverage and health care (to be discussed in more detail later).

The slow pace of job creation worries many people. The latest recession officially ended at the end of 2001. But the rebound in jobs that normally occurs after a recession has lagged behind expectations, leaving many formerly employed—and insured—Americans without coverage.

In addition to cost and job worries, the 2004 presidential campaign is focusing on how we might make certain that many more Americans have access to health coverage in our country.

We're justifiably afraid that as health coverage becomes more and more expensive, we may not be able to afford our share of coverage offered on the job—if we are offered coverage at all.

Many Americans are worried about health coverage and health costs. For instance, a Kaiser Family Foundation poll conducted in January 2004 found that health care ranked second to the economy and jobs among issues respondents said would determine their vote for president this fall.[6]

Even so, many Americans are not convinced that being uninsured is a problem. A majority of Americans polled mistakenly believe the uninsured can receive the care they need through clinics and hospital emergency departments.[7] Another challenge: Although people tell pollsters they want help for the uninsured, they are less enthusiastic about paying higher taxes for this purpose.[8] Yet another challenge: Neither the public nor policy-makers have settled on one preferred approach to providing health coverage for the uninsured.[9]

PERSONAL STORIES OF THE UNINSURED

To read personal stories about those who are uninsured, told in their own words, go to the Web site for **Cover the Uninsured Week,** www.CoverTheUninsuredWeek.org/stories.

Insured Myths & Facts

MYTH: People without health coverage don't work.

FACT: Eight out of 10 people who are uninsured are in working families.[10]

MYTH: Most uninsured people in the U.S. are minorities.

FACT: Non-Hispanic whites make up three-fourths of the uninsured.[11]

MYTH: Most people without health insurance are poor.

FACT: Almost 29 million of the uninsured in 2002 had household incomes of $25,000 or more, compared with 14.8 million in households earning less.[12] *(The federal poverty guideline for a family of four in 2002 was $18,100. As noted, that has increased to $18,850 for 2004.)*

MYTH: It doesn't really matter whether a person has health insurance.

FACT: About 18,000 Americans die each year of treatable diseases because they don't have health coverage, according to the highly respected, nonpartisan Institute of Medicine.[13]

MYTH: Virtually everyone who works for a large employer has health coverage.

FACT: More than one out of four of the nation's uninsured in 2001 (nearly 10 million people) either worked for a firm with 500 or more employees or were dependents of someone who worked for a large firm.[14]

Why Is Health Coverage So Important?

Why does health coverage make such a big difference in people's everyday lives? Let's look at the evidence.

Effects on Health and Treatment

Not having coverage can be dangerous to your health, according to a wide array of studies conducted by the most respected research institutions in the United States, including the National Academy of Sciences' Institute of Medicine (IOM).

People without health insurance often go without care or delay care. The care they do receive is likely to be of lower quality than the care received by insured people, and they may be charged more for it. An estimated 18,000 adults die each year because they are uninsured and can't get appropriate health care, according to the federally chartered IOM, which produced a series of six reports on the consequences of not having health coverage.[15]

The length of time a person goes without health insurance also makes a difference. The Institute of Medicine noted that people uninsured for at least a year report being in worse health than those uninsured for a shorter period. Some 20 percent of those without coverage for at least a year said their health was poor or fair, compared with 14 percent of those uninsured for less than a year.[16] But even those uninsured for a short period of time experience problems getting access to care.[17]

Among the IOM's key findings were:

- Uninsured women with breast cancer are less likely than insured women to receive breast-conserving surgery.
- Hospitalized patients without health insurance receive fewer needed services and worse quality care, and have a greater risk of dying in the hospital or shortly after discharge than patients with insurance.
- The uninsured are less likely to receive care even when they have serious symptoms (see Chart 2).
- Uninsured trauma victims are less likely to be admitted to the hospital or receive the full range of needed services, and they are 37 percent more likely to die of their injuries.
- Uninsured adults with HIV are less likely to receive highly effective "drug cocktails." When they do get the new drug therapies, their wait to receive them has been an average four months longer than patients who have insurance.[18]

The Institute of Medicine concluded: "Health insurance is associated with better health outcomes for adults and with their receipt of appropriate care across a range of preventive, chronic and acute care services. Adults without health insurance coverage experience greater declines in health status and die sooner than do adults with continuous coverage."[19]

Children too suffer health consequences when they lack coverage. Uninsured children are more likely than insured children to lack a usual source of health care, to go without needed care, and to experience worse health outcomes.[20]

Studies have found that, compared to children with insurance, uninsured children are:

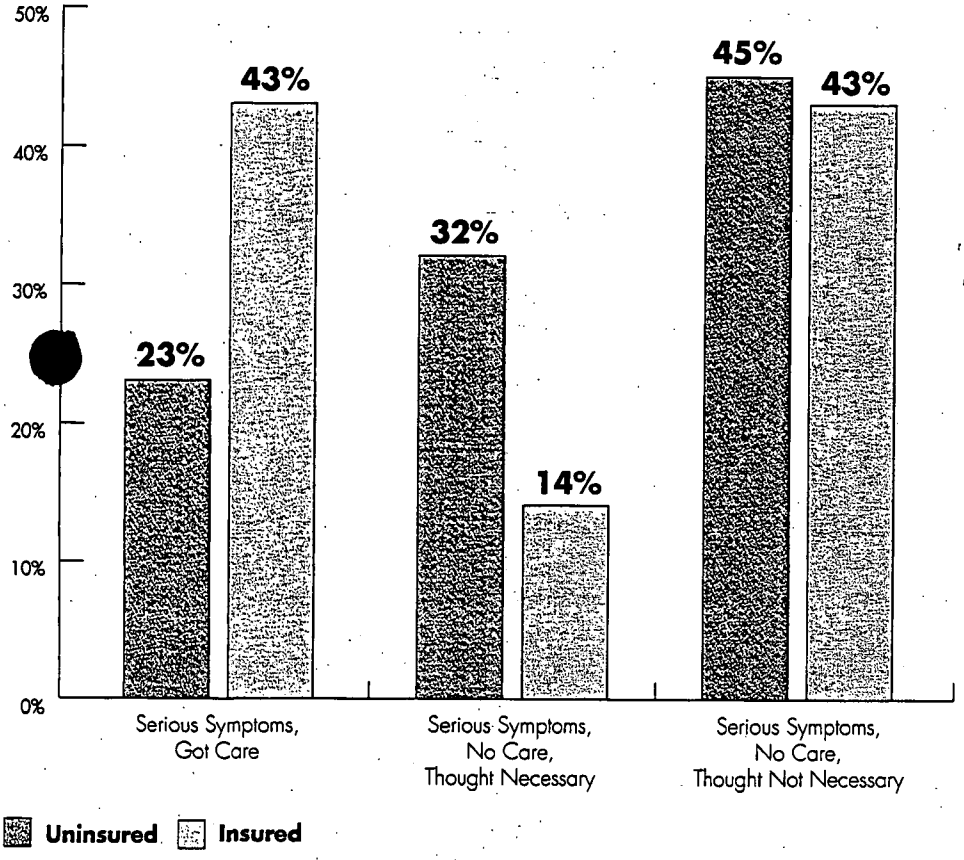
1. Just one-sixth as likely to have a usual site of health care (4 percent vs. 24 percent)

2. More than five times as likely to have an unmet need for medical care each year

3. More than three times as likely not to get a needed prescription drug

4. At least 70 percent more likely to go without care for common childhood conditions such as asthma, ear infections and sore throats[21]

2. UNINSURED LESS LIKELY TO GET CARE, EVEN FOR SERIOUS SYMPTOMS



Note: Respondents were asked whether they had experienced any of 15 symptoms during the previous three months. "Serious" symptoms among the 15 were previously identified by a national sample of physicians. Respondents experiencing symptoms were asked if they had thought it necessary to get care for their symptoms and if they did receive care. Bars show the percentage of uninsured respondents for whom the situation was true, compared to the percentage of insured respondents.

Source: David W. Baker et al., "Health Insurance and Access to Care for Symptomatic Conditions," Archives of Internal Medicine, Vol. 160, May 8, 2000, p. 1272.

Effects on Family Finances

Not having insurance threatens the financial security of families. On average, uninsured families pay more than 40 percent of their health care costs out of pocket, according to the Institute of Medicine. Because families with at least one uninsured member tend to have lower incomes than do fully insured families, as well as very few assets, they generally have fewer financial resources to help cope with these higher medical expenses.

This may destabilize a family's financial standing:

- More than half of uninsured working age adults report serious problems paying medical bills, compared with less than a quarter of insured adults.[22]

- Of those lacking coverage, 39 percent who also have medical bill problems or accrued medical debt reported that they struggled to pay for expenses such as food, rent or heat. Half (53 percent) said they were forced to use most or all of their savings to pay medical bills. One out of five said they had run up large credit card debts or had to take out a loan against their home to pay medical expenses.[23]

Who Is Uninsured?

Nearly 44 million people in the U.S. lack health coverage, including nearly 8.5 million children. Almost one in five adults age 18 to 64 was uninsured in 2002; one in 12 children was without coverage.[24]

The uninsured are members of every race and ethnic group, every age group and every income level. Compared to the general population, however, people who lack health insurance are younger, have lower incomes, have fewer years of schooling, and are more likely to be members of minority groups.[25]

A common misconception is that those who lack insurance are also out of the job market. In fact, eight of 10 of those who lack insurance are in working families, as noted earlier (see Chart 1).[26] Six of 10 had at least one member of the family working full time all year. Jobs held by the working uninsured tend to be in service industries and in smaller firms, where employees are less likely to be offered coverage, rather than in other job settings. The key point, though, is this: the overwhelming majority of the uninsured are from families actively in the labor force.

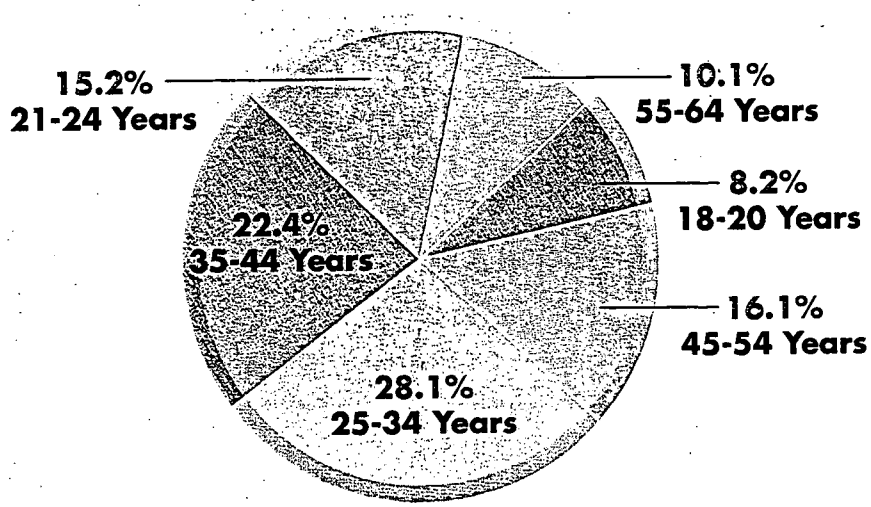
Americans with incomes below the federal poverty level are most likely to lack coverage—30.4 percent were uninsured in 2002 vs. 15.2 percent of the total population. For 2004, the poverty level is $18,850 for a family of four in every state except Alaska and Hawaii, where the figure is higher (see box, "What Does 'Federal Poverty Level' Mean?").

There are also key differences in insurance coverage among racial and ethnic groups. Hispanics are far more likely than any other ethnic group to be uninsured. In 2002, 32.4 percent of Hispanics were uninsured for the entire year, compared to 20.2 percent of blacks, 18.4 percent of Asian and Pacific Islanders, and 10.7 percent of non-Hispanic whites.[27]

Also in 2002, 22.7 percent of Hispanic children were uninsured, followed by 13.9 percent of black children, 11.5 percent of Asian American children, and 7.8 percent of non-Hispanic white children.[28]

The Hispanic community encounters difficulties in securing coverage in part because so many members are recent immigrants who earn modest incomes. Among working-age Hispanic immigrants who have been in the United States for less than five years, 72 percent are uninsured.[29] Like other uninsured Americans, uninsured Hispanics are often in low-wage service jobs that don't offer health coverage. In

3. UNINSURED NON-ELDERLY ADULTS BY AGE, 2002



Source: Employee Benefit Research Institute (2004). Estimates from the March Current Population Survey, 2003 Supplement.

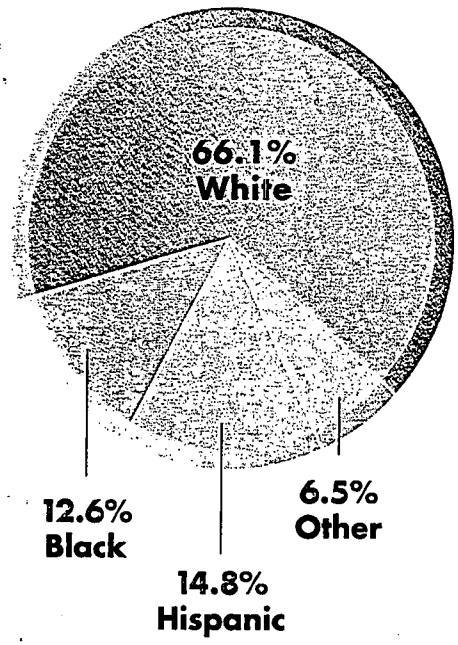
WHAT DOES "FEDERAL POVERTY LEVEL" MEAN?

The federal poverty guidelines (also referred to as the "federal poverty level") are family income figures produced each year by the U.S. Department of Health and Human Services to determine eligibility for certain federal programs, including Head Start, the Food Stamp Program, the National School Lunch Program and the State Children's Health Insurance Program. Eligibility for certain state assistance programs is also tied to the federal poverty guidelines. For 2004, the guidelines are:

Size of Family Unit	48 Contiguous States & D.C.	Alaska	Hawaii
1	$9,310	$11,630	$10,700
2	$12,490	$15,610	$14,360
3	$15,670	$19,590	$18,020
4	$18,850	$23,570	$21,680
For each additional person, add	$3,180	$3,980	$3,660

Source: The 2004 HHS Poverty Guidlines," U.S. Dept. of Health and Human Services (aspe.hhs.gov/poverty/04poverty.shtml)

4. UNINSURED NON-ELDERLY POPULATION BY RACE AND ETHNICITY, 2002



Note: White = non-Hispanic whites.
Black = non-Hispanic blacks.
Hispanics can be of any race.

Source: Employee Benefit Research Institute (2004). Estimates from the March Current Population Survey, 2003 Supplement.

addition, many low-income new immigrants, even when in the U.S. legally, are not eligible for public programs such as Medicaid, although their children are sometimes eligible.

One often-overlooked aspect of the uninsured is that, though the number of uninsured is relatively stable from month to month, it is not the same individuals who are uninsured from month to month and year to year. Hundreds of thousands of Americans lose coverage over the course of a year, and similar numbers regain it after lacking coverage for relatively short periods of time.

The dynamic nature of the uninsured population has implications for what strategies might be used to deal with the problem. A Commonwealth Fund study found that the number of uninsured, low-income children would decline by nearly 40 percent and the number of uninsured adults would decline by more than 25 percent if every person with public or private insurance at the beginning of a given year retained it through the next 12 months.[30]

Moreover, barriers prevent people from joining public or private insurance plans. Such barriers include waiting periods before a worker can sign up for an employer plan, and complex enrollment and renewal procedures that discourage people from applying for public insurance and keeping it if they get it.

How Do Americans Get Health Coverage?

Employer-Sponsored Coverage

In the United States, most Americans—175.3 million workers and their dependents—received health coverage through the workplace in 2002 (see Chart 5).[31] This is far more than the total number of people covered through other means (108.5 million).

Workplace coverage began in the 1930s, developed by the Blue Cross hospital insurance plans. At about the same time, Henry J. Kaiser started a prepaid group health plan for employees of his construction company in the West, which became the model for today's health maintenance organizations (HMOs).

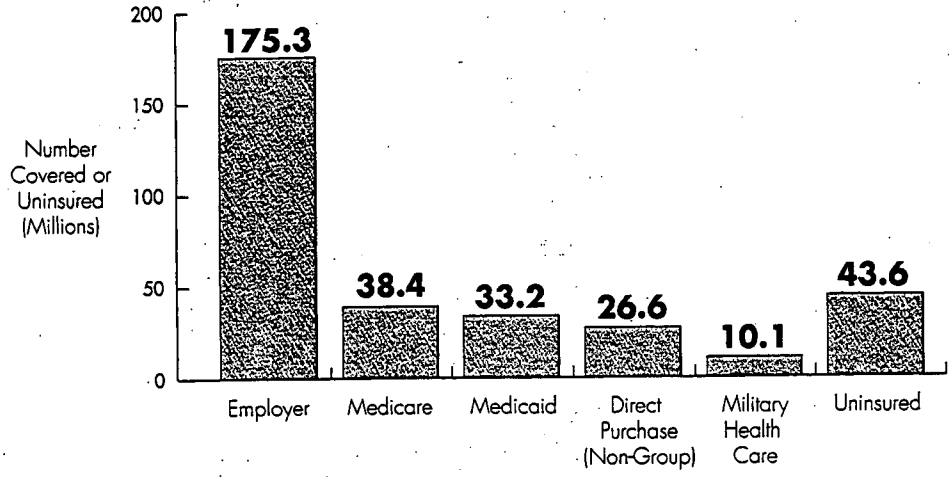
These were among the first examples in the U.S. of health insurance "pools," or groups of people who jointly purchase coverage. The main advantage of insurance pools is that they combine many people who are generally healthy with a few who are likely to need expensive medical care. This spreads risk by offsetting the costs of those with costly medical bills through the premiums of healthier enrollees. Thus, pools help keep coverage affordable.

The practice of getting health coverage through one's employer got a boost during World War II. The labor market was very tight because so many men and women were serving in the military. The government froze wages to help control inflation, but decided not to consider health benefits as earnings, so they were not frozen. Providing health coverage for employees became a popular tool for recruiting and keeping employees.

After the war, unions in major manufacturing industries, such as the automobile, rubber and steel industries, made the introduction and expansion of health insurance a key demand in their bargaining talks. Employer-sponsored coverage spread rapidly throughout the economy, in union and nonunion companies alike.

Although it has fluctuated with the economy, employer-sponsored health insurance remains an important and popular source of coverage. Health insurance through the workplace has

5. HOW THOSE IN THE U.S. GET HEALTH COVERAGE



Note: A person having more than one type of insurance is counted more than once.

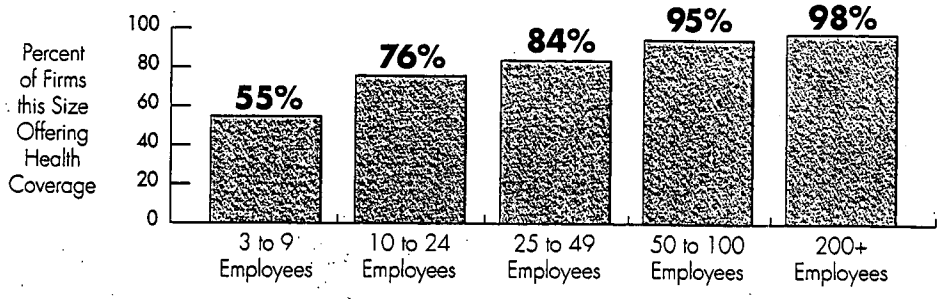
Source: U.S. Census Bureau, September 2003 (www.census.gov/hhes/hlthins/historic/hihist1.html)

remained popular for many reasons. For one, health coverage on the job also carries significant tax advantages for employer and employee. Amounts that employers pay for their employees' coverage are a tax-deductible business expense to the employers. And the money that an employer pays for an employee's insurance is not counted as taxable income to the employee.

Thus, a company's paying $50 toward an employee's health coverage is more valuable to the employee, dollar-for-dollar, than $50 per month in pay (for which the employee would have to pay income taxes). Some analysts have estimated that if the cash value of benefits were taxed like income, the value would be close to $188.5 billion in federal taxes and $21.4 billion in state taxes for 2004.[32] To put that foregone revenue—almost $210 billion—into perspective, total Medicare spending in 2004 is estimated at $289 billion.[33]

Coverage through an employer, even if the employee pays the full premium, is generally cheaper for the same covered services than if the employee were to shop for coverage on his or her own. An employer, representing many employees, naturally has more clout than any individual employee in negotiating prices with health plans. Insuring a group of employees also represents less overhead cost per person for health plans than insuring an individual. This is reflected in the lower prices charged for group coverage compared to individual coverage.

6. SMALL FIRMS LESS LIKELY TO OFFER COVERAGE THAN LARGE FIRMS



Source: Kaiser Family Foundation and Health Research & Educational Trust, "Employer Health Benefits: 2003" (www.kff.org/insurance/loader.cfm?url=/commonspot/security/getfile.cfm&PageID=21185)

In addition, a group of employees will have many people with minimal medical expenses, balancing the small number who will need expensive care. This mix of people with different levels of risk spreads an insurer's financial risk, another factor that generally leads to lower insurance rates for groups.

Disadvantages of Employer-Sponsored Coverage

Despite its many advantages, employer-sponsored health coverage has a number of disadvantages:

1. Millions of working Americans don't have the opportunity to get it. In 2001, more than 20 percent of "wage and salary" workers in the U.S. were not offered health coverage through their own employers.[34] A third of firms in the U.S. did not offer coverage in 2003.[35] Two-thirds of uninsured workers in 2001 worked for employers who didn't offer health benefits.[36]
2. Even if employees are offered coverage on the job, they can't always afford their portion of the premium.
3. Losing a job, or quitting voluntarily, can mean losing affordable coverage—not only for the worker but also for their entire family.
4. A person's link to employer-sponsored coverage can also be cut by a change from full-time to part-time work, or self-employment, retirement or divorce.
5. Most employers offer a small number of health insurance plans for employees to choose from—or only one.

Let's examine these disadvantages in more detail. As mentioned, a third of firms in the U.S. don't offer health insurance at all. Health coverage as a benefit has become widespread among large companies—98 percent of companies with more than 200 workers offer coverage.[37] But most new jobs in the economy come from small firms, and these small companies are the least likely to offer health insurance (see Chart 6).

Among small employers who don't offer coverage, three out of four (76 percent) say premiums are too expensive. A third (36 percent) say they believe their employees can get coverage elsewhere.[38]

Premiums for employer-sponsored coverage are rising much faster than workers' earnings or inflation (see Chart 7). Between spring of 2002 and spring of 2003, premiums for coverage offered by employers across the U.S. increased 13.9 percent—more than six times faster than the growth in the Consumer Price Index. (This includes amounts paid for coverage by both employer and employee.) Employers with three to 199 workers saw an average increase of 15.5 percent; firms larger than that had an average increase of 13.2 percent.[39]

Health premiums are expected to rise by an average of 13 to 16 percent in 2004, according to several consulting firms.[40] In contrast, the Consumer Price Index is expected to grow by 2.2 percent.[41]

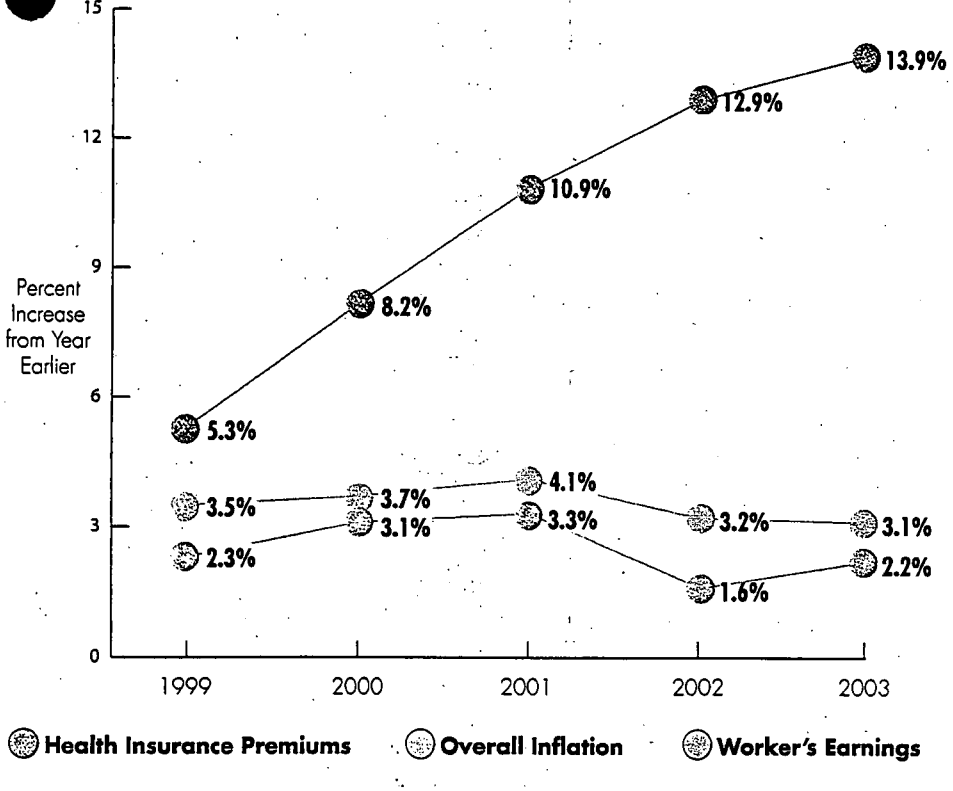
In response to such double-digit premium hikes, many companies are asking their employees to cover some of the new costs. For instance, workers taking single coverage through an employer paid 8 percent more for their coverage in 2003 compared with 2002—$42 monthly vs. $39. Family premiums paid by workers increased 13 percent—from $178 per month to $201.[42]

In addition to charging higher premiums, employers are requiring larger copayments, higher deductibles, and restrictions on benefits. As a result of these various cost-sharing measures, many more employees who are offered the chance to buy health insurance on the job may not be able to afford it.

The fact that employers are asking employees to share a higher percentage of the cost of health coverage has been the stated reason for a number of labor disputes in recent months. Almost 60,000 supermarket workers in Southern California were off the job from October 2003 through February 2004, a walkout triggered in part by management demands that workers pay more for health benefits.[43] The agreement that ended the strike requires new hires to pay $450 a year for health benefits while existing employees continue to pay nothing.[44]

At about the same time the Southern California dispute was settled, a strike among 42,000 Stop & Shop grocery workers in New England was averted when the company agreed to continue paying 100 percent of workers' health insurance premiums. Management had proposed that workers pay 20 percent of the premium cost.[45]

7. COST OF HEALTH INSURANCE PREMIUMS IS RISING FASTER THAN EARNINGS OR INFLATION



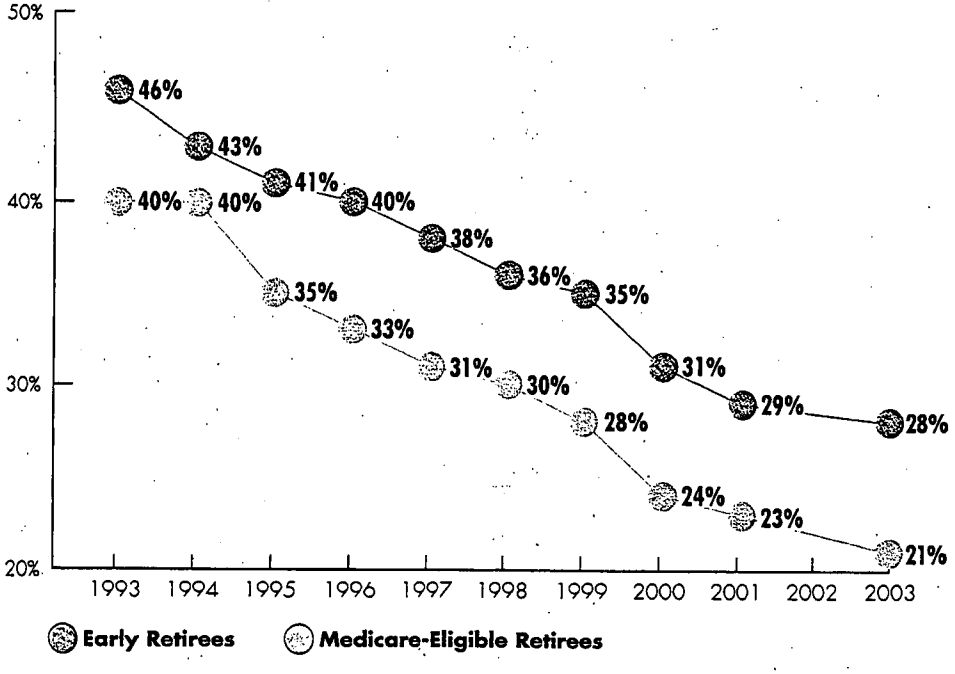
Source: Kaiser Family Foundation and Health Research & Educational Trust, "Employer Health Benefits: 2003," ch[illegible]k p.2. (www.kff.org/insurance/loader.cfm?url=/commonspot/security/getfile.cfm&PageID=21185)

Even in large firms (more than 500 employees) the number of uninsured workers has increased sharply. As of 2001, 26 percent of the nation's uninsured worked for large firms or were dependents of these workers.[46] Some are not eligible for employer coverage because they work part-time or haven't worked long enough to qualify. Others can't afford their share of the premium, as noted earlier.

