2015-2016

HOUSE
HEALTH

MINUTES

HOUSE COMMITTEE ON HEALTH

MEMBER		ASSISTANT	PHONE	OFFICE	SEAT
BROWN, Brian	Chairman	Theresa Lopez	733-5757	604	90
BURR, Justin	Chairman	Dina Long	733-5908	307A	16
JONES, Bert	Chairman	Brenda Olls	733-5779	416A	54
LAMBETH, Donny	Chairman	Pan Briles	733-5747	303	77
AVILA, Marilyn	Vice-Chair	Susan Lewis	733-5530	2217	50
BRISSON, William	Vice Chair	Caroline Stirling	733-5772	405	23
DOLLAR, Nelson	Vice-Chair	Candace Slate	715-0795	307B	4
EARLE, Beverly	Vice -Chair	Ann Raeford	715-2530	514	60
FARMER-BUTTERFIELD, Jean	Vice Chair	Tijuana Locus	733-5898	1220	45
ADCOCK, Gale		Seth Morris	733-5602	1211	119
BISHOP, Dan		David Larson	715-3009	607	86
BRAWLEY, Bill		Lynn Taylor	733-5800	534	31
BLACKWELL, Hugh		Dixie Riehm	733-5805	541	102
BROWN, Rayne		Andrew Bailey	715-0873	633	61
CARNEY, Becky		Beth LeGrande	733-5827	1221	12
COTHAM, Tricia		Carol Erichsen	715-0706	402	33
DOBSON, Josh		Julie Ryan	733-5862	301N	114
FORD, Carl		Anna Helms	733-5881	608	76
GOODMAN, Ken		Judy Veorse	733-5823	542	47
[illegible]AGER, Mike		Baxter Knight	733-5749	301F	30
[illegible]ALL, Larry		Theresa Wright-Brown	733-5872	506	69
HASTINGS, Kelly		James Jenkins	715-2002	1206	20
INSKO, Verla		Gina Insko	733-7208	502	72
LEWIS, David		Grace Rogers	715-3015	2301	6
LUCAS, Marvin		Thelma Utley	733-5775	509	22
MARTIN, Susan		R. Lynn Taylor	715-3023	306C	43
PENDLETON, Gary		Kathy Peters	733-5860	610	97
SAINE, Jason		Laura Puryear	733-5782	1326	26
SETZER, Mitchell		Margaret Herring	733-4948	2204	7
SZOKA, John		Beverly Slagle	733-9892	2223	73
WADDELL, Ken		Sherry Jordan	733-5821	403	80
WRAY, Michael		Susan Burleson	733-5662	503	24
YARBOROUGH, Larry		Leslie Murray	715-0850	1301	101

RESEARCH STAFF		
MATULA, Theresa	733-2578	545
BARHAM, Susan	733-2578	545
FOSTER, Tawanda	733-2578	545
HARRIS, Kristen	733-2578	545
MUNDT, Jennifer	733-2578	545
	733-2578	545

COMMITTEE CLERKS

LONG, Dina	733-5908	307A
LOPEZ, Theresa	733-5757	604
OLLS, Brenda	733-5779	416A

NORTH CAROLINA GENERAL ASSEMBLY

HEALTH
2015-2016 SESSION

Rep. Brian Brown
Co- chair

Rep. Justin Burr
Co-Chair

Rep. Bert Jones
Co-Chair

Rep. Donny Lambeth
Co-Chair

Rep. Marilyn Avila
Vice-Chair

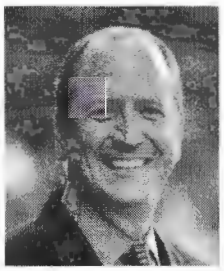
Rep. William Brisson
Vice-Chair

Rep. Nelson Dollar
Vice-Chair

Rep. Beverly Earle
Vice-Chair

Rep. Jean Farmer-Butterfield
Vice-Chair

Rep. Gale Adcock



Rep. Dan Bishop

Rep. Hugh Blackwell

Rep. Bill Brawley

Rep. Rayne Brown

Rep. Becky Carney

Rep. Tricia Cotham

Rep. Josh Dobson

Rep. Carl Ford

Rep. Ken Goodman

NORTH CAROLINA GENERAL ASSEMBLY

HEALTH
2015-2016 SESSION

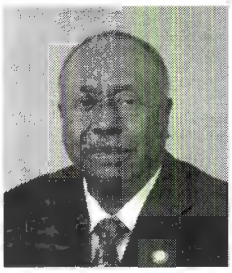
Rep. Mike Hager

Rep. Larry Hall

Rep. Kelly Hastings

Rep. Verla Insko

Rep. David Lewis


Rep. Marvin Lucas

Rep. Susan Martin

Rep. Gary Pendleton

Rep. Jason Saine

Rep. Mitchell Setzer

Rep. John Szoka

Rep. Ken Waddell

Rep. Michael Wray

Rep. Larry Yarborough

ATTENDANCE

COMMITTEE on HEALTH

2015-2016 SESSION

DATES	03/04/2015	03/11/2015	03/18/2015	03/25/2015	04/01/2015	04/15/2015	04/16/2015	04/20/2015	04/22/2015	04/23/2015	04/27/2015	04/29/2015	05/27/2015	06/03/2015	06/10/2015
BROWN, Brian CHAIR	X	X	X		X	X	X	X	X	X	X	X	X	X	
BURR, Justin CHAIR									X		X				X
JONES, Bert CHAIR	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
LAMBETH, Donny CHAIR	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
AVILA, Marilyn VICE-CHAIR	X		X	X	X	X	X	X	X	X	X	X	X	X	X
BRISSON, William VICE-CHAIR	X			X				X							X
DOLLAR, Nelson VICE-CHAIR			X	X	X	X	X	X	X	X	X	X	X	X	X
EARLE, Beverly VICE-CHAIR	X		X	X	X	X			X	X				X	X
FARMER-BUTTERFIELD, Jean VICE-CHAIR	X		X		X	X	X	X	X	X	X	X	X	X	X
ADCOCK, Gale (04/08/2015)					X	X	X	X	X	X	X	X	X	X	X
BISHOP, Dan	X			X	X		X	X	X		X		X	X	X
BRAWLEY, Bill (04/20/2015)								X	X			X	X	X	X
BLACKWELL, Hugh	X	X		X							X		X	X	X
BROWN, Rayne	X		X	X	X	X		X	X		X	X	X	X	
CARNEY, Becky	X	X	X	X	X	X		X	X		X	X	X		X
COTHAM, Tricia	X	X			X	X		X	X		X	X			X
DOBSON, Josh	X	X		X		X		X	X	X		X	X	X	X
FORD, Carl	X	X	X	X	X	X		X	X		X	X	X	X	X
GOODMAN, Ken	X	X	X	X	X	X		X	X	X	X	X	X		X
HAGER, Mike (04/20/2015)									X		X				X
HALL, Larry				X	X		X	X	X						X
HASTINGS, Kelly	X		X		X		X	X	X		X	X	X		X
INSKO, Verla	X		X	X	X	X		X	X		X	X	X	X	X
LEWIS, David								X							
LUCAS, Marvin	X	X	X	X	X	X		X	X	X	X			X	X

ATTENDANCE

COMMITTEE on HEALTH

2015-2016 SESSION

DATES	06/24/2015														
BROWN, Brian CHAIR	X														
BURR, Justin CHAIR															
JONES, Bert CHAIR	X														
LAMBETH, Donny CHAIR	X														
AVILA, Marilyn VICE-CHAIR	X														
BRISSON, William VICE-CHAIR	X														
DOLLAR, Nelson VICE-CHAIR															
EARLE, Beverly VICE-CHAIR															
FARMER-BUTTERFIELD, Jean VICE-CHAIR	X														
ADCOCK, Gale (04/08/2015)	X														
BISHOP, Dan															
BRAWLEY, Bill (04/20/2015)	X														
BLACKWELL, Hugh	X														
BROWN, Rayne	X														
CARNEY, Becky															
COTHAM, Tricia	X														
DOBSON, Josh															
FORD, Carl	X														
GOODMAN, Ken	X														
HAGER, Mike (04/20/2015)															
HALL, Larry															
HASTINGS, Kelly	X														
INSKO, Verla	X														
LEWIS, David															
LUCAS, Marvin	X														

ATTENDANCE

COMMITTEE on HEALTH

2015-2016 Session

DATES	03/04/2015	03/11/2015	03/18/2015	03/25/2015	04/01/2015	04/15/2015	04/16/2015	04/20/2015	04/22/2015	04/23/2015	04/27/2015	04/29/2015	05/27/2015	06/03/2015	06/10/2015
MARTIN, Susan	X	X	X	X	X	X	X	X	X	X	X		X	X	X
PENDLETON, Gary	X	X	X	X	X	X		X	X		X	X	X	X	X
SAINE, Jason					X				X						X
SETZER, Mitchell					X				X					X	X
SZOKA, John		X	X		X	X		X	X		X	X	X		
WADDELL, Ken		X		X	X	X		X	X	X	X	X			X
WRAY, Michael		X		X	X	X		X	X		X	X	X	X	X
YARBOROUGH, Larry	X	X	X	X	X	X		X	X		X	X	X	X	X
Research Staff															
JOHNSON, Amy Jo (04/30/2015)	X	X	X	X	X	X	X	X	X	X	X	X			
BARHAM, Susan	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
FOSTER, Tawanda (03/11/2015)		X	X	X	X	X	X	X	X	X	X	X	X	X	X
HARRIS, Kristen	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
MATULA, Theresa	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
MUNDT, Jennifer (05/19/2015)											X	X	X	X	X
Committee Clerks															
LONG, Dina	X	X	X	X											
LOPEZ, Theresa	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
OLLS, Brenda	X	X	X	X	X	X	X		X	X	X	X	X	X	X

ATTENDANCE

COMMITTEE on HEALTH

2015-2016 Session

DATES	06/24/2015														
MARTIN, Susan	X														
PENDLETON, Gary	X														
SAINE, Jason															
SETZER, Mitchell															
SZOKA, John															
WADDELL, Ken	X														
WRAY, Michael	X														
YARBOROUGH, Larry	X														
Research Staff															
JOHNSON, Amy Jo (04/30/2015)															
BARHAM, Susan	X														
FOSTER, Tawanda (03/11/2015)	X														
HARRIS, Kristen	X														
MATULA, Theresa	X														
MUNDT, Jennifer (05/19/2015)	X														
Committee Clerks															
LONG, Dina															
LOPEZ, Theresa	X														
OLLS, Brenda	X														

NORTH CAROLINA HOUSE OF REPRESENTATIVES
COMMITTEE MEETING NOTICE
AND
BILL SPONSOR NOTIFICATION
2015-2016 SESSION

You are hereby notified that the **House Committee on Health** will meet as follows:

DAY & DATE: Wednesday, March 4, 2015
TIME: **10:00 AM**
LOCATION: **643 LOB**

The following bills will be considered:

BILL NO.	SHORT TITLE	SPONSOR
HB 13	Amend School Health Assessment Requirement.	Representative Torbett

Respectfully,

Representative Brian Brown, Co-Chair
Representative Justin P. Burr, Co-Chair
Representative Bert Jones, Co-Chair
Representative Donny Lambeth, Co-Chair

I hereby certify this notice was filed by the committee assistant at the following offices at 2:09 PM on Tuesday, March 03, 2015.

___ Principal Clerk
___ Reading Clerk – House Chamber

Brenda Olls (Committee Assistant)

House Committee on Health
Wednesday, March 4, 2015, 10:00 AM
643 Legislative Office Building

AGENDA

Welcome and Opening Remarks

Introduction of Pages

Bills

BILL NO.	SHORT TITLE	SPONSOR
HB 13	Amend School Health Assessment Requirement.	Representative Torbett

Presentations

Other Business

Adjournment

House Committee on Health
Wednesday, March 4, 2015 at 10:00 AM
Room 643 of the Legislative Office Building

MINUTES

The House Committee on Health met at 10:00 AM on March 4, 2015 in Room 643 of the Legislative Office Building. Representatives Avila, Bishop, Blackwell, Brisson, B. Brown, R. Brown, Carney, Cotham, Dobson, Earle, Farmer-Butterfield, Ford, Goodman, Hastings, Insko, Jones, Lambeth, Lucas, S. Martin, Pendleton, and Yarborough attended.

Representative Bert Jones, Chair, presided. He recognized the other Chairs, as well as the Pages and Sergeant-at-Arms Staff.

The following bill was considered:

HB 13 Amend School Health Assessment Requirement. (Representative Torbett)

Representative Torbett presented the bill and several committee members asked questions. Staff said that immunization records were not included in the bill. Representative Avilla made a motion for a favorable report with referral to Education K-12. All in favor, the motion passed.

The meeting adjourned at 10:15.

Representative Bert Jones, Chair
Presiding

Brenda Olls, Committee Clerk

HOUSE BILL 13:
Amend School Health Assessment Requirement

2015-2016 General Assembly

Committee:	House Health, if favorable, Education - K-12	**Date:**	February 25, 2015
Introduced by:	Rep. Torbett	**Prepared by:**	Amy Jo Johnson
Analysis of:	First Edition		Committee Counsel

SUMMARY: House bill 13 would require submission of a form indicating the completion of a recent health assessment prior to the first admission of a child into public schools. House bill 13 would also require the health assessment to be permanently maintained as part of the child's official school record.

CURRENT LAW: Health assessments for children in the public schools are regulated under Article 18 of Chapter 130A of the General Statutes. Currently, no child is able to enter kindergarten in the North Carolina public schools without the completion of a heath assessment. The health assessment must be made not more than 12 months prior to entry. The required health assessment includes a medical history and physical examination with a screening for vision and hearing, as well as testing for anemia and tuberculosis. It may also include dental screening and development screening. The health assessment results must be submitted to the school principal on forms developed by the Department of Health and Human Services and the Department of Instruction.

BILL ANALYSIS: House Bill 13 would amend G.S.130A-440 by requiring a health assessment for students before entering into kindergarten *or a higher grade in public school.* The requirement is limited to the student's initial entry into the public schools.

Section1 of the bill also makes clarifying changes that specify that a parent, guardian, or person in loco parentis is responsible for submitting the health assessment to the school principal on or before the student's first day of attendance. The health assessment must be made not more than 12 months prior entry. **Section 1** also requires the health assessment form be permanently maintained in the student's official school record.

Section 2 of the bill makes a conforming change to G.S. 115C-402(b) by adding the health assessment to the items required to be maintained in an official school record.

EFFECTIVE DATE: The bill is effective when it comes law and applies to children entering in the public schools for the first time beginning with the 2015-2016 school year.

HOUSE BILL 13

Short Title:	Amend School Health Assessment Requirement.	(Public)
Sponsors:	Representative Torbett (Primary Sponsor). *For a complete list of Sponsors, refer to the North Carolina General Assembly Web Site.*	
Referred to:	Health, if favorable, Education - K-12.	

January 29, 2015

A BILL TO BE ENTITLED

AN ACT REQUIRING EACH CHILD PRESENTED FOR ADMISSION INTO THE PUBLIC SCHOOLS FOR THE FIRST TIME TO SUBMIT PROOF OF A RECENT HEALTH ASSESSMENT AND REQUIRING THE HEALTH ASSESSMENT TRANSMITTAL FORM TO BE PERMANENTLY MAINTAINED IN THE CHILD'S OFFICIAL SCHOOL RECORD.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 130A-440 reads as rewritten:

"**§ 130A-440. Health assessment required.**

(a) Every parent, guardian, or person in loco parentis shall submit proof of a health assessment for each child in this State ~~entering kindergarten in~~ who is presented for admission into kindergarten or a higher grade in the public schools ~~shall receive a health assessment.~~ for the first time. The health assessment shall be made no more than 12 months prior to the date of ~~school entry.~~ initial entry into the public schools. No child ~~shall attend kindergarten~~ is eligible for initial entry into kindergarten or a higher grade in the public schools unless a health assessment transmittal form, developed pursuant to G.S. 130A-441, indicating that the child has received the health assessment required by this section, is presented to the school principal. The medical provider, or the parent, guardian, or person in loco parentis, must present a completed health assessment transmittal form to the principal of the school on or before the child's first day of attendance. If a health assessment transmittal form is not presented on or before the child's first ~~day,~~day of attendance, the principal shall present a notice of deficiency to the parent, guardian, or responsible person. The parent, guardian, or responsible person shall have 30 calendar days from the first day of attendance to present the required health assessment transmittal form for the child. Upon termination of 30 calendar days, the principal shall not permit the child to attend the school until the required health assessment transmittal form has been presented. The health assessment transmittal form shall be permanently maintained in the child's official school record.

(b) A health assessment shall include a medical history and physical examination with screening for vision and hearing and, if appropriate, testing for anemia and tuberculosis. Vision screening shall be conducted in accordance with G.S. 130A-440.1. The health assessment may also include dental screening and developmental screening for cognition, language, and motor function. The developmental screening of cognition and language abilities may be conducted in accordance with G.S. 115C-83.5(a).

(c) The health assessment shall be conducted by a physician licensed to practice medicine, a physician's assistant as defined in G.S. 90-18.1(a), a certified nurse practitioner, or

a public health nurse meeting the Department's Standards for Early Periodic Screening, Diagnosis, and Treatment Screening.

(d) This Article shall not apply to children entering ~~kindergarten in~~ private church schools, schools of religious charter, or qualified nonpublic schools, regulated by Article 39 of Chapter 115C of the General Statutes."

SECTION 2. G.S. 115C-402(b) reads as rewritten:

"(b) The official record shall contain, ~~as~~ at a minimum, adequate identification data including date of birth, attendance data, grading and promotion ~~data,~~ data; a health assessment transmittal form as required by G.S. 130A-440; and such other factual information as may be deemed appropriate by the local board of education having jurisdiction over the school wherein the record is maintained. Each student's official record also shall include notice of any long-term suspension or expulsion imposed pursuant to G.S. 115C-390.7 through G.S. 115C-390.11 and the conduct for which the student was suspended or expelled. The superintendent or the superintendent's designee shall expunge from the record the notice of suspension or expulsion if the following criteria are met:

(1) One of the following persons makes a request for expungement:
   a. The student's parent, legal guardian, or custodian.
   b. The student, if the student is at least 16 years old or is emancipated.

(2) The student either graduates from high school or is not expelled or suspended again during the two-year period commencing on the date of the student's return to school after the expulsion or suspension.

(3) The superintendent or the superintendent's designee determines that the maintenance of the record is no longer needed to maintain safe and orderly schools.

(4) The superintendent or the superintendent's designee determines that the maintenance of the record is no longer needed to adequately serve the child."

SECTION 3. This act is effective when it becomes law and applies to children enrolling in the public schools for the first time beginning with the 2015-2016 school year.

NORTH CAROLINA GENERAL ASSEMBLY
HOUSE OF REPRESENTATIVES

HEALTH COMMITTEE REPORT

Representative Brian Brown, Co-Chair
Representative Justin P. Burr, Co-Chair
Representative Bert Jones, Co-Chair
Representative Donny Lambeth, Co-Chair

FAVORABLE AND RE-REFERRED

HB **13** Amend School Health Assessment Requirement.

Draft Number:	None
Serial Referral:	**EDUCATION - K-12**
Recommended Referral:	None
Long Title Amended:	No
Floor Manager:	Torbett

TOTAL REPORTED: 1

Committee Sergeants at Arms

NAME OF COMMITTEE House Comm. on Health

DATE: 03/04/15 Room: 643

House Sgt-At Arms:

1. Name: Young Bae
2. Name: Bill Morris
3. Name: Jim Moran
4. Name: _____
5. Name: _____

Senate Sgt-At Arms:

1. Name: _____
2. Name: _____
3. Name: _____
4. Name: _____
5. Name: _____

Wednesday, March 4 HEALTH	Room 643	Time 10:00 am

Name	County	Sponsor
Lauren Trivette	Bladen	William D. Brisson
Drew West	Buncombe	Michele D. Presnell

VISITOR REGISTRATION SHEET

House Comm. on Health — 03/04/15

Name of Committee — Date

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
[signature]	NP
Lexi Morgan	NCRMA
[signature]	NC DHHS - DMH
Amanda Horaker	Troutman Sanders
[signature]	NCMS
Jennifer Caspelini	NCMS
Joanna Spruill	NCATP
Evelyn Hawkins	ETHOR
Adam Pridemore	NCASA
Erica Nelson	NCHA
Christine Chung	WakeMed

VISITOR REGISTRATION SHEET

House Comm. on Health — Name of Committee

03/04/15 — Date

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Mike James	ACP
Katie McClintock	Duke Med

VISITOR REGISTRATION SHEET

House Comm. on Health — 03/04/15

Name of Committee — Date

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Leah Smith	NCSEG
Annalicse Dolph	Dolph Law
Jon Carr	NC Pediatric Society

VISITOR REGISTRATION SHEET

House Comm. on Health — 03/04/15

Name of Committee — Date

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Joe Maynard	G.P. Maynard & Assoc.
Douglas Holbrook Jr	NCSBA
Bruce Muldrow	NCSBA
Tom F	DST
Chuck Stone	SEANC
Andy Chase	KMA
Fred Bone	Bone Assoc.
Colleen Kochanek	NCCEP
Ciara Zabany	NC Justice
Tina Gordon	NC Nurses
ANDY WALSH	SA
Erma Stilwell	NC SBE
	BCI

Corrected #3: Time Change. Vote will be taken.

NORTH CAROLINA HOUSE OF REPRESENTATIVES
COMMITTEE MEETING NOTICE
AND
BILL SPONSOR NOTIFICATION
2015-2016 SESSION

You are hereby notified that the **House Committee on Health** will meet as follows:

DAY & DATE: Wednesday, March 11, 2015
TIME: **12:30 PM**
LOCATION: **643 LOB**
COMMENTS: **Chairman Brown will preside.**

The following bills will be considered:

BILL NO.	SHORT TITLE	SPONSOR
HB 158	Jim Fulghum Teen Skin Cancer Prevention Act.	Representative Lambeth Representative Dollar Representative Hurley Representative McElraft

Respectfully,

Representative Brian Brown, Co-Chair
Representative Justin P. Burr, Co-Chair
Representative Bert Jones, Co-Chair
Representative Donny Lambeth, Co-Chair

I hereby certify this notice was filed by the committee assistant at the following offices at 4:15 PM on Tuesday, March 10, 2015.

___ Principal Clerk
___ Reading Clerk – House Chamber

Brenda Olls (Committee Assistant)

House Committee on Health
Wednesday, March 11, 2015, 12:30 PM
643 Legislative Office Building

AGENDA

Welcome and Opening Remarks

Introduction of Pages

Bills

BILL NO.	SHORT TITLE	SPONSOR
HB 158	Jim Fulghum Teen Skin Cancer Prevention Act.	Representative Lambeth Representative Dollar Representative Hurley Representative McElraft

Presentations

Other Business

Adjournment

House Committee on Health
Wednesday, March 11, 2015 at 12:30 PM
Room 643 of the Legislative Office Building

MINUTES

The House Committee on Health met at 12:30 PM on March 11, 2015 in Room 643 of the Legislative Office Building. Representatives Blackwell, B. Brown, Carney, Cotham, Dobson, Ford, Goodman, Jones, Lambeth, Lucas, S. Martin, Szoka, Waddell, Wray, and Yarborough attended.

Representative Brian Brown, Chair, presided. He recognized the Pages and Sergeant-at-Arms.

The following bill was considered:

HB 158 Jim Fulghum Teen Skin Cancer Prevention Act. (Representatives Lambeth, Dollar, Hurley, McElraft)

Representative Lambeth presented the bill, after brief discussion Chairman Brown recognized Representative Carney who thanked Representative Lambeth and the other Bill Sponsors for bringing back the bill that Jim Fulghum was so passionate about and the naming of it was a true way to honor Jim Fulghum and that passion. Representative Carney moved for a favorable report to the bill and the motioned carried.

The meeting adjourned at 12:40.

Representative Brian Brown, Chair
Presiding

Theresa Lopez, Committee Clerk

HOUSE BILL 158*

Short Title:	Jim Fulghum Teen Skin Cancer Prevention Act.	(Public)
Sponsors:	Representatives Lambeth, Dollar, Hurley, and McElraft (Primary Sponsors). *For a complete list of Sponsors, refer to the North Carolina General Assembly Web Site.*	
Referred to:	Health.	

March 5, 2015

A BILL TO BE ENTITLED

AN ACT PROHIBITING PERSONS UNDER EIGHTEEN YEARS OF AGE FROM USING TANNING EQUIPMENT.

The General Assembly of North Carolina enacts:

SECTION 1. This act shall be known as the Jim Fulghum Teen Skin Cancer Prevention Act.

SECTION 2. G.S. 104E-9.1(a) reads as rewritten:

"(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~~under 18 years of age 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.~~equipment.

(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."

SECTION 3. This act becomes effective October 1, 2015.

HOUSE BILL 158:
Jim Fulghum Teen Skin Cancer Prevention Act

2013-2014 General Assembly

Committee:	House Health	**Date:**	March 11, 2015
Introduced by:	Reps. Lambeth, Dollar, Hurley, McElraft	**Prepared by:**	Amy Jo Johnson
Analysis of:	First Edition		Committee Counsel

SUMMARY: ***House Bill 18 would require operators of tanning equipment to prohibit any person less than 18 years old from using the equipment.***

[As introduced, this bill was identical to S125, as introduced by Sens. Tucker, Meredith, Curtis, which is currently in Rules and Operations of the Senate.]

CURRENT LAW: G.S. 104E-9.1(a)(2) prohibits operators of tanning equipment from allowing any person 13 years old or younger to use the equipment without a written prescription from their medical physician that specifies the nature of the medical condition requiring the treatment, the number of visits, and the amount of exposure time for each visit.

BILL ANALYSIS: House Bill 18 would amend G.S. 104E-9.1(a)(2) to require that operators of tanning equipment prohibit any person less than 18 years old from using the equipment.

EFFECTIVE DATE: This act becomes effective October 1, 2015.

O. Walker Reagan
Director

* H 1 5 8 - S M T K - 3 E 1 - V 2 *

Research Division
(919) 733-2578

NORTH CAROLINA GENERAL ASSEMBLY
HOUSE OF REPRESENTATIVES

HEALTH COMMITTEE REPORT
Representative Brian Brown, Co-Chair
Representative Justin P. Burr, Co-Chair
Representative Bert Jones, Co-Chair
Representative Donny Lambeth, Co-Chair

FAVORABLE

HB **158** Jim Fulghum Teen Skin Cancer Prevention Act.

Draft Number:	None
Serial Referral:	None
Recommended Referral:	None
Long Title Amended:	No
Floor Manager:	Lambeth

TOTAL REPORTED: 1

Committee Sergeants at Arms

NAME OF COMMITTEE House Comm. on Health

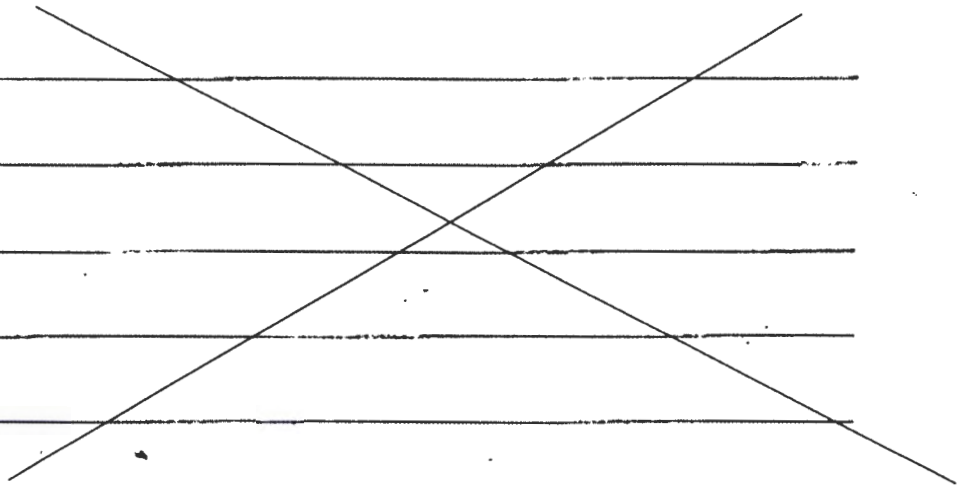
DATE: 03/11/15 Room: 643

House Sgt-At Arms:

1. Name: Young Bae
2. Name: Bill Morris
3. Name: Jim Moran
4. Name:
5. Name:

Senate Sgt-At Arms:

1. Name:
2. Name:
3. Name:
4. Name:
5. Name:



Wednesday, March 11 HEALTH	Room 643	Time 12:30 pm

Name	County	Sponsor
Abby Martin	Wilson	Susan Martin
Miles Hunt	Wake	Rosa U. Gill

VISITOR REGISTRATION SHEET

House Comm. on Health — 03/11/15

Name of Committee — Date

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Rachel Urban	American Cancer Society
Eric Heydorn	American Cancer Society CAN
Carrie Phillips	American Cancer Society
CARRIE KLAMUT	American Cancer Society Cancer Action Network
Kelly Hurley	American Cancer Society
Allyson Cathey	American Cancer Society
Erica Nelson	NCHA
JOANNE RUHLAND	WFBMC
ANDY WALSH	SMITH ANDERSON
Michelle Fisher	American Cancer Society
Angela Burns	American Cancer Society
Ashley Golden	ACS

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House Comm. on Health — 03/11/15

Name of Committee — Date

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Caitlin Dev	American Cancer Society CAN
Miranda Stewart	American Cancer Society CAN
Tracy Gentry	American Cancer Society CAN
Kay Castillo	NASW-NC
Kelsey A Kemp	
Michael Houser	THC6
Jon Charest	American Cancer Society CAN
Damon Neanover	ACSCAN
Pat N Cuni	ACS CAN
Frances Garrett	ACS Can
Rhonda Ferrell	ACS CAN

VISITOR REGISTRATION SHEET

House Comm. on Health — Name of Committee

03/11/15 — Date

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Alex Laws	Voyager Academy, ACS CAN
JoAnna Jones	Voyager Academy, ACS CAN
Russell J Kilpatrick MD	PRESIDENT, NC DERMATOLOGY ASSOCIATION DERMATOLOGIST, GREENVILLE NC
Sarah Wolfe, MD	Duke Dermatology, Durham, NC
Susan Sanders MD	Dermatology Group of the Carolinas · Concord, NC
Dave Horne	Smith Anderson
Laura Gunter	NCBIO
Benjamin Boyd	Voyager Academy ACS CAN
Chandler Fowler	Voyager Academy, ACS CAN
Mackenzie Crooks	Voyager Academy ACS CAN
Anna Jones	American Cancer Society - CAN

VISITOR REGISTRATION SHEET

House Comm. on Health — Name of Committee

03/11/15 — Date

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Steven Gatlin	Voyager Academy, ACS
Gail Reid-Vestal	American Cancer Society
Debi Nelson	nc Division of Public Health
Juanita Taylor	American Cancer Society CAN
Adam C. Jones	American Cancer Society-CAN
[illegible] Keef	American Cancer Society Cancer Action Network

VISITOR REGISTRATION SHEET

House Comm. on Health — Name of Committee

03/11/15 — Date

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Tiffany Fountain	ACS

NORTH CAROLINA HOUSE OF REPRESENTATIVES
COMMITTEE MEETING NOTICE
AND
BILL SPONSOR NOTIFICATION
2015-2016 SESSION

You are hereby notified that the **House Committee on Health** will meet as follows:

DAY & DATE: Wednesday, March 18, 2015
TIME: **10:00 AM**
LOCATION: **643 LOB**
COMMENTS: **Chairman Lambeth will be presiding.**

The following bills will be considered:

BILL NO.	SHORT TITLE	SPONSOR
HB 119	PED Recs/Publicly Funded Substance Abuse Svcs.	Representative Horn Representative Hurley Representative Saine

Respectfully,

Representative Brian Brown, Co-Chair
Representative Justin P. Burr, Co-Chair
Representative Bert Jones, Co-Chair
Representative Donny Lambeth, Co-Chair

I hereby certify this notice was filed by the committee assistant at the following offices at 1:17 PM on Thursday, March 12, 2015.

___ Principal Clerk
___ Reading Clerk – House Chamber

Brenda Olls (Committee Assistant)

House Committee on Health
Wednesday, March 18, 2015, 10:00 AM
643 Legislative Office Building

AGENDA

Welcome and Opening Remarks

Introduction of Pages

Bills

BILL NO.	SHORT TITLE	SPONSOR
HB 119	PED Recs/Publicly Funded Substance Abuse Svcs.	Representative Horn Representative Hurley Representative Saine

Presentations

Other Business

Adjournment

House Committee on Health
Wednesday, March 18, 2015 at 10:00 AM
Room 643 of the Legislative Office Building

MINUTES

The House Committee on Health met at 10:00 AM on March 18, 2015 in Room 643 of the Legislative Office Building. Representatives Avila, R. Brown, B. Brown, Carney, Dollar, Earle, Farmer-Butterfield, Ford, Goodman, Hastings, Insko, Jones, Lambeth, Lucas, S. Martin, Pendleton, Szoka, and Yarborough attended.

Chairman Donny Lambeth presided. He called the meeting to order and welcomed all members and staff. He introduced the Sergeant-At-Arms staff who would be assisting with the meeting.

The following bill was considered:

HB 119 PED Recs/Publicly Funded Substance Abuse Svcs. (Representatives Horn, Hurley, Saine).

Representative Horn was recognized to present the bill.

Representative Dollar moved a motion for a favorable report with referral to House Appropriations.

Chairman Lambeth recognized members for question of the bill sponsor. Representative Horn called on staff member, Theresa Matula, to give a brief overview of the bill. Chairman Lambeth then stated the meeting was open to public comment. All comments favored the bill.

Representative Dollar moved for a favorable report with referral to House Appropriations. Motion passed.

The meeting adjourned at 10:25 A.M.

Representative Donny Lambeth, Chair
Presiding

Dina Long, Committee Clerk

HOUSE BILL 119*

Short Title:	PED Recs/Publicly Funded Substance Abuse Svcs.	(Public)
Sponsors:	Representatives Horn, Hurley, and Saine (Primary Sponsors). *For a complete list of Sponsors, refer to the North Carolina General Assembly Web Site.*	
Referred to:	Health, if favorable, Appropriations.	

March 2, 2015

A BILL TO BE ENTITLED

AN ACT INTEGRATING STATE-OPERATED ALCOHOL AND DRUG ABUSE TREATMENT CENTERS (ADATCS) INTO THE ARRAY OF PUBLICLY FUNDED SUBSTANCE ABUSE SERVICES MANAGED BY LOCAL MANAGEMENT ENTITIES/MANAGED CARE ORGANIZATIONS, REALLOCATING DIRECT STATE APPROPRIATIONS FOR ADATCS TO THE DIVISION OF MENTAL HEALTH, DEVELOPMENTAL DISABILITIES, AND SUBSTANCE ABUSE SERVICES FOR MANAGEMENT BY THE LME/MCOS, AND STRENGTHENING THE PERFORMANCE MANAGEMENT SYSTEM FOR PUBLICLY FUNDED SUBSTANCE ABUSE SERVICES, AS RECOMMENDED BY THE JOINT LEGISLATIVE PROGRAM EVALUATION OVERSIGHT COMMITTEE.

The General Assembly of North Carolina enacts:

PART I. DEFINITIONS

SECTION 1. As used in this act, the following definitions apply unless the context requires otherwise:

(1) ADATCs. – All of the Alcohol and Drug Treatment Centers under the jurisdiction of the DHHS Secretary, as identified in G.S. 122C-181.

(2) DHHS. – The North Carolina Department of Health and Human Services.

(3) DMH/DD/SAS. – The Division of Mental Health, Developmental Disabilities, and Substance Abuse Services of the North Carolina Department of Health and Human Services.

(4) DSOHF. – The Division of State-Operated Healthcare Facilities of the North Carolina Department of Health and Human Services.

(5) LME/MCO or Local Management Entity/Managed Care Organization. – As defined in G.S. 122C-3; a local management entity that is under contract with DHHS to operate the combined Medicaid Waiver program authorized under Section 1915(b) and Section 1915(c) of the Social Security Act.

(6) Transition period. – The three-year period beginning July 1, 2016, and ending June 30, 2019, during which ADATCs are to be fully integrated into the array of publicly funded substance abuse services managed by the LME/MCOs.

PART II. DHHS TRANSITION BUSINESS PLAN FOR INTEGRATING ADATCS INTO THE ARRAY OF PUBLICLY FUNDED SUBSTANCE ABUSE SERVICES MANAGED BY LME/MCOS.

SECTION 2.(a) It is the intent of the General Assembly to integrate the ADATCs into the array of publicly funded substance abuse services managed by the LME/MCOs over a three-year period, beginning no earlier than July 1, 2016, and ending with full integration by June 30, 2019.

SECTION 2.(b) By April 1, 2016, DHHS shall prepare and submit to the Joint Legislative Oversight Committee on Health and Human Services a three-year transition business plan for integrating all ADATCs into the array of publicly funded substance abuse services managed by the LME/MCOs. The plan shall include at least all of the following components:

(1) The projected demand by LME/MCOs for substance abuse services provided by the ADATCs during (i) each fiscal year of the transition period and (ii) the first three fiscal years subsequent to full integration of the ADATCs into the array of publicly funded substance abuse services managed by the LME/MCOs.

(2) The projected availability of services at all ADATCs during (i) each fiscal year of the transition period and (ii) the first three fiscal years subsequent to full integration of the ADATCs into the array of publicly funded substance abuse services managed by the LME/MCOs.

(3) Procedures for making operational adjustments at each of the ADATCs during the transition period based upon the demand for services and the availability of funding to provide these services. Operational adjustments may include one or any combination of the following:
   a. Staffing adjustments.
   b. Changes in the use of contract staff.
   c. Facility closures.

(4) A methodology for establishing and updating the rates to be paid by LME/MCOs for substance abuse services provided by ADATCs to individuals receiving these services under the management of the LME/MCOs.

(5) A uniform process for LME/MCOs to give prior authorization for ADATCs to admit and treat individuals whose care is managed and paid for by the LME/MCOs. The prior authorization process developed pursuant to this subsection shall be developed by DHHS, in consultation with the LME/MCOs. As part of this process, an ADATC shall provide screening and triage services and notify the appropriate LME/MCO when an individual reliant upon State funds for substance abuse services seeks direct admission to the ADATC. The LME/MCO for the catchment area in which the individual resides shall determine if the individual should be admitted to the ADATC based upon clinical information provided by the ADATC. If the LME/MCO approves admission, the LME/MCO shall be financially responsible for all inpatient substance abuse services rendered by the ADATC to the individual. If the LME/MCO denies admission, the LME/MCO shall be responsible for paying the cost of assessment services performed by the ADATC and for making arrangements for the individual to receive alternative substance abuse services.

PART III. TERMINATION AND REALLOCATION OF DIRECT STATE APPROPRIATIONS FOR ADATCS

SECTION 3.(a) It is the intent of the General Assembly to gradually terminate all direct State appropriations for ADATCs by the beginning of the 2019-2020 fiscal year and instead reallocate this funding to DMH/DD/SAS for community services in order to allow the LME/MCOs to assume responsibility for managing the full array of publicly funded substance abuse services, including those delivered through the ADATCs. To this end and notwithstanding any other provision of law, all direct State appropriations for ADATCs are terminated effective July 1, 2019, and reallocated to DMH/DD/SAS for allocation to the LME/MCOs. The LME/MCOs shall use these reallocated funds to manage and pay for the utilization of substance abuse treatment and services for individuals within their respective catchment areas.

SECTION 3.(b) In order to allow the LME/MCOs to plan in advance how to effectively and efficiently manage these reallocated ADATC funds, DMH/DD/SAS shall do all of the following:

(1) Calculate and notify each LME/MCO by August 1, 2015, of its estimated share of these fund allocations for each fiscal year of the transition period. The estimated share of fund allocations for each LME/MCO shall be:
   a. Based on the total amount of direct State appropriations allocated to the ADATCs for the 2015-2016 fiscal year.
   b. Proportional to the total population of the LME/MCO catchment area, except that the estimated share of allocations for the LME/MCO known as Cardinal Innovations Healthcare Solutions (Cardinal) shall be reduced by an amount sufficient to reflect the ADATC state institution fund allocation received by Cardinal for the original counties under the Piedmont Demonstration Project.

(2) As a condition of receiving its share of reallocated ADATC funds, require each LME/MCO to submit by February 1, 2016, a written transition plan describing how the LME/MCO plans to use these reallocated ADATC funds to (i) build capacity for community-based substance abuse services, (ii) reduce gaps in substance abuse services, (iii) purchase substance abuse services from the ADATCs, or (iv) any combination of these. DMH/DD/SAS shall review the written transition plans to ensure each LME/MCO proposes using these reallocated ADATC funds to purchase substance abuse services.

PART IV. LME/MCO PAYMENT AND UTILIZATION MANAGEMENT FOR ADATC SERVICES

SECTION 4. In order to allow the LME/MCOs to effectively and efficiently manage utilization of, and payment for, ADATC services for individuals within their respective catchment areas, each LME/MCO shall do all of the following:

(1) By February 1, 2016, submit to DMH/DD/SAS a written transition plan describing how it plans to use reallocated ADATC funds to (i) build capacity for community-based substance abuse services, (ii) reduce gaps in substance abuse services, (iii) purchase substance abuse services from the ADATCs, or (iv) any combination of these.

(2) By February 1 of each year, submit to DSOHF its projected demand for ADATC services for the upcoming fiscal year.

(3) By April 1 of each year, enter into a contract with DSOHF for the ADATC services it intends to utilize during the next fiscal year. The contract shall include at least all of the following terms:
   a. The projected amount of substance abuse services to be provided by the ADATCs to individuals within the LME/MCO catchment area.

b. The negotiated rate to be paid by the LME/MCO for substance abuse services provided by the ADATCs to individuals receiving these services under the management of the LME/MCOs. The negotiated rate shall be sufficient to cover one hundred percent (100%) of the actual cost to the ADATCs for providing these services, except that during the transition period the negotiated rate shall be calculated as follows:
   1. For fiscal year 2016-2017, LME/MCOs shall pay twenty-five percent (25%) of the facility's per bed day cost for ADATC services provided to individuals under the management of the LME/MCOs.
   2. For fiscal year 2017-2018, LME/MCOs shall pay fifty percent (50%) of the per bed day cost for ADATC services provided to individuals under the management of the LME/MCOs.
   3. For the 2018-2019 fiscal year, LME/MCOs shall pay seventy-five percent (75%) of the per bed day cost for ADATC services provided to individuals under the management of the LME/MCOs.

c. Any conditions imposed upon the ADATCs for receiving payment from the LME/MCOs for services provided to individuals whose care is managed and paid for by the LME/MCOs, including prior authorization.

(4) Implement and enforce the prior authorization process established by DHHS, in consultation with the LME/MCOs, pursuant to Section 2(b)(5) of this act.

PART V. ADJUSTMENT OF ADATC OPERATIONS

SECTION 5. It is the intent of the General Assembly that at the end of the transition period, each of the ADATCs be wholly receipt-supported. To this end, during the transition period, each of the ADATCs shall annually evaluate and adjust their operations based upon the projected demand for services and the availability of funding to meet the demand for services from direct State appropriations and estimated receipts from Medicare, Medicaid, insurance, self-pay, and the LME/MCOs. These operational adjustments shall be in compliance with the procedures established by DHHS pursuant to Section 2(b)(3) of this act.

PART VI. OVERSIGHT AND REPORTING

SECTION 6.(a) During the transition period, DMH/DD/SAS shall monitor each of the following with respect to integration of the ADATCs into the array of publicly funded substance abuse services managed by the LME/MCOs:

(1) Expenditures by LME/MCOs and by ADATCs to ensure that North Carolina continues to meet the maintenance of effort requirements of the federal Substance Abuse Prevention and Treatment Block Grant.

(2) Efforts by each of the LME/MCOs to increase capacity for substance abuse treatment to ensure the development of community-based services to meet the needs of individuals formerly served by the ADATCs.

(3) Utilization by LME/MCOs of substance abuse services provided by the ADATCs.

SECTION 6.(b) Beginning October 1, 2016, and annually thereafter until October 1, 2020, DHHS shall report to the Joint Legislative Oversight Committee on Health and Human Services and the Joint Legislative Program Evaluation Oversight Committee on each of the following:

(1) The status of fully integrating the ADATCs into the array of publicly funded substance abuse services managed by the LME/MCOs.

(2) A breakdown of how direct State appropriations reallocated from the ADATCs to the LME/MCOs have been used to purchase substance abuse services.

PART VII. PLAN FOR STRENGTHENING PERFORMANCE MANAGEMENT FOR THE STATE'S PUBLICLY FUNDED SUBSTANCE ABUSE SERVICES

SECTION 7. By January 15, 2016, DMH/DD/SAS, in consultation with the LME/MCOs, shall develop and submit to the Joint Legislative Oversight Committee on Health and Human Services a plan to strengthen performance management for the State's publicly funded substance abuse services. The Department is encouraged to consult with other Divisions under its jurisdiction, the North Carolina Court System, and other State agencies, including the Departments of Public Safety, Revenue, and Commerce, in order to develop a plan that integrates other data into a performance management system that measures outcomes. The plan shall identify at least all of the following:

(1) Specific long-term outcome measures to be tracked by DMH/DD/SAS.

(2) Challenges with the current information technology system used for Medicaid claim adjudication that may limit the State's ability to implement meaningful performance management, and proposed remedies for either eliminating this limitation in the system or collecting needed data from the LME/MCOs.

(3) Time lines for all steps necessary for DMH/DD/SAS to begin tracking long-term outcome measures.

(4) Data elements, such as patient placement criteria data, that would allow DMH/DD/SAS to improve the process for analyzing service gaps in substance abuse services.

(5) Protocols for using long-term outcomes to (i) assess the effectiveness of treatment modalities and practices, (ii) measure the performance of providers and LME/MCOs in the delivery of substance abuse services, and (iii) hold LME/MCOs accountable for effective and efficient treatment.

PART VIII. EFFECTIVE DATE

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

HOUSE BILL 119:
PED Recs/Publicly Funded Substance Abuse Svcs

2015-2016 General Assembly

Committee:	House Health, if favorable, Appropriations	**Date:**	March 17, 2015
Introduced by:	Reps. Horn, Hurley, Saine	**Prepared by:**	Theresa Matula Committee Staff
Analysis of:	First Edition		

SUMMARY: ***House Bill 199 integrates State-operated Alcohol and Drug Treatment Centers (ADATCs) into the array of publicly funded substance abuse services managed by Local Management Entities/Managed Care Organizations (LME/MCOs), as recommended by the Joint Legislative Program Evaluation Oversight Committee. The transition would take place over a three-year period with full integration occurring by June 30, 2019.***

BACKGROUND: The Program Evaluation Division's report, 2014-14, found that the three Alcohol and Drug Treatment Centers (ADATCs), Julian Keith, RJ Blackley, and WB Jones, operate autonomously from the LME/MCO managed community-based system thereby limiting the ability to address service gaps, provide a continuum of care, and manage cost. The report also identified the need for a performance management system to track long-term outcomes of substance abuse treatment.

BILL ANALYSIS: House Bill 119 is divided into eight Parts outlined below.

PART I. Definitions - Defines or describes the following terms and abbreviations: ADATCs, DHHS, DMH/DD/SAS, DSOHF, LME/MCO, and transition period.

PART II. DHHS Transition Business Plan for Integrating ADATCs into the array of publicly funded substance abuse services managed by LME/MCOs - Establishes the intent to integrate ADATCs into the range of services managed by the LME/MCOs over a three year period beginning July 1, 2016, and achieving full integration by June 30, 2019.

By April 1, 2015, the Department of Health and Human Services (DHHS) must submit to the Joint Legislative Oversight Committee on Health and Human Services, a three-year transition business plan consisting of the information outlined below.

- Projected demand by LME/MCOs for substance abuse services provided by ADATCs for: (i) each fiscal year of the transition, and (ii) the first three fiscal years subsequent to full integration.
- Projected availability of services at all ADATCS during (i) each fiscal year of the transition period, and (ii) the first three fiscal years subsequent to full integration.
- Procedures for making operational adjustments at each ADATC during the transition period.
- Methodology for establishing and updating the rates paid by LME/MCOs for substance abuse services provided by ADATCS.
- Uniform process for LME/MCOs to give prior authorization for ADATCs to admit and treat individuals whose care is managed and paid for by the LME/MCO.

PART III. Termination and Reallocation of Direct State Appropriations for ADATCs –Notwithstanding anything to the contrary, the intent is to terminate all direct State appropriations for ADATCs by July 1, 2019, and to reallocate the funding to DMH/DD/SAS for allocation to LME/MCOs. This will allow the LME/MCOs to assume responsibility for managing all publicly funded substance abuse services for individuals within their respective catchment areas.

To provide the LME/MCOs an opportunity to plan the efficient and effective management of reallocated ADATC funds, DMH/DD/SAS must carry out the tasks outlined below.

1) Calculate and notify each LME/MCO by August 1, 2015, of its estimated share of fund allocations.

2) Require each LME/MCO to submit by February 1, 2016, a written transition plan describing how the LME/MCO plans to use reallocated ADATC funds to accomplish the following related to substance abuse services: (i) build capacity for community-based services, (ii) reduce service gaps, (iii) purchase services from the ADATC, or (iv) a combination of these. DMH/DD/SAS must review the plans to ensure reallocated funds are used to purchase substance abuse services.

PART IV. LME/MCO Payment and Utilization Management for ADATC Services – Each LME/MCO is required to do all of the following:

- By February 1, 2016, submit to DMH/DD/SAS a written transition plan.
- By February 1 of each year, submit projected demand for ADATC services for the upcoming fiscal year to the Division of State-Operated Healthcare Facilities (DSOHF), DHHS.
- By April 1 of each year, enter into a contract with DSOHF for the ADATC services it intends to utilize during the next fiscal year. The contract must include all of the terms specified in the bill.
- Implement and enforce the prior authorization process established by DHHS as required in Part II of the bill.

PART V. Adjustment of ADATC Operations – The intent is for each ADATC to be wholly receipt-supported by the end of the transition period. As such, each ADATC must annually evaluate and adjust their operations based on projected demand for services and the availability of funding from direct State appropriations and estimated receipts. Operational adjustments must comply with procedures specified in Part II of the bill.

PART VI. Oversight and Reporting – During the transition period, DMH/DD/SAS must monitor the following: 1) expenditures by the LME/MCO to ensure it meets maintenance of effort requirements of the federal Substance Abuse Prevention and Treatment Block Grant; 2) efforts by LME/MCO to increase capacity for substance abuse treatment and development of community-based services; 3) utilization by LME/MCO of substance abuse services provided by ADATCs.

Beginning October 1, 2016, and annually thereafter until October 1, 2020, DHHS must report to the Joint Legislative Oversight Committee on Health and Human Services and the Joint Legislative Program Evaluation Oversight Committee on: 1) the status of fully integrating the ADATCs, and 2) a breakdown of how direct State appropriations reallocated from the ADATCs to the LME/MCOs have been used to purchase substance abuse services.

PART VII. Plan for Strengthening Performance Management for the State's Publicly Funded Substance Abuse Services – By January 15, 2016, DMH/DD/SAS, DHHS, in consultation with LME/MCOs must develop and submit to the Joint Legislative Oversight Committee on Health and Human Services, a plan to strengthen performance management for the State's publicly funded substance abuse services. DHHS is encouraged to consult with various entities. The plan must include: 1) specific long-term outcome measures; 2) information technology challenges and proposed remedies; 3) time lines for tracking long-term outcome measures; 4) data elements to improve the process of analyzing service gaps; and 5) protocols for using long-term outcomes to assess, measure and hold LME/MCOs accountable for effective and efficient treatment.

EFFECTIVE DATE: This bill becomes effective when it becomes law.

NORTH CAROLINA GENERAL ASSEMBLY
HOUSE OF REPRESENTATIVES

HEALTH COMMITTEE REPORT

Representative Brian Brown, Co-Chair
Representative Justin P. Burr, Co-Chair
Representative Bert Jones, Co-Chair
Representative Donny Lambeth, Co-Chair

FAVORABLE AND RE-REFERRED

HB **119** PED Recs/Publicly Funded Substance Abuse Svcs.

Draft Number:	None
Serial Referral:	**APPROPRIATIONS**
Recommended Referral:	None
Long Title Amended:	No
Floor Manager:	Horn

TOTAL REPORTED: 1

CMR53-V-1

Committee Sergeants at Arms

NAME OF COMMITTEE House Comm. on Health

DATE: 03/18/15 Room: 643

House Sgt-At Arms:

1. Name: Young Bae
2. Name: Bill Morris
3. Name: Jim Moran
4. Name: _____
5. Name: _____

Senate Sgt-At Arms:

1. Name: _____
2. Name: _____
3. Name: _____
4. Name: _____
5. Name: _____

VISITOR REGISTRATION SHEET

House Comm. on Health — Name of Committee

03/18/15 — Date

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Dave Reinfer	CCR
Roger Safrit	Town of Sandis NC
DENNIS BROWN	TOWN of LANDIS
Pat O. Yancey	APPC NC
Allison Guenther	NC Grange
Wayne Stack	NC Grange
DAVID FOWLER	NC GRANGE
PAUL FITZGERALD	TOWN OF WAXHAW
JAMES WARNER	TOWN OF WAXHAW
Chris Bryant	NCMS

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House Comm. on Health — 03/18/15

Name of Committee — Date

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
J DELANIER	CARDINAL
Joel Maynard	GPM: ASSOC
Carson Ehrie	MVA
Josh Ehrich	JDA
CURTIS MCDONALD	BMS
John DelGiorno	Brubaker + Assoc.
Rob Lallier	REI
Trent Womble	DHHS
Jenny Wood &	DHHS / DSHF
Dale Armstrong	DHHS / TCSOFT

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House Comm. on Health — 03/18/15

Name of Committee — Date

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Erica Nelson	NCHA
Ryan Blackledge	Cone Health
[illegible]	[illegible]
[illegible]	[illegible]
[illegible]	.ECBIA
Ann Rodriguez	NC Council of Community Programs
[illegible]	School Gov.
[illegible]	CSS
Judy Jenkins	DAPI
Allison Wescott	Cardinal Innovations
Jeff Barnhart	MWC

VISITOR REGISTRATION SHEET

House Comm. on Health — 03/18/15

Name of Committee — Date

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Adam Scholar	DHHS
Meghan O'Donnell	Express Scripts
Leti Morgan	NCRMA
Elizabeth Robinson	NCRMA
Mary Yadon	GSK
Rick Techi.	LUN
Kara Weisbaar	SA
Sandy Sorg	MP
Jennifer Carpenter	NCMS
Joanna Spruill	NCAHP
TJ Bugbee	NP

VISITOR REGISTRATION SHEET

House Comm. on Health — 03/18/15

Name of Committee — Date

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Meghan Cook	OITS
Hugh Johnson	NCAcc
Anne Lee Dolph	DC
Elizabeth Willis	NC Board of Nursing
David Knollenberg	NC Board of Nursing
Lanier Hodgson	UNC Health Care
Evelyn Hawkins	OHOR
Flo Stein	DMH
Ashley Parker	Parkinson Law
Kristin Gordon	Parkinson Law
Mark Eggold	APNC

Corrected #1: Remove HB 261.

NORTH CAROLINA HOUSE OF REPRESENTATIVES
COMMITTEE MEETING NOTICE
AND
BILL SPONSOR NOTIFICATION
2015-2016 SESSION

You are hereby notified that the **House Committee on Health** will meet as follows:

DAY & DATE: Wednesday, March 25, 2015
TIME: **10:00 AM**
LOCATION: **643 LOB**
COMMENTS: **Chairman Jones will preside.**

The following bills will be considered:

BILL NO.	SHORT TITLE	SPONSOR
HB 261	Require Typed Death Certificates.	Representative Setzer Representative L. Hall
HB 267	Amend Respiratory Care Practice Act.-AB	Representative Goodman Representative Glazier Representative Blackwell
HB 281	Records to Medical Examiner.	Representative L. Hall Representative Setzer Representative Cunningham Representative Pierce
HB 286	Dental Hygienists/Intraoral Local Anesthetics.	Representative Jones

Respectfully,

Representative Brian Brown, Co-Chair
Representative Justin P. Burr, Co-Chair
Representative Bert Jones, Co-Chair
Representative Donny Lambeth, Co-Chair

I hereby certify this notice was filed by the committee assistant at the following offices at 4:36 PM on Monday, March 23, 2015.

___ Principal Clerk
___ Reading Clerk – House Chamber

Brenda Olls (Committee Assistant)

NORTH CAROLINA HOUSE OF REPRESENTATIVES
COMMITTEE MEETING NOTICE
AND
BILL SPONSOR NOTIFICATION
2015-2016 SESSION

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Respectfully,

Representative Brian Brown, Co-Chair
Representative Justin P. Burr, Co-Chair
Representative Bert Jones, Co-Chair
Representative Donny Lambeth, Co-Chair

I hereby certify this notice was filed by the committee assistant at the following offices at 4:08 PM on Monday, March 23, 2015.

___ Principal Clerk
___ Reading Clerk – House Chamber

Brenda Olls (Committee Assistant)

House Committee on Health
Wednesday, March 25, 2015, 10:00 AM
643 Legislative Office Building

AGENDA

Welcome and Opening Remarks

Introduction of Pages

Bills

BILL NO.	SHORT TITLE	SPONSOR
HB 267	Amend Respiratory Care Practice Act.-AB	Representative Goodman Representative Glazier Representative Blackwell
HB 281	Records to Medical Examiner.	Representative L. Hall Representative Setzer Representative Cunningham Representative Pierce
HB 286	Dental Hygienists/Intraoral Local Anesthetics.	Representative Jones

Presentations

Other Business

Adjournment

House Committee on Health
Wednesday, March 25, 2015 at 10:00 AM
Room 643 of the Legislative Office Building

MINUTES

The House Committee on Health met at 10:00 AM on March 25, 2015 in Room 643 of the Legislative Office Building. Representatives Avila, Bishop, Blackwell, Brisson, R. Brown, Carney, Dobson, Dollar, Earle, Ford, Goodman, L. Hall, Insko, Jones, Lucas, S. Martin, Pendleton, Waddell, Wray, and Yarborough attended.

Representative Bert Jones, Chair, presided. He recognized the Pages and Sergeant-at-Arms.

The following bills were considered:

HB 267 Amend Respiratory Care Practice Act.-AB (Representatives Goodman, Glazier, Blackwell)

Representative Goodman presented HB 267 and offered a technical amendment. Discussion of the bill followed. Representative Waddell made a motion to roll the amendment into a PCS, with a favorable report and referral to Finance. All in favor, the motion passed.

/

HB 281 Records to Medical Examiner. (Representatives L. Hall, Setzer, Cunningham, Pierce)

Representative L. Hall was recognized to explain HB 281 and an amendment to the bill. The amendment passed. Representative Goodman offered a second amendment, which also passed. Ryan Combs stated that the Department of Public Safety supported the bill with the two amendments. After some discussion, Representative Hall moved that the two amendments be rolled into a PCS, with a favorable report, unfavorable to the original. The motion carried.

HB 286 Dental Hygienists/Intraoral Local Anesthetics. (Representative Jones)

Representative Avila presided when Representative Jones presented his bill, recognizing him to explain HB 286. He knows of no opposition to the bill, and that Dental Hygienists are trained and under direct supervision of a dentist. Representative Avila recognized committee members for questions. Staff was recognized to answer why this change was being made now. Susan Barham, staff member. Stated that this had been a gradual progression from the 1970's and now 45 states allow Dental Hygienists to administer local anesthetics. Representative Jones was recognized to offer a technical amendment, which passed. Representative Dollar moved that the amendment be rolled into a PCS, with a favorable report. The motion carried.

The meeting adjourned at 10:50.

Bert Jones

Representative Bert Jones, Chair
Presiding

Brenda Olls

Brenda Olls, Committee Clerk

HOUSE BILL 267

Short Title:	Amend Respiratory Care Practice Act.-AB	(Public)
Sponsors:	Representatives Goodman, Glazier, and Blackwell (Primary Sponsors). *For a complete list of Sponsors, refer to the North Carolina General Assembly Web Site.*	
Referred to:	Health, if favorable, Finance.	

March 18, 2015

A BILL TO BE ENTITLED

AN ACT AMENDING THE RESPIRATORY CARE PRACTICE ACT.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 90-648 reads as rewritten:

"**§ 90-648. Definitions.**

The following definitions apply in this Article:

(1) Board. – The North Carolina Respiratory Care Board.

(2) Diagnostic testing. – Cardiopulmonary procedures and tests performed on the written order of a physician licensed under Article 1 of this Chapter that provide information to the physician to formulate a diagnosis of the patient's condition. The tests and procedures may include pulmonary function testing, electrocardiograph testing, cardiac stress testing, and sleep related testing.

(3) Direct supervision. – The authority and responsibility to direct the performance of activities as established by policies and procedures for safe and appropriate completion of services.

(4) Individual. – A human being.

(5) License. – A certificate issued by the Board recognizing the person named therein as having met the requirements to practice respiratory care as defined in this Article.

(6) Licensee. – A person who has been issued a license under this Article.

(7) Medical director. – An appointed physician who is licensed under Article 1 of this Chapter and a member of the entity's medical staff, and who is granted the authority and responsibility for assuring and establishing policies and procedures and that the provision of such is provided to the quality, safety, and appropriateness standards as recognized within the defined scope of practice for the entity.

(8) Person. – An individual, corporation, partnership, association, unit of government, or other legal entity.

(9) Physician. – A doctor of medicine licensed by the State of North Carolina in accordance with Article 1 of this Chapter.

(10) Practice of respiratory care. – As defined by the written order of a physician licensed under Article 1 of this Chapter, the observing and monitoring of signs and symptoms, general behavior, and general physical response to respiratory care treatment and diagnostic testing, including the determination of whether such signs, symptoms, reactions, behavior, or general response

exhibit abnormal characteristics, and the performance of diagnostic testing and therapeutic application or assessment of:

a. Medical gases, humidity, and aerosols including the ~~maintenance~~ use of associated ~~apparatus,~~respiratory care equipment, except for the purpose of anesthesia.

b. Pharmacologic agents related to respiratory care procedures, including those agents necessary to perform hemodynamic monitoring.

c. Mechanical or physiological ventilatory support.

d. Cardiopulmonary resuscitation and maintenance of natural airways, the insertion and maintenance of artificial airways under the direct supervision of a recognized medical director in a health care environment which identifies these services within the scope of practice by the facility's governing board.

e. Hyperbaric oxygen therapy.

f. New and innovative respiratory care and related support activities in appropriately identified environments and under the training and practice guidelines established by the American Association of Respiratory Care.

g. The therapeutic effectiveness of medical equipment used in respiratory care treatment for an individual patient.

The term "practice of respiratory care" also means the interpretation and implementation of a physician's written or verbal order pertaining to the acts described in this ~~subdivision.~~subdivision and any act by which an individual holds out to the public or represents in any manner that the individual is authorized to practice respiratory care in this State.

(11) Respiratory care. – As defined by the written order of a physician licensed under Article 1 of Chapter 90, the treatment, management, diagnostic testing, and care of patients with deficiencies and abnormalities associated with the cardiopulmonary system.

(12) Respiratory care practitioner. – ~~A person~~ An individual who has been licensed by the Board ~~to engage in the practice of respiratory care.~~as a respiratory care practitioner.

(13) Support activities. – ~~Procedures~~ Tasks that do not require formal academic training, including the delivery, setup, and routine maintenance and repair of ~~apparatus. The term also includes giving instructions on the use, fitting, and application of apparatus, but does not include therapeutic evaluation and assessment.~~respiratory care equipment as defined in rules adopted by the Board. The term "support activities" does not include the evaluation or assessment of the therapeutic effectiveness of any respiratory care treatment or respiratory care equipment for an individual patient."

SECTION 2. G.S. 90-652 reads as rewritten:

"**§ 90-652. Powers and duties of the Board.**

The Board shall have the power and duty to:

(1) Determine the qualifications and fitness of applicants for licensure, renewal of licensure, and reciprocal licensure. The Board shall, in its discretion, investigate the background of an applicant to determine the applicant's qualifications with due regard given to the applicant's competency, honesty, truthfulness, and integrity. The Department of Public Safety may provide a criminal record check to the Board for a person who has applied for a license

through the Board. The Board shall provide to the Department of Public Safety, along with the request, the fingerprints of the ~~applicant,~~applicant and any additional information required by the Department of ~~Public Safety, and a form signed by the applicant consenting to the check of the criminal record and to the use of the fingerprints and other identifying information required by the State or national repositories.~~Public Safety. The applicant's fingerprints shall be forwarded to the State Bureau of Investigation for a search of the State's criminal history record file, and the State Bureau of Investigation shall forward a set of the fingerprints to the Federal Bureau of Investigation for a national criminal history check. The Board shall keep all information pursuant to this subdivision privileged, in accordance with applicable State law and federal guidelines, and the information shall be confidential and shall not be a public record under Chapter 132 of the General Statutes. The Board shall collect any fees required by the Department of Public Safety and shall remit the fees to the Department of Public Safety for expenses associated with conducting the criminal history record check.

...

(5) Conduct investigations, subpoena individuals and records, and do all other things necessary and proper to discipline persons licensed under this Article and to enforce this ~~Article.~~Article, including the following:

a. Investigate the activities of persons not licensed under this Article whom the Board has reasonable cause to believe are engaged in the practice of respiratory care.

b. Designate one or more of its employees to issue and serve subpoenas and other papers on behalf of the Board. Service under this subdivision is permitted in accordance with any methods of service allowed by law.

...."

SECTION 3. G.S. 90-653 reads as rewritten:

"**§ 90-653. Licensure requirements; examination.**

(a) Each applicant for licensure under this Article shall ~~meet the following requirements:~~do all of the following:

(1) Submit a completed application as required by the ~~Board.~~Board, including a form signed by the applicant consenting to the check of the applicant's criminal record and to the use of the applicant's fingerprints and other identifying information required by the State and national repositories.

(2) Submit any fees required by the Board.

(3) Submit to the Board written evidence, verified by oath, that the applicant has successfully completed the minimal requirements of ~~a~~ an associate's degree respiratory care education program as approved by the Commission for Accreditation ~~of Allied Health Educational Programs, or the Canadian Council on Accreditation for Respiratory Therapy Education.~~for Respiratory Care (CoARC) or its successor by arranging for the applicant's respiratory care education program to submit a verified transcript directly to the Board.

(4) Submit to the Board written evidence, verified by oath, that the applicant has successfully completed the minimal requirements for Basic Cardiac Life Support as recognized by the American Heart Association, the American Red Cross, or the American Safety and Health Institute.

(5) ~~Pass the entry-level examination given by the National Board for Respiratory Care, Inc.~~Submit to the Board written evidence, verified by oath,

that the applicant has earned the advanced level credential or its successor awarded by the National Board for Respiratory Care, Inc.

~~(b) At least three times each year, the Board shall cause the examination required in subdivision (5) of subsection (a) of this section to be given to applicants at a time and place to be announced by the Board. Any applicant who fails to pass the first examination may take additional examinations in accordance with rules adopted pursuant to this Article.~~

(b1) When issuing a license, the Board shall state the terms and conditions of use of the license to the licensee."

SECTION 4. G.S. 90-656 reads as rewritten:

"**§ 90-656. Provisional license.**

(a) The Board may grant a provisional license ~~for a period not exceeding 12 months~~ to any applicant who has ~~successfully~~ done all of the following:

(1) Successfully completed ~~the education requirements under G.S. 90-653(a)(3) and has made application to take the examination required under G.S. 90-653(a)(5).~~the minimal requirements of an associate's degree program in respiratory care currently approved by the Commission on Accreditation for Respiratory Care (CoARC) or its successor by arranging for the applicant's respiratory care education program to submit a verified transcript directly to the Board.

(2) Submitted to the Board written evidence, verified by oath, that the applicant has successfully completed the minimal requirements for Basic Cardiac Life Support as recognized by the American Heart Association, the American Red Cross, or the American Safety and Health Institute.

(3) Submitted to the Board written evidence, verified by oath, that the applicant has earned the entry level credential or its successor awarded by the National Board for Respiratory Care, Inc.

(b) Each provisional license issued under this section shall be effective for a period of up to one year, and may be renewed annually subject to compliance with rules adopted by the Board, but shall not be in effect for a total period exceeding five years from the initial effective date of the provisional license. A provisional license allows the individual to practice respiratory care under the direct supervision of a respiratory care practitioner and in accordance with rules adopted pursuant to this Article. A license granted under this section shall contain an endorsement indicating that the license is provisional and stating the terms and conditions of its use by the licensee and shall state the date the license was granted and the date it expires."

SECTION 5. G.S. 90-659 reads as rewritten:

"**§ 90-659. Suspension, revocation, and refusal to renew a license.**

(a) The Board shall take the necessary actions to deny or refuse to ~~renew a license,~~renew, suspend or revoke a ~~license, or~~license; to impose probationary conditions on a ~~licensee or applicant if the~~license, including placing limitations on the practice of respiratory care; to reprimand a licensee or applicant; to assess a monetary penalty, costs, or both on a licensee or applicant; and to require a licensee or applicant to demonstrate satisfactory completion of treatment or educational programs, if any of the following are true of the licensee or applicant:

(1) Has engaged in any of the following conduct:

a. Employed fraud, deceit, bribery, or misrepresentation in (i) obtaining or attempting to obtain a ~~license or~~license or (ii) obtaining or attempting to obtain the renewal of a ~~license.~~license.

b. Committed an act of malpractice, gross negligence, or incompetence in the practice of respiratory care.

c. Practiced respiratory care without a license.

d. Engaged in health care practices that are determined to be hazardous to public health, safety, or welfare.

(2) Was convicted of or entered a plea of guilty or nolo contendere to any crime involving moral turpitude.

(3) ~~Was adjudicated insane or incompetent, until proof of recovery from the condition can be established.~~Has developed a physical or mental impairment that renders the licensee or applicant unfit to practice respiratory care with reasonable skill and competence and in a manner not harmful to the public. An adjudication of mental incompetency in a court of competent jurisdiction or a determination of mental incompetency by other lawful means shall be conclusive proof of unfitness to practice respiratory care until the licensee or applicant is subsequently adjudicated mentally competent.

(4) ~~Engaged~~ Has engaged in any act or practice that violates any of the provisions of this Article or any rule adopted pursuant to this Article, or aided, abetted, or assisted any person in such a violation.

(5) Has failed 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 a license to practice respiratory care.

(6) Has developed an impairment caused by the licensee's or applicant's use of alcohol, drugs, or controlled substances, which interferes with the ability of the licensee or applicant to practice respiratory care with reasonable skill, competence, and in a manner not harmful to the public.

(7) Has practiced respiratory care outside the boundaries of demonstrated competence or the limitations of education, training, or supervised experience.

(8) Has had a license for the practice of respiratory care in any other jurisdiction suspended or revoked or been disciplined by any licensing or certification board in any other jurisdiction for conduct that would subject the licensee or applicant to disciplinary action under this Article.

(9) Is a hazard to the public health by reason of having a serious communicable disease.

(b) ~~Denial,~~Except as provided in subsection (c) of this section, denial, refusal to renew, suspension, or revocation of a license, or imposition of probationary conditions upon a licensee may be ordered by the Board after a hearing held in accordance with Article 3A of Chapter 150B of the General Statutes and rules adopted pursuant to this Article. An application may be made to the Board for reinstatement of a revoked license if the revocation has been in effect for at least one year.

(c) The Board may deny an initial application for a license as a respiratory care practitioner without a hearing if the individual fails to submit a complete application which demonstrates that the applicant has met the education and entry level credential requirements of G.S. 90-653.

(d) If after notice is duly issued, a licensee or applicant fails to appear for a scheduled hearing and no continuance has been granted, the Board may hear the evidence of witnesses that have appeared, and the Board may proceed to consider the matter and dispose of the matter on the basis of the evidence before the Board. For good cause, the Board may reopen any case for further hearing.

(e) 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.

(f) A person acting in good faith without fraud or malice shall be immune from civil liability for the following:

(1) Reporting, investigating, assessing, monitoring, or providing an expert medical opinion to the Board regarding the acts or omissions of a licensee or applicant that violate the provisions of subsection (a) of this section or any other provision of law relating to the fitness of a licensee or applicant to practice respiratory care.

(2) Initiating or conducting proceedings or an action against a licensee or applicant.

(3) Testifying before the Board in good faith in any proceeding involving a violation of subsection (a) of this section or any other law relating to the fitness of an applicant or licensee to practice respiratory care.

(4) Making a recommendation to the Board in the nature of peer review.

(g) A licensee may, with the consent of the Board, voluntarily relinquish a license at any time. The Board may delay or refuse the granting of its consent as it may deem necessary in order to investigate any pending complaint, allegation, or issue regarding violation of any provisions of this Article by the licensee. Notwithstanding any provision to the contrary, the Board retains full jurisdiction to investigate alleged violations of this Article by any person whose license is relinquished under this subsection and, upon proof of any violation of this Article by any such person, the Board may take disciplinary action as authorized by this section."

SECTION 6. G.S. 90-661 reads as rewritten:

"**§ 90-661. Requirement of license.**

(a) It shall be unlawful for any person who is not currently licensed under this Article to:

(1) Engage in the practice of respiratory care.

(2) Use the title "respiratory care practitioner".

(3) Use the letters ~~"RCP", "RTT", "RT",~~"RCP" or any facsimile or combination in any words, letters, abbreviations, or ~~insignia.~~insignia that indicate or imply the person is a licensed respiratory care practitioner.

(4) Imply orally or in writing or indicate in any way that the person is a respiratory care practitioner or is otherwise licensed under this Article.

(5) Employ or solicit for employment unlicensed persons to practice respiratory care.

(b) It shall be unlawful for any person to employ or solicit for employment unlicensed persons to practice respiratory care.

(c) Any person, partnership, firm, corporation, association, authority, or other entity acting in good faith without fraud or malice, including the Board, its staff, and its counsel shall be immune from civil liability for (i) reporting, investigating, assessing, monitoring, or providing an expert medical opinion to the Board regarding the acts or omissions of a person who is not licensed by the Board on the ground that the person is violating subsection (a) of this section or any other provision of law or (ii) initiating or conducting proceedings against a person not licensed by the Board on the ground that the person is violating subsection (a) of this section or any other provision of law, if a complaint is filed or action is taken in good faith without fraud or malice. A person shall not be held liable in any civil proceeding for testifying before the Board in good faith and without fraud or malice in any proceeding commenced on the ground that the person is violating subsection (a) of this section or any other provision of law."

SECTION 7. G.S. 90-664 reads as rewritten:

"**§ 90-664. Persons and practices not affected.**

The requirements of this Article shall not apply to:

(1) Any person registered, certified, credentialed, or licensed to engage in another profession or occupation or any person working under the

supervision of a person registered, certified, credentialed, or licensed to engage in another profession or occupation in this State who is performing work incidental to or within the practice of that profession or occupation and does not represent himself or herself as a respiratory care practitioner.

(2) A student or trainee working under the direct supervision of a respiratory care practitioner while fulfilling an experience requirement or pursuing a course of study to meet requirements for licensure in accordance with rules adopted pursuant to this Article.

(3) A respiratory care practitioner serving in the Armed Forces or the Public Health Service of the United States or employed by the Veterans Administration ~~when performing duties associated with that service or employment.~~or other federal agency, to the extent permitted under federal law, so long as the individual limits services to those directly related to work with the employing federal agency.

(4) A person who performs only support activities as defined in G.S. 90-648(13).

(5) A person licensed as a respiratory care practitioner in another jurisdiction while providing respiratory care in a declared emergency in this State, providing respiratory care as a member of an organ harvesting team, or providing respiratory care on board an ambulance as part of an ambulance transport team transporting a patient into or out of this State."

SECTION 8. Notwithstanding any other provision of law to the contrary, any person licensed by the North Carolina Respiratory Care Board on October 1, 2016, who has passed the entry-level examination administered by the National Board for Respiratory Care, Inc., shall be deemed to have complied with the requirements of subdivision G.S. 90-653(a)(5), as amended by this act.

SECTION 9. G.S. 90-654 and G.S. 90-660(b)(6) are repealed.

SECTION 10. This act becomes effective October 1, 2016, and applies to licenses issued or renewed on or after that date.

HOUSE BILL 267:
Amend Respiratory Care Practice Act.-AB

2015-2016 General Assembly

Committee:	House Health, if favorable, Finance	**Date:**	March 25, 2015
Introduced by:	Reps. Goodman, Glazier, Blackwell	**Prepared by:**	Amy Jo Johnson
Analysis of:	PCS to First Edition H267-CSTK-2		Committee Counsel

SUMMARY: ***Article 38 of Chapter 90 regulates the practice of respiratory care and creates the North Carolina Respiratory Care Board (Board). The PCS to House Bill 267 makes a variety of changes to this Article.***

BILL ANALYSIS:

Section 1 makes changes to the definition of "practice of respiratory care," "respiratory care practitioner," and "support activities." The practice of respiratory care is expanded to include not only the performance of diagnostic testing and therapeutic application of specified activities, but also the assessment of the activities. Added to the list of activities included in the practice of respiratory care is the "therapeutic effectiveness of medical equipment used in respiratory care treatment for an individual patient." The definition of "respiratory care practitioner" is changed to "an individual who has been licensed by the Board as a respiratory care practitioner." The definition of "support activities" has been amended to include "tasks that do not require formal academic training, including the delivery, setup, and routine maintenance and repair of respiratory care equipment as defined in rules adopted by the Board."

Section 2 of the PCS specifies that the power of the North Carolina Respiratory Care Board (Board) to conduct investigations, subpoena individuals and records, and otherwise take necessary actions to discipline its licensees, also includes the authority to designate one or more of its employees to issue and serve subpoenas and other papers on the Board's behalf.

Section 3 of the PCS makes several changes to G.S. 90-653 which outlines licensure requirements. A conforming change is made with regards to an application that is submitted for licensure. The application must include consent to the check of an applicant's criminal record and the use of fingerprints. This language was removed from G.S. 90-652 and inserted into G.S. 90-653. **Section 3** also specifies that an associate's degree is required from a program approved by the Commission for Accreditation for Respiratory Care (CoARC). An applicant must also submit to the Board written evidence, verified by oath, that the applicant has earned the advanced level credential awarded by the National Board for Respiratory Care. **Section 9** provides a deemed status with regards to the new educational requirements in **Section 3** of the PCS and allows a person licensed by the Board on October 1, 2016, who has passed the entry level exam administered by the National Board for Respiratory Care to be considered in compliance with the new requirements.

Under current law, G.S. 90-653(b) required the Board to give an entry level exam for applicants three times a year. **Section 3** eliminates this requirement.

Section 4 makes amendments to the provisional license of respiratory care practitioners. The Board is able to grant a provisional license to any applicant who has completed all of the following new requirements:

- Successfully completed the minimal requirements of an associate's degree program in respiratory care approved by CoARC.
- Submitted written evidence to the Board, verified by oath, that the applicant has completed the minimal requirements for Basic Cardiac Life Support.
- Submitted written evidence to the Board, verified by oath, that the applicant has earned the entry level credential awarded by the National Board for Respiratory Care.

Provisional licenses are effective for up to one year. The PCS allows the license to be renewed annually but does not allow the provisional license to be in effect for more than a total of 5 years from the initial effective date of the provisional license.

Section 5 adds to the limitations the Board may place on a licensee – including assessment of a monetary penalty, costs, or both. The Board may take actions on a licensee or applicant if any of the following are true of the licensee or applicant:

- Employed fraud, deceit, bribery, or misrepresentation in (i) obtaining or attempting to obtain a license or (ii) obtaining or attempting to obtain the renewal of a license.
- Committed an act of malpractice, gross negligence, or incompetence in the practice of respiratory care.
- Practiced respiratory care without a license.
- Engaged in health care practices that are determined to be hazardous to public health, safety, or welfare.
- Was convicted of or entered a plea of guilty or nolo contendere to any crime involving moral turpitude.
- Has developed a physical or mental impairment that renders the licensee or applicant unfit to practice respiratory care with reasonable skill and competence and in a manner not harmful to the public. An adjudication of mental incompetency in a court of competent jurisdiction or a determination of mental incompetency by other lawful means shall be conclusive proof of unfitness to practice respiratory care until the licensee or applicant is subsequently adjudicated mentally competent.
- Has engaged in any act or practice that violates any of the provisions of this Article or any rule adopted pursuant to this Article, or aided, abetted, or assisted any person in such a violation.
- Has failed 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 a license to practice respiratory care.
- Has developed an impairment caused by the licensee's or applicant's use of alcohol, drugs, or controlled substances, which interferes with the ability of the licensee or applicant to practice respiratory care with reasonable skill, competence, and in a manner not harmful to the public.
- Has practiced respiratory care outside the boundaries of demonstrated competence or the limitations of education, training, or supervised experience.
- Has had a license for the practice of respiratory care in any other jurisdiction suspended or revoked or been disciplined by any licensing or certification board in any other jurisdiction

for conduct that would subject the licensee or applicant to disciplinary action under this Article.

- Is a hazard to the public health by reason of having a serious communicable disease.

Section 5 also makes changes allowing the Board to deny an initial application for a license without a hearing if the applicant fails to submit a complete application showing the individual has met the education and entry level credential requirements. **Section 5** allows the Board to hear the evidence of witnesses that have appeared and to consider and dispose of the matter before it if a licensee or applicant fails to appear for a scheduled hearing and no continuance has been granted. The Board is allowed to reopen any case for good cause. **Section 5** also contains provisions granting immunity to the Board, its members and staff for exercising, in good faith, the powers and duties authorized by law. Any person acting in good faith without fraud or malice is also granted immunity for performing various specified acts.

Section 5 also contains provisions allowing a licensee to voluntarily relinquish his or her license.

Section 6 specifies that it is unlawful to hold oneself out to the public, advertise, or represent in any manner that an individual is authorized to practice respiratory care without a license.

Section 7 creates a new section creating immunity from civil liability for any person or entity acting in good faith, without malice or fraud, for reporting, investigating, assessing, monitoring, or providing a medical expert opinion to the Board regarding a violation of the Respiratory Care Act (Act) or from initiating or conducting proceedings, or testifying in those proceedings, on the ground that a person is violating the Act.

Section 8 adds to the list of individual to whom the Act does not apply a person licensed as a respiratory car practitioner in another jurisdiction while providing respiratory care in a declared emergency in North Carolina, as a member of an organ harvesting team, or on board an ambulance transporting a patient in or out of North Carolina.

As referenced above, **Section 9** provides a deemed status with regards to the new educational requirements in **Section 3** of the PCS and allows a person licensed by the Board on October 1, 2016, who has passed the entry level exam administered by the National Board for Respiratory Care to be considered in compliance with the new requirements.

Section 10 repeals language dealing with temporary licenses.

EFFECTIVE DATE: Section 5 of this act becomes effective October 1, 2015. Sections 3 and 4 of this act become effective October 1, 2016. The remainder of the act is effective when it becomes law.

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2015

H D

HOUSE BILL 267
PROPOSED COMMITTEE SUBSTITUTE H267-CSTK-2 [v.2]

3/24/2015 6:23:39 PM

Short Title: Amend Respiratory Care Practice Act.-AB (Public)

Sponsors:

Referred to:

March 18, 2015

A BILL TO BE ENTITLED

AN ACT AMENDING THE RESPIRATORY CARE PRACTICE ACT.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 90-648 reads as rewritten:

"**§ 90-648. Definitions.**

The following definitions apply in this Article:

(1) Board. – The North Carolina Respiratory Care Board.

(2) Diagnostic testing. – Cardiopulmonary procedures and tests performed on the written order of a physician licensed under Article 1 of this Chapter that provide information to the physician to formulate a diagnosis of the patient's condition. The tests and procedures may include pulmonary function testing, electrocardiograph testing, cardiac stress testing, and sleep related testing.

(3) Direct supervision. – The authority and responsibility to direct the performance of activities as established by policies and procedures for safe and appropriate completion of services.

(4) Individual. – A human being.

(5) License. – A certificate issued by the Board recognizing the person named therein as having met the requirements to practice respiratory care as defined in this Article.

(6) Licensee. – A person who has been issued a license under this Article.

(7) Medical director. – An appointed physician who is licensed under Article 1 of this Chapter and a member of the entity's medical staff, and who is granted the authority and responsibility for assuring and establishing policies and procedures and that the provision of such is provided to the quality, safety, and appropriateness standards as recognized within the defined scope of practice for the entity.

(8) Person. – An individual, corporation, partnership, association, unit of government, or other legal entity.

(9) Physician. – A doctor of medicine licensed by the State of North Carolina in accordance with Article 1 of this Chapter.

(10) Practice of respiratory care. – As defined by the written order of a physician licensed under Article 1 of this Chapter, the observing and monitoring of signs and symptoms, general behavior, and general physical response to respiratory care treatment and diagnostic testing, including the determination of whether such signs, symptoms, reactions, behavior, or general response

exhibit abnormal characteristics, and the performance of diagnostic testing and therapeutic application or assessment of:

a. Medical gases, humidity, and aerosols including the ~~maintenance~~ use of associated ~~apparatus,~~respiratory care equipment, except for the purpose of anesthesia.

b. Pharmacologic agents related to respiratory care procedures, including those agents necessary to perform hemodynamic monitoring.

c. Mechanical or physiological ventilatory support.

d. Cardiopulmonary resuscitation and maintenance of natural airways, the insertion and maintenance of artificial airways under the direct supervision of a recognized medical director in a health care environment which identifies these services within the scope of practice by the facility's governing board.

e. Hyperbaric oxygen therapy.

f. New and innovative respiratory care and related support activities in appropriately identified environments and under the training and practice guidelines established by the American Association of Respiratory Care.

g. The therapeutic effectiveness of medical equipment used in respiratory care treatment for an individual patient.

The term "practice of respiratory care" also means the interpretation and implementation of a physician's written or verbal order pertaining to the acts described in this subdivision.

(11) Respiratory care. – As defined by the written order of a physician licensed under Article 1 of Chapter 90, the treatment, management, diagnostic testing, and care of patients with deficiencies and abnormalities associated with the cardiopulmonary system.

(12) Respiratory care practitioner. – ~~A person~~ An individual who has been licensed by the Board ~~to engage in the practice of respiratory care.~~as a respiratory care practitioner.

(13) Support activities. – ~~Procedures~~ Tasks that do not require formal academic training, including the delivery, setup, and routine maintenance and repair of ~~apparatus. The term also includes giving instructions on the use, fitting, and application of apparatus, but does not include therapeutic evaluation and assessment.~~respiratory care equipment as defined in rules adopted by the Board. The term "support activities" does not include the evaluation or assessment of the therapeutic effectiveness of any respiratory care treatment or respiratory care equipment for an individual patient."

SECTION 2. G.S. 90-652 reads as rewritten:

"**§ 90-652. Powers and duties of the Board.**

The Board shall have the power and duty to:

(1) Determine the qualifications and fitness of applicants for licensure, renewal of licensure, and reciprocal licensure. The Board shall, in its discretion, investigate the background of an applicant to determine the applicant's qualifications with due regard given to the applicant's competency, honesty, truthfulness, and integrity. The Department of Public Safety may provide a criminal record check to the Board for a person who has applied for a license through the Board. The Board shall provide to the Department of Public Safety, along with the request, the fingerprints of the ~~applicant,~~applicant and any additional information required by the Department of ~~Public Safety, and~~

~~a form signed by the applicant consenting to the check of the criminal record and to the use of the fingerprints and other identifying information required by the State or national repositories.~~Public Safety. The applicant's fingerprints shall be forwarded to the State Bureau of Investigation for a search of the State's criminal history record file, and the State Bureau of Investigation shall forward a set of the fingerprints to the Federal Bureau of Investigation for a national criminal history check. The Board shall keep all information pursuant to this subdivision privileged, in accordance with applicable State law and federal guidelines, and the information shall be confidential and shall not be a public record under Chapter 132 of the General Statutes. The Board shall collect any fees required by the Department of Public Safety and shall remit the fees to the Department of Public Safety for expenses associated with conducting the criminal history record check.

...

(5) Conduct investigations, subpoena individuals and records, and do all other things necessary and proper to discipline persons licensed under this Article and to enforce this ~~Article.~~Article, including the designation of one or more of its employees to issue and serve subpoenas and other papers on behalf of the Board. Service under this subdivision is permitted in accordance with any methods of service allowed by law.

...."

SECTION 3. G.S. 90-653 reads as rewritten:

"**§ 90-653. Licensure requirements; examination.**

(a) Each applicant for licensure under this Article shall ~~meet the following requirements:~~do all of the following:

(1) Submit a completed application as required by the ~~Board.~~Board, including a form signed by the applicant consenting to the check of the applicant's criminal record and to the use of the applicant's fingerprints and other identifying information required by the State and national repositories.

(2) Submit any fees required by the Board.

(3) Submit to the Board written evidence, verified by oath, that the applicant has successfully completed the minimal requirements of ~~a~~ an associate's degree respiratory care education program as approved by the Commission for Accreditation ~~of Allied Health Educational Programs, or the Canadian Council on Accreditation for Respiratory Therapy Education.~~for Respiratory Care (CoARC) or its successor by arranging for the applicant's respiratory care education program to submit a verified transcript directly to the Board.

(4) Submit to the Board written evidence, verified by oath, that the applicant has successfully completed the minimal requirements for Basic Cardiac Life Support as recognized by the American Heart Association, the American Red Cross, or the American Safety and Health Institute.

(5) ~~Pass the entry-level examination given by the National Board for Respiratory Care, Inc.~~Submit to the Board written evidence, verified by oath, that the applicant has earned the advanced level credential or its successor awarded by the National Board for Respiratory Care, Inc.

~~(b) At least three times each year, the Board shall cause the examination required in subdivision (5) of subsection (a) of this section to be given to applicants at a time and place to be announced by the Board. Any applicant who fails to pass the first examination may take additional examinations in accordance with rules adopted pursuant to this Article.~~

(b1) When issuing a license, the Board shall state the terms and conditions of use of the license to the licensee."

SECTION 4. G.S. 90-656 reads as rewritten:

"**§ 90-656. Provisional license.**

(a) The Board may grant a provisional license ~~for a period not exceeding 12 months~~ to any applicant who has ~~successfully~~ done all of the following:

(1) Successfully completed ~~the education requirements under G.S. 90-653(a)(3) and has made application to take the examination required under G.S. 90-653(a)(5).~~the minimal requirements of an associate's degree program in respiratory care currently approved by the Commission on Accreditation for Respiratory Care (CoARC) or its successor by arranging for the applicant's respiratory care education program to submit a verified transcript directly to the Board.

(2) Submitted to the Board written evidence, verified by oath, that the applicant has successfully completed the minimal requirements for Basic Cardiac Life Support as recognized by the American Heart Association, the American Red Cross, or the American Safety and Health Institute.

(3) Submitted to the Board written evidence, verified by oath, that the applicant has earned the entry level credential or its successor awarded by the National Board for Respiratory Care, Inc.

(b) Each provisional license issued under this section shall be effective for a period of up to one year, and may be renewed annually subject to compliance with rules adopted by the Board, but shall not be in effect for a total period exceeding five years from the initial effective date of the provisional license. A provisional license allows the individual to practice respiratory care under the direct supervision of a respiratory care practitioner and in accordance with rules adopted pursuant to this Article. A license granted under this section shall contain an endorsement indicating that the license is provisional and stating the terms and conditions of its use by the licensee and shall state the date the license was granted and the date it expires."

SECTION 5. G.S. 90-659 reads as rewritten:

"**§ 90-659. Suspension, revocation, and refusal to renew a license.**

(a) The Board shall take the necessary actions to deny or refuse to ~~renew a license,~~renew, suspend or revoke a ~~license, or~~license; to impose probationary conditions on a ~~licensee or applicant if the~~license, including placing limitations on the practice of respiratory care; to reprimand a licensee or applicant; to assess a monetary penalty, costs, or both on a licensee or applicant; and to require a licensee or applicant to demonstrate satisfactory completion of treatment or educational programs, if any of the following are true of the licensee or applicant:

(1) Has engaged in any of the following conduct:

a. Employed fraud, deceit, bribery, or misrepresentation in (i) obtaining or attempting to obtain a ~~license or~~license or (ii) obtaining or attempting to obtain the renewal of a ~~license.~~license.

b. Committed an act of malpractice, gross negligence, or incompetence in the practice of respiratory care.

c. Practiced respiratory care without a license.

d. Engaged in health care practices that are determined to be hazardous to public health, safety, or welfare.

(2) Was convicted of or entered a plea of guilty or nolo contendere to any crime involving moral turpitude.

(3) ~~Was adjudicated insane or incompetent, until proof of recovery from the condition can be established.~~Has developed a physical or mental impairment that renders the licensee or applicant unfit to practice respiratory care with

reasonable skill and competence and in a manner not harmful to the public. An adjudication of mental incompetency in a court of competent jurisdiction or a determination of mental incompetency by other lawful means shall be conclusive proof of unfitness to practice respiratory care until the licensee or applicant is subsequently adjudicated mentally competent.

(4) ~~Engaged~~ Has engaged in any act or practice that violates any of the provisions of this Article or any rule adopted pursuant to this Article, or aided, abetted, or assisted any person in such a violation.

(5) Has failed 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 a license to practice respiratory care.

(6) Has developed an impairment caused by the licensee's or applicant's use of alcohol, drugs, or controlled substances, which interferes with the ability of the licensee or applicant to practice respiratory care with reasonable skill, competence, and in a manner not harmful to the public.

(7) Has practiced respiratory care outside the boundaries of demonstrated competence or the limitations of education, training, or supervised experience.

(8) Has had a license for the practice of respiratory care in any other jurisdiction suspended or revoked or been disciplined by any licensing or certification board in any other jurisdiction for conduct that would subject the licensee or applicant to disciplinary action under this Article.

(9) Is a hazard to the public health by reason of having a serious communicable disease.

(b) ~~Denial,~~Except as provided in subsection (c) of this section, denial, refusal to renew, suspension, or revocation of a license, or imposition of probationary conditions upon a licensee may be ordered by the Board after a hearing held in accordance with Article 3A of Chapter 150B of the General Statutes and rules adopted pursuant to this Article. An application may be made to the Board for reinstatement of a revoked license if the revocation has been in effect for at least one year.

(c) The Board may deny an initial application for a license as a respiratory care practitioner without a hearing if the individual fails to submit a complete application which demonstrates that the applicant has met the education and entry level credential requirements of G.S. 90-653.

(d) If after notice is duly issued, a licensee or applicant fails to appear for a scheduled hearing and no continuance has been granted, the Board may hear the evidence of witnesses that have appeared, and the Board may proceed to consider the matter and dispose of the matter on the basis of the evidence before the Board. For good cause, the Board may reopen any case for further hearing.

(e) 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.

(f) A person acting in good faith without fraud or malice shall be immune from civil liability for the following:

(1) Reporting, investigating, assessing, monitoring, or providing an expert medical opinion to the Board regarding the acts or omissions of a licensee or applicant that violate the provisions of subsection (a) of this section or any other provision of law relating to the fitness of a licensee or applicant to practice respiratory care.

(2) Initiating or conducting proceedings or an action against a licensee or applicant.

(3) Testifying before the Board in good faith in any proceeding involving a violation of subsection (a) of this section or any other law relating to the fitness of an applicant or licensee to practice respiratory care.

(4) Making a recommendation to the Board in the nature of peer review.

(g) A licensee may, with the consent of the Board, voluntarily relinquish a license at any time. The Board may delay or refuse the granting of its consent as it may deem necessary in order to investigate any pending complaint, allegation, or issue regarding violation of any provisions of this Article by the licensee. Notwithstanding any provision to the contrary, the Board retains full jurisdiction to investigate alleged violations of this Article by any person whose license is relinquished under this subsection and, upon proof of any violation of this Article by any such person, the Board may take disciplinary action as authorized by this section."

SECTION 6. G.S. 90-661 reads as rewritten:

"**§ 90-661. Requirement of license.**

(a) It shall be unlawful for any person who is not currently licensed under this Article to:

(1) Engage in the practice of respiratory care.

(2) Use the title "respiratory care practitioner".

(3) Use the letters ~~"RCP", "RTT", "RT",~~"RCP" or any facsimile or combination in any words, letters, abbreviations, or ~~insignia.~~insignia that indicate or imply the person is a licensed respiratory care practitioner.

(4) Imply orally or in writing or indicate in any way that the person is a respiratory care practitioner or is otherwise licensed under this Article.

(5) Employ or solicit for employment unlicensed persons to practice respiratory care.

(6) Advertise, hold out to the public, or represent in any manner that the individual is authorized to practice respiratory care in this State.

(b) It shall be unlawful for any person to employ or solicit for employment unlicensed persons to practice respiratory care.

SECTION 7. Article 38 of Chapter 90 of the General Statutes is amended by adding a new section to read:

"**§ 90-633.1. Immunity from civil liability.**

(c) Any person, partnership, firm, corporation, association, authority, or other entity acting in good faith without fraud or malice, including the Board, its staff, and its counsel shall be immune from civil liability for (i) reporting, investigating, assessing, monitoring, or providing an expert medical opinion to the Board regarding the acts or omissions of a person on the ground that the person is violating this Article, (ii) initiating or conducting proceedings against a person on the ground that the person is violating this Article. A person shall not be held liable in any civil proceeding for testifying before the Board in good faith and without fraud or malice in any proceeding commenced on the ground that the person is violating this Article."

SECTION 8. G.S. 90-664 reads as rewritten:

"**§ 90-664. Persons and practices not affected.**

The requirements of this Article shall not apply to:

(1) Any person registered, certified, credentialed, or licensed to engage in another profession or occupation or any person working under the supervision of a person registered, certified, credentialed, or licensed to engage in another profession or occupation in this State who is performing work incidental to or within the practice of that profession or occupation and does not represent himself or herself as a respiratory care practitioner.

(2) A student or trainee working under the direct supervision of a respiratory care practitioner while fulfilling an experience requirement or pursuing a course of study to meet requirements for licensure in accordance with rules adopted pursuant to this Article.

(3) A respiratory care practitioner serving in the Armed Forces or the Public Health Service of the United States or employed by the Veterans Administration ~~when performing duties associated with that service or employment.~~or other federal agency, to the extent permitted under federal law, so long as the individual limits services to those directly related to work with the employing federal agency.

(4) A person who performs only support activities as defined in G.S. 90-648(13).

(5) A person licensed as a respiratory care practitioner in another jurisdiction while providing respiratory care in a declared emergency in this State, providing respiratory care as a member of an organ harvesting team, or providing respiratory care on board an ambulance as part of an ambulance transport team transporting a patient into or out of this State."

SECTION 9. Notwithstanding any other provision of law to the contrary, any person licensed by the North Carolina Respiratory Care Board on October 1, 2016, who has passed the entry-level examination administered by the National Board for Respiratory Care, Inc., shall be deemed to have complied with the requirements of subdivision G.S. 90-653(a)(5), as amended by this act.

SECTION 10. G.S. 90-654 and G.S. 90-660(b)(6) are repealed.

SECTION 11. Section 5 of this act becomes effective October 1, 2015. Sections 3 and 4 of this act become effective October 1, 2016. The remainder of the act is effective when it becomes law.

NORTH CAROLINA GENERAL ASSEMBLY
AMENDMENT
House Bill 267

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

H267-ATK-5 [v.2]

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

Date _____ ,2015

Representative Goodman

moves to amend the bill on page 6, line 32, by deleting the phrase ""**§ 90-633.1.**" and substituting the phrase ""**§ 90-663.1.**"".

SIGNED _____
Amendment Sponsor

SIGNED _____
Committee Chair if Senate Committee Amendment

ADOPTED _____ FAILED _____ TABLED _____

HOUSE BILL 281

Short Title:	Records to Medical Examiner.	(Public)
Sponsors:	Representatives L. Hall, Setzer, Cunningham, and Pierce (Primary Sponsors). *For a complete list of Sponsors, refer to the North Carolina General Assembly Web Site.*	
Referred to:	Health.	

March 19, 2015

A BILL TO BE ENTITLED

AN ACT TO PROVIDE FOR THE DIVISION OF ADULT CORRECTION TO PROVIDE COPIES OF ALL RECORDS TO THE OFFICE OF THE CHIEF MEDICAL EXAMINER IN THE EVENT OF THE DEATH OF AN INMATE IN THE CUSTODY OF THE DIVISION.

The General Assembly of North Carolina enacts:

SECTION 1. Article 1 of Chapter 148 of the General Statutes is amended by adding a new section to read:

"**§ 148-10.5. Death of an inmate; records to the Office of the Chief Medical Examiner.**

In addition to any other requirements under State law, and consistent with the responsibilities and jurisdiction of medical examiners under Part 1 of Article 16 of Chapter 130A of the General Statutes, whenever an inmate dies while in the custody of the Division of Adult Correction, the Division shall provide full and accurate copies of all records associated with the deceased inmate, including any records made after the inmate's death, to the Office of the Chief Medical Examiner. In the event that the State Bureau of Investigation conducts an investigation into the death, a full and accurate copy of the report of that investigation shall also be provided to the Office of the Chief Medical Examiner. Notwithstanding any other provision of law, no right of privacy considerations shall prevent the Office of the Chief Medical Examiner from obtaining copies of all such records directly from the Division of Adult Correction or the State Bureau of Investigation."

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

HOUSE BILL 281:
Records to Medical Examiner

2015-2016 General Assembly

Committee:	House Health	**Date:**	March 24, 2015
Introduced by:	Reps. L. Hall, Setzer, Cunningham, Pierce	**Prepared by:**	Theresa Matula
Analysis of:	First Edition		Committee Staff

SUMMARY: House Bill 281 requires the Division of Adult Correction to provide copies of all records to the Office of the Chief Medical Examiner when an inmate dies while in the custody of the Division of Adult Correction.

CURRENT LAW:

Chapter 130A, Article 16, Part 1 pertains to Postmortem Medicolegal Examinations and Services.

G.S. 130A-383 provides that upon the death of any person resulting from violence, poisoning, accident, suicide or homicide; occurring suddenly when the deceased had been in apparent good health or when unattended by a physician; *occurring in a jail, prison, correctional institution* or in police custody; occurring in State facilities operated in accordance with Part 5 of Article 4 of Chapter 122C of the General Statutes; occurring pursuant to Article 19 of Chapter 15 of the General Statutes; or occurring under any suspicious, unusual or unnatural circumstance, the medical examiner of the county in which the body of the deceased is found shall be notified by a physician in attendance, hospital employee, law-enforcement officer, funeral home employee, emergency medical technician, relative or by any other person having suspicion of such a death.

BILL ANALYSIS:

House Bill 281 adds a new section to Chapter 148. State Prison System, Article 1. Organization and Management. The new statute, G.S. 148-10.5, provides that in addition to any other legal requirements and consistent with the jurisdiction and responsibilities of medical examiners, the Division of Adult Correction must provide full and accurate copies of all records associated with a deceased inmate, including any record made after the inmate's death, when the inmate dies in the custody of the Division. The records are provided to the Office of the Chief Medical Examiner. If the State Bureau of Investigation conducts an investigation into the death, a full and accurate copy of the report of the investigation must also be provided to the Office of the Chief Medical Examiner. Notwithstanding any other law, no right of privacy considerations prevent the Office of the Chief Medical Examiner from obtaining copies of such records directly from the Division of Adult Correction or the State Bureau of Investigation.

EFFECTIVE DATE: This bill would become effective when it becomes law.

NORTH CAROLINA GENERAL ASSEMBLY
AMENDMENT
House Bill 281

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

H281-ASH-3 [v.1]

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

Date March 25, 2015 ~~2015~~

Representative Goodman

moves to amend the bill on page 1, line 20, by rewriting the line to read:

"Correction or the State Bureau of Investigation. Records provided to the Office of the Chief Medical Examiner pursuant to this section shall not be public records as defined by G.S. 132-1 if the records would not be public records in the custody of the Division of Adult Correction or the State Bureau of Investigation.".

SIGNED _____
Amendment Sponsor

SIGNED _____
Committee Chair if Senate Committee Amendment

ADOPTED _____ FAILED _____ TABLED _____

NORTH CAROLINA GENERAL ASSEMBLY
AMENDMENT
House Bill 281

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

H281-ASH-4 [v.1]

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

Date March 25, 2015

Representative L. Hall

moves to amend the bill on page 1, lines 13-14, by rewriting the lines to read:

"Adult Correction, the Division shall provide, for the purpose of determining the cause and manner of death, full and accurate copies of all records associated with the deceased inmate, including any records made after the inmate's death, as requested by the Office of the"

And on line 17, by rewriting the line to read:

"be provided upon request to the Office of the Chief Medical Examiner. Notwithstanding any other provision".

SIGNED Larry D. Hall
Amendment Sponsor

SIGNED _____
Committee Chair if Senate Committee Amendment

ADOPTED _____ FAILED _____ TABLED _____

HOUSE BILL 286

Short Title:	Dental Hygienists/Intraoral Local Anesthetics.	(Public)
Sponsors:	Representative Jones (Primary Sponsor). *For a complete list of Sponsors, refer to the North Carolina General Assembly Web Site.*	
Referred to:	Health.	

March 19, 2015

A BILL TO BE ENTITLED

AN ACT AMENDING THE DENTAL HYGIENE ACT TO AUTHORIZE PROPERLY TRAINED DENTAL HYGIENISTS TO ADMINISTER INTRAORAL LOCAL DENTAL ANESTHETICS UNDER THE DIRECT SUPERVISION OF A LICENSED DENTIST.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 90-221 reads as rewritten:

"**§ 90-221. Definitions.**

The following definitions apply in this Article:

(1) Board. – The North Carolina State Board of Dental Examiners created by Chapter 139, Public Laws of 1879, and Chapter 178, Public Laws of 1915 as continued in existence by G.S. 90-22.

~~(a)~~(2) ~~"Dental hygiene" as used in this Article shall mean the~~Dental hygiene. – The performance of the following functions: Complete oral prophylaxis, application of preventive agents to oral structures, exposure and processing of radiographs, administration of medicaments prescribed by a licensed dentist, preparation of diagnostic aids, and written records of oral conditions for interpretation by the dentist, together with such other and further functions as may be permitted by rules and regulations of the Board not inconsistent herewith. For a dental hygienist who has completed additional training and is currently certified as required by G.S. 90-223(a6), the term also includes administration of intraoral local dental anesthetics by infiltration and block techniques, but only under the direct supervision of a dentist licensed in this State.

~~(b)~~(3) ~~"Dental hygienist" as used in this Article, shall mean any~~Dental hygienist. – Any person who is a graduate of a Board-accredited school of dental hygiene, who has been licensed by the Board, and who practices dental hygiene as prescribed by the Board.

(4) Direct supervision. – Acts are deemed to be under direct supervision of a licensed dentist when performed in a locale where the supervising licensed dentist is physically present during the performance of such acts. The term does not include lesser supervision under G.S. 90-233(a) or G.S. 90-233(a1).

~~(c)~~(5) ~~"License" shall mean a~~License. – A certificate issued to any applicant upon completion of requirements for admission to practice dental hygiene.

~~(d)~~(6) ~~"Renewal certificate" shall mean the~~Renewal certificate. – The annual certificate of renewal of license to continue practice of dental hygiene in the State of North Carolina.

~~(e) "Board" shall mean "The North Carolina State Board of Dental Examiners" created by Chapter 139, Public Laws of 1879, and Chapter 178, Public Laws of 1915 as continued in existence by G.S. 90-22.~~

~~(f)~~(7) ~~"Supervision" as used in this Article shall mean that acts~~Supervision. – Acts are deemed to be under the supervision of a licensed dentist when performed in a locale where a licensed dentist is physically present during the performance of such acts, except those acts performed under direction and in compliance with G.S. 90-233(a) or ~~G.S. 90-233(a1), and such acts~~G.S. 90-233(a1), and which are being performed pursuant to the dentist's order, control and approval."

SECTION 2. G.S. 90-233(a1) reads as rewritten:

"(a1) A dental hygienist who has three years of experience in clinical dental hygiene or a minimum of 2,000 hours performing primarily prophylaxis or periodontal debridement under the supervision of a licensed dentist, who (i) completes annual CPR certification, ~~who~~ (ii) completes six hours each year of Board-approved continuing education in medical emergencies in addition to the requirements of G.S. 90-225.1, and ~~who~~ (iii) is designated by the employing dentist as being capable of performing clinical hygiene procedures without the direct supervision of the dentist, may perform one or more dental hygiene functions as described in the first sentence of ~~G.S. 90-221(a)~~ G.S. 90-221(2) without a licensed dentist being physically present if all of the following conditions are met:

(1) A licensed dentist directs in writing the hygienist to perform the dental hygiene functions.

(2) The licensed dentist has personally conducted an evaluation of the patient which shall include a complete oral examination of the patient, a thorough analysis of the patient's health history, a diagnosis of the patient's condition, and a specific written plan for treatment.

(3) The dental hygiene functions directed to be performed in accordance with this subsection shall be conducted within 120 days ~~of~~ after the dentist's evaluation.

(4) The services are performed in nursing homes; rest homes; long-term care facilities; rural and community clinics operated by Board-approved nonprofits; rural and community clinics operated by federal, State, county, or local governments; and any other facilities identified by the Office of Rural Health and approved by the Board as serving dental access shortage areas."

SECTION 3. G.S. 90-233 is amended by adding a new subsection to read:

"(a6) A dental hygienist who has completed a program approved by the Board in accordance with G.S. 90-233.5, may administer intraoral local dental anesthetics by infiltration and block techniques, but only under the direct supervision of a dentist licensed in this State."

SECTION 4. Article 16 of Chapter 90 of the General Statutes is amended by adding a new section to read:

"**§ 90-233.5. Board approval of programs to qualify dental hygienists to administer intraoral local dental anesthetics.**

(a) The Board is authorized to approve any program that qualifies dental hygienists to administer intraoral local dental anesthetics as described in G.S. 90-221(2). The Board's authority includes approval over the content of required courses, the length of training, and the nature of a subsequent preceptorship under a dentist licensed and practicing in this State. The

Board shall not approve any certification program that does not, at a minimum, require all of the following:

(1) Instruction using lecture and laboratory or clinical formats at the University of North Carolina School of Dentistry, the East Carolina University School of Dental Medicine, or both.

(2) Instruction by a dentist who has a DDS or DMD degree from a program of dentistry in a school or college accredited by the Commission on Dental Accreditation of the American Dental Association and approved by the Board.

(3) A faculty to student ratio of no greater than 1:4 for laboratory or clinical instruction.

(4) Instruction to enable attainment of a minimum level of competence and upon successful attainment of that minimum level of competence, issuance of a certificate of completion.

(5) Completion of a training program that includes, at a minimum, a three-day session on intraoral local dental anesthetics that includes all of the following:

a. Fourteen lecture hours on pharmacology, physiology, equipment, and technique.

b. Three lecture hours on medical emergencies.

c. A two-hour laboratory or clinical course.

d. Three one-hour evaluations of a student's competence.

(6) Within 12 months after successful completion of a training program that meets the requirements of subdivision (5) of this subsection, completion of a six-month preceptorship that includes a minimum of 750 hours performing primarily the administration of intraoral local dental anesthetics by infiltration and block techniques under the direct supervision of a dentist licensed and practicing in this State. The preceptorship process shall (i) include a comprehensive evaluation and assessment of the dental hygienist's knowledge and abilities in administration of intraoral local dental anesthetics and (ii) require the preceptor dentist to execute a certificate of qualification upon successful completion of the preceptorship to demonstrate that the dental hygienist is qualified to administer intraoral local dental anesthetics as described in G.S. 90-221(2).

(b) The Board may approve an application by a dental hygienist licensed under G.S. 90-225 to administer intraoral local dental anesthetics as described in G.S. 90-221(2) without completing a program approved by the Board in accordance with subsection (a) of this section upon evidence that (i) the licensed dental hygienist was qualified to administer intraoral local dental anesthetics in another state, country, or territory and (ii) the education, training, and qualification requirements for administering intraoral local dental anesthetics in the other jurisdiction are substantially equivalent to the requirements of subsection (a) of this section. If the Board determines that the education, training, and qualification requirements of the other jurisdiction are not substantially equivalent to the requirements of subsection (a) of this section, the Board may require the licensed dental hygienist to complete all or parts of the requirements specified in subsection (a) of this section in order to become qualified to administer intraoral local dental anesthetics in this State.

(c) The Board shall require a dental hygienist to annually submit to the Board evidence of continuing competence to administer intraoral local dental anesthetics as described in G.S. 90-221(2). Evidence of continuing competence shall be satisfied upon demonstration that the dental hygienist has completed annual CPR certification and at least two hours each year of Board-approved continuing education related to the administration of intraoral local dental anesthetics. The Board may apply these continuing education hours toward satisfaction of the

six hours of continuing education in medical emergencies required each year of licensed dental hygienists pursuant to G.S. 90-233(a1), or require that these hours be completed in addition to the six hours required by G.S. 90-225.1.

(d) As long as a lawfully authorized dental hygienist qualified to administer intraoral local dental anesthetics is properly working under the direct supervision of a dentist licensed to practice in North Carolina, the administration of intraoral local dental anesthetics by the dental hygienist shall not be prohibited or otherwise limited by G.S. 90-29(b)(6)."

SECTION 5. The North Carolina Board of Dental Examiners shall, under G.S. 90-48, 90-222, and 90-223(b), have full power and authority to adopt rules not inconsistent with Article 2 and Article 16 of Chapter 90 of the General Statutes to implement and enforce the provisions of this act.

SECTION 6. G.S. 90-233.1 is recodified as G.S. 90-233.10 under Article 16 of Chapter 90 of the General Statutes.

SECTION 7. G.S. 90-233.1 through G.S. 90-233.4 are reserved for future codification purposes.

SECTION 8. This act becomes effective January 1, 2016.

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2015

H D

HOUSE BILL 286
PROPOSED COMMITTEE SUBSTITUTE H286-CSTK-1 [v.4]

3/24/2015 8:47:51 PM

Short Title: Dental Hygienists/Intraoral Local Anesthetics. (Public)

Sponsors:

Referred to:

March 19, 2015

A BILL TO BE ENTITLED

AN ACT AMENDING THE DENTAL HYGIENE ACT TO AUTHORIZE PROPERLY TRAINED DENTAL HYGIENISTS TO ADMINISTER INTRAORAL LOCAL DENTAL ANESTHETICS UNDER THE DIRECT SUPERVISION OF A LICENSED DENTIST.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 90-29(b)(6) reads as rewritten:

"(b) A person shall be deemed to be practicing dentistry in this State who does, undertakes or attempts to do, or claims the ability to do any one or more of the following acts or things which, for the purposes of this Article, constitute the practice of dentistry:

...

(6) Administers an anesthetic of any kind in the treatment of dental or oral diseases or physical conditions, or in preparation for or incident to any operation within the oral cavity; provided, however, that this subsection shall not apply to a lawfully qualified nurse anesthetist who administers such anesthetic under the supervision and direction of a licensed dentist or physician or to a lawfully certified dental hygienist who administers intraoral local dental anesthetics by infiltration and block techniques under the direct supervision of a dentist licensed in this State;"

SECTION 2. G.S. 90-221 reads as rewritten:

"**§ 90-221. Definitions.**

The following definitions apply in this Article:

(1) Board. – The North Carolina State Board of Dental Examiners created by Chapter 139, Public Laws of 1879, and Chapter 178, Public Laws of 1915 as continued in existence by G.S. 90-22.

~~(a)~~(2) ~~"Dental hygiene" as used in this Article shall mean the~~Dental hygiene. – The performance of the following functions:

(a) Complete oral prophylaxis, application of preventive agents to oral structures, exposure and processing of radiographs, administration of medicaments prescribed by a licensed dentist, preparation of diagnostic aids, and written records of oral conditions for interpretation by the dentist, together with such other and further functions as may be permitted by rules and regulations of the Board not inconsistent herewith.

(b) For a dental hygienist who has completed additional training and is currently certified as required by G.S. 90-223(a6), the term also includes administration of intraoral local dental

anesthetics by infiltration and block techniques, but only under the direct supervision of a dentist licensed in this State.

~~(b)~~(3) ~~"Dental hygienist" as used in this Article, shall mean any~~Dental hygienist. – Any person who is a graduate of a Board-accredited school of dental hygiene, who has been licensed by the Board, and who practices dental hygiene as prescribed by the Board.

~~(c)~~(4) ~~"License" shall mean a~~License. – A certificate issued to any applicant upon completion of requirements for admission to practice dental hygiene.

~~(d)~~(5) ~~"Renewal certificate" shall mean the~~Renewal certificate. – The annual certificate of renewal of license to continue practice of dental hygiene in the State of North Carolina.

~~(e) "Board" shall mean "The North Carolina State Board of Dental Examiners" created by Chapter 139, Public Laws of 1879, and Chapter 178, Public Laws of 1915 as continued in existence by G.S. 90-22.~~

~~(f)~~(6) ~~"Supervision" as used in this Article shall mean that acts~~Supervision. – Acts are deemed to be under the supervision of a licensed dentist when performed in a locale where a licensed dentist is physically present during the performance of such acts, except those acts performed under direction and in compliance with G.S. 90-233(a) or ~~G.S. 90-233(a1), and such acts~~G.S. 90-233(a1), and that are being performed pursuant to the dentist's order, control and approval."

SECTION 3. G.S. 90-233(a1) reads as rewritten:

"(a1) A dental hygienist who has three years of experience in clinical dental hygiene or a minimum of 2,000 hours performing primarily prophylaxis or periodontal debridement under the supervision of a licensed dentist, who (i) completes annual CPR certification, ~~who~~ (ii) completes six hours each year of Board-approved continuing education in medical emergencies in addition to the requirements of G.S. 90-225.1, and ~~who~~ (iii) is designated by the employing dentist as being capable of performing clinical hygiene procedures without the direct supervision of the dentist, may perform one or more dental hygiene functions as described in G.S. 90-221(a) without a licensed dentist being physically present if all of the following conditions are met:

(1) A licensed dentist directs in writing the hygienist to perform the dental hygiene functions.

(2) The licensed dentist has personally conducted an evaluation of the patient which shall include a complete oral examination of the patient, a thorough analysis of the patient's health history, a diagnosis of the patient's condition, and a specific written plan for treatment.

(3) The dental hygiene functions directed to be performed in accordance with this subsection shall be conducted within 120 days ~~of~~ after the dentist's evaluation.

(4) The services are performed in nursing homes; rest homes; long-term care facilities; rural and community clinics operated by Board-approved nonprofits; rural and community clinics operated by federal, State, county, or local governments; and any other facilities identified by the Office of Rural Health and approved by the Board as serving dental access shortage areas."

SECTION 4. G.S. 90-233 is amended by adding a new subsection to read:

"(a6) A dental hygienist who has completed a program approved by the Board in accordance with G.S. 90-233.6 and who has been properly certified by the Board may administer intraoral local dental anesthetics by infiltration and block techniques, but only under the direct supervision of a dentist licensed in this State."

SECTION 5. Article 16 of Chapter 90 of the General Statutes is amended by adding a new section to read:

"**§ 90-233.5. Board certification of properly trained dental hygienists to administer intraoal local dental anesthetics.**

The Board shall certify a licensed dental hygienist who has completed a program approved by the Board in accordance with G.S. 90-233.6 to administer intraoral local dental anesthetics, but only under the direct supervision of a dentist licensed in this State."

SECTION 6. Article 16 of Chapter 90 of the General Statutes is amended by adding a new section to read:

"**§ 90-233.6. Board approval of programs to qualify dental hygienists to administer intraoral local dental anesthetics.**

(a) The Board is authorized to approve any program that qualifies dental hygienists to administer intraoral local dental anesthetics as described in G.S. 90-221(2)(b). The Board's authority includes approval over the content of required courses, the length of training, and the nature of a subsequent preceptorship under a dentist licensed and practicing in this State. The Board shall not approve any certification program that does not, at a minimum, require all of the following:

(1) Instruction using lecture and laboratory or clinical formats at the University of North Carolina School of Dentistry, the East Carolina University School of Dental Medicine, or both.

(2) Instruction by a dentist who has a DDS or DMD degree from a program of dentistry in a school or college accredited by the Commission on Dental Accreditation of the American Dental Association and approved by the Board.

(3) A faculty to student ratio of no greater than 1:4 for laboratory or clinical instruction.

(4) Instruction to enable attainment of a minimum level of competence and upon successful attainment of that minimum level of competence, issuance of a certificate of completion.

(5) Completion of a training program that includes, at a minimum, a three-day session on intraoral local dental anesthetics that includes all of the following:

a. Fourteen lecture hours on pharmacology, physiology, equipment, and technique.

b. Three lecture hours on medical emergencies.

c. A two-hour laboratory or clinical course.

d. Three one-hour evaluations of a student's competence.

(6) Within 12 months after successful completion of a training program that meets the requirements of subdivision (5) of this subsection, completion of a six-month preceptorship that includes a minimum of 750 hours performing primarily the administration of intraoral local dental anesthetics by infiltration and block techniques under the direct supervision of a dentist licensed and practicing in this State. The preceptorship process shall (i) include a comprehensive evaluation and assessment of the dental hygienist's knowledge and abilities in administration of intraoral local dental anesthetics and (ii) require the preceptor dentist to execute a certificate of qualification upon successful completion of the preceptorship to demonstrate that the dental hygienist is qualified to administer intraoral local dental anesthetics as described in G.S. 90-221(2)(b).

(b) The Board may approve an application by a dental hygienist licensed under G.S. 90-225 to administer intraoral local dental anesthetics as described in G.S. 90-221(2)(b) without completing a program approved by the Board in accordance with subsection (a) of this

section upon evidence that (i) the licensed dental hygienist was qualified to administer intraoral local dental anesthetics in another state, country, or territory and (ii) the education, training, and qualification requirements for administering intraoral local dental anesthetics in the other jurisdiction are substantially equivalent to the requirements of subsection (a) of this section. If the Board determines that the education, training, and qualification requirements of the other jurisdiction are not substantially equivalent to the requirements of subsection (a) of this section, the Board may require the licensed dental hygienist to complete all or parts of the requirements specified in subsection (a) of this section in order to become qualified to administer intraoral local dental anesthetics in this State.

(c) The Board shall require a dental hygienist to annually submit to the Board evidence of continuing competence to administer intraoral local dental anesthetics as described in G.S. 90-221(2)(b). Evidence of continuing competence shall be satisfied upon demonstration that the dental hygienist has completed annual CPR certification and at least two hours each year of Board-approved continuing education related to the administration of intraoral local dental anesthetics. The Board may apply these continuing education hours toward satisfaction of the continuing education requirements for hygienists by the Board under G.S. 90-225.1, or the Board may require that the two hours of annual continuing education for intraoral local dental anesthetics qualified dental hygienists required by this subsection be completed in addition to the hours required under G.S. 90-225.1."

SECTION 7. The North Carolina Board of Dental Examiners shall, under G.S. 90-48, 90-222, and 90-223(b), have full power and authority to adopt rules not inconsistent with Article 2 and Article 16 of Chapter 90 of the General Statutes to implement and enforce the provisions of this act.

SECTION 8. G.S. 90-233.1 is recodified as G.S. 90-233.10 under Article 16 of Chapter 90 of the General Statutes.

SECTION 9. G.S. 90-233.1 through G.S. 90-233.4 are reserved for future codification purposes.

SECTION 10. This act becomes effective January 1, 2016.

HOUSE BILL 286:
Dental Hygienists/Intraoral Local Anesthetics

2015-2016 General Assembly

Committee:	House Health	**Date:**	March 24, 2015
Introduced by:	Rep. Jones	**Prepared by:**	Amy Jo Johnson Committee Counsel
Analysis of:	PCS to First Edition H286-CSTK-1		

SUMMARY: ***The PCS to House bill 286 would authorize the North Carolina State Board of Dental Examiners to certify properly trained dental hygienist to administer intraoral local dental anesthetics under the direct supervision of a dentist. The bill further outlines the educational requirements dental hygientists must possess in order to apply for this certification. The PCS makes some technical changes.***

CURRENT LAW: G.S. 90-20(b) specifies that the practice of dentistry includes the administration of "anesthetics of any kind in the treatment of dental or oral diseases or physical conditions, or in preparation for or incident to any operation within the oral cavity" and specifically does not include lawfully qualified nurse anesthetists under the supervision and direction of a licensed dentist or physician. Currently, dental hygienists are not able to administer any anesthetic.

BACKGROUND: 45 states, including the District of Columbia, allow for local anesthesia administration by dental hygienists.

BILL ANALYSIS:

Section 1 of the PCS amends G.S. 90-20(b) to also exclude a lawfully certified dental hygientist, under the direction supervision of a dentist licensed in this State, who administers intraoral local dental anesthetics by infiltration and block techniques from the statutes regulating the practice of dentisty. **Section 2** of the PCS amends G.S.90-221 to include within the performance of dental hygiene the administration of local dental anesthetics by infiltration and block techniques under the direct supervision of a licensed dentist, only for dental hygienists who have completed additional training and who are certified by the NC State Board of Dental Examiners (Board) to perform this function.

Section 3 includes technical changes.

Section 4 creates a new subsection to G.S.90-233 – the statute that regulates the practice of dental hygiene. This amendment allows for a dental hygienist who has completed a program approved by the Board and who has been certified by the Board to administer intraoral local dental anesthetics by infiltration and block techniques under the direct supervision of a dentist licensed in the state of North Carolina.

Section 5 creates a new section 90-233.5 which directs the NC State Board of Dental Examiners to certify a licensed dental hygienist who has completed the required training program approved by the Board to administer intraoral local dental anesthetics by infiltration and block techniques.

Section 6 creates a new section 90-233.6. This new section authorizes the Board to approve any program that qualifies dental hygienists to administer intraoral local dental anesthetics by infiltration and block techniques. The Board has authority over the approval of the content, the length of training and

the nature of a subsequent preceptorship. However, the section states the Board will not approve any certification program that does not, at a minimum, require all of the following:

- Instruction using lecture and laboratory or clinical formats at the University of North Carolina School of Dentistry, the East Carolina University School of Dental Medicine, or both.
- Instruction by a dentist who has a DDS or DMD degree from a program of dentistry in a school or college accredited by the Commission on Dental Accreditation of the American Dental Association and approved by the Board.
- A faculty to student ratio of no greater than 1:4 for lab or clinical instruction.
- Instruction to enable attainment of a minimum level of competence and upon successful attainment, issuance of a certificate of completion.
- A minimum of a three-day session on intraoral local dental anesthetics by infiltration that includes: 14 lecture hours on pharmacology, physiology, equipment, and technique; 3 lecture hours on medical emergencies; 2 hour lab or clinicals; and 3 one-hour evaluations of the student's competence.
- Within 12 months of a successful completion of the training program, completion of a 6 month preceptorship that includes a minimum of 750 hours performing the administration of intraoral local dental anesthetics by infiltration and block techniques under the direction supervision of a licensed dentist. The preceptorship must include a comprehensive evaluation and assessment of the hygienist and require the preceptor dentist to execute a certificate of qualification upon successful completed of the preceptorship.

If a dental hygienist was qualified to administer intraoral local dental anesthetics by in another state, country, or territory and the educational, training, and qualification requirements for doing so in the other jurisdiction were substantially similar to those required by the Board, the Board may approve an application by a dental hygienist licensed in this State to administer intraoral local dental anesthetics by infiltration and block techniques. If the educational, training, and qualification requirements for doing so in the other jurisdiction were **not** substantially similar to those required by the Board, the Board may require the licensed dental hygienist to complete all or parts of the Board's requirements in order to administer intraoral local dental anesthetics in this State.

Dental hygienists will be required to annually submit to the Board evidence of continuing competence to administer intraoral local dental anesthetics by infiltration and block techniques. Such evidence will include annual CPR certification and at least 2 hours of Board-approved continuing education related to the administration of intraoral local dental anesthetics.

Section 7 authorizes the Board to adopt rules to implement these new provisions.

Section 8 and **Section 9** contain technical changes.

EFFECTIVE DATE: This act becomes effective January 1, 2016.

NORTH CAROLINA GENERAL ASSEMBLY
AMENDMENT
House Bill 286

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

H286-ATK-4 [v.2]

Comm. Sub. [YES]
Amends Title [NO]
H286-CSTK-1

Date _____,2015

Representative Jones

moves to amend the bill on page 2, line 30, by deleting the phrase "G.S. 90-221(a)" and substituting the phrase "~~G.S. 90-221~~(a)G.S.90-221(2)(a)".

SIGNED _____
Amendment Sponsor

SIGNED _____
Committee Chair if Senate Committee Amendment

ADOPTED _____ FAILED _____ TABLED _____

NORTH CAROLINA GENERAL ASSEMBLY
HOUSE OF REPRESENTATIVES

HEALTH COMMITTEE REPORT
Representative Brian Brown, Co-Chair
Representative Justin P. Burr, Co-Chair
Representative Bert Jones, Co-Chair
Representative Donny Lambeth, Co-Chair

FAVORABLE COM SUB , UNFAVORABLE ORIGINAL BILL

HB **281** Records to Medical Examiner.

Draft Number:	H281-PCS40183-SH-9
Serial Referral:	None
Recommended Referral:	None
Long Title Amended:	No
Floor Manager:	L. Hall

HB **286** Dental Hygienists/Intraoral Local Anesthetics.

Draft Number:	H286-PCS10151-TK-1
Serial Referral:	None
Recommended Referral:	None
Long Title Amended:	No
Floor Manager:	Jones

FAVORABLE COM SUB , UNFAVORABLE ORIGINAL BILL AND RE-REFERRED

HB **267** Amend Respiratory Care Practice Act.-AB

Draft Number:	H267-PCS30153-TK-2
Serial Referral:	**FINANCE**
Recommended Referral:	None
Long Title Amended:	No
Floor Manager:	Goodman

TOTAL REPORTED: 3

CMR83-V-1

Committee Sergeants at Arms

NAME OF COMMITTEE House Comm. on Health

DATE: 03/25/15 Room: 643

House Sgt-At Arms:

1. Name: Young Bae
2. Name: Bill Morris
3. Name: Jim Moran
4. Name: _____
5. Name: _____

Senate Sgt-At Arms:

1. Name: _____
2. Name: _____
3. Name: _____
4. Name: _____
5. Name: _____

Wednesday, March 25 HEALTH	Room 643	Time 10:00 am

Name	County	Sponsor
Jayden Cheese	Wake	Rosa U. Gill
Amy Clemmons	Wake	Paul Stam

VISITOR REGISTRATION SHEET

House Comm. on Health — 03/25/15

Name of Committee — Date

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Brett Dye	NCSU MSW Program / NASW
Penny Hueftle	School of Gov
Bobby D White	NC Dental Board
Bill Shenton	Poyner Spruill LLP
Bill Croft	NC Respiratory Care Board
Mary Oystar	NC Dental Society
Lisa Ward	NC Dental Society
Alec Parker	NC Dental Society
Pam Kuras	NCSU Social Work Dept.
Lorrinda Janik	NCSU Social Work Dept.
Lydia Short	UNC Chapel Hill SSW

NCCCB

VISITOR REGISTRATION SHEET

House Comm. on Health — 03/25/15

Name of Committee — Date

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Kathryn Pacos	NC State Dept. of Social Work
Kylie Polzer	NC State Dept of Social Work
Donna Suko	NC Society of Otolaryngology
Eileen Raynor	NC Society of Otolaryngology
Robert Leinbach	NC Society of Otolaryngology
Thomas Gantt	NCSU dept. of Social Work
Ciara Albritton	NCSU dept. of Social Work

VISITOR REGISTRATION SHEET

House Comm. on Health — 03/25/15

Name of Committee — Date

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Erin Kirchgessner	UNC-CH School of Social Work
Melissa Cochran	UNC CH School of Social Work
Jeneva Russell	UNC-CH School of Social Work
melanie Sadur	UNC-CH School of Social Work
Kate Fahje Steber	UNC-CH school of Social work
Stephanie Everette Freeman	UNC-CH school of social work
Lisa di Zerden	UNC-CH school of Social work
Emma Sheedy	UNC-C School of social work
Chris Rolle	UNC-C School of Social Work
Stephanie Pantschyschak	UNC-C School of Social Work
Adrianna Parker	NC State Dept of Social Work

VISITOR REGISTRATION SHEET

House Comm. on Health — 03/25/15

Name of Committee — Date

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Brooke Ramage	UNC Charlotte School of Social Work MSW
Holly Nash	UNC Charlotte School of Social Work, MSW
Michael Ferguson	UNC charlotte
Joseph Barker	UNCG- Social Work
Quanya Eaton	UNCG- Social work
Jualena Younger	UNCG - Social work
Candice Brown	NCSU - social work (BSW)
Liliana Galvan	NCSU - Social Work (BSW)
Adolph G. Wu	R. Davie Intern
Evelyn Hawthorne	OTHER
David Wallbackler	NC Board of Nursing
Ryan Combs	NCARS
Jarret Burr	NCAPS

VISITOR REGISTRATION SHEET

House Comm. on Health — 03/25/15

Name of Committee — Date

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
John Hardin	MFHS
Michelle Frazier	MFHS

VISITOR REGISTRATION SHEET

House Comm. on Health — 03/25/15

Name of Committee — Date

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Neal deJong	UNC Pediatrics
Emily VanderSchaaf	UNC Pediatrics
Jonathan Kotch	Health Care for All NC
Rita Kuwahara	Health Care for All NC
Dill Smith	Law Office of [illegible] PLLC
ERIN FREY	AstraZeneca
Lisa Baker	NCOHA/CCCC
Vicky Wesner	CCCC
Shelby Benton	NC BA
(Heath Reece Jarnagin)	NCBA
J PERRY	CSS

VISITOR REGISTRATION SHEET

House Comm. on Health — 03/25/15

Name of Committee — Date

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Ryan Merwald	Williams Mullen
Jacqueline Smith	NCSU, NASW
Alexandra Burton	NCSU, NASW
Dori Wooten	NCSU, NASW
John Craichy	NCSU, MSW Prog
Paige L. Moore	NC State, Social Work Department
Wallace Kennedy	North Carolina Bar Association
Vanessa Drew Branch	University North Carolina Charlotte School of Social work – NASW
Danielle Hitchcock	University of North Carolina Charlotte School of Social Work
Nicole Echeandia	UNC Charlotte School of Social Work MSW
Heather Bartlett	UNC Charlotte School of Social Work – MSW
David Collins & Chuck Stone	SEANC
Renee Batts	NC Community College System
Mary Shuping	NCCCS

VISITOR REGISTRATION SHEET

House Comm. on Health — 03/25/15

Name of Committee — Date

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
J Bode	B & H
D Simpson	SA
Chris Sgro	NCMS
Ken Melton	K. M. H
Peggy Myers	[illegible]
[illegible]	[illegible]
Andy Chase	KMA
Lou Turner	NC DPH / OCME
Deborah Radisch	NC DPH / SCME
Trent Womble	DHHS
Jim Hamm	BH
W A Potter Jr	NC Dept Sec

NORTH CAROLINA HOUSE OF REPRESENTATIVES
COMMITTEE MEETING NOTICE
AND
BILL SPONSOR NOTIFICATION
2015-2016 SESSION

You are hereby notified that the **House Committee on Health** will meet as follows:

DAY & DATE: Wednesday, April 1, 2015
TIME: **10:00 AM**
LOCATION: **643 LOB**

The following bills will be considered:

BILL NO.	SHORT TITLE	SPONSOR
HB 195	Allow Substitution of Biosimilars.	Representative Dollar Representative S. Martin Representative Avila Representative Lambeth

Respectfully,

Representative Brian Brown, Co-Chair
Representative Justin P. Burr, Co-Chair
Representative Bert Jones, Co-Chair
Representative Donny Lambeth, Co-Chair

I hereby certify this notice was filed by the committee assistant at the following offices at 9:36 AM on Thursday, March 26, 2015.

___ Principal Clerk
___ Reading Clerk – House Chamber

Theresa Lopez (Committee Assistant)

House Committee on Health
Wednesday, April 1, 2015, 10:00 AM
643 Legislative Office Building

AGENDA

Welcome and Opening Remarks

Introduction of Pages & Sgt-of-Arms

Bills

BILL NO.	SHORT TITLE	SPONSOR
HB 195	Allow Substitution of Biosimilars.	Representative Dollar Representative S. Martin Representative Avila Representative Lambeth

Adjournment

House Committee on Health
Wednesday, April 1, 2015 at 10:00 AM
Room 643 of the Legislative Office Building

MINUTES

The House Committee on Health met at 10:00 AM on April 1, 2015 in Room 643 of the Legislative Office Building. Representatives Avila, Bishop, R. Brown, B. Brown, Carney, Cotham, Dollar, Earle, Farmer-Butterfield, Ford, Goodman, L. Hall, Hastings, Insko, Jones, Lambeth, Lucas, S. Martin, Pendleton, Saine, Setzer, Szoka, Waddell, Wray, and Yarborough attended.

Representative Brian Brown, Chair, presided.

The following bills were considered:

HB 195 Allow Substitution of Biosimilars. (Representatives Dollar, S. Martin, Avila, Lambeth)

AN ACT AMENDING THE NORTH CAROLINA PHARMACY PRACTICE ACT TO ALLOW FOR THE SUBSTITUTION OF AN INTERCHANGEABLE BIOLOGICAL PRODUCT.

Chairman Brown stated there was a PCS for HB195 and was there a motion to place it before the committee? Representative Cotham motioned to bring forth the PCS seconded by Representative Saine. Hearing no objections the PCS was before the committee.

Representatives Dollar and co-sponsors Representative Avila and Martin explained the bill. Representative Farmer-Butterfield asked was there any opposition to the bill from the Pharmacies or Physicians? Representative Dollar stated they are both neutral.

Chairman Brown recognized Mr. Jay Campbell, Director of the NC Pharmacy Board who stated it is possible to have Biosimilars in NC without this bill; however the clarification would serve as a valuable purpose to the Pharmacists. The committee members followed with additional questions and comments for the bill sponsors.

Representative Insko asked to be recognized to send forth an amendment. After the introduction of the amendment and the explanation of the changes she stated that the bill was an undue burden and an additional unnecessary regulation on Pharmacists by requiring additional reporting that this bill unnecessary. Representative Insko motions for the adoption of the amendment. Chairman Brown brought the vote before the committee, the amendment failed.

Chairman Brown called for a vote on the PCS for HB195; Representative Farmer-Butterfield motioned for a favorable report, unfavorable to the original bill.

The meeting adjourned at 10:55.

Representative Brian Brown, Chair
Presiding

Theresa Lopez, Committee Clerk

HOUSE BILL 195*

Short Title:	Allow Substitution of Biosimilars.	(Public)
Sponsors:	Representatives Dollar, S. Martin, Avila, and Lambeth (Primary Sponsors). *For a complete list of Sponsors, refer to the North Carolina General Assembly Web Site.*	
Referred to:	Health.	

March 11, 2015

A BILL TO BE ENTITLED

AN ACT AMENDING THE NORTH CAROLINA PHARMACY PRACTICE ACT TO ALLOW FOR THE SUBSTITUTION OF AN INTERCHANGEABLE BIOLOGICAL PRODUCT.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 90-85.27 reads as rewritten:

"**§ 90-85.27. Definitions.**

As used in G.S. 90-85.28 through G.S. 90-85.31:

(1) Biological product. – As defined in section 351(i) of the Public Health Service Act, 42 U.S.C. § 262(i).

(1a) ~~"Equivalent drug product" means a~~Equivalent drug product. – A drug product which has the same established name, active ingredient, strength, quantity, and dosage form, and which is therapeutically equivalent to the drug product identified in the ~~prescription;~~prescription.

(2) ~~"Established name" has the meaning given~~Established name. – As defined in section 502(e)(3) of the Federal Food, Drug and Cosmetic Act, ~~21 U.S.C. 352(e)(3);~~21 U.S.C. § 352(e)(3).

(3) ~~"Good manufacturing practice" has the meaning given it~~Good manufacturing practice. – As defined in Part 211 of Chapter 1 of Title 21 of the Code of Federal ~~Regulations;~~Regulations.

(3a) Interchangeable biological product. – A biological product determined by the United States Food and Drug Administration to meet the standards set forth in 42 U.S.C. § 262(k)(4), or deemed therapeutically equivalent by the United States Food and Drug Administration.

(4) ~~"Manufacturer" means the~~Manufacturer. – The actual manufacturer of the finished dosage form of the ~~drug;~~drug.

(4a) ~~"Narrow therapeutic index drugs" means those~~Narrow therapeutic index drugs. – Those pharmaceuticals having a narrowly defined range between risk and benefit. Such drugs have less than a twofold difference in the minimum toxic concentration and minimum effective concentration in the blood or are those drug product formulations that exhibit limited or erratic absorption, formulation-dependent bioavailability, and wide intrapatient pharmacokinetic variability that requires blood-level monitoring. Drugs identified as having narrow therapeutic indices shall be designated by the

North Carolina Secretary of Health and Human Services upon the advice of the State Health Director, North Carolina Board of Pharmacy, and North Carolina Medical Board, as narrow therapeutic index drugs and shall be subject to the provisions of G.S. 90-85.28(b1). The North Carolina Board of Pharmacy shall submit the list of narrow therapeutic index drugs to the Codifier of Rules, in a timely fashion for publication in January of each year in the North Carolina Register.

(5) ~~"Prescriber" means anyone~~Prescriber. – Anyone authorized to prescribe drugs pursuant to the laws of this State."

SECTION 2. G.S. 90-85.28 reads as rewritten:

"**§ 90-85.28. Selection by pharmacists permissible; prescriber may permit or prohibit selection; price limit on selected ~~drugs.~~drugs; communication of dispensed biological products under specified circumstances.**

(a) A pharmacist dispensing a prescription for a drug product prescribed by its brand name may select any equivalent drug or interchangeable biological product which meets all of the following standards:

(1) The manufacturer's name and the distributor's name, if different from the manufacturer's name, shall appear on the label of the stock ~~package;~~package.

(2) It shall be manufactured in accordance with current good manufacturing ~~practices;~~practices.

(3) ~~Effective January 1, 1982, all~~All oral solid dosage forms shall have a logo, or other identification mark, or the product name to identify the manufacturer or ~~distributor;~~distributor.

(4) The manufacturer shall have adequate provisions for drug ~~recall; and~~recall.

(5) The manufacturer shall have adequate provisions for return of outdated drugs, through ~~his~~ the distributor or otherwise.

(b) The pharmacist shall not select an equivalent drug or interchangeable biological product if the prescriber instructs otherwise by one of the following methods:

(1) A prescription form shall be preprinted or stamped with two signature lines at the bottom of the form which read:

" _____ _____

Product Selection Permitted Dispense as Written"

On this form, the prescriber shall communicate ~~his~~ instructions to the pharmacist by signing the appropriate line.

(2) In the event the preprinted or stamped prescription form specified in ~~(b)(1)~~ subdivision (1) of subsection (b) of this section is not readily available, the prescriber may handwrite "Dispense as Written" or words or abbreviations of the same meaning on a prescription form.

(3) When ordering a prescription orally, the prescriber shall specify either that the prescribed drug product be dispensed as written or that product selection is permitted. The pharmacist shall note the instructions on the file copy of the prescription and retain the prescription form for the period prescribed by law.

(b1) A prescription for a narrow therapeutic index drug shall be refilled using only the same drug product by the same manufacturer that the pharmacist last dispensed under the prescription, unless the prescriber is notified by the pharmacist prior to the dispensing of another manufacturer's product, and the prescriber and the patient give documented consent to the dispensing of the other manufacturer's product. For purposes of this subsection, the term "refilled" shall include a new prescription written at the expiration of a prescription which continues the patient's therapy on a narrow therapeutic index drug.

(b2) Within a reasonable time following the dispensing of a biological product, the pharmacist or a designee shall communicate to the prescriber the product name and manufacturer of the specific biological product dispensed to the patient. This required communication shall be through an interoperable electronic medical records system, electronic prescribing technology, or a pharmacy record that is electronically accessible by the prescriber. Otherwise, the pharmacist or a designee shall provide the required communication to the prescriber by facsimile, telephone, electronic transmission, or other prevailing means, provided that communication shall not be required under any of the following circumstances:

(1) There is no United States Food and Drug Administration-approved interchangeable biological product for the product prescribed.

(2) A refill prescription is not changed from the product dispensed on the prior filling of the prescription.

(b3) The Board of Pharmacy shall maintain a link on its Internet Web site to the current list of biological products determined by the United States Food and Drug Administration to be interchangeable with a specific biological product.

(c) The pharmacist shall not select an equivalent drug or interchangeable biological product unless its price to the purchaser is less than the price of the prescribed drug product."

SECTION 3. G.S. 90-85.31 reads as rewritten:

"**§ 90-85.31. Prescriber and pharmacist liability not extended.**

The selection of an equivalent drug or interchangeable biological product pursuant to this Article shall impose no greater liability upon the pharmacist for selecting the dispensed drug or biological product or upon the prescriber of the same than would be incurred by either for dispensing the drug or biological product specified in the prescription."

SECTION 4. G.S. 58-3-178(c)(4) reads as rewritten:

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

a. The prescription drug known as "RU-486" or any "equivalent drug product" as defined in ~~G.S. 90-85.27(1).~~G.S. 90-85.27.

b. The prescription drug marketed under the name "Preven" or any "equivalent drug product" as defined in ~~G.S. 90-85.27(1).~~G.S. 90-85.27."

SECTION 5. This act becomes effective October 1, 2015.

HOUSE BILL 195:
Allow Substitution of Biosimilars

2015-2016 General Assembly

Committee:	House Health	**Date:**	March 31, 2015
Introduced by:	Reps. Dollar, S. Martin, Avila, Lambeth	**Prepared by:**	Amy Jo Johnson Committee Counsel
Analysis of:	PCS to First Edition H195-CSTK-3		

SUMMARY: The PCS to House Bill 195 amends the NC Pharmacy Practice Act to provide for a definition of biological products and interchangeable biological products and allow for the substitution of interchangeable biological products. The PCS also requires pharmacist communication with the prescriber under specified circumstances when a biological product is dispensed. The PCS to House Bill 195 requires the Board of Pharmacy to maintain a list of biological products determined by the US FDA to be interchangeable with a specific biological product. The bill also makes conforming statutory changes.

[As introduced, this bill was identical to S197, as introduced by Sens. Apodaca, Hise, which is currently in Senate Health Care.]

CURRENT LAW: The NC Pharmacy Practice Act allows a pharmacist to dispense an equivalent drug product (typically referred to as a generic) when a brand name drug is prescribed, provided that certain standards are met. Under 90-85.28, the prescriber may specify that an equivalent drug product is not to be used by utilizing one of three methods:

- By selecting on the prescription form whether product selection is permitted or whether the pharmacist must dispense as written.
- Notating "dispense as written" on the prescription.
- When ordering a prescription orally, specifying that the product be dispensed as written or allowing for product selection.

With regards to refills, a narrow therapeutic index drug, a drug having a narrowly defined range between risk and benefit, must be refilled using the same drug product by the same manufacturer that the pharmacist last dispensed, unless the pharmacist notifies the prescriber prior to dispensing another manufacturer's product and the patient consents.

Pharmacists are not allowed to select an equivalent drug product unless it's cost to the purchaser is less than the price of the prescribed drug.

BACKGROUND:

The Patient Protection and Affordable Care Act (ACA) created an abbreviated licensure pathway for biological products that are determined to be "biosimilar" to an already-approved biological product. According to the US Food and Drug Administration, a biosimilar is "a biological product that is highly similar to a U.S.-licensed reference biological product notwithstanding minor differences in the clinically inactive components, and for which there are no clinically meaningful differences between the biological product and the reference product in terms of safety, purity, and potency of the product."[1] The

[1] http://www.fda.gov/Drugs/DevelopmentApprovalProcess/HowDrugsareDevelopedandApproved/ApprovalApplications/TherapeuticBiologicApplications/Biosimilars/ucm241718.htm

first biosimilar was approved on March 6, 2015. At this time, there are no approved interchangeable biological products.

BILL ANALYSIS:

Section 1 of H195 adds the terms biological product and interchangeable biological product to the definitions found in G.S. 90-85.27 which is part of the North Carolina Pharmacy Practice Act. Both definitions reference those found in the federal regulations under 42 USC 352.

Section 2 of H195 makes some conforming changes to allow for interchangeable biological products to be treated the same as equivalent drug products when a pharmacist is making a substitution. **Section 2** also adds two new subsections to G.S. 90-85.28.

The new subsection (b2) requires that a pharmacist or a designee communicate to the prescriber the product name and manufacturer of a biological product dispensed to a patient. If available, the communication must be done by making an entry into an interoperable electronic medical records system, electronic prescribing technology, a pharmacy benefit management system (added by the PCS), or a pharmacy record that can be electronically accessed by the provider. If no such communication method is available, then the pharmacist or designee must provide the product name and manufacturer of a biological product dispensed to a patient using fax, phone, email or other means. Additionally, if an interoperable electronic medical records system, electronic prescribing technology, a pharmacy benefit management system, or a pharmacy record that can be electronically accessed by the provider is not available, the pharmacist or designee will not be required to send the communication via fax, phone, email or other means if there is no interchangeable biological product approved by the FDA for the product prescribed or a refill prescription is not changed from the product dispensed on the prior filling of the prescription.

The new subsection (b3) requires the North Carolina Board of Pharmacy to maintain a link on its website to the current list of biological products determined by the FDA to be interchangeable with a specific biological product.

The PCS adds a new subsection (b4) which directs that if the State mandates electronic medical records between a pharmacist and a prescriber as described in subsection (b2), then the pharmacist is only be required to communicate the biological product dispensed through an electronic medical records system when such a system is in place and the information is accessible by the prescriber.

Section 3 extends the same protections from liability that a pharmacist or prescriber has when selecting an equivalent drug product to the selection of an interchangeable biological product. The selection of an equivalent drug product or an interchangeable drug product would not impose a greater liability upon the pharmacist or upon the prescriber would have by either dispensing the drug or biological product specified in the prescription.

Section 4 makes a technical change.

EFFECTIVE DATE: This act becomes effective October 1, 2015. G.S. 90-85.28(b2) and G.S. 90-85.28(b4) as enacted by Section 2 of this act expire on October 1, 2020.

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2015

H D

HOUSE BILL 195*
PROPOSED COMMITTEE SUBSTITUTE H195-CSTK-3 [v.3]

3/31/2015 8:37:02 PM

Short Title: Allow Substitution of Biosimilars. (Public)

Sponsors:

Referred to:

March 11, 2015

A BILL TO BE ENTITLED

AN ACT AMENDING THE NORTH CAROLINA PHARMACY PRACTICE ACT TO ALLOW FOR THE SUBSTITUTION OF AN INTERCHANGEABLE BIOLOGICAL PRODUCT.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 90-85.27 reads as rewritten:

"**§ 90-85.27. Definitions.**

As used in G.S. 90-85.28 through G.S. 90-85.31:

(1) Biological product. – As defined in section 351(i) of the Public Health Service Act, 42 U.S.C. § 262(i).

(1a) ~~"Equivalent drug product" means a~~Equivalent drug product. – A drug product which has the same established name, active ingredient, strength, quantity, and dosage form, and which is therapeutically equivalent to the drug product identified in the ~~prescription;~~prescription.

(2) ~~"Established name" has the meaning given~~Established name. – As defined in section 502(e)(3) of the Federal Food, Drug and Cosmetic Act, ~~21 U.S.C. 352(e)(3);~~21 U.S.C. § 352(e)(3).

(3) ~~"Good manufacturing practice" has the meaning given it~~Good manufacturing practice. – As defined in Part 211 of Chapter 1 of Title 21 of the Code of Federal ~~Regulations;~~Regulations.

(3a) Interchangeable biological product. – A biological product determined by the United States Food and Drug Administration to meet the standards set forth in 42 U.S.C. § 262(k)(4), or deemed therapeutically equivalent by the United States Food and Drug Administration.

(4) ~~"Manufacturer" means the~~Manufacturer. – The actual manufacturer of the finished dosage form of the ~~drug;~~drug.

(4a) ~~"Narrow therapeutic index drugs" means those~~Narrow therapeutic index drugs. – Those pharmaceuticals having a narrowly defined range between risk and benefit. Such drugs have less than a twofold difference in the minimum toxic concentration and minimum effective concentration in the blood or are those drug product formulations that exhibit limited or erratic absorption, formulation-dependent bioavailability, and wide intrapatient pharmacokinetic variability that requires blood-level monitoring. Drugs identified as having narrow therapeutic indices shall be designated by the North Carolina Secretary of Health and Human Services upon the advice of the State Health Director, North Carolina Board of Pharmacy, and North

Carolina Medical Board, as narrow therapeutic index drugs and shall be subject to the provisions of G.S. 90-85.28(b1). The North Carolina Board of Pharmacy shall submit the list of narrow therapeutic index drugs to the Codifier of Rules, in a timely fashion for publication in January of each year in the North Carolina Register.

(5) ~~"Prescriber" means anyone~~Prescriber. – Anyone authorized to prescribe drugs pursuant to the laws of this State."

SECTION 2. G.S. 90-85.28 reads as rewritten:

"**§ 90-85.28. Selection by pharmacists permissible; prescriber may permit or prohibit selection; price limit on selected ~~drugs.~~drugs; communication of dispensed biological products under specified circumstances.**

(a) A pharmacist dispensing a prescription for a drug product prescribed by its brand name may select any equivalent drug or interchangeable biological product which meets all of the following standards:

(1) The manufacturer's name and the distributor's name, if different from the manufacturer's name, shall appear on the label of the stock ~~package;~~package.

(2) It shall be manufactured in accordance with current good manufacturing ~~practices;~~practices.

(3) ~~Effective January 1, 1982, all~~All oral solid dosage forms shall have a logo, or other identification mark, or the product name to identify the manufacturer or ~~distributor;~~distributor.

(4) The manufacturer shall have adequate provisions for drug ~~recall; and~~recall.

(5) The manufacturer shall have adequate provisions for return of outdated drugs, through ~~his~~ the distributor or otherwise.

(b) The pharmacist shall not select an equivalent drug or interchangeable biological product if the prescriber instructs otherwise by one of the following methods:

(1) A prescription form shall be preprinted or stamped with two signature lines at the bottom of the form which read:

" _____ _____

Product Selection Permitted Dispense as Written"

On this form, the prescriber shall communicate ~~his~~ instructions to the pharmacist by signing the appropriate line.

(2) In the event the preprinted or stamped prescription form specified in ~~(b)(1)~~ subdivision (1) of subsection (b) of this section is not readily available, the prescriber may handwrite "Dispense as Written" or words or abbreviations of the same meaning on a prescription form.

(3) When ordering a prescription orally, the prescriber shall specify either that the prescribed drug product be dispensed as written or that product selection is permitted. The pharmacist shall note the instructions on the file copy of the prescription and retain the prescription form for the period prescribed by law.

(b1) A prescription for a narrow therapeutic index drug shall be refilled using only the same drug product by the same manufacturer that the pharmacist last dispensed under the prescription, unless the prescriber is notified by the pharmacist prior to the dispensing of another manufacturer's product, and the prescriber and the patient give documented consent to the dispensing of the other manufacturer's product. For purposes of this subsection, the term "refilled" shall include a new prescription written at the expiration of a prescription which continues the patient's therapy on a narrow therapeutic index drug.

(b2) Within a reasonable time following the dispensing of a biological product requiring a prescription, the pharmacist or a designee shall communicate to the prescriber the product name and manufacturer of the specific biological product dispensed to the patient. This

required communication shall be conveyed by making an entry into an interoperable electronic medical records system, or electronic prescribing technology, or a pharmacy benefit management system, or a pharmacy record that can be electronically accessible by the prescriber. Entry into one of the above referenced methods of communication is presumed to provide the required communication. Otherwise, the pharmacist or a designee shall provide the required communication to the prescriber by facsimile, telephone, electronic transmission, or other prevailing means, provided that communication shall not be required under any of the following circumstances:

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(b3) The Board of Pharmacy shall maintain a link on its Internet Web site to the current list of biological products determined by the United States Food and Drug Administration to be interchangeable with a specific biological product.

(b4) If the State mandates electronic medical records between a pharmacist and a prescriber as described in subsection (b2) of this section, then the pharmacist shall only be required to communicate the biological product dispensed through an electronic medical records system when such a system is in place and the information is accessible by the prescriber.

(c) The pharmacist shall not select an equivalent drug or interchangeable biological product unless its price to the purchaser is less than the price of the prescribed drug product."

SECTION 3. G.S. 90-85.31 reads as rewritten:

"**§ 90-85.31. Prescriber and pharmacist liability not extended.**

The selection of an equivalent drug or interchangeable biological product pursuant to this Article shall impose no greater liability upon the pharmacist for selecting the dispensed drug or biological product or upon the prescriber of the same than would be incurred by either for dispensing the drug or biological product specified in the prescription."

SECTION 4. G.S. 58-3-178(c)(4) reads as rewritten:

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

a. The prescription drug known as "RU-486" or any "equivalent drug product" as defined in ~~G.S. 90-85.27(1).~~G.S. 90-85.27.

b. The prescription drug marketed under the name "Preven" or any "equivalent drug product" as defined in ~~G.S. 90-85.27(1).~~G.S. 90-85.27."

SECTION 5. This act becomes effective October 1, 2015. G.S. 90-85.28(b2) and G.S. 90-85.28(b4) as enacted by Section 2 of this act shall expire on October 1, 2020.

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2015

H D

HOUSE BILL 195*
PROPOSED COMMITTEE SUBSTITUTE H195-PCS20173-TK-3

Short Title: Allow Substitution of Biosimilars. (Public)

Sponsors:

Referred to:

March 11, 2015

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(3a) Interchangeable biological product. – A biological product determined by the United States Food and Drug Administration to meet the standards set forth in 42 U.S.C. § 262(k)(4), or deemed therapeutically equivalent by the United States Food and Drug Administration.

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Carolina Medical Board, as narrow therapeutic index drugs and shall be subject to the provisions of G.S. 90-85.28(b1). The North Carolina Board of Pharmacy shall submit the list of narrow therapeutic index drugs to the Codifier of Rules, in a timely fashion for publication in January of each year in the North Carolina Register.

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(3) When ordering a prescription orally, the prescriber shall specify either that the prescribed drug product be dispensed as written or that product selection is permitted. The pharmacist shall note the instructions on the file copy of the prescription and retain the prescription form for the period prescribed by law.

(b1) A prescription for a narrow therapeutic index drug shall be refilled using only the same drug product by the same manufacturer that the pharmacist last dispensed under the prescription, unless the prescriber is notified by the pharmacist prior to the dispensing of another manufacturer's product, and the prescriber and the patient give documented consent to the dispensing of the other manufacturer's product. For purposes of this subsection, the term "refilled" shall include a new prescription written at the expiration of a prescription which continues the patient's therapy on a narrow therapeutic index drug.

(b2) Within a reasonable time following the dispensing of a biological product requiring a prescription, the pharmacist or a designee shall communicate to the prescriber the product name and manufacturer of the specific biological product dispensed to the patient. This

required communication shall be conveyed by making an entry into an interoperable electronic medical records system, or electronic prescribing technology, or a pharmacy benefit management system, or a pharmacy record that can be electronically accessible by the prescriber. Entry into one of the above referenced methods of communication is presumed to provide the required communication. Otherwise, the pharmacist or a designee shall provide the required communication to the prescriber by facsimile, telephone, electronic transmission, or other prevailing means, provided that communication shall not be required under any of the following circumstances:

(1) There is no United States Food and Drug Administration-approved interchangeable biological product for the product prescribed.

(2) A refill prescription is not changed from the product dispensed on the prior filling of the prescription.

(b3) The Board of Pharmacy shall maintain a link on its Internet Web site to the current list of biological products determined by the United States Food and Drug Administration to be interchangeable with a specific biological product.

(b4) If the State mandates electronic medical records between a pharmacist and a prescriber as described in subsection (b2) of this section, then the pharmacist shall only be required to communicate the biological product dispensed through an electronic medical records system when such a system is in place and the information is accessible by the prescriber.

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

a. The prescription drug known as "RU-486" or any "equivalent drug product" as defined in ~~G.S. 90-85.27(1).~~G.S. 90-85.27.

b. The prescription drug marketed under the name "Preven" or any "equivalent drug product" as defined in ~~G.S. 90-85.27(1).~~G.S. 90-85.27."

SECTION 5. This act becomes effective October 1, 2015. G.S. 90-85.28(b2) and G.S. 90-85.28(b4) as enacted by Section 2 of this act shall expire on October 1, 2020.

NORTH CAROLINA GENERAL ASSEMBLY AMENDMENT

(Please type or use ballpoint pen)

EDITION No. PCS

H. B. No. 195 DATE April 1, 2015

S. B. No. _____ Amendment No. _____
(to be filled in by Principal Clerk)

COMMITTEE SUBSTITUTE _____

Rep.) Insko
)
Sen.)

1 moves to amend the bill on page beginning 2, line 49
2 ( ) WHICH CHANGES THE TITLE
3 ~~by~~ through page 3, line 12, by deleting the lines;
4
5 and on page 3, lines 16-20 by deleting the lines;
6
7 and by amending the bill on page 3, lines 41-
8 42 by rewriting the lines to read:
9 "Section 5. The act becomes effective
10 October 1, 2015.".
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19

SIGNED Ursula Insko

ADOPTED _____ FAILED _____ TABLED _____

GA-33-A

PRINCIPAL CLERK'S OFFICE (FOR ENGROSSMENT)

NORTH CAROLINA GENERAL ASSEMBLY
HOUSE OF REPRESENTATIVES

HEALTH COMMITTEE REPORT

Representative Brian Brown, Co-Chair
Representative Justin P. Burr, Co-Chair
Representative Bert Jones, Co-Chair
Representative Donny Lambeth, Co-Chair

FAVORABLE COM SUB , UNFAVORABLE ORIGINAL BILL

HB **195** Allow Substitution of Biosimilars.

Draft Number:	H195-PCS20173-TK-3
Serial Referral:	None
Recommended Referral:	None
Long Title Amended:	No
Floor Manager:	Dollar

TOTAL REPORTED: 1

Committee Sergeants at Arms

NAME OF COMMITTEE House Comm. on Health

DATE: 04/01/15 Room: 643

House Sgt-At Arms:

1. Name: Young Bae
2. Name: Bill Morris
3. Name: Jim Moran
4. Name: _____
5. Name: _____

Senate Sgt-At Arms:

1. Name: _____
2. Name: _____
3. Name: _____
4. Name: _____
5. Name: _____

Wednesday, March 1 HEALTH	Room 643	Time 10:00 am

Name	County	Sponsor
Caroline Hoyle	Vance	Speaker
Asheer McCutchen	Wake	Rosa U. Gill

VISITOR REGISTRATION SHEET

House Committee on Health — 4/1/15

Name of Committee — **Date**

Public Speakers

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Jay Campbell	NCBOP
Candie Phipps	Sandoz

VISITOR REGISTRATION SHEET

House Comm. on Health — 04/01/15

Name of Committee — Date

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Tracy Kimbrell	Parker Poe
Deron Johnson	Amgen
Dan Withby	Lilly
Laura Gunter	NCBIO
Mike McBrierty	Biogen
Rivan Marwald	Williams Mullen
Neal Orr	RBP
Amanda Hoaker	TSS
Ben Twilley	Express Scripts
[illegible]	TSS
JREEDS	CSS

VISITOR REGISTRATION SHEET

House Comm. on Health — 04/01/15

Name of Committee — Date

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Andy Edlen	NCRMA
Erica Nelson	NCHA
Matthew Robinson	NCRMA
Lexi Morgan	NCRMA
Jennifer Casperini	NCMS
Joanna Spruill	NCIFP
TJ Bugbee	NP
[signature]	NCBOT
Jodi Maynard	GPM: Assoc
Peyton Maynard	GPM: Assoc
Lanier Hodgson	UNC Health Care

VISITOR REGISTRATION SHEET

House Comm. on Health — 04/01/15

Name of Committee — Date

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Steve Mitchell	Actellas
[illegible]	CSS
Chip Killian	Nelson Mullins
Bill Custer	ACP
Mike James	ACP
Tim Lea	Novartis
Dana Sipsa	SA
Candie Rupps	Sandoz
Kara Weishaar	SA
J.J. Darby	J+J.
G.F. Schimizzi, MD	Carolina Arthritis Associates Wilm. NC North Carolina Rheumatology Association Coalition of State Rheumatology Organizations

VISITOR REGISTRATION SHEET

House Comm. on Health — 04/01/15

Name of Committee — Date

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Bill Scoggin	TS
Gerry Cohen	Nelson Mullins
Chris Evans	Blue Cross Blue Shield
Marty Bocock	Prime Therapeutics
Heather Babcock	NC Chamber
Mark Gumy	BCBSNC
L Penny	CSS
Lori Ann Harris	~~LA~~ ITA
Bo ~~Heath~~	McGuire Woods
John Delbonno	Brubaker + Assoc.
Daniel Amburn	UCB Biosciences

VISITOR REGISTRATION SHEET

House Comm. on Health — Name of Committee

04/01/15 — Date

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Jonathan Brubaker	Brubaker + Assoc.
Hayden Baugess	FSP
Tim Fitzgerald	FSP
John McMillan	MFS
Jeff Hendricks	MFS
Sam Taylor	NCBIO
Ben Matthews	NCDPI
Regan Reynolds	Patient advocate GHLF.org
Tom Friedman	DST
David Brown	Troutman Sanders
M Patty Lasater	AStellas

VISITOR REGISTRATION SHEET

House Comm. on Health — 04/01/15

Name of Committee — Date

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Fred Dyne	Bonn Aqua.

VISITOR REGISTRATION SHEET

House Comm. on Health — Name of Committee

04/01/15 — Date

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
David Collins	SEANC
[illegible]	[illegible]
Scott Smith	SSmith Consulting
[illegible]	ETHOS
Andy Chase	KMA
Ken Melton	K.M.A.
John Bode	[illegible]
[illegible]	NWC
[illegible]	[illegible]
Andy Sandusky	AbbVie
Brian Smith	Hospira

VISITOR REGISTRATION SHEET

House Comm. on Health — Name of Committee

04/01/15 — Date

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Michelle Frazier	MF+S

NORTH CAROLINA HOUSE OF REPRESENTATIVES
COMMITTEE MEETING NOTICE
AND
BILL SPONSOR NOTIFICATION
2015-2016 SESSION

You are hereby notified that the **House Committee on Health** will meet as follows:

DAY & DATE: Wednesday, April 15, 2015
TIME: **10:00 AM**
LOCATION: **643 LOB**
COMMENTS: **Representative Lambeth is presiding.**

The following bills will be considered:

BILL NO.	SHORT TITLE	SPONSOR
HB 355	Enhance Protection for Group Home Residents.	Representative Reives Representative Stam
HB 437	Create Permit Exemptions/Home Renal Products.	Representative Dobson
HB 543	Amend Laws Pertaining to NC Medical Board.	Representative Brawley Representative Jones
HB 580	Ban Smoking in Foster Care Setting/Infants.	Representative Cotham Representative Adcock

Respectfully,

Representative Brian Brown, Co-Chair
Representative Justin P. Burr, Co-Chair
Representative Bert Jones, Co-Chair
Representative Donny Lambeth, Co-Chair

I hereby certify this notice was filed by the committee assistant at the following offices at 2:25 PM on Tuesday, April 07, 2015.

___ Principal Clerk
___ Reading Clerk – House Chamber

Brenda Olls (Committee Assistant)

House Committee on Health
Wednesday, April 15, 2015, 10:00 AM
643 Legislative Office Building

AGENDA

Welcome and Opening Remarks

Introduction of Pages

Bills

BILL NO.	SHORT TITLE	SPONSOR
HB 355	Enhance Protection for Group Home Residents.	Representative Reives Representative Stam
HB 437	Create Permit Exemptions/Home Renal Products.	Representative Dobson
HB 543	Amend Laws Pertaining to NC Medical Board.	Representative Brawley Representative Jones
HB 580	Ban Smoking in Foster Care Setting/Infants.	Representative Cotham Representative Adcock

Presentations

Other Business

Adjournment

House Committee on Health
Wednesday, April 15, 2015 at 10:00 AM
Room 643 of the Legislative Office Building

MINUTES

The House Committee on Health met at 10:00 AM on April 15, 2015 in Room 643 of the Legislative Office Building. Representatives Avila, R. Brown, B. Brown, Carney, Cotham, Dobson, Dollar, Earle, Farmer-Butterfield, Ford, Goodman, Insko, Jones, Lambeth, Lucas, S. Martin, Pendleton, Szoka, Waddell, Wray, and Yarborough attended.

Representative Donny Lambeth, Chair, presided.

The following bills were considered:

HB 355 Enhance Protection for Group Home Residents. (Representatives Reives, Stam)

There is a PCS for HB355, Representative Cotham made the motion to accept PCS and the motion carried. Representative Reives was recognized to explain the bill.

Representative Reives: This bill is in response to abuse in group homes, and is designed to protect residents from having their possessions taken, harassment, and other abuse by ensuring their safety when reporting these incidents and making these actions a class 1 misdemeanor.

Rep. Goodman moves for a favorable report for the PCS, unfavorable to the original bill with a serial referral to Judiciary 2. The motion carried.

HB 437 Create Permit Exemptions/Home Renal Products. (Representative Dobson)

There is a PCS for HB437, Representative Carney made the motion to accept the PCS and the motion carried. Representative Dobson was recognized to explain the bill.

Rep. Dobson: This bill seeks to streamline the end of the supply line for the medication to the patient's door. The current supply chain has several checks down the line to ensure the correct medication has been shipped, and this supply chain will not be changed by this bill. The inspection we are trying to exempt occurs after the medication is administered, and is additional unnecessary regulation. No opposition currently exists that has not been resolved. Several other states have passed similar legislation.

Rep. Avila moves for favorable report to PCS, unfavorable to the original bill. The motion carried.

HB 543 Amend Laws Pertaining to NC Medical Board. (Representatives Brawley, Jones)

There is a PCS for HB543, Representative Ford made the motion to accept PCS and the motion carried. Representative Brawley and Jones were recognized to explain the bill.

Rep. Brawley: This group is not insurance, rather they attempt to prevent medical cost issues in the future. This bill has process changes to limit members to 2 terms and make it more democratic while introducing some new technology while reducing reporting requirements. Fees are changed since their last alteration 9 years ago.

Rep. Jones: "This bill is supported by the NC medical board and I know of no opposition and see nothing controversial. The fee increase is both modest and necessary. I also have a grammatical amendment." Representative Jones motions for the adoption of the amendment and the amendment passes.

Representative Jones motions for passage of H543 rolled in with amendments unfavorable to the original with a serial referral to Finance. The motion carried.

HB 580 Ban Smoking in Foster Care Setting/Infants. (Representatives Cotham, Adcock)

There is a PCS for HB580, Representative Lucas made the motion to accept the PCS and the motioned carried. Representative Cotham was recognized to explain the bill.

Representative Cotham: This bill prevents smoking in foster care facilities around infants. This bill is what the children in foster care asked for the most, especially those with asthma issues."

After concerns from members of the committee Representative Cotham asked Representative Lambeth to displace the bill.

The meeting adjourned at 10:50

Representative Donny Lambeth, Chair
Presiding

Theresa Lopez, Committee Clerk

HOUSE BILL 355:
Enhance Protection for Group Home Residents

2015-2016 General Assembly

Committee:	House Health, if favorable, Judiciary II	**Date:**	April 14, 2015
Introduced by:	Reps. Reives, Stam	**Prepared by:**	Tawanda Foster Committee Counsel
Analysis of:	PCS to First Edition H355-CSTV-5		

SUMMARY: ***House Bill 355 would enhance protections for clients of facilities whose primary purpose is to provide services for the care, treatment, habilitation, and rehabilitation of individuals with mental illness, developmental disabilities, or substance abuse disorders. Further, this bill increases punishments for client abuse, exploitation, or neglect; imposes a reporting requirement on employees and volunteers who witness a sexual offense or offense against morality perpetrated against a client; and makes the failure to report these violations a Class A1 or Class 1 misdemeanor.***

The PCS to House Bill 355 adds a requirement that the Commission for Mental Health, Developmental Disabilities, and Substance Abuse Services (the Commission) establish standardized procedures to train and keep records of the measures used to comply with the employee and volunteer reporting requirements in G.S. 122C-66.

CURRENT LAW: G.S. 122C-26 provides the Commission with powers and duties to issue declaratory rulings, to make rules to meet the provisions and purposes of the Article and to govern licensure and accreditation of residential treatment facilities.

G.S. 122C-66 provides protection from abuse and exploitation, as well as reporting requirements for individuals in facilities that provide care, treatment, habilitation, or rehabilitation of mentally ill, developmentally disabled, or substance abuser clients.

BILL ANALYSIS:

House Bill 355 would make the following changes to the current statute.

- Increases the penalty from a Class 1 misdemeanor to a Class A1 misdemeanor for any employee or volunteer who knowingly causes pain or injury to a client.
- Increases the penalty from a Class 3 misdemeanor to a Class 1 misdemeanor for any employee or volunteer who witnesses and does not report another employee or volunteer who knowingly causes pain or injury to a client or takes personal property from a client.
- Adds a provision that requires an employee or volunteer who witnesses a sex crime or offense against morality perpetrated against a client to report the alleged crime within 24 hours to the department of social services in the county where the facility serves the client and the district attorney in the district where the facility serves the client. Failure to report this alleged crime would be a Class A1 misdemeanor.

- Adds a provision that the county department of social services and district attorney who receives a report of an alleged sex crime or offense against morality shall investigate or provide for the investigation of each such report.

The PCS to House Bill 355 adds a section to require the Commission establish standardized procedures for facilities in training and record keeping of the measures taken to inform employees and volunteers of these duties to report abuse of a client they witness or have knowledge of to the appropriate person or agency.

EFFECTIVE DATE: This act would become effective December 1, 2015 and would apply to offenses committed on or after that date.

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2015

H D

HOUSE BILL 355
PROPOSED COMMITTEE SUBSTITUTE H355-CSTV-5 [v.2]

4/14/2015 4:29:26 PM

Short Title: Enhance Protection for Group Home Residents. (Public)

Sponsors:

Referred to:

March 26, 2015

A BILL TO BE ENTITLED

AN ACT TO ENHANCE PROTECTIONS FOR CLIENTS OF FACILITIES WHOSE PRIMARY PURPOSE IS TO PROVIDE SERVICES FOR THE CARE, TREATMENT, HABILITATION, OR REHABILITATION OF INDIVIDUALS WITH MENTAL ILLNESS, DEVELOPMENTAL DISABILITIES, OR SUBSTANCE ABUSE DISORDERS BY INCREASING PUNISHMENTS FOR CLIENT ABUSE, EXPLOITATION, OR NEGLECT; BY IMPOSING A REPORTING REQUIREMENT ON EMPLOYEES AND VOLUNTEERS WHO WITNESS A SEXUAL OFFENSE OR OFFENSE AGAINST MORALITY PERPETRATED AGAINST A CLIENT; AND BY MAKING FAILURE TO REPORT THESE VIOLATIONS A CLASS 1 MISDEMEANOR.

The General Assembly of North Carolina enacts:

SECTION 1. G.S.122C-26(5) is amended to read as rewritten:

"(5) Adopt rules applicable to facilities licensed under this ~~Article:~~ Article that do the following:

a. Establishing personnel requirements of staff employed in ~~facilities;~~facilities.

b. Establishing qualifications of facility administrators or ~~directors;~~directors.

c. Establishing requirements for death reporting including confidentiality provisions related to death ~~reporting;~~reporting.

d. Establishing requirements for patient ~~advocates; and~~advocates.

e. Requiring facility personnel who refer clients to provider agencies to disclose any pecuniary interest the referring person has in the provider agency, or other interest that may give rise to the appearance of impropriety.

f. Establishing standardized procedures for facilities in training and recordkeeping of the measures taken to inform employees and volunteers of the duties imposed by G.S. 122C-66."

SECTION 2. G.S. 122C-66 reads as rewritten:

"**§ 122C-66. Protection from abuse and exploitation; reporting.**

(a) An employee of or a volunteer at a facility who, other than as a part of generally accepted medical or therapeutic procedure, knowingly causes pain or injury to a client ~~or borrows or takes personal property from a client~~ is guilty of a ~~Class 1~~Class A1 misdemeanor. Any employee or volunteer who uses reasonable force to carry out the provisions of G.S. 122C-60 or to protect himself or others from a violent client does not violate this subsection.

(a1) An employee of or a volunteer at a facility who borrows or takes personal property from a client is guilty of a Class 1 misdemeanor. Any employee or volunteer who uses

reasonable force to carry out the provisions of G.S. 122C-60 or to protect himself or others from a violent client does not violate this subsection.

(b) An employee of or a volunteer at a facility who witnesses or has knowledge of a violation of ~~subsection (a)~~subsection (a), subsection (a1), or of an accidental injury to a client shall report the violation or accidental injury to authorized personnel designated by the facility. No employee making a report may be threatened or harassed by any other employee or volunteer on account of the report. Violation of this subsection is a ~~Class 3 misdemeanor punishable only by a fine, not to exceed five hundred dollars ($500.00).~~Class 1 misdemeanor.

(b1) The employee of or a volunteer at a facility who witnesses a client become a victim of a violation of Article 7A or Article 26 of Chapter 14 of the General Statutes shall report the allegations within 24 hours after witnessing the violation to (i) the department of social services in the county where the facility serves the client and (ii) the district attorney in the district where the facility serves the client. A violation of this section is a Class A1 misdemeanor. No employee making a report may be threatened or harassed by any other employee or volunteer on account of the report.

(c) The identity of an individual who makes a report under this section or who cooperates in an ensuing investigation may not be disclosed without ~~his~~ the reporting individual's consent, except to persons authorized by the facility or by State or federal law to investigate or prosecute these incidents, or in a grievance or personnel hearing or civil or criminal action in which ~~a~~ the reporting individual is testifying, or when disclosure is legally compelled or authorized by judicial discovery. This subsection shall not be interpreted to require the disclosure of the identity of an individual where it is otherwise prohibited by law.

(d) An employee who makes a report in good faith under this section is immune from any civil liability that might otherwise occur for the report. In any case involving liability, making of a report under this section is prima facie evidence that the maker acted in good faith.

(e) The duty imposed by this section is in addition to any duty imposed by G.S. 7B-301 or G.S. 108A-102.

(f) ~~The~~ Except for reports made pursuant to subsection (b1) of this section, the facility shall investigate or provide for the investigation of all reports made under the provisions of this section.

(g) The county department of social services and the district attorney to whom a report is made under subsection (b1) of this section shall investigate or provide for the investigation of each such report."

SECTION 3. This act becomes effective December 1, 2015, and applies to offenses committed on or after that date.

HOUSE BILL 355

Short Title:	Enhance Protection for Group Home Residents.	(Public)
Sponsors:	Representatives Reives and Stam (Primary Sponsors). *For a complete list of Sponsors, refer to the North Carolina General Assembly Web Site.*	
Referred to:	Health, if favorable, Judiciary II.	

March 26, 2015

A BILL TO BE ENTITLED

AN ACT TO ENHANCE PROTECTIONS FOR CLIENTS OF FACILITIES WHOSE PRIMARY PURPOSE IS TO PROVIDE SERVICES FOR THE CARE, TREATMENT, HABILITATION, OR REHABILITATION OF INDIVIDUALS WITH MENTAL ILLNESS, DEVELOPMENTAL DISABILITIES, OR SUBSTANCE ABUSE DISORDERS BY INCREASING PUNISHMENTS FOR CLIENT ABUSE, EXPLOITATION, OR NEGLECT; BY IMPOSING A REPORTING REQUIREMENT ON EMPLOYEES AND VOLUNTEERS WHO WITNESS A SEXUAL OFFENSE OR OFFENSE AGAINST MORALITY PERPETRATED AGAINST A CLIENT; AND BY MAKING FAILURE TO REPORT THESE VIOLATIONS A CLASS 1 MISDEMEANOR.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 122C-66 reads as rewritten:

"**§ 122C-66. Protection from abuse and exploitation; reporting.**

(a) An employee of or a volunteer at a facility who, other than as a part of generally accepted medical or therapeutic procedure, knowingly causes pain or injury to a client ~~or borrows or takes personal property from a client~~ is guilty of a ~~Class 1~~Class A1 misdemeanor. Any employee or volunteer who uses reasonable force to carry out the provisions of G.S. 122C-60 or to protect himself or others from a violent client does not violate this subsection.

(a1) An employee of or a volunteer at a facility who borrows or takes personal property from a client is guilty of a Class 1 misdemeanor. Any employee or volunteer who uses reasonable force to carry out the provisions of G.S. 122C-60 or to protect himself or others from a violent client does not violate this subsection.

(b) An employee of or a volunteer at a facility who witnesses or has knowledge of a violation of ~~subsection (a)~~subsection (a), subsection (a1), or of an accidental injury to a client shall report the violation or accidental injury to authorized personnel designated by the facility. No employee making a report may be threatened or harassed by any other employee or volunteer on account of the report. Violation of this subsection is a ~~Class 3 misdemeanor punishable only by a fine, not to exceed five hundred dollars ($500.00).~~Class 1 misdemeanor.

(b1) The employee of or a volunteer at a facility who witnesses a client become a victim of a violation of Article 7A or Article 26 of Chapter 14 of the General Statutes shall report the allegations within 24 hours after witnessing the violation to (i) the department of social services in the county where the facility serves the client and (ii) the district attorney in the district where the facility serves the client. A violation of this section is a Class A1 misdemeanor. No

employee making a report may be threatened or harassed by any other employee or volunteer on account of the report.

(c) The identity of an individual who makes a report under this section or who cooperates in an ensuing investigation may not be disclosed without ~~his~~ the reporting individual's consent, except to persons authorized by the facility or by State or federal law to investigate or prosecute these incidents, or in a grievance or personnel hearing or civil or criminal action in which ~~a~~ the reporting individual is testifying, or when disclosure is legally compelled or authorized by judicial discovery. This subsection shall not be interpreted to require the disclosure of the identity of an individual where it is otherwise prohibited by law.

(d) An employee who makes a report in good faith under this section is immune from any civil liability that might otherwise occur for the report. In any case involving liability, making of a report under this section is prima facie evidence that the maker acted in good faith.

(e) The duty imposed by this section is in addition to any duty imposed by G.S. 7B-301 or G.S. 108A-102.

(f) ~~The~~ Except for reports made pursuant to subsection (b1) of this section, the facility shall investigate or provide for the investigation of all reports made under the provisions of this section.

(g) The county department of social services and the district attorney to whom a report is made under subsection (b1) of this section shall investigate or provide for the investigation of each such report."

SECTION 2. This act becomes effective December 1, 2015, and applies to offenses committed on or after that date.

HOUSE BILL 437:
Create Permit Exemptions/Home Renal Products

2015-2016 General Assembly

Committee:	House Health	**Date:**	April 10, 2015
Introduced by:	Rep. Dobson	**Prepared by:**	Amy Jo Johnson
Analysis of:	PCS to First Edition H437-CSTK-6		Committee Counsel

SUMMARY: ***House bill 437 would amend the North Carolina Pharmacy Practice Act to create a pharmacy permit exemption and a device and medical equipment permit exemption for the dispensing and delivery of home renal products. The PCS makes technical changes and adds provisions allowing dialysis facilities to be designated agents to receive home medications for patients with renal failure.***

CURRENT LAW: G.S. 90-85.21 and G.S. 90-85.21A regulate pharmacy permits. Each pharmacy in North Carolina is required to annually register with the Board of Pharmacy (Board) and include specified information about its pharmacist-manager and all pharmacy personnel. Physicians who dispense prescription drugs must also annually register with the Board and with the licensing board having jurisdiction over the physician. Out-of-state pharmacy operations which ship, mail, or deliver prescription drugs must also annually register with the Board. The out-of-state operations must certify that they employ a pharmacist who is responsible for dispensing, shipping, mailing, or delivering prescription drugs into this State or in a state approved by the Board and has met requirements for licensure equivalent to the requirements for licensure in North Carolina. The out-of-state pharmacist must agree in writing to be subject to the jurisdiction of the Board, the provisions of the Pharmacy Practice Act, and the rules adopted by the Board.

With regards to medical devices and equipment, G.S. 90-85.22 requires each location where devises are dispensed or delivered, or that delivers medical equipment, to a user in North Carolina must register annually with the Board, unless the business already has a current pharmacy permit.

G.S. 106-145.3 requires every wholesale distributor of prescription drugs in this State to obtain a license from the Department of Agriculture for each location from which prescription drugs are distributed and renew the license annually.

BILL ANALYSIS:

The PCS to House Bill 437 would exempt any location or facility within or outside of North Carolina from which dialysate or drugs necessary to perform home renal dialysis are dispensed and delivered to a patient in North Carolina from the requirement to obtain a pharmacy permit as required by G.S. 90-85.21 and G.S. 90-85.21A if the following criteria are met:

- The dialysate or drugs have been approved or cleared by the United States Food and Drug Administration.
- The dialysate or drugs are lawfully held by a manufacturer, or agent of the manufacturer, or wholesaler that is properly licensed in North Carolina.
- The dialysate or drugs are held, delivered, and dispensed in their original sealed packaging from the manufacturing facility.

- The dialysate or drugs are delivered only by the manufacturer or agent of a manufacturer and only upon receipt of a physician's order.
- The manufacturer or agent of the manufacturer delivers the dialysate drugs to either of the following:
    - A patient with chronic kidney failure or a designee of the patient, for self-administration of the dialysis therapy.
    - A health care provider or health care facility licensed under Chapter 122C, 131D, or 131E of the General Statutes, for administration or delivery of the dialysis therapy to a patient with chronic kidney failure.

Section 2 of the bill would also exempt such dispensing and delivery of home renal products from requiring a device and medical equipment permit.

The PCS would also create a new G.S. 90-85.21D which would allow pharmacies to mail medications for home use by patients with renal failure to renal dialysis facilities for use in one of two specified locations: a Medicare certified dialysis facility or the patient's home for self-dialysis. The bill contains various criteria that must be met before a pharmacy may mail medications to the renal dialysis facilities.

EFFECTIVE DATE: This act becomes effective October 1, 2015.

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2015

H D

HOUSE BILL 437*
PROPOSED COMMITTEE SUBSTITUTE H437-CSTK-6 [v.6]

4/14/2015 4:56:28 PM

Short Title: Create Permit Exemptions/Home Renal Products. (Public)

Sponsors:

Referred to:

April 1, 2015

A BILL TO BE ENTITLED

AN ACT AMENDING THE PHARMACY PRACTICE ACT TO CREATE A PHARMACY PERMIT EXEMPTION AND A DEVICE AND MEDICAL EQUIPMENT PERMIT EXEMPTION FOR THE DISPENSING AND DELIVERY OF HOME RENAL PRODUCTS AND TO ALLOW FOR DIALYSIS FACILITIES TO BE DESIGNATED AS AGENTS TO RECEIVE HOME MEDICATIONS FOR PATIENTS WITH RENAL FAILURE.

The General Assembly of North Carolina enacts:

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

"**§ 90-85.21C. Pharmacy permit exemption for dispensing and delivery of home renal products.**

Each location or facility within or outside this State from which dialysate or drugs necessary to perform home renal dialysis are dispensed and delivered to a patient in this State is exempt from the pharmacy permit requirements established by G.S. 90-85.21 and G.S. 90-8.21A, provided that all the following criteria are met:

(1) The dialysate or drugs have been approved or cleared by United States Food and Drug Administration.

(2) The dialysate or drugs are lawfully held by a manufacturer or an agent of the manufacturer that is properly licensed by the North Carolina Department of Agriculture and Consumer Services as a manufacturer, or as a wholesaler, or as both, as required by G.S. 106-145.3.

(3) The dialysate or drugs are held, delivered, and dispensed in their original, sealed packaging from the manufacturing facility.

(4) The dialysate or drugs are delivered only by the manufacturer, or an agent of the manufacturer, and only upon receipt of a physician's order.

(5) The manufacturer or an agent of the manufacturer delivers the dialysate or drugs directly to either of the following:

a. A patient with chronic kidney failure or a designee of the patient, for self-administration of the dialysis therapy.

b. A health care provider, or health care facility licensed under Chapter 122C, 131D, or 131E of the General Statutes, for administration or delivery of the dialysis therapy to a patient with chronic kidney failure.

"**§ 90-85.21D. Dialysis facilities as designated agents to receive home medications for patients with renal failure.**

Pharmacies may ship medications for home use by patients with renal failure to renal dialysis facilities for delivery to (i) patients who receive dialysis treatments in a Medicare certified dialysis facility or (ii) patients who self-dialyze at home, provided that all of the following criteria are met:

(1) The patient authorizes, in writing, the dialysis facility staff to act as the patient's designated agent for the purpose of receiving mailed medical packages at the dialysis facility.

(2) The pharmacy, whether in-state or out-of-state, is licensed as a pharmacy in North Carolina.

(3) The medications for home use are dispensed by the licensed pharmacist pursuant to a valid prescription order.

(4) The delivered medication packages are held in a secure location in an area not accessible to the public, and delivered by the dialysis facility staff, unopened, to the patient.

(5) Medication packages are individually labeled with the patient name

(6) The medications exclude controlled substances, as defined under G.S. 90-87."

SECTION 2. G.S. 90-85.22 reads as rewritten:

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

...

(c) This section shall not apply to ~~either~~ any of the following:

(1) A pharmaceutical manufacturer registered with the Food and Drug Administration.

(2) A wholly owned subsidiary of a pharmaceutical manufacturer registered with the Food and Drug Administration.

(3) The dispensing and delivery of home renal products in accordance with the criteria specified in G.S. 90-85.21C."

SECTION 3. This act becomes effective October 1, 2015.

HOUSE BILL 437*

Short Title:	Create Permit Exemptions/Home Renal Products.	(Public)
Sponsors:	Representative Dobson (Primary Sponsor). *For a complete list of Sponsors, refer to the North Carolina General Assembly Web Site.*	
Referred to:	Health.	

April 1, 2015

A BILL TO BE ENTITLED

AN ACT AMENDING THE PHARMACY PRACTICE ACT TO CREATE A PHARMACY PERMIT EXEMPTION AND A DEVICE AND MEDICAL EQUIPMENT PERMIT EXEMPTION FOR THE DISPENSING AND DELIVERY OF HOME RENAL PRODUCTS.

The General Assembly of North Carolina enacts:

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

"**§ 90-85.21C. Pharmacy permit exemption for dispensing and delivery of home renal products.**

Each location or facility within or outside this State from which dialysate or drugs necessary to perform home renal dialysis are dispensed and delivered to a patient in this State is exempt from the pharmacy permit requirements established by G.S. 90-85.21, provided that all the following criteria are met:

(1) The dialysate or drugs have been approved or cleared by United States Food and Drug Administration.

(2) The dialysate or drugs are lawfully held by a manufacturer or an agent of the manufacturer that is properly registered with the Board as a manufacturer or a wholesaler, or both, as required by the Board.

(3) The dialysate or drugs are held, delivered, and dispensed in their original, sealed packaging from the manufacturing facility.

(4) The dialysate or drugs are delivered only by the manufacturer or an agent of the manufacturer and only upon receipt of a physician's order.

(5) The manufacturer or an agent of the manufacturer delivers the dialysate or drugs directly to either or both of the following:

a. A patient with chronic kidney failure or a designee of the patient, for self-administration of the dialysis therapy.

b. A health care provider, or health care facility licensed under Chapter 122C, 131D, or 131E of the General Statutes, for administration or delivery of the dialysis therapy to a patient with chronic kidney failure.

SECTION 2. G.S. 90-85.22 reads as rewritten:

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

...

(c) This section shall not apply to ~~either~~ any of the following:

(1) A pharmaceutical manufacturer registered with the Food and Drug Administration.

(2) A wholly owned subsidiary of a pharmaceutical manufacturer registered with the Food and Drug Administration.

(3) The dispensing and delivery of home renal products in accordance with the criteria specified in G.S. 90-85.21C."

SECTION 3. This act becomes effective October 1, 2015.

HOUSE BILL 543:
Amend Laws Pertaining to NC Medical Board

2015-2016 General Assembly

Committee:	House Health, if favorable, Finance	**Date:**	April 14, 2015
Introduced by:	Reps. Brawley, Jones	**Prepared by:**	Theresa Matula
Analysis of:	PCS to First Edition H543-CSSH-14		Committee Staff

SUMMARY: House Bill 543 makes a number of changes to the laws pertaining to the NC Medical Board as outlined in the summary below.

BILL ANALYSIS:

Section 1 limits the terms of the terms of a Medical Board member to two complete three-year terms in a lifetime.

Section 2 amends the qualifications for a physician, physician assistant, or nurse practitioner to add the requirement that the individual must not have served more than 72 months as a member of the Board.

Section 3 is a technical change to capitalize "Review Panel."

Section 4 adds new language to the law pertaining to recommending Board members to: (i) allow the Board to provide confidential and nonpublic licensing and investigative information to the Review Panel; (ii) to specify that all applications, records, papers, files, reports, investigative and licensing information received by the Review Panel as a result of soliciting, receiving and reviewing applications and making recommendations will not be considered public records; and (iii) to provide that the Review Panel is a public body within the meaning of Article 33C, Chapter 143, which establishes the policy of the state to conduct open hearings, deliberations, and actions, but species that the Review Panel will meet in closed session to review applications; interview applicants; review and discuss information; and to discuss, debate, and vote on recommendations from the Governor. The Review Panel is required to publish on its Internet site the names and practice addresses of all applicants within 10 days after the application deadline and to publish the names and practice address of nominees recommended to the Governor within 10 days and not less than 30 days prior to the expiration of the open position on the Board.

Section 5 amends the law on the Board's requirement to collect and publish data by removing the requirement to report fax numbers, but does continue to require a current, active email address, which is considered a public record, and may be used or made available by the Board for the purpose of disseminating or soliciting information affecting public health or the practice of medicine.

Section 6 removes a reference to making fax numbers available.

Section 7 amends the law to specify that the Board must not deny an application for licensure based solely on the applicant's failure to become board certified.

Section 8 increases from $350 to $400, the application fee payable to the NC Medical Board for each applicant for a license to practice medicine and surgery in the State.

O. Walker Reagan
Director

H543-SMSH-28 CSSH-14 -V2

Research Division
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This bill analysis was prepared by the nonpartisan legislative staff for the use of legislators in their deliberations and does not constitute an official statement of legislative intent.

Section 9 increases from $175 to $250, the annual registration fee for every person licensed to practice medicine by the Board, except those who have a limited license to practice in a medical education and training program shall pay $125, and those who have a retired limited volunteer license pay no annual registration fee. This section also removes duplicate language contained in two subsections. A subsection is added to provide that the Board must not deny a licensee's annual registration based solely on the licensee's failure to become board certified.

Section 10 amends the law on disciplinary authority of the Board to provide that if the licensee has retained counsel, the Board may serve to both the licensee and the licensee's counsel orders to produce, appear, submit to assessment or examination or orders following a hearing or provide notice that the Board will not be taking further action against a licensee.

Section 11 amends the law on disciplinary action pertaining to the written notice indicating charges made against the licensee to add a requirement that once charges have been issued, the parties may engage in discovery as provided in G.S. 1A 1, the North Carolina Rules of Civil Procedure. Additionally, the Board must provide the respondent or respondent's counsel with all exculpatory evidence in its possession, except for the following:

1) Information that is subject to attorney client privilege.
2) Information that would identify an anonymous complainant.
3) Information related to advisory opinions, recommendations, or deliberations by the Board, its staff, and its consultants that will not be entered into evidence.

Section 12 amends the reporting requirements of disciplinary action by health care institutions to eliminate the requirement that hospitals report suspensions for delinquent medical records.

Section 13 renames Article 1D, "Health Program for Medical Professionals."

Section 14 amends the peer review agreement to provide that the Medical Board (Board) may enter into agreements with the NC Medical Society (Society), the NC Academy of Physician Assistants (Academy) and the NC Physicians Health Program (Program) to identify, review, and evaluate licensees of the Board, who have been referred to the Program, with regard to their ability to function in their professional capacity and to coordinate regimens for treatment and rehabilitation. The agreement must include guidelines for all items outlined below:

1) The assessment, referral, monitoring, support, and education of licensees of the Board by reason of a physical or mental illness, a substance use disorder, or professional sexual misconduct.
2) Procedures for the Board to refer licensees to the Program.
3) Criteria for the Program to report licensees to the Board.
4) A procedure by which licensees may obtain review of recommendations for assessment or treatment by the Program.
5) Periodic reporting of statistical information by the Program to the Board, the Society, and the Academy.
6) Maintaining the confidentiality of nonpublic information.

The NC Physicians Health Program (Program) is described as an independent organization for medical professionals that provides screening, referral, monitoring, education, and support services. The Board, Society, and the Academy may provide funds for administration of the Program.

The Program is required to report immediately to the Board detailed information about any licensee of the Board who meets any of the following criteria:

1) The licensee constitutes an imminent danger to patient care.
2) The licensee refuses to submit to an assessment as ordered by the Board, has entered into a monitoring contract and fails to comply with terms of the contract, or continues to be unsafe to practice medicine after treatment.

Any information acquired, created, or used in good faith by the Program under this health program is privileged, confidential, and not subject to discovery, subpoena, or other means of legal compulsion for release. No person participating in good faith in the Program can be required to disclose participation in a civil case. Activities conducted in good faith regarding to the agreements are not grounds for civil action.

Upon written request of a licensee, the Program must provide the licensee and the licensee's legal counsel with a copy of a written assessment of the licensee. The licensee is also entitled to a copy of any written assessment created by a treatment provider or facility at the recommendation of the Program, to the extent permitted by State and federal laws and regulations. Such information is limited in its use and availability.

The Board is granted authority to adopt, amend, or repeal rules to enforce the provisions above.

Section 15 repeals the requirement that the Board provide the licensee or applicant access to all information its possession that the Board intends to offer into evidence in presenting its case at the contested hearing.

EFFECTIVE DATE: This act would become effective October 1, 2015.

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2015

H D

HOUSE BILL 543
PROPOSED COMMITTEE SUBSTITUTE H543-CSSH-14 [v.3]

4/14/2015 6:28:38 PM

Short Title: Amend Laws Pertaining to NC Medical Board. (Public)

Sponsors:

Referred to:

April 6, 2015

A BILL TO BE ENTITLED

AN ACT AMENDING LAWS PERTAINING TO THE NORTH CAROLINA MEDICAL BOARD.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 90-2(b) reads as rewritten:

"(b) No member shall serve more than two complete ~~consecutive~~ three-year ~~terms.~~terms in a lifetime, except that each member shall serve until a successor is chosen and qualifies."

SECTION 2. G.S. 90-3(b) reads as rewritten:

"(b) To be considered qualified for a physician position or the physician assistant or nurse practitioner position on the Board, an applicant shall meet each of the following criteria:

...

(10) Have not served more than 72 months as a member of the Board."

SECTION 3. G.S. 90-3(c) reads as rewritten:

"(c) The ~~review panel~~Review Panel shall recommend at least two qualified nominees for each open position on the Board. If the Governor chooses not to appoint either of the recommended nominees, the Review Panel shall recommend at least two new qualified nominees."

SECTION 4. G.S. 90-3 is amended by adding new subsections to read:

"(f) Notwithstanding any provision of G.S. 90-16, the Board may provide confidential and nonpublic licensing and investigative information in its possession to the Review Panel.

(g) All applications, records, papers, files, reports, and all investigative and licensing information received by the Review Panel from the Board and other documents received or gathered by the Review Panel, its members, employees, agents, and consultants as a result of soliciting, receiving, and reviewing applications and making recommendations as required in this section shall not be considered public records within the meaning of Chapter 132 of the General Statutes. All such information shall be privileged, confidential, and not subject to discovery, subpoena, or other means of legal compulsion for release to any person other than ~~to~~ the Review Panel, the Board, and their employees, agents, or consultants, except as provided in this section. The Review Panel shall publish on its Internet Web site the names and practice addresses of all applicants within 10 days after the application deadline. The Review Panel shall publish on its Internet Web site the names and practice addresses of the nominees recommended to the Governor within 10 days after notifying the Governor of those recommendations and not less than 30 days prior to the expiration of the open position on the Board.

(h) The Review Panel is a public body within the meaning of Article 33C of Chapter 143 of the General Statutes. In addition to the provisions contained in Article 33C of Chapter

143 of the General Statutes permitting a public body to conduct business in a closed session, the Review Panel shall meet in closed session to review applications; interview applicants; review and discuss information received from the Board; and discuss, debate, and vote on recommendations to the Governor."

SECTION 5. G.S. 90-5.2(7) reads as rewritten:

"(7) ~~An~~ A current, active e-mail ~~address or facsimile number~~ address, which shall not be ~~made available to the public and shall~~considered a public record within the meaning of Chapter 132 of the General Statutes. This information may be used or made available by the Board for the purpose of ~~expediting the dissemination of~~disseminating or soliciting information ~~about~~ affecting public health ~~emergency.~~or the practice of medicine."

SECTION 6. G.S. 90-5.2(a1) reads as rewritten:

"(a1) The Board shall make e-mail addresses ~~and facsimile numbers~~ reported pursuant to G.S. 90-5.2(a)(7) available to the Department of Health and Human Services for use in the North Carolina Controlled Substance Reporting System established by Article 5E of this Chapter."

SECTION 7. G.S. 90-8.1 reads as rewritten:

"**§ 90-8.1. Rules governing applicants for licensure.**

(a) The North Carolina Medical Board is empowered to adopt rules that prescribe additional qualifications for an applicant, including education and examination requirements and application procedures.

(b) The Board shall not deny an application for licensure based solely on the applicant's failure to become board certified."

SECTION 8. G.S. 90-13.1(a) reads as rewritten:

"(a) Each applicant for a license to practice medicine and surgery in this State under either G.S. 90-9.1 or G.S. 90-9.2 shall pay to the North Carolina Medical Board an application fee of ~~three~~ four hundred ~~fifty~~ dollars ~~($350.00).~~($400.00)."

SECTION 9. G.S. 90-13.2 reads as rewritten:

"**§ 90-13.2. Registration every year with Board.**

(a) Every person licensed to practice medicine by the North Carolina Medical Board shall register annually with the Board within 30 days of the person's birthday.

(b) A person who registers with the Board shall report to the Board the person's name and office and residence address and any other information required by the Board, and shall pay an annual registration fee of ~~one hundred seventy-five~~two hundred fifty dollars ~~($175.00),~~($250.00), except those who have a limited license to practice in a medical education and training program approved by the Board for the purpose of education or training shall pay a registration fee of one hundred twenty-five dollars ~~($125.00),~~($125.00) and those who have a retired limited volunteer license pursuant to G.S. 90-12.1B ~~shall pay an annual registration fee of twenty-five dollars ($25.00), and those who have~~or a limited volunteer license pursuant to G.S. 90-12.1A shall pay no annual registration fee. However, licensees who have a limited license to practice for the purpose of education and training under G.S. 90-12.01 shall not be required to pay more than one annual registration fee for each year of training.

~~(c) A physician who is not actively engaged in the practice of medicine in North Carolina and who does not wish to register the license may direct the Board to place the license on inactive status.~~

(d) A physician who is not actively engaged in the practice of medicine in North Carolina and who does not wish to register the license may direct the Board to place the license on inactive status.

(e) A physician who fails to register as required by this section shall pay an additional fee of fifty dollars ($50.00) to the Board. The license of any physician who fails to register and who remains unregistered for a period of 30 days after certified notice of the failure is

automatically inactive. The Board shall retain jurisdiction over the holder of the inactive license.

(f) Except as provided in G.S. 90-12.1B, a person whose license is inactive shall not practice medicine in North Carolina nor be required to pay the annual registration fee.

(g) Upon payment of all accumulated fees and penalties, the license of the physician may be reinstated, subject to the Board requiring the physician to appear before the Board for an interview and to comply with other licensing requirements. The penalty may not exceed the maximum fee for a license under G.S. 90-13.1.

(h) The Board shall not deny a licensee's annual registration based solely on the licensee's failure to become board certified."

SECTION 10. G.S. 90-14(n) reads as rewritten:

"(n) Notwithstanding subsection (m) of this section, if the licensee has retained ~~counsel and the Board has not made a nonpublic determination to initiate disciplinary proceedings,~~counsel, the Board may serve to both the licensee and the licensee's counsel orders to produce, ~~orders to~~ appear, ~~or~~ submit to assessment or examination or orders following a hearing, or provide notice that the Board will not be taking any further action against a ~~licensee to both the licensee and the licensee's counsel.~~licensee."

SECTION 11. G.S. 90-14.2 is amended by adding a new subsection to read:

"(c) Once charges have been issued, the parties may engage in discovery as provided in G.S. 1A-1, the North Carolina Rules of Civil Procedure. Additionally, the Board shall provide the respondent or respondent's counsel with all exculpatory evidence in its possession, except for the following:

(1) Information that is subject to attorney-client privilege.

(2) Information that would identify an anonymous complainant.

(3) Information related to advisory opinions, recommendations, or deliberations by the Board, its staff, and its consultants that will not be entered into evidence."

SECTION 12. G.S. 90-14.13(a1)(1) reads as rewritten:

"(a1) A hospital is not required to report:

(1) The suspension or limitation of a physician's privileges for failure to timely complete medical ~~records unless the suspension or limitation is the third within the calendar year for failure to timely complete medical records. Upon reporting the third suspension or limitation, the hospital shall also report the previous two suspensions or limitations.~~records."

SECTION 13. Article 1D of Chapter 90 of the General Statutes is renamed as follows:

"Article 1D.

~~Peer Review.~~Health Program for Medical Professionals."

SECTION 14. G.S. 90-21.22 reads as rewritten:

"**§ 90-21.22. ~~Peer review agreements.~~Health program for medical professionals.**

(a) The North Carolina Medical Board ~~may, under rules adopted by the Board in compliance with Chapter 150B of the General Statutes,~~(Board) may enter into agreements with the North Carolina Medical Society (Society), ~~and its local medical society components, and with~~ the North Carolina Academy of Physician Assistants (Academy), and the North Carolina Physicians Health Program (Program) for the ~~purpose~~ purposes of ~~conducting peer review activities.~~identifying, reviewing, and evaluating the ability of licensees of the Board who have been referred to the Program to function in their professional capacity and to coordinate regimens for treatment and rehabilitation. ~~Peer review activities to be covered by such agreements shall include investigation, review, and evaluation of records, reports, complaints, litigation and other information about the practices and practice patterns of physicians licensed by the Board, and of physician assistants approved by the Board, and shall include programs~~

~~for impaired physicians and impaired physician assistants. Agreements between the Academy and the Board shall be limited to programs for impaired physicians and physician assistants and shall not include any other peer review activities.~~The agreement shall include guidelines for all items outlined below.

(1) The assessment, referral, monitoring, support, and education of licensees of the Board by reason of a physical or mental illness, a substance use disorder, or professional sexual misconduct.

(2) Procedures for the Board to refer licensees to the Program.

(3) Criteria for the Program to report licensees to the Board.

(4) A procedure by which licensees may obtain review of recommendations for assessment or treatment by the Program.

(5) Periodic reporting of statistical information by the Program to the Board, the Society, and the Academy.

(6) Maintaining the confidentiality of nonpublic information.

~~(b) Peer review agreements shall include provisions for the society and for the Academy to receive relevant information from the Board and other sources, conduct the investigation and review in an expeditious manner, provide assurance of confidentiality of nonpublic information and of the review process, make reports of investigations and evaluations to the Board, and to do other related activities for promoting a coordinated and effective peer review process. Peer review agreements shall include provisions assuring due process.~~

(c) ~~Each society which enters a peer review agreement with the Board shall establish and maintain a program for impaired physicians licensed by the Board. The Academy, after entering a peer review agreement with the Board, shall either enter an agreement with the North Carolina Medical Society for the inclusion of physician assistants in the Society's program for impaired physicians, or shall establish and maintain the Academy's own program for impaired physician assistants. The purpose of the programs shall be to identify, review, and evaluate the ability of those physicians and physician assistants to function in their professional capacity and to provide programs for treatment and rehabilitation.~~ The North Carolina Physicians Health Program (Program) is an independent organization for medical professionals that provides screening, referral, monitoring, educational, and support services. The ~~Board~~ Board, Society, and the Academy may provide funds for the administration of ~~impaired physician and impaired physician assistant programs and shall adopt rules with provisions for definitions of impairment; guidelines for program elements; procedures for receipt and use of information of suspected impairment; procedures for intervention and referral; monitoring treatment, rehabilitation, post-treatment support and performance; reports of individual cases to the Board; periodic reporting of statistical information; assurance of confidentiality of nonpublic information and of the review process.~~the Program.

(d) ~~Upon investigation and review of a physician licensed by the Board, or a physician assistant approved by the Board, or upon receipt of a complaint or other information, a society which enters a peer review agreement with the Board, or the Academy if it has a peer review agreement with the Board, as appropriate,~~The Program shall report immediately to the Board detailed information about any ~~physician or physician assistant licensed or approved by the Board if:~~licensee of the Board who meets any of the following criteria:

(1) ~~The physician or physician assistant constitutes~~The licensee constitutes an imminent danger to ~~the public or to himself~~patient care by reason of ~~impairment,~~ mental illness, physical illness, ~~the commission of~~ substance use disorder, professional sexual misconduct, ~~boundary violations,~~ or any other ~~reason;~~ reason.

(2) ~~The physician or physician assistant~~ The licensee refuses to ~~cooperate with the program, refuses to submit to treatment, or is still impaired after~~

~~treatment and exhibits professional incompetence; or~~ submit to an assessment as ordered by the Board, has entered into a monitoring contract and fails to comply with the terms of the Program's monitoring contract, or is still unsafe to practice medicine after treatment.

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

(c) Any ~~confidential patient~~ information ~~and other nonpublic information~~ acquired, created, or used in good faith by the ~~Academy or a society~~Program pursuant to this section is privileged, confidential, and not subject to discovery, subpoena ~~shall remain confidential and shall not be subject to discovery or subpoena in a civil case.~~ or other means of legal compulsion for release to any person other than to the Board, the Program, or their employees or consultants. No person participating in good faith in the ~~peer review or impaired physician or impaired physician assistant programs~~Program ~~of this section~~ shall be required in a civil case to disclose the fact of participation in the Program or any information acquired or opinions, recommendations, or evaluations acquired or developed solely in the course of participating in ~~any agreements~~the Program pursuant to this section.

(f) ~~Peer review activities~~ Activities conducted in good faith pursuant to ~~any~~ the agreement authorized by subsection (a) of ~~under~~ this section shall not be grounds for civil action under the laws of this ~~State and are deemed to be State directed and sanctioned and shall constitute State action for the purposes of application of antitrust laws.~~State.

(g) Upon the written request of a licensee, the Program shall provide the licensee and the licensee's legal counsel with a copy of a written assessment of the licensee prepared as part of the licensee's participation in the Program. In addition, the licensee shall be entitled to a copy of any written assessment created by a treatment provider or facility at the recommendation of the Program, to the extent permitted by State and federal laws and regulations. Any information furnished to a licensee pursuant to this subsection shall be inadmissible in evidence and shall not be subject to discovery in any civil proceeding. However, this subsection shall not be construed to make information, documents, or records otherwise available for discovery or use in a civil action immune from discovery or use in a civil action merely because the information, documents, or records were included as part of the Program's assessment of the licensee or were the subject of information furnished to the licensee pursuant to this subsection. For purposes of this subsection, a civil action or proceeding shall not include administrative actions or proceedings conducted in accordance with Article 1 of Chapter 90 and Chapter 150B of the General Statutes.

(h) The Board has authority to adopt, amend, or repeal rules as may be necessary to carry out and enforce the provisions of this section."

SECTION 15. G.S. 90-16(d) is repealed.

SECTION 16. This act becomes effective October 1, 2015.

HOUSE BILL 543

Short Title:	Amend Laws Pertaining to NC Medical Board.	(Public)
Sponsors:	Representatives Brawley and Jones (Primary Sponsors). *For a complete list of Sponsors, refer to the North Carolina General Assembly Web Site.*	
Referred to:	Health, if favorable, Finance.	

April 6, 2015

A BILL TO BE ENTITLED

AN ACT AMENDING LAWS PERTAINING TO THE NORTH CAROLINA MEDICAL BOARD.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 90-2(b) reads as rewritten:

"(b) No member shall serve more than two complete consecutive three-year ~~terms,~~terms in a lifetime, except that each member shall serve until a successor is chosen and qualifies."

SECTION 2. G.S. 90-3(b) reads as rewritten:

"(b) To be considered qualified for a physician position or the physician assistant or nurse practitioner position on the Board, an applicant shall meet each of the following criteria:

...

(10) Have not served more than 72 months as a member of the Board."

SECTION 3. G.S. 90-3(c) reads as rewritten:

"(c) The ~~review panel~~Review Panel shall recommend at least two qualified nominees for each open position on the Board. If the Governor chooses not to appoint either of the recommended nominees, the Review Panel shall recommend at least two new qualified nominees."

SECTION 4. G.S. 90-3 is amended by adding new subsections to read:

"(f) Notwithstanding any provision of G.S. 90-16, the Board may provide confidential and nonpublic licensing and investigative information in its possession to the Review Panel.

(g) All applications, records, papers, files, reports, and all investigative and licensing information received by the Review Panel from the Board and other documents received or gathered by the Review Panel, its members, employees, agents, and consultants as a result of soliciting, receiving, and reviewing applications and making recommendations as required in this section shall not be considered public records within the meaning of Chapter 132 of the General Statutes. All such information shall be privileged, confidential, and not subject to discovery, subpoena, or other means of legal compulsion for release to any person other than to the Review Panel, the Board, and their employees, agents, or consultants, except as provided in this section. The Review Panel shall publish on its Internet Web site the names and practice addresses of all applicants within 10 days after the application deadline. The Review Panel shall publish on its Internet Web site the names and practice addresses of the nominees recommended to the Governor within 10 days after notifying the Governor of those recommendations and not less than 30 days prior to the expiration of the open position on the Board.

(h) The Review Panel is a public body within the meaning of Article 33C of Chapter 143 of the General Statutes. In addition to the provisions contained in Article 33C of Chapter 143 of the General Statutes permitting a public body to conduct business in a closed session, the Review Panel shall meet in closed session to review applications; interview applicants; review and discuss information received from the Board; and discuss, debate, and vote on recommendations to the Governor."

SECTION 5. G.S. 90-5.2(7) reads as rewritten:

"(7) ~~An~~ A current, active e-mail ~~address or facsimile number~~ address, which shall not be ~~made available to the public and shall~~considered a public record within the meaning of Chapter 132 of the General Statutes. This information may be used or made available by the Board for the purpose of ~~expediting the dissemination of~~disseminating or soliciting information ~~about a~~affecting public health ~~emergency.~~or the practice of medicine."

SECTION 6. G.S. 90-5.2(a1) reads as rewritten:

"(a1) The Board shall make e-mail addresses ~~and facsimile numbers~~ reported pursuant to G.S. 90-5.2(a)(7) available to the Department of Health and Human Services for use in the North Carolina Controlled Substance Reporting System established by Article 5E of this Chapter."

SECTION 7. G.S. 90-8.1 reads as rewritten:

"**§ 90-8.1. Rules governing applicants for licensure.**

(a) The North Carolina Medical Board is empowered to adopt rules that prescribe additional qualifications for an applicant, including education and examination requirements and application procedures.

(b) The Board shall not deny an application for licensure based solely on the applicant's failure to become board certified."

SECTION 8. G.S. 90-13.1(a) reads as rewritten:

"(a) Each applicant for a license to practice medicine and surgery in this State under either G.S. 90-9.1 or G.S. 90-9.2 shall pay to the North Carolina Medical Board an application fee of ~~three~~ four hundred ~~fifty~~ dollars ~~($350.00).~~($400.00)."

SECTION 9. G.S. 90-13.2 reads as rewritten:

"**§ 90-13.2. Registration every year with Board.**

(a) Every person licensed to practice medicine by the North Carolina Medical Board shall register annually with the Board within 30 days of the person's birthday.

(b) A person who registers with the Board shall report to the Board the person's name and office and residence address and any other information required by the Board, and shall pay an annual registration fee of ~~one hundred seventy-five~~two hundred fifty dollars ~~($175.00),~~($250.00), except those who have a limited license to practice in a medical education and training program approved by the Board for the purpose of education or training shall pay a registration fee of one hundred twenty-five dollars ~~($125.00),~~($125.00) and those who have a retired limited volunteer license pursuant to G.S. 90-12.1B ~~shall pay an annual registration fee of twenty-five dollars ($25.00), and those who have~~or a limited volunteer license pursuant to G.S. 90-12.1A shall pay no annual registration fee. However, licensees who have a limited license to practice for the purpose of education and training under G.S. 90-12.01 shall not be required to pay more than one annual registration fee for each year of training.

~~(c) A physician who is not actively engaged in the practice of medicine in North Carolina and who does not wish to register the license may direct the Board to place the license on inactive status.~~

(d) A physician who is not actively engaged in the practice of medicine in North Carolina and who does not wish to register the license may direct the Board to place the license on inactive status.

(e) A physician who fails to register as required by this section shall pay an additional fee of fifty dollars ($50.00) to the Board. The license of any physician who fails to register and who remains unregistered for a period of 30 days after certified notice of the failure is automatically inactive. The Board shall retain jurisdiction over the holder of the inactive license.

(f) Except as provided in G.S. 90-12.1B, a person whose license is inactive shall not practice medicine in North Carolina nor be required to pay the annual registration fee.

(g) Upon payment of all accumulated fees and penalties, the license of the physician may be reinstated, subject to the Board requiring the physician to appear before the Board for an interview and to comply with other licensing requirements. The penalty may not exceed the maximum fee for a license under G.S. 90-13.1.

(h) The Board shall not deny a licensee's annual registration based solely on the licensee's failure to become board certified."

SECTION 10. G.S. 90-14(n) reads as rewritten:

"(n) Notwithstanding subsection (m) of this section, if the licensee has retained ~~counsel and the Board has not made a nonpublic determination to initiate disciplinary proceedings,~~counsel, the Board may serve to both the licensee and the licensee's counsel orders to produce, ~~orders to~~ appear, ~~or~~ submit to assessment or examination or orders following a hearing, or provide notice that the Board will not be taking any further action against a ~~licensee to both the licensee and the licensee's counsel.~~licensee."

SECTION 11. G.S. 90-14.2 is amended by adding a new subsection to read:

"(c) Once charges have been issued, the parties may engage in discovery as provided in G.S. 1A-1, the North Carolina Rules of Civil Procedure. Additionally, the Board shall provide the respondent or respondent's counsel with all exculpatory evidence in its possession, except for the following:

(1) Information that is subject to attorney-client privilege.

(2) Information that would identify an anonymous complainant.

(3) Information related to advisory opinions, recommendations, or deliberations by the Board, its staff, and its consultants that will not be entered into evidence."

SECTION 12. G.S. 90-14.13(a1)(1) reads as rewritten:

"(a1) A hospital is not required to report:

(1) The suspension or limitation of a physician's privileges for failure to timely complete medical ~~records unless the suspension or limitation is the third within the calendar year for failure to timely complete medical records. Upon reporting the third suspension or limitation, the hospital shall also report the previous two suspensions or limitations.~~records."

SECTION 13. G.S. 90-21.22A is recodified as G.S. 90-21.22B under Article 1D of Chapter 90 of the General Statutes.

SECTION 14. Article 1D of Chapter 90 of the General Statutes is renamed as follows:

"Article 1D.

~~Peer Review.~~Health Program for Medical Professionals."

SECTION 15. Article 1D of Chapter 90 of the General Statutes is amended by adding a new section to read:

"**§ 90-21.22A. Health Program for Medical Professionals.**

(a) The Board may enter into an agreement with the North Carolina Medical Society, the North Carolina Academy of Physician Assistants, and the North Carolina Physicians Health Program for the purposes of identifying, reviewing, and evaluating the ability of licensees of the Board who have been referred to the North Carolina Physicians Health Program to function

in their professional capacity; and coordinating regimens for treatment and rehabilitation. The agreement shall include guidelines for all of the following:

(1) The assessment, referral, monitoring, support, and education of licensees of the Board by reason of a physical or mental illness, a substance abuse-related disorder, or professional sexual misconduct.

(2) Procedures for the Board to refer licensees to the North Carolina Physicians Health Program.

(3) Criteria for the North Carolina Physicians Health Program to report licensees to the Board.

(4) A procedure by which licensees may obtain review of recommendations for assessment or treatment by the North Carolina Physicians Health Program.

(5) Periodic reporting of statistical information by the North Carolina Physicians Health Program to the Board, the North Carolina Medical Society, and the North Carolina Academy of Physician Assistants.

(6) Maintaining the confidentiality of nonpublic information.

(b) The Board, the North Carolina Medical Society, and the North Carolina Academy of Physician Assistants may provide funds for the administration of the North Carolina Physicians Health Program.

(c) The North Carolina Physicians Health Program shall report immediately to the Board detailed information about any licensee of the Board who meets any of the following criteria:

(1) Constitutes an imminent danger to patient care by reason of a physical or mental illness, a substance abuse-related disorder, professional sexual misconduct, or any other reason.

(2) Has entered into a monitoring contract with the health program and fails to comply with the terms of the monitoring contract.

(3) Refuses to submit to an assessment as ordered by the Board.

(4) Is still unsafe to practice medicine after treatment.

(d) Any information acquired, created, or used in good faith by the North Carolina Physicians Health Program pursuant to this section is privileged, confidential, and not subject to discovery, subpoena, or other means of legal compulsion for release to any person other than to the Board, the North Carolina Physicians Health Program, or their employees or consultants. No person who participates in good faith in the North Carolina Physicians Health Program shall be required to disclose in a civil case the fact of participation or any information acquired or opinions, recommendations, or evaluations acquired or developed solely during the course of participating in the program pursuant to this section.

(e) Upon the written request of a licensee, the North Carolina Physicians Health Program shall provide the licensee or the licensee's legal counsel with a copy of a written assessment of the licensee prepared as part of the licensee's participation in the program. In addition, the licensee shall be entitled to a copy of any written assessment created by an alcohol or chemical dependency treatment facility at the recommendation of the North Carolina Physicians Health Program, to the extent permitted by State and federal laws and regulations. Any information furnished to a licensee pursuant to this subsection shall be inadmissible in evidence and shall not be subject to discovery in any civil proceeding. However, this subsection shall not be construed to make information, documents, or records otherwise available for discovery or use in a civil action immune from discovery or use in a civil action merely because the information, documents, or records were included as part of the North Carolina Physicians Health Program's assessment of the licensee or were the subject of information furnished to the licensee pursuant to this subsection.

(f) Activities conducted in good faith pursuant to the agreement authorized by subsection (a) of this section shall not be grounds for civil action under the laws of this State.

(g) The Board has authority to adopt, amend, or repeal rules as may be necessary to carry out and enforce the provisions of this section.

SECTION 16. G.S. 90-16(d) and G.S. 90-21.22 are repealed.

SECTION 17. This act becomes effective October 1, 2015.

NORTH CAROLINA GENERAL ASSEMBLY
AMENDMENT
House Bill 543

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

H543-ASH-6 [v.1]

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

Date _____, 2015

Representative Jones

moves to amend the proposed committee substitute for the bill on page 4, lines 10-11 by rewriting the lines to read:

"(4) A procedure by which licensees may obtain review of recommendations by the Program regarding assessment or treatment." .

SIGNED _____
Amendment Sponsor

SIGNED _____
Committee Chair if Senate Committee Amendment

ADOPTED ✓ FAILED _____ TABLED _____

HOUSE BILL 580:
Ban Smoking in Foster Care Setting/Infants

2015-2016 General Assembly

Committee:	House Health	**Date:**	April 15, 2015
Introduced by:	Reps. Cotham, Adcock	**Prepared by:**	Kristen Harris Committee Counsel
Analysis of:	PCS to First Edition H580-CSTU-8		

SUMMARY: ***The Proposed Committee Substitute for House Bill 580 would direct the Social Services Commission (the Commission) to adopt rules restricting a foster parent's smoking in the presence of an infant in the foster parent's care.***

BILL ANALYSIS:

Section 1 would require the Commission to adopt rules restricting a foster parent's smoking in the presence of an infant in the foster parent's care, as discussed in Section 2.

Section 2 would require the Department of Health and Human Resources and the Division of Social Services to enforce a written policy prohibiting a foster parent from smoking in the presence of an infant in the foster parent's care.

An infant is defined as a child less than one year of age.

Smoking is defined in G.S. 143-596(5) as "the use or possession of a lighted cigarette, lighted cigar, lighted pipe, or any other lighted tobacco product".

EFFECTIVE DATE: This act is effective when it becomes law.

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2015

H D

HOUSE BILL 580
PROPOSED COMMITTEE SUBSTITUTE H580-CSTU-8 [v.1]

4/10/2015 5:14:03 PM

Short Title: Ban Smoking in Foster Care Setting/Infants. (Public)

Sponsors:

Referred to:

April 6, 2015

A BILL TO BE ENTITLED

AN ACT AUTHORIZING THE SOCIAL SERVICES COMMISSION TO ADOPT A POLICY PROHIBITING A FOSTER PARENT FROM SMOKING IN THE PRESENCE OF AN INFANT IN THE FOSTER PARENT'S CARE.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 131D-10.5 is amended by adding a new subdivision to read:

"**§ 131D-10.5. Powers and duties of the Commission.**

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

...

(8) Adopt rules establishing a policy to prohibit a foster parent from smoking in the presence of an infant in the foster parent's care pursuant to G.S. 131D-10.7A."

SECTION 2. Article 1A of Chapter 131D of the General Statutes is amended by adding the following new section to read:

"**§ 131D-10.7A. Policy prohibiting smoking in the presence of an infant in foster care setting.**

(a) For purposes of this section, the following definitions apply:

(1) Infant. – A child less than one year of age.

(2) Smoking. – As defined in G.S. 143-596(5).

(b) Pursuant to rules adopted by the Social Services Commission under G.S. 131D-10.5(8), the Department of Health and Human Services and the Division of Social Services, shall enforce a written policy prohibiting a foster parent from smoking in the presence of an infant in the foster parent's care."

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

HOUSE BILL 580

Short Title:	Ban Smoking in Foster Care Setting/Infants.	(Public)
Sponsors:	Representatives Cotham and Adcock (Primary Sponsors). *For a complete list of Sponsors, refer to the North Carolina General Assembly Web Site.*	
Referred to:	Health.	

April 6, 2015

A BILL TO BE ENTITLED

AN ACT AUTHORIZING THE SOCIAL SERVICES COMMISSION TO ADOPT A POLICY PROHIBITING A FOSTER PARENT FROM SMOKING IN THE PRESENCE OF AN INFANT IN THE FOSTER PARENT'S CARE.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 131D-10.5 is amended by adding a new subdivision to read:

"**§ 131D-10.5. Powers and duties of the Commission.**

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

...

(8) Adopt rules establishing a policy to prohibit a foster parent from smoking in the presence of an infant in the foster parent's care pursuant to G.S. 131D-10.7A."

SECTION 2. Article 1A of Chapter 131D of the General Statutes is amended by adding the following new section to read:

"**§ 131D-10.7A. Policy prohibiting smoking in the presence of an infant in foster care setting.**

(a) For purposes of this section, the following definitions apply:

(1) Infant. – A young child less than one year of age.

(2) Smoking. – As defined in G.S. 143-596(5).

(b) Pursuant to rules adopted by the Commission under G.S. 131D-10.5(8), the Department of Health and Human Services, Division of Social Services, shall enforce a written policy prohibiting a foster parent from smoking in a private residence used to provide licensed foster care to infants. The policy shall further prohibit a foster parent from smoking in the presence of an infant in the foster parent's care while the infant and the foster parent are in a motor vehicle. The policy shall require a foster parent to prohibit others from smoking in the presence of an infant in that foster parent's care."

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

NORTH CAROLINA GENERAL ASSEMBLY
HOUSE OF REPRESENTATIVES

HEALTH COMMITTEE REPORT
Representative Brian Brown, Co-Chair
Representative Justin P. Burr, Co-Chair
Representative Bert Jones, Co-Chair
Representative Donny Lambeth, Co-Chair

FAVORABLE COM SUB , UNFAVORABLE ORIGINAL BILL

HB **437** Create Permit Exemptions/Home Renal Products.

Draft Number:	H437-PCS30309-TK-6
Serial Referral:	None
Recommended Referral:	None
Long Title Amended:	Yes
Floor Manager:	Dobson

FAVORABLE COM SUB , UNFAVORABLE ORIGINAL BILL AND RE-REFERRED

HB **355** Enhance Protection for Group Home Residents.

Draft Number:	H355-PCS40395-TV-5
Serial Referral:	**JUDICIARY II**
Recommended Referral:	None
Long Title Amended:	No
Floor Manager:	Reives

HB **543** Amend Laws Pertaining to NC Medical Board.

Draft Number:	H543-PCS20288-SH-14
Serial Referral:	**FINANCE**
Recommended Referral:	None
Long Title Amended:	No
Floor Manager:	Brawley

TOTAL REPORTED: 3

CMR150-V-1

Wednesday, April 15 HEALTH	Room 643	Time 10:00 am

Name	County	Sponsor
Rachel Chism	Guilford	John Faircloth
Eli Hornback	Rutherford	Mike Hager

Committee Sergeants at Arms

NAME OF COMMITTEE House Comm. on Health

DATE: 4/15/15 Room: 643

House Sgt-At Arms:

1. Name: Young Bae
2. Name: Bill Morris
3. Name: Jim Moran
4. Name:
5. Name:

Senate Sgt-At Arms:

1. Name:
2. Name:
3. Name:
4. Name:
5. Name:

VISITOR REGISTRATION SHEET

House Comm. on Health — 04/15/15

Name of Committee — Date

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Robert Rich MD	NCAFP
R.W. WATKINS, MD	NCAFP
Christine Craig	WakeMed
Lanier Swann Hodgson	UNC Healthcare
Jennifer Gasperini	NCMS
Kerri Burke	NCMS
Amanda Horaker	TSS
Joel MAYNARD	GPM & Assoc
Allison Stewart	cardinal innovations
JOE LANIER	19
Thom Moon	Ev Wake
Peg Mann	
Chip Bell	NCMS.

VISITOR REGISTRATION SHEET

House Comm. on Health — 04/15/15

Name of Committee — Date

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Andy Ellen	NCRMA
Ryan Blackledge	Core Health
Doug Heron	DUKE
JEFF BARNHART	MWC
Lori Kroll	Novant Health

VISITOR REGISTRATION SHEET

House Comm. on Health — 04/15/15

Name of Committee — Date

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Kenya Caldwell	NCAFP - med student
Marlana Sheriden	NCAFP - MS4 (med student)
TJ Bugbee	NP
[illegible]	MD
[illegible]	[illegible]
[illegible]	PENC
Dodie Renfer	CCR
Elizabeth Stell	Baxter
CHRISTY KIM	BAXTER
Chip Kelbar	nelson mullins
Brent Hazlett	NCAFP

VISITOR REGISTRATION SHEET

House Comm. on Health — 04/15/15

Name of Committee — Date

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
[signature]	NCALHD
[signature]	NCAFP
Dana Simpson	SA
Warren Pendergast	NCPHP
Elizabeth Meredith	NCMB
Thom Mansfield	NCMB
Joanna Spruill	NCAFP
[signature]	NCAFP
Shannon Dowler	NCAFP
Deanna Didiano	NCAFP
Hugh Johnson	NCACC

VISITOR REGISTRATION SHEET

House Comm. on Health — 04/15/15

Name of Committee — Date

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Pamela Kilbourne	NC Board of Nursing
Andy Chase	KMA
TRACY GLUSTRD	~~AHHE~~
Neil Lee	PIAB
WILLIAM GARNEAU	NCAFP
Franklin Niblock	NCAFP
Cleveland Piggott	NC Academy of Family Physicians (NCAFP)
Eli Tiller	NCAFP
Brian Fitzgerald	NCAFP
YEE LAM	NCAFP
Amy Jane Nayo	NCAFP

VISITOR REGISTRATION SHEET

House Comm. on Health — 04/15/15

Name of Committee — Date

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Josh Ehrich	JAA
Judy Jenkins	Otsuka
Phoebe Landon	Brooks Pierce
Keyona Gullett	NCAFP
Morgan McEachern	NCAFP
Lindsay Cass	NCAFP
Kenzie Johnston, MD	NCAFP
Cathy Feller, MD	NCAFP
Catherine Coe, MD	NCAFP
Caitlin Higgins, MD	NCAFP
Rhian Morwakl	UM

VISITOR REGISTRATION SHEET

House Comm. on Health — 04/15/15

Name of Committee — Date

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Caroline Mullin, MD	UNC Family Medicine Dept
Cayce Dunn	DRNC
Annaliese Dolph	bL
Kay Castillo	NASW NC
David Collins	SEANC
Jason Joyner	New Frame
Sarah Wolf	MWC
Pam Seamans	NC Alliance for Health

Speakers Sign up.

~~VISITOR REGISTRATION SHEET~~

Name of Committee **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Christy Kim	BAXTER
Thom Mansfield	NC Medical Board

NORTH CAROLINA HOUSE OF REPRESENTATIVES
COMMITTEE MEETING NOTICE
AND
BILL SPONSOR NOTIFICATION
2015-2016 SESSION

You are hereby notified that the **House Committee on Health** will meet as follows:

DAY & DATE: Thursday, April 16, 2015
TIME: **15 Minutes After Session**
LOCATION: **643 LOB**
COMMENTS: **Representative Jones will preside.**

The following bills will be considered:

BILL NO.	SHORT TITLE	SPONSOR
HB 647	Epi Pens in All Child-Serving Businesses.	Representative McGrady Representative Avila Representative Stevens Representative Glazier
HB 652	Right to Try Act for Terminally Ill Patients.	Representative Blackwell Representative Hager Representative Lambeth Representative Reives
HB 684	Medicaid County of Origin.	Representative Avila Representative Lambeth Representative Hager Representative Malone

Respectfully,

Representative Brian Brown, Co-Chair
Representative Justin P. Burr, Co-Chair
Representative Bert Jones, Co-Chair
Representative Donny Lambeth, Co-Chair

I hereby certify this notice was filed by the committee assistant at the following offices at 2:59 PM on Wednesday, April 15, 2015.

___ Principal Clerk
___ Reading Clerk – House Chamber

Brenda Olls (Committee Assistant)

House Committee on Health
Thursday, April 16, 2015, 15 Minutes After Session
643 Legislative Office Building

AGENDA

Welcome and Opening Remarks

Introduction of Pages

Bills

BILL NO.	SHORT TITLE	SPONSOR
HB 647	Epi Pens in All Child-Serving Businesses.	Representative McGrady Representative Avila Representative Stevens Representative Glazier
HB 652	Right to Try Act for Terminally Ill Patients.	Representative Blackwell Representative Hager Representative Lambeth Representative Reives

Presentations

Other Business

Adjournment

House Committee on Health
Thursday, April 16, 2015 at 15 Minutes After Session
Room 643 of the Legislative Office Building

MINUTES

The House Committee on Health met at 15 Minutes After Session on April 16, 2015 in Room 643 of the Legislative Office Building. Representatives Avila, Adcock, Bishop, B. Brown, Dollar, Farmer-Butterfield, L. Hall, Hastings, Jones, Lambeth, and S. Martin attended.

Representative Bert Jones, Chair, presided.

The following bills were considered:

HB 647 Epi Pens in All Child-Serving Businesses. (Representatives McGrady, Avila, Stevens, Glazier)

There is a PCS for HB 647, Representative McGrady made the motion to accept the PCS and the motion carried. Representatives McGrady and Avila were recognized to explain the bill.

Representatives McGrady and Avila: This bill would authorize health care providers to prescribe EPI Pens to a business that serves children and to allow that business to dispense the EPI Pen where there are allergens that may cause anaphylaxis. It will also allow employees or agents of the authorized business to provide or administer epinephrine under certain circumstances.
Rep. McGrady: "If these are required in a school setting, why wouldn't they be permitted in others? I am not aware of any opposition to this."

Rep. Waddell moved for a favorable report for the PCS, unfavorable to the original bill. The motion carried.

HB 652 Right to Try Act for Terminally Ill Patients. (Representatives Blackwell, Hager, Lambeth, Reives)

There is a PCS for HB652, Representative Avila made the motion to accept PCS and the motion carried. Representative Blackwell was recognized to explain the bill.

Representative Blackwell: The sickest patients do not qualify for clinical trials and have to apply through the FDA which creates massive delays and is an expensive process for people without much time. The goal of this bill is to remove some of these barriers and give patients access to treatments that have been through phase 1 of FDA regulation."

Rep. Dobson moved for a favorable report for the PCS, unfavorable to the original bill with a recommended referral to Judiciary 4. The motion carried.

The meeting adjourned at 4:35

Representative Bert Jones, Chair
Presiding

Theresa Lopez, Committee Clerk

HOUSE BILL 647:
Epi Pens in All Child-Serving Businesses

2015-2016 General Assembly

Committee:	House Health	**Date:**	April 16, 2015
Introduced by:	Reps. McGrady, Avila, Stevens, Glazier	**Prepared by:**	Amy Jo Johnson Committee Counsel
Analysis of:	PCS to First Edition H647-CSTK-11		

SUMMARY: ***The PCS to House Bill 647 would authorize health care providers to prescribe and dispense epinephrine auto-injectors to authorized entities at which allergens capable of causing anaphylaxis may occur. The bill allows employees or agents of authorized entities to provide or administer epinephrine under certain circumstances to specified individuals. The bill would also confer immunity on individuals acting pursuant to the act and specifies that actions taken pursuant to the act do not constitute the practice of medicine. The PCS makes technical changes and allows the Board of Pharmacy to adopt rules.***

CURRENT LAW: G.S. 115C-375.2A requires a local board of education to provide for an emergency supply of epinephrine auto-injectors on school property for use by trained school personnel to provide emergency aid to persons suffering from an anaphylactic reaction on school property. Designated personnel must undergo training related to the use of the epinephrine auto-injector and the principal must develop an emergency plan for the use of the auto-injectors. A local board of education, its members, employees, designees, agents, or volunteers, and a physician, physician assistant, or nurse practitioner of the local health department shall not be liable in civil damages for actions taken under the statute unless those actions constitute gross negligence, wanton conduct, or intentional wrongdoing.

BILL ANALYSIS:

The PCS for H647 would allow any entity or organization, other than a school as addressed in G.S. 115C-375.2A, at which allergens capable of causing anaphylaxis may be present to maintain a supply of epinephrine auto-injectors. Epinephrine auto-injectors are defined as "a single-use device used for the automatic injection of a premeasured dose of epinephrine into the human body." The bill would allow for a health care provider to prescribe epinephrine auto-injectors in the name of the authorized entity and for pharmacist and health care providers to dispense epinephrine auto-injectors to the authorized entities. The prescription will be valid for no more than 2 years. The epinephrine auto-injectors may be supplied and/or administered by the entity to any individual experiencing anaphylaxis or provided to the parent, guardian, or caregiver of any person experiencing anaphylaxis.

If an authority entity does acquire and stock a supply of epinephrine auto-injectors, the entity must do so in accordance with the manufacturer's instructions. That entity must also designate employees or agents to be responsible for the storage, maintenance, control, and general oversight of the epinephrine auto-injectors. The designated employees or agents must undergo training as outlined in the bill regarding recognizing signs and symptoms of anaphylaxis, procedures for storage and administration of epinephrine auto-injectors and emergency follow-up procedures. The bill would grant immunity to specified individuals for any injuries or related damages that result from any act or omission taken pursuant to the bill, but would not apply to acts or omissions constituting gross negligence, wanton conduct, or intentional wrongdoing.

The PCS would allow the North Carolina Board of Pharmacy to adopt rules addressing the authorization for authorized entities to obtain a prescription for epinephrine auto-injectors.

EFFECTIVE DATE: This act becomes effective October 1, 2015.

O. Walker Reagan
Director

H647-SMTK-30 CSTK-11 -V4

Research Division
(919) 733-2578

This bill analysis was prepared by the nonpartisan legislative staff for the use of legislators in their deliberations and does not constitute an official statement of legislative intent.

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2015

H D

HOUSE BILL 647
PROPOSED COMMITTEE SUBSTITUTE H647-CSTK-11 [v.3]

4/15/2015 6:16:48 PM

Short Title: Epi Pens in All Child-Serving Businesses. (Public)

Sponsors:

Referred to:

April 14, 2015

A BILL TO BE ENTITLED

AN ACT AUTHORIZING HEALTH CARE PROVIDERS TO PRESCRIBE, AND PHARMACISTS TO DISPENSE, EPINEPHRINE AUTO-INJECTORS TO AUTHORIZED CHILD-SERVING ENTITIES OTHER THAN SCHOOLS FOR THE EMERGENCY TREATMENT OF ANAPHYLAXIS.

The General Assembly of North Carolina enacts:

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

"**§ 90-21.15A. Emergency treatment using epinephrine auto-injector; immunity.**

(a) Definitions. – The following definitions apply in this section:

(1) Administer. – The direct application of an epinephrine auto-injector to the body of an individual.

(2) Authorized entity. – Any entity or organization, other than a school described in G.S. 115C-375.2A, at which allergens capable of causing anaphylaxis may be present, including, but not limited to, recreation camps, colleges, universities, day care facilities, youth sports leagues, amusement parks, restaurants, places of employment, and sports arenas.

(3) Epinephrine auto-injector. – A single-use device used for the automatic injection of a premeasured dose of epinephrine into the human body.

(4) Health care provider. – A health care provider licensed to prescribe drugs under the laws of this State.

(5) Provide. – To supply one or more epinephrine auto-injectors to an individual.

(b) Prescribing to Authorized Entities Permitted. – A health care provider may prescribe epinephrine auto-injectors in the name of an authorized entity for use in accordance with this section, and pharmacists and health care providers may dispense epinephrine auto-injectors pursuant to a prescription issued in the name of an authorized entity. A prescription issued pursuant to this section shall be valid for no more than two years.

(c) Authorized Entities Permitted to Maintain Supply. – An authorized entity may acquire and stock a supply of epinephrine auto-injectors pursuant to a prescription issued in accordance with this section. The supply of epinephrine auto-injectors shall be stored in accordance with the epinephrine auto-injector manufacturer's instructions for use and any additional requirements that may be established by the Department of Health and Human Services. An authorized entity that acquires and stocks a supply of epinephrine auto-injectors pursuant to a prescription issued in accordance with this section shall designate employees or

agents to be responsible for the storage, maintenance, control, and general oversight of epinephrine auto-injectors acquired by the authorized entity.

(d) Use of Epinephrine Auto-Injectors by Authorized Entities. – An employee or agent of an authorized entity or other individual may use epinephrine auto-injectors prescribed pursuant to G.S. 90-726.1 to do any of the following:

(1) Provide an epinephrine auto-injector to any individual who the employee, agent, or other individual believes in good faith is experiencing anaphylaxis, or the parent, guardian, or caregiver of such individual, for immediate administration, regardless of whether the individual has a prescription for an epinephrine auto-injector or has previously been diagnosed with an allergy.

(2) Administer an epinephrine auto-injector to any individual who the employee, agent, or other individual believes in good faith is experiencing anaphylaxis, regardless of whether the individual has a prescription for an epinephrine auto-injector or has previously been diagnosed with an allergy.

(e) Mandatory Training Program. – Designated employees or agents of authorized entities described in subsection (c) of this section shall complete an anaphylaxis training program. The training shall be conducted by (i) a physician, physician assistant, or registered nurse licensed to practice in this State; (ii) a nationally recognized organization experienced in training laypersons in emergency health treatment; or (iii) an entity or individual approved by the Department of Health and Human Services. The training may be conducted online or in person, and shall at a minimum include all of the following components:

(1) How to recognize signs and symptoms of severe allergic reactions, including anaphylaxis.

(2) Standards and procedures for the storage and administration of an epinephrine auto-injector.

(3) Emergency follow-up procedures.

(f) Immunity. – None of the following persons shall be liable for any injuries or related damages that result from any act or omission taken pursuant to this section:

(1) Any authorized entity that voluntarily and without expectation of payment possesses and makes available epinephrine auto-injectors.

(2) Any employee or agent of an authorized entity, or any other individual, who provides or administers an epinephrine auto-injector to an individual whom the employee, agent, or other individual believes in good faith is experiencing anaphylaxis.

(3) A health care provider that prescribes epinephrine auto-injectors to an authorized entity.

(4) A pharmacist or health care provider that dispenses epinephrine auto-injectors to an authorized entity.

(5) Any individual or entity that conducts the training mandated by subsection (e) of this section.

The immunity conferred by this section does not (i) apply to acts or omissions constituting gross negligence, wanton conduct, or intentional wrongdoing or (ii) eliminate, limit, or reduce any other immunity or defense that may be available under State law, including that provided under G.S. 90-21.14.

(g) Liability for Acts Outside of This State. – An authorized entity located in this State shall not be liable under the laws of this State for any injuries or related damages resulting from the provision or administration of an epinephrine auto-injector outside of this State under either of the following circumstances:

(1) If the authorized entity would not have been liable for such injuries or related damages if the epinephrine auto-injector had been provided or administered within this State.

(2) If the authorized entity is not liable for such injuries or related damages under the laws of the state in which the epinephrine auto-injector was provided or administered.

(h) Does Not Constitute Practice of Medicine. – The administration of an epinephrine auto-injector in accordance with this section is not the practice of medicine or any other profession that otherwise requires licensure."

SECTION 2. The North Carolina Board of Pharmacy may adopt temporary and permanent rules addressing the authorization for authorized entities under Section 1 of this act to obtain a prescription for epinephrine for emergency health circumstances.

SECTION 3. This act becomes effective October 1, 2015.

HOUSE BILL 647

Short Title:	Epi Pens in All Child-Serving Businesses.	(Public)
Sponsors:	Representatives McGrady, Avila, Stevens, and Glazier (Primary Sponsors). *For a complete list of Sponsors, refer to the North Carolina General Assembly Web Site.*	
Referred to:	Health.	

April 14, 2015

A BILL TO BE ENTITLED

AN ACT AUTHORIZING HEALTH CARE PROVIDERS TO PRESCRIBE, AND PHARMACISTS TO DISPENSE, EPINEPHRINE AUTO-INJECTORS TO AUTHORIZED CHILD-SERVING ENTITIES OTHER THAN SCHOOLS FOR THE EMERGENCY TREATMENT OF ANAPHYLAXIS.

The General Assembly of North Carolina enacts:

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

"**§ 90-21.15A. Emergency treatment using epinephrine auto-injector; immunity.**

(a) Definitions. – The following definitions apply in this section:

(1) Administer. – The direct application of an epinephrine auto-injector to the body of an individual.

(2) Authorized entity. – Any entity or organization, other than a school described in G.S. 115C-375.2A, at which allergens capable of causing anaphylaxis may be present, including, but not limited to, recreation camps, colleges, universities, day care facilities, youth sports leagues, amusement parks, restaurants, places of employment, and sports arenas.

(3) Epinephrine auto-injector. – A single-use device used for the automatic injection of a premeasured dose of epinephrine into the human body.

(4) Health care provider. – A health care provider licensed to prescribe drugs under the laws of this State.

(5) Provide. – To supply one or more epinephrine auto-injectors to an individual.

(b) Prescribing to Authorized Entities Permitted. – A health care provider may prescribe epinephrine auto-injectors in the name of an authorized entity for use in accordance with this section, and pharmacists and health care providers may dispense epinephrine auto-injectors pursuant to a prescription issued in the name of an authorized entity. A prescription issued pursuant to this section shall be valid for no more than two years.

(c) Authorized Entities Permitted to Maintain Supply. – An authorized entity may acquire and stock a supply of epinephrine auto-injectors pursuant to a prescription issued in accordance with this section. The supply of epinephrine auto-injectors shall be stored in a location readily accessible in an emergency and in accordance with the epinephrine auto-injector's instructions for use and any additional requirements that may be established by the Department of Health and Human Services. An authorized entity shall designate employees

or agents to be responsible for the storage, maintenance, control, and general oversight of epinephrine auto-injectors acquired by the authorized entity.

(d) Use of Epinephrine Auto-Injectors by Authorized Entities. – An employee or agent of an authorized entity or other individual may use epinephrine auto-injectors prescribed pursuant to G.S. 90-726.1 to do any of the following:

(1) Provide an epinephrine auto-injector to any individual who the employee, agent, or other individual believes in good faith is experiencing anaphylaxis, or the parent, guardian, or caregiver of such individual, for immediate administration, regardless of whether the individual has a prescription for an epinephrine auto-injector or has previously been diagnosed with an allergy.

(2) Administer an epinephrine auto-injector to any individual who the employee, agent, or other individual believes in good faith is experiencing anaphylaxis, regardless of whether the individual has a prescription for an epinephrine auto-injector or has previously been diagnosed with an allergy.

(e) Mandatory Training Program. – Designated employees or agents of authorized entities described in subsection (c) of this section shall complete an anaphylaxis training program. The training shall be conducted by (i) a physician, physician assistant, or registered nurse licensed to practice in this State; (ii) a nationally recognized organization experienced in training laypersons in emergency health treatment; or (iii) an entity or individual approved by the Department of Health and Human Services. The training may be conducted online or in person, and shall at a minimum include all of the following components:

(1) How to recognize signs and symptoms of severe allergic reactions, including anaphylaxis.

(2) Standards and procedures for the storage and administration of an epinephrine auto-injector.

(3) Emergency follow-up procedures.

(f) Immunity. – None of the following persons shall be liable for any injuries or related damages that result from any act or omission taken pursuant to this section:

(1) Any authorized entity that voluntarily and without expectation of payment possesses and makes available epinephrine auto-injectors.

(2) Any employee or agent of an authorized entity, or any other individual, who provides or administers an epinephrine auto-injector to an individual whom the employee, agent, or other individual believes in good faith is experiencing anaphylaxis.

(3) A health care provider that prescribes epinephrine auto-injectors to an authorized entity.

(4) A pharmacist or health care provider that dispenses epinephrine auto-injectors to an authorized entity.

(5) Any individual or entity that conducts the training mandated by subsection (e) of this section.

The immunity conferred by this section does not (i) apply to acts or omissions constituting gross negligence, wanton conduct, or intentional wrongdoing or (ii) eliminate, limit, or reduce any other immunity or defense that may be available under State law, including that provided under G.S. 90-21.14.

(g) Liability for Acts Outside of This State. – An authorized entity located in this State shall not be liable under the laws of this State for any injuries or related damages resulting from the provision or administration of an epinephrine auto-injector outside of this State under either of the following circumstances:

(1) If the authorized entity would not have been liable for such injuries or related damages if the epinephrine auto-injector had been provided or administered within this State.

(2) If the authorized entity is not liable for such injuries or related damages under the laws of the state in which the epinephrine auto-injector was provided or administered.

(h) Does Not Constitute Practice of Medicine. – The administration of an epinephrine auto-injector in accordance with this section is not the practice of medicine or any other profession that otherwise requires licensure."

SECTION 2. This act becomes effective October 1, 2015.

HOUSE BILL 652:
Right to Try Act for Terminally Ill Patients

2015-2016 General Assembly

Committee:	House Health	**Date:**	April 15, 2015
Introduced by:	Reps. Blackwell, Hager, Lambeth, Reives	**Prepared by:**	Amy Jo Johnson Committee Counsel
Analysis of:	PCS to First Edition H652-CSTK-12		

SUMMARY: The PCS to House Bill 652 would establish a process by which eligible patients who are terminally ill could obtain access to investigational drugs, biological products, and devices so long as various requirements are met. The PCS makes technical and clarifying changes.

CURRENT LAW: Generally, non-US Food and Drug Administration (FDA) approved prescription drugs are not available for patient use. Patients may participate, if eligible, in FDA approved clinical trials. If a patient is not eligible for a clinical trial, the FDA has an expanded access program for unapproved drugs; however the patient must be approved to obtain access by the FDA.

BILL ANALYSIS:

The PCS to House Bill 652 would allow the manufacturer of an investigational drug, biological product, or device to make available to an eligible patient that manufacturer's investigational drug, biological product, or device. The manufacturer may provide this investigational drug, biological product, or device with or without a cost to the patient. The phrase "investigational drug, biological product, or device" is defined as "a drug, biological product, or device that has successfully completed Phase I of a clinical trial but has not yet been approved for general use by the [FDA] and remains under investigation in a clinical trial approved by the [FDA]."

In order for a person to be eligible to receive the investigation drug, biological product, or device, the following criteria must be met:

- The person must have a progressive medical or surgical condition that (i) entails significant functional impairment, (ii) is not considered by a treating physician to be reversible even with the administration of available treatments approved by the FDA, and (iii) will soon result in death without life-sustaining procedures. This diagnosis of a terminal illness must be attested by a physician.
- The person must have, in consultation with the treating physician, considered all other treatment options currently approved by the FDA.
- The person must have received a recommendation by the treating physician for use of the investigational drug, biological product, or device.
- The person must have given written, informed consent to use of the investigational drug, biological product, or device.
- There must be documentation from the treating physician that the person meets all of the criteria above. This documentation must include an attestation from the treating physician that the treating physician was consulted in the creation of the required written, informed consent.

This bill analysis was prepared by the nonpartisan legislative staff for the use of legislators in their deliberations and does not constitute an official statement of legislative intent.

With regards to the required written informed consent, House Bill 652 would require that the informed consent must be a written document that is signed by an eligible patient; or if the patient is a minor, by a parent or legal guardian; or if the patient is incapacitated, by a designated health care agent pursuant to a health care power of attorney. The written informed consent must include the following:

- An explanation of the currently approved products and treatments for the eligible patient's terminal illness.
- An attestation that the eligible patient concurs with the treating physician in believing that all currently approved treatments are unlikely to prolong the eligible patient's life.
- Clear identification of the specific investigational drug, biological product, or device proposed for treatment of the eligible patient's terminal illness.
- A description of the potentially best and worst outcomes resulting from use of the investigational drug, biological product, or device to treat the eligible patient's terminal illness, along with a realistic description of the most likely outcome.
- A statement that eligibility for hospice care may be withdrawn if the eligible patient begins treatment of the terminal illness with an investigational drug, biological product, or device, and that hospice care may be reinstated if such treatment ends and the eligible patient meets hospice eligibility requirements.
- A statement that the eligible patient's health benefit plan or third party administrator and provider are not obligated to pay for any care or treatments consequent to the use of the investigational drug, biological product, or device, unless specifically required to do so by law or contract.
- A statement that the eligible patient understands that he or she is liable for all expenses consequent to the use of the investigational drug, biological product, or device and that this liability extends to the eligible patient's estate, unless a contract between the patient and the manufacturer of the drug, biological product, or device states otherwise.
- A statement that the eligible patient or, for an eligible patient who is a minor or lacks capacity to provide informed consent, that the parent or legal guardian consents to the use of the investigational drug, biological product, or device for treatment of the terminal condition.

House Bill 652 would also prohibit any liability to the heirs of the eligible patient for any outstanding debt related to the use of investigational drugs, biological products, or devices.

House Bill 652 also contains provisions that would prohibit certain punitive actions from being taken against health care providers based upon a recommendation to an eligible patient regarding investigational drugs, biological products, or devices. No official, employee, or agent of the State would be able to take action to block or attempt to block an eligible patient's access to investigational drugs, biological products, or devices.

Under House Bill 652, no private right of action would be able to be brought against a manufacturer of an investigational drug, biological product, or device, or against any other person or entity involved in the care of an eligible patient using an investigational drug, biological product, or device, for any harm caused to the eligible patient resulting from use of the investigational drug, biological product, or device as long as the manufacturer or other person or entity has made a good faith effort to comply with the provisions of the act and has exercised reasonable care in undertaking his or her actions.

EFFECTIVE DATE: This act becomes effective October 1, 2015.

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2015

H D

HOUSE BILL 652
PROPOSED COMMITTEE SUBSTITUTE H652-CSTK-12 [v.3]

4/15/2015 8:43:34 PM

Short Title: Right to Try Act for Terminally Ill Patients. (Public)

Sponsors:

Referred to:

April 14, 2015

A BILL TO BE ENTITLED

AN ACT ESTABLISHING A RIGHT TO TRY ACT TO PROVIDE EXPANDED ACCESS TO INVESTIGATIONAL DRUGS, BIOLOGICAL PRODUCTS, AND DEVICES FOR PATIENTS DIAGNOSED WITH TERMINAL ILLNESS.

The General Assembly of North Carolina enacts:

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

"Article 23A.
"Right to Try Act.

"**§ 90-325. Short title; purpose.**

(a) This Article shall be known and may be cited as The Right to Try Act.

(b) The purpose of this Article is to authorize access to and use of experimental treatments for patients with a terminal illness; to establish conditions for use of experimental treatment; to prohibit sanctions of health care providers solely for recommending or providing experimental treatment; to clarify duties of a health insurer with regard to experimental treatment authorized under this Article; to prohibit certain actions by State officials, employees, and agents; and to restrict certain causes of action arising from experimental treatment.

"**§ 90-325.1. Definitions.**

The following definitions apply in this Article, unless the context requires otherwise:

(1) Eligible patient. – An individual who meets all of the following criteria:

a. Has a terminal illness, attested to by a treating physician.

b. Has, in consultation with a treating physician, considered all other treatment options currently approved by the United States Food and Drug Administration.

c. Has received a recommendation from the treating physician for use of an investigational drug, biological product, or device for treatment of the terminal illness.

d. Has given informed consent in writing to use of the investigational drug, biological product, or device for treatment of the terminal illness or, if the individual is a minor or is otherwise incapable of providing informed consent, the parent or legal guardian has given informed consent in writing to use of the investigational drug, biological product, or device.

e. Has documentation from the treating physician that the individual meets all of the criteria for this definition. This documentation shall include an attestation from the treating physician that the treating

physician was consulted in the creation of the written, informed consent required under this Article.

(2) Investigational drug, biological product, or device. – A drug, biological product, or device that has successfully completed Phase I of a clinical trial but has not yet been approved for general use by the United States Food and Drug Administration and remains under investigation in a clinical trial approved by the United States Food and Drug Administration.

(3) Terminal illness. – A progressive disease or medical or surgical condition that (i) entails significant functional impairment, (ii) is not considered by a treating physician to be reversible even with administration of available treatments approved by the United States Food and Drug Administration, and (iii) will soon result in death without life-sustaining procedures.

(4) Written, informed consent. – A written document that is signed by an eligible patient; or if the patient is a minor, by a parent or legal guardian; or if the patient is incapacitated, by a designated health care agent pursuant to a health care power of attorney, that at a minimum includes all of the following:

a. An explanation of the currently approved products and treatments for the eligible patient's terminal illness.

b. An attestation that the eligible patient concurs with the treating physician in believing that all currently approved treatments are unlikely to prolong the eligible patient's life.

c. Clear identification of the specific investigational drug, biological product, or device proposed for treatment of the eligible patient's terminal illness.

d. A description of the potentially best and worst outcomes resulting from use of the investigational drug, biological product, or device to treat the eligible patient's terminal illness, along with a realistic description of the most likely outcome. The description shall be based on the treating physician's knowledge of the proposed treatment in conjunction with an awareness of the eligible patient's terminal illness and shall include a statement acknowledging that new, unanticipated, different, or worse symptoms might result from, and that death could be hastened by, the proposed treatment.

e. A statement that eligibility for hospice care may be withdrawn if the eligible patient begins treatment of the terminal illness with an investigational drug, biological product, or device, and that hospice care may be reinstated if such treatment ends and the eligible patient meets hospice eligibility requirements.

f. A statement that the eligible patient's health benefit plan or third-party administrator and provider are not obligated to pay for any care or treatments consequent to the use of the investigational drug, biological product, or device, unless specifically required to do so by law or contract.

g. A statement that the eligible patient understands that he or she is liable for all expenses consequent to the use of the investigational drug, biological product, or device and that this liability extends to the eligible patient's estate, unless a contract between the patient and the manufacturer of the drug, biological product, or device states otherwise.

h. A statement that the eligible patient or, for an eligible patient who is a minor or lacks capacity to provide informed consent, that the parent or legal guardian consents to the use of the investigational drug, biological product, or device for treatment of the terminal condition.

"**§ 90-325.2. Authorized access to and use of investigational drugs, biological products, and devices.**

(a) A manufacturer of an investigational drug, biological product, or device may make available to an eligible patient, and an eligible patient may request, the manufacturer's investigational drug, biological product, or device. However, nothing in this Article shall be construed to require a manufacturer of an investigational drug, biological product, or device to make such investigational drug, biological product, or device available to an eligible patient.

(b) A manufacturer of an investigational drug, biological product, or device may provide the investigational drug, biological product, or device to an eligible patient without receiving compensation, or may require the eligible patient to pay the costs of, or the costs associated with, the manufacture of the investigational drug, biological product, or device.

"**§ 90-352.3. No liability to heirs for outstanding debt related to use of investigational drugs, biological products, or devices.**

If an eligible patient dies while being treated with an investigational drug, biological product, or device, the eligible patient's heirs are not liable for any outstanding debt related to the treatment, including any costs attributed to lack of insurance coverage for the treatment.

"**§ 90-325.4. Sanctions against health care providers prohibited.**

(a) A licensing board shall not revoke, fail to renew, suspend, or take any other disciplinary action against a health care provider licensed under this Chapter, based solely on the health care provider's recommendations to an eligible patient regarding access to or treatment with an investigational drug, biological product, or device.

(b) An entity responsible for Medicare certification shall not take action against a health care provider's Medicare certification based solely on the health care provider's recommendation that a patient have access to an investigational drug, biological product, or device.

"**§ 90-325.5. Prohibited conduct by State officials.**

No official, employee, or agent of this State shall block or attempt to block an eligible patient's access to an investigational drug, biological product, or device. Counseling, advice, or a recommendation consistent with medical standards of care from a licensed health care provider does not constitute a violation of this section.

"**§ 90-325.6. No private right of action against manufacturers of investigational drugs, biological products, or devices.**

No private right of action may be brought against a manufacturer of an investigational drug, biological product, or device, or against any other person or entity involved in the care of an eligible patient using an investigational drug, biological product, or device, for any harm caused to the eligible patient resulting from use of the investigational drug, biological product, or device as long as the manufacturer or other person or entity has made a good-faith effort to comply with the provisions of this Article and has exercised reasonable care in actions undertaken pursuant to this Article.

"**§ 90-325.7. Insurance coverage of clinical trials.**

Nothing in this Article shall be construed to affect a health benefit plan's obligation to provide coverage for an insured's participation in a clinical trial pursuant to G.S. 58-3-255."

SECTION 2. This act becomes effective October 1, 2015.

HOUSE BILL 652

Short Title:	Right to Try Act for Terminally Ill Patients.	(Public)
Sponsors:	Representatives Blackwell, Hager, Lambeth, and Reives (Primary Sponsors). *For a complete list of Sponsors, refer to the North Carolina General Assembly Web Site.*	
Referred to:	Health.	

April 14, 2015

A BILL TO BE ENTITLED

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c. Has received a recommendation from the treating physician for use of an investigational drug, biological product, or device for treatment of the terminal illness.

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e. Has documentation from the treating physician that the individual meets all of the criteria for this definition.

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(4) Written, informed consent. – A written document that is signed by an eligible patient; or if the patient is a minor, by a parent or legal guardian; or if the patient is incapacitated, by a health care power of attorney, that at a minimum includes all of the following:

a. An explanation of the currently approved products and treatments for the eligible patient's terminal illness.

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g. A statement that the eligible patient understands that he or she is liable for all expenses consequent to the use of the investigational drug, biological product, or device and that this liability extends to the eligible patient's estate, unless a contract between the patient and the manufacturer of the drug, biological product, or device states otherwise.