Health insurance premiums are rising sharply too for retirees who obtain their coverage through their former employers. In 2003, new retirees under age 65 had to pay 20 percent more for their health coverage than a year earlier. Those retirees age 65 and older had to pay 18 percent more.[47]

The great majority of employers offer no health coverage at all to retirees. Only 28 percent of large employers offered such coverage to early retirees in 2003. An even smaller percentage offered coverage to former employees eligible for Medicare. Both figures have been shrinking over time (see Chart 8), and will likely continue to do so. Some 20 percent of large employers surveyed in mid-2003 said they were likely to end health benefits for future retirees in the next three years.[48] Noted health economist Uwe Reinhardt of Princeton University believes that "20 years from now, no company will offer retiree health care."[49]

8. STEADY DECLINE IN NUMBER OF LARGE COMPANIES OFFERING RETIREE COVERAGE



Source: William M. Mercer, 2002.

Historically, the highest levels of insurance coverage have been found in manufacturing, the sector of the economy most likely to have labor unions. But union membership is dwindling, dropping in 2003 to the lowest level in two decades—12.9 percent of the workforce.[50] And the number of manufacturing jobs in the U.S. has declined almost every year since peaking in 1978.[51] Since 2000 alone, manufacturing jobs have shrunk by 12 percent. Many of these jobs are gone forever, as many news stories have pointed out.

Individual Coverage

For those who either have no access to insurance through the workplace, or can't afford their share of the premium, the individual or "non-group" market is one possible alternative. (Though this type of insurance is popularly known as "individual," analysts refer to it as "non-group," since such policies cover both individuals and families.) The Census Bureau says 26.6 million people had non-group coverage in 2002.[52]

People might seek individual policies if they are self-employed, or if the firm they work for doesn't offer coverage. (As noted earlier, 34 percent of firms didn't offer coverage in 2003.) Layoffs, divorce, the death of a spouse, or a child's growing too old to be on a parent's policy could lead someone to turn to the individual market. One 2001 study concluded that more than one in four working-age adults had sought out coverage in the individual market over a three-year period.[53]

STATE VS. FEDERAL REGULATION

State and federal regulations profoundly affect health coverage and would likely need to be changed to enact comprehensive coverage reforms. States have primary regulatory authority over all insurance, including health insurance. Some employers, by paying for health services directly rather than by buying insurance, avoid state insurance regulation and are covered under a federal law known by its acronym, ERISA (Employee Retirement Income Security Act). Those who have chosen to be regulated under ERISA account for about 43 percent of all privately insured persons.[54]

Those regulated by states, some 57 percent of all of the privately insured, find that their policies must by state dictate cover certain health services, such as breast cancer screenings. Businesses complain that the added expense of these mandated benefits drives up the cost of health coverage. Consumer advocates, on the other hand, say that the mandates are vital for the patients who are guaranteed access to the services covered.

Occasionally, states take giant steps toward trying to make health coverage more affordable. These efforts, like more modest ones, can have unintended consequences.

Washington State, for example, passed a law in 1993 attempting to make individual, or non-group, coverage less restrictive and less expensive. The result: Most insurers stopped writing individual policies in the state.[55] To keep insurers in the market, the state legislature in 1995 repealed some of the reforms and made big changes to others.[56]

Non-group insurance reform in Kentucky suffered the same fate. In 1994, the Kentucky legislature passed a law creating standard benefits packages that were to become the only health insurance products sold in the state after July 1995. The law also prohibited insurers from charging more for a policy based on a person's health status, past claims or gender, and restricted insurers' ability to cancel policies. As in Washington State, nearly all insurers exited the market and the legislature had to repeal many of the reforms in 1996.[57]

Those companies that pay for their workers' health benefits directly are under federal supervision and therefore are exempt from state insurance regulations. These "self-insured" companies are thus not bound by laws or regulations governing mandated services.

In order to make substantial changes to the way health insurance works in the U.S., ERISA would likely have to be amended or replaced.

For some, the individual insurance market offers a wider array of health plans to choose from than buying coverage through an employer. And since such insurance is not tied to an employer, it is portable. A person can change jobs, move from full-time to part-time work, or start their own business without losing the coverage.

Some analysts believe that expanding the individual market may offer major benefits to the health care system. They say that coverage chosen and paid for directly by the person covered, rather than by an employer or government, holds the potential for both restraining cost growth and improving the quality of care. People are more prudent, they assert, when spending what they perceive as their "own" money.[58]

Disadvantages of Individual Insurance

Individual policies usually cost more and may cover less than those obtained through an employer. By definition, insurers and their agents sell individual policies one at a time, rather than as part of a group. This means the insurer's administrative costs for an individual policy are higher than for group policies. These higher costs are reflected in the premiums charged for individual policies.

Also, because people who resort to the individual market tend to have high health care costs, individual market insurers can charge high premiums or deny coverage altogether in most states. This practice is called "medical underwriting."

If they are denied coverage, individuals usually have few places to turn. They can try another company, or turn to their state's high risk insurance pool, if they live in one of the 30 states that have one.[59] These pools offer health insurance to people who can't get it elsewhere, usually because of a pre-existing medical condition. But the premium cost may

)e out of reach. And in a few states, :he pool is closed to new people. (For nformation about your state, go to vww.healthinsuranceinfo.net—a Web :ite maintained by Georgetown Jniversity's Health Policy Institute.)

For all these reasons, a person ooking for an individual insurance)olicy may or may not find one. In :he study cited earlier, more than half)f those looking said they found it 'very difficult or impossible" to find a)lan they could afford.[60]

Medicaid

The Medicaid program offers a elatively generous package of benefits :ov[illegible] low-income mothers and :hil[illegible], persons with disabilities and :ertain seniors. Some 51 million people were covered by Medicaid at some)oint in 2002, according to the federal Centers for Medicare and Medicaid Services.[61] (This is the number accepted)y most health services researchers. The U.S. Census Bureau, however, based on ts survey of households, puts the 1umber at 33.3 million.)[62]

In contrast to employer-sponsored :overage, Medicaid enrollment grew :ach year during the recession of 2001 nd 2002.[63] Without this growth, the 1umber of uninsured in those years vould have been even higher.

Medicaid is funded by both state nd federal dollars. Medicaid spending aries significantly among the groups :overed. Children—the healthiest of Medicaid beneficiaries—account for 50 p[illegible]nt of the enrollees but just 18 percent of the spending. Those over 65 and people with disabilities, by contrast, are, as a group, in poorer health and need more services. They comprise only 25 percent of beneficiaries but account for 70 percent of spending (see Chart 9).[64]

Medicaid also pays for nearly half of all long-term care services, including custodial nursing home care. Nearly 70 percent of all nursing home residents receive support from Medicaid.[65]

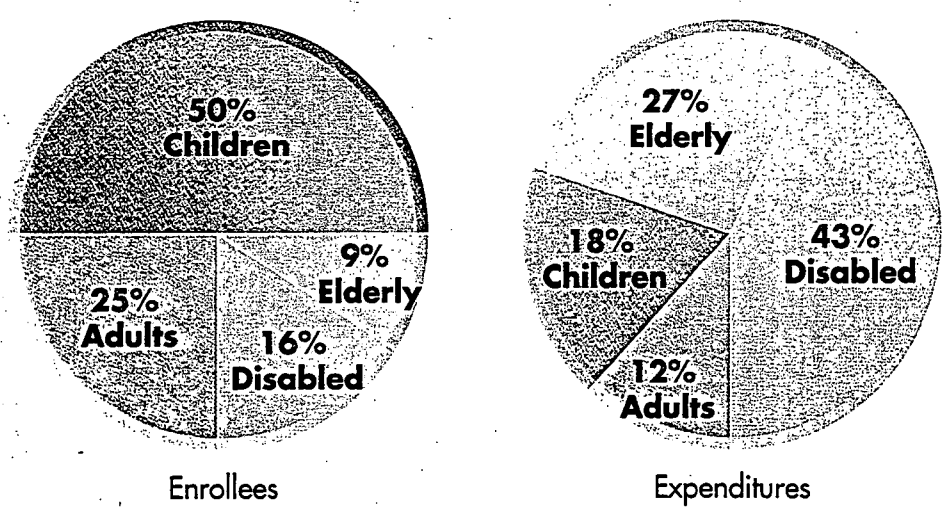
Eligibility rules for Medicaid are complex, reflect a mix of federal requirements and state options, and vary widely from state to state. They are linked to both income and other factors like family makeup and disability status. Federal law makes some people automatically eligible. Major categories of people whom states must cover include:

- Pregnant women and children up to age 6 in families with incomes up to 133 percent of the federal poverty level
- Children ages 6 to 18 in families with incomes up to 100 percent of the poverty level
- People who would have been eligible for welfare according to the criteria in effect before welfare reform in 1996
- People receiving Supplemental Security Income (SSI) due to disability or being elderly

Disadvantages of Medicaid

Medicaid consumes a high proportion of spending by state governments—12 percent of all state-financed spending in fiscal year 2002.[66] (Connecticut had the highest

9. MEDICAID ENROLLEES & EXPENDITURES



Source: www.kff.org/medicaid/loader.cfm?url=/commonspot/security/getfile.cfm&PageID=30463

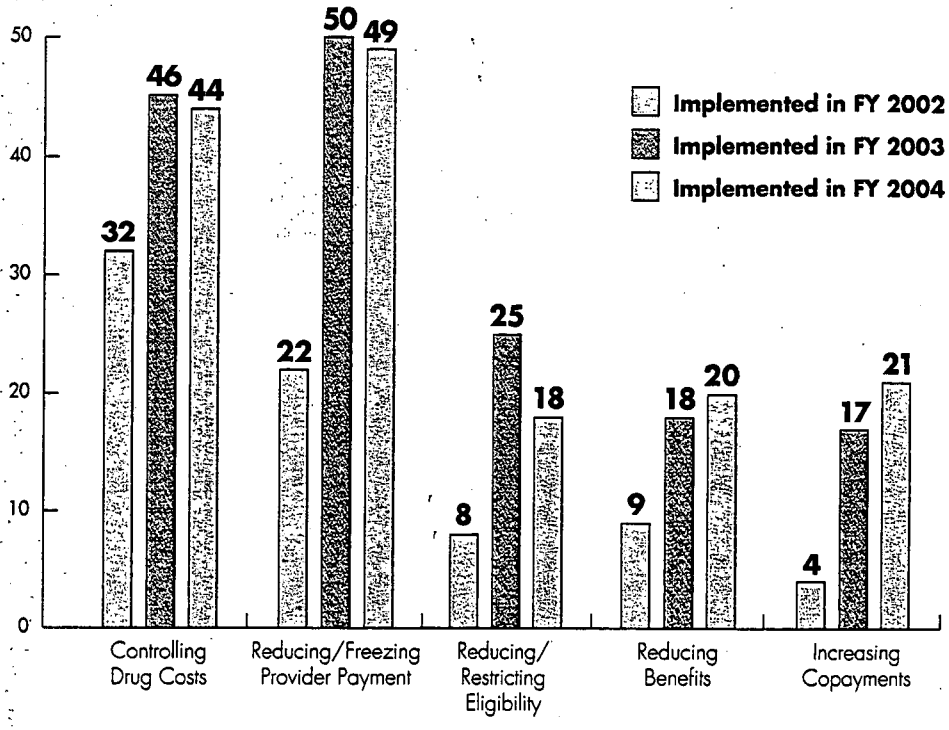
percentage—20.5—and Alaska the lowest—4.4.) That share, after growing fast during the early 1990s, remained fairly stable for several years beginning in 1995.

But the situation changed radically with the economic slowdown in 2001-2002, which forced governors and legislators to cope with large imbalances between declining revenues and increasing spending needs. Although the federal government can incur deficits from one year to the next, states cannot. With the exception of Vermont, all states and the District of Columbia are required by their own constitutions to balance their budgets each year.

Though many states have tried to protect Medicaid, a program that serves such vulnerable populations and brings substantial federal matching funds into the state, its sheer size has forced all states to restrain Medicaid spending growth.

Options for restraining Medicaid spending are few and unattractive: cut payments to providers and plans, restrict benefits, or curtail eligibility. A recent study shows that 50 states reduced or froze Medicaid payments to health care providers in fiscal year 2003, 46 states controlled drug costs, 25 reduced or restricted Medicaid eligibility, 18 reduced benefits, and 17 increased the copayments that beneficiaries must pay for their care (see Chart 10). These moves were on top of cost-cutting measures implemented earlier.

10. STATES UNDERTAKING MEDICAID COST CONTAINMENT STRATEGIES (FY 2002-FY 2004)



Source: Kaiser Commission on Medicaid and the Uninsured (2004). States Respond to Fiscal Pressure: A 50-State Update of State Medicaid Spending Growth and Cost Containment Actions. January 2004 www.kff.org/medicaid/7001.cfm)

More cutbacks are planned for fiscal year 2004. The study found that 43 states plan to control Medicaid drug costs, 39 will reduce or freeze provider payments, 21 will increase copayments, 18 will reduce or restrict Medicaid eligibility, and 17 will reduce benefits.[67] To save even more money, some states have also reduced their efforts to inform the population about the program.

The states' fiscal crunch is not likely to improve anytime soon. The National Association of State Budget Officers reports that 32 states assume that they will have a shortfall in their Medicaid budgets for fiscal year 2004.[68] FY 2005 could be even worse.[69]

The Congressional Budget Office estimates that national Medicaid spending will grow by 8.5 percent yearly for the rest of this decade. This rate of growth, although smaller than that seen in fiscal years 2002 and 2003, is faster than tax revenue is expected to grow in the typical state.

Even before the states' recent financial dilemma, Medicaid was criticized by health care providers who say it doesn't pay them enough. As a result, many physicians accept Medicaid patients only rarely, if at all.

Children's Coverage

Some 46 million children—about two-thirds of children under age 18—were covered by a parent's employer-sponsored policy in 2002. Some 17.5 million children were covered by Medicaid or the State Children's Health Insurance Program, the Census Bureau says (see Chart 11).[70]

Congress created SCHIP in 1997. Financed jointly by the federal and state governments, the program is intended for children whose parents earn too much to qualify for Medicaid yet too little to afford private coverage. The federal government has authorized $48 billion over 10 years for SCHIP. The program must be renewed in 2007, if it is going to continue.

The federal government picks up a larger share of SCHIP costs than Medicaid costs. The federal share ranges from 65 to 84 percent, depending on the state, compared with 50 to 77 percent for Medicaid.

States were given considerable flexibility in the use of SCHIP money. They could create an entirely new program, expand their current Medicaid program to include children eligible under SCHIP, or use a combination of both approaches. Sixteen states established separate state programs, 16 expanded Medicaid, and 19 combined the options. Children applying for a separate state program or a combination program must first be screened to make sure they are not eligible for Medicaid. No one eligible for Medicaid can be enrolled in SCHIP, a rule designed to discourage states from claiming the richer SCHIP matching dollars for Medicaid-eligible children.

SCHIP eligibility generally extends to children in families with incomes up to 200 percent of the federal poverty level. (Eleven states have a lower income ceiling—Alaska, Colorado, Idaho, Montana, Nebraska, North Dakota, Oklahoma, Oregon, South Carolina, Wisconsin and Wyoming.)[71]

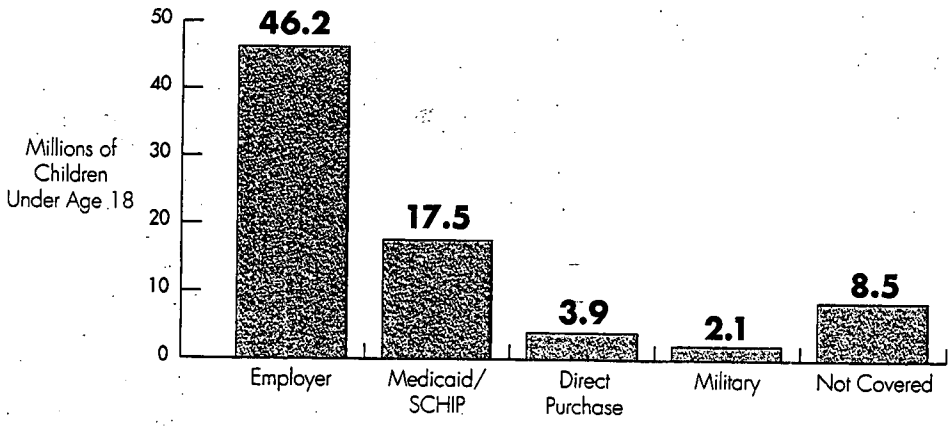
Some states have brought children into the program with much higher family incomes. New Jersey's NJ FamilyCare program, for instance, allows children into the program with family incomes as high as 350 percent of the federal poverty level. Unfortunately, the trend is toward discouraging SCHIP enrollment, rather than encouraging it. As of January 2004, six states had frozen enrollment for an indefinite period—Alabama, Colorado, Florida, Maryland, Montana and Utah.[72]

Medicare

Virtually everyone over 65 is eligible for Medicare, along with certain individuals who have permanent disabilities and those with end-stage renal disease. Eligibility for Medicare does not depend on a person's income or assets. (This sets it apart from most other government health care financing programs, which are restricted to those with limited finances.) Medicare, which is financed by the federal government and those enrolled in the program, covered 40.5 million people in 2004.[73]

Medicare is not often part of discussions about the uninsured, so it is not covered in detail in this guide. (General information about Medicare is available at www.medicare.gov.)

11. HOW CHILDREN GET COVERAGE



Note: Children with more than one type of coverage are counted more than once.

Source: U.S. Census Bureau "Historical Health Insurance Tables, Table HI-3 (www.census.gov/hhes/hlthins/historic/hihistt3.html)

Approaches to Covering the Uninsured

While the current system of covering Americans has many advantages, clearly its complexity and, more importantly, the fact that tens of millions each year are uninsured suggest that we could be doing a better job in making health care coverage accessible to everyone. Indeed, policy-makers have been trying to do this for more than a half century.

Certainly, there is no shortage of opinion about how to expand coverage; politicians, academics, policy-makers and others have considered a wide range of policies to cover the uninsured. Proposals differ in terms of political philosophy, cost, the number of people who will be insured and many other factors.

As with most complex public policy issues, there is no agreed-upon "best" way to make certain all have health coverage. Proposals differ in whether we should cover only some portion of those who lack coverage now, all Americans whether insured or uninsured, or some variation in between.

In order to better understand the range of policy options available to lawmakers, it's helpful to look at a series of general approaches to covering the uninsured, ranging from making progress step by step to a wholesale overhaul of our system. It is important to remember that the following isn't an exhaustive list of options but rather a representative selection of approaches. You can find more information on different approaches to covering the uninsured at the Web site of the Economic and Social Research Institute (ESRI), www.esresearch.org. ESRI analyzed a range of specific proposals from across the political spectrum. The Lewin Group, a prominent consulting firm, estimated the reduction in the number of uninsured that would occur under each of those proposals, as well as the associated costs or savings for the federal and state governments, employers, and households. Those results are available at www.rwjf.org.

More information on all aspects of the topic of the uninsured is available at the Web site of *Cover the Uninsured*, www.CoverTheUninsured.org.

Employer contribution requirements, better known as employer mandates, would require employers to either provide insurance to their workers or pay a payroll tax that covers all or most of the cost of enrolling their workers under a newly created public plan. Such proposals are also called "pay or play."

Proponents say that such a requirement would treat all employers fairly; that is, they would have to offer coverage to workers and pay for a portion of that coverage, or else pay the tax. No employer could gain an unfair advantage over its competitors—as it can now—by refusing to cover its workers. Employees and their dependents would have access to health care coverage.

Opponents say that "pay or play" is unfair because it would create an economic burden on employers that don't now offer insurance to their workers. Employers also generally oppose requirements of any sort, on the grounds that it is up to them to create the appropriate benefit package to attract the types of workers they are looking for. And by adding to the cost of employment, this plan would discourage firms from hiring more workers.

Individual mandates would require everyone to have some basic form of health insurance. Such insurance could

QUESTIONS TO ASK ABOUT ANY HEALTH COVERAGE PROPOSAL

1. How many uninsured people will likely gain coverage?
2. How much new spending of any kind will be necessary to cover each newly insured person?
3. Who will be asked to pay the added costs needed? Government? Employers? Individuals?
4. What is the likelihood that those newly covered will be able to keep their coverage for more than a few months?
5. What is the chance that some people presently insured will lose their coverage as a result of a proposal being implemented? If so, how many?
6. Is funding for the proposal permanent? Can it be sustained over many years?
7. If the proposal is adopted, how might other "players" react, such as physicians, hospitals, insurance companies, employers?
8. What help does the proposal offer to those with special situations, such as unusually high medical expenses?
9. Does the proposal help keep medical expenses in check for those presently paying for coverage, including governments, employers and individuals?

be provided by employers, the public sector or private insurers. An individual mandate is akin to how automobile insurance works—every driver has to buy some sort of coverage, from the legally required minimum amount to a gold-plated policy.

Proponents say that requiring everyone to have insurance would give Americans more "skin in the game" and make them care more about costs and quality. With tens of millions of Americans seeking coverage, insurers would flock to respond, providing a range of policies. Doing so would lower the price of coverage, it is argued, due both to increased competition among carriers and to the addition of so many relatively healthy, low-cost people to the risk-sharing pool.

Opponents say that merely requiring individuals to have coverage wouldn't necessarily mean that individuals would follow up by getting it. For instance, compliance is far from universal in the automobile insurance market. In fact, 14.5 percent of drivers in states where insurance is compulsory violate the law, according to the Insurance Research Council.

Reasons individuals might not sign up for coverage, despite a mandate, might include cost, fear of being deported (for those who are in the United States illegally) or a lack of concern about the consequences of being uninsured. What's more, it is argued, government should not stop individuals from deciding how best to spend their own money.

Expansions of existing public programs are another proposed solution for covering the uninsured. Some policy experts suggest that the current structure, with minor adjustments, can help a larger percentage of the uninsured. They argue that public programs such as Medicaid, SCHIP and community clinics can, with additional funds, cover or treat the uninsured. Funding could be provided through a variety of mechanisms, including state, local and federal tax revenue, and tax increases on private insurers.

Proponents say that working within the current framework is the easiest and most efficient way to expand coverage. Federal, state and local officials have already

worked through many of the management changes, and no new bureaucracy is required.

Opponents say that current programs are confusing and inefficient, and have been unable to enroll millions who are already eligible. Moreover, red ink at virtually all levels of government makes it almost certain that additional funds will be difficult to secure.

Tax credits seek to make private health insurance more affordable by allowing individuals and/or employers to deduct the cost of their health insurance premiums directly from the amount they owe in income taxes. The credits can be a fixed amount of money or a percentage of the premium. They can be made refundable (even if the person owes no income taxes, they would get a refund equal to the premium) or advanceable (available at the time when the person is actually paying the premiums instead of having to wait until April 15) or adjusted in other ways. Proponents say that this approach enhances affordability while retaining choice. Because the credit would have some sort of dollar limit, the person would be responsible for the cost beyond the value of the credit. They argue this would make consumers more price conscious when choosing a health plan, and therefore restrain health care inflation. In theory, restraining costs would make it easier to expand coverage.

Opponents say that individuals and employers often don't have the information they need to make good choices, nor the market clout to get good prices. Another problem is that many proposed policies offer tax credits that are too small, relative to the cost of insurance, to induce many uninsured people to buy insurance.

A tax-financed health care system would replace the current mixed financing system in which employers, the government and individuals pay for health care coverage. The most commonly advocated tax-financed system is some form of the "single-payer" approach. Under a completely tax-financed system, providers would remain private, but the government would administer payment for health care—much like the system in Canada. Proponents say that tax-financed systems are the likeliest way to get virtually everyone covered; more efficient, since much of the current complex administrative structure would be eliminated; and more effective at controlling costs, since government would be able to negotiate prices with doctors, hospitals, drug companies and other providers of health care.

Opponents say that such proposals would represent radical change, create too great a role for government, cost the public treasury too much, diminish choice and reduce competition. When government is the sole buyer, they argue, it does not negotiate prices; it sets them. They also claim that the private sector can more efficiently administer health care.

CONCLUSION

The current system of health insurance covers the majority of Americans, but far too many are left without any help at all. Despite efforts stretching over decades, history has shown how hard it has been to solve this persistent problem.

There is no ideal solution to the problem of the uninsured. Most proposals combine coverage expansion with other objectives, such as limiting growth in total national health care spending, limiting the amount of new federal dollars, targeting new spending to just the previously uninsured or increasing consumer choice. Such goals cannot all be achieved simultaneously. Decision makers must balance these objectives and make trade-offs among them, and citizens need to understand these trade-offs and become involved in public discussions.

It is our hope that this guide will help make those discussions more informed and more focused on finding a consensus for action.

To order or download additional copies of this guide please visit the *Cover the Uninsured* Web site at **www.CoverTheUninsured.org/Materials.**

GLOSSARY

ADVERSE SELECTION – When a disproportionately high number of individuals who are in poorer than average health enroll in a health plan.

COPAYMENT – A portion of the bill for a medical service that is not covered by the patient's health insurance policy and, therefore, must be paid out of pocket by the patient. Copayment refers to a flat dollar amount, e.g. $5 per office visit.

DEDUCTIBLE – A fixed amount, usually expressed in dollars, that the beneficiary of a health insurance plan must pay directly to the health care provider before a health insurance plan begins to pay for any costs associated with the insured medical service.

EMPLOYER CONTRIBUTION REQUIREMENT OR "EMPLOYER MANDATE" – A requirement that employers either provide insurance to their workers or pay a payroll tax that automatically covers their workers under a newly created public plan. Such proposals are also called "pay or play."

PAY OR PLAY – A requirement that employers either provide insurance to their workers or pay a payroll tax that automatically covers their workers under a newly created public plan.

REFUNDABLE TAX CREDIT – A way of providing a tax subsidy to an individual or business for a defined purpose, such as health coverage, even if the person owes no taxes. (See "tax credit" below.) If a person doesn't owe any tax, the government sends the person (or a third party) a check for the amount of the refundable tax credit.

SINGLE PAYER – A health care system in which a government entity finances most health care as the "single payer" for most health care services. Typically, the government takes in taxes for health care purposes. The government then pays health care providers, such as hospitals and physicians, to provide care to those enrolled in the government health care plan. An example is the Canadian health system.

SUPPLEMENTAL SECURITY INCOME (SSI) – A federal program providing cash assistance to low-income individuals who are elderly, blind or disabled.

TAX CREDIT – An amount that can be subtracted from the tax a person or business owes. A tax credit is much more valuable than a tax deduction of the same amount, since the deduction simply reduces the income on which a person or business pays taxes.

TAX EXCLUSION – Excluding the value of an employer-sponsored benefit, such as health coverage premiums paid by an employer, from an employee's taxable income.

For a list of resources, analysts, advocates, government and related organizations please visit the online version of *Health Care Coverage in America: Understanding the Issues and Proposed Solutions* at **www.CoverTheUninsuredWeek.org/Materials**

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CALL FOR ACTION 2004

Since 2000, the percentage of people in North Carolina without health insurance has grown faster than in every other state except Mississippi.

In 2000-01, 1.1 million North Carolinians were uninsured. In 2001-02, the number grew by 200,000 people to 1.3 million.

Today, every plant closing and corporate downsizing in North Carolina means thousands more families without health insurance.

The North Carolina General Assembly has taken no action to address this problem.

In fact, the General Assembly last year cut Medicaid health coverage for low-income working families. This is projected to mean an additional 16,000 parents in these families joining the ranks of the uninsured.

This year, the General Assembly is considering more cuts to the Medicaid and Health Choice health coverage programs that would result in thousands more uninsured families.

A large coalition of groups has joined together to CALL FOR ACTION to address the rising number of uninsured in North Carolina with a two-part plan:

First, we CALL FOR ACTION on the one bill in the General Assembly that is the first step to solving this problem. Representative Verla Insko has sponsored House Bill 1098, Health Care Fundamental Right. This bill would ask North Carolina voters to decide if the NC Constitution should be amended to guarantee a right to basic health care for all.

Second, if North Carolina voters passed the amendment, the General Assembly would be charged with developing a plan to ensure all North Carolinians have basic health coverage by the year 2010.

Our CALL FOR ACTION does not endorse any particular plan to assure access to health care for everyone. There is no shortage of ideas on how to guarantee coverage for all. Tax credits for businesses and individuals, extension of current family insurance programs, insurance company reform, and a complete restructuring of the current system are all options now being tried in other states.

North Carolina will need a unique solution to our fast-growing problem of the uninsured endorsed by our voters and fashioned with debate and care by our elected leaders.

However, with North Carolina leading the nation in the growth of the uninsured we cannot wait. We CALL FOR ACTION that the process to address this growing problem start now by passing House Bill 1098.