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(a) A manufacturer of an investigational drug, biological product, or device may make available, and an eligible patient may request, the manufacturer's investigational drug, biological product, or device. However, nothing in this Article shall be construed to require a manufacturer of an investigational drug, biological product, or device to make such investigational drug, biological product, or device available to an eligible patient.

(b) A manufacturer of an investigational drug, biological product, or device may provide the investigational drug, biological product, or device to an eligible patient without receiving compensation, or may require the eligible patient to pay the costs of, or the costs associated with, the manufacture of the investigational drug, biological product, or device.

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(a) A licensing board shall not revoke, fail to renew, suspend, or take any other disciplinary action against a health care provider licensed under this Chapter, based solely on the health care provider's recommendations to an eligible patient regarding access to or treatment with an investigational drug, biological product, or device.

(b) An entity responsible for Medicare certification shall not take action against a health care provider's Medicare certification based solely on the health care provider's recommendation that a patient have access to an investigational drug, biological product, or device.

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No private right of action may be brought against a manufacturer of an investigational drug, biological product, or device, or against any other person or entity involved in the care of an eligible patient using an investigational drug, biological product, or device, for any harm caused to the eligible patient resulting from use of the investigational drug, biological product, or device as long as the manufacturer or other person or entity has made a good-faith effort to comply with the provisions of this Article and has exercised reasonable care in actions undertaken pursuant to this Article.

"**§ 90-325.7. Insurance coverage of clinical trials.**

Nothing in this Article shall be construed to affect a health benefit plan's obligation to provide coverage for an insured's participation in a clinical trial pursuant to G.S. 58-3-255."

SECTION 2. This act becomes effective October 1, 2015.

NORTH CAROLINA GENERAL ASSEMBLY
HOUSE OF REPRESENTATIVES

HEALTH COMMITTEE REPORT

Representative Brian Brown, Co-Chair
Representative Justin P. Burr, Co-Chair
Representative Bert Jones, Co-Chair
Representative Donny Lambeth, Co-Chair

FAVORABLE COM SUB , UNFAVORABLE ORIGINAL BILL

HB **647** Epi Pens in All Child-Serving Businesses.

Draft Number:	H647-PCS10346-TK-11
Serial Referral:	None
Recommended Referral:	None
Long Title Amended:	No
Floor Manager:	McGrady

FAVORABLE COM SUB , UNFAVORABLE ORIGINAL BILL AND RE-REFERRED

HB **652** Right to Try Act for Terminally Ill Patients.

Draft Number:	H652-PCS20314-TK-12
Serial Referral:	None
Recommended Referral:	**JUDICIARY IV**
Long Title Amended:	No
Floor Manager:	Blackwell

TOTAL REPORTED: 2

CMR180-V-1

VISITOR REGISTRATION SHEET

House Comm. on Health — Name of Committee

04/16/15 — Date

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
JOE LANIER	CARDINAL
JOEL RAMIREZ	J'R US
Trent Womble	DHHS
Sarah Preston	ACLU-NC
Lexi Morgan	NCRMA
Chris Ingraham	Blackwell
Tom Coffe	NCGA
Jon Carr	Jordan Price
Mark Bibbs	Long Leaf Pine
JOHN MARCH	Policy Council
Patricia Jones	APPCNC

VISITOR REGISTRATION SHEET

House Comm. on Health — 04/16/15

Name of Committee — Date

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Tom West	NCICU
MJillian DTotman	MWCLLC
Peyton Myers	S
Steve Mauge	NCRLA
Joel Maynard	GPM - Assoc.
Ryan Blackburn	Cone Health
J Tells	MWC
Reggie Holley	Longmire Group
S Taylor	NCBIB
Dodie Renfro	CCR
Macon Bordeaux	GSK

VISITOR REGISTRATION SHEET

House Comm. on Health — 04/16/15

Name of Committee — Date

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Sarah Bales	Brubaker & Assoc
Bill Scoggin	TI
Wendy Kelly	Farm Bureau

NORTH CAROLINA HOUSE OF REPRESENTATIVES
COMMITTEE MEETING NOTICE
AND
BILL SPONSOR NOTIFICATION
2015-2016 SESSION

You are hereby notified that the **House Committee on Health** will meet as follows:

DAY & DATE: Monday, April 20, 2015
TIME: **4:00 PM**
LOCATION: **643 LOB**
COMMENTS: **Representative Lambeth will preside.**

The following bills will be considered:

BILL NO.	SHORT TITLE	SPONSOR
HB 200	Amend Certificate of Need Laws.	Representative Avila Representative Bishop Representative Collins Representative Michaux

Respectfully,

Representative Brian Brown, Co-Chair
Representative Justin P. Burr, Co-Chair
Representative Bert Jones, Co-Chair
Representative Donny Lambeth, Co-Chair

I hereby certify this notice was filed by the committee assistant at the following offices at 3:13 PM on Wednesday, April 15, 2015.

___ Principal Clerk
___ Reading Clerk – House Chamber

Brenda Olls (Committee Assistant)

House Committee on Health
Monday, April 20, 2015, 4:00 PM
643 Legislative Office Building

AGENDA

Welcome and Opening Remarks

Introduction of Pages

Bills

BILL NO.	SHORT TITLE	SPONSOR
HB 200	Amend Certificate of Need Laws.	Representative Avila Representative Bishop Representative Collins Representative Michaux

Presentations

Connie Wilson, Lobbyist
North Carolina Orthopaedic Associations, North Carolina Surgeons and Eye Physicians Society

Cody Hand, Vice President and Deputy General Counsel of the North Carolina Hospital Association

Adjournment

House Committee on Health
Monday, April 20, 2015 at 4:00 PM
Room 643 of the Legislative Office Building

MINUTES

The House Committee on Health met at 4:00 PM on April 20, 2015 in Room 643 of the Legislative Office Building. Representatives Avila, Bishop, Brawley, Brisson, R. Brown, B. Brown, Carney, Cotham, Dobson, Dollar, Farmer-Butterfield, Ford, Goodman, L. Hall, Hastings, Insko, Jones, Lambeth, Lewis, Lucas, S. Martin, Pendleton, Szoka, Waddell, Wray, and Yarborough attended.

Representative Donny Lambeth, Chair, presided.

The following bills were considered:

HB 200 Amend Certificate of Need Laws. (Representatives Avila, Bishop, Collins, Michaux)

HB 200 was for Discussion Only.

Ms. Connie Wilson: Presents a case for the passage of the bill, including the creation of a competitive edge to solve healthcare problems in NC.

Mr. Cody Hand: Presents a case against the passage for the bill. While he agrees with the facts presented by Ms. Wilson, he disagrees that the passage of this bill will not fix the competition issue and expands the availability of healthcare.

Questions

Rep. Bishop: "Ms. Wilson, you said any county could be exempted?"

- Ms. Wilson: "That is correct"

Rep. Bishop: "How does this affect Medicaid patients?"

- Ms. Wilson: "There are limited facilities that can provide care. This bill will provide 80 to 100 additional ASCs and will allow counties to keep patients in their own districts."

Rep. Bishop: "Cody, why not take an area and experiment with it in a limited fashion?"

- Mr. Hand: "21 other states have done this so we have data on hand. In Texas, their in-patient rate is 11-15% higher. Most of those states deregulated ambulance care facilities.

You cannot separate rural and urban; no one wants to open ASCs in a rural area. The cost of Medicaid will most likely rise due to this bill in rural areas."

Rep. Bishop: "I've seen data out of Texas, and my impression is that certificate need laws limited the availability of medical services, are they wrong?"

- Mr. Hand: "It isn't wrong, but much is changing in healthcare that we need to control "

Rep. Dobson: "You cannot pick and choose what is free market, and hospitals running for 24 hours are not free market and neither is charity care. Rural areas are on the margins."

- Ms. Wilson: "There is a separation of rural and urban NC. Large hospitals are doing extremely well and then there are rural hospitals and the people stuck in the middle."

Rep. Szoka: "In section 7 of the PCS, self-pay is undefined and we're going to set a standard on self-pay which will allow us to make the numbers whatever we want. Subparagraph 4 causes an issue wherein major harm in inflicted on swamped hospitals should they have to serve everyone who walks through the ER doors 24/7.

- Ms. Wilson: "The important picture here is what the patients are paying for care. If you don't use the 7% you lose your license. Additionally, these hospitals want to be seen as non-profits even though they are businesses and they do not wish to tell us what they are spending on when they ask for assistance. The major purchases are doctor practices which are expensive and increase the cost for healthcare."
-

Rep. Waddell: "The 100,000 person threshold is a concern, how will these effect smaller counties?"

- Ms. Wilson: "People are already migrating out of their areas to go to other healthcare providers due to the market. Opening up ASCs in these areas frees up the system."

Rep. Waddell: "In relation to the 7% charity cases, vs Medicare and Medicaid pay, up to 60% of payment given to hospitals it from these programs."

- Wilson: "Hospitals are different; hospitals can name the value of the procedure while our program is limited to Medicare."

- Mr. Hand: "I disagree with that characterization, the IRS defines what we can say is charity care, we are not required to take 7%, we are required to take who walks through the door."

Rep. Dollar: "Do either of the presenters know of the GAO report that came out in 2012 that dealt with imaging and the fact that they studied imaging with surgery centers and those without and found their report stated in 2010 there were 400,000 more imaging referrals which cost Medicaid 145,000 dollars. If you have more procedure rooms, it seems logical you would have more procedures which could be lower cost. What would the savings to the taxpayers be?"

- Ms. Wilson: "Doctors self-referred 25-40% more, and patients left hospitals and went to the doctor's personal office which was far cheaper. Utilization went up 20% and cost savings were 244 million dollars.

Rep. Goodman: "Is there discretion in the charity care in which you pick and choose or do you take whoever shows up? Do you reject people after the 7% threshold?"

- Ms. Wilson: "Doctors consistently put the patient first due to the Hippocratic oath, going up to 90% charitable care."

Chairman Brown: "I urge you to take this estimate from Blue Cross Blue Shield with a grain of salt. From an overall perspective I have two major concerns: The 100,000 limits which helps enable these hospitals to stay open, and self-reference which has no interests in expanding to more patients beyond the original borders."

The meeting adjourned at 5:05.

Representative Donny Lambeth, Chair
Presiding

Theresa Lopez, Committee Clerk

Attachments:
HB200 Amend Certificate of Need Laws
Analysis of Outmigration od ASC Cases by County
Ambulatory Surgery % by Site of Service
Impact of CON Regulations on Healthcare Costs
List of Critical Access Hospitals
Research Regarding ASC's and Hospitals by State
Koopman Certificate of Need
Hospital Indigent Charity Care in NC Counties with over 100,000 Populations
Winston Salem Journal Article-NC Regulations Drive up Health Care Costs
Ranking of States by Number of Certificate-Of-Need Laws

Estimate Health Care Costs Specific Services: Albemarle, Charlotte, Dunn, Durham, Fayetteville, Greenville, Halifax, Laurinburg, Lincolnton, Marion, Morganton, Newton, Raleigh, Oxford, Rockingham, Salisbury, Shelby, Whiteville, Wilson, Winston-Salem

HOUSE BILL 200:
Amend Certificate of Need Laws

2015-2016 General Assembly

Committee:	House Health, if favorable, Judiciary I, if favorable, Appropriations	**Date:**	April 17, 2015
Introduced by:	Reps. Avila, Bishop, Collins, Michaux	**Prepared by:**	Amy Jo Johnson Committee Counsel
Analysis of:	PCS to First Edition H200-CSTK-15		

SUMMARY: ***House bill 200 would exempt diagnostic centers, ambulatory surgical facilities, gastrointestinal endoscopy rooms, and psychiatric hospitals from the certificate of need requirements of Article 9, Chapter 131E of the General Statutes. The bill would also prohibit the State Medical Facilities Plan from limiting the number of operating rooms and gastrointestinal endoscopy rooms. The bill would add additional licensing requirements for the development, acquisition, or replacement of ambulatory surgical facilities.***

CURRENT LAW:

North Carolina law requires a person who wishes to offer or develop a "new institutional health service" to first obtain a certificate of need (CON) from the Department of Health and Human Services. G.S. 131E-178. The definition of a "new institutional health service" includes the development or expansion of a health services facility such as a hospital, ambulatory surgery center, operating room, gastrointestinal endoscopy room, or diagnostic center, the obligation of a capital expenditure above the statutory threshold of $2 million, changes in bed capacity, the offering of a health service such as dialysis services, bone marrow transplant services, cardiac catheterization services, and neonatal intensive care services, and the acquisition of major medical equipment costing in excess of the statutory threshold of $750,000. G.S. 131E-176(16). Applications for a CON are reviewed against statutory criteria set forth in G.S. 131E-183. An application must be consistent with all applicable policies and with the need determinations for the service or facility contained in the State Medical Facilities Plan (SMFP). The need determination in the SMFP for the provision of a health service, health service facilty or beds, dialysis stations, operating rooms, or home health offices provides a determinative limit on what may be approved. G.S. 131E-183.

A **diagnostic center** is defined as a freestanding facility, program, or provider, including physician's offices, clinical laboratories, radiology centers and mobile diagnostic programs, in which the total cost of all the medical diagnostic equipment which costs $10,000 or more exceeds $500,000. G.S. 131E-176(7a). An **ambulatory surgical facility** is a facility that provides a single or multispecialty ambulatory surgical program that serves patients who require local, regional, or general anesthesia and a period of post op observation. They may only admit patients for less than a 24 hour period and must provide at least one designated operating room. G.S. 131E-176(1b). A **gastrointestinal endoscopy room** is a room used for the performance of procedures that require the insertion of a flexible endoscope into a gastrointestinal orifice to visualize the gastrointestinal lining and adjacent organs for diagnostic or therapeutic purposes. G.S. 131E-176(7d). An **operating room** is used for the performance of surgical procedures requiring one or more incisions and that is required to comply with applicable licensure codes and standards for an operating room. G.S. 131E-176(18c). A **psychiatric facility** is a public or

private facility licensed under Article 2 of Chapter 122C and which is primarily engaged in providing psychiatric services for diagnosis and treatment of mentally ill persons. G.S. 131E-176(21).

BILL ANALYSIS:

House Bill 200 would exempt diagnostic centers, ambulatory surgical facilities, gastrointestinal endoscopy rooms, and psychiatric hospitals from the certificate of need requirements outlined in Chapter 131E of the General Statutes. **Sections 1, 2, and 4** all contain technical changes to accomplish the removal of the certificate of need requirements for these health services. **Section** 3 of House Bill 200 would also prohibit the State Medical Facilities Plan from including policies or need determinations that limit the number of operating rooms or gastrointestinal endoscopy rooms and **Sections 4, 5 and 8** make conforming changes.

Section 6 of the bill would add the following to the list of health services that are exempt from obtaining a certificate of need:

- The development, acquisition, construction, expansion, or replacement of a health service facility or service that obtained certificate of need approval prior to the effective date of this act as a diagnostic center; ambulatory surgical facility, including an ambulatory surgical facility with one or more gastrointestinal endoscopy procedure rooms; or psychiatric hospital.

Section 7 would add a new subsection to the licensure requirements for ambulatory surgical facilities of G.S. 131E-147. The bill specifies that the Department of Health and Human Services must not issue or renew license to operate an ambulatory surgical facility unless the licensure application includes the following:

- A commitment that the Medicare allowable amount for self-pay and Medicaid surgical cases minus all revenue collected from self-pay and Medicaid surgical cases shall be at least seven percent (7%) of the total revenue collected for all surgical cases performed in the facility or proposed facility.
- For each year of operation, a commitment to report to the Department the total number of cases by each of the following payer categories:
    - Self-pay surgical cases.
    - Medicaid surgical cases.
    - Medicare surgical cases.
    - Commercial insurance surgical cases.
    - Managed care surgical cases.
    - Other surgical cases.
- A commitment to report utilization and payment data for services provided by the ambulatory surgical facility to the statewide data processor.
- For a license to operate in any county with a population of less than 100,000:
    - Written documentation of support from each hospital located within that county.
    - A written transfer agreement between the ambulatory surgical facility and each hospital located within that county.

EFFECTIVE DATE: This act becomes effective October 1, 2015.

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2015

H D

HOUSE BILL 200
PROPOSED COMMITTEE SUBSTITUTE H200-PCS30329-TK-15

Short Title: Amend Certificate of Need Laws. (Public)

Sponsors:

Referred to:

March 11, 2015

A BILL TO BE ENTITLED

AN ACT EXEMPTING DIAGNOSTIC CENTERS, AMBULATORY SURGICAL FACILITIES, GASTROINTESTINAL ENDOSCOPY ROOMS, AND PSYCHIATRIC HOSPITALS FROM CERTIFICATE OF NEED REVIEW; PROHIBITING THE STATE MEDICAL FACILITIES PLAN FROM LIMITING THE NUMBER OF OPERATING ROOMS AND GASTROINTESTINAL ENDOSCOPY ROOMS; AND ENHANCING LICENSING REQUIREMENTS FOR THE DEVELOPMENT, ACQUISITION, OR REPLACEMENT OF AMBULATORY SURGICAL FACILITIES.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 131E-176(9b) reads as rewritten:

"(9b) "Health service facility" means a hospital; long-term care hospital; ~~psychiatric facility;~~ rehabilitation facility; nursing home facility; adult care home; kidney disease treatment center, including freestanding hemodialysis units; intermediate care facility for the mentally retarded; home health agency office; chemical dependency treatment facility; ~~diagnostic center;~~ hospice office, hospice inpatient facility, and hospice residential care ~~facility; and ambulatory surgical~~ facility."

SECTION 2. G.S. 131E-176(16) reads as rewritten:

"(16) "New institutional health services" means any of the following:

…

~~r. The conversion of a specialty ambulatory surgical program to a multispecialty ambulatory surgical program or the addition of a specialty to a specialty ambulatory surgical program.~~

…

~~u. The construction, development, establishment, increase in the number, or relocation of an operating room or gastrointestinal endoscopy room in a licensed health service facility, other than the relocation of an operating room or gastrointestinal endoscopy room within the same building or on the same grounds or to grounds not separated by more than a public right-of-way adjacent to the grounds where the operating room or gastrointestinal endoscopy room is currently located.~~

~~v. The change in designation, in a licensed health service facility, of an operating room to a gastrointestinal endoscopy room or change in designation of a gastrointestinal endoscopy room to an operating room that results in a different number of each type of room than is~~

~~reflected on the health service facility's license in effect as of January 1, 2005.~~"

SECTION 3. G.S. 131E-177 reads as rewritten:

"**§ 131E-177. Department of Health and Human Services is designated State Health Planning and Development Agency; powers and duties.**

The Department of Health and Human Services is designated as the State Health Planning and Development Agency for the State of North Carolina, and is empowered to exercise the following powers and duties:

(1) To establish standards and criteria or plans required to carry out the provisions and purposes of this Article and to adopt rules pursuant to Chapter 150B of the General Statutes, to carry out the purposes and provisions of this ~~Article;~~Article.

(2) Adopt, amend, and repeal such rules and regulations, consistent with the laws of this State, as may be required by the federal government for grants-in-aid for health service facilities and health planning which may be made available by the federal government. This section shall be liberally construed in order that the State and its citizens may benefit from such ~~grants-in-aid;~~grants-in-aid.

(3) Define, by rule, procedures for submission of periodic reports by persons or health service facilities subject to agency review under this ~~Article;~~Article.

(4) ~~Develop~~ With respect to health service facilities planning, all of the following:

a. Develop policy, criteria, and standards for health service facilities ~~planning; shall conduct~~ planning.

b. Conduct statewide registration and inventories of and make determinations of need for health service facilities, health services as specified in G.S. 131E-176(16)f., and equipment as specified in G.S. 131E-176(16)f1., which shall include consideration of adequate geographic location of equipment and ~~services; and develop~~services.

c. Develop a State Medical Facilities ~~Plan;~~Plan, provided however, that the State Medical Facilities plan shall not include policies or need determinations that limit the number of operating rooms or gastrointestinal endoscopy rooms.

(5) Implement, by rule, criteria for project ~~review;~~review.

(6) Have the power to grant, deny, or withdraw a certificate of need and to impose such sanctions as are provided for by this ~~Article;~~Article.

(7) Solicit, accept, hold and administer on behalf of the State any grants or devises of money, securities or property to the Department for use by the Department in the administration of this ~~Article; and~~Article.

(8) Repealed by Session Laws 1987, c. 511, s. 1.

(9) Collect fees for submitting applications for certificates of need.

(10) The authority to review all records in any recording medium of any person or health service facility subject to agency review under this Article which pertain to construction and acquisition activities, staffing or costs and charges for patient care, including but not limited to, construction contracts, architectural contracts, consultant contracts, purchase orders, cancelled checks, accounting and financial records, debt instruments, loan and security agreements, staffing records, utilization statistics and any other records the Department deems to be reasonably necessary to determine compliance with this Article.

The Secretary of Health and Human Services shall have final decision-making authority with regard to all functions described in this section."

SECTION 4. G.S. 131E-178(a) reads as rewritten:

"(a) No person shall offer or develop a new institutional health service without first obtaining a certificate of need from the ~~Department; provided, however, no person who provides gastrointestinal endoscopy procedures in one or more gastrointestinal endoscopy rooms located in a nonlicensed setting, shall be required to obtain a certificate of need to license that setting as an ambulatory surgical facility with the existing number of gastrointestinal endoscopy rooms, provided that:~~

~~(1) The license application is postmarked for delivery to the Division of Health Service Regulation by December 31, 2006;~~

~~(2) The applicant verifies, by affidavit submitted to the Division of Health Service Regulation within 60 days of the effective date of this act, that the facility is in operation as of the effective date of this act or that the completed application for the building permit for the facility was submitted by the effective date of this act;~~

~~(3) The facility has been accredited by The Accreditation Association for Ambulatory Health Care, The Joint Commission on Accreditation of Healthcare Organizations, or The American Association for Accreditation of Ambulatory Surgical Facilities by the time the license application is postmarked for delivery to the Division of Health Service Regulation of the Department; and~~

~~(4) The license application includes a commitment and plan for serving indigent and medically underserved populations.~~

~~All other persons proposing to obtain a license to establish an ambulatory surgical facility for the provision of gastrointestinal endoscopy procedures shall be required to obtain a certificate of need. The annual State Medical Facilities Plan shall not include policies or need determinations that limit the number of gastrointestinal endoscopy rooms that may be approved.~~Department."

SECTION 5. G.S. 131E-183(a)(1) reads as rewritten:

"(1) The proposed project shall be consistent with applicable policies and need determinations in the State Medical Facilities Plan, the need determination of which constitutes a determinative limitation on the provision of any health service, health service facility, health service facility beds, dialysis stations, ~~operating rooms,~~ or home health offices that may be approved."

SECTION 6. G.S. 131E-184(a) reads as rewritten:

"(a) Except as provided in subsection (b), the Department shall exempt from certificate of need review a new institutional health service if it receives prior written notice from the entity proposing the new institutional health service, which notice includes an explanation of why the new institutional health service is required, for any of the following:

(1) To eliminate or prevent imminent safety hazards as defined in federal, State, or local fire, building, or life safety codes or regulations.

(1a) To comply with State licensure standards.

(1b) To comply with accreditation or certification standards which must be met to receive reimbursement under Title XVIII of the Social Security Act or payments under a State plan for medical assistance approved under Title XIX of that act.

(2) Repealed by Session Laws 1987, c. 511, s. 1.

(3) To provide data processing equipment.

(4) To provide parking, heating or cooling systems, elevators, or other basic plant or mechanical improvements, unless these activities are integral

portions of a project that involves the construction of a new health service facility or portion thereof and that is subject to certificate of need review.

(5) To replace or repair facilities destroyed or damaged by accident or natural disaster.

(6) To provide any nonhealth service facility or service.

(7) To provide replacement equipment.

(8) To acquire an existing health service facility, including equipment owned by the health service facility at the time of acquisition.

(9) To develop or acquire a physician office building regardless of cost, unless a new institutional health service other than defined in G.S. 131E-176(16)b. is offered or developed in the building.

(10) To develop, acquire, construct, expand, or replace a health service facility or service that obtained certificate of need approval prior to October 1, 2015, as a diagnostic center; ambulatory surgical facility, including an ambulatory surgical facility with one or more gastrointestinal endoscopy procedure rooms; or psychiatric hospital."

SECTION 7. G.S. 131E-147 is amended by adding new subsections to read:

"(f) The Department shall not issue or renew a license to operate an ambulatory surgical facility developed, acquired, or replaced on or after October 1, 2015, unless the application includes all of the following:

(1) A commitment that the Medicare allowable amount for self-pay and Medicaid surgical cases minus all revenue collected from self-pay and Medicaid surgical cases shall be at least seven percent (7%) of the total revenue collected for all surgical cases performed in the facility or proposed facility.

(2) For each year of operation, a commitment to report to the Department the total number of cases by each of the following payer categories:

a. Self-pay surgical cases.

b. Medicaid surgical cases.

c. Medicare surgical cases.

d. Commercial insurance surgical cases.

e. Managed care surgical cases.

f. Other surgical cases.

(3) A commitment to report utilization and payment data for services provided by the ambulatory surgical facility to the statewide data processor, as required by G.S. 131E-214.2.

(4) For a license to operate in any county with a population of less than 100,000 as of the effective date of this act:

a. Written documentation of support from each hospital located within that county.

b. A written transfer agreement between the ambulatory surgical facility and each hospital located within that county."

SECTION 8. G.S. 131E-175(11) and (12) are repealed.

SECTION 9. This act becomes effective October 1, 2015.

HOUSE BILL 200

Short Title:	Amend Certificate of Need Laws.	(Public)
Sponsors:	Representatives Avila, Bishop, Collins, and Michaux (Primary Sponsors). *For a complete list of Sponsors, refer to the North Carolina General Assembly Web Site.*	
Referred to:	Health, if favorable, Judiciary I, if favorable, Appropriations.	

March 11, 2015

A BILL TO BE ENTITLED

AN ACT EXEMPTING DIAGNOSTIC CENTERS, AMBULATORY SURGICAL FACILITIES, GASTROINTESTINAL ENDOSCOPY ROOMS, AND PSYCHIATRIC HOSPITALS FROM CERTIFICATE OF NEED REVIEW; PROHIBITING THE STATE MEDICAL FACILITIES PLAN FROM LIMITING THE NUMBER OF OPERATING ROOMS AND GASTROINTESTINAL ENDOSCOPY ROOMS; AND ENHANCING LICENSING REQUIREMENTS FOR THE DEVELOPMENT, ACQUISITION, OR REPLACEMENT OF AMBULATORY SURGICAL FACILITIES.

The General Assembly of North Carolina enacts:

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~~u. The construction, development, establishment, increase in the number, or relocation of an operating room or gastrointestinal endoscopy room in a licensed health service facility, other than the relocation of an operating room or gastrointestinal endoscopy room within the same building or on the same grounds or to grounds not separated by more than a public right-of-way adjacent to the grounds where the operating room or gastrointestinal endoscopy room is currently located.~~

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(3) Define, by rule, procedures for submission of periodic reports by persons or health service facilities subject to agency review under this ~~Article;~~Article.

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b. Conduct statewide registration and inventories of and make determinations of need for health service facilities, health services as specified in G.S. 131E-176(16)f., and equipment as specified in G.S. 131E-176(16)f1., which shall include consideration of adequate geographic location of equipment and ~~services; and develop~~services.

c. Develop a State Medical Facilities ~~Plan;~~Plan, provided however, that the State Medical Facilities plan shall not include policies or need determinations that limit the number of operating rooms or gastrointestinal endoscopy rooms.

(5) Implement, by rule, criteria for project ~~review;~~review.

(6) Have the power to grant, deny, or withdraw a certificate of need and to impose such sanctions as are provided for by this ~~Article;~~Article.

(7) Solicit, accept, hold and administer on behalf of the State any grants or devises of money, securities or property to the Department for use by the Department in the administration of this ~~Article; and~~Article.

(8) Repealed by Session Laws 1987, c. 511, s. 1.

(9) Collect fees for submitting applications for certificates of need.

(10) The authority to review all records in any recording medium of any person or health service facility subject to agency review under this Article which pertain to construction and acquisition activities, staffing or costs and charges for patient care, including but not limited to, construction contracts, architectural contracts, consultant contracts, purchase orders, cancelled checks, accounting and financial records, debt instruments, loan and security agreements, staffing records, utilization statistics and any other records the Department deems to be reasonably necessary to determine compliance with this Article.

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~~(1) The license application is postmarked for delivery to the Division of Health Service Regulation by December 31, 2006;~~

~~(2) The applicant verifies, by affidavit submitted to the Division of Health Service Regulation within 60 days of the effective date of this act, that the facility is in operation as of the effective date of this act or that the completed application for the building permit for the facility was submitted by the effective date of this act;~~

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~~All other persons proposing to obtain a license to establish an ambulatory surgical facility for the provision of gastrointestinal endoscopy procedures shall be required to obtain a certificate of need. The annual State Medical Facilities Plan shall not include policies or need determinations that limit the number of gastrointestinal endoscopy rooms that may be approved.~~Department."

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"(1) The proposed project shall be consistent with applicable policies and need determinations in the State Medical Facilities Plan, the need determination of which constitutes a determinative limitation on the provision of any health service, health service facility, health service facility beds, dialysis stations, ~~operating rooms,~~ or home health offices that may be approved."

SECTION 6. G.S. 131E-184(a) reads as rewritten:

"(a) Except as provided in subsection (b), the Department shall exempt from certificate of need review a new institutional health service if it receives prior written notice from the entity proposing the new institutional health service, which notice includes an explanation of why the new institutional health service is required, for any of the following:

(1) To eliminate or prevent imminent safety hazards as defined in federal, State, or local fire, building, or life safety codes or regulations.

(1a) To comply with State licensure standards.

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(4) To provide parking, heating or cooling systems, elevators, or other basic plant or mechanical improvements, unless these activities are integral

portions of a project that involves the construction of a new health service facility or portion thereof and that is subject to certificate of need review.

(5) To replace or repair facilities destroyed or damaged by accident or natural disaster.

(6) To provide any nonhealth service facility or service.

(7) To provide replacement equipment.

(8) To acquire an existing health service facility, including equipment owned by the health service facility at the time of acquisition.

(9) To develop or acquire a physician office building regardless of cost, unless a new institutional health service other than defined in G.S. 131E-176(16)b. is offered or developed in the building.

(10) To develop, acquire, construct, expand, or replace a health service facility or service that obtained certificate of need approval prior to the effective date of this act as a diagnostic center; ambulatory surgical facility, including an ambulatory surgical facility with one or more gastrointestinal endoscopy procedure rooms; or psychiatric hospital."

SECTION 7. G.S. 131E-147 is amended by adding new subsections to read:

"(f) The Department shall not issue or renew a license to operate an ambulatory surgical facility developed, acquired, or replaced on or after the effective date of this act, unless the application includes all of the following:

(1) A commitment that the Medicare allowable amount for self-pay and Medicaid surgical cases minus all revenue collected from self-pay and Medicaid surgical cases shall be at least seven percent (7%) of the total revenue collected for all surgical cases performed in the facility or proposed facility.

(2) For each year of operation, a commitment to report to the Department the total number of cases by each of the following payer categories:

a. Self-pay surgical cases.

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d. Commercial insurance surgical cases.

e. Managed care surgical cases.

f. Other surgical cases.

(3) A commitment to report utilization and payment data for services provided by the ambulatory surgical facility to the statewide data processor, as required by G.S. 131E-214.2.

(4) For a license to operate in any county with a population of less than 100,000 as of the effective date of this act:

a. Written documentation of support from each hospital located within that county.

b. A written transfer agreement between the ambulatory surgical facility and each hospital located within that county."

SECTION 8. G.S. 131E-175(11) and (12) are repealed.

SECTION 9. This act is effective when it becomes law.

4-20-15

☑ Lower Healthcare Costs *Now!*

Certificate of Need REFORM

HB200 Amend Certificate of Need Laws

Bringing NC Healthcare Regulations Into The 21st Century

Eliminates the CON Requirement for ASC's

- ASC's can be owned by physicians, hospitals, for-profit companies or a partnership of any of the three.
- Exempts rural hospitals because there is a prohibition of these ASC's in counties with 100,000 or less in population unless the hospital approves – 74 counties would be exempted.
- Requires a 7% charity care for the new ASC's – This requirement was developed by DHHS for three physician-owned ASC's and is currently being used as a requirement.

Eliminates the CON Requirement for Diagnostic Centers

- Physicians will be treated like other providers regarding diagnostic equipment like CT scanners, mammography and ultrasound.
- North Carolina is the only state in the country that has this requirement only for physician offices.

Addresses A 2012 Lawsuit Settlement Regarding Procedure Rooms

Due to settlement there is no limit on procedure rooms that can be built to exact operating room standards as long as hospital has CON for operating room. Operating Room data collected by DHSR is inaccurate and showing no need for operating rooms. This bill eliminates the needs determination for operating rooms since the data is flawed.

Eliminates the CON Requirement for Psychiatric Beds

- Because of low reimbursement there has been little interest in applying for this CON.
- This elimination removes an unneeded regulatory hurdle.

Connie Wilson 919-274-0557 | NC Orthopaedic Association | REFORMCONNOW.com
Laurie Onorio 919-412-9371

Procedure: ACL Repair by Arthroscopy
Location: Charlotte, NC (within 25 miles)

Estimate Health Care Costs

Cost estimates are averages based on historical BCBSNC claims data. Amounts listed typically include physician fees, facility fees and costs for things like anesthesia, drugs, medical supplies – as well as customer responsibility (deductible, co-pay and co-insurance). Your actual costs may be different based on variations in these factors as well as your health plan design, deductibles/co-insurance and out-of-pocket limits.

Gateway Surgery Center 1025 NE Gateway Ct NE Concord, NC 28025	Blue Value **$10,061** Blue Options, Blue Advantage **$10,061**
Michael Dockery **Charlotte Surgery Center** 2825 Randolph Rd Charlotte, NC 28211	Blue Value **$10,800** Blue Options, Blue Advantage **$10,800**
Erik Johnson **Caromont Regional Medical Center** 2525 Court Dr Gastonia, NC 28054	Blue Value **$12,496** Blue Options, Blue Advantage **$12,496**
Matthew Gullickson **Matthews Surgery Center LLC** 710 Park Center Dr, Ste 100 Matthews, NC 28105	Blue Value **$13,104** Blue Options, Blue Advantage **$13,104**
Bryan Edwards **Presb Surgery Center at Huntersville** 10030 Gilead Rd Huntersville, NC 28078	Blue Value **$16,355** Blue Options, Blue Advantage **$16,355**
Lake Norman Regional Medical Center 171 Fairview Rd Mooresville, NC 28117	Blue Value **$17,092** Blue Options, Blue Advantage **$17,092**
Bryan Edwards **Novant Health Huntersville Med Center** 10030 Gilead Rd Huntersville, NC 28078	Blue Value **$24,118** Blue Options, Blue Advantage **$26,860**
Scott O'Neal **Carolinas Medical Center-Pineville** 10628 Park Rd Charlotte, NC 28210	Blue Options, Blue Advantage **$24,799**
Jerry Barron **Novant Health Charlotte Orthopedic** 1901 Randolph Rd Charlotte, NC 28207	Blue Value **$28,834** Blue Options, Blue Advantage **$28,834**

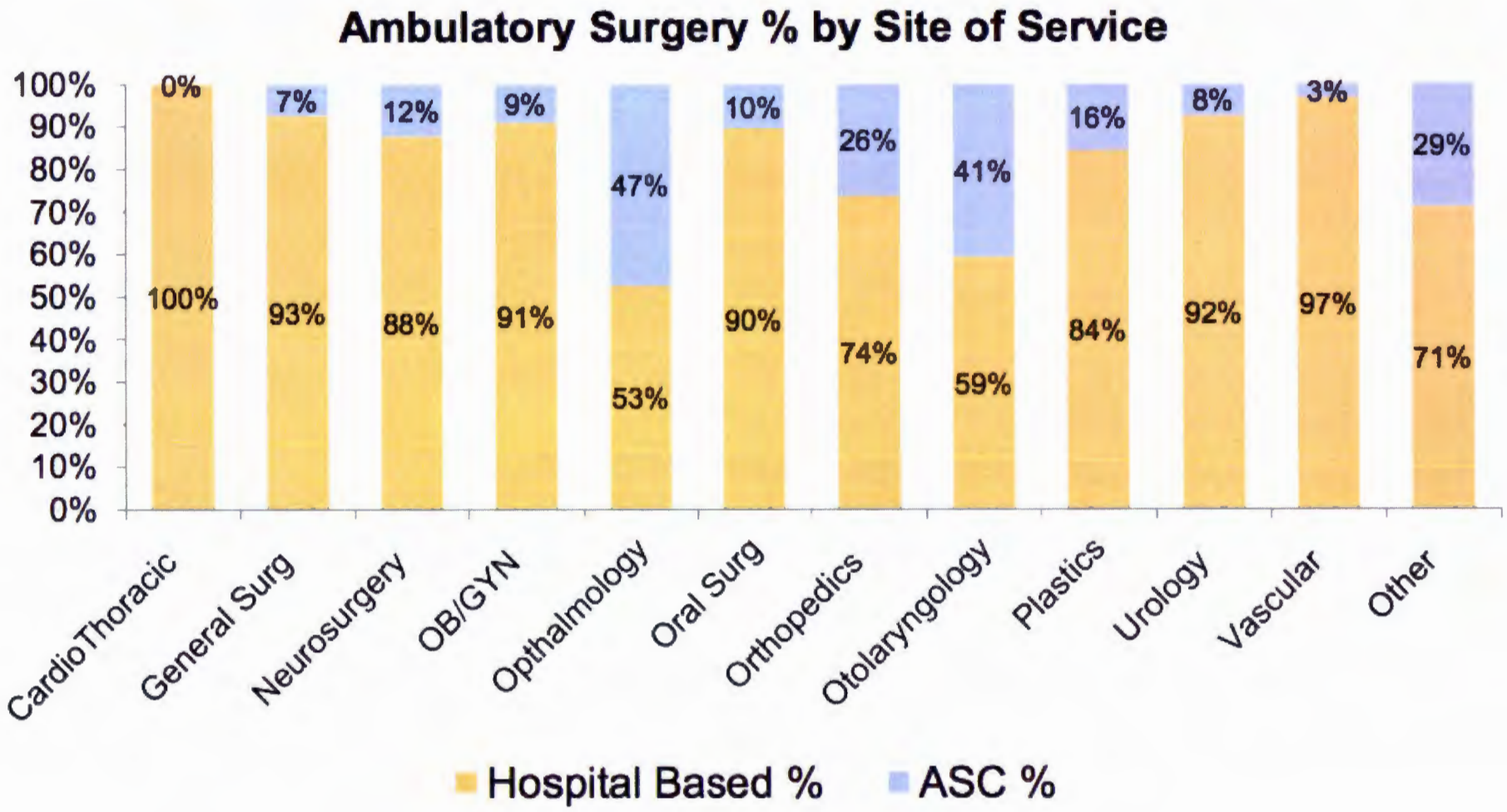
Analysis of Outmigration of ASC Cases By County

County	2013 Population	Names of In-County Hospitals	Names of In-County Freestanding ASCs (Excludes GI Endoscopy Centers)	ASC Patient Outmigration Percentage of Total ASC Cases
Alamance	154,058	Alamance Regonal Medical Center	None	44.25%
Alexander	37,183	Alexander Hospital - closed	None	100.00%
Anson	26,638	Anson County Hospital	None	94.66%
Avery	17,872	Cannon Memorial Hospital	None	75.10%
Beaufort	47,979	Vidant Pungo Hospital	None	55.45%
		Vidant Beaufort Hospital		
Bladen	35,201	Cape Fear Valley - Bladen County Hospital	None	71.47%
Burke	89,551	CMC-Blue Ridge (Grace and Valdese Hospitals)	Eye Surgery Center and Laser	43.85%
Caldwell	83,312	Caldwell Memorial	None	63.78%
Caswell	23,642	None	None	100.00%
Cleveland	97,276	Cleveland Regional Medical Center	Eye Surgery Center of Shelby	34.78%
		Kings Mountain Hospital	Cleveland Ambulatory Surgery Center	
Columbus	58,123	Columbus Regional Healthcare	None	50.00%
Craven	105,354	Carolina East Medical Center	None	24.58%
Cumberland	334,076	Cape Fear Valley Medical Center	Fayetteville Ambulatory Surgery	19.88%
		Highsmith-Rainey Specialty hospital		
Davie	41,429	Davie County Hospital	None	92.47%
Halifax	53,705	Halifax Regional Medical Center	None	
Henderson	108,590	Park Ridge Hospital	None	37.07%
		Pardee Hospital		
Hoke	50,672	None (Two In Development)	None	100.00%
Iredell	164,785	Iredell Memorial Hospital	Iredell Surgery Center	27.31%
		Davis Regional hospital	Iredell Head and Neck Ambulatory Surgery Center	
		Lake Norman Regional Medical Center		
Lee	59,856	Central Carolina Hospital	None	55.68%
Lenoir	59,380	Lenoir Memorial Hospital	None	59.60%
McDowell	45,231	McDowell Hospital	None	83.20%
Mitchell	15,407	Blue Ridge Regional	None	77.00%
Montgomery	27,768	FirstHealth Montgomery Memorial	None	92.40%
Northampton	21,244	None	None	100.00%
Nash	94,637	Nash General Hospital	None	43.13%
Onslow	194,206	Onslow Memorial Hospital	None	60.93%
Richmond	46,041	FirstHealth Richmond Memorial, Sandhills Regional	None	60.30%
Robeson	134,010	Southeastern Regional Medical Center	Southeastern Surgery Center	56.70%
Rockingham	92,447	Cone Health - Annie Penn	None	54.55%
		Morehead Memorial Hospital		
Scotland	36,233	Scotland Memorial Hospital	Non	45.30%
Stokes	46,828	Pioneer Community Hospital	None	93.29%
Wilkes	70,047	Wilkes Regional Medical Center	Wilkes Regional ASC (within Hospital)	54.29%

*** ASC cases for NC citizens performed in facilities in other States are not included in the above data.**

Counties with the highest outmigration percentages are those with no freestanding ASCs

The majority of ambulatory surgery for all specialties is performed in hospital outpatient departments.



Source: Division of Health Service Regulation data, 2014

Carolinas HealthCare System

Impact of CON Regulations on Healthcare Costs

One

CHS Commissioned Research on CON

- CHS contracted with Navigant Consulting, a national healthcare consulting firm, to compare healthcare costs in North Carolina versus two states without certificate of need regulations (Indiana and Texas).
- These states were selected based on the length of time since CON laws were abolished and population size (one larger one smaller).

State	Population	Physicians	ASCs	CON
North Carolina	9,748,364	24,476	90	Y
Indiana	6,537,782	15,654	116	N
Texas	26,060,796	57,815	364	N

Source: CMS and Census Bureau, 2013

Findings validate that North Carolina's CON laws are likely a factor in reducing overall total cost of care for Commercial members and Medicare beneficiaries.

Total Cost of Care Comparisons ($ PMPM)

Medicare	NC	TX	IN	TX Variance	IN Variance
Inpatient	$279.08	$327.43	$287.60	$48.35	$8.52
Outpatient	$29.55	$31.19	$30.88	$1.64	$1.33
Total	$311.57	$373.62	$322.79	$62.05	$11.22

Commercial	NC	TX	IN	TX Variance	IN Variance
Inpatient	$57.49	$70.23	$61.12	$12.74	$3.63
Outpatient	$17.04	$29.91	$29.26	$12.87	$12.22
Total	$74.52	$100.14	$90.38	$25.62	$15.86

- North Carolina's total cost of care for all Commercial and Medicare inpatient and outpatient services is lower than in Texas and Indiana, which is a function of both unit price and utilization variations.
  - **Commercial**: Pricing variations across IP and OP services are fairly minimal overall between the states (NC is lower for both), but **significant differentials in utilization lead to an overall lower total cost of care in NC**.
  - **Medicare**: Similar to Commercial, the overall PMPM for TX and IN is higher than NC's.

Source: Navigant Consulting, 2015

Note: PMPM = Per Member Per Month

Significant variances for Commercial outpatient utilization result in lower overall cost of care in NC.

	Utilization			Utilization Variance	
Medicare	**NC**	**TX**	**IN**	**TX**	**IN**
Inpatient	291.6	336.5	329.0	15%	13%
Outpatient	982.2	1,008.1	976.9	3%	-1%
Commercial	**NC**	**TX**	**IN**	**TX**	**IN**
Inpatient	48.0	56.7	41.6	18%	-13%
Outpatient	99.7	789.5	154.0	**692%**	**54%**
ASC	7.9	104.0	18.2	**1216%**	**130%**

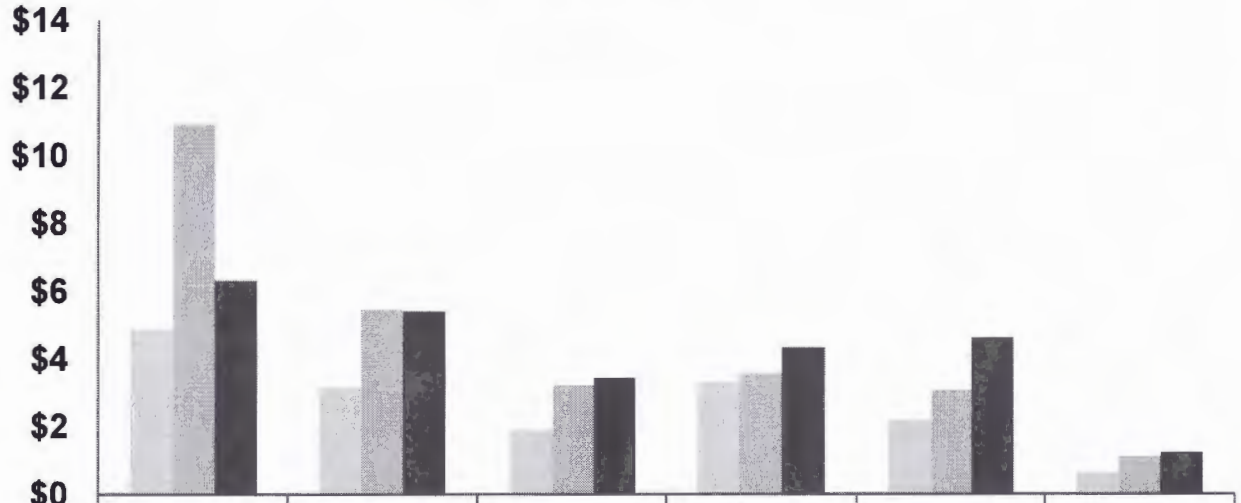
	Pricing			Pricing Variance	
Medicare	**NC**	**TX**	**IN**	**TX**	**IN**
Inpatient	$11,605	$11,963	$10,764	3%	-7%
Outpatient	$361	$358	$364	-1%	1%
Commercial	**NC**	**TX**	**IN**	**TX**	**IN**
Inpatient	$14,361	$14,951	$16,476	4%	15%
Outpatient	$1,932	$1,993	$1,977	3%	2%
ASC	$1,482	$1,581	$2,462	7%	66%

Source: Navigant Consulting, 2015

NC has a significantly lower PMPM in Hospital Outpatient and Ambulatory Surgery Centers services than in both Texas and Indiana.

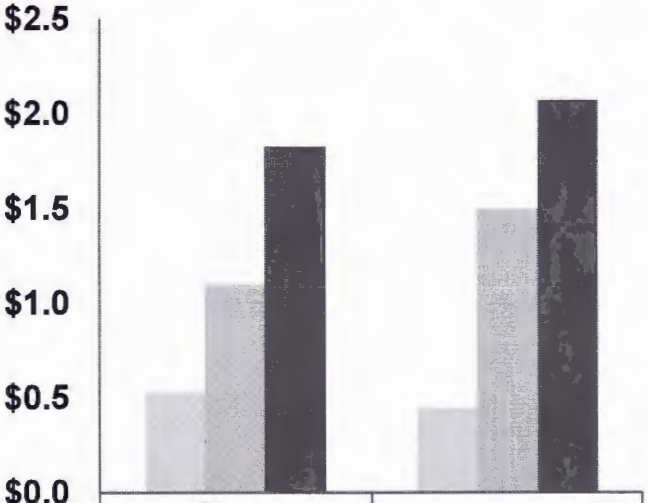
- Hospital OP Services PMPM in NC are 41% lower than TX and 37% lower than IN
- ASC OP services PMPM in NC are 62% lower than TX and 75% lower than IN ($0.98 vs. $2.59 and $3.90)

PMPM by OP Product Line (Hospital)



	ED	CT	MRI	Proc Musculo-skeletal	Proc Digestive	Cardiac Cath
NC	$4.88	$3.16	$1.89	$3.31	$2.17	$0.64
TX	$10.92	$5.46	$3.21	$3.57	$3.06	$1.11
IN	$6.32	$5.41	$3.44	$4.34	$4.62	$1.23

PMPM by OP Product Line (ASC)



	Proc Musculo-skeletal	Proc Digestive
NC	$0.53	$0.44
TX	$1.10	$1.49
IN	$1.83	$2.07

Source: Navigant Consulting, 2015

Note: PMPM = Per Member Per Month

Ambulatory Surgery Centers

Recent Legislative Activity on ASC CON

House Bill 177

- The final HB 177 called for research by the Legislative Research Commission on:
  1. Federal and state barriers to a market-based healthcare delivery system.
  2. Comparison of same day surgery offered by hospitals and ASCs:
     a) Cost
     b) Quality
     c) Availability
     d) Charity care

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2013

H **2**

HOUSE BILL 177
Committee Substitute Favorable 5/14/13

Short Title: Amend Certificate of Need Laws. (Public)

Sponsors:

Referred to:

February 28, 2013

A BILL TO BE ENTITLED

AN ACT TO AUTHORIZE THE LEGISLATIVE RESEARCH COMMISSION TO STUDY FEDERAL AND STATE BARRIERS TO A MARKET-BASED HEALTH CARE DELIVERY SYSTEM, TO COMPARE HOSPITAL-BASED OPERATING ROOM AND AMBULATORY SURGICAL CENTERS AS A VENUE FOR THE PROVISION OF SURGICAL SERVICES, TO STUDY NORTH CAROLINA'S CERTIFICATE OF NEED PROGRAM IN COMPARISON WITH OTHER STATES, AND TO STUDY OTHER RELATED CERTIFICATE OF NEED ISSUES.

The General Assembly of North Carolina enacts:

SECTION 1. The Legislative Research Commission is authorized to conduct a study of the State's health care delivery system and certificate of need law. The study shall include:

(1) A study of barriers to a market-based health care delivery system from the federal level, including:
   a. Federal health care laws.
   b. Federal regulation of health care service delivery.
   c. Federal reimbursement issues.

(2) A study of barriers to a market-based health care delivery system at the State level including:
   a. State health care laws.
   b. State regulation of health service delivery.
   c. State reimbursement issues.

(3) A comparison of same day surgery offered by hospital-based or hospital-owned operating rooms and nonhospital-based ambulatory surgical centers. The comparison shall include the following factors: cost, quality of care, availability, and charity care.

(4) A study of the North Carolina certificate of need law in comparison to other states both with and without certificate of need programs.

(5) Any other issues pertinent to this study.

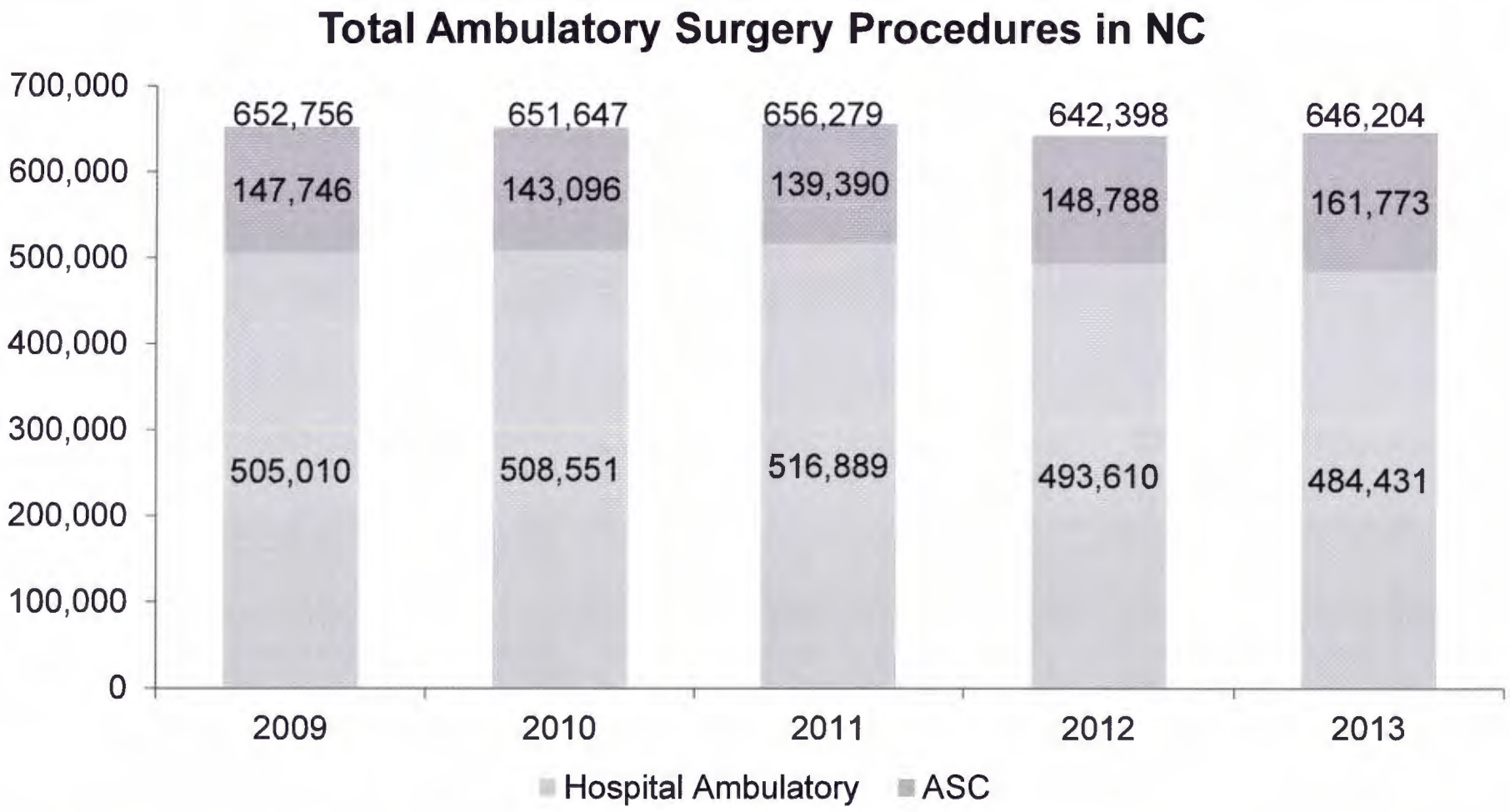
SECTION 2. The Legislative Research Commission may make an interim report, including recommended legislation, to the 2014 General Assembly and shall make a final report to the 2015 General Assembly.

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

Areas of Major Concern

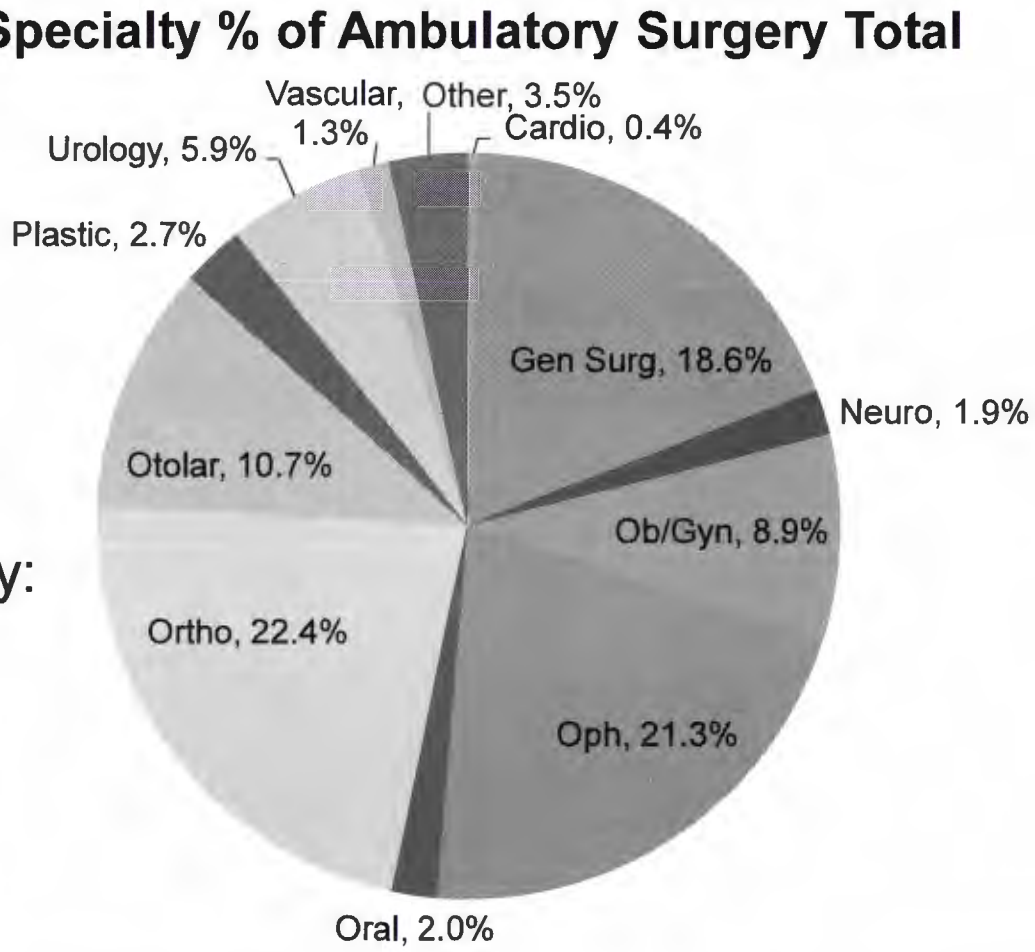
- Why eliminate a law that has served the state well to benefit a small number of physicians?
- There are significant numbers of underutilized operating rooms in the state.
- If CON is eliminated, there need to be other measures taken to protect safety net hospitals, especially in rural settings or small counties adjacent to urban counties.

The total volume of ambulatory surgery has declined over the last five years.



Source: Division of Health Service Regulation data, 2014

Ambulatory surgery is highly concentrated into a few specialties.

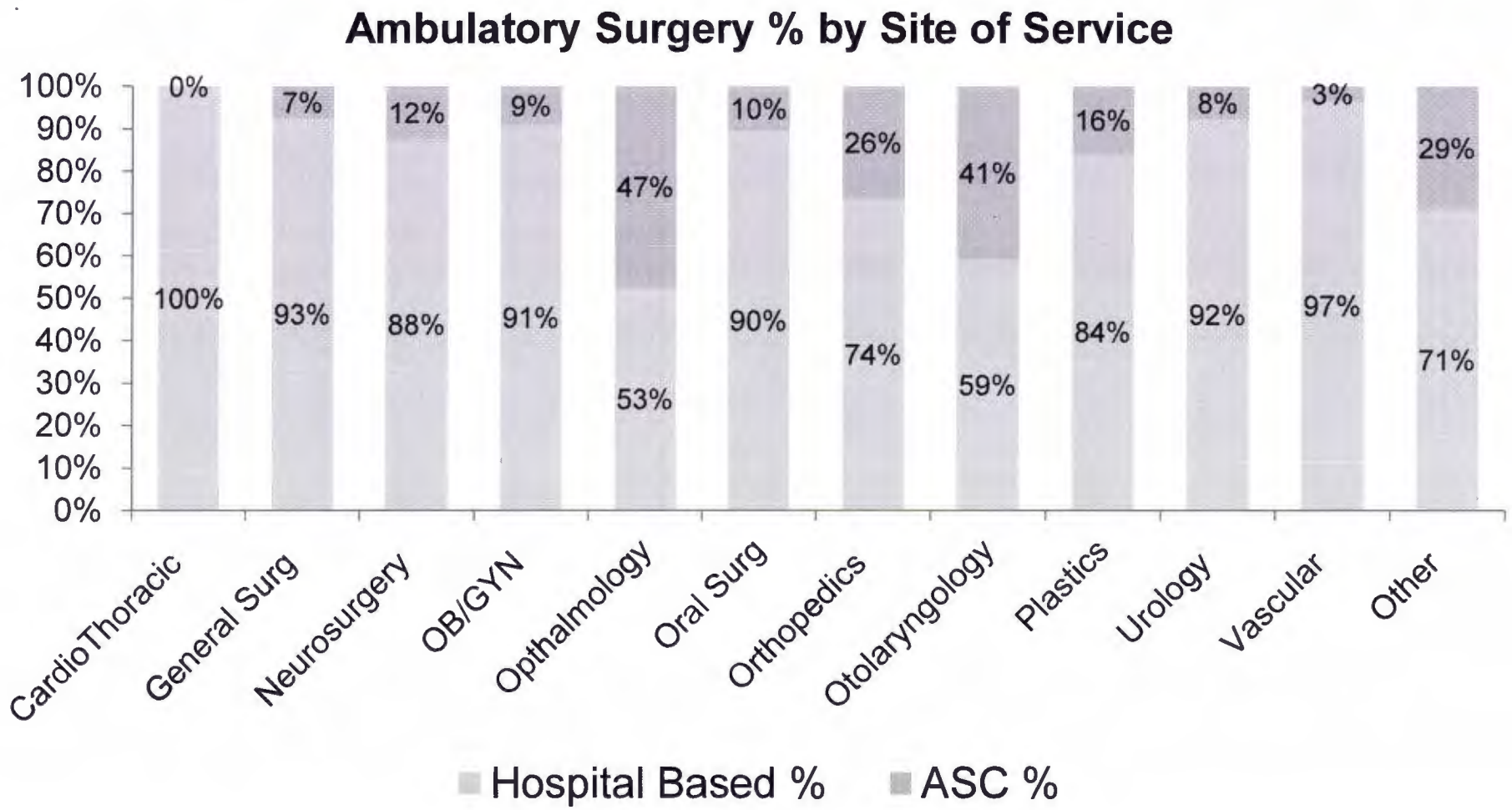


Four specialties account for 73 percent of all ambulatory surgery:

- Orthopedics
- Ophthalmology
- General Surgery
- Otolaryngology

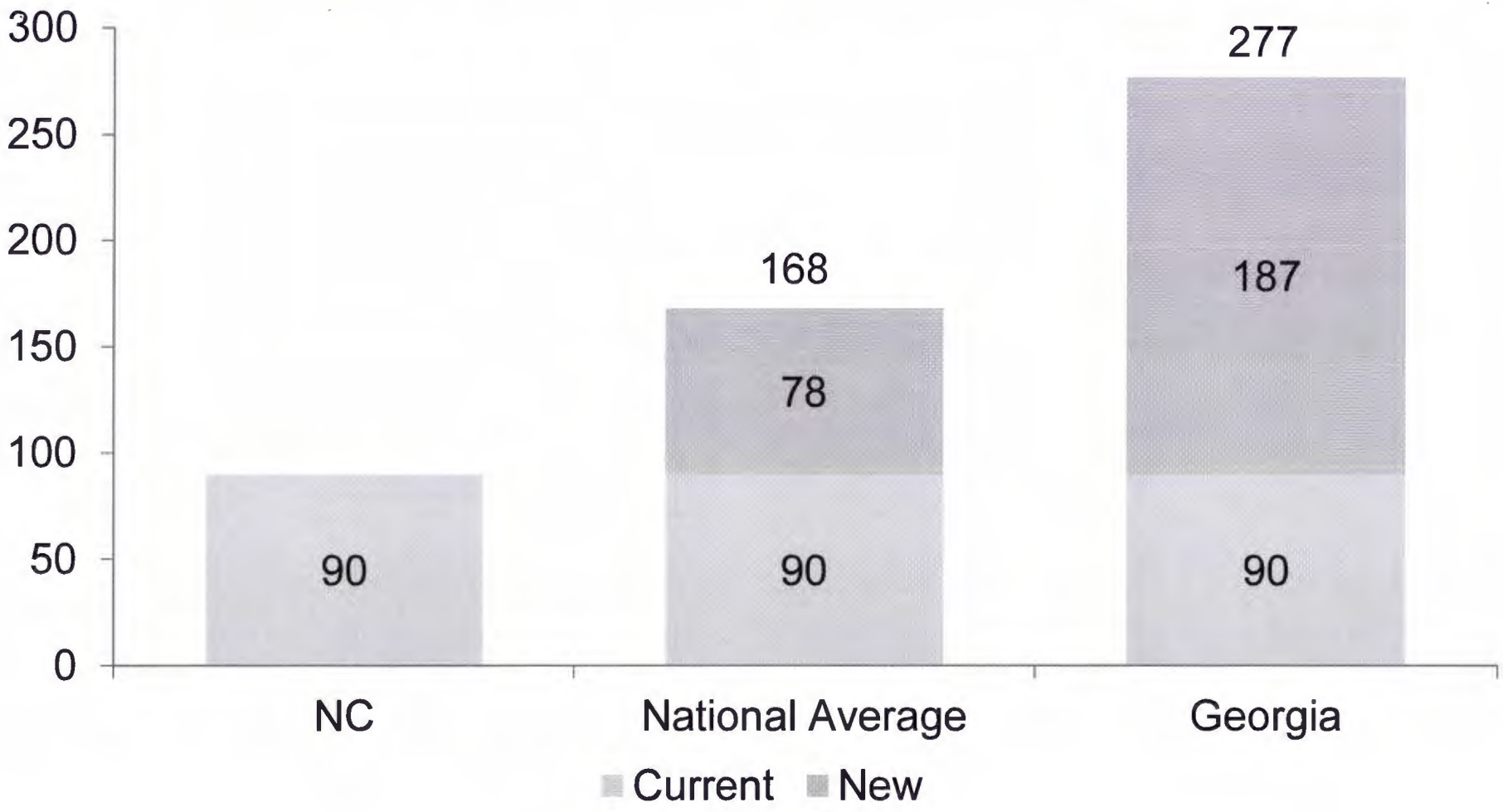
Source: Division of Health Service Regulation data, 2014

The majority of ambulatory surgery for all specialties is performed in hospital outpatient departments.



Source: Division of Health Service Regulation data, 2014

How many new ASC's could be added if NC had a population to ASC ratio similar to other states?



Source: CMS and Census Bureau, 2013

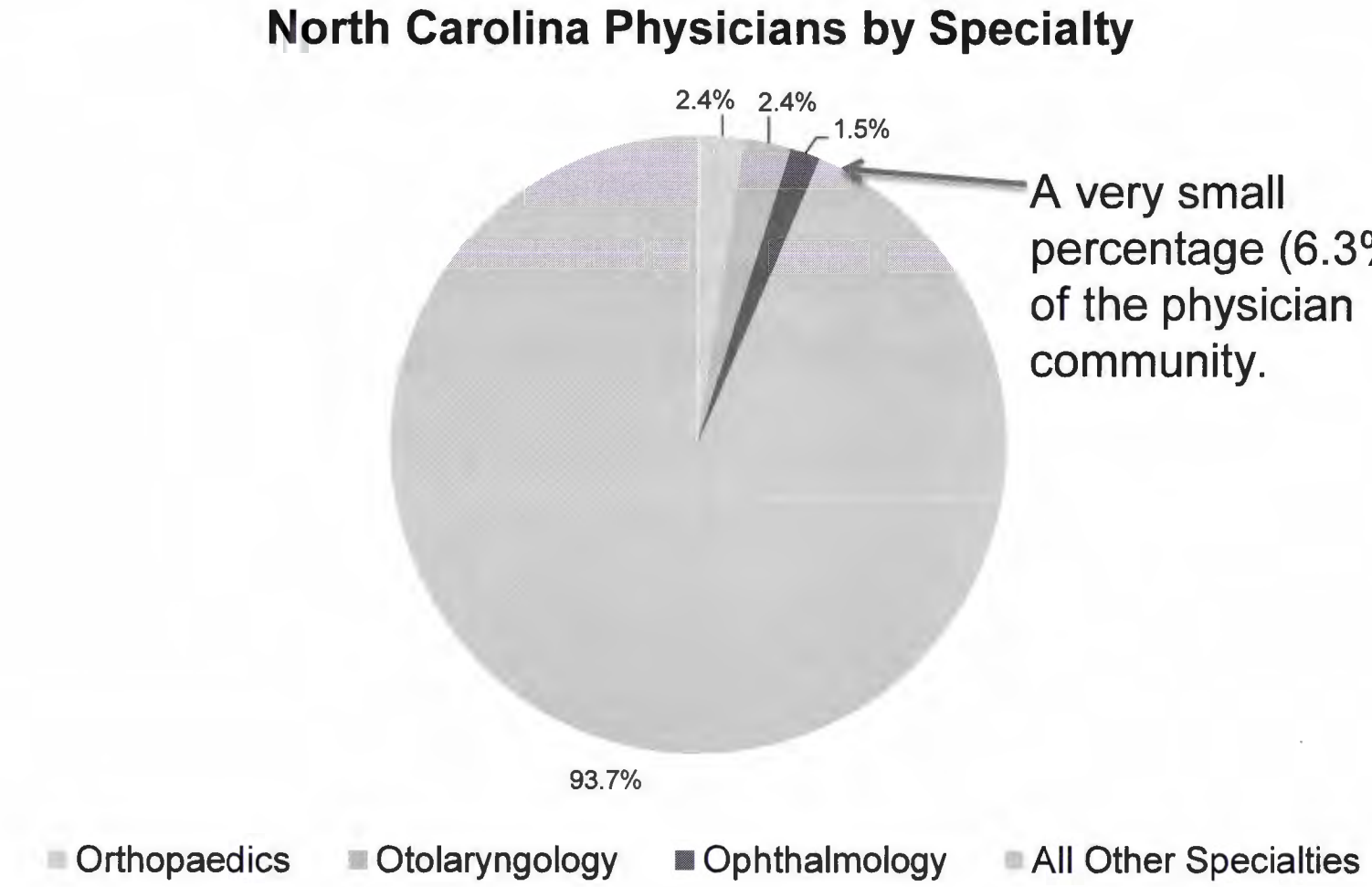
Impact of Additional ASCs on Hospitals

- The total number of ambulatory surgeries is not growing in the state.
- If new ambulatory surgery centers are opened, the cases will be relocated from hospital outpatient surgery departments.
- **If NC were to add ASCs to match the national ASC/100,000 rate hospitals would lose 26 percent of their ambulatory cases.**

	New ASCs	Average Cases per 2 OR ASC	Cases Shifted	2013 Hospital Ambulatory Cases	% of Hospital Ambulatory Shifted
Shift to National Average	78	1,617	126,126	484,431	26.0%
Shift to Georgia Rate	187	1,617	302,379	484,431	62.4%

Source: Division of Health Service Regulation data, 2014

Who benefits the most by exempting single-specialty ASCs?



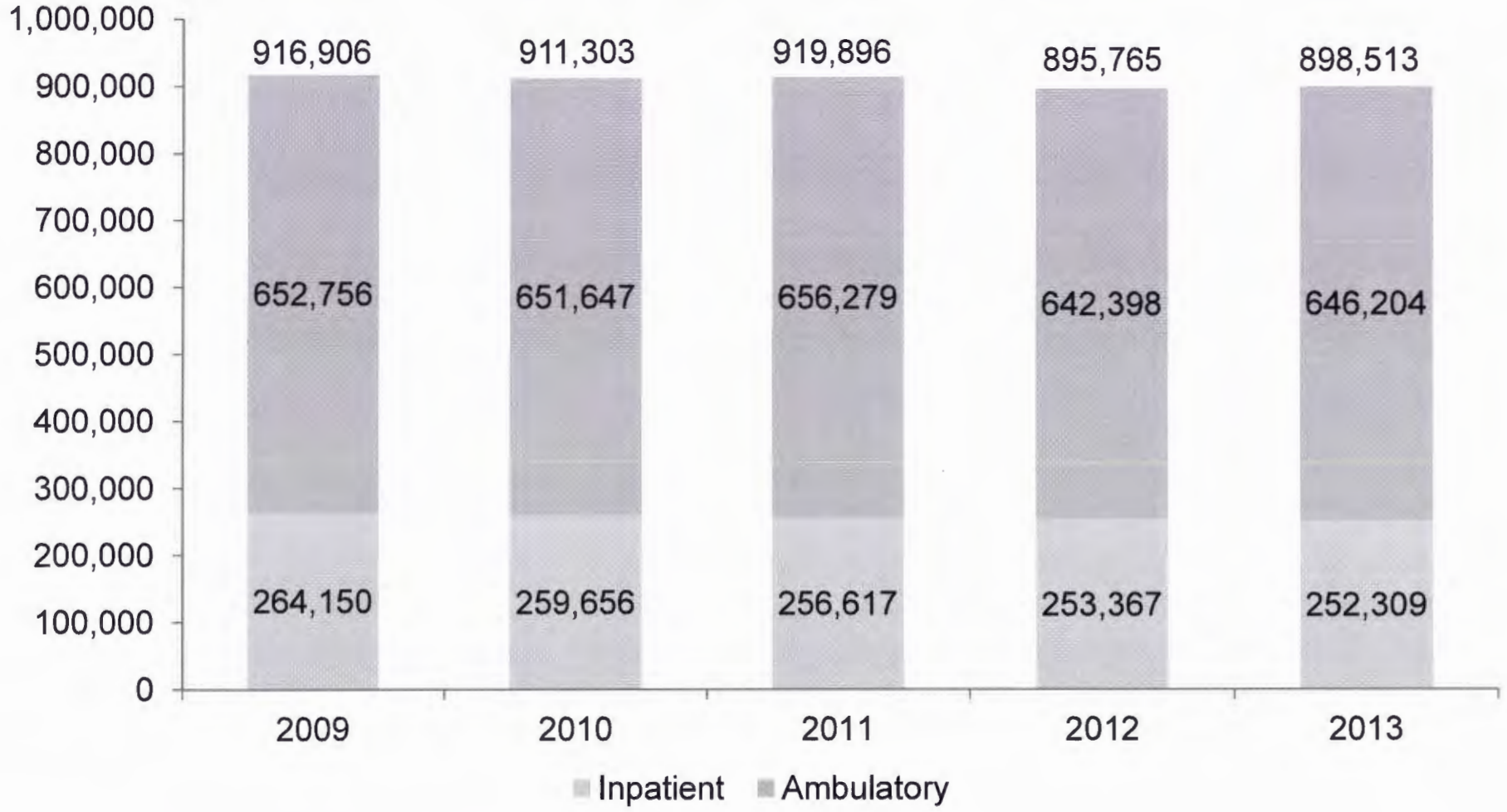
Source: North Carolina Medical Board, 2013

Appendix

Navigant CON Research Methodology

- Overall
  - Pricing and utilization patterns were compared at the statewide level for North Carolina (a CON state) versus Texas and Indiana (non-CON states)
  - Analysis included:
    - 3 years (2010-2012) of commercial insurance pricing and membership data from the Truven MarketScan database
    - One year (2012) of Medicare pricing and membership data from the MedPAR database
    - Specific services evaluated include all Inpatient Cases & 6 OP Product Lines related to ambulatory surgery, ED, advanced diagnostic imaging and cardiac catheterization
- Unit Pricing
  - Mean allowed amount extracted at the MS-DRG and CPT Code level, and aggregated to the service line level;
  - Per Member Per Month (PMPM) calculated as Total Allowed Amount / Member Months
- Utilization Rates
  - Shown as per 1,000 members & were calculated as service count / enrollment volume

Total surgery cases declined over five years; ambulatory surgery declined but had a slight increase last year.

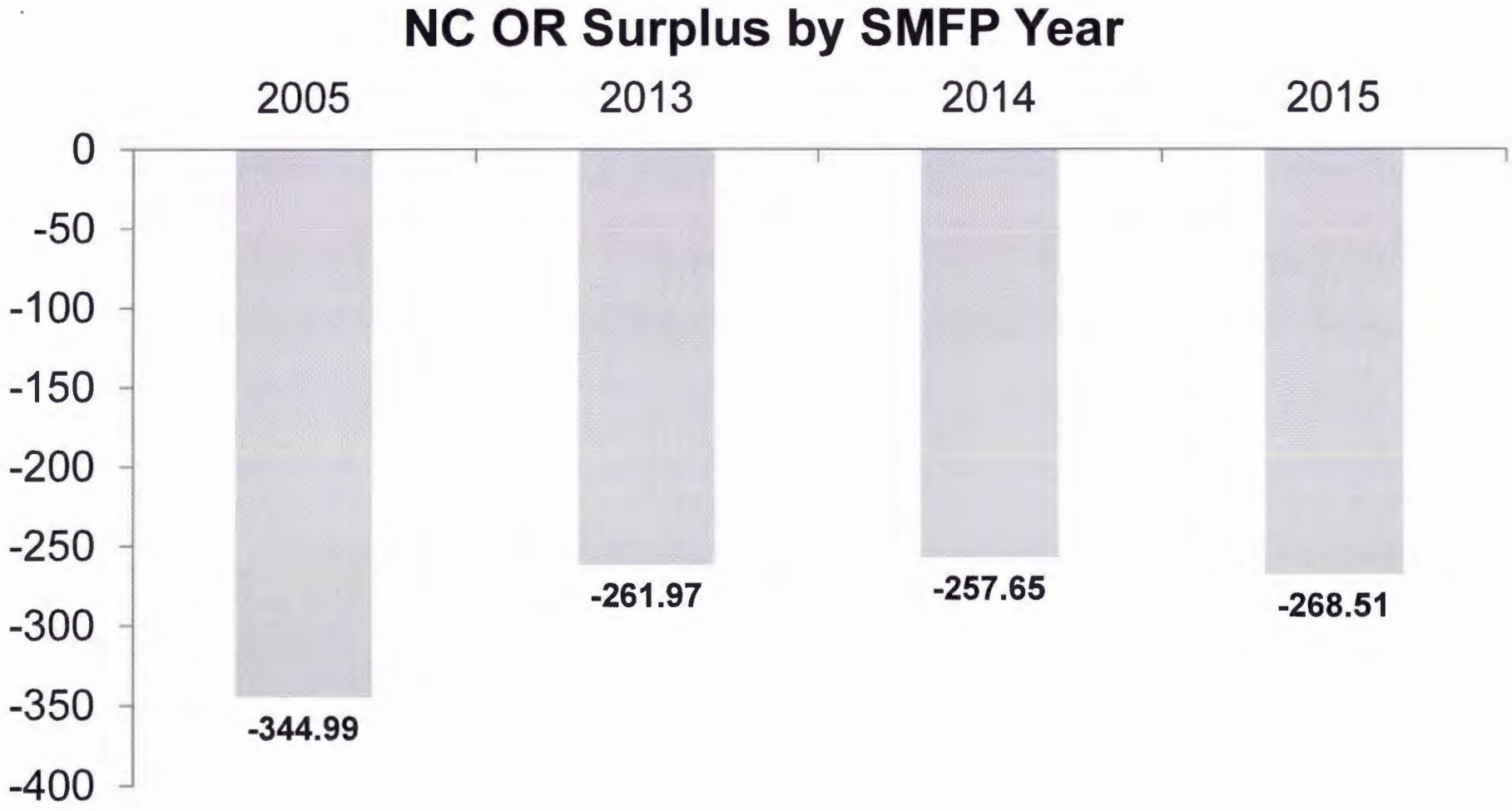


Source: Division of Health Service Regulation data, 2014

Ambulatory Surgery Centers in NC

Centers in purple font could not be mapped

North Carolina has a major OR surplus



Source: North Carolina State Medical Facilities Plans

Research Regarding ASC's and Hospitals by State

24 States Do Not Have CON Laws Regulating ASC's

States	# ASCs	# Hospitals	CON Regulation of ASCs	2012 Population	ASCs per 100,000 Population	Hospitals per 100,000 Population	Does State Have CON Laws
Alabama	42	93	Yes	4,822,023	0.871	1.93	Yes
Alaska	15	12	Yes	731,449	2.051	1.64	Yes
Arizona	165	73	No	6,553,255	2.518	1.11	No
Arkansas	60	50	No	2,949,131	2.034	1.70	Yes
California	754	356	No	38,041,430	1.982	0.94	No
Colorado	120	53	No	5,187,582	2.313	1.02	No
Connecticut	61	34	Yes	3,590,347	1.699	0.95	Yes
Delaware	17	8	Yes	917,092	1.854	0.87	Yes
Florida	606	213	No	19,317,568	3.137	1.10	Yes
Georgia	341	115	Yes	9,919,945	3.438	1.16	Yes
Hawaii	20	13	Yes	1,392,313	1.436	0.93	No
Idaho	51	17	No	1,595,728	3.196	1.07	No
Illinois	144	142	Yes	12,875,255	1.118	1.10	Yes
Indiana	130	97	No	6,537,334	1.989	1.48	Yes
Iowa	25	40	Yes	3,074,186	0.813	1.30	No
Kansas	71	61	No	2,885,905	2.460	2.11	Yes
Kentucky	39	77	Yes	4,380,415	0.890	1.76	Yes
Louisiana	109	112	No	4,601,893	2.369	2.43	Yes
Maine	17	22	Yes	1,329,192	1.279	1.66	Yes
Maryland	325	50	Yes	5,884,563	5.523	0.85	Yes
Massachusetts	59	81	Yes	6,646,144	0.888	1.22	Yes
Michigan	122	109	Yes	9,883,360	1.234	1.10	Yes
Minnesota	65	56	No	5,379,139	1.208	1.04	No
Mississippi	69	73	Yes	2,984,926	2.312	2.45	Yes
Missouri	109	89	No	6,021,988	1.810	1.48	Yes
Montana	18	15	Yes	1,005,141	1.791	1.49	Yes
Nebraska	48	30	No	1,855,525	2.587	1.62	Yes
Nevada	60	28	Yes	2,758,931	2.175	1.01	Yes

New Hampshire	29	14	Yes	1,320,718	2.196	1.06	Yes
New Jersey	168	75	No	8,864,590	1.895	0.85	Yes
New Mexico	24	40	No	2,085,538	1.151	1.92	Yes
New York	116	202	Yes	19,570,261	0.593	1.03	Yes
North Carolina	118	106	Yes	9,752,073	1.210	1.09	Yes
North Dakota	12	11	No	699,628	1.715	1.57	No
Ohio	201	152	No	11,544,225	1.741	1.32	Yes
Oklahoma	48	102	No	3,814,820	1.258	2.67	Yes
Oregon	92	38	No	3,899,353	2.359	0.97	Yes
Pennsylvania	297	183	No	12,763,536	2.327	1.43	No
Rhode Island	9	12	Yes	1,050,292	0.857	1.14	Yes
South Carolina	75	66	Yes	4,723,723	1.588	1.40	Yes
South Dakota	19	28	No	833,354	2.280	3.36	No
Tennessee	156	119	Yes	6,456,243	2.416	1.84	Yes
Texas	434	385	No	26,059,203	1.665	1.48	No
Utah	81	37	No	2,855,287	2.837	1.30	No
Vermont	1	7	Yes	626,011	0.160	1.12	Yes
Virginia	51	92	Yes	8,185,867	0.623	1.12	Yes
Washington	288	64	Yes	6,897,012	4.176	0.93	Yes
West Virginia	9	37	Yes	1,855,413	0.485	1.99	Yes
Wisconsin	74	78	No	5,726,398	1.292	1.36	Yes
Wyoming	17	13	No	576,412	2.949	2.26	No

***Note*: Some of the numbers reflect the state-licensed facilities, whereas others reflect the total number of facilities in that state. Usually, those states with the total number of facilities do not have licensing requirements for ASCs.**

[1] **Ariz. has 165 Medicare-certified ASCs.**

[2] **Includes state licensed and certified facilities**

[3] **W.Va. has nine Medicare-certified ASCs. ASCs are not licensed in W.Va.**

Sources:

Gordon, Dani, "How many licensed ASCs are in your state?", Becker's Hospital Review, August 28, 2014

National Conference of State Legislatures, http://www.ncsl.org/research/health/con-certificate-of-need-state-laws.aspx

World Atlas, Interactive List of US States (2012 populations) http://www.worldatlas.com/aatlas/populations/usapoptable.htm

American Hospital Directory, http://www.ahd.com/states/hospital_AK.html

MERCATUS ON POLICY

Certificate-of-Need Laws: Implications for North Carolina

Christopher Koopman and Thomas Stratmann

February 2015

MERCATUS CENTER
George Mason University

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Thomas Stratmann is a scholar at the Mercatus Center and a professor of economics at George Mason University. His primary research interests are political economy, fiscal policy, law and economics, health economics, and experimental economics. He received his BA from the Free University of Berlin and his MA and PhD in economics from the University of Maryland.

Thirty-five states and the District of Columbia currently limit entry or expansion of health care facilities through certificate-of-need (CON) programs.[1] These programs prohibit health care providers from entering new markets or making changes to their existing capacity without first gaining the approval of state regulators. Since 1978, North Carolina has been among the states that restrict the supply of health care in this way, with 25 devices and services—ranging from acute hospital beds to magnetic resonance imaging (MRI) scanners to psychiatric services—requiring a certificate of need from the state before the device may be purchased or the service may be offered.[2]

CON restrictions are in addition to the standard licensing and training requirements for medical professionals, but are neither designed nor intended to ensure public health or ensure that medical professionals have the necessary qualifications to do their jobs. Instead, CON laws are specifically designed to limit the supply of health care, and are traditionally justified with the claim that they reduce and control health care costs.[3] The theory is that by restricting market entry and expansion, states might reduce overinvestment in facilities and equipment. In addition, many states—including North Carolina—justify CON programs as a way to cross-subsidize health care for the poor. Under these "charity care" requirements providers that receive a certificate of need are typically required to increase the amount of care they provide to the poor. In effect, these programs intend to create *quid pro quo* arrangements: state governments restrict competition, increasing the cost of health care for some, and in return medical providers use these contrived profits to increase the care they provide to the poor.[4]

However, these claimed benefits have failed to materialize as intended. Recent research by Thomas Stratmann and Jacob Russ demonstrates that there is no relationship between CON programs and increased access to health care for the poor.[5] There are, however, serious consequences for continuing to enforce CON regulations. In particular, for North Carolina these programs could mean approximately 12,900 fewer hospital beds, 49 fewer hospitals offering MRI services, and 67 fewer hospitals offering computed tomography (CT) scans. For those seeking quality health care throughout North Carolina, this means less competition and fewer choices, without increased access to care for the poor.

THE RISE OF CON PROGRAMS

CON programs were first adopted by New York in 1964 as a way to strengthen regional health planning programs. Over the following 10 years, 23 other states adopted CON programs.[6] Many of these programs were initiated as "Section 1122" programs, which were federally funded programs providing Medicare and Medicaid reimbursement for certain approved capital expenditures. The passage of the National Health Planning and Resources Development Act of 1974, which made certain federal funds contingent on the enactment of CON programs, provided a strong incentive for the remaining states to implement CON programs.[7] In the seven years following this mandate, nearly every state without a CON program, including North Carolina, took steps to adopt certificate-of-need statutes. By 1982 every state except Louisiana had some form of a CON program.

In 1987, the federal government repealed its CON program mandate when the ineffectiveness of CON regulations as a cost-control measure became clear. Twelve states rapidly followed suit and repealed their certificate-of-need laws in the 1980s.[8] By 2000, Indiana, North Dakota, and Pennsylvania had also repealed their CON programs. Since 2000, Wisconsin has been the only state to repeal its program.

North Carolina remains among the 36 states, along with the District of Columbia, that continue to limit entry and expansion within their respective health care markets through certificates of need. On average, states with CON programs regulate 14 different services, devices, and procedures. North Carolina's CON program currently regulates 25 different services, devices, and procedures, which is much more than the national average. As figure 1 shows, North Carolina's certificate-of-need program ranks fourth most restrictive in the United States.

DO CON PROGRAMS CONTROL COSTS AND INCREASE THE POOR'S ACCESS TO CARE?

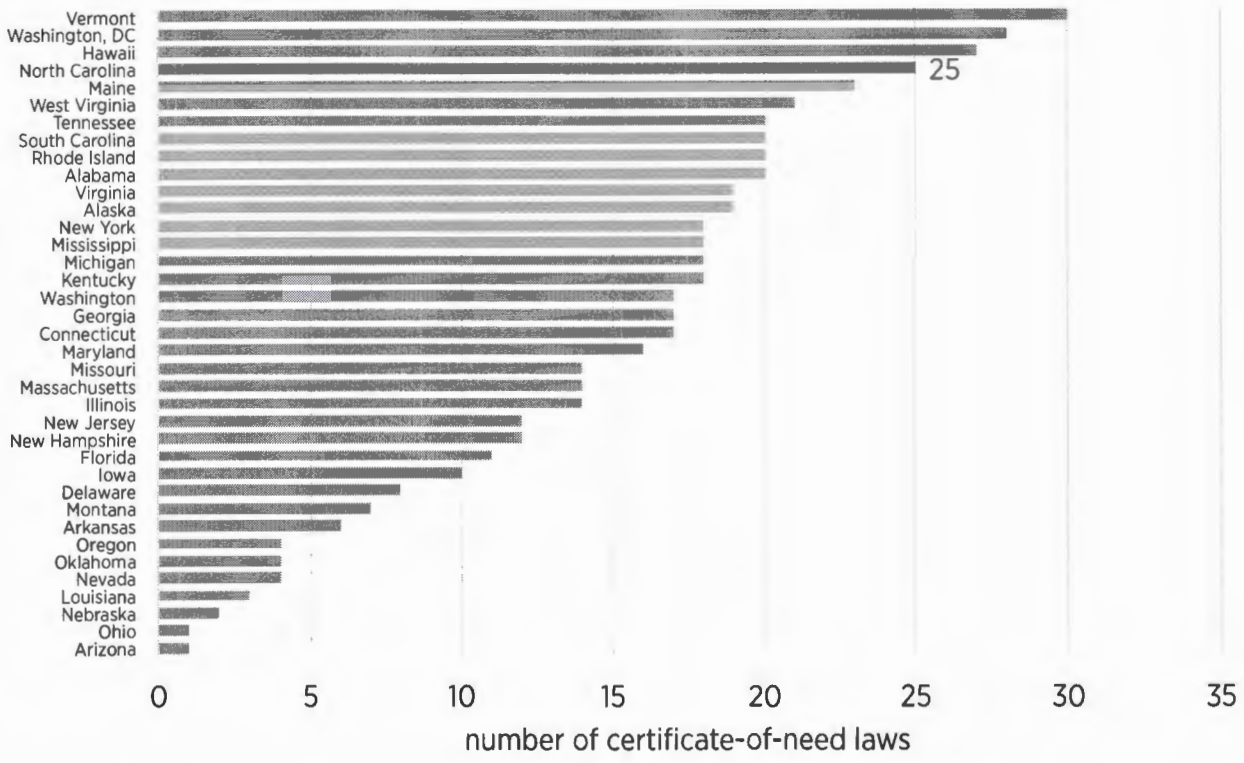
Many early studies of CON programs found that these programs fail to reduce investment by hospitals.[9] These early studies also found that the programs fail to control costs.[10] Such findings contributed to the federal repeal of CON requirements. More recently, research into the effectiveness of remaining CON programs as a cost-control measure has been mixed. While some studies find that CON regulations may have some limited cost-control effect,[11] others find that strict CON programs may in fact increase costs by 5 percent.[12] The latter finding is not surprising, given that CON programs restrict competition and reduce the available supply of regulated services.

While there is little evidence to support the claim that certificates of need are an effective cost-control measure, many states continue to justify these programs using the rationale that they increase the provision of health care for the poor. To achieve this, 14 states—including North Carolina—include some requirement for charity care within their respective CON programs.[13] This is what economists have come to refer to as a "cross subsidy."[14]

The theory behind cross-subsidization through these programs is straightforward. By limiting the number of providers that can enter a particular practice and by limiting the expansion of incumbent providers, CON regulations effectively give a limited monopoly privilege to providers that receive approval in the form of a certificate of need. Approved providers are therefore able to charge higher prices than would be possible under truly competitive conditions. As a result, it is hoped that providers will use their enhanced profits to cover the losses from providing otherwise unprofitable, uncompensated care for the poor. In effect, those who can pay are charged higher prices to subsidize those who cannot.

In reality, however, this cross-subsidization is not occurring. While early studies found some evidence of cross-subsidization among hospitals and nursing homes,[15] the more recent academic literature does not show this cross-subsidy taking place. The most comprehensive empirical study to date, conducted by Thomas

FIGURE 1. RANKING OF STATES BY NUMBER OF CERTIFICATE-OF-NEED LAWS



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☑ Lower Healthcare Costs *Now!*

Certificate of Need **REFORM**

HB200 Amend Certificate of Need Laws

Bringing NC Healthcare Regulations Into The 21st Century

Eliminates the CON Requirement for ASC's

- ASC's can be owned by physicians, hospitals, for-profit companies or a partnership of any of the three.
- Exempts rural hospitals because there is a prohibition of these ASC's in counties with 100,000 or less in population unless the hospital approves – 74 counties would be exempted.
- Requires a 7% charity care for the new ASC's – This requirement was developed by DHHS for three physician-owned ASC's and is currently being used as a requirement.

Eliminates the CON Requirement for Diagnostic Centers

- Physicians will be treated like other providers regarding diagnostic equipment like CT scanners, mammography and ultrasound.
- North Carolina is the only state in the country that has this requirement only for physician offices.

Addresses A 2012 Lawsuit Settlement Regarding Procedure Rooms

Due to settlement there is no limit on procedure rooms that can be built to exact operating room standards as long as hospital has CON for operating room. Operating Room data collected by DHSR is inaccurate and showing no need for operating rooms. This bill eliminates the needs determination for operating rooms since the data is flawed.

Eliminates the CON Requirement for Psychiatric Beds

- Because of low reimbursement there has been little interest in applying for this CON.
- This elimination removes an unneeded regulatory hurdle.

Connie Wilson 919-274-0557 | NC Orthopaedic Association | REFORMCONNOW.com
Laurie Onorio 919-412-9371

Procedure: ACL Repair by Arthroscopy
Location: Charlotte, NC (within 25 miles)

NC Estimate Health Care Costs

Cost estimates are averages based on historical BCBSNC claims data. Amounts listed typically include physician fees, facility fees and costs for things like anesthesia, drugs, medical supplies – as well as customer responsibility (deductible, co-pay and co-insurance). Your actual costs may be different based on variations in these factors as well as your health plan design, deductibles/co-insurance and out-of-pocket limits.

Gateway Surgery Center 1025 NE Gateway Ct NE Concord, NC 28025	Blue Value **$10,061** Blue Options, Blue Advantage **$10,061**
Michael Dockery **Charlotte Surgery Center** 2825 Randolph Rd Charlotte, NC 28211	Blue Value **$10,800** Blue Options, Blue Advantage **$10,800**
Erik Johnson **Caromont Regional Medical Center** 525 Court Dr Gastonia, NC 28054	Blue Value **$12,496** Blue Options, Blue Advantage **$12,496**
Matthew Gullickson **Matthews Surgery Center LLC** 710 Park Center Dr, Ste 100 Matthews, NC 28105	Blue Value **$13,104** Blue Options, Blue Advantage **$13,104**
Bryan Edwards **Presb Surgery Center at Huntersville** 10030 Gilead Rd Huntersville, NC 28078	Blue Value **$16,355** Blue Options, Blue Advantage **$16,355**
Lake Norman Regional Medical Center 171 Fairview Rd Mooresville, NC 28117	Blue Value **$17,092** Blue Options, Blue Advantage **$17,092**
Bryan Edwards **Novant Health Huntersville Med Center** 10030 Gilead Rd Huntersville, NC 28078	Blue Value **$24,118** Blue Options, Blue Advantage **$26,860**
Scott O'Neal **Carolinas Medical Center-Pineville** 10628 Park Rd Charlotte, NC 28210	Blue Options, Blue Advantage **$24,799**
Jerry Barron **Novant Health Charlotte Orthopedic** 1901 Randolph Rd Charlotte, NC 28207	Blue Value **$28,834** Blue Options, Blue Advantage **$28,834**

List of Critical Access Hospitals (CAH)

Alleghany Memorial Hospital	Sparta	North Carolina	28675
Angel Medical Center	Franklin	North Carolina	28734
Ashe Memorial Hospital *	Jefferson	North Carolina	28640
Bladen County Hospital	Elizabethtown	North Carolina	28337
Blowing Rock Hospital	Blowing Rock	North Carolina	28605
Charles A. Cannon Jr. Memorial Hospital	Linville	North Carolina	28604
Chatham Hospital	Siler City	North Carolina	27344
Davie County Hospital	Mocksville	North Carolina	27028
Highlands-Cashiers Hospital	Highlands	North Carolina	28741
Hoots Memorial Hospital	Yadkinville	North Carolina	27055
J. Arthur Dosher Hospital	Southport	North Carolina	28461
Montgomery Memorial Hospital	Troy	North Carolina	27371
Our Community Hospital	Scotland Neck	North Carolina	27874
Outer Banks Hospital	Nags Head	North Carolina	27959
Pender Memorial Hospital	Burgaw	North Carolina	28425
St. Lukes Hospital	Columbus	North Carolina	28722
Stokes-Reynolds Memorial Hospital	Danbury	North Carolina	27016
Swain County Hospital	Bryson City	North Carolina	28713
Transylvania Hospital	Brevard	North Carolina	28712
Vidant Bertie Hospital	Windsor	North Carolina	27983
Vidant Chowan Hospital	Edenton	North Carolina	27932
Vidant Pungo District Hospital	Belhaven	North Carolina	27810
Washington County Hospital	Plymouth		

Research Regarding ASC's and Hospitals by State

24 States Do Not Have CON Laws Regulating ASC's

States	# ASCs	# Hospitals	CON Regulation of ASCs	2012 Population	ASCs per 100,000 Population	Hospitals per 100,000 Population	Does State Have CON Laws
Alabama	42	93	Yes	4,822,023	0.871	1.93	Yes
Alaska	15	12	Yes	731,449	2.051	1.64	Yes
Arizona	165	73	No	6,553,255	2.518	1.11	No
Arkansas	60	50	No	2,949,131	2.034	1.70	Yes
California	754	356	No	38,041,430	1.982	0.94	No
Colorado	120	53	No	5,187,582	2.313	1.02	No
Connecticut	61	34	Yes	3,590,347	1.699	0.95	Yes
Delaware	17	8	Yes	917,092	1.854	0.87	Yes
Florida	606	213	No	19,317,568	3.137	1.10	Yes
Georgia	341	115	Yes	9,919,945	3.438	1.16	Yes
Hawaii	20	13	Yes	1,392,313	1.436	0.93	No
Idaho	51	17	No	1,595,728	3.196	1.07	No
Illinois	144	142	Yes	12,875,255	1.118	1.10	Yes
Indiana	130	97	No	6,537,334	1.989	1.48	Yes
Iowa	25	40	Yes	3,074,186	0.813	1.30	No
Kansas	71	61	No	2,885,905	2.460	2.11	Yes
Kentucky	39	77	Yes	4,380,415	0.890	1.76	Yes
Louisiana	109	112	No	4,601,893	2.369	2.43	Yes
Maine	17	22	Yes	1,329,192	1.279	1.66	Yes
Maryland	325	50	Yes	5,884,563	5.523	0.85	Yes
Massachusetts	59	81	Yes	6,646,144	0.888	1.22	Yes
Michigan	122	109	Yes	9,883,360	1.234	1.10	Yes
Minnesota	65	56	No	5,379,139	1.208	1.04	No
Mississippi	69	73	Yes	2,984,926	2.312	2.45	Yes
Missouri	109	89	No	6,021,988	1.810	1.48	Yes
Montana	18	15	Yes	1,005,141	1.791	1.49	Yes
Nebraska	48	30	No	1,855,525	2.587	1.62	Yes
Nevada	60	28	Yes	2,758,931	2.175	1.01	Yes

New Hampshire	29	14	Yes	1,320,718	2.196	1.06	Yes
New Jersey	168	75	No	8,864,590	1.895	0.85	Yes
New Mexico	24	40	No	2,085,538	1.151	1.92	Yes
New York	116	202	Yes	19,570,261	0.593	1.03	Yes
North Carolina	118	106	Yes	9,752,073	1.210	1.09	Yes
North Dakota	12	11	No	699,628	1.715	1.57	No
Ohio	201	152	No	11,544,225	1.741	1.32	Yes
Oklahoma	48	102	No	3,814,820	1.258	2.67	Yes
Oregon	92	38	No	3,899,353	2.359	0.97	Yes
Pennsylvania	297	183	No	12,763,536	2.327	1.43	No
Rhode Island	9	12	Yes	1,050,292	0.857	1.14	Yes
South Carolina	75	66	Yes	4,723,723	1.588	1.40	Yes
South Dakota	19	28	No	833,354	2.280	3.36	No
Tennessee	156	119	Yes	6,456,243	2.416	1.84	Yes
Texas	434	385	No	26,059,203	1.665	1.48	No
Utah	81	37	No	2,855,287	2.837	1.30	No
Vermont	1	7	Yes	626,011	0.160	1.12	Yes
Virginia	51	92	Yes	8,185,867	0.623	1.12	Yes
Washington	288	64	Yes	6,897,012	4.176	0.93	Yes
West Virginia	9	37	Yes	1,855,413	0.485	1.99	Yes
Wisconsin	74	78	No	5,726,398	1.292	1.36	Yes
Wyoming	17	13	No	576,412	2.949	2.26	No

***Note*: Some of the numbers reflect the state-licensed facilities, whereas others reflect the total number of facilities in that state. Usually, those states with the total number of facilities do not have licensing requirements for ASCs.**

[1] **Ariz. has 165 Medicare-certified ASCs.**

[2] **Includes state licensed and certified facilities**

[3] **W.Va. has nine Medicare-certified ASCs. ASCs are not licensed in W.Va.**

Sources:

Gordon, Dani, "How many licensed ASCs are in your state?", Becker's Hospital Review, August 28, 2014

National Conference of State Legislatures, http://www.ncsl.org/research/health/con-certificate-of-need-state-laws.aspx

World Atlas, Interactive List of US States (2012 populations) http://www.worldatlas.com/aatlas/populations/usapoptable.htm

American Hospital Directory, http://www.ahd.com/states/hospital_AK.html

MERCATUS ON POLICY

Certificate-of-Need Laws: Implications for North Carolina

Christopher Koopman and Thomas Stratmann

February 2015

MERCATUS CENTER
George Mason University

Christopher Koopman is a research fellow at the Mercatus Center at George Mason University. His research interests include economic regulations, competition, and innovation, with a particular focus on public choice and the economics of government favoritism. He received his JD from Ave Maria University and his LLM in law and economics from George Mason University.

Thomas Stratmann is a scholar at the Mercatus Center and a professor of economics at George Mason University. His primary research interests are political economy, fiscal policy, law and economics, health economics, and experimental economics. He received his BA from the Free University of Berlin and his MA and PhD in economics from the University of Maryland.

Thirty-five states and the District of Columbia currently limit entry or expansion of health care facilities through certificate-of-need (CON) programs.[1] These programs prohibit health care providers from entering new markets or making changes to their existing capacity without first gaining the approval of state regulators. Since 1978, North Carolina has been among the states that restrict the supply of health care in this way, with 25 devices and services—ranging from acute hospital beds to magnetic resonance imaging (MRI) scanners to psychiatric services—requiring a certificate of need from the state before the device may be purchased or the service may be offered.[2]

CON restrictions are in addition to the standard licensing and training requirements for medical professionals, but are neither designed nor intended to ensure public health or ensure that medical professionals have the necessary qualifications to do their jobs. Instead, CON laws are specifically designed to limit the supply of health care, and are traditionally justified with the claim that they reduce and control health care costs.[3] The theory is that by restricting market entry and expansion, states might reduce overinvestment in facilities and equipment. In addition, many states—including North Carolina—justify CON programs as a way to cross-subsidize health care for the poor. Under these "charity care" requirements providers that receive a certificate of need are typically required to increase the amount of care they provide to the poor. In effect, these programs intend to create *quid pro quo* arrangements: state governments restrict competition, increasing the cost of health care for some, and in return medical providers use these contrived profits to increase the care they provide to the poor.[4]

However, these claimed benefits have failed to materialize as intended. Recent research by Thomas Stratmann and Jacob Russ demonstrates that there is no relationship between CON programs and increased access to health care for the poor.[5] There are, however, serious consequences for continuing to enforce CON regulations. In particular, for North Carolina these programs could mean approximately 12,900 fewer hospital beds, 49 fewer hospitals offering MRI services, and 67 fewer hospitals offering computed tomography (CT) scans. For those seeking quality health care throughout North Carolina, this means less competition and fewer choices, without increased access to care for the poor.

THE RISE OF CON PROGRAMS

CON programs were first adopted by New York in 1964 as a way to strengthen regional health planning programs. Over the following 10 years, 23 other states adopted CON programs.[6] Many of these programs were initiated as "Section 1122" programs, which were federally funded programs providing Medicare and Medicaid reimbursement for certain approved capital expenditures. The passage of the National Health Planning and Resources Development Act of 1974, which made certain federal funds contingent on the enactment of CON programs, provided a strong incentive for the remaining states to implement CON programs.[7] In the seven years following this mandate, nearly every state without a CON program, including North Carolina, took steps to adopt certificate-of-need statutes. By 1982 every state except Louisiana had some form of a CON program.

In 1987, the federal government repealed its CON program mandate when the ineffectiveness of CON regulations as a cost-control measure became clear. Twelve states rapidly followed suit and repealed their certificate-of-need laws in the 1980s.[8] By 2000, Indiana, North Dakota, and Pennsylvania had also repealed their CON programs. Since 2000, Wisconsin has been the only state to repeal its program.

North Carolina remains among the 36 states, along with the District of Columbia, that continue to limit entry and expansion within their respective health care markets through certificates of need. On average, states with CON programs regulate 14 different services, devices, and procedures. North Carolina's CON program currently regulates 25 different services, devices, and procedures, which is much more than the national average. As figure 1 shows, North Carolina's certificate-of-need program ranks fourth most restrictive in the United States.

DO CON PROGRAMS CONTROL COSTS AND INCREASE THE POOR'S ACCESS TO CARE?

Many early studies of CON programs found that these programs fail to reduce investment by hospitals.[9] These early studies also found that the programs fail to control costs.[10] Such findings contributed to the federal repeal of CON requirements. More recently, research into the effectiveness of remaining CON programs as a cost-control measure has been mixed. While some studies find that CON regulations may have some limited cost-control effect,[11] others find that strict CON programs may in fact increase costs by 5 percent.[12] The latter finding is not surprising, given that CON programs restrict competition and reduce the available supply of regulated services.

While there is little evidence to support the claim that certificates of need are an effective cost-control measure, many states continue to justify these programs using the rationale that they increase the provision of health care for the poor. To achieve this, 14 states—including North Carolina—include some requirement for charity care within their respective CON programs.[13] This is what economists have come to refer to as a "cross subsidy."[14]

The theory behind cross-subsidization through these programs is straightforward. By limiting the number of providers that can enter a particular practice and by limiting the expansion of incumbent providers, CON regulations effectively give a limited monopoly privilege to providers that receive approval in the form of a certificate of need. Approved providers are therefore able to charge higher prices than would be possible under truly competitive conditions. As a result, it is hoped that providers will use their enhanced profits to cover the losses from providing otherwise unprofitable, uncompensated care for the poor. In effect, those who can pay are charged higher prices to subsidize those who cannot.

In reality, however, this cross-subsidization is not occurring. While early studies found some evidence of cross-subsidization among hospitals and nursing homes,[15] the more recent academic literature does not show this cross-subsidy taking place. The most comprehensive empirical study to date, conducted by Thomas

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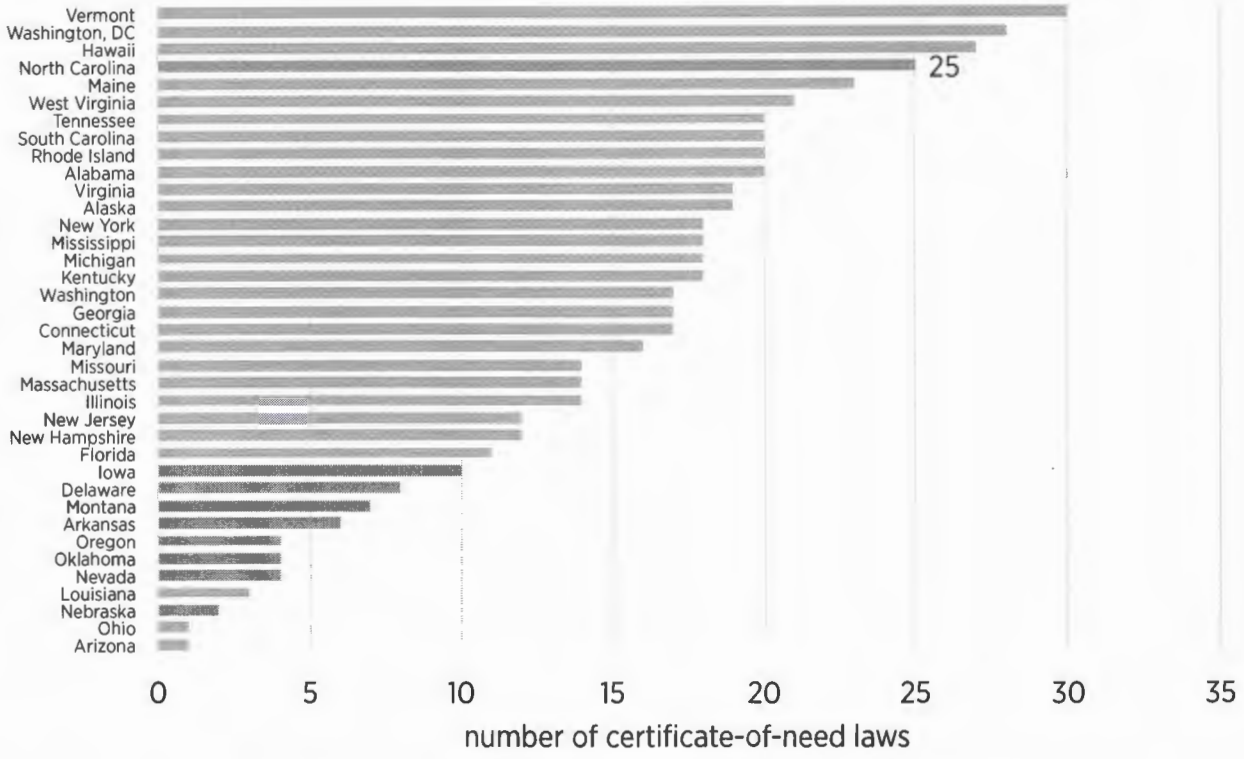

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[redacted]rity Care for All Other Hospitals in Counties with Over 100,000 Population

The criteria and definitions for self pay / charity / indigent may differ by facility.

Source: 2013 Hospital License Renewal Applications (Self reported data by the hospitals. facility.)

Hospital Name	Ambulatory Surgery	
	# Cases	% of Total
UNC Hospitals	1913	11.1%
Onslow Memorial	476	12.6%
CMC-NorthEast	536	8.0%
North Carolina Baptist	1271	6.3%
Vidant Medical Center	537	6.1%
WakeMed	806	5.9%
Carolinas Medical Center	851	5.6%
Randolph Hospital	133	5.3%
Catawba Memorial Hospital	290	5.1%
Iredell Memorial	208	5.1%
High Point Regional	165	4.9%
Cone Health	805	4.7%
Southeastern Regional	209	4.7%
Cleveland Regional	188	4.6%
C[redacted] Fear Valley Medical Center	283	4.5%
P[redacted]byterian Hospital Huntersville	148	4.4%
Wayne Memorial	316	4.3%
CMC-Union	202	4.2%
New Hanover Regional	710	4.1%
Gaston Memorial	343	3.7%
Presbyterian Hospital Matthews	163	3.7%
Durham Regional	120	3.7%
Margaret Pardee Memorial	174	3.6%
Lexington Medical Center	195	3.5%
Thomasville Medical Center	125	3.4%
Park Ridge Health	152	3.4%
North Carolina Specialty Hospital	166	3.3%
Davis Hospital	47	3.2%
First Health Moore Regional	138	3.1%
Brunswick Community	91	3.1%
Alamance Regional	231	3.1%
Duke University Hospital	661	3.1%
CMC-Mercy/Pineville	313	3.0%
Presbyterian Orthopaedics	114	2.8%
F[redacted]th Memorial Hospital	385	2.7%
CMC-University	178	2.5%

Mission Hospitals	531	2.5%
Johnston Memorial	114	2.5%
[redacted]al Park	233	2.4%
J. Arthur Dosher Hospital	25	2.4%
WakeMed Cary	123	2.3%
Rowan Regional	163	2.3%
Presbyterian Hospital	345	2.2%
CarolinaEast Medical Center (Craver	214	2.2%
Betsy Johnson	45	1.8%
Rex Hospital	304	1.8%
Duke Raleigh	195	1.6%
Frye Regional	126	0.5%
Lake Norman Regional	28	0.5%

Average 3.91%

WINSTON-SALEM JOURNAL

Study: NC regulations drive up health care costs

Richard Craver/Winston-Salem Journal | Posted: Sunday, February 22, 2015 12:00 am

A new study casts a shadow on the effectiveness of North Carolina's certificate-of-need regulations, which determine how many hospitals and health-care services are needed within the state.
The George Mason University study listed North Carolina's CON program as the third most restrictive of the 37 states with such regulations. North Carolina introduced its program in 1978.

A certificate is required before a health-care system or provider can build a medical facility, buy equipment or offer a medical procedure.

The study's authors claim North Carolinians are paying more for services, procedures and equipment because of the CON program.They also claim the program allows systems and providers to charge more in hopes they will use some of the additional revenue to cover otherwise unprofitable, uncompensated charity-care expenses for the poor.

At its essence, CON regulations are meant to prevent unnecessary duplication of services within a community or a region. The goal is preventing oversaturation of services as a means of controlling costs, which as a byproduct helps the majority of systems and providers maintain a healthy revenue stream and market share.

[redacted]orth Carolina, the CON program has helped fortify not-for-profit health-care systems, such as Cone Health, Novant Health Inc. and Wake Forest Baptist Medical Center. Analysts say the program also has made it more financially challenging to for-profit groups to obtain a meaningful ownership presence in the state.

"By limiting the number of providers that can enter a particular practice, and by limiting the expansion of incumbent providers, CON regulations effectively give a limited monopoly privilege to providers that receive approval in the form of a certificate of need," the authors said. "Approved providers are therefore able to charge higher prices than would be possible under truly competitive conditions. In effect, those who can pay are charged higher prices to subsidize those who cannot."

N.C. near top for regulations

North Carolina's program covers 25 regulated devices and services, ranging from hospitals and ambulatory surgical centers to adult care homes, dialysis centers and medical equipment, such as MRI scanners. Only Vermont, with 30, and Hawaii, with 27, has more regulated devices and services covered by a CON. By contrast, both Arizona and Ohio have one regulated device and service that requires a CON.

The authors determined that states with CON programs have, on average, 131 fewer hospital beds per 100,000 residents. They estimated that based on North Carolina's population of 9.85 million, this could mean 12,900 fewer hospital beds than needed, as well as 49 fewer hospitals offering MRI services and 67 fewer hospitals offering computed tomography (CT) scans.

"It is important to note that CONs were neither designed, nor intended, to ensure public health or ensure that medical professionals have the necessary qualifications to do their jobs," study author Chris Koopman said.

"[redacted]eparate laws and regulations cover those issues. These programs are solely focused on controlling which [redacted]iders can compete within a state, as well as when and how they go about it."
[redacted]one and Wake Forest Baptist deferred comment on the study to the N.C. Hospital Association.

Association spokeswoman Julie Henry said she questions the premise, saying there is not a lack of access to hospital health care in North Carolina. "The CON system helps prevent groups from coming in to cherry-pick the most profitable medical procedures that the not-for-profit systems need to maintain a healthy source of excess revenue and to help provide charity care," Henry said.

David Meyer, a senior partner with Keystone Planning Group of Durham, said it is "ludicrous" the authors' finding that there is deficit of 12,900 hospital beds in the state.

"That is the equivalent of 16 800-bed hospitals," Meyer said. "Right now, there are 21,000 acute-care beds with an average occupancy rate of 57 percent. Where would those additional beds and hospitals be needed?

Meyer said only 11 of North Carolina's 111 hospitals do not have a fixed MRI scanner, and nine of those have a mobile scanner. He said he knows of no hospital that does not have a CT scanner. The authors said their study offers legislators and policymakers in North Carolina "a particularly rich opportunity to reverse course and open the market for greater entry, more competition, and ultimately more options for those seeking care."

Legislative fights

Each year, the N.C. Division of Health Service Regulation issues a state medical facilities plan that announces projected infrastructure or equipment needs within a community or region. Health-care systems and providers submit bids to fill the need.

Each request can take several months to more than a year for regulators to approve or deny, with a lengthy appeal process on top of that.Even though in many cases the not-for-profit systems compete against each other, there is an understood concession that it is better to win some and lose some among themselves than to allow for-profit systems to gain a foothold.

"Certificate-of need laws don't necessarily differentiate between in-state and out-of-state providers," the authors said. "Instead, these programs protect incumbent providers from all competition, both in-state and out-of-state. With that said, the practical effect in some instances has been to limit the ability of out-of-state providers to come into a state and compete with in-state providers."

The authors said many states, including North Carolina, justify CON programs "as a way to cross-subsidize health care for the poor. "Under these charity care requirements, providers that receive a certificate are typically required to increase the amount of care they provide to the poor.

"In effect, these programs intend to create quid pro quo arrangements: state governments restrict competition, increasing the cost of health care for some, and in return medical providers use these contrived profits to increase the care they provide to the poor."

In 2013, the state's hospitals fought bills that would have opened them up to competition from lower-cost same-day surgery centers

.

House Bill 177 and Senate Bill 202 would have amended the CON laws to make it easier for doctors to open ambulatory surgery centers. The N.C. Hospital Association contended the bill would benefit a few doctors at the expense of hospitals, but would not cut costs or save state money.

House Bill 177 supporters said the CON program squelches competition and makes routine surgeries more expensive. The bill passed the House by a 112-2 vote, but never emerged from the Senate Committee on Rules and Operations. Senate Bill 202 never came up for a vote.

Triad example

The most vivid Triad example of CON competition occurred between Novant and Wake Forest Baptist. The state Medical Facilities Plan at that time indicated a need for a community hospital in the western Triad.

It took more than two years of heated rhetoric, community pep rallies, economic analyses and several appeals of regulatory CON decisions before the systems agreed in December 2009 to settle their competition for building a 50-bed, $100 million community hospital.

Both hospitals got a conditional CON approval in 2008 through different application cycles. Those approvals both validated and demonstrated the weakness of the CON program since each system proved the need for a facility even though the hospitals are about four miles apart.

Both appealed the decision favoring their rival, citing unnecessary duplication as their main point. "There were times when emotions ran high and some people thought litigation would be the only way to get to the finish line," Greg Beier, then-president of acute-care services for Novant, said in December 2009.

But the realities of legal expenses of more than $1 million a year, and the prospects of seven to 10 years of litigation and appeals, persuaded the systems to reach a compromise.

Each system has built the first phase of its hospital – Clemmons for Novant and Davie for Wake Forest Baptist – each with several hundred employees. Medical offices have been built near each hospital, though hoped-for new commercial investment ripple effect adjacent to either site has not materialized to date.

The systems hedged their construction plans by agreeing not to offer inpatient beds before 2017, which appears fortuitous given both hospitals have had limited usage since opening in 2013.

Bucking the odds

In February 2012, Piedmont Ear Nose and Throat Associates of Winston-Salem opened a $4.1 million outpatient surgery center at 2465 Hanestowne Lane. Piedmont officials are handling about 2,770 cases annually.

The project was part of the state's 2010 Medical Facilities Plan, which identified the need for one specialty ambulatory-surgery facility covering Forsyth and Guilford counties.

In October 2010, Piedmont received a certificate to have two operating rooms for ear, nose and throat surgeries and reconstructive facial plastic surgery for healthy patients needing elective, preventive or therapeutic procedures. The pre-operation, surgical and post-operation areas are within feet of each other.

Dr. Ronald Shealy, the surgical center's medical director, said Piedmont "bucked the odds" in getting the CON because they typically are awarded to large medical centers or their affiliates. It competed with surgical centers proposed by Novant and Wake Forest Baptist.

Shealy said Piedmont has been able to perform some outpatient procedures at "roughly half the cost that it can be in a hospital."

"We get a set fee for the procedure, with no facility fees that the hospitals charge. It's not that we do the procedures better than the hospitals, per se. We're just not incented to be use more or do more. We do the right amount."

Piedmont is participating in a five-year demonstration project to determine whether it's more cost effective to allow physicians' groups to perform certain surgeries in-house rather than in a hospital or outpatient clinic.

As part of the project, Piedmont will provide annual data to the N.C. State Health Coordinating Council on its volume and cost of its outpatient surgeries. It also will be measured on patient outcome, such as wound-infection rates, post-operative infections, post-procedure complications, readmission rates and medication errors.

Shealy said he would encourage state health officials to begin "chipping away at the CON process a bit at a time," introducing more devices and procedures to the same opening bidding as the 2010 ambulatory surgical center need. "If they could one or two a year, it would help reduce overall costs because there would be more competition."

[redacted]ver@wsjournal.com (336) 727-7376

Research Regarding ASC's and Hospitals by State

24 States Do Not Have CON Laws Regulating ASC's

States	# ASCs	# Hospitals	CON Regulation of ASCs	2012 Population	ASCs per 100,000 Population	Hospitals per 100,000 Population	Does State Have CON Laws
Alabama	42	93	Yes	4,822,023	0.871	1.93	Yes
Alaska	15	12	Yes	731,449	2.051	1.64	Yes
Arizona	165	73	No	6,553,255	2.518	1.11	No
Arkansas	60	50	No	2,949,131	2.034	1.70	Yes
California	754	356	No	38,041,430	1.982	0.94	No
Colorado	120	53	No	5,187,582	2.313	1.02	No
Connecticut	61	34	Yes	3,590,347	1.699	0.95	Yes
Delaware	17	8	Yes	917,092	1.854	0.87	Yes
Florida	606	213	No	19,317,568	3.137	1.10	Yes
Georgia	341	115	Yes	9,919,945	3.438	1.16	Yes
Hawaii	20	13	Yes	1,392,313	1.436	0.93	No
Idaho	51	17	No	1,595,728	3.196	1.07	No
Illinois	144	142	Yes	12,875,255	1.118	1.10	Yes
Indiana	130	97	No	6,537,334	1.989	1.48	Yes
Iowa	25	40	Yes	3,074,186	0.813	1.30	No
Kansas	71	61	No	2,885,905	2.460	2.11	Yes
Kentucky	39	77	Yes	4,380,415	0.890	1.76	Yes
Louisiana	109	112	No	4,601,893	2.369	2.43	Yes
Maine	17	22	Yes	1,329,192	1.279	1.66	Yes
Maryland	325	50	Yes	5,884,563	5.523	0.85	Yes
Massachusetts	59	81	Yes	6,646,144	0.888	1.22	Yes
Michigan	122	109	Yes	9,883,360	1.234	1.10	Yes
Minnesota	65	56	No	5,379,139	1.208	1.04	No
Mississippi	69	73	Yes	2,984,926	2.312	2.45	Yes
Missouri	109	89	No	6,021,988	1.810	1.48	Yes
Montana	18	15	Yes	1,005,141	1.791	1.49	Yes
Nebraska	48	30	No	1,855,525	2.587	1.62	Yes
Nevada	60	28	Yes	2,758,931	2.175	1.01	Yes

New Hampshire	29	14	Yes	1,320,718	2.196	1.06	Yes
New Jersey	168	75	No	8,864,590	1.895	0.85	Yes
New Mexico	24	40	No	2,085,538	1.151	1.92	Yes
New York	116	202	Yes	19,570,261	0.593	1.03	Yes
North Carolina	118	106	Yes	9,752,073	1.210	1.09	Yes
North Dakota	12	11	No	699,628	1.715	1.57	No
Ohio	201	152	No	11,544,225	1.741	1.32	Yes
Oklahoma	48	102	No	3,814,820	1.258	2.67	Yes
Oregon	92	38	No	3,899,353	2.359	0.97	Yes
Pennsylvania	297	183	No	12,763,536	2.327	1.43	No
Rhode Island	9	12	Yes	1,050,292	0.857	1.14	Yes
South Carolina	75	66	Yes	4,723,723	1.588	1.40	Yes
South Dakota	19	28	No	833,354	2.280	3.36	No
Tennessee	156	119	Yes	6,456,243	2.416	1.84	Yes
Texas	434	385	No	26,059,203	1.665	1.48	No
Utah	81	37	No	2,855,287	2.837	1.30	No
Vermont	1	7	Yes	626,011	0.160	1.12	Yes
Virginia	51	92	Yes	8,185,867	0.623	1.12	Yes
Washington	288	64	Yes	6,897,012	4.176	0.93	Yes
West Virginia	9	37	Yes	1,855,413	0.485	1.99	Yes
Wisconsin	74	78	No	5,726,398	1.292	1.36	Yes
Wyoming	17	13	No	576,412	2.949	2.26	No

***Note*: Some of the numbers reflect the state-licensed facilities, whereas others reflect the total number of facilities in that state. Usually, those states with the total number of facilities do not have licensing requirements for ASCs.**

[1] **Ariz. has 165 Medicare-certified ASCs.**

[2] **Includes state licensed and certified facilities**

[3] **W.Va. has nine Medicare-certified ASCs. ASCs are not licensed in W.Va.**

Sources:

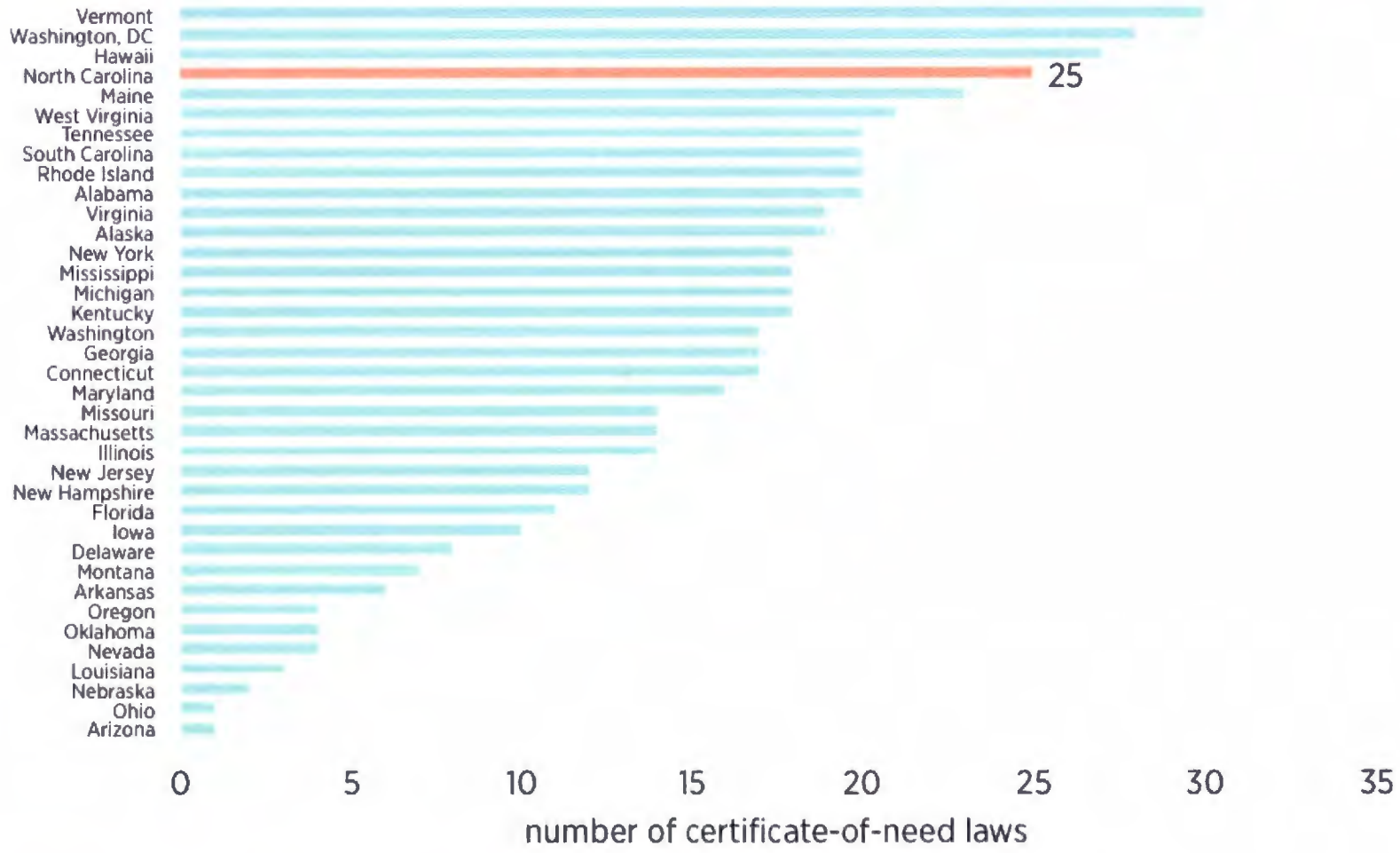
Gordon, Dani, "How many licensed ASCs are in your state?", Becker's Hospital Review, August 28, 2014

National Conference of State Legislatures, http://www.ncsl.org/research/health/con-certificate-of-need-state-laws.aspx

World Atlas, Interactive List of US States (2012 populations) http://www.worldatlas.com/aatlas/populations/usapoptable.htm

American Hospital Directory, http://www.ahd.com/states/hospital_AK.html

FIGURE 1. RANKING OF STATES BY NUMBER OF CERTIFICATE-OF-NEED LAWS



Note: Fourteen states either have no certificate-of-need laws or they are not in effect. In addition, Arizona is typically not counted as a certificate-of-need state. It is included in this chart because it is the only state to regulate ground ambulance services.

Source: *Mercatus On Policy* Certificate-of-Need Laws: Implications for North Carolina
Christopher Koopman & Thomas Stratmann, February 2015; Mercatus Center, George Mason University

Estimate Health Care Costs

[redacted]nter a treatment or service

ACL Repair by Arthroscopy

Location

Albemarle, NC

Estimated Treatment Cost Results

Cost estimates are averages based on historical BCBSNC claims data. Amounts listed typically include physician fees, facility fees and costs for things like anesthesia, drugs, medical supplies – as well as customer responsibility (deductible, co-pay and co-insurance). Your actual costs may be different based on variations in these factors as well as your health plan design, deductibles/co-insurance and out-of-pocket limits.

HOPD: Hospital Outpatient Department

Non-HOPD: Non-Hospital Outpatient Department

Gateway Surgery Center
Non-HOPD
1025 NE Gateway Ct NE
Concord, NC 28025

Blue Value
$9,710
Blue Options, Blue Advantage
$9,710

[redacted]ovant Health Rowan Medical Center
[redacted]PD
[redacted]12 Mocksville Ave
Salisbury, NC 28144

Blue Value
$16,529
Blue Options, Blue Advantage
$18,313

Estimate Health Care Costs

Enter a treatment or service

Bunionectomy

Location

Albemarle, NC

Estimated Treatment Cost Results

Cost estimates are averages based on historical BCBSNC claims data. Amounts listed typically include physician fees, facility fees and costs for things like anesthesia, drugs, medical supplies – as well as customer responsibility (deductible, co-pay and co-insurance). Your actual costs may be different based on variations in these factors as well as your health plan design, deductibles/co-insurance and out-of-pocket limits.

HOPD: Hospital Outpatient Department

Non-HOPD: Non-Hospital Outpatient Department

Union West Surgery Center **Non-HOPD** 6068 W Highway 74 Indian Trail, NC 28079	Blue Value **$3,084** Blue Options, Blue Advantage **$3,084**
Gateway Surgery Center **Non-HOPD** 1025 NE Gateway Ct NE Concord, NC 28025	Blue Value **$3,492** Blue Options, Blue Advantage **$3,492**
Novant Health Rowan Medical Center **HOPD** 612 Mocksville Ave Salisbury, NC 28144	Blue Value **$9,087** Blue Options, Blue Advantage **$10,055**

Estimate Health Care Costs

[redacted]nter a treatment or service

Cataract Removal

Location

Albemarle, NC

Estimated Treatment Cost Results

Cost estimates are averages based on historical BCBSNC claims data. Amounts listed typically include physician fees, facility fees and costs for things like anesthesia, drugs, medical supplies – as well as customer responsibility (deductible, co-pay and co-insurance). Your actual costs may be different based on variations in these factors as well as your health plan design, deductibles/co-insurance and out-of-pocket limits.

HOPD: Hospital Outpatient Department

Non-HOPD: Non-Hospital Outpatient Department

Central Peidmont Surgery Center LLC
Non-HOPD
724 Thomas St
Asheboro, NC 27203

Blue Value
$2,739
Blue Options, Blue Advantage
$2,739

[redacted]vant Health Rowan Medical Center
[redacted]OPD
612 Mocksville Ave
Salisbury, NC 28144

Blue Value
$5,762
Blue Options, Blue Advantage
$5,762

Stanly Regional Medical Center
HOPD
301 Yadkin St
Albemarle, NC 28001

Blue Value
$9,067
Blue Options, Blue Advantage
$9,067

Estimate Health Care Costs

Enter a treatment or service

CT Scan Head/Brain

Location

Albemarle, NC

Estimated Treatment Cost Results

Cost estimates are averages based on historical BCBSNC claims data. Amounts listed typically include physician fees, facility fees and costs for things like anesthesia, drugs, medical supplies – as well as customer responsibility (deductible, co-pay and co-insurance). Your actual costs may be different based on variations in these factors as well as your health plan design, deductibles/co-insurance and out-of-pocket limits.

HOPD: Hospital Outpatient Department

Non-HOPD: Non-Hospital Outpatient Department

West Stanly Imaging LLC
HOPD
103 Stanly Pkwy, Ste E
Locust, NC 28097

Blue Value
$380
Blue Options, Blue Advantage
$380

Novant Health Imaging Cabarrus
HOPD
925 Bradley St
Concord, NC 28025

Blue Value
$383
Blue Options, Blue Advantage
$383

Carolina Neurosurgery & Spine Associates
Non-HOPD
225 Baldwin Ave
Charlotte, NC 28204

Blue Value
$461
Blue Options, Blue Advantage
$461

Stanly Regional Medical Center
HOPD
301 Yadkin St
Albemarle, NC 28001

Blue Value
$1,229
Blue Options, Blue Advantage
$1,229

CMC Northeast
HOPD
920 Church St N
Concord, NC 28025

Blue Options, Blue Advantage
$1,473

Estimate Health Care Costs

[redacted]ter a treatment or service

Nasal/Sinus - Corrective Surgery

Location

Albemarle, NC

Estimated Treatment Cost Results

Cost estimates are averages based on historical BCBSNC claims data. Amounts listed typically include physician fees, facility fees and costs for things like anesthesia, drugs, medical supplies – as well as customer responsibility (deductible, co-pay and co-insurance). Your actual costs may be different based on variations in these factors as well as your health plan design, deductibles/co-insurance and out-of-pocket limits.

HOPD: Hospital Outpatient Department

Non-HOPD: Non-Hospital Outpatient Department

Gateway Surgery Center
Non-HOPD
1025 NE Gateway Ct NE
Concord, NC 28025

Blue Value
$5,610
Blue Options, Blue Advantage
$5,610

[redacted]nly Regional Medical Center
[redacted]PD
301 Yadkin St
Albemarle, NC 28001

Blue Value
$12,830
Blue Options, Blue Advantage
$12,830

Novant Health Rowan Medical Center
HOPD
612 Mocksville Ave
Salisbury, NC 28144

Blue Value
$15,737
Blue Options, Blue Advantage
$17,269

Estimate Health Care Costs

Enter a treatment or service

Tonsillectomy and Adenoidectomy

Location

Albemarle, NC

Estimated Treatment Cost Results

Cost estimates are averages based on historical BCBSNC claims data. Amounts listed typically include physician fees, facility fees and costs for things like anesthesia, drugs, medical supplies – as well as customer responsibility (deductible, co-pay and co-insurance). Your actual costs may be different based on variations in these factors as well as your health plan design, deductibles/co-insurance and out-of-pocket limits.

HOPD: Hospital Outpatient Department

Non-HOPD: Non-Hospital Outpatient Department

Gateway Surgery Center
Non-HOPD
1025 NE Gateway Ct NE
Concord, NC 28025

Blue Options, Blue Advantage
$2,696

Union West Surgery Center
Non-HOPD
6068 W Highway 74
Indian Trail, NC 28079

Blue Value
$3,135
Blue Options, Blue Advantage
$3,135

Novant Health Rowan Medical Center
HOPD
612 Mocksville Ave
Salisbury, NC 28144

Blue Value
$5,255
Blue Options, Blue Advantage
$5,786

Stanly Regional Medical Center
HOPD
301 Yadkin St
Albemarle, NC 28001

Blue Value
$8,447
Blue Options, Blue Advantage
$8,447

Estimate Health Care Costs

[redacted]ter a treatment or service

ACL Repair by Arthroscopy

Location

Charlotte, NC

Estimated Treatment Cost Results

Cost estimates are averages based on historical BCBSNC claims data. Amounts listed typically include physician fees, facility fees and costs for things like anesthesia, drugs, medical supplies – as well as customer responsibility (deductible, co-pay and co-insurance). Your actual costs may be different based on variations in these factors as well as your health plan design, deductibles/co-insurance and out-of-pocket limits.

HOPD: Hospital Outpatient Department

Non-HOPD: Non-Hospital Outpatient Department

Gateway Surgery Center
Non-HOPD
1025 NE Gateway Ct NE
Concord, NC 28025

Blue Value
$9,710
Blue Options, Blue Advantage
$9,710

[redacted]harlotte Surgery Center
[redacted]-HOPD
[redacted]25 Randolph Rd
Charlotte, NC 28211

Blue Value
$10,800
Blue Options, Blue Advantage
$10,800

Caromont Regional Medical Center
HOPD
2525 Court Dr
Gastonia, NC 28054

Blue Options, Blue Advantage
$12,496

Presbyterian Surgery Center at Huntersville
HOPD
10030 Gilead Rd
Huntersville, NC 28078

Blue Value
$16,355
Blue Options, Blue Advantage
$16,355

Carolina Center for Specialty Surgery
HOPD
1822 Brunswick Ave
Charlotte, NC 28207

Blue Value
$17,228
Blue Options, Blue Advantage
$17,228

Carolinas Medical Center-Mercy
HOPD
2001 Vail Ave
Charlotte, NC 28207

Blue Options, Blue Advantage
$24,451

Carolinas Medical Center-Pineville
HOPD
[redacted]0628 Park Rd
[redacted]lotte, NC 28210

Blue Options, Blue Advantage
$24,799

Novant Health Charlotte Orthopedic
HOPD
1901 Randolph Rd
Charlotte, NC 28207

Blue Value
$29,565
Blue Options, Blue Advantage
$29,565

Estimate Health Care Costs

Enter a treatment or service

Bunionectomy

Location

Charlotte, NC

Estimated Treatment Cost Results

Cost estimates are averages based on historical BCBSNC claims data. Amounts listed typically include physician fees, facility fees and costs for things like anesthesia, drugs, medical supplies – as well as customer responsibility (deductible, co-pay and co-insurance). Your actual costs may be different based on variations in these factors as well as your health plan design, deductibles/co-insurance and out-of-pocket limits.

HOPD: Hospital Outpatient Department

Non-HOPD: Non-Hospital Outpatient Department

Union West Surgery Center
HOPD
6068 W Highway 74
Indian Trail, NC 28079

Blue Options, Blue Advantage
$3,071

Gateway Surgery Center
Non-HOPD
1025 NE Gateway Ct NE
Concord, NC 28025

Blue Options, Blue Advantage
$3,341

Charlotte Surgery Center
Non-HOPD
2825 Randolph Rd
Charlotte, NC 28211

Blue Options, Blue Advantage
$4,273

Gaston Memorial Hospital
HOPD
2525 Court Dr
Gastonia, NC 28054

Blue Options, Blue Advantage
$5,499

Novant Health Ballantyne Outpatient
HOPD
14215 Ballantyne Corporate Pl
Charlotte, NC 28277

Blue Value
$7,277
Blue Options, Blue Advantage
$7,277

Novant Health Matthews Medical Center
HOPD
1500 Matthews Township Pkwy
Matthews, NC 28105

Blue Value
$11,838
Blue Options, Blue Advantage
$13,194

Novant Health Charlotte Orthopedic
HOPD
1901 Randolph Rd
Charlotte, NC 28207

Blue Value
$14,013
Blue Options, Blue Advantage
$14,013

Carolinas Medical Center-Mercy
HOPD
2001 Vail Ave
Charlotte, NC 28207

Blue Options, Blue Advantage
$15,526

Estimate Health Care Costs

[redacted]ter a treatment or service

Cataract Removal

Location

Charlotte, NC

Estimated Treatment Cost Results

Cost estimates are averages based on historical BCBSNC claims data. Amounts listed typically include physician fees, facility fees and costs for things like anesthesia, drugs, medical supplies – as well as customer responsibility (deductible, co-pay and co-insurance). Your actual costs may be different based on variations in these factors as well as your health plan design, deductibles/co-insurance and out-of-pocket limits.

HOPD: Hospital Outpatient Department

Non-HOPD: Non-Hospital Outpatient Department

Eye Surgery & Laser Clinic **Non-HOPD** 201 Le Phillip Ct NE Concord, NC 28025	Blue Options, Blue Advantage **$1,643**
[redacted]outhpark Surgery Center **[redacted]-HOPD** [redacted]035 Fairview Rd Charlotte, NC 28210	Blue Value **$2,436** Blue Options, Blue Advantage **$2,436**
Charlotte Surgery Center **Non-HOPD** 2825 Randolph Rd Charlotte, NC 28211	Blue Options, Blue Advantage **$2,736**
Caromont Specialty Surgery **HOPD** 2511 Court Dr Gastonia, NC 28054	Blue Options, Blue Advantage **$2,737**
Union West Surgery Center **HOPD** 6068 W Highway 74 Indian Trail, NC 28079	Blue Options, Blue Advantage **$3,717**
Presbyterian Surgery Center at Huntersville **HOPD** 10030 Gilead Rd Huntersville, NC 28078	Blue Value **$5,241** Blue Options, Blue Advantage **$5,241**
Carolinas Medical Center University **HOPD** 8800 N Tryon St [redacted]rlotte, NC 28262	Blue Value **$8,594** Blue Options, Blue Advantage **$8,594**
Novant Health Presbyterian Med Center **HOPD** 200 Hawthorne Ln Charlotte, NC 28204	Blue Value **$10,687** Blue Options, Blue Advantage **$11,871**

Estimate Health Care Costs

Enter a treatment or service

CT Scan Head/Brain

Location

Charlotte, NC

Estimated Treatment Cost Results

Cost estimates are averages based on historical BCBSNC claims data. Amounts listed typically include physician fees, facility fees and costs for things like anesthesia, drugs, medical supplies – as well as customer responsibility (deductible, co-pay and co-insurance). Your actual costs may be different based on variations in these factors as well as your health plan design, deductibles/co-insurance and out-of-pocket limits.

HOPD: Hospital Outpatient Department

Non-HOPD: Non-Hospital Outpatient Department

Robert Cherichella **Non-HOPD** 1001 Blythe Blvd, CMC Childrens Specialty Charlotte, NC 28203	Blue Options, Blue Advantage **$346**
Carolina Neurosurgery & Spine Associates **Non-HOPD** 225 Baldwin Ave Charlotte, NC 28204	Blue Value **$461** Blue Options, Blue Advantage **$461**
Novant Health Presbyterian Med Center **HOPD** 200 Hawthorne Ln Charlotte, NC 28204	Blue Value **$695** Blue Options, Blue Advantage **$777**
Gaston Memorial Hospital **HOPD** 2525 Court Dr Gastonia, NC 28054	Blue Options, Blue Advantage **$769**
Carolinas Medical Center University **HOPD** 8800 N Tryon St Charlotte, NC 28262	Blue Value **$802** Blue Options, Blue Advantage **$802**
Caromont Regional Medical Center **HOPD** 2525 Court Dr Gastonia, NC 28054	Blue Options, Blue Advantage **$937**
Novant Health Charlotte Orthopedic **HOPD** 1901 Randolph Rd Charlotte, NC 28207	Blue Value **$964** Blue Options, Blue Advantage **$964**
Carolinas Medical Center **HOPD** 1000 Blythe Blvd Charlotte, NC 28203	Blue Options, Blue Advantage **$1,072**
CMC Northeast **HOPD** 920 Church St N Concord, NC 28025	Blue Options, Blue Advantage **$1,473**

Estimate Health Care Costs

[redacted]ter a treatment or service

Hernia

Location

Charlotte, NC

Estimated Treatment Cost Results

Cost estimates are averages based on historical BCBSNC claims data. Amounts listed typically include physician fees, facility fees and costs for things like anesthesia, drugs, medical supplies – as well as customer responsibility (deductible, co-pay and co-insurance). Your actual costs may be different based on variations in these factors as well as your health plan design, deductibles/co-insurance and out-of-pocket limits.

HOPD: Hospital Outpatient Department

Non-HOPD: Non-Hospital Outpatient Department

Gateway Surgery Center
Non-HOPD
1025 NE Gateway Ct NE
Concord, NC 28025

Blue Options, Blue Advantage
$3,357

Gaston Memorial Hospital
[redacted]PD
[redacted]5 Court Dr
Gastonia, NC 28054

Blue Options, Blue Advantage
$7,481

Caromont Regional Medical Center
HOPD
2525 Court Dr
Gastonia, NC 28054

Blue Options, Blue Advantage
$7,506

Novant Health Matthews Medical Center
HOPD
1500 Matthews Township Pkwy
Matthews, NC 28105

Blue Value
$8,238
Blue Options, Blue Advantage
$9,173

CMC Northeast
HOPD
920 Church St N
Concord, NC 28025

Blue Options, Blue Advantage
$8,958

Carolinas Medical Center University
HOPD
8800 N Tryon St
Charlotte, NC 28262

Blue Value
$9,124
Blue Options, Blue Advantage
$9,124

Novant Health Huntersville Med Center
HOPD
10030 Gilead Rd
[redacted]ntersville, NC 28078

Blue Value
$9,462
Blue Options, Blue Advantage
$10,564

Novant Health Presbyterian Med Center
HOPD
200 Hawthorne Ln
Charlotte, NC 28204

Blue Value
$12,038
Blue Options, Blue Advantage
$13,434

Estimate Health Care Costs

Enter a treatment or service

Nasal/Sinus - Corrective Surgery

Location

Charlotte, NC

Estimated Treatment Cost Results

Cost estimates are averages based on historical BCBSNC claims data. Amounts listed typically include physician fees, facility fees and costs for things like anesthesia, drugs, medical supplies – as well as customer responsibility (deductible, co-pay and co-insurance). Your actual costs may be different based on variations in these factors as well as your health plan design, deductibles/co-insurance and out-of-pocket limits.

HOPD: Hospital Outpatient Department

Non-HOPD: Non-Hospital Outpatient Department

Southpark Surgery Center **Non-HOPD** 6035 Fairview Rd Charlotte, NC 28210	Blue Value **$4,434** Blue Options, Blue Advantage **$4,434**
Caromont Specialty Surgery **HOPD** 2511 Court Dr Gastonia, NC 28054	Blue Value **$4,745** Blue Options, Blue Advantage **$4,745**
Gateway Surgery Center **Non-HOPD** 1025 NE Gateway Ct NE Concord, NC 28025	Blue Options, Blue Advantage **$5,346**
Union West Surgery Center **HOPD** 6068 W Highway 74 Indian Trail, NC 28079	Blue Value **$7,979** Blue Options, Blue Advantage **$7,979**
Novant Health Presbyterian Med Center **HOPD** 200 Hawthorne Ln Charlotte, NC 28204	Blue Value **$9,948** Blue Options, Blue Advantage **$10,965**
Presbyterian Surgery Center at Huntersville **HOPD** 10030 Gilead Rd Huntersville, NC 28078	Blue Value **$15,346** Blue Options, Blue Advantage **$15,346**
Carolinas Medical Center University **HOPD** 8800 N Tryon St Charlotte, NC 28262	Blue Value **$16,292** Blue Options, Blue Advantage **$16,292**
Carolinas Medical Center **HOPD** 1000 Blythe Blvd Charlotte, NC 28203	Blue Options, Blue Advantage **$27,164**

Estimate Health Care Costs

[redacted]ter a treatment or service

Rotator Cuff Repair

Location

Charlotte, NC

Estimated Treatment Cost Results

Cost estimates are averages based on historical BCBSNC claims data. Amounts listed typically include physician fees, facility fees and costs for things like anesthesia, drugs, medical supplies – as well as customer responsibility (deductible, co-pay and co-insurance). Your actual costs may be different based on variations in these factors as well as your health plan design, deductibles/co-insurance and out-of-pocket limits.

HOPD: Hospital Outpatient Department

Non-HOPD: Non-Hospital Outpatient Department

Carolinas Medical Center University
HOPD
8800 N Tryon St
Charlotte, NC 28262

Blue Value
$16,047
Blue Options, Blue Advantage
$16,047

[redacted]vant Health Presbyterian Med Center
[redacted]PD
200 Hawthorne Ln
Charlotte, NC 28204

Blue Value
$16,522
Blue Options, Blue Advantage
$18,129

Caromont Regional Medical Center
HOPD
2525 Court Dr
Gastonia, NC 28054

Blue Options, Blue Advantage
$18,811

Carolinas Medical Center
HOPD
1000 Blythe Blvd
Charlotte, NC 28203

Blue Options, Blue Advantage
$26,185

Estimate Health Care Costs

Enter a treatment or service

Tonsillectomy and Adenoidectomy

Location

Charlotte, NC

Estimated Treatment Cost Results

Cost estimates are averages based on historical BCBSNC claims data. Amounts listed typically include physician fees, facility fees and costs for things like anesthesia, drugs, medical supplies – as well as customer responsibility (deductible, co-pay and co-insurance). Your actual costs may be different based on variations in these factors as well as your health plan design, deductibles/co-insurance and out-of-pocket limits.

HOPD: Hospital Outpatient Department

Non-HOPD: Non-Hospital Outpatient Department

Caromont Specialty Surgery **HOPD** 2511 Court Dr Gastonia, NC 28054	Blue Value **$2,135** Blue Options, Blue Advantage **$2,135**
Southpark Surgery Center **Non-HOPD** 6035 Fairview Rd Charlotte, NC 28210	Blue Value **$2,238** Blue Options, Blue Advantage **$2,238**
Gateway Surgery Center **Non-HOPD** 1025 NE Gateway Ct NE Concord, NC 28025	Blue Value **$2,664** Blue Options, Blue Advantage **$2,664**
Union West Surgery Center **HOPD** 6068 W Highway 74 Indian Trail, NC 28079	Blue Value **$2,730** Blue Options, Blue Advantage **$2,730**
Carolinas Medical Center University **HOPD** 8800 N Tryon St Charlotte, NC 28262	Blue Value **$6,305** Blue Options, Blue Advantage **$6,305**
Carolinas Medical Center **HOPD** 1000 Blythe Blvd Charlotte, NC 28203	Blue Options, Blue Advantage **$8,733**

Estimate Health Care Costs

[redacted]ter a treatment or service

Tympanostomy and Myringotomy

Location

Charlotte, NC

Estimated Treatment Cost Results

Cost estimates are averages based on historical BCBSNC claims data. Amounts listed typically include physician fees, facility fees and costs for things like anesthesia, drugs, medical supplies – as well as customer responsibility (deductible, co-pay and co-insurance). Your actual costs may be different based on variations in these factors as well as your health plan design, deductibles/co-insurance and out-of-pocket limits.

HOPD: Hospital Outpatient Department

Non-HOPD: Non-Hospital Outpatient Department

Southpark Surgery Center **Non-HOPD** 6035 Fairview Rd Charlotte, NC 28210	Blue Value **$2,008** Blue Options, Blue Advantage **$2,008**
[redacted]teway Surgery Center **[redacted]-HOPD** [redacted]025 NE Gateway Ct NE Concord, NC 28025	Blue Options, Blue Advantage **$2,127**
Caromont Specialty Surgery **HOPD** 2511 Court Dr Gastonia, NC 28054	Blue Value **$2,182** Blue Options, Blue Advantage **$2,182**
Union West Surgery Center **HOPD** 6068 W Highway 74 Indian Trail, NC 28079	Blue Value **$2,453** Blue Options, Blue Advantage **$2,453**
Presbyterian Surgery Center at Huntersville **HOPD** 10030 Gilead Rd Huntersville, NC 28078	Blue Options, Blue Advantage **$4,264**
Novant Health Presbyterian Med Center **HOPD** 200 Hawthorne Ln Charlotte, NC 28204	Blue Value **$4,359** Blue Options, Blue Advantage **$4,807**
Carolinas Medical Center University **HOPD** 8800 N Tryon St [redacted]lotte, NC 28262	Blue Value **$4,811** Blue Options, Blue Advantage **$4,811**
Presbyterian Surgery Center at Huntersville **HOPD** 10030 Gilead Rd Huntersville, NC 28078	Blue Value **$4,924** Blue Options, Blue Advantage **$4,924**

Estimate Health Care Costs

[redacted]ter a treatment or service

ACL Repair by Arthroscopy

Location

Dunn, NC

Estimated Treatment Cost Results

Cost estimates are averages based on historical BCBSNC claims data. Amounts listed typically include physician fees, facility fees and costs for things like anesthesia, drugs, medical supplies – as well as customer responsibility (deductible, co-pay and co-insurance). Your actual costs may be different based on variations in these factors as well as your health plan design, deductibles/co-insurance and out-of-pocket limits.

HOPD: Hospital Outpatient Department

Non-HOPD: Non-Hospital Outpatient Department

Fayetteville Ambulatory Surgical
[redacted]-HOPD
[redacted] Metromedical Dr
Fayetteville, NC 28304

Blue Value
$11,855
Blue Options, Blue Advantage
$11,855

Betsy Johnson Reg Hospital
HOPD
800 Tilghman Dr
Dunn, NC 28334

Blue Value
$21,407
Blue Options, Blue Advantage
$21,407

High and low costs for the same procedure in the Raleigh area are shown below for comparison.

James E. Davis Ambulatory Surgery Center
HOPD
120 Carver St
Durham, NC 27704

Blue Options, Blue Advantage
$8,839

Duke Raleigh Hospital
HOPD
3400 Wake Forest Rd
Raleigh, NC 27609

Blue Options, Blue Advantage
$20,389

Enter a treatment or service

Bunionectomy

Location

Dunn, NC

Incomplete Data - Information for Betsy Johnson Reg Hospital Not Available on BCBS Cost Estimator

Estimated Treatment Cost Results

Cost estimates are averages based on historical BCBSNC claims data. Amounts listed typically include physician fees, facility fees and costs for things like anesthesia, drugs, medical supplies – as well as customer responsibility (deductible, co-pay and co-insurance). Your actual costs may be different based on variations in these factors as well as your health plan design, deductibles/co-insurance and out-of-pocket limits.

HOPD: Hospital Outpatient Department

Non-HOPD: Non-Hospital Outpatient Department

Fayetteville Ambulatory Surgical
Non-HOPD
1781 Metromedical Dr
Fayetteville, NC 28304

Blue Value
$4,413
Blue Options, Blue Advantage
$4,413

High and low costs for the same procedure in the Raleigh area are shown below for comparison.

Blue Ridge Surgery Center
Non-HOPD
2308 Wesvill Ct
Raleigh, NC 27607

Blue Value
$3,604
Blue Options, Blue Advantage
$3,604

Capital City Surgery Center LLC
HOPD
23 Sunnybrook Rd, Ste 100
Raleigh, NC 27610

Blue Value
$13,346
Blue Options, Blue Advantage
$13,346

Estimate Health Care Costs

[redacted]ter a treatment or service

Cataract Removal

Location

Dunn, NC

Estimated Treatment Cost Results

Cost estimates are averages based on historical BCBSNC claims data. Amounts listed typically include physician fees, facility fees and costs for things like anesthesia, drugs, medical supplies – as well as customer responsibility (deductible, co-pay and co-insurance). Your actual costs may be different based on variations in these factors as well as your health plan design, deductibles/co-insurance and out-of-pocket limits.

HOPD: Hospital Outpatient Department

Non-HOPD: Non-Hospital Outpatient Department

Fayetteville Ambulatory Surgical
Non-HOPD
1781 Metromedical Dr
Fayetteville, NC 28304

Blue Value
$3,373
Blue Options, Blue Advantage
$3,373

[redacted]entral Carolina Hospital
[redacted]PD
[redacted]35 Carthage St
Sanford, NC 27330

Blue Value
$4,741
Blue Options, Blue Advantage
$4,741

Betsy Johnson Reg Hospital
HOPD
800 Tilghman Dr
Dunn, NC 28334

Blue Value
$5,044
Blue Options, Blue Advantage
$5,044

Cape Fear Valley Medical Center
HOPD
1638 Owen Dr
Fayetteville, NC 28304

Blue Options, Blue Advantage
$6,122

Estimate Health Care Costs

Enter a treatment or service

CT Scan Head/Brain

Location

Dunn, NC

Estimated Treatment Cost Results

Cost estimates are averages based on historical BCBSNC claims data. Amounts listed typically include physician fees, facility fees and costs for things like anesthesia, drugs, medical supplies – as well as customer responsibility (deductible, co-pay and co-insurance). Your actual costs may be different based on variations in these factors as well as your health plan design, deductibles/co-insurance and out-of-pocket limits.

HOPD: Hospital Outpatient Department

Non-HOPD: Non-Hospital Outpatient Department

Ibrahim Oudeh **Non-HOPD** 731 Tilghman Dr Dunn, NC 28334	Blue Value **$256** Blue Options, Blue Advantage **$256**
Carolina Imaging LLC of Fayetteville **Non-HOPD** 3628 Cape Center Dr Fayetteville, NC 28304	Blue Value **$349** Blue Options, Blue Advantage **$349**
David Fisher **Non-HOPD** 169 Rawls Rd Angier, NC 27501	Blue Value **$355** Blue Options, Blue Advantage **$355**
Cancer Centers of North Carolina **Non-HOPD** 805 Tilghman Dr, Ste C Dunn, NC 28334	Blue Value **$367** Blue Options, Blue Advantage **$367**
Eastern Carolina Med Center **HOPD** 1 Medical Dr Benson, NC 27504	Blue Value **$376** Blue Options, Blue Advantage **$376**
Central Carolina Hospital **HOPD** 1135 Carthage St Sanford, NC 27330	Blue Value **$450** Blue Options, Blue Advantage **$450**
Betsy Johnson Reg Hospital **HOPD** 800 Tilghman Dr Dunn, NC 28334	Blue Value **$1,316** Blue Options, Blue Advantage **$1,316**
Cape Fear Valley Medical Center **HOPD** 1638 Owen Dr Fayetteville, NC 28304	Blue Value **$1,408** Blue Options, Blue Advantage **$1,408**

Estimate Health Care Costs

[redacted]ter a treatment or service

Hernia

Location

Dunn, NC

Estimated Treatment Cost Results

Cost estimates are averages based on historical BCBSNC claims data. Amounts listed typically include physician fees, facility fees and costs for things like anesthesia, drugs, medical supplies – as well as customer responsibility (deductible, co-pay and co-insurance). Your actual costs may be different based on variations in these factors as well as your health plan design, deductibles/co-insurance and out-of-pocket limits.

HOPD: Hospital Outpatient Department

Non-HOPD: Non-Hospital Outpatient Department

Fayetteville Ambulatory Surgical **Non-HOPD** [redacted]1 Metromedical Dr [redacted]etteville, NC 28304	Blue Value **$3,339** Blue Options, Blue Advantage **$3,339**
Cape Fear Valley Medical Center **HOPD** 1638 Owen Dr Fayetteville, NC 28304	Blue Value **$8,607** Blue Options, Blue Advantage **$8,607**
Betsy Johnson Reg Hospital **HOPD** 800 Tilghman Dr Dunn, NC 28334	Blue Value **$11,816** Blue Options, Blue Advantage **$11,816**
Central Carolina Hospital **HOPD** 1135 Carthage St Sanford, NC 27330	Blue Value **$13,067** Blue Options, Blue Advantage **$13,067**

Estimate Health Care Costs

Enter a treatment or service

Nasal/Sinus - Corrective Surgery

Location

Dunn, NC

Estimated Treatment Cost Results

Cost estimates are averages based on historical BCBSNC claims data. Amounts listed typically include physician fees, facility fees and costs for things like anesthesia, drugs, medical supplies – as well as customer responsibility (deductible, co-pay and co-insurance). Your actual costs may be different based on variations in these factors as well as your health plan design, deductibles/co-insurance and out-of-pocket limits.

HOPD: Hospital Outpatient Department

Non-HOPD: Non-Hospital Outpatient Department

Fayetteville Ambulatory Surgical
Non-HOPD
1781 Metromedical Dr
Fayetteville, NC 28304

Blue Value
$6,018
Blue Options, Blue Advantage
$6,018

High and low costs for the same procedure in the Raleigh area are shown below for comparison.

Blue Ridge Surgery Center
Non-HOPD
2308 Wesvill Ct
Raleigh, NC 27607

Blue Value
$4,702
Blue Options, Blue Advantage
$4,702

Capital City Surgery Center LLC
HOPD
23 Sunnybrook Rd, Ste 100
Raleigh, NC 27610

Blue Options, Blue Advantage
$20,029

Estimate Health Care Costs

Enter a treatment or service

Rotator Cuff Repair

Location

Dunn, NC

Estimated Treatment Cost Results

Cost estimates are averages based on historical BCBSNC claims data. Amounts listed typically include physician fees, facility fees and costs for things like anesthesia, drugs, medical supplies – as well as customer responsibility (deductible, co-pay and co-insurance). Your actual costs may be different based on variations in these factors as well as your health plan design, deductibles/co-insurance and out-of-pocket limits.

HOPD: Hospital Outpatient Department

Non-HOPD: Non-Hospital Outpatient Department

Fayetteville Ambulatory Surgical
Non-HOPD
1781 Metromedical Dr
Fayetteville, NC 28304

Blue Value
$9,476
Blue Options, Blue Advantage
$9,476

High and low costs for the same procedure in the Raleigh area are shown below for comparison.

Blue Ridge Surgery Center
Non-HOPD
2308 Wesvill Ct
Raleigh, NC 27607

Blue Value
$9,164
Blue Options, Blue Advantage
$9,164

Duke University Hospital
HOPD
2301 Erwin Rd
Durham, NC 27710

Blue Options, Blue Advantage
$19,577

Estimate Health Care Costs

Enter a treatment or service

Tonsillectomy and Adenoidectomy

Location

Dunn, NC

Estimated Treatment Cost Results

Cost estimates are averages based on historical BCBSNC claims data. Amounts listed typically include physician fees, facility fees and costs for things like anesthesia, drugs, medical supplies – as well as customer responsibility (deductible, co-pay and co-insurance). Your actual costs may be different based on variations in these factors as well as your health plan design, deductibles/co-insurance and out-of-pocket limits.

HOPD: Hospital Outpatient Department

Non-HOPD: Non-Hospital Outpatient Department

Fayetteville Ambulatory Surgical
Non-HOPD
1781 Metromedical Dr
Fayetteville, NC 28304

Blue Value
$3,111
Blue Options, Blue Advantage
$3,111

Central Carolina Hospital
HOPD
1135 Carthage St
Sanford, NC 27330

Blue Value
$6,258
Blue Options, Blue Advantage
$6,258

High and low costs for the same procedure in the Raleigh area are shown below for comparison.

Blue Ridge Surgery Center
Non-HOPD
2308 Wesvill Ct
Raleigh, NC 27607

Blue Value
$2,850
Blue Options, Blue Advantage
$2,850

Duke Raleigh Hospital
HOPD
3400 Wake Forest Rd
Raleigh, NC 27609

Blue Options, Blue Advantage
$7,366

Estimate Health Care Costs

[redacted]ter a treatment or service

Tympanostomy and Myringotomy

Location

Dunn, NC

Estimated Treatment Cost Results

Cost estimates are averages based on historical BCBSNC claims data. Amounts listed typically include physician fees, facility fees and costs for things like anesthesia, drugs, medical supplies – as well as customer responsibility (deductible, co-pay and co-insurance). Your actual costs may be different based on variations in these factors as well as your health plan design, deductibles/co-insurance and out-of-pocket limits.

HOPD: Hospital Outpatient Department

Non-HOPD: Non-Hospital Outpatient Department

Fayetteville Ambulatory Surgical
Non-HOPD
[redacted]1 Metromedical Dr
[redacted]etteville, NC 28304

Blue Value
$3,156
Blue Options, Blue Advantage
$3,156

Central Carolina Hospital
HOPD
1135 Carthage St
Sanford, NC 27330

Blue Value
$3,919
Blue Options, Blue Advantage
$3,919

High and low costs for the same procedure in the Raleigh area are shown below for comparison.

North Carolina Specialty Hospital
Non-HOPD
3916 Ben Franklin Blvd
Durham, NC 27704

Blue Options, Blue Advantage
$2,114

UNC Hospitals
HOPD
101 Manning Dr
Chapel Hill, NC 27514

Blue Value
$11,380
Blue Options, Blue Advantage
$13,812

[redacted]

Estimate Health Care Costs

Enter a treatment or service

Bunionectomy

Location

Durham, NC

Estimated Treatment Cost Results

Cost estimates are averages based on historical BCBSNC claims data. Amounts listed typically include physician fees, facility fees and costs for things like anesthesia, drugs, medical supplies – as well as customer responsibility (deductible, co-pay and co-insurance). Your actual costs may be different based on variations in these factors as well as your health plan design, deductibles/co-insurance and out-of-pocket limits.

HOPD: Hospital Outpatient Department **Non-HOPD:** Non-Hospital Outpatient Department

Blue Ridge Surgery Center **Non-HOPD** 2308 Wesvill Ct Raleigh, NC 27607	Blue Options, Blue Advantage **$3,649**
James E. Davis Ambulatory Surgery Center **HOPD** 120 Carver St Durham, NC 27704	Blue Options, Blue Advantage **$4,623**
Triangle Orthopaedics Surgery Center LLC **Non-HOPD** 7921 ACC Blvd Raleigh, NC 27617	Blue Value **$4,757** Blue Options, Blue Advantage **$4,757**
WakeMed **HOPD** 3000 New Bern Ave Raleigh, NC 27610	Blue Options, Blue Advantage **$6,863**
Raleigh Orthopaedic Surgery Center **HOPD (Joint Physician Ownership)** 3001 Edwards Mill Rd, Ste 100 Raleigh, NC 27612	Blue Value **$7,248** Blue Options, Blue Advantage **$7,248**
UNC Hospitals **HOPD** 101 Manning Dr Chapel Hill, NC 27514	Blue Value **$9,955** Blue Options, Blue Advantage **$11,869**
Rex Hospital **HOPD** 4420 Lake Boone Trl Raleigh, NC 27607	Blue Value **$12,768** Blue Options, Blue Advantage **$15,332**
Capital City Surgery Center LLC **HOPD (Joint Physician Ownership)** 23 Sunnybrook Rd, Ste 100 Raleigh, NC 27610	Blue Value **$13,346** Blue Options, Blue Advantage **$13,346**
Duke University Hospital **HOPD** 3916 Ben Franklin Blvd Durham, NC 27704	Blue Options, Blue Advantage **$16,435**

Estimate Health Care Costs

Enter a treatment or service

Cataract Removal

Location

Durham, NC

Estimated Treatment Cost Results

Cost estimates are averages based on historical BCBSNC claims data. Amounts listed typically include physician fees, facility fees and costs for things like anesthesia, drugs, medical supplies – as well as customer responsibility (deductible, co-pay and co-insurance). Your actual costs may be different based on variations in these factors as well as your health plan design, deductibles/co-insurance and out-of-pocket limits.

HOPD: Hospital Outpatient Department **Non-HOPD:** Non-Hospital Outpatient Department

Blue Ridge Surgery Center **Non-HOPD** 2308 Wesvill Ct Raleigh, NC 27607	Blue Value **$2,973** Blue Options, Blue Advantage **$2,973**
North Carolina Specialty Hospital **HOPD (Physician Owned)** 3916 Ben Franklin Blvd Durham, NC 27704	Blue Value **$3,682** Blue Options, Blue Advantage **$3,682**
James E. Davis Ambulatory Surgery Center **HOPD** 120 Carver St Durham, NC 27704	Blue Options, Blue Advantage **$4,841**
WakeMed **HOPD** 3000 New Bern Ave Raleigh, NC 27610	Blue Options, Blue Advantage **$5,106**
Rex Hospital **HOPD** 4420 Lake Boone Trl Raleigh, NC 27607	Blue Options, Blue Advantage **$6,360**
Duke Raleigh Hospital **HOPD** 3400 Wake Forest Rd Raleigh, NC 27609	Blue Options, Blue Advantage **$7,823**
UNC Hospitals **HOPD** 101 Manning Dr Chapel Hill, NC 27514	Blue Value **$10,424** Blue Options, Blue Advantage **$10,424**
Duke University Hospital **HOPD** 2301 Erwin Rd Durham, NC 27710	Blue Options, Blue Advantage **$10,500**

NC Estimate Health Care Costs

Enter a treatment or service

CT Scan Head/Brain

Location

Durham, NC

Estimated Treatment Cost Results

Cost estimates are averages based on historical BCBSNC claims data. Amounts listed typically include physician fees, facility fees and costs for things like anesthesia, drugs, medical supplies – as well as customer responsibility (deductible, co-pay and co-insurance). Your actual costs may be different based on variations in these factors as well as your health plan design, deductibles/co-insurance and out-of-pocket limits.

HOPD: Hospital Outpatient Department **Non-HOPD:** Non-Hospital Outpatient Department

Raleigh Radiology **Non-HOPD** 3900 Barrett Dr, Ste 100 Raleigh Radiology Breast Center Raleigh, NC 27609	Blue Value **$328** Blue Options, Blue Advantage **$328**
Triangle Medical Park **Non-HOPD** 5107 S Park Dr, Ste 101 Durham, NC 27713	Blue Value **$351** Blue Options, Blue Advantage **$351**
Wake Radiology Diagnostic Imaging **Non-HOPD** 300 Ashville Ave, Ste 100 Cary, NC 27518	Blue Value **$531** Blue Options, Blue Advantage **$531**
Rex Hospital **HOPD** 4420 Lake Boone Trl Raleigh, NC 27607	Blue Value **$750** Blue Options, Blue Advantage **$919**
UNC Hospitals **HOPD** 101 Manning Dr Chapel Hill, NC 27514	Blue Value **$773** Blue Options, Blue Advantage **$939**
Duke University Hospital **HOPD** 2301 Erwin Rd Durham, NC 27710	Blue Options, Blue Advantage **$928**
Duke Regional Hospital **HOPD** 3643 N Roxboro St Durham, NC 27704	Blue Options, Blue Advantage **$1,177**

Estimate Health Care Costs

Enter a treatment or service

Nasal/Sinus - Corrective Surgery

Location

Durham, NC

Estimated Treatment Cost Results

Cost estimates are averages based on historical BCBSNC claims data. Amounts listed typically include physician fees, facility fees and costs for things like anesthesia, drugs, medical supplies – as well as customer responsibility (deductible, co-pay and co-insurance). Your actual costs may be different based on variations in these factors as well as your health plan design, deductibles/co-insurance and out-of-pocket limits.

HOPD: Hospital Outpatient Department **Non-HOPD:** Non-Hospital Outpatient Department

North Carolina Specialty Hospital **HOPD (Physician Owned)** 3916 Ben Franklin Blvd Durham, NC 27704	Blue Options, Blue Advantage **$4,906**
Blue Ridge Surgery Center **Non-HOPD** 2308 Wesvill Ct Raleigh, NC 27607	Blue Value **$5,625** Blue Options, Blue Advantage **$5,625**
James E. Davis Ambulatory Surgery Center **HOPD** 120 Carver St Durham, NC 27704	Blue Options, Blue Advantage **$6,843**
WakeMed **HOPD** 3000 New Bern Ave Raleigh, NC 27610	Blue Options, Blue Advantage **$7,922**
Duke University Hospital **Non-HOPD** 2301 Erwin Rd Durham, NC 27710	Blue Options, Blue Advantage **$9,629**
Capital City Surgery Center LLC **HOPD (Joint Physician Ownership)** 23 Sunnybrook Rd, Ste 100 Raleigh, NC 27610	Blue Value **$12,268** Blue Options, Blue Advantage **$12,268**
Rex Hospital **HOPD** 4420 Lake Boone Trl Raleigh, NC 27607	Blue Options, Blue Advantage **$15,867**

Estimate Health Care Costs

Enter a treatment or service

Tonsillectomy and Adenoidectomy

Location

Durham, NC

Estimated Treatment Cost Results

Cost estimates are averages based on historical BCBSNC claims data. Amounts listed typically include physician fees, facility fees and costs for things like anesthesia, drugs, medical supplies – as well as customer responsibility (deductible, co-pay and co-insurance). Your actual costs may be different based on variations in these factors as well as your health plan design, deductibles/co-insurance and out-of-pocket limits.

HOPD: Hospital Outpatient Department **Non-HOPD:** Non-Hospital Outpatient Department

North Carolina Specialty Hospital **HOPD (Physician Owned)** 3916 Ben Franklin Blvd Durham, NC 27704	Blue Options, Blue Advantage **$2,899**
Blue Ridge Surgery Center **Non-HOPD** 2308 Wesvill Ct Raleigh, NC 27607	Blue Value **$3,108** Blue Options, Blue Advantage **$3,108**
James E. Davis Ambulatory Surgery Center **HOPD** 120 Carver St Durham, NC 27704	Blue Options, Blue Advantage **$3,344**
Capital City Surgery Center LLC **HOPD (Joint Physician Ownership)** 23 Sunnybrook Rd, Ste 100 Raleigh, NC 27610	Blue Value **$5,077** Blue Options, Blue Advantage **$5,077**
WakeMed **HOPD** 3000 New Bern Ave Raleigh, NC 27610	Blue Options, Blue Advantage **$5,760**
Duke University Hospital **HOPD** 2301 Erwin Rd Durham, NC 27710	Blue Options, Blue Advantage **$6,140**
Rex Hospital **HOPD** 4420 Lake Boone Trl Raleigh, NC 27607	Blue Value **$7,079** Blue Options, Blue Advantage **$8,485**
Duke Raleigh Hospital **HOPD** 3400 Wake Forest Rd Raleigh, NC 27609	Blue Options, Blue Advantage **$7,366**

NC Estimate Health Care Costs

Enter a treatment or service

ACL Repair by Arthroscopy

Location

Fayetteville, NC

Incomplete Data - Information for Cape Fear Valley Medical Center Not Available on BCBS Cost Estimator

Estimated Treatment Cost Results

Cost estimates are averages based on historical BCBSNC claims data. Amounts listed typically include physician fees, facility fees and costs for things like anesthesia, drugs, medical supplies – as well as customer responsibility (deductible, co-pay and co-insurance). Your actual costs may be different based on variations in these factors as well as your health plan design, deductibles/co-insurance and out-of-pocket limits.

HOPD: Hospital Outpatient Department **Non-HOPD:** Non-Hospital Outpatient Department

Fayetteville Ambulatory Surgical **Non-HOPD** 1781 Metromedical Dr Fayetteville, NC 28304	Blue Value **$9,219** Blue Options, Blue Advantage **$9,219**
Fayetteville Ambulatory Surgical **Non-HOPD** 1781 Metromedical Dr Fayetteville, NC 28304	Blue Value **$14,005** Blue Options, Blue Advantage **$14,005**
Betsy Johnson Reg Hospital **HOPD** 800 Tilghman Dr Dunn, NC 28334	Blue Value **$21,407** Blue Options, Blue Advantage **$21,407**
Betsy Johnson Reg Hospital **HOPD** 800 Tilghman Dr Dunn, NC 28334	Blue Value **$23,427** Blue Options, Blue Advantage **$23,427**

Not all HOPD facilities in this area are listed on the BCBS Cost Estimator. High and low costs for the same procedure in the Raleigh area are shown below for comparison.

James E. Davis Ambulatory Surgery Center **HOPD** 120 Carver St Durham, NC 27704	Blue Options, Blue Advantage **$8,839**
Duke Raleigh Hospital **HOPD** 3400 Wake Forest Rd Raleigh, NC 27609	Blue Options, Blue Advantage **$20,389**

NC Estimate Health Care Costs

Enter a treatment or service

Bunionectomy

Location

Fayetteville, NC

Incomplete Data - Information for Cape Fear Valley Medical Center Not Available on BCBS Cost Estimator

Estimated Treatment Cost Results

Cost estimates are averages based on historical BCBSNC claims data. Amounts listed typically include physician fees, facility fees and costs for things like anesthesia, drugs, medical supplies – as well as customer responsibility (deductible, co-pay and co-insurance). Your actual costs may be different based on variations in these factors as well as your health plan design, deductibles/co-insurance and out-of-pocket limits.

HOPD: Hospital Outpatient Department **Non-HOPD:** Non-Hospital Outpatient Department

Fayetteville Ambulatory Surgical
Non-HOPD
1781 Metromedical Dr
Fayetteville, NC 28304

Blue Value
$4,381
Blue Options, Blue Advantage
$4,381

Fayetteville Ambulatory Surgical
Non-HOPD
1781 Metromedical Dr
Fayetteville, NC 28304

Blue Value
$4,413
Blue Options, Blue Advantage
$4,413

Fayetteville Ambulatory Surgical
Non-HOPD
1781 Metromedical Dr
Fayetteville, NC 28304

Blue Value
$4,659
Blue Options, Blue Advantage
$4,659

Not all HOPD facilities in this area are listed on the BCBS Cost Estimator. High and low costs for the same procedure in the Raleigh area are shown below for comparison.

Blue Ridge Surgery Center
Non-HOPD
2308 Wesvill Ct
Raleigh, NC 27607

Blue Value
$3,604
Blue Options, Blue Advantage
$3,604

Capital City Surgery Center LLC
HOPD
23 Sunnybrook Rd, Ste 100
Raleigh, NC 27610

Blue Value
$13,346
Blue Options, Blue Advantage
$13,346

NC Estimate Health Care Costs

Enter a treatment or service

Cataract Removal

Location

Fayetteville, NC

Estimated Treatment Cost Results

Cost estimates are averages based on historical BCBSNC claims data. Amounts listed typically include physician fees, facility fees and costs for things like anesthesia, drugs, medical supplies – as well as customer responsibility (deductible, co-pay and co-insurance). Your actual costs may be different based on variations in these factors as well as your health plan design, deductibles/co-insurance and out-of-pocket limits.

HOPD: Hospital Outpatient Department **Non-HOPD:** Non-Hospital Outpatient Department

Fayetteville Ambulatory Surgical **Non-HOPD** 1781 Metromedical Dr Fayetteville, NC 28304	Blue Value **$3,373** Blue Options, Blue Advantage **$3,373**
Central Carolina Hospital **HOPD** 1135 Carthage St Sanford, NC 27330	Blue Value **$4,741** Blue Options, Blue Advantage **$4,741**
Betsy Johnson Reg Hospital **HOPD** 800 Tilghman Dr Dunn, NC 28334	Blue Value **$5,232** Blue Options, Blue Advantage **$5,232**
Cape Fear Valley Medical Center **HOPD** 1638 Owen Dr Fayetteville, NC 28304	Blue Options, Blue Advantage **$6,122**

Estimate Health Care Costs

Enter a treatment or service

CT Scan Head/Brain

Location

Fayetteville, NC

Estimated Treatment Cost Results

Cost estimates are averages based on historical BCBSNC claims data. Amounts listed typically include physician fees, facility fees and costs for things like anesthesia, drugs, medical supplies – as well as customer responsibility (deductible, co-pay and co-insurance). Your actual costs may be different based on variations in these factors as well as your health plan design, deductibles/co-insurance and out-of-pocket limits.

HOPD: Hospital Outpatient Department **Non-HOPD:** Non-Hospital Outpatient Department

Walter Hatcher **Non-HOPD** 3628 Cape Center Dr Fayetteville, NC 28304	Blue Value **$336** Blue Options, Blue Advantage **$336**
David Fisher **Non-HOPD** 169 Rawls Rd Angier, NC 27501	Blue Value **$355** Blue Options, Blue Advantage **$355**
Central Carolina Hospital **HOPD** 1135 Carthage St Sanford, NC 27330	Blue Value **$382** Blue Options, Blue Advantage **$382**
Carolina Regional Radiology **Non-HOPD** 3186 Village Dr, Ste 201 Fayetteville, NC 28304	Blue Value **$551** Blue Options, Blue Advantage **$551**
Betsy Johnson Reg Hospital **HOPD** 800 Tilghman Dr Dunn, NC 28334	Blue Value **$1,316** Blue Options, Blue Advantage **$1,316**
Cape Fear Valley Medical Center **HOPD** 1638 Owen Dr Fayetteville, NC 28304	Blue Value **$1,408** Blue Options, Blue Advantage **$1,408**

NC Estimate Health Care Costs

Enter a treatment or service

Hernia

Location

Fayetteville, NC

Incomplete Data - Information for Cape Fear Valley Medical Center Not Available on BCBS Cost Estimator

Estimated Treatment Cost Results

Cost estimates are averages based on historical BCBSNC claims data. Amounts listed typically include physician fees, facility fees and costs for things like anesthesia, drugs, medical supplies – as well as customer responsibility (deductible, co-pay and co-insurance). Your actual costs may be different based on variations in these factors as well as your health plan design, deductibles/co-insurance and out-of-pocket limits.

HOPD: Hospital Outpatient Department **Non-HOPD:** Non-Hospital Outpatient Department

Central Carolina Hospital
HOPD
1135 Carthage St
Sanford, NC 27330

Blue Value
$7,808
Blue Options, Blue Advantage
$7,808

Betsy Johnson Reg Hospital
HOPD
800 Tilghman Dr
Dunn, NC 28334

Blue Value
$8,520
Blue Options, Blue Advantage
$8,520

Betsy Johnson Reg Hospital
HOPD
800 Tilghman Dr
Dunn, NC 28334

Blue Value
$11,816
Blue Options, Blue Advantage
$11,816

Central Carolina Hospital
HOPD
1135 Carthage St
Sanford, NC 27330

Blue Value
$13,067
Blue Options, Blue Advantage
$13,067

Not all HOPD facilities in this area are listed on the BCBS Cost Estimator. High and low costs for the same procedure in the Raleigh area are shown below for comparison.

North Carolina Specialty Hospital
HOPD (Joint Physician Ownership)
3916 Ben Franklin Blvd
Durham, NC 27704

Blue Value
$4,247
Blue Options, Blue Advantage
$4,247

Duke Regional Hospital
HOPD
3643 N Roxboro St
Durham, NC 27704

Blue Options, Blue Advantage
$9,423

NC Estimate Health Care Costs

Enter a treatment or service

Nasal/Sinus - Corrective Surgery

Location

Fayetteville, NC

Incomplete Data - Information for Cape Fear Valley Medical Center Not Available on BCBS Cost Estimator

Estimated Treatment Cost Results

Cost estimates are averages based on historical BCBSNC claims data. Amounts listed typically include physician fees, facility fees and costs for things like anesthesia, drugs, medical supplies – as well as customer responsibility (deductible, co-pay and co-insurance). Your actual costs may be different based on variations in these factors as well as your health plan design, deductibles/co-insurance and out-of-pocket limits.

HOPD: Hospital Outpatient Department **Non-HOPD:** Non-Hospital Outpatient Department

Fayetteville Ambulatory Surgical **Non-HOPD** 1781 Metromedical Dr Fayetteville, NC 28304	Blue Value **$5,284** Blue Options, Blue Advantage **$5,284**
Fayetteville Ambulatory Surgical **Non-HOPD** 1781 Metromedical Dr Fayetteville, NC 28304	Blue Value **$5,415** Blue Options, Blue Advantage **$5,415**
Fayetteville Ambulatory Surgical **Non-HOPD** 1781 Metromedical Dr Fayetteville, NC 28304	Blue Value **$6,018** Blue Options, Blue Advantage **$6,018**
Fayetteville Ambulatory Surgical **Non-HOPD** 1781 Metromedical Dr Fayetteville, NC 28304	Blue Value **$6,808** Blue Options, Blue Advantage **$6,808**

Not all HOPD facilities in this area are listed on the BCBS Cost Estimator. High and low costs for the same procedure in the Raleigh area are shown below for comparison.

Blue Ridge Surgery Center **Non-HOPD** 2308 Wesvill Ct Raleigh, NC 27607	Blue Value **$4,702** Blue Options, Blue Advantage **$4,702**
Capital City Surgery Center LLC **HOPD** 23 Sunnybrook Rd, Ste 100 Raleigh, NC 27610	Blue Options, Blue Advantage **$20,029**

NC Estimate Health Care Costs

Enter a treatment or service

Rotator Cuff Repair

Location

Fayetteville, NC

Incomplete Data - Information for Cape Fear Valley Medical Center Not Available on BCBS Cost Estimator

Estimated Treatment Cost Results

Cost estimates are averages based on historical BCBSNC claims data. Amounts listed typically include physician fees, facility fees and costs for things like anesthesia, drugs, medical supplies – as well as customer responsibility (deductible, co-pay and co-insurance). Your actual costs may be different based on variations in these factors as well as your health plan design, deductibles/co-insurance and out-of-pocket limits.

HOPD: Hospital Outpatient Department **Non-HOPD:** Non-Hospital Outpatient Department

Fayetteville Ambulatory Surgical
Non-HOPD
1781 Metromedical Dr
Fayetteville, NC 28304

Blue Value
$8,103
Blue Options, Blue Advantage
$8,103

Fayetteville Ambulatory Surgical
Non-HOPD
1781 Metromedical Dr
Fayetteville, NC 28304

Blue Value
$9,476
Blue Options, Blue Advantage
$9,476

Not all HOPD facilities in this area are listed on the BCBS Cost Estimator. High and low costs for the same procedure in the Raleigh area are shown below for comparison.

Blue Ridge Surgery Center
Non-HOPD
2308 Wesvill Ct
Raleigh, NC 27607

Blue Value
$9,164
Blue Options, Blue Advantage
$9,164

Duke University Hospital
HOPD
2301 Erwin Rd
Durham, NC 27710

Blue Options, Blue Advantage
$19,577

NC Estimate Health Care Costs

Enter a treatment or service

Tonsillectomy and Adenoidectomy

Location

Fayetteville, NC

Estimated Treatment Cost Results

Cost estimates are averages based on historical BCBSNC claims data. Amounts listed typically include physician fees, facility fees and costs for things like anesthesia, drugs, medical supplies – as well as customer responsibility (deductible, co-pay and co-insurance). Your actual costs may be different based on variations in these factors as well as your health plan design, deductibles/co-insurance and out-of-pocket limits.

HOPD: Hospital Outpatient Department **Non-HOPD:** Non-Hospital Outpatient Department

Fayetteville Ambulatory Surgical **Non-HOPD** 1781 Metromedical Dr Fayetteville, NC 28304	Blue Value **$2,960** Blue Options, Blue Advantage **$2,960**
Cape Fear Valley Medical Center **HOPD** 1638 Owen Dr Fayetteville, NC 28304	Blue Value **$3,246** Blue Options, Blue Advantage **$3,246**
Central Carolina Hospital **HOPD** 1135 Carthage St Sanford, NC 27330	Blue Value **$6,258** Blue Options, Blue Advantage **$6,258**

NC Estimate Health Care Costs

Enter a treatment or service

Tympanostomy and Myringotomy

Location

Fayetteville, NC

Incomplete Data - Information for Cape Fear Valley Medical Center Not Available on BCBS Cost Estimator

Estimated Treatment Cost Results

Cost estimates are averages based on historical BCBSNC claims data. Amounts listed typically include physician fees, facility fees and costs for things like anesthesia, drugs, medical supplies – as well as customer responsibility (deductible, co-pay and co-insurance). Your actual costs may be different based on variations in these factors as well as your health plan design, deductibles/co-insurance and out-of-pocket limits.

HOPD: Hospital Outpatient Department **Non-HOPD:** Non-Hospital Outpatient Department

Fayetteville Ambulatory Surgical **Non-HOPD** 1781 Metromedical Dr Fayetteville, NC 28304	Blue Value **$2,873** Blue Options, Blue Advantage **$2,873**
Fayetteville Ambulatory Surgical **Non-HOPD** 1781 Metromedical Dr Fayetteville, NC 28304	Blue Value **$3,156** Blue Options, Blue Advantage **$3,156**
Fayetteville Ambulatory Surgical **Non-HOPD** 1781 Metromedical Dr Fayetteville, NC 28304	Blue Value **$3,598** Blue Options, Blue Advantage **$3,598**
Central Carolina Hospital **HOPD** 1135 Carthage St Sanford, NC 27330	Blue Value **$3,900** Blue Options, Blue Advantage **$3,900**

Not all HOPD facilities in this area are listed on the BCBS Cost Estimator. High and low costs for the same procedure in the Raleigh area are shown below for comparison.

North Carolina Specialty Hospital **HOPD (Joint Physician Ownership)** 3916 Ben Franklin Blvd Durham, NC 27704	Blue Options, Blue Advantage **$2,114**
UNC Hospitals **HOPD** 101 Manning Dr Chapel Hill, NC 27514	Blue Value **$11,380** Blue Options, Blue Advantage **$13,812**

NC Estimate Health Care Costs

Enter a treatment or service

ACL Repair by Arthroscopy

Location

Greenville, NC

Estimated Treatment Cost Results

Cost estimates are averages based on historical BCBSNC claims data. Amounts listed typically include physician fees, facility fees and costs for things like anesthesia, drugs, medical supplies – as well as customer responsibility (deductible, co-pay and co-insurance). Your actual costs may be different based on variations in these factors as well as your health plan design, deductibles/co-insurance and out-of-pocket limits.

HOPD: Hospital Outpatient Department **Non-HOPD:** Non-Hospital Outpatient Department

Surgicenter of Eastern Carolina LLC **HOPD** 102 Bethesda Dr Greenville, NC 27834	Blue Options, Blue Advantage **$11,850**
Surgicenter of Eastern Carolina LLC **HOPD** 102 Bethesda Dr Greenville, NC 27834	Blue Options, Blue Advantage **$13,127**
Vidant Surgicenter **HOPD** 102 Bethesda Dr Greenville, NC 27834	Blue Value **$14,215** Blue Options, Blue Advantage **$14,215**

High and low costs for the same procedure in Raleigh are shown below for comparison.

James E. Davis Ambulatory Surgery Center **HOPD** 120 Carver St Durham, NC 27704	Blue Options, Blue Advantage **$8,839**
uke Raleigh Hospital **HOPD** 3400 Wake Forest Rd Raleigh, NC 27609	Blue Options, Blue Advantage **$20,389**

NC Estimate Health Care Costs

Enter a treatment or service

Bunionectomy

Location

Greenville, NC

Estimated Treatment Cost Results

Cost estimates are averages based on historical BCBSNC claims data. Amounts listed typically include physician fees, facility fees and costs for things like anesthesia, drugs, medical supplies – as well as customer responsibility (deductible, co-pay and co-insurance). Your actual costs may be different based on variations in these factors as well as your health plan design, deductibles/co-insurance and out-of-pocket limits.

HOPD: Hospital Outpatient Department **Non-HOPD:** Non-Hospital Outpatient Department

Lenoir Memorial Hospital **HOPD** 100 Airport Rd Kinston, NC 28501	Blue Value **$4,625** Blue Options, Blue Advantage **$4,625**
Vidant Surgicenter **HOPD** 102 Bethesda Dr Greenville, NC 27834	Blue Value **$6,565** Blue Options, Blue Advantage **$6,565**
Vidant Beaufort Hospital **HOPD** 628 E 12th St Washington, NC 27889	Blue Value **$11,427** Blue Options, Blue Advantage **$11,427**

High and low costs for the same procedure in Raleigh are shown below for comparison.

Blue Ridge Surgery Center **Non-HOPD** 2308 Wesvill Ct Raleigh, NC 27607	Blue Value **$3,604** Blue Options, Blue Advantage **$3,604**
Capital City Surgery Center LLC **HOPD** 23 Sunnybrook Rd, Ste 100 Raleigh, NC 27610	Blue Value **$13,346** Blue Options, Blue Advantage **$13,346**

Estimate Health Care Costs

Enter a treatment or service

Cataract Removal

Location

Greenville, NC

Estimated Treatment Cost Results

Cost estimates are averages based on historical BCBSNC claims data. Amounts listed typically include physician fees, facility fees and costs for things like anesthesia, drugs, medical supplies – as well as customer responsibility (deductible, co-pay and co-insurance). Your actual costs may be different based on variations in these factors as well as your health plan design, deductibles/co-insurance and out-of-pocket limits.

HOPD: Hospital Outpatient Department **Non-HOPD:** Non-Hospital Outpatient Department

Surgicenter of Eastern Carolina LLC **HOPD** 102 Bethesda Dr Greenville, NC 27834	Blue Options, Blue Advantage **$2,404**
Lenoir Memorial Hospital **HOPD** [illegible]00 Airport Rd [illegible]inston, NC 28501	Blue Value **$2,490** Blue Options, Blue Advantage **$2,490**
Vidant Surgicenter **HOPD** 102 Bethesda Dr Greenville, NC 27834	Blue Value **$2,359** Blue Options, Blue Advantage **$2,359**
Vidant Surgicenter **HOPD** 102 Bethesda Dr Greenville, NC 27834	Blue Value **$2,532** Blue Options, Blue Advantage **$2,532**
Vidant Edgecombe Hospital **HOPD** 111 Hospital Dr Tarboro, NC 27886	Blue Options, Blue Advantage **$5,030**
Vidant Beaufort Hospital **HOPD** 628 E 12th St Washington, NC 27889	Blue Value **$6,084** Blue Options, Blue Advantage **$6,084**

NC Estimate Health Care Costs

Enter a treatment or service

CT Scan Head/Brain

Location

Greenville, NC

Estimated Treatment Cost Results

Cost estimates are averages based on historical BCBSNC claims data. Amounts listed typically include physician fees, facility fees and costs for things like anesthesia, drugs, medical supplies – as well as customer responsibility (deductible, co-pay and co-insurance). Your actual costs may be different based on variations in these factors as well as your health plan design, deductibles/co-insurance and out-of-pocket limits.

HOPD: Hospital Outpatient Department **Non-HOPD:** Non-Hospital Outpatient Department

Greenville Womens Clinic **Non-HOPD** 2251 Stantonsburg Rd Greenville, NC 27834	Blue Value **$336** Blue Options, Blue Advantage **$336**
Kinston Medical Specialist **HOPD** 05 N Queen St, Ste A Kinston, NC 28501	Blue Value **$367** Blue Options, Blue Advantage **$367**
Eastern Radiologists **Non-HOPD** 9 Doctors Park Greenville, NC 27834	Blue Value **$511** Blue Options, Blue Advantage **$511**
CarolinaEast Internal Medicine **HOPD** 620 Farm Life Ave Vanceboro, NC 28586	Blue Value **$544** Blue Options, Blue Advantage **$544**
Vidant Medical Center **HOPD** 2100 Stantonsburg Rd Greenville, NC 27834	Blue Value **$1,279** Blue Options, Blue Advantage **$1,279**
Lenoir Memorial Hospital **HOPD** 100 Airport Rd Kinston, NC 28501	Blue Value **$1,481** Blue Options, Blue Advantage **$1,481**
Vidant Beaufort Hospital **HOPD** 628 E 12th St ashington, NC 27889	Blue Value **$1,509** Blue Options, Blue Advantage **$1,509**

NC Estimate Health Care Costs

Enter a treatment or service

Hernia

Location

Greenville, NC

Estimated Treatment Cost Results

Cost estimates are averages based on historical BCBSNC claims data. Amounts listed typically include physician fees, facility fees and costs for things like anesthesia, drugs, medical supplies – as well as customer responsibility (deductible, co-pay and co-insurance). Your actual costs may be different based on variations in these factors as well as your health plan design, deductibles/co-insurance and out-of-pocket limits.

HOPD: Hospital Outpatient Department **Non-HOPD:** Non-Hospital Outpatient Department

Lenoir Memorial Hospital
HOPD
100 Airport Rd
Kinston, NC 28501

Blue Value
$3,031
Blue Options, Blue Advantage
$3,031

Surgicenter of Eastern Carolina LLC
HOPD
102 Bethesda Dr
Greenville, NC 27834

Blue Options, Blue Advantage
$5,927

Vidant Medical Center
HOPD
2100 Stantonsburg Rd
Greenville, NC 27834

Blue Value
$11,032
Blue Options, Blue Advantage
$11,032

Vidant Medical Center
HOPD
2100 Stantonsburg Rd
Greenville, NC 27834

Blue Value
$12,145
Blue Options, Blue Advantage
$12,145

NC Estimate Health Care Costs

Enter a treatment or service

Nasal/Sinus - Corrective Surgery

Location

Greenville, NC

Estimated Treatment Cost Results

Cost estimates are averages based on historical BCBSNC claims data. Amounts listed typically include physician fees, facility fees and costs for things like anesthesia, drugs, medical supplies – as well as customer responsibility (deductible, co-pay and co-insurance). Your actual costs may be different based on variations in these factors as well as your health plan design, deductibles/co-insurance and out-of-pocket limits.

HOPD: Hospital Outpatient Department **Non-HOPD:** Non-Hospital Outpatient Department

Lenoir Memorial Hospital **HOPD** 100 Airport Rd Kinston, NC 28501	Blue Value **$4,560** Blue Options, Blue Advantage **$4,560**
Vidant Surgicenter **HOPD** 102 Bethesda Dr Greenville, NC 27834	Blue Value **$6,510** Blue Options, Blue Advantage **$6,510**
Surgicenter of Eastern Carolina LLC **HOPD** 102 Bethesda Dr Greenville, NC 27834	Blue Options, Blue Advantage **$12,852**
Surgicenter of Eastern Carolina LLC **HOPD** 102 Bethesda Dr Greenville, NC 27834	Blue Options, Blue Advantage **$14,130**

NC Estimate Health Care Costs

Enter a treatment or service

Rotator Cuff Repair

Location

Greenville, NC

Incomplete Data - Only HOPD facilities are shown on BCBS Estimator

Estimated Treatment Cost Results

Cost estimates are averages based on historical BCBSNC claims data. Amounts listed typically include physician fees, facility fees and costs for things like anesthesia, drugs, medical supplies -- as well as customer responsibility (deductible, co-pay and co-insurance). Your actual costs may be different based on variations in these factors as well as your health plan design, deductibles/co-insurance and out-of-pocket limits.

HOPD: Hospital Outpatient Department **Non-HOPD:** Non-Hospital Outpatient Department

CarolinaEast Medical Center
Non-HOPD
2000 Neuse Blvd
New Bern, NC 28560

Blue Value
$21,305
Blue Options, Blue Advantage
$21,305

High and low costs for the same procedure in Raleigh are shown below for comparison.

Blue Ridge Surgery Center
Non-HOPD
2308 Wesvill Ct
Raleigh, NC 27607

Blue Value
$9,164
Blue Options, Blue Advantage
$9,164

Duke University Hospital
HOPD
2301 Erwin Rd
Durham, NC 27710

Blue Options, Blue Advantage
$19,577

NC Estimate Health Care Costs

Enter a treatment or service

Tonsillectomy and Adenoidectomy

Location

Greenville, NC

Incomplete Data - Only HOPD facilities are shown on BCBS Estimator

Estimated Treatment Cost Results

Cost estimates are averages based on historical BCBSNC claims data. Amounts listed typically include physician fees, facility fees and costs for things like anesthesia, drugs, medical supplies – as well as customer responsibility (deductible, co-pay and co-insurance). Your actual costs may be different based on variations in these factors as well as your health plan design, deductibles/co-insurance and out-of-pocket limits.

HOPD: Hospital Outpatient Department **Non-HOPD:** Non-Hospital Outpatient Department

Lenoir Memorial Hospital
HOPD
100 Airport Rd
Kinston, NC 28501

Blue Value
$3,178
Blue Options, Blue Advantage
$3,178

Vidant Surgicenter
HOPD
102 Bethesda Dr
Greenville, NC 27834

Blue Value
$4,144
Blue Options, Blue Advantage
$4,144

Only HOPD facilities are shown in this area on the BCBS Cost Estimator. High and low costs for the same procedure in Raleigh are shown below for comparison.

Blue Ridge Surgery Center
Non-HOPD
2308 Wesvill Ct
Raleigh, NC 27607

Blue Value
$2,850
Blue Options, Blue Advantage
$2,850

Duke Raleigh Hospital
HOPD
3400 Wake Forest Rd
Raleigh, NC 27609

Blue Options, Blue Advantage
$7,366

NC Estimate Health Care Costs

Enter a treatment or service

Tympanostomy and Myringotomy

Location

Greenville, NC

Estimated Treatment Cost Results

Cost estimates are averages based on historical BCBSNC claims data. Amounts listed typically include physician fees, facility fees and costs for things like anesthesia, drugs, medical supplies – as well as customer responsibility (deductible, co-pay and co-insurance). Your actual costs may be different based on variations in these factors as well as your health plan design, deductibles/co-insurance and out-of-pocket limits.

HOPD: Hospital Outpatient Department **Non-HOPD:** Non-Hospital Outpatient Department

Lenoir Memorial Hospital **HOPD** 100 Airport Rd Kinston, NC 28501	Blue Value **$1,327** Blue Options, Blue Advantage **$1,327**
Surgicenter of Eastern Carolina LLC **HOPD** 02 Bethesda Dr Greenville, NC 27834	Blue Options, Blue Advantage **$3,883**
Vidant Surgicenter **HOPD** 102 Bethesda Dr Greenville, NC 27834	Blue Value **$5,164** Blue Options, Blue Advantage **$5,164**

NC Estimate Health Care Costs

Enter a treatment or service

ACL Repair by Arthroscopy

Location

Halifax, NC

Estimated Treatment Cost Results

Cost estimates are averages based on historical BCBSNC claims data. Amounts listed typically include physician fees, facility fees and costs for things like anesthesia, drugs, medical supplies – as well as customer responsibility (deductible, co-pay and co-insurance). Your actual costs may be different based on variations in these factors as well as your health plan design, deductibles/co-insurance and out-of-pocket limits.

HOPD: Hospital Outpatient Department **Non-HOPD:** Non-Hospital Outpatient Department

Eastern Regional Surgical Center **Non-HOPD** 1709 Medical Park Dr W Wilson, NC 27893	Blue Value **$8,739** Blue Options, Blue Advantage **$8,739**
Vidant Roanoke-Chowan Hospital **HOPD** 500 Academy St S Ahoskie, NC 27910	Blue Value **$9,773** Blue Options, Blue Advantage **$9,773**
Granville Medical Center **HOPD** 1010 College St Oxford, NC 27565	Blue Options, Blue Advantage **$19,561**

NC Estimate Health Care Costs

Enter a treatment or service

Bunionectomy

Location

Halifax, NC

Estimated Treatment Cost Results

Cost estimates are averages based on historical BCBSNC claims data. Amounts listed typically include physician fees, facility fees and costs for things like anesthesia, drugs, medical supplies – as well as customer responsibility (deductible, co-pay and co-insurance). Your actual costs may be different based on variations in these factors as well as your health plan design, deductibles/co-insurance and out-of-pocket limits.

HOPD: Hospital Outpatient Department **Non-HOPD:** Non-Hospital Outpatient Department

Eastern Regional Surgical Center
Non-HOPD
1709 Medical Park Dr W
Wilson, NC 27893

Blue Options, Blue Advantage
$4,118

Nash General Hospital
HOPD
460 Curtis Ellis Dr
Rocky Mount, NC 27804

Blue Value
$6,177
Blue Options, Blue Advantage
$6,177

Wilson Medical Center
HOPD
1705 S Tarboro St
Wilson, NC 27893

Blue Options, Blue Advantage
$7,569

Enter a treatment or service

Cataract Removal

Location

Halifax, NC

Estimated Treatment Cost Results

Cost estimates are averages based on historical BCBSNC claims data. Amounts listed typically include physician fees, facility fees and costs for things like anesthesia, drugs, medical supplies – as well as customer responsibility (deductible, co-pay and co-insurance). Your actual costs may be different based on variations in these factors as well as your health plan design, deductibles/co-insurance and out-of-pocket limits.

HOPD: Hospital Outpatient Department **Non-HOPD:** Non-Hospital Outpatient Department

Eastern Regional Surgical Center **Non-HOPD** 1709 Medical Park Dr W Wilson, NC 27893	Blue Value **$3,208** Blue Options, Blue Advantage **$3,208**
Nash General Hospital **HOPD** 2460 Curtis Ellis Dr Rocky Mount, NC 27804	Blue Value **$3,430** Blue Options, Blue Advantage **$3,430**
Wilson Medical Center **HOPD** 1705 S Tarboro St Wilson, NC 27893	Blue Options, Blue Advantage **$4,853**
Vidant Edgecombe Hospital **HOPD** 111 Hospital Dr Tarboro, NC 27886	Blue Options, Blue Advantage **$5,030**
Vidant Bertie Hospital **HOPD** 1403 S King St Windsor, NC 27983	Blue Value **$5,961** Blue Options, Blue Advantage **$5,961**
Granville Medical Center **HOPD** 1010 College St Oxford, NC 27565	Blue Options, Blue Advantage **$6,944**
D. L. P. Maria Parham Medical Center LLC **HOPD** 566 Ruin Creek Rd Henderson, NC 27536	Blue Value **$7,192** Blue Options, Blue Advantage **$7,192**
Novant Health Franklin Medical Center **HOPD** 100 Hospital Dr Louisburg, NC 27549	Blue Options, Blue Advantage **$8,111**
Halifax Regional Medical Center **HOPD** 250 Smith Church Rd Roanoke Rapids, NC 27870	Blue Value **$9,282** Blue Options, Blue Advantage **$9,282**

NC Estimate Health Care Costs

Enter a treatment or service

CT Scan Head/Brain

Location

Halifax, NC

Estimated Treatment Cost Results

Cost estimates are averages based on historical BCBSNC claims data. Amounts listed typically include physician fees, facility fees and costs for things like anesthesia, drugs, medical supplies – as well as customer responsibility (deductible, co-pay and co-insurance). Your actual costs may be different based on variations in these factors as well as your health plan design, deductibles/co-insurance and out-of-pocket limits.

HOPD: Hospital Outpatient Department **Non-HOPD:** Non-Hospital Outpatient Department

Boice Willis Clinic **Non-HOPD** 100 Dodd St Spring Hope, NC 27882	Blue Value **$384** Blue Options, Blue Advantage **$384**
Eastern North Carolina Medical **Non-HOPD** 041 Noell Ln, Ste 105 Rocky Mount, NC 27804	Blue Value **$408** Blue Options, Blue Advantage **$408**
Granville Medical Center **HOPD** 1010 College St Oxford, NC 27565	Blue Options, Blue Advantage **$860**
Halifax Regional Medical Center **HOPD** 250 Smith Church Rd Roanoke Rapids, NC 27870	Blue Value **$1,328** Blue Options, Blue Advantage **$1,328**

NC Estimate Health Care Costs

Enter a treatment or service

Nasal/Sinus - Corrective Surgery

Location

Halifax, NC

Estimated Treatment Cost Results

Cost estimates are averages based on historical BCBSNC claims data. Amounts listed typically include physician fees, facility fees and costs for things like anesthesia, drugs, medical supplies – as well as customer responsibility (deductible, co-pay and co-insurance). Your actual costs may be different based on variations in these factors as well as your health plan design, deductibles/co-insurance and out-of-pocket limits.

HOPD: Hospital Outpatient Department **Non-HOPD:** Non-Hospital Outpatient Department

Eastern Regional Surgical Center **Non-HOPD** 1709 Medical Park Dr W Wilson, NC 27893	Blue Value **$6,618** Blue Options, Blue Advantage **$6,618**
Wilson Medical Center **HOPD** 1705 S Tarboro St Wilson, NC 27893	Blue Options, Blue Advantage **$6,752**
Nash General Hospital **HOPD** 2460 Curtis Ellis Dr Rocky Mount, NC 27804	Blue Value **$6,761** Blue Options, Blue Advantage **$6,761**
Granville Medical Center **HOPD** 1010 College St Oxford, NC 27565	Blue Options, Blue Advantage **$7,941**

NC Estimate Health Care Costs

Enter a treatment or service

Tonsillectomy and Adenoidectomy

Location

Halifax, NC

Estimated Treatment Cost Results

Cost estimates are averages based on historical BCBSNC claims data. Amounts listed typically include physician fees, facility fees and costs for things like anesthesia, drugs, medical supplies – as well as customer responsibility (deductible, co-pay and co-insurance). Your actual costs may be different based on variations in these factors as well as your health plan design, deductibles/co-insurance and out-of-pocket limits.

HOPD: Hospital Outpatient Department **Non-HOPD:** Non-Hospital Outpatient Department

Eastern Regional Surgical Center **Non-HOPD** 1709 Medical Park Dr W Wilson, NC 27893	Blue Value **$3,166** Blue Options, Blue Advantage **$3,166**
Nash General Hospital **HOPD** 2460 Curtis Ellis Dr Rocky Mount, NC 27804	Blue Value **$4,231** Blue Options, Blue Advantage **$4,231**
Vidant Roanoke-Chowan Hospital **HOPD** 500 Academy St S Ahoskie, NC 27910	Blue Value **$9,227** Blue Options, Blue Advantage **$9,227**
Novant Health Franklin Medical Center **HOPD** 100 Hospital Dr Louisburg, NC 27549	Blue Value **$11,546** Blue Options, Blue Advantage **$11,546**

Estimate Health Care Costs

Enter a treatment or service

ACL Repair by Arthroscopy

Location

Laurinburg, NC

Estimated Treatment Cost Results

Cost estimates are averages based on historical BCBSNC claims data. Amounts listed typically include physician fees, facility fees and costs for things like anesthesia, drugs, medical supplies – as well as customer responsibility (deductible, co-pay and co-insurance). Your actual costs may be different based on variations in these factors as well as your health plan design, deductibles/co-insurance and out-of-pocket limits.

HOPD: Hospital Outpatient Department

Non-HOPD: Non-Hospital Outpatient Department

Surgery Center of Pinehurst **Non-HOPD** 10 First Village Dr Pinehurst, NC 28374	Blue Value **$6,228** Blue Options, Blue Advantage **$6,228**
FirstHealth Moore Regional **HOPD** [illegible] Memorial Dr Pinehurst, NC 28374	Blue Value **$17,851** Blue Options, Blue Advantage **$17,851**
Scotland Memorial Hospital **HOPD** 500 Lauchwood Dr Laurinburg, NC 28352	Blue Options, Blue Advantage **$24,170**

Estimate Health Care Costs

Enter a treatment or service

Bunionectomy

Location

Laurinburg, NC

Estimated Treatment Cost Results

Cost estimates are averages based on historical BCBSNC claims data. Amounts listed typically include physician fees, facility fees and costs for things like anesthesia, drugs, medical supplies – as well as customer responsibility (deductible, co-pay and co-insurance). Your actual costs may be different based on variations in these factors as well as your health plan design, deductibles/co-insurance and out-of-pocket limits.

HOPD: Hospital Outpatient Department

Non-HOPD: Non-Hospital Outpatient Department

Surgery Center of Pinehurst
Non-HOPD
10 First Village Dr
Pinehurst, NC 28374

Blue Value
$2,966
Blue Options, Blue Advantage
$2,966

Union West Surgery Center
Non-HOPD
6068 W Highway 74
Indian Trail, NC 28079

Blue Value
$3,084
Blue Options, Blue Advantage
$3,084

Fayetteville Ambulatory Surgical
Non-HOPD
1781 Metromedical Dr
Fayetteville, NC 28304

Blue Value
$4,381
Blue Options, Blue Advantage
$4,381

CMC-Union
HOPD
600 Hospital Dr
Monroe, NC 28112

Blue Options, Blue Advantage
$11,084

Estimate Health Care Costs

Enter a treatment or service

Cataract Removal

Location

Laurinburg, NC

Estimated Treatment Cost Results

Cost estimates are averages based on historical BCBSNC claims data. Amounts listed typically include physician fees, facility fees and costs for things like anesthesia, drugs, medical supplies – as well as customer responsibility (deductible, co-pay and co-insurance). Your actual costs may be different based on variations in these factors as well as your health plan design, deductibles/co-insurance and out-of-pocket limits.

HOPD: Hospital Outpatient Department

Non-HOPD: Non-Hospital Outpatient Department

Eye Surgery Center of The Carolinas **Non-HOPD** 2170 Midland Rd Southern Pines, NC 28387	Blue Value **$3,123** Blue Options, Blue Advantage **$3,123**
Eye Surgery Center of The Carolinas **Non-HOPD** 2170 Midland Rd Southern Pines, NC 28387	Blue Value **$3,267** Blue Options, Blue Advantage **$3,267**
Scotland Memorial Hospital **HOPD** 500 Lauchwood Dr Laurinburg, NC 28352	Blue Options, Blue Advantage **$7,008**
Stanly Regional Medical Center **HOPD** 301 Yadkin St Albemarle, NC 28001	Blue Value **$8,889** Blue Options, Blue Advantage **$8,889**

Estimate Health Care Costs

Enter a treatment or service

CT Scan Head/Brain

Location

Laurinburg, NC

Estimated Treatment Cost Results

Cost estimates are averages based on historical BCBSNC claims data. Amounts listed typically include physician fees, facility fees and costs for things like anesthesia, drugs, medical supplies – as well as customer responsibility (deductible, co-pay and co-insurance). Your actual costs may be different based on variations in these factors as well as your health plan design, deductibles/co-insurance and out-of-pocket limits.

HOPD: Hospital Outpatient Department

Non-HOPD: Non-Hospital Outpatient Department

Southern Pines Diagnostic Imaging **Non-HOPD** 355 S Bennett St Southern Pines, NC 28387	Blue Value **$350** Blue Options, Blue Advantage **$350**
Pinehurst Medical Clinic **Non-HOPD** 205 Page Rd Pinehurst, NC 28374	Blue Value **$406** Blue Options, Blue Advantage **$406**
Anson County Hospital **HOPD** 500 Morven Rd Wadesboro, NC 28170	BBlue Options, Blue Advantage **$461**
FirstHealth Moore Regional **HOPD** 155 Memorial Dr Pinehurst, NC 28374	Blue Value **$984** Blue Options, Blue Advantage **$984**
Stanly Regional Medical Center **HOPD** 301 Yadkin St Albemarle, NC 28001	Blue Value **$1,229** Blue Options, Blue Advantage **$1,229**
Scotland Memorial Hospital **HOPD** 500 Lauchwood Dr Laurinburg, NC 28352	Blue Options, Blue Advantage **$1,401**

Estimate Health Care Costs

[redacted]er a treatment or service

Nasal/Sinus - Corrective Surgery

Location

Laurinburg, NC

Estimated Treatment Cost Results

Cost estimates are averages based on historical BCBSNC claims data. Amounts listed typically include physician fees, facility fees and costs for things like anesthesia, drugs, medical supplies – as well as customer responsibility (deductible, co-pay and co-insurance). Your actual costs may be different based on variations in these factors as well as your health plan design, deductibles/co-insurance and out-of-pocket limits.

HOPD: Hospital Outpatient Department

Non-HOPD: Non-Hospital Outpatient Department

Surgery Center of Pinehurst **Non-HOPD** 10 First Village Dr Pinehurst, NC 28374	Blue Value **$4,023** Blue Options, Blue Advantage **$4,023**
FirstHealth Moore Regional **[redacted]D** [redacted] Memorial Dr Pinehurst, NC 28374	Blue Value **$8,748** Blue Options, Blue Advantage **$8,748**
Stanly Regional Medical Center **HOPD** 301 Yadkin St Albemarle, NC 28001	Blue Value **$12,830** Blue Options, Blue Advantage **$12,830**
Scotland Memorial Hospital **HOPD** 500 Lauchwood Dr Laurinburg, NC 28352	Blue Options, Blue Advantage **$18,035**

[redacted]

Estimate Health Care Costs

Enter a treatment or service

Tonsillectomy and Adenoidectomy

Location

Laurinburg, NC

Estimated Treatment Cost Results

Cost estimates are averages based on historical BCBSNC claims data. Amounts listed typically include physician fees, facility fees and costs for things like anesthesia, drugs, medical supplies – as well as customer responsibility (deductible, co-pay and co-insurance). Your actual costs may be different based on variations in these factors as well as your health plan design, deductibles/co-insurance and out-of-pocket limits.

HOPD: Hospital Outpatient Department

Non-HOPD: Non-Hospital Outpatient Department

Surgery Center of Pinehurst
Non-HOPD
10 First Village Dr
Pinehurst, NC 28374

Blue Value
$3,041
Blue Options, Blue Advantage
$3,041

FirstHealth Moore Regional
HOPD
155 Memorial Dr
Pinehurst, NC 28374

Blue Value
$4,740
Blue Options, Blue Advantage
$4,740

Stanly Regional Medical Center
HOPD
301 Yadkin St
Albemarle, NC 28001

Blue Value
$9,124
Blue Options, Blue Advantage
$9,124

Scotland Memorial Hospital
HOPD
500 Lauchwood Dr
Laurinburg, NC 28352

Blue Options, Blue Advantage
$10,001

NC Estimate Health Care Costs

Enter a treatment or service

ACL Repair by Arthroscopy

Location

Lincolnton, NC

Estimated Treatment Cost Results

Cost estimates are averages based on historical BCBSNC claims data. Amounts listed typically include physician fees, facility fees and costs for things like anesthesia, drugs, medical supplies – as well as customer responsibility (deductible, co-pay and co-insurance). Your actual costs may be different based on variations in these factors as well as your health plan design, deductibles/co-insurance and out-of-pocket limits.

HOPD: Hospital Outpatient Department **Non-HOPD:** Non-Hospital Outpatient Department

Viewmont Surgery Center LLC **HOPD (Joint Physician Ownership)** [redacted] 13th Ave NE Hickory, NC 28601	Blue Value **$12,295** Blue Options, Blue Advantage **$12,295**
Gaston Memorial Hospital **HOPD** 2525 Court Dr Gastonia, NC 28054	Blue Options, Blue Advantage **$12,496**
Frye Regional Medical Center **HOPD** 420 N Center St Hickory, NC 28601	Blue Value **$17,977** Blue Options, Blue Advantage **$17,977**
Cleveland Regional Medical Center **HOPD** 201 E Grover St Shelby, NC 28150	Blue Options, Blue Advantage **$19,848**
Novant Health Huntersville Med Center **HOPD** 10030 Gilead Rd Huntersville, NC 28078	Blue Value **$24,118** Blue Options, Blue Advantage **$26,860**
CHS Blue Ridge Valdese **HOPD** 720 Malcolm Blvd Valdese, NC 28690	Blue Options, Blue Advantage **$27,889**
CMC Lincoln **HOPD** [redacted]33 McAlister Rd Lincolnton, NC 28092	Blue Options, Blue Advantage **$27,997**

NC Estimate Health Care Costs

Enter a treatment or service

Bunionectomy

Location

Lincolnton, NC

Estimated Treatment Cost Results

Cost estimates are averages based on historical BCBSNC claims data. Amounts listed typically include physician fees, facility fees and costs for things like anesthesia, drugs, medical supplies – as well as customer responsibility (deductible, co-pay and co-insurance). Your actual costs may be different based on variations in these factors as well as your health plan design, deductibles/co-insurance and out-of-pocket limits.

HOPD: Hospital Outpatient Department **Non-HOPD:** Non-Hospital Outpatient Department

Viewmont Surgery Center LLC **HOPD (Joint Physician Ownership)** [redacted] 13th Ave NE Hickory, NC 28601	Blue Value **$3,506** Blue Options, Blue Advantage **$3,506**
Cleveland Ambulatory Service **HOPD** 1100 N Lafayette St Shelby, NC 28150	Blue Options, Blue Advantage **$4,559**
Caromont Specialty Surgery **HOPD** 2511 Court Dr Gastonia, NC 28054	Blue Options, Blue Advantage **$6,090**
Frye Regional Medical Center **HOPD** 420 N Center St Hickory, NC 28601	Blue Value **$10,082** Blue Options, Blue Advantage **$10,082**
CMC Lincoln **HOPD** 433 McAlister Rd Lincolnton, NC 28092	Blue Options, Blue Advantage **$12,887**
Catawba Valley Med Center **HOPD** 810 Fairgrove Church Rd Hickory, NC 28602	Blue Value **$15,921** Blue Options, Blue Advantage **$15,921**

Enter a treatment or service

Cataract Removal

Location

Lincolnton, NC

Estimated Treatment Cost Results

Cost estimates are averages based on historical BCBSNC claims data. Amounts listed typically include physician fees, facility fees and costs for things like anesthesia, drugs, medical supplies – as well as customer responsibility (deductible, co-pay and co-insurance). Your actual costs may be different based on variations in these factors as well as your health plan design, deductibles/co-insurance and out-of-pocket limits.

HOPD: Hospital Outpatient Department **Non-HOPD:** Non-Hospital Outpatient Department

Eye Surgery Center of Shelby **Non-HOPD** 1622 E Marion St Shelby, NC 28150	Blue Value **$2,127** Blue Options, Blue Advantage **$2,127**
Graystone Eye Surgery Center LLC **Non-HOPD** 424 Century Pl SE Hickory, NC 28602	Blue Options, Blue Advantage **$2,179**
Caromont Specialty Surgery **HOPD** 2511 Court Dr Gastonia, NC 28054	Blue Options, Blue Advantage **$2,737**
Cleveland Ambulatory Service **HOPD** 1100 N Lafayette St Shelby, NC 28150	Blue Value **$3,696** Blue Options, Blue Advantage **$3,696**
Frye Regional Medical Center **HOPD** 420 N Center St Hickory, NC 28601	Blue Value **$5,241** Blue Options, Blue Advantage **$5,241**
Catawba Valley Med Center **HOPD** 810 Fairgrove Church Rd Hickory, NC 28602	Blue Value **$6,888** Blue Options, Blue Advantage **$6,888**
Kings Mountain Hospital **HOPD** 706 W King St Kings Mountain, NC 28086	Blue Value **$7,012** Blue Options, Blue Advantage **$7,012**
CMC Lincoln **HOPD** 433 McAlister Rd Lincolnton, NC 28092	Blue Options, Blue Advantage **$8,778**

Enter a treatment or service

CT Scan Head/Brain

Location

Lincolnton, NC

Estimated Treatment Cost Results

Cost estimates are averages based on historical BCBSNC claims data. Amounts listed typically include physician fees, facility fees and costs for things like anesthesia, drugs, medical supplies – as well as customer responsibility (deductible, co-pay and co-insurance). Your actual costs may be different based on variations in these factors as well as your health plan design, deductibles/co-insurance and out-of-pocket limits.

HOPD: Hospital Outpatient Department **Non-HOPD:** Non-Hospital Outpatient Department

Piedmont Healthcare, PA **Non-HOPD** 9735 Kincey Ave, Ste 203 Huntersville, NC 28078	Blue Value **$408** Blue Options, Blue Advantage **$408**
Carolina Neurosurgery & Spine Associates **Non-HOPD** 9735 Kincey Ave, Ste 300 Huntersville, NC 28078	Blue Value **$461** Blue Options, Blue Advantage **$461**
Frye Regional Medical Center **HOPD** 420 N Center St Hickory, NC 28601	Blue Value **$524** Blue Options, Blue Advantage **$524**
Novant Health Huntersville Med Center **HOPD** 10030 Gilead Rd Huntersville, NC 28078	Blue Value **$835** Blue Options, Blue Advantage **$935**
Gaston Memorial Hospital **HOPD** 2525 Court Dr Gastonia, NC 28054	Blue Options, Blue Advantage **$986**
CMC Lincoln **HOPD** 433 McAlister Rd Lincolnton, NC 28092	Blue Options, Blue Advantage **$1,143**
Catawba Valley Med Center **HOPD** 810 Fairgrove Church Rd Hickory, NC 28602	Blue Value **$1,249** Blue Options, Blue Advantage **$1,249**
Kings Mountain Hospital **HOPD** 706 W King St Kings Mountain, NC 28086	Blue Options, Blue Advantage **$1,416**
Cleveland Regional Medical Center **HOPD** 201 E Grover St Shelby, NC 28150	Blue Options, Blue Advantage **$1,677**

NC Estimate Health Care Costs

Enter a treatment or service

Nasal/Sinus - Corrective Surgery

Location

Lincolnton, NC

Estimated Treatment Cost Results

Cost estimates are averages based on historical BCBSNC claims data. Amounts listed typically include physician fees, facility fees and costs for things like anesthesia, drugs, medical supplies – as well as customer responsibility (deductible, co-pay and co-insurance). Your actual costs may be different based on variations in these factors as well as your health plan design, deductibles/co-insurance and out-of-pocket limits.

HOPD: Hospital Outpatient Department **Non-HOPD:** Non-Hospital Outpatient Department

Caromont Specialty Surgery **HOPD** 511 Court Dr Gastonia, NC 28054	Blue Value **$4,745** Blue Options, Blue Advantage **$4,745**
Cleveland Ambulatory Service **HOPD** 1100 N Lafayette St Shelby, NC 28150	Blue Value **$5,667** Blue Options, Blue Advantage **$5,667**
Viewmont Surgery Center LLC **HOPD (Joint Physician Ownership)** 50 13th Ave NE Hickory, NC 28601	Blue Value **$5,850** Blue Options, Blue Advantage **$5,850**
Presb Surgery Center at Huntersville **HOPD** 10030 Gilead Rd Huntersville, NC 28078	Blue Value **$10,200** Blue Options, Blue Advantage **$10,200**

NC Estimate Health Care Costs

Enter a treatment or service

Tonsillectomy and Adenoidectomy

Location

Lincolnton, NC

Estimated Treatment Cost Results

Cost estimates are averages based on historical BCBSNC claims data. Amounts listed typically include physician fees, facility fees and costs for things like anesthesia, drugs, medical supplies – as well as customer responsibility (deductible, co-pay and co-insurance). Your actual costs may be different based on variations in these factors as well as your health plan design, deductibles/co-insurance and out-of-pocket limits.

HOPD: Hospital Outpatient Department **Non-HOPD:** Non-Hospital Outpatient Department

Caromont Specialty Surgery **HOPD** 511 Court Dr Gastonia, NC 28054	Blue Value **$2,135** Blue Options, Blue Advantage **$2,135**
Viewmont Surgery Center LLC **HOPD (Joint Physician Ownership)** 50 13th Ave NE Hickory, NC 28601	Blue Value **$2,935** Blue Options, Blue Advantage **$2,935**
Cleveland Ambulatory Service **HOPD** 1100 N Lafayette St Shelby, NC 28150	Blue Value **$3,058** Blue Options, Blue Advantage **$3,058**
Presb Surgery Center at Huntersville **HOPD** 10030 Gilead Rd Huntersville, NC 28078	Blue Value **$4,816** Blue Options, Blue Advantage **$4,816**
Catawba Valley Med Center **HOPD** 810 Fairgrove Church Rd Hickory, NC 28602	Blue Value **$6,325** Blue Options, Blue Advantage **$6,325**
Novant Health Huntersville Med Center **HOPD** 10030 Gilead Rd Huntersville, NC 28078	Blue Value **$6,916** Blue Options, Blue Advantage **$6,916**
CMC Lincoln **HOPD** 433 McAlister Rd Lincolnton, NC 28092	Blue Options, Blue Advantage **$9,974**

Estimate Health Care Costs

Enter a treatment or service

ACL Repair by Arthroscopy

Location

Marion, NC

Estimated Treatment Cost Results

Cost estimates are averages based on historical BCBSNC claims data. Amounts listed typically include physician fees, facility fees and costs for things like anesthesia, drugs, medical supplies – as well as customer responsibility (deductible, co-pay and co-insurance). Your actual costs may be different based on variations in these factors as well as your health plan design, deductibles/co-insurance and out-of-pocket limits.

HOPD: Hospital Outpatient Department **Non-HOPD:** Non-Hospital Outpatient Department

Orthopaedic Surgery Center **Non-HOPD** 34 Granby St Asheville, NC 28801	Blue Value **$9,002** Blue Options, Blue Advantage **$9,002**
Gaston Memorial Hospital **HOPD** 525 Court Dr Gastonia, NC 28054	Blue Options, Blue Advantage **$12,496**
Frye Regional Medical Center **HOPD** 420 N Center St Hickory, NC 28601	Blue Value **$15,167** Blue Options, Blue Advantage **$15,167**
Marg R. Pardee Memorial Hospital **HOPD** 800 N Justice St Hendersonville, NC 28791	Blue Value **$19,361** Blue Options, Blue Advantage **$19,361**
Cleveland Regional Medical Center **HOPD** 201 E Grover St Shelby, NC 28150	Blue Options, Blue Advantage **$21,943**
Transylvania Community Hospital **HOPD** 260 Hospital Dr Brevard, NC 28712	Blue Value **$23,103** Blue Options, Blue Advantage **$23,103**
Mission Hospital Inc. **HOPD** 509 Biltmore Ave Asheville, NC 28801	Blue Options, Blue Advantage **$25,039**
CHS Blue Ridge Morganton **HOPD** 2201 S Sterling St Morganton, NC 28655	Blue Options, Blue Advantage **$30,609**
Watauga Medical Center, Inc. **HOPD** 336 Deerfield Rd Boone, NC 28607	Blue Value **$39,003** Blue Options, Blue Advantage **$39,003**

Enter a treatment or service

Bunionectomy

Location

Marion, NC

Estimated Treatment Cost Results

Cost estimates are averages based on historical BCBSNC claims data. Amounts listed typically include physician fees, facility fees and costs for things like anesthesia, drugs, medical supplies – as well as customer responsibility (deductible, co-pay and co-insurance). Your actual costs may be different based on variations in these factors as well as your health plan design, deductibles/co-insurance and out-of-pocket limits.

HOPD: Hospital Outpatient Department **Non-HOPD:** Non-Hospital Outpatient Department

Frye Regional Medical Center **HOPD** [illegible]20 N Center St [illegible]ickory, NC 28601	Blue Value **$10,082** Blue Options, Blue Advantage **$10,082**
Caldwell Memorial Hospital **HOPD** 321 Mulberry St SW Lenoir, NC 28645	Blue Value **$11,552** Blue Options, Blue Advantage **$11,552**
Mission Hospital Inc. **HOPD** 509 Biltmore Ave Asheville, NC 28801	Blue Value **$12,644** Blue Options, Blue Advantage **$12,644**
CMC Lincoln **HOPD** 433 McAlister Rd Lincolnton, NC 28092	Blue Options, Blue Advantage **$12,887**
Catawba Valley Med Center **HOPD** 810 Fairgrove Church Rd Hickory, NC 28602	Blue Value **$15,921** Blue Options, Blue Advantage **$15,921**

NC

Estimate Health Care Costs

Enter a treatment or service

Cataract Removal

Location

Marion, NC

Estimated Treatment Cost Results

Cost estimates are averages based on historical BCBSNC claims data. Amounts listed typically include physician fees, facility fees and costs for things like anesthesia, drugs, medical supplies – as well as customer responsibility (deductible, co-pay and co-insurance). Your actual costs may be different based on variations in these factors as well as your health plan design, deductibles/co-insurance and out-of-pocket limits.

HOPD: Hospital Outpatient Department **Non-HOPD:** Non-Hospital Outpatient Department

Surgery Center of Morganton Eye Physicians
Non-HOPD
335 E Parker Rd
Morganton, NC 28655

Blue Value
$2,183
Blue Options, Blue Advantage
$2,183

Blue Ridge Regional Hospital
HOPD
125 Hospital Dr
Spruce Pine, NC 28777

Blue Options, Blue Advantage
$4,806

Watauga Medical Center, Inc.
HOPD
336 Deerfield Rd
Boone, NC 28607

Blue Value
$7,561
Blue Options, Blue Advantage
$7,561

NC Estimate Health Care Costs

Enter a treatment or service

CT Scan Head/Brain

Location

Marion, NC

Estimated Treatment Cost Results

Cost estimates are averages based on historical BCBSNC claims data. Amounts listed typically include physician fees, facility fees and costs for things like anesthesia, drugs, medical supplies – as well as customer responsibility (deductible, co-pay and co-insurance). Your actual costs may be different based on variations in these factors as well as your health plan design, deductibles/co-insurance and out-of-pocket limits.

HOPD: Hospital Outpatient Department **Non-HOPD:** Non-Hospital Outpatient Department

Blue Ridge Radiology **Non-HOPD** 1860 Sugar Hill Rd Marion, NC 28752	Blue Value **$468** Blue Options, Blue Advantage **$468**
Rutherford Regional Medical Center **HOPD** 288 S Ridgecrest Ave Rutherfordton, NC 28139	Blue Value **$1,013** Blue Options, Blue Advantage **$1,013**
Blue Ridge Regional Hospital **HOPD** 125 Hospital Dr Spruce Pine, NC 28777	Blue Value **$1,049** Blue Options, Blue Advantage **$1,049**
The McDowell Hospital **HOPD** 430 Rankin Dr Marion, NC 28752	Blue Value **$1,052** Blue Options, Blue Advantage **$1,052**
CHS Blue Ridge Morganton **HOPD** 2201 S Sterling St Morganton, NC 28655	Blue Options, Blue Advantage **$1,166**

Enter a treatment or service

Nasal/Sinus - Corrective Surgery

Location

Marion, NC

Estimated Treatment Cost Results

Cost estimates are averages based on historical BCBSNC claims data. Amounts listed typically include physician fees, facility fees and costs for things like anesthesia, drugs, medical supplies – as well as customer responsibility (deductible, co-pay and co-insurance). Your actual costs may be different based on variations in these factors as well as your health plan design, deductibles/co-insurance and out-of-pocket limits.

HOPD: Hospital Outpatient Department **Non-HOPD:** Non-Hospital Outpatient Department

Caromont Specialty Surgery **HOPD** 511 Court Dr Gastonia, NC 28054	Blue Value **$4,745** Blue Options, Blue Advantage **$4,745**
Viewmont Surgery Center LLC **HOPD (Joint Physician Ownership)** 50 13th Ave NE Hickory, NC 28601	Blue Value **$5,850** Blue Options, Blue Advantage **$5,850**
Mission Hospital Inc. **HOPD** 509 Biltmore Ave Asheville, NC 28801	Blue Options, Blue Advantage **$8,300**
Haywood Regional Medical Center **HOPD** 262 Leroy George Dr Clyde, NC 28721	Blue Value **$11,869** Blue Options, Blue Advantage **$11,869**
Park Ridge Health **HOPD** 100 Hospital Dr Hendersonville, NC 28792	Blue Value **$13,890** Blue Options, Blue Advantage **$13,890**
Watauga Medical Center, Inc. **HOPD** 336 Deerfield Rd Boone, NC 28607	Blue Value **$20,732** Blue Options, Blue Advantage **$20,732**

Estimate Health Care Costs

Enter a treatment or service

Tonsillectomy and Adenoidectomy

Location

Marion, NC

Estimated Treatment Cost Results

Cost estimates are averages based on historical BCBSNC claims data. Amounts listed typically include physician fees, facility fees and costs for things like anesthesia, drugs, medical supplies – as well as customer responsibility (deductible, co-pay and co-insurance). Your actual costs may be different based on variations in these factors as well as your health plan design, deductibles/co-insurance and out-of-pocket limits.

HOPD: Hospital Outpatient Department **Non-HOPD:** Non-Hospital Outpatient Department

Caromont Specialty Surgery **HOPD** 2511 Court Dr Gastonia, NC 28054	Blue Value **$2,100** Blue Options, Blue Advantage **$2,100**
Viewmont Surgery Center LLC **HOPD (Joint Physician Ownership)** 30 13th Ave NE Hickory, NC 28601	Blue Value **$2,935** Blue Options, Blue Advantage **$2,935**
Cleveland Ambulatory Service **HOPD** 1100 N Lafayette St Shelby, NC 28150	Blue Value **$3,058** Blue Options, Blue Advantage **$3,058**
Mission Hospital Inc. **HOPD** 509 Biltmore Ave Asheville, NC 28801	Blue Options, Blue Advantage **$3,940**
Park Ridge Health **HOPD** 100 Hospital Dr Hendersonville, NC 28792	Blue Value **$5,325** Blue Options, Blue Advantage **$5,325**
Catawba Valley Med Center **HOPD** 810 Fairgrove Church Rd Hickory, NC 28602	Blue Value **$6,325** Blue Options, Blue Advantage **$6,325**
Watauga Medical Center, Inc. **HOPD** 336 Deerfield Rd Boone, NC 28607	Blue Value **$8,988** Blue Options, Blue Advantage **$8,988**
CMC Lincoln **HOPD** 433 McAlister Rd Lincolnton, NC 28092	Blue Options, Blue Advantage **$9,974**

Estimate Health Care Costs

Enter a treatment or service

ACL Repair by Arthroscopy

Location

Morganton, NC

Estimated Treatment Cost Results

Cost estimates are averages based on historical BCBSNC claims data. Amounts listed typically include physician fees, facility fees and costs for things like anesthesia, drugs, medical supplies – as well as customer responsibility (deductible, co-pay and co-insurance). Your actual costs may be different based on variations in these factors as well as your health plan design, deductibles/co-insurance and out-of-pocket limits.

HOPD: Hospital Outpatient Department

Non-HOPD: Non-Hospital Outpatient Department

Viewmont Surgery Center LLC

HOPD (Joint Physician Ownership)
8th Ave NE Hickory, NC 28601

Blue Value
$12,295
Blue Options, Blue Advantage
$12,295

Frye Regional Medical Center

HOPD
420 N Center St
Hickory, NC 28601

Blue Value
$17,977
Blue Options, Blue Advantage
$17,977

CHS Blue Ridge Valdese

HOPD
720 Malcolm Blvd
Valdese, NC 28690

Blue Options, Blue Advantage
$27,889

CHS Blue Ridge Morganton

HOPD
2201 S Sterling St
Morganton, NC 28655

Blue Options, Blue Advantage
$30,609

Estimate Health Care Costs

[redacted]er a treatment or service

Bunionectomy

Location

Morganton, NC

Estimated Treatment Cost Results

Cost estimates are averages based on historical BCBSNC claims data. Amounts listed typically include physician fees, facility fees and costs for things like anesthesia, drugs, medical supplies – as well as customer responsibility (deductible, co-pay and co-insurance). Your actual costs may be different based on variations in these factors as well as your health plan design, deductibles/co-insurance and out-of-pocket limits.

HOPD: Hospital Outpatient Department

Non-HOPD: Non-Hospital Outpatient Department

Viewmont Surgery Center LLC
[redacted]PD (Joint Physician Ownership)
[redacted]th Ave NE
[redacted]kory, NC 28601

Blue Value
$2,970
Blue Options, Blue Advantage
$2,970

Frye Regional Medical Center
HOPD
420 N Center St
Hickory, NC 28601

Blue Value
$10,082
Blue Options, Blue Advantage
$10,082

Caldwell Memorial Hospital
HOPD
321 Mulberry St SW
Lenoir, NC 28645

Blue Value
$11,552
Blue Options, Blue Advantage
$11,552

Catawba Valley Med Center
HOPD
810 Fairgrove Church Rd
Hickory, NC 28602

Blue Value
$15,921
Blue Options, Blue Advantage
$15,921

Estimate Health Care Costs

Enter a treatment or service

Cataract Removal

Location

Morganton, NC

Estimated Treatment Cost Results

Cost estimates are averages based on historical BCBSNC claims data. Amounts listed typically include physician fees, facility fees and costs for things like anesthesia, drugs, medical supplies – as well as customer responsibility (deductible, co-pay and co-insurance). Your actual costs may be different based on variations in these factors as well as your health plan design, deductibles/co-insurance and out-of-pocket limits.

HOPD: Hospital Outpatient Department

Non-HOPD: Non-Hospital Outpatient Department

Surgery Center of Morganton Eye Physicians
Non-HOPD
335 E Parker Rd
Morganton, NC 28655

Blue Value
$2,093
Blue Options, Blue Advantage
$2,093

Graystone Eye Surgery Center LLC
Non-HOPD
[redacted] Century Pl SE
Hickory, NC 28602

Blue Options, Blue Advantage
$2,181

Catawba Valley Med Center
HOPD
810 Fairgrove Church Rd
Hickory, NC 28602

Blue Value
$6,888
Blue Options, Blue Advantage
$6,888

Not all HOPD facilities in this area are listed on the BCBS Cost Estimator. High and low costs for the same procedure in the Charlotte area are shown below for comparison.

Eye Surgery & Laser Clinic
Non-HOPD
201 Le Phillip Ct NE
Concord, NC 28025

Blue Options, Blue Advantage
$1,643

Novant Health Presbyterian Med Center
HOPD
200 Hawthorne Ln
Charlotte, NC 28204

Blue Value
$10,687
Blue Options, Blue Advantage
$11,871

Estimate Health Care Costs

Enter a treatment or service

CT Scan Head/Brain

Location

Morganton, NC

Estimated Treatment Cost Results

Cost estimates are averages based on historical BCBSNC claims data. Amounts listed typically include physician fees, facility fees and costs for things like anesthesia, drugs, medical supplies – as well as customer responsibility (deductible, co-pay and co-insurance). Your actual costs may be different based on variations in these factors as well as your health plan design, deductibles/co-insurance and out-of-pocket limits.

HOPD: Hospital Outpatient Department **Non-HOPD:** Non-Hospital Outpatient Department

Jeffrey Zapawa **Non-HOPD** 1041 Morganton Blvd SW, S.W. # 200 Lenoir, NC 28645	Blue Value **$405** Blue Options, Blue Advantage **$405**
Brook Hill **Non-HOPD** 1041 Morganton Blvd SW, S.W. # 200 Lenoir, NC 28645	Blue Value **$472** Blue Options, Blue Advantage **$472**
Frye Regional Medical Center **HOPD** 420 N Center St Hickory, NC 28601	Blue Value **$557** Blue Options, Blue Advantage **$557**
CMC Blue Ridge Morganton **HOPD** 2201 S Sterling St Morganton, NC 28655	Blue Value **$1,166**
Catawba Valley Med Center **HOPD** 810 Fairgrove Church Rd Hickory, NC 28602	Blue Value **$1,249** Blue Options, Blue Advantage **$1,249**
CHS Blue Ridge Valdese **HOPD** 720 Malcolm Blvd Valdese, NC 28690	Blue Options, Blue Advantage **$1,373**

Estimate Health Care Costs

[redacted]ter a treatment or service

Nasal/Sinus - Corrective Surgery

Location

Morganton, NC

Estimated Treatment Cost Results

Cost estimates are averages based on historical BCBSNC claims data. Amounts listed typically include physician fees, facility fees and costs for things like anesthesia, drugs, medical supplies – as well as customer responsibility (deductible, co-pay and co-insurance). Your actual costs may be different based on variations in these factors as well as your health plan design, deductibles/co-insurance and out-of-pocket limits.

HOPD: Hospital Outpatient Department

Non-HOPD: Non-Hospital Outpatient Department

Viewmont Surgery Center LLC
HOPD (Joint Physician Ownership)
[redacted]3th Ave NE
[redacted]ory, NC 28601

Blue Value
$5,850
Blue Options, Blue Advantage
$5,850

Not all HOPD facilities in this area are listed on the BCBS Cost Estimator. High and low costs for the same procedure in the Lincolnton area are shown below for comparison.

Caromont Specialty Surgery
HOPD
2511 Court Dr
Gastonia, NC 28054

Blue Value
$4,745
Blue Options, Blue Advantage
$4,745

Presb Surgery Center at Huntersville
HOPD
10030 Gilead Rd
Huntersville, NC 28078

Blue Value
$10,200
Blue Options, Blue Advantage
$10,200

Estimate Health Care Costs

[redacted]er a treatment or service

Tonsillectomy and Adenoidectomy

Location

Morganton, NC

Estimated Treatment Cost Results

Cost estimates are averages based on historical BCBSNC claims data. Amounts listed typically include physician fees, facility fees and costs for things like anesthesia, drugs, medical supplies – as well as customer responsibility (deductible, co-pay and co-insurance). Your actual costs may be different based on variations in these factors as well as your health plan design, deductibles/co-insurance and out-of-pocket limits.

HOPD: Hospital Outpatient Department

Non-HOPD: Non-Hospital Outpatient Department

Viewmont Surgery Center LLC
HOPD (Joint Physician Ownership)
[redacted]8th Ave NE
[redacted]ory, NC 28601

Blue Value
$2,841
Blue Options, Blue Advantage
$2,841

Catawba Valley Med Center
HOPD
810 Fairgrove Church Rd
Hickory, NC 28602

Blue Value
$6,325
Blue Options, Blue Advantage
$6,325

Not all HOPD facilities in this area are listed on the BCBS Cost Estimator. High and low costs for the same procedure in the Charlotte area are shown below for comparison.

Caromont Specialty Surgery
HOPD
2511 Court Dr
Gastonia, NC 28054

Blue Value
$2,135
Blue Options, Blue Advantage
$2,135

Carolinas Medical Center
HOPD
1000 Blythe Blvd
Charlotte, NC 28203

Blue Options, Blue Advantage
$8,733

[redacted]

Estimate Health Care Costs

Enter a treatment or service

ACL Repair by Arthroscopy

Location

Newton, NC

Estimated Treatment Cost Results

Cost estimates are averages based on historical BCBSNC claims data. Amounts listed typically include physician fees, facility fees and costs for things like anesthesia, drugs, medical supplies – as well as customer responsibility (deductible, co-pay and co-insurance). Your actual costs may be different based on variations in these factors as well as your health plan design, deductibles/co-insurance and out-of-pocket limits.

HOPD: Hospital Outpatient Department **Non-HOPD:** Non-Hospital Outpatient Department

Viewmont Surgery Center LLC **HOPD (Joint Physician Ownership)** 50 13th Ave NE Hickory, NC 28601	Blue Value **$12,295** Blue Options, Blue Advantage **$12,295**
Presbyterian Surgery Center at Huntersville **HOPD** 10030 Gilead Rd Huntersville, NC 28078	Blue Value **$16,355** Blue Options, Blue Advantage **$16,355**
Frye Regional Medical Center **HOPD** 420 N Center St Hickory, NC 28601	Blue Value **$17,977** Blue Options, Blue Advantage **$17,977**
Lake Norman Regional Medical Center **HOPD** 171 Fairview Rd Mooresville, NC 28117	Blue Value **$18,361** Blue Options, Blue Advantage **$18,361**
Novant Health Huntersville Med Center **HOPD** 10030 Gilead Rd Huntersville, NC 28078	Blue Value **$24,118** Blue Options, Blue Advantage **$26,860**
Iredell Memorial Hospital **HOPD** 557 Brookdale Dr Statesville, NC 28677	Blue Value **$27,590** Blue Options, Blue Advantage **$27,590**
CMC Lincoln **HOPD** 433 McAlister Rd Lincolnton, NC 28092	Blue Options, Blue Advantage **$27,997**

Estimate Health Care Costs

[redacted]ter a treatment or service

Bunionectomy

Location

Newton, NC

Estimated Treatment Cost Results

Cost estimates are averages based on historical BCBSNC claims data. Amounts listed typically include physician fees, facility fees and costs for things like anesthesia, drugs, medical supplies – as well as customer responsibility (deductible, co-pay and co-insurance). Your actual costs may be different based on variations in these factors as well as your health plan design, deductibles/co-insurance and out-of-pocket limits.

HOPD: Hospital Outpatient Department

Non-HOPD: Non-Hospital Outpatient Department

Viewmont Surgery Center LLC
HOPD (Joint Physician Ownership)
[redacted]3th Ave NE
[redacted]ory, NC 28601

Blue Value
$2,970
Blue Options, Blue Advantage
$2,970

Iredell Surgical Center
HOPD
1720 Davie Ave
Statesville, NC 28677

Blue Value
$3,127
Blue Options, Blue Advantage
$3,127

Frye Regional Medical Center
HOPD
420 N Center St
Hickory, NC 28601

Blue Value
$10,082
Blue Options, Blue Advantage
$10,082

CMC Lincoln
HOPD
433 McAlister Rd
Lincolnton, NC 28092

Blue Options, Blue Advantage
$11,477

Catawba Valley Med Center
HOPD
810 Fairgrove Church Rd
Hickory, NC 28602

Blue Value
$12,747
Blue Options, Blue Advantage
$12,747

Lake Norman Regional Medical Center
HOPD
171 Fairview Rd
[redacted]resville, NC 28117

Blue Value
$14,526
Blue Options, Blue Advantage
$14,526

Catawba Valley Med Center
HOPD
810 Fairgrove Church Rd
Hickory, NC 28602

Blue Value
$15,921
Blue Options, Blue Advantage
$15,921

Estimate Health Care Costs

Enter a treatment or service

Cataract Removal

Location

Newton, NC

Estimated Treatment Cost Results

Cost estimates are averages based on historical BCBSNC claims data. Amounts listed typically include physician fees, facility fees and costs for things like anesthesia, drugs, medical supplies – as well as customer responsibility (deductible, co-pay and co-insurance). Your actual costs may be different based on variations in these factors as well as your health plan design, deductibles/co-insurance and out-of-pocket limits.

HOPD: Hospital Outpatient Department

Non-HOPD: Non-Hospital Outpatient Department

Graystone Eye Surgery Center LLC
Non-HOPD
2424 Century Pl SE
Hickory, NC 28602

Blue Options, Blue Advantage
$2,181

Iredell Surgical Center
HOPD
1720 Davie Ave
Statesville, NC 28677

Blue Value
$3,157
Blue Options, Blue Advantage
$3,157

Lake Norman Regional Medical Center
HOPD
171 Fairview Rd
Mooresville, NC 28117

Blue Value
$3,556
Blue Options, Blue Advantage
$3,556

Presbyterian Surgery Center at Huntersville
HOPD
10030 Gilead Rd
Huntersville, NC 28078

Blue Value
$5,176
Blue Options, Blue Advantage
$5,176

Iredell Memorial Hospital
HOPD
557 Brookdale Dr
Statesville, NC 28677

Blue Value
$5,375
Blue Options, Blue Advantage
$5,375

Catawba Valley Med Center
HOPD
810 Fairgrove Church Rd
Hickory, NC 28602

Blue Value
$6,888
Blue Options, Blue Advantage
$6,888

CMC Lincoln
HOPD
433 McAlister Rd
Lincolnton, NC 28092

Blue Options, Blue Advantage
$8,778

Enter a treatment or service

CT Scan Head/Brain

Location

Newton, NC

Estimated Treatment Cost Results

Cost estimates are averages based on historical BCBSNC claims data. Amounts listed typically include physician fees, facility fees and costs for things like anesthesia, drugs, medical supplies – as well as customer responsibility (deductible, co-pay and co-insurance). Your actual costs may be different based on variations in these factors as well as your health plan design, deductibles/co-insurance and out-of-pocket limits.

HOPD: Hospital Outpatient Department

Non-HOPD: Non-Hospital Outpatient Department

Piedmont Healthcare, PA **Non-HOPD** 191A W Plaza Dr Mooresville, NC 28117	Blue Value **$408** Blue Options, Blue Advantage **$408**
Frye Regional Medical Center **HOPD** N Center St Hickory, NC 28601	Blue Value **$524** Blue Options, Blue Advantage **$524**
Lake Norman Regional Medical Center **HOPD** 171 Fairview Rd Mooresville, NC 28117	Blue Value **$791** Blue Options, Blue Advantage **$791**
Iredell Memorial Hospital **HOPD** 557 Brookdale Dr Statesville, NC 28677	Blue Value **$994** Blue Options, Blue Advantage **$994**
Catawba Valley Med Center **HOPD** 810 Fairgrove Church Rd Hickory, NC 28602	Blue Value **$1,249** Blue Options, Blue Advantage **$1,249**

Estimate Health Care Costs

Enter a treatment or service

Nasal/Sinus - Corrective Surgery

Location

Newton, NC

Estimated Treatment Cost Results

Cost estimates are averages based on historical BCBSNC claims data. Amounts listed typically include physician fees, facility fees and costs for things like anesthesia, drugs, medical supplies – as well as customer responsibility (deductible, co-pay and co-insurance). Your actual costs may be different based on variations in these factors as well as your health plan design, deductibles/co-insurance and out-of-pocket limits.

HOPD: Hospital Outpatient Department

Non-HOPD: Non-Hospital Outpatient Department

Iredell Head Neck & Ear
Non-HOPD
1720 Davie Ave
Statesville, NC 28677

Blue Value
$3,234
Blue Options, Blue Advantage
$3,234

Lake Norman Regional Medical Center
HOPD
171 Fairview Rd
Mooresville, NC 28117

Blue Value
$6,890
Blue Options, Blue Advantage
$6,890

Iredell Surgical Center
HOPD
1720 Davie Ave
Statesville, NC 28677

Blue Value
$8,318
Blue Options, Blue Advantage
$8,318

Estimate Health Care Costs

Enter a treatment or service

Tonsillectomy and Adenoidectomy

Location

Newton, NC

Estimated Treatment Cost Results

Cost estimates are averages based on historical BCBSNC claims data. Amounts listed typically include physician fees, facility fees and costs for things like anesthesia, drugs, medical supplies – as well as customer responsibility (deductible, co-pay and co-insurance). Your actual costs may be different based on variations in these factors as well as your health plan design, deductibles/co-insurance and out-of-pocket limits.

HOPD: Hospital Outpatient Department **Non-HOPD:** Non-Hospital Outpatient Department

Iredell Head Neck & Ear **Non-HOPD** 1720 Davie Ave Statesville, NC 28677	Blue Value **$1,536** Blue Options, Blue Advantage **$1,536**
Iredell Surgical Center **HOPD** [redacted]0 Davie Ave [redacted]tesville, NC 28677	Blue Value **$2,840** Blue Options, Blue Advantage **$2,840**
Viewmont Surgery Center LLC **HOPD (Joint Physician Ownership)** 50 13th Ave NE Hickory, NC 28601	Blue Value **$2,935** Blue Options, Blue Advantage **$2,935**
Lake Norman Regional Medical Center **HOPD** 171 Fairview Rd Mooresville, NC 28117	Blue Value **$4,863** Blue Options, Blue Advantage **$4,863**
Catawba Valley Med Center **HOPD** 810 Fairgrove Church Rd Hickory, NC 28602	Blue Value **$6,325** Blue Options, Blue Advantage **$6,325**
Iredell Memorial Hospital **HOPD** 557 Brookdale Dr Statesville, NC 28677	Blue Value **$6,706** Blue Options, Blue Advantage **$6,706**
Novant Health Huntersville Med Center **HOPD** [redacted]930 Gilead Rd [redacted]ntersville, NC 28078	Blue Value **$6,916** Blue Options, Blue Advantage **$7,656**
CMC Lincoln **HOPD** 433 McAlister Rd Lincolnton, NC 28092	Blue Options, Blue Advantage **$9,974**

Estimate Health Care Costs

[redacted]ter a treatment or service

ACL Repair by Arthroscopy

Location

Raleigh, NC

Estimated Treatment Cost Results

Cost estimates are averages based on historical BCBSNC claims data. Amounts listed typically include physician fees, facility fees and costs for things like anesthesia, drugs, medical supplies – as well as customer responsibility (deductible, co-pay and co-insurance). Your actual costs may be different based on variations in these factors as well as your health plan design, deductibles/co-insurance and out-of-pocket limits.

HOPD: Hospital Outpatient Department

Non-HOPD: Non-Hospital Outpatient Department

James E. Davis Ambulatory Surgery Center
HOPD
120 Carver St
Durham, NC 27704

Blue Options, Blue Advantage
$8,839

North Carolina Specialty Hospital
HOPD (Physician Owned)
[redacted]6 Ben Franklin Blvd
[redacted]am, NC 27704

Blue Value
$9,964
Blue Options, Blue Advantage
$9,964

North Carolina Specialty Hospital
HOPD
3916 Ben Franklin Blvd
Durham, NC 27704

Blue Value
$11,046
Blue Options, Blue Advantage
$11,046

Rex Surgery Center of Cary
HOPD
1505 SW Cary Pkwy, Ste 100
Cary, NC 27511

Blue Value
$12,557
Blue Options, Blue Advantage
$12,557

Duke University Hospital
HOPD
2301 Erwin Rd
Durham, NC 27710

Blue Options, Blue Advantage
$15,310

Raleigh Orthopaedic Surgery Center
HOPD (Joint Physician Ownership)
3001 Edwards Mill Rd, Ste 100
Raleigh, NC 27612

Blue Value
$15,354
Blue Options, Blue Advantage
$15,354

UNC Hospitals
HOPD
101 Manning Dr
Chapel Hill, NC 27514

Blue Value
$15,962
Blue Options, Blue Advantage
$18,885

Capital City Surgery Center LLC
[redacted]PD (Joint Physician Ownership)
[redacted]unnybrook Rd, Ste 100
[redacted]aleigh, NC 27610

Blue Value
$19,386
Blue Options, Blue Advantage
$19,386

Duke Raleigh Hospital
HOPD
3400 Wake Forest Rd
Raleigh, NC 27609

Blue Options, Blue Advantage
$20,389

Estimate Health Care Costs

Enter a treatment or service

Bunionectomy

Location

Raleigh, NC

Estimated Treatment Cost Results

Cost estimates are averages based on historical BCBSNC claims data. Amounts listed typically include physician fees, facility fees and costs for things like anesthesia, drugs, medical supplies – as well as customer responsibility (deductible, co-pay and co-insurance). Your actual costs may be different based on variations in these factors as well as your health plan design, deductibles/co-insurance and out-of-pocket limits.

HOPD: Hospital Outpatient Department

Non-HOPD: Non-Hospital Outpatient Department

Blue Ridge Surgery Center
Non-HOPD
2308 Wesvill Ct
Raleigh, NC 27607

Blue Value
$3,604
Blue Options, Blue Advantage
$3,604

Triangle Orthopaedics Surgery Center LLC
HOPD (Physician Owned)
7921 ACC Blvd
Raleigh, NC 27617

Blue Value
$5,162
Blue Options, Blue Advantage
$5,162

Rex Surgery Center of Cary
HOPD
1505 SW Cary Pkwy, Ste 100
Cary, NC 27511

Blue Value
$5,636
Blue Options, Blue Advantage
$5,636

WakeMed
HOPD
3000 New Bern Ave
Raleigh, NC 27610

Blue Value
$6,863
Blue Options, Blue Advantage
$6,863

Raleigh Orthopaedic Surgery Center
HOPD (Joint Physician Ownership)
3001 Edwards Mill Rd, Ste 100
Raleigh, NC 27612

Blue Value
$7,154
Blue Options, Blue Advantage
$7,154

Duke University Hospital
HOPD
3916 Ben Franklin Blvd
Durham, NC 27704

Blue Options, Blue Advantage
$10,680

Rex Hospital
HOPD
4420 Lake Boone Trl
Raleigh, NC 27607

Blue Value
$12,768
Blue Options, Blue Advantage
$15,332

Capital City Surgery Center LLC
HOPD (Joint Physician Ownership)
23 Sunnybrook Rd, Ste 100
Raleigh, NC 27610

Blue Value
$13,346
Blue Options, Blue Advantage
$13,346

Estimate Health Care Costs

[redacted]ter a treatment or service

Cataract Removal

Location

Raleigh, NC

Estimated Treatment Cost Results

Cost estimates are averages based on historical BCBSNC claims data. Amounts listed typically include physician fees, facility fees and costs for things like anesthesia, drugs, medical supplies – as well as customer responsibility (deductible, co-pay and co-insurance). Your actual costs may be different based on variations in these factors as well as your health plan design, deductibles/co-insurance and out-of-pocket limits.

HOPD: Hospital Outpatient Department

Non-HOPD: Non-Hospital Outpatient Department

Blue Ridge Surgery Center **Non-HOPD** 2308 Wesvill Ct Raleigh, NC 27607	Blue Value **$2,813** Blue Options, Blue Advantage **$2,813**
[redacted]th Carolina Specialty Hospital **HOPD (Physician Owned)** 3916 Ben Franklin Blvd Durham, NC 27704	Blue Options, Blue Advantage **$3,632**
Capital City Surgery Center LLC **HOPD (Joint Physician Ownership)** 23 Sunnybrook Rd, Ste 100 Raleigh, NC 27610	Blue Value **$4,434** Blue Options, Blue Advantage **$4,434**
WakeMed **HOPD** 3000 New Bern Ave Raleigh, NC 27610	Blue Options, Blue Advantage **$5,106**
James E. Davis Ambulatory Surgery Center **HOPD** 120 Carver St Durham, NC 27704	Blue Options, Blue Advantage **$5,274**
Rex Hospital **HOPD** 4420 Lake Boone Trl Raleigh, NC 27607	Blue Options, Blue Advantage **$5,537**
UNC Hospitals **HOPD** [redacted] Manning Dr [redacted]pel Hill, NC 27514	Blue Value **$7,798** Blue Options, Blue Advantage **$9,170**
Duke University Hospital **HOPD** 2301 Erwin Rd Durham, NC 27710	Blue Options, Blue Advantage **$10,613**

Estimate Health Care Costs

Enter a treatment or service

CT Scan Head/Brain

Location

Raleigh, NC

Estimated Treatment Cost Results

Cost estimates are averages based on historical BCBSNC claims data. Amounts listed typically include physician fees, facility fees and costs for things like anesthesia, drugs, medical supplies – as well as customer responsibility (deductible, co-pay and co-insurance). Your actual costs may be different based on variations in these factors as well as your health plan design, deductibles/co-insurance and out-of-pocket limits.

HOPD: Hospital Outpatient Department

Non-HOPD: Non-Hospital Outpatient Department

Raleigh Radiology **Non-HOPD** 3900 Barrett Dr, Ste 100 Raleigh Radiology Breast Center Raleigh, NC 27609	Blue Value **$328** Blue Options, Blue Advantage **$328**
Wake Internal Med Consultants, Inc. **Non-HOPD** 3100 Blue Ridge Rd, Ste 200 Raleigh, NC 27612	Blue Value **$338** Blue Options, Blue Advantage **$338**
Cancer Centers of North Carolina **Non-HOPD** 4101 Macon Pond Rd Raleigh, NC 27607	Blue Value **$367** Blue Options, Blue Advantage **$367**
WakeMed **HOPD** 3000 New Bern Ave Raleigh, NC 27610	Blue Options, Blue Advantage **$639**
Rex Hospital **HOPD** 4420 Lake Boone Trl Raleigh, NC 27607	Blue Value **$750** Blue Options, Blue Advantage **$919**
Duke Raleigh Hospital **HOPD** 3400 Wake Forest Rd Raleigh, NC 27609	Blue Options, Blue Advantage **$995**

Estimate Health Care Costs

[redacted]ter a treatment or service

Hernia

Location

Raleigh, NC

Estimated Treatment Cost Results

Cost estimates are averages based on historical BCBSNC claims data. Amounts listed typically include physician fees, facility fees and costs for things like anesthesia, drugs, medical supplies – as well as customer responsibility (deductible, co-pay and co-insurance). Your actual costs may be different based on variations in these factors as well as your health plan design, deductibles/co-insurance and out-of-pocket limits.