Background Information

House Bill 1098, Health Care Fundamental Right
Sponsors: Representative Insko, Representative Alexander, Representative Wright, Representative Luebke

According to the US Census Bureau, North Carolina tied with Mississippi as the two states with the largest growth in the percentage of their residents without health insurance since 2000.

In 2000-01, 1.1 million North Carolinians were uninsured. In 2001-02, the number grew by 200,000 people to 1.3 million.

With the growth in the number of the uninsured in North Carolina, only 12 other states in the nation have the same or higher percentage of population without health insurance.

With the growth in the number of the uninsured in North Carolina, only 7 other states in the nation have a higher number of people without health insurance.

The average cost for a family health insurance plan in North Carolina is $584 / month or $7008 / year.

Sources: Health Insurance Coverage in the United States: 2002, US Census Bureau, Sept. 2003, www.census.gov ; State Health Facts Online, Kaiser Family Foundation, www.statehealthfacts.org.

NC COMMITTEE TO DEFEND HEALTH CARE
www.ncdefendhealthcare.org, 919-402-0133

Mission statement:
The North Carolina Committee to Defend Health Care works to educate about and advocate for the "Right to Health Care", so that access to appropriate health care on a regular basis is assured for all North Carolinians regardless of age, sex, race/ethnicity, marital or employment status, pre-existing medical condition or geography.

NORTH CAROLINA COMMITTEE TO DEFEND HEALTH CARE

A non-profit, citizen action group working for quality, affordable health care for all NC residents.

PMB # 142, 1815 MLK Pkwy # 2, Durham, NC 27707; voice (919) 402-0133
www.ncdefendhealthcare.org email: pres@ncdefendhealthcare.org

Public Endorsement as of May 19, 2004 of "The Right to Health Care" Appropriate health care on a regular basis

Organizations

Health Professional

Alcoholism Professionals of North Carolina (APNC)
American Medical Student Association at UNC, Chapel Hill
American Medical Student Association at Wake Forest University, School of Medicine
National Association of Social Workers-North Carolina Chapter (NASW-NC)
NC College of Emergency Physicians
NC Council of Child and Adolescent Psychiatry
NC Nurses Association
NC Pediatric Society
NC Primary Health Care Association
NC Psychiatric Association
NC Public Health Association
NC Substance Abuse Federation
UNC-CH SNMA (Student - National Medical Association)
UNC Hospitals Housestaff Council
Whitehead Medical Society (Student Government of the UNC Medical School)

Community Health Organizations

Alcohol/Drug Council of North Carolina
Breast Cancer Coalition of NC
Coalition for Continuity of Care in Geriatric Services
Community Health Coalition, Durham, NC
Community Health Collective, Freemont, NC
Durham Crisis Response Center: Domestic & Sexual Violence Services
FirstHealth Community Voices
Friends of Residents in Long Term Care
National Alliance for the Mentally Ill - North Carolina
NC Child Advocacy Institute
NC Coalition of Mental Health Professionals and Consumers, Inc.
NC Health Access Coalition
NC Occupational Safety & Health Project (NCOSH)
NC Student Rural Health Coalition
Senior PHARM*Assist*

Political & Labor Organizations

Democracy North Carolina
Durham County Board of Commissioners 2000
Durham People's Alliance
Moore County Democratic Party
NC Democratic Party (2002 Resolution # 9)
NC Public Service Workers Union - UE Local 150
NC Public Interest Research Group, NC-PIRG
NC State AFL-CIO
NC Women United
New Hanover Democratic Party
Orange County Board of Commissioners 2001
Orange County Democratic Party
SEANC (State Employees Association of NC)
SEANC District 25
Triangle J Council of Governments
Tyrell County Board of Commissioners 2000
Warren County Board of Commissioners 2000
University of North Carolina at Chapel Hill - Student Congress

Community Justice & Religious Organizations

American Association of Retired Persons, AARP – NC
Black Workers for Justice
Catholic Diocese of Raleigh (continued on page 2.)

Chapel Hill Area Chapter of NC - AARP
Chapel Hill Friends Meeting
Charles M. Jones Peace and Justice Committee of the Community Church, Chapel Hill
Concerned Citizens of Tillery
El Pueblo, Inc. (A statewide advocacy and public policy Latino organization)
Eno River Unitarian Universalist Fellowship-Social Justice Committee
NC Alliance for Economic Justice
NC Consumers' Council
NC Council of Churches
NC Fair Share
NC Hunger Network
NC Low Income Housing Coalition
NC Society for Ethical Culture
Peace and Justice Mission Group, Pullen Memorial Baptist Church
Shared Visions Foundation, Chapel Hill
Social Justice Committee, Highland United Methodist Church, Raleigh
The Advocacy for the Poor, Winston-Salem
Waughtown Street Neighborhood Assoc., Winston-Salem

County-Level Estimates of the Uninsured in North Carolina, 1999-2001

February 19, 2003

Prepared by

S. Dyson, A. Howard and T. Ricketts

Cecil G. Sheps Center for Health Services Research

The University of North Carolina at Chapel Hill

(An update of the 1995-1999 report by J. Ostermann, T. Pendergraft and T. Ricketts)

County-level estimates of the uninsured in North Carolina for persons under 65 years of age, 1999-2001

Background

In March 2001, the Cecil G. Sheps Center for Health Services Research at the University of North Carolina at Chapel Hill issued a report entitled *County-Level Estimates of the Uninsured in North Carolina, 1995-1999*. That report used data from the US Census Bureau's Current Population Surveys (CPS) and other data sources to estimate the number of persons under the age of 65 years who did not have health insurance in each of North Carolina's 100 counties. This report uses more recent data to update the county-level estimates of the under-65 uninsured in North Carolina to the three-year period, 1999-2001, including gender, age, race, ethnicity, poverty status, educational attainment, and employment characteristics. Because data sources and methodology differ between the two reports, direct comparison of rates from the two time periods should be viewed with caution.

The data used for the estimates of uninsurance are drawn primarily from the US Census Bureau's annual survey of insurance coverage, which reports a statewide rate. In order to make county-level uninsurance estimates, three years of CPS data are pooled and reported in this analysis. The three-year weighted average creates an overall statewide estimate that differs slightly from the CPS estimates for any year during that period.

Findings in Brief

This report provides annual county-level estimates of the number and percentage of people under the age of 65 who lack health insurance for the three-year period, 1999-2001. The model used pooled data from the US Census Bureau's CPS and population characteristics of each of North Carolina's 100 counties to estimate uninsurance. Calculations were made for two subsets of the population: under age 18 years and those 18 to 64 years of age. The county level estimates ranged from a low of 11.79% for Orange County in 2000 to a high of 25.14% for Robeson County in 2001. Along with Orange—Wake, Davie, Transylvania, Dare and Catawba Counties appeared in the top five counties for insured persons under 65 years over the three-year period. Northampton, Duplin, Halifax, Sampson, Greene and Hertford Counties joined Robeson County in the bottom five for insurance coverage at some point between 1999 and 2001.

State Level Estimates

The goal of this study was to develop county-level estimates. The process involved pooling data for three years of CPS statewide surveys and applying those state level estimates to individual county-level data for each of the three years. This procedure adjusts for the specific

characteristics prevailing in each county for each of those years. Summing the county level estimates to a statewide number creates a slightly different overall estimate of the number of uninsured in the state from what is reported in the Census Bureau CPS estimates. Summing the county level estimates yields statewide estimates of the percentage of North Carolinians under 65 years who were uninsured to be 17.54% 1999, 15.55% in 2000, and 17.70% in 2001. Table 1 compares the summed county level estimates with CPS estimates for the three years. Note that the CPS has made several adjustments to its estimates using updated population adjustments.

Table 1. Comparison of Estimates of Uninsured in North Carolina: Cecil G. Sheps Center for Health Services Research and Current Population Survey.

	Estimate of Uninsured in North Carolina			CPS Estimate
	0-17 years	*18-64 years*	*Total (<65 years)*	*<65 years*
1999	11.38 %	19.91 %	17.54 %	16.2%
2000	9.33 %	19.41 %	15.55 %	15.3%*
2001	11.13 %	22.17 %	17.7 %	16.2%**

* Statewide rate also estimated at 14.8% with follow-up survey data included, the 15.3% estimate is based on a further adjustment to match 2000 Census results.

** Revised after follow-up survey; the original estimate was 17.3%.

Data Sources and Assumptions

The 2000 through 2002 Current Population Surveys[1] contained responses from between 2,651 and 3,887 North Carolina residents each year who were under age 65 and not members of the armed forces. The weighted percentage of respondents (18-64 years) lacking health insurance coverage was 20.93 percent in 2000, 17.92 percent in 2001, and 21.2 percent in 2002. The weighted percentage of respondents (<18 years) lacking health insurance coverage was 13.14 percent in 2000, 9.97 percent in 2001, and 11.58 percent in 2002. *Note that each year's survey data refer to the previous calendar year, e.g. 2000 survey data refer to calendar year 1999.*

Like the earlier study, several individual level characteristics were used to quantify the extent to which individual characteristics influence a person's likelihood of having health insurance coverage. The most recent data source was used to update this information, but data sources for some characteristics differed from the earlier report. The selection of variables that are used to make the estimates was limited by the availability of corresponding county-level variables, used to make predictions of the number of uninsured in each county in North Carolina. Demographic characteristics, educational attainment, and income at varying degrees of poverty, as well as

[1] US Census Bureau, www.census.gov

sector of employment and lack of employment, respectively, were included in the model for persons age 18 to 64 (see Table 2). The model for respondents under age 18 included race, ethnicity, and poverty variables (see Table 3).

The data were gathered from several sources:

- The Log Into North Carolina (LINC) database was used to obtain county-level data on the population distribution by age and gender for each county in North Carolina for each of the three years. These data are based on Census Bureau county-level population estimates by age, gender, race, and Hispanic origin.[2]
- Information on educational attainment for this revision was obtained from the 2000 Census.[3] These data reflect educational attainment for the population 25 years and older. These rates have not been adjusted for the 18 and older population, but are assumed to be the same proportion for the 25 and older population.
- Information on the number of individuals in each county with annual incomes at varying percentages of the Federal Poverty Guidelines in 1999 was derived from the 2000 Census.[4] Cut points for percent of poverty level differed from the earlier report. The percentages of the population falling into various poverty and education categories were assumed to have remained constant throughout the 1999-2001 study period.
- Information on unemployment rates and sector of employment were obtained from the Employment Security Commission.[5]

Methods

Linear probability regression models[6] were used to quantify the extent to which individual characteristics influence a person's likelihood of having health insurance coverage. Two separate models were estimated for respondents under age 18, and those between ages 18 and 64. For respondents over age 65, Medicare coverage was assumed; hence respondents over age 65 were excluded from the analysis. Members of the armed forces were also excluded.

The coefficients derived from the logistic regression were applied to county-level population data. The distribution of the population in each county across the variable categories in Table 2

[2] Hispanic origin data for 2000 was applied to both 2000 and 2001.

[3] The earlier report used educational attainment data from the Employment Security Commission.

[4] The earlier report used data from a 1996 study on the working poor.

[5] Industry employment sector data was not available for the full 2001 year. Quarter 4 data of 2001 were used and are assumed to be applicable for the full year. Quarter 3 data of 2001 were used for Clay County.

[6] A linear probability model was chosen over logistic regression, because of the non-linearity in predictions associated with the logistic regression. Refer to Appendix I for details.

was used to identify the characteristics of a (fictive) person who is representative of the entire population in that county. For example, if females age 25-29 represent three percent of a county's population, the representative person was assigned a value for that particular variable of 0.03. Using these values, and the coefficients obtained from the regression model, a probability of being uninsured was calculated for this representative person. The probability of being uninsured was then multiplied with the number of persons under age 65 in that particular county to estimates the total number of uninsured. This process was repeated for every county for each of the three years, and for each of the two population subgroups (0 < 18 years; 18 - 64 years). The estimated total number of uninsured between the ages of 0 and 64 for each county and year was obtained by adding the estimated number of uninsured across the two age groups.

Results

The results of the regression analyses are displayed in Tables 4, 4a (18 – 64 years) and 5, 5a (0 < 18 years). Males below age 35 appear to be much more likely to be uninsured than females. A preliminary analysis of the effect of race on the probability of being uninsured showed that the distribution of the uninsured by age and gender was very similar for whites and nonwhites, except for a relatively constant additive effect. Therefore, race was used as a unique predictor in the equation and was not interacted with age and gender. The estimating equation included dummy variables for non-whites and Hispanics. Dummy variables for being unemployed and the sector of employment, respectively, appear to be important predictors of insurance coverage, through their role as determinants of the availability of coverage to the individual through the employer. Household income at or near the federal poverty level, less education, being Hispanic or non-white all increased a person's likelihood of lacking health insurance coverage. The annual fixed effects suggest a slight decrease in the uninsured population between 1999 and 2000, and a sharp increase of between 2000 and 2001.

Among respondents under age 18, age and gender did not appear to be significant predictors of insurance coverage. Education and employment variables were not included in the model. Other variables had effects similar to those described above. A significant drop in the number of uninsured occurred between 1999 and 2000, and an increase of nearly identical magnitude between 2000 and 2001.

The projected number of uninsured, as well as the percentage of the population under age 65 estimated to lack insurance coverage in 1999, 2000, and 2001 in each county are displayed in Tables 6.1999 through 6.2001. The estimated number of uninsured persons in North Carolina appears to have decreased between 1999 and 2000 from 17.54 percent to 15.55 percent. The increase in the estimated number of uninsured between 2000 and 2001, from 15.5 percent to 17.7 percent, offsets the earlier decrease. This increase results in an estimated 1.2 million people in North Carolina who lack insurance in 2001.

The estimates reveal substantial variation across counties in the percentage of the population without insurance. In 2001, the estimated percentage of people under age 65 lacking health insurance ranged from a low of 13.80 percent in Orange County to a high of 25.14 percent for Robeson County. The ranking of counties according to the percentage of the population without coverage (Table 6.1999-2001) for most counties fluctuate slightly over time.

Appendix I

A linear probability model was chosen over the commonly used logistic regression model, because of the non-linearity in predictions associated with the latter. The problem is identical to the difference between the probability of the mean and the mean of probabilities. For this particular estimation, the sample mean for lack of insurance was 18.12 percent. For a person with exactly average characteristics, however, the estimated probability of being uninsured was 13.44 percent, significantly understating the actual probability of being uninsured. Applying coefficient estimates from the logistic regression to aggregate county-level data would have a similar effect. For example, in a county with characteristics exactly identical to those of the sample, 13.44 percent of the population would be estimated to lack insurance coverage, while the actual percentage would likely be much closer to the 18.12 percent found in the sample.

A linear probability model ensures that the estimated probability of being uninsured for a person *representative of the entire population* (in this case the CPS sample) is the same as the percentage of individuals in the sample that are uninsured. Stated differently, a fictive person with average age, gender, education, poverty, etc., will have a probability of being uninsured that is identical to the percentage of the sample without insurance. Therefore a linear probability model is conceptually preferred if the estimates are to be applied to aggregate data.

One drawback of linear probability models is that theoretically predictions below 0 percent or above 100 percent are possible. These would be particularly likely for data points near, at, or outside the range of values in the survey sample. This, however, is unlikely in this particular scenario. All variables in the logistic regression are entered as dummy variables with values of *either* 0 or 1. All county characteristics are percentages, i.e., have values *between* 0 and 1. However, to estimate the theoretical maximum and minimum probabilities across counties, the maximum and minimum data points in the entire sample of 100 counties were selected, and used to define the characteristics of two fictional counties, with the maximum and minimum percentage of uninsured, respectively. For the "maximum" county, maximum values were used for variables positively related to lack of insurance, and minimum values for variables negatively related to lack of insurance. The estimated percentage of individuals without insurance coverage for this county was approximately 40 percent. For the "minimum" county, minimum values were used for variables positively related to lack of insurance, and maximum values for variables negatively related to lack of insurance. The estimated percentage of individuals without coverage for this county was approximately 3 percent. Both estimates are well within the 0-1 interval, and appear reasonable, minimizing concerns relating to possibly distorted predictions in counties with very high or low values for predictors of insurance coverage.

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U.S. Census Bureau. Sex by Educational Attainment for the Population 25 Years and Over, http://factfinder.census.gov/servlet/DTTable?_ts=61471294170 November 25, 2002.

U.S. Census Bureau. Ratio of Income in 1999 to Poverty Level, http://factfinder.census.gov/servlet/DTTable?_ts=61471599440 November 25, 2002.

FROM THE CENTER FOR ECONOMIC AND POLICY RESEARCH:

Health Insurance Coverage of Dependent Children Declines,
Latino Access Down Sharply

April 13, 2004

The Center for Economic and Policy Research (CEPR) has released a series of data briefs to coincide with the American Public Health Association's National Public Health Week.

Among the key findings in these briefs:

- Health insurance coverage has fallen from the economic peak in 1999 through the recovery in 2002, with nearly 70 million Americans lacking coverage during all of 2002.
- Dependents (both children and adults) and Latinos are the groups most likely to lack coverage. Legislative solutions must focus on increasing access to health insurance as well as ensuring equity across age, race, and employment status.
- While most Americans are covered either through their employer or the employer of a family member, nearly 40 percent of the population goes without employer provided coverage for at least part of the year.
- Coverage of dependents had fallen during the nineties, but the decline has been much sharper since the onset of the economic contraction, with children being hit hardest. Increasingly, families are turning to Medicaid to cover the children of low-wage workers.
- Low-wage workers are about half as likely as high-wage workers to have employer-provided health insurance from either their own employer or a family member's. Less than half (47.3 percent) of low-wage workers had any employer-provided health insurance during all of 2002.
- The expansion of Medicaid through SCHIP was insufficient to overcome the loss of employer-provided health insurance and health insurance coverage fell among children over the economic contraction. However, more children of the working poor do have Medicaid now than a decade ago.
- Young adults (age 18 to 25) are less likely than other adults to have health insurance coverage. This group is least likely to have employer-provided coverage and coverage as a dependent has fallen sharply over the economic contraction.

This in-depth analysis of access to health insurance by Heather Boushey, Joseph Wright, and Marya Murray Diaz, has found that lack of coverage is due to a number of factors, the most important being cutbacks in employer-provided health insurance. This has resulted in unequal access to health insurance. Policy responses to declining coverage have so far been inadequate.

The full set of briefs are available at: http://www.cepr.net/health_insurance/hi_brief.htm

Please feel free to contact Dr. Heather Boushey at (202) 293-5380 x212 and hboushey@cepr.net and Marya Murray Díaz at (202) 387-5082 and murraydiaz@cepr.net if you have questions.

The data used in this analysis is from CEPR's analysis of the Survey of Income and Program Participation. CEPR creates user-friendly Data Sets from this survey and makes the data and programs available to other researchers via our website (www.cepr.net).

This project was funded by a generous grant from the Rockefeller Foundation.

The Center for Economic and Policy Research is an independent, nonpartisan think tank that was established to promote democratic debate on the most important economic and social issues that affect people's lives.

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Statistical Brief #19: The Uninsured in America - 2002

Estimates for the Civilian Noninstitutionalized Population Under Age 65

By: Jeffrey A. Rhoades, Ph.D.

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- Figure 2. Percent uninsured by race/ethnicity: People under age 65, first half 2002
- Figure 3. Percent distribution of total population and the uninsured by race/ethnicity: People under age 65, first half 2002
- Figure 4. Percent uninsured by race/ethnicity and sex: People under age 65, first half 2002
- Figure 5. Percent uninsured by marital status: People under age 65, first half 2002

Introduction

The uninsured population in the United States is an issue of public policy concern for several reasons. First, health insurance is viewed as necessary to ensure that people have access to medical care and protection against the risk of costly and unforeseen medical events.

Second, timely and reliable estimates of the population's health insurance status are vital to evaluate the costs and expected impact of public policy interventions to expand coverage or to change the way that private and public insurance is funded. Finally, comparisons of the characteristics of insured and uninsured populations over time give information on whether greater equity has been achieved in insurance coverage or whether serious gaps remain.

Data from the 2002 Medical Expenditure Panel Survey (MEPS) of the Agency for Healthcare Research and Quality (AHRQ) show that health insurance status among people under age 65 varies according to demographic characteristics such as age, race/ethnicity, sex, and marital status. This report shows the estimated size of the civilian noninstitutionalized population under age 65 that was uninsured throughout the first half of 2002 and identifies groups especially at risk of lacking health insurance.

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Definition of Uninsured

The uninsured were defined as people not covered by Medicare, TRICARE (Armed-Forces-related coverage), Medicaid, other public hospital/physician programs, or private hospital/physician insurance (including Medigap coverage) from January 2002 through the MEPS interview date. People covered only by noncomprehensive State-specific programs (e.g., Maryland Kidney Disease Program) or private single-service plans (e.g., coverage for dental or vision care only, coverage for accidents or specific diseases) were not considered to be insured.

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Findings

In early 2002, 16.4 percent of the U.S. civilian noninstitutionalized population (46.2 million people) was uninsured (data not shown). Among those less than age 65, 18.5 percent (45.9 million people) of Americans were uninsured (data not shown). Age plays a key role in whether a person has health insurance coverage. Young adults ages 19-24, 34.9 percent of whom were uninsured, were the age group at the greatest risk of being uninsured (Figure 1). This group represents 9.3 percent of the total non-elderly population but 17.5 percent of the uninsured population (data not shown). For children (under 18) 26.3 percent had public insurance only, 12.9 percent were uninsured, and the remainder (60.8 percent) had private insurance. This compares to 23.1, 14.6, and 62.4 percent respectively for 2001 (data not shown). For children, differences in rates of insurance between the two years are significant for public insurance only and the percent uninsured. There has been an increase in the percent and number (2.4 million, data not shown) of children covered by public insurance only and an accompanying decline in the percent uninsured.

Among people under age 65, minorities were substantially more likely than whites to lack health insurance. Among Hispanics under 65, 36.1 percent were uninsured, compared to 20.4 percent of black non-Hispanics and 14.6 percent of white non-Hispanics (Figure 2). Hispanics were disproportionately represented among the uninsured. Although 14.3 percent of non-elderly Americans were Hispanic, they accounted for 27.9 percent of uninsured

persons (Figure 3). Among males under age 65, being uninsured was more likely among Hispanics (38.4 percent) than among black non-Hispanics (22.5 percent) or white non-Hispanics (15.3 percent). Similarly, among females under 65, being uninsured was more likely among Hispanics (33.8 percent) than among black non-Hispanics (18.5 percent) or white non-Hispanics (14.0 percent) (Figure 4).

Persons who never married accounted for nearly a quarter (23.0 percent) of the non-elderly population but over a third (35.4 percent) of the uninsured population (data not shown). Also, about a third (33.6 percent) of all persons under 65 who were separated were uninsured (Figure 5).

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Briefly Stated

- In early 2002, 16.4 percent of the U.S. civilian noninstitutionalized population (46.2 million people) was uninsured. Among those less than age 65, 18.5 percent (45.9 million people) of Americans were uninsured. These estimates do not differ significantly from the comparable figures for 2001.
- The percentage of children (age less than 18) covered by public insurance only increased from 23.1 percent in 2001 to 26.3 percent in 2002 (representing 2.4 million children). Concurrently, the percent of uninsured children declined by less than 2 percentage points from 14.6 percent to 12.9 percent, 2001 vs. 2002, respectively.
- Among the U.S. civilian noninstitutionalized population under 65, more than a third of Hispanics (36.1 percent) and 20.4 percent of black non-Hispanics were uninsured during the first half of 2002, compared with 14.6 percent of white non-Hispanics.
- Among people under 65, Hispanics accounted for more than one-fourth (27.9 percent) of the uninsured civilian noninstitutionalized population even though they represented only 14.3 percent of the overall population this age.
- Young adults ages 19-24 were the age group at the greatest risk of being uninsured, with over one-third (34.9 percent) of this group lacking health insurance.

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About MEPS

The Medical Expenditure Panel Survey (MEPS) collects nationally representative data on health care use, expenditures, sources of payment, and insurance coverage for the U.S. civilian noninstitutionalized population. MEPS is cosponsored by the Agency for Healthcare Research and Quality (AHRQ) and the National Center for Health Statistics (NCHS). This *Statistical Brief* summarizes data concerning the characteristics of the uninsured population in the United States during the first half of 2002, as derived from the MEPS Household Component. For more information about MEPS, see the sources listed on the back page.

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Figure 1. Percent uninsured by age : People under age 65, first half of 2002

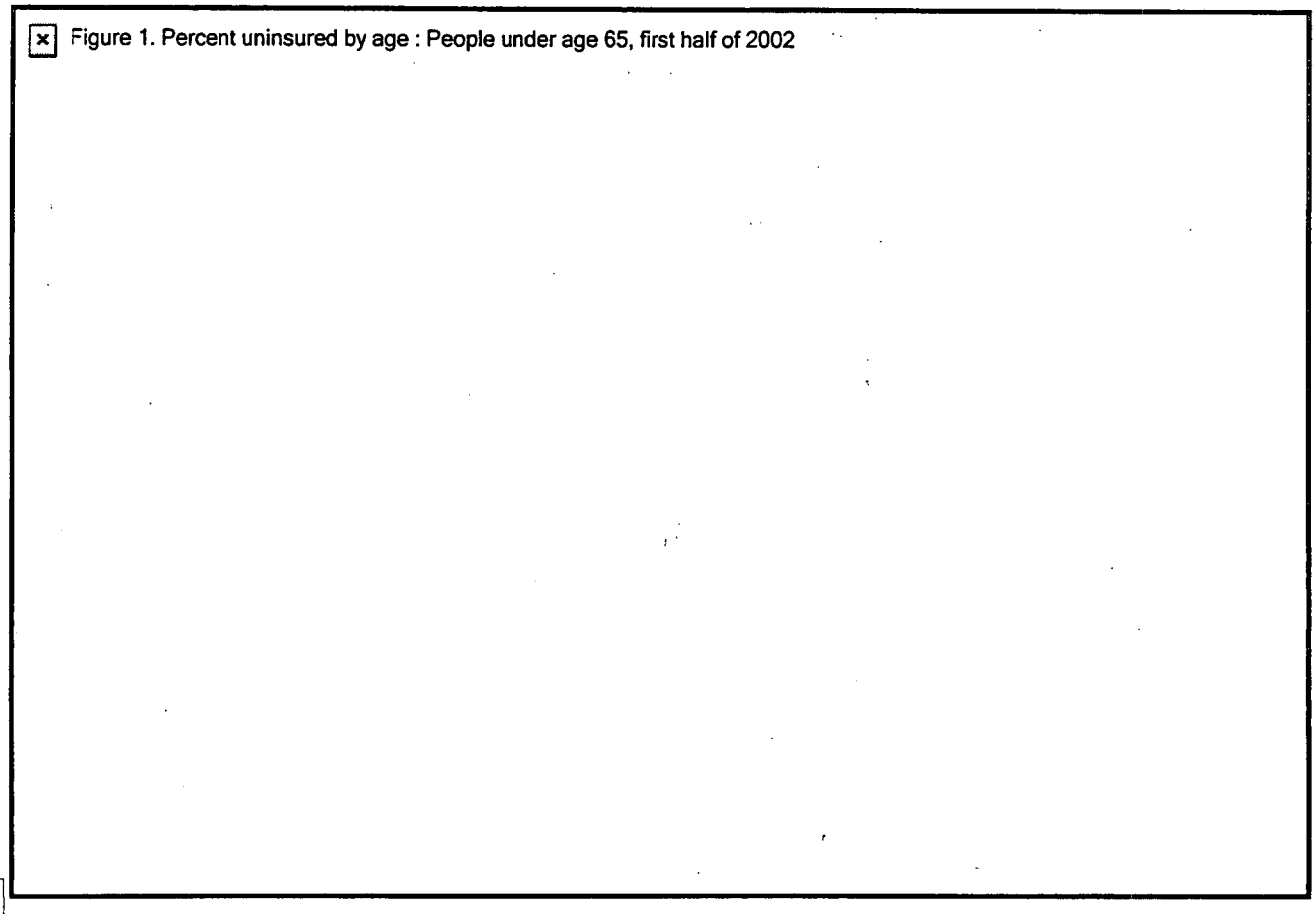

Figure 1. Percent uninsured by age: People under age 65, first half of 2002

Under 18	18	19-24	25-29	30-34	35-54	55-64
12.9%	22.0%	34.9%	30.6%	21.7%	16.9%	13.8%

Note: Young adults ages 19-24 were more likely than any other age group to be uninsured.

Source: Center for Cost and Financing Studies, AHRQ, Medical Expenditure Panel Survey, 2002 Point-in-Time File.