HOPD: Hospital Outpatient Department

Non-HOPD: Non-Hospital Outpatient Department

North Carolina Specialty Hospital **HOPD (Physician Owned)** 3916 Ben Franklin Blvd Durham, NC 27704	Blue Value **$4,247** Blue Options, Blue Advantage **$4,247**
[redacted]mes E. Davis Ambulatory Surgery Center **[redacted]PD** 120 Carver St Durham, NC 27704	Blue Options, Blue Advantage **$4,645**
Capital City Surgery Center LLC **HOPD (Joint Physician Ownership)** 23 Sunnybrook Rd, Ste 100 Raleigh, NC 27610	Blue Value **$6,723** Blue Options, Blue Advantage **$6,723**
Rex Hospital **HOPD** 4420 Lake Boone Trl Raleigh, NC 27607	Blue Value **$7,060** Blue Options, Blue Advantage **$8,304**
Duke Raleigh Hospital **HOPD** 3400 Wake Forest Rd Raleigh, NC 27609	Blue Options, Blue Advantage **$8,711**
UNC Hospitals **HOPD** 101 Manning Dr Chapel Hill, NC 27514	Blue Value **$8,784** Blue Options, Blue Advantage **$10,347**
WakeMed **HOPD** [redacted]0 New Bern Ave [redacted]eigh, NC 27610	Blue Options, Blue Advantage **$9,396**
Duke Regional Hospital **HOPD** 3643 N Roxboro St Durham, NC 27704	Blue Options, Blue Advantage **$9,423**

Enter a treatment or service

Nasal/Sinus - Corrective Surgery

Location

Raleigh, NC

Estimated Treatment Cost Results

Cost estimates are averages based on historical BCBSNC claims data. Amounts listed typically include physician fees, facility fees and costs for things like anesthesia, drugs, medical supplies – as well as customer responsibility (deductible, co-pay and co-insurance). Your actual costs may be different based on variations in these factors as well as your health plan design, deductibles/co-insurance and out-of-pocket limits.

HOPD: Hospital Outpatient Department

Non-HOPD: Non-Hospital Outpatient Department

Blue Ridge Surgery Center **Non-HOPD** 2308 Wesvill Ct Raleigh, NC 27607	Blue Value **$4,702** Blue Options, Blue Advantage **$4,702**
North Carolina Specialty Hospital **HOPD (Physician Owned)** 3916 Ben Franklin Blvd Durham, NC 27704	Blue Options, Blue Advantage **$4,906**
James E. Davis Ambulatory Surgery Center **HOPD** 120 Carver St Durham, NC 27704	Blue Options, Blue Advantage **$6,843**
Duke University Hospital **HOPD** 2301 Erwin Rd Durham, NC 27710	Blue Options, Blue Advantage **$8,244**
Blue Ridge Surgery Center **Non-HOPD** 2308 Wesvill Ct Raleigh, NC 27607	Blue Value **$10,147** Blue Options, Blue Advantage **$10,147**
Rex Hospital **HOPD** 4420 Lake Boone Trl Raleigh, NC 27607	Blue Options, Blue Advantage **$10,099**
UNC Hospitals **HOPD** 101 Manning Dr Chapel Hill, NC 27514	Blue Value **$13,765** Blue Options, Blue Advantage **$16,036**
Capital City Surgery Center LLC **HOPD (Joint Physician Ownership)** 23 Sunnybrook Rd, Ste 100 Raleigh, NC 27610	Blue Options, Blue Advantage **$20,029**

Estimate Health Care Costs

Enter a treatment or service

Rotator Cuff Repair

Location

Raleigh, NC

Estimated Treatment Cost Results

Cost estimates are averages based on historical BCBSNC claims data. Amounts listed typically include physician fees, facility fees and costs for things like anesthesia, drugs, medical supplies – as well as customer responsibility (deductible, co-pay and co-insurance). Your actual costs may be different based on variations in these factors as well as your health plan design, deductibles/co-insurance and out-of-pocket limits.

HOPD: Hospital Outpatient Department

Non-HOPD: Non-Hospital Outpatient Department

Blue Ridge Surgery Center **Non-HOPD** 2308 Wesvill Ct Raleigh, NC 27607	Blue Value **$9,164** Blue Options, Blue Advantage **$9,164**
Capital City Surgery Center LLC **HOPD (Joint Physician Ownership)** 23 Sunnybrook Rd, Ste 100 Raleigh, NC 27610	Blue Value **$10,267** Blue Options, Blue Advantage **$10,267**
Blue Ridge Surgery Center **Non-HOPD** 2308 Wesvill Ct Raleigh, NC 27607	Blue Value **$11,801** Blue Options, Blue Advantage **$11,801**
Raleigh Orthopaedic Surgery Center **HOPD (Joint Physician Ownership)** 3001 Edwards Mill Rd, Ste 100 Raleigh, NC 27612	Blue Value **$13,454** Blue Options, Blue Advantage **$13,454**
Raleigh Orthopaedic Surgery Center **Non-HOPD** 3001 Edwards Mill Rd, Ste 100 Raleigh, NC 27612	Blue Value **$13,636** Blue Options, Blue Advantage **$13,636**
Duke University Hospital **HOPD** 2301 Erwin Rd Durham, NC 27710	Blue Options, Blue Advantage **$14,930**
Duke Raleigh Hospital **HOPD** [redacted] Wake Forest Rd [redacted]igh, NC 27609	Blue Options, Blue Advantage **$15,111**
Duke University Hospital **HOPD** 2301 Erwin Rd Durham, NC 27710	Blue Options, Blue Advantage **$19,577**

Estimate Health Care Costs

Enter a treatment or service

Tonsillectomy and Adenoidectomy

Location

Raleigh, NC

Estimated Treatment Cost Results

Cost estimates are averages based on historical BCBSNC claims data. Amounts listed typically include physician fees, facility fees and costs for things like anesthesia, drugs, medical supplies – as well as customer responsibility (deductible, co-pay and co-insurance). Your actual costs may be different based on variations in these factors as well as your health plan design, deductibles/co-insurance and out-of-pocket limits.

HOPD: Hospital Outpatient Department

Non-HOPD: Non-Hospital Outpatient Department

Blue Ridge Surgery Center **Non-HOPD** 2308 Wesvill Ct Raleigh, NC 27607	Blue Value **$2,850** Blue Options, Blue Advantage **$2,850**
North Carolina Specialty Hospital **HOPD (Physician Owned)** 3916 Ben Franklin Blvd Durham, NC 27704	Blue Options, Blue Advantage **$2,899**
James E. Davis Ambulatory Surgery Center **HOPD** 120 Carver St Durham, NC 27704	Blue Options, Blue Advantage **$3,344**
Capital City Surgery Center LLC **HOPD (Joint Physician Ownership)** 23 Sunnybrook Rd, Ste 100 Raleigh, NC 27610	Blue Value **$5,077** Blue Options, Blue Advantage **$5,077**
WakeMed **HOPD** 3000 New Bern Ave Raleigh, NC 27610	Blue Options, Blue Advantage **$5,787**
Rex Hospital **HOPD** 4420 Lake Boone Trl Raleigh, NC 27607	Blue Value **$7,079** Blue Options, Blue Advantage **$8,485**
Duke Raleigh Hospital **HOPD** 3400 Wake Forest Rd Raleigh, NC 27609	Blue Options, Blue Advantage **$7,366**

Estimate Health Care Costs

[redacted]ter a treatment or service

Tympanostomy and Myringotomy

Location

Raleigh, NC

Estimated Treatment Cost Results

Cost estimates are averages based on historical BCBSNC claims data. Amounts listed typically include physician fees, facility fees and costs for things like anesthesia, drugs, medical supplies – as well as customer responsibility (deductible, co-pay and co-insurance). Your actual costs may be different based on variations in these factors as well as your health plan design, deductibles/co-insurance and out-of-pocket limits.

HOPD: Hospital Outpatient Department

Non-HOPD: Non-Hospital Outpatient Department

North Carolina Specialty Hospital
HOPD (Physician Owned)
3916 Ben Franklin Blvd
Durham, NC 27704

Blue Options, Blue Advantage
$2,114

Blue Ridge Surgery Center
Non-HOPD
[redacted] Wesvill Ct
[redacted]eigh, NC 27607

Blue Value
$2,744
Blue Options, Blue Advantage
$2,744

James E. Davis Ambulatory Surgery Center
HOPD
120 Carver St
Durham, NC 27704

Blue Options, Blue Advantage
$2,902

UNC Hospitals
HOPD
101 Manning Dr
Chapel Hill, NC 27514

Blue Value
$3,540
Blue Options, Blue Advantage
$4,176

Capital City Surgery Center LLC
HOPD (Joint Physician Ownership)
23 Sunnybrook Rd, Ste 100
Raleigh, NC 27610

Blue Value
$4,212
Blue Options, Blue Advantage
$4,212

WakeMed
HOPD
3000 New Bern Ave
Raleigh, NC 27610

Blue Options, Blue Advantage
$4,693

UNC Hospitals
HOPD
101 Manning Dr
Chapel Hill, NC 27514

Blue Value
$5,294
Blue Options, Blue Advantage
$6,208

Duke University Hospital
HOPD
[redacted] Erwin Rd
[redacted]ham, NC 27710

Blue Options, Blue Advantage
$6,671

UNC Hospitals
HOPD
101 Manning Dr
Chapel Hill, NC 27514

Blue Value
$11,380
Blue Options, Blue Advantage
$13,812

Enter a treatment or service

ACL Repair by Arthroscopy

Location

Oxford, NC

Estimated Treatment Cost Results

Cost estimates are averages based on historical BCBSNC claims data. Amounts listed typically include physician fees, facility fees and costs for things like anesthesia, drugs, medical supplies – as well as customer responsibility (deductible, co-pay and co-insurance). Your actual costs may be different based on variations in these factors as well as your health plan design, deductibles/co-insurance and out-of-pocket limits.

HOPD: Hospital Outpatient Department **Non-HOPD:** Non-Hospital Outpatient Department

James E. Davis Ambulatory Surgery Center **HOPD** 120 Carver St Durham, NC 27704	Blue Options, Blue Advantage **$8,839**
Blue Ridge Surgery Center **Non-HOPD** 2308 Wesvill Ct Raleigh, NC 27607	Blue Value **$9,687** Blue Options, Blue Advantage **$9,687**
North Carolina Specialty Hospital **Non-HOPD** 3916 Ben Franklin Blvd Durham, NC 27704	Blue Value **$9,964** Blue Options, Blue Advantage **$9,964**
Rex Surgery Center of Cary **HOPD** 1505 SW Cary Pkwy, Ste 100 Cary, NC 27511	Blue Value **$12,068** Blue Options, Blue Advantage **$12,068**
Rex Hospital **HOPD** 4420 Lake Boone Trl Raleigh, NC 27607	Blue Value **$14,642** Blue Options, Blue Advantage **$17,473**
UNC Hospitals **HOPD** 101 Manning Dr Chapel Hill, NC 27514	Blue Value **$15,189** Blue Options, Blue Advantage **$17,979**
Raleigh Orthopaedic Surgery Center **Non-HOPD** 3001 Edwards Mill Rd, Ste 100 Raleigh, NC 27612	Blue Value **$15,213** Blue Options, Blue Advantage **$15,213**
Granville Medical Center **HOPD** 1010 College St Oxford, NC 27565	Blue Options, Blue Advantage **$19,561**
Duke Raleigh Hospital **HOPD** 3400 Wake Forest Rd Raleigh, NC 27609	Blue Options, Blue Advantage **$19,613**

NC Estimate Health Care Costs

Enter a treatment or service

Bunionectomy

Location

Oxford, NC

Estimated Treatment Cost Results

Cost estimates are averages based on historical BCBSNC claims data. Amounts listed typically include physician fees, facility fees and costs for things like anesthesia, drugs, medical supplies – as well as customer responsibility (deductible, co-pay and co-insurance). Your actual costs may be different based on variations in these factors as well as your health plan design, deductibles/co-insurance and out-of-pocket limits.

HOPD: Hospital Outpatient Department **Non-HOPD:** Non-Hospital Outpatient Department

Blue Ridge Surgery Center **Non-HOPD** 2308 Wesvill Ct Raleigh, NC 27607	Blue Options, Blue Advantage **$4,024**
James E. Davis Ambulatory Surgery Center **HOPD** 120 Carver St Durham, NC 27704	Blue Options, Blue Advantage **$4,623**
Rex Surgery Center of Cary **HOPD** 1505 SW Cary Pkwy, Ste 100 Cary, NC 27511	Blue Value **$6,032** Blue Options, Blue Advantage **$6,032**
Raleigh Orthopaedic Surgery Center **HOPD** 3001 Edwards Mill Rd, Ste 100 Raleigh, NC 27612	Blue Value **$7,248** Blue Options, Blue Advantage **$7,248**
North Carolina Specialty Hospital **Non-HOPD** 3916 Ben Franklin Blvd Durham, NC 27704	Blue Value **$8,081** Blue Options, Blue Advantage **$8,081**
Alamance Regional Medical Center **HOPD** 1240 Huffman Mill Rd Burlington, NC 27215	Blue Value **$9,629** Blue Options, Blue Advantage **$9,629**
UNC Hospitals **HOPD** 101 Manning Dr Chapel Hill, NC 27514	Blue Value **$9,955** Blue Options, Blue Advantage **$11,869**
Rex Hospital **HOPD** 4420 Lake Boone Trl Raleigh, NC 27607	Blue Value **$12,768** Blue Options, Blue Advantage **$15,332**
Duke University Hospital **HOPD** 3916 Ben Franklin Blvd Durham, NC 27704	Blue Options, Blue Advantage **$16,435**

Enter a treatment or service

Cataract Removal

Location

Oxford, NC

Estimated Treatment Cost Results

Cost estimates are averages based on historical BCBSNC claims data. Amounts listed typically include physician fees, facility fees and costs for things like anesthesia, drugs, medical supplies – as well as customer responsibility (deductible, co-pay and co-insurance). Your actual costs may be different based on variations in these factors as well as your health plan design, deductibles/co-insurance and out-of-pocket limits.

HOPD: Hospital Outpatient Department **Non-HOPD:** Non-Hospital Outpatient Department

Blue Ridge Surgery Center **Non-HOPD** 2308 Wesvill Ct Raleigh, NC 27607	Blue Value **$2,813** Blue Options, Blue Advantage **$2,813**
North Carolina Specialty Hospital **HOPD (Physician Owned Hospital)** 916 Ben Franklin Blvd Durham, NC 27704	Blue Options, Blue Advantage **$3,520**
Alamance Regional Medical Center **HOPD** 1240 Huffman Mill Rd Burlington, NC 27215	Blue Value **$4,210** Blue Options, Blue Advantage **$4,210**
James E. Davis Ambulatory Surgery Center **HOPD** 120 Carver St Durham, NC 27704	Blue Options, Blue Advantage **$4,987**
Dlp Person Memorial Hospital LLC **HOPD** 615 Ridge Rd Roxboro, NC 27573	Blue Value **$5,666** Blue Options, Blue Advantage **$5,666**
Granville Medical Center **HOPD** 1010 College St Oxford, NC 27565	Blue Options, Blue Advantage **$6,944**
D. L. P. Maria Parham Medical Center LLC **HOPD** 566 Ruin Creek Rd Henderson, NC 27536	Blue Value **$7,341** Blue Options, Blue Advantage **$7,341**
Novant Health Franklin Medical Center **HOPD** 100 Hospital Dr Louisburg, NC 27549	Blue Value **$8,111** Blue Options, Blue Advantage **$8,111**
Duke University Hospital **HOPD** 2301 Erwin Rd Durham, NC 27710	Blue Options, Blue Advantage **$10,500**

NC Estimate Health Care Costs

Enter a treatment or service

CT Scan Head/Brain

Location

Oxford, NC

Estimated Treatment Cost Results

Cost estimates are averages based on historical BCBSNC claims data. Amounts listed typically include physician fees, facility fees and costs for things like anesthesia, drugs, medical supplies – as well as customer responsibility (deductible, co-pay and co-insurance). Your actual costs may be different based on variations in these factors as well as your health plan design, deductibles/co-insurance and out-of-pocket limits.

HOPD: Hospital Outpatient Department **Non-HOPD:** Non-Hospital Outpatient Department

Wake Internal Med Consultants, Inc. **Non-HOPD** 3100 Blue Ridge Rd, Ste 200 Raleigh, NC 27612	Blue Value **$283** Blue Options, Blue Advantage **$283**
Raleigh Radiology **Non-HOPD** 3900 Barrett Dr, Ste 100 Raleigh Radiology Breast Center Raleigh, NC 27609	Blue Value **$328** Blue Options, Blue Advantage **$328**
Alliance Medical Associates **Non-HOPD** 2905 Crouse Ln Burlington, NC 27215	Blue Value **$336** Blue Options, Blue Advantage **$336**
Wake Radiology Diagnostic Imaging **HOPD** 3309 Rogers Rd, Ste 209 Wake Forest, NC 27587	Blue Value **$531** Blue Options, Blue Advantage **$531**
Granville Medical Center **HOPD** 1010 College St Oxford, NC 27565	Blue Options, Blue Advantage **$860**
Duke Raleigh Hospital **HOPD** 3400 Wake Forest Rd Raleigh, NC 27609	Blue Options, Blue Advantage **$1,014**
Alamance Regional Medical Center **HOPD** 1240 Huffman Mill Rd Burlington, NC 27215	Blue Value **$1,020** Blue Options, Blue Advantage **$1,020**
Novant Health Franklin Medical Center **HOPD** 100 Hospital Dr Louisburg, NC 27549	Blue Value **$1,088** Blue Options, Blue Advantage **$1,088**
. L. P. Maria Parham Medical Center LLC **HOPD** 566 Ruin Creek Rd Henderson, NC 27536	Blue Value **$1,153** Blue Options, Blue Advantage **$1,153**

Estimate Health Care Costs

Enter a treatment or service

Nasal/Sinus - Corrective Surgery

Location

Oxford, NC

Estimated Treatment Cost Results

Cost estimates are averages based on historical BCBSNC claims data. Amounts listed typically include physician fees, facility fees and costs for things like anesthesia, drugs, medical supplies – as well as customer responsibility (deductible, co-pay and co-insurance). Your actual costs may be different based on variations in these factors as well as your health plan design, deductibles/co-insurance and out-of-pocket limits.

HOPD: Hospital Outpatient Department **Non-HOPD:** Non-Hospital Outpatient Department

North Carolina Specialty Hospital **HOPD (Physician Owned Hospital)** 3916 Ben Franklin Blvd Durham, NC 27704	Blue Options, Blue Advantage **$4,906**
lue Ridge Surgery Center **on-HOPD** 2308 Wesvill Ct Raleigh, NC 27607	Blue Value **$5,401** Blue Options, Blue Advantage **$5,401**
Alamance Regional Medical Center **HOPD** 1240 Huffman Mill Rd Burlington, NC 27215	Blue Value **$7,628** Blue Options, Blue Advantage **$7,628**
Granville Medical Center **HOPD** 1010 College St Oxford, NC 27565	Blue Options, Blue Advantage **$7,941**
Rex Surgery Center of Cary **HOPD** 1505 SW Cary Pkwy, Ste 100 Cary, NC 27511	Blue Value **$9,595** Blue Options, Blue Advantage **$9,595**
Duke University Hospital **HOPD** 2301 Erwin Rd Durham, NC 27710	Blue Options, Blue Advantage **$10,084**
UNC Hospitals **HOPD** 101 Manning Dr hapel Hill, NC 27514	Blue Value **$13,597** Blue Options, Blue Advantage **$15,843**

NC Estimate Health Care Costs

Enter a treatment or service

Tonsillectomy and Adenoidectomy

Location

Oxford, NC

Estimated Treatment Cost Results

Cost estimates are averages based on historical BCBSNC claims data. Amounts listed typically include physician fees, facility fees and costs for things like anesthesia, drugs, medical supplies – as well as customer responsibility (deductible, co-pay and co-insurance). Your actual costs may be different based on variations in these factors as well as your health plan design, deductibles/co-insurance and out-of-pocket limits.

HOPD: Hospital Outpatient Department **Non-HOPD:** Non-Hospital Outpatient Department

North Carolina Specialty Hospital **HOPD (Physician Owned Hospital)** 3916 Ben Franklin Blvd Durham, NC 27704	Blue Options, Blue Advantage **$2,899**
Blue Ridge Surgery Center **Non-HOPD** 308 Wesvill Ct Raleigh, NC 27607	Blue Value **$3,094** Blue Options, Blue Advantage **$3,094**
James E. Davis Ambulatory Surgery Center **HOPD** 120 Carver St Durham, NC 27704	Blue Options, Blue Advantage **$3,301**
Rex Surgery Center of Cary **HOPD** 1505 SW Cary Pkwy, Ste 100 Cary, NC 27511	Blue Options, Blue Advantage **$3,785**
Alamance Regional Medical Center **HOPD** 1240 Huffman Mill Rd Burlington, NC 27215	Blue Value **$4,153** Blue Options, Blue Advantage **$4,153**
UNC Hospitals **HOPD** 101 Manning Dr Chapel Hill, NC 27514	Blue Value **$5,147** Blue Options, Blue Advantage **$5,147**
Duke University Hospital **Non-HOPD** 2301 Erwin Rd Durham, NC 27710	Blue Options, Blue Advantage **$6,801**
Duke Raleigh Hospital **HOPD** 3400 Wake Forest Rd Raleigh, NC 27609	Blue Options, Blue Advantage **$7,366**
Novant Health Franklin Medical Center **HOPD** 100 Hospital Dr Louisburg, NC 27549	Blue Value **$11,546** Blue Options, Blue Advantage **$11,546**

NC Estimate Health Care Costs

Enter a treatment or service

ACL Repair by Arthroscopy

Location

Rockingham County

Estimated Treatment Cost Results

Cost estimates are averages based on historical BCBSNC claims data. Amounts listed typically include physician fees, facility fees and costs for things like anesthesia, drugs, medical supplies – as well as customer responsibility (deductible, co-pay and co-insurance). Your actual costs may be different based on variations in these factors as well as your health plan design, deductibles/co-insurance and out-of-pocket limits.

HOPD: Hospital Outpatient Department **Non-HOPD:** Non-Hospital Outpatient Department

Surgical Center of Greensboro **Non-HOPD** 1211 Virginia St Greensboro, NC 27401	Blue Value **$9,737** Blue Options, Blue Advantage **$9,737**
Moses Cone Memorial Hospital **HOPD** 1200 N Elm St Greensboro, NC 27401	Blue Value **$10,560** Blue Options, Blue Advantage **$10,560**
Moses Cone Memorial Hospital **HOPD** 1200 N Elm St Greensboro, NC 27401	Blue Options, Blue Advantage **$12,665**
Surgical Center of Greensboro **Non-HOPD** 1211 Virginia St Greensboro, NC 27401	Blue Value **$13,039** Blue Options, Blue Advantage **$13,039**

NC Estimate Health Care Costs

Enter a treatment or service

Bunionectomy

Location

Rockingham County

Estimated Treatment Cost Results

Cost estimates are averages based on historical BCBSNC claims data. Amounts listed typically include physician fees, facility fees and costs for things like anesthesia, drugs, medical supplies – as well as customer responsibility (deductible, co-pay and co-insurance). Your actual costs may be different based on variations in these factors as well as your health plan design, deductibles/co-insurance and out-of-pocket limits.

HOPD: Hospital Outpatient Department **Non-HOPD:** Non-Hospital Outpatient Department

High Point Surgery Center
HOPD
600 N Lindsay St
High Point, NC 27262

Blue Value
$9,030
Blue Options, Blue Advantage
$9,030

Surgical Center of Greensboro
Non-HOPD
211 Virginia St
Greensboro, NC 27401

Blue Value
$10,859
Blue Options, Blue Advantage
$10,859

Moses Cone Memorial Hospital
HOPD
1200 N Elm St
Greensboro, NC 27401

Blue Options, Blue Advantage
$12,665

Estimate Health Care Costs

Enter a treatment or service

Cataract Removal

Location

Rockingham County

Estimated Treatment Cost Results

Cost estimates are averages based on historical BCBSNC claims data. Amounts listed typically include physician fees, facility fees and costs for things like anesthesia, drugs, medical supplies – as well as customer responsibility (deductible, co-pay and co-insurance). Your actual costs may be different based on variations in these factors as well as your health plan design, deductibles/co-insurance and out-of-pocket limits.

HOPD: Hospital Outpatient Department **Non-HOPD:** Non-Hospital Outpatient Department

Surgical Eye Center of Greensboro **Non-HOPD** 3312 Battleground Ave Greensboro, NC 27410	Blue Value **$2,402** Blue Options, Blue Advantage **$2,402**
Greensboro Specialty Surgical Center **Non-HOPD** 812 N Elm St Greensboro, NC 27455	Blue Options, Blue Advantage **$2,845**
Pioneer Community Hospital of Stoke **HOPD** 1570 Nc 8 And 89 Hwy N Danbury, NC 27016	Blue Options, Blue Advantage **$4,285**
Morehead Memorial Hospital **HOPD** 117 E Kings Hwy Eden, NC 27288	Blue Value **$5,752** Blue Options, Blue Advantage **$5,752**
Moses Cone Memorial Hospital **HOPD** 1200 N Elm St Greensboro, NC 27401	Blue Options, Blue Advantage **$5,934**

Estimate Health Care Costs

Enter a treatment or service

CT Scan Head/Brain

Location

Rockingham County

Estimated Treatment Cost Results

Cost estimates are averages based on historical BCBSNC claims data. Amounts listed typically include physician fees, facility fees and costs for things like anesthesia, drugs, medical supplies – as well as customer responsibility (deductible, co-pay and co-insurance). Your actual costs may be different based on variations in these factors as well as your health plan design, deductibles/co-insurance and out-of-pocket limits.

HOPD: Hospital Outpatient Department **Non-HOPD:** Non-Hospital Outpatient Department

Advanced Heart Failure Clinic **Non-HOPD** 1200 N Elm St Greensboro, NC 27401	Blue Value **$379** Blue Options, Blue Advantage **$379**
Lebauer Healthcare **HOPD** 618 S Main St, Heartcare At Reidsville Reidsville, NC 27320	Blue Value **$479** Blue Options, Blue Advantage **$479**
Greensboro Radiology, PA **Non-HOPD** 117 E Kings Hwy, Morehead Hospital Eden, NC 27288	Blue Value **$560** Blue Options, Blue Advantage **$560**
Greensboro Radiology, PA **Non-HOPD** 618 S Main St, Annie Penn Hospital Reidsville, NC 27320	Blue Value **$560** Blue Options, Blue Advantage **$560**
Moses Cone Memorial Hospital **HOPD** 1200 N Elm St Greensboro, NC 27401	Blue Options, Blue Advantage **$1,084**
Alamance Regional Medical Center **HOPD** 1240 Huffman Mill Rd Burlington, NC 27215	Blue Value **$1,090** Blue Options, Blue Advantage **$1,090**

NC Estimate Health Care Costs

Enter a treatment or service

Nasal/Sinus - Corrective Surgery

Location

Rockingham County

Estimated Treatment Cost Results

Cost estimates are averages based on historical BCBSNC claims data. Amounts listed typically include physician fees, facility fees and costs for things like anesthesia, drugs, medical supplies – as well as customer responsibility (deductible, co-pay and co-insurance). Your actual costs may be different based on variations in these factors as well as your health plan design, deductibles/co-insurance and out-of-pocket limits.

HOPD: Hospital Outpatient Department **Non-HOPD:** Non-Hospital Outpatient Department

Surgical Center of Greensboro **Non-HOPD** 1211 Virginia St Greensboro, NC 27401	Blue Value **$6,329** Blue Options, Blue Advantage **$6,329**
Moses Cone Memorial Hospital **HOPD** 1200 N Elm St Greensboro, NC 27401	Blue Options, Blue Advantage **$7,310**
Alamance Regional Medical Center **HOPD** 1240 Huffman Mill Rd Burlington, NC 27215	Blue Value **$7,628** Blue Options, Blue Advantage **$7,628**
High Point Surgery Center **HOPD** 600 N Lindsay St High Point, NC 27262	Blue Value **$7,802** Blue Options, Blue Advantage **$7,802**
Moses Cone Memorial Hospital **HOPD** 1200 N Elm St Greensboro, NC 27401	Blue Options, Blue Advantage **$8,050**

Estimate Health Care Costs

Enter a treatment or service

Tonsillectomy and Adenoidectomy

Location

Rockingham County

Estimated Treatment Cost Results

Cost estimates are averages based on historical BCBSNC claims data. Amounts listed typically include physician fees, facility fees and costs for things like anesthesia, drugs, medical supplies – as well as customer responsibility (deductible, co-pay and co-insurance). Your actual costs may be different based on variations in these factors as well as your health plan design, deductibles/co-insurance and out-of-pocket limits.

HOPD: Hospital Outpatient Department **Non-HOPD:** Non-Hospital Outpatient Department

High Point Surgery Center **HOPD** 600 N Lindsay St High Point, NC 27262	Blue Value **$2,699** Blue Options, Blue Advantage **$2,699**
Surgical Center of Greensboro **Non-HOPD** 211 Virginia St Greensboro, NC 27401	Blue Value **$3,021** Blue Options, Blue Advantage **$3,021**
Alamance Regional Medical Center **HOPD** 1240 Huffman Mill Rd Burlington, NC 27215	Blue Value **$4,847** Blue Options, Blue Advantage **$4,847**
Moses Cone Memorial Hospital **HOPD** 1200 N Elm St Greensboro, NC 27401	Blue Options, Blue Advantage **$5,006**
Morehead Memorial Hospital **HOPD** 117 E Kings Hwy Eden, NC 27288	Blue Value **$5,656** Blue Options, Blue Advantage **$5,656**

NC Estimate Health Care Costs

Enter a treatment or service

ACL Repair by Arthroscopy

Location

Durham, NC

Estimated Treatment Cost Results

Cost estimates are averages based on historical BCBSNC claims data. Amounts listed typically include physician fees, facility fees and costs for things like anesthesia, drugs, medical supplies – as well as customer responsibility (deductible, co-pay and co-insurance). Your actual costs may be different based on variations in these factors as well as your health plan design, deductibles/co-insurance and out-of-pocket limits.

HOPD: Hospital Outpatient Department **Non-HOPD:** Non-Hospital Outpatient Department

James E. Davis Ambulatory Surgery Center **HOPD** 120 Carver St Durham, NC 27704	Blue Options, Blue Advantage **$9,724**
North Carolina Specialty Hospital **HOPD (Physician Owned)** 3916 Ben Franklin Blvd Durham, NC 27704	Blue Value **$9,964** Blue Options, Blue Advantage **$9,964**
Blue Ridge Surgery Center **Non-HOPD** 2308 Wesvill Ct Raleigh, NC 27607	Blue Value **$10,959** Blue Options, Blue Advantage **$10,959**
Triangle Orthopaedics Surgery Center LLC **Non-HOPD** 7921 ACC Blvd Raleigh, NC 27617	Blue Value **$11,120** Blue Options, Blue Advantage **$11,120**
Raleigh Orthopaedic Surgery Center **HOPD (Joint Physician Ownership)** 3001 Edwards Mill Rd, Ste 100 Raleigh, NC 27612	Blue Value **$15,264** Blue Options, Blue Advantage **$15,264**
Rex Hospital **HOPD** 4420 Lake Boone Trl Raleigh, NC 27607	Blue Value **$15,790** Blue Options, Blue Advantage **$18,768**
UNC Hospitals **HOPD** 101 Manning Dr Chapel Hill, NC 27514	Blue Value **$16,793** Blue Options, Blue Advantage **$19,883**
Capital City Surgery Center LLC **HOPD (Joint Physician Ownership)** 23 Sunnybrook Rd, Ste 100 Raleigh, NC 27610	Blue Value **$19,386** Blue Options, Blue Advantage **$19,386**
Duke Raleigh Hospital **HOPD** 3400 Wake Forest Rd Raleigh, NC 27609	Blue Options, Blue Advantage **$19,613**

NC Estimate Health Care Costs

Enter a treatment or service

ACL Repair by Arthroscopy

Location

Salisbury, NC

Estimated Treatment Cost Results

Cost estimates are averages based on historical BCBSNC claims data. Amounts listed typically include physician fees, facility fees and costs for things like anesthesia, drugs, medical supplies – as well as customer responsibility (deductible, co-pay and co-insurance). Your actual costs may be different based on variations in these factors as well as your health plan design, deductibles/co-insurance and out-of-pocket limits.

HOPD: Hospital Outpatient Department **Non-HOPD:** Non-Hospital Outpatient Department

Gateway Surgery Center **Non-HOPD** 1025 NE Gateway Ct NE Concord, NC 28025	Blue Value **$9,710** Blue Options, Blue Advantage **$9,710**
Carolinas Medical Center University **HOPD** 8800 N Tryon St Charlotte, NC 28262	Blue Value **$15,465** Blue Options, Blue Advantage **$15,465**
Novant Health Rowan Medical Center **HOPD** 612 Mocksville Ave Salisbury, NC 28144	Blue Value **$16,529** Blue Options, Blue Advantage **$18,313**
Novant Health Huntersville Med Center **HOPD** 10030 Gilead Rd Huntersville, NC 28078	Blue Value **$24,118** Blue Options, Blue Advantage **$26,860**
Iredell Memorial Hospital **HOPD** 557 Brookdale Dr Statesville, NC 28677	Blue Value **$27,590** Blue Options, Blue Advantage **$27,590**

NC Estimate Health Care Costs

Enter a treatment or service

Bunionectomy

Location

Salisbury, NC

Estimated Treatment Cost Results

Cost estimates are averages based on historical BCBSNC claims data. Amounts listed typically include physician fees, facility fees and costs for things like anesthesia, drugs, medical supplies – as well as customer responsibility (deductible, co-pay and co-insurance). Your actual costs may be different based on variations in these factors as well as your health plan design, deductibles/co-insurance and out-of-pocket limits.

HOPD: Hospital Outpatient Department **Non-HOPD:** Non-Hospital Outpatient Department

Gateway Surgery Center **Non-HOPD** 1025 NE Gateway Ct NE Concord, NC 28025	Blue Options, Blue Advantage **$3,341**
resbyterian Surgery Center at Huntersville **OPD** 10030 Gilead Rd Huntersville, NC 28078	Blue Value **$8,445** Blue Options, Blue Advantage **$8,445**
Novant Health Rowan Medical Center **HOPD** 612 Mocksville Ave Salisbury, NC 28144	Blue Value **$9,087** Blue Options, Blue Advantage **$10,055**
Lake Norman Regional Medical Center **HOPD** 171 Fairview Rd Mooresville, NC 28117	Blue Value **$14,526** Blue Options, Blue Advantage **$14,526**

Estimate Health Care Costs

Enter a treatment or service

Cataract Removal

Location

Salisbury, NC

Estimated Treatment Cost Results

Cost estimates are averages based on historical BCBSNC claims data. Amounts listed typically include physician fees, facility fees and costs for things like anesthesia, drugs, medical supplies – as well as customer responsibility (deductible, co-pay and co-insurance). Your actual costs may be different based on variations in these factors as well as your health plan design, deductibles/co-insurance and out-of-pocket limits.

HOPD: Hospital Outpatient Department **Non-HOPD:** Non-Hospital Outpatient Department

Eye Surgery & Laser Clinic **Non-HOPD** 201 Le Phillip Ct NE Concord, NC 28025	Blue Options, Blue Advantage **$1,687**
Iredell Surgical Center **HOPD** 1720 Davie Ave Statesville, NC 28677	Blue Value **$3,536** Blue Options, Blue Advantage **$3,536**
Iredell Memorial Hospital **HOPD** 557 Brookdale Dr Statesville, NC 28677	Blue Value **$4,459** Blue Options, Blue Advantage **$4,459**
Presbyterian Surgery Center at Huntersville **HOPD** 10030 Gilead Rd Huntersville, NC 28078	Blue Value **$5,241** Blue Options, Blue Advantage **$5,241**
Novant Health Rowan Medical Center **HOPD** 612 Mocksville Ave Salisbury, NC 28144	Blue Value **$6,212** Blue Options, Blue Advantage **$6,874**
Davie County Hospital **HOPD** 223 Hospital St Mocksville, NC 27028	Blue Value **$7,500** Blue Options, Blue Advantage **$7,500**
Carolinas Medical Center University **HOPD** 8300 N Tryon St Charlotte, NC 28262	Blue Value **$8,594** Blue Options, Blue Advantage **$8,594**

Enter a treatment or service

CT Scan Head/Brain

Location

Salisbury, NC

Estimated Treatment Cost Results

Cost estimates are averages based on historical BCBSNC claims data. Amounts listed typically include physician fees, facility fees and costs for things like anesthesia, drugs, medical supplies – as well as customer responsibility (deductible, co-pay and co-insurance). Your actual costs may be different based on variations in these factors as well as your health plan design, deductibles/co-insurance and out-of-pocket limits.

HOPD: Hospital Outpatient Department **Non-HOPD:** Non-Hospital Outpatient Department

Rowan Diagnostic Clinic, PA **Non-HOPD** 611 Mocksville Ave Salisbury, NC 28144	Blue Value **$341** Blue Options, Blue Advantage **$341**
Carolina Neurosurgery & Spine Associates **Non-HOPD** [redacted]25 Baldwin Ave [redacted]harlotte, NC 28204	Blue Value **$461** Blue Options, Blue Advantage **$461**
Lake Norman Regional Medical Center **HOPD** 171 Fairview Rd Mooresville, NC 28117	Blue Value **$791** Blue Options, Blue Advantage **$791**
Novant Health Rowan Medical Center **HOPD** 612 Mocksville Ave Salisbury, NC 28144	Blue Value **$857** Blue Options, Blue Advantage **$959**
Novant Health Rowan Medical Center **HOPD** 612 Mocksville Ave Salisbury, NC 28144	Blue Value **$887** Blue Options, Blue Advantage **$993**
Novant Health Huntersville Med Center **HOPD** 10030 Gilead Rd Huntersville, NC 28078	Blue Value **$948** Blue Options, Blue Advantage **$1,062**
CMC Northeast **HOPD** 920 Church St N Concord, NC 28025	Blue Options, Blue Advantage **$1,302**
[redacted]arolinas Medical Center University **HOPD** 8800 N Tryon St Charlotte, NC 28262	Blue Value **$1,424** Blue Options, Blue Advantage **$1,424**

Enter a treatment or service

Hernia

Location

Salisbury, NC

Estimated Treatment Cost Results

Cost estimates are averages based on historical BCBSNC claims data. Amounts listed typically include physician fees, facility fees and costs for things like anesthesia, drugs, medical supplies – as well as customer responsibility (deductible, co-pay and co-insurance). Your actual costs may be different based on variations in these factors as well as your health plan design, deductibles/co-insurance and out-of-pocket limits.

HOPD: Hospital Outpatient Department **Non-HOPD:** Non-Hospital Outpatient Department

Iredell Surgical Center **HOPD** 1720 Davie Ave Statesville, NC 28677	Blue Value **$2,909** Blue Options, Blue Advantage **$2,909**
Gateway Surgery Center **Non-HOPD** 1025 NE Gateway Ct NE Concord, NC 28025	Blue Options, Blue Advantage **$3,813**
Carolinas Medical Center University **HOPD** 8800 N Tryon St Charlotte, NC 28262	Blue Value **$9,124** Blue Options, Blue Advantage **$9,124**
Iredell Memorial Hospital **HOPD** 557 Brookdale Dr Statesville, NC 28677	Blue Value **$9,551** Blue Options, Blue Advantage **$9,551**
Davis Medical Center **HOPD** 218 Old Mocksville Rd Statesville, NC 28625	Blue Value **$9,761** Blue Options, Blue Advantage **$9,761**
Novant Health Huntersville Med Center **HOPD** 10030 Gilead Rd Huntersville, NC 28078	Blue Value **$10,309** Blue Options, Blue Advantage **$11,512**
Lake Norman Regional Medical Center **HOPD** 171 Fairview Rd Mooresville, NC 28117	Blue Value **$11,867** Blue Options, Blue Advantage **$11,867**

NC Estimate Health Care Costs

Enter a treatment or service

Nasal/Sinus - Corrective Surgery

Location

Salisbury, NC

Estimated Treatment Cost Results

Cost estimates are averages based on historical BCBSNC claims data. Amounts listed typically include physician fees, facility fees and costs for things like anesthesia, drugs, medical supplies – as well as customer responsibility (deductible, co-pay and co-insurance). Your actual costs may be different based on variations in these factors as well as your health plan design, deductibles/co-insurance and out-of-pocket limits.

HOPD: Hospital Outpatient Department **Non-HOPD:** Non-Hospital Outpatient Department

Iredell Head Neck & Ear **Non-HOPD** 1720 Davie Ave Statesville, NC 28677	Blue Value **$3,950** Blue Options, Blue Advantage **$3,950**
Gateway Surgery Center **Non-HOPD** 1025 NE Gateway Ct NE Concord, NC 28025	Blue Options, Blue Advantage **$6,780**
Iredell Surgical Center **HOPD** 1720 Davie Ave Statesville, NC 28677	Blue Value **$8,318** Blue Options, Blue Advantage **$8,318**
Lake Norman Regional Medical Center **HOPD** 171 Fairview Rd Mooresville, NC 28117	Blue Value **$8,591** Blue Options, Blue Advantage **$8,591**
Presbyterian Surgery Center at Huntersville **HOPD** 10030 Gilead Rd Huntersville, NC 28078	Blue Value **$15,346** Blue Options, Blue Advantage **$15,346**
Novant Health Rowan Medical Center **HOPD** 612 Mocksville Ave Salisbury, NC 28144	Blue Value **$15,737** Blue Options, Blue Advantage **$17,269**
Carolinas Medical Center University **HOPD** 800 N Tryon St Charlotte, NC 28262	Blue Value **$16,292** Blue Options, Blue Advantage **$16,292**

Enter a treatment or service

Rotator Cuff Repair

Location

Salisbury, NC

Estimated Treatment Cost Results

Cost estimates are averages based on historical BCBSNC claims data. Amounts listed typically include physician fees, facility fees and costs for things like anesthesia, drugs, medical supplies – as well as customer responsibility (deductible, co-pay and co-insurance). Your actual costs may be different based on variations in these factors as well as your health plan design, deductibles/co-insurance and out-of-pocket limits.

HOPD: Hospital Outpatient Department **Non-HOPD:** Non-Hospital Outpatient Department

Carolinas Medical Center University
HOPD
8800 N Tryon St
Charlotte, NC 28262

Blue Value
$16,047
Blue Options, Blue Advantage
$16,047

Novant Health Rowan Medical Center
HOPD
612 Mocksville Ave
Salisbury, NC 28144

Blue Value
$18,275
Blue Options, Blue Advantage
$20,156

Iredell Memorial Hospital
HOPD
557 Brookdale Dr
Statesville, NC 28677

Blue Value
$26,504
Blue Options, Blue Advantage
$26,504

NC Estimate Health Care Costs

Enter a treatment or service

Tonsillectomy and Adenoidectomy

Location

Salisbury, NC

Estimated Treatment Cost Results

Cost estimates are averages based on historical BCBSNC claims data. Amounts listed typically include physician fees, facility fees and costs for things like anesthesia, drugs, medical supplies – as well as customer responsibility (deductible, co-pay and co-insurance). Your actual costs may be different based on variations in these factors as well as your health plan design, deductibles/co-insurance and out-of-pocket limits.

HOPD: Hospital Outpatient Department **Non-HOPD:** Non-Hospital Outpatient Department

Iredell Head Neck & Ear **Non-HOPD** 1720 Davie Ave Statesville, NC 28677	Blue Value **$1,607** Blue Options, Blue Advantage **$1,607**
Gateway Surgery Center **Non-HOPD** 1025 NE Gateway Ct NE Concord, NC 28025	Blue Options, Blue Advantage **$2,718**
Iredell Surgical Center **HOPD** 1720 Davie Ave Statesville, NC 28677	Blue Value **$3,162** Blue Options, Blue Advantage **$3,162**
Lake Norman Regional Medical Center **HOPD** 171 Fairview Rd Mooresville, NC 28117	Blue Value **$4,863** Blue Options, Blue Advantage **$4,863**
Novant Health Rowan Medical Center **HOPD** 612 Mocksville Ave Salisbury, NC 28144	Blue Value **$5,474** Blue Options, Blue Advantage **$6,052**
Carolinas Medical Center University **HOPD** 8800 N Tryon St Charlotte, NC 28262	Blue Value **$6,565** Blue Options, Blue Advantage **$6,565**
Iredell Memorial Hospital **HOPD** 557 Brookdale Dr Statesville, NC 28677	Blue Value **$6,706** Blue Options, Blue Advantage **$6,706**

NC Estimate Health Care Costs

Enter a treatment or service

Tympanostomy and Myringotomy

Location

Salisbury, NC

Estimated Treatment Cost Results

Cost estimates are averages based on historical BCBSNC claims data. Amounts listed typically include physician fees, facility fees and costs for things like anesthesia, drugs, medical supplies – as well as customer responsibility (deductible, co-pay and co-insurance). Your actual costs may be different based on variations in these factors as well as your health plan design, deductibles/co-insurance and out-of-pocket limits.

HOPD: Hospital Outpatient Department **Non-HOPD:** Non-Hospital Outpatient Department

Iredell Head Neck & Ear **Non-HOPD** 1720 Davie Ave Statesville, NC 28677	Blue Value **$1,411** Blue Options, Blue Advantage **$1,411**
Gateway Surgery Center **Non-HOPD** 1025 NE Gateway Ct NE Concord, NC 28025	Blue Value **$2,163** Blue Options, Blue Advantage **$2,163**
Lake Norman Regional Medical Center **HOPD** 171 Fairview Rd Mooresville, NC 28117	Blue Value **$3,563** Blue Options, Blue Advantage **$3,563**
Novant Health Rowan Medical Center **HOPD** 612 Mocksville Ave Salisbury, NC 28144	Blue Value **$3,921** Blue Options, Blue Advantage **$4,318**
Carolinas Medical Center University **HOPD** 8800 N Tryon St Charlotte, NC 28262	Blue Value **$4,680** Blue Options, Blue Advantage **$4,680**
Presbyterian Surgery Center at Huntersville **HOPD** 10030 Gilead Rd Huntersville, NC 28078	Blue Value **$4,900** Blue Options, Blue Advantage **$4,900**
Iredell Memorial Hospital **HOPD** 557 Brookdale Dr Statesville, NC 28677	Blue Value **$4,934** Blue Options, Blue Advantage **$4,934**

NC Estimate Health Care Costs

Enter a treatment or service

ACL Repair by Arthroscopy

Location

Shelby, NC

Estimated Treatment Cost Results

Cost estimates are averages based on historical BCBSNC claims data. Amounts listed typically include physician fees, facility fees and costs for things like anesthesia, drugs, medical supplies – as well as customer responsibility (deductible, co-pay and co-insurance). Your actual costs may be different based on variations in these factors as well as your health plan design, deductibles/co-insurance and out-of-pocket limits.

HOPD: Hospital Outpatient Department **Non-HOPD:** Non-Hospital Outpatient Department

Viewmont Surgery Center LLC **HOPD (Joint Physician Ownership)** 0 13th Ave NE Hickory, NC 28601	Blue Value **$12,295** Blue Options, Blue Advantage **$12,295**
Frye Regional Medical Center **HOPD** 420 N Center St Hickory, NC 28601	Blue Value **$17,977** Blue Options, Blue Advantage **$17,977**
Cleveland Regional Medical Center **HOPD** 201 E Grover St Shelby, NC 28150	Blue Options, Blue Advantage **$21,943**
CHS Blue Ridge Valdese **HOPD** 720 Malcolm Blvd Valdese, NC 28690	Blue Options, Blue Advantage **$27,889**
CMC Lincoln **HOPD** 433 McAlister Rd Lincolnton, NC 28092	Blue Options, Blue Advantage **$27,997**

Estimate Health Care Costs

Enter a treatment or service

Bunionectomy

Location

Shelby, NC

Estimated Treatment Cost Results

Cost estimates are averages based on historical BCBSNC claims data. Amounts listed typically include physician fees, facility fees and costs for things like anesthesia, drugs, medical supplies – as well as customer responsibility (deductible, co-pay and co-insurance). Your actual costs may be different based on variations in these factors as well as your health plan design, deductibles/co-insurance and out-of-pocket limits.

HOPD: Hospital Outpatient Department **Non-HOPD:** Non-Hospital Outpatient Department

Viewmont Surgery Center LLC **HOPD (Joint Physician Ownership)** [redacted] 13th Ave NE Hickory, NC 28601	Blue Value **$3,506** Blue Options, Blue Advantage **$3,506**
Cleveland Ambulatory Service **HOPD** 1100 N Lafayette St Shelby, NC 28150	Blue Options, Blue Advantage **$4,559**
Caromont Regional Medical Center **HOPD** 2525 Court Dr Gastonia, NC 28054	Blue Options, Blue Advantage **$5,499**
Caromont Specialty Surgery **HOPD** 2511 Court Dr Gastonia, NC 28054	Blue Options, Blue Advantage **$6,090**
Frye Regional Medical Center **HOPD** 420 N Center St Hickory, NC 28601	Blue Value **$10,082** Blue Options, Blue Advantage **$10,082**
CMC Lincoln **HOPD** 433 McAlister Rd Lincolnton, NC 28092	Blue Options, Blue Advantage **$12,887**
Catawba Valley Med Center **HOPD** [redacted]10 Fairgrove Church Rd Hickory, NC 28602	Blue Value **$15,921** Blue Options, Blue Advantage **$15,921**

NC Estimate Health Care Costs

Enter a treatment or service

Cataract Removal

Location

Shelby, NC

Estimated Treatment Cost Results

Cost estimates are averages based on historical BCBSNC claims data. Amounts listed typically include physician fees, facility fees and costs for things like anesthesia, drugs, medical supplies – as well as customer responsibility (deductible, co-pay and co-insurance). Your actual costs may be different based on variations in these factors as well as your health plan design, deductibles/co-insurance and out-of-pocket limits.

HOPD: Hospital Outpatient Department **Non-HOPD:** Non-Hospital Outpatient Department

Eye Surgery Center of Shelby **Non-HOPD** 1622 E Marion St Shelby, NC 28150	Blue Value **$2,083** Blue Options, Blue Advantage **$2,083**
Graystone Eye Surgery Center LLC **Non-HOPD** 424 Century Pl SE Hickory, NC 28602	Blue Options, Blue Advantage **$2,181**
Caromont Specialty Surgery **HOPD** 2511 Court Dr Gastonia, NC 28054	Blue Options, Blue Advantage **$2,631**
Cleveland Ambulatory Service **HOPD** 1100 N Lafayette St Shelby, NC 28150	Blue Value **$3,696** Blue Options, Blue Advantage **$3,696**
Catawba Valley Med Center **HOPD** 810 Fairgrove Church Rd Hickory, NC 28602	Blue Value **$6,888** Blue Options, Blue Advantage **$6,888**
Kings Mountain Hospital **HOPD** 706 W King St Kings Mountain, NC 28086	Blue Value **$7,012** Blue Options, Blue Advantage **$7,012**
CMC Lincoln **HOPD** 433 McAlister Rd Lincolnton, NC 28092	Blue Options, Blue Advantage **$8,778**

Estimate Health Care Costs

Enter a treatment or service

CT Scan Head/Brain

Location

Shelby, NC

Estimated Treatment Cost Results

Cost estimates are averages based on historical BCBSNC claims data. Amounts listed typically include physician fees, facility fees and costs for things like anesthesia, drugs, medical supplies – as well as customer responsibility (deductible, co-pay and co-insurance). Your actual costs may be different based on variations in these factors as well as your health plan design, deductibles/co-insurance and out-of-pocket limits.

HOPD: Hospital Outpatient Department **Non-HOPD:** Non-Hospital Outpatient Department

Gaston Hematology & Oncology Associates **Non-HOPD** 2610 Aberdeen Blvd Gastonia, NC 28054	Blue Value **$387** Blue Options, Blue Advantage **$387**
Frye Regional Medical Center **HOPD** 420 N Center St Hickory, NC 28601	Blue Value **$444** Blue Options, Blue Advantage **$444**
aston Memorial Hospital **HOPD** 2525 Court Dr Gastonia, NC 28054	Blue Options, Blue Advantage **$986**
Caromont Regional Medical Center **HOPD** 2525 Court Dr Gastonia, NC 28054	Blue Options, Blue Advantage **$1,053**
CMC Lincoln **HOPD** 433 McAlister Rd Lincolnton, NC 28092	Blue Options, Blue Advantage **$1,143**
Catawba Valley Med Center **HOPD** 810 Fairgrove Church Rd Hickory, NC 28602	Blue Value **$1,173** Blue Options, Blue Advantage **$1,173**
CHS Blue Ridge Valdese **HOPD** 720 Malcolm Blvd Valdese, NC 28690	Blue Options, Blue Advantage **$1,186**
CHS Blue Ridge Valdese **HOPD** 720 Malcolm Blvd Valdese, NC 28690	Blue Options, Blue Advantage **$1,373**
Kings Mountain Hospital **HOPD** 706 W King St ngs Mountain, NC 28086	Blue Options, Blue Advantage **$1,416**
Cleveland Regional Medical Center **HOPD** 201 E Grover St Shelby, NC 28150	Blue Options, Blue Advantage **$1,755**

Estimate Health Care Costs

Enter a treatment or service

Nasal/Sinus - Corrective Surgery

Location

Shelby, NC

Estimated Treatment Cost Results

Cost estimates are averages based on historical BCBSNC claims data. Amounts listed typically include physician fees, facility fees and costs for things like anesthesia, drugs, medical supplies – as well as customer responsibility (deductible, co-pay and co-insurance). Your actual costs may be different based on variations in these factors as well as your health plan design, deductibles/co-insurance and out-of-pocket limits.

HOPD: Hospital Outpatient Department **Non-HOPD:** Non-Hospital Outpatient Department

Caromont Specialty Surgery **HOPD** 511 Court Dr Gastonia, NC 28054	Blue Value **$4,745** Blue Options, Blue Advantage **$4,745**
Cleveland Ambulatory Service **HOPD** 1100 N Lafayette St Shelby, NC 28150	Blue Value **$5,667** Blue Options, Blue Advantage **$5,667**
Viewmont Surgery Center LLC **HOPD (Joint Physician Ownership)** 50 13th Ave NE Hickory, NC 28601	Blue Value **$5,989** Blue Options, Blue Advantage **$5,989**

Estimate Health Care Costs

Enter a treatment or service

Tonsillectomy and Adenoidectomy

Location

Shelby, NC

Estimated Treatment Cost Results

Cost estimates are averages based on historical BCBSNC claims data. Amounts listed typically include physician fees, facility fees and costs for things like anesthesia, drugs, medical supplies – as well as customer responsibility (deductible, co-pay and co-insurance). Your actual costs may be different based on variations in these factors as well as your health plan design, deductibles/co-insurance and out-of-pocket limits.

HOPD: Hospital Outpatient Department **Non-HOPD:** Non-Hospital Outpatient Department

Caromont Specialty Surgery **HOPD** 511 Court Dr Gastonia, NC 28054	Blue Value **$2,135** Blue Options, Blue Advantage **$2,135**
Viewmont Surgery Center LLC **HOPD (Joint Physician Ownership)** 50 13th Ave NE Hickory, NC 28601	Blue Value **$2,935** Blue Options, Blue Advantage **$2,935**
Cleveland Ambulatory Service **HOPD** 1100 N Lafayette St Shelby, NC 28150	Blue Value **$3,058** Blue Options, Blue Advantage **$3,058**
Catawba Valley Med Center **HOPD** 810 Fairgrove Church Rd Hickory, NC 28602	Blue Value **$6,325** Blue Options, Blue Advantage **$6,325**
CMC Lincoln **HOPD** 433 McAlister Rd Lincolnton, NC 28092	Blue Options, Blue Advantage **$9,974**

NC Estimate Health Care Costs

Enter a treatment or service

ACL Repair by Arthroscopy

Location

Whiteville, NC

Estimated Treatment Cost Results

Cost estimates are averages based on historical BCBSNC claims data. Amounts listed typically include physician fees, facility fees and costs for things like anesthesia, drugs, medical supplies – as well as customer responsibility (deductible, co-pay and co-insurance). Your actual costs may be different based on variations in these factors as well as your health plan design, deductibles/co-insurance and out-of-pocket limits.

HOPD: Hospital Outpatient Department **Non-HOPD:** Non-Hospital Outpatient Department

Wilmington Surgcare **Non-HOPD** 1801 S 17th St Wilmington, NC 28401	Blue Value **$8,203** Blue Options, Blue Advantage **$8,203**
Sampson Regional Med Center **HOPD** 307 Beaman St Clinton, NC 28328	Blue Value **$8,921** Blue Options, Blue Advantage **$8,921**
Fayetteville Ambulatory Surgical **Non-HOPD** 1781 Metromedical Dr Fayetteville, NC 28304	Blue Value **$10,098** Blue Options, Blue Advantage **$10,098**
New Hanover Regional Medical Center **HOPD** 1415 Physicians Dr Wilmington, NC 28401	Blue Value **$13,278** Blue Options, Blue Advantage **$14,340**
New Hanover Regional Medical Center **HOPD** 1415 Physicians Dr Wilmington, NC 28401	Blue Value **$17,562** Blue Options, Blue Advantage **$19,041**
Scotland Memorial Hospital **HOPD** 500 Lauchwood Dr Laurinburg, NC 28352	Blue Options, Blue Advantage **$24,170**

Estimate Health Care Costs

Enter a treatment or service

Bunionectomy

Location

Whiteville, NC

Estimated Treatment Cost Results

Cost estimates are averages based on historical BCBSNC claims data. Amounts listed typically include physician fees, facility fees and costs for things like anesthesia, drugs, medical supplies – as well as customer responsibility (deductible, co-pay and co-insurance). Your actual costs may be different based on variations in these factors as well as your health plan design, deductibles/co-insurance and out-of-pocket limits.

HOPD: Hospital Outpatient Department **Non-HOPD:** Non-Hospital Outpatient Department

Wilmington Surgcare **Non-HOPD** 1801 S 17th St Wilmington, NC 28401	Blue Value **$3,238** Blue Options, Blue Advantage **$3,238**
Fayetteville Ambulatory Surgical **Non-HOPD** 7781 Metromedical Dr Fayetteville, NC 28304	Blue Value **$4,282** Blue Options, Blue Advantage **$4,282**
New Hanover Regional Medical Center **HOPD** 2131 S 17th St Wilmington, NC 28401	Blue Value **$7,576** Blue Options, Blue Advantage **$8,189**
New Hanover Regional Medical Center **HOPD** 2131 S 17th St Wilmington, NC 28401	Blue Value **$9,555** Blue Options, Blue Advantage **$10,325**
Novant Health Brunswick Medical Center **HOPD** 240 Hospital Dr NE Bolivia, NC 28422	Blue Value **$9,660** Blue Options, Blue Advantage **$11,340**

NC Estimate Health Care Costs

Enter a treatment or service

Cataract Removal

Location

Whiteville, NC

Estimated Treatment Cost Results

Cost estimates are averages based on historical BCBSNC claims data. Amounts listed typically include physician fees, facility fees and costs for things like anesthesia, drugs, medical supplies – as well as customer responsibility (deductible, co-pay and co-insurance). Your actual costs may be different based on variations in these factors as well as your health plan design, deductibles/co-insurance and out-of-pocket limits.

HOPD: Hospital Outpatient Department **Non-HOPD:** Non-Hospital Outpatient Department

Wilmington Surgcare **Non-HOPD** 1801 S 17th St Wilmington, NC 28401	Blue Value **$2,393** Blue Options, Blue Advantage **$2,393**
Fayetteville Ambulatory Surgical **Non-HOPD** 1781 Metromedical Dr Fayetteville, NC 28304	Blue Value **$3,373** Blue Options, Blue Advantage **$3,373**
Dosher Memorial Hospital **HOPD** 924 N Howe St Southport, NC 28461	Blue Value **$3,795** Blue Options, Blue Advantage **$3,795**
New Hanover Regional Medical Center **HOPD** 2131 S 17th St Wilmington, NC 28401	Blue Value **$5,053** Blue Options, Blue Advantage **$5,483**
Cape Fear Valley Medical Center **HOPD** 1638 Owen Dr Fayetteville, NC 28304	Blue Value **$5,642** Blue Options, Blue Advantage **$5,642**
Southeastern Regional Medical Center **HOPD** 300 W 27th St Lumberton, NC 28358	Blue Value **$6,218** Blue Options, Blue Advantage **$6,218**
Bladen County Hospital **HOPD** 501 S Poplar St Elizabethtown, NC 28337	Blue Value **$6,301** Blue Options, Blue Advantage **$6,301**
Columbus Regional Healthcare System **HOPD** 500 Jefferson St Whiteville, NC 28472	Blue Value **$7,208** Blue Options, Blue Advantage **$7,208**
Scotland Memorial Hospital **HOPD** 500 Lauchwood Dr Laurinburg, NC 28352	Blue Options, Blue Advantage **$8,861**

Enter a treatment or service

CT Scan Head/Brain

Location

Whiteville, NC

Estimated Treatment Cost Results

Cost estimates are averages based on historical BCBSNC claims data. Amounts listed typically include physician fees, facility fees and costs for things like anesthesia, drugs, medical supplies – as well as customer responsibility (deductible, co-pay and co-insurance). Your actual costs may be different based on variations in these factors as well as your health plan design, deductibles/co-insurance and out-of-pocket limits.

HOPD: Hospital Outpatient Department **Non-HOPD:** Non-Hospital Outpatient Department

Whiteville Medical Associates **Non-HOPD** 823 Jefferson St Whiteville, NC 28472	Blue Value **$314** Blue Options, Blue Advantage **$314**
Demir Bastug **Non-HOPD** [illegible]9 N Jk Powell Blvd Whiteville, NC 28472	Blue Value **$373** Blue Options, Blue Advantage **$373**
Columbus Regional Healthcare System **HOPD** 500 Jefferson St Whiteville, NC 28472	Blue Value **$608** Blue Options, Blue Advantage **$608**
Southeastern Regional Medical Center **HOPD** 300 W 27th St Lumberton, NC 28358	Blue Value **$999** Blue Options, Blue Advantage **$999**

NC Estimate Health Care Costs

Enter a treatment or service

Nasal/Sinus - Corrective Surgery

Location

Whiteville, NC

Estimated Treatment Cost Results

Cost estimates are averages based on historical BCBSNC claims data. Amounts listed typically include physician fees, facility fees and costs for things like anesthesia, drugs, medical supplies – as well as customer responsibility (deductible, co-pay and co-insurance). Your actual costs may be different based on variations in these factors as well as your health plan design, deductibles/co-insurance and out-of-pocket limits.

HOPD: Hospital Outpatient Department **Non-HOPD:** Non-Hospital Outpatient Department

Fayetteville Ambulatory Surgical **Non-HOPD** 1781 Metromedical Dr Fayetteville, NC 28304	Blue Value **$5,284** Blue Options, Blue Advantage **$5,284**
Wilmington Surgcare **Non-HOPD** 2301 S 17th St Wilmington, NC 28401	Blue Value **$6,990**
New Hanover Regional Medical Center **HOPD** 2131 S 17th St Wilmington, NC 28401	Blue Options, Blue Advantage **$9,034**
Columbus Regional Healthcare System **HOPD** 500 Jefferson St Whiteville, NC 28472	Blue Options, Blue Advantage **$11,589**
Southeastern Regional Medical Center **HOPD** 300 W 27th St Lumberton, NC 28358	Blue Value **$13,587** Blue Options, Blue Advantage **$13,587**
Scotland Memorial Hospital **HOPD** 500 Lauchwood Dr Laurinburg, NC 28352	Blue Options, Blue Advantage **$18,035**

Enter a treatment or service

Tonsillectomy and Adenoidectomy

Location

Whiteville, NC

Estimated Treatment Cost Results

Cost estimates are averages based on historical BCBSNC claims data. Amounts listed typically include physician fees, facility fees and costs for things like anesthesia, drugs, medical supplies – as well as customer responsibility (deductible, co-pay and co-insurance). Your actual costs may be different based on variations in these factors as well as your health plan design, deductibles/co-insurance and out-of-pocket limits.

HOPD: Hospital Outpatient Department **Non-HOPD:** Non-Hospital Outpatient Department

Wilmington Surgcare **Non-HOPD** 1801 S 17th St Wilmington, NC 28401	Blue Value **$2,624** Blue Options, Blue Advantage **$2,624**
Fayetteville Ambulatory Surgical **Non-HOPD** 1781 Metromedical Dr Fayetteville, NC 28304	Blue Value **$2,821** Blue Options, Blue Advantage **$2,821**
New Hanover Regional Medical Center **HOPD** 2131 S 17th St Wilmington, NC 28401	Blue Options, Blue Advantage **$3,746**
New Hanover Regional Medical Center **HOPD** 1415 Physicians Dr Wilmington, NC 28401	Blue Options, Blue Advantage **$3,966**
Columbus Regional Healthcare System **HOPD** 500 Jefferson St Whiteville, NC 28472	Blue Options, Blue Advantage **$8,419**
Scotland Memorial Hospital **HOPD** 500 Lauchwood Dr Laurinburg, NC 28352	Blue Options, Blue Advantage **$10,001**

NC Estimate Health Care Costs

Enter a treatment or service

ACL Repair by Arthroscopy

Location

Wilson, NC

Estimated Treatment Cost Results

Cost estimates are averages based on historical BCBSNC claims data. Amounts listed typically include physician fees, facility fees and costs for things like anesthesia, drugs, medical supplies – as well as customer responsibility (deductible, co-pay and co-insurance). Your actual costs may be different based on variations in these factors as well as your health plan design, deductibles/co-insurance and out-of-pocket limits.

HOPD: Hospital Outpatient Department **Non-HOPD:** Non-Hospital Outpatient Department

Eastern Regional Surgical Center
Non-HOPD
1709 Medical Park Dr W
Wilson, NC 27893

Blue Value
$8,739
Blue Options, Blue Advantage
$8,739

Not all facilities in this area are shown on the BCBS Cost Estimator. High and low costs for the same procedure in Raleigh are shown below for comparison.

James E. Davis Ambulatory Surgery Center
HOPD
120 Carver St
Durham, NC 27704

Blue Options, Blue Advantage
$8,839

Duke Raleigh Hospital
HOPD
3400 Wake Forest Rd
Raleigh, NC 27609

Blue Options, Blue Advantage
$20,389

Estimate Health Care Costs

Enter a treatment or service

Bunionectomy

Location

Wilson, NC

Estimated Treatment Cost Results

Cost estimates are averages based on historical BCBSNC claims data. Amounts listed typically include physician fees, facility fees and costs for things like anesthesia, drugs, medical supplies – as well as customer responsibility (deductible, co-pay and co-insurance). Your actual costs may be different based on variations in these factors as well as your health plan design, deductibles/co-insurance and out-of-pocket limits.

HOPD: Hospital Outpatient Department **Non-HOPD:** Non-Hospital Outpatient Department

Lenoir Memorial Hospital **HOPD** 100 Airport Rd Kinston, NC 28501	Blue Value **$4,652** Blue Options, Blue Advantage **$4,652**
Vidant Surgicenter **HOPD** 102 Bethesda Dr Greenville, NC 27834	Blue Value **$5,715** Blue Options, Blue Advantage **$5,715**
Surgicenter of Eastern Carolina LLC **HOPD** 102 Bethesda Dr Greenville, NC 27834	Blue Options, Blue Advantage **$6,565**
Vidant Beaufort Hospital **HOPD** 628 E 12th St Washington, NC 27889	Blue Value **$11,427** Blue Options, Blue Advantage **$11,427**

Estimate Health Care Costs

Enter a treatment or service

Cataract Removal

Location

Wilson, NC

Estimated Treatment Cost Results

Cost estimates are averages based on historical BCBSNC claims data. Amounts listed typically include physician fees, facility fees and costs for things like anesthesia, drugs, medical supplies – as well as customer responsibility (deductible, co-pay and co-insurance). Your actual costs may be different based on variations in these factors as well as your health plan design, deductibles/co-insurance and out-of-pocket limits.

HOPD: Hospital Outpatient Department **Non-HOPD:** Non-Hospital Outpatient Department

Surgicenter of Eastern Carolina LLC **HOPD** 102 Bethesda Dr Greenville, NC 27834	Blue Options, Blue Advantage **$2,532**
Lenoir Memorial Hospital **HOPD** 00 Airport Rd Kinston, NC 28501	Blue Value **$2,657** Blue Options, Blue Advantage **$2,657**
Vidant Surgicenter **HOPD** 102 Bethesda Dr Greenville, NC 27834	Blue Value **$3,259** Blue Options, Blue Advantage **$3,259**
Vidant Edgecombe Hospital **HOPD** 111 Hospital Dr Tarboro, NC 27886	Blue Options, Blue Advantage **$5,030**
Vidant Beaufort Hospital **HOPD** 628 E 12th St Washington, NC 27889	Blue Value **$6,037** Blue Options, Blue Advantage **$6,037**

NC Estimate Health Care Costs

Enter a treatment or service

CT Scan Head/Brain

Location

Wilson, NC

Estimated Treatment Cost Results

Cost estimates are averages based on historical BCBSNC claims data. Amounts listed typically include physician fees, facility fees and costs for things like anesthesia, drugs, medical supplies – as well as customer responsibility (deductible, co-pay and co-insurance). Your actual costs may be different based on variations in these factors as well as your health plan design, deductibles/co-insurance and out-of-pocket limits.

HOPD: Hospital Outpatient Department **Non-HOPD:** Non-Hospital Outpatient Department

Kinston Medical Specialist **Non-HOPD** 905 N Queen St, Ste A Kinston, NC 28501	Blue Value **$367** Blue Options, Blue Advantage **$367**
Greenville Womens Clinic **Non-HOPD** 2251 Stantonsburg Rd Greenville, NC 27834	Blue Value **$410** Blue Options, Blue Advantage **$410**
CarolinaEast Internal Medicine **HOPD** 620 Farm Life Ave Vanceboro, NC 28586	Blue Value **$544** Blue Options, Blue Advantage **$544**
Vidant Beaufort Hospital **HOPD** 628 E 12th St Washington, NC 27889	Blue Value **$1,241** Blue Options, Blue Advantage **$1,241**
Vidant Medical Center **HOPD** 2100 Stantonsburg Rd Greenville, NC 27834	Blue Value **$1,279** Blue Options, Blue Advantage **$1,279**
Lenoir Memorial Hospital **HOPD** 100 Airport Rd Kinston, NC 28501	Blue Value **$1,481** Blue Options, Blue Advantage **$1,481**
Lenoir Memorial Hospital **HOPD** 100 Airport Rd Kinston, NC 28501	Blue Value **$1,510** Blue Options, Blue Advantage **$1,510**

Enter a treatment or service

Nasal/Sinus - Corrective Surgery

Location

Wilson, NC

Estimated Treatment Cost Results

Cost estimates are averages based on historical BCBSNC claims data. Amounts listed typically include physician fees, facility fees and costs for things like anesthesia, drugs, medical supplies – as well as customer responsibility (deductible, co-pay and co-insurance). Your actual costs may be different based on variations in these factors as well as your health plan design, deductibles/co-insurance and out-of-pocket limits.

HOPD: Hospital Outpatient Department **Non-HOPD:** Non-Hospital Outpatient Department

Eastern Regional Surgical Center **Non-HOPD** 1709 Medical Park Dr W Wilson, NC 27893	Blue Value **$6,618** Blue Options, Blue Advantage **$6,618**
Wilson Medical Center **HOPD** 1705 S Tarboro St Wilson, NC 27893	Blue Value **$6,752** Blue Options, Blue Advantage **$6,752**
Nash General Hospital **HOPD** 2460 Curtis Ellis Dr Rocky Mount, NC 27804	Blue Value **$6,761** Blue Options, Blue Advantage **$6,761**
Wayne Memorial Hospital **HOPD** 2700 Wayne Memorial Dr Goldsboro, NC 27534	Blue Options, Blue Advantage **$7,662**

NC Estimate Health Care Costs

Enter a treatment or service

Tonsillectomy and Adenoidectomy

Location

Wilson, NC

Estimated Treatment Cost Results

Cost estimates are averages based on historical BCBSNC claims data. Amounts listed typically include physician fees, facility fees and costs for things like anesthesia, drugs, medical supplies – as well as customer responsibility (deductible, co-pay and co-insurance). Your actual costs may be different based on variations in these factors as well as your health plan design, deductibles/co-insurance and out-of-pocket limits.

HOPD: Hospital Outpatient Department **Non-HOPD:** Non-Hospital Outpatient Department

Eastern Regional Surgical Center
Non-HOPD
1709 Medical Park Dr W
Wilson, NC 27893

Blue Value
$3,143
Blue Options, Blue Advantage
$3,143

Nash General Hospital
HOPD
2460 Curtis Ellis Dr
Rocky Mount, NC 27804

Blue Value
$4,231
Blue Options, Blue Advantage
$4,231

Wilson Medical Center
HOPD
1705 S Tarboro St
Wilson, NC 27893

Blue Options, Blue Advantage
$4,361

Only HOPD facilities are shown in this area on the BCBS Cost Estimator. High and low costs for the same procedure in Raleigh are shown below for comparison.

Blue Ridge Surgery Center
Non-HOPD
2308 Wesvill Ct
Raleigh, NC 27607

Blue Value
$2,850
Blue Options, Blue Advantage
$2,850

Duke Raleigh Hospital
HOPD
3400 Wake Forest Rd
Raleigh, NC 27609

Blue Options, Blue Advantage
$7,366

NC Estimate Health Care Costs

Enter a treatment or service

ACL Repair by Arthroscopy

Location

Winston-Salem, NC

Estimated Treatment Cost Results

Cost estimates are averages based on historical BCBSNC claims data. Amounts listed typically include physician fees, facility fees and costs for things like anesthesia, drugs, medical supplies – as well as customer responsibility (deductible, co-pay and co-insurance). Your actual costs may be different based on variations in these factors as well as your health plan design, deductibles/co-insurance and out-of-pocket limits.

HOPD: Hospital Outpatient Department **Non-HOPD:** Non-Hospital Outpatient Department

High Point Surgery Center **HOPD** 600 N Lindsay St High Point, NC 27262	Blue Value **$7,615** Blue Options, Blue Advantage **$7,615**
Surgical Center of Greensboro **Non-HOPD** 1211 Virginia St Greensboro, NC 27401	Blue Value **$11,550** Blue Options, Blue Advantage **$11,550**
Moses Cone Memorial Hospital **HOPD** 1200 N Elm St Greensboro, NC 27401	Blue Options, Blue Advantage **$12,665**
North Carolina Baptist Hospital **HOPD** Medical Center Blvd Winston Salem, NC 27157	Blue Value **$23,782** Blue Options, Blue Advantage **$26,574**

Estimate Health Care Costs

Enter a treatment or service

Bunionectomy

Location

Winston-Salem, NC

Estimated Treatment Cost Results

Cost estimates are averages based on historical BCBSNC claims data. Amounts listed typically include physician fees, facility fees and costs for things like anesthesia, drugs, medical supplies – as well as customer responsibility (deductible, co-pay and co-insurance). Your actual costs may be different based on variations in these factors as well as your health plan design, deductibles/co-insurance and out-of-pocket limits.

HOPD: Hospital Outpatient Department **Non-HOPD:** Non-Hospital Outpatient Department

High Point Surgery Center **HOPD** 600 N Lindsay St High Point, NC 27262	Blue Value **$3,200** Blue Options, Blue Advantage **$3,200**
Piedmont Surgical Center **Non-HOPD** 7819 National Service Rd, Ste 404 Greensboro, NC 27409	Blue Value **$4,218** Blue Options, Blue Advantage **$4,218**
Greensboro Specialty Surgical Center **Non-HOPD** 3812 N Elm St Greensboro, NC 27455	Blue Options, Blue Advantage **$5,167**
Pioneer Community Hospital of Stoke **HOPD** 1570 Nc 8 And 89 Hwy N Danbury, NC 27016	Blue Options, Blue Advantage **$5,609**
North Carolina Baptist Hospital **HOPD** Medical Center Blvd Winston Salem, NC 27157	Blue Value **$8,146** Blue Options, Blue Advantage **$9,001**
Novant Health Thomasville Medical **HOPD** 207 Old Lexington Rd Thomasville, NC 27360	Blue Value **$9,095** Blue Options, Blue Advantage **$10,317**
Moses Cone Memorial Hospital **HOPD** 1200 N Elm St Greensboro, NC 27401	Blue Options, Blue Advantage **$10,547**

NC Estimate Health Care Costs

Enter a treatment or service

Cataract Removal

Location

Winston-Salem, NC

Estimated Treatment Cost Results

Cost estimates are averages based on historical BCBSNC claims data. Amounts listed typically include physician fees, facility fees and costs for things like anesthesia, drugs, medical supplies – as well as customer responsibility (deductible, co-pay and co-insurance). Your actual costs may be different based on variations in these factors as well as your health plan design, deductibles/co-insurance and out-of-pocket limits.

HOPD: Hospital Outpatient Department **Non-HOPD:** Non-Hospital Outpatient Department

Surgical Eye Center of Greensboro **Non-HOPD** 3312 Battleground Ave Greensboro, NC 27410	Blue Value **$2,286** Blue Options, Blue Advantage **$2,286**
Greensboro Specialty Surgical Center **Non-HOPD** 312 N Elm St Greensboro, NC 27455	Blue Options, Blue Advantage **$2,976**
Surgical Center of Greensboro **Non-HOPD** 1211 Virginia St Greensboro, NC 27401	Blue Value **$3,167** Blue Options, Blue Advantage **$3,167**
High Point Surgery Center **HOPD** 600 N Lindsay St High Point, NC 27262	Blue Value **$3,991** Blue Options, Blue Advantage **$3,991**
Pioneer Community Hospital of Stoke **HOPD** 1570 Nc 8 And 89 Hwy N Danbury, NC 27016	Blue Options, Blue Advantage **$4,285**
Novant Health Thomasville Medical **HOPD** 207 Old Lexington Rd Thomasville, NC 27360	Blue Value **$5,212** Blue Options, Blue Advantage **$5,924**
North Carolina Baptist Hospital **HOPD** Medical Center Blvd Winston Salem, NC 27157	Blue Value **$6,284** Blue Options, Blue Advantage **$6,912**
Moses Cone Memorial Hospital **HOPD** 1200 N Elm St Greensboro, NC 27401	Blue Options, Blue Advantage **$6,960**

Enter a treatment or service

CT Scan Head/Brain

Location

Winston-Salem, NC

Estimated Treatment Cost Results

Cost estimates are averages based on historical BCBSNC claims data. Amounts listed typically include physician fees, facility fees and costs for things like anesthesia, drugs, medical supplies – as well as customer responsibility (deductible, co-pay and co-insurance). Your actual costs may be different based on variations in these factors as well as your health plan design, deductibles/co-insurance and out-of-pocket limits.

HOPD: Hospital Outpatient Department **Non-HOPD:** Non-Hospital Outpatient Department

Cornerstone Imaging **Non-HOPD** 1814 Westchester Dr High Point, NC 27262	Blue Value **$302** Blue Options, Blue Advantage **$302**
Premier Imaging LLC **Non-HOPD** 4515 Premier Dr, Ste 101 High Point, NC 27265	Blue Value **$355** Blue Options, Blue Advantage **$355**
Piedmont Healthcare, PA **Non-HOPD** 340 Signal Hill Dr, Ste C Statesville, NC 28625	Blue Value **$408** Blue Options, Blue Advantage **$408**
Lebauer Healthcare **Non-HOPD** 4810 W Wendover Ave Jamestown, NC 27282	Blue Value **$479** Blue Options, Blue Advantage **$479**
North Carolina Baptist Hospital **HOPD** Medical Center Blvd Winston Salem, NC 27157	Blue Value **$564** Blue Options, Blue Advantage **$633**
Novant Health Thomasville Medical **HOPD** 207 Old Lexington Rd Thomasville, NC 27360	Blue Value **$780** Blue Options, Blue Advantage **$898**
High Point Regional Hospital **HOPD** 601 N Elm St High Point, NC 27262	Blue Value **$871** Blue Options, Blue Advantage **$871**
Lexington Memorial Hospital **HOPD** 250 Hospital Dr Lexington, NC 27292	Blue Value **$1,075** Blue Options, Blue Advantage **$1,075**

Enter a treatment or service

Hernia

Location

Winston-Salem, NC

Estimated Treatment Cost Results

Cost estimates are averages based on historical BCBSNC claims data. Amounts listed typically include physician fees, facility fees and costs for things like anesthesia, drugs, medical supplies – as well as customer responsibility (deductible, co-pay and co-insurance). Your actual costs may be different based on variations in these factors as well as your health plan design, deductibles/co-insurance and out-of-pocket limits.

HOPD: Hospital Outpatient Department **Non-HOPD:** Non-Hospital Outpatient Department

High Point Surgery Center **HOPD** 600 N Lindsay St High Point, NC 27262	Blue Value **$2,991** Blue Options, Blue Advantage **$2,991**
Surgical Center of Greensboro **Non-HOPD** 211 Virginia St Greensboro, NC 27401	Blue Options, Blue Advantage **$4,528**
Novant Health Medical Park Hospital **HOPD** 1950 S Hawthorne Rd Winston Salem, NC 27103	Blue Value **$6,217** Blue Options, Blue Advantage **$6,973**
Moses Cone Memorial Hospital **HOPD** 1200 N Elm St Greensboro, NC 27401	Blue Options, Blue Advantage **$7,265**
Novant Health Medical Park Hospital **HOPD** 1950 S Hawthorne Rd Winston Salem, NC 27103	Blue Value **$8,758** Blue Options, Blue Advantage **$9,911**
North Carolina Baptist Hospital **HOPD** Medical Center Blvd Winston Salem, NC 27157	Blue Value **$9,268** Blue Options, Blue Advantage **$10,702**
Lexington Memorial Hospital **HOPD** 250 Hospital Dr Lexington, NC 27292	Blue Value **$10,719** Blue Options, Blue Advantage **$10,719**

NC Estimate Health Care Costs

Enter a treatment or service

Nasal/Sinus - Corrective Surgery

Location

Winston-Salem, NC

Estimated Treatment Cost Results

Cost estimates are averages based on historical BCBSNC claims data. Amounts listed typically include physician fees, facility fees and costs for things like anesthesia, drugs, medical supplies – as well as customer responsibility (deductible, co-pay and co-insurance). Your actual costs may be different based on variations in these factors as well as your health plan design, deductibles/co-insurance and out-of-pocket limits.

HOPD: Hospital Outpatient Department **Non-HOPD:** Non-Hospital Outpatient Department

Surgical Center of Greensboro **Non-HOPD** 1211 Virginia St Greensboro, NC 27401	Blue Value **$5,080** Blue Options, Blue Advantage **$5,080**
Piedmont Outpatient Surgery Center **Non-HOPD** [redacted]465 Hanestown Ln Winston Salem, NC 27103	Blue Value **$7,028** Blue Options, Blue Advantage **$7,028**
High Point Surgery Center **HOPD** 600 N Lindsay St High Point, NC 27262	Blue Value **$7,802** Blue Options, Blue Advantage **$7,802**
Moses Cone Memorial Hospital **HOPD** 1200 N Elm St Greensboro, NC 27401	Blue Options, Blue Advantage **$8,050**
Lexington Memorial Hospital **HOPD** 250 Hospital Dr Lexington, NC 27292	Blue Value **$9,429** Blue Options, Blue Advantage **$9,429**
North Carolina Baptist Hospital **HOPD** Medical Center Blvd Winston Salem, NC 27157	Blue Value **$17,928** Blue Options, Blue Advantage **$19,851**

NC Estimate Health Care Costs

Enter a treatment or service

Rotator Cuff Repair

Location

Winston-Salem, NC

Incomplete Data - Not all providers in Forsyth County are listed on the BCBS Cost Estimator

Estimated Treatment Cost Results

Cost estimates are averages based on historical BCBSNC claims data. Amounts listed typically include physician fees, facility fees and costs for things like anesthesia, drugs, medical supplies – as well as customer responsibility (deductible, co-pay and co-insurance). Your actual costs may be different based on variations in these factors as well as your health plan design, deductibles/co-insurance and out-of-pocket limits.

HOPD: Hospital Outpatient Department **Non-HOPD:** Non-Hospital Outpatient Department

Lexington Memorial Hospital **HOPD** 250 Hcspital Dr Lexington, NC 27292	Blue Value **$10,078** Blue Options, Blue Advantage **$10,078**
High Point Surgery Center **HOPD** 600 N Lindsay St High Point, NC 27262	Blue Value **$11,003** Blue Options, Blue Advantage **$11,003**
Moses Cone Memorial Hospital **HOPD** 1200 N Elm St Greensboro, NC 27401	Blue Options, Blue Advantage **$11,928**

High and low costs for the same procedure in the Raleigh area are shown below for comparison.

Carolinas Medical Center University **HOPD** 8800 N Tryon St Charlotte, NC 28262	Blue Value **$16,047** Blue Options, Blue Advantage **$16,047**
Carolinas Medical Center **HOPD** 1000 Blythe Blvd Charlotte, NC 28203	Blue Options, Blue Advantage **$26,185**

Enter a treatment or service

Tonsillectomy and Adenoidectomy

Location

Winston-Salem, NC

Estimated Treatment Cost Results

Cost estimates are averages based on historical BCBSNC claims data. Amounts listed typically include physician fees, facility fees and costs for things like anesthesia, drugs, medical supplies – as well as customer responsibility (deductible, co-pay and co-insurance). Your actual costs may be different based on variations in these factors as well as your health plan design, deductibles/co-insurance and out-of-pocket limits.

HOPD: Hospital Outpatient Department **Non-HOPD:** Non-Hospital Outpatient Department

High Point Surgery Center **HOPD** 600 N Lindsay St High Point, NC 27262	Blue Value **$2,482** Blue Options, Blue Advantage **$2,482**
Piedmont Outpatient Surgery Center **Non-HOPD** 465 Hanestown Ln Winston Salem, NC 27103	Blue Value **$3,624** Blue Options, Blue Advantage **$3,624**
Moses Cone Memorial Hospital **HOPD** 1200 N Elm St Greensboro, NC 27401	Blue Options, Blue Advantage **$4,381**
Lexington Memorial Hospital **HOPD** 250 Hospital Dr Lexington, NC 27292	Blue Value **$5,579** Blue Options, Blue Advantage **$5,579**
Novant Health Medical Park Hospital **HOPD** 1950 S Hawthorne Rd Winston Salem, NC 27103	Blue Value **$6,423** Blue Options, Blue Advantage **$6,423**
North Carolina Baptist Hospital **HOPD** Medical Center Blvd Winston Salem, NC 27157	Blue Options, Blue Advantage **$6,867**
Novant Health Thomasville Medical **HOPD** 207 Old Lexington Rd Thomasville, NC 27360	Blue Value **$7,913** Blue Options, Blue Advantage **$9,072**

Enter a treatment or service

Tympanostomy and Myringotomy

Location

Winston-Salem, NC

Estimated Treatment Cost Results

Cost estimates are averages based on historical BCBSNC claims data. Amounts listed typically include physician fees, facility fees and costs for things like anesthesia, drugs, medical supplies – as well as customer responsibility (deductible, co-pay and co-insurance). Your actual costs may be different based on variations in these factors as well as your health plan design, deductibles/co-insurance and out-of-pocket limits.

HOPD: Hospital Outpatient Department **Non-HOPD:** Non-Hospital Outpatient Department

High Point Surgery Center **HOPD** 600 N Lindsay St High Point, NC 27262	Blue Value **$2,077** Blue Options, Blue Advantage **$2,077**
Lexington Memorial Hospital **HOPD** 250 Hospital Dr Lexington, NC 27292	Blue Value **$2,493** Blue Options, Blue Advantage **$2,493**
Surgical Center of Greensboro **Non-HOPD** 1211 Virginia St Greensboro, NC 27401	Blue Value **$2,842** Blue Options, Blue Advantage **$2,842**
Novant Health Thomasville Medical **HOPD** 207 Old Lexington Rd Thomasville, NC 27360	Blue Value **$2,968** Blue Options, Blue Advantage **$3,338**
North Carolina Baptist Hospital **HOPD** Medical Center Blvd Winston Salem, NC 27157	Blue Value **$3,207** Blue Options, Blue Advantage **$3,533**
Piedmont Outpatient Surgery Center **Non-HOPD** 2465 Hanestown Ln Winston Salem, NC 27103	Blue Value **$3,399** Blue Options, Blue Advantage **$3,399**
Moses Cone Memorial Hospital **HOPD** 1200 N Elm St Greensboro, NC 27401	Blue Options, Blue Advantage **$3,414**
Moses Cone Memorial Hospital **HOPD** 1200 N Elm St Greensboro, NC 27401	Blue Options, Blue Advantage **$3,521**
Novant Health Medical Park Hospital **HOPD** 1950 S Hawthorne Rd Winston Salem, NC 27103	Blue Value **$4,953** Blue Options, Blue Advantage **$5,566**

Committee Sergeants at Arms

NAME OF COMMITTEE House Comm. on Health

DATE: 04/20/15 Room: 643

House Sgt-At Arms:

1. Name: Young Bae
2. Name: Bill Morris
3. Name: Jim Moran
4. Name:
5. Name:

Senate Sgt-At Arms:

1. Name:
2. Name:
3. Name:
4. Name:
5. Name:

VISITOR REGISTRATION SHEET

House Comm. on Health — Name of Committee

04/20/15 — Date

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Kara Weishaar	Smith Anderson
Dana Simpson	SA
Jon Carr	Jordan Price Law Firm
Karl Stein	Raleigh Orthodontic Clinic
Alex Miller	KLG

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House Comm. on Health — Name of Committee

04/20/15 — Date

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JOE LANIER	CARDINAL
Wendy Keeg	Focus Consulting
Jennifer Crispens	NCMS
Joanna Spruill	NCAFP
DANIEL VAN LIERE	VIDANT HEALTH
JERRY COHEN	Nelson Mullins
Ryan Blackledge	Cone Health
J. Bode	BTA
Kristen Lasater	SSGNC
Scott Lasater	SSGNC
Erica Nelson	NC HA

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House Comm. on Health — 04/20/15

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Ken Melton	K.M.A.
NANCY LANE	PDA
HUGH TILSON	NCHA
Thom Moore	The Wiki
Lanier Hodgson	UNC Health Care
Christine Craig	WakeMed
David Crawford	AIM NC
Cody Hand	NCHA
Mallard McConnell	Carolinas HealthCare Sys
Tracy Kimbrell	Parker Poe
Joel Maynard	GSK & Assoc

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House Comm. on Health — 04/20/15

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NAME	FIRM OR AGENCY AND ADDRESS
Austin Clark	AFP
Stephen Creech	AFP
Emma Benson	AFP
Victoria Wakefield	AFP
Brent Busker	AFP
Jacob Broussard	AFP
Tom Harper	AFP
David Robertson	NCBON
Elizabeth Curlin	NCBON
Gordon Hawthorne	EHCR
Julie Adams Johnson	AIC/MARC/ASPA

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House Comm. on Health — 04/20/15

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NAME	FIRM OR AGENCY AND ADDRESS
L Peyton	CSS
Tony Adams	Adams & Assoc.
Carson Hicks	MVA
NICHOLE KAMM	NAMI NC
J Peters	CSS
Steve Pine	K & L Gates
Rob Lamm	RLA
Abby Parkman	Parkinson Law
Frank	MWC
Donald Bryson	AFP
Abbie Bolton	NCAS

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NAME	FIRM OR AGENCY AND ADDRESS
Trent Womble	DHHS
Sarah Preston	ACLU-NC
Annaliese Dolph	DL
Uday Reckye	T:C
Shannon Rorer	Rorse Norton
Virginia Jones	Knowles Smith & Associates
Keith Richard	Solferino North LLC
Max Mason	Principle LTC
Andy Chase	KMA
Seth Smith	Raleigh
Kevin Le Count	SEANC

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NAME	FIRM OR AGENCY AND ADDRESS
TRACY GOLLADAY	AHA
David Collins	SEHNC
Flint Benson	SEANC
Jasmine Brown	Triangle Business Journal
Katherine Restrepo	John Locke Foundation
Laurie Amorio	LOLLC
Richard Branch	Triangle Orthopaedic Associates, PA
Justin Puleo	Smith Moore Leatherwood
John Cooper	Capital City Strategies
Charlene Thomas	Strategic Healthcare Advisors
Donna P. [illegible]	[illegible]

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House Comm. on Health — 04/20/15

Name of Committee — Date

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NAME	FIRM OR AGENCY AND ADDRESS
S Todd Hagwood	Poyner Spruill 300 Fayetteville St Raleigh NC
JEFF BARNHART	MWC
[illegible]	LSS
Brenda Greenberg	NCSRT Inc
KATHY YOUNG	POAIAZ HOLLY SPRINGS
KIM FINK	646 Goose Creek New Bern NC 28562
Elizabeth Berg	112 Pleasant Ct Jacksonville 28540
Linda Harper	210 Bayleaf Dr. Goldsboro, NC 27534
JUDE BRADLEY	209 SANDYBROOK Rd WILM. 28411
[illegible]	BCBS
[illegible]	DHHS / DMSR

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NAME	FIRM OR AGENCY AND ADDRESS
KATELYN GARLOW	AMERICANS FOR PROSPERITY NORTH CAROLINA
Misty Odell	Americans For Prosperity
Joseph Kyzer	AFP
Robert Freeman	AFP
CHARLES BESECKER	AFP
Marlene Beseeker	AFP
Patricia Dixon	AFP
Sandra North	AFP
Edward Redmond	AFP
Ed Shelf	AFP
DEEDEE MURPHY	William Mullen

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NAME	FIRM OR AGENCY AND ADDRESS
Rick Hopkins	Coastal Carolina Taxpayers Assoc. New Bern, NC (CCTA)
HAL JAMES	11
RAYNOR JAMES	11
Connie Hanna	C.C.T.A - New Bern, NC
MARY GRISWOLD	CCTA NEW BERN, NC
ROBERT GRISWOLD	CCTA NEW BERN, NC
[illegible]	NEW BERN
Kathryn Blankley	CCTA New Bern, N.C.
Nancy Murdoch	CCTA Havelock NC
Carol Meyer	The Carolina Center for Hospice
TOM AKINS	LEADINGAGE NC

Corrected #1: Remove HB 623

NORTH CAROLINA HOUSE OF REPRESENTATIVES
COMMITTEE MEETING NOTICE
AND
BILL SPONSOR NOTIFICATION
2015-2016 SESSION

You are hereby notified that the **House Committee on Health** will meet as follows:

DAY & DATE: Wednesday, April 22, 2015
TIME: **10:00 AM**
LOCATION: **643 LOB**
COMMENTS: **Representative Brown is presiding.**

The following bills will be considered:

BILL NO.	SHORT TITLE	SPONSOR
HB 465	Clarify & Modify Certain Abortion Laws.	Representative Schaffer Representative McElraft Representative R. Turner Representative S. Martin
HB 746	LME/MCO Board Amendments.	Representative Dollar Representative J. Bell Representative Avila

Respectfully,

Representative Brian Brown, Co-Chair
Representative Justin P. Burr, Co-Chair
Representative Bert Jones, Co-Chair
Representative Donny Lambeth, Co-Chair

I hereby certify this notice was filed by the committee assistant at the following offices at 2:22 PM on Wednesday, April 22, 2015.

___ Principal Clerk
___ Reading Clerk – House Chamber

Brenda Olls (Committee Assistant)

House Committee on Health
Wednesday, April 22, 2015, 10:00 AM
643 Legislative Office Building

AGENDA

Welcome and Opening Remarks

Introduction of Pages

Bills

BILL NO.	SHORT TITLE	SPONSOR
HB 465	Clarify & Modify Certain Abortion Laws.	Representative Schaffer Representative McElraft Representative R. Turner Representative S. Martin
HB 746	LME/MCO Board Amendments.	Representative Dollar Representative J. Bell Representative Avila

Adjournment

House Committee on Health
Wednesday, April 22, 2015 at 10:00 AM
Room 643 of the Legislative Office Building

MINUTES

The House Committee on Health met at 10:00 AM on April 22, 2015 in Room 643 of the Legislative Office Building. Representatives Adcock, Avila, Bishop, Brawley, R. Brown, B. Brown, Burr, Carney, Cotham, Dobson, Dollar, Earle, Farmer-Butterfield, Ford, Goodman, Hager, L. Hall, Hastings, Insko, Jones, Lambeth, Lucas, S. Martin, Pendleton, Saine, Setzer, Szoka, Waddell, Wray, and Yarborough attended.

Representative Brian Brown, Chair, presided.

The following bills were considered:

HB 746 LME/MCO Board Amendments. (Representatives Dollar, J. Bell, Avila)

Rep. Dollar was recognized to explain the bill.

What this bill basically does is gives us some flexibility we need with our LME/NCO boards. We put together a group several years ago with all the stakeholders and put up a structure for the LME/NCO boards. We are still in the process of consolidating from nine into somewhere between 4 and 6. This has challenges due to geographic size of counties. This bill creates a slight change in the structure to accommodate the consolidation of these boards. Instead of requiring a unanimous vote of all the counties in order to make structural changes under the existing law, you need only 2/3 of these constituent counties. This will allow us to move forward with these changes. Rep. Dollar stated I haven't had any opposition brought to me that I am aware of.

Rep. Lucas made a motion for a favorable report. The motion carried.

The Committee stands at ease.

HB 465 72 Hours Informed Consent by Person or Phone. (Representatives Schaffer, McElraft, R. Turner, S. Martin)

There is a PCS for HB465, Representative Szoka made the motion to accept PCS and the motion carried. Representatives Schaffer, McElraft, R. Turner and S. Martin were recognized to explain the bill.

Rep. Schaffer: I want to go through this PCS with you. There are three points on the top of the page which I will take in order and give more information on each point. The first point requires physicians who perform abortions to report certain information to DHHS. The second point increases the 72 hour waiting period for women who voluntarily consent to an abortion. Finally there are few technical and conforming changes. As for the reporting requirements there are two issues. Reporting requirements refer to post 20-week abortions which require physicians

performing these procedures to report certain information to DHHS to ensure statutory rational is being provided for these abortions. We want to make sure the exceptions that are allowed in these cases are being followed. Secondly, for abortions between 18 and 20 weeks, we require certain statistical information be reported to DHHS for these specific types of abortions to ensure the statutory rational is still being followed. Finally, we are changing the 72 hour consent waiting period. Under current law, for a woman to legally consent to an abortion she must receive certain information by phone or in person at least 24 hours before the abortion, this bill extends that to 72 hours. This information can be received by phone by current law and we are not changing that. Technical changes refer to ensure the current law is being followed in regards to professionals who have moral or ethical obligations in relation to abortions.
Rep. Martin: The goals of this bill include protecting the health of women and protecting their choice. This is a difficult and permanent decision and as such more time is very important. In other cases you can change your mind on similarly important decisions such as home ownership but you cannot go back on this decision. This bill gives more time and may protect peoples' health and lives."

Rep. McElraft: We are here to protect life, and a women's right to choose and have all the information she needs to make this decision. We did another bill, where we interviewed many women who chose to have an abortion who said they did not have enough time to make this important life decision. Many of them had psychological issues on this decision. This will give a woman time to reach out and look for alternatives to abortion and time to contact anyone she needs to contact.

Rep. Turner: Thank you for hearing this bill. We want to get the information out that we are not limiting any abortion ability but we are looking after women's health to enable them to seek out other information. This is a difficult decision to make and we appreciate your time looking into this bill.

Questions from Members.

Rep. Cotham: Members it was just stated that this type of procedure would affect a women for the rest of their life. What are the other medical procedures that require a 72 hour waiting period? My friend just had a double vasectomy and that will affect her for the rest of her life. Should we require the same for that?

Rep. Schaffer: A medical professional I was talking to before recommended longer waiting periods for dramatic procedures such as that. We have these types of waiting periods across several medical and other procedures throughout society such as marital situations. If you are going in for a voluntary sterilization you go through a 30 day waiting period. There is existing waiting periods for such irreversible medical decisions. This time frame gives them the option to make an informed decision.

Rep. Cotham: On another issue, when the information is reported to DHHS, how are you going to protect the patient's information and privacy?

Rep. Schaffer: There is specific language to maintain the confidentiality that is very important that is still conforming to requirements. We were concerned about this issue from the start.

Rep. Cotham: Where is that language?

Staff: Page 1, lines 31 through 35 of the PCS.

Rep. Butterfield: In terms of the original bill, there was a section on the state medical school departments beings prohibited from authorizing employees to perform abortions. Based on the proposed substitute is that not removed at this point in time?
Rep. Schaffer: "To clarify, that section has been removed. To be clear, it is current state law that state funds not be used to perform abortions. In the current PCS that section has been removed.

Rep. Butterfield: Could you clarify the difference between the original and substitute bills?

Rep. Schaffer: There are two major differences; one is the removal of provisions forbidding abortions, though it is still law that it is forbidden to use state funds to perform abortions. There is also language that required an obstetrician or gynecologist to be the one performing an abortion. There were some questions in terms of what do we do with the current medical professionals who perform abortions and what changes to state law will do to that, and so we omitted that language.

Rep. Lucas: On page 2, line 6; it states that medical assistance benefits may be available for premarital care, childbirth. It does not say 'shall'. What happens to a potential mother who lives in adverse poverty, what insurance do we have that that mother will be able to get the proper care?

Rep. Schaffer: The point you are referring to is actually current law, the PCS makes no change to that provision.

Rep. Insko for comment: I would like to clarify that this bill is not for anyone's medical safety. Abortions are one of the safest medical procedures we have. 99% of abortions are performed with no medical problems at all. If this is done for emotional protection, it flies in the face of all our other comments that people must live with their own decisions. That makes this a paternalistic bill. The main problem I have with it is that we are removing a woman's right to have control over a woman's body. I think that it is one of the worst things to happen to a woman is to have someone else make decisions about her body. Women have a responsibility to take care to themselves and the government has to right to get in the way of that.

Rep. Insko: At the proper time, I would like to ask for the ayes and noes.

Public Comment

Dr. Deliabramy: I am a board certified family physician; I practice medicine in Fayetteville and Chapel Hill. I am an expert on global health with a focus on contraception and abortion and was recruited to this area from the World Health Association to create a NC based organization that works to reduce maternal mortality from unsafe abortion in developing countries. As a physician it is my ethical duty to provide patients with informed consent, allowing them to be an involved participant. H465 is dangerous legislation, as it would mandate an unnecessary mandatory 72 hour delay on a legal and safe procedure. Delaying limits the options of medical abortion and may force a surgical abortion where a pill based one might be preferred.

Dr. Melinda Snyder: I am a physician and practiced medicine in this state for 40 years now. I support this bill as my experience with this population shows me that the sadness of women who made this choice quickly is only the tip of the iceberg as women are unwilling to talk about it. Many people have been coerced into this decision, and with the addition of new electronic devices isolation has increased and made informed consent a nightmare. I've never known of an emergency abortion that couldn't wait for a few hours. It is an irrevocable decision and education on this topic is very important. Very sadly, abortion in this day and age is not so much about the women but about the bottom line and many of these lobbyists are worried about the bottom line of their big business.

Jackie Brown: I am the director of project Rachel which is a post abortion healing ministry of the Catholic Church. I have facilitated retreat weekends for men and women. I have heard many stories of women and some from men and I have come to recognize two common themes in these stories, first is that the woman is always in a difficult and desperate situation. Secondly each woman I've spoken to has expressed regret and remorse and would say she would reverse the decision if she could. A woman may come to regret her decision due to the abortion corning into three aspects of her personality, and this may come several years later. These issues are her sexuality, her maternal nature and her morality. I would also say that the time of 72 hours is important as this is a life changing decision and one of the factors in making a decision that won't be regretted in the decision is a short term emotional response. When a person is in an emotional state, their thinking narrows, this sometimes results in a fight or flight response. Therefore it is necessary to have the time to work through the short term emotional response to this problematic situation in order to make a decision she won't regret in the future.

Dr. Stacy Bolten: I'm a board certified OBGYN and I have been in practice for over 10 years. In that time I've counseled women through many difficult times. Often I find the most important thing is time. I often find something that scares them on their ultrasound and they make a rash emotional decision. However, when they have time and information they reconsider their

decision. We owe women to allow them to make an informed decision on their life and their child's life. The difference of 48 hours as far as complications in abortions is negligible, as literature states risk of death from abortion is .7 per 100,000, and that the risk increases by 38% per week of gestation.

Lisa Hackett: Writes through a letter, read by Janice Lewis- I regret have multiple abortions over 30 years and it negatively affected me and my marriage. I ask that you pass this bill for women like me so they can have the time to consider this life decision, and for those that still choose to do so at least they can do so at the hands of a licensed OBGYN. My second abortion was performed at a clinic in New York that looked like an abortion factory. No one checked my ID, which forged because I was underage in New York. There was no OBGYN even on site, and I was rushed on an assembly line of patients and beds. After the abortion was performed I was in excruciating pain. They performed an evaluation of me and an hour later I was sent on my way home. No instructions or follow up care, instead a gaping hole in my heart and how little these healthcare providers care about me or any other patients. It not healthcare, it was a perverted procedure that was performed for profit only. Let women have all the information about the pain and risk of depression.

Lana Smith: Writes through a letter, read by Catherine Williams- "9 years ago I was a recent college graduate and I thought I was not ready for a baby at the time. My boyfriend and I thought getting an abortion was the best option at the time. I wanted to make an informed decision, so I scheduled an ultrasound for the following week. What I saw on the ultrasound screen changed my life. To this day my husband and I still talk about how seeing that changed our minds to keep our son. If I had not taken the time to get an ultrasound than my son Christian would not be here today. I cannot stress enough how important it was that it was important to take the time to think the decision through.

Rep. Insko: Point of order- Typically when we have a bill like this we have our speakers pro, con, pro, con. So I would like for you to move to the other side and let people talk who are opposed to this bill.

Chairman Brown: Your suggestion is taken under advisement.

Catherine Hern: Writes through a letter, read by Shirley Tucker- "I will never forget April 10, 1976. On this day, I went to the abortion clinic in Raleigh and had an abortion. When I found out I was pregnant I called the abortion clinic in Raleigh and since I was only 6 weeks pregnant that this was not yet a baby. I scheduled an abortion for a couple days later other than the father who lent me the money and my roommate who lent me her car. I wasn't counseled or told the truth for what would happen or how I would feel. I left the clinic and never went back for the follow-up. Many years passed and I got married and finally got a pregnancy that ended in a miscarriage. For 25 years I suffered silently with the secret of my abortion. I truly believe if I had been afforded more time I would never have had the abortion. I believe every young mother needs to

be provided this time and protection. Time to decide and to realize they are the mother of this baby whether they have the abortion or not.

Wendy Bannister: I am the executive director of Gateway, a pregnancy and sexual health resource center here in Raleigh. From our perspective H465 is about introducing a measure that can potentially protect little girls from a lifetime of regret and grief. A lot of women are in crisis mode and are not coping well with the news. Many women coming to our center believe their circumstances leave them only one option, and that is to abort. What we see all the time, the majority of women need time to process the crisis they are in and to inform themselves of all their options. It is particularly important to allow those younger girls to talk to their parents, engage the support of those who love and care for them. Time allows you to make alternative academic decisions. Time allows women to opportunity to see their future differently and yet still successfully. Time gives the opportunity to problem solve and engage a women's innate ability to come up with solutions. Legislation that extends the time a woman has before taking an abortion can serve to protect women in crisis from making a permanent life altering decision before considering all facets of their decision. It may just be that 72 hours is what makes the difference for women when she exercises her right to choose.

Amber Laymen: I am the CEO of First Choice pregnancy solutions, a resource in this area for women with unplanned pregnancies. 20 years ago I myself walked through the abortion clinic doors with little information and made a decision that I regretted. 8 years later when I found out that my baby had fingers, toes, a heartbeat, a spinal system, when I found those things out I was devastated. I should have known before I walked through those doors. Now, I can help women who walk through those doors at First Choice. We give women medically accurate information to help them understand there are more resources to them. There are resources with people that want to work with them. When women have support and take the time to decide, they prefer to have their children.

Mary O'Shay: I am the program manager with First choice pregnancy solutions. I've been practicing nursing in the area for 21 years. I've experienced 2 unplanned pregnancies before. What I've seen from the women walking through our doors is that they really don't have a choice. We provide women with medically accurate information. We provide a mutual, safe, and judgmental environment. When you take the time to make your choices, you can make the best one for yourself. There is no need to take a choice away from somebody, but they need time and accurate information to make it. I support this bill because it will give women some extra time.

Tammy Fitzgerald: I am the executive director of the NC Values Coalition. I am reading a direct quote: This case is about a doctor who killed babies and injured women, what we mean is that this doctor delivered babies unsafely and killed them by severing their spinal cords. He spread disease amongst his patients with unclean instruments. I am reading from the official report from the grand jury in the case against Dr. Kermit Goznel in Pennsylvania. The grand jury concluded that the real business of his clinic was not health, it was profit. What does this case have to do

with this bill? You see the horrors of Kermit Goznel's clinic were allowed to continue by the health department in Pennsylvania who chose to stick its head in the sand and ignore regular inspections, the duty of the state to regulate an industry motivated by profit, not health, and the pain of suffering of the women and babies who frequented that place. They didn't care. It is time for this state to care. It is time for us to care about the safety of women who enter these wretched abortion clinics. It is time to stop putting abortion on a pedestal which does not have to play by the same rules as other health issues. Profiteers of abortion have created this fictitious war on women so they can hide their abuses. I ask you to pass H465.

Chairman Brown: It is ten till and we are going to take a vote on this now.

Rep. Avila moves for favorable report for PCS H465 unfavorable to the original with referral to Judiciary 4.

Rep. Insko has called for the ayes and noes. A Roll Call Vote was taken.

Ayes: Representatives Avila, Bishop, Brawley, B. Brown, Burr, R. Brown, Dobson, Dollar, Ford, Hager, Hastings, Jones, Lambeth, Martin, Pendleton, Saine, Setzer, Szoka and Yarborough (19)

Noes: Representatives Adcock, Carney, Cotham, Earle, Farmer-Butterfield, Goodman, Hall, Insko, Lucas, Waddell and Wray. (11)

The motion carried.

The meeting adjourned at 11:00

Representative Brian Brown, Chair
Presiding

Theresa Lopez, Committee Clerk

HOUSE BILL 465:
72hrs Informed Consent By Person or Phone.

2015-2016 General Assembly

Committee:	House Health, if favorable, Judiciary IV	**Date:**	April 21, 2015
Introduced by:	Reps. Schaffer, McElraft, R. Turner, S. Martin	**Prepared by:**	Kelly Tornow Committee Counsel
Analysis of:	PCS to First Edition H465-CSTK-29		

SUMMARY: The PCS for House Bill 465 would: (1) require physicians who perform abortions to report certain information to DHHS; (2) increase to 72 hours the waiting period for women who voluntarily consent to an abortion; and (3) make technical and conforming changes.

CURRENT LAW & BILL ANALYSIS

Section 1

CURRENT LAW: G.S. 14-45.1 sets forth the circumstances under which an abortion may be lawfully performed.

Hospitals and clinics where abortions are performed are required to annually provide to the Department of Health and Human Services (DHHS) statistical summary reports concerning the medical and demographic characteristics of the abortions allowed under this statute. The reports are for statistical purposes only and the confidentiality of the patient relationship is protected.

ANALYSIS: Section 1 would require a physician who advises, procures, or causes a miscarriage or abortion after the 18th week of a woman's pregnancy to record the following and provide the information to DHHS: (1) the method used by the physician to determine the probable gestational age of the unborn child, (2) the results of the methodology including the measurements of the unborn child, and (3) an ultrasound image of the unborn child that depicts the measurements. A physician who procures or causes an abortion after the 20th week of a woman's pregnancy would be required to record the findings and analysis on which the physician based the determination that continuance of the pregnancy would threaten the life or gravely impair the health of the woman and provide that information to DHHS.

Section 1 would also make technical and conforming changes.

Sections 2 and 3

CURRENT LAW: The Women's Right to Know Act (Article 11 of Chapter 90 of the General Statutes) outlines the requirements for informed consent to abortion. At least 24 hours prior to an abortion, a physician or qualified professional must provide certain information to a woman voluntarily consenting to an abortion. This can be done by telephone or in person.

ANALYSIS: Section 2 would increase the timeframe for providing certain information to a woman voluntarily consenting to an abortion to 72 hours. Section 3 would make a conforming change.

This bill analysis was prepared by the nonpartisan legislative staff for the use of legislators in their deliberations and does not constitute an official statement of legislative intent.

Section 4

ANALYSIS: Section 4 contains a severability cause which would provide that if any provision of the act is held invalid, the invalidity would not affect other provisions of the act that can be given effect without the invalid provisions.

EFFECTIVE DATE: The substantive provisions in Section 1 become effective January 1, 2016, and apply to abortions performed or attempted on or after that date. Sections 4 is effective when it becomes law. The remainder of this act becomes effective October 1, 2015, and applies to abortions performed or attempted on or after that date.

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2015

H 1

HOUSE BILL 465

Short Title:	Clarify & Modify Certain Abortion Laws.	(Public)
Sponsors:	Representatives Schaffer, McElraft, R. Turner, and S. Martin (Primary Sponsors). *For a complete list of Sponsors, refer to the North Carolina General Assembly Web Site.*	
Referred to:	Health, if favorable, Judiciary IV.	

April 2, 2015

A BILL TO BE ENTITLED

AN ACT TO CLARIFY AND MODIFY CERTAIN LAWS PERTAINING TO ABORTION.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 14-45.1 reads as rewritten:

"**§ 14-45.1. When abortion not unlawful.**

(a) Notwithstanding any of the provisions of G.S. 14-44 and 14-45, it shall not be unlawful, during the first 20 weeks of a woman's pregnancy, to advise, procure, or cause a miscarriage or abortion when the procedure is performed by ~~a physician~~ an obstetrician or gynecologist licensed to practice medicine in North Carolina in a hospital or clinic certified by the Department of Health and Human Services to be a suitable facility for the performance of abortions.

(b) Notwithstanding any of the provisions of G.S. 14-44 and 14-45, it shall not be unlawful, after the twentieth week of a woman's pregnancy, to advise, procure or cause a miscarriage or abortion when the procedure is performed by ~~a physician~~ an obstetrician or a gynecologist licensed to practice medicine in North Carolina in a hospital licensed by the Department of Health and Human Services, if there is substantial risk that continuance of the pregnancy would threaten the life or gravely impair the health of the woman.

(b1) A physician who advises, procures, or causes a miscarriage or abortion after the sixteenth week of a woman's pregnancy shall record all of the following: the method used by the physician to determine the probable gestational age of the unborn child at the time the procedure is to be performed; the results of the methodology, including the measurements of the unborn child; and an ultrasound image of the unborn child that depicts the measurements. The physician shall provide this information, including the ultrasound image, to the Department of Health and Human Services pursuant to G.S. 14-45.1(c).

A physician who procures or causes a miscarriage or abortion after the twentieth week of a woman's pregnancy shall record the findings and analysis on which the physician based the determination that continuance of the pregnancy would threaten the life or gravely impair the health of the woman and shall provide that information to the Department of Health and Human Services pursuant to G.S. 14-45.1(c).

The information provided under this subsection shall be for statistical purposes only, and the confidentiality of the patient shall be protected. It is the duty of the physician to submit information to the Department of Health and Human Services that omits identifying information of the patient and complies with HIPPA.

(c) The Department of Health and Human Services shall prescribe and collect on an annual basis, from hospitals or ~~clinics~~ clinics, including ambulatory surgical facilities, where abortions are performed, ~~such representative samplings of~~ statistical summary reports concerning the medical and demographic characteristics of the abortions provided for in this ~~section~~ section, including the information described in subsection (b1) of this section as it shall deem to be in the public interest. Hospitals or clinics where abortions are performed shall be responsible for providing these statistical summary reports to the Department of Health and Human Services. The reports shall be for statistical purposes only and the confidentiality of the patient relationship shall be protected.

(d) The requirements of ~~G.S. 130-43~~ G.S. 130A-114 are not applicable to abortions performed pursuant to this section.

(e) ~~Nothing in this section shall require a physician licensed to practice medicine in North Carolina, any~~ No physician, nurse, or any other health care provider who shall state an objection to abortion on moral, ethical, or religious ~~grounds,~~ grounds shall be required to perform or participate in medical procedures which result in an abortion. The refusal of a physician, nurse, or health care provider to perform or participate in these medical procedures shall not be a basis for damages for the refusal, or for any disciplinary or any other recriminatory action against the physician, nurse, or health care provider. For purposes of this section, the phrase "health care provider" shall have the same meaning as defined under G.S. 90-410(1).

(f) Nothing in this section shall require a hospital, other health care institution, or other health care provider to perform an abortion or to provide abortion services."

SECTION 2. G.S. 90-21.82 reads as rewritten:

"**§ 90-21.82. Informed consent to abortion.**

No abortion shall be performed upon a woman in this State without her voluntary and informed consent. Except in the case of a medical emergency, consent to an abortion is voluntary and informed only if all of the following conditions are satisfied:

(1) At least ~~24 hours~~ 72 hours prior to the abortion, a physician or qualified professional has orally informed the woman, by telephone or in person, of all of the following:

...

If the physician or qualified professional does not know the information required in sub-subdivisions a., f., or g. of this subdivision, the woman shall be advised that this information will be directly available from the physician who is to perform the abortion. However, the fact that the physician or qualified professional does not know the information required in sub-subdivisions a., f., or g. shall not restart the ~~24-hour~~ 72-hour period. The information required by this subdivision shall be provided in English and in each language that is the primary language of at least two percent (2%) of the State's population. The information may be provided orally either by telephone or in person, in which case the required information may be based on facts supplied by the woman to the physician and whatever other relevant information is reasonably available. The information required by this subdivision may not be provided by a tape recording but shall be provided during a consultation in which the physician is able to ask questions of the patient and the patient is able to ask questions of the physician. If, in the medical judgment of the physician, a physical examination, tests, or the availability of other information to the physician subsequently indicates a revision of the information previously supplied to the patient, then that revised information may be communicated to the patient at any time before the performance of the abortion. Nothing in this section may be construed to

preclude provision of required information in a language understood by the patient through a translator.

(2) The physician or qualified professional has informed the woman, either by telephone or in person, of each of the following at least ~~24 hours~~ 72 hours before the abortion:

a. That medical assistance benefits may be available for prenatal care, childbirth, and neonatal care.

b. That public assistance programs under Chapter 108A of the General Statutes may or may not be available as benefits under federal and State assistance programs.

c. That the father is liable to assist in the support of the child, even if the father has offered to pay for the abortion.

d. That the woman has other alternatives to abortion, including keeping the baby or placing the baby for adoption.

e. That the woman has the right to review the printed materials described in G.S. 90-21.83, that these materials are available on a State-sponsored Web site, and the address of the State-sponsored Web site. The physician or a qualified professional shall orally inform the woman that the materials have been provided by the Department and that they describe the unborn child and list agencies that offer alternatives to abortion. If the woman chooses to view the materials other than on the Web site, the materials shall either be given to her at least ~~24 hours~~ 72 hours before the abortion or be mailed to her at least 72 hours before the abortion by certified mail, restricted delivery to addressee.

f. That the woman is free to withhold or withdraw her consent to the abortion at any time before or during the abortion without affecting her right to future care or treatment and without the loss of any State or federally funded benefits to which she might otherwise be entitled.

The information required by this subdivision shall be provided in English and in each language that is the primary language of at least two percent (2%) of the State's population. The information required by this subdivision may be provided by a tape recording if provision is made to record or otherwise register specifically whether the woman does or does not choose to have the printed materials given or mailed to her. Nothing in this subdivision shall be construed to prohibit the physician or qualified professional from e-mailing a Web site link to the materials described in this subdivision or G.S. 90-21.83.

...."

SECTION 3. G.S. 90-21.86 reads as rewritten:

"**§ 90-21.86. Procedure in case of medical emergency.**

When a medical emergency compels the performance of an abortion, the physician shall inform the woman, before the abortion if possible, of the medical indications supporting the physician's judgment that an abortion is necessary to avert her death or that a ~~24-hour~~ 72-hour delay will create a serious risk of substantial and irreversible impairment of a major bodily function, not including psychological or emotional conditions. As soon as feasible, the physician shall document in writing the medical indications upon which the physician relied and shall cause the original of the writing to be maintained in the woman's medical records and a copy given to her."

SECTION 4. G.S. 116-36.1(d) reads as rewritten:

"(d) Trust funds are subject to the oversight of the State Auditor pursuant to Article 5A of Chapter 147 of the General Statutes but are not subject to the provisions of the State Budget Act except ~~for capital~~ as follows:

(1) Capital improvements projects which shall be authorized and executed in accordance with G.S. 143C-8-8 and G.S. 143C-8-9.

(2) All trust funds shall be subject to G.S. 143C-6-5.5."

SECTION 5. Article 1 of Chapter 116 of the General Statutes is amended by adding a new section to read:

"**§ 116-36.7. State medical school departments prohibited from authorizing employees to perform abortions.**

(a) No department at the medical school at East Carolina University or the University of North Carolina at Chapel Hill shall permit an employee to perform or supervise the performance of an abortion as part of the employee's official duties.

(b) The prohibitions in this section shall not apply where (i) the life of the mother would be endangered if the unborn child were carried to term or (ii) the pregnancy is the result of a rape or incest. Nothing in this section shall be construed to limit medical care provided after a spontaneous miscarriage.

(c) For purposes of this section, the term abortion is defined the same as in G.S. 90-21.81."

SECTION 6. G.S. 116-37 is amended by adding the following new subsection to read:

"(l) Limitation on use of finances and facilities for abortion. – No moneys of The University of North Carolina Health Care System that are described in subsection (e) of this section may be used for the performance of abortions. No State facility created, owned, controlled, or managed by The University of North Carolina Health Care System may be used for the performance of abortions. The prohibitions in this subsection shall not apply where (i) the life of the mother would be endangered if the unborn child were carried to term or (ii) the pregnancy is the result of a rape or incest. Nothing in this subsection shall be construed to limit medical care provided after a spontaneous miscarriage. For purposes of this subsection, the term abortion is defined the same as in G.S. 90-21.81."

SECTION 7. G.S. 116-37.2(e) reads as rewritten:

"(e) Funds under this section are subject to the oversight of the State Auditor pursuant to Article 5A of Chapter 147 of the General Statutes but are not subject to the provisions of the State Budget Act except ~~for capital~~ as follows:

(1) Capital improvements projects, which shall be authorized and executed in accordance with G.S. 143C-8-8 and G.S. 143C-8-9.

(2) All funds under this section are subject to G.S. 143C-6-5.5."

SECTION 8. If any provision of this act or its application is held invalid, the invalidity does not affect other provisions or applications of this act that can be given effect without the invalid provisions or application, and to this end the provisions of this act are severable. If any provision of this act is temporarily or permanently restrained or enjoined by judicial order, this act shall be enforced as though such restrained or enjoined provisions had not been adopted, provided that whenever such temporary or permanent restraining order or injunction is stayed, dissolved, or otherwise ceases to have effect, such provisions shall have full force and effect.

SECTION 9. This section and Sections 4, 5, 6, 7, and 8 are effective when this act becomes law. G.S. 14-45.1(b1) and G.S. 14-45.1(c) as enacted by Section 1 of this act become effective January 1, 2016, and apply to abortions performed or attempted on or after January 1, 2016. The remainder of this act becomes effective October 1, 2015, and applies to abortions performed or attempted on or after October 1, 2015.

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2015

H D

HOUSE BILL 465
PROPOSED COMMITTEE SUBSTITUTE H465-CSTK-29 [v.2]

4/21/2015 4:08:15 PM

Short Title: 72hrs Informed Consent By Person or Phone. (Public)

Sponsors:

Referred to:

April 2, 2015

A BILL TO BE ENTITLED

AN ACT TO REQUIRE 72 HOURS FOR THE PROVISION OF INFORMED CONSENT, EITHER BY TELEPHONE OR IN PERSON, AND TO CLARIFY AND MODIFY CERTAIN LAWS PERTAINING TO ABORTION .

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 14-45.1 reads as rewritten:

"**§ 14-45.1. When abortion not unlawful.**

(a) Notwithstanding any of the provisions of G.S. 14-44 and 14-45, it shall not be unlawful, during the first 20 weeks of a woman's pregnancy, to advise, procure, or cause a miscarriage or abortion when the procedure is performed by a physician licensed to practice medicine in North Carolina in a hospital or clinic certified by the Department of Health and Human Services to be a suitable facility for the performance of abortions.

(b) Notwithstanding any of the provisions of G.S. 14-44 and 14-45, it shall not be unlawful, after the twentieth week of a woman's pregnancy, to advise, procure or cause a miscarriage or abortion when the procedure is performed by a physician licensed to practice medicine in North Carolina in a hospital licensed by the Department of Health and Human Services, if there is substantial risk that continuance of the pregnancy would threaten the life or gravely impair the health of the woman.

(b1) A physician who advises, procures, or causes a miscarriage or abortion after the eighteenth week of a woman's pregnancy shall record all of the following: the method used by the physician to determine the probable gestational age of the unborn child at the time the procedure is to be performed; the results of the methodology, including the measurements of the unborn child; and an ultrasound image of the unborn child that depicts the measurements. The physician shall provide this information, including the ultrasound image, to the Department of Health and Human Services pursuant to G.S. 14-45.1(c).

A physician who procures or causes a miscarriage or abortion after the twentieth week of a woman's pregnancy shall record the findings and analysis on which the physician based the determination that continuance of the pregnancy would threaten the life or gravely impair the health of the woman and shall provide that information to the Department of Health and Human Services pursuant to G.S. 14-45.1(c).

The information provided under this subsection shall be for statistical purposes only, and the confidentiality of the patient shall be protected. It is the duty of the physician to submit information to the Department of Health and Human Services that omits identifying information of the patient and complies with Health Insurance Portability and Accountability Act of 1996 (HIPAA).

(c) The Department of Health and Human Services shall prescribe and collect on an annual basis, from hospitals or ~~clinics~~ clinics, including ambulatory surgical facilities, where abortions are performed, ~~such representative samplings of~~ statistical summary reports concerning the medical and demographic characteristics of the abortions provided for in this ~~section~~ section, including the information described in subsection (b1) of this section as it shall deem to be in the public interest. Hospitals or clinics where abortions are performed shall be responsible for providing these statistical summary reports to the Department of Health and Human Services. The reports shall be for statistical purposes only and the confidentiality of the patient relationship shall be protected.

(d) The requirements of ~~G.S. 130-43~~ G.S. 130A-114 are not applicable to abortions performed pursuant to this section.

(e) ~~Nothing in this section shall require a physician licensed to practice medicine in North Carolina, any~~ No physician, nurse, or any other health care provider who shall state an objection to abortion on moral, ethical, or religious ~~grounds,~~ grounds shall be required to perform or participate in medical procedures which result in an abortion. The refusal of a physician, nurse, or health care provider to perform or participate in these medical procedures shall not be a basis for damages for the refusal, or for any disciplinary or any other recriminatory action against the physician, nurse, or health care provider. For purposes of this section, the phrase "health care provider" shall have the same meaning as defined under G.S. 90-410(1).

(f) Nothing in this section shall require a hospital, other health care institution, or other health care provider to perform an abortion or to provide abortion services."

SECTION 2. G.S. 90-21.82 reads as rewritten:

"**§ 90-21.82. Informed consent to abortion.**

No abortion shall be performed upon a woman in this State without her voluntary and informed consent. Except in the case of a medical emergency, consent to an abortion is voluntary and informed only if all of the following conditions are satisfied:

(1) At least ~~24 hours~~ 72 hours prior to the abortion, a physician or qualified professional has orally informed the woman, by telephone or in person, of all of the following:

...

If the physician or qualified professional does not know the information required in sub-subdivisions a., f., or g. of this subdivision, the woman shall be advised that this information will be directly available from the physician who is to perform the abortion. However, the fact that the physician or qualified professional does not know the information required in sub-subdivisions a., f., or g. shall not restart the ~~24-hour~~ 72-hour period. The information required by this subdivision shall be provided in English and in each language that is the primary language of at least two percent (2%) of the State's population. The information may be provided orally either by telephone or in person, in which case the required information may be based on facts supplied by the woman to the physician and whatever other relevant information is reasonably available. The information required by this subdivision may not be provided by a tape recording but shall be provided during a consultation in which the physician is able to ask questions of the patient and the patient is able to ask questions of the physician. If, in the medical judgment of the physician, a physical examination, tests, or the availability of other information to the physician subsequently indicates a revision of the information previously supplied to the patient, then that revised information may be communicated to the patient at any time before the performance of the abortion. Nothing in this section may be construed to

preclude provision of required information in a language understood by the patient through a translator.

(2) The physician or qualified professional has informed the woman, either by telephone or in person, of each of the following at least ~~24 hours~~ 72 hours before the abortion:

a. That medical assistance benefits may be available for prenatal care, childbirth, and neonatal care.

b. That public assistance programs under Chapter 108A of the General Statutes may or may not be available as benefits under federal and State assistance programs.

c. That the father is liable to assist in the support of the child, even if the father has offered to pay for the abortion.

d. That the woman has other alternatives to abortion, including keeping the baby or placing the baby for adoption.

e. That the woman has the right to review the printed materials described in G.S. 90-21.83, that these materials are available on a State-sponsored Web site, and the address of the State-sponsored Web site. The physician or a qualified professional shall orally inform the woman that the materials have been provided by the Department and that they describe the unborn child and list agencies that offer alternatives to abortion. If the woman chooses to view the materials other than on the Web site, the materials shall either be given to her at least ~~24 hours~~ 72 hours before the abortion or be mailed to her at least 72 hours before the abortion by certified mail, restricted delivery to addressee.

f. That the woman is free to withhold or withdraw her consent to the abortion at any time before or during the abortion without affecting her right to future care or treatment and without the loss of any State or federally funded benefits to which she might otherwise be entitled.

The information required by this subdivision shall be provided in English and in each language that is the primary language of at least two percent (2%) of the State's population. The information required by this subdivision may be provided by a tape recording if provision is made to record or otherwise register specifically whether the woman does or does not choose to have the printed materials given or mailed to her. Nothing in this subdivision shall be construed to prohibit the physician or qualified professional from e-mailing a Web site link to the materials described in this subdivision or G.S. 90-21.83.

...."

SECTION 3. G.S. 90-21.86 reads as rewritten:

"**§ 90-21.86. Procedure in case of medical emergency.**

When a medical emergency compels the performance of an abortion, the physician shall inform the woman, before the abortion if possible, of the medical indications supporting the physician's judgment that an abortion is necessary to avert her death or that a ~~24-hour~~ 72-hour delay will create a serious risk of substantial and irreversible impairment of a major bodily function, not including psychological or emotional conditions. As soon as feasible, the physician shall document in writing the medical indications upon which the physician relied and shall cause the original of the writing to be maintained in the woman's medical records and a copy given to her."

SECTION 4. If any provision of this act or its application is held invalid, the invalidity does not affect other provisions or applications of this act that can be given effect

without the invalid provisions or application, and to this end the provisions of this act are severable. If any provision of this act is temporarily or permanently restrained or enjoined by judicial order, this act shall be enforced as though such restrained or enjoined provisions had not been adopted, provided that whenever such temporary or permanent restraining order or injunction is stayed, dissolved, or otherwise ceases to have effect, such provisions shall have full force and effect.

SECTION 5. This section and section 4 are effective when this act becomes law. G.S. 14-45.1(b1) and G.S. 14-45.1(c) as enacted by Section 1 of this act become effective January 1, 2016, and apply to abortions performed or attempted on or after January 1, 2016. The remainder of this act becomes effective October 1, 2015, and applies to abortions performed or attempted on or after October 1, 2015.