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Figure 2. Percent uninsured by race/ethnicity: People under age 65, first half 2002

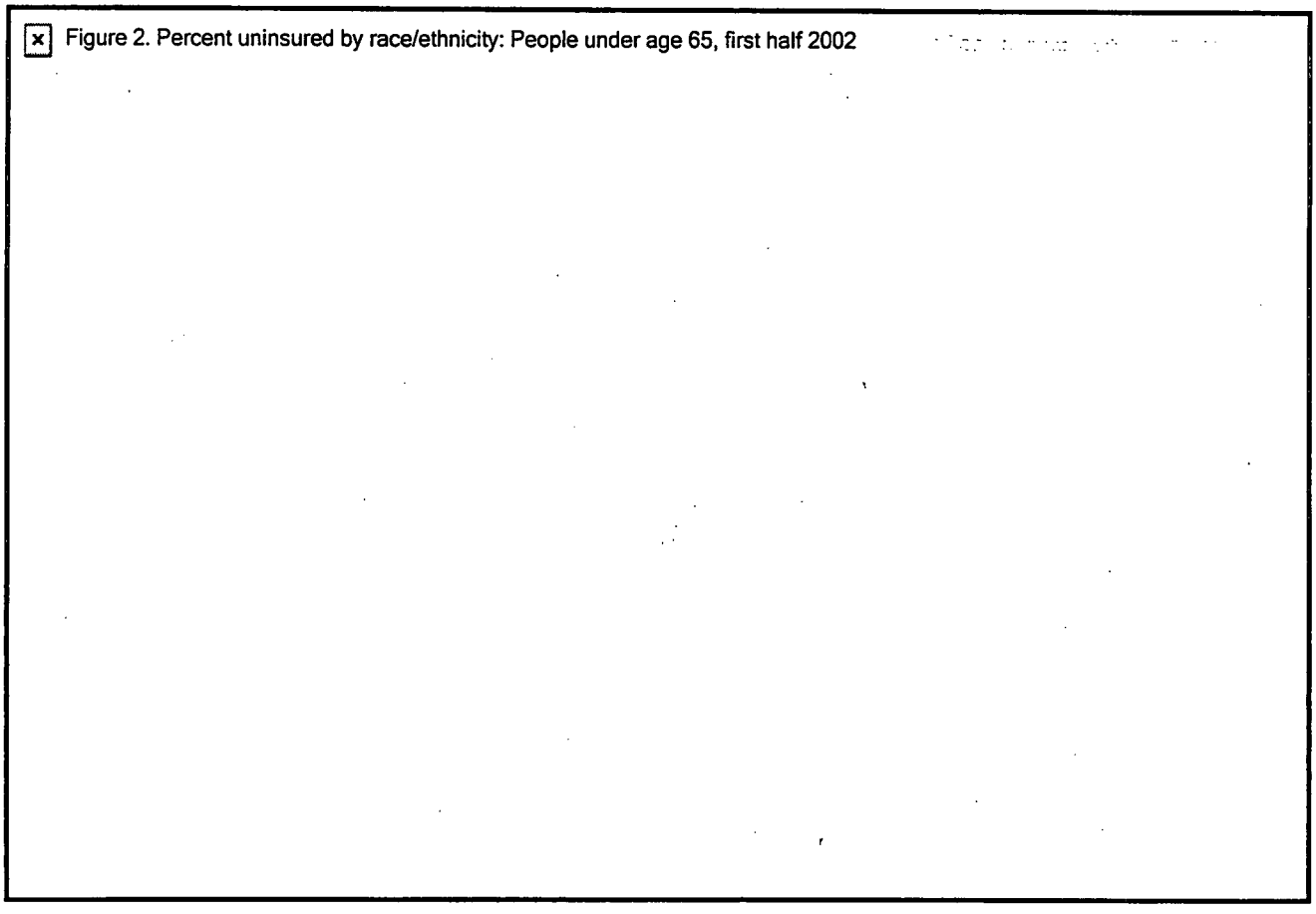

Figure 2. Percent uninsured by race/ethnicity: People under age 65, first half 2002

Hispanic	Black	White	Other
36.1%	20.4%	14.6%	16.3%

Note: Whites were less likely to be uninsured than Hispanics or Blacks.

Source: Center for Cost and Financing Studies, AHRQ, Medical Expenditure Panel Survey, 2002 Point-in-Time File.

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Figure 3. Percent distribution of total population and the uninsured by race/ethnicity: People under age 65, first half 2002

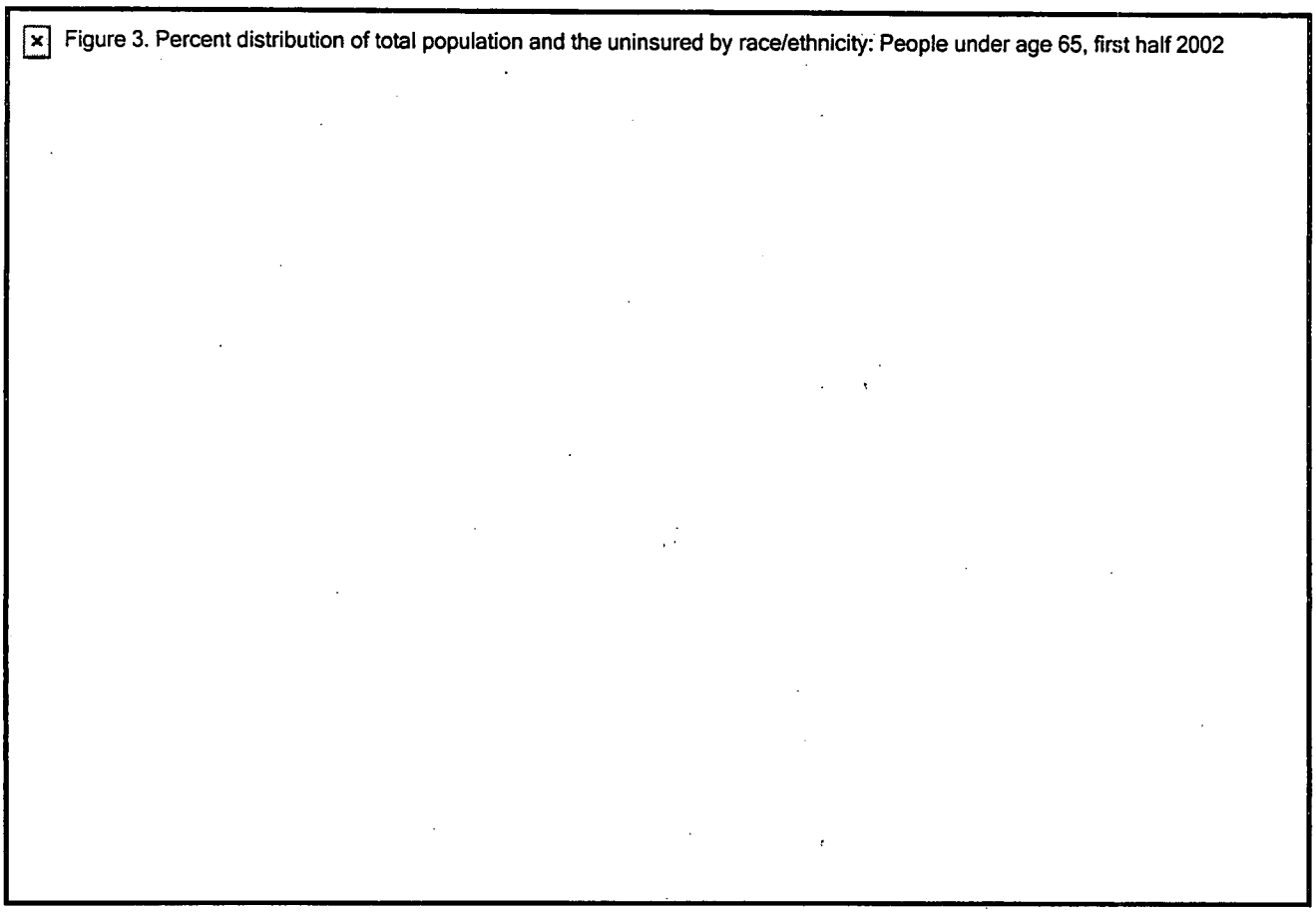

Figure 3. Percent distribution of total population and the uninsured by race/ethnicity: People under age 65, first half 2002

Total			
Hispanic	**Black**	**White**	**Other**
14.3%	12.8%	67.4%	5.5%

Uninsured			
Hispanic	**Black**	**White**	**Other**
27.9%	14.1%	53.2%	4.8%

Note: Hispanics were disproportionately represented among the uninsured.

Source: Center for Cost and Financing Studies, AHRQ, Medical Expenditure Panel Survey, 2002 Point-in-Time File.

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Figure 4. Percent uninsured by race/ethnicity and sex: People under age 65, first half 2002

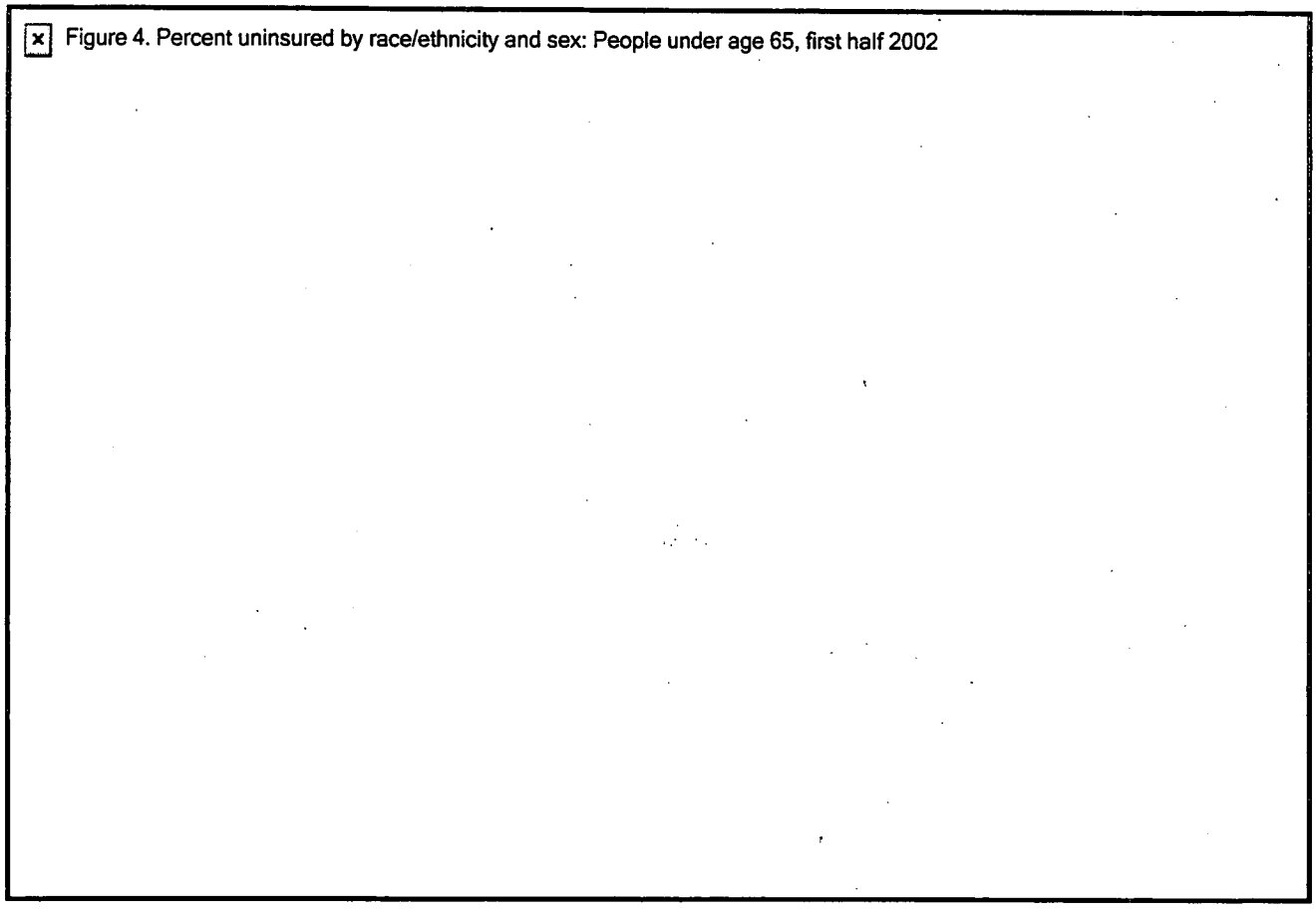

Figure 4. Percent uninsured by race/ethnicity and sex: People under age 65, first half 2002

Male				Female			
Hispanic	Black	White	Other	Hispanic	Black	White	Other
38.4%	22.5%	15.3%	17.3%	33.8%	18.5%	14.0%	15.4%

Note: Among both males and females, Hispanics were the most likely to be uninsured.

Source: Center for Cost and Financing Studies, AHRQ, Medical Expenditure Panel Survey, 2002 Point-in-Time File.

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Figure 5. Percent uninsured by marital status: People under age 65, first half 2002

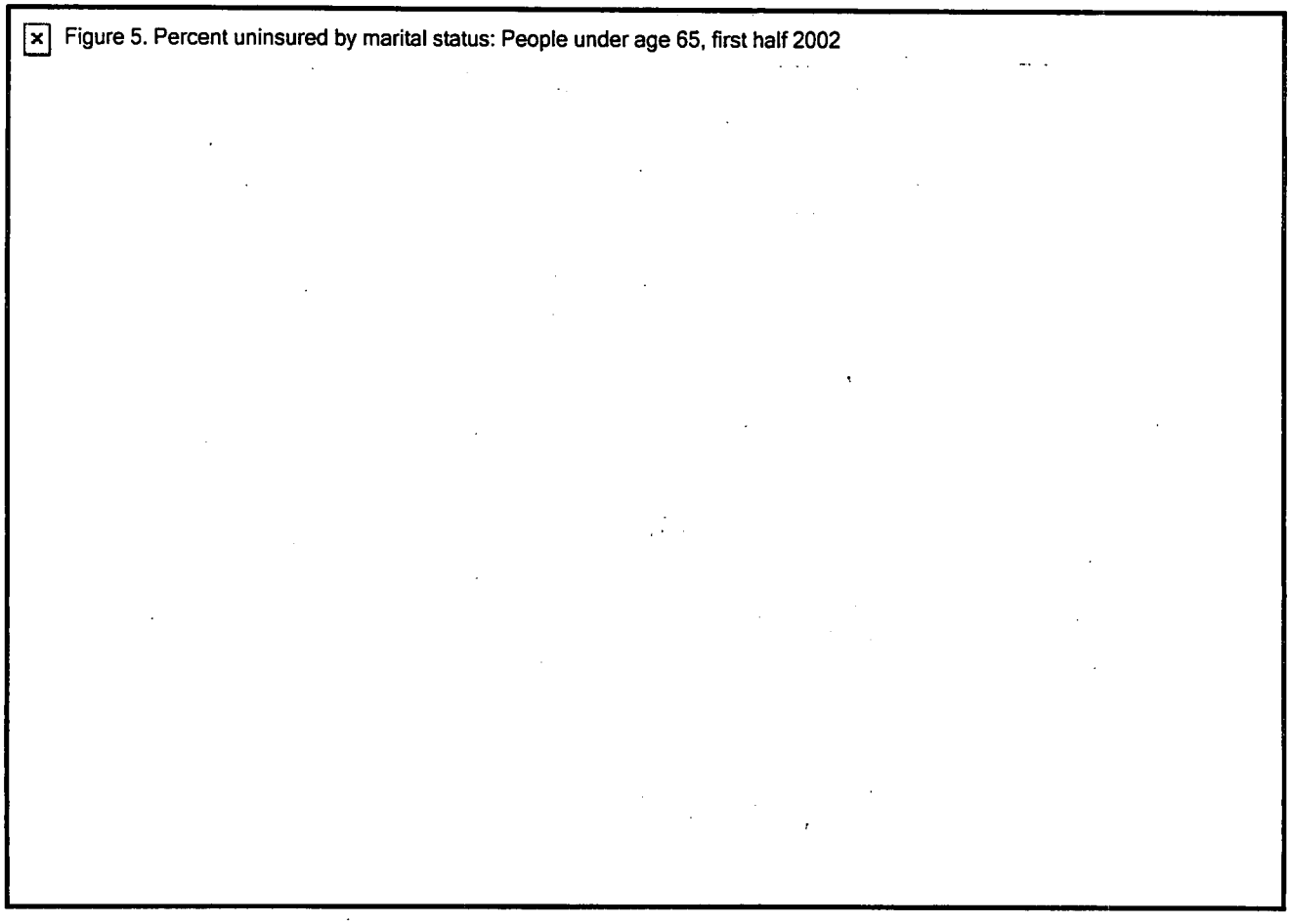

Figure 5. Percent uninsured by marital status: People under age 65, first half 2002

Married	Widowed	Divorced	Separated	Never Married
14.9%	23.8%	23.3%	33.6%	28.6%

Note: Married people were the least likely to be uninsured.

Source: Center for Cost and Financing Studies, AHRQ, Medical Expenditure Panel Survey, 2002 Point-in-Time File.

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Sources

For more information about MEPS, call the MEPS information coordinator at AHRQ (301-594-1406) or visit the MEPS Web site at:

http://www.meps.ahrq.gov/

For a detailed description of the MEPS survey design, sample design, and methods used to reduce sources of nonsampling error, see the following publications:

Cohen J. Design and methods of the Medical Expenditure Panel Survey Household Component. Rockville (MD): Agency for Health Care Policy and Research; 1997. MEPS Methodology Report No. 1. AHCPR Pub. No. 97-0026.

Cohen S. Sample design of the 1996 Medical Expenditure Panel Survey Household Component. Rockville (MD): Agency for Health Care Policy and Research; 1997. MEPS Methodology Report No. 2 AHCPR Pub. No. 97-0027.

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Internet Citation:

Statistical Brief #19: The Uninsured in America - 2002. May 2004.July 2003. Agency for Healthcare Research and Quality, Rockville, MD. http://www.meps.ahrq.gov/papers/st19/stat19.htm

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email MEPS at mepspd@ahrq.gov

THE NEWS & OBSERVER
SUNDAY, JANUARY 18, 2004

OUR VIEWS

Universal solution

America needs leadership to fix the health care system, which is causing the deaths of 18,000 uninsured people every year.

Babies die because prenatal medical care for their uninsured mothers is lacking. Uninsured people who have kidney disease don't receive dialysis treatments until late in their illness when anemia is already sapping their strength. Others who have easily controlled ailments, such as hypertension, go undiagnosed and uncared for until a medical emergency allows them to enter the health care system.

This is not health care in some Third World country. This is health care in the wealthiest nation on Earth, as seen by a panel of 15 experts who have studied it for three years. The newly published report of the National Academy of Sciences, available on the Internet at www.nationalacademies.org/morenews/, is a call to action.

Good health care is a core value in this country. Yet the financing system that applies to most people treats it as an employment benefit dependent on the good will of employers. And the medical services that are essential to good health have become so expensive today that, without insurance, they are beyond the reach of wage earners.

What's most encouraging about the academy panel's report is its assertion that universal health care coverage is achievable. Past efforts, notably the Clinton administration's attempt in 1994, have led to little more than patches and Band-aids for a system going into shock.

In 2000, research began to show wear and tear on the nation's safety net of public hospitals, community health centers and other providers who care for patients without health insurance. No longer is the uninsured population clustered in industrial cities where the safety net is positioned. That worrisome conclusion has led the academy to take on a comprehensive and timely review of health care financing.

An unhealthy mess

The panel's study found poor health and premature death all too common among uninsured Americans — and not because of national penny-pinching. We pay an annual health care bill that amounts to more than $5,000 for every man, woman and child, far more than is spent in other developed countries.

The problem lies in how that money is spent. Too little goes toward preventing serious health problems, especially among the 43 million who either aren't offered insurance at work or can't afford it. Uninsured diabetics, for instance, fail to get regular foot and eye exams that can prevent foot ulcers and blindness.

An advanced illness can devastate whole families as costs soar into the stratosphere without an insurer to negotiate discounts. The academy found that insured patients paid up to $3,434 for hospital treatment of pneumonia, compared with $9,812 charged to pneumonia patients lacking insurance.

Perhaps the most painful irony is that U.S. insurers spend millions of dollars on treatments that don't do much good. Waste adds to rising costs, which lead employers to ask workers for bigger contributions or to drop health coverage altogether. The unhappy result is more uninsured Americans.

The experts' prescription

Though health insurance coverage has expanded for subgroups, such as children of the working poor, it hasn't been enough to take broad advantage of medical advances that can prevent costly, debilitating illnesses. As the academy's research shows, America needs health insurance for every resident, and it must be coverage that is continuous and affordable for individuals as well as for the nation as a whole.

Favoring none, the academy examined four possible solutions, including tax credits to subsidize health insurance purchases and a single tax-supported program administered by the federal government. The single-payer system has the advantage of offering blanket coverage, as well as eliminating the need for the layers of administrative costs burdening the present system. It also spreads the costs of caring for the sickest patients among the largest population. Rather than wasting more time and money on partial solutions, the nation needs to reconsider a single-payer solution.

America's choice of health financing options will involve trade-offs between providers, insurers, employers and families. Despite the difficulty involved in making those political decisions, the academy believes universal coverage by 2010 to be a reasonable goal. Certainly, opposition from groups and industries with their own financial agendas cannot be allowed to deter this effort.

Right now, time is wasting. Yet the Bush administration's response to the academy report was timid. The secretary of health and human services, Tommy Thompson, said universal coverage in six years is unrealistic.

The president has a health care proposal, and so do all the Democrats now vying for his job. Among the supporters of a single-payer system of health care financing include two strong candidates, U.S. Rep. Richard Gephardt of Missouri and Gen. Wesley Clark. They should be encouraged to provoke a spirited debate on this issue during the presidential campaign. It's one that surely would help Americans choose their leaders.

Holly Biola is a Family Doctor who trained in Georgia and Virginia. After becoming frustrated with the current health care system, last year she decided to come to North Carolina in order to study health care services reform at UNC Chapel Hill. She currently cares for patients at the Chatham County Hospital Emergency Department and the Family Practice Center in Chapel Hill.

STATEMENT

I am a family physician and I work in a family practice office and the local ER. I see women and men, seniors and children, pregnant women and their babies – in family medicine I see them all – and I see them all suffering in our current system. There is no question about it, "the System" is broken. Time is being wasted, money is being wasted, and most importantly of all, people are suffering without universal health coverage.

So many ER visits could be prevented – so many hospitalizations could be avoided if people could afford to go to a doctor's office, or get their prescriptions filled. The night before last I admitted a diabetic man for the umpteenth time for the simple reason that he cannot afford his medical supplies.

While working a recent ER shift I saw a teenage girl for a minor ailment. Why did she come to the ER for this? I asked her mother. "We owe her regular doctor too much money—we didn't think he'd see her for this." I wish that was the first time I'd hear that response. Several times a shift I see people for non-urgent conditions because the patient "couldn't afford to go to a doctor's office." The truth is, an ER visit is roughly 10 times the cost of a doctor's office visit, but ER's do not refuse care. So, who will pay for that ER visit?? ALL OF US.

Recently released studies indicate that one-third of health care costs for uninsured patients—about $41 BILLION dollars will never be paid. Federal, state, and local governments will pay about 85% of that, and health care providers will absorb the rest of

that loss. So we already pay for the care of the uninsured, but the way we do it now it destroys credit ratings, destroys families, destroys lives.

Recently we saw a seven year old girl in our office with a hereditary arthritis that goes along with a disfiguring skin disease. The child's mother and grandmother suffer from the same disease, but cannot afford treatment. The girl's 52 year old grandmother was visibly suffering, but her job-- giving childcare for several neighborhood children while their parents worked – provides her with no insurance. So every morning before school, she gives her granddaughter her medicine—the same medicine she cannot afford for herself. Medicaid currently covers the treatment for the little 7 year old girl, but when she turns 18, if she doesn't find a way to get insurance, she will suffer with this disease like the rest of the family who continue to work, pay their taxes with this painful and disfiguring condition.

And lastly I will never forget the lovely 46 year old woman who was a home health aide for one of my office patients-- with severe lung disease. I saw her several times with him, bringing him back and forth for his doctor's visits, carrying his oxygen tank. The man began to notice her losing weight so encouraged her to see a doctor while she was there with him at one of his visits, but she had no insurance, and felt she could not afford an office visit. Finally, when she had visibly deteriorated he insisted that she come to the doctor and paid for it himself. When she came to see me it was the first time she'd seen a doctor for HERSELF since her child was born 20 years ago. One look at her and you knew she was dying. On that visit I found a small breast lump, and found metastases throughout her chest on her first chest x-ray. She was dead in 6 weeks. She was a mother, a sister, a friend, a taxpaying citizen and a caretaker...and she's gone. It did not have to be this way. If there were universal coverage she would have seen a doctor. I truly believe that if there had been universal coverage she would be here today.

I came today because every day I see the inefficiencies, the tragedies that come from our current system. I came today to urge you all to push for state funding of universal coverage.

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2003

S 2

SENATE BILL 582*

Health & Human Resources Committee Substitute Adopted 4/30/03

Short Title: Establish Commission on Childhood Obesity. (Public)

Sponsors:

Referred to:

March 31, 2003

A BILL TO BE ENTITLED

AN ACT TO ESTABLISH THE COMMISSION ON CHILDHOOD OBESITY.

Whereas, the four leading causes of death in North Carolina are stroke, heart disease, cancer, and diabetes, all of which are associated with overweight and obesity; and

Whereas, the prevalence of obesity has doubled in children and tripled in adolescents in the last two decades, bringing with it increased risk for future disease, as well as pediatric diagnoses of sleep apnea, orthopedic problems, psychological stress, and type 2 diabetes (formerly termed adult onset diabetes as it was rarely seen in persons under 30); and

Whereas, overweight teens have a 70% chance of becoming overweight or obese adults, making the next generation likely to have more adults with chronic diseases related to obesity at earlier ages than past generations; and

Whereas, the cost attributed to obesity and associated chronic diseases in the United States is more than $100 billion and these costs are spiraling upward; and

Whereas, children and adolescents are not meeting the recommendations of the Dietary Guidelines for Americans, including fruits and vegetables, but are consuming increasing amounts of foods high in fat and sugar; and

Whereas, standards were adopted in 1995 for meals served in the National School Lunch and School Breakfast Programs, but no standards exist for foods and beverages served a la carte in the cafeteria or in other venues during the school day; and

Whereas, regular physical activity substantially reduces the risk of dying of coronary heart disease and decreases the risk for stroke, colon cancer, diabetes, and high blood pressure. It also helps to control weight; contributes to healthy bones, muscles, and joints; reduces symptoms of anxiety and depression; and is associated with fewer hospitalizations, physician visits, and medications; Now, therefore,

The General Assembly of North Carolina enacts:

SECTION 1. There is established the Commission on Childhood Obesity.

SECTION 2. The Commission on Childhood Obesity shall be composed of 27 members who have knowledge and interest in reversing the epidemic of childhood obesity and taking steps to prevent obesity. The members shall be appointed as follows:

(1) The Superintendent of Public Instruction or his or her designee.

(2) One member of the Health and Wellness Trust Fund appointed by the chair of the Health and Wellness Trust Fund.

(3) Two parents of public school children and one public high school student appointed by the Governor after receiving recommendations from the North Carolina State Parent Teacher Association.

(4) Two members of the Senate appointed by the President Pro Tempore of the Senate.

(5) Two members of the House of Representatives appointed by the Speaker of the House of Representatives.

(6) Two members of a local board of education appointed by the Governor, after receiving recommendations from the North Carolina School Boards Association.

(7) One public school child nutrition director appointed by the Governor, after receiving recommendations from the Superintendent of Public Instruction.

(8) One public school nutrition education specialist appointed by the Governor, after receiving recommendations from the Superintendent of Public Instruction.

(9) One at-large member appointed by the Governor.

(10) Five members appointed by the President Pro Tempore of the Senate. In making these appointments, the President Pro Tempore shall appoint the following:

a. One public school health education teacher.
b. One representative from the Smart Start Program.
c. One pediatrician.
d. One psychiatrist, specializing in obesity.
e. One school administrator.

Professional associations representing teachers, school administrators, and the medical community may recommend appointees to the President Pro Tempore of the Senate.

(11) Five members appointed by the Speaker of the House of Representatives. In making these appointments, the Speaker of the House of Representatives shall appoint the following:

a. One public school physical education specialist.
b. One representative from the More At Four Program.
c. One dentist.
d. One member of the research community addressing the obesity epidemic.
e. One school administrator.

Professional associations representing teachers, school administrators, and dentists may recommend appointees to the Speaker of the House of Representatives.

(12) One representative of the vending machine industry, who is appointed by the Health and Wellness Trust Fund Commission, after receiving recommendations from the North Carolina Citizens for Business and Industry.

(13) One nutritionist, who is appointed by the Health and Wellness Trust Fund Commission, after receiving recommendations from professional associations.

(14) One economist, with expertise in the socioeconomic issues associated with obesity, who is appointed by the Health and Wellness Trust Fund Commission, after receiving recommendations from the research community.

Each of the following organizations or agencies may select a representative from its organization or agency to advise the Commission. These members shall provide information to the Commission about the obesity epidemic in North Carolina: North Carolina Department of Health and Human Services, Division of Public Health; North Carolina Department of Public Instruction, Child Nutrition Services; Be Active North Carolina, Inc., Prevention Partners; American Cancer Society; American Heart Association; Action for Healthy Kids NC; Healthy Weight Initiative; and the Office of the Governor.

SECTION 3. The member of the Health and Wellness Trust Fund Commission appointed by the chair of the Health and Wellness Trust Fund Commission shall serve as the chair of the Commission. Vacancies on the Commission shall be filled by the same appointing authority as made the initial appointment.

SECTION 4. The study shall include the following:

(1) The causes of obesity in North Carolina's children.

(2) The socioeconomic issues associated with childhood obesity.

(3) How the State should deal with childhood obesity.

(4) The steps that should be taken to prevent obesity in North Carolina.

SECTION 5. The Commission shall make recommendations that include the following:

(1) Nutritional guidelines for food served in public schools outside of the National School Lunch and School Breakfast Programs.

(2) Physical education in public schools.

(3) Physical activities in public schools.

(4) Healthy and nutritional behavior by North Carolina students and, when possible, their families.

The Commission is encouraged to explore different settings for its recommendations, including families, schools/child care, communities, health care, media/communication/social marketing, and surveillance/research.

SECTION 6. The Commission shall submit a final written report of its findings and recommendations to the Joint Legislative Health Care Oversight

Committee, the Joint Legislative Education Oversight Committee, and the Health and Wellness Trust Fund Commission no later than Friday, May 7, 2004. The final report may contain a summary of recommendations for changes to any law, rule, and policy that would lower or eradicate the obesity rates in North Carolina and our schools. Upon filing its final report, the Commission shall terminate.

SECTION 7. Members of the Commission shall be paid per diem, subsistence, and travel allowances in accordance with G.S. 120-3.1, 138-5, and 138-6, as appropriate.

SECTION 8. Federal funds, private funds, and existing State funds may be used to support the Commission. No new State funds shall be used to support the Commission.

SECTION 9. This act is effective when it becomes law.

House Committee on Health

June 1, 2004

Minutes

The House Committee on Health met on Tuesday, June 1, 2004 at 12:00 noon in Room 544 of the Legislative Office Building. A silent roll was taken. A copy of the roll denoting members present is attached to the minutes (Attachment I) along with a copy of the agenda and Visitor Registration Sheet (Attachments II and III).

Rep. Verla Insko, Chair welcomed visitors and members and recognized the the sergeant-in-arms. (Attachment IV). No pages were present at meeting.

Chair Insko makes motion upon request by the primary bill sponsors Reps. Clary, Nye and Weiss that HB 1487 A BILL TO BE ENTITLED AN ACT TO DIRECT THE DEPARTMENT OF HEALTH AND HUMAN SERVICES TO CONTRACT WITH A THIRD PARTY TO STUDY WHETHER AN INSTITUTIONAL BIAS EXISTS IN THE STATE'S MEDICAID PROGRAM, AS RECOMMENDED BY THE NORTH CAROLINA STUDY COMMISSION ON AGING (Bill – Attachment V and Bill Analysis – Attachment VI) and HB 1490 A BILL TO BE ENTITLED AN ACT TO DIRECT THE DEPARTMENT OF HEALTH AND HUMAN SERVICES TO STUDY ISSUES RELATED TO MENTALLY ILL RESIDENTS IN LONG-TERM CARE FACILITIES, AS RECOMMENDED BY THE NORTH CAROLINA STUDY COMMISSION ON AGING (Bill – Attachment VII and Bill Analysis – Attachment VIII) be reported out without prejudice and recommended that the bill be re-referred to the Committee on Appropriations. Motion is adopted. (Committee Reports – Attachments IX and X)

Chair Insko then recognizes Rep. Rick Glazier to explain SB 582 A BILL TO BE ENTITLED AN ACT TO ESTABLISH THE COMMISSION ON CHILDHOOD OBESITY. (Attachment XI) Rep. Glazier advises that there is a proposed committee substitute and new bill analysis (Attachments XII and XIII). A handout is provided from the Department of Health and Human Services (Attachment XIV). Rep. Munford makes motion that the proposed committee substitute be adopted for discussion purposes. Motion is adopted.

Rep. Glazier explains that while the original bill would have established the Commission on Childhood Obesity the proposed committee substitute changes the bill to the public health laws relating to quarantine and isolation authority and the confidentially of medical records and other information. In 2002 the General Assembly approved legislation to improve NC's efforts to respond to bioterrorism and other public health threats. This legislation provided the state Health Director and local public health officials with the authority to isolate or quarantine individuals for up to ten days in order to contain a public health emergency such as smallpox, SARS or other diseases. It also

provided individuals who are subject to an isolation or quarantine order with right to appeal that order. With the outbreaks of SARS in China and Canada – and here in the North Carolina – public health officials have been forced to rethink their strategies for containing SARS and other deadly diseases. State and local officials are concerned that, in a SARS-like emergency, current law will force them to spend countless hours in court when their resources will be greatly needed elsewhere to contain the disease. This bill adopts the definition of "Isolation Authority" from the Model State Public Health Act and the Model State Emergency Health Powers Act, to include persons reasonably suspected of being infected with a communicable disease or condition. It extends the authority of the state and local health director for quarantine and isolation from 10 days to 30 days, while preserving the individual's right to be heard in Superior Court within 72 hours. In the case of a person with tuberculosis, the Superior Court is authorized to extend an isolation order limiting the freedom of movement for up to one year to ensure that the patient is no longer communicable. North Carolina has appropriately 50 tuberculosis patients a year that require isolation and a course of treatment for up to one year. The court order automatically terminates once the patient is no longer communicable. The bill also adds new procedural safeguards that require notice of appeal rights when invoking quarantine or isolation authority. It also revises language for consistency with HIPPA, gives the state health director authority to issue temporary orders for up to 90 days requiring health care providers to report information necessary for a communicable disease investigation and clarifies other laws related to public health access to information for communicable disease or bioterrorism investigation.

Rep. Glazier advises that Public Health and the Department of Health and Human Services worked on this bill and it has their support.

Chair Insko recognizes Rep. Bowie. Rep. Bowie requests Representative Glazier to walk her through a hypothetical case. Rep. Glazier explains that the state Health Director or local health director can quarantine or isolate a person suspected of a communicable disease for 30 days without a court order. That person can request a superior court hearing to be held within 72 hours of filing that request to challenge the quarantine or isolation order. At the end of 30 days if the state or local health director feels that the person is still contagious, then the state or local health director can request a 30-day extension of the order in court. Again that person has the immediate right to a hearing. If a person is indigent, counsel will be appointed in accordance with the general statutes to represent such person. Also, the order is automatically terminated upon written notice from the state or local health director that the quarantine or isolation order is no longer necessary.

Upon being recognized by Chair Insko, Rep. Bowie asks where does the process first start. Rep. Glazier responses doctors are required to report contagious diseases to their local/state health directors and then the local/state health director or law enforcement serve the quarantine or isolation order.

After being recognized, Rep. Bernard Allen asks how is a person notified of their rights to appeal. Rep. Glazier states that public health provides the patient with information, both orally and in writing, explaining their rights.

Chair Insko recognizes Rep. Bowie who asks where is a person isolated or quarantined. Rep. Glazier indicates that it depends on the illness. He then asks Dr. Leah Devlin if she can respond. Dr. Devlin says that a person can be hospitalized or the quarantine can be in a less restrictive manner including the person's home.

Rep. Justus upon being recognized makes motion to give the proposed committee substitute for SB 582 a favorable report, unfavorable to the original bill. Motion is adopted. (Committee Report – Attachment XV)

Chair Insko indicates that HB 1469 DHHS Disease Management Activities will be heard at the next meeting. (Attachment XVI)

Meeting is adjourned at 12:22 p.m.

Representative Verla Insko, Chair

Pamela J. Evans, Committee Clerk

Attachment I

ATTENDANCE

HOUSE COMMITTEE ON HEALTH

DATES		2/1/04														
INSKO, Verla	CHAIR	✓														
JUSTUS, Carolyn	CHAIR	✓														
ENGLAND, Bob	VICE-CHAIR	✓														
ADAMS, Alma																
ALLEN, Bernard		✓														
ALLEN, Gordon																
ALLRED, Cary																
BARNHART, Jeff																
BOWIE, Joni		✓														
CLARY, Debbie																
EARLE, Beverly																
GLAZIER, Rick		✓														
HILTON, Mark		✓														
McALLISTER, Mary																
MUNFORD, Don		✓														
SETZER, Mitchell		✓														
SHERRILL, Wilma																
WAINWRIGHT, William																
WILSON, Connie		✓														
WRIGHT, Tom																
Ex officio Members																
Brubaker, Bru																
Culpepper, Bill																
Cunningham, Pete																
Eddins, Rick																

Attachment II

AGENDA

HOUSE COMMITTEE ON HEALTH

June 1, 2004
Room 544 LOB
12:00 Noon

OPENING REMARKS

Representative Verla Insko, Chair
Representative Carolyn Justus, Chair

AGENDA ITEMS

SB	**582**	**Establish Commission on Childhood Obesity – Sen. Purcell**
HB	**1469**	**DHHS Disease Mgmt Activities – Reps. Nye, Barbee, Justus and Insko**
HB	**1487**	**DHHS Study/Medicaid Institutional Bias – Reps. Clary, Nye and Weiss**
HB	**1490**	**Study Mentally Ill LTC Resident Issues – Reps. Clary, Nye and Weiss**

ADJOURNMENT

VISITOR REGISTRATION SHEET

HOUSE COMMITTEE ON HEALTH — June 1, 2003

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Christian Duke	Rep. Clary
Leah Devlin	DPH - ~~DHHS~~
Chris Hoke	DPH - ~~DHHS~~
Anna Wood	DPH · DHHS
Starla McKeeney	DHHS
Lor. Ann Harris	CALLA
Lyle Conbry	office of Gov.
Peggy Balah	DMH/DD/SAS
	DAAs - DHHS
Tina Stricklan	Lazy Beverly & Assc.

VISITOR REGISTRATION SHEET

HOUSE COMMITTEE ON HEALTH — June 1, 2003

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Steve Climo	DPH - DHHS
Jim Edgerton	AHIC
Jack Cozort	Parker Poe
Ann Lee	DHHS
Mark Benson	Capitol Group
Jeff Engel	DHHS
Kevin Leonard	WCSR
Kathy Goff	National MS Society
Joe Donovan	NAMI
Jimmy Hicks	Nurse of the Day
Carol P Lanier	CRNA (certified RN anesthetist)

VISITOR REGISTRATION SHEET

HOUSE COMMITTEE ON HEALTH — June 1, 2003

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Carin Savel	Rep Glazier
Ryan Pursley	Rep. Glazier
TIM MURRY	NCANA
DAVID McLEOD	NCDA&CS
PINE ISENHOWER	VISITOR
JERRY HARDESTY	NC PORK COUNCIL
Gordon Payne	Edwards & Hales
Charlene Rahn	NCANA
GARY SALAMIDO	GSK

Attachment IV

Health
6/1/10K

House Pages

1. Name: _____

   County: _____

   Sponsor: _____

2. Name: _____

   County: _____

   Sponsor: _____

3. Name: _____

   County: _____

   Sponsor: _____

4. Name: _____

   County: _____

   Sponsor: _____

5. Name: _____

   County: _____

   Sponsor: _____

Sgt-At-Arms

1. Name: Dusty Rhodes
2. Name: Frank Prevo
3. Name: Bill Fakkema
4. Name: Leslie Oakley

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2003

HOUSE BILL 1487*

Short Title:	DHHS Study/Medicaid Institutional Bias.	(Public)
Sponsors:	Representatives Clary, Nye, Weiss (Primary Sponsors); Adams, Bell, Culp, Fisher, Glazier, Gorman, Insko, Luebke, and Moore.	
Referred to:	Health, if favorable, Appropriations.	

May 17, 2004

A BILL TO BE ENTITLED

AN ACT TO DIRECT THE DEPARTMENT OF HEALTH AND HUMAN SERVICES TO CONTRACT WITH A THIRD PARTY TO STUDY WHETHER AN INSTITUTIONAL BIAS EXISTS IN THE STATE'S MEDICAID PROGRAM, AS RECOMMENDED BY THE NORTH CAROLINA STUDY COMMISSION ON AGING.

The General Assembly of North Carolina enacts:

SECTION 1. The Department of Health and Human Services shall contract with an independent third party to study whether the State's Medicaid program has a bias that favors support for individuals in institutional settings over support for individuals living at home and if a bias is found, to determine and recommend ways to alleviate the bias. The independent third party with whom the Department shall contract shall have documented experience in conducting similar studies. The study shall include consideration of all in-home services paid under the State's Medicaid program, including CAP/DA, home health, and personal care services. The Department shall report the results of the study to the North Carolina Study Commission on Aging by January 2005.

SECTION 2. 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 2004-2005 fiscal year to fund the study in this act.

SECTION 3. This act becomes effective July 1, 2004.

HOUSE BILL 1487:
DHHS Study/Medicaid Institutional Bias

BILL ANALYSIS

Committee:	House Health	**Introduced by:**	Reps. Clary, Nye, Weiss
Date:	June 1, 2004	**Summary by:**	Dianna Jessup
Version:	First Edition		Committee Counsel

SUMMARY: ***House Bill 1487 would require the Department of Health and Human Services to contract with a third party to study whether an institutional bias exists in the State's Medicaid program. The bill is a recommendation of the North Carolina Study Commission on Aging. The act would become effective July 1, 2004.***

CURRENT LAW: Under existing laws, individuals can qualify for either nursing home care or State-County Special Assistance for adult care homes with higher monthly incomes than they can if they want to obtain Medicaid coverage for health services provided in their own home. With these different income eligibility limits, individuals living at home who may have too much income to qualify for Medicaid coverage as long as they remain in their home, may qualify if they move into a more costly institutional or residential setting.

BILL ANALYSIS: The bill would require the Department of Health and Human Services to contract with a third party to study whether the State's Medicaid program has a bias that favors support for individuals in institutional settings over support for individuals living at home and if a bias is found, to determine and recommend ways to alleviate the bias. The study would have to include consideration of all in-home services paid by Medicaid. The bill would appropriate $150,000 to the Department to fund the study. The Department would have to report the results of its study to the North Carolina Study Commission on Aging by January 2005.

BACKGROUND: The Final Report by The North Carolina Institute of Medicine Task Force on Long-Term Care reported an institutional bias in Medicaid eligibility rules. The report stated that a reason public funding is weighted toward institutional care is that Medicaid and other public program rules make it easier for people to qualify for financial assistance with institutional or residential care than for services provided at home or in the community.

H1487-SMSW-001

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2003

H 1

HOUSE BILL 1490*

Short Title:	Study Mentally Ill LTC Resident Issues.	(Public)
Sponsors:	Representatives Clary, Nye, Weiss (Primary Sponsors); Adams, Bell, Bordsen, Culp, Farmer-Butterfield, Fisher, Glazier, Gorman, Insko, Lewis, Luebke, Moore, and Walend.	
Referred to:	Health, if favorable, Appropriations.	

May 17, 2004

A BILL TO BE ENTITLED

AN ACT TO DIRECT THE DEPARTMENT OF HEALTH AND HUMAN SERVICES TO STUDY ISSUES RELATED TO MENTALLY ILL RESIDENTS IN LONG-TERM CARE FACILITIES, AS RECOMMENDED BY THE NORTH CAROLINA STUDY COMMISSION ON AGING.

The General Assembly of North Carolina enacts:

SECTION 1. The Department of Health and Human Services shall work with long-term care providers and advocates for the elderly and the mentally ill to study issues concerning the care of mentally ill individuals residing in long-term care facilities. The study shall include:

(1) Examining whether current State statutes and Departmental rules adequately address the populations served by long-term care facilities.

(2) Exploring the development of separate licensure categories within the adult care home and nursing home designations to address the various populations being served.

(3) Examining adult care home rules to determine whether they are easy to understand, attainable under current staffing patterns, give appropriate guidance to facility operators according to the needs and characteristics of residents served, support residents' freedom of choice, and whether they support the autonomy, dignity, and independence philosophy of assisted living.

(4) Determining the most effective way to identify mentally ill individuals that have mental health treatment needs.

(5) Examining the criteria for admission of mentally ill individuals to long-term care facilities to ensure that the health and safety of all residents are safeguarded.

(6) Providing recommendations for improving the quality of care for mentally ill individuals in adult care homes and nursing homes including the potential cost associated with implementing the recommendations.

SECTION 2. The Department shall report its findings and recommendations to the North Carolina Study Commission on Aging by October 1, 2005. The Department of Health and Human Services shall include in this report how it defines "mentally ill" for purposes of this study.

SECTION 3. The Department of Health and Human Services may use up to one hundred fifty thousand dollars ($150,000) of funds appropriated to it for the 2004-2005 fiscal year to contract for the study required in this act.

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

Attachment VIII

HOUSE BILL 1490:
Study Mentally Ill LTC Resident Issues

BILL ANALYSIS

Committee:	House Health	**Introduced by:**	Reps. Clary, Nye, Weiss
Date:	June 1, 2004	**Summary by:**	Dianna Jessup
Version:	First Edition		Committee Counsel

SUMMARY: ***House Bill 1490 directs the Department of Health and Human Services to study issues concerning the care of mentally ill individuals residing in long-term care facilities. This bill represents a recommendation from the North Carolina Study Commission on Aging.***

The Senate companion to this bill (S1150) received a favorable report from the Senate Health and Human Resources committee on May 26, 2004.

BILL ANALYSIS:

House Bill 1490 requires the Department of Health and Human Services (DHHS) to work with long-term care providers and advocates for the elderly and the mentally ill to study issues concerning the care of mentally ill residents residing in long-term care facilities.

Elements of the study include:

- Examining whether current State statutes and Departmental rules adequately address the populations served by long-term care facilities.
- Exploring the development of separate licensure categories within the adult care home and nursing home designations to address the various populations being served.
- Examining adult care home rules to determine whether they are easy to understand, attainable under current staffing patterns, give appropriate guidance to facility operators according to the needs and characteristics of residents served, support residents' freedom of choice, and whether they support the autonomy, dignity, and independence philosophy of assisted living.
- Determining the most effective way to identify mentally ill individuals that have mental health treatment needs.
- Examining the criteria for admission of mentally ill individuals to long-term care facilities to ensure that the health and safety of all residents are safeguarded.
- Providing recommendations for improving the quality of care for mentally ill individuals in adult care homes and nursing homes including the potential cost associated with implementing the recommendations.

The Department is required to report findings and recommendations to the North Carolina Study Commission on Aging by October 1, 2005 and shall include how "mentally ill" was defined for purposes of the study. The bill provides that the Department may use up to one hundred fifty thousand dollars ($150,000) of funds appropriated to it for the 2004-2005 fiscal year to contract for the study.

The act is effective when it becomes law.

BACKGROUND:

In the report to the Governor and the 2004 Regular Session of the 2003 General Assembly, the North Carolina Study Commission on Aging recommended that the General Assembly require the Department of Health and

Human Services to work with long-term care providers and advocates for the elderly and the mentally ill to study issues related to mentally ill individuals residing in long-term care facilities.

This recommendation was in response to presentations on February 10, 2004 and March 9, 2004, from the Division of Facility Services, Department of Health and Human Services (DHHS); the NC National Alliance for the Mentally Ill (NAMI); the NC Association Long Term Care Facilities; and the Community Policy Section, Division of Mental Health, Developmental Disabilities and Substance Abuse Services, Department of Health and Human Services. During these presentations, concerns arose regarding whether adult care homes were appropriate housing options for mentally ill individuals and the appropriateness of staffing and training at these facilities. Specific concerns included: a possible need for appropriate training on the administration of psychiatric medications; a possible need for training on appropriate interaction with residents based on their particular mental illness; and long-term care providers unfamiliarity with the mental health system.

Adult care home providers requested the creation of a new licensure law and rules that are more realistic. During discussions at the April 13, 2004 meeting, Commission members voiced support for examining whether current State statutes and Departmental rules adequately address the populations served by long-term care facilities. They also supported examining adult care home rules to determine whether they are easy to understand, attainable under current staffing patterns, give appropriate guidance to facility operators according to the needs and characteristics of residents served, support resident's freedom of choice, and whether they support the autonomy, dignity and independence philosophy of assisted living.

In its report, the North Carolina Study Commission on Aging expressed support for quality care for mentally ill individuals and elderly individuals and recommended that the General Assembly require the Department of Health and Human Services to work with long-term care providers and advocates for the elderly and the mentally ill to study issues related to mentally ill individuals residing in long-term care facilities.

H1490-SMSW-001

Theresa Matula, staff to the NC Study Commission on Aging, substantially contributed to this summary.

2003 COMMITTEE REPORT
HOUSE OF REPRESENTATIVES

Attachment IX

The following report(s) from standing committee(s) is/are presented:
By Representatives **Verla Insko and Carolyn Justus,** Chairs for the Committee on **HEALTH.**

☐ Committee Substitute for
H.B. 1487 A BILL TO BE ENTITLED AN ACT TO DIRECT THE DEPARTMENT OF HEALTH AND HUMAN SERVICES TO CONTRACT WITH A THIRD PARTY TO STUDY WHETHER AN INSTITUTIONAL BIAS EXISTS IN THE STATE'S MEDICAID PROGRAM, AS RECOMMENDED BY THE NORTH CAROLINA STUDY COMMISSION ON AGING.

☐ 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 (# H.B.), ☐ 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 and recommended that the bill 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)

3/06/03

FOR JOURNAL USE ONLY

____ Pursuant to Rule 36(b), the bill/resolution is placed on the Calendar of _____.

____ The (committee substitute) bill/resolution (, as amended,) is (ordered engrossed and) re-referred to the Committee on _____.

____ The bill/resolution is re-referred to the Committee on _____.

____ On motion of (Rep. _____,) (the Chair,) the (committee substitute) bill/resolution is (ordered engrossed and) re-referred to the Committee on _____.

____ Pursuant to Rule 36(b), the (House)committee substitute bill (No. ____)/resolution is placed on the Calendar of _____. (The original bill) (House Committee Substitute Bill No. ____)/resolution is placed on the Unfavorable Calendar.

____ On motion of Rep. _____, (the rules are suspended) (Rule ____ is suspended) and the bill/resolution is placed on today's calendar. (for immediate consideration.)

____ On motion of Rep. _____, Committee Amendment No.(s) _____ is/are adopted (by EV____ ____).

____ On motion of Rep. _____, Committee Amendment No.(s) _____ is/are adopted (by EV____ ____).

____ Rep. _____ offers Amendment No. _____ which (is adopted.) (fails of adoption.) (by EV ____ ____.) ( ) This amendment changes the title.

____ The bill/resolution (, as amended,) passes its second reading (by following vote, ____ ____ RC) (, by EV ____ ____,) and (remains on the Calendar,) (and there being no objection is read a third time).

____ The bill/resolution (, as amended,) passes its third reading (by the following vote, ____ ____ RC) (, by EV ____ ____,) and is ordered
____ sent to the Senate.
____ without engrossment. ____ by Special message.
____ sent to the Senate for concurrence in
_____ the House amendment (s).
_____the House committee substitute bill.
____ enrolled.

____ On motion of Rep. _____, the House concurs in the (material) Senate _____ (by the following vote, ____ ____ RC) (, by EV ____ ____,) and the bill is ordered enrolled.

Attachment X

2003 COMMITTEE REPORT
HOUSE OF REPRESENTATIVES

The following report(s) from standing committee(s) is/are presented:
By Representatives **Verla Insko and Carolyn Justus,** Chairs for the Committee on **HEALTH**.

☐ Committee Substitute for
H.B. 1490 A BILL TO BE ENTITLED AN ACT TO DIRECT THE DEPARTMENT OF HEALTH AND HUMAN SERVICES TO STUDY ISSUES RELATED TO MENTALLY ILL RESIDENTS IN LONG-TERM CARE FACILITIES, AS RECOMMENDED BY THE NORTH CAROLINA STUDY COMMISSION ON AGING.

☐ 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 (# H.B.), ☐ 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 and recommended that the bill 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)

3/06/03

FOR JOURNAL USE ONLY

____ Pursuant to Rule 36(b), the bill/resolution is placed on the Calendar of _____.

____ The (committee substitute) bill/resolution (, as amended,) is (ordered engrossed and) re-referred to the Committee on _____.

____ The bill/resolution is re-referred to the Committee on _____.

____ On motion of (Rep. _____,) (the Chair,) the (committee substitute) bill/resolution is (ordered engrossed and) re-referred to the Committee on _____.

____ Pursuant to Rule 36(b), the (House)committee substitute bill (No. ____)/resolution is placed on the Calendar of _____. (The original bill) (House Committee Substitute Bill No. ____)/resolution is placed on the Unfavorable Calendar.

____ On motion of Rep. _____, (the rules are suspended) (Rule ____ is suspended) and the bill/resolution is placed on today's calendar. (for immediate consideration.)

____ On motion of Rep. _____, Committee Amendment No.(s) _____ is/are adopted (by EV____ ____).

____ On motion of Rep. _____, Committee Amendment No.(s) _____ is/are adopted (by EV____ ____).

____ Rep. _____ offers Amendment No. _____ which (is adopted.) (fails of adoption.) (by EV ____ ____.) ( ) This amendment changes the title.

____ The bill/resolution (, as amended,) passes its second reading (by following vote, ____ ____ RC) (, by EV ____ ____,) and (remains on the Calendar,) (and there being no objection is read a third time).

____ The bill/resolution (, as amended,) passes its third reading (by the following vote, ____ ____ RC) (, by EV ____ ____,) and is ordered
____ sent to the Senate.
____ without engrossment. ____ by Special message.
____ sent to the Senate for concurrence in
_____ the House amendment (s).
_____the House committee substitute bill.
____ enrolled.

____ On motion of Rep. _____, the House concurs in the (material) Senate _____ (by the following vote, ____ ____ RC) (, by EV ____ ____,) and the bill is ordered enrolled.

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2003

S 2

SENATE BILL 582*
Health & Human Resources Committee Substitute Adopted 4/30/03

Short Title: Establish Commission on Childhood Obesity. (Public)

Sponsors:

Referred to:

March 31, 2003

A BILL TO BE ENTITLED

AN ACT TO ESTABLISH THE COMMISSION ON CHILDHOOD OBESITY.

Whereas, the four leading causes of death in North Carolina are stroke, heart disease, cancer, and diabetes, all of which are associated with overweight and obesity; and

Whereas, the prevalence of obesity has doubled in children and tripled in adolescents in the last two decades, bringing with it increased risk for future disease, as well as pediatric diagnoses of sleep apnea, orthopedic problems, psychological stress, and type 2 diabetes (formerly termed adult onset diabetes as it was rarely seen in persons under 30); and

Whereas, overweight teens have a 70% chance of becoming overweight or obese adults, making the next generation likely to have more adults with chronic diseases related to obesity at earlier ages than past generations; and

Whereas, the cost attributed to obesity and associated chronic diseases in the United States is more than $100 billion and these costs are spiraling upward; and

Whereas, children and adolescents are not meeting the recommendations of the Dietary Guidelines for Americans, including fruits and vegetables, but are consuming increasing amounts of foods high in fat and sugar; and

Whereas, standards were adopted in 1995 for meals served in the National School Lunch and School Breakfast Programs, but no standards exist for foods and beverages served a la carte in the cafeteria or in other venues during the school day; and

Whereas, regular physical activity substantially reduces the risk of dying of coronary heart disease and decreases the risk for stroke, colon cancer, diabetes, and high blood pressure. It also helps to control weight; contributes to healthy bones, muscles, and joints; reduces symptoms of anxiety and depression; and is associated with fewer hospitalizations, physician visits, and medications; Now, therefore,

The General Assembly of North Carolina enacts:

SECTION 1. There is established the Commission on Childhood Obesity.

SECTION 2. The Commission on Childhood Obesity shall be composed of 27 members who have knowledge and interest in reversing the epidemic of childhood obesity and taking steps to prevent obesity. The members shall be appointed as follows:

(1) The Superintendent of Public Instruction or his or her designee.

(2) One member of the Health and Wellness Trust Fund appointed by the chair of the Health and Wellness Trust Fund.

(3) Two parents of public school children and one public high school student appointed by the Governor after receiving recommendations from the North Carolina State Parent Teacher Association.

(4) Two members of the Senate appointed by the President Pro Tempore of the Senate.

(5) Two members of the House of Representatives appointed by the Speaker of the House of Representatives.

(6) Two members of a local board of education appointed by the Governor, after receiving recommendations from the North Carolina School Boards Association.

(7) One public school child nutrition director appointed by the Governor, after receiving recommendations from the Superintendent of Public Instruction.

(8) One public school nutrition education specialist appointed by the Governor, after receiving recommendations from the Superintendent of Public Instruction.

(9) One at-large member appointed by the Governor.

(10) Five members appointed by the President Pro Tempore of the Senate. In making these appointments, the President Pro Tempore shall appoint the following:

a. One public school health education teacher.
b. One representative from the Smart Start Program.
c. One pediatrician.
d. One psychiatrist, specializing in obesity.
e. One school administrator.

Professional associations representing teachers, school administrators, and the medical community may recommend appointees to the President Pro Tempore of the Senate.