4-22-2015

ROLL CALL VOTE

19 YES 11 NO 30 (TOTAL)

HB# 465
SB# ____

HOUSE STANDING COMMITTEE ON HEALTH

House Subcommittee on _____

YES	NO	MEMBER (last name)	YES	NO	MEMBER (last name)
	✓	Adcock	✓		Pendleton
✓		Avila	✓		Saine
✓		Bishop	✓		Setzer
		Blackwell	✓		Szoka
		Brisson		✓	Waddell
✓		R. Brown			Wray
	✓	Carney	✓		Yarborough
	✓	Cotham			
✓		Dobson			
✓		Dollar	✓		Brown
	✓	Earle	✓		Burr
	✓	Farmer-Butterfield	✓		Jones
✓		Ford	✓		Lambeth
	✓	Goodman			
	✓	Hall			
✓		Hastings			
	✓	Insko			
		Lewis			
	✓	Lucas			
✓		Martin			

Blackwell Yes

Haggerty Yes

- Steve Keen, ~~[illegible]~~
- ~~Spoke to Brian this morning @ [illegible]~~
- ~~Governor will be in Greenville, 1:00 PM~~
- ~~PCC, progress Student~~ vented
- ~~This Friday~~
-

HOUSE BILL 746:
LME/MCO Board Amendments

2015-2016 General Assembly

Committee:	House Health	**Date:**	April 22, 2015
Introduced by:	Reps. Dollar, J. Bell, Avila	**Prepared by:**	Theresa Matula Committee Staff
Analysis of:	First Edition		

SUMMARY: House Bill 746 amends the appointment process for LME/MCO governing boards to provide that the optional process by which county commissioners can appoint members to an area board requires the adoption of a resolution by two-thirds of the constituent counties and authorizes the Secretary of DHHS to approve an alternate appointment process that includes constituent counties delegating appointment authority to intermediary bodies, created by the counties, to represent regions of a multicounty area authority.

BILL ANALYSIS: House Bill 746 amends G.S. 122C-118.1 which provides for the structure of area Local Management Entity/ Managed Care Organization (LME/MCO) board.

The removal of current law on lines 12-14 of the bill, is actually relocation to lines 9-10 of the bill to place it in subsection (a).

A new subsection (a1) is created which prescribes the process for appointing members to ensure participation from each of the constituent counties of a multicounty area authority. Under the current law, the boards of county commissioners within a multicounty area with a catchment population of at least 1,250,000 have the option to appoint members of the area board in a manner or with a composition other than as required by the section by each county adopting a resolution to that effect and receiving written approval from the Secretary. The new language requires at least two-thirds of the constituent counties to adopt the resolution and authorizes the Secretary of DHHS to approve an appointment process that includes the constituent counties delegating appointment authority to intermediary bodies created by counties to represent regions of a multicounty are authority.

EFFECTIVE DATE: House Bill 746 would become effective when it becomes law.

CURRENT LAW: G.S. 122C-118.1 provides for the structure of area local management entity/managed care organization (LME/MCO) governing boards. The law requires an area board to have no fewer than 11 and no more than 21 voting members. The board of county commissioners, or boards of county commissioners within the area appoint members to the area board consistent with requirements outlined in G.S. 122C-118.1(b) which requires the membership of the area board to reside within the catchment area and be composed as follows:

(1) At least one member who is a current county commissioner.
(2) The chair of the local Consumer and Family Advisory Committee (CFAC) or the chair's designee.
(3) At least one family member of the local CFAC, as recommended by the local CFAC, representing the interests of the following:
    a. Individuals with mental illness.
    b. Individuals in recovery from addiction.
    c. Individuals with intellectual or other developmental disabilities.

O. Walker Reagan
Director

H 7 4 6 - S M S H - 4 1 E 1 - V 4

Research Division
(919) 733-2578

This bill analysis was prepared by the nonpartisan legislative staff for the use of legislators in their deliberations and does not constitute an official statement of legislative intent

(4) At least one openly declared consumer member of the local CFAC, as recommended by the local CFAC, representing the interests of the following:
   a. Individuals with mental illness.
   b. Individuals with intellectual or other developmental disabilities.
   c. Individuals in recovery from addiction.
(5) An individual with health care expertise and experience in the fields of mental health, intellectual or other developmental disabilities, or substance abuse services.
(6) An individual with health care administration expertise consistent with the scale and nature of the managed care organization.
(7) An individual with financial expertise consistent with the scale and nature of the managed care organization.
(8) An individual with insurance expertise consistent with the scale and nature of the managed care organization.
(9) An individual with social services expertise and experience in the fields of mental health, intellectual or other developmental disabilities, or substance abuse services.
(10) An attorney with health care expertise.
(11) A member who represents the general public and who is not employed by or affiliated with the Department of Health and Human Services, as appointed by the Secretary.
(12) The President of the LME/MCO Provider Council or the President's designee to serve as a nonvoting member who shall participate only in Board activities that are open to the public.
(13) An administrator of a hospital providing mental health, developmental disabilities, and substance abuse emergency services to serve as a nonvoting member who shall participate only in Board activities that are open to the public.

Except as provided in subdivisions (12) and (13) of this subsection, an individual that contracts with a local management entity (LME) for the delivery of mental health, developmental disabilities, and substance abuse services may not serve on the board of the LME for the period during which the contract for services is in effect. No person registered as a lobbyist under Chapter 120C of the General Statutes shall be appointed to or serve on an area authority board. Of the members described in subdivisions (2) through (4) of this subsection, the boards of county commissioners shall ensure there is at least one member representing the interest of each of the following: (i) individuals with mental illness, (ii) individuals with intellectual or other developmental disabilities, and (iii) individuals in recovery from addiction.

G.S. 122C-118.1(c) provides that board of county commissioners may elect to appoint a member of the area authority board to fill concurrently no more than two categories of membership if the member has the qualifications or attributes of the two categories of membership.

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2015

HOUSE BILL 746

Short Title:	LME/MCO Board Amendments.	(Public)
Sponsors:	Representatives Dollar, J. Bell, and Avila (Primary Sponsors). *For a complete list of Sponsors, refer to the North Carolina General Assembly Web Site.*	
Referred to:	Health.	

April 15, 2015

A BILL TO BE ENTITLED

AN ACT TO MAKE MODIFICATIONS TO LME/MCO GOVERNING BOARDS.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 122C-118.1(a) reads as rewritten:

"**§ 122C-118.1. Structure of area board.**

(a) An area board shall have no fewer than 11 and no more than 21 voting members. The board of county commissioners, or the boards of county commissioners within the area, shall appoint members consistent with the requirements provided in subsection (b) of this section. If the board or boards fail to comply with the requirements of subsection (b) of this section, the Secretary shall appoint the unrepresented category.

(a1) The process for appointing members shall ensure participation from each of the constituent counties of a multicounty area authority. ~~If the board or boards fail to comply with the requirements of subsection (b) of this section, the Secretary shall appoint the unrepresented category.~~ The boards of county commissioners within a multicounty area with a catchment population of at least 1,250,000 shall have the option to appoint members of the area board ~~in a manner or with a composition~~ through a process other than as required by this section by at least two-thirds of the constituent counties each ~~county~~ adopting a resolution to that effect and receiving written approval from the Secretary. The Secretary may approve an appointment process that includes the constituent counties delegating appointment authority to intermediary bodies created by counties to represent regions of a multicounty area authority. A member of the board may be removed with or without cause by the ~~initial~~ appointing authority.

(a2) The area board may declare vacant the office of an appointed member who does not attend three consecutive scheduled meetings without justifiable excuse. The chair of the area board shall notify the appropriate appointing authority of any vacancy. Vacancies on the board shall be filled by the ~~initial~~ appointing authority before the end of the term of the vacated seat or within 90 days of the vacancy, whichever occurs first, and the appointments shall be for the remainder of the unexpired term."

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

NORTH CAROLINA GENERAL ASSEMBLY
HOUSE OF REPRESENTATIVES

HEALTH COMMITTEE REPORT
Representative Brian Brown, Co-Chair
Representative Justin P. Burr, Co-Chair
Representative Bert Jones, Co-Chair
Representative Donny Lambeth, Co-Chair

FAVORABLE

HB **746** LME/MCO Board Amendments.

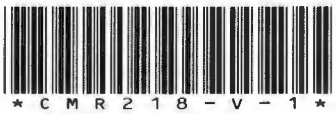
Draft Number:	None
Serial Referral:	None
Recommended Referral:	None
Long Title Amended:	No
Floor Manager:	Dollar

FAVORABLE COM SUB , UNFAVORABLE ORIGINAL BILL AND RE-REFERRED

HB **465** Clarify & Modify Certain Abortion Laws.

Draft Number:	H465-PCS30342-TK-29
Serial Referral:	**JUDICIARY IV**
Recommended Referral:	None
Long Title Amended:	Yes
Floor Manager:	Schaffer

TOTAL REPORTED: 2



Committee Sergeants at Arms

NAME OF COMMITTEE House Comm. on Health

DATE: 04/22/15 Room: 643

House Sgt-At Arms:

1. Name: Young Bae
2. Name: Bill Morris
3. Name: Jim Moran
4. Name: _____
5. Name: _____

Senate Sgt-At Arms:

1. Name: _____
2. Name: _____
3. Name: _____
4. Name: _____
5. Name: _____

Wednesday, April 22 HEALTH	Room 643	Time 10:00 am

Name	County	Sponsor
Lizzie O'Briant	Randolph	Pat B. Hurley
Davis Privette	Guilford	John Faircloth
Joe Swaim	Randolph	Allen McNeill
Jessica Vazquez	Guilford	John Faircloth

VISITOR REGISTRATION SHEET

House Comm. on Health — 04/22/15

Name of Committee — Date

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Ben Thompson	UNC School of Medicine
Charles Hill	North Carolina Provider Council
Chris Dalton	Rescare - CANC Charlotte NC
Angie Hughes	Rescare - CANC Charlotte, NC
Anna Brumsberg	NC Family Action
[illegible]	Citizen
Paul Weber	Citizens Link - Colorado Springs
Lowell Lackey	Sen. Waddell
Emily Hardesty	Private citizen
Kelly Gilmore	Private citizen
Sonia Angga	Duke Family Planning

VISITOR REGISTRATION SHEET

House Comm. on Health — Name of Committee

04/22/15 — Date

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Emilia Samuel	Duke OBGyn
Beverly Gray	Duke University Medical Center
Matthew Zerden	OBGYN ; Private Citizen
Jeremy Belch	Duke OB/GYN
Jamie Krashin	OBGYN & Private citizen
Narger Faraha	Family Physician & Private Citizen
Kathleen Tompkins	UNC medical Student & Private Citizen
Noah Wohlert	UNC Family Medicine Residency
Eli Tiller	UNC Family Medicine Residency
Jason Yoder	Yoder Law PLLC

VISITOR REGISTRATION SHEET

House Comm. on Health — 04/22/15

Name of Committee — Date

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
TRACY GOLVARD	AHHC
Joanna P Closch	UNC School Govt.
Jim BLEVINS	PRO LIFE NC
Andy Chase	KMA
Amy Bryant	UNC (but here on my own)
David Stamilio	UNC / NC State obstetrician
Jina Dhillon	Ipas
Julia Adams Scheinck	NARAL/NC ACT Fund/NARAL/NC
Wendy Bannister	Gateway pregnancy resource center
Jane Fitzgerald	NC Values Coalition
Mary Griffin	MD
Shirley Tucker	Raleigh NC

VISITOR REGISTRATION SHEET

House Comm. on Health — Name of Committee

04/22/15 — Date

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
DALIA BRAHMI	FAMILY PHYSICIAN
Maria Munoz	Obstetrician
Jessica Mortl	Ob/Gyn
KARA MCELLIGOTT	OB/GYN
Carolynn Dale	OB/GYN
Jen Rygall	NC Family Policy Council
Sarah Preston	ACLU-NC
Matt Gray	NCAE
Kay Castillo	NASW-NC
Courtney Coyle	NASW-NC
Cory Burr	DRNC

VISITOR REGISTRATION SHEET

House Comm. on Health — Name of Committee

04/22/15 — Date

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Maria Canty	7521 Kisco Dr., Fay. NC

No

VISITOR REGISTRATION SHEET

House Comm. on Health — 04/22/15

Name of Committee — Date

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Jessa Goodmon	DHHS/DHSR
J.W. Joyner	CACNC
E Ingram	BAYER
Alison Kiser	PPSAT
[illegible]	NARAL
Jenny Black	PPSAT
Emily Callen	PPSAT
Hannah Osborne	NARAL
Chavi Korets	NARAL
Nancy Bolinkeyne	PPSAT
Keyanka Bailey	PPSAT
Keitha Tr[illegible]	

VISITOR REGISTRATION SHEET

House Comm. on Health — 04/22/15

Name of Committee — Date

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Alexia Montague	PPSAT
Julia Santiago	PPSAT
Lauren Finn	PPSAT
Jina Dhillon	NARAL NC
Sarah Cannady	NARAL NC
Emma Akpan	PPSAT
Janet Colvin	PPSAT
Susan Eder	PPSAT
Martin Nyhelt	PPV
Ann Rodriguez	NC Council of Community Programs
Cheryl Dickens	Wake Med

VISITOR REGISTRATION SHEET

House Comm. on Health — 04/22/15

Name of Committee — Date

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
MaryLynn Henderson	RN
Joyce Mitchell-Antoine	PPSAT
Bradley King MD	UNC Ophthalmology, NCMS.
Sylvia Groth MD	UNC ophthalmology NCMS
Jennifer Williamson MD	UNC Ophthalmology NCMS
Sheryl Zerbe	ResCare Inc
Traci Holloman	ResCare, Inc
Kandy John	RHA-Howelis
Shantena Thomas	RHA Behavioral Health
Carmen Davis	NVA
Madeline Keeter	CaroMont Health

VISITOR REGISTRATION SHEET

House Comm. on Health — 04/22/15

Name of Committee — Date

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Inga Warnung	ECBT
John DelGrosso	Brubaker & Assoc.
David Price	DHHS / DHSR
Jeff Colby	DHHS / DHSR
Amanda Horaker	Troutman Sanders
Tony Adams	Adams & assoc.
Sadaf Sedaghat	NP
Erica Nelson	NCHA
Ryan Brown	NCAFP
Joanna Spruill	NCNP
Dodie Harper	CCR

VISITOR REGISTRATION SHEET

House Comm. on Health — 04/22/15

Name of Committee — Date

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Ryan Blackledge	Cone Health
Daniel VanLiere	Vidant Health
E. Fleet	Sci. Prop
Laure McDaniel	HomeCare Management Corporation
Gretchen Stuart	Chapel Hill
Lanier Swann Hodges	UNC Health Care
Michelle Brooks	East Carolina University
Jennifer Ousperino	NCMS
Chip Baggett	NCMS
-CS 4/15	

VISITOR REGISTRATION SHEET

House Comm. on Health — Name of Committee

04/22/15 — Date

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Melinda S Snyder MD	Granville Co MELINDA S SNYDER MD PA
Barbara Host	NCRTR
Jackie Bonk	Project Rachel
GRAYSON GRECO	NC VALUES COALITION
PETRINA WILLIAMS	SBA / NC VALUES COALITION
Jim Howard	B+H
Harry Lyda	MWC
Denise Dorkowski	North Carolina Providers Council
Margaret Mason	North Carolina Providers Council

VISITOR REGISTRATION SHEET

House Comm. on Health — Name of Committee

04/22/15 — Date

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Amber Lehman	First Choice Pregnancy Solutions
Mary O'Shea	First Choice Pregnancy Solutions
Sarah Mills	Planned Parenthood
Mildred Spearman	NCAOC
Alana Mitchell	First Choice Pregnancy Solutions
Austin Pruitt	Perkinson Law
Ashley Perkinson	Perkinson Law
Scottie Sequrll	Planned Parenthood
Jay Singleton	CON Reform/repeal
[illegible]	RLN

VISITOR REGISTRATION SHEET

House Comm. on Health — Name of Committee

04/22/15 — Date

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
John McCarty	
Greg Alley	St. Joseph Catholic Church, Raleigh
Steve Barbara	Raleigh, NC
Krysti Adams	Raleigh NC
Janice Lewis	FUQUAY VARINA, NC

Speaker Sign Up

~~VISITOR REGISTRATION SHEET~~

Name of Committee | Date

~~VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK~~

NAME	FIRM OR AGENCY AND ADDRESS
Dr. DALIA Brahmi	Doctor, Physician, Family Med.
Dr. Melinda Snyder	Doctor, general medicine, pediatrics
Jacki Bonk	Director of Project Rachel
Dr. Stacy Bolton	Doctor,
Lisa Hackett	resident of NC (Janice Lewis)
Eliana Smith	" "
Katherine Hearn	" (Emily Tucker)
Wendy Banister	"
Amber Lieman	"
Mary O'shea	"
Tami Fitzgerald	NC Values Coalition
Barbara Holt	NC Right To Life
Melissa Reed	Planned Parenthood
Patrina Williams	Susan B. Anthony - NC values coalition
Janice Lewis	NC Values Coalition

Speaker Sign Up.

VISITOR REGISTRATION SHEET

Name of Committee **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Shoshannah Sayers	NARAL Pro-Choice North Carolina
Amy Bryant	Amy Bryant

House Committee on Health
Thursday, April 23, 2015, 10:00 AM
423 Legislative Office Building

AGENDA

Welcome and Opening Remarks

Introduction of Pages

Bills

BILL NO.	SHORT TITLE	SPONSOR
HB 728	Amend Laws Pertaining to Chiropractic Board.	Representative Conrad Representative Bryan Representative Setzer
HB 729	Standards for Chiropractic Peer Review. (NOT HEARD)	Representative Conrad Representative Bryan Representative Setzer
HB 842	Medicaid Waiver Protections/Military Families.	Representative G. Martin Representative Avila Representative Adcock

Adjournment

House Committee on Health
Thursday, April 23, 2015 at 10:00 AM
Room 423 of the Legislative Office Building

MINUTES

The House Committee on Health met at 10:00 AM on April 23, 2015 in Room 423 of the Legislative Office Building. Representatives Adcock, Avila, B. Brown, Dobson, Dollar, Earle, Farmer-Butterfield, Goodman, Jones, Lambeth, Lucas, S. Martin, and Waddell attended.

Representative Lambeth, Chair, presided. He recognized the Pages and Sergeant-at-Arms.

The following bills were considered:

HB 728 Amend Laws Pertaining to Chiropractic Board. (Representatives Conrad, Bryan, Setzer)

Representative Lucas made a motion to bring the PCS for HB 728 before the committee. Representative Conrad presented the bill. Discussion by the committee members followed. Vance Kinlaw, attorney for the Chiropractic Board, stated that the Board supported HB 728. Representative Jones motioned for a favorable report, unfavorable to the original bill, with referral to Finance. The motion carried.

HB 842 Medicaid Waiver Protections/Military Families. (Representatives G. Martin, Avila, Adcock)

Representative Brian Brown made a motion to bring the PCS for HB 842 before the committee. Representative Grier Martin explained the bill. HB 842 ensures that a dependent of a member of the Armed forces maintains his or her position on a waiting list for a waiver slot when the Armed Force member is transferred outside North Carolina. Questions followed. Representative Goodman motioned for a favorable report, unfavorable to the original. The motion carried.

The meeting adjourned at 10:16.

Representative Donny Lambeth, Chair
Presiding

Brenda Olls, Committee Clerk

HOUSE BILL 728:
Amend Laws Pertaining to Chiropractic Board

2015-2016 General Assembly

Committee:	House Health, if favorable, Finance	**Date:**	April 22, 2015
Introduced by:	Reps. Conrad, Bryan, Setzer	**Prepared by:**	Amy Jo Johnson Committee Counsel
Analysis of:	PCS to First Edition H728-CSTK-33		

SUMMARY: ***House Bill 728 increases the amount of time by 60 days for a chiropractic clinical assistant to obtain a certificate of competency from the State Board of Chiropractic Examiners; authorizes the State Board of Chiropractic Examiners to impose fines for a violation or rule adopted under Article 8 of Chapter 90; and increases the annual license renewal fees. The PCS makes a technical change.***

BILL ANALYSIS:

Section 1 increases the amount of time from 120 day to 180 days after employment for a chiropractic clinical assistant to obtain a certificate of competency from the State Board of Chiropractic Examiners (Board).

Section 2 makes technical changes and allows the Board to impose and collect a penalty of up to $5000 from a licensee for each violation of Article 8 of Chapter 90 or a rule adopted under Article 8 of Chapter 90.

Section 3 increases the maximum allowable fee from $150 to $300 that the Board may set as the annual renewal fee for a license to practice chiropractic in North Carolina.

EFFECTIVE DATE: Section 2 of this act becomes effective December 1, 2015, and applies to offenses committed on or after that date. The remainder is effective when it becomes law.

O. Walker Reagan
Director

* H 7 2 8 - S M T K - 5 1 C S T K - 3 3 - V 1 *

Research Division
(919) 733-2578

This bill analysis was prepared by the nonpartisan legislative staff for the use of legislators in their deliberations and does not constitute an official statement of legislative intent.

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2015

H D

HOUSE BILL 728
PROPOSED COMMITTEE SUBSTITUTE H728-PCS20330-TK-33

Short Title: Amend Laws Pertaining to Chiropractic Board. (Public)

Sponsors:

Referred to:

April 15, 2015

A BILL TO BE ENTITLED

AN ACT ENLARGING THE TIME FOR CERTIFICATION OF CHIROPRACTIC CLINICAL ASSISTANTS BY THE STATE BOARD OF CHIROPRACTIC EXAMINERS; AND AUTHORIZING THE STATE BOARD OF CHIROPRACTIC EXAMINERS TO IMPOSE FINES AS SANCTIONS AND TO INCREASE ANNUAL LICENSE RENEWAL FEES.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 90-143.4(b) reads as rewritten:

"(b) Any person employed as a chiropractic clinical assistant shall obtain a certificate of competency from the State Board of Chiropractic Examiners (Board) within ~~120~~ 180 days after the person begins employment. Certification shall not be required for employees whose duties are limited to administrative activities of a nonclinical nature. Except as otherwise provided in this section, it shall be unlawful for any person to practice as a chiropractic clinical assistant unless duly certified by the Board."

SECTION 2. G.S. 90-154(a) reads as rewritten:

"(a) The Board of Chiropractic Examiners may impose any of the following sanctions, singly or in combination, when it finds that a practitioner or applicant is guilty of any offense described in subsection (b):

(1) Permanently revoke a license to practice ~~chiropractic;~~chiropractic.
(2) Suspend a license to practice ~~chiropractic;~~chiropractic.
(3) Refuse to grant a ~~license;~~license.
(4) Censure a ~~practitioner;~~practitioner.
(5) Issue a letter of ~~reprimand;~~reprimand.
(6) Place a practitioner on probationary status and require him to report regularly to the Board upon the matters which are the basis of probation.
(7) Impose and collect from a licensee a civil monetary penalty of up to five thousand dollars ($5,000) for each violation of this Article or a rule adopted under this Article. The clear proceeds of civil penalties imposed pursuant to this subdivision shall be remitted to the Civil Penalty and Forfeiture Fund in accordance with G.S. 115C-457.2."

SECTION 3. G.S. 90-155 reads as rewritten:

"**§ 90-155. Annual fee for renewal of license.**

Any person practicing chiropractic in this State, in order to renew ~~his~~ a license, shall, on or before the first Tuesday after the first Monday in January in each year after a license is issued ~~to him~~ as herein provided, pay to the secretary of the Board of Chiropractic Examiners a renewal license fee as prescribed and set by the said Board which fee shall not be more than

~~one hundred fifty~~three hundred dollars ~~($150.00),~~($300.00) and shall furnish the Board evidence ~~that he has~~of having attended two days of educational sessions or programs approved by the Board during the preceding 12 months, provided the Board may waive this educational requirement due to sickness or other hardship of the applicant.

Any license or certificate granted by the Board under this Article shall automatically be canceled if the holder ~~thereof~~ of the license or certificate fails to secure a renewal within 30 days from the time herein provided; but any license thus canceled may, upon evidence of good moral character and proper proficiency, be restored upon the payment of the renewal fee and an additional twenty-five dollars ($25.00) reinstatement fee.

If any licensee of the Board retires from active practice, the licensee may renew his or her license annually by paying the license fee and shall not be required to furnish the Board proof of continuing education; however, if at a later time the licensee desires to resume active practice, the licensee shall first appear before the Board and the Board shall determine ~~his~~ the licensee's competency to practice."

SECTION 4. Section 2 of this act becomes effective December 1, 2015, and applies to offenses committed on or after that date. The remainder of this act is effective when it becomes law.

HOUSE BILL 728

Short Title:	Amend Laws Pertaining to Chiropractic Board.	(Public)
Sponsors:	Representatives Conrad, Bryan, and Setzer (Primary Sponsors). *For a complete list of Sponsors, refer to the North Carolina General Assembly Web Site.*	
Referred to:	Health, if favorable, Finance.	

April 15, 2015

A BILL TO BE ENTITLED

AN ACT ENLARGING THE TIME FOR CERTIFICATION OF CHIROPRACTIC CLINICAL ASSISTANTS BY THE STATE BOARD OF CHIROPRACTIC EXAMINERS; AND AUTHORIZING THE STATE BOARD OF CHIROPRACTIC EXAMINERS TO IMPOSE FINES AS SANCTIONS AND TO INCREASE ANNUAL LICENSE RENEWAL FEES.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 90-143.4(b) reads as rewritten:

"(b) Any person employed as a chiropractic clinical assistant shall obtain a certificate of competency from the State Board of Chiropractic Examiners (Board) within ~~120~~ 180 days after the person begins employment. Certification shall not be required for employees whose duties are limited to administrative activities of a nonclinical nature. Except as otherwise provided in this section, it shall be unlawful for any person to practice as a chiropractic clinical assistant unless duly certified by the Board."

SECTION 2. G.S. 90-154(a) reads as rewritten:

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(2) Suspend a license to practice ~~chiropractic;~~chiropractic.
(3) Refuse to grant a ~~license;~~license.
(4) Censure a ~~practitioner;~~practitioner.
(5) Issue a letter of ~~reprimand;~~reprimand.
(6) Place a practitioner on probationary status and require him to report regularly to the Board upon the matters which are the basis of probation.
(7) Impose and collect from a licensee a civil monetary penalty of up to five thousand dollars ($5,000) for each violation of this Article or a rule adopted under this Article. The clear proceeds of civil penalties imposed pursuant to this subdivision shall be remitted to the Civil Penalty and Forfeiture Fund in accordance with G.S. 115C-457.2."

SECTION 3. G.S. 90-155 reads as rewritten:

"**§ 90-155. Annual fee for renewal of license.**

Any person practicing chiropractic in this State, in order to renew ~~his~~ a license, shall, on or before the first Tuesday after the first Monday in January in each year after a license is issued ~~to him~~ as herein provided, pay to the secretary of the Board of Chiropractic Examiners a

renewal license fee as prescribed and set by the said Board which fee shall not be more than ~~one hundred fifty~~three hundred dollars ~~($150.00),~~($300.00) and shall furnish the Board evidence ~~that he has~~of having attended two days of educational sessions or programs approved by the Board during the preceding 12 months, provided the Board may waive this educational requirement due to sickness or other hardship of the applicant.

Any license or certificate granted by the Board under this Article shall automatically be canceled if the holder ~~thereof~~ of the license or certificate fails to secure a renewal within 30 days from the time herein provided; but any license thus canceled may, upon evidence of good moral character and proper proficiency, be restored upon the payment of the renewal fee and an additional twenty-five dollars ($25.00) reinstatement fee.

If any licensee of the Board retires from active practice, the licensee may renew his or her license annually by paying the license fee and shall not be required to furnish the Board proof of continuing education; however, if at a later time the licensee desires to resume active practice, the licensee shall first appear before the Board and the Board shall determine ~~his~~ the licensee's competency to practice."

SECTION 4. Section 3 of this act becomes effective December 1, 2015, and applies to offenses committed on or after that date. The remainder of this act is effective when it becomes law.

HOUSE BILL 842:
Medicaid Waiver Protections/Military Families

2015-2016 General Assembly

Committee:	House Health	**Date:**	April 22, 2015
Introduced by:	Reps. G. Martin, Avila, Adcock	**Prepared by:**	Jennifer Hillman Staff Attorney
Analysis of:	PCS to First Edition H842-CSTR-2		

SUMMARY: ***House Bill 842 would require the Department of Health and Human Services (DHHS) to ensure that the eligibility criteria for Medicaid home- and community-based waivers allow a dependent of a member of the Armed Forces to maintain the dependent's waiver status upon transfer of the service member to an assignment outside of North Carolina, so long as the member maintains North Carolina as the legal residence to which the member intends to return upon completion of military service.***

CURRENT LAW: In accordance with federal law, North Carolina residents meeting Medicaid eligibility criteria are eligible for Medicaid state plan services. As permitted under federal law, individuals requiring an institutional level of care may be eligible for additional home and community-based services through a Medicaid waiver program. North Carolina operates three home and community-based waiver programs serving individuals with developmental disabilities, disabled adults, and medically fragile children. Due to waiver funding restrictions, there are a limited number of slots for individuals to be served through a waiver program, and a waiting list of individuals who have requested a slot is maintained.

BILL ANALYSIS:

Section 1 of the bill would require the Department of Health and Human Services (DHHS) to ensure that a dependent of a member of the Armed Forces maintain his or her position on the waiting list for a waiver slot when the service member is transferred to an assignment outside of North Carolina, as long as the service member intends to return to North Carolina upon completion of the military service. If a dependent of a service member was receiving waiver services prior to the transfer out of North Carolina, then upon return to North Carolina, the dependent shall be reinstated to his or her slot, if it remains available, or receive a priority position on the waiting list for the next available slot. Upon return to North Carolina, the dependent must meet Medicaid eligibility requirements and all other waiver eligibility requirements.

Section 2 of the bill would require DHHS to submit any Medicaid State Plan amendments or waiver amendments necessary to implement the act.

EFFECTIVE DATE: Section 1 of this bill would become effective January 1, 2016, and the remainder of the bill would become effective when the bill becomes law.

This bill analysis was prepared by the nonpartisan legislative staff for the use of legislators in their deliberations and does not constitute an official statement of legislative intent.

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2015

H D

HOUSE BILL 842
PROPOSED COMMITTEE SUBSTITUTE H842-PCS10354-TR-2

Short Title: Medicaid Waiver Protections/Military Families. (Public)

Sponsors:

Referred to:

April 15, 2015

A BILL TO BE ENTITLED

AN ACT TO PROTECT ACCESS TO MEDICAID WAIVERS BY DEPENDENTS OF MEMBERS OF THE ARMED FORCES.

The General Assembly of North Carolina enacts:

SECTION 1. The Department of Health and Human Services shall ensure that the eligibility criteria for Medicaid home- and community-based waivers allow the dependent of a member of the Armed Forces to maintain the dependent's waiver status upon the transfer of the service member to an assignment outside of North Carolina, so long as the service member maintains the State of North Carolina as the legal residence to which the service member intends to return following completion of military service, and the dependent meets Medicaid eligibility criteria and all other waiver eligibility criteria upon returning to North Carolina. Consequently, a dependent who is on the waiting list for a waiver slot would maintain the dependent's position on the waiting list. A dependent who was receiving waiver services prior to the service member's transfer, upon the dependent's return to North Carolina, would be reinstated to the dependent's waiver slot, if the slot remains available, or would receive a priority position on the waiting list for the next available waiver slot. This section shall not be construed to authorize the provision of waiver services outside of North Carolina.

SECTION 2. The Department of Health and Human Services shall submit any Medicaid State Plan Amendments or waiver amendments necessary to accomplish the requirements in Section 1 of this act.

SECTION 3. Section 1 of this act becomes effective January 1, 2016. The remainder of this act is effective when it becomes law.

HOUSE BILL 842

Short Title:	Medicaid Waiver Protections/Military Families.	(Public)
Sponsors:	Representatives G. Martin, Avila, and Adcock (Primary Sponsors). *For a complete list of Sponsors, refer to the North Carolina General Assembly Web Site.*	
Referred to:	Homeland Security, Military, and Veterans Affairs, if favorable, Health.	

April 15, 2015

A BILL TO BE ENTITLED

AN ACT TO PROTECT ACCESS TO MEDICAID WAIVERS BY DEPENDENTS OF MEMBERS OF THE ARMED FORCES.

The General Assembly of North Carolina enacts:

SECTION 1. The Department of Health and Human Services shall ensure that the eligibility criteria for Medicaid home- and community-based waivers allow the dependent of a member of the Armed Forces to maintain the dependent's waiver status upon the transfer of the service member to an assignment outside of North Carolina, so long as the service member maintains the State of North Carolina as the legal residence to which the service member intends to return following completion of military service. Consequently, a dependent who is on the waiting list for a waiver slot would maintain the dependent's position on the waiting list. A dependent who was receiving waiver services prior to the service member's transfer, upon the dependent's return to North Carolina, would be reinstated to the dependent's waiver slot, if the slot remains available, or would receive a priority position on the waiting list for the next available waiver slot. This section shall not be construed to authorize the provision of waiver services outside of North Carolina.

SECTION 2. The Department of Health and Human Services shall submit any Medicaid State Plan amendments or waiver amendments necessary to accomplish the requirements in Section 1 of this act.

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

NORTH CAROLINA GENERAL ASSEMBLY
AMENDMENT
House Bill 729

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

H729-ATK-15 [v.2]

Amends Title [NO]
First Edition

Date _____ ,2015

Representative _____

moves to amend the bill on page 1, lines 11-13 by rewriting the lines to read:

"function. Each appeal shall be evaluated by (i) a medical doctor licensed to practice medicine in this State who was not involved in the noncertification or, (ii) for the noncertification of chiropractic services, a chiropractor qualified to perform peer reviews pursuant to G.S. 90-153.1.'".

SIGNED _____
Amendment Sponsor

SIGNED _____
Committee Chair if Senate Committee Amendment

ADOPTED _____ FAILED _____ TABLED _____

NORTH CAROLINA GENERAL ASSEMBLY
HOUSE OF REPRESENTATIVES

HEALTH COMMITTEE REPORT
Representative Brian Brown, Co-Chair
Representative Justin P. Burr, Co-Chair
Representative Bert Jones, Co-Chair
Representative Donny Lambeth, Co-Chair

FAVORABLE COM SUB , UNFAVORABLE ORIGINAL BILL

HB **842** Medicaid Waiver Protections/Military Families.

Draft Number:	H842-PCS10354-TR-2
Serial Referral:	None
Recommended Referral:	None
Long Title Amended:	No
Floor Manager:	G. Martin

FAVORABLE COM SUB , UNFAVORABLE ORIGINAL BILL AND RE-REFERRED

HB **728** Amend Laws Pertaining to Chiropractic Board.

Draft Number:	H728-PCS20330-TK-33
Serial Referral:	**FINANCE**
Recommended Referral:	None
Long Title Amended:	No
Floor Manager:	Conrad

TOTAL REPORTED: 2

CMR242-V-1

Committee Sergeants at Arms

NAME OF COMMITTEE House Comm. on Health

DATE: 04/23/15 Room: 423

House Sgt-At Arms:

1. Name: Young Bae
2. Name: Bill Morris
3. Name: Jim Moran
4. Name: _____
5. Name: _____

Senate Sgt-At Arms:

1. Name: _____
2. Name: _____
3. Name: _____
4. Name: _____
5. Name: _____

Thursday, April 23	Room	Time
HEALTH	423	10:00 am

Name	County	Sponsor
Jacob Johnson	Haywood	Joe Sam Queen
Ethan Mastin	Surry	Sarah Stevens
Joe Swaim	Randolph	Allen McNeill

VISITOR REGISTRATION SHEET

House Comm. on Health — 04/23/15

Name of Committee — Date

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Rachel Barlia	NCDPI
Tommy Sewell	MVA
Dr. Ricky Sides	NC BOE
VANCE KINLAW	NCBCE
Phoebe Landon	Brooks Pierce
Lennie Owens	LCLC
Sarah Wolfe	NMC
Trent Wamble	DHHS
Monica Hamlin	DMA
David Collins	SEANC
Amanda Horaker	TSS

VISITOR REGISTRATION SHEET

House Comm. on Health — 04/23/15

Name of Committee — Date

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Amy Falk	30 PR
Carson Kuie	NVA
Jennifer Casperson	NCMS
Matthew Eisley	SA
Joanna Spruill	NCAFP
Mark Fiery	BCBSNC
Tony Adams	Adams and Assoc.
Greg Holden	HPI
Crystal Goldston	Essential Supportive Services, LLC
JAKE PARKER	NCFB

VISITOR REGISTRATION SHEET

House Comm. on Health — 04/23/15

Name of Committee — Date

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Rhian Mensald	WBM
Mary Gore	VCR

Corrected #1: Add H814, H847,, H20, H925, H729

NORTH CAROLINA HOUSE OF REPRESENTATIVES
COMMITTEE MEETING NOTICE
AND
BILL SPONSOR NOTIFICATION
2015-2016 SESSION

You are hereby notified that the **House Committee on Health** will meet as follows:

DAY & DATE: Monday, April 27, 2015
TIME: **3:00 PM**
LOCATION: **643 LOB**
COMMENTS: **Representative Jones will be presiding.**

The following bills will be considered:

BILL NO.	SHORT TITLE	SPONSOR
HB 135	Modernize Physical Therapy Practice.	Representative Dollar Representative B. Brown Representative Torbett Representative S. Martin
HB 309	Got Natural Milk.	Representative Riddell Representative Queen Representative Harrison Representative McGrady
HB 290	Prohibit Powdered Alcohol.	Representative Willingham Representative L. Hall
HB 712	Pilot Project/Used Needle Disposal.	Representative Faircloth Representative Horn Representative Avila Representative Harrison
HB 724	Amend Composition of NC Medical Board.	Representative Lambeth Representative Malone Representative S. Martin Representative Hurley
HB 768	Heat Stroke Prevention/Student Athletes.	Representative Richardson
HB 796	Modernize Dietetics/Nutrition Practice Act.	Representative B. Brown
HB 823	Establish Advisory Council on Rare Diseases.	Representative Carney Representative Avila Representative Earle Representative Bishop
HB 832	Revise Certain Policies/Child Care	Representative Dobson

	Subsidy.	
HB 814	The William C. Lindley, Jr. SUDEP Law.	Representative Riddell Representative Ross
HB 847	Amend Laws Re: Medical Treatment for Minors.	Representative Jordan
HB 20	Reegan's Rule/Childhood Diabetes Screening.	Representative C. Graham
HB 925	Require Hospitals to Offer Influenza Vaccine.	Representative Burr
HB 729	Standards for Chiropractic Peer Review.	Representative Conrad Representative Bryan Representative Setzer

Respectfully,

Representative Brian Brown, Co-Chair
Representative Justin P. Burr, Co-Chair
Representative Bert Jones, Co-Chair
Representative Donny Lambeth, Co-Chair

I hereby certify this notice was filed by the committee assistant at the following offices at 1:15 PM on Thursday, April 23, 2015.

___ Principal Clerk
___ Reading Clerk – House Chamber

Brenda Olls (Committee Assistant)

NORTH CAROLINA HOUSE OF REPRESENTATIVES
COMMITTEE MEETING NOTICE
AND
BILL SPONSOR NOTIFICATION
2015-2016 SESSION

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The following bills will be considered:

BILL NO.	SHORT TITLE	SPONSOR
HB 135	Modernize Physical Therapy Practice.	Representative Dollar Representative B. Brown Representative Torbett Representative S. Martin
HB 309	Got Natural Milk.	Representative Riddell Representative Queen Representative Harrison Representative McGrady
HB 290	Prohibit Powdered Alcohol.	Representative Willingham Representative L. Hall
HB 712	Pilot Project/Used Needle Disposal.	Representative Faircloth Representative Horn Representative Avila Representative Harrison
HB 724	Amend Composition of NC Medical Board.	Representative Lambeth Representative Malone Representative S. Martin Representative Hurley
HB 768	Heat Stroke Prevention/Student Athletes.	Representative Richardson
HB 796	Modernize Dietetics/Nutrition Practice Act.	Representative B. Brown
HB 821	Proper Administration of Step Therapy.	Representative Lewis Representative Wray
HB 823	Establish Advisory Council on Rare Diseases.	Representative Carney Representative Avila Representative Earle Representative Bishop
HB 832	Revise Certain Policies/Child Care	Representative Dobson

Subsidy.

Respectfully,

Representative Brian Brown, Co-Chair
Representative Justin P. Burr, Co-Chair
Representative Bert Jones, Co-Chair
Representative Donny Lambeth, Co-Chair

I hereby certify this notice was filed by the committee assistant at the following offices at 1:15 PM on Tuesday, April 21, 2015.

___ Principal Clerk
___ Reading Clerk – House Chamber

Brenda Olls (Committee Assistant)

House Committee on Health
Monday, April 27, 2015, 3:00 PM
643 Legislative Office Building

AGENDA

Welcome and Opening Remarks

Introduction of Pages

Bills

BILL NO.	SHORT TITLE	SPONSOR
HB 135	Modernize Physical Therapy Practice.	Representative Dollar Representative B. Brown Representative Torbett Representative S. Martin
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HB 796	Modernize Dietetics/Nutrition Practice Act.	Representative B. Brown
HB 823	Establish Advisory Council on Rare Diseases.	Representative Carney Representative Avila Representative Earle Representative Bishop
HB 832	Revise Certain Policies/Child Care Subsidy.	Representative Dobson
HB 814	The William C. Lindley, Jr. SUDEP Law.	Representative Riddell Representative Ross
HB 847	Amend Laws Re: Medical Treatment for Minors.	Representative Jordan
HB 20	Reegan's Rule/Childhood Diabetes	Representative C. Graham

	Screening.	
HB 925	Require Hospitals to Offer Influenza Vaccine.	Representative Burr
HB 729	Standards for Chiropractic Peer Review.	Representative Conrad Representative Bryan Representative Setzer

Presentations

Other Business

Adjournment

House Committee on Health
Monday, April 27, 2015 at 3:00 PM
Room 643 of the Legislative Office Building

MINUTES

The House Committee on Health met at 3:00 PM on April 27, 2015 in Room 643 of the Legislative Office Building. Representatives Adcock, Avila, Bishop, Blackwell, R. Brown, B. Brown, Burr, Carney, Cotham, Dollar, Farmer-Butterfield, Ford, Goodman, Hager, Hastings, Insko, Jones, Lambeth, Lucas, S. Martin, Pendleton, Szoka, Waddell, Wray, and Yarborough attended.

Representative Bert Jones, Chair, presided. He recognized the Sergeant-at-Arms.

The following bills were considered:

HB 768 Heat Stroke Prevention/Student Athletes. (Representative Richardson)

Representative Richardson was recognized to present the bill, which will provide new requirements related to heat strokes in public education facilities. The requirements will ensure student safety during athletic activities. Representative Lucas offered a motion for a favorable report, with referral to Education K-12. The bill passed.

HB 847 Parental Rights and Med. Treatment of Minors. (Representative Jordan)

Representative Jordan was recognized to explain the bill which comes to the committee as a PCS. Discussion followed, including remarks by Brenda Brown, state coordinator for parentalrights.org. Her group supports the bill. Representative Avila made a motion for a favorable report, unfavorable to the original bill with referral to Judiciary II. The motion passed.

HB 832 Revise Certain Policies/Child Care Subsidy. (Representative Dobson)

Representative Lambeth was recognized to explain the PCS for the bill, which redefines part time care. After some discussion, Representative Dollar motioned for a favorable report, unfavorable to the original bill, with referral to Appropriations.

HB 20 Reegan's Rule/Childhood Diabetes Education. (Representative C. Graham)

Representative Graham was recognized to explain the PCS for the bill which aims to prevent deaths due to juvenile diabetes. Discussion followed, with comments from Reps. Avila and Hager. Representative Lucas offered an amendment which passed. Representative Waddell motioned for a favorable report unfavorable to the original, with referral to Appropriations.

HB 309 Got Natural Milk. (Representatives Riddell, Queen, Harrison, McGrady)

Representative Riddell was recognized to explain the bill which seeks to recognize natural milk as a healthy food option, if handled properly. Presently, you can only drink unpasteurized milk from your own cow or "cowshare". Public speakers for and against the bill were allowed 2 minutes total. Representative Pendleton motioned for a favorable report for HB 309, with referral to Agriculture. The motion carried.

HB 814 The William C. Lindley, Jr. SUDEP Law. (Representatives Riddell, Ross)

Representative Riddell was recognized to explain the PCS for the bill which attempts to gather more information on epilepsy in young adults. Discussion followed. Representative Pendleton motioned for a favorable report, unfavorable to the original. The motion carried.

HB 290 Prohibit Powdered Alcohol. (Representatives Willingham, L. Hall)

The bill sponsor, Representative Willingham, explained the PCS for HB 290, which prohibits the sale of powdered alcohol in NC. This product goes on the market in June. Discussion followed. Representative Farmer-Butterfield motioned for a favorable report, unfavorable to the original. The motion passed.

HB 724 Amend Composition of NC Medical Board. (Representatives Lambeth, Malone, S. Martin, Hurley)

Representative Lambeth was recognized to explain the bill which amends the composition of the NC Medical Board to assure that at least one nurse sits on the board. Representative Adcock motioned for a favorable report. The motion carried.

HB 823 Establish Advisory Council on Rare Diseases. (Representatives Carney, Avila, Earle, Bishop)

Representative Carney was recognized to explain the bill which establishes an advisory council on rare diseases. One million people in NC have such diseases. Representative Hager motioned for a favorable report for HB 823. The motion carried.

HB 712 Pilot Project/Used Needle Disposal. (Representatives Faircloth; Horn; Avila; Harrison)

Representative Faircloth was recognized to explain the bill, which has a PCS. The PCS amends the number of counties that can potentially participate in the program. Questions followed. The

SBI supports the bill. Representative Hager motioned for a favorable report for the bill, unfavorable to the original. The motion carried.

HB 135 Modernize Physical Therapy Practice. (Representatives Dollar, B. Brown, Torbett, and S. Martin)

Representative Dollar was recognized to explain the bill which removes the requirement that a prescription by a physician be obtained when manipulation of the spine is performed by a licensed physical therapist. Public speakers supported the bill. Representative Brian Brown motioned for a favorable report for HB 135. The motion carried.

HB 925 Require Hospitals to Offer Influenza Vaccine. (Representative Burr)

Representative Burr was recognized to explain the bill's PCS, which requires hospitals to offer inpatients 65 years of age or older immunization against the influenza virus. Some discussion followed and Representative Adcock motioned for a favorable report, unfavorable to the original. The motion carried.

HB 729 Standards for Chiropractic Peer Review. (Representatives Conrad; Bryan; Setzer)

Representative Conrad was recognized to explain the PCS for HB 729, which specifies that some requirements apply only in motor vehicle claims. Vance Kinlaw, attorney for the Chiropractic Board answered questions. Representative Hager offered an amendment to be rolled into the PCS, which passed. Representative Dollar motioned for a favorable report for HB 729, unfavorable to the original and recommendation to Insurance. The motion carried.

The meeting adjourned at 4:50.

Bert Jones

Representative Bert Jones, Chair
Presiding

Brenda Olls

Brenda Olls, Committee Clerk

HOUSE BILL 768:
Heat Stroke Prevention/Student Athletes

2015-2016 General Assembly

Committee:	House Health, if favorable, Education - K-12	**Date:**	April 25, 2015
Introduced by:	Rep. Richardson	**Prepared by:**	Theresa Matula
Analysis of:	First Edition		Committee Staff

SUMMARY: House Bill 768 amends Chapter 115C Elementary and Secondary Education, to add a new Article on Student Safety in Athletics which contains: new requirements pertaining to heat related illnesses including heat exhaustion and heat stroke, relocates the current law on concussion safety to this Article, relocates the current law providing for venue-specific emergency action plans to this Article, and requires the State Board of Education to adopt rules in accordance with the new Article to ensure student safety during athletic activities.

BILL ANALYSIS:

Section 1 of House Bill 768 adds a new Article 29E. Student Safety in Athletics to Chapter 115C of the General Statutes. Sections of the new Article are outlined below.

Definitions are outlined in G.S. 115C-407.40 for the following terms: athletic activity, concussion, heat exhaustion, and heat stroke.

Heat exhaustion and heat stroke education; removal from athletic participation is a new section created by G.S. 115C 407.41. Elements of this section are outlined below.

- Requires the State Board of Education to adopt guidelines and educational materials to be used by local boards of education informing students who participate in athletic activities and those students' parents and coaches on (i) heat related illnesses, including heat stroke and heat exhaustion and (ii) the health risks associated with continuing athletic play or practice after experiencing signs and symptoms of a heat related illness.
- Requires the student's parent or guardian to sign and return to the student's school an acknowledgment of receipt and review of the information sheet developed.
- Requires each local board of education to adopt a mandatory heat stroke prevention protocol for students participating in athletic activities consistent with the guidelines and educational materials adopted. Further provides that a student who exhibits symptoms of heat exhaustion or heat stroke, as determined by a game official, coach from the student's team, verified athletic trainer, licensed healthcare professional, or other designated official, at any time prior to, during, or following an athletic activity must be removed by the coach from participation in an athletic activity. The venue specific emergency action plan shall provide for circumstances in which specific cooling methods must be made available during an athletic activity, including weather conditions requiring access to an immersion pool. A student removed or prevented from participating in an athletic activity in accordance with this subsection shall not return to participation until the student is evaluated and cleared for return to participation in writing by a licensed healthcare professional or other official designated by the school under the venue specific emergency action plan.

This bill analysis was prepared by the nonpartisan legislative staff for the use of legislators in their deliberations and does not constitute an official statement of legislative intent.

Concussion safety is provided in the new Article in G.S. 115C-407.42, which requires the State Board of Education to adopt rules pertaining to concussion safety for student athletes in middle and high schools that are involved in interscholastic athletic activities. The requirements in this section have been relocated to this new Article from G.S. 115C-12(23) a. and b.

Venue specific emergency action plans are relocated from G.S. 115C-12(23)c. to G.S. 115C-407.43 of the new Article. This section specifies that a local board of education must require each middle school and high school to develop a venue specific emergency action plan to deal with serious injuries and acute medical conditions in which the condition of the patient may deteriorate rapidly.

Section 2 removes current law in G.S. 115C-12(23) to conform to the relocation of concussion safety and venue specific emergency action plan requirements in the new Article created by Section 1 of the bill. G.S. 115C-12(23) is amended to require the State Board of Education to adopt rules governing student safety in interscholastic athletic activities conducted by local boards of education in accordance with the new Article 29E.

EFFECTIVE DATE: The bill would become effective when it becomes law and applies beginning with the 2015-2016 school year.

HOUSE BILL 768

Short Title:	Heat Stroke Prevention/Student Athletes.	(Public)
Sponsors:	Representative Richardson (Primary Sponsor). *For a complete list of Sponsors, refer to the North Carolina General Assembly Web Site.*	
Referred to:	Health, if favorable, Education - K-12.	

April 15, 2015

A BILL TO BE ENTITLED

AN ACT TO REQUIRE THE STATE BOARD OF EDUCATION AND LOCAL BOARDS OF EDUCATION TO ADDRESS HEAT-RELATED ILLNESSES DURING SCHOOL ATHLETIC ACTIVITIES AND TO RECODIFY THE STATUTORY PROVISIONS ON CONCUSSION SAFETY AND EMERGENCY ACTION PLANS.

The General Assembly of North Carolina enacts:

SECTION 1. Chapter 115C of the General Statutes is amended by adding a new Article to read:

"Article 29E.

"Student Safety in Athletics.

"**§ 115C-407.40. Definitions.**

The following definitions apply in this Article:

(1) Athletic activity. – An activity offered to students in any of the following circumstances:

a. Interscholastic athletics.

b. An athletic contest or competition, other than interscholastic athletics, that is sponsored by a school, including cheerleading, or any other sports activities provided by a club or school-affiliated organization that is school-sponsored.

c. Practices, interschool practices, and scrimmages for all of the activities listed under this subdivision.

(2) Concussion. – A traumatic brain injury caused by a direct or indirect impact to the head that results in disruption of normal brain function, which may or may not result in loss of consciousness.

(3) Heat exhaustion. – A heat-related illness resulting in the depletion of body fluids and causing weakness, dizziness, nausea, and possible collapse.

(4) Heat stroke. – A heat-related illness in which the person's core body temperature is greater than 105 degrees Fahrenheit, with complications involving the central nervous system that occur after exposure to high temperatures.

"**§ 115C-407.41. Heat exhaustion and heat stroke education; removal from athletic participation.**

(a) The State Board of Education shall adopt guidelines and educational materials to be used by local boards of education to inform students who participate in athletic activities and those students' parents and coaches on (i) heat-related illnesses, including heat stroke and heat

exhaustion and (ii) the health risks associated with continuing athletic play or practice after experiencing signs and symptoms of a heat-related illness. In developing these guidelines and materials, the State Board may utilize existing materials on the signs, symptoms, and prevention of heat-related illnesses, including guidelines on heat and humidity adopted by the North Carolina High School Athletic Association.

(b) Each school year, prior to participation by a student in an athletic activity, the student's parent or guardian shall sign and return to the student's school an acknowledgment of receipt and review of an information sheet developed in accordance with materials provided by the State Board of Education under subsection (a) of this section.

(c) Each local board of education shall adopt a mandatory heat stroke prevention protocol for students participating in athletic activities consistent with the guidelines and educational materials adopted in accordance with subsection (a) of this section. A student who exhibits symptoms of heat exhaustion or heat stroke, as determined by a game official, coach from the student's team, verified athletic trainer, licensed healthcare professional, or other official designated by the school under the venue-specific emergency action plan under G.S. 115C-407.43, at any time prior to, during, or following an athletic activity shall be removed by the coach from participation in an athletic activity. The venue-specific emergency action plan shall provide for circumstances in which specific cooling methods must be made available during an athletic activity, including weather conditions requiring access to an immersion pool. A student removed or prevented from participating in an athletic activity in accordance with this subsection shall not return to participation until the student is evaluated and cleared for return to participation in writing by a licensed healthcare professional or other official designated by the school under the venue-specific emergency action plan.

"**§ 115C-407.42. Concussion safety.**

The State Board of Education shall adopt rules governing interscholastic athletic activities with regard to concussion safety for student athletes in middle schools and high schools that provide for the following:

(1) All coaches, school nurses, athletic directors, first responders, volunteers, students who participate in interscholastic athletic activities, and the parents of those students shall receive, on an annual basis, a concussion and head injury information sheet. School employees, first responders, volunteers, and students must sign the sheet and return it to the coach before they can participate in interscholastic athletic activities, including tryouts, practices, or competition. Parents must sign the sheet and return it to the coach before their children can participate in any such interscholastic athletic activities. The signed sheets shall be maintained in accordance with subdivision (3) of this subsection.

(2) If a student participating in an interscholastic athletic activity exhibits signs or symptoms consistent with concussion, the student shall be removed from the activity at that time and shall not be allowed to return to play or practice that day. The student shall not return to play or practice on a subsequent day until the student is evaluated by and receives written clearance for such participation from (i) a physician licensed under Article 1 of Chapter 90 of the General Statutes with training in concussion management, (ii) a neuropsychologist licensed under Article 18A of Chapter 90 of the General Statutes with training in concussion management and working in consultation with a physician licensed under Article 1 of Chapter 90 of the General Statutes, (iii) an athletic trainer licensed under Article 34 of Chapter 90 of the General Statutes, (iv) a physician assistant, consistent with the limitations of G.S. 90-18.1, or (v) a nurse practitioner, consistent with the limitations of G.S. 90-18.2.

(3) Each school shall maintain complete and accurate records of its compliance with the requirements of this section pertaining to head injuries.

"**§ 115C-407.43. Venue-specific emergency action plans.**

A local board of education shall require each middle school and high school to develop a venue-specific emergency action plan to deal with serious injuries and acute medical conditions in which the condition of the patient may deteriorate rapidly. The plan shall include a delineation of roles, methods of communication, available emergency equipment, and access to and plan for emergency transport. This plan must be (i) in writing, (ii) reviewed by an athletic trainer licensed in North Carolina, (iii) approved by the principal of the school, (iv) distributed to all appropriate personnel, (v) posted conspicuously at all venues, and (vi) reviewed and rehearsed annually by all licensed athletic trainers, first responders, coaches, school nurses, athletic directors, and volunteers for interscholastic athletic activities."

SECTION 2. G.S. 115C-12(23) reads as rewritten:

"(23) Power to Adopt Eligibility Rules for Interscholastic Athletic Competition. – The State Board of Education shall adopt rules governing interscholastic athletic activities conducted by local boards of education, including (i) eligibility for student ~~participation.~~participation and (ii) student safety in accordance with Article 29E of this Chapter. ~~With regard to middle schools and high schools, the rules shall provide for the following:~~

~~a. All coaches, school nurses, athletic directors, first responders, volunteers, students who participate in interscholastic athletic activities, and the parents of those students shall receive, on an annual basis, a concussion and head injury information sheet. School employees, first responders, volunteers, and students must sign the sheet and return it to the coach before they can participate in interscholastic athletic activities, including tryouts, practices, or competition. Parents must sign the sheet and return it to the coach before their children can participate in any such interscholastic athletic activities. The signed sheets shall be maintained in accordance with sub-subdivision d. of this subdivision.~~

~~For the purpose of this subdivision, a concussion is a traumatic brain injury caused by a direct or indirect impact to the head that results in disruption of normal brain function, which may or may not result in loss of consciousness.~~

~~b. If a student participating in an interscholastic athletic activity exhibits signs or symptoms consistent with concussion, the student shall be removed from the activity at that time and shall not be allowed to return to play or practice that day. The student shall not return to play or practice on a subsequent day until the student is evaluated by and receives written clearance for such participation from (i) a physician licensed under Article 1 of Chapter 90 of the General Statutes with training in concussion management, (ii) a neuropsychologist licensed under Article 18A of Chapter 90 of the General Statutes with training in concussion management and working in consultation with a physician licensed under Article 1 of Chapter 90 of the General Statutes, (iii) an athletic trainer licensed under Article 34 of Chapter 90 of the General Statutes, (iv) a physician assistant, consistent with the limitations of G.S. 90-18.1, or (v) a nurse practitioner, consistent with the limitations of G.S. 90-18.2.~~

~~c. Each school shall develop a venue specific emergency action plan to deal with serious injuries and acute medical conditions in which the condition of the patient may deteriorate rapidly. The plan shall include a delineation of roles, methods of communication, available emergency equipment, and access to and plan for emergency transport. This plan must be (i) in writing, (ii) reviewed by an athletic trainer licensed in North Carolina, (iii) approved by the principal of the school, (iv) distributed to all appropriate personnel, (v) posted conspicuously at all venues, and (vi) reviewed and rehearsed annually by all licensed athletic trainers, first responders, coaches, school nurses, athletic directors, and volunteers for interscholastic athletic activities.~~

~~d. Each school shall maintain complete and accurate records of its compliance with the requirements of this subdivision pertaining to head injuries.~~

The State Board of Education may authorize a designated organization to apply and enforce the Board's rules governing participation in interscholastic athletic activities at the high school level."

SECTION 3. This act is effective when it becomes law and applies beginning with the 2015-2016 school year.

HOUSE BILL 847:
Parental Rights and Med. Treatment for Minors

2015-2016 General Assembly

Committee:	House Health, if favorable, Judiciary II	**Date:**	April 27, 2015
Introduced by:	Rep. Jordan	**Prepared by:**	Walker Reagan Staff Attorney
Analysis of:	PCS to First Edition H847-CSRU-4		Tawanda Foster Committee Counsel

SUMMARY: ***The Proposed Committee Substitute for House Bill 847 would except from the mandatory reporting requirements for suspected child abuse and neglect, the mere failure of a parent to follow a certain recommended treatment plan suggested by a health care provider. The PCS also sets out the fundamental right of parents to direct the upbringing, education and care of their child.***

CURRENT LAW: G.S. 7B-301 requires any person or institution who suspects a juvenile is abused, neglected or dependent to report the case of that juvenile to the department of social services. Persons required to report include health care providers. The penalty for failure to report suspected abuse, neglect, or dependency is a Class 1 misdemeanor.

Part 1 of Article 1A of Chapter 90 establishes under what circumstances or conditions physicians can lawfully provide medical treatment to minors without parental consent. Part 2 of Article 1A of Chapter 90 limits the authority of physicians to perform abortions on minors to situations where the parent consents to the abortion, or the court authorizes the abortion in response to a petition of an unemancipated minor.

BILL ANALYSIS:

Section 1 of the proposed committee substitute provides an exception to the duty to report abuse, neglect, and dependency in situations where the action or inaction is the decision of the parent to follow treatment recommended by a health care provider. This section provides that a parent has the right to follow the advice and treatment plan of a health care or mental health services provider over a contrary opinion or recommended treatment plan of another provider if the decision does not involve an "immediate, life threatening situation." If the decision involves an "immediate, life threating situation," the decision of the parent shall not give rise to an obligation to report suspected abuse or neglect.

Section 2 adds a new section to Article 1A of Chapter 90 stating parents have a fundamental liberty right to direct the upbringing, education and care of their child. It also provides the State shall not infringe upon this fundamental right unless there is a compelling State interest and the least restrictive means in furthering that compelling State interest is used. This section shall not apply to a parent's action or decision that would end life.

EFFECTIVE DATE: The act becomes effective October 1, 2015.

O. Walker Reagan
Director

H847-SMTV-32 CSRU-4 -V5

Research Division
(919) 733-2578

This bill analysis was prepared by the nonpartisan legislative staff for the use of legislators in their deliberations and does not constitute an official statement of legislative intent.

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2015

H D

HOUSE BILL 847
PROPOSED COMMITTEE SUBSTITUTE H847-CSRU-4 [v.2]

4/26/2015 6:53:15 PM

Short Title: Parental Rights and Med. Treatment of Minors. (Public)

Sponsors:

Referred to:

April 15, 2015

A BILL TO BE ENTITLED

AN ACT PROTECTING PARENTS FROM REPORTS OF ABUSE OR NEGLECT BASED SOLELY ON A DECISION TO FOLLOW TREATMENT RECOMMENDED BY A HEALTH CARE PROVIDER OR MENTAL HEALTH CARE PROVIDER AND TO PROVIDE FOR PARENTS' FUNDAMENTAL RIGHTS.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 7B-301 is amended by adding a new subsection to read:

"(d) No person or institution shall file, or be obligated to file, a report of abuse or neglect under this section based solely on the decision of a parent or legal guardian to follow treatment recommended by a licensed health care provider or licensed provider of mental health services. A parent or legal guardian has the right to follow the advice and treatment plan of a licensed health care provider or a licensed provider of mental health services over a contrary opinion or recommended treatment plan of another licensed health care provider or licensed provider of mental health services if the decision does not involve an immediate, life-threatening situation, and a parent's decision to follow a contrary opinion or recommended treatment plan does not give rise to suspected abuse or neglect for which a person or institution is obligated to report under this section. Even in the case of an immediate, life-threatening situation, the decision of the parent or legal guardian to follow the advice or treatment plan of a licensed health care provider or a licensed provider of mental health services shall not give rise to an obligation to report suspected abuse or neglect under this section."

SECTION 2. Article 1A of Chapter 90 of the General Statutes is amended by adding a Part to read:

"Part 3.
"PARENTS' FUNDAMENTAL RIGHTS.

§ 90-21.10A. Parents' fundamental rights.

The liberty of a parent to direct the upbringing, education, and care of his or her child is a fundamental right. Neither the State nor any agency or locality of the State shall infringe upon a parent's fundamental rights to the care, custody, and control of his or her child without demonstrating a compelling State interest and use of the least restrictive means of furthering that compelling State interest. This section shall not be construed to apply to a parent's action or decision that would end life."

SECTION 3. This act becomes effective October 1, 2015.

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2015

HOUSE BILL 847

Short Title:	Amend Laws Re: Medical Treatment for Minors.	(Public)
Sponsors:	Representative Jordan (Primary Sponsor). *For a complete list of Sponsors, refer to the North Carolina General Assembly Web Site.*	
Referred to:	Health, if favorable, Judiciary II.	

April 15, 2015

A BILL TO BE ENTITLED

AN ACT PROTECTING PARENTS FROM REPORTS OF ABUSE OR NEGLECT BASED SOLELY ON A DECISION TO FOLLOW TREATMENT RECOMMENDED BY A HEALTH CARE PROVIDER OR MENTAL HEALTH CARE PROVIDER; AND ELIMINATING CERTAIN EXCEPTIONS FOR PARENTAL CONSENT FOR MEDICAL TREATMENT OF UNEMANCIPATED MINORS UNDER THE LAWS PERTAINING TO THE PRACTICE OF MEDICINE.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 7B-301 is amended by adding a new subsection to read:

"(d) No person or institution shall file a report of abuse or neglect under this section based solely on the decision of a parent or legal guardian to follow treatment recommended by a licensed health care provider or licensed provider of mental health services. A parent or legal guardian has the right to follow the advice and treatment plan of a licensed health care provider or a licensed provider of mental health services over a contrary opinion or recommended treatment plan of another licensed health care provider or licensed provider of mental health services if the decision does not involve an immediate, life-threatening situation. Even in the case of an immediate, life-threatening situation, the decision of the parent or legal guardian to follow the advice or treatment plan of a licensed health care provider or a licensed provider of mental health services shall not be overridden unless there is clear and convincing evidence that warrants a different decision."

SECTION 2. G.S. 90-21.5 reads as rewritten:

"**§ 90-21.5. Minor's consent sufficient for certain medical health services.**

~~(a) Any minor may give effective consent to a physician licensed to practice medicine in North Carolina for medical health services for the prevention, diagnosis and treatment of (i) venereal disease and other diseases reportable under G.S. 130A-135, (ii) pregnancy, (iii) abuse of controlled substances or alcohol, and (iv) emotional disturbance. This section does not authorize the inducing of an abortion, performance of a sterilization operation, or admission to a 24-hour facility licensed under Article 2 of Chapter 122C of the General Statutes except as provided in G.S. 122C-223. This section does not prohibit the admission of a minor to a treatment facility upon his own written application in an emergency situation as authorized by G.S. 122C-223.~~

(a1) Except as otherwise provided by law, no person, corporation, association, organization, State-supported institution, or individual employed by any of these entities shall

perform any of the following acts without first obtaining the notarized written consent of the parent or legal guardian of the minor:

(1) Procure, solicit to perform, arrange for the performance of, or perform a surgical procedure on a minor.

(2) Perform a physical examination of a minor.

(3) Prescribe any prescription drug for the treatment of a minor.

(a2) A hospital or medical center shall not permit a surgical procedure to be performed upon a minor in any of its facilities without first obtaining the notarized written consent of the parent or legal guardian of the minor.

(a3) The provisions of this section do not apply upon a determination of any of the following by a physician licensed to practice medicine in North Carolina:

(1) A medical emergency exists and it is necessary to perform a surgical procedure on the minor in order to treat that medical emergency.

(2) The minor is in need of treatment for substance abuse.

(3) Treatment is necessary to save the life of the minor, and reasonable efforts to contact the parent or legal guardian of the minor have been unsuccessful.

(a4) A person who violates a provision of this section is guilty of an unclassified misdemeanor, punishable by a fine of not more than one thousand dollars ($1,000), or imprisonment of not more than one year, or both.

(b) Any minor who is emancipated may consent to any medical treatment, dental and health services for himself or for his child."

SECTION 3. The title of Part 2 of Article 1A of Chapter 90 of the General Statutes reads as rewritten:

"Part 2. Parental or Judicial Consent for ~~Abortion.~~Abortion, Treatment for Sexually Transmitted Diseases, Abuse of Controlled Substances or Alcohol, Mental Illness, and Pregnancy."

SECTION 4. G.S. 90-21.7 reads as rewritten:

"**§ 90-21.7. Parental consent required.**

(a) No physician licensed to practice medicine in North Carolina shall perform an abortion upon an unemancipated minor unless the physician or agent thereof or another physician or agent thereof first obtains the written consent of the minor and ~~of:~~the notarized written consent of any of the following:

(1) A parent with custody of the ~~minor; or~~minor.

(2) The legal guardian or legal custodian of the ~~minor; or~~minor.

(3) A parent with whom the minor is ~~living; or~~living.

(4) A grandparent with whom the minor has been living for at least six months immediately preceding the date of the minor's written consent.

(a1) Except as prohibited by federal law, unless a parent or legal guardian or legal custodian of an unemancipated minor is present with the unemancipated minor and gives consent, no health care provider duly licensed in the State of North Carolina, or agent thereof, shall provide health care services for the prevention, diagnosis, and treatment of (i) sexually transmitted diseases, including Human Immunodeficiency Virus/Acquired Immune Deficiency Syndrome, (ii) abuse of controlled substances or alcohol, (iii) mental illness, or (iv) pregnancy unless the health care provider or agent thereof, or another health care provider or agent thereof, first obtains the written consent of the minor and the notarized written consent of any one of the following:

(1) A parent with custody of the minor.

(2) The legal guardian or legal custodian of the minor.

(3) A parent with whom the minor is living.

(4) A grandparent with whom the minor has been living for at least six months immediately preceding the date of the minor's written consent.

(b) The ~~pregnant~~ minor may petition, on his or her own behalf or by guardian ad litem, the district court judge assigned to the juvenile proceedings in the district court where the minor resides or where ~~she~~ the minor is physically present for a waiver of the parental consent requirement ~~if:~~if one of the following is true:

(1) None of the persons from whom consent must be obtained pursuant to this section is available to the physician performing the abortion or providing health care services for the prevention, diagnosis, and treatment of (i) sexually transmitted diseases, including Human Immunodeficiency Virus/Acquired Immune Deficiency Syndrome, (ii) abuse of controlled substances or alcohol, (iii) mental illness, or (iv) pregnancy or to the physician's agent or the referring physician or the agent thereof within a reasonable time or ~~manner; or~~manner.

(2) All of the persons from whom consent must be obtained pursuant to this section refuse to consent to the performance of an ~~abortion; or~~abortion or the provision of health care services as described in subdivision (1) of this section.

(3) The minor elects not to seek consent of the person from whom consent is required."

SECTION 5. G.S. 90-21.8 reads as rewritten:

"**§ 90-21.8. Procedure for waiver of parental consent.**

(a) The requirements and procedures under Part 2 of this Article are available and apply to unemancipated minors seeking treatment in this State.

(b) The court shall ensure that the minor or ~~her~~ the minor's guardian ad litem is given assistance in preparing and filing the petition and shall ensure that the minor's identity is kept confidential.

(c) The minor may participate in proceedings in the court on his or her own behalf or through a guardian ad litem. The court shall advise ~~her that she has a~~the minor of the right to appointed counsel, and counsel shall be provided upon ~~her~~ request in accordance with rules adopted by the Office of Indigent Defense Services.

(d) Court proceedings under this section shall be confidential and shall be given precedence over other pending matters necessary to ensure that the court may reach a decision promptly. In no case shall the court fail to rule within seven days of the time of filing the application. This time limitation may be extended at the request of the minor. At the hearing, the court shall hear evidence relating to the emotional development, maturity, intellect, and understanding of the minor; the nature, possible consequences, and alternatives to the ~~abortion;~~abortion or other health care services sought by the minor; and any other evidence that the court may find useful in determining whether the parental consent requirement shall be waived.

(e) The parental consent requirement shall be waived if the court ~~finds:~~makes any of the following findings:

(1) ~~That the~~The minor is mature and well-informed enough to make the decision on his or her own regarding abortion ~~decision on her own; or~~ other health care services for the prevention, diagnosis, and treatment of (i) sexually transmitted diseases, including Human Immunodeficiency Virus/Acquired Immune Deficiency Syndrome, (ii) abuse of controlled substances or alcohol, (iii) mental illness, or (iv) pregnancy.

(2) ~~That it~~It would be in the minor's best interests that parental consent not be ~~required; or~~required.

(3) ~~That~~ In instances where an abortion is sought, the minor is a victim of rape or of felonious incest under G.S. 14-178.

(f) The court shall make written findings of fact and conclusions of law supporting its decision and shall order that a confidential record of the evidence be maintained. If the court finds that the minor has been a victim of incest, whether felonious or misdemeanor, it shall advise the Director of the Department of Social Services of its findings for further action pursuant to Article 3 of Chapter 7B of the General Statutes.

(g) If the ~~female~~ petitioner so requests in ~~her~~ the petition, no summons or other notice may be served upon the parents, guardian, or custodian of the ~~minor female.~~minor.

(h) The minor may appeal an order issued in accordance with this section. The appeal shall be a de novo hearing in superior court. The notice of appeal shall be filed within 24 hours from the date of issuance of the district court order. The de novo hearing may be held out of district and out of session and shall be held as soon as possible within seven days of the filing of the notice of appeal. The record of the de novo hearing is a confidential record and shall not be open for general public inspection. The Chief Justice of the North Carolina Supreme Court shall adopt rules necessary to implement this subsection.

(i) No court costs shall be required of any minor who avails ~~herself~~ of the procedures provided by this section."

SECTION 6. G.S. 90-21.9 reads as rewritten:

"**§ 90-21.9. Medical emergency exception.**

The requirements of parental consent prescribed by G.S. 90-21.7(a) and G.S. 90-21.7(a1) shall not apply when, in the best medical judgment of the physician based on the facts of the case before the physician, a medical emergency exists that so complicates the pregnancy as to require an immediate ~~abortion,~~abortion or the immediate provision of health care services, or when the conditions prescribed by G.S. 90-21.1(4) are met."

SECTION 7. Article 1A of Chapter 90 of the General Statutes is amended by adding a new section to read:

"**§ 90-21.10A. Construction of Article; parents' fundamental rights.**

The liberty of a parent to direct the upbringing, education, and care of his or her child is a fundamental right. This Article shall not be construed to apply to a parent's action or decision that would end life. Neither the State nor any agency or locality of the State shall infringe upon on a parent's fundamental rights to the care, custody, and control of his or her child without demonstrating a compelling State interest and use of the least restrictive means of furthering that compelling State interest."

SECTION 8. G.S. 122C-221(a) reads as rewritten:

"(a) Except as otherwise provided in this Part, a minor may be admitted to a facility if the minor (i) is mentally ill or a substance ~~abuser and in need of treatment.~~abuser, (ii) is in need of treatment, and (iii) has complied with the consent requirements of G.S. 90-21.7. Except as otherwise provided in this ~~Part,~~Part and to the extent allowed under G.S. 90-21.7, the provisions of G.S. 122C-211 shall apply to admissions of minors under this Part. ~~Except as provided in G.S. 90-21.5, in~~In applying for admission to a ~~facility, in consenting to medical treatment when consent is required,~~ facility and in any other legal procedure under this Article, the legally responsible person shall act for the minor. If a minor reaches the age of 18 while in treatment under this Part, further treatment is authorized only on the written authorization of the client or under the provisions of Part 7 or Part 8 of Article 5 of this Chapter."

SECTION 9. This act becomes effective October 1, 2015.

HOUSE BILL 20:
Reegan's Rule/Childhood Diabetes Screening

2015-2016 General Assembly

Committee:	House Health, if favorable, Appropriations	**Date:**	April 27, 2015
Introduced by:	Rep. C. Graham	**Prepared by:**	Amy Jo Johnson
Analysis of:	PCS to First Edition H20-CSTK-31		Committee Counsel

SUMMARY: ***The PCS to House Bill 20 would require parent education during certain well child visits regarding Type I diabetes.***

BILL ANALYSIS:

The PCS to House Bill 20 would require that each physician, physician assistant, or certified nurse practitioner who provides well-child care to ensure that he or she provides education on the warning signs and symptoms of Type I diabetes. This education must take place with each parent for each child under the care of the health care provider at least once at birth, twelve months of age, and at twenty-four months of age of the child.

EFFECTIVE DATE: This act becomes effective October 1, 2015.

O. Walker Reagan
Director

H20-SMTK-59 CSTK-31 -V2

Research Division
(919) 733-2578

This bill analysis was prepared by the nonpartisan legislative staff for the use of legislators in their deliberations and does not constitute an official statement of legislative intent.

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2015

H D

HOUSE BILL 20
PROPOSED COMMITTEE SUBSTITUTE H20-CSTK-40 [v.2]

Short Title: Reegan's Rule/Childhood Diabetes Education. (Public)

Sponsors:

Referred to:

January 29, 2015

A BILL TO BE ENTITLED

AN ACT REQUIRING PARENT EDUCATION DURING WELL-CHILD VISITS AT SPECIFIC AGE INTERVALS REGARDING TYPE I DIABETES.

The General Assembly of North Carolina enacts:

SECTION 1. Part 3 of Article 7 of Chapter 130A of the General Statutes is amended by adding a new section to read:

"**§ 130A-221.5. Diabetes education as part of well-child care.**

Each physician, physician assistant, or certified nurse practitioner who provides well-child care shall ensure that education of warning signs of Type I diabetes and symptoms are discussed with each parent for each child under the care of the physician, physician assistant, or certified nurse practitioner at least once at the following age intervals:

(1) Birth.

(2) Twelve months of age.

(3) Twenty-four months of age."

SECTION 2. This act becomes effective October 1, 2015.

HOUSE BILL 20

Short Title:	Reegan's Rule/Childhood Diabetes Screening.	(Public)
Sponsors:	Representative C. Graham (Primary Sponsor). *For a complete list of Sponsors, refer to the North Carolina General Assembly Web Site.*	
Referred to:	Health, if favorable, Appropriations.	

January 29, 2015

A BILL TO BE ENTITLED

AN ACT REQUIRING DIABETES SCREENING DURING WELL-CHILD VISITS AT SPECIFIC AGE INTERVALS.

The General Assembly of North Carolina enacts:

SECTION 1. Chapter 130A of the General Statutes is amended by adding a new section to read:

"**§ 130A-221.5. Mandatory diabetes screening as part of well-child care.**

Each physician, physician's assistant, or certified nurse practitioner who provides well-child care shall ensure that diabetes screening is performed upon each child under the care of the physician, physician's assistant, or certified nurse practitioner at least once at the following age intervals:

(1) Birth.
(2) Twelve months of age.
(3) Twenty-four months of age."

SECTION 2. This act becomes effective October 1, 2015.

NORTH CAROLINA GENERAL ASSEMBLY
AMENDMENT
House Bill 20

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

H20-ATK-22 [v.1]

Amends Title [NO]
First Edition

Date _____ ,2015

Representative _____

moves to amend the bill on page 1, lines 8-10 by rewriting the lines to read:

"Each physician, physician assistant, or certified nurse practitioner who provides well-child care is encouraged to educate and discuss the warning signs of Type I diabetes and symptoms with each parent for each child under the care of the physician, physician assistant, or".

SIGNED _____
Amendment Sponsor

SIGNED _____
Committee Chair if Senate Committee Amendment

ADOPTED ✓ FAILED _____ TABLED _____

HOUSE BILL 832:
Revise Certain Policies/Child Care Subsidy

2015-2016 General Assembly

Committee:	House Health, if favorable, Finance	**Date:**	April 24, 2015
Introduced by:	Rep. Dobson	**Prepared by:**	Tawanda Foster Committee Counsel
Analysis of:	PCS to First Edition H832-CSTV-14		

SUMMARY: ***House Bill 832 would provide for prorated co-payments for part-time subsidized child care and revise the definition of income unit in the child care subsidy policy to no longer include nonparent relative caretaker. The PCS makes a technical change only.***

CURRENT LAW: S.L. 2014-100, The Current Operations and Capital Improvements Appropriations Act of 2014, includes the budget appropriations for state departments, institutions, and agencies. Section 12B.3 addresses child care subsidy rates. Section 12B.3(b) sets forth the percentage of fees for families who are required to share in the cost of care. It prohibits prorated co-payments for part-time care.

BILL ANALYSIS: The PCS to House Bill 832 would amend Section 12B.3(b) to allow copayments for part time care equal to or less than 25 hours per week to be prorated at 50% of the full parent fee.

The bill also amends Section 12B.3(b1) to revise the definition of income unit to no longer a nonrelative caretaker, and the caretaker's spouse and child, if applicable, when the parent of the child receiving the child care subsidy does not live in the home with the child.

EFFECTIVE DATE: This act becomes effective July 1, 2015.

O. Walker Reagan
Director

* H 8 3 2 - S M T V - 3 1 C S T V - 1 4 - V 1 *

Research Division
(919) 733-2578

This bill analysis was prepared by the nonpartisan legislative staff for the use of legislators in their deliberations and does not constitute an official statement of legislative intent.

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2015

H D

HOUSE BILL 832
PROPOSED COMMITTEE SUBSTITUTE H832-CSTV-14 [v.1]

4/24/2015 5:40:37 PM

Short Title: Revise Certain Policies/Child Care Subsidy. (Public)

Sponsors:

Referred to:

April 15, 2015

A BILL TO BE ENTITLED

AN ACT TO PROVIDE FOR PRORATED CO-PAYMENTS FOR PART-TIME SUBSIDIZED CHILD CARE AND REVISE THE DEFINITION OF INCOME UNIT IN THE CHILD CARE SUBSIDY POLICY TO NO LONGER INCLUDE NONPARENT RELATIVE CARETAKER.

The General Assembly of North Carolina enacts:

SECTION 1. Section 12B.1 of S.L. 2014-100 reads as rewritten:

"…

"**SECTION 12B.3.(b)** Beginning ~~October 1, 2014,~~July 1, 2015, fees for families who are required to share in the cost of care shall be established based on ten percent (10%) of gross family income. Co-payments shall ~~not be prorated for part-time care.~~be prorated at fifty percent (50%) of the full parent fee for part-time care equal to or less than 25 hours per week."

"**SECTION 12B.3.(b1)** ~~No later than January 1, 2015,~~Effective July 1, 2015, the Department of Health and Human Services, Division of Child Development and Early Education, shall revise its child care subsidy policy to include in the policy's definition of "income unit" ~~the following:~~a parent, stepparent, and the stepparent's child, if applicable.

~~(1) A stepparent and the stepparent's child, if applicable.~~

~~(2) A nonparent relative caretaker, and the caretaker's spouse and child, if applicable, when the parent of the child receiving child care subsidy does not live in the home with the child.~~

…."

SECTION 2. This act becomes effective July 1, 2015.

HOUSE BILL 832

Short Title:	Revise Certain Policies/Child Care Subsidy.	(Public)
Sponsors:	Representative Dobson (Primary Sponsor). *For a complete list of Sponsors, refer to the North Carolina General Assembly Web Site.*	
Referred to:	Health, if favorable, Finance.	

April 15, 2015

A BILL TO BE ENTITLED

AN ACT TO PROVIDE FOR PRORATED CO-PAYMENTS FOR PART-TIME SUBSIDIZED CHILD CARE AND REVISE THE DEFINITION OF INCOME UNIT IN THE CHILD CARE SUBSIDY POLICY TO NO LONGER INCLUDE NONPARENT RELATIVE CARETAKER.

The General Assembly of North Carolina enacts:

SECTION 1. Section 12B.3 of S.L. 2014-100 reads as rewritten:

"…

"**SECTION 12B.3.(b)** Beginning ~~October 1, 2014,~~July 1, 2015, fees for families who are required to share in the cost of care shall be established based on ten percent (10%) of gross family income. Co-payments shall ~~not be prorated for part-time care.~~be prorated at fifty percent (50%) of the full parent fee for part-time care equal to or less than 25 hours per week."

"**SECTION 12B.3.(b1)** ~~No later than January 1, 2015,~~Effective July 1, 2015, the Department of Health and Human Services, Division of Child Development and Early Education, shall revise its child care subsidy policy to include in the policy's definition of "income unit" ~~the following:~~a parent, stepparent, and the stepparent's child, if applicable.

~~(1) A stepparent and the stepparent's child, if applicable.~~

~~(2) A nonparent relative caretaker, and the caretaker's spouse and child, if applicable, when the parent of the child receiving child care subsidy does not live in the home with the child.~~

…."

SECTION 2. This act becomes effective July 1, 2015.

HOUSE BILL 309: Got Natural Milk

2015-2016 General Assembly

Committee:	House Health, if favorable, Agriculture	**Date:**	April 27, 2015
Introduced by:	Reps. Riddell, Queen, Harrison, McGrady	**Prepared by:**	Amy Jo Johnson Committee Counsel
Analysis of:	First Edition		

SUMMARY: ***House Bill 309 allows for the dispensing of raw milk and raw milk products to independent or partial owners of lactating animals for personal use or consumption.***

CURRENT LAW:

It is illegal to sell or dispense raw milk or raw milk products for human consumption in North Carolina. G.s. 106-266.35 allows only milk that is Grade "A" pasteurized milk to be sold or dispensed directly to consumers for human consumption. Raw milk and raw milk prodcuts are only able to be sold or dispensed to a permitted milk hauler or a milk processing facility. Raw milk and raw milk products may be dispensed for nonhuman consumption and any product dispensed as animal feed must be labeled with the statement "IT IS NOT LEGAL TO SELL RAW MILK FOR HUMAN CONSUMPTION IN NORTH CAROLINA."

Federal law prohibits the interstate sale of unpasteurized milk for human consumption. 21 CFR 1240.61(a) states: "No person shall cause to be delivered into interstate commerce or shall sell, otherwise distribute, or hold for sale or other distribution after shipment in interstate commerce any milk or milk product in final package form for direct human consumption unless the product has been pasteurized or is made from dairy ingredients (milk or milk products) that have all been pasteurized, except where alternative procedures to pasteurization are provided for by regulation..."

BILL ANALYSIS:

House bill 309 would amend G.S. 106-266.35 to allow for the transfer or dispensing of raw milk or raw milk projects for the personal use of or consumption by an independent or partial owner of a cow, goat, or other lactating animal.

EFFECTIVE DATE: This act becomes effective October 1, 2015.

HOUSE BILL 309

Short Title:	Got Natural Milk.	(Public)
Sponsors:	Representatives Riddell, Queen, Harrison, and McGrady (Primary Sponsors). *For a complete list of Sponsors, refer to the North Carolina General Assembly Web Site.*	
Referred to:	Health, if favorable, Agriculture.	

March 23, 2015

A BILL TO BE ENTITLED

AN ACT ALLOWING THE DISPENSING OF RAW MILK AND RAW MILK PRODUCTS TO INDEPENDENT OR PARTIAL OWNERS OF LACTATING ANIMALS FOR PERSONAL USE OR CONSUMPTION.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 106-266.35 reads as rewritten:

"**§ 106-266.35. Sale or dispensing of milk.**

(a) Except as provided in subsection (d) of this section:

(1) Only milk that is Grade "A" pasteurized milk may be sold or dispensed directly to consumers for human consumption.

(2) Raw milk and raw milk products shall be sold or dispensed only to a permitted milk hauler or to a processing facility at which the processing of milk is permitted, graded, or regulated by a local, State, or federal agency.

(b) The Board of Agriculture may adopt rules to provide exceptions for dispensing raw milk and raw milk products for nonhuman consumption. Any raw milk or raw milk product dispensed as animal feed shall include on its label the statement "NOT FOR HUMAN CONSUMPTION" in letters at least one-half inch in height. Any raw milk or raw milk product dispensed as animal feed shall also include on its label the statement "IT IS NOT LEGAL TO SELL RAW MILK FOR HUMAN CONSUMPTION IN NORTH CAROLINA." This labeling requirement does not apply to raw milk or raw milk products dispensed for personal use or consumption to the independent or partial owner of a cow, goat, or other lactating animal.

~~"Sale"~~

(c) As used in this section, the term "sale" or "sold" ~~shall mean~~means any transaction that involves the transfer or dispensing of milk and milk products or the right to acquire milk and milk products through barter or contractual arrangement or in exchange for any other form of ~~compensation including, but not limited to, the sale of shares or interest in a cow, goat, or other lactating animal or herd.~~compensation. The term "sale" or "sold" does not include the transfer or dispensing of raw milk and raw milk products to, or the right to acquire raw milk or raw milk products by, the independent or partial owner of a cow, goat, or other lactating animal.

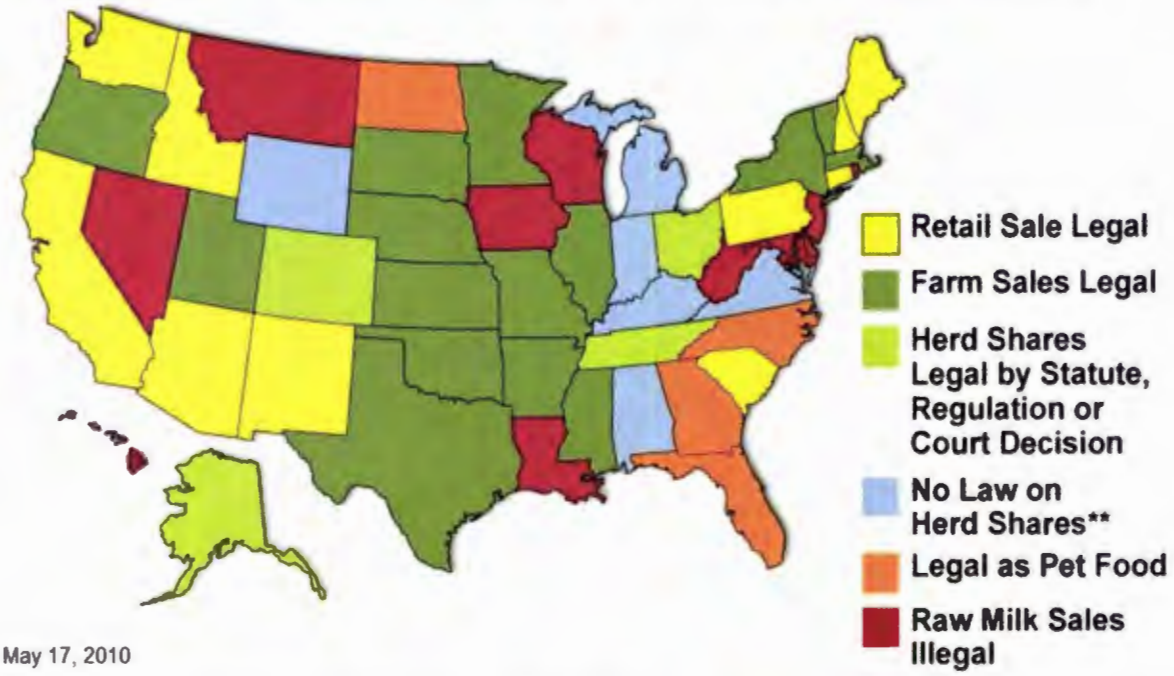
(d) Nothing in this section shall prohibit the dispensing of raw milk or raw milk products for personal use or consumption to, or the acquisition of raw milk or raw milk products for personal use or consumption by, an independent or partial owner of a cow, goat, or other lactating animal."

SECTION 2. This act becomes effective October 1, 2015.

Colleagues, I know you are all being lobbied by different groups to vote against HB309 Got Natural Milk. Please take a look at this information and I would ask you to keep an open mind until we have had the opportunity to present the bill in committee on Monday.

Thank you, Dennis

State-by-State* Review of Raw Milk Laws



May 17, 2010

* Other forms of raw milk distribution may also be allowed in any particular state.
** There is no law either legalizing or prohibiting herd shares. State is aware herd share programs currently exist and has taken no action to try to stop them.

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HOUSE BILL 814:
The William C. Lindley, Jr. SUDEP Law

2015-2016 General Assembly

Committee:	House Health	**Date:**	April 27, 2015
Introduced by:	Reps. Riddell, Ross	**Prepared by:**	Amy Jo Johnson
Analysis of:	PCS to First Edition H814-CSTK-37		Committee Counsel

SUMMARY: ***The PCS to House bill 814 requires the Office of the Chief Medical Examiner to establish a medical examiner training program that includes training regarding sudden unexplained death in epilepsy.***

CURRENT LAW:

A medical examiner makes inquiries regarding the cause and manner of death for each body in his or her charge. A medical examiner is required to reduce the findings to writing and make a full report to the Chief Medical Examiner. In doing so, the medical examiners are authorized to inspect and copy medical records of the decedent. Upon completion of the investigation, the medical examiner is required to complete a death certificate, which includes the cause, means or manner of death, including if such a cause, means, or manner is undeterminable. G.S. 130A-379.

BILL ANALYSIS:

The PCS to H814 would amend G.S. 130A-382 to include training requirements for medical examiners. County medical examiners would be required to complete annual continuing education requirements that include training on sudden unexplained death in epilepsy. This training would be based upon established guidelines and policies as directed by the Office of Chief Medical Examiner. The guidelines would be published and annually updated on the website of the Office of Chief Medical Examiner. Any newly appointed county medical examiners would be required to complete mandatory orientation within 90 days of their appointment.

The PCS would allow the Chief Medical Examiner to revoke a county medical examiner's appointment for failure to adequately perform the duties of the office after giving written notice of the basis for the revocation and opportunity to respond.

EFFECTIVE DATE: This act becomes effective January 1, 2016.

BACKGROUND: According to the Epilepsy Foundation, SUDEP "is said to occur when a person with epilepsy dies unexpectedly and was previously in their usual state of health. The death is not known to be related to an accident or seizure emergency such as status epilepticus. When an autopsy is done, no other of cause of death can be found. Each year, more than 1 out of 1,000 people with epilepsy die from SUDEP." [1]

[1] http://www.epilepsy.com/sudep-institute

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2015

H D

HOUSE BILL 814
PROPOSED COMMITTEE SUBSTITUTE H814-CSTK-37 [v.3]

4/26/2015 7:57:45 AM

Short Title: The William C. Lindley, Jr. SUDEP Law. (Public)

Sponsors:

Referred to:

April 15, 2015

A BILL TO BE ENTITLED

AN ACT REQUIRING THE CHIEF MEDICAL EXAMINER TO ESTABLISH A MEDICAL EXAMINER TRAINING PROGRAM THAT INCLUDES TRAINING REGARDING SUDDEN UNEXPLAINED DEATH IN EPILEPSY DURING MEDICOLEGAL DEATH INVESTIGATIONS.

Whereas, sudden, unexpected death in epilepsy (SUDEP) is a mysterious, rare condition in which typically young or middle-aged individuals with epilepsy die without a clear cause, and is generally defined by the medical community as a sudden, unexpected, nontraumatic, nondrowning death in an otherwise healthy individual with epilepsy, where the postmortem examination does not reveal an anatomic or toxicologic cause of the death; and

Whereas, SUDEP is believed to account for up to 17 percent of deaths in individuals with epilepsy; and

Whereas, autopsy plays a key role in determining the diagnosis of SUDEP, yet the Institute of Medicine has found that SUDEP may be underreported for several reasons, including, but not limited to, a lack of awareness about SUDEP among medical examiners; and

Whereas, the cause of SUDEP is not known, and opportunities for its prevention have been hindered by the lack of a systematic effort to collect information about individuals who have died from SUDEP, as is done with many other disorders; and

Whereas, it is appropriate to raise awareness of SUDEP among medical examiners by developing a SUDEP awareness program and by facilitating research into the causes and prevention of SUDEP; Now, therefore,

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 130A-382 reads as rewritten:

"**§ 130A-382. County medical examiners; appointment; term of office; ~~vacancies.~~vacancies, training requirements; revocation for cause.**

(a) The Chief Medical Examiner shall appoint one or more county medical examiners for each county for a three-year term. In appointing medical examiners for each county, the Chief Medical Examiner shall give preference to physicians licensed to practice medicine in this State but may also appoint licensed physician assistants, nurse practitioners, nurses, ~~coroners,~~ or emergency medical technician paramedics. A medical examiner may serve more than one county. The Chief Medical Examiner may take jurisdiction in any case or appoint another medical examiner to do so.

(b) County medical examiners shall complete annual continuing education training that shall include training regarding sudden unexplained death in epilepsy, as directed by the Office of the Chief Medical Examiner and based on established and published guidelines. Guidelines shall be published and annually updated on the Web site of the Office of the Chief Medical

Examiner. Newly appointed county medical examiners shall complete mandatory orientation training as directed by the Office of the Chief Medical Examiner within 90 days of their appointment.

(c) The Chief Medical Examiner may revoke a county medical examiner's appointment for failure to adequately perform the duties of the office after giving written notice of the basis for the revocation and opportunity to respond."

SECTION 2. This section becomes effective January 1, 2016.

HOUSE BILL 814

Short Title:	The William C. Lindley, Jr. SUDEP Law.	(Public)
Sponsors:	Representatives Riddell and Ross (Primary Sponsors). *For a complete list of Sponsors, refer to the North Carolina General Assembly Web Site.*	
Referred to:	Health.	

April 15, 2015

A BILL TO BE ENTITLED

AN ACT REQUIRING THE CHIEF MEDICAL EXAMINER TO ESTABLISH A MEDICAL EXAMINER TRAINING PROGRAM AND STANDARD PROTOCOLS GOVERNING THE INVESTIGATION OF SUDDEN UNEXPLAINED DEATH IN EPILEPSY DURING MEDICOLEGAL DEATH INVESTIGATIONS.

Whereas, sudden, unexpected death in epilepsy (SUDEP) is a mysterious, rare condition in which typically young or middle-aged individuals with epilepsy die without a clear cause, and is generally defined by the medical community as a sudden, unexpected, nontraumatic, nondrowning death in an otherwise healthy individual with epilepsy, where the postmortem examination does not reveal an anatomic or toxicologic cause of the death; and

Whereas, SUDEP is believed to account for up to 17 percent of deaths in individuals with epilepsy; and

Whereas, autopsy plays a key role in determining the diagnosis of SUDEP, yet the Institute of Medicine has found that SUDEP may be underreported for several reasons, including, but not limited to, a lack of awareness about SUDEP among medical examiners; and

Whereas, the cause of SUDEP is not known, and opportunities for its prevention have been hindered by the lack of a systematic effort to collect information about individuals who have died from SUDEP, as is done with many other disorders; and

Whereas, it is appropriate to raise awareness of SUDEP among medical examiners by developing a SUDEP awareness program and by facilitating research into the causes and prevention of SUDEP; Now, therefore,

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 130A-379 reads as rewritten:

"**§ 130A-379. ~~Duties~~ Powers and duties of the Chief Medical Examiner.**

(a) The Chief Medical Examiner shall ~~perform~~do all of the following:

(1) Perform postmortem medicolegal examinations as provided in this Part.

(2) Establish a training program to educate medical examiners about sudden unexplained death in epilepsy; and standard protocols governing medicolegal death investigations involving seizure disorders in order to identify sudden unexplained death in epilepsy as a known or suspected cause of death.

(b) The Chief Medical Examiner may, upon request, provide instruction in health science, legal medicine and other subjects related to his duties at The University of North Carolina, the North Carolina Justice Academy and other institutions of higher learning."

SECTION 2. G.S. 130A-385 reads as rewritten:

"**§ 130A-385. Duties of medical examiner upon receipt of notice; reports; copies.**

(a) Upon receipt of a notification under G.S. 130A-383, the medical examiner shall take charge of the body, make inquiries regarding the cause and manner of death, reduce the findings to writing and promptly make a full report to the Chief Medical Examiner on forms prescribed for that purpose.

(a1) For each death under investigation, the Chief Medical Examiner's inquiries regarding the cause and manner of death shall include an inquiry to determine whether the death was a direct result of a seizure or epilepsy. If the findings of an autopsy are consistent with the definition of known or suspected sudden unexplained death in epilepsy, the Chief Medical Examiner shall do all of the following:

(1) Indicate on the death certificate that sudden unexplained death in epilepsy is the cause or suspected cause of death.

(2) Retain and track information about the number of deaths determined to be a direct result of a seizure or epilepsy and make unidentifiable data concerning these deaths available upon request to the public.

(3) Work with relevant organizations in this State to assist in requesting that the decedent's authorized representative submit relevant medical information about the decedent, consistent with the federal Health Insurance Portability and Accountability Act, Privacy Rule and Security Rule, 45 C.F.R. §§ 160, 164, to a sudden unexplained death in epilepsy registry for research purposes.

(4) Work with relevant organizations in the State in requesting that a person authorized to make an anatomical gift of the decedent's body or body part under G.S. 130A-412.11 consider making an anatomical gift of the decedent's brain to maximize the opportunity for research or education on sudden unexplained death in epilepsy.

(a2) The Chief Medical Examiner or the county medical examiner is authorized to inspect and copy the medical records of the decedent whose death is under investigation. In addition, in an investigation conducted pursuant to this Article, the Chief Medical Examiner or the county medical examiner is authorized to inspect all physical evidence and documents which may be relevant to determining the cause and manner of death of the person whose death is under investigation, including decedent's personal possessions associated with the death, clothing, weapons, tissue and blood samples, cultures, medical equipment, X rays and other medical images. The Chief Medical Examiner or county medical examiner is further authorized to seek an administrative search warrant pursuant to G.S. 15-27.2 for the purpose of carrying out the duties imposed under this Article. In addition to the requirements of G.S. 15-27.2, no administrative search warrant shall be issued pursuant to this section unless the Chief Medical Examiner or county medical examiner submits an affidavit from the office of the district attorney in the district in which death occurred stating that the death in question is not under criminal investigation.

(a3) The Chief Medical Examiner shall provide directions as to the nature, character and extent of an investigation and appropriate forms for the required reports. The facilities of the central and district offices and their staff services shall be available to the medical examiners and designated pathologists in their investigations.

(b) The medical examiner shall complete a certificate of death, stating the name of the disease which in ~~his~~ the medical examiner's opinion caused death. If the death was from external causes, the medical examiner shall state on the certificate of death the means of death, and whether, in the medical examiner's opinion, the manner of death was accident, suicide, homicide, execution by the State, or undetermined. The medical examiner shall also furnish any information as may be required by the State Registrar of Vital Statistics in order to properly classify the death.

(c) The Chief Medical Examiner shall have authority to amend a medical examiner death certificate.

(d) A copy of the report of the medical examiner investigation may be forwarded to the appropriate district attorney.

(e) In cases where death occurred due to an injury received in the course of the decedent's employment, the Chief Medical Examiner shall forward to the Commissioner of Labor a copy of the medical examiner's report of the investigation, including the location of the fatal injury and the name and address of the decedent's employer at the time of the fatal injury. The Chief Medical Examiner shall forward this report within 30 days of receipt of the information from the medical examiner.

(f) If a death occurred in a facility licensed subject to Article 2 or Article 3 of Chapter 122C of the General Statutes, or Articles 1 or 1A of Chapter 131D of the General Statutes, and the deceased was a client or resident of the facility or a recipient of facility services at the time of death, then the Chief Medical Examiner shall forward a copy of the medical examiner's report to the Secretary of Health and Human Services within 30 days of receipt of the report from the medical examiner."

SECTION 3. This act becomes effective October 1, 2015.

HOUSE BILL 290:
Prohibit Powdered Alcohol

2015-2016 General Assembly

Committee:	House Health	**Date:**	April 29, 2015
Introduced by:	Reps. Willingham, L. Hall	**Prepared by:**	Theresa Matula
Analysis of:	PCS to Second Edition H290-CSSH-35		Committee Staff

SUMMARY: ***House Bill 290 does the following: (i) defines powdered alcohol and prohibits the manufacture, sale, transport, import, delivery, furnishing, purchase, consumption, or possession of powdered alcohol, (ii) clarifies that suspension of an Alcoholic Beverage Control Commission (ABC Commission) permit due to charging five or more people with criminal violations of gambling, disorderly conduct, prostitution, controlled substance, or felony criminal counterfeit trademark laws is not a contested case under the North Carolina Administrative Procedures Act (APA), and (iii) provides that contested cases heard by the ABC Commission are covered by the Article of the APA that governs other administrative hearings. The PCS corrects an omission in the effective date.***

BILL ANALYSIS: **Section 1** of the bill amends G.S. 18B-101 to define "powdered alcohol" as any powder or crystalline substance capable of being converted into a liquid alcoholic beverage fit for human consumption. **Section 2** amends G.S. 18B-102 to make it unlawful for any person to manufacture, sell, transport, import, deliver, furnish, purchase, consume, or possess powdered alcohol.

Section 3 amends G.S. 18B-906 providing for the applicability of the Administrative Procedure Act. The section provides that an ABC permit is a "license" within the meaning of G.S. 150B-2, and except for suspension pursuant to G.S. 18B-904(e)4 is a contested case[1] subject to the provisions of Chapter 150B. This means that the suspension of an ABC Commission permit is not a contested case covered by the APA when the suspension is the result of Alcohol Law Enforcement agents or local ABC Board officers providing advance notice of an ongoing undercover operation and upon the execution of a search warrant, five or more persons are criminally charged with violations of the gambling, disorderly conduct, prostitution, controlled substance, or felony criminal counterfeit trademark laws as provided in G.S. 18B-904(e)(4).

Section 4 of the bill provides that the ABC Commission is covered by Article 3A of the APA, which governs "other administrative hearings."

EFFECTIVE DATE: Sections 1 and 2 of the bill become effective when it becomes law. Section 3 of the bill becomes effective May 1, 2015, and applies to suspensions issued on or after that date. Section 4 of the bill becomes effective May 1, 2015, and applies to contested cases brought on or after that date. The PCS adds that the remainder of the act is effective when it becomes law, which primarily impacts the effective date section of the bill.

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[1] A contested case is defined in the APA as "an administrative proceeding ... to resolve a dispute between an agency and another person that involves the person's rights, duties, or privileges, including licensing or the levy of a monetary penalty." Article 3A of the APA, governing "other administrative hearings," sets forth a process for hearing contested cases by the board or agency that made the initial ruling at issue in the contested case.

Chris Saunders, Staff Attorney, Research Division, contributed to this summary.

O. Walker Reagan
Director

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Research Division
(919) 733-2578

This bill analysis was prepared by the nonpartisan legislative staff for the use of legislators in their deliberations and does not constitute an official statement of legislative intent.

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2015

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HOUSE BILL 290
Committee Substitute Favorable 4/15/15
PROPOSED COMMITTEE SUBSTITUTE H290-CSSH-35 [v.2]
4/24/2015 5:54:47 PM

Short Title: Prohibit Powdered Alcohol. (Public)

Sponsors:

Referred to:

March 19, 2015

A BILL TO BE ENTITLED

AN ACT TO PROHIBIT THE SALE, POSSESSION, OR CONSUMPTION OF POWDERED ALCOHOL AND TO CLARIFY THAT THE ADMINISTRATIVE PROCEDURE ACT APPLIES TO CERTAIN ACTIONS TAKEN BY THE ABC COMMISSION.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 18B-101 reads as rewritten:

"**§ 18B-101. Definitions.**

As used in this Chapter, unless the context requires otherwise:

...

(12a) "Premises" means all areas, whether inside or outside the licensed premises, where the permittee has control of the property through a lease, deed, or other legal process.

(12b) "Powdered alcohol" means any powder or crystalline substance capable of being converted into a liquid alcoholic beverage fit for human consumption.

(13) "Sale" means any transfer, trade, exchange, or barter, in any manner or by any means, for consideration.

...."

SECTION 2. G.S. 18B-102 is amended by adding a new subsection to read:

"(a1) Powdered Alcohol Prohibition. – It shall be unlawful for any person to manufacture, sell, transport, import, deliver, furnish, purchase, consume, or possess powdered alcohol."

SECTION 3. G.S. 18B-906(a) reads as rewritten:

"(a) Act Applies. – An ABC permit is a "license" within the meaning of G.S. 150B-2, and, except for revocation pursuant to ~~G.S. 18B-904(e)(3)~~G.S. 18B-904(e)(3), suspension pursuant to G.S. 18B-904(e)(4), or for a confirmation pursuant to G.S. 18B-900(a)(8), a Commission action on issuance, suspension, or revocation of an ABC permit, other than a temporary permit issued under G.S. 18B-905, is a "contested case" subject to the provisions of Chapter 150B except as provided in this section."

SECTION 4. G.S. 150B-38(a) is amended by adding a new subdivision to read:

"(7) The Alcoholic Beverage Control Commission."

SECTION 5. Sections 1 and 2 of this act are effective when this act becomes law. Section 3 of this act becomes effective May 1, 2015, and applies to suspensions issued on or after that date. Section 4 of this act becomes effective May 1, 2015, and applies to contested cases brought on or after that date. The remainder of the act is effective when it becomes law.

HOUSE BILL 290
Committee Substitute Favorable 4/15/15

Short Title: Prohibit Powdered Alcohol. (Public)

Sponsors:

Referred to:

March 19, 2015

A BILL TO BE ENTITLED

AN ACT TO PROHIBIT THE SALE, POSSESSION, OR CONSUMPTION OF POWDERED ALCOHOL AND TO CLARIFY THAT THE ADMINISTRATIVE PROCEDURE ACT APPLIES TO CERTAIN ACTIONS TAKEN BY THE ABC COMMISSION.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 18B-101 reads as rewritten:

"**§ 18B-101. Definitions.**

As used in this Chapter, unless the context requires otherwise:

...

(12a) "Premises" means all areas, whether inside or outside the licensed premises, where the permittee has control of the property through a lease, deed, or other legal process.

(12b) "Powdered alcohol" means any powder or crystalline substance capable of being converted into a liquid alcoholic beverage fit for human consumption.

(13) "Sale" means any transfer, trade, exchange, or barter, in any manner or by any means, for consideration.

...."

SECTION 2. G.S. 18B-102 is amended by adding a new subsection to read:

"(a1) Powdered Alcohol Prohibition. – It shall be unlawful for any person to manufacture, sell, transport, import, deliver, furnish, purchase, consume, or possess powdered alcohol."

SECTION 3. G.S. 18B-906(a) reads as rewritten:

"(a) Act Applies. – An ABC permit is a "license" within the meaning of G.S. 150B-2, and, except for revocation pursuant to ~~G.S. 18B-904(e)(3)~~G.S. 18B-904(e)(3), suspension pursuant to G.S. 18B-904(e)(4), or for a confirmation pursuant to G.S. 18B-900(a)(8), a Commission action on issuance, suspension, or revocation of an ABC permit, other than a temporary permit issued under G.S. 18B-905, is a "contested case" subject to the provisions of Chapter 150B except as provided in this section."

SECTION 4. G.S. 150B-38(a) is amended by adding a new subdivision to read:

"(7) The Alcoholic Beverage Control Commission."

SECTION 5. Sections 1 and 2 of this act are effective when this act becomes law. Section 3 of this act becomes effective May 1, 2015, and applies to suspensions issued on or after that date. Section 4 of this act becomes effective May 1, 2015, and applies to contested cases brought on or after that date.

HOUSE BILL 724:
Amend Composition of NC Medical Board

2015-2016 General Assembly

Committee:	House Health	**Date:**	April 25, 2015
Introduced by:	Reps. Lambeth, Malone, S. Martin, Hurley	**Prepared by:**	Theresa Matula
Analysis of:	First Edition		Committee Staff

SUMMARY: House Bill 724 increases the membership of the NC Medical Board by one to ensure that at least one physician assistant and one nurse practitioner are members of the Board.

CURRENT LAW:

The NC Medical Board currently consists of 12 members. One member must be a physician assistant or a nurse practitioner.

BILL ANALYSIS:

House Bill 724 amends G.S. 90-2(a) which provides for the North Carolina Medical Board. The bill increases the board membership from 12 to 13 members. The new member ensures that the composition of the Medical Board includes both a physician assistant and a nurse practitioner.

EFFECTIVE DATE: This bill would become effective when it becomes law.

O. Walker Reagan
Director

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Research Division
(919) 733-2578

This bill analysis was prepared by the nonpartisan legislative staff for the use of legislators in their deliberations and does not constitute an official statement of legislative intent.

HOUSE BILL 724

Short Title:	Amend Composition of NC Medical Board.	(Public)
Sponsors:	Representatives Lambeth, Malone, S. Martin, and Hurley (Primary Sponsors). *For a complete list of Sponsors, refer to the North Carolina General Assembly Web Site.*	
Referred to:	Health.	

April 15, 2015

A BILL TO BE ENTITLED

AN ACT REVISING THE MEMBERSHIP OF THE NORTH CAROLINA MEDICAL BOARD TO ENSURE THAT AT LEAST ONE PHYSICIAN ASSISTANT AND AT LEAST ONE NURSE PRACTITIONER SERVE AS MEMBERS OF THE BOARD.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 90-2(a) reads as rewritten:

"(a) 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~~ 13 members.

(1) Seven of the members shall be duly licensed physicians recommended by the Review Panel and appointed by the Governor as set forth in G.S. 90-3.

(2) The remaining ~~five~~ six members shall all be appointed by the Governor as follows:

a. One shall be a duly licensed physician who is a doctor of osteopathy or a full-time faculty member of one of the medical schools in North Carolina who utilizes integrative medicine in that person's clinical practice or a member of The Old North State Medical Society. This Board position shall not be subject to recommendations of the Review Panel pursuant to G.S. 90-3.

b. Three shall be public members, and these Board positions shall not be subject to recommendations of the Review Panel pursuant to G.S. 90-3. A public member shall not be a health care provider nor the spouse of a health care provider. For the purpose of Board membership, "health care provider" means any licensed health care professional, agent or employee of a 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 as preparation 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.

c. 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~~ as recommended by the Review Panel pursuant to G.S. 90-3.

d. One shall be a nurse practitioner as defined in G.S. 90-18.2 as recommended by the Review Panel pursuant to G.S. 90-3."

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

HOUSE BILL 823:
Establish Advisory Council on Rare Diseases

2015-2016 General Assembly

Committee:	House Health	**Date:**	April 27, 2015
Introduced by:	Reps. Carney, Avila, Earle, Bishop	**Prepared by:**	Theresa Matula Kristen Harris Committee Counsel
Analysis of:	First Edition		

SUMMARY: ***House Bill 823 establishes the Advisory Council on Rare Diseases within the Department of Health and Human Resources.***

CURRENT LAW: 21 U.S.C. § 360bb – defines "rare disease or condition'' to mean any disease or condition which (A) affects less than 200,000 persons in the United States, or (B) affects more than 200,000 in the United States and for which there is no reasonable expectation that the cost of developing and making available in the United States a drug for such disease or condition will be recovered from sales in the United States of such drug.

BILL ANALYSIS: House Bill 823 establishes the Advisory Council on Rare Diseases within the Department of Health and Human Services (DHHS) to advise the Secretary on research, diagnosis, treatment, and education relating to rare diseases. For purposes of this section, "rare disease" has the same meaning as provided in 21 U.S.C. § 360bb, as amended.

Members - The Advisory Council membership is provided below and members are appointed by the Secretary:

- Up to five physicians licensed and practicing in the State with experience researching, diagnosing, or treating rare diseases.
- A medical researcher with experience conducting research concerning rare diseases.
- A registered nurse or advanced practice registered nurse licensed and practicing in the State with experience treating rare diseases.
- One hospital administrator from each hospital in the State that provides care to persons diagnosed with a rare disease, or a designee of the hospital administrator.
- Two rare disease survivors over the age of 18.
- A caregiver of a pediatric rare disease survivor.
- A representative of the North Carolina Board of Education.
- A representative in the field of biostatistics.
- A representative in the field of public health.
- Up to three representatives of patient based organizations operating within the State.

The members above can serve for a term of three years, and no member shall serve more than two consecutive terms.

Additional Members

- The chairpersons of the Joint Legislative Oversight Committee on Health and Human Services, or the chairpersons' designees, shall be members of the advisory council.

This bill analysis was prepared by the nonpartisan legislative staff for the use of legislators in their deliberations and does not constitute an official statement of legislative intent.

- The Secretary, or the Secretary's designee, shall be an ex officio, nonvoting member of the advisory council and shall attend all meetings of the advisory council.

Appointments, First Meeting, Chair, Quorum, Per Diem, Administrative Support

- Appointments to the advisory council must be made not later than 30 days after the effective date the bill.
- The Secretary must schedule the first meeting of the advisory council, which shall be held not later than October 1, 2015.
- The members must elect the chairperson of the advisory council from among the members of the council. A majority of the council members will constitute a quorum. A majority vote of a quorum must be required for any official action of the advisory council. The advisory council must meet upon the call of the chairperson or upon the request of a majority of council members.
- Members of the advisory council shall receive per diem and necessary travel and subsistence expenses in accordance with the provisions of G.S. 138-5 or G.S. 138-6, or travel and subsistence expenses in accordance with the provisions of G.S. 120-3.1, as applicable.
- DHHS provides administrative support and other services required by the advisory council.

Powers and Duties - The advisory council has the following powers and duties:

- Coordinate statewide efforts for the study of the incidence of rare disease within the State and the status of the rare disease community.
- Act as the advisory body on rare diseases to the Secretary on research, diagnosis, treatment, and education relating to rare diseases.
- Coordinate the performance of the advisory council's duties with other rare disease advisory bodies, community based organizations, and other public and private organizations within the State for the purpose of ensuring greater cooperation regarding the research, diagnosis, and treatment of rare diseases between the State and federal agencies, including but not exclusive to, the United States National Institutes of Health (NIH) and the United States Food and Drug Administration (FDA). Such coordination shall require, when appropriate, the following:
    - Disseminating the advisory council's research, identified best practices, and policy recommendations.
    - Utilizing common research collection and dissemination procedures.
- Research and identify priorities relating to the quality and cost effectiveness of, and access to, treatment and services provided to persons with rare diseases in the State; and develop policy recommendations on those issues.
- Identify best practices for rare disease care from other states and at the national level that will improve rare disease care in this State.
- Develop recommendations for effective strategies to raise public awareness of rare diseases in the State.
- Determine recommendations for best practices for ensuring that the public and health care providers are sufficiently informed of the most effective strategies for recognizing and treating rare disease.
- Develop recommendations for effective strategies to aid in determining any genetic or environmental contributors to rare diseases.
- Report to the Joint Legislative Oversight Committee on Health and Human Services.
- Apply for, and accept, any grant of money from the federal government, private foundations, or other sources which may be available for the operation of the advisory council and State programs related to rare diseases.

Report to Joint Legislative Oversight Committee on Health and Human Services
Not later than January 1, 2016, and annually thereafter, the advisory council shall report to the Joint Legislative Oversight Committee on Health and Human Services on the activities of the advisory council and its findings and recommendations regarding rare disease research and care in North Carolina.

EFFECTIVE DATE: This bill would become effective July 1, 2015.

HOUSE BILL 823

Short Title:	Establish Advisory Council on Rare Diseases.	(Public)
Sponsors:	Representatives Carney, Avila, Earle, and Bishop (Primary Sponsors). *For a complete list of Sponsors, refer to the North Carolina General Assembly Web Site.*	
Referred to:	Health.	

April 15, 2015

A BILL TO BE ENTITLED

AN ACT ESTABLISHING AN ADVISORY COUNCIL ON RARE DISEASES WITHIN THE DEPARTMENT OF HEALTH AND HUMAN SERVICES.

The General Assembly of North Carolina enacts:

SECTION 1. Article 1B of Chapter 130A of the General Statutes is amended by adding a new Part to read:

"Part 5. Advisory Council on Rare Diseases.

"**§ 130A-33.52. Advisory Council on Rare Diseases; membership.**

(a) There is established the Advisory Council on Rare Diseases within the Department to advise the Secretary on research, diagnosis, treatment, and education relating to rare diseases. For purposes of this section, "rare disease" has the same meaning as provided in 21 U.S.C. § 360bb, as amended from time to time.

(b) The advisory council shall consist of the following members, who shall be appointed by the Secretary:

(1) Up to five physicians licensed and practicing in the State with experience researching, diagnosing, or treating rare diseases.

(2) A medical researcher with experience conducting research concerning rare diseases.

(3) A registered nurse or advanced practice registered nurse licensed and practicing in the State with experience treating rare diseases.

(4) One hospital administrator from each hospital in the State that provides care to persons diagnosed with a rare disease, or a designee of the hospital administrator.

(5) Two rare disease survivors over the age of 18.

(6) A caregiver of a pediatric rare disease survivor.

(7) A representative of the North Carolina Board of Education.

(8) A representative in the field of biostatistics.

(9) A representative in the field of public health.

(10) Up to three representatives of patient-based organizations operating within the State.

(c) The chairpersons of the Joint Legislative Oversight Committee on Health and Human Services, or the chairpersons' designees, shall be members of the advisory council.

(d) The Secretary, or the Secretary's designee, shall be an ex officio, nonvoting member of the advisory council and shall attend all meetings of the advisory council.

(e) Any member of the advisory council appointed under subsection (c) of this section may be a member of the General Assembly.

(f) All appointments to the advisory council shall be made not later than 30 days after the effective date of this section. Members appointed pursuant to subsection (b) of this section shall serve for a term of three years, and no member shall serve more than two consecutive terms.

(g) Members of the advisory council shall receive per diem and necessary travel and subsistence expenses in accordance with the provisions of G.S. 138-5 or G.S. 138-6, or travel and subsistence expenses in accordance with the provisions of G.S. 120-3.1, as applicable.

(h) All administrative support and other services required by the advisory council shall be provided by the Department.

(i) The Secretary shall schedule the first meeting of the advisory council, which shall be held not later than October 1, 2015. The members shall elect the chairperson of the advisory council from among the members of the council. A majority of the council members shall constitute a quorum. A majority vote of a quorum shall be required for any official action of the advisory council. The advisory council shall meet upon the call of the chairperson or upon the request of a majority of council members.

"**§ 130A-33.53. Advisory Council on Rare Diseases; powers and duties.**

The advisory council shall exercise the following powers and duties:

(1) Coordinate statewide efforts for the study of the incidence of rare disease within the State and the status of the rare disease community.

(2) Act as the advisory body on rare diseases to the Secretary on research, diagnosis, treatment, and education relating to rare diseases.

(3) Coordinate the performance of the advisory council's duties with other rare disease advisory bodies, community-based organizations, and other public and private organizations within the State for the purpose of ensuring greater cooperation regarding the research, diagnosis, and treatment of rare diseases between the State and federal agencies, including but not exclusive to, the United States National Institutes of Health (NIH) and the United States Food and Drug Administration (FDA). Such coordination shall require, when appropriate, the following:

a. Disseminating the advisory council's research, identified best practices, and policy recommendations.

b. Utilizing common research collection and dissemination procedures.

(4) Research and identify priorities relating to the quality and cost-effectiveness of, and access to, treatment and services provided to persons with rare diseases in the State; and develop policy recommendations on those issues.

(5) Identify best practices for rare disease care from other states and at the national level that will improve rare disease care in this State.

(6) Develop recommendations for effective strategies to raise public awareness of rare diseases in the State.

(7) Determine recommendations for best practices for ensuring that the public and health care providers are sufficiently informed of the most effective strategies for recognizing and treating rare disease.

(8) Develop recommendations for effective strategies to aid in determining any genetic or environmental contributors to rare diseases.

(9) Not later than January 1, 2016, and annually thereafter, the advisory council shall report to the Joint Legislative Oversight Committee on Health and Human Services on the activities of the advisory council and its findings and recommendations regarding rare disease research and care in North Carolina.

(10) Apply for, and accept, any grant of money from the federal government, private foundations, or other sources which may be available for the operation of the advisory council and State programs related to rare diseases."

SECTION 2. This act becomes effective July 1, 2015.

HOUSE BILL 135:
Modernize Physical Therapy Practice

2015-2016 General Assembly

Committee:	House Health	**Date:**	April 27, 2015
Introduced by:	Reps. Dollar, B. Brown, Torbett, S. Martin	**Prepared by:**	Amy Jo Johnson Committee Counsel
Analysis of:	First Edition		

SUMMARY: ***House Bill 135 removes the requirement that a prescription by a physician be obtained when manipulation of the spine is performed by a licensed physical therapist.***

[As introduced, this bill was identical to S190, as introduced by Sens. Pate, Rabin, Woodard, which is currently in Rules and Operations of the Senate.]

CURRENT LAW: Under G.S. 90-270.24(4), a licensed physical therapist may engage in manipulation of the spine so long as a prescription to do so is obtained from a licensed physician.

BILL ANALYSIS: House Bill 135 would remove the requirement that a prescription be obtained prior to a licensed physical therapist engaging in manipulation of the spine.

EFFECTIVE DATE: This act becomes effective October 1, 2015.

O. Walker Reagan
Director

H135-SMTK-57 E1 -V2

Research Division
(919) 733-2578

This bill analysis was prepared by the nonpartisan legislative staff for the use of legislators in their deliberations and does not constitute an official statement of legislative intent.

HOUSE BILL 135

Short Title:	Modernize Physical Therapy Practice.	(Public)
Sponsors:	Representatives Dollar, B. Brown, Torbett, and S. Martin (Primary Sponsors). *For a complete list of Sponsors, refer to the North Carolina General Assembly Web Site.*	
Referred to:	Rules, Calendar, and Operations of the House.	

March 4, 2015

A BILL TO BE ENTITLED

AN ACT UPDATING THE DEFINITION OF PHYSICAL THERAPY TO INCLUDE MANIPULATION OF THE SPINE WITHOUT A PRESCRIPTION FROM A PHYSICIAN LICENSED TO PRACTICE MEDICINE IN THIS STATE.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 90-270.24(4) reads as rewritten:

"(4) "Physical therapy" means the evaluation or treatment of any person by the use of physical, chemical, or other properties of heat, light, water, electricity, sound, massage, or therapeutic exercise, or other rehabilitative procedures, with or without assistive devices, for the purposes of preventing, correcting, or alleviating a physical or mental disability. Physical therapy includes the performance of specialized tests of neuromuscular function, administration of specialized therapeutic procedures, interpretation and implementation of referrals from licensed medical doctors or dentists, and establishment and modification of physical therapy programs for patients. Evaluation and treatment of patients may involve physical measures, methods, or procedures as are found commensurate with physical therapy education and training and generally or specifically authorized by regulations of the Board. Physical therapy education and training shall include study of the skeletal manifestations of systemic disease. Physical therapy does not include the application of roentgen rays or radioactive materials, surgery, ~~manipulation of the spine unless prescribed by a physician licensed to practice medicine in North Carolina,~~ or medical diagnosis of disease."

SECTION 2. This act becomes effective October 1, 2015.

REP. DOLLAR.

Goldsboro Orthopedics

April 27, 2015

This letter is to fully support and endorse NC House Bill 135 as written to allow a licensed physical therapist to select appropriate patients for spinal manipulation and to independently perform that intervention in accordance with their professional training and knowledge in the state of North Carolina. My personal experience with physical therapists has been very positive and professional regarding the care of my patients.
This bill will allow a physical therapist to appropriately utilize his/her skill set without unnecessary oversight and lag time to provide their professional interventions.

Thank you for your consideration in my support for NC House Bill 135.

William deAraujo, MD
Past President of North Carolina Orthopaedic Association
Goldsboro Orthopedics
Wayne Health Physicians
2808 McLamb Place
Goldsboro, NC 27534

HOUSE BILL 925:
Require Hospitals to Offer Influenza Vaccine

2015-2016 General Assembly

Committee:	House Health	**Date:**	April 25, 2015
Introduced by:	Rep. Burr	**Prepared by:**	Theresa Matula
Analysis of:	PCS to First Edition H925-CSSH-37		Committee Staff

SUMMARY: ***House Bill 925 requires hospitals to offer inpatients 65 years of age or older immunization against the influenza virus.***

BILL ANALYSIS:

House Bill 925 adds a new section (G.S. 131E-79.10) to Chapter 131E, Article 5. Hospital Licensure Act. The new section requires that each year, from October 1 through March 1, prior to discharging a patient 65 years of age or older who has been admitted for inpatient care, the hospital must offer the patient immunization against the influenza virus if: (i) it has been determined that the patient has not already receive the immunization, (ii) contingent upon availability of the influenza vaccine, and (iii) unless the immunization is medically contraindicated. The offering of the influenza vaccine to inpatients aged 65 and older must be in accordance with the latest recommendations of the Advisory Committee on Immunizations Practices of the Centers for Disease Control and Prevention.

EFFECTIVE DATE: This bill would become effective when it becomes law.

O. Walker Reagan
Director

H925-SMSH-51 CSSH-37 -V1

Research Division
(919) 733-2578

This bill analysis was prepared by the nonpartisan legislative staff for the use of legislators in their deliberations and does not constitute an official statement of legislative intent.

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2015

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HOUSE BILL 925
PROPOSED COMMITTEE SUBSTITUTE H925-CSSH-37 [v.3]

4/24/2015 5:57:53 PM

Short Title: Require Hospitals to Offer Influenza Vaccine. (Public)

Sponsors:

Referred to:

April 20, 2015

A BILL TO BE ENTITLED

AN ACT AMENDING THE HOSPITAL LICENSURE ACT TO REQUIRE HOSPITALS TO OFFER INPATIENTS SIXTY-FIVE YEARS OF AGE OR OLDER IMMUNIZATION AGAINST THE INFLUENZA VIRUS.

The General Assembly of North Carolina enacts:

SECTION 1. Article 5 of Chapter 131E of the General Statutes is amended by adding a new section to read:

"**§ 131E-79.10. Offering influenza vaccine to inpatients aged 65 and older.**

Annually from October 1 through March 1, and in accordance with the latest recommendations of the Advisory Committee on Immunizations Practices of the Centers for Disease Control and Prevention, each hospital licensed under this Article shall, prior to discharging a patient 65 years of age or older who has been admitted for inpatient care, offer the patient immunization against the influenza virus if it has been determined that the patient has not already received the immunization, contingent upon availability of the influenza vaccine, and unless the immunization is medically contraindicated."

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

HOUSE BILL 925

Short Title:	Require Hospitals to Offer Influenza Vaccine.	(Public)
Sponsors:	Representative Burr (Primary Sponsor). *For a complete list of Sponsors, refer to the North Carolina General Assembly Web Site.*	
Referred to:	Appropriations.	

April 20, 2015

A BILL TO BE ENTITLED

AN ACT AMENDING THE HOSPITAL LICENSURE ACT TO REQUIRE HOSPITALS TO OFFER INPATIENTS SIXTY-FIVE YEARS OF AGE OR OLDER IMMUNIZATION AGAINST THE INFLUENZA VIRUS AND APPROPRIATING FUNDS FOR THE DEPARTMENT OF HEALTH AND HUMAN SERVICES, DIVISION OF HEALTH SERVICE REGULATION, TO DEVELOP A CAMPAIGN TO MAKE HOSPITALS AWARE OF THIS NEW REQUIREMENT.

The General Assembly of North Carolina enacts:

SECTION 1. Article 5 of Chapter 131E of the General Statutes is amended by adding a new section to read:

"**§ 131E-79.10. Offering influenza vaccine to inpatients aged 65 and older.**

Annually from October 1 through March 1, and in accordance with the latest recommendations of the Advisory Committee on Immunizations Practices of the Centers for Disease Control and Prevention, each hospital licensed under this Article shall, prior to discharging a patient 65 years of age or older who has been admitted for inpatient care, offer the patient immunization against the influenza virus, unless medically contraindicated and contingent upon availability of the influenza vaccine."

SECTION 2. There is appropriated from the General Fund to the Department of Health and Human Services, Division of Health Service Regulation, the sum of twenty-five thousand dollars ($25,000) for the 2015-2016 fiscal year to be used for the development of a campaign to ensure that all hospitals subject to the requirements of G.S. 131E-79.10, as enacted by Section 1 of this act, are aware of these requirements and understand what constitutes compliance with these requirements.

SECTION 3. This act becomes effective July 1, 2015.

HOUSE BILL 712:
Pilot Project/Used Needle Disposal

2015-2016 General Assembly

Committee:	House Health	**Date:**	April 24, 2015
Introduced by:	Reps. Faircloth, Horn, Avila, Harrison	**Prepared by:**	Theresa Matula Committee Staff
Analysis of:	PCS to First Edition H712-CSSH-34		

SUMMARY: House Bill 712 requires the State Bureau of Investigation to establish and implement a used needle and hypodermic syringe disposal pilot program and amends the law on charging a person for residual amounts of a controlled substance contained in a needle or sharp object if the person advised the officer of the needle or sharp object prior to the search.

The PCS amends the number of counties that can potentially participate in the program.