(11) Five members appointed by the Speaker of the House of Representatives. In making these appointments, the Speaker of the House of Representatives shall appoint the following:

a. One public school physical education specialist.
b. One representative from the More At Four Program.
c. One dentist.
d. One member of the research community addressing the obesity epidemic.
e. One school administrator.

Professional associations representing teachers, school administrators, and dentists may recommend appointees to the Speaker of the House of Representatives.

(12) One representative of the vending machine industry, who is appointed by the Health and Wellness Trust Fund Commission, after receiving recommendations from the North Carolina Citizens for Business and Industry.

(13) One nutritionist, who is appointed by the Health and Wellness Trust Fund Commission, after receiving recommendations from professional associations.

(14) One economist, with expertise in the socioeconomic issues associated with obesity, who is appointed by the Health and Wellness Trust Fund Commission, after receiving recommendations from the research community.

Each of the following organizations or agencies may select a representative from its organization or agency to advise the Commission. These members shall provide information to the Commission about the obesity epidemic in North Carolina: North Carolina Department of Health and Human Services, Division of Public Health; North Carolina Department of Public Instruction, Child Nutrition Services; Be Active North Carolina, Inc., Prevention Partners; American Cancer Society; American Heart Association; Action for Healthy Kids NC; Healthy Weight Initiative; and the Office of the Governor.

SECTION 3. The member of the Health and Wellness Trust Fund Commission appointed by the chair of the Health and Wellness Trust Fund Commission shall serve as the chair of the Commission. Vacancies on the Commission shall be filled by the same appointing authority as made the initial appointment.

SECTION 4. The study shall include the following:

(1) The causes of obesity in North Carolina's children.

(2) The socioeconomic issues associated with childhood obesity.

(3) How the State should deal with childhood obesity.

(4) The steps that should be taken to prevent obesity in North Carolina.

SECTION 5. The Commission shall make recommendations that include the following:

(1) Nutritional guidelines for food served in public schools outside of the National School Lunch and School Breakfast Programs.

(2) Physical education in public schools.

(3) Physical activities in public schools.

(4) Healthy and nutritional behavior by North Carolina students and, when possible, their families.

The Commission is encouraged to explore different settings for its recommendations, including families, schools/child care, communities, health care, media/communication/social marketing, and surveillance/research.

SECTION 6. The Commission shall submit a final written report of its findings and recommendations to the Joint Legislative Health Care Oversight

Committee, the Joint Legislative Education Oversight Committee, and the Health and Wellness Trust Fund Commission no later than Friday, May 7, 2004. The final report may contain a summary of recommendations for changes to any law, rule, and policy that would lower or eradicate the obesity rates in North Carolina and our schools. Upon filing its final report, the Commission shall terminate.

SECTION 7. Members of the Commission shall be paid per diem, subsistence, and travel allowances in accordance with G.S. 120-3.1, 138-5, and 138-6, as appropriate.

SECTION 8. Federal funds, private funds, and existing State funds may be used to support the Commission. No new State funds shall be used to support the Commission.

SECTION 9. This act is effective when it becomes law.

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2003

S D

SENATE BILL 582*

Health & Human Resources Committee Substitute Adopted 4/30/03

PROPOSED HOUSE COMMITTEE SUBSTITUTE S582-PCS85301-LN-46

Short Title: Public Health Preparedness and Response. (Public)

Sponsors:

Referred to:

March 31, 2003

A BILL TO BE ENTITLED

AN ACT TO IMPROVE PUBLIC HEALTH PREPAREDNESS AND RESPONSE.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 130A-2(3a) reads as rewritten:

"(3a) 'Isolation authority' means the authority to issue an order to limit the freedom of movement or action of ~~a person or animal~~ persons or animals that are infected or reasonably suspected to be infected with a communicable disease or communicable condition for the period of communicability to prevent the direct or indirect conveyance of the infectious agent from the person or animal to other persons or animals who are susceptible or who may spread the agent to others."

SECTION 2. G.S. 130A-145(d) reads as rewritten:

"(d) When quarantine or isolation limits the freedom of movement of a person or animal or of access to a person or animal whose freedom of movement is limited, the period of limited freedom of movement or access shall not exceed ~~10~~ 30 calendar days. Any person substantially affected by that limitation may institute in superior court in Wake County or in the county in which the limitation is imposed an action to review that limitation. If a person or a person's representative requests a hearing, the hearing shall be held within 72 hours of the filing of that request, excluding Saturdays and Sundays. The person substantially affected by that limitation is entitled to be represented by counsel of the person's own choice or if the person is indigent, the person shall be represented by counsel appointed in accordance with Article 36 of Chapter 7A of the General Statutes and the rules adopted by the Office of Indigent Defense Services. The court shall reduce the limitation ~~if~~ unless it determines, by the preponderance of the evidence, that the limitation is ~~not~~ reasonably necessary to prevent or limit the conveyance of a communicable disease or condition to others.

If the State Health Director or the local health director determines that a ~~10-calendar-day~~30-calendar-day limitation on freedom of movement or access is not adequate to protect the public health, the State Health Director or local health director must institute in superior court in the county in which the limitation is imposed an action to obtain an order extending the period of limitation of freedom of movement or access. If the person substantially affected by the limitation has already instituted an action in superior court in Wake County, the State Health Director must institute the action in superior court in Wake ~~County. The~~ County or as a counterclaim in the pending case. Except as provided below for persons with tuberculosis, the court shall continue the limitation for a period not to exceed 30 days if it determines, by the preponderance of the evidence, that the limitation is reasonably necessary to prevent or limit the conveyance of a communicable disease or condition to others. The court order shall specify the period of time the limitation is to be continued and shall provide for automatic termination of the order upon written determination by the State Health Director or local health director that the quarantine or isolation is no longer necessary to protect the public health. In addition, where the petitioner can prove by clear, cogent, and convincing evidence that quarantine or isolation was not or is no longer needed for protection of the public health, the person quarantined or isolated may move the trial court to reconsider its order extending quarantine or isolation before the time for the order otherwise expires and may seek immediate or expedited termination of the order. The decision to hear a motion for reconsideration is in the discretion of the trial court and no evidentiary hearing is required on this motion. The decision of the trial court on the motion is reviewable only for abuse of discretion. Before the expiration of an order issued under this section, the State Health Director or local health director may move to continue the order for additional periods not to exceed 30 days each. If the person whose freedom of movement has been limited has tuberculosis, the court shall continue the limitation for a period not to exceed one calendar year if it determines, by clear, cogent, and convincing evidence, that the limitation is reasonably necessary to prevent or limit the conveyance of tuberculosis to others. The court order shall specify the period of time the limitation is to be continued and shall provide for automatic termination of the order upon written determination by the State Health Director or local health director that the quarantine or isolation is no longer necessary to protect the public health. In addition, where the petitioner can prove by clear, cogent, and convincing evidence that quarantine or isolation was not or is no longer needed for protection of the public health, the person quarantined or isolated may move the trial court, to reconsider its order extending quarantine or isolation before the time for the order otherwise expires, and may seek immediate or expedited termination of the order. The decision to hear a motion for reconsideration is in the discretion of the trial court, and no evidentiary hearing is required on this motion. The decision of the trial court on the motion is reviewable only for abuse of discretion. Before the expiration of an order limiting the freedom of movement of a person with tuberculosis, the State Health Director or local health director may move to continue the order for additional periods not to exceed one calendar year each."

SECTION 3. G.S. 130A-475(b) reads as rewritten:

"(b) The authority under subsection (a) of this section shall be exercised only when and so long as a public health threat may exist, all other reasonable means for correcting the problem have been exhausted, and no less restrictive alternative exists. Before applying the authority under subdivision (4) or (5) of subsection (a) of this section to livestock or poultry for the purpose of preventing the direct or indirect conveyance of a biological, chemical or nuclear agent to persons, the State Health Director shall consult with the State Veterinarian in the Department of Agriculture and Consumer Services.

The period of limited freedom of movement or access under subdivisions (4) and (5) of subsection (a) of this section shall not exceed ~~10~~ 30 calendar days. Any person substantially affected by that limitation may institute, in superior court in Wake County or in the county in which the limitation is imposed, an action to review the limitation. If a person or a person's representative requests a hearing, the hearing shall be held within 72 hours of the filing of the request, excluding Saturdays and Sundays. The person substantially affected by that limitation is entitled to be represented by counsel of the person's own choice or if the person is indigent, the person shall be represented by counsel appointed in accordance with Article 36 of Chapter 7A of the General Statutes and the rules adopted by the Office of Indigent Defense Services. The court shall reduce the limitation if it determines, by the preponderance of the evidence, that the limitation is not reasonably necessary to prevent or limit the conveyance of biological, chemical or nuclear agents to others, and may apply such conditions to the limitation as the court deems reasonable and necessary.

If the State Health Director determines that a ~~10-calendar-day~~ 30-calendar-day limitation on freedom of movement or access is not adequate to protect the public health, the State Health Director must institute in superior court in the county in which the limitation is imposed, an action to obtain an order extending the period limiting the freedom of movement or access. If the person substantially affected by the limitation has already instituted an action in superior court in Wake County, the State Health Director must institute the action in superior court in Wake ~~County.~~County or as a counterclaim in the pending case. The court shall continue the limitation for a period not to exceed 30 days, subject to conditions it deems reasonable and necessary, if it determines by the preponderance of the evidence, that additional limitation is reasonably necessary to prevent or limit the conveyance of biological, chemical, or nuclear agents to others. The court order shall specify the period of time the limitation is to be continued and shall provide for automatic termination of the order upon written determination by the State Health Director or local health director that the quarantine or isolation is no longer necessary to protect the public health. In addition, where the petitioner can prove by clear, cogent, and convincing evidence that quarantine or isolation was not or is no longer needed for protection of the public health, the person quarantined or isolated may move the trial court to reconsider its order extending quarantine or isolation before the time for the order otherwise expires, and may seek immediate or expedited termination of the order. The decision to hear a motion for reconsideration is in the discretion of the trial court, and no evidentiary hearing is required on this motion. The decision of the trial court on the motion is reviewable only

for abuse of discretion. Before the expiration of an order issued under this section, the State Health Director may move to continue the order for additional periods not to exceed 30 days each."

SECTION 4. G.S. 130A-5(2) reads as rewritten:

"**§ 130A-5. Duties of the Secretary.**

The Secretary shall have the authority:

...

"(2) To investigate the causes of epidemics and of infectious, communicable and other diseases affecting the public health in order to control and prevent these diseases; to provide, under the rules of the Commission, for the prevention, detection, reporting and control of communicable, infectious or any other diseases or health hazards considered harmful to the public health; ~~to obtain, notwithstanding the provisions of G.S. 8-53, a copy or a summary of pertinent portions of privileged patient medical records deemed necessary for investigating a disease or health hazard that may present a clear danger to the public health. Records shall be identified as necessary by joint agreement of a Department physician and the patient's attending physician. However, if the Department is unable to contact the attending physician after reasonable attempts to do so, or if the Department determines that contacting all attending physicians of patients involved in an investigation would be impractical or would unreasonably delay the inquiry and thereby endanger the public health, the records shall be identified as necessary by joint agreement of a Department physician and the health care facility's chief of staff. For a facility with no chief of staff, the facility's chief administrator may consent to the Department's review of the records. Any person, authorized to have or handle such records, providing copies or summaries of privileged patient medical records pursuant to this subdivision shall be immune from civil or criminal liability that might otherwise be incurred or imposed based upon invasion of privacy or breach of physician-patient confidentiality arising out of the furnishing of or agreement to furnish such records;~~.

SECTION 5. G.S. 130A-12 reads as rewritten:

"**§ 130A-12. Confidentiality of records.**

All records containing privileged patient medical information or information subject to most recent federal regulations promulgated at 45 C.F.R. Parts 160 and 164 that are in the possession of the Department or local health departments shall be confidential and shall not be public records pursuant to G.S. 132-1. Information contained in the records may be disclosed only when disclosure is authorized or required by State or federal law. Notwithstanding G.S. 8-53 or G.S. 130A-143, the information contained in the records may be disclosed for purposes of treatment, payment, or health care operations. For purposes of this section, the terms 'treatment,' 'payment,' and 'health care operations' have the meanings given those terms in 45 C.F.R. § 164.501."

SECTION 6. Article 1 of Chapter 130A of the General Statutes is amended by adding the following new sections to read:

"**§ 130A-12.1. Access to health information for public health investigations.**

(a) When the State Health Director determines that access to health information is necessary for investigating a disease or health hazard that may present a clear danger to the public health, health care providers and persons in charge of health care facilities or laboratories shall, upon written request and proper identification, permit the State Health Director or a local health director to examine, review, and obtain a copy of records containing confidential or protected health information, or a summary of pertinent portions of the records.

(b) A person who permits examination, review, or copying of medical records pursuant to subsection (a) of this section is immune from any civil or criminal liability that otherwise might be incurred or imposed as a result of complying with a request made pursuant to this section.

(c) For purposes of this section, the terms 'health care provider' and 'health care facilities' have the definitions set out for those terms in G.S. 130A-476(g).

"**§ 130A-12.2. Authority to disclose information.**

The provisions of G.S. 8-53 do not supercede provisions of this Chapter that authorize or require the disclosure of health or other information."

SECTION 7. Part 1 of Article 6 of Chapter 130A of the General Statutes is amended by adding the following new section to read:

"**§ 130A-141.1. Temporary order to report.**

(a) The State Health Director may issue a temporary order requiring health care providers to report symptoms, diseases, conditions, trends in use of health care services, or other health-related information when necessary to conduct a public health investigation or surveillance of an illness, condition, or symptoms that may indicate the existence of a communicable disease or condition that presents a danger to the public health. The order shall specify which health care providers must report, what information is to be reported, and the period of time for which reporting is required. The period of time for which reporting is required pursuant to a temporary order shall not exceed 90 days. The Commission may adopt rules to continue the reporting requirement when necessary to protect the public health.

(b) For the purposes of this section, the term 'health care provider' has the definition set out in G.S. 130A-476(g)."

SECTION 8. G.S. 130A-144(b) reads as rewritten:

"(b) Physicians and persons in charge of medical facilities or laboratories shall, upon request and proper identification, permit a local health director or the State Health Director to examine, review, and obtain a copy of medical or other records in their possession or under their control which the State Health Director or a local health director determines pertain to the (i) diagnosis, treatment, or prevention of a communicable disease or communicable condition for a person infected, exposed, or reasonably suspected of being infected or exposed to such a disease or ~~condition.~~condition, or (ii) the investigation of a known or reasonably suspected outbreak of a communicable disease or communicable condition."

SECTION 9. G.S. 130A-476(c) reads as rewritten:

"(c) ~~The~~ Health care providers and persons in charge of health care facilities or laboratories shall, upon request and proper identification, permit the State Health Director ~~and~~ or a local health director ~~may~~ to examine, review, and obtain a copy of records containing confidential or protected health information, or a summary of pertinent portions of those records, (i) that pertain to a report authorized by subsection (a) or required by subsection (b) of this ~~section.~~section, or (ii) that, in the opinion of the State Health Director or local health director, are necessary for an investigation of a case or outbreak of an illness, condition, or health hazard that may have been caused by a terrorist incident using nuclear, biological, or chemical agents."

SECTION 10. This act is effective when it becomes law.

SENATE BILL 582:
Public Health Preparedness and Response

BILL ANALYSIS

Committee:	House Health	**Introduced by:**	Sen. Purcell
Date:	June 1, 2004	**Summary by:**	Dianna Jessup
Version:	PCS S582-CSSW-72		Committee Counsel

SUMMARY: ***The PCS would make changes to the public health laws relating to quarantine and isolation authority and the confidentiality of medical records and other information. The act would become effective when it becomes law.***

The original bill would have established the Commission on Childhood Obesity.

CURRENT LAW: ***Communicable Disease Control Laws***: Under these laws, the Commission for Health Services adopts rules as to which communicable diseases must be reported by which entities. Physicians, schools, clinical laboratories, etc., are required to report all cases of a communicable disease or condition to the local health director. The legal definition of "communicable disease" is an illness caused by an infectious agent such as a virus or bacterium or its toxic products, that can be transmitted from person to person, from an animal to a person, through an intermediate host or vector, or through the inanimate environment. Currently the list of reportable diseases includes 68 communicable diseases and conditions, including AIDS, meningococcal disease, rabies, and SARS. A "communicable condition" is when a person has been infected with a communicable agent but does not have symptoms of disease. Local health directors then investigate reported cases and ensure that control measures are in place to prevent the spread of the disease. The State Health Director and local health directors have the authority to examine patient records pertaining to communicable diseases and may exercise isolation or quarantine authority in appropriate circumstances.

Local health directors and the State Health Director have isolation and quarantine authority in order to prevent the spread of communicable diseases or conditions. Isolation applies to persons who actually have a communicable disease or condition, and quarantine applies to persons who have been or are reasonably suspected of having been exposed to a communicable disease or condition. Isolation and quarantine authority may only be exercised when and for so long as the public health is endangered, and only when all other reasonable means for correcting the problem have been exhausted and no less restrictive alternative exists. When a person or animal is quarantined, their freedom of movement is restricted. An area of land or a facility is quarantined by restricting access by persons or animals to the area of land or facility. When quarantine or isolation limits the freedom of movement of a person or animal or access to a person or animal whose freedom of movement is limited, the period of quarantine or isolation cannot exceed 10 days. Persons affected by the limitation can file an action in superior court to review the limitation. If the State Health Director or the local health director determines that the 10 day limit is not adequate, the State Health Director or local health director must institute an action in superior court to obtain an order extending the period of limitation, which can be extended for a period not to exceed 30 days if the court determines by the preponderance of the evidence that the limitation is reasonably necessary to prevent or limit the conveyance of a communicable disease or condition.

Public Health Threats Caused by Acts of Terrorism: The State Health Director is authorized to undertake an investigation upon a reasonable suspicion that a public health threat may exist as a result of a terrorist incident using nuclear, biological, or chemical agents. "Public health threat" is defined as a

situation likely to cause an immediate risk to human life, of serious physical injury or illness, or of serious adverse health effects.

The State Health Director may, with the concurrence of the Governor issue orders to (i) require persons and animals to submit to testing to determine possible exposure, (ii) test property to determine presence of nuclear, biological, or chemical agents, (iii) close property to investigate suspected contamination, (iv) limit the movement or action of animals or persons that may be contaminated with a biological, chemical or nuclear agent, (v) limit access to areas housing persons or animals that may have been contaminated with a biological, chemical or nuclear agent, and (vi) quarantine or isolate persons and animals. The State Health Director may only take these actions when a public health threat may exist and all other reasonable means for correcting the problem have been exhausted and no less restrictive alternative exists. Before quarantining, isolating, or limiting the movement or access of livestock or poultry, the Director must consult with the State Veterinarian. An order to limit movement or access or to quarantine or isolate is limited to a period of 10 calendar days. A person substantially affected by one of these limitations to institute an action in superior court to review the order. If the Director determines that 10 days is inadequate to protect the public health, the Director must institute an action in superior court to obtain an order to extend the period of limitation. The court may continue the period of limitation up to 30 days if it determines by the preponderance of evidence that the limitation is reasonably necessary to prevent or limit the conveyance of nuclear, biological, or chemical agents to others. The court may apply conditions deemed reasonable and necessary. Before an order has expired the Director may move to continue the limitation for additional periods not to exceed 30 days each. A person who is indigent shall be represented by counsel pursuant to Article 36 of Chapter 7A of the General Statutes and the Office of Indigent Services.

Access to Confidential Health Information: Current law provides the State Health Director or local health directors access to confidential health information related to any communicable disease or condition or if necessary to investigate a suspected public health threat that may be caused by an act of terrorism using biological, chemical or nuclear weapons. The State Health Director can issue a temporary order (no longer than 90 days) requiring certain health care providers to make reports for a specific period of time that might indicate a suspected illness, condition, or health hazard that may have been caused by an act of terrorism using nuclear, biological or chemical agents. The State Health Director or local health director may also obtain and review copies of confidential medical records.

Confidentiality of patient medical information: Current law provides that all records containing privileged patient medical information that are in the possession of the Department or local health departments are confidential and are not public records. If the Department or a local health department wishes to use patient information for the purposes of further treatment, for payment, or for other reasons, consent of the patient is required.

BILL ANALYSIS:

Changes to Article 1 of the Public Health Statutes (the General article):

Section 1 would change the definition of "isolation authority" to extend the authority of the State Health Director and local health directors to persons or animals that are reasonably suspected to be infected with a communicable disease. This is the same authority the State Health Director and the local health directors have with respect to quarantine authority.

Section 4 would add a new section to Article 1 that would exempt all information subject to federal HIPAA regulations from the public records statutes, but would permit the disclosure of information when

authorized or required by State or federal law, or for purposes of treatment, payment, or health care operations, as those terms are defined under federal law.[1] This would give the Department and local health departments the same ability as private providers to disclose certain information for the purposes described, without having to obtain the consent of the patient.

Changes to Article 6 (the Communicable Disease article):

Section 2 would extend the initial time the State Health Director or local health director can quarantine or isolate a person or animal, without a court order, from 10 days to 30 days. If a person substantially affected by the limitation files an action, the court shall reduce or terminate the limitation unless it determines by the preponderance of the evidence, that the limitation is reasonably necessary to prevent or limit the conveyance of the disease. Persons known to be substantially affected by the limitation have to be notified of the right to challenge the limitation. If the State Health Director or local health director wants to extend the 30 day time period for an additional 30 days, the State Health Director or local health director must institute an action in Wake County Superior Court or file a counterclaim in a pending case. If the court determines that the time is to be extended, the court order shall provide for automatic termination of the limitation upon written determination by the State Health Director or local health director that the limitation is no longer necessary. If a person wants to terminate the extension, the person has to file a motion in court and must prove by a preponderance of the evidence that the quarantine or isolation is no longer necessary.

The section also adds a new provision as it relates to tuberculosis. If a person has tuberculosis, the court can extend the period for up to a year if it determines, by a preponderance of the evidence that the limitation is reasonably necessary. If a person wants to terminate the extension, the person has to file a motion in court and must prove by a preponderance of the evidence that the quarantine or isolation is no longer necessary.

Section 5 would authorize the State Health Director to issue temporary orders requiring health care providers to report symptoms, diseases, conditions, trends in use of health care services, or other health-related information when necessary to conduct a public health investigation or surveillance of an illness, condition, or symptoms that may indicate the existence of a communicable disease or condition that presents a danger to the public health. The State Health Director currently has this authority with respect to illnesses caused by a terrorist incident.[2]

Section 6 would require physicians and persons in charge of medical facilities or laboratories to permit a local health director or the State Health Director to examine, review and obtain a copy of *any* record the State Health Director or a local health director determines pertain to (i) diagnosis, treatment, or prevention

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[1] **Treatment** is the provision, coordination, or management of health care and related services for an individual by one or more health care providers, including consultation between providers regarding a patient and referral of a patient by one provider to another. **Payment** encompasses activities of a health plan to obtain premiums, determine or fulfill responsibilities for coverage and provisions of benefits, and furnish or obtain reimbursement for health care delivered to an individual and activities of a health care provider to obtain payment or be reimbursed for the provision of health care to an individual. **Health care operations** are any of the following activities: (a) quality assessment and improvement activities, including case management and care coordination; (b) competency assurance activities, including provider or health plan performance evaluation, credentialing, and accreditation; (c) conducting or arranging for medical reviews, audits, or legal services, including fraud and abuse detection and compliance programs; (d) specified insurance functions, such as underwriting, risk rating, and reinsuring risk; (e) business planning, development, management, and administration; and (f) business management an general administrative activities of the entity, including de-identifying protected health information, creating a limited data set, and certain fundraising for the benefit of the covered entity.

[2] G.S. 130A-476(b).

of a communicable disease or communicable condition or (ii) the investigation or a known or reasonably suspected outbreak of a communicable disease or communicable condition.

Changes to Article 22 (the bioterrorism article)

Section 3 would make the same changes to this article described in the explanation to Section 2.

Section 7 would make the same changes to this article described in the explanation to Section 6.

Section 8 would make the act effective when it becomes law.

BACKGROUND INFORMATION CONCERNING SARS: According to the federal Centers for Disease Control and Prevention, SARS (severe acute respiratory syndrome) is a viral respiratory illness. The primary way that SARS appears to spread is by close person-to-person contact. Available information suggests that persons with SARS are most likely to be contagious only when they have symptoms, such as fever or cough. The incubation period for SARS is typically 2 to 7 days, although in some cases it may be as long as 10 days.

During November 2002 through July 2003, a total of 8,098 persons worldwide became sick with SARS. Of these, 774 died. In the United States during this outbreak, 8 persons were laboratory-confirmed as SARS cases, and there were no SARS-related deaths.

As of April 26, 2004, eight possible cases of SARS were reported in China.

S582-SMSW-002

AN ACT TO IMPROVE PUBLIC HEALTH PREPAREDNESS AND RESPONSE

Background

In 2002 the General Assembly approved legislation to improve NC's efforts to respond to bioterrorism and other public health threats. The legislation helped make NC one of the leading states in bioterrorism prevention and response. Among other provisions, the 2002 legislation provided the state Health Director and local public health officials with the authority to isolate or quarantine individuals for up to ten days in order to contain a public health emergency such as smallpox, SARS or other diseases. The legislation also provided individuals who are subject to an isolation or quarantine order with the right to appeal the order. If the isolation order is approved by the court, the legislation requires public health officials to return to court every thirty days to renew it.

Meeting the Challenge of SARS

Outbreaks of SARS in China and Canada – and here in North Carolina – have forced public health officials to rethink their strategies for containing this and other deadly diseases. More specifically, public health officials have learned from their counterparts in Canada that responding to a SARS outbreak can require officials to order the isolation and quarantine of thousands of people – and to monitor their health and physical location on a daily basis.

NC public health officials fear that a SARS outbreak or one similar to it would test the limits of the state's resources – and make it difficult if not impossible to go to court within ten days to justify the continued isolation or quarantine of each individual affected by the disease.

Simply put, state and local officials are concerned that, in a SARS-like emergency, current law will force them to spend countless hours in court when their resources will be greatly needed elsewhere to contain the disease.

The solution

To address this challenge, NC DHHS has offered a revision to the 2002 bill. This revision:

- Adopts the definition of "Isolation Authority" from the Model State Public Health Act and the Model State Emergency Health Powers Act, to include persons reasonably suspected of being infected with a communicable disease or condition.
- Extends the authority of the State and local health director for quarantine and isolation from 10 days to 30 days, while preserving the individual's right to be heard in Superior Court within 72 hours.
- In the case of a person with tuberculosis, the Superior Court is authorized to extend an isolation order limiting the freedom of movement for up to one year - now 30 days – to ensure that the patient is no longer communicable. North Carolina has approximately fifty

tuberculosis patients a year that require isolation and a course of treatment for up to one year. The court order will automatically terminate once the patient is determined to be no longer communicable.

- Adds new procedural safeguards that require notice of appeal rights when invoking quarantine or isolation authority, and that authorize any person subject to a court-ordered quarantine or isolation to petition the court for early termination of the order if the public health is no longer endangered.

In addition, the bill makes other changes in the 2002 statutes to ensure that public health officials have appropriate access to health information necessary to protect the public:

- Revises language for consistency with HIPPA
- Gives the State Health Director authority to issue temporary orders for up to 90 days requiring health care providers to report information necessary for a communicable disease investigation.
- Clarifies other laws related to public health access to information for communicable disease or bioterrorism investigation.

2003 COMMITTEE REPORT
HOUSE OF REPRESENTATIVES

The following report(s) from standing committee(s) is/are presented:
By Representatives **Verla Insko and Carolyn Justus,** Chairs for the Committee on **HEALTH**.

☒ Committee Substitute for
S.B. 582 A BILL TO BE ENTITLED AN ACT TO ESTABLISH THE COMMISSION ON CHILDHOOD OBESITY

☐ 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 (# H.B.), ☐ 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)

3/06/03

FOR JOURNAL USE ONLY

____ Pursuant to Rule 36(b), the bill/resolution is placed on the Calendar of _____.

____ The (committee substitute) bill/resolution (, as amended,) is (ordered engrossed and) re-referred to the Committee on _____.

____ The bill/resolution is re-referred to the Committee on _____.

____ On motion of (Rep. _____,) (the Chair,) the (committee substitute) bill/resolution is (ordered engrossed and) re-referred to the Committee on _____.

____ Pursuant to Rule 36(b), the (House)committee substitute bill (No. ____)/resolution is placed on the Calendar of _____. (The original bill) (House Committee Substitute Bill No. ____)/resolution is placed on the Unfavorable Calendar.

____ On motion of Rep. _____, (the rules are suspended) (Rule ____ is suspended) and the bill/resolution is placed on today's calendar. (for immediate consideration.)

____ On motion of Rep. _____, Committee Amendment No.(s) _____ is/are adopted (by EV____ ____).

____ On motion of Rep. _____, Committee Amendment No.(s) _____ is/are adopted (by EV____ ____).

____ Rep. _____ offers Amendment No. _____ which (is adopted.) (fails of adoption.) (by EV ____ ____.) ( ) This amendment changes the title.

____ The bill/resolution (, as amended,) passes its second reading (by following vote, ____ ____ RC) (, by EV ____ ____,) and (remains on the Calendar,) (and there being no objection is read a third time).

____ The bill/resolution (, as amended,) passes its third reading (by the following vote, ____ ____ RC) (, by EV ____ ____,) and is ordered
____ sent to the Senate.
____ without engrossment. ____ by Special message.
____ sent to the Senate for concurrence in
_____ the House amendment (s).
_____the House committee substitute bill.
____ enrolled.

____ On motion of Rep. _____, the House concurs in the (material) Senate _____ (by the following vote, ____ ____ RC) (, by EV ____ ____,) and the bill is ordered enrolled.

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2003

HOUSE BILL 1469

Short Title:	DHHS Disease Mgmt Activities.	(Public)
Sponsors:	Representatives Nye, Barbee, Justus, Insko (Primary Sponsors); Glazier and Warner.	
Referred to:	Health.	

May 17, 2004

A BILL TO BE ENTITLED

AN ACT TO DIRECT THE DEPARTMENT OF HEALTH AND HUMAN SERVICES TO INITIATE OR CONTINUE CERTAIN DISEASE MANAGEMENT ACTIVITIES, AS RECOMMENDED BY THE HOUSE SELECT COMMITTEE ON THE RISING COST OF HEALTH CARE.

The General Assembly of North Carolina enacts:

SECTION 1. The Department of Health and Human Services shall take action to address the rising cost of health care provided under the State Medical Assistance Plan as follows:

(1) Adopt contractual agreements with providers of services that require and reward use of evidence-based practice standards and guidelines for Medicaid and NC Health Choice.

(2) The Division of Mental Health, Developmental Disabilities, and Substance Abuse Services shall:

a. Ensure collaboration between local management entities providing mental health services and Community Care of North Carolina providers that serve Medicaid enrollees diagnosed with depression, and

b. Require evidence-based practices for the treatment of psychotic illnesses.

(3) The Secretary of Health and Human Services shall consider developing a program of supplemental rebates for improvements to the State's Medicaid program.

(4) The Division of Medical Assistance shall consider the following as it develops plans to improve the quality, utilization, and cost-effectiveness of the State's Medicaid program:

a. New disease management initiatives that target such costly diseases or conditions as congestive heart failure, chronic lung

disease, chronic kidney disease, sickle cell disease, and low birth weight.

b. Collaborate with the Division of Public Health and other community organizations to improve the coordination and implementation of key initiatives to address obesity, premature birth, and smoking cessation.

c. Collaborate with local management entities that provide mental health services to develop local systems and processes that enhance the ability of primary care physicians to care for nontargeted mental illness and substance abuse clients.

d. Use case management processes to improve the utilization and access to such community-based services as ancillary and in-home support services.

e. Investigate the use of incentives or technology to promote the effective use of evidence-based guidelines by Program participants.

The Department shall report on the progress of these activities to the House of Representatives Appropriations Subcommittee on Health and Human Services and the Senate Appropriations Committee on Health and Human Services not later than March 1, 2005.

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

HOUSE BILL 1469:
DHHS Disease Mgmt Activities

BILL ANALYSIS

Committee:	House Health	**Introduced by:**	Reps. Nye, Barbee, Justus, Insko
Date:	June 1, 2004		
Version:	First Edition	**Summary by:**	Dianna Jessup Committee Counsel

SUMMARY: ***House Bill 1469 would require the Department of Health and Human Services to initiate or continue certain disease management activities in the State's Medicaid program and to consider other actions to contain health care costs. The bill is a recommendation of the House Select Committee on the Rising Cost of Health Care. The bill would become effective when it becomes law.***

CURRENT LAW: States are pursuing ways to contain escalating costs in their Medicaid programs. One cost containment strategy being undertaken by over half of the states is the implementation of disease management programs. Disease management (DM) programs are designed to improve health care outcomes and reduce costs by identifying patients with certain high cost chronic conditions, educating those patients on how to better manage their health, improving provider awareness and adherence to evidence-based care strategies, and establishing coordinated care interventions and follow-up systems to prevent unnecessary and more expensive health complications.

Community Care of North Carolina (formerly Carolina Access II and III) is the State's Medicaid program of community-based medical care management. The central philosophy of Community Care is to develop local networks of primary care providers to coordinate prevention, treatment, referral and institutional services for Medicaid beneficiaries. Current disease management initiatives being undertaken in Community Care include programs for asthma and diabetes. Pilot programs are being undertaken for depression, ADHD, special needs children, gastroenteritis, otitis media, and low birth weight.

Another strategy states are undertaking to control Medicaid costs is to implement supplemental rebates for prescription drugs. Federal law (OBRA '90) requires drug manufacturers to enter into national rebate agreements with the U.S. Department of Health and Human Services for states to receive federal funding for drugs dispensed to Medicaid patients. Supplemental rebates are additional rebates to a state's Medicaid program that are above and beyond those required by federal law. North Carolina does not have a supplemental rebate program, but the Secretary of Heath and Human Services could implement one.

Using evidence-based practices in medicine has also been recommended as a method to save health care costs. Using evidence-based practices involves applying the best available scientific evidence to make decisions about the care of individual patients.

BILL ANALYSIS: House Bill 1469 would require the Department of Health and Human Services to take the following actions:

- Adopt contractual agreements that require and reward evidence-based practice standards.
- Require the Division of Mental Health, Developmental Disabilities, and Substance Abuse Services to ensure collaboration between local providers and Community Care providers that service Medicaid enrollees diagnosed with depression and require evidence-based practices for the treatment of psychotic illnesses.
- Consider developing a program of supplemental rebates.

- Require the Division of Medical Assistance to consider new disease management initiatives, collaborate with the Division of Public Health and other community organizations to improve coordination and implementation of key initiatives to address obesity, premature birth, and smoking cessation, collaborate with local management entities to develop ways to care for nontargeted mental illness and substance abuse clients, use casement management processes to improve utilization and access to community-based services, and investigate the use of incentives or technology to promote the effective use of evidence-based guidelines in the Medicaid program.

The Department would be required to report on the progress of these activities to the House and Senate health and human services appropriations subcommittees no later than March 1, 2005.

BACKGROUND: The Cecil G. Sheps Center for Health Services Research at UNC-Chapel Hill undertook has studied the effects of the disease management efforts within Community Care. Findings from the Sheps Center show a CY2002 savings of $1,580,000 in the asthma program and a three year cost savings for diabetes care of approximately $2.1 million. The Sheps findings also indicate there could have been a potential savings of more than $11.3 million in 2003 had Community Care been implemented statewide for asthma and diabetes disease management.

H1469-SMSW-001

House Committee on Health

June 15, 2004

Minutes

The House Committee on Health met on Tuesday, June 15, 2004 at 12:00 noon in Room 544 of the Legislative Office Building. A silent roll was taken. A copy of the roll denoting members present is attached to the minutes (Attachment I) along with a copy of the agenda and Visitor Registration Sheet (Attachments II and III).

Rep. Carolyn Justus, Chair welcomed visitors and members and recognized the pages: Aaron Goodson from Cumberland County sponsored by Rep. McAllister, Kayla Hall from Stokes County sponsored by Rep. Baker, David Epps from Wake County sponsored by Speaker Morgan, Lauren Bollinger from Mecklenburg County sponsored by Speaker Black, Lauren Ross from Mecklenburg County sponsored by Speaker Black. Dusty Rhodes, Leslie Oakley and James Williams were recognized as the sergeant-in-arms. (Attachment IV)

Chair Justus recognizes Rep. Nye to explain his bill HB 1469 A BILL TO BE ENTITLED AN ACT TO DIRECT THE DEPARTMENT OF HEALTH AND HUMAN SERVICES TO INITIATE OR CONTINUE CERTAIN DISEASE MANAGEMENT ACTIVITIES, AS RECOMMENDED BY THE HOUSE SELECT COMMITTEE ON THE RISING COST OF HEALTH CARE. (Bill - Attachment V and Bill Analysis – Attachment VI) A proposed Committee Substitute is introduced and adopted for discussion purposes (Attachment VII) This bill requires the Department of Health and Human Services to initiate or continue certain disease management activities in the State's Medicaid program and to consider other actions to contain health care costs. The bill is a recommendation of the House Select Committee on the Rising Cost of Health Care. (New Bill Analysis – Attachment VIII)

Chair Justus recognizes Rep. Insko who makes a motion to give the proposed committee substitute for HB 1469 a favorable report; unfavorable as to the original bill. Motion is adopted. (Committee Report – Attachment IX)

Chair Justus then recognizes Reps. Linda Johnson and Jeff Barnhart to explain their bill HB 1509 A BILL TO BE ENTITLED AN ACT TO PROVIDE THAT CABARRUS MEMORIAL HOSPITAL MAY AWARD ADVANCED DEGREES TO GRADUATES OF ITS NURSING AND ALLIED HEALTH SCIENCES PROGRAMS AS APPROPRIATE. (Bill - Attachment X and Bill Analysis – Attachment XI) Rep. Barnhart explains that this bill allows the Executive Committee of Cabarrus Memorial Hospital to award advance degrees to graduates of the nursing education or allied health sciences programs. The bill also allows an exemption from the provisions relating to the licensure of nonpublic post-secondary educational institutions in G.S. 116-15. Rep. Barnhart states that this program is great, has been teaching nursing since 1942 and wants to add advance degrees.

Chair Justus recognizes Rep. Bernard Allen. Rep. Allen makes motion for a favorable report.

Chair Justus then recognizes Rep. McAllister. Rep. McAllister asks if program is accredited. Rep. Johnson responses yes.

Chair Justus calls upon Rep. Insko who asks if there are any plans for advanced degrees at a master level. Rep. Barnhart indicates no.

Chair Justus then calls upon Rep. Sherrill who asks if there is any opposition to bill. Rep. Barnhart advises no.

Chair Justus upon motion by Representative Bernard Allen to give HB1509 a favorable report calls upon committee for a vote. Motion is adopted.

Chair Justus adjourns meeting at 12:13 p.m.

Carolyn Justus, Chair

Pamela J. Evans, Committee Clerk

ATTENDANCE

HOUSE COMMITTEE ON HEALTH

DATES															
INSKO, Verla	CHAIR	✓													
JUSTUS, Carolyn	CHAIR	✓													
ENGLAND, Bob	VICE-CHAIR	✓													
ADAMS, Alma															
ALLEN, Bernard		✓													
ALLEN, Gordon		✓													
ALLRED, Cary															
BARNHART, Jeff		✓													
BOWIE, Joni															
CLARY, Debbie															
EARLE, Beverly		✓													
GLAZIER, Rick															
HILTON, Mark		✓													
McALLISTER, Mary		✓													
MUNFORD, Don		✓													
SETZER, Mitchell															
SHERRILL, Wilma		✓													
WAINWRIGHT, William															
WILSON, Connie															
WRIGHT, Tom		✓													
Ex officio Members															
Brubaker, Bru															
Culpepper, Bill															
Cunningham, Pete															
Eddins, Rick															

Attachment II

AGENDA

HOUSE COMMITTEE ON HEALTH

June 15, 2004
Room 544 LOB
12:00 Noon

OPENING REMARKS

Representative Verla Insko, Chair
Representative Carolyn Justus, Chair

AGENDA ITEMS

HB 1469	**DHHS Disease Mgmt Activities – Reps. Nye, Barbee, Justus and Insko**
HB 1509	**Cabarrus Memorial Hospital Advanced Degrees – Reps. Barnhart and L. Johnson**

ADJOURNMENT

VISITOR REGISTRATION SHEET

HOUSE COMMITTEE ON HEALTH — JUNE 15, 2003

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
[illegible]	NCMS
Andy Allen	NCRMA
John Cyrus	NC Grange
Jennifer Kinser	Nurse of the Day
Jon Carr	Jordan Price
Matt Sheffield	BIPI
Stacia McKinney	NC DHHS
Jamie Beasley	LDA
Glenn Wells	HCR Inc
Michael Carr	NCBIO
TOMMY SUTER	WYETH

VISITOR REGISTRATION SHEET

HOUSE COMMITTEE ON HEALTH — JUNE 15, 2003

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Karen Gillespie	BMS
	JD, AL, P.A.
Sharri	SMART START
John McMillan	MFAS
Sam Taylor	NCBIO
Dana Simpson	Smith Anderson
DAVID BARNES	Poyner + Spruill LLP
	NCICU
	FAJ
George Irving	JAJ
John Goodwin	Blue Cross NC

VISITOR REGISTRATION SHEET

HOUSE COMMITTEE ON HEALTH — JUNE 15, 2003

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Evelyn Hawthorne	DHGR
Andy Romanet	NCLM
M. Suits	GSK
H TILSON	NCHA
S FLANNERY	NCHFA
Trisha Hardin	Policy Office of Governor
Abby Emanuelson	Nat'l MS Society
Anita L Brown	Cabarrus College
Tom Carroll	Cabarrus College
Ruth Nunez	Novartis Pharm
Steve Mitchell	Novartis
Roger Bone	Assoc

VISITOR REGISTRATION SHEET

HOUSE COMMITTEE ON HEALTH — JUNE 15, 2003

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
[signature]	[illegible]
[signature]	NC [illegible]

HEALTH 6/15/04

Attachment IV

House Pages

1. Name: Aaron Goodson
   County: Cumberland
   Sponsor: Rep. McAllister
2. Name: Kayla Hall
   County: Stokes
   Sponsor: Rep Baker
3. Name: David Epps
   County: Wake
   Sponsor: Morgan
4. Name: Lauren Bollinger
   County: Mecklenburg
   Sponsor: Black
5. Name: Lauren Ross
   County: Mecklenburg
   Sponsor: Speaker Black

Sgt-At-Arms

1. Name: Dusty Rhodes
2. Name: Leslie Bailey
3. Name: James Williams
4. Name:

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2003

HOUSE BILL 1469

Short Title:	DHHS Disease Mgmt Activities.	(Public)
Sponsors:	Representatives Nye, Barbee, Justus, Insko (Primary Sponsors); Glazier and Warner.	
Referred to:	Health.	

May 17, 2004

A BILL TO BE ENTITLED

AN ACT TO DIRECT THE DEPARTMENT OF HEALTH AND HUMAN SERVICES TO INITIATE OR CONTINUE CERTAIN DISEASE MANAGEMENT ACTIVITIES, AS RECOMMENDED BY THE HOUSE SELECT COMMITTEE ON THE RISING COST OF HEALTH CARE.

The General Assembly of North Carolina enacts:

SECTION 1. The Department of Health and Human Services shall take action to address the rising cost of health care provided under the State Medical Assistance Plan as follows:

(1) Adopt contractual agreements with providers of services that require and reward use of evidence-based practice standards and guidelines for Medicaid and NC Health Choice.

(2) The Division of Mental Health, Developmental Disabilities, and Substance Abuse Services shall:

a. Ensure collaboration between local management entities providing mental health services and Community Care of North Carolina providers that serve Medicaid enrollees diagnosed with depression, and

b. Require evidence-based practices for the treatment of psychotic illnesses.

(3) The Secretary of Health and Human Services shall consider developing a program of supplemental rebates for improvements to the State's Medicaid program.

(4) The Division of Medical Assistance shall consider the following as it develops plans to improve the quality, utilization, and cost-effectiveness of the State's Medicaid program:

a. New disease management initiatives that target such costly diseases or conditions as congestive heart failure, chronic lung

disease, chronic kidney disease, sickle cell disease, and low birth weight.

b. Collaborate with the Division of Public Health and other community organizations to improve the coordination and implementation of key initiatives to address obesity, premature birth, and smoking cessation.

c. Collaborate with local management entities that provide mental health services to develop local systems and processes that enhance the ability of primary care physicians to care for nontargeted mental illness and substance abuse clients.

d. Use case management processes to improve the utilization and access to such community-based services as ancillary and in-home support services.

e. Investigate the use of incentives or technology to promote the effective use of evidence-based guidelines by Program participants.

The Department shall report on the progress of these activities to the House of Representatives Appropriations Subcommittee on Health and Human Services and the Senate Appropriations Committee on Health and Human Services not later than March 1, 2005.

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

Attachment VI

HOUSE BILL 1469:
DHHS Disease Mgmt Activities

BILL ANALYSIS

Committee:	House Health	**Introduced by:**	Reps. Nye, Barbee, Justus, Insko
Date:	June 1, 2004		
Version:	First Edition	**Summary by:**	Dianna Jessup Committee Counsel

SUMMARY: House Bill 1469 would require the Department of Health and Human Services to initiate or continue certain disease management activities in the State's Medicaid program and to consider other actions to contain health care costs. The bill is a recommendation of the House Select Committee on the Rising Cost of Health Care. The bill would become effective when it becomes law.

CURRENT LAW: States are pursuing ways to contain escalating costs in their Medicaid programs. One cost containment strategy being undertaken by over half of the states is the implementation of disease management programs. Disease management (DM) programs are designed to improve health care outcomes and reduce costs by identifying patients with certain high cost chronic conditions, educating those patients on how to better manage their health, improving provider awareness and adherence to evidence-based care strategies, and establishing coordinated care interventions and follow-up systems to prevent unnecessary and more expensive health complications.

Community Care of North Carolina (formerly Carolina Access II and III) is the State's Medicaid program of community-based medical care management. The central philosophy of Community Care is to develop local networks of primary care providers to coordinate prevention, treatment, referral and institutional services for Medicaid beneficiaries. Current disease management initiatives being undertaken in Community Care include programs for asthma and diabetes. Pilot programs are being undertaken for depression, ADHD, special needs children, gastroenteritis, otitis media, and low birth weight.

Another strategy states are undertaking to control Medicaid costs is to implement supplemental rebates for prescription drugs. Federal law (OBRA '90) requires drug manufacturers to enter into national rebate agreements with the U.S. Department of Health and Human Services for states to receive federal funding for drugs dispensed to Medicaid patients. Supplemental rebates are additional rebates to a state's Medicaid program that are above and beyond those required by federal law. North Carolina does not have a supplemental rebate program, but the Secretary of Heath and Human Services could implement one.

Using evidence-based practices in medicine has also been recommended as a method to save health care costs. Using evidence-based practices involves applying the best available scientific evidence to make decisions about the care of individual patients.

BILL ANALYSIS: House Bill 1469 would require the Department of Health and Human Services to take the following actions:

- Adopt contractual agreements that require and reward evidence-based practice standards.
- Require the Division of Mental Health, Developmental Disabilities, and Substance Abuse Services to ensure collaboration between local providers and Community Care providers that service Medicaid enrollees diagnosed with depression and require evidence-based practices for the treatment of psychotic illnesses.
- Consider developing a program of supplemental rebates.

- Require the Division of Medical Assistance to consider new disease management initiatives, collaborate with the Division of Public Health and other community organizations to improve coordination and implementation of key initiatives to address obesity, premature birth, and smoking cessation, collaborate with local management entities to develop ways to care for nontargeted mental illness and substance abuse clients, use casement management processes to improve utilization and access to community-based services, and investigate the use of incentives or technology to promote the effective use of evidence-based guidelines in the Medicaid program.

The Department would be required to report on the progress of these activities to the House and Senate health and human services appropriations subcommittees no later than March 1, 2005.

BACKGROUND: The Cecil G. Sheps Center for Health Services Research at UNC-Chapel Hill undertook has studied the effects of the disease management efforts within Community Care. Findings from the Sheps Center show a CY2002 savings of $1,580,000 in the asthma program and a three year cost savings for diabetes care of approximately $2.1 million. The Sheps findings also indicate there could have been a potential savings of more than $11.3 million in 2003 had Community Care been implemented statewide for asthma and diabetes disease management.

H1469-SMSW-001

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2003

H D

HOUSE BILL 1469
PROPOSED COMMITTEE SUBSTITUTE H1469-CSSP-18 [v.1]

6/15/2004 11:17:07 AM

Short Title: DHHS Disease Mgmt Activities. (Public)

Sponsors:

Referred to:

May 17, 2004

A BILL TO BE ENTITLED

AN ACT TO DIRECT THE DEPARTMENT OF HEALTH AND HUMAN SERVICES TO INITIATE OR CONTINUE CERTAIN DISEASE MANAGEMENT ACTIVITIES, AS RECOMMENDED BY THE HOUSE SELECT COMMITTEE ON THE RISING COST OF HEALTH CARE.

The General Assembly of North Carolina enacts:

SECTION 1. The Department of Health and Human Services shall take action to address the rising cost of health care provided under the State Medical Assistance Plan as follows:

(1) Adopt contractual agreements with providers of services that require and reward use of evidence-based practice standards and guidelines for Medicaid and NC Health Choice.

(2) The Division of Mental Health, Developmental Disabilities, and Substance Abuse Services shall:

a. Ensure collaboration between local management entities providing mental health services and Community Care of North Carolina providers that serve Medicaid enrollees diagnosed with depression, and

b. Require evidence-based practices for the treatment of psychotic illnesses.

(3) The Division of Medical Assistance shall consider the following as it develops plans to improve the quality, utilization, and cost-effectiveness of the State's Medicaid program:

a. New disease management initiatives that target such costly diseases or conditions as congestive heart failure, chronic lung disease, chronic kidney disease, sickle cell disease, and low birth weight.

b. Collaborate with the Division of Public Health and other community organizations to improve the coordination and implementation of key initiatives to address obesity, premature birth, and smoking cessation.

c. Collaborate with local management entities that provide mental health services to develop local systems and processes that enhance the ability of primary care physicians to care for nontargeted mental illness and substance abuse clients.

d. Use case management processes to improve the utilization and access to such community-based services as ancillary and in-home support services.

e. Investigate the use of incentives or technology to promote the effective use of evidence-based guidelines by Program participants.

The Department shall report on the progress of these activities to the House of Representatives Appropriations Subcommittee on Health and Human Services and the Senate Appropriations Committee on Health and Human Services not later than March 1, 2005.

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

HOUSE BILL 1469:
DHHS Disease Mgmt Activities

Attachment VIII

BILL ANALYSIS

Committee:	House Health	**Introduced by:**	Reps. Nye, Barbee, Justus, Insko
Date:	June 15, 2004		
Version:	H1469-CSSP-18 [v.1]	**Summary by:**	Sandra Alley Committee Counsel

SUMMARY: ***House Bill 1469 would require the Department of Health and Human Services to initiate or continue certain disease management activities in the State's Medicaid program and to consider other actions to contain health care costs. The bill is a recommendation of the House Select Committee on the Rising Cost of Health Care. The bill would become effective when it becomes law.***

CURRENT LAW: States are pursuing ways to contain escalating costs in their Medicaid programs. One cost containment strategy being undertaken by over half of the states is the implementation of disease management programs. Disease management (DM) programs are designed to improve health care outcomes and reduce costs by identifying patients with certain high cost chronic conditions, educating those patients on how to better manage their health, improving provider awareness and adherence to evidence-based care strategies, and establishing coordinated care interventions and follow-up systems to prevent unnecessary and more expensive health complications.

Community Care of North Carolina (formerly Carolina Access II and III) is the State's Medicaid program of community-based medical care management. The central philosophy of Community Care is to develop local networks of primary care providers to coordinate prevention, treatment, referral and institutional services for Medicaid beneficiaries. Current disease management initiatives being undertaken in Community Care include programs for asthma and diabetes. Pilot programs are being undertaken for depression, ADHD, special needs children, gastroenteritis, otitis media, and low birth weight.

Another strategy states are undertaking to control Medicaid costs is to implement supplemental rebates for prescription drugs. Federal law (OBRA '90) requires drug manufacturers to enter into national rebate agreements with the U.S. Department of Health and Human Services for states to receive federal funding for drugs dispensed to Medicaid patients. Supplemental rebates are additional rebates to a state's Medicaid program that are above and beyond those required by federal law. North Carolina does not have a supplemental rebate program, but the Secretary of Heath and Human Services could implement one.

Using evidence-based practices in medicine has also been recommended as a method to save health care costs. Using evidence-based practices involves applying the best available scientific evidence to make decisions about the care of individual patients.

BILL ANALYSIS: House Bill 1469 would require the Department of Health and Human Services to take the following actions:

- Adopt contractual agreements that require and reward evidence-based practice standards.
- Require the Division of Mental Health, Developmental Disabilities, and Substance Abuse Services to ensure collaboration between local providers and Community Care providers that service Medicaid enrollees diagnosed with depression and require evidence-based practices for the treatment of psychotic illnesses.

- Require the Division of Medical Assistance to consider new disease management initiatives, collaborate with the Division of Public Health and other community organizations to improve coordination and implementation of key initiatives to address obesity, premature birth, and smoking cessation, collaborate with local management entities to develop ways to care for nontargeted mental illness and substance abuse clients, use casement management processes to improve utilization and access to community-based services, and investigate the use of incentives or technology to promote the effective use of evidence-based guidelines in the Medicaid program.

The Department would be required to report on the progress of these activities to the House and Senate health and human services appropriations subcommittees no later than March 1, 2005.

BACKGROUND: The Cecil G. Sheps Center for Health Services Research at UNC-Chapel Hill undertook has studied the effects of the disease management efforts within Community Care. Findings from the Sheps Center show a CY2002 savings of $1,580,000 in the asthma program and a three year cost savings for diabetes care of approximately $2.1 million. The Sheps findings also indicate there could have been a potential savings of more than $11.3 million in 2003 had Community Care been implemented statewide for asthma and diabetes disease management.

Dianna Jessup, Staff Attorney, contributed significantly to this summary.

H1469-CSSP-18[v.1]-SMSP-001

Attachment IX

2003OMMITTEE REPORT
HOUSE OF REPRESENTATIVES

The following report(s) from standing committee(s) is/are presented:
By Representatives **Verla Insko and Carolyn Justus,** Chairs for the Committee on **HEALTH**.

☐ Committee Substitute for
H.B. 1469 A BILL TO BE ENTITLED AN ACT TO DIRECT THE DEPARTMENT OF HEALTH AND HUMAN SERVICES TO INITIATE OR CONTINUE CERTAIN DISEASE MANAGEMENT ACTIVITIES, AS RECOMMENDED BY THE HOUSE SELECT COMMITTEE ON THE RISING COST OF HEALTH CARE.

☐ 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 (~~# H.B.), ☐ 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 and recommended that the bill 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)

3/06/03

FOR JOURNAL USE ONLY

____ Pursuant to Rule 36(b), the bill/resolution is placed on the Calendar of _____.

____ The (committee substitute) bill/resolution (, as amended,) is (ordered engrossed and) re-referred to the Committee on _____.

____ The bill/resolution is re-referred to the Committee on _____.

____ On motion of (Rep. _____,) (the Chair,) the (committee substitute) bill/resolution is (ordered engrossed and) re-referred to the Committee on _____.

____ Pursuant to Rule 36(b), the (House)committee substitute bill (No. ____)/resolution is placed on the Calendar of _____. (The original bill) (House Committee Substitute Bill No. ____)/resolution is placed on the Unfavorable Calendar.

____ On motion of Rep. _____, (the rules are suspended) (Rule ____ is suspended) and the bill/resolution is placed on today's calendar. (for immediate consideration.)

____ On motion of Rep. _____, Committee Amendment No.(s) _____ is/are adopted (by EV____ ____).

____ On motion of Rep. _____, Committee Amendment No.(s) _____ is/are adopted (by EV____ ____).

____ Rep. _____ offers Amendment No. _____ which (is adopted.) (fails of adoption.) (by EV ____ ____.) ( ) This amendment changes the title.

____ The bill/resolution (, as amended,) passes its second reading (by following vote, ____ ____ RC) (, by EV ____ ____,) and (remains on the Calendar,) (and there being no objection is read a third time).

____ The bill/resolution (, as amended,) passes its third reading (by the following vote, ____ ____ RC) (, by EV ____ ____,) and is ordered
____ sent to the Senate.
____ without engrossment. ____ by Special message.
____ sent to the Senate for concurrence in
_____ the House amendment (s).
_____the House committee substitute bill.
____ enrolled.

____ On motion of Rep. _____, the House concurs in the (material) Senate _____ (by the following vote, ____ ____ RC) (, by EV ____ ____,) and the bill is ordered enrolled.

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2003

HOUSE BILL 1509*

Short Title:	Cabarrus Memorial Hospital Advanced Degrees.	(Local)
Sponsors:	Representatives Barnhart, L. Johnson (Primary Sponsors); and Steen.	
Referred to:	Health.	

May 19, 2004

A BILL TO BE ENTITLED

AN ACT TO PROVIDE THAT CABARRUS MEMORIAL HOSPITAL MAY AWARD ADVANCED DEGREES TO GRADUATES OF ITS NURSING AND ALLIED HEALTH SCIENCES PROGRAMS AS APPROPRIATE.

The General Assembly of North Carolina enacts:

SECTION 1. Section 11 of Chapter 307, Public-Local Laws of 1935, as amended by Chapter 947 of the 1987 Session Laws and by S.L. 1998-204, reads as rewritten:

"Sec. 11. Notwithstanding G.S. 116-15, the Executive Committee of Cabarrus Memorial Hospital may establish and maintain in connection with and as a part of the hospital an educational program for nursing and allied health sciences. The Executive Committee may award an ~~Associate Degree or~~ Associate, ~~Baccalaureate Degree~~ Baccalaureate, and advanced degrees to graduates of the nursing education or allied health sciences programs as appropriate."