BILL ANALYSIS:

Section 1 of House Bill 712 requires the State Bureau of Investigation (SBI), in consultation and collaboration with the North Carolina Harm Reduction Coalition, to establish and implement a used needle and hypodermic syringe disposal pilot program by December 1, 2015.

Pilot Program: The pilot program must offer the free disposal of used needles and hypodermic syringes and include all of the following:

(1) Reasonable and adequate security of disposal sites and equipment.
(2) An accounting of the approximate number of used needles and hypodermic syringes returned and disposed of.
(3) Within each of the counties chosen pursuant to subsection (b) of this section, a general report of the availability of relevant educational materials; HIV and viral hepatitis counseling and testing; referral services to provide education regarding HIV, AIDS, and viral hepatitis transmission; and drug abuse prevention and treatment counseling and referral services.

Sites: The PCS changes the number of counties potentially participating in the pilot. Under the PCS, the SBI must select two counties in which to operate the pilot initially, but may select up to four counties total after successful demonstration of the pilot. The SBI must collaborate with the local health departments and local law enforcement agencies of the counties when implementing and operating the pilot program established under this section.

Limited Immunity: The bill provides that any person participating in the pilot program established under this section must not be charged with or prosecuted for possession of drug paraphernalia for any used needle or hypodermic syringe returned and disposed of, or for residual amounts of a controlled substance contained in the used needle or hypodermic syringe returned and disposed of. The limited immunity under Section 1(b) of the bill does not apply to the possession of needles or hypodermic syringes that are not a part of the pilot program.

Report: No later than one year after implementing the pilot program, the SBI is required to report the results of the pilot program to the chairs of the Joint Legislative Oversight Committee on Health and Human Services and the chairs of the Joint Legislative Oversight Committee on Justice and Public Safety. The PCS provides that if the SBI determines the initial pilot program in two counties is a

This bill analysis was prepared by the nonpartisan legislative staff for the use of legislators in their deliberations and does not constitute an official statement of legislative intent.

success, the report may include a recommendation to add two additional counties to the pilot program which would allow the extension of the pilot for an additional year and at the conclusion the SBI would report to the two Committees outlined above.

Expiration: The pilot program will expire upon the submission of the report.

Section 2 of the bill amends G.S. 90-113.22(c) to prohibit a person from being charged with or prosecuted for possession of residual amounts of a controlled substance contained in a needle or sharp object if the person alerts the officer to the needle or other sharp object prior to the search.

EFFECTIVE DATE: Section 2 of the bill becomes effective December 1, 2015, the remainder of the bill is effective when it becomes law.

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2015

H D

HOUSE BILL 712
PROPOSED COMMITTEE SUBSTITUTE H712-CSSH-34 [v.1]

4/23/2015 4:03:48 PM

Short Title: Pilot Project/Used Needle Disposal. (Public)

Sponsors:

Referred to:

April 15, 2015

A BILL TO BE ENTITLED

AN ACT TO DIRECT THE STATE BUREAU OF INVESTIGATION TO ESTABLISH AND IMPLEMENT A USED NEEDLE AND HYPODERMIC SYRINGE DISPOSAL PILOT PROGRAM.

The General Assembly of North Carolina enacts:

SECTION 1.(a) Pilot Program. – By no later than December 1, 2015, the State Bureau of Investigation, in consultation and collaboration with the North Carolina Harm Reduction Coalition, shall establish and implement a used needle and hypodermic syringe disposal pilot program. The pilot program shall offer the free disposal of used needles and hypodermic syringes to reduce the spread of HIV, AIDS, viral hepatitis, and other bloodborne diseases through needle stick injuries resulting from physical contact with improperly discarded used needles and hypodermic syringes. The pilot program shall include all of the following:

(1) Reasonable and adequate security of disposal sites and equipment.

(2) An accounting of the approximate number of used needles and hypodermic syringes returned and disposed of.

(3) Within each of the counties chosen pursuant to subsection (b) of this section, a general report of the availability of relevant educational materials; HIV and viral hepatitis counseling and testing; referral services to provide education regarding HIV, AIDS, and viral hepatitis transmission; and drug abuse prevention and treatment counseling and referral services.

SECTION 1.(b) Sites. – The State Bureau of Investigation shall select two counties in which to operate the pilot program initially, but may select up to four counties total in which to operate the pilot program after successful demonstration of the pilot in at least two counties. The State Bureau of Investigation shall collaborate with the local health departments and local law enforcement agencies of the counties when implementing and operating the pilot program established under this section.

SECTION 1.(c) Limited Immunity. – Any person participating in the pilot program established under this section shall not be charged with or prosecuted for possession of drug paraphernalia for any used needle or hypodermic syringe returned and disposed of, or for residual amounts of a controlled substance contained in the used needle or hypodermic syringe returned and disposed of. The limited immunity under this subsection does not apply to the possession of needles or hypodermic syringes that are not a part of the pilot program established under this section.

SECTION 1.(d) Report. – No later than one year after implementing the pilot program required by this section, the State Bureau of Investigation shall report the results of the pilot program to the chairs of the Joint Legislative Oversight Committee on Health and Human

Services and the chairs of the Joint Legislative Oversight Committee on Justice and Public Safety. If the State Bureau of Investigation deems the initial pilot program in two counties a success, the report may include a recommendation to continue the pilot in those counties for an additional year and may include a recommendation to add two additional counties to the pilot program, this would allow the extension of the pilot program for an additional year and at the conclusion of that second year, the State Bureau of Investigation shall provide another report to the Joint Legislative Oversight Committee on Health and Human Services and the Joint Legislative Oversight Committee on Justice and Public Safety.

SECTION 1.(e) Expiration. – The pilot program required by this section shall expire upon the submission of the report required by subsection (d) of this section.

SECTION 2. G.S. 90-113.22(c) reads as rewritten:

"(c) Prior to searching a person, a person's premises, or a person's vehicle, an officer may ask the person whether the person is in possession of a hypodermic needle or other sharp object that may cut or puncture the officer or whether such a hypodermic needle or other sharp object is on the premises or in the vehicle to be searched. If there is a hypodermic needle or other sharp object on the person, on the person's premises, or in the person's vehicle and the person alerts the officer of that fact prior to the search, the person shall not be charged with or prosecuted for possession of drug paraphernalia for the needle or sharp ~~object.~~object, or for residual amounts of a controlled substance contained in the needle or sharp object. The exemption under this subsection does not apply to any other drug paraphernalia that may be present and found during the search. For purposes of this subsection, the term "officer" includes "criminal justice officers" as defined in G.S. 17C-2(3) and a "justice officer" as defined in G.S. 17E-2(3)."

SECTION 3. Section 2 of this act becomes effective December 1, 2015. The remainder of this act is effective when it becomes law.

HOUSE BILL 712

Short Title:	Pilot Project/Used Needle Disposal.	(Public)
Sponsors:	Representatives Faircloth, Horn, Avila, and Harrison (Primary Sponsors). *For a complete list of Sponsors, refer to the North Carolina General Assembly Web Site.*	
Referred to:	Health.	

April 15, 2015

A BILL TO BE ENTITLED

AN ACT TO DIRECT THE STATE BUREAU OF INVESTIGATION TO ESTABLISH AND IMPLEMENT A USED NEEDLE AND HYPODERMIC SYRINGE DISPOSAL PILOT PROGRAM.

The General Assembly of North Carolina enacts:

SECTION 1.(a) Pilot Program. – By no later than December 1, 2015, the State Bureau of Investigation, in consultation and collaboration with the North Carolina Harm Reduction Coalition, shall establish and implement a used needle and hypodermic syringe disposal pilot program. The pilot program shall offer the free disposal of used needles and hypodermic syringes to reduce the spread of HIV, AIDS, viral hepatitis, and other bloodborne diseases through needle stick injuries resulting from physical contact with improperly discarded used needles and hypodermic syringes. The pilot program shall include all of the following:

(1) Reasonable and adequate security of disposal sites and equipment.

(2) An accounting of the approximate number of used needles and hypodermic syringes returned and disposed of.

(3) Within each of the counties chosen pursuant to subsection (b) of this section, a general report of the availability of relevant educational materials; HIV and viral hepatitis counseling and testing; referral services to provide education regarding HIV, AIDS, and viral hepatitis transmission; and drug abuse prevention and treatment counseling and referral services.

SECTION 1.(b) Sites. – The State Bureau of Investigation shall select two counties in which to operate the pilot program established under this section. The State Bureau of Investigation shall collaborate with the local health departments and local law enforcement agencies of the counties when implementing and operating the pilot program established under this section.

SECTION 1.(c) Limited Immunity. – Any person participating in the pilot program established under this section shall not be charged with or prosecuted for possession of drug paraphernalia for any used needle or hypodermic syringe returned and disposed of, or for residual amounts of a controlled substance contained in the used needle or hypodermic syringe returned and disposed of. The limited immunity under this subsection does not apply to the possession of needles or hypodermic syringes that are not a part of the pilot program established under this section.

SECTION 1.(d) Report. – No later than one year after implementing the pilot program required by this section, the State Bureau of Investigation shall report the results of the pilot program to the chairs of the Joint Legislative Oversight Committee on Health and Human

Services and the chairs of the Joint Legislative Oversight Committee on Justice and Public Safety. The report may include a recommendation to extend the pilot program for an additional fiscal year, if deemed advisable by the State Bureau of Investigation.

SECTION 1.(e) Expiration. – The pilot program required by this section shall expire upon the submission of the report required by subsection (d) of this section.

SECTION 2. G.S. 90-113.22(c) reads as rewritten:

"(c) Prior to searching a person, a person's premises, or a person's vehicle, an officer may ask the person whether the person is in possession of a hypodermic needle or other sharp object that may cut or puncture the officer or whether such a hypodermic needle or other sharp object is on the premises or in the vehicle to be searched. If there is a hypodermic needle or other sharp object on the person, on the person's premises, or in the person's vehicle and the person alerts the officer of that fact prior to the search, the person shall not be charged with or prosecuted for possession of drug paraphernalia for the needle or sharp ~~object.~~object, or for residual amounts of a controlled substance contained in the needle or sharp object. The exemption under this subsection does not apply to any other drug paraphernalia that may be present and found during the search. For purposes of this subsection, the term "officer" includes "criminal justice officers" as defined in G.S. 17C-2(3) and a "justice officer" as defined in G.S. 17E-2(3)."

SECTION 3. Section 2 of this act becomes effective December 1, 2015. The remainder of this act is effective when it becomes law.

HOUSE BILL 729:
Standards for Chiropractic Peer Review

2015-2016 General Assembly

Committee:	House Health	**Date:**	April 27, 2015
Introduced by:	Reps. Conrad, Bryan, Setzer	**Prepared by:**	Amy Jo Johnson Committee Counsel
Analysis of:	PCS to First Edition H729-CSTK-36		

SUMMARY: The PCS to House Bill 729 requires chiropractic peer review to be performed by certain individuals licensed to practice chiropractic in North Carolina. The PCS specifies that the requirements apply only to motor vehicle liability claims for personal jury and to motor vehicle medical payments claims.

BILL ANALYSIS:

The PCS to House Bill 729 would enact a new 90-153.1 that would require any individual, who is not a patient's treating chiropractor, who performs a retrospective review of the treatment records of a chiropractic patient for the purposes of advising third-party payer as to whether the services rendered were clinically necessary and supported by adequate documentation to meet specified qualifications. These new requirements apply only to motor vehicle liability claims for personal jury and to motor vehicle medical payments claims. The individual performing the review must meet the following criteria:

- Hold a current license to practice chiropractic in North Carolina.
- Has practiced chiropractic in North Carolina during the five-year period immediately preceding the review.
- Derive at least half of his or her professional income from providing care and treatment to chiropractic patients.
- Does not collect a fee based on the extent to which the third party payer reduces the treating chiropractor's bill.
- If reviewing the treatment records of a chiropractor who has been certified as a Diplomate in a specialty recognized by the State Board of Chiropractors, holds a diploma in the same specialty.

The PCS would also require that the chiropractor performing the review must disclose her or her identity and office address to the treating chiropractor whose bill or treatment is being reviewed. The reviewer must apply the standards of acceptable care in effect in North Carolina at the time the services were rendered when conducting the review.

Any licensed chiropractor who does not comply will be guilty of unethical conduct and subject to disciplinary action. Any individual who does not possess a North Carolina chiropractic license and who performs a review in violation of the requirements will be subject to prosecution and injunctive action as provided in G.S. 90-147. G.S. 90-147 states that practicing chiropractic without a license is a Class 1 misdemeanor.

This bill analysis was prepared by the nonpartisan legislative staff for the use of legislators in their deliberations and does not constitute an official statement of legislative intent.

EFFECTIVE DATE: This act becomes effective October 1, 2015, and applies to reviews conducted on or after that date.

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2015

H D

HOUSE BILL 729
PROPOSED COMMITTEE SUBSTITUTE H729-PCS10363-TK-36

Short Title: Standards for Chiropractic Peer Review. (Public)

Sponsors:

Referred to:

April 15, 2015

A BILL TO BE ENTITLED

AN ACT REQUIRING CHIROPRACTIC PEER REVIEW TO BE PERFORMED BY INDIVIDUALS LICENSED TO PRACTICE CHIROPRACTIC IN THIS STATE.

The General Assembly of North Carolina enacts:

SECTION 1. Article 8 of Chapter 90 of the General Statutes is amended by adding a new section to read:

"**§ 90-153.1. Chiropractic peer review.**

(a) Claims Subject to This Section. – This section shall apply only to motor vehicle liability claims for personal injury and to motor vehicle medical payments claims. This section shall not apply to workers' compensation claims, general accident and health insurance claims, or claims submitted by, or on behalf of, enrollees to health benefit plans.

(b) Definitions. – As used in this section, "chiropractic peer review" means the retrospective review of the treatment records of a chiropractic patient, performed by an individual who was not the patient's treating chiropractor, for the purpose of advising a third-party payer as to whether, in the reviewer's opinion, the services rendered by the treating chiropractor were clinically necessary and supported by adequate documentation.

(c) Qualifications of Reviewers. – Any individual who performs chiropractic peer review of a chiropractor licensed under this Article shall meet all of the following criteria:

(1) Holds a current license to practice chiropractic in this State.

(2) Has practiced chiropractic in this State during the five-year period immediately preceding the chiropractic peer review.

(3) Derives at least half of his or her professional income from providing care and treatment to chiropractic patients.

(4) If reviewing the treatment records of a chiropractor who has been certified as a Diplomate in a specialty recognized by the State Board of Chiropractic Examiners, holds a diploma in the same specialty.

(5) Does not collect a fee based on the extent to which the third-party payer reduces the treating chiropractor's bill.

(d) Standard of Care. – When performing a peer review, the reviewer shall apply the standards of acceptable care in effect in this State at the time services were rendered.

(e) Disclosure of Identity. – Any person performing a peer review shall disclose his or her identity and office address to the treating chiropractor.

(f) Enforcement. – Any chiropractor licensed under this Article by the Board of Chiropractic Examiners who fails to comply with this section shall be guilty of unethical conduct and shall be subject to disciplinary action under G.S. 90-154(b)(4). Any individual

who performs chiropractic peer review without possessing a license as provided in this Article shall be subject to prosecution and injunctive action as provided in G.S. 90-147."

SECTION 2. This act becomes effective October 1, 2015, and applies to reviews conducted on or after that date.

HOUSE BILL 729

Short Title:	Standards for Chiropractic Peer Review.	(Public)
Sponsors:	Representatives Conrad, Bryan, and Setzer (Primary Sponsors). *For a complete list of Sponsors, refer to the North Carolina General Assembly Web Site.*	
Referred to:	Health.	

April 15, 2015

A BILL TO BE ENTITLED

AN ACT REQUIRING CHIROPRACTIC PEER REVIEW TO BE PERFORMED BY INDIVIDUALS LICENSED TO PRACTICE CHIROPRACTIC IN THIS STATE.

The General Assembly of North Carolina enacts:

SECTION 1. Article 8 of Chapter 90 of the General Statutes is amended by adding a new section to read:

"**§ 90-153.1. Chiropractic peer review.**

(a) Definitions. – As used in this section, "chiropractic peer review" means the retrospective review of the treatment and billing records of a chiropractic patient, performed by an individual who was not the patient's treating chiropractor, for the purpose of advising a third-party payor as to whether, in the reviewer's opinion, the services rendered by the treating chiropractor were clinically necessary, whether the charges billed by the treating chiropractor were reasonable, or both.

(b) Qualifications of Reviewers. – Any individual who performs chiropractic peer review of a chiropractor licensed under this Article shall meet all of the following criteria:

(1) Holds a current license to practice chiropractic in this State.

(2) Has practiced chiropractic in this State during the five-year period immediately preceding the chiropractic peer review.

(3) Derives at least half of his or her professional income from providing care and treatment to chiropractic patients.

(4) If reviewing the treatment and billing records of a chiropractor who has been certified as a Diplomate in a specialty recognized by the State Board of Chiropractic Examiners, holds a diploma in the same specialty.

(5) Does not collect a fee based on the extent to which the individual recommends a reduction of the treating chiropractor's bill.

(c) Standard of Care. – When performing a peer review, the reviewer shall apply the standards of acceptable care in effect in this State at the time services were rendered.

(d) Disclosure of Identity. – Any person performing a peer review shall disclose his or her identity and office address to the treating chiropractor.

(e) Enforcement. – Any chiropractor licensed under this Article by the Board of Chiropractic Examiners who fails to comply with this section shall be guilty of unethical conduct and shall be subject to disciplinary action under G.S. 90-154(b)(4). Any individual who performs chiropractic peer review without possessing a license as provided in this Article shall be subject to prosecution and injunctive action as provided in G.S. 90-147."

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

NORTH CAROLINA GENERAL ASSEMBLY
AMENDMENT
House Bill 729

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

H729-ATK-23 [v.1]

Amends Title [YES]
First Edition

Date _____,2015

Representative Hager

moves to amend the bill on page 1, line 2 by rewriting the line to read:

"AN ACT REQUIRING CHIROPRACTIC PEER REVIEW OF MOTOR VEHICLE LIABILITY AND MEDICAL PAYMENT CLAIMS TO BE PERFORMED BY";

and to further amend the bill on page 1, line 16, by adding the following to the end of that line:

"Chiropractic peer review shall not include automated screening programs.";

and to further amend the bill on page 1, lines 31-32, by removing the lines;

and to reletter the remaining subsections.

SIGNED _____
Amendment Sponsor

SIGNED _____
Committee Chair if Senate Committee Amendment

ADOPTED _____ FAILED _____ TABLED _____

NORTH CAROLINA GENERAL ASSEMBLY
HOUSE OF REPRESENTATIVES

HEALTH COMMITTEE REPORT

Representative Brian Brown, Co-Chair
Representative Justin P. Burr, Co-Chair
Representative Bert Jones, Co-Chair
Representative Donny Lambeth, Co-Chair

FAVORABLE

HB **135** Modernize Physical Therapy Practice.

Draft Number:	None
Serial Referral:	None
Recommended Referral:	None
Long Title Amended:	No
Floor Manager:	Dollar

HB **724** Amend Composition of NC Medical Board.

Draft Number:	None
Serial Referral:	None
Recommended Referral:	None
Long Title Amended:	No
Floor Manager:	Lambeth

HB **823** Establish Advisory Council on Rare Diseases.

Draft Number:	None
Serial Referral:	None
Recommended Referral:	None
Long Title Amended:	No
Floor Manager:	Carney

FAVORABLE AND RE-REFERRED

HB **309** Got Natural Milk.

Draft Number:	None
Serial Referral:	**AGRICULTURE**
Recommended Referral:	None
Long Title Amended:	No
Floor Manager:	Riddell

HB **768** Heat Stroke Prevention/Student Athletes.

Draft Number:	None
Serial Referral:	**EDUCATION - K-12**
Recommended Referral:	None
Long Title Amended:	No
Floor Manager:	Richardson

FAVORABLE COM SUB , UNFAVORABLE ORIGINAL BILL

HB **712** Pilot Project/Used Needle Disposal.

Draft Number:	H712-PCS30354-SH-34
Serial Referral:	None
Recommended Referral:	None
Long Title Amended:	No
Floor Manager:	Faircloth

HB **814** The William C. Lindley, Jr. SUDEP Law.

Draft Number:	H814-PCS30357-TK-37
Serial Referral:	None
Recommended Referral:	None
Long Title Amended:	Yes
Floor Manager:	Riddell

HB **925** Require Hospitals to Offer Influenza Vaccine.

Draft Number:	H925-PCS30356-SH-37
Serial Referral:	None
Recommended Referral:	None
Long Title Amended:	Yes
Floor Manager:	Burr

FAVORABLE COM SUB , UNFAVORABLE ORIGINAL BILL AND RE-REFERRED

HB **20** Reegans Rule/Childhood Diabetes Screening.

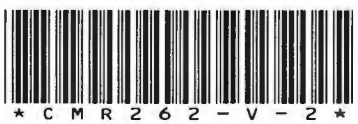
Draft Number:	H20-PCS20338-TK-43
Serial Referral:	**APPROPRIATIONS**
Recommended Referral:	None
Long Title Amended:	Yes
Floor Manager:	C. Graham

HB **832** Revise Certain Policies/Child Care Subsidy.

Draft Number:	H832-PCS20336-TV-14
Serial Referral:	**FINANCE**
Recommended Referral:	**APPROPRIATIONS**
Long Title Amended:	No
Floor Manager:	Dobson

HB **847** Amend Laws Re: Medical Treatment for Minors.

Draft Number:	H847-PCS10365-RU-4
Serial Referral:	**JUDICIARY II**
Recommended Referral:	None
Long Title Amended:	Yes
Floor Manager:	Jordan



FAVORABLE COM SUB NO. 2, UNFAVORABLE COM SUB NO. 1

HB **290** **(CS#1)** Prohibit Powdered Alcohol.

Draft Number:	H290-PCS30355-SH-35
Serial Referral:	None
Recommended Referral:	None
Long Title Amended:	No
Floor Manager:	Willingham

TOTAL REPORTED: 12

NORTH CAROLINA GENERAL ASSEMBLY
HOUSE OF REPRESENTATIVES

HEALTH COMMITTEE REPORT
Representative Brian Brown, Co-Chair
Representative Justin P. Burr, Co-Chair
Representative Bert Jones, Co-Chair
Representative Donny Lambeth, Co-Chair

FAVORABLE COM SUB , UNFAVORABLE ORIGINAL BILL

HB **729** Standards for Chiropractic Peer Review.

Draft Number:	H729-PCS10363-TK-36
Serial Referral:	None
Recommended Referral:	None
Long Title Amended:	Yes
Floor Manager:	Conrad

TOTAL REPORTED: 1

CMR270-V-1

Committee Sergeants at Arms

NAME OF COMMITTEE House Comm. on Health

DATE: 04/27/15 Room: 643

House Sgt-At Arms:

1. Name: Young Bae
2. Name: Bill Morris
3. Name: Jim Moran
4. Name: _____
5. Name: _____

Senate Sgt-At Arms:

1. Name: _____
2. Name: _____
3. Name: _____
4. Name: _____
5. Name: _____

VISITOR REGISTRATION SHEET

House Comm. on Health — 04/27/15

Name of Committee — Date

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Brenda Brown	Parental Rights.Org 7225 Cedarbrook Dr charlotte NC
Tommy Scott	MVA
Carmen Ledford	NCCHE
Jennifer Mahan	ASNC
Tony Adams	adams and assoc.
Benjamin Brown	
Ashton Brown	Charlotte NC
David Blackmon	NC Board of Nursing
[illegible]	[illegible]
[illegible]	EH 01
Michael Delafield	UNC

VISITOR REGISTRATION SHEET

House Comm. on Health 04/27/15

Name of Committee Date

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Brad Woodson	NLSSM/UNL
Jonathan Koppler	UNL-GA
Sharon Desmond	BREN Alliance Raleigh NC
Harry Lyda	NLC
Joe Reardon	NCDAECS
Cady Thomas	Food Carolina
Jane Fogarty	NCFPC
Adam Sholar	DHHS

VISITOR REGISTRATION SHEET

House Comm. on Health — 04/27/15

Name of Committee — Date

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
[illegible]	UCB
Chris McClellan	BSB
Amanda Honaker	TSS
Mary Ellen Arnett	Kinetic Institute P.T
Erica Nelson	NCHA
Allison Stewart	Cardinal Innovations
Kim Illes	NCDA
Charla Bunch	NCBON
Jamie Morris	LALC
TJ Burkee	NP
[illegible]	[illegible]

VISITOR REGISTRATION SHEET

House Comm. on Health 04/27/15

Name of Committee Date

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Angel Sams	WCSR
Joe SRAGUSA	NCCA
Laura DeVivo	WCSR
Laurie Payne	NC GRANGE
Jeff Barnhart	MWC
Chester Lowder	NC Farm Bureau
Melanie Robins	NC Dairy Producers Assoc.
Andy Chase	KMA
Joanna Spruill	NCAFP
Rob Lamm	PLT
Rochelle Sparks	CFSA

VISITOR REGISTRATION SHEET

House Comm. on Health — 04/27/15

Name of Committee — Date

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Jennifer Gasperini	NCMS
Lynette Jones	NCALHD
Greg Dedrick	
Jon Carr	Jordan Price Law Firm
JAKE PARKER	NCFB
PAUL SHERMAN	NCFB
CSHolls	CSH
Ken Melton	K. M.A
Steve Monge	NCRLA
Michelle Frazier	MF+S
Peyton Maynard	
Peyton Maynard	

VISITOR REGISTRATION SHEET

House Comm. on Health — 04/27/15

Name of Committee — Date

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NAME	FIRM OR AGENCY AND ADDRESS
Polly Riddle	MBA
John Adcox	UP
Ellen	NCRMA
Hugh Johnson	NCACC
Wm H Potter, Jr.	NC Physical Therapy Assn
David Edwards PTDPT	NC Physical Therapy Assoc.
Alo Moses, PT	NC Physical Therapy Assoc.
Jenny Schill	NC Fisheries Assoc.
Liz Reeser	NC Physical Therapy Assoc.
Mike Schmidt	Duke University Physical Therapy
Rita Chorba	US Marine Corps Forces Special Operations Comm
Richard M. Guthrie	US Marine Corps Forces Special Operations Comm

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House Comm. on Health — 04/27/15

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NAME	FIRM OR AGENCY AND ADDRESS
Brendan Malay	NCPT Association
Robert Hamilton	NC ABC Commission
Agnes Stevens	NC ABC Commission
Max Todoroff PT	NCPT Association
Daryl Lawson, PT	NCPTA / Elon University
Deb Stotts PT	NCPT Association
Allan Buccola	NCPTA
Melissa Reed	PP
Debby Givens, PT	NCPTA
Mike McMorris PT	NCPTA
Alicia Kinsey, PT	NCPTA
Michael Essa, PT	NCPTA

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House Comm. on Health — 04/27/15

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VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
J Peters	CSS
[illegible]	CSS
Patrick McCarthy	Lifeforce PT - Wilmington NC
Liz Henry	Lifeforce PT Wilmington, NC.
Summer Price	Lifeforce PT Wilmington, NC
John Hannah	U.S. Army, retired
Sharon Johnson	Patriot PT Raleigh NC
Jessie Mathers	Duke University Health System
Karl Kosobucki	
James Thorp	ECU
Scott Gibson	Goldsboro Orthoped.. Physical Therapy

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NAME	FIRM OR AGENCY AND ADDRESS
Cary J. Morin	Campbell University DPT Program Buies Creek NC 2750
Lawrie Beardsley PT	Moses Cone Health System
Haley Harrell	Duke University Doctor of Physical Therapy
Amy McMillion	Elon University 762 E. Haggard, Elon, NC
Gabby Pulliam	Elon University 762 E. Haggard, Elon, NC
Ruth Ann Foster	
Dick Carlton	Law Office, KHC
Lee Easley	Campbell University, DPT 123 main St Buies Creek, NC 27506
Daniel Stoot	Campbell University SPT, Buies Creek NC, 27506
Michael Mize	Campbell University DPT Buies Creek NC 27506
Brett A Windsor	Campbell University
Michael Edwards	Campbell University

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NAME	FIRM OR AGENCY AND ADDRESS
Daniel Steele	UNC-DPT, Chapel Hill, NC
Cristina Raiti	UNC, Chapel Hill – DPT
Melody Tran	UNC-DPT, Chapel Hill
Reid Medlin	UNC DPT, Chapell Hill, NC
Sarah van der Horst	UNC - DPT, Chapel Hill, NC
Amy Gwynn	UNC-DPT student, Chapel Hill, NC
Jeff Tippett	TARGETED PERSUASION 206 NSW RSW PL
Burt Jenkins	NCDPI
Mindi McLaurin	NC Physical Therapy Assn
Benf Massey, Jr.	N.C Board of PT Examiners

VISITOR REGISTRATION SHEET

House Comm. on Health 04/27/15

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VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Fred Bone	Bone & Assoc.
Amanda Friedline Weber	UNC-CH DPT
Chris Green	UNC-CH DPT
Anthony Pastore	UNC-CH DPT
Elizabeth Huber	UNC-CH DPT
Brian Mewald	WM
Don Jarboe	Port City Physical Therapy
Todd Koos	Physical Therapy Center
Khiem Bui	UNC-CH DPT
Debbie Regan	NCPTA
Mary Kay Hannah	Physical therapist

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House Comm. on Health — 04/27/15

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NAME	FIRM OR AGENCY AND ADDRESS
Megan Standish	PT Supporter
Gail Young	APPCNC
Kay Phillips	APPCNC
Steve Ketterbaugh	sanofi pasteur
Sarah Wolfe	MMC
Cathie Feild	NC Academy of PAs
Audrey Pilkington	NC Dept of Agriculture
Joy Hicks	NCDA&CS
Matt Gross	NCPC
Annaliese Dolph	DL
Rev. Mark Creech	CAL
John Bode	BH

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House Comm. on Health 04/27/15

Name of Committee Date

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NAME	FIRM OR AGENCY AND ADDRESS
Mark Ezzell	APNC
Jonathan Bowbaker	Bowbaker + Assoc.
Hayden Burgess	FSP
J.W. Joyner	New Frame LLC
[illegible]	DHHS
Trent Womble	DHHS
Larry Michael	DHHS
CARL WILLIAMS	DHHS
[illegible]	[illegible]
Ben Popkin	DOI
VANCE KINLAW	NC BCE

Speakers

VISITOR REGISTRATION SHEET

House Health — April 27, 2015

Name of Committee — **Date**

(Print)

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS	Which bill?
Dr Mary Kay Hannah	Physical Therapy	135 1
CPT (RET) Megan Standish	PT patient / Iraq casualty	135 2
Dr Debby Givens	UNC DPT Director	135 3
Dr Greg Dedrick	Campbell Univ DPT Director	135 4
Dr Mike Schmidt	Duke Ortho residency	135 5
Mr Karl Kosobucki	PT patient	135 6
Dr David Edwards	NC PTA President	135 8
Dr Joe Siragusa	NCCA	135 7
Ruth ann Foster		309
Ruth Ann Foste		796
~~Joe Reardon~~	~~NCDAECS~~	~~309~~
~~CARL WILLIAMS~~	~~NC DHHS~~	~~309~~

Speakers

VISITOR REGISTRATION SHEET

House Health — April 27, 2015

Name of Committee — **Date**

(Print)

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS	Which bill?
~~Darice Oxendine~~	PO Box 1298 Pembroke NC, 28372	20
Brenda Brown	725 Cedarbrook Dr Charlotte NC 28215 ParentalRights.Org	847
~~Jesse Castillo~~	904 Broad St ~~Durham~~	~~712~~
~~Captain Lars Paul~~	461 Hay St. Fayetteville	~~712~~

Speakers

VISITOR REGISTRATION SHEET

House Health — April 27, 2015

Name of Committee — **Date**

(Print)

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS	Which bill?
Sharon Drennan	BRBN Alliance	823

Speakers

VISITOR REGISTRATION SHEET

House Health — April 27, 2015

Name of Committee — **Date**

(Print)

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS	Which bill?
✓ Malarie Robins	North Carolina Dairy Producers Assoc	H 309

NORTH CAROLINA HOUSE OF REPRESENTATIVES
COMMITTEE MEETING NOTICE
AND
BILL SPONSOR NOTIFICATION
2015-2016 SESSION

You are hereby notified that the **House Committee on Health** will meet as follows:

DAY & DATE: Wednesday, April 29, 2015
TIME: **10:00 AM**
LOCATION: **643 LOB**
COMMENTS: **Representative Brian Brown will preside.**

The following bills will be considered:

BILL NO.	SHORT TITLE	SPONSOR
HB 796	Modernize Dietetics/Nutrition Practice Act.	Representative B. Brown

Respectfully,

Representative Brian Brown, Co-Chair
Representative Justin P. Burr, Co-Chair
Representative Bert Jones, Co-Chair
Representative Donny Lambeth, Co-Chair

I hereby certify this notice was filed by the committee assistant at the following offices at 9:49 AM on Tuesday, April 28, 2015.

___ Principal Clerk
___ Reading Clerk – House Chamber

Brenda Olls (Committee Assistant)

House Committee on Health
Wednesday, April 29, 2015, 10:00 AM
643 Legislative Office Building

AGENDA

Welcome and Opening Remarks

Introduction of Pages

Bills

BILL NO.	SHORT TITLE	SPONSOR
HB 796	Modernize Dietetics/Nutrition Practice Act.	Representative B. Brown

Adjournment

House Committee on Health
Wednesday, April 29, 2015 at 10:00 AM
Room 643 of the Legislative Office Building

MINUTES

The House Committee on Health met at 10:00 AM on April 29, 2015 in Room 643 of the Legislative Office Building. Representatives Avila, Brawley, R. Brown, B. Brown, Carney, Cotham, Dobson, Dollar, Farmer-Butterfield, Ford, Goodman, Hastings, Insko, Jones, Lambeth, S. Martin, Pendleton, Szoka, Waddell, Wray, and Yarborough attended.

Representative Bert Jones, Chair, presided.

The following bills were considered:

HB 796 Modernize Dietetics/Nutrition Practice Act. (Representative B. Brown)

There is a PCS for HB796; Representative Jones motioned to accept the PCS, without objection the motion passes. Representative Brown was recognized to explain the bill.

Representative Brown: This bill makes amendments to the dietician nutritionist practice act which regulates dieticians and nutritionists; it adds a new licensing path for nutritionists while keeping the old path for dieticians and nutritionists. It sets out new board membership requirements and outlines new education requirements for the new licensure and what those with the license can and cannot do.

Representative Jones asks the audience for public speakers, one in opposition and one in favor of the bill.

Ruth Ann Foster: I am opposed to this bill as I am a former nurse. I do not have my license right now and I am working on my doctorate in holistic nutrition, not dietetics. I found that I could not work as a dietician in NC and I do not want to get licensed. This board that licenses these dieticians is not necessary. The language of this bill stops me from working with members of my family who are ill in my own capacity."

Robin Smith Brown: "I am with the NC dietetic association. Dieticians can be the primary care provider in the hospital setting. These medical procedures are high risk areas of medical care and therefore it is essential that these individuals have licensure."

Rep. Waddell moves to make a favorable report for the house committee substitute unfavorable to the original. The motion passes.

The meeting adjourned at 10:40

Bert Jones

Representative Bert Jones, Chair
Presiding

Theresa Lopez

Theresa Lopez, Committee Clerk

HOUSE BILL 796:
Modernize Dietetics/Nutrition Practice Act

2015-2016 General Assembly

Committee:	House Health	**Date:**	April 28, 2015
Introduced by:	Rep. B. Brown	**Prepared by:**	Amy Jo Johnson
Analysis of:	PCS to First Edition H796-CSTK-47		Committee Counsel

SUMMARY: ***The PCS to House Bill 796 makes amendments to the Dietetics/Nutrition Practice Act which regulates licensed dietitian/nutritionists. The PCS adds a new licensure for nutritionists, sets out new Board membership requirements, new education requirements for licensure and makes conforming changes.***

BILL ANALYSIS:

Article 25 of Chapter 90 of the General Statues is the Dietetics/Nutrition Practice Act. The PCS to House Bill 796 would make a variety of changes to update terms used under this Act. The PCS to House Bill 796 would create two pathways to licensure under Article 25 by retaining the current licensure for dietitian/nutritionists and adding licensure for nutritionists.

Section 3 of the bill changes the Board membership, effective July 1, 2015. The Board would then consist of the following seven members:

- Three members would be licensed dietitians/nutritionists.
- Two members would be licensed nutritionists.
- One member would be a licensed physician licensed.
- One member would represent the public at large.

Appointments are made by the appointing authority outlined in **Section 4** of the bill. **Section 5** of the bill directs that no rulemaking may take place until the two licensed nutritionists are appointed to the Board.

Section 7 of the bill outlines the licensing requirements for both a licensed dietitian/nutritionist and a licensed nutritionist. The bill specifies that all persons licensed, or who have submitted an application for licensure, as a dietitian/nutritionist prior to July 1, 2015, would remain licensed, eligible for reactivation, or eligible for licensure under the requirements in place at the time of licensure or application, so long as the applicant or licensee remains in good standing and maintains an active or inactive license.

The PCS to House Bill 796 would allow for the use of the titles Registered Dietitian, Certified Nutrition Specialist, and Diplomate, American Clinical Board of Nutrition when an individual obtains registration or certification with these national organizations.

House Bill 796 adds additional persons and practices not affected by Article 25 to include individuals providing nutrition services without remuneration to family members and individuals proving nutrition information, guidance, encouragement, recommendations, or weight control services who do not hold themselves out as licensed by Article 25 and who do not provide medical nutrition therapy.

O. Walker Reagan
Director

H796-SMTK-71 CSTK-47 -V2

Research Division
(919) 733-2578

This bill analysis was prepared by the nonpartisan legislative staff for the use of legislators in their deliberations and does not constitute an official statement of legislative intent.

The PCS also adds a new section to Article 25 dealing with the ordering of therapeutic diets. Under the PCS to House Bill 528, enteral and parenteral nutrition therapy would consist of enteral feedings or specialized intravenous solutions and can only be ordered by an individual licensed under Article 25 who meets one of the following criteria:

- The individual is a Registered Dietitian Nutritionist registered with the Commission on Dietetic Registration.
- The individual is a Certified Nutrition Support Clinician certified by the National Board of Nutrition Support Certification.
- The individual meets the requirements set forth in the rules of the Board.

The PCS to House Bill 528 would specify that nothing in Article 25 shall be construed to limit the ability of any other licensed health care provider in this State to order therapeutic diets, so long as the ordering of therapeutic diets falls within the scope of the license held by the health care provider.

EFFECTIVE DATE: Section 12 becomes effective October 1, 2015, and applies to acts committed on or after that date. The remainder of this act becomes effective July 1, 2015.

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2015

H D

HOUSE BILL 796
PROPOSED COMMITTEE SUBSTITUTE H796-CSTK-47 [v.1]

Short Title: Modernize Dietetics/Nutrition Practice Act. (Public)

Sponsors:

Referred to:

April 15, 2015

A BILL TO BE ENTITLED

AN ACT EXPANDING THE ABILITY OF QUALIFIED NUTRITION PROFESSIONALS TO PRACTICE IN THIS STATE AND TO AMEND THE DIETETICS/NUTRITION PRACTICE ACT.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 90-351 reads as rewritten:

"**§ 90-351. Purpose.**

It is the purpose of this Article to safeguard the public health, safety and welfare and to protect the public from being harmed by unqualified persons by providing for the licensure and regulation of persons engaged in the practice of ~~dietetics/nutrition~~dietetics or nutrition and by the establishment of educational standards for those persons."

SECTION 2. G.S. 90-352 reads as rewritten:

"**§ 90-352. Definitions.**

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

(1) ACEND. – The Accreditation Council for Education in Nutrition and Dietetics, which is the Academy of Nutrition and Dietetics' accrediting agency for education programs preparing students for careers as Registered Dietitian Nutritionists or Dietetic Technicians, Registered.

(1a) ~~"Board" means the~~ Board. – The North Carolina Board of Dietetics/Nutrition.

(1b) Certified Nutrition Specialist. – An individual certified by the Board for Certification of Nutrition Specialists.

(2) ~~"Dietetics/nutrition" means the~~ Dietetics. – The integration and application of principles derived from the science of nutrition, biochemistry, physiology, food, and management and from behavioral and social sciences to achieve and maintain a healthy status. The primary function of ~~dietetic/nutrition~~dietetics ~~practice~~ is the provision of ~~nutrition care services.~~medical nutrition therapy.

(2a) Diplomate of the American Clinical Board of Nutrition. – An individual certified by the American Clinical Board of Nutrition.

(3) ~~"Licensed dietitian/nutritionist" means an~~ Licensed dietitian/nutritionist or licensed nutritionist. – An individual licensed in good standing to practice ~~dietetics/nutrition.~~dietetics, nutrition, or both.

(3a) Medical nutrition therapy. – The provision of nutrition care services for the purpose of managing or treating a medical condition.

(3b) Nutrition. – The integration and application of principles derived from the science of nutrition, biochemistry, metabolism, and pathophysiology to achieve and maintain a healthy status. The primary function of nutrition practice is the provision of medical nutrition therapy.

(4) ~~"Nutrition care services" means any,~~ Nutrition care services. – Any part or all of the following:

a. Assessing and evaluating the nutritional needs of individuals and groups, and determining resources and constraints in the practice setting.

b. Establishing priorities, goals, and objectives that meet nutritional needs and are consistent with available resources and constraints.

c. Providing nutrition counseling in health and disease.

d. Developing, implementing, and managing nutrition care ~~systems.~~systems, and ordering therapeutic diets.

e. Evaluating, making changes in, and maintaining appropriate standards of quality in food and nutrition services.

~~"Nutrition care services"~~ The term does not include the retail sale of food products or vitamins.

(5) Registered Dietitian Nutritionist. – An individual registered with the Commission on Dietetic Registration, the credentialing agency of the Academy of Nutrition and Dietetics.

(6) Telepractice. – The delivery of services under this Article by means other than in-person, including, but not limited to, telephone, email, Internet, or other methods of electronic communication. Telepractice is not prohibited under this Article provided that the provision of the telepractice services is appropriate for the client and the level of care provided meets the required level of care for that client. Individuals providing services regulated by this Article via telepractice shall comply with, and shall be subject to, all licensing and disciplinary provisions of the Article."

SECTION 3. G.S. 90-353 reads as rewritten:

"**§ 90-353. Creation of Board.**

(a) The North Carolina Board of Dietetics/Nutrition is created. ~~The Board shall consist of seven members as follows:~~

~~(1) One member shall be a professional whose primary practice is clinical dietetics/nutrition;~~

~~(2) One member shall be a professional whose primary practice is community or public health dietetics/nutrition;~~

~~(3) One member shall be a professional whose primary practice is consulting in dietetics/nutrition;~~

~~(4) One member shall be a professional whose primary practice is in management of nutritional services;~~

~~(5) One member shall be an educator on the faculty of a college or university specializing in the field of dietetics/nutrition;~~

~~(6) Two members shall represent the public at large.~~

(a1) The Board shall consist of the following seven members:

(1) Three members shall be dietitians/nutritionists licensed under this Article.

(2) Two members shall be nutritionists licensed under this Article.

(3) One member shall be a physician licensed under Article 1 of Chapter 90 of the General Statutes.

(4) One member shall not be licensed under this Article and who shall represent the public at large.

(b) ~~Professional~~ Licensed dietitian/nutritionist or licensed nutritionist members of the Board ~~shall:~~meet all of the following criteria:

(1) Be citizens of the United States and residents of this ~~State;~~State.

(2) Have practiced in the field of ~~dietetics/nutrition~~dietetics or nutrition for at least ~~five years; and~~three years.

(3) Be licensed under this ~~Article, except that initial appointees shall be licensed under this Article no later than March 31, 1992.~~Article. The first appointed licensed nutritionists need not be licensed under this Article nor have practiced for three years for appointment to their first terms on the Board, but must possess the qualifications necessary for licensure under this Article and shall apply for licensure within six months of its availability.

(b1) The licensed physician member of the Board shall be a citizen of the United States and a resident of this State.

(c) The members of the Board appointed from the public at large shall be citizens of the United States and residents of this State and shall not be any of the following:

(1) A ~~dietician/nutritionist.~~dietitian/nutritionist or nutritionist.

(2) An agent or employee of a person engaged in the profession of ~~dietetics/nutrition.~~dietetics or nutrition.

(3) A licensed health care professional or enrolled in a program to become prepared to be a licensed health care professional.

(4) An agent or employee of a health care institution, a health care insurer, or a health care professional school.

(5) A member of any allied health profession or enrolled in a program to become prepared to be a member of an allied health profession.

(6) The spouse of an individual ~~who may not~~ not eligible to serve as a public member of the Board."

SECTION 4. G.S. 90-354 reads as rewritten:

"**§ 90-354. Appointments and removal of Board members, terms and compensation.**

(a) The members of the Board shall be appointed as follows:

(1) The Governor shall appoint ~~the professional member~~ the following members:

a. One licensed dietitian/nutritionist as described in ~~G.S. 90-353(a)(5) and the two~~ G.S. 90-353(a1)(1), who shall be an educator on the faculty of a college or university accredited at the time from the appropriate regional accrediting agency recognized by the Council on Higher Education Accreditation and the United States Department of Education, specializing in the field of dietetics or nutrition.

b. The licensed physician as described in G.S. 90-353(a1)(3).

c. The public ~~members~~ member described in ~~G.S. 90-353(a)(6);~~G.S. 90-353(a1)(4).

(2) The General Assembly upon the recommendation of the Speaker of the House of Representatives shall appoint ~~the professional members~~ one licensed dietitian/nutritionist as described in ~~G.S. 90-353(a)(1)~~ G.S. 90-353(a1)(1) and ~~G.S. 90-353(a)(2)~~ one licensed nutritionist as described in G.S. 90-353(a1)(2) in accordance with ~~G.S. 120-121, one~~ G.S. 120-121. One of ~~whom~~ these appointees shall be a dietitian/nutritionist or a nutritionist ~~with a masters or higher degree in a nutrition-related discipline; and~~whose primary practice is clinical dietetics or nutrition in a hospital or long-term care institution regulated under Article 5 or Part 1 of Article 6 of Chapter 131E of the General Statutes.

(3) The General Assembly upon the recommendation of the President Pro Tempore of the Senate shall appoint ~~the professional members~~ one licensed dietitian/nutritionist as described in ~~G.S. 90-353(a)(3)~~ G.S. 90-353(a1)(1) and ~~G.S. 90-353(a)(4)~~ one licensed nutritionist as described in G.S. 90-353(a1)(2) in accordance with ~~G.S. 120-121, one of whom~~ G.S. 120-121. One of these appointees shall be a dietitian/nutritionist or a nutritionist ~~with a masters or higher degree in a nutrition-related discipline.~~whose primary practice is consulting or private practice in dietetics or nutrition.

(b) Members of the Board shall take office on the first day of July immediately following the expired term of that office and shall serve for a term of three years and until their successors are appointed and qualified. Members of the Board appointed prior to July 1, 2015, shall continue to serve until their terms expire, and they are not reappointed, so long as, beginning July 1, 2015, as two members on the Board are licensed nutritionists as described in G.S. 90-357(c).

(c) No member shall serve on the Board for more than two consecutive terms.

(d) The Governor may remove members of the Board, after notice and opportunity for hearing, for:

(1) Incompetence;
(2) Neglect of duty;
(3) Unprofessional conduct;
(4) Conviction of any felony;
(5) Failure to meet the qualifications of this Article; or
(6) Committing any act prohibited by this Article.

(e) Any vacancy shall be filled by the appointing authority originally filling that position, except that any vacancy in appointments by the General Assembly shall be filled in accordance with G.S. 120-122.

(f) Members of the Board shall receive no compensation for their services, but shall be entitled to travel, per diem, and other expenses authorized by G.S. 93B-5."

SECTION 5. G.S. 90-356 reads as rewritten:

"**§ 90-356. Power and responsibility of Board.**

The Board shall:

(1) Determine the qualifications and fitness of applicants for licenses, renewal of licenses, and reciprocal ~~licenses;~~licenses.
(2) Adopt rules necessary to conduct its business, carry out its duties, and administer this Article; provided however that, as of July 1, 2015, no rule making shall be performed by the Board until two licensed nutritionists have been appointed to the Board.
(3) Adopt and publish a code of ~~ethics;~~ethics.
(4) Deny, issue, suspend, revoke, and renew licenses in accordance with this ~~Article;~~Article.
(5) Conduct investigations, subpoena individuals and records, and do all other things necessary and proper to discipline persons licensed under this Article and to enforce this ~~Article;~~Article.
(6) Employ professional, clerical, investigative or special personnel necessary to carry out the provisions of this Article, and purchase or rent office space, equipment and ~~supplies;~~supplies.
(7) Adopt a seal by which it shall authenticate its proceedings, official records, and ~~licenses;~~licenses.

(8) Conduct administrative hearings in accordance with Article 3A of Chapter 150B of the General Statutes when a "contested case" as defined in G.S. 150B-2(2) arises under this ~~Article;~~Article.

(9) Establish reasonable fees for applications for examination; initial, provisional, and renewal licenses; and other services provided by the ~~Board;~~Board.

(10) Submit an annual report to the Governor and General Assembly of all its official actions during the preceding year, together with any recommendations and findings regarding improvements of the practice of ~~dietetics/nutrition;~~dietetics or nutrition.

(11) Publish and make available upon request the licensure standards prescribed under this Article and all rules adopted by the ~~Board;~~Board.

(12) Request and receive the assistance of State educational institutions or other State ~~agencies;~~agencies.

(13) Approve ~~educational curricula, clinical practice and~~ and evaluate continuing education requirements for persons seeking to renew licensure under this Article.

(14) Publish, and make available to the public, records of any Board action resulting in any disciplinary action taken by the Board or criminal action taken by the State for any violation of this Article."

SECTION 6. G.S. 90-357 is repealed.

SECTION 7. Article 25 of Chapter 90 of the General Statutes is amended by adding a new section to read:

"**§ 90-357.5. License Requirements.**

(a) Each applicant for a license as a licensed dietitian/nutritionist shall submit a completed application as required by the Board, submit any fees as required by the Board, and shall meet one of the following criteria:

(1) The applicant shall submit proof of completion for the following educational, supervised practice experience, and examination requirements:

a. The applicant has received a baccalaureate degree, master's, or doctoral degree or validated foreign equivalent in human nutrition, foods and nutrition, dietetics, food systems management, nutrition education, nutrition, nutrition science, clinical nutrition, applied clinical nutrition, nutrition counseling, nutrition and functional medicine, nutritional biochemistry, nutrition and integrative health, or an equivalent course of study from a college or university accredited at the time of graduation from the appropriate regional accrediting agency recognized by the Council on Higher Education Accreditation and the United States Department of Education and that, as approved by the Board, meets the competency requirements of an ACEND accredited didactic program in dietetics that shall, at a minimum, include the following courses:

1. Fifteen semester hours of clinical or life sciences. These hours must include human anatomy and physiology or the equivalent, microbiology or the equivalent, organic chemistry, and biochemistry.

2. Three semester hours of behavioral sciences, such as psychology, sociology, cultural anthropology, counseling, or educational psychology.

3. Twenty-four semester hours of food and nutrition. At least three semester hours must have been received in each of the following categories:
   I. Diet therapy, medical dietetics, clinical nutrition, or the equivalent.
   II. Nutrition through life cycle, applied human nutrition, advanced human nutrition, or the equivalent.
   III. Foods, food science, food composition and menu planning, food service management, or the equivalent.

b. The applicant has completed a Board approved internship or documented, supervised practice experience that meets the competency requirements of an ACEND accredited supervised practice experience and is not less than 900 hours under the supervision of a Certified Nutrition Specialist, a Diplomate of American Clinical Board of Nutrition, a Registered Dietitian Nutritionist, a licensed dietitian/nutritionist, a licensed nutritionist, a State licensed health care practitioner whose licensed scope of practice includes nutrition, or an individual with a doctoral degree conferred by a United States regionally accredited college or university with a major course of study in human nutrition, foods and nutrition, dietetics, food systems management, nutrition education, nutrition, nutrition science, clinical nutrition, applied clinical nutrition, nutrition counseling, nutrition and functional medicine, nutritional biochemistry, nutrition and integrative health, or an equivalent course of study, with a reasonable threshold of academic credits in nutrition and nutrition sciences as described in sub-subdivision a. of this subdivision. Supervisors who obtained their doctoral degree outside of the United States and its territories must have their degrees validated by the Board as equivalent to the doctoral degree conferred by a United States regionally accredited college or university.

c. The applicant has successfully completed the registration examination for dietitian nutritionists administered by the Commission on Dietetic Registration.

(2) The applicant has a valid current registration with the Commission on Dietetic Registration that gives the applicant the right to use the term "Registered Dietitian Nutritionist" or "RDN."

(b) All persons licensed or who have submitted an application for licensure as a dietitian/nutritionist prior to July 1, 2015 shall remain licensed, eligible for reactivation, or eligible for licensure under the requirements in place at the time of licensure or application, so long as the applicant or licensee remains in good standing and maintains an active or inactive license if obtained or once it is obtained.

(c) Each applicant for a license as a licensed nutritionist shall submit a completed application as required by the Board, submit any fees as required by the Board, and shall submit proof of the completion of all of the following educational, supervised practice experience, and examination requirements:

(1) The applicant has received a master's or doctoral nutrition degree or validated foreign equivalent with a major in human nutrition, foods and nutrition, community nutrition, public health nutrition, nutrition education, nutrition, nutrition science, clinical nutrition, applied clinical nutrition, nutrition counseling, nutrition and functional medicine, nutritional

biochemistry, nutrition and integrative health, or a comparable title major, or doctoral degree, or validated foreign equivalent, in a field of clinical healthcare from a college or university accredited at the time of graduation from the appropriate regional accrediting agency recognized by the Council on Higher Education Accreditation and the United States Department of Education, and have completed coursework in medical nutrition therapy that shall consist of the following courses:

a. Fifteen semester hours of clinical or life sciences, including such courses as chemistry, organic chemistry, biology, molecular biology, biotechnology, botany, genetics, genomics, neuroscience, experimental science, immunotherapy, pathology, pharmacology, toxicology, research methods, applied statistics, biostatistics, epidemiology, oxidative/reductive dynamics, energy production, molecular pathways, hormone and transmitter regulations and imbalance, biotransformation pathways and imbalances, and pathophysiologic basis of disease. Three semester hours must be in human anatomy and physiology or the equivalent.

b. Fifteen semester hours of nutrition and metabolism, including such courses as nutrition assessment, developmental nutrition, nutritional aspects of disease, human nutrition, macronutrients, micronutrients, vitamins and minerals, functional medicine nutrition, molecular metabolism, clinical nutrition, nutritional biochemistry, nutrition and digestive health, and public health nutrition. At least six semester hours must be in biochemistry.

(2) The applicant must have completed a Board approved internship or a documented, supervised practice experience in nutrition services of not less than 900 hours involving at least 200 hours of nutrition assessment, 200 hours of nutrition intervention, education, counseling, or management, and 200 hours of nutrition monitoring or evaluation under the supervision of a Certified Nutrition Specialist, a Diplomate of the American Clinical Board of Nutrition, a Registered Dietitian Nutritionist, a licensed dietitian/nutritionist, a licensed nutritionist, a State licensed health care practitioner whose licensed scope of practice includes nutrition, or an individual with a doctoral degree conferred by a United States regionally accredited college or university with a major course of study in human nutrition, foods and nutrition, dietetics, nutrition education, nutrition, nutrition science, clinical nutrition, applied clinical nutrition, nutrition counseling, nutrition and functional medicine, nutritional biochemistry, nutrition and integrative health, or an equivalent course of study, with a reasonable threshold of academic credits in nutrition and nutrition sciences as described in subdivision (1) of this subsection. Supervisors who obtained their doctoral degree outside of the United States and its territories must have their degrees validated by the Board as equivalent to the doctoral degree conferred by a United States regionally accredited college or university.

(3) The applicant meets one of the following criteria:

a. The applicant has successfully completed either the examination administered by the Board for Certification of Nutrition Specialists, the examination administered by the American Clinical Board of Nutrition, or another examination approved by the Board and meeting the requirements defined in G.S. 90-359.

b. The applicant has either a valid current certification with the Board for Certification of Nutrition Specialists that gives the applicant the right to use the term "Certified Nutrition Specialist" or "CNS" or a valid current certification with the American Clinical Board of Nutrition that gives the applicant the right to use the term "Diplomate, American Clinical Board of Nutrition" or "DACBN.""

SECTION 8. G.S. 90-359 reads as rewritten:

"**§ 90-359. Examinations.**

Competency examinations shall be administered at least twice each year to qualified applicants for licensing. The examinations may be administered by a national testing service. The ~~Board~~ examinations shall ~~prescribe or develop the examinations which may~~ include ~~an examination~~ the examinations given by the Commission on Dietetic ~~Registration of the American Dietetic Association or any other examination~~ Registration, the Board for Certification of Nutrition Specialists, or the American Clinical Board of Nutrition. The Board may include other nutrition therapy-focused examinations accredited by the National Commission for Certifying Agencies for graduates with a baccalaureate degree or higher from a college or university accredited at the time from the appropriate regional accrediting agency recognized by the Council on Health Education Accreditation and the United States Department of Education that are approved by two-thirds vote of the entire Board."

SECTION 9. G.S. 90-360 reads as rewritten:

"**§ 90-360. Granting license without examination.**

The Board may grant, upon application and payment of proper fees, a license ~~without examination~~ as licensed dietitian/nutritionist or a licensed nutritionist to a person who has met the examination requirements under G.S. 90-359 at the time of application and holds a valid license or certification as a ~~licensed dietitian/nutritionist~~ dietitian/nutritionist, dietitian, or nutritionist issued by another state or any political territory or jurisdiction acceptable to the Board if in the Board's opinion the requirements for that license or certification are substantially the same as the requirements of this Article."

SECTION 10. G.S. 90-361 reads as rewritten:

"**§ 90-361. Provisional licenses.**

The Board may grant a provisional license for a period not exceeding 12 months to any individual who has successfully completed the educational and clinical practice requirements and has made application to take one of the ~~examination~~ examinations required under ~~G.S. 90-357.~~ G.S. 90-357.5. A provisional license shall allow the individual to practice as a dietitian/nutritionist or nutritionist under the supervision of a dietitian/nutritionist or nutritionist licensed in this State and shall be valid until revoked by the Board."

SECTION 11. G.S. 90-363 reads as rewritten:

"**§ 90-363. Suspension, revocation and refusal to renew license.**

(a) The Board may deny or refuse to renew a license, may suspend or revoke a license, or may impose probationary conditions on a license if the licensee or applicant for licensure has engaged in any of the following conduct:

(1) Employment of fraud, deceit or misrepresentation in obtaining or attempting to obtain a license, or the renewal of a ~~license;~~license.

(2) Committing an act or acts of malpractice, gross negligence or incompetence in the practice of ~~dietetics/nutrition;~~dietetics or nutrition.

(3) Practicing as a licensed dietitian/nutritionist or a licensed nutritionist without a current ~~license;~~license.

(4) Engaging in conduct that one could reasonably foresee, based on available evidence, could result in harm or injury to the ~~public;~~public.

(5) Conviction of or a plea of guilty or nolo contendere to any crime involving moral ~~turpitude;~~turpitude.

(6) Adjudication of insanity or incompetency, until proof of recovery from the condition can be ~~established;~~established.

(7) Engaging in any act or practice ~~violative~~ in violation of any of the provisions of this Article or any rule adopted by the Board, or aiding, abetting or assisting any person in such a violation.

(b) Denial, refusal to renew, suspension, revocation or imposition of probationary conditions upon a license may be ordered by the Board after a hearing held in accordance with Chapter 150B of the General Statutes and rules adopted by the Board. An application may be made to the Board for reinstatement of a revoked license if the revocation has been in effect for at least one year."

SECTION 12. G.S. 90-365 reads as rewritten:

"**§ 90-365. Requirement of license.**

(a) ~~After March 31, 1992, it~~ It shall be unlawful for any person who is not currently licensed under this Article to do any of the following:

~~(1) Engage in the practice of dietetics/nutrition.~~

(1a) Provide medical nutrition therapy.

(2) Use the title ~~"dietitian/nutritionist".~~"dietitian/nutritionist" or "nutritionist."

(3) Use the words "dietitian," "nutritionist," "licensed nutritionist," or "licensed dietitian/nutritionist" alone or ~~in combination.~~hold oneself out as a dietitian or nutritionist unless licensed under this Article.

(4) Use the letters "LD," "LN," or "LDN," or any facsimile or combination in any words, letters, abbreviations, or insignia.

(5) To imply orally or in writing or indicate in any way that the person is a licensed ~~dietitian/nutritionist.~~dietitian/nutritionist or licensed nutritionist.

(b) Notwithstanding any law to the contrary, an individual registered with the Commission on Dietetic Registration has the right to use the title "Registered Dietitian," "Registered Dietitian Nutritionist," and the designation "RD" or "RDN." Notwithstanding any law to the contrary, an individual certified by the Board of Certification of Nutrition Specialists has the right to use the title "Certified Nutrition Specialist" and the designation "CNS" and an individual certified by the American Clinical Board of Nutrition has the right to use the title "Diplomate, American Clinical Board of Nutrition" and use the designation "DACBN.""

SECTION 13. G.S. 90-368 reads as rewritten:

"**§ 90-368. Persons and practices not affected.**

The requirements of this Article shall not apply to:

(1) A health care professional duly licensed in accordance with Chapter 90 of the General ~~Statutes.~~Statutes who is acting within the scope of the individual's licensed profession, provided that the individual does not use the titles licensed dietitian/nutritionist or licensed nutritionist.

(2) A student or trainee, working under the direct supervision of ~~a licensed dietitian/nutritionist~~ an individual who meets the criteria outlined in G.S. 90-357.5(a)(1)b. or G.S. 90-357.5(c)(2) while fulfilling an experience requirement or pursuing a course of study to meet requirements for licensure, for a limited period of time as determined by the Board.

(3) A dietitian/nutritionist or nutritionist serving in the Armed Forces or the Public Health Service of the United States or employed by the Veterans Administration when performing duties associated with that service or employment.

(4) A person aiding the practice of ~~dietetics/nutrition~~ dietetics or nutrition if the person works under the direct supervision of a licensed dietitian/nutritionist or licensed nutritionist and performs only support activities that do not require formal academic training in the basic food, nutrition, chemical,

biological, behavioral, and social sciences that are used in the practice of ~~dietetics.~~dietetics or nutrition.

(5) An employee of the State, a local political subdivision, or a local school administrative unit or a person that contracts with the State, a local political subdivision, or a local school administrative unit while engaged in the practice of ~~dietetics/nutrition~~ dietetics or nutrition within the scope of that employment.

(6) A retailer who does not hold himself out to be a dietitian or nutritionist when that retailer furnishes nutrition information to customers on food, food materials, dietary supplements and other goods sold at his retail establishment in connection with the marketing and distribution of those goods at his retail establishment.

(7) A person who provides weight control services; provided the program has been reviewed by, consultation is available from, and no program change can be initiated without prior approval ~~of:~~of the following individuals:

a. A licensed ~~dietitian/nutritionist;~~dietitian/nutritionist, licensed nutritionist, or other licensed independent practitioner.

b. A ~~dietitian/nutritionist~~ dietitian/nutritionist, licensed nutritionist, or other licensed independent practitioner licensed or certified in another state that has licensure or certification requirements that are at least as stringent as under this ~~Article; or~~Article.

c. A ~~dietitian~~ dietitian/nutritionist or nutritionist registered by the Commission on Dietetic ~~Registration of the American Dietetic Association.~~Registration, the Board for Certification of Nutrition Specialists, or the American Clinical Board of Nutrition.

(8) Employees or independent contractors of a hospital or health care facility licensed under Article 5 or Part A of Article 6 of Chapter 131E or Article 2 of Chapter 122C of the General Statutes.

(9) A person who does not hold himself or herself out to be a dietitian or nutritionist when that person furnishes nutrition information on food, food materials, or dietary supplements. This Article does not prohibit that person from making explanations to customers about foods or food products in connection with the marketing and distribution of these products.

(10) An herbalist or other person who does not hold himself or herself out to be a dietitian or nutritionist when the person furnishes nonfraudulent specific nutritional information and counseling about the reported or historical use of herbs, vitamins, minerals, amino acids, carbohydrates, sugars, enzymes, food concentrates, or other foods.

(11) Any individual who provides nutrition services without remuneration to family members.

(12) Any individual who provides nutrition information, guidance, encouragement, individualized nutrition recommendations, or weight control services that do not constitute medical nutrition therapy as defined in G.S. 90-352, provided that the individual does not hold himself or herself out as a licensed dietitian or a licensed nutritionist as prohibited under G.S. 90-365 and that the individual does not seek to provide medical nutrition therapy as defined in G.S. 90-352."

SECTION 14. Article 25 of Chapter 90 of the General Statutes is amended by adding a new section to read:

"**§ 90-371. Enteral and parenteral nutrition therapy.**

(a) Enteral and parenteral nutrition therapy shall consist of enteral feedings or specialized intravenous solutions and shall only be ordered by an individual licensed under this Article who meets one of the following criteria:

(1) The individual is a Registered Dietitian Nutritionist registered with the Commission on Dietetic Registration.

(2) The individual is a Certified Nutrition Support Clinician certified by the National Board of Nutrition Support Certification.

(3) The individual meets the requirements set forth in the rules of the Board.

(b) Nothing in this Article shall be construed to limit the ability of any other licensed health care provider in this State to order therapeutic diets, so long as the ordering of therapeutic diets falls within the scope of the license held by the health care provider."

SECTION 15. Section 12 becomes effective October 1, 2015, and applies to acts committed on or after that date. The remainder of this act becomes effective July 1, 2015.

HOUSE BILL 796

Short Title:	Modernize Dietetics/Nutrition Practice Act.	(Public)
Sponsors:	Representative B. Brown (Primary Sponsor). *For a complete list of Sponsors, refer to the North Carolina General Assembly Web Site.*	
Referred to:	Health.	

April 15, 2015

A BILL TO BE ENTITLED

AN ACT EXPANDING THE ABILITY OF QUALIFIED NUTRITION PROFESSIONALS TO PRACTICE IN THIS STATE.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 90-352 reads as rewritten:

"**§ 90-352. Definitions.**

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

(1) ~~"Board" means the~~Board. – The North Carolina Board of Dietetics/Nutrition.

(2) ~~"Dietetics/nutrition" means the~~Dietetics/nutrition. – The integration and application of principles derived from the science of nutrition, biochemistry, physiology, food, and management and from behavioral and social sciences to achieve and maintain a healthy status. The primary function of dietetic/nutrition practice is the provision of nutrition care services.

(3) ~~"Licensed dietitian/nutritionist" means an~~Licensed dietitian/nutritionist. – An individual licensed in good standing to practice dietetics/nutrition.

(3a) Medical nutrition therapy. – The provision of nutrition care services for the purpose of managing or treating a medical condition.

(4) ~~"Nutrition care services" means any,~~Nutrition care services. – Any, part or all of the following:

a. Assessing the nutritional needs of individuals and groups, and determining resources and constraints in the practice setting.

b. Establishing priorities, goals, and objectives that meet nutritional needs and are consistent with available resources and constraints.

c. Providing nutrition counseling in health and disease.

d. Developing, implementing, and managing nutrition care systems.

e. Evaluating, making changes in, and maintaining appropriate standards of quality in food and nutrition services.

~~"Nutrition care services"~~The term does not include the retail sale of food products or vitamins."

SECTION 2. G.S. 90-365 reads as rewritten:

"**§ 90-365. Requirement of license.**

~~After March 31, 1992, it~~It shall be unlawful for any person who is not currently licensed under this Article to do any of the following:

~~(1) Engage in the practice of dietetics/nutrition.~~

(1a) Engage in the practice of medical nutrition therapy.

(2) Use the title "dietitian/nutritionist".

(3) Use the words "dietitian," "nutritionist," or "licensed dietitian/nutritionist" alone or in combination.

(4) Use the letters "LD," "LN," or "LDN," or any facsimile or combination in any words, letters, abbreviations, or insignia.

(5) To imply orally or in writing or indicate in any way that the person is a licensed dietitian/nutritionist."

SECTION 3. This act becomes effective July 1, 2015.

NORTH CAROLINA GENERAL ASSEMBLY
HOUSE OF REPRESENTATIVES

HEALTH COMMITTEE REPORT
Representative Brian Brown, Co-Chair
Representative Justin P. Burr, Co-Chair
Representative Bert Jones, Co-Chair
Representative Donny Lambeth, Co-Chair

FAVORABLE COM SUB , UNFAVORABLE ORIGINAL BILL

HB **796** Modernize Dietetics/Nutrition Practice Act.

Draft Number:	H796-PCS30367-TK-47
Serial Referral:	None
Recommended Referral:	None
Long Title Amended:	Yes
Floor Manager:	B. Brown

TOTAL REPORTED: 1

Wednesday, April 29	Room	Time
HEALTH	643	10:00 am

Name	County	Sponsor
Phillip Armentrout	Craven	John R. Bell, IV
Kaitlin Avery	Pitt	Susan Martin

Committee Sergeants at Arms

NAME OF COMMITTEE House Comm. on Health

DATE: 04/29/15 Room: 643

House Sgt-At Arms:

1. Name: Young Bae
2. Name: Bill Morris
3. Name: Jim Moran
4. Name: _____
5. Name: _____

Senate Sgt-At Arms:

1. Name: _____
2. Name: _____
3. Name: _____
4. Name: _____
5. Name: _____

VISITOR REGISTRATION SHEET

House Comm. on Health — 04/29/15

Name of Committee — Date

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
J Kerns	CSS
Robin Huffman	NC Psychiatric Assoc
Ashley Killen	NC Psychiatric Assoc.
Burt Johnson	NC Psychiatric Association
Kenya Caldwell	NC Psychiatric Assoc - Med student
Sarita O'Neal	NC Psychiatric Assoc & NC Council of child & Adolescent Psych
Elizabeth Falchook	NCPA
Silpa Kamisetti, MD	NCPA
Katie Dunlap, MD	NCPA
John Shin, MD	NC Psychiatric Association
Heyne Nicholas 4, MD	NCPA

VISITOR REGISTRATION SHEET

House Comm. on Health — 04/29/15

Name of Committee — Date

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Rebecca Taylor, MD	NC Psychiatric Association (NCPA)
Laura Willing, MD	NCPA
Brittany Rodgers, MD	NCPA
Robin Casey, MD	NCPA
Kristin Milam	NCPA
John McMillan	NFOS
Frank Gray	NCRLA
Steve Mange	NCRLA
Evelyn Hawthorne	ETGR

VISITOR REGISTRATION SHEET

House Comm. on Health — 04/29/15

Name of Committee — Date

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Barbara Ann Hughes	4208 Delay Dr, Raleigh 27612
Manju Karkare	4937 Cromshaw Ct. Raleigh 27614
Kim Iles	NCDA
Henry Jones	NC BC D/N
Donna B Clark	UNC Dept Genet
Betsy Vetter	American Heart Association
Austin Pruitt	Perkinson Law
NICHOLE KALIM	NAMI NC
Sheela Ann Foster	
Lauren Coffey	Policy / gov office.
Flint Benson	SE DNC

VISITOR REGISTRATION SHEET

House Comm. on Health — 04/29/15

Name of Committee — Date

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Andy Chase	KMA
Jennifer Gasperini	NCMS
Amandatbraker	TSS
TJ Buybee	NP
Angel Sams	WCSR
Kara Weishaar	SA

NORTH CAROLINA HOUSE OF REPRESENTATIVES
COMMITTEE MEETING NOTICE
AND
BILL SPONSOR NOTIFICATION
2015-2016 SESSION

You are hereby notified that the **House Committee on Health** will meet as follows:

DAY & DATE: Wednesday, May 27, 2015
TIME: **10:00 AM**
LOCATION: **643 LOB**
COMMENTS: **Representative Brian Brown will preside.**

The following bills will be considered:

BILL NO.	SHORT TITLE	SPONSOR
HB 698	Baby Carlie Nugent Bill.	Representative Jeter Representative Lambeth Representative Adcock
SB 7	Allow Seating for Food Stand Customers.	Senator Tillman
SB 286	Regulate the Sale of E-Liquid Containers.	Senator Bingham Senator D. Davis

Respectfully,

Representative Brian Brown, Co-Chair
Representative Justin P. Burr, Co-Chair
Representative Bert Jones, Co-Chair
Representative Donny Lambeth, Co-Chair

I hereby certify this notice was filed by the committee assistant at the following offices at 11:01 AM on Tuesday, May 26, 2015.

___ Principal Clerk
___ Reading Clerk – House Chamber

Brenda Olls (Committee Assistant)

House Committee on Health
Wednesday, May 27, 2015, 10:00 AM
643 Legislative Office Building

AGENDA

Welcome and Opening Remarks

Introduction of Pages & Sgt-at-Arms

Bills

BILL NO.	SHORT TITLE	SPONSOR
HB 698	Baby Carlie Nugent Bill.	Representative Jeter Representative Lambeth Representative Adcock
SB 7	Allow Seating for Food Stand Customers.	Senator Tillman
SB 286	Regulate the Sale of E-Liquid Containers.	Senator Bingham Senator D. Davis

Adjournment

House Committee on Health
Wednesday, May 27, 2015 at 10:00 AM
Room 643 of the Legislative Office Building

MINUTES

The House Committee on Health met at 10:00 AM on May 27, 2015 in Room 643 of the Legislative Office Building. Representatives Adcock, Avila, Bishop, Blackwell, Brawley, R. Brown, B. Brown, Carney, Dobson, Dollar, Farmer-Butterfield, Ford, Goodman, Hastings, Insko, Jones, Lambeth, S. Martin, Pendleton, Szoka, Wray, and Yarborough attended.

Representative Brian Brown, Chair, presided.

The following bills were considered:

HB 698 Baby Carlie Nugent Bill. (Representatives Jeter, Lambeth, Adcock)

There is a PCS for HB 698, Representative Brawley made the motion to accept the PCS and the motion carried. Representative Jeter was recognized to explain the bill.

The Baby Carlie bill addresses Severe Combined Immunodeficiency, or SCID, also known as Bubble Boy Disease by adding a screening test for SCID to the newborn screening panel. Also setting up the implementation of the machinery, through grants and various monetary services, secondarily, increasing the fee paid by patients by five dollars, from $19- $24, which was agreed to by the hospitals and budget committee.

Representative Brawley made the motion for a favorable report for the PCS, unfavorable to the original bill and re-reffered to the Committee on Finance. The motioned carried.

SB 7 Food Stand Seating & Outdoor Food Service. (Senator Tillman)

There is a PCS for SB7, Representative Bishop made the motion the accept the PCS and the motioned carried. Senator Tillman was recognized to explain the bill,

The PCS allows pushcarts or mobile food units to allow food stands to provide seating for at least eight customers to use while eating or drinking on the premises provided that they are based from a permitted commissary or restaurant located on the premises of a facility containing at least 3,000 seats.

Representative Avila motioned for a favorable report to the House PCS for SB7, unfavorable to the original bill with a referral to Committee on Commerce & Job Development. The motion passed.

SB 286 Regulate the Sale of E-Liquid Containers. (Senators Bingham, D. Davis)

Senator Bingham was recognized to explain the bill.

This bill requires child resistant packaging of E-Liquid containers, mainly packaging of products containing nicotine, which is poisonous and hazardous to children and to provide punishments for the violator, with the violator being charged with an A1 misdemeanor and will be liable for damages to the injured party.

Representative Carney motioned for a favorable report with a referral to the Committee on Commerce & Job Development. The bill passes.

The meeting adjourned at 10:30.

Representative Brian Brown, Chair
Presiding

Theresa Lopez, Committee Clerk

SENATE BILL 7:
Allow Seating for Food Stand Customers

2015-2016 General Assembly

Committee:	House Health, if favorable, Commerce and Job Development	**Date:**	May 26, 2015
Introduced by:	Sen. Tillman	**Prepared by:**	Theresa Matula Committee Staff
Analysis of:	PCS to Third Edition S7-CSSH-45		

SUMMARY: The PCS for Senate Bill 7 does the following: 1) allows a food stand to provide tables and not more than eight seats for customers to use while eating or drinking on the premises; and 2) allows pushcarts or mobile food units to prepare and serve food on the premises provided they are based from a permitted commissary or restaurant that is located on the premises of a facility containing at least 3,000 permanent seats.

BILL ANALYSIS:

Section 1 of the PCS for Senate Bill 7 amends G.S. 130A-248 to add a new subsection pertaining to food stands. Notwithstanding Chapter 130A, Article 8, Part 6, Regulation of Food and Lodging Facilities and G.S. 130A-335(e), the new subsection would allow a food stand, without obtaining a restaurant permit, to provide tables and not more than eight (8) seats for customers to use while eating or drinking on the premises. The addition of seats under this subsection will not require further evaluation of the adequacy of the approved sanitary sewage system.

Section 2 of the PCS allows pushcarts or mobile food units to prepare and serve food on the premises provided they are based from a permitted commissary or restaurant that is located on the premises of a facility containing at least 3,000 permanent seats. Additionally, the following are required:

- Raw meat, poultry, and fish must be prepared in a permitted commissary or restaurant in pre-portioned or ready-to-cook form. Pushcarts or mobile food units that handle raw ingredients must be equipped with a handwashing sink.
- Open food and utensils must be provided with overhead protection or otherwise equipped with individual covers such as domes, chafing lids, or cookers with hinged lids.
- Food equipment and supplies must be located in enclosed areas and protected from environmental contamination when not in operation.

EFFECTIVE DATE: Section 1 of the bill would become effective October 1, 2015, the remainder of the bill would become effective when it becomes law.

CURRENT LAW:

G.S. 130A-248 pertains to the regulation of food and lodging establishments. G.S. 130A-248(a) requires the Commission for Public Health to adopt rules governing the sanitation of establishments that prepare or serve drink or food for pay.

G.S. 130A-335 pertains to wastewater collection, treatment and disposal. **G.S. 130A-335(e)** requires the rules of the Commission and the rules of the local board of health to address specified items related to wastewater collection, treatment and disposal systems. The rules regarding required design capacity and

required design volume for wastewater systems shall provide that exceptions may be granted upon showing that a system is adequate to meet actual daily water consumption. The design of a sewage treatment and disposal system is based on the type and use of the establishment. Flow rates for various establishments including restaurants and food stands are outlined in the rules (15A NCAC 18A.1949).

15A NCAC 18A.2651 provides the following definitions:

- Food establishment – an operation that is conducted in a mobile, stationary, temporary, or permanent facility or location and where consumption is on or off the premises. It does not include entities exempted in G.S. 130A-250 or those that only serve such items as dip ice cream, popcorn, candied apples, or cotton candy.
- Food stand - a food establishment that prepares or serves food and that does not provide seating facilities for customers to use while eating or drinking.
- Mobile food unit - a food establishment or pushcart designed to be readily moved to vend food.
- Pushcart – a mobile piece of equipment or vehicle used to vend food.
- Commissary – a food establishment that services a mobile food unit or a pushcart.
- Restaurant – a food establishment that prepares or serves food and provides seating.

15A NCAC 18A.2659 provides that a food establishment must obtain a permit and no permit is issued until an evaluation by the regulatory authority shows that the establishment is in compliance. The regulatory authority is required to impose conditions if necessary to ensure the food establishment remains in compliance.

15A NCAC 18A.2670 provides general requirements for pushcarts and mobile food units.

15A NCAC 18A.2671 provides specific requirements for pushcarts.

15A NCAC 18A .2672 provides specific requirements for mobile food units.

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2015

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SENATE BILL 7

Health Care Committee Substitute Adopted 3/10/15
Commerce Committee Substitute Adopted 4/15/15
PROPOSED HOUSE COMMITTEE SUBSTITUTE S7-CSSH-45 [v.2]
5/26/2015 6:08:39 PM

Short Title: Food Stand Seating & Outdoor Food Service. (Public)

Sponsors:

Referred to:

February 2, 2015

A BILL TO BE ENTITLED

AN ACT TO ALLOW FOOD STANDS TO PROVIDE TABLES AND CHAIRS FOR CUSTOMERS TO USE WHILE CONSUMING DRINKS OR FOOD UPON THE PREMISES AND TO AUTHORIZE PUSHCARTS OR MOBILE FOOD UNITS TO PREPARE AND SERVE FOOD ON THE PREMISES, PROVIDED THEY ARE BASED FROM A COMMISSARY OR RESTAURANT LOCATED ON THE PREMISES OF A FACILITY CONTAINING THREE THOUSAND PERMANENT SEATS.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 130A-248 is amended by adding a new subsection to read:

"(a6) Notwithstanding any provision of this Part or any rules adopted pursuant to G.S. 130A-335(e), a permitted food stand may elect to provide tables and not more than eight seats for customers to use while eating or drinking on the premises. Addition of seats under this subsection shall not require further evaluation of the adequacy of the approved sanitary sewage system."

SECTION 2. G.S. 130A-248(c1) reads as rewritten:

"(c1) The Commission shall adopt rules governing the sanitation of pushcarts and mobile food units. A permitted restaurant or commissary shall serve as a base of operations for a pushcart. A mobile food unit shall meet all of the sanitation requirements of a permitted commissary or shall have a permitted restaurant or commissary that serves as its base of operation. Pushcarts or mobile food units that are based from a permitted commissary or restaurant that is located on the premises of a facility which contains at least 3,000 permanent seats shall be allowed to prepare and serve food on the premises. Raw meat, poultry, and fish shall be prepared in a permitted commissary or restaurant in a pre-portioned or ready-to-cook form. Pushcarts or mobile food units that handle raw ingredients shall be equipped with a handwashing sink. All open food and utensils shall be provided with overhead protection or otherwise equipped with individual covers, such as domes, chafing lids, or cookers with hinged lids. Food equipment and supplies shall be located in enclosed areas and protected from environmental contamination when not in operation."

SECTION 3. Section 1 of this act becomes effective October 1, 2015, the remainder of the act is effective when it becomes law.

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2015

S 3

SENATE BILL 7
Health Care Committee Substitute Adopted 3/10/15
Commerce Committee Substitute Adopted 4/15/15

Short Title: Allow Seating for Food Stand Customers. (Public)

Sponsors:

Referred to:

February 2, 2015

A BILL TO BE ENTITLED

AN ACT ALLOWING FOOD STANDS TO PROVIDE TABLES AND CHAIRS FOR CUSTOMERS TO USE WHILE CONSUMING DRINKS OR FOOD UPON THE PREMISES.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 130A-248 is amended by adding a new subsection to read:

"(a6) Notwithstanding any provision of this Part or any rules adopted pursuant to G.S. 130A-335(e), a permitted food stand may elect to provide tables and not more than eight seats for customers to use while eating or drinking on the premises. Addition of seats under this subsection shall not require further evaluation of the adequacy of the approved sanitary sewage system."

SECTION 2. This act becomes effective October 1, 2015.

SENATE BILL 286:
Regulate the Sale of E-Liquid Containers

2015-2016 General Assembly

Committee:	House Health, if favorable, Commerce and Job Development	**Date:**	May 26, 2015
Introduced by:	Sens. Bingham, D. Davis	**Prepared by:**	Theresa Matula Committee Staff
Analysis of:	Third Edition		

SUMMARY: ***Senate Bill 286 makes it unlawful to sell e-liquid containers without child-resistant packaging; makes it unlawful to sell an e-liquid product containing nicotine unless the packaging states that the product contains nicotine; makes violation a Class A1 misdemeanor; and provides that any person, firm, or corporation would be liable for damages as a result of selling e-liquid containers without child-resistant packaging.***

BILL ANALYSIS: Senate Bill 286 creates G.S. 14-401.18A prohibiting the sale of certain e-liquid containers. The bill provides definitions for the following: child-resistant packaging, e-liquid, e-liquid container, and vapor product.

- Child-resistant packaging - Packaging that is designed or constructed to be significantly difficult for children under five years of age to open or obtain a toxic or harmful amount of the substance contained therein within a reasonable time and not difficult for adults to use properly, but does not mean packaging which all such children cannot open or obtain a toxic or harmful amount within a reasonable time.
- E-liquid - a liquid product intended to be vaporized and inhaled using a vapor product, whether or not it contains nicotine.
- E-liquid container – a bottle or other container of e-liquid. The term does not include a container holding liquid that is intended for use in a vapor product if the container is pre-filled and sealed by the manufacturer and is not intended to be opened by the consumer.
- Vapor product – any noncombustible product that employs a mechanical heating element, battery, or electronic circuit regardless of shape or size and that can be used to heat a liquid solution contained in a vapor cartridge. The term includes: electronic cigarette, electronic cigar, electronic cigarillo, and electronic pipe.

The bill makes it unlawful for any person, firm or corporation to sell, offer for sale, or introduce into commerce in the State an e-liquid container unless the container constitutes child-resistant packaging. Violation is a Class A1 misdemeanor.

The bill also makes it unlawful for any person, firm or corporation to sell, offer for sale, or introduce into commerce in the State an e-liquid container for a product containing nicotine unless the packaging for the e-liquid states that it contains nicotine. Violation is a Class A1 misdemeanor.

Any person, firm, or corporation in violation of this section will be liable for damages to any person injured as a result of the violation.

EFFECTIVE DATE: This act would become effective December 1, 2015, and apply to offenses committed on or after that date.

** Amy Jo Johnson, former Committee staff, contributed to this summary.*

O. Walker Reagan
Director

S286-SMSH-62 E3 -V2

Research Division
(919) 733-2578

This bill analysis was prepared by the nonpartisan legislative staff for the use of legislators in their deliberations and does not constitute an official statement of legislative intent.

GENERAL ASSEMBLY OF NORTH CAROLINA

Session 2015

Legislative Incarceration Fiscal Note

REVISED

BILL NUMBER: Senate Bill 286 (Third Edition)

SHORT TITLE: Regulate the Sale of E-Liquid Containers.

SPONSOR(S):

FISCAL IMPACT

($ in millions)

☐ Yes ☐ No ☑ No Estimate Available

State Impact	FY 2015-16	FY 2016-17	FY 2017-18	FY 2018-19	FY 2019-20
General Fund Revenues:					
General Fund Expenditures					
State Positions:					
NET STATE IMPACT	Likely budget cost. See Assumptions & Methodology section for additional details.				

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

Administrative Office of the Courts; Indigent Defense Services; Department of Public Safety

EFFECTIVE DATE: December 1, 2015

TECHNICAL CONSIDERATIONS:

None

Revision Note: ***This note has been revised to correct the fiscal year column headers in the table above.***

FISCAL IMPACT SUMMARY:

The proposed bill may have a fiscal impact to address a new chargeable offense being enforced, adjudicated, and having penalties applied to those convicted of the new offense. However, given that there is no historical data on this new offense or similar offenses to use as a proxy for predicting the total number of new offenses, the Fiscal Research Division cannot reasonably estimate the total additional costs that may be incurred. The following costs may be incurred for every one person charged and convicted of this crime:

- Administrative Office of the Courts: $286 per disposition
- Indigent Defense Services: $204 per disposition
- Department of Public Safety (DPS) - Prison Section: No cost.
- DPS - Community Corrections: Minimum of $2,219

Please see the Assumptions and Methodology section for additional information.

BILL SUMMARY:

The bill creates a new Class A1 misdemeanor for violation of new G.S. 14-401.18A, Sale of certain e-liquid containers prohibited, which requires that e-liquid containers constitute child-resistant packaging.

ASSUMPTIONS AND METHODOLOGY:

General

The Sentencing and Policy Advisory Commission prepares prison population projections for each bill containing a criminal penalty. The Commission assumes for such bills that expanding existing or creating new criminal offenses produces no deterrent or incapacitative effect on crime. Therefore, the Fiscal Research Division does not assume deterrent effects for any criminal penalty bill.

S.L. 2011-192 (H.B. 642), the Justice Reinvestment Act (JRA), made changes to North Carolina's court system, corrections system (both to prisons and probation), and to post-release supervision. All F-I felons are now subject to nine months of post-release supervision (PRS). B1-E felony PRS has been increased from nine months to twelve months. Due to the lack of historical data about JRA implementation, it is not possible to estimate the number of prison beds that may be needed as a result of revocations.

JRA also created the Statewide Misdemeanant Confinement Program (SMCP) for housing misdemeanants with sentences between 90 and 180 days in county jails (misdemeanants with shorter sentences were already the responsibility of the counties). County participation in the program is voluntary. The SMCP pays participating counties for misdemeanants' housing, transportation, and medical costs. In 2014, the program was expanded to include all misdemeanants with sentences longer than 90 days. The Sentencing and Policy Advisory Commission does not track county jail capacity, so it is not possible to estimate the impact of new or increased misdemeanor penalties on county jails.

Judicial Branch

The Administrative Office of the Courts provides Fiscal Research with a fiscal impact analysis for most criminal penalty bills. For such bills, fiscal impact is typically based on the assumption that court time will increase due to anticipated increases in trials and corresponding increases in workload for judges, clerks, and prosecutors. This increased court time is also expected to result in greater expenditures for jury fees and indigent defense.

The bill creates a new Class A1 misdemeanor offense. Because this is a new offense, AOC does not have historical data upon which to estimate the number of charges that might occur. AOC provides estimates of the average cost to the court for a charge by offense class. For every additional person charged with a Class A1 misdemeanor, the average cost to the court would be $286.

IDS has provided Fiscal Research with the frequency and cost of indigent defense services for each level of crime, including the cost differentials for district and superior court with and without a trial and the percentage of cases handled in each category. Fiscal Research used this data to calculate a weighted average of IDS costs. In FY 2011-12, 52% of Class A1 misdemeanor cases were handled through the Office of Indigent Defense Services (IDS). The weighted average cost of a new Class A1 misdemeanor is $204 per case for a private appointed counsel (PAC) attorney. This estimate assumes the appointment of a PAC attorney. In districts that have Public Defender offices, cases may be handled by those offices. In those instances, this cost may not be incurred.

Department of Public Safety–Prison Section

This bill creates a new Class A1 misdemeanor offense. The North Carolina Sentencing and Policy Advisory Commission expects no impact on the prison population because all misdemeanor offenders who

receive active sentences will serve them in the local jail. Therefore, the Department of Public Safety does not anticipate an impact on prison custody projections.

Department of Public Safety – Community Correction Section

All misdemeanor offenders may be given non-active (intermediate or community) sentences exclusively, or in conjunction with imprisonment (split-sentence). Sanctions include electronic house arrest, community service, substance abuse treatment, participation in educational or vocational skills development, payment of court costs, fines, and restitution, and short-term jail sentences not exceeding six days per month.

JRA essentially eliminated the distinction between "community" and "intermediate" supervision. Under structured sentencing, the two types of supervision were each defined by a set of specific sanctions. Under JRA, both community and intermediate probation may now include electronic monitoring, short-term periods of confinement, substance abuse assessment, monitoring, and treatment, participation in educational programs or vocational skills development. Whether a probationer is subject to more stringent conditions is determined by the results of a risk-needs assessment administered by the Department of Public Safety.

All types of post-release supervision, including intermediate or community sanctions, are supervised by the Community Corrections Section (CCS); CCS also oversees community service. General post-release supervision and supervision of intermediate and community offenders by a probation officer costs $130.50 per offender, per month; no cost is assumed for those receiving unsupervised probation, or who are only ordered to pay fines, fees, or restitution. Total costs are based on average supervision length and the percentage of offenders (per offense class) sentenced to active sentences requiring post-release supervision, intermediate sanctions and supervised probation.

In FY 2013-14, 35% of Class A1 misdemeanor offenders received active sentences; 65% received probation. Active misdemeanor sentences of less than 180 days are served in local jails and do not require any post-release supervision. The average length of probation imposed for this offense class was 17 months. Therefore, at a minimum, one conviction resulting from the bill will require at least 17 months of supervision. The cost of 17 months of supervision is $2,219 per offender ($130.50 per month times 17 months).[1]

SOURCES OF DATA: Department of Public Safety; Administrative Office of the Courts; North Carolina Sentencing and Policy Advisory Commission; Office of Indigent Defense Services.

TECHNICAL CONSIDERATIONS: None

FISCAL RESEARCH DIVISION: (919) 733-4910

PREPARED BY: Kristine Leggett

APPROVED BY:

Mark Trogdon, Director
Fiscal Research Division

[1] Due to the effective date of December 1, 2015 and the typical lag time between charge and conviction (6 months), little impact is assumed for CCS in FY 2015-16. Though some offenders may come under CCS supervision during this time, this note assumes an even entry over the course of FY 2016-17.

DATE: April 22, 2015

Signed Copy Located in the NCGA Principal Clerk's Offices

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2015

S 3

SENATE BILL 286
Health Care Committee Substitute Adopted 4/21/15
Third Edition Engrossed 4/22/15

Short Title: Regulate the Sale of E-Liquid Containers. (Public)

Sponsors:

Referred to:

March 16, 2015

A BILL TO BE ENTITLED

AN ACT PROHIBITING THE SALE OF E-LIQUID CONTAINERS WITHOUT CHILD-RESISTANT PACKAGING AND WITHOUT LABELING E-LIQUID CONTAINERS THAT CONTAIN NICOTINE.

The General Assembly of North Carolina enacts:

SECTION 1. Article 52 of Chapter 14 of the General Statutes is amended by adding a new section to read:

"**§ 14-401.18A. Sale of certain e-liquid containers prohibited.**

(a) The following definitions apply in this section:

(1) Child-resistant packaging. – Packaging that is designed or constructed to be significantly difficult for children under five years of age to open or obtain a toxic or harmful amount of the substance contained therein within a reasonable time and not difficult for adults to use properly, but does not mean packaging which all such children cannot open or obtain a toxic or harmful amount within a reasonable time.

(2) E-liquid. – A liquid product, whether or not it contains nicotine, that is intended to be vaporized and inhaled using a vapor product.

(3) E-liquid container. – A bottle or other container of e-liquid. The term does not include a container holding liquid that is intended for use in a vapor product if the container is pre-filled and sealed by the manufacturer and is not intended to be opened by the consumer.

(4) Vapor product. – Any noncombustible product that employs a mechanical heating element, battery, or electronic circuit regardless of shape or size and that can be used to heat a liquid solution contained in a vapor cartridge. The term includes an electronic cigarette, electronic cigar, electronic cigarillo, and electronic pipe.

(b) It shall be unlawful for any person, firm, or corporation to sell, offer for sale, or introduce into commerce in this State an e-liquid container unless the container constitutes child-resistant packaging. Any person who violates this section is guilty of a Class A1 misdemeanor.

(c) It shall be unlawful for any person, firm, or corporation to sell, offer for sale, or introduce into commerce in this State an e-liquid container for an e-liquid product containing nicotine unless the packaging for the e-liquid product states that the product contains nicotine. Any person who violates this section is guilty of a Class A1 misdemeanor.

(d) Any person, firm, or corporation that violates the provisions of this section shall be liable in damages to any person injured as a result of the violation."

SECTION 2. This act becomes effective December 1, 2015, and applies to offenses committed on or after that date.

HOUSE BILL 698:
Baby Carlie Nugent Bill

2015-2016 General Assembly

Committee:	House Health, if favorable, Finance, if favorable, Appropriations	**Date:**	May 26, 2015
Introduced by:	Reps. Jeter, Lambeth, Adcock	**Prepared by:**	Theresa Matula Committee Staff
Analysis of:	PCS to First Edition H698-CSSH-44		

SUMMARY: House Bill 698 requires the Commission for Public Health to adopt rules to implement a screening test for severe combined immunodeficiency (SCID) and other T-Cell lymphopenias detectable as a result of SCID; it authorizes a fee increase from $19 to $24; and it contains an appropriation of $466,132 for the 2015-16 fiscal year to purchase laboratory instrumentation and upgrades to the NC State Laboratory of Public Health. The PCS corrects a statutory citation.

CURRENT LAW: **G.S. 130A-125** pertains to the screening of newborns for metabolic and other hereditary and congenital disorders. **G.S. 130A-25(a)** requires the Department to establish and administer a Newborn Screening Program to include the development and distribution of educational materials regarding the availability and benefits of newborn screening; laboratory testing; the development of follow-up protocols to assure early treatment for identified children, and the provision of genetic counseling and support services; the provision of necessary dietary treatment products or medications for identified children; the provision of physiological screening in each ear for the presence of permanent hearing loss; and the provision of pulse oximetry screening to detect congenital heart defects. **G.S. 130A-125(c)** authorizes a fee $19.00 for the laboratory test performed by the State Laboratory of Public Health under this section. The fee for a laboratory test is a departmental receipt and must be used to offset the cost of the Newborn Screening Program.

BILL ANALYSIS: **Section 1** of House Bill 698 amends G.S. 130A-125(c) to authorize a fee increase from $19 to $24 for the Newborn Screening Program laboratory tests. **Section 2** requires the Commission for Public Health to amend the rules for the Newborn Screening Program to require a screening test for severe combined immunodeficiency (SCID) and other T-Cell lympopenias detectable as a result of SCID. **Section 3** contains a $466,132 appropriation to the Department of Health and Human Services, Division of Public Health, for the 2015-16 fiscal year to be used to purchase laboratory instrumentation and upgrades to the existing NC State Laboratory of Public Health Laboratory Information System in order to provide the required informatics capabilities for newborn screening and other laboratory operations.

EFFECTIVE DATE: The bill would become effective July 1, 2015.

BACKGROUND: HB 97, v.5, provides funding for "Pending Legislation" under "Reserves and Debt Service" and HB 698 is listed as pending legislation under item #12 in Section L: Reserves Debt Service and Adjustments, House money report.

Newborns are tested through the State Laboratory of Public Health for a number of conditions and disorders. The following link provides NC newborn screening information: http://slph.ncpublichealth.com/newborn/default.asp. Additional information on SCID: National Human Genome Research Institute: http://www.genome.gov/13014325 & Centers for Disease Control and Prevention: http://www.cdc.gov/newbornscreening/scid.html.

O. Walker Reagan
Director

H698-SMSH-64 CSSH-44 -V3

Research Division
(919) 733-2578

This bill analysis was prepared by the nonpartisan legislative staff for the use of legislators in their deliberations and does not constitute an official statement of legislative intent.

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2015

H D

HOUSE BILL 698
PROPOSED COMMITTEE SUBSTITUTE H698-CSSH-44 [v.1]

5/26/2015 11:45:41 AM

Short Title: Baby Carlie Nugent Bill. (Public)

Sponsors:

Referred to:

April 15, 2015

A BILL TO BE ENTITLED

AN ACT INCREASING THE FEE FOR LABORATORY TESTS PERFORMED BY THE STATE LABORATORY OF PUBLIC HEALTH UNDER THE NEWBORN SCREENING PROGRAM; ADDING A SCREENING TEST FOR SEVERE COMBINED IMMUNODEFICIENCY TO THE NEWBORN SCREENING PANEL; AND APPROPRIATING FUNDS TO THE DEPARTMENT OF HEALTH AND HUMAN SERVICES, DIVISION OF PUBLIC HEALTH, TO PURCHASE NECESSARY EQUIPMENT AND UPGRADES AT THE STATE LABORATORY OF PUBLIC HEALTH FOR NEWBORN SCREENING AND ALL OTHER LABORATORY OPERATIONS.

Whereas, severe combined immunodeficiency (SCID), often known as "bubble boy disease," is a primary immune deficiency caused by several different genetic defects, most of which are hereditary; and

Whereas, children born with SCID lack immunity against bacteria, viruses, and fungi and are prone to repeated and persistent infections that would not cause serious illness in a person or infant with a normal immune system; and

Whereas, unless treated early, a child will mostly likely die from opportunistic infections as an infant; and

Whereas, it has been known for the past 15 years that early recognition of SCID through newborn screening is critical to successful management of patients with SCID; and

Whereas, Baby Carlie Nugent of Harrisburg died in 2000 at the age of 7 months from complications of SCID following a bone marrow transplant because her condition was not diagnosed until she was more than 6 months old; and

Whereas, early screening for SCID prior to 3.5 months of age could have saved her life; and

Whereas, development and implementation of a screening test for T-Cell lymphopenia has been accomplished, which led to the unanimous recommendation by the United States Secretary of Health and Human Service's Advisory Committee on Heritable Disorders of Newborns and Children in January 2010 to add SCID to the list of conditions routinely screened for at birth; and

Whereas, as of November 2014, there are 26 states screening for SCID and the North Carolina Newborn Screening Advisory Committee unanimously approved adding SCID to this State's newborn screening panel in January 2011, yet SCID screening still has not started in this State; and

Whereas, the leading center for treatment of SCID in the United States is located in North Carolina at the Duke University Medical Center; and

Whereas, that Center demonstrated in 1999 that, if a bone marrow transplant could be performed before a baby is 3.5 months of age, there is a 94% survival rate, compared with a 70% survival rate if the infant is transplanted after that age; and

Whereas, infants who do not receive a bone marrow transplant are likely to die before the age of two; and

Whereas, in addition to saving lives, the early diagnosis of SCID also saves money, considering the cost of testing a SCID newborn who is not diagnosed until there is a serious infection can range from five hundred thousand dollars ($500,000) to well over four million five hundred thousand dollars ($4,500.000), while the cost of transplanting a SCID infant who is not sick is usually less than one hundred thousand dollars ($100,000); Now, therefore,

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 130A-125(c) reads as rewritten:

"(c) A fee of ~~nineteen~~ twenty-four dollars ~~($19.00)~~($24.00) applies to a laboratory test performed by the State Laboratory of Public Health pursuant to this section. The fee for a laboratory test is a departmental receipt of the Department and shall be used to offset the cost of the Newborn Screening Program."

SECTION 2. The Commission for Public Health shall amend rules adopted pursuant to G.S. 130A-125 to implement the Newborn Screening Program established under said section to add to the newborn screening panel a screening test for severe combined immunodeficiency (SCID) and other T-Cell lymphopenias detectable as a result of SCID.

SECTION 3. There is appropriated from the General Fund to the Department of Health and Human Services, Division of Public Health, the sum of four hundred sixty-six thousand one hundred thirty-two dollars ($466,132) for the 2015-2016 fiscal year. These funds shall be used to purchase laboratory instrumentation and upgrades to the existing North Carolina State Laboratory of Public Health (NCSLPH) Laboratory Information System in order to provide the required informatics capabilities for newborn screening and all other laboratory operations at the NCSLPH.

SECTION 4. This act becomes effective July 1, 2015.

HOUSE BILL 698

Short Title:	Baby Carlie Nugent Bill.	(Public)
Sponsors:	Representatives Jeter, Lambeth, and Adcock (Primary Sponsors). *For a complete list of Sponsors, refer to the North Carolina General Assembly Web Site.*	
Referred to:	Health, if favorable, Finance, if favorable, Appropriations.	

April 15, 2015

A BILL TO BE ENTITLED

AN ACT INCREASING THE FEE FOR LABORATORY TESTS PERFORMED BY THE STATE LABORATORY OF PUBLIC HEALTH UNDER THE NEWBORN SCREENING PROGRAM; ADDING A SCREENING TEST FOR SEVERE COMBINED IMMUNODEFICIENCY TO THE NEWBORN SCREENING PANEL; AND APPROPRIATING FUNDS TO THE DEPARTMENT OF HEALTH AND HUMAN SERVICES, DIVISION OF PUBLIC HEALTH, TO PURCHASE NECESSARY EQUIPMENT AND UPGRADES AT THE STATE LABORATORY OF PUBLIC HEALTH FOR NEWBORN SCREENING AND ALL OTHER LABORATORY OPERATIONS.

Whereas, severe combined immunodeficiency (SCID), often known as "bubble boy disease," is a primary immune deficiency caused by several different genetic defects, most of which are hereditary; and

Whereas, children born with SCID lack immunity against bacteria, viruses, and fungi and are prone to repeated and persistent infections that would not cause serious illness in a person or infant with a normal immune system; and

Whereas, unless treated early, a child will mostly likely die from opportunistic infections as an infant; and

Whereas, it has been known for the past 15 years that early recognition of SCID through newborn screening is critical to successful management of patients with SCID; and

Whereas, Baby Carlie Nugent of Harrisburg died in 2000 at the age of 7 months from complications of SCID following a bone marrow transplant because her condition was not diagnosed until she was more than 6 months old; and

Whereas, early screening for SCID prior to 3.5 months of age could have saved her life; and

Whereas, development and implementation of a screening test for T-Cell lymphopenia has been accomplished, which led to the unanimous recommendation by the United States Secretary of Health and Human Service's Advisory Committee on Heritable Disorders of Newborns and Children in January 2010 to add SCID to the list of conditions routinely screened for at birth; and

Whereas, as of November 2014, there are 26 states screening for SCID and the North Carolina Newborn Screening Advisory Committee unanimously approved adding SCID to this State's newborn screening panel in January 2011, yet SCID screening still has not started in this State; and

Whereas, the leading center for treatment of SCID in the United States is located in North Carolina at the Duke University Medical Center; and

Whereas, that Center demonstrated in 1999 that, if a bone marrow transplant could be performed before a baby is 3.5 months of age, there is a 94% survival rate, compared with a 70% survival rate if the infant is transplanted after that age; and

Whereas, infants who do not receive a bone marrow transplant are likely to die before the age of two; and

Whereas, in addition to saving lives, the early diagnosis of SCID also saves money, considering the cost of testing a SCID newborn who is not diagnosed until there is a serious infection can range from five hundred thousand dollars ($500,000) to well over four million five hundred thousand dollars ($4,500,000), while the cost of transplanting a SCID infant who is not sick is usually less than one hundred thousand dollars ($100,000); Now, therefore,

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 130A-125(c) reads as rewritten:

"(c) A fee of ~~nineteen~~ twenty-four dollars ~~($19.00)~~($24.00) applies to a laboratory test performed by the State Laboratory of Public Health pursuant to this section. The fee for a laboratory test is a departmental receipt of the Department and shall be used to offset the cost of the Newborn Screening Program."

SECTION 2. The Commission for Public Health shall amend rules adopted pursuant to G.S. 130A-25 to implement the Newborn Screening Program established under said section to add to the newborn screening panel a screening test for severe combined immunodeficiency (SCID) and other T-Cell lymphopenias detectable as a result of SCID.

SECTION 3. There is appropriated from the General Fund to the Department of Health and Human Services, Division of Public Health, the sum of four hundred sixty-six thousand one hundred thirty-two dollars ($466,132) for the 2015-2016 fiscal year. These funds shall be used to purchase laboratory instrumentation and upgrades to the existing North Carolina State Laboratory of Public Health (NCSLPH) Laboratory Information System in order to provide the required informatics capabilities for newborn screening and all other laboratory operations at the NCSLPH.

SECTION 4. This act becomes effective July 1, 2015.

march of dimes
working together for stronger, healthier babies

A bone marrow transplant was supposed to be the key to saving my seven-month-old daughter's life. Six weeks prior, Carlie had been diagnosed with Severe Combined Immune Deficiency (SCID), a genetic immunodeficiency also known as "bubble boy" disease. Simply put, she did not have an immune system.

20 days after her bone marrow transplant, Carlie seemed stable, so the doctors took her off the ventilator. My husband and I watched her squirm and wiggle as she tried to cough out the tube, fighting the ventilator. Her numbers looked good for a baby who had Respiratory Syncytial Virus (RSV) with pneumonia and adenovirus and no immune system to fight them.

I got to hold Carlie that day, which I hadn't been able to do for a while. Getting to hold her was amazing, and watching her move around was like seeing my child reborn. These simple acts filled us with hope that the transplant was working—that we had caught the disease in time to save her.

Carlie fought so hard to breathe on her own, but after 16 hours, she was put back on the ventilator. Around 9 a.m. her heart stopped. The doctors were able to quickly revive her, but a few hours later, her heart stopped again. When it happened a third time, all our hope was lost. I watched helplessly as Carlie's heartbeat faded and her life slipped away from me. Her poor little body simply couldn't endure anymore. Carlie Michelle Nugent passed away at 2 p.m., Wednesday, February 23, 2000, at the age of seven months.

After her death, I desperately wanted to turn back the clock to the day she was born and test her for this disease that doesn't show symptoms until it's too late. She seemed so healthy at birth and that's the thing about SCID: babies appear perfectly healthy. I never could have imagined that just seven short months after I brought her into this world I would be kissing her forehead, saying goodbye and watching her drift away from me. Her death left a sharp pain in my heart that has never dulled.

I've spent the past 15 years trying to bury the pain of losing my daughter so I can be the mom my two surviving children need me to be and the wife my husband needs while trying to cope with knowing how easy and inexpensive it would have been to save her life by testing her at birth.

As a mother of a baby born with SCID, I don't want other parents to have to spend the rest of their lives haunted by the idea that a simple blood test at birth was all that stood in the way of watching their babies grow up. We must test all infants at birth so we can eradicate this treatable but deadly disorder. And if, because of Carlie, other lives can be saved—and other mothers can watch their babies live full, healthy lives—her short, little life will hold greater meaning, and I will know she wasn't taken in vain.

With hope,

Stephanie Nugent

Stephanie Nugent

NORTH CAROLINA GENERAL ASSEMBLY
HOUSE OF REPRESENTATIVES

HEALTH COMMITTEE REPORT
Representative Brian Brown, Co-Chair
Representative Justin P. Burr, Co-Chair
Representative Bert Jones, Co-Chair
Representative Donny Lambeth, Co-Chair

FAVORABLE COM SUB , UNFAVORABLE ORIGINAL BILL AND RE-REFERRED

HB **698** Baby Carlie Nugent Bill.

Draft Number:	H698-PCS30387-SH-44
Serial Referral:	**FINANCE**
Recommended Referral:	None
Long Title Amended:	No
Floor Manager:	Jeter

TOTAL REPORTED: 1

NORTH CAROLINA GENERAL ASSEMBLY
HOUSE OF REPRESENTATIVES

HEALTH COMMITTEE REPORT
Representative Brian Brown, Co-Chair
Representative Justin P. Burr, Co-Chair
Representative Bert Jones, Co-Chair
Representative Donny Lambeth, Co-Chair

FAVORABLE AND RE-REFERRED

SB **286** **(CS#1)** Regulate the Sale of E-Liquid Containers.

Draft Number:	None
Serial Referral:	**COMMERCE AND JOB DEVELOPMENT**
Recommended Referral:	None
Long Title Amended:	No
Floor Manager:	Watford

FAVORABLE HOUSE COM SUB, UNFAVORABLE SENATE COM SUB NO. 2 AND RE-REFERRED

SB **7** **(CS#2)** Allow Seating for Food Stand Customers.

Draft Number:	S7-PCS45371-SH-45
Serial Referral:	**COMMERCE AND JOB DEVELOPMENT**
Recommended Referral:	None
Long Title Amended:	Yes
Floor Manager:	B. Brown

TOTAL REPORTED: 2

Wednesday, May 27 HEALTH	Room 643	Time 10:00 am

Name	County	Sponsor
Kerry Aguilera	Yadkin	Lee Zachary
Tim Montague	Wake	Rosa U. Gill
Tanner Morrison	Forsyth	Donny Lambeth
Kyle Corbett	Moore	James L. Boles, Jr.
Allee Reid	Randolph	Allen McNeill

Committee Sergeants at Arms

NAME OF COMMITTEE House Comm. on Health

DATE: 05/27/15 Room: 643

House Sgt-At Arms:

1. Name: Young Bae
2. Name: Bill Morris
3. Name: Jim Moran
4. Name: Joe Crook
5. Name: _____

Senate Sgt-At Arms:

1. Name: _____
2. Name: _____
3. Name: _____
4. Name: _____
5. Name: _____

VISITOR REGISTRATION SHEET

House Comm. on Health — 05/27/15

Name of Committee — Date

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Sandi Buchanan	Mecklenburg County Medical Society 1112 Harding Place, Charlotte NC 28204
SIMON WARD	" AS ABOVE "
ALAN DELLAPENNA	DIVISION OF PUBLIC HEALTH 5505 SIX FORKS ROAD, RALEIGH, NC
Tanika Reddon	Division of Public Health 5505 Six Forks Rd. Raleigh, NC
Jennifer Gasperini	NCMS
Robert Mitth	Meck Cty Med Soc (see above)
ANDREW W	NCMS
Paul	NCMS
Derek Schroder	NCMS
Brian Merwald	WM
Pat O'Connell	MOP
Tiffany Gladin	Blue Cross Blue Shield of NC 4554 Falls of Neuse Suite 100 Raleigh NC 27609
C	AT&T

VISITOR REGISTRATION SHEET

House Comm. on Health — 05/27/15

Name of Committee — Date

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Catherine Heindselman	March of Dimes 6504 Falls of Neuse Rd Ste 100 Raleigh NC 27615
Jim Martin	TRCB, Div of Public Health
[signature]	BCI
Gene Ainsworth	A&A
Elizabeth Hudgins	NCPeds
Jeff Furst	March of Dimes
Stephanie Nugent	March of Dimes
Rebecca H. Buckley	March of Dimes
Annaliese Dolph	DL
Tom Vitagliano	NC Child
J.W. Joyner	New Frame
Bubba White	New Frame

VISITOR REGISTRATION SHEET

House Comm. on Health — 05/27/15

Name of Committee — Date

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Amanda Honaker	TSS
Lou Turner	DHHS/SLPH
Scott Zimmerman	DHHS/SLPH
[illegible]	NCPHA
Kate Torrey	NCGV
Sarah Wolfe	NMC
Elizabeth Schab	NCPHA
Sarah Beller	Brubaker CHS SCC
[illegible]	CSS
[illegible]	CSS
[illegible]	CSS

VISITOR REGISTRATION SHEET

House Comm. on Health — 05/27/15

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NAME	FIRM OR AGENCY AND ADDRESS
Judy Jenkins	Otsuka
Cindy Callahan	NCDHHS
Larry Michael	NCDHHS
Rochelle Spanko	CFSA
Steven Mange	NCRLA
Trent Womble	DHHS
Lori Ann Thomas	LNHA
[illegible]	[illegible]
TJ Bugbee	NP
Matthew McConnell	Carolinas HealthCare Sys
Christine Craig	WakeMed

VISITOR REGISTRATION SHEET

House Comm. on Health — 05/27/15

Name of Committee — Date

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NAME	FIRM OR AGENCY AND ADDRESS
Cody Hand	NCHA
Erica Nelson	NCHHA
Lori Kroll	Novant Health
Daniel VanLiere	Vidant Health
Ryan Blackledge	Cone Health
Peg Thompson	
Carmen Johnson	MVA
Joana Sprunt	NCAFP
Allison Stewart	cardinal
Amy McConkey	NC Beverage
Joe Lanier	Cardinal

VISITOR REGISTRATION SHEET

House Comm. on Health — 05/27/15

Name of Committee — Date

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Madeline Keeter	Caremont Health

VISITOR REGISTRATION SHEET

House Comm. on Health — 05/27/15

Name of Committee — Date

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Kay Castillo	NASW-NC
James Stanley	Benchmark/Methodist Home NC
	R. Randolph Assoc.
Courtney Lockamy	Randolph Clark & assoc.
Matt Fox	NCPC

House Committee on Health
Wednesday, June 3, 2015, 10:00 AM
643 Legislative Office Building

AGENDA

Welcome and Opening Remarks

Introduction of Pages & Sgt.-at-Arms

Bills

BILL NO.	SHORT TITLE	SPONSOR
SB 366	Amend Certain Reqs/Permanency Innovation Comm.	Senator Barringer
SB 487	Health Choice Technical Revisions.-AB	Senator Pate
SB 423	Foster Care Family Act.	Senator Barringer Senator Harrington Senator Tucker

Adjournment

House Committee on Health
Wednesday, June 3, 2015 at 10:00 AM
Room 643 of the Legislative Office Building

MINUTES

The House Committee on Health met at 10:00 AM on June 3, 2015 in Room 643 of the Legislative Office Building. Representatives Adcock, Avila, Bishop, Blackwell, Brawley, R. Brown, B. Brown, Dobson, Dollar, Earle, Farmer-Butterfield, Insko, Jones, Lambeth, Lucas, S. Martin, Pendleton, Setzer, Waddell, and Yarborough attended.

Representative Donny Lambeth, Chair, presided.

The following bills were considered:

SB 366 Amend Certain Reqs/Permanency Innovation Comm. (Senator Barringer)

Senator Barringer was recognized to present the bill, which corrects certain committee requirements. Representative Avila moved for a favorable report. The motion carried.

SB 487 Health Choice Technical Revisions.-AB (Senator Pate)

Representative B. Brown made a motion to bring the PCS for the bill to the committee. Senator Barringer was recognized to explain SB 487, which makes technical corrections to NC Health Choice Program. Representatives Blackwell and Dobson had questions. Adam Sholar, DHH, was recognized to answer questions about the bill. Representative Blackwell moved for a favorable report, unfavorable to the original. The motion carried.

SB 423 Foster Care Family Act. (Senators Barringer, Harrington, Tucker)

Senator Barringer was recognized to present the bill, which helps strengthen and reform the current foster care system in North Carolina. Several committee members had comments in support of this bill. Representative Farmer-Butterfield made a motion for a favorable report with re-referral to Judiciary III. The motion carried.

The meeting adjourned at 10:42.

Representative Donny Lambeth, Chair
Presiding

Brenda Olls, Committee Clerk

SENATE BILL 366: Amend Certain Reqs/Permanency Innovation Comm

2015-2016 General Assembly

Committee:	House Health	**Date:**	June 3, 2015
Introduced by:	Sen. Barringer	**Prepared by:**	Jennifer Mundt Committee Staff
Analysis of:	First Edition		

SUMMARY: ***Senate Bill 366 would amend the reporting and meeting requirements of the Permanency Innovation Initiative Oversight Committee.***

CURRENT LAW and BILL ANALYSIS:

Under current law, the Permanency Innovation Initiative Oversight Committee (Committee) is directed to meet at least once a quarter and to report its findings and recommendations to the General Assembly by September 15 each year.

Senate Bill 366 would reduce number of meetings the Committee must hold from quarterly to at least twice a year. The bill would also change the Committee's reporting requirements to specifically name the chairs of the Senate and House Appropriations Subcommittees on Health and Human Services and the Fiscal Research Division and move the reporting date to February 15 each year.

EFFECTIVE DATE: This act is effective when it becomes law.

BACKGROUND: The Permanency Innovation Initiative Oversight Committee (Committee) was established in the 2013 Appropriation Act (Section 12C.10 of S.L. 2013-360; Part 2 of Article 1A of Chapter 131D of the General Statutes). The 11-member Committee is tasked with:

- Designing and implementing a data tracking methodology to collect and analyze information to gauge the success of the initiative.
- Developing a methodology to identify short- and long-term cost savings in the provision of foster care and any potential reinvestment strategies.
- Overseeing program implementation to ensure fidelity to the *Family Finding* and *Child Specific Adoption Recruitment Services* program models.
- Studying, reviewing, and recommending other policies and services that may positively impact permanency and well-being outcomes.

The Committee oversees the services the Children's Home Society of North Carolina which is directed to develop a demonstration project to: (i) improve permanency outcomes for children living in foster care through reunification with parents, providing placement or guardianship with other relatives, or adoption; (ii) improve engagement with biological relatives of children in or at risk of entering foster care; and (iii) reduce costs associated with maintaining children in foster care.

Section 12C.6 of the 5th Edition of the 2015 House Budget would do the following

- Increase the membership of Committee from 11 to 12; the new member must be a representative from Youth Villages and appointed by the Governor.
- Amend the powers and duties of the Committee to include gauging the success of the proposed *Transitional Living Services* program and review of the program's implementation.

O. Walker Reagan
Director

Research Division
(919) 733-2578

This analysis was prepared by the nonpartisan legislative staff for the use of legislators in their deliberations and does not constitute an official statement of legislative intent.

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2015

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SENATE BILL 366

Short Title:	Amend Certain Reqs/Permanency Innovation Comm.	(Public)
Sponsors:	Senator Barringer (Primary Sponsor).	
Referred to:	Rules and Operations of the Senate.	

March 24, 2015

A BILL TO BE ENTITLED

AN ACT TO AMEND THE REPORTING AND MEETING REQUIREMENTS UNDER THE LAWS PERTAINING TO THE PERMANENCY INNOVATION INITIATIVE OVERSIGHT COMMITTEE.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 131D-10.9A reads as rewritten:

"**§ 131D-10.9A. Permanency Innovation Initiative Oversight Committee created.**

...

(d) Reports. – The Committee shall report its analysis and any findings and recommendations to the ~~General Assembly by September 15~~chairs of the Senate Appropriations Committee on Health and Human Services, the chairs of the House of Representatives Appropriations Committee on Health and Human Services, and the Fiscal Research Division by February 15 of each year.

(e) Organization. – The President Pro Tempore of the Senate and the Speaker of the House of Representatives shall each designate a cochair of the Committee. The Committee shall meet at least ~~once a quarter~~twice each year upon the joint call of the cochairs. A quorum of the Committee is seven members. No action may be taken except by a majority vote at a meeting at which a quorum is present.

...."

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

SENATE BILL 487:
Health Choice Technical Revisions.-AB

2015-2016 General Assembly

Committee:	House Health	**Date:**	June 3, 2015
Introduced by:	Sen. Pate	**Prepared by:**	Jennifer Mundt Committee Staff
Analysis of:	PCS to Second Edition S487-CSTA-8 [v.1]		

SUMMARY: The proposed committee substitute (PCS) for Senate Bill 487 would amend the statutes governing the Health Insurance Program for Children (North Carolina Health Choice), as recommended by the Department of Health and Human Services (Department).

The PCS makes technical and conforming changes only.

CURRENT LAW and BILL ANALYSIS:

Section 1 would repeal the obsolete definition "Processor Plan" from the statutes governing North Carolina Health Choice for Children (Program).

Section 2 would provide that the administration of timely claims processing under the Program must be provided as described in federal law.

Section 3 would repeal the Child Health Insurance Fund. The Fund was established in 2008 and is comprised of deposits from premium receipts or any other receipts, including earnings on investments, occurring or arising in connection with acute medical care benefits provided under the Program. Disbursements from the Fund include any and all amounts required to pay the benefits and administrative costs of the Program.

Section 4 would clarify that payments to Program providers must be paid in full and not subject to cost settlement.

Section 5 would make conforming changes and repeal the requirement that the Department periodically report to the Joint Legislative Oversight Committee on Health and Human Services on data collected pursuant to the Program.

EFFECTIVE DATE: This act is effective when it becomes law.

BACKGROUND: The North Carolina Health Choice Insurance Program for Children (Program) is a comprehensive health coverage program for low-income children between the ages of 6 and 18 who are residents of this State. The children must: (i) be ineligible for Medicaid, Medicare, or other federal government sponsored health insurance; (ii) be uninsured; (iii) be in a family whose income is between 133% and 200% of the federal poverty level; (iv) be State residents and eligible under federal law; and (v) pay the required Program enrollment fee.

Coverage is provided from federal funds received, State funds appropriated, and other nonappropriated funds made available for this purpose. The Department provides services to children enrolled in the Program through Community Care of North Carolina and pays providers per member, per month fees as allowed under Medicaid.

O. Walker Reagan
Director

S487-SMTA-18 CSTA-8 -V4

Research Division
(919) 733-2578

This bill analysis was prepared by the nonpartisan legislative staff for the use of legislators in their deliberations and does not constitute an official statement of legislative intent.

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2015

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SENATE BILL 487
Second Edition Engrossed 4/15/15
PROPOSED HOUSE COMMITTEE SUBSTITUTE S487-CSTA-8 [v.1]

5/29/2015 4:41:14 PM

Short Title: Health Choice Technical Revisions.-AB (Public)

Sponsors:

Referred to:

March 26, 2015

A BILL TO BE ENTITLED

AN ACT TO UPDATE OUTDATED AND OBSOLETE PROVISIONS IN CHAPTER 108A OF THE GENERAL STATUTES ON THE NC HEALTH CHOICE PROGRAM IN ORDER TO AVOID CONFUSION BY STAKEHOLDERS AND TO INCREASE EFFICIENCIES IN THE ADMINISTRATION OF THE PROGRAM.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 108A-70.18 reads as rewritten:

"**§ 108A-70.18. Definitions.**

As used in this Part, unless the context clearly requires otherwise, the term:

(1) "Comprehensive health coverage" means creditable health coverage as defined under Title XXI.

(2) "Family income" has the same meaning as used in determining eligibility for the Medical Assistance Program.

(3) "FPL" or "federal poverty level" means the federal poverty guidelines established by the United States Department of Health and Human Services, as revised each April 1.

(4) "Medical Assistance Program" means the State Medical Assistance Program established under Part 6 of Article 2 of Chapter 108A of the General Statutes.

~~(4a) "Predecessor Plan" means the North Carolina Teachers' and State Employees' Comprehensive Major Medical Plan in effect prior to July 1, 2008.~~

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

(6) "State Plan" means the State Child Health Plan for the State Children's Health Insurance Program established under Title XXI.

(7) "Title XXI" means Title XXI of the Social Security Act, as added by Pub. L. 105-33, 111 Stat. 552, codified in scattered sections of 42 U.S.C.

(8) "Uninsured" means the applicant for Program benefits is not covered under any private or employer-sponsored comprehensive health insurance plan on the date of enrollment."

SECTION 2. G.S. 108A-70.20 reads as rewritten:

"**§ 108A-70.20. Program established.**

The Health Insurance Program for Children is established. The Program shall be known as North Carolina Health Choice for Children, and it shall be administered by the Department of

Health and Human Services in accordance with this Part and as required under Title XXI and related federal rules and regulations. Administration of ~~Program benefits and~~ claims processing shall be as ~~provided under Part 5 of Article 3 of Chapter 135 of the General Statutes.~~described in 42 C.F.R. 447.45(d)(1)."

SECTION 3. G.S. 108A-70.20A is repealed.

SECTION 4. G.S. 108A-70.21 reads as rewritten:

"**§ 108A-70.21. Program eligibility; benefits; enrollment fee and other cost-sharing; coverage from private plans; purchase of extended coverage.**

...

(b1) Payments. – Prescription drug providers shall accept as payment in full, for outpatient prescriptions filled, amounts allowable for prescription drugs under Medicaid. For all other providers, services provided to children enrolled in the Program shall be provided at rates equivalent to one hundred percent (100%) of Medicaid rates, less any co-payments assessed to enrollees under this Part. Payments to NC Health Choice Program providers under this Part shall be paid in full and shall not be subject to cost settlement.

...

(e) Cost-Sharing Limitations. – The ~~department~~ Department shall establish maximum annual cost-sharing limits per individual or family, provided that the total annual aggregate cost-sharing, including enrollment fees, with respect to all children in a family receiving benefits under this section shall not exceed five percent (5%) of the family's income for the year involved.

...."

SECTION 5. G.S. 108A-70.27 reads as rewritten:

"**§ 108A-70.27. Data collection; reporting.**

(a) The Department shall ensure that the following data are collected, analyzed, and reported in a manner that will most effectively and expeditiously enable the State to evaluate Program goals, objectives, operations, and health outcomes for children:

(1) Number of applicants for coverage under the Program;

(2) Number of Program applicants deemed eligible for Medicaid;

(3) Number of applicants deemed eligible for the Program, by income level, age, and family size;

(4) Number of applicants deemed ineligible for the Program and the basis for ineligibility;

(5) Number of applications made at county departments of social services, public health departments, and by mail;

(6) Total number of children enrolled in the Program to date and for the immediately preceding fiscal year;

(7) Total number of children enrolled in Medicaid through the Program application process;

(8) Trends showing the Program's impact on hospital utilization, immunization rates, and other indicators of quality of care, and cost-effectiveness and efficiency;

(9) Trends relating to the health status of children;

(10) Other data that would be useful in carrying out the purposes of this Part.

(b) Repealed by Session Laws 2013-360, s. 12A.8(e), effective July 1, 2013.

(c) The Division of Medical Assistance shall provide to the Department data required under this section that are collected by ~~the Plan~~ this Division. Data shall be reported by ~~the Plan~~ the Division of Medical Assistance in sufficient detail to meet federal reporting requirements under Title XXI. ~~The Plan shall report periodically to the Joint Legislative Oversight Committee on Health and Human Services claims processing data for the Program and any~~

~~other information the Plan or the Committee deems appropriate and relevant to assist the Committee in its review of the Program.~~"

SECTION 6. This act is effective when it becomes law.

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2015

S D

SENATE BILL 487
Second Edition Engrossed 4/15/15
PROPOSED HOUSE COMMITTEE SUBSTITUTE S487-CSTA-8 [v.1]

5/29/2015 4:41:14 PM

Short Title: Health Choice Technical Revisions.-AB (Public)

Sponsors:

Referred to:

March 26, 2015

A BILL TO BE ENTITLED

AN ACT TO UPDATE OUTDATED AND OBSOLETE PROVISIONS IN CHAPTER 108A OF THE GENERAL STATUTES ON THE NC HEALTH CHOICE PROGRAM IN ORDER TO AVOID CONFUSION BY STAKEHOLDERS AND TO INCREASE EFFICIENCIES IN THE ADMINISTRATION OF THE PROGRAM.

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SECTION 6. This act is effective when it becomes law.

SENATE BILL 487
Second Edition Engrossed 4/15/15

Short Title:	Health Choice Technical Revisions.-AB	(Public)
Sponsors:	Senators Pate (Primary Sponsor); and Hise.	
Referred to:	Rules and Operations of the Senate.	

March 26, 2015

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SECTION 6. This act is effective when it becomes law.

SENATE BILL 423:
Foster Care Family Act

2015-2016 General Assembly

Committee:	House Health, if favorable, Judiciary III, if favorable, Insurance	**Date:**	June 2, 2015
Introduced by:	Sens. Barringer, Harrington, Tucker	**Prepared by:**	Tawanda Foster Committee Counsel
Analysis of:	Third Edition		

SUMMARY:

Senate Bill 423 would amend the law applying to foster care families through: 1) the implementation of a reasonable and prudent parent standard; 2) providing liability insurance for foster parents; 3) reducing barriers to obtaining a driver's license for foster children; and 4) requiring the Department of Health and Human Services (DHHS) to study a Medicaid waiver for children with serious emotional disturbance.

[As introduced, this bill was identical to H407, as introduced by Reps. Stevens, Glazier, which is currently in Rules and Operations of the Senate.]

BILL ANALYSIS:

Section 2.1 creates a new section that would establish the reasonable and prudent parenting standard for foster care caregivers. A caregiver must apply the standard when determining if a child can participate in extracurricular, enrichment, or social activities. A caregiver has the authority to provide or withhold permission to participate in normal childhood activities, which includes sleepovers, without prior approval of the court or a county department of social services.

Under the new section, a caregiver would not be liable for 1) an act or omission of a foster child if the caregiver or county department of social services acted in accordance with the reasonable and prudent parenting standard or 2) for injuries to the child that occur as a result of reasonable and prudent parenting standard. The burden of proof for a breach of the reasonable and prudent parenting standard would be by clear and convincing evidence.

The caregiver would be liable for any action or inaction of gross negligence, willful and wanton conduct, or intentional wrongdoing that results in injury.

Section 2.2 would amend G.S. 7B-505(b) to require DHHS to make diligent efforts to notify relatives and any custodial parents of the juvenile's siblings that the juvenile is in nonsecure custody and of nonsecure custody hearings.

Section 2.3 would amend G.S. 7B-800.1(a)(4) to require the court to consider, prior to the adjudicatory hearing, whether parents with custody of a sibling of the juvenile have been identified and notified as potential resources for placement and support.

Section 2.4 would amend G.S. 7B-901 to require the court to inquire, at dispositional hearings, about efforts made to identify and notify parents with custody of a sibling of the juvenile as potential resources for placement or support.

Section 2.5 would add a new section to authorize a county department of social services (DSS) with custody of a juvenile to make decisions about matters generally made by a juvenile's custodian and to provide or withhold permission to allow a juvenile to participate in normal childhood activities.

Second, it would also add requirements for every permanency planning hearing for a juvenile in the custody of DSS who has reached the age of 14 years or more, including that the court inquire and make written findings regarding the child's transition to adulthood and whether Another Planned Permanent Living Arrangement (APPLA) would be an appropriate plan for the juvenile.