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

HOUSE BILL 1509:
Cabarrus Memorial Hospital Advanced Degrees.

BILL ANALYSIS

Committee:	House Health	**Introduced by:**	Reps. Barnhart and L. Johnson
Date:	June 8, 2004	**Summary by:**	Sara Kamprath
Version:	First Edition		Committee Analyst

SUMMARY: ***House Bill 1509 amends the charter of Cabarrus Memorial Hospital to allow for the awarding of advanced degrees to the graduates of the nursing and allied health sciences program. The bill is effective when it becomes law.***

BILL ANALYSIS: House Bill 1509 would allow the Executive Committee of Cabarrus Memorial Hospital to award advanced degrees to graduates of the nursing education or allied health sciences programs. Currently, only Associate Degrees and Baccalaureate Degrees are awarded. The bill would also allow an exemption from the provisions relating to the licensure of nonpublic post-secondary educational institutions in G.S. 116-15.

BACKGROUND: In February 1973, the North Carolina Board of Nursing approved the first two-year hospital based diploma program in the State at Cabarrus Memorial Hospital. The first class of nursing students was admitted in June 1974 and graduated in June 1976. In 1988, the General Assembly granted the Executive Committee of Cabarrus Memorial Hospital (Executive Committee) the authority to award an "Associate Degree to graduates of the nursing" program. In 1998, the General Assembly granted the Executive Committee the authority to award a "Baccalaureate Degree to graduates of the nursing program or allied health sciences programs as appropriate".

The 1998 legislation also included an exemption from the provisions of G.S. 116-15 relating to the State policy that the UNC Board of Governors shall license certain nonpublic institutions conducting post-secondary degree activity in the State. State licensure fulfills a consumer protection function by protecting the public, including potential students and employers. G.S. 116-15 outlines the minimum standards that an institution must meet in order to be licensed.

In 2000, the Commission on Colleges of the Southern Association of Colleges and Schools reaffirmed the accreditation of the Cabarrus College of Health Sciences. The College is accredited at Level II meaning that a Baccalaureate Degree is the highest degree that can be awarded.

The College offers the following academic programs:

- Associate in Science Degree
- Associate of Science Degree Nursing
- Bachelor of Science in Health Services Management
- Bachelor of Science in Nursing Degree (BSN)
- Medical Assistant
- Occupational Therapy Assistant
- Surgical Technology

H1509-SMRJ-001

Attachment XII

2004 COMMITTEE REPORT
HOUSE OF REPRESENTATIVES

The following report(s) from standing committee(s) is/are presented:
By Representatives **Verla Insko and Carolyn Justus,** Chairs for the Committee on **HEALTH**.

☐ Committee Substitute for
H.B. 1509 A BILL TO BE ENTITLED AN ACT TO PROVIDE THAT CABARRUS MEMORIAL HOSPITAL MAY AWARD ADVANCED DEGREES TO GRADUATES OF ITS NURSING AND ALLIED HEALTH SCIENCES PROGRAMS AS APPROPRIATE.

☒ 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 (# H.B.), ☐ 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)

3/06/03

FOR JOURNAL USE ONLY

____ Pursuant to Rule 36(b), the bill/resolution is placed on the Calendar of _____.

____ The (committee substitute) bill/resolution (, as amended,) is (ordered engrossed and) re-referred to the Committee on _____.

____ The bill/resolution is re-referred to the Committee on _____.

____ On motion of (Rep. _____,) (the Chair,) the (committee substitute) bill/resolution is (ordered engrossed and) re-referred to the Committee on _____.

____ Pursuant to Rule 36(b), the (House)committee substitute bill (No. ____)/resolution is placed on the Calendar of _____. (The original bill) (House Committee Substitute Bill No. ____)/resolution is placed on the Unfavorable Calendar.

____ On motion of Rep. _____, (the rules are suspended) (Rule ____ is suspended) and the bill/resolution is placed on today's calendar. (for immediate consideration.)

____ On motion of Rep. _____, Committee Amendment No.(s) _____ is/are adopted (by EV____ ____).

____ On motion of Rep. _____, Committee Amendment No.(s) _____ is/are adopted (by EV____ ____).

____ Rep. _____ offers Amendment No. _____ which (is adopted.) (fails of adoption.) (by EV ____ ____.) ( ) This amendment changes the title.

____ The bill/resolution (, as amended,) passes its second reading (by following vote, ____ ____ RC) (, by EV ____ ____,) and (remains on the Calendar,) (and there being no objection is read a third time).

____ The bill/resolution (, as amended,) passes its third reading (by the following vote, ____ ____ RC) (, by EV ____ ____,) and is ordered
____ sent to the Senate.
____ without engrossment. ____ by Special message.
____ sent to the Senate for concurrence in
_____ the House amendment (s).
_____the House committee substitute bill.
____ enrolled.

____ On motion of Rep. _____, the House concurs in the (material) Senate _____ (by the following vote, ____ ____ RC) (, by EV ____ ____,) and the bill is ordered enrolled.

House Committee on Health

July 15, 2004

Minutes

The House Committee on Health met on Thursday, July 15, 2004 at 12:00 noon in Room 544 of the Legislative Office Building. A silent roll was taken. A copy of the roll denoting members present is attached to the minutes (Attachment I) along with a copy of the agenda and Visitor Registration Sheet (Attachments II and III). A copy of the house pages and sergeant-in-arms is attached. (Attachment IV)

Rep. Verla Insko, Chair recognizes Senator Forrester to explain his bill S657 A BILL TO BE ENTITLED AN ACT IMPOSING RESTRICTIONS ON THE USE AND OPERATION OF TANNING FACILITIES AND EQUIPMENT. (Bill - Attachment V, and Handout – Attachment VI) Sen. Forrester indicates that there is a proposed committee substitute for this bill. (Attachment VII) Representative Glazier moves to adopt the proposed committee substitute for discussion purposes. Motion is adopted.

Sen. Forrester explains that the American Academy of Dermatologist recommends this bill. (Bill Analysis – Attachment VIII) On an average day in the US, more than one million people visit indoor tanning salons for the purpose of tanning the skin. Most indoor tanning salons provide a significant amount of UVA and UVB radiation, both types of which are found in the outdoor sun and can cause various types of damage to skin that may lead to skin cancer. Repeated exposure may also cause premature aging. Sen. Forrester states that he is running this bill to protect the health of the public. Sen. Forrester calls upon staff to explain changes in bill.

Dianna Jessup, staff, explains the proposed committee substitute changes the language as it relates to the use of tanning equipment by minors. The second edition prohibits the use of tanning equipment by persons under 18 without a written consent of the person's parent, prohibits the use of tanning equipment by persons under 13 without written authorization of the person's physician and unless the person's parent are present during tanning, and requires the presence of a parent during tanning for 13, 14, and 15 year olds. Under the language in the proposed committee substitute, persons 13 years or younger would not be able to use tanning equipment without a written prescription from the person's medical specifying the nature of the medical condition requiring the treatment, the number of visits, and the time of exposure for each visit.

Chair Insko recognizes Rep. Joni Bowie. Rep. Bowie tells the committee about her experience using a tanning bed and states that usually the managers are young people.

Chair Insko then recognizes Rep. Rick Glazier who asks if a consent form is used now. Sen. Forrester replies yes. Current law requires an operator to provide and request a user to read and sign a warning statement before allowing a person to use the tanning

equipment for the first time. He then tells about tanning beds in little "mom and pop" stores in his district. Rep. Forrester indicates that legitimate operators should have no problem with this bill. The bill is designed to help keep young people out of tanning beds as a safety precaution.

Rep. Bowie is recognized by Chair Insko and asks if a person age 13 and under will need a doctor's prescription before using a tanning bed. Sen. Forrester replies yes. Rep. Bowie then asks what input has there been from the medical society. Amy Jo Horne of the NC Medical Society is recognized and indicates Society's support for bill.

Rufus Edmisten is then recognized by Chair Insko and states that the tanning salon industry is opposed to the wording "longer than recommended". When people come to a tanning salon, they want to see results. Mr. Edmisten introduces Chad Essick from his law firm. Mr. Essick states that in high school he was an operator of a tanning bed and that operators attend an all day training session on the use of tanning beds. He also indicates that people don't want to pay $7.50 to $8 to use the machine for only 3 minutes a visit until they reach the manufacturer's suggestions for a base tan. People using tanning beds want to see results.

William Johnson from the Radiation Protection Division at the Department of Environment and Natural Resources is recognized to speak. Mr. Johnson indicates the Radiation Protection Commission is a statutorily-created commission within DENR charged with adopting rules providing for a program to regulate and inspect sources of nonionizing radiation, which includes tanning equipment. Current rules require tanning facilities to register with the Department and renew their registration annually. They also address the posting of warning signs, equipment requirements, the wearing of protective eyewear, what records must be maintained, registration of persons who service tanning equipments and fees for registration. He explains to the committee that there is a label on each tanning bed displaying the different skin types and the recommended minutes to use the equipment. Once a base tan is established then the minutes can be increased. All tanning equipment is required to have remote timers and the time should not exceed the manufacturer's maximum recommended exposure time for a person's specific skin type. Also operators of tanning equipment must be trained and certified.

A discussion then ensues between Rep. Glazier, Rep. Bowie, Chad Essick and William Johnson as to who is responsible for setting the timer and the number of times necessary for a person to go to tanning bed before establishing a base tan.

Chair Insko advises committee that if approved the bill should be re-referred to Rules since it will likely cause lengthy debate on the floor.

Rep. Bowie is then recognized and makes motion to give the proposed house committee substitute a favorable report, unfavorable as to the senate committee substitute and recommends that the committee substitute bill be re-referred to the committee on Rules, Calendar and Operations of the House. Motion is adopted. (Committee Report – Attachment IX)

Meeting adjourns at 12:38 p.m.

Representative Verla Insko, Chair

Pamela J. Evans, Committee Clerk

ATTENDANCE

HOUSE COMMITTEE ON HEALTH

DATES	2/11/04														
INSKO, Verla CHAIR	✓														
JUSTUS, Carolyn CHAIR	✓														
ENGLAND, Bob VICE-CHAIR	✓														
ADAMS, Alma															
ALLEN, Bernard															
ALLEN, Gordon	✓														
ALLRED, Cary															
BARNHART, Jeff															
BOWIE, Joni	✓														
CLARY, Debbie															
EARLE, Beverly															
GLAZIER, Rick	✓														
HILTON, Mark	✓														
McALLISTER, Mary															
MUNFORD, Don															
SETZER, Mitchell	✓														
SHERRILL, Wilma															
WAINWRIGHT, William															
WILSON, Connie	✓														
WRIGHT, Tom															
Ex officio Members															
Brubaker, Bru															
Culpepper, Bill															
Cunningham, Pete															
Eddins, Rick															

AGENDA

HOUSE COMMITTEE ON HEALTH

July 15, 2004
Room 544 LOB
10:00 a.m.

OPENING REMARKS

Representative Verla Insko, Chair
Representative Carolyn Justus, Chair

AGENDA ITEMS

SB 657 Tanning Salons/Restrictions on Use – Senator James Forrester

ADJOURNMENT

Attachment III

VISITOR REGISTRATION SHEET

Health — 7-15-04

Name of Committee — Date

VISITORS: PLEASE SIGN BELOW AND RETURN TO COMMITTEE ASSISTANT

NAME	FIRM OR AGENCY
Joshua Boardleish	AstraZeneca
Paige Johnson	Planned Parenthood of Central NC
[illegible]	[illegible]
William Johnson	NC Registration & Protection Section
Chad Essick	Edmisten & Webb
Cedric Payne	Edmisten & Webb
Sara Benjamin	INC-CH
Ben Mount	NCGA Intern Rep. Insko
Michael Houser	NCAE
Johanna Reese	DENR
Hal Miller	NC ACCT
[illegible]	DENR
Steve Johnson	Novartis
[illegible]	Gov Off
David Barnes	Poyner & Spruill
Paul Pulley	NCATTL
[illegible]	HHS
Rufus L. Edmisten	Edmisten Webb

2/15/07

Attachment IV

House Pages

1. Name: Katlyn Brahmer
   County: Jackon
   Sponsor: Haire

Joseph Winslow III
Pasquotank
Rep. Bill Owens

2. Name: Kimberly White
   County: Buncombe
   Sponsor: Goforth

3. Name: Chris Snyder
   County: Mecklenburg
   Sponsor: Martha Alexander

4. Name: Johnny Brown
   County: Guilford
   Sponsor:

5. Name: John Flynt
   County: Guilford
   Sponsor: Blust

Sgt-At-Arms

1. Name: PAUL CURRY
2. Name: JAMES WILLIAMS
3. Name: LESLIE OAKLEY
4. Name: CHARLES WILLIAMS

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2003

S 2

SENATE BILL 657

Health & Human Resources Committee Substitute Adopted 4/10/03

Short Title: Tanning Salons/Restrictions on Use. (Public)

Sponsors:

Referred to:

April 1, 2003

A BILL TO BE ENTITLED

AN ACT IMPOSING RESTRICTIONS ON THE USE AND OPERATION OF TANNING FACILITIES AND EQUIPMENT.

Whereas, on an average day in the United States, more than one million people visit indoor tanning salons for the purpose of tanning the skin; and

Whereas, studies have found that indoor tanning may be just as harmful to the skin as outdoor sun exposure; and

Whereas, most indoor tanning salon bulbs provide a significant amount of UVA and UVB radiation, both types of which are found in the outdoor sun and cause various types of damage to the skin that may lead to skin cancer; and

Whereas, past studies have suggested that tanning beds contribute to the incidence of melanoma, and a recent study in the Journal of the National Cancer Institute indicates that the use of tanning devices may also contribute to the incidence of nonmelanoma skin cancers; and

Whereas, dermatologists across the country are alarmed with the number of teenagers and young adults who continue to patronize tanning salons regardless of studies reporting the link between sun exposure and a wide array of skin cancers; and

Whereas, the Centers for Disease Control and Prevention reports an estimated 700 emergency department visits per year related to tanning salon exposure; Now, therefore,

The General Assembly of North Carolina enacts:

SECTION 1. Chapter 104E of the General Statutes is amended by adding the following new section to read:

"**§ 104E-9.1. Restrictions on use and operation of tanning equipment.**

(a) Operators of tanning equipment and owners of tanning facilities subject to rules adopted pursuant to this Chapter shall comply with or ensure compliance with the following:

(1) The operator shall provide to each consumer a warning statement that defines the potential hazards and consequences of exposure to

ultraviolet radiation. Before allowing the consumer's initial use of the tanning equipment, the operator shall obtain the signature of the consumer on the warning statement acknowledging receipt of the warning.

(2) The operator shall not allow a person younger than the age of 18 years to use tanning equipment unless the person gives the operator a written informed consent statement signed and dated by the person's parent or legal guardian and sworn before a notary public stating that the parent or legal guardian has read and understands the warnings given by the tanning facility, consents to the minor's use of the tanning equipment, and agrees that the minor shall use protective eyewear.

(3) The operator shall not allow a person younger than the age of 13 years to use tanning equipment unless:

a. The tanning facility receives written permission from the person's physician allowing the person to use the tanning equipment, and

b. The person's parent or legal guardian remains at the tanning facility while the person uses the tanning equipment.

(4) The operator shall not allow a person 13, 14, or 15 years of age to use tanning equipment unless the person's parent or legal guardian remains at the tanning facility while the person uses the tanning equipment.

(5) Neither an operator nor an owner shall claim or distribute promotional materials that claim that using tanning equipment is safe or free from risk or that using tanning equipment will result in medical or health benefits.

(6) The operator shall not allow a person to use tanning equipment longer than the recommended exposure time provided by the manufacturer of the tanning equipment as shown on the label of the tanning equipment.

(b) The Commission may adopt and the Department shall enforce rules to implement this section. The requirements of this section are in addition to other rules adopted pursuant to this Chapter that are applicable to tanning facilities and do not conflict with this section.

(c) As used in this section, unless the context requires otherwise, the term:

(1) 'Consumer' means any individual who is provided access to a tanning facility that is subject to registration and regulation under this Chapter.

(2) 'Tanning facility' means any location, place, area, structure, or business that provides consumers access to tanning equipment. For the purpose of this definition, tanning equipment registered to different persons at the same location and tanning equipment registered to the same person, but at separate locations, shall constitute separate tanning facilities.

(3) 'Tanning equipment' means ultraviolet or other lamps and equipment containing such lamps intended to induce skin tanning through the

irradiation of any part of the living human body with ultraviolet radiation."

SECTION 2. This act becomes effective October 1, 2003.

Attachment VI

Representative Verla C. Insko
NORTH CAROLINA HOUSE OF REPRESENTATIVES
56TH DISTRICT
2121 Legislative Building
Raleigh, NC 27601-1096
(919) 733-7208
(919) 754-3185 Fax
E-Mail: verlai@ncleg.net
Home Address
610 Surry Road
Chapel Hill, NC 27514
(919) 929-6115
(919) 929-6119 Fax

BASAL CELL
SQUAMOUS CELL
ACTINIC KERATOSIS
CHILDREN
KIDS' PAGE
OLDER ADULTS
HOME
SUN SAFETY
FAQ
PREVENTION
TANNING BEDS
SUNLESS TANNING
OUTDOOR WORKERS
SEAL OF RECOMMENDATION
CORPORATE COUNCIL
INTERNATIONAL OUTREACH
RESEARCH GRANTS
GIVING OPPORTUNITIES
DR. REX AND JOHNNIE AMONETTE CIRCLE
INNER CIRCLE
OFFICERS AND STAFF
OUR COUNCILS
PROFESSIONAL MEMBERSHIP

The Skin Cancer FOUNDATION

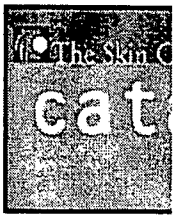
Strike Three Against Tanning Machines

If anyone thought the jury was still out on the danger of tanning machines, new research may provide the clincher. A study from Dartmouth Medical School in Lebanon, NH, links tanning device use to basal cell carcinoma (BCC) and squamous cell carcinoma (SCC), the most common forms of skin cancer.

The researchers interviewed 603 BCC and 293 SCC patients (plus 540 healthy subjects) about their sunbed and sunlamp use, history of sun exposure, sun sensitivity, sunburns, and other skin cancer risk factors. With all factors accounted for, tanning device users had 2.5 times the risk of SCC and 1.5 times the risk of BCC, compared to non-users.

"Our study strongly suggests that sunbed and sunlamp use may increase the incidence of nonmelanoma skin cancers," says lead author Margaret R. Karagas, PhD. "Further research is needed to determine an appropriate public health response."

Sun & Skin News readers know that we've frequently presented evidence of the harm caused by indoor tanning. Our last issue described recent research showing that people exposed to full-body tanning salon sessions have a significant increase in skin repair proteins typically associated with sun damage. ("Regulations Don't Make Tanning Salons Safe," Vol. 18, No. 4 2001). We also noted previous findings that women who frequent tanning parlors have a greater incidence of melanoma, the deadliest form of skin cancer.



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GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2003

S D

SENATE BILL 657

Health & Human Resources Committee Substitute Adopted 4/10/03
PROPOSED HOUSE COMMITTEE SUBSTITUTE S657-CSSW-85 [v.5]

7/15/2004 9:25:16 AM

Short Title: Tanning Salons/Restrictions on Use. (Public)

Sponsors:

Referred to:

April 1, 2003

A BILL TO BE ENTITLED

AN ACT TO IMPOSE RESTRICTIONS ON THE USE AND OPERATION OF TANNING FACILITIES AND EQUIPMENT, INCLUDING NOT ALLOWING PERSONS 13 YEARS AND YOUNGER TO USE TANNING EQUIPMENT WITHOUT A WRITTEN PRESCRIPTION FROM THE PERSON'S MEDICAL PHYSICIAN SPECIFYING THE NATURE OF THE MEDICAL CONDITION REQUIRING THE TREATMENT, THE NUMBER OF VISITS, AND THE TIME OF EXPOSURE FOR EACH VISIT.

Whereas, on an average day in the United States, more than one million people visit indoor tanning salons for the purpose of tanning the skin; and

Whereas, studies have found that indoor tanning may be just as harmful to the skin as outdoor sun exposure; and

Whereas, most indoor tanning salon bulbs provide a significant amount of UVA and UVB radiation, both types of which are found in the outdoor sun and cause various types of damage to the skin that may lead to skin cancer; and

Whereas, past studies have suggested that tanning beds contribute to the incidence of melanoma, and a recent study in the Journal of the National Cancer Institute indicates that the use of tanning devices may also contribute to the incidence of nonmelanoma skin cancers; and

Whereas, dermatologists across the country are alarmed with the number of teenagers and young adults who continue to patronize tanning salons regardless of studies reporting the link between sun exposure and a wide array of skin cancers; and

Whereas, the Centers for Disease Control and Prevention reports an estimated 700 emergency department visits per year related to tanning salon exposure; Now, therefore,

The General Assembly of North Carolina enacts:

SECTION 1. Chapter 104E of the General Statutes is amended by adding the following new section to read:

"**§ 104E-9.1. Restrictions on use and operation of tanning equipment.**

(a) Operators of tanning equipment and owners of tanning facilities subject to rules adopted pursuant to this Chapter shall comply with or ensure compliance with the following:

(1) The operator shall provide to each consumer a warning statement that defines the potential hazards and consequences of exposure to ultraviolet radiation. Before allowing the consumer's initial use of the tanning equipment, the operator shall obtain the signature of the consumer on the warning statement acknowledging receipt of the warning.

(2) The operator shall not allow a person 13 years and younger to use tanning equipment without a written prescription from the person's medical physician specifying the nature of the medical condition requiring the treatment, the number of visits, and the time of exposure for each visit.

(3) Neither an operator nor an owner shall claim or distribute promotional materials that claim that using tanning equipment is safe or free from risk or that using tanning equipment will result in medical or health benefits.

(4) The operator shall not allow a person to use tanning equipment longer than the recommended exposure time provided by the manufacturer of the tanning equipment as shown on the label of the tanning equipment.

(b) The Commission may adopt and the Department shall enforce rules to implement this section. The requirements of this section are in addition to other rules adopted pursuant to this Chapter that are applicable to tanning facilities and do not conflict with this section.

(c) As used in this section, unless the context requires otherwise, the term:

(1) 'Consumer' means any individual who is provided access to a tanning facility that is subject to registration and regulation under this Chapter.

(2) 'Tanning facility' means any location, place, area, structure, or business that provides consumers access to tanning equipment. For the purpose of this definition, tanning equipment registered to different persons at the same location and tanning equipment registered to the same person, but at separate locations, shall constitute separate tanning facilities.

(3) 'Tanning equipment' means ultraviolet or other lamps and equipment containing such lamps intended to induce skin tanning through the irradiation of any part of the living human body with ultraviolet radiation."

SECTION 2. This act becomes effective October 1, 2004.

Attachment III

SENATE BILL 657: Tanning Salons/Restrictions on Use

BILL ANALYSIS

Committee:	House Health	**Introduced by:**	Sen. Forrester
Date:	July 14, 2004	**Summary by:**	Dianna Jessup
Version:	PCS S657-CSSW-85		Committee Counsel

SUMMARY: ***Senate Bill 657 would require operators of tanning equipment to provide warning statements to consumers warning of the consequences of exposure to radiation, impose restrictions on the use of tanning equipment by persons younger than 16, prohibit operators in tanning facilities from claiming that tanning equipment is safe, and prohibit operators from allowing persons to use tanning equipment longer than the recommended exposure time by the manufacturer of the equipment. Violations could result in administrative penalties. The act would become effective October 1, 2004.***

The PCS changes the language as it relates to the use of tanning equipment by minors. The second edition prohibited the use of tanning equipment by persons under 18 without the written consent of the person's parent, prohibited the use of tanning equipment by persons under 13 without written authorization of the person's physician and unless the person's parent was present during tanning, and required the presence of a parent during tanning for 13, 14, and 15 year olds. Under the language in the PCS, persons 13 years and younger would not be able to use tanning equipment without a written prescription from the person's medical physician specifying the nature of the medical condition requiring the treatment, the number of visits, and the time of exposure for each visit.

CURRENT LAW: The Radiation Protection Commission is a statutorily-created commission within the Department of Environment and Natural Resources (Department) charged with adopting rules providing for a program to regulate and inspect sources of nonionizing radiation, which includes tanning equipment. Current rules require tanning facilities to register with the Department and renew their registration annually and also address the posting of warning signs, equipment requirements, the wearing of protective eyewear, what records must be maintained, registration of persons who service tanning equipment, and fees for registration. Operators of tanning equipment must be trained and certified.

Specific to this bill, the rules require operators to provide consumers the opportunity to read a copy of the warning concerning exposure to radiation and to request that the consumer sign the statement, prohibit registrants from allowing a person under age 18 to use tanning equipment unless the person provides a consent form signed by that person's parent, and require remote timers on tanning equipment with a maximum timer interval that does not exceed the manufacturer's maximum recommended exposure time.

The Department may impose an administrative penalty on any person who fails to comply with the rules. Each day of a continuing violation constitutes a separate violation. An administrative penalty may not exceed $10,000 per day. Penalties may be contested.

BILL ANALYSIS: In addition to the rules prescribed for tanning facilities, operators must comply with the following:

- Provide a warning statement to the consumer and obtain the consumer's signature acknowledging receipt of the statement before allowing the consumer to use the tanning equipment for the first time. Current rules require operators to provide the consumer the "opportunity" to read the warning and to "request" the consumer to sign the statement.

- Operators could not allow persons to use tanning equipment longer than the recommended exposure time provided by the manufacturer of the tanning equipment as shown on the label of the equipment. Current rules require timers with a maximum timer interval that does not exceed the manufacturer's maximum recommended exposure time.
- Operators would be prohibited from claiming or distributing promotional materials that claim that using tanning equipment is safe or free from risk or that using tanning equipment will result in medical or health benefits. Current rules do not address this issue.
- Operators could only allow persons 13 years and younger to use tanning equipment if the person has a written prescription specifying the nature of the medical condition requiring the treatment, the number of visits, and the time of exposure for each visit.

The current rule that requires parental consent for persons under 18 would still remain in effect.

The Commission would be permitted to adopt rules to implement the requirements described above. The Department, as in other matters relating to tanning equipment, would enforce the rules.

Finally, the bill defines the terms "consumer", "tanning facility", and "tanning equipment". These definitions are consistent with the definitions for these terms currently in the rules.

S657-SMSW-002

2003 COMMITTEE REPORT
HOUSE OF REPRESENTATIVES

The following report(s) from standing committee(s) is/are presented:
By Representatives **Verla Insko and Carolyn Justus,** Chairs for the Committee on **HEALTH**.

☒ Committee Substitute for
S.B. 657 A BILL TO BE ENTITLED AN ACT IMPOSING RESTRICTIONS ON THE USE AND OPERATION OF TANNING FACILITIES AND EQUIPMENT.

☐ 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 and recommendation that the committee substitute bill be re-referred to the Committee on RULES, CALENDAR AND OPERATIONS OF THE HOUSE.

☐ 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)

3/06/03

FOR JOURNAL USE ONLY

____ Pursuant to Rule 36(b), the bill/resolution is placed on the Calendar of _____.

____ The (committee substitute) bill/resolution (, as amended,) is (ordered engrossed and) re-referred to the Committee on _____.

____ The bill/resolution is re-referred to the Committee on _____.

____ On motion of (Rep. _____,) (the Chair,) the (committee substitute) bill/resolution is (ordered engrossed and) re-referred to the Committee on _____.

____ Pursuant to Rule 36(b), the (House)committee substitute bill (No. ____)/resolution is placed on the Calendar of _____. (The original bill) (House Committee Substitute Bill No. ____)/resolution is placed on the Unfavorable Calendar.

____ On motion of Rep. _____, (the rules are suspended) (Rule ____ is suspended) and the bill/resolution is placed on today's calendar. (for immediate consideration.)

____ On motion of Rep. _____, Committee Amendment No.(s) _____ is/are adopted (by EV____ ____).

____ On motion of Rep. _____, Committee Amendment No.(s) _____ is/are adopted (by EV____ ____).

____ Rep. _____ offers Amendment No. _____ which (is adopted.) (fails of adoption.) (by EV ____ ____.) ( ) This amendment changes the title.

____ The bill/resolution (, as amended,) passes its second reading (by following vote, ____ ____ RC) (, by EV ____ ____,) and (remains on the Calendar,) (and there being no objection is read a third time).

____ The bill/resolution (, as amended,) passes its third reading (by the following vote, ____ ____ RC) (, by EV ____ ____,) and is ordered
____ sent to the Senate.
____ without engrossment. ____ by Special message.
____ sent to the Senate for concurrence in
_____ the House amendment (s).
_____the House committee substitute bill.
____ enrolled.

____ On motion of Rep. _____, the House concurs in the (material) Senate _____ (by the following vote, ____ ____ RC) (, by EV ____ ____,) and the bill is ordered enrolled.