Section 3.1 would add a new section to require the Rate Bureau to develop an optional policy form or endorsement to be filed with the Commissioner of Insurance for approval no later than May 1, 2016 that provides liability insurance to licensed foster parents.

Section 4.1 would add a new section to deem minors 16 years or older in the legal custody of DSS qualified and competent to contract for the purchase of an automobile insurance policy with the consent of the court. The minor would be responsible for paying for the insurance and be liable for damages caused by his or her negligent operation of a vehicle.

Section 4.2 would amend G.S. 20-11(i) to clarify who must sign an application for a learner's permit or provisional driver's license for a minor in the legal custody of the DSS.

Section 4.3 would add a new section to allow a foster parent to meet the financial responsibility requirements for vehicle registration, even if a foster child residing in the household is excluded under the parent's policy, as long as the child is insured under some other policy of liability insurance or a named non-owner's liability policy. The Rate Bureau would establish, with the Commissioner's approval, a named driver exclusion endorsement for foster children.

Section 4.4 would make conforming changes to G.S. 20-279.21(b) ("Motor vehicle liability policy" defined) consistent with Section 4.3.

Section 5.1(a) would require the DHHS, Division of Medical Assistance to design and draft, but not submit, a 1915(c) Medicaid waiver to serve children with Serious Emotional Disturbance (SED) in home and community-based settings.

Section 5.1(b) would require the DHHS to report the draft waiver, other findings, and any other options or recommendations to best serve children with SED to the Joint Legislative Oversight Committee on Health and Human Services by December 1, 2015.

EFFECTIVE DATE: Parts 2 and 4 of this act would become effective on October 1, 2015. The remainder of this act is effective when it becomes law.

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2015

S 3

SENATE BILL 423
Health Care Committee Substitute Adopted 4/15/15
Insurance Committee Substitute Adopted 4/23/15

Short Title: Foster Care Family Act. (Public)

Sponsors:

Referred to:

March 26, 2015

A BILL TO BE ENTITLED

AN ACT TO ALIGN STATE LAW WITH FEDERAL LAW BY PROVIDING FOR THE SUPPORT OF HEALTHY DEVELOPMENT OF YOUTH IN FOSTER CARE THROUGH IMPLEMENTATION OF A REASONABLE AND PRUDENT PARENTING STANDARD FOR DECISIONS MADE BY A FOSTER PARENT OR A DESIGNATED OFFICIAL FOR A CHILD CARE INSTITUTION AND REVISING THE LAWS PERTAINING TO ABUSE, NEGLECT, AND DEPENDENCY REGARDING JUVENILE PLACEMENT UNDER THE JUVENILE CODE; TO PROVIDE LIABILITY INSURANCE FOR FOSTER PARENTS; TO REDUCE BARRIERS TO OBTAINING A DRIVERS LICENSE FOR FOSTER CHILDREN BY PROVIDING THAT MINORS AGED SIXTEEN AND OVER IN THE CUSTODY OF THE COUNTY DEPARTMENT OF SOCIAL SERVICES ARE COMPETENT TO CONTRACT FOR AUTOMOBILE INSURANCE, BY SPECIFYING PERSONS OTHER THAN THE FOSTER PARENT WHO MAY SIGN FOR A FOSTER CHILD TO OBTAIN A LEARNER'S PERMIT OR PROVISIONAL DRIVERS LICENSE, AND BY CLARIFYING THAT FOSTER PARENTS DO NOT VIOLATE FINANCIAL RESPONSIBILITY REQUIREMENTS BY ALLOWING FOSTER CHILDREN WITH THEIR OWN INSURANCE COVERAGE TO OPERATE A VEHICLE OWNED BY THE FOSTER PARENT; AND TO REQUIRE THE DEPARTMENT OF HEALTH AND HUMAN SERVICES TO STUDY A MEDICAID WAIVER FOR CHILDREN WITH SERIOUS EMOTIONAL DISTURBANCE.

The General Assembly of North Carolina enacts:

PART I. SHORT TITLE

SECTION 1.1. This act shall be known and may be cited as the "Foster Care Family Act."

PART II. REASONABLE AND PRUDENT PARENTING STANDARD IN FOSTER CARE

SECTION 2.1. Part 1 of Article 1A of Chapter 131D of the General Statutes is amended by adding a new section to read:

"**§ 131D-10.2A. Reasonable and prudent parenting standard.**

(a) The reasonable and prudent parenting standard is characterized by careful and sensible parental decisions that maintain a child's health, safety, and best interests while encouraging the child's emotional and developmental growth.

(b) Every child care institution shall designate an on-site official who is authorized to apply the reasonable and prudent parenting standard pursuant to this section.

(c) A caregiver, including the child's foster parent, whether the child is in a family foster home or a therapeutic foster home, the designated official at a child care institution where the child is placed, or the county department of social services, must use the reasonable and prudent parenting standard when determining whether to allow a child in foster care to participate in extracurricular, enrichment, and social activities.

(d) A caregiver, including the child's foster parent, whether the child is in a family foster home or a therapeutic foster home, the designated official at a child care institution where the child is placed, the county department of social services, or the Department of Health and Human Services with custody of or placement authority over a child in foster care shall not be held liable for an act or omission of the child if the caregiver or county department of social services is acting in accordance with the reasonable and prudent parenting standard under this section.

(e) Unless otherwise ordered by a court with jurisdiction pursuant to G.S. 7B-200, a caregiver, including the child's foster parent, whether the child is in a family foster home or a therapeutic foster home, exercising the reasonable and prudent parenting standard has the authority to provide or withhold permission, without prior approval of the court or a county department of social services, allowing a child in foster care, in the custody of a county department of social services, or under the placement authority of a county department of social services through a voluntary placement agreement, to participate in normal childhood activities. Normal childhood activities shall include, but are not limited to, extracurricular, enrichment, and social activities and may include overnight activities outside the direct supervision of the caregiver for periods of over 24 hours and up to 72 hours.

(f) The caregiver, including the child's foster parent, whether the child is in a family foster home or a therapeutic foster home, the designated official at a child care institution where the child is placed, the county department of social services, or the Department of Health and Human Services, shall not be liable for injuries to the child that occur as a result of the reasonable and prudent parenting standard. The burden of proof with respect to a breach of the reasonable and prudent parenting standard shall be by clear and convincing evidence.

(g) The caregiver, including the child's foster parent, whether the child is in a family foster home or a therapeutic foster home, the designated official at a child care institution where the child is placed, the county department of social services, or the Department of Health and Human Services, shall be liable for any action or inaction of gross negligence, willful and wanton conduct, or intentional wrongdoing that results in the injury to the child."

SECTION 2.2. G.S. 7B-505(b) reads as rewritten:

"(b) The court shall order the Department to make diligent efforts to notify relatives and any custodial parents of the juvenile's siblings that the juvenile is in nonsecure custody and of any hearings scheduled to occur pursuant to G.S. 7B-506, unless the court finds such notification would be contrary to the best interests of the juvenile. In placing a juvenile in nonsecure custody under this section, the court shall first consider whether a relative of the juvenile is willing and able to provide proper care and supervision of the juvenile in a safe home. If the court finds that the relative is willing and able to provide proper care and supervision in a safe home, then the court shall order placement of the juvenile with the relative unless the court finds that placement with the relative would be contrary to the best interests of the juvenile."

SECTION 2.3. G.S. 7B-800.1(a)(4) reads as rewritten:

"(a) Prior to the adjudicatory hearing, the court shall consider the following:

...

(4) Whether relatives or parents with custody of a sibling of the juvenile have been identified and notified as potential resources for placement or support."

SECTION 2.4. G.S. 7B-901 reads as rewritten:

"**§ 7B-901. Dispositional hearing.**

The dispositional hearing shall take place immediately following the adjudicatory hearing and shall be concluded within 30 days of the conclusion of the adjudicatory hearing. The dispositional hearing may be informal and the court may consider written reports or other evidence concerning the needs of the juvenile. The juvenile and the juvenile's parent, guardian, or custodian shall have the right to present evidence, and they may advise the court concerning the disposition they believe to be in the best interests of the juvenile. The court may consider any evidence, including hearsay evidence as defined in G.S. 8C-1, Rule 801, including testimony or evidence from any person who is not a party, that the court finds to be relevant, reliable, and necessary to determine the needs of the juvenile and the most appropriate disposition. The court may exclude the public from the hearing unless the juvenile moves that the hearing be open, which motion shall be granted.

At the dispositional hearing, the court shall inquire as to the identity and location of any missing parent and whether paternity is at issue. The court shall include findings of the efforts undertaken to locate the missing parent and to serve that parent and efforts undertaken to establish paternity when paternity is an issue. The order may provide for specific efforts in determining the identity and location of any missing parent and specific efforts in establishing paternity. The court shall also inquire about efforts made to identify and notify ~~relatives~~ relatives or parents with custody of a sibling of the juvenile, as potential resources for placement or support."

SECTION 2.5. Article 9 of Chapter 7B of the General Statutes is amended by adding the following new sections to read:

"**§ 7B-903.1. Juvenile placed in custody of a county department of social services.**

(a) To the extent authorized by federal law, a county department of social services with custody of a juvenile is authorized to make decisions about matters not addressed in this section that are generally made by a juvenile's custodian including, but not limited to, educational decisions and consenting to the sharing of the juvenile's information. The county department of social services may delegate any part of this authority to the juvenile's parent, foster parent, or another individual.

(b) When a juvenile is in the custody or placement responsibility of a county department of social services, the placement provider may, in accordance with G.S. 131D-10.2A, provide or withhold permission, without prior approval of the court or county department of social services, allowing a juvenile to participate in normal childhood activities. If such authorization is not in the juvenile's best interest, the court shall set forth alternative parameters for approving normal childhood activities.

"**§ 7B-912. Juveniles 14 years of age and older; Another Planned Permanent Living Arrangement.**

(a) In addition to the permanency planning requirements under G.S. 7B-906.1, at every permanency planning hearing for a juvenile in the custody of a county department of social services who has attained the age of 14 years, the court shall inquire and make written findings regarding each of the following:

(1) The services provided to assist the juvenile in making a transition to adulthood.

(2) The steps the county department of social services is taking to ensure that the foster family or other licensed placement provider follows the reasonable and prudent parenting standard as provided in G.S. 131D-10.2A.

(3) Whether the juvenile has regular opportunities to engage in age-appropriate or developmentally appropriate activities.

(b) At or before the last scheduled permanency planning hearing, but at least 90 days before a juvenile attains 18 years of age, the court shall (i) inquire as to whether the juvenile

has a copy of the juvenile's birth certificate, Social Security card, health insurance information, drivers license or other identification card, and any educational or medical records the juvenile requests and (ii) determine the person or entity that should assist the juvenile in obtaining these documents before the juvenile attains the age of 18 years.

(c) If the court finds each of the following conditions applies, the court shall approve Another Planned Permanent Living Arrangement (APPLA) as the juvenile's primary permanent plan:

(1) The juvenile is 16 or 17 years old.

(2) The county department of social services has made diligent efforts to place the juvenile permanently with a parent or relative or in a guardianship or adoptive placement.

(3) Compelling reasons exist that it is not in the best interest of the juvenile to be placed permanently with a parent or relative or in a guardianship or adoptive placement.

(4) APPLA is the best permanency plan for the juvenile.

(d) If the court approves APPLA as the juvenile's permanent plan, the court shall, after questioning the juvenile, make written findings addressing the juvenile's desired permanency outcome."

PART III. LIABILITY INSURANCE FOR FOSTER PARENTS

SECTION 3.1. Article 36 of Chapter 58 of the General Statutes is amended by adding a new section to read:

"**§ 58-36-44. Development of policy form or endorsement for personal liability insurance for foster parents.**

(a) The Rate Bureau shall develop an optional policy form or endorsement to be filed with the Commissioner for approval no later than May 1, 2016, that provides liability insurance for foster parents licensed under Article 1A of Chapter 131D of the General Statutes to provide foster care in a family foster home or therapeutic foster home. The policy form or endorsement shall provide coverage for acts or omissions of the foster parent while the parent is acting in his or her capacity as a foster parent in a licensed family foster home or therapeutic foster home licensed under Article 1A of Chapter 131D of the General Statutes.

(b) Nothing in this section is intended to require that the liability insurance policy or endorsement required by this section cover an act or omission that results from any action or inaction of gross negligence, willful and wanton conduct, or intentional wrongdoing that results in injury to the child."

PART IV. REDUCE DRIVING BARRIERS FOR FOSTER CHILDREN

SECTION 4.1. Article 1 of Chapter 48A of the General Statutes is amended by adding a new section to read:

"**§ 48A-4. Certain minors competent to contract.**

A minor who is 16 years of age or older and who is in the legal custody of the county department of social services, shall be qualified and competent to contract for the purchase of an automobile insurance policy with the consent of the court with continuing jurisdiction over the minor's placement under G.S. 7B-1000(b). The minor shall be responsible for paying the costs of the insurance premiums and shall be liable for damages caused by the minor's negligent operation of a motor vehicle. No State or local government agency, foster parent, or entity providing services to the minor under contract or at the direction of a State or local government agency shall be responsible for paying any insurance premiums or liable for damages of any kind as a result of the operation of a motor vehicle by the minor."

SECTION 4.2. G.S. 20-11(i) reads as rewritten:

"(i) Application. — An application for a permit or license authorized by this section must be signed by both the applicant and another person. That person must be:

(1) The applicant's parent or guardian;

(2) A person approved by the applicant's parent or guardian; or

(3) A person approved by the Division.

(4) With respect to minors in the legal custody of the county department of social services, any of the following:

a. A guardian ad litem or attorney advocate appointed to advocate for the minor.

b. The director or his or her designee or other type of caseworker assigned to work with the minor.

c. If no person listed in sub-subdivision a. or b. of this subdivision is available, the court with continuing jurisdiction over the minor's placement under G.S. 7B-1000(b)."

SECTION 4.3. G.S. 20-309 is amended by adding a new subsection to read:

"(a2) Notwithstanding any other provision of this Chapter, an owner's policy of liability insurance issued to a foster parent or parents, which policy includes an endorsement excluding coverage for one or more foster children residing in the foster parent's or parents' household, may be certified as proof of financial responsibility, provided that each foster child for whom coverage is excluded is insured in an amount equal to or greater than the minimum limits required by G.S. 20-279.21 under some other owner's policy of liability insurance or a named nonowner's policy of liability insurance. The North Carolina Rate Bureau shall establish, with the approval of the Commissioner of Insurance, a named driver exclusion endorsement or endorsements for foster children as described herein."

SECTION 4.4. G.S. 20-279.21(b) reads as rewritten:

"(b) ~~Such~~ Except as provided in G.S. 20-309(a2), such owner's policy of liability insurance:

...."

PART V. STUDY MEDICAID WAIVER FOR CHILDREN WITH SERIOUS EMOTIONAL DISTURBANCE (SED)

SECTION 5.1.(a) The Department of Health and Human Services, Division of Medical Assistance, shall design and draft, but not submit, a 1915(c) Medicaid waiver to serve children with Serious Emotional Disturbance (SED) in home and community-based settings. The Department may submit drafts of the waiver to the Centers for Medicare and Medicaid Services (CMS) to solicit feedback but shall not submit the waiver for CMS approval until authorized by the General Assembly.

SECTION 5.1.(b) The Department shall report the draft waiver, other findings, and any other options or recommendations to best serve children with SED to the Joint Legislative Oversight Committee on Health and Human Services by December 1, 2015. Specifically, the report shall provide an in-depth analysis of the cost per slot, including an analysis of the estimated number of waiver recipients who would be transitioned from a facility to a home and community-based setting and the estimated number of waiver recipients who would avoid placement in a facility.

PART VI. EFFECTIVE DATE

SECTION 6.1. Parts 2 and 4 of this act become effective October 1, 2015. The remainder of this act is effective when it becomes law.

NORTH CAROLINA GENERAL ASSEMBLY
HOUSE OF REPRESENTATIVES

HEALTH COMMITTEE REPORT

Representative Brian Brown, Co-Chair
Representative Justin P. Burr, Co-Chair
Representative Bert Jones, Co-Chair
Representative Donny Lambeth, Co-Chair

FAVORABLE

SB **366** Amend Certain Reqs/Permanency Innovation Comm.

Draft Number:	None
Serial Referral:	None
Recommended Referral:	None
Long Title Amended:	No
Floor Manager:	Avila

FAVORABLE AND RE-REFERRED

SB **423** **(CS#2)** Foster Care Family Act.

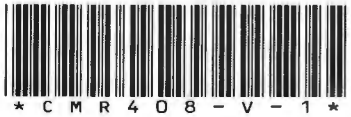
Draft Number:	None
Serial Referral:	**JUDICIARY III**
Recommended Referral:	None
Long Title Amended:	No
Floor Manager:	Lambeth

FAVORABLE HOUSE COM SUB, UNFAVORABLE ORIGINAL BILL

SB **487** Health Choice Technical Revisions.-AB

Draft Number:	S487-PCS35285-TA-8
Serial Referral:	None
Recommended Referral:	None
Long Title Amended:	No
Floor Manager:	Jones

TOTAL REPORTED: 3



Wednesday, June 3	Room	Time
HEALTH	643	10:00 am

Name	County	Sponsor
Michael Smith	Mecklenburg	Speaker Moore
Jakara Steed	Vance	Nathan Baskerville
Skylar Teague	Wake	Brian Brown
Collin Winstead	Person	Larry Yarborough
Ona Ojo	Cumberland	Rick Glazier

Committee Sergeants at Arms

NAME OF COMMITTEE House Committee on Health

DATE: 06/03/15 Room: 643

House Sgt-At Arms:

1. Name: Young Bae
2. Name: Bill Morris
3. Name: Jim Moran
4. Name: _____
5. Name: _____

Senate Sgt-At Arms:

1. Name: _____
2. Name: _____
3. Name: _____
4. Name: _____
5. Name: _____

VISITOR REGISTRATION SHEET

House Committee on Health 06/03/15

Name of Committee Date

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Erica Nelson	NCHA
Doug Heron	Duke
Rob Lamm	RLA
Elizabeth Kleinholm	Stumpwork Inc.
Stephanie Niena	SJF Ventures
Pete Alberse	Seventh Generation

VISITOR REGISTRATION SHEET

House Committee on Health 06/03/15

Name of Committee Date

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Dodie Renfer	CCR
John DelGrosso	Brubaker Assoc.
[illegible]	NCMS
Peyton Maynard	[illegible]
Cody Hand	NCHA
Michael Houser	THCG
Breeden Blackwell	CFVMC
H. Johnson	NCACC

VISITOR REGISTRATION SHEET

House Committee on Health 06/03/15

Name of Committee Date

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Sheria Reid	IOG
Patricia A. Yancey	SHIFT NC
Natalie Hobson	NCHFA
[illegible]	[illegible]
Chris Emanuel	Emanuel GRP
Jamaica Pfister	Childrens Home Society
Tim Lucas	NC Rate Bureau
Robert Paschal	Young Moore
Kathleen Boncimino	NCMS Leadership College
DR. GAURI DALVI	NCMS / KIDZCARE PEDIATRICS
Karen Cannon, MD	NCMS / CHESS

VISITOR REGISTRATION SHEET

House Committee on Health 06/03/15

Name of Committee Date

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
KATHRYN COLACCHIO	NORTH CAROLINA MEDICAL SOCIETY
Jessica Troche	NC Medical Society
K Brooke Chalk	"
NICHOLLE KARIM	NAMI NC
Jennifer Gasparini	NCMS
Kristina Nattochdag	NCMS

VISITOR REGISTRATION SHEET

House Committee on Health 06/03/15

Name of Committee Date

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
[illegible]	Hall
[illegible]	Focus Carolinas
Lori Kroll	NOVANT
Daniel Van Liere	Novant Health
[illegible]	GSK
Joe Lanier	CARDINAL
Lanier Hodgson	UNC Health Care
Christine [illegible]	WakeMed

VISITOR REGISTRATION SHEET

House Committee on Health 06/03/15

Name of Committee Date

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Allie Maccioli	Department of Health & Human Services
Trent Womble	DHHS
Sarah Pfau	DMA, DHHS
Jeff Horton	DHHS-DMA
Courtney Johnson	NP
Susan Latta	Nurse Aunt
Amanda Honaker	TSS
Elizabeth Scott	NCPHA
Alex Bowen	CCS
Peter Daniel	CCS
Kristin O'Connor	NCDHHS/Division of Social Services
Heather Robinson	NCRMA

NORTH CAROLINA HOUSE OF REPRESENTATIVES
COMMITTEE MEETING NOTICE
AND
BILL SPONSOR NOTIFICATION
2015-2016 SESSION

You are hereby notified that the **House Committee on Health** will meet as follows:

DAY & DATE: Wednesday, June 10, 2015
TIME: **10:00 AM**
LOCATION: **643 LOB**
COMMENTS: **Representative Jones will preside.**

The following bills will be considered:

BILL NO.	SHORT TITLE	SPONSOR
HB 372	2015 Medicaid Modernization.	Representative Dollar Representative Lambeth Representative B. Brown Representative Jones
HB 714	Behavior Analyst Licensure.	Representative Jeter Representative McGrady Representative Shepard Representative Cotham

Respectfully,

Representative Brian Brown, Co-Chair
Representative Justin P. Burr, Co-Chair
Representative Bert Jones, Co-Chair
Representative Donny Lambeth, Co-Chair

I hereby certify this notice was filed by the committee assistant at the following offices at 9:25 AM on Tuesday, June 09, 2015.

___ Principal Clerk
___ Reading Clerk – House Chamber

Brenda Olls (Committee Assistant)

House Committee on Health
Wednesday, June 10, 2015, 10:00 AM
643 Legislative Office Building

AGENDA

Welcome and Opening Remarks

Introduction of Pages

Bills

BILL NO.	SHORT TITLE	SPONSOR
HB 372	2015 Medicaid Modernization.	Representative Dollar Representative Lambeth Representative B. Brown Representative Jones
HB 714	Behavior Analyst Licensure.	Representative Jeter Representative McGrady Representative Shepard Representative Cotham

Presentations

Other Business

Adjournment

House Committee on Health
Wednesday, June 10, 2015 at 10:00 AM
Room 643 of the Legislative Office Building

MINUTES

The House Committee on Health met at 10:00 AM on June 10, 2015 in Room 643 of the Legislative Office Building. Representatives Adcock, Avila, Bishop, Blackwell, Brawley, Brisson, Burr, Carney, Cotham, Dobson, Dollar, Earle, Farmer-Butterfield, Ford, Goodman, Hager, L. Hall, Hastings, Insko, Jones, Lambeth, Lucas, S. Martin, Pendleton, Saine, Waddell, Wray, and Yarborough attended.

Representative Bert Jones, Chair, presided.

The following bills were considered:

HB 372 2015 Medicaid Modernization. (Representatives Dollar, Lambeth, B. Brown, Jones)

Representative Jones motioned for the PCS for HB 372 to be brought before the Health Committee.
Representatives Dollar and Lambeth were recognized to explain the bill. Kory Goldsmith explained many of the lines of the bill. Cody Hand, Chip Baggett, Jim Harrell and Lisa Wainwright spoke in support of the bill, on behalf of several health organizations. The Health Committee will reconvene 15 minutes after Session today to complete discussions and vote.

HB 714 Behavior Analyst Licensure. (Representatives Jeter, McGrady, Shepard, Cotham

A motion to bring the PCS for HB 714 before the Health Committee was made by Chairman Jones. Representative Jeter explained the bill, which establishes a licensure process for behavior analysts. Representative Earle made a motion for a Favorable Report, Unfavorable to the original bill, with referral to Finance. The motion carried.

The meeting adjourned at 10:50.

Bert Jones
Representative Bert Jones, Chair
Presiding

Brenda Olls
Brenda Olls, Committee Clerk

HOUSE BILL 714:
Behavior Analyst Licensure

2015-2016 General Assembly

Committee:	House Health, if favorable, Finance	**Date:**	June 9, 2015
Introduced by:	Reps. Jeter, McGrady, Shepard, Cotham	**Prepared by:**	Theresa Matula Committee Staff
Analysis of:	PCS to First Edition H714-CSSH-47		

SUMMARY: ***The Proposed Committee Substitute for HB 714 establishes a licensure process for behavior analysts.***

CURRENT LAW: G.S. 90-270.2(8) provides that the practice of psychology includes, but is not limited to behavior analysis and therapy.

BILL ANALYSIS: The Proposed Committee Substitute (PCS) for HB 714 creates Article 43, Behavior Analyst Licensure, in Chapter 90, Medicine and Allied Occupations. **Section 1** of the PCS contains the elements outlined below:

Declaration of Purpose [G.S. 90-726.1] – The stated purpose is to protect the public from unqualified persons or unprofessional, unethical, or harmful conduct as it relates to the practice of behavior analysis.

Definitions [G.S. 90-726.2] – The PCS provides definitions for: board, certifying entity, licensed assistant behavior analyst, licensed behavior analyst, and practice of behavior analysis. The practice of behavior analysis pertains to the design, implementation, and evaluation of instructional and environmental modifications to produce socially significant improvements in human behavior. The certifying entity is the Behavior Analyst Certification Board.

Board [G.S. 90-726.3] – The PCS establishes the North Carolina Behavior Analysis Board (Board) consisting of nine (9) members: 3 appointed by the General Assembly upon the recommendation of the Speaker of the House of Representatives, 3 appointed by the General Assembly upon the recommendation of the President Pro Tempore of the Senate; and 3 appointed by the Governor. Board members will include: 3 licensed behavior analysts, 3 licensed assistant behavior analysts, and 3 public members. The section provides the qualifications of the Board, removal from the Board, specifies the payment of per diem, and allows the Board to hire employees.

Powers and Duties of the Board [G.S. 90-726.4] – The Board's powers and duties include: administering the Article, adopting rules, evaluating applicants for licensure, issuing licenses, establishing fees, disciplining licensees, adopting a seal for use, and conducting investigations.

Annual Report [G.S. 90-726.5] – The Board is required to report to the Governor on June 30 each year.

Licensure Application [G.S. 90-726.6] – Applicants for licensure are required to submit specified criteria on a prescribed form.

Licensure as a Behavior Analyst and an Assistant Behavior Analyst [G.S. 90-726.7 & 8] – An applicant for licensure must pass the Certification Board's examination and be in active status with the certifying entity. An assistant behavior analyst must have an arrangement for supervision by a licensed behavior analyst.

O. Walker Reagan
Director

H714-SMSH-73 CSSH-47 -V1

Research Division
(919) 733-2578

This bill analysis was prepared by the nonpartisan legislative staff for the use of legislators in their deliberations and does not constitute an official statement of legislative intent.

License renewal [G.S. 90-726.9] – Licenses are granted for a period of two years. Renewal requires proof of any required continuing education, payment of a renewal fee, active certification, and a supervision arrangement for an assistant behavior analyst.

Temporary license [G.S. 90-726.10] – An individual residing and practicing behavior analysis in another state and who is certified, or who is licensed in another state, may apply for a temporary license to practice in NC.

Reciprocity [G.S. 90-726.11] – Licensure by reciprocity is permitted when the other state has comparable licensure requirements and upon the applicant's submission of specified documents.

Denial, suspension, revocation of licenses and other disciplinary actions [G.S. 90-726.12] – Outlines requirements for complying with ethical and professional standards specified in the Code of Conduct. This section also includes provisions related to denial, suspension or revocation of licenses and other disciplinary and remedial actions. (The content in this section is substantially similar to that contained in G.S. 90-270.15 of the Psychology Practice Act.)

Fees [G.S. 90-726.13] – Fees collected by the Board will be established pursuant to rules, but must not exceed the following: Application: $250; Renewal: $200; Late Renewal: $50; Reciprocal application: $250; Temporary License: $100.

Criminal History Record Checks [G.S. 90-726.14] – The criminal history record check process is similar to other licensure processes for criminal history record checks. The PCS changes the "Department of Justice" to the "Department of Public Safety" consistent with changes made in S.L. 2014-100, Section 17.1, for other criminal history record checks.

Limitation [G.S. 90-726.15] – Clarifies that the Article does not permit licensed behavior analysts or licensed assistant behavior analysts to engage in the practice of psychology.

Section 2 provides prohibited acts and penalties; injunctions; and exemptions from licensure; it becomes effective March 1, 2016.

Section 3 amends the exemptions under the Psychology Practice Act to conform to changes enacted by Sections 1 and 2, and it becomes effective March 1, 2016.

Section 4 requires the Board to adopt temporary rules no later than January 1, 2016.

Section 5 amends Chapter 8 of the General Statutes pertaining to the Competency of Witnesses to cover communications between behavior analyst and client or patient.

EFFECTIVE DATE: As provided above, Sections 2 and 3 become effective March 1, 2016. The remainder of the act is effective when it becomes law.

BACKGROUND: The Behavior Analyst Certification Board http://www.bacb.com/ was created in 1998 and provides credentialing for the: Board Certified Behavior Analyst (BCBA) and the Board Certified Assistant Behavior Analyst (BCaBA).

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2015

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HOUSE BILL 714
PROPOSED COMMITTEE SUBSTITUTE H714-CSSH-47 [v.5]

6/9/2015 8:19:59 PM

Short Title: Behavior Analyst Licensure. (Public)

Sponsors:

Referred to:

April 15, 2015

A BILL TO BE ENTITLED

AN ACT TO CREATE LICENSURE PROCESS FOR BEHAVIOR ANALYSTS.

The General Assembly of North Carolina enacts:

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

"Article 43.

"Behavior Analyst Licensure.

"**§ 90-726.1. Declaration of purpose.**

The practice of behavior analysis in North Carolina is hereby declared to affect the public health, safety, and welfare of citizens of North Carolina and to be subject to regulation to protect the public from (i) the practice of behavior analysis by unqualified persons and (ii) unprofessional, unethical, or harmful conduct by individuals licensed to practice behavior analysis.

"**§ 90-726.2. Definitions.**

The following definitions apply in this Article:

(1) Board. – The North Carolina Behavior Analysis Board.

(2) Certifying entity. – The Behavior Analyst Certification Board, Inc., whose certification programs are nationally accredited, or its successor.

(3) Licensed assistant behavior analyst. – An individual who is certified by the certifying entity as a Board Certified Assistant Behavior Analyst and to whom a license has been issued pursuant to this Article, if the license is in force and not suspended or revoked, and whose license permits the individual to engage in the practice of behavior analysis under the supervision of a licensed behavior analyst.

(4) Licensed behavior analyst. – An individual who is certified by the certifying entity as a Board Certified Behavior Analyst and to whom a license has been issued pursuant to this Article, if the license is in force and not suspended or revoked.

(5) Practice of behavior analysis. – The design, implementation, and evaluation of instructional and environmental modifications to produce socially significant improvements in human behavior. The practice of behavior analysis includes the empirical identification of functional relations between behavior and environmental factors, known as functional assessment and analysis. Behavior analysis interventions are based on scientific research and the direct observation and measurement of behavior and the environment. In the practice of behavior analysis, behavior analysts utilize contextual factors,

motivating operations, antecedent stimuli, positive reinforcement, and other consequences to help people develop new behaviors, increase or decrease existing behaviors, and emit behaviors under specific environmental conditions. The practice of behavior analysis expressly excludes psychological testing, cognitive therapy, sex therapy, psychoanalysis, hypnotherapy, psychotherapy, and long-term counseling as treatment modalities.

"**§ 90-726.3. North Carolina Behavior Analysis Board.**

(a) Establishment. – The North Carolina Behavior Analysis Board is created. The Board shall consist of nine members.

(b) Appointments. – The appointments to the Board are as follows:

(1) The General Assembly, upon the recommendation of the Speaker of the House of Representatives, shall appoint one licensed behavior analyst, one licensed assistant behavior analyst, and one public member.

(2) The General Assembly, upon the recommendation of the President Pro Tempore of the Senate, shall appoint one licensed behavior analyst, one licensed assistant behavior analyst, and one public member.

(3) The Governor shall appoint one licensed behavior analyst, one licensed assistant behavior analyst, and one public member.

(4) The initial behavior analytic appointees to the Board shall be persons who have been certified by the certifying entity and who meet the requirements for licensure under this Article. The initial appointees that are certified behavior analysts and certified assistant behavior analysts shall become licensed as soon as practicable. The initial appointees shall be appointed on or before October 1, 2015. For the initial appointments under subdivision (1) of this subsection: the behavior analyst shall serve a one-year term, the assistant behavior analyst shall serve a two-year term, and the public member shall serve a three-year term. For the initial appointments under subdivision (2) of this subsection: the behavior analyst shall serve a two-year term, the assistant behavior analyst shall serve a three-year term, and the public member shall serve a one-year term. For the initial appointments under subdivision (3) of this subsection: the behavior analyst shall serve a three-year term, the assistant behavior analyst shall serve a one-year term, and the public member shall serve a two-year term.

(5) Upon the expiration of the terms of the initial Board members established under subdivision (4) of this subsection, each member shall be appointed by the appointing authorities designated in subdivisions (1) through (3) of this subsection for a three-year term to begin on October 1, shall be licensed under this Article, and shall serve until a successor is appointed and qualified. No member may serve more than two consecutive full terms.

(c) Qualifications of Board Members. –

(1) Each licensed behavior analyst or licensed assistant behavior analyst member of the Board shall have all the following qualifications:

a. Shall be a resident of this State and a citizen of the United States.

b. Shall be free of conflict of interest or the appearance of such conflict in performing the duties of the Board.

(2) Each public member of the Board shall have all the following qualifications:

a. Shall be a resident of this State and a citizen of the United States.

b. Shall be free of conflict of interest or the appearance of such conflict in performing the duties of the Board.

c. Shall not be a licensed behavior analyst or licensed assistant behavior analyst, an applicant or former applicant for licensure as a behavior analyst or assistant behavior analyst, or a member of a household that includes a licensed behavior analyst or licensed assistant behavior analyst.

(d) Removal of Board Members. – A Board member shall be automatically removed from the Board if he or she does any of the following:

(1) Ceases to meet the qualifications specified in this section.

(2) Fails to attend three successive Board meetings without just cause as determined by the remainder of the Board.

(3) Is found by the remainder of the Board to be in violation of the provisions of this Article or to have engaged in immoral, dishonorable, unprofessional, or unethical conduct, and such conduct is deemed to compromise the integrity of the Board.

(4) Is found to be guilty of a felony or an unlawful act involving moral turpitude by a court of competent jurisdiction or is found to have entered a plea of nolo contendere to a felony or an unlawful act involving moral turpitude.

(5) Is found guilty of malfeasance, misfeasance, or nonfeasance in relation to his or her Board duties by a court of competent jurisdiction.

(6) Is incapacitated and without reasonable likelihood of resuming Board duties, as determined by the Board.

(e) Vacancies. – In the event that a member of the Board cannot complete a term of office, the vacancy shall be filled in the same manner as the original appointment, for the remainder of the unexpired term. No Board member shall participate in any matter before the Board in which the member has a pecuniary interest or similar conflict of interest.

(f) Meetings. – The Board shall annually elect a chair and other officers as it deems necessary to carry out the purposes of this Article. The Board may hold additional meetings upon the call of the chair or any two board members. A majority of the Board shall constitute a quorum.

(e) Per diem. – Members of the Board shall receive no compensation for their services but shall receive per diem and necessary travel and subsistence expenses as provided in G.S. 93B-5.

(g) Employees. – The Board may employ necessary personnel for the performance of its functions and fix the compensation. The Board shall not employ any of its members to perform inspectional or similar ministerial tasks for the Board. In no event shall the State of North Carolina be liable for expenses incurred by the Board in excess of the income derived from this Article.

"**§ 90-726.4. Powers and duties of Board.**

(a) The Board shall have the following powers and duties:

(1) Administer, coordinate, and enforce the provisions of this Article.

(2) Adopt, amend, or repeal rules to administer and enforce this Article.

(3) Establish and determine qualification and fitness of applicants for licensure under this Article.

(4) Issue, renew, deny, suspend, revoke, or refuse to issue or renew any license under this Article.

(5) Establish fees for applications, initial and renewal licenses, and other services provided by the Board.

(6) Discipline persons licensed under this Article.

(7) Adopt an official seal, which shall be affixed to all licenses issued.

(b) The Board may empower any member to conduct any proceeding or investigation necessary to its purposes and may empower its agent or counsel to conduct any investigation

necessary to its purposes, but any action shall be taken at a meeting of the Board by a majority of the members of the Board. The Board may order that any records concerning the practice of behavior analysis relevant to a complaint received by the Board or an inquiry or investigation conducted by or on behalf of the Board be produced before the Board or for inspection and copying by representatives of or counsel to the Board by the custodian of such records.

"**§ 90–726.5. Annual report.**

On June 30 of each year, the Board shall submit a report to the Governor of the Board's activities since the preceding July 1, that includes the names of all licensed behavior analysts and licensed assistant behavior analysts to whom licenses have been granted under this Article, any cases heard and decisions rendered in matters before the Board, the recommendations of the Board as to future actions and policies, and a financial report. Each member of the Board shall review and sign the report before its submission to the Governor. Any Board member shall have the right to record a dissenting view.

"**§ 90-726.6. License application.**

(a) Each individual who desires to obtain a license under this Article shall apply to the Board upon the form and in the manner prescribed by the Board. Each applicant shall furnish evidence satisfactory to the Board that the applicant meets all of the following criteria:

(1) The individual is of good moral character and conducts his or her professional activities in accordance with accepted professional and ethical standards.

(2) The individual has not engaged in or is not engaged in any practice that would be a ground for denial, revocation, or suspension of a license under G.S. 90-726.12.

(3) The individual has submitted the required criminal history record, as required by G.S. 90-726.14.

(4) The individual is qualified for licensure pursuant to the requirements of this Article.

(b) A license obtained through fraud or by any false representation is void.

"**§ 90-726.7. Requirements for licensure as a behavior analyst.**

Each applicant shall be issued a license by the Board to engage in the practice of behavior analysis as a licensed behavior analyst if the applicant meets the qualifications set forth in G.S. 90-726.6(a) and provides satisfactory evidence to the Board of all the following criteria:

(1) The applicant has passed the certifying entity's Board Certified Behavior Analyst examination.

(2) The applicant has an active status with the certifying entity as a Board Certified Behavior Analyst.

(3) Payment of application fee.

"**§ 90-726.8. Requirement of licensure as an assistant behavior analyst.**

Each applicant shall be issued a license by the Board to engage in the practice of behavior analysis as a licensed assistant behavior analyst if the applicant meets the qualifications set forth in G.S. 90-726.6(a) and provides satisfactory evidence to the Board of all the following criteria:

(1) The applicant has passed the certifying entity's Board Certified Assistant Behavior Analyst examination.

(2) The applicant has an active status with the certifying entity as a Board Certified Assistant Behavior Analyst.

(3) Payment of application fee.

(4) The applicant has an ongoing arrangement for supervision by a licensed behavior analyst in a manner consistent with the certifying entity's requirements for supervision of Board Certified Assistant Behavior Analysts.

"**§ 90-726.9. Renewal of license.**

(a) A license shall be granted under this Article for the period of two years.

(b) The Board shall renew a license granted under this Article upon receipt of the following:

(1) Proof of completion of any continuing education required by the certifying entity.

(2) Payment of the renewal fee.

(3) Evidence of active certification by certifying entity.

(4) For assistant behavior analysts, evidence of the ongoing arrangement for supervision by a licensed behavior analyst, as required by G.S. 90-726.8.

"**§ 90-726.10. Temporary licensure.**

(a) An individual residing and practicing behavior analysis in another state and who is certified as a Board Certified Behavior Analyst by the certifying entity may apply to the Board for a temporary license to practice behavior analysis in North Carolina.

(b) An individual residing and practicing behavior analysis in another state who is actively licensed in another state as a behavior analyst may apply to the Board for a temporary license to practice behavior analysis in North Carolina.

(c) A temporary license is available only if the behavior analysis services are to be delivered during a limited and defined period of service approved by the Board.

"**§ 90-726.11. Reciprocity.**

(a) The Board shall issue a license to an individual who is actively licensed as a behavior analyst or assistant behavior analyst in another state that currently imposes comparable licensure requirements as those imposed by this Article and that offers reciprocity to individuals licensed under this Article.

(b) Applicants for licensure by reciprocity shall submit the following items:

(1) Proof of ethical compliance.

(2) Proof of current licensure.

(3) Proof of current certification by the certifying entity.

(4) A criminal history record check as required by G.S. 90-726.14.

(5) Any other eligibility requirement as deemed appropriate by the Board.

"**§ 90-726.12. Denial, suspension, or revocation of licenses and other disciplinary and remedial actions for violations of the Code of Conduct; relinquishing of license.**

(a) Any applicant for licensure and any person licensed under this Article shall comply with the ethical and professional standards adopted by the Board by rule and shall not violate the Code of Conduct as set forth in this subsection. The Board may deny, suspend, or revoke licensure and may discipline, place on probation, limit practice, and require examination, remediation, and rehabilitation, or any combination thereof, all as provided for in subsection (b) of this section. The following are considered violations of the Code of Conduct:

(1) Conviction of a felony or entry of a plea of guilty or nolo contendere to any felony charge.

(2) Conviction of a felony or entry of a plea of guilty or nolo contendere to any misdemeanor involving moral turpitude, misrepresentation or fraud in dealing with the public, or conduct otherwise relevant to fitness to practice, or a misdemeanor charge reflecting the inability to practice behavior analysis with due regard to the health and safety of clients or patients.

(3) Using fraud or deceit in securing or attempting to secure or renew a license under this Article or has willfully concealed from the Board material information in connection with application for a license or for renewal of a license under this Article.

(4) Using fraud, deceit, or misrepresentation upon the public, the Board, or any individual in connection with the practice of behavior analysis, the filing of

Medicare, Medicaid, or other claims to any third-party payor, or in any manner otherwise relevant to fitness for the practice of behavior analysis.

(5) Making fraudulent, misleading, or intentionally or materially false statements pertaining to education, licensure, license renewal, supervision, continuing education, any disciplinary actions or sanctions pending or occurring in any other jurisdiction, professional credentials, or qualifications or fitness for the practice of behavior analysis to the public, any individual, the Board, or any other organization.

(6) Revocation or suspension of a license for the practice of behavior analysis in any other jurisdiction or having been disciplined by the licensing board or certifying entity in any other jurisdiction for conduct which would subject the licensee to discipline under this Article.

(7) Violation of any provision of this Article or rules adopted pursuant to the Article.

(8) Aiding or abetting the unlawful practice of behavior analysis by any person not licensed by the Board.

(9) Engaging in immoral, dishonorable, unprofessional, or unethical conduct as defined in this subsection, or the current Ethics Code of the certifying entity.

(10) Practicing behavior analysis in such a manner as to endanger the welfare of clients or patients.

(11) Demonstrating an inability to practice behavior analysis with reasonable skill and safety by reason of illness, inebriation, misuse of drugs, narcotics, alcohol, chemicals, or any other substance affecting mental or physical functioning, or as a result of any mental or physical condition.

(12) Practicing behavior analysis outside the boundaries of demonstrated competence or the limitations of education, training, or supervised experience.

(13) Failing to provide competent treatment, consultation, or supervision, in keeping with standards of usual and customary practice in this State.

(14) Failing to take all reasonable steps to ensure the competence of services.

(15) Failing to maintain a clear and accurate case record which documents the following for each patient or client:

a. Presenting problems, diagnosis, or purpose of the evaluation, treatment, or other services provided.

b. Fees, dates of services, and itemized charges.

c. Summary content of each session of evaluation, treatment, or other services, except that summary content need not include specific information that may cause significant harm to any person if the information were released.

d. Copies of all reports prepared.

(16) Except when prevented from doing so by circumstances beyond the behavior analyst's control, failing to retain securely and confidentially the complete case record for at least seven years from the date of the last provision of services; or, except when prevented from doing so by circumstances beyond the behavior analyst's control, has failed to retain securely and confidentially the complete case record indefinitely if there are pending legal or ethical matters or if there is any other compelling circumstance.

(17) Failing to cooperate with other behavior analysts or other professionals to the potential or actual detriment of clients, patients, or other recipients of service, or behaving in ways which substantially impede or impair other

licensed behavior analysts, licensed assistant behavior analysts, or other professionals' abilities to perform professional duties.

(18) Exercising undue influence in such a manner as to exploit the client, patient, student, supervisee, or trainee for the financial or other personal advantage or gratification of the licensed behavior analyst, licensed assistant behavior analyst, or a third party.

(19) Harassing or abusing, sexually or otherwise, a client, patient, student, supervisee, or trainee.

(20) Failing to cooperate with or to respond promptly, completely, and honestly to the Board, to credentials committees, or to ethics committees of professional behavior analyst associations, hospitals, or other health care organizations or educational institutions, when those organizations or entities have jurisdiction; or has failed to cooperate with institutional review boards or professional standards review organizations, when those organizations or entities have jurisdiction.

(21) Refusing to appear before the Board after having been ordered to do so in writing by the Chair.

(b) Upon proof that an applicant or licensee under this Article has engaged in any of the prohibited actions specified in subsection (a) of this section, the Board may, in lieu of denial, suspension, or revocation: (i) issue a formal reprimand or formally censure the applicant or licensee; (ii) may place the applicant or licensee on probation with such appropriate conditions upon the continued practice as the Board may deem advisable; (iii) may require examination, remediation, or rehabilitation for the applicant or licensee, including care, counseling, or treatment by a professional or professionals designated or approved by the Board, the expense to be borne by the applicant or licensee; (iv) may require supervision for the services provided by the applicant or licensee by a licensee designated or approved by the Board, the expense to be borne by the applicant or licensee; (v) may limit or circumscribe the practice of behavior analysis provided by the applicant or licensee with respect to the extent, nature, or location of the services provided, as the Board deems advisable; or (vi) may discipline and impose any appropriate combination of the foregoing. In addition, the Board may impose such conditions of probation or restrictions upon continued practice at the conclusion of a period of suspension or as requirements for the restoration of a revoked or suspended license. In lieu of or in connection with any disciplinary proceedings or investigation, the Board may enter into a consent order relative to the discipline, supervision, probation, remediation, rehabilitation, or practice limitation of a licensee or applicant for a license.

(c) The Board may assess costs of disciplinary action against an applicant or licensee found to be in violation of this Article.

(d) When considering whether an applicant or licensee is physically or mentally capable of practicing behavior analysis with reasonable skill and safety with patients or clients, then, upon a showing of probable cause to the Board that the applicant or licensee is not capable of practicing behavior analysis with reasonable skill and safety with patients or clients, the Board may petition a court of competent jurisdiction to order the applicant or licensee in question to submit to a psychological evaluation by a psychologist to determine psychological status or a physical evaluation by a physician to determine physical condition, or both. Such psychologist or physician shall be designated by the court. The expenses of such evaluations shall be borne by the Board. Where the applicant or licensee raises the issue of mental or physical competence or appeals a decision regarding mental or physical competence, the applicant or licensee shall be permitted to obtain an evaluation at the applicant's or licensee's expense. If the Board suspects the objectivity or adequacy of the evaluation, the Board may compel an evaluation by its designated practitioners at its own expense.

(e) Except as otherwise provided in this Article, the procedure for revocation, suspension, denial, limitations of the license, or other disciplinary, remedial, or rehabilitative actions shall be in accordance with the provisions of Chapter 150B of the General Statutes. The Board is required to provide the opportunity for a hearing under Chapter 150B of the General Statutes to any applicant whose license is denied or to whom licensure is offered subject to any restrictions, probation, disciplinary action, remediation, or other conditions or limitations or to any licensee before revoking, suspending, or restricting a license or imposing any other disciplinary action or remediation. If the applicant or licensee waives the opportunity for a hearing, the Board's denial, revocation, suspension, or other proposed action becomes final without a hearing having been conducted. Notwithstanding any other provision of this subsection, no applicant or licensee is entitled to a hearing for failure to pass an examination. In any proceeding before the Board, in any record of any hearing before the Board, in any complaint or notice of charges against any licensee or applicant for licensure, and in any decision rendered by the Board, the Board may withhold from public disclosure the identity of any clients or patients who have not consented to the public disclosure of behavior analysis services having been provided by the licensee or applicant. The Board may close a hearing to the public and receive in executive session evidence involving or concerning the treatment of or delivery of behavior analysis services to a client or a patient who has not consented to the public disclosure of such treatment or services as may be necessary for the protection and rights of such patient or client of the accused applicant or licensee and the full presentation of relevant evidence. All records, papers, and other documents containing information collected and compiled by or on behalf of the Board, as a result of investigations, inquiries, or interviews conducted in connection with licensing or disciplinary matters will not be considered public records as defined in G.S. 132-1. However, any notice or statement of charges against any licensee or applicant, or any notice to any licensee or applicant of a hearing in any proceeding, or any decision rendered in connection with a hearing in any proceeding, shall be a public record notwithstanding that it may contain information collected and compiled as a result of such investigation, inquiry, or hearing except that identifying information concerning the treatment of or delivery of services to a patient or client who has not consented to the public disclosure of such treatment or services may be deleted. If any such record, paper, or other document containing information theretofore collected and compiled by or on behalf of the Board under this section, is received and admitted in evidence in any hearing before the Board, it shall thereupon be a public record, subject to any deletions of identifying information concerning the treatment of or delivery of behavior analysis services to a patient or client who has not consented to the public disclosure of such treatment or services.

(f) A license issued under this Article is suspended automatically by operation of law after failure to renew a license for a period of more than 60 days after the renewal date. The Board may reinstate a license suspended under this subsection upon payment of a fee as specified in G.S. 90-726.13, and may require that the applicant file a new application, furnish references or otherwise update his or her credentials, or submit to examination for reinstatement. Notwithstanding any provision to the contrary, Board retains full jurisdiction to investigate alleged violations of this Article by any person whose license is suspended under this subsection, and, upon proof of any violation of this Article by any such person, the Board may take disciplinary action as authorized by this section.

(g) A person whose license has been denied or revoked may reapply to the Board for licensure after the passage of one calendar year from the date of such denial or revocation.

(h) A licensee may, with the consent of the Board, voluntarily relinquish his or her license at any time. The Board may delay or refuse the granting of its consent as it may deem necessary in order to investigate any pending complaint, allegation, or issue regarding violation of any provision of this Article by the licensee. Notwithstanding any provision of this subsection, the Board retains full jurisdiction to investigate alleged violations of this Article by

any person whose license is relinquished under this subsection, and, upon proof of any violation of this Article by any such person, the Board may take disciplinary action as authorized by this section.

(i) The Board may adopt such rules as it deems reasonable and appropriate to interpret and implement the provisions of this section.

"**§ 90-726.13. Fees.**

The Board may collect fees established by its rules, but those fees shall not exceed the following amounts:

(1)	Application fee for licensure	$250.00
(2)	License renewal	$200.00
(3)	Late renewal fee	$50.00
(4)	Reciprocal license application	$250.00
(5)	Temporary license application	$100.00.

"**§ 90-726.14. Criminal history record checks of applicants for licensure.**

(a) Criminal History Record Check. – All applicants for licensure shall consent to a criminal history record check. Refusal to consent to a criminal history record check may constitute grounds for the Board to deny licensure to an applicant. The Board shall be responsible for providing to the North Carolina Department of Public Safety the fingerprints of the applicant to be checked, a form signed by the applicant consenting to the criminal history record check and the use of fingerprints and other identifying information required by the State or National Repositories of Criminal Histories, and any additional information required by the Department of Public Safety. The Board shall keep all information obtained pursuant to this section confidential.

(b) Cost. – The cost of the criminal history record check and the fingerprinting shall be borne by the applicant. The Board shall collect any fees required by the Department of Public Safety and shall remit the fees to the Department of Public Safety for expenses associated with conducting the criminal history record check.

(c) Convictions. – If an applicant's criminal history record reveals one or more criminal convictions, the conviction shall not automatically bar licensure. The Board shall consider all of the following factors regarding the conviction:

(1) The level of seriousness of the crime.
(2) The date of the crime.
(3) The age of the applicant at the time of conviction.
(4) The circumstances surrounding the commission of the crime, if known.
(5) The nexus between the criminal conduct of the person and the job duties of the position to be filled.
(6) The applicant's prison, jail, probation, parole, rehabilitation, and employment records since the date the crime was committed.

(d) Denial of Licensure. – If, after reviewing the factors, the Board determines that any of the grounds to deny licensure exist, the Board may deny licensure of the applicant. The Board may disclose to the applicant information contained in the criminal history record that is relevant to the denial if disclosure of the information is permitted by applicable State and federal law. The Board shall not provide a copy of the criminal history to the applicant. The applicant shall have the right to appear before the Board to appeal the Board's decision. An appearance before the full Board shall constitute an exhaustion of administrative remedies in accordance with Chapter 150B of the General Statutes.

(e) Limited Immunity .– The Board, its officers, and employees, acting in good faith and in compliance with this section, shall be immune from civil liability for denying licensure to an applicant based on information provided in the applicant's criminal history record.

"**§ 90–726.15. Practice of psychology not permitted.**

Nothing in this Article shall be construed as permitting licensed behavior analysts or licensed assistant behavior analysts to engage in any manner in the practice of psychology as defined in G.S. 90-270.2(8), other than the practice of behavior analysis, as defined in G.S. 90-726.2(5). A licensed behavior analyst or licensed assistant behavior analyst shall assist his or her client or patient in obtaining professional help for all aspects of the client's or patient's problems that fall outside the boundaries of the licensed behavior analyst's or licensed assistant behavior analyst's own competence, including diagnosis, counseling, psychological testing, neuropsychology, psychotherapy, cognitive-behavior therapy, sex therapy, psychoanalysis, or hypnotherapy as treatment modalities."

SECTION 2. Article 43 of Chapter 90 of the General Statutes, as enacted by Section 1 of this act, is amended by adding the following new sections to read:

"**§ 90-726.16. Prohibited acts and penalties.**

(a) Except as permitted in G.S. 90-726.18, it shall be a violation of this Article for any person who is not licensed in accordance with the provisions of this Article to practice behavior analysis or to hold himself or herself out to the public as a person practicing behavior analysis.

(b) Any person who is not licensed in accordance with the provisions of this Article practicing behavior analysis or holding himself or herself out to the public as a person practicing behavior analysis in violation of this Article is guilty of a Class 2 misdemeanor. Each violation shall constitute a separate offense.

"**§ 90-726.17. Injunction.**

The Board may apply to the superior court for an injunction to prevent violations of this Article or any rules enacted pursuant to this Article. The court is empowered to grant such injunctions regardless of whether criminal prosecution or other action has been or may be instituted as a result of such violation.

"**§ 90-726.18. Exemptions from licensure.**

(a) A person is exempt from the requirements of this Article if any of the following conditions are met:

(1) The person is a duly licensed psychologist or psychological associate in this State, individuals acting under the extended authority and direction of licensed psychologists (e.g., graduate students, interns, postdoctoral trainees), or a person providing ancillary services pursuant to G.S. 90-270.21.

(2) The person only implements an intervention based on behavior analysis under the direction of an appropriately licensed individual.

(3) The person is a family member, guardian, or other caretaker implementing a behavior analysis treatment plan under the direction of a licensed behavior analyst or a licensed assistant behavior analyst.

(4) The person is engaged in the practice of behavior analysis with nonhuman subjects. This includes persons who are animal behaviorists and animal trainers.

(5) The person provides general behavior analysis services to organizations, so long as the services are for the benefit of the organizations and do not involve direct services to individuals.

(6) The person is a professional licensed under this Chapter or Chapter 90B of the General Statutes, so long as the licensed professional does not represent that he or she is a licensed behavior analyst or licensed assistant behavior analyst and the services of the licensed professional are within the scope of practice of the license possessed by that professional and the services performed are commensurate with the licensed professional's education, training, and experience.

(7) The activities the person participates in are part of a defined college or university course program of study, practicum, or intensive practicum in behavior analysis, so long as that person is under direct supervision of (i) a licensed behavior analyst, (ii) an instructor in a course sequence approved by the certifying entity, or (iii) a qualified faculty member.

(8) The person is pursuing experience in behavior analysis consistent with the certifying entity's experience requirements, so long as the person's activities are supervised by a licensed behavior analyst."

SECTION 3. G.S. 90-270.4 is amended by adding a new subsection to read:

"(f1) Nothing in this Article shall be construed to prevent a behavior analyst or an assistant behavior analyst licensed under Article 43 of Chapter 90 of the General Statutes from offering services within the scope of practice authorized by the North Carolina Behavior Analysis Board."

SECTION 4. The North Carolina Behavior Analysis Board shall adopt temporary rules to implement this act no later than January 1, 2016. The temporary rules shall remain in effect until permanent rules that replace the temporary rules become effective.

SECTION 5. Chapter 8 of the General Statutes is amended by adding a new section to read:

"**§ 8-53.14. Communications between behavior analyst and client or patient.**

No person, duly authorized as licensed behavior analyst or licensed assistant behavior analyst, nor any of the person's employees or associates, shall be required to disclose any information which the person may have acquired in the practice of behavior analysis and which information was necessary to enable the person to practice behavior analysis. Any resident or presiding judge in the district in which the action is pending may, subject to G.S. 8-53.6, compel disclosure, either at the trial or prior thereto, if in his or her opinion disclosure is necessary to a proper administration of justice. If the case is in district court the judge shall be a district court judge, and if the case is in superior court the judge shall be a superior court judge.

Notwithstanding the provisions of this section, the behavior analyst-client or behavior analyst-patient privilege shall not be grounds for failure to report suspected child abuse or neglect to the appropriate county department of social services or for failure to report a disabled adult suspected to be in need of protective services to the appropriate county department of social services. Notwithstanding the provisions of this section, the behavior analyst-client or behavior analyst-patient privilege shall not be grounds for excluding evidence regarding the abuse or neglect of a child, or an illness of or injuries to a child, or the cause thereof, or for excluding evidence regarding the abuse, neglect, or exploitation of a disabled adult, or an illness of or injuries to a disabled adult, or the cause thereof, in any judicial proceeding related to a report pursuant to the Child Abuse Reporting Law, Article 3 of Chapter 7B of the General Statutes."

SECTION 6. Sections 2 and 3 of this act become effective March 1, 2016. The remainder of this act is effective when it becomes law.

HOUSE BILL 714

Short Title:	Behavior Analyst Licensure.	(Public)
Sponsors:	Representatives Jeter, McGrady, Shepard, and Cotham (Primary Sponsors). *For a complete list of Sponsors, refer to the North Carolina General Assembly Web Site.*	
Referred to:	Health, if favorable, Finance.	

April 15, 2015

A BILL TO BE ENTITLED

AN ACT TO CREATE LICENSURE PROCESS FOR BEHAVIOR ANALYSTS.

The General Assembly of North Carolina enacts:

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

"Article 43.

"Behavior Analyst Licensure.

"**§ 90-726.1. Declaration of purpose.**

The practice of behavior analysis in North Carolina is hereby declared to affect the public health, safety, and welfare of citizens of North Carolina and to be subject to regulation to protect the public from (i) the practice of behavior analysis by unqualified persons and (ii) unprofessional, unethical, or harmful conduct by individuals licensed to practice behavior analysis.

"**§ 90-726.2. Definitions.**

The following definitions apply in this Article:

(1) Board. – The North Carolina Behavior Analyst Board.

(2) Certifying entity. – The nationally accredited Behavior Analyst Certification Board, Inc., or its successor.

(3) Licensed assistant behavior analyst. – An individual who is certified by the certifying entity as a Board Certified Assistant Behavior Analyst and to whom a license has been issued pursuant to this Article, if the license is in force and not suspended or revoked, and whose license permits the individual to engage in the practice of behavior analysis under the supervision of a licensed behavior analyst.

(4) Licensed behavior analyst. – An individual who is certified by the certifying entity as a Board Certified Behavior Analyst and to whom a license has been issued pursuant to this Article, if the license is in force and not suspended or revoked.

(5) Practice of behavior analysis. – The design, implementation, and evaluation of instructional and environmental modifications to produce socially significant improvements in human behavior. The practice of behavior analysis includes the empirical identification of functional relations between behavior and environmental factors, known as functional assessment and analysis. Behavior analysis interventions are based on scientific research and the direct observation and measurement of behavior and the environment. In

the practice of behavior analysis, behavior analysts utilize contextual factors, motivating operations, antecedent stimuli, positive reinforcement, and other consequences to help people develop new behaviors, increase or decrease existing behaviors, and emit behaviors under specific environmental conditions. The practice of behavior analysis expressly excludes psychological testing, cognitive therapy, sex therapy, psychoanalysis, hypnotherapy, and long-term counseling as treatment modalities.

"**§ 90–726.2A. Practice of psychology not permitted.**

Nothing in this Article shall be construed as permitting licensed behavior analysts or licensed assistant behavior analysts to engage in any manner in the practice of psychology as defined in G.S. 90-270.2(8), other than the practice of behavior analysis, as defined in G.S. 90-726.2(5). A licensed behavior analyst or licensed assistant behavior analyst shall assist his or her client or patient in obtaining professional help for all aspects of the client's or patient's problems that fall outside the boundaries of the licensed behavior analyst's or licensed assistant behavior analyst's own competence, including diagnosis, counseling, psychological testing, neuropsychology, psychotherapy, cognitive-behavior therapy, sex therapy, psychoanalysis, or hypnotherapy as treatment modalities.

"**§ 90-726.3. North Carolina Behavior Analysis Board.**

(a) Establishment. – The North Carolina Behavior Analysis Board is created. The Board shall consist of seven members who shall serve staggered terms. The initial Board shall be selected on or before August 1, 2015, as follows:

(1) The General Assembly, upon the recommendation of the Speaker of the House of Representatives, shall appoint the following three members:
   a. One licensed behavior analyst, who is certified by the certifying entity as a Board Certified Behavior Analyst, to serve a one-year term.
   b. One licensed behavior analyst, who is certified by the certifying entity as a Board Certified Behavior Analyst, to serve a two-year term.
   c. One licensed assistant behavior analyst, who is certified by the certifying entity as a Board Certified Assistant Behavior Analyst, to serve a three-year term.

(2) The General Assembly, upon the recommendation of the President Pro Tempore of the Senate, shall appoint the following three members:
   a. One licensed assistant behavior analyst, who is certified by the certifying entity as a Board Certified Assistant Behavior Analyst, to serve a one-year term.
   b. One licensed behavior analyst, who is certified by the certifying entity as a Board Certified Behavior Analyst, to serve a two-year term.
   c. One licensed behavior analyst, who is certified by the certifying entity as a Board Certified Behavior Analyst, to serve a three-year term.

(3) The Governor shall appoint one public member to serve a two-year term.

Upon the expiration of the terms of the initial Board members, each member shall be appointed by the appointing authorities designated in subdivisions (1) through (3) of this subsection for a three-year term, shall be required to be licensed under this Article, and shall serve until a successor is appointed and qualified. No member may serve more than two consecutive full terms.

(b) Vacancies. – In the event that a member of the Board cannot complete a term of office, the vacancy shall be filled in the same manner as the original appointment, for the

remainder of the unexpired term. No Board member shall participate in any matter before the Board in which the member has a pecuniary interest or similar conflict of interest.

(c) Qualifications of Board Members; Removal of Board Members. –

(1) Each licensed behavior analyst or licensed assistant behavior analyst member of the Board shall have all the following qualifications:

a. Shall be a resident of this State and a citizen of the United States.

b. Shall be free of conflict of interest or the appearance of such conflict in performing the duties of the Board.

(2) Each public member of the Board shall have all the following qualifications:

a. Shall be a resident of this State and a citizen of the United States.

b. Shall be free of conflict of interest or the appearance of such conflict in performing the duties of the Board.

c. Shall not be a licensed behavior analyst or licensed assistant behavior analyst, an applicant or former applicant for licensure as a behavior analyst or assistant behavior analyst, or a member of a household that includes a licensed behavior analyst or licensed assistant behavior analyst.

(3) A Board member shall be automatically removed from the Board if he or she does any of the following:

a. Ceases to meet the qualifications specified in this subsection.

b. Fails to attend three successive Board meetings without just cause as determined by the remainder of the Board.

c. Is found by the remainder of the Board to be in violation of the provisions of this Article or to have engaged in immoral, dishonorable, unprofessional, or unethical conduct, and such conduct is deemed to compromise the integrity of the Board.

d. Is found to be guilty of a felony or an unlawful act involving moral turpitude by a court of competent jurisdiction or is found to have entered a plea of nolo contendere to a felony or an unlawful act involving moral turpitude.

e. Is found guilty of malfeasance, misfeasance, or nonfeasance in relation to his or her Board duties by a court of competent jurisdiction.

f. Is incapacitated and without reasonable likelihood of resuming Board duties, as determined by the Board.

(d) Meetings. – The Board shall elect annually a chair and other officers as it deems necessary to carry out the purposes of this Article. The Board may hold additional meetings upon the call of the chairperson or any two board members. A majority of the Board shall constitute a quorum.

(e) Compensation of Members; Expenses; Employees. – Members of the Board shall receive no compensation for their services but shall receive per diem and necessary travel and subsistence expenses as provided in G.S. 138-5. The Board may employ necessary personnel for the performance of its functions and fix the compensation. The Board shall not employ any of its members to perform inspectional or similar ministerial tasks for the Board. In no event shall the State of North Carolina be liable for expenses incurred by the Board in excess of the income derived from this Article.

"**§ 90-726.5. Powers and duties of Board.**

(a) The Board shall have the following powers and duties:

(1) Administer, coordinate, and enforce the provisions of this Article.

(2) Adopt, amend, or repeal rules to administer and enforce this Article.

(3) Establish and determine qualification and fitness of applicants for licensure under this Article.

(4) Issue, renew, deny, suspend, revoke, or refuse to issue or renew any license under this Article.

(5) Establish fees for applications, initial and renewal licenses, and other services provided by the Board.

(6) Discipline persons licensed under this Article.

(b) The Board may empower any member to conduct any proceeding or investigation necessary to its purposes and may empower its agent or counsel to conduct any investigation necessary to its purposes, but any final action requires a quorum of the Board. The Board may order that any records concerning the practice of psychology relevant to a complaint received by the Board or an inquiry or investigation conducted by or on behalf of the Board be produced before the Board or for inspection and copying by representatives of or counsel to the Board by the custodian of such records. The Board shall adopt an official seal, which shall be affixed to all licenses issued by it.

"**§ 90–726.6. Annual report.**

On June 30 of each year, the Board shall submit a report to the Governor of the Board's activities since the preceding July 1, including the names of all licensed behavior analysts and licensed assistant behavior analysts to whom licenses have been granted under this Article, any cases heard and decisions rendered in matters before the Board, the recommendations of the Board as to future actions and policies, and a financial report. Each member of the Board shall review and sign the report before its submission to the Governor. Any Board member shall have the right to record a dissenting view.

"**§ 90-726.7. License application.**

(a) Each individual desiring to obtain a license under this Article shall apply to the Board upon the form and in the manner prescribed by the Board. Each applicant shall furnish evidence satisfactory to the Board that the applicant meets all of the following criteria:

(1) The individual is of good moral character and conducts his or her professional activities in accordance with accepted professional and ethical standards.

(2) The individual has not engaged in or is not engaged in any practice that would be a ground for denial, revocation, or suspension of a license under G.S. 90-726.11.

(3) The individual has submitted the required criminal history record, as required by G.S. 90-726.13.

(4) The individual is qualified for licensure pursuant to the requirements of this Article.

(b) A license obtained through fraud or by any false representation is void.

"**§ 90-726.8. Requirements for licensure as a behavior analyst.**

Each applicant shall be issued a license by the Board to engage in the practice of behavior analysis as a licensed behavior analyst if the applicant meets the qualifications set forth in G.S. 90-726.5(a) and provides satisfactory evidence to the Board of all the following criteria:

(1) The applicant has passed the certifying entity's Board Certified Behavior Analyst examination.

(2) The applicant has an active status with the certifying entity as a Board Certified Behavior Analyst.

"**§ 90-726.9. Requirement of licensure as an assistant behavior analyst.**

Each applicant shall be issued a license by the Board to engage in the practice of behavior analysis as a licensed assistant behavior analyst if the applicant meets the qualifications set forth in G.S. 90-726.5(a) and provides satisfactory evidence to the Board of all the following criteria:

(1) The applicant has passed the certifying entity's Board Certified Assistant Behavior Analyst examination.
(2) The applicant has an active status with the certifying entity as a Board Certified Assistant Behavior Analyst.
(3) The applicant has an ongoing arrangement for supervision by a licensed behavior analyst in a manner consistent with the certifying entity's requirements for supervision of Board Certified Assistant Behavior Analysts.

"**§ 90-726.10. Renewal of license.**

(a) A license shall be granted under this Article for the period of two years.

(b) The Board shall renew a license granted under this Article upon completion of the following:

(1) Proof of completion of any continuing education required by the certifying entity.
(2) Payment of the renewal fee.
(3) Evidence of active certification by certifying entity.
(4) For assistant behavior analysts, evidence of the ongoing arrangement for supervision by a licensed behavior analyst, as required by G.S. 90-726.7.

"**§ 90-726.11. Temporary licensure.**

(a) An individual residing and practicing behavior analysis in another state and who is certified as a Board Certified Behavior Analyst by the certifying entity may apply to the Board for a temporary license to practice behavior analysis in North Carolina.

(b) An individual residing and practicing behavior analysis in another state who is actively licensed in another state as a behavior analyst may apply to the Board for a temporary license to practice behavior analysis in North Carolina.

(c) A temporary license is available only if the behavior analysis services are to be delivered during a limited and defined period of service approved by the Board.

"**§ 90-726.12. Reciprocity.**

(a) The Board shall issue a license to an individual who is actively licensed as a behavior analyst or assistant behavior analyst in another state that currently imposes comparable licensure requirements as those imposed by this Article and that offers reciprocity to individuals licensed under this Article.

(b) Applicants for licensure by reciprocity shall submit the following items:

(1) Proof of ethical compliance.
(2) Proof of current licensure.
(3) Proof of current certification by the certifying entity.
(4) A criminal history record check as required by G.S. 90-726.15.
(5) Any other eligibility requirement as deemed appropriate by the Board.

"**§ 90-726.13. Denial, suspension, or revocation of licenses and other disciplinary and remedial actions for violations of the Code of Conduct; relinquishing of license.**

(a) Any applicant for licensure and any person licensed under this Article shall comply with the ethical and professional standards specified in this Code of Conduct and in the rules of the Board. The Board may deny, suspend, or revoke licensure and may discipline, place on probation, limit practice, and require examination, remediation, and rehabilitation, or any combination thereof, all as provided for in subsection (b) below. The following are considered violations of the Code of Conduct:

(1) Conviction of a felony or entry of a plea of guilty or nolo contendere to any felony charge.
(2) Conviction of a felony or entry of a plea of guilty or nolo contendere to any misdemeanor involving moral turpitude, misrepresentation or fraud in dealing with the public, or conduct otherwise relevant to fitness to practice,

or a misdemeanor charge reflecting the inability to practice behavior analysis with due regard to the health and safety of clients or patients.

(3) Using fraud or deceit in securing or attempting to secure or renew a license under this Article or has willfully concealed from the Board material information in connection with application for a license or for renewal of a license under this Article.

(4) Using fraud, deceit, or misrepresentation upon the public, the Board, or any individual in connection with the practice of behavior analysis, the filing of Medicare, Medicaid, or other claims to any third-party payor, or in any manner otherwise relevant to fitness for the practice of behavior analysis.

(5) Making fraudulent, misleading, or intentionally or materially false statements pertaining to education, licensure, license renewal, supervision, continuing education, any disciplinary actions or sanctions pending or occurring in any other jurisdiction, professional credentials, or qualifications or fitness for the practice of behavior analysis to the public, any individual, the Board, or any other organization.

(6) Revocation or suspension of a license for the practice of behavior analysis in any other jurisdiction or having been disciplined by the licensing board or certifying entity in any other jurisdiction for conduct which would subject the licensee to discipline under this Article.

(7) Violation of any provision of this Article or of the duly adopted rules of the Board.

(8) Aiding or abetting the unlawful practice of behavior analysis by any person not licensed by the Board.

(9) Engaging in immoral, dishonorable, unprofessional, or unethical conduct as defined in this subsection, or the current Ethics Code of the certifying entity.

(10) Practicing behavior analysis in such a manner as to endanger the welfare of clients or patients.

(11) Demonstrating an inability to practice behavior analysis with reasonable skill and safety by reason of illness, inebriation, misuse of drugs, narcotics, alcohol, chemicals, or any other substance affecting mental or physical functioning, or as a result of any mental or physical condition.

(12) Practicing behavior analysis outside the boundaries of demonstrated competence or the limitations of education, training, or supervised experience.

(13) Failing to provide competent treatment, consultation, or supervision, in keeping with standards of usual and customary practice in this State.

(14) Failing to take all reasonable steps to ensure the competence of services.

(15) Failing to maintain a clear and accurate case record which documents the following for each patient or client:

a. Presenting problems, diagnosis, or purpose of the evaluation, treatment, or other services provided.

b. Fees, dates of services, and itemized charges.

c. Summary content of each session of evaluation, treatment, or other services, except that summary content need not include specific information that may cause significant harm to any person if the information were released.

d. Copies of all reports prepared.

(16) Except when prevented from doing so by circumstances beyond the behavior analyst's control, failing to retain securely and confidentially the complete case record for at least seven years from the date of the last provision of

services; or, except when prevented from doing so by circumstances beyond the behavior analysist's control, has failed to retain securely and confidentially the complete case record indefinitely if there are pending legal or ethical matters or if there is any other compelling circumstance.

(17) Failing to cooperate with other behavior analysts or other professionals to the potential or actual detriment of clients, patients, or other recipients of service, or behaving in ways which substantially impede or impair other licensed behavior analysts, licensed assistant behavior analysts, or other professionals' abilities to perform professional duties.

(18) Exercising undue influence in such a manner as to exploit the client, patient, student, supervisee, or trainee for the financial or other personal advantage or gratification of the licensed behavior analyst, licensed assistant behavior analyst, or a third party.

(19) Harassing or abusing, sexually or otherwise, a client, patient, student, supervisee, or trainee.

(20) Failing to cooperate with or to respond promptly, completely, and honestly to the Board, to credentials committees, or to ethics committees of professional behavior analyst associations, hospitals, or other health care organizations or educational institutions, when those organizations or entities have jurisdiction; or has failed to cooperate with institutional review boards or professional standards review organizations, when those organizations or entities have jurisdiction.

(21) Refusing to appear before the Board after having been ordered to do so in writing by the Chair.

(b) Upon proof that an applicant or licensee under this Article has engaged in any of the prohibited actions specified in subsection (a) of this section, the Board may, in lieu of denial, suspension, or revocation, issue a formal reprimand or formally censure the applicant or licensee, may place the applicant or licensee on probation with such appropriate conditions upon the continued practice as the Board may deem advisable, may require examination, remediation, or rehabilitation for the applicant or licensee, including care, counseling, or treatment by a professional or professionals designated or approved by the Board, the expense to be borne by the applicant or licensee, may require supervision for the services provided by the applicant or licensee by a licensee designated or approved by the Board, the expense to be borne by the applicant or licensee, may limit or circumscribe the practice of behavior analysis provided by the applicant or licensee with respect to the extent, nature, or location of the services provided, as the Board deems advisable, or may discipline and impose any appropriate combination of the foregoing. In addition, the Board may impose such conditions of probation or restrictions upon continued practice at the conclusion of a period of suspension or as requirements for the restoration of a revoked or suspended license. In lieu of or in connection with any disciplinary proceedings or investigation, the Board may enter into a consent order relative to the discipline, supervision, probation, remediation, rehabilitation, or practice limitation of a licensee or applicant for a license.

(c) The Board may assess costs of disciplinary action against an applicant or licensee found to be in violation of this Article.

(d) When considering whether an applicant or licensee is physically or mentally capable of practicing behavior analysis with reasonable skill and safety with patients or clients, then, upon a showing of probable cause to the Board that the applicant or licensee is not capable of practicing behavior analysis with reasonable skill and safety with patients or clients, the Board may petition a court of competent jurisdiction to order the applicant or licensee in question to submit to a psychological evaluation by a psychologist to determine psychological status or a physical evaluation by a physician to determine physical condition, or both. Such psychologist

or physician shall be designated by the court. The expenses of such evaluations shall be borne by the Board. Where the applicant or licensee raises the issue of mental or physical competence or appeals a decision regarding mental or physical competence, the applicant or licensee shall be permitted to obtain an evaluation at the applicant's or licensee's expense. If the Board suspects the objectivity or adequacy of the evaluation, the Board may compel an evaluation by its designated practitioners at its own expense.

(e) Except as provided otherwise in this Article, the procedure for revocation, suspension, denial, limitations of the license, or other disciplinary, remedial, or rehabilitative actions shall be in accordance with the provisions of Chapter 150B of the General Statutes. The Board is required to provide the opportunity for a hearing under Chapter 150B of the General Statutes to any applicant whose license is denied or to whom licensure is offered subject to any restrictions, probation, disciplinary action, remediation, or other conditions or limitations or to any licensee before revoking, suspending, or restricting a license or imposing any other disciplinary action or remediation. If the applicant or licensee waives the opportunity for a hearing, the Board's denial, revocation, suspension, or other proposed action becomes final without a hearing having been conducted. Notwithstanding the foregoing, no applicant or licensee is entitled to a hearing for failure to pass an examination. In any proceeding before the Board, in any record of any hearing before the Board, in any complaint or notice of charges against any licensee or applicant for licensure, and in any decision rendered by the Board, the Board may withhold from public disclosure the identity of any clients or patients who have not consented to the public disclosure of behavior analysis services having been provided by the licensee or applicant. The Board may close a hearing to the public and receive in executive session evidence involving or concerning the treatment of or delivery of behavior analysis services to a client or a patient who has not consented to the public disclosure of such treatment or services as may be necessary for the protection and rights of such patient or client of the accused applicant or licensee and the full presentation of relevant evidence. All records, papers, and other documents containing information collected and compiled by or on behalf of the Board, as a result of investigations, inquiries, or interviews conducted in connection with licensing or disciplinary matters will not be considered public records as defined in G.S. 132-1. However, any notice or statement of charges against any licensee or applicant, or any notice to any licensee or applicant of a hearing in any proceeding, or any decision rendered in connection with a hearing in any proceeding, shall be a public record notwithstanding that it may contain information collected and compiled as a result of such investigation, inquiry, or hearing except that identifying information concerning the treatment of or delivery of services to a patient or client who has not consented to the public disclosure of such treatment or services may be deleted. If any such record, paper, or other document containing information theretofore collected and compiled by or on behalf of the Board, as hereinbefore provided, is received and admitted in evidence in any hearing before the Board, it shall thereupon be a public record, subject to any deletions of identifying information concerning the treatment of or delivery of behavior analysis services to a patient or client who has not consented to the public disclosure of such treatment or services.

(f) A license issued under this Article is suspended automatically by operation of law after failure to renew a license for a period of more than 60 days after the renewal date. The Board may reinstate a license suspended under this subsection upon payment of a fee as specified in G.S. 90-726.14, and may require that the applicant file a new application, furnish references or otherwise update his or her credentials, or submit to examination for reinstatement. Notwithstanding any provision to the contrary, the Board retains full jurisdiction to investigate alleged violations of this Article by any person whose license is suspended under this subsection, and, upon proof of any violation of this Article by any such person, the Board may take disciplinary action as authorized by this section.

(g) A person whose license has been denied or revoked may reapply to the Board for licensure after the passage of one calendar year from the date of such denial or revocation.

(h) A licensee may, with the consent of the Board, voluntarily relinquish his or her license at any time. The Board may delay or refuse the granting of its consent as it may deem necessary in order to investigate any pending complaint, allegation, or issue regarding violation of any provision of this Article by the licensee. Notwithstanding any provision to the contrary, the Board retains full jurisdiction to investigate alleged violations of this Article by any person whose license is relinquished under this subsection, and, upon proof of any violation of this Article by any such person, the Board may take disciplinary action as authorized by this section.

(i) The Board may adopt such rules as it deems reasonable and appropriate to interpret and implement the provisions of this section.

"**§ 90-726.14. Fees.**

The Board may collect fees established by its rules, but those fees shall not exceed the amounts listed below:

(1)	Application fee for licensure	$250.00
(2)	License renewal	$200.00
(3)	Late renewal fee	$50.00
(4)	Reciprocal license application	$250.00
(5)	Temporary license application	$100.00.

"**§ 90-726.15. Criminal history record checks of applicants for licensure.**

(a) All applicants for licensure shall consent to a criminal history record check. Refusal to consent to a criminal history record check may constitute grounds for the Board to deny licensure to an applicant. The Board shall be responsible for providing to the North Carolina Department of Justice the fingerprints of the applicant to be checked, a form signed by the applicant consenting to the criminal history record check and the use of fingerprints and other identifying information required by the State or National Repositories, and any additional information required by the Department of Justice. The Board shall keep all information obtained pursuant to this section confidential.

(b) The cost of the criminal history record check and the fingerprinting shall be borne by the applicant. The Board shall collect any fees required by the Department of Justice and shall remit the fees to the Department of Justice for expenses associated with conducting the criminal history record check.

(c) If an applicant's criminal history record reveals one or more criminal convictions, the conviction shall not automatically bar licensure. The Board shall consider all of the following factors regarding the conviction:

(1) The level of seriousness of the crime.
(2) The date of the crime.
(3) The age of the person at the time of conviction.
(4) The circumstances surrounding the commission of the crime, if known.
(5) The nexus between the criminal conduct of the person and the job duties of the position to be filled.
(6) The applicant's prison, jail, probation, parole, rehabilitation, and employment records since the date the crime was committed.

(d) If, after reviewing the factors, the Board determines that any of the grounds to deny licensure exist, the Board may deny licensure of the applicant. The Board may disclose to the applicant information contained in the criminal history record that is relevant to the denial if disclosure of the information is permitted by applicable State and federal law. The Board shall not provide a copy of the criminal history to the applicant. The applicant shall have the right to appear before the Board to appeal the Board's decision. An appearance before the full Board

shall constitute an exhaustion of administrative remedies in accordance with Chapter 150B of the General Statutes.

(e) The Board, its officers, and employees, acting in good faith and in compliance with this section, shall be immune from civil liability for denying licensure to an applicant based on information provided in the applicant's criminal history record."

SECTION 2. Article 43 of Chapter 90 of the General Statutes is amended by adding the following new sections to read:

"**§ 90-726.16. Prohibited acts and penalties.**

(a) Except as permitted in G.S. 90-726.18, it shall be a violation of this Article for any person not licensed in accordance with the provisions of this Article to practice behavior analysis or to hold himself or herself out to the public as a person practicing behavior analysis.

(b) Any person not licensed in accordance with the provisions of this Article practicing behavior analysis or holding himself or herself out to the public as a person practicing behavior analysis in violation of this Article is guilty of a Class 2 misdemeanor. Each violation shall count as a separate offense.

"**§ 90-726.17. Injunction.**

The Board may apply to the Superior Court of Wake County for an injunction to prevent violations of this Article or any rules enacted pursuant thereto. The court is empowered to grant such injunctions regardless of whether criminal prosecution or other action has been or may be instituted as a result of such violation.

"**§ 90-726.18. Exemptions from licensure.**

(a) A person is exempt from the requirements of this Article if any of the following conditions are met:

(1) The person is a duly licensed psychologist or psychological associate in this State or a person providing ancillary services pursuant to G.S. 90-270.21.

(2) The person is a Registered Behavior Technician and is acting under the extended authority or direction of a licensed behavior analyst or a licensed assistant behavior analyst.

(3) The person is a family member, guardian, or other caretaker implementing a behavior analysis treatment plan under the direction of a licensed behavior analyst or a licensed assistant behavior analyst.

(4) The person engages in the practice of behavior analysis with nonhuman subjects. This includes, but is not limited to, persons who are animal behaviorists and animal trainers.

(5) The person provides general behavior analysis services to organizations, so long as the services are for the benefit of the organizations and do not involve direct services to individuals.

(6) The person is a professional licensed under this Chapter or Chapter 90B of the General Statutes, so long as the licensed professional does not represent that he or she is a licensed behavior analyst or licensed assistant behavior analyst and the services of the licensed professional are within the scope of practice of the license possessed by that professional and the services performed are commensurate with the licensed professional's education, training, and experience.

(7) The activities are part of a defined college or university course program of study, practicum, or intensive practicum, so long as that person is under direct supervision of (i) a licensed behavior analyst, (ii) an instructor in a course sequence approved by the certifying entity, or (iii) a qualified faculty member.

(8) The person is pursuing experience in behavior analysis consistent with the certifying entity's experience requirements, so long as the person's activities are supervised by a licensed behavior analyst."

SECTION 3. G.S. 90-270.4 is amended by adding a new subsection to read:

"(f1) Nothing in this Article shall be construed to prevent a behavior analyst or an assistant behavior analyst licensed under Article 43 of Chapter 90 of the General Statutes from offering services within the scope of practice authorized by the North Carolina Behavior Analysis Board."

SECTION 4. The North Carolina Behavior Analysis Board shall adopt temporary rules to implement this section no later than November 1, 2015. The temporary rules shall remain in effect until permanent rules that replace the temporary rules become effective.

SECTION 5. Chapter 8 of the General Statutes is amended by adding a new section to read:

"**§ 8-53.14. Communications between behavior analyst and client or patient.**

No person, duly authorized as licensed behavior analyst, nor any of the person's employees or associates, shall be required to disclose any information which the person may have acquired in the practice of behavior analysis and which information was necessary to enable the person to practice behavior analysis. Any resident or presiding judge in the district in which the action is pending may, subject to G.S. 8-53.6, compel disclosure, either at the trial or prior thereto, if in his or her opinion disclosure is necessary to a proper administration of justice. If the case is in district court the judge shall be a district court judge, and if the case is in superior court the judge shall be a superior court judge.

Notwithstanding the provisions of this section, the behavior analyst-client or behavior analyst-patient privilege shall not be grounds for failure to report suspected child abuse or neglect to the appropriate county department of social services or for failure to report a disabled adult suspected to be in need of protective services to the appropriate county department of social services. Notwithstanding the provisions of this section, the behavior analyst-client or behavior analyst-patient privilege shall not be grounds for excluding evidence regarding the abuse or neglect of a child, or an illness of or injuries to a child, or the cause thereof, or for excluding evidence regarding the abuse, neglect, or exploitation of a disabled adult, or an illness of or injuries to a disabled adult, or the cause thereof, in any judicial proceeding related to a report pursuant to the Child Abuse Reporting Law, Article 3 of Chapter 7B of the General Statutes."

SECTION 6. Sections 2 and 3 of this act become effective January 1, 2016. The remainder of this act is effective when it becomes law.

NORTH CAROLINA GENERAL ASSEMBLY
HOUSE OF REPRESENTATIVES

HEALTH COMMITTEE REPORT

Representative Brian Brown, Co-Chair
Representative Justin P. Burr, Co-Chair
Representative Bert Jones, Co-Chair
Representative Donny Lambeth, Co-Chair

FAVORABLE COM SUB , UNFAVORABLE ORIGINAL BILL AND RE-REFERRED

HB **714** Behavior Analyst Licensure.

Draft Number:	H714-PCS10396-SH-47
Serial Referral:	**FINANCE**
Recommended Referral:	None
Long Title Amended:	No
Floor Manager:	Jeter

TOTAL REPORTED: 1

Tuesday, June 10	Room	Time
HEALTH	643	10:00 am

Name	County	Sponsor
Chris Boulton	Mecklenburg	Jacqueline Michelle Schaffer
Carson Butts	Wake	N. Leo Daughtry
Matthew Caropolo	New Hanover	Ted Davis, Jr.
Seth Cashion	Randolph	Pat B. Hurley
Spencer Mangum	Wake	George Robinson

Committee Sergeants at Arms

NAME OF COMMITTEE House Comm. on Health

DATE: 6-10-2015 Room: 643

House Sgt-At Arms:

1. Name: Young Bae
2. Name: Bill Morris
3. Name: Jim Moran
4. Name: _____
5. Name: _____

Senate Sgt-At Arms:

1. Name: _____
2. Name: _____
3. Name: _____
4. Name: _____
5. Name: _____

VISITOR REGISTRATION SHEET

House Comm. on Health — 6-10-2015

Name of Committee — Date

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Wendy Kelly	FOCUS Carolina
Katherine Davis	Esthering Davis & Assoc Inc.
Susanna Davis	NCFA
Carly Abney	NCFA
Joel MAYNARD	GTM & Assoc
Elizabeth Robinson	NCMA
TJ Bugbee	NP
Doug Heron	DUKE
Christine Cray	WakeMed
DED	Vidant
Dana Simpson	SCA

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House Comm. on Health — 6-10-2015

Name of Committee — Date

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NAME	FIRM OR AGENCY AND ADDRESS
Lynette Doe	NCALHD
Elizabeth Schad	NCPHA
Dirk Coulton	Law office of Dirk Coulton
Katherine P. [illegible]	John Locke Foundation
David Collins	SEANC
Hay Lloyd	MWC
Liam Zachary	NCJC
Mike McBrayer	Biogen
Fred Bone	Bone Assoc
Mark [illegible]	UHG
Chris Conn	UHC

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House Comm. on Health — 6-10-2015

Name of Committee — Date

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NAME	FIRM OR AGENCY AND ADDRESS
Dodie Benfer	CCR
Greg Grays	NCAFP
Charles Rhodes	NCAFP
Kara Weishaar	SA
Lori Kroll	Novant Health
John Poteat	VCMA
Maurice Worness MD	NCANP
Holly Biola, MD	NCAFP (Family Physicians)

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House Comm. on Health — 6-10-2015

Name of Committee — Date

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NAME	FIRM OR AGENCY AND ADDRESS
Ed Lunsford	BP
Courtney Dehnson	NP
Jeff Barnhart	MWC
Arlie White	NCMHC
Betsy Ketter	AHA
Peg Gerrald	NASW
Rob Robinson	Alliance Behavioral Healthcare
Matt Gross	NCPC
Kate Steber	DPFC
Shymari Huntley	DPI - intern
Frank Hill	PSG

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House Comm. on Health — 6-10-2015

Name of Committee — Date

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NAME	FIRM OR AGENCY AND ADDRESS
Alex Bowen	CCS
John Cooper	CCS
Peter Daniel	CCS
JW Joyner	New Frame
Bubba White	New Frame
Patrick Stevens	SA
Peggie Holley	The Longmire Group
Jason Mercier	Poliggroup
NICHOLE KARIM	NAMI NC
Sally Cameron	NC Psychological Assoc
Kay Castillo	NASW NC

VISITOR REGISTRATION SHEET

House Comm. on Health 6-10-2015

Name of Committee Date

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NAME	FIRM OR AGENCY AND ADDRESS
Alan Miller	KCG
Tom West	NCICU
Sue Ann Forrest	NCICU
Steve Monge	NCRLA
BRIAN INGRAHAM	SMOKY MTN
Rick Zechini	WM
James Stanley	Methodist Home

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House Comm. on Health — 6-10-2015

Name of Committee — Date

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NAME	FIRM OR AGENCY AND ADDRESS
Kristen Dubay	NC Community Health Center Assoc.
Rhonda Thomas	NC Community Health Center Assoc.
Viviana Martinez-Bianchi	NC Academy of Family Physicians
Joanna Spruill	NCAFP
Austin Pruitt	Parkinson Law
Sarah Woolfe	MMC
Michelle Brooks	ECU
Douglas Holland	NCSBA
Amy McConkey	NC Beverage
Sarah McMillan	KJ & GNC
Omoni Meyer	The Carolinas Center for Hospice

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House Comm. on Health — 6-10-2015

Name of Committee — Date

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NAME	FIRM OR AGENCY AND ADDRESS
Lorri Unumb	Autism Speaks
Selene Johnson	ABC of NC Winston Salem NC
[signature]	BCI
[signature]	[illegible]
Mike Jones	[illegible]
Callie Plattner	Carolina Center for ABA + Autism Treatment
KYLE ROBINSON	FATHER W/ AUTISTIC CHILD
Ali Ivancic	Butterfly Effects
Carson Hise	MVA
Trent Womble	DHHS
Allie Maccion	DHHS

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House Comm. on Health — 6-10-2015

Name of Committee — Date

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NAME	FIRM OR AGENCY AND ADDRESS
J Bode	BHH
Sarah Bales	Brubaker Assoc.
John DelGiorno	Brubaker GA's SOC
Leza Wainwright	ECBH
Peyton Mayo	
Mac Boxley	NC Forest Alliance
Tom Teague	NMRS
Michelle Frazier	MFS
Meghan Cook	OITS
Judy Jenkins	Otsuka
Peters	C55
Jon Carr	NCPJ
Elizabeth Hodgin	NCPJ

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House Comm. on Health — 6-10-2015

Name of Committee — Date

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Amy Hobbs	CCNC
Mark Fleming	BCBSNC
John McMillan	MF&S
Allison Stewart	Cardinal

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House Comm. on Health — 6-10-2015

Name of Committee — Date

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NAME	FIRM OR AGENCY AND ADDRESS
Lanier Hodgson	UNC Health Care
Ryan Blackledge	Cone Health
Erica Nelson	NCHA
JERRY COWEN	Nelson Mullins
LAO Russell	CJPC
Jim Johnson	BSA

NORTH CAROLINA HOUSE OF REPRESENTATIVES
COMMITTEE MEETING NOTICE
AND
BILL SPONSOR NOTIFICATION
2015-2016 SESSION

You are hereby notified that the **House Committee on Health** will meet as follows:

DAY & DATE: Wednesday, June 10, 2015
TIME: **15 Minutes After Session**
LOCATION: **643 LOB**
COMMENTS: **Representative Jones is presiding.**

The following bills will be considered:

BILL NO.	SHORT TITLE	SPONSOR
HB 372	2015 Medicaid Modernization.	Representative Dollar Representative Lambeth Representative B. Brown Representative Jones

Respectfully,

Representative Brian Brown, Co-Chair
Representative Justin P. Burr, Co-Chair
Representative Bert Jones, Co-Chair
Representative Donny Lambeth, Co-Chair

I hereby certify this notice was filed by the committee assistant at the following offices at 11:09 AM on Wednesday, June 10, 2015.

___ Principal Clerk
___ Reading Clerk – House Chamber

Brenda Olls (Committee Assistant)

House Committee on Health
Wednesday, June 10, 2015 at 15 Minutes After Session
Room 544 of the Legislative Office Building

MINUTES

The House Committee on Health met at 15 Minutes After Session on June 10, 2015 in Room 544 of the Legislative Office Building. Representatives Adcock, Avila, Bishop, Blackwell, Brawley, Brisson, Burr, Carney, Dobson, Dollar, Farmer-Butterfield, Ford, Goodman, Hager, L. Hall, Insko, Jones, Lambeth, and Lucas attended.

Representative Bert Jones, Chair, presided.

The following bills were considered:

HB 372 2015 Medicaid Modernization. (Representatives Dollar, Lambeth, B. Brown, Jones)

Representatives Dollar and Lambeth answered questions and concerns from the Committee members, as the meeting continued from earlier in the day. Ken Lewis, president of NC Association of Health Plans spoke in opposition of the bill. After much discussion, Representative Dobson made a motion for a Favorable Report, Unfavorable to the original with referral to Appropriations. The majority being in favor, the motion carried.

The meeting adjourned at 6:20.

Bert Jones
Representative Bert Jones, Chair
Presiding

Brenda Olls
Brenda Olls, Committee Clerk

HOUSE BILL 372:
2015 Medicaid Modernization

2015-2016 General Assembly

Committee:	House Health, if favorable, Appropriations	**Date:**	June 10, 2015
Introduced by:	Reps. Dollar, Lambeth, B. Brown, Jones	**Prepared by:**	Kory Goldsmith Staff Attorney
Analysis of:	PCS to First Edition H372-CSTR-1		

SUMMARY: The Proposed Committee Substitute to HB 372 would transition the Medicaid and NC Health Choice programs from fee-for-service to full-risk capitated health plans operated by provider-led entities to manage and coordinate the care for enough program aid categories to cover at least 90% of Medicaid and NC Health Choice recipients within five years of the act becoming law. All physical health services would be included in the coverage except dental and pharmacy. The Department of Health and Human Services (Department) would manage and administer the program within the budget appropriated by the General Assembly. Once fully implemented, the State would retain only the risk of enrollment numbers and enrollment mix of populations receiving services.

BILL ANALYSIS:

Section 1 sets out the intent of the General Assembly which is to transform the current Medicaid program so that it provides budget predictability while ensuring quality of care.

Section 2 provides definitions including the following:

- Capitation payment – A payment the State agency periodically makes to a contractor on behalf of each beneficiary enrolled under a contract for the provision of medical services under the State plan. The State agency makes the payment regardless of whether the particular beneficiary receives services during the period covered by the payment.
- Provider – An individual or business entity required to enroll in the North Carolina Medical Assistance Program or the North Carolina Health Insurance Program for Children to provide services, goods, supplies, or merchandise to a Medicaid or Health Choice recipient.
- Provider-led entity (PLE) – A provider, an entity with the primary purpose of owning or operating one or more providers, or a business entity in which providers hold a controlling ownership interest. In addition, a majority of each PLE's governing board must be comprised of physicians who treat Medicaid and NC Health Choice patients.
- Recipient – An individual who has been determined to be eligible for Medicaid or NC Health Choice.

Section 3 sets out the structure of the transformed Medicaid and NC Health Choice programs which shall include:

- Implementation of full-risk capitated health plans by provider-led organizations to be phased in over five years from the date the act becomes law. The health plans would include enough program aid categories to cover at least 90% of Medicaid recipients in all 100 counties.
- Once fully implemented, the State retains the budgetary risk of enrollment numbers and enrollment mix of populations for which capitated payments are made.

This bill analysis was prepared by the nonpartisan legislative staff for the use of legislators in their deliberations and does not constitute an official statement of legislative intent.

- PLE contracts control the State's cost growth to at least 2% below national Medicaid spending growth based on the CMS annual report for nonexpansion states.
- Administrative costs are minimized and the Department shall establish medical loss ratios which allocate at least 90% of the capitated payment to patient care.
- PLEs will be responsible for all administrative functions including claims processing, appeals, and care and case management.

Section 4 sets out the following timeline for implementation:

- Within 1 year of the act becoming law, the Department must submit an application for an 1115 Medicaid demonstration waiver.
- Within 2 years of the act becoming law and approval by CMS of the demonstration waiver, the Department must issue a request for proposals (RFP) for provider-led organizations to bid on contracts.
- Within 5 years of the act becoming law, 90% of recipients will be enrolled in full-risk, capitated health plans for all services except those provided by LME/MCOs, dental and pharmacy.
- Within 6 years of the act becoming law, each PLE must meet the risk, cost, performance, and quality goals set by the act and the contract.

Sections 5 and 10(b) directs the Department to submit the 1115 demonstration waiver and to continue implementing the existing 1915(b)/(c) waiver.

Section 6 sets out the minimum requirements for the RFPs and contracts. In addition to the mandatory components described above, each contract must cover at least 30,000 recipients, ensure appropriate access to care for recipients, and include defined measures of critical metrics. Collectively, the contracts must cover all 100 counties. All successful PLEs must meet the solvency requirements set by the Department of Insurance for health maintenance organizations. All contracts must be for 5 years and must contain clear performance goals with penalties for failure to meet the goals and financial rewards for meeting the goals.

Section 7 delegates to the Department full authority to implement the transformation of the Medicaid and NC Health Choice programs, including the authority to hire individuals with the experience and competencies to manage the Medicaid and NC Health Choice programs in a contract environment.

Section 8 directs the Secretary of the Department to convene an advisory committee of experts to advise the Department on the development of the 1115 waiver application and on the performance goals to be contained in the contracts.

Section 9 requires periodic audits of the plans.

Section 10 directs the Department to work with CMS to preserve existing levels of funding.

Section 11 creates the Joint Legislative Oversight Committee on Medicaid which would oversee the transformation. It would be composed of 7 members from the Senate, 7 members from the House of Representatives, and 2 members from each chamber would be members of the minority party.

Section 12 appropriates $2.5 million of non-recurring funds to the Department for the 2015-16 and the 2016-17 fiscal years to provide a State match for federal funds to pay for Medicaid transformation.

EFFECTIVE DATE: Section 12 of the bill becomes effective upon appropriation by the General Assembly of the funds for implementation of the act. The remainder of the act is effective when it becomes law.

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2015

H D

HOUSE BILL 372
PROPOSED COMMITTEE SUBSTITUTE H372-CSTR-1 [v.31]

6/9/2015 7:26:39 PM

Short Title: 2015 Medicaid Modernization. (Public)

Sponsors:

Referred to:

March 30, 2015

A BILL TO BE ENTITLED

AN ACT TO MODERNIZE AND STABILIZE NORTH CAROLINA'S MEDICAID PROGRAM THROUGH PROVIDER-LED CAPITATED HEALTH PLANS.

The General Assembly of North Carolina enacts:

SECTION 1. Intent and Goals. – It is the intent of the General Assembly to transform the State's current Medicaid program to a program that provides budget predictability for the taxpayers of this State while ensuring quality care to those in need. The new Medicaid program shall be designed to achieve the following goals:

(1) Ensure budget predictability through shared risk and accountability.
(2) Ensure balanced quality, patient satisfaction, and financial measures.
(3) Ensure efficient and cost-effective administrative systems and structures.
(4) Ensure a sustainable delivery system.
(5) Improve health outcomes for the State's Medicaid population.

SECTION 2. Definitions. – As used in this act, the following terms have the following definitions:

(1) Capitation payment. – As defined in 42 C.F.R. 438.2.
(2) CMS. – The Centers for Medicare and Medicaid Services.
(3) Department. – The North Carolina Department of Health and Human Services.
(4) Provider. – As defined in G.S. 108C-2(10).
(5) Provider-led entity. – Any of the following:
  a. A provider.
  b. An entity with the primary purpose of owning or operating one or more providers.
  c. A business entity in which providers hold a controlling ownership interest.
(6) Recipient. – An individual who has been determined to be eligible for Medicaid or NC Health Choice.
(7) Secretary. – The Secretary of the Department.

SECTION 3. Structure of Delivery System. – The structure of the transformed Medicaid program required in Section 1 of this act shall be as follows:

(1) Provider-led entities shall implement full-risk capitated health plans to manage and coordinate the care for enough program aid categories to cover at least ninety percent (90%) of Medicaid recipients to be phased in over five years from the date this act becomes law. Program aid category coverage shall not include dual eligibles for whom Medicaid pays only Medicare

premiums. In aggregate, provider-led entities shall cover Medicaid recipients in all 100 counties.

(2) Provider-led entities ensure appropriate access to care for Medicaid recipients in all 100 counties while building upon the existing enhanced primary care medical home model.

(3) Provider-led entity contracts result in controlling the State's cost growth at least two percentage (2%) points below national Medicaid spending growth as documented and projected in the annual report prepared for CMS by the Office of the Actuary for nonexpansion states.

(4) The Department implements a process for recipient assignment to provider-led entities. Assignment shall be based on the recipient's selection of a provider-led entity, or if the recipient fails to choose a provider-led entity during initial enrollment, the Department shall develop a process for auto-assignment to a provider-led entity. The Department may limit the circumstances under which a Medicaid recipient may change provider-led entity, including creating an open enrollment period.

(5) When fully implemented, the State retains only the risk of enrollment numbers and enrollment mix of the populations for which capitated payments are received.

(6) Capitated payments will be actuarially sound and risk-adjusted, based on the mix of enrollees by program aid category and other appropriate factors.

(7) The Department ensures administrative costs are minimized and establishes appropriate medical loss ratio for contractors accepting full-risk capitation, which allocates at least ninety percent (90%) of the capitated payments to cover patient care.

(8) The Department ensures contracts required under this act contain effective program integrity features to protect against provider fraud, waste, and abuse at all levels of the system.

(9) Provider-led entities will be responsible for all administrative functions for recipients enrolled in their plan, including but not limited to all claims processing, care management, case management, appeals, and all other necessary administrative services.

(10) A majority of each provider-led entity's governing board shall be comprised of physicians who treat Medicaid patients including those who provide clinical services to Medicaid patients.

SECTION 4. Timeline. – The following milestones for Medicaid transformation shall occur in the following order and relative timeframe.

(1) Within 12 months of this act becoming law, the Department shall develop, with meaningful stakeholder engagement, and submit to CMS a request for an 1115 Medicaid demonstration waiver to implement the components of this act.

(2) Within 24 months of this act becoming law and with waiver approvals from CMS, the Department will issue an RFP for provider-led entities to bid on contracts required under this act.

(3) Within five years of the date this act becomes law, ninety percent (90%) of Medicaid recipients shall be enrolled in full-risk, capitated health plans for all services other than the services contracted for through the local management entities/managed care organizations (LME/MCOs), dental services, and pharmaceutical products. However, prior to reaching the coverage required under this subdivision, the Department may accept a full-

risk, capitated health plan as a pilot that begins within three years of enactment of this act.

(4) Within six years of the date this act becomes law, each provider-led entity under contract with the Department must meet the risk, cost, performance, and quality goals required by this act and as contained in the contract with the Department.

SECTION 5. Submission of Waiver. – The Department shall submit to CMS the 1115 waiver and any other waivers and state plan amendments necessary to accomplish the requirements of this act within the required timeframes.

SECTION 6. Components of RFP/Terms & Conditions of Contracts. – The following are mandatory components the Department must include in the RFP and in all contracts required under Section 3 of this act.

(1) No bid may be considered if it does not, at a minimum, provide for all of the following:
   a. Cover a defined population of at least 30,000 recipients.
   b. Ensure appropriate access to care for recipients.

(2) Individually, bidders must:
   a. Agree to receive risk-adjusted capitation rates for all health benefits and administrative services, including physical, long term services and supports, and other medical services generally considered physical care.
   b. Agree to transition to full-risk capitation for all services and related administrative costs for enrolled populations within the three to five years following the enactment of this act.
   c. Agree to defined measures for risk adjusted health outcomes, quality of care, patient satisfaction, and costs.
   d. Meet financial solvency requirements developed by the Department of Insurance that are equivalent to the solvency requirements for health maintenance organizations in G.S. 58-67-110.
   e. Assume responsibility for complying with appeal rights and program integrity functions.
   f. Meet all data systems standards.

(3) Collectively, bidders are responsible for:
   a. Coverage for all 100 counties.
   b. Managing ninety percent (90%) of the State's Medicaid population within five years of enactment. All dual eligibles shall be excluded..
   c. A reduction of at least two percentage (2%) points below the national Medicaid spending growth as documented and projected in the annual report prepared for CMS by the Office of the Actuary for nonexpansion states.

(4) All contracts must:
   a. Include clear performance goals based on the defined measures that are monitored and measured at specified and appropriate intervals.
   b. Provide penalties for failure to meet the performance goals.
   c. Provide financial rewards for achieving performance goals.
   d. Be for a term of five years with options to renew or extend based upon successful performance, as determined by the Department and contained in the contract.
   e. Adhere to the quality standards that are developed by the Quality Assurance Advisory Committee and are consistent with State and national quality measures.

SECTION 7. DHHS to Lead. – The General Assembly delegates full authority to the Department of Health and Human Services to take all actions necessary to implement the Medicaid transformation described in this act. The Department shall administer and manage the program within the budget enacted by the General Assembly provided that the total expenditures, net of agency receipts, for the Medicaid program do not exceed the enacted budget. The Department shall employ or contract with individuals who have the appropriate experience and competencies to manage the State's Medicaid program in a predominantly contract environment. To ensure a successful program, the Department shall do all of the following:

(1) Establish procedures and criteria for certifying that contracts entered into under Section 6 of this act establish an adequate medical services delivery network, including determining criteria to ensure Medicaid recipients have access to all medically necessary services.

(2) Establish quality standards and minimum services delivery network requirements for contracts entered into under Section 6 of this act.

(3) Ensure recipients have appropriate access to primary care and specialty care services and shall develop a rate floor for this purpose.

(4) Establish and implement quality assurance measures for the contracts entered into under Section 6 of this act.

(5) Adopt and implement requirements for the contracts entered into under Section 6 of this act concerning Health Information Technology, robust data analytics, quality of care, and care-quality improvement.

(6) Ensure that providers are required to manage care under appropriate evidence-based standards of care to more efficiently manage utilization and clinical resources.

(7) Encourage providers to utilize appropriate technologies, such as telemedicine, to provide expeditious care and ensure access to services.

(8) Establish procedures for termination of a contract entered into under Section 6 of this act for non-performance of contractual duty or failure to meet or maintain benchmarks, standards, or requirements provided by this act or established by the Department.

SECTION 8.(a) Quality Assurance Advisory Committee. – The Secretary shall convene an advisory committee consisting of experts in the areas of Medicaid, actuarial science, health economics, health benefits, and administration of health law and policy. At least one shall be a member of the North Carolina State Health Coordinating Council.

The Committee shall advise the Department on the development and submission of requests for all federal waivers that are necessary to implement this act and to support the development and approval of the performance goals that will serve as the basis of the pay for performance system. The committee shall terminate five years from the date of enactment of this act.

SECTION 9. Audits of Plans. – The Department shall contract for periodic financial audits of each successful bidder based on the terms and conditions of the awarded contract.

SECTION 10.(a) Maintain Funding Mechanisms. – The Department shall work with CMS to attempt to preserve existing levels of funding generated from Medicaid specific funding streams, such as assessments, to the greatest extent possible. If such Medicaid specific funding cannot be maintained, then the Department shall advise the Joint Legislative Oversight Committee created in Section 12 of this act of any modifications necessary to maintain as much revenue as possible within the context of Medicaid transformation.

SECTION 10.(b) Maintain Existing 1915 (b)/(c) Waiver. – The Department shall continue implementation of the existing 1915(b)/(c) waiver.

SECTION 11.(a) Legislative Oversight of Medicaid. – (a) Chapter 120 of the General Statutes is amended by adding the following new Article:

"Article 23B.

"Joint Legislative Oversight Committee on Medicaid.

"**§ 120-209. Creation and membership of Joint Legislative Oversight Committee on Medicaid.**

(a) The Joint Legislative Oversight Committee on Medicaid is established. The Committee consists of 14 members as follows:

(1) Seven members of the Senate appointed by the President Pro Tempore of the Senate, at least two of whom are members of the minority party.

(2) Seven members of the House of Representatives appointed by the Speaker of the House of Representatives, at least two of whom are members of the minority party.

(b) Terms on the Committee are for two years and begin on the convening of the General Assembly in each odd-numbered year. Members may complete a term of service on the Committee even if they do not seek reelection or are not reelected to the General Assembly, but resignation or removal from service in the General Assembly constitutes resignation or removal from service on the Committee.

(c) A member continues to serve until a successor is appointed. A vacancy shall be filled within 30 days by the officer who made the original appointment.

"**§ 120-209.1. Purpose and powers of Committee.**

(a) The Joint Legislative Oversight Committee on Medicaid shall examine budgeting, financing, administrative, and operational issues related to the Medicaid and Health Choice programs and to the Department of Health and Human Services.

(b) The Committee shall make periodic reports to the General Assembly on matters for which it may report to a regular session of the General Assembly.

"**§ 120-209.2. Organization of Committee.**

(a) The President Pro Tempore of the Senate and the Speaker of the House of Representatives shall each designate a cochair of the Joint Legislative Oversight Committee on Medicaid. The Committee shall meet upon the joint call of the cochairs.

(b) A quorum of the Committee is eight members. No action may be taken except by a majority vote at a meeting at which a quorum is present.

(c) Members of the Committee receive subsistence and travel expenses, as provided in G.S. 120-3.1. The Committee may contract for consultants or hire employees in accordance with G.S. 120-32.02. The Legislative Services Commission, through the Legislative Services Officer, shall assign professional staff to assist the Committee in its work. Upon the direction of the Legislative Services Commission, the Directors of Legislative Assistants of the Senate and of the House of Representatives shall assign clerical staff to the Committee. The expenses for clerical employees shall be borne by the Committee.

(d) The Committee cochairs may establish subcommittees for the purpose of examining issues relating to its Committee charge.

"**§ 120-209.3. Additional powers.**

The Joint Legislative Oversight Committee on Medicaid, while in discharge of official duties, shall have access to any paper or document, and may compel the attendance of any State official or employee before the Committee or secure any evidence under G.S. 120-19. In addition, G.S. 120-19.1 through G.S. 120-19.4 shall apply to the proceedings of the Committee.

"**§ 120-209.4. Reports to Committee.**

Whenever the Department is required by law to report to the General Assembly or to any of its permanent, study, or oversight committees or subcommittees on matters affecting the Medicaid or Health Choice programs, the Department shall transmit a copy of the report to the cochairs of the Joint Legislative Oversight Committee on Medicaid."

SECTION 11.(b) G.S. 120-208.1(a)(2)b. is repealed.

SECTION 12. Appropriation. – To accomplish the Medicaid transformation required by this act, there is appropriated from the General Fund to the Department of Health and Human Services, Division of Medical Assistance the sum of two million five hundred thousand dollars ($2,500,000) in nonrecurring funds for the 2015-2016 and the 2016-2017 fiscal years. These funds shall provide a State match for an estimated two million five hundred thousand dollars ($2,500,000) in federal funds beginning in the 2015-2016 fiscal year, and those federal funds are hereby appropriated to the Division of Medical Assistance to pay for Medicaid transformation.

SECTION 13. Section 12 of this act becomes effective upon appropriation by the General Assembly of funds for the implementation of this act. The remainder of this act is effective when it becomes law.

HOUSE BILL 372

Short Title:	2015 Medicaid Modernization.	(Public)
Sponsors:	Representatives Dollar, Lambeth, B. Brown, and Jones (Primary Sponsors). *For a complete list of Sponsors, refer to the North Carolina General Assembly Web Site.*	
Referred to:	Health, if favorable, Appropriations.	

March 30, 2015

A BILL TO BE ENTITLED

AN ACT TO MODERNIZE AND STABILIZE NORTH CAROLINA'S MEDICAID PROGRAM THROUGH PROVIDER-LED CAPITATED HEALTH PLANS.

The General Assembly of North Carolina enacts:

SECTION 1. Intent and Goals. – It is the intent of the General Assembly to transform the State's current Medicaid program to a program that provides budget predictability for the taxpayers of this State while ensuring quality care to those in need. The new Medicaid program shall be designed to achieve the following goals:

(1) Ensure budget predictability through shared risk and accountability.
(2) Ensure balanced quality, patient satisfaction, and financial measures.
(3) Ensure efficient and cost-effective administrative systems and structures.
(4) Ensure a sustainable delivery system.
(5) Ensure a successful health information exchange.

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

VISITOR REGISTRATION SHEET

House Comm. on Health — 6-10-2015 (After Session)

Name of Committee — Date

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Amanda Simpson	SDK
Lori Krall	Novant Health
Drew Hobby	WellCare
Mandy Paul	WellCare
[illegible]	UHG
[illegible]	UHC
Chris McClure	BP
Ed Turlington	BP
Dana Simpson	SA

VISITOR REGISTRATION SHEET

House Comm. on Health — 6-10-2015 (After Session)

Name of Committee — Date

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Jon Bon	Bon & Asso.
Rep David	NCGA
Ciara Zachary	NC Justice Center
Joel Maynard	GPM; ASSA
Amy Hobbs	CCNC
AJ [illegible]	[illegible]
Erica Nelson	NCHA
Allison Glenn	Cardinal
L Payne	CSS
J Peters	CSS
[illegible]	[illegible]

VISITOR REGISTRATION SHEET

House Comm. on Health — 6-10-2015 (After Session)

Name of Committee — Date

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Ken McEwen	Bundy
BRIAN INGRAHAM	SMOKY LAKE/MCO
Trent Womble	DHHS
Katherine Restrepo	John Locke Foundation
Jennifer Cecchini	NCMS
Vaughan Cook	OITS
Courtney Patterson	NP
Dodie Benfer	CCR
BILL RUSTIN	ACP
Mike Jones	ACP
[illegible]	NFIB

VISITOR REGISTRATION SHEET

House Comm. on Health — 6-10-2015 (After Session)

Name of Committee — Date

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Peter Parker	NMC
John Bode	B&H
Lisa Martin	Capitol Adv.
Daniel Van Lierle	Vidant Health
Lanier Hodgson	UNC Health Care
	DCI
	FSP
	NCHA

VISITOR REGISTRATION SHEET

House Comm. on Health — 6-10-2015 (After Session)

Name of Committee — Date

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Bill Scobon	TI
Joanna Spruill	NCAFP
Annaliese Dolph	DC
[signature]	MWC
[signature]	NCAHP
Joe Winn	Aetna
CS Wells	CSX
Jonathan Brubaker	Brubaker + Assoc.
John DelGiorno	"
Sarah Bates	"
Leza Wainwright	ECBH

NORTH CAROLINA HOUSE OF REPRESENTATIVES
COMMITTEE MEETING NOTICE
AND
BILL SPONSOR NOTIFICATION
2015-2016 SESSION

You are hereby notified that the **House Committee on Health** will meet as follows:

DAY & DATE: Wednesday, June 24, 2015
TIME: **10:00 AM**
LOCATION: **643 LOB**
COMMENTS: **Representative Lambeth will preside.**
We will have a presentation on telemedicine.

Respectfully,

Representative Brian Brown, Co-Chair
Representative Justin P. Burr, Co-Chair
Representative Bert Jones, Co-Chair
Representative Donny Lambeth, Co-Chair

I hereby certify this notice was filed by the committee assistant at the following offices at 9:35 AM on Tuesday, June 23, 2015.

___ Principal Clerk
___ Reading Clerk – House Chamber

Brenda Olls (Committee Assistant)

House Committee on Health
Wednesday, June 24, 2015, 10:00 AM
643 Legislative Office Building

AGENDA

Welcome and Opening Remarks

Introduction of Pages

Presentations

Telemedicine: A tool for Clinical Care in North Carolina Today

Dr. Lewis P. Martin, Orthopedic Surgeon, Surgical Specialist, Sports Medicine Specialist
Dr. Alan Stiles, Sr. VP for Network Development and Strategic Affiliations, UNC Health Care System

Other Business

Adjournment

House Committee on Health
Wednesday, June 24, 2015 at 10:00 AM
Room 643 of the Legislative Office Building

MINUTES

The House Committee on Health met at 10:00 AM on June 24, 2015 in Room 643 of the Legislative Office Building. Representatives Adcock, Avila, Blackwell, Brawley, Brisson, R. Brown, B. Brown, Cotham, Farmer-Butterfield, Ford, Goodman, Hastings, Insko, Jones, Lambeth, Lucas, S. Martin, Pendleton, Waddell, Wray, and Yarborough attended.

Representative Donny Lambeth, Chair, presided.

Presentations:

Telemedicine: A Tool for Clinical Care in North Carolina Today

Dr. Alan Stiles, Sr. VP for Network Development and Strategic Affiliations, UNC Health Care

Telehealth is helpful especially for patients with severe disabilities because some of these patients live hours away and with this program, they can have care and help instantaneously and for less cost.

Much of UNC Chapel Hill Health system is using this to a degree. This includes the Jaycee Burn Center and the Pediatric Dep. (See page 2-3 of presentation copy)

According to Dr. Stiles, this robotic system, used within Telehealth, can be used to provide General Care advice; surgical advice; Provider to Patient care; communication with other departments, such as Radiology; Provider to Consultant communication; Home monitoring; and eventually E-health, which is care through a mobile device.

Telehealth will be great for NC because the state, largely, is geographically rural and this will save money on hospital costs and also on travel time for care.

Challenges: Financial funding, technology, Provider acceptance.

How to catalyze expansion: Provider engagement, technology selection, and reimbursement on appropriate telemedicine services.

(Teleheath presentation attached).

Dr. Lewis P. Martin, Orthopedic Surgeon, Surgical Specialist, Sports Medicine Specialist

The purpose of this presentation is to show that we are doing live work with a robot for rounding on patients that we have already operated on.
There is an impersonal issue/ access issue in Eastern North Carolina that this robotic system can remedy.

What this does is allow doctors, like myself, to operate on patients, such as those in Wilson, from North Carolina Specialty Hospital, which is located in Durham. This issue arose because, since I perform robotic surgery, I have to go the NC Specialty hospital in Durham to perform it, but would then have to go all the way to Wilson to do any follow up work with the patient, leaving me unable to see patients on a daily basis.

While you could use a nurse or PA to fill this problem, it creates that impersonal issue.
What this robot does is allow us to utilize it so that we can at least see and interact with my patients.

The robot is about 5 ft tall, named IVAN. IVAN projects audio so that I may speak to the patient as well as automatic controls so that the robot can find its own way to the specific rooms, however there are manual controls available. The patient can see the doctor and vice versa. Zoom features are available, as well as a stethoscope that is, frankly, better than the one I use on a daily basis.

The robot does require a high bandwidth to operate.

Another benefit of this is that, since the robot doesn't have arms, nurses are required to come with the robot, which inadvertently creates continuity of care, which is a huge benefit in the medical field. This also creates better electronic records.

IVAN can create large cost savings for hospitals across the board due to smaller wait times as well as smaller operating times. Efficiency is increased drastically.

Questions & Comments

Rep. Brisson: The basic function of the emergency room is to stabilize and transfer. How do we get these people, both providers and patients, involved and how do we get public to trust the system?

Dr. Stiles: Telehealth doesn't change the staff in an emergency setting, and as far as getting the public to trust the system, people tend to like a local setting than going somewhere else for care.

Rep. Lucas: Is there any particular concern among the physicians about the increased numbers and risk for malpractice issues?

Dr. Stiles: Over the last 20 years, there has not been a single telemedicine claim. Nationally, there are very few claims. I don't know what the stance of the individual physicians are.

Rep. Farmer-Butterfield: In terms of cost to patient, do you envision that there will be a reduction in cost for medical treatment?

Dr. Stiles: I think we will see a general reduction in cost, including a reduction for care because that's what we can sustain because this system will increase volume of patients, thus increasing revenue.

Rep. Farmer-Butterfield: Anything involved in Tele-psychiatry?

Dr. Stiles: Tela-psychiatry is crucially important to the healthcare system, and we will have to drive ourselves to that crucial innovation.

Rep. Pendleton: On this presentation on the map, it has proposed parity bill and he asked the chairman if NC has anything like that?

Rep. Lambeth: Rep. Insko and I have spoken concerning an Interm Committee out of session to explore Telehealth.

Rep. Pendelton: Do we need additional sites connected in the rural parts of the state since the internet may not be broad enough and will this help us keep our rural hospitals open?

Dr. Stiles: From the hospital perspective, most hospitals are well connected at this point to support this system. As far as speed, to put this in perspective it takes more to download a movie than to use this system. My personal belief is that it will have an impact on keeping patients within the community.

Rep. Avila: Looking way down the road, currently these Telehealth systems are all located in hospitals. For rural areas where there is no physician available, would it be feasible to have a point of contact outside of the hospital that works independently but using the Telehealth system as the oversight when they need to go to a physician for advice or higher help. Would this be an answer for routine health care in rural settings?

Dr. Stiles: Since most caretakers know their limits, in a primary care setting, the nurses have the ability to perform their jobs very well with access to a physician today. What they don't have is that reimbursement for doing that from the physician perspective. I am very open to alternate models and frankly excited about it. But to do this, we must have some leeway from a medical-legal standpoint. Accuracy is always important, but even with an MRI, there is error. It is important to be able to operate without the threat of losing a house.

Rep. Cotham: If we have an E-visit, is that considered telehealth?

Dr. Stiles: It is but is not considered a reimbursable tool as traditional Telehealth.

Rep. Cotham: Are there options for group classes and care so we can eliminate time constraints so that they can understand their various conditions (Ex. Type 2 Diabeties

Dr. Stiles: Yes you can do both group sessions and can use them for classes. These sessions address the issue you brought up head on.

Rep. Cotham: How do the licensing regulations work?

Dr. Stiles: There aren't any regulations as of yet in direct relation to this, but that is up to you, the government. In this state, you must be licensed to perform medical care, so if you're a specialist in Kansas, you'll still need a NC license.

The meeting adjourned at 11:00.

Representative Donny Lambeth, Chair
Presiding

Theresa Lopez, Committee Clerk

Telehealth: A Tool for clinical care in NC today

Alan Stiles, MD
Sr. VP Network Development and Strategic Affiliations
UNC Health Care
Professor of Pediatrics

Telerehabilitation

Dr. Josh Alexander

TelAbility is an innovative, community oriented, interdisciplinary program from the UNC Department of Physical Medicine and Rehabilitation that uses telecommunications to improve the lives of children with disabilities. Using real time video-conferencing and internet technologies, TelAbility provides comprehensive, coordinated, family centered care to children with disabilities and the people who care for them. This saves families travel time and expense, school and work absences, and challenges of moving a child with disabilities and equipment from a local clinic to the medical center at Chapel Hill.

Teleburn: Specialists at the Jaycee Burn Center at UNC connect to NC community emergency rooms

- 24/7 Telehealth access to burn specialists for Emergency room physicians and burn victims
- Allows direct assessment of a burn, an immediate management plan jointly developed with the physician in the emergency room and the burn specialist
- This program will substantially reduce transfers of patients from community hospitals to higher levels of care. For those patients needing higher levels of care, decisions and facilitation of transfer to a hospital that can provide the needed care will occur.
- Follow-up care for patients post-burn can be provided using these tools to avoid travel by patients and loss of time at work or school.
- This same technology can be used for
  - Stroke care
  - ED coverage by specialists (e.g., cardiology)
  - Clinical collaboration via multisite video collaboration (e.g., surgical consultations)

What is Telehealth in 2015?

Telehealth: a clinical tool for patient care

- **Definition: The use of technology to interact with patients or facilitate patient care at a distance**
- **Telehealth has been proven through multiple studies to: 1) deliver health care or health related information, 2) improve access to medical care, 3) reduce costs of care (direct and indirect), and 4) improve compliance of patients with care plans**
- **Applications include:**
  - **Provider to patient* (video conference patient care delivery including examination, patient-provider contact, e.g. email or video conference progress checks)**
  - **Store/forward* (data transfer for interpretation, e.g. radiology studies, echocardiograms)**
  - **Provider to provider consultation (e.g. tumor board, primary care to specialist consultation)**
  - **Provider to patient group care* (e.g. diabetes education, mental health support groups, telepsychiatry)**
  - **Hybrids of these systems* (e.g. prenatal ultrasound data transfer followed by patient visit with Maternal-Fetal Medicine-patient visit, E-ICUs)**
  - **Home monitoring of patients (including device reporting to providers and extension of independent living for at risk patients [elderly with motion sensors or video monitoring])**
  - **M-Health or E-Health (wellness or health care prompts pushed out (and in some cases bi-directionally communicating information) through mobile devices**

Patients acceptance telehealth is rapid with appreciation for the convenience

* Billable activities under current payer models; others, although not billable have the "halo" effect of impacting referrals or providing greater "value" in care.

Is the environment right to expand telehealth in NC now?

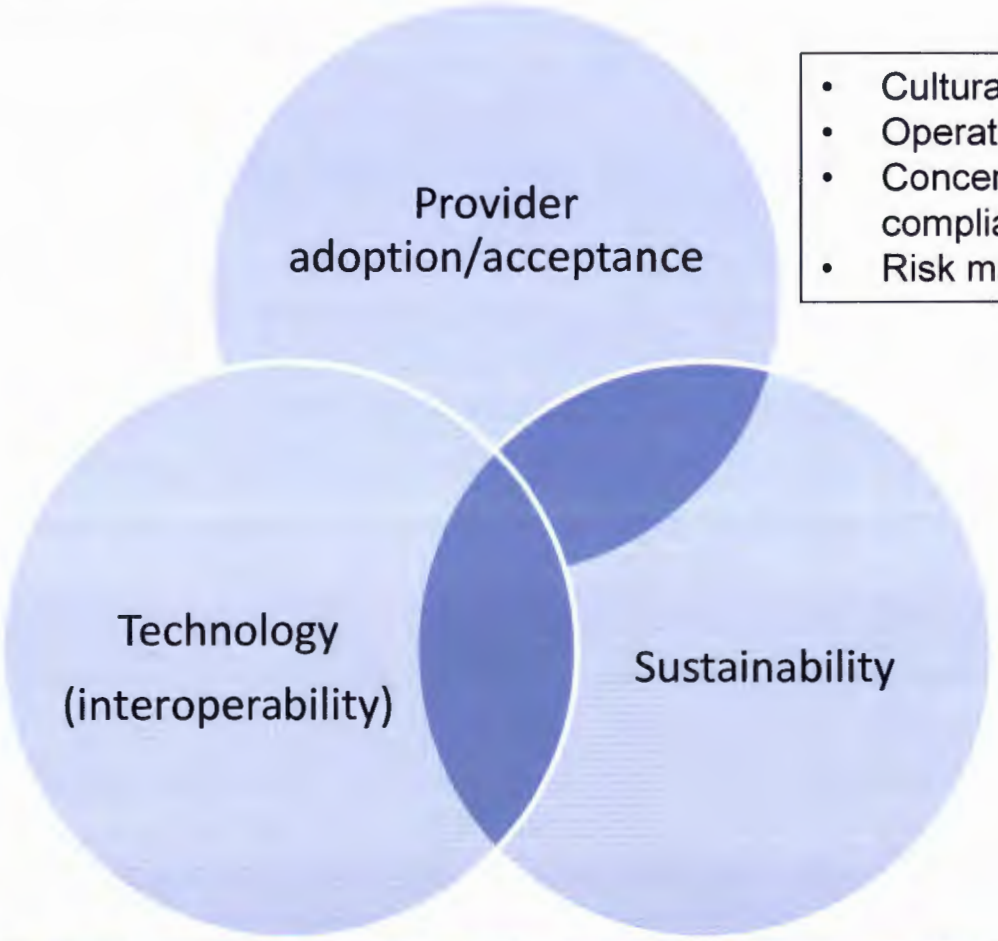
- **NC is a "rural" state with geographic challenges for patient access through traditional face to face health care encounters**
- **NC is a "wired" state for internet, the platform for much of telehealth.**
- **Supportive legislature and leadership seeking innovation and leveraging technology for better access to health care and improved health of NC citizens**
- **Long history of NC engagement with telehealth including developers and early adopters in NC medical teaching institutions**
- **NC health care systems are under pressure to expand population care with changes to value based payments and care delivery using limited manpower**
- **Multiple vendors of telehealth equipment and software have resulted in rapidly decreasing costs for the needed technology**
- **Medical care insurers are recognizing telehealth as a "legitimate" health delivery model.**
- **There is a growing appetite for telehealth in NC from patients, hospitals, physicians and other medical professionals as efficiency of care and easier connections with care are sought**

What is happening with telehealth in NC over the three years?

- Rapid growth in specific telehealth programs (e.g. Telestroke for evaluation of interventions for patients in the emergency room at presentation) and programs that operate under hospital contracts for professional services.
- The Board of Medicine has revised the Telehealth Guidelines to allow broader use of telehealth within the scope of practice for NC physicians
- An "Ad Hoc" State Telehealth Work Group including representatives from all the NC academic medical centers, MCNC, NCHICA, NCHIE, AHEC, and other interested stakeholders has been meeting to identify means to accelerate adoption and use of telehealth in NC. Some of the identified areas needing attention ilnclude:
  - Continued expansion of high speed (and large capacity) internet connectivity across the state
  - Developing consensus for collaboration across health systems for telehealth deployment to promote inter-connectivity
  - Evolving interest in development of a "state" telehealth resource center housed in a "neutral" site to aid with technology selection and collaboration on operational issues among users
  - Advocacy for reimbursement reform to promote telehealth adoption and state regulation reform through Board of Medicine and Board of Pharmacy to moderate practice barriers for telehealth

Challenges slowing expansion of telehealth in North Carolina

- Selection of technology has been erratic with limited consideration of interoperability, connection to EMRs, or broad connectivity issues.
- Would a "neutral" state Resource Center for NC help?



- Cultural issues
- Operational concerns
- Concerns with regulatory compliance issues
- Risk management

- Reimbursement for telehealth is not standard among NC insurers.
- Nationally "telehealth parity legislation" state by state is occurring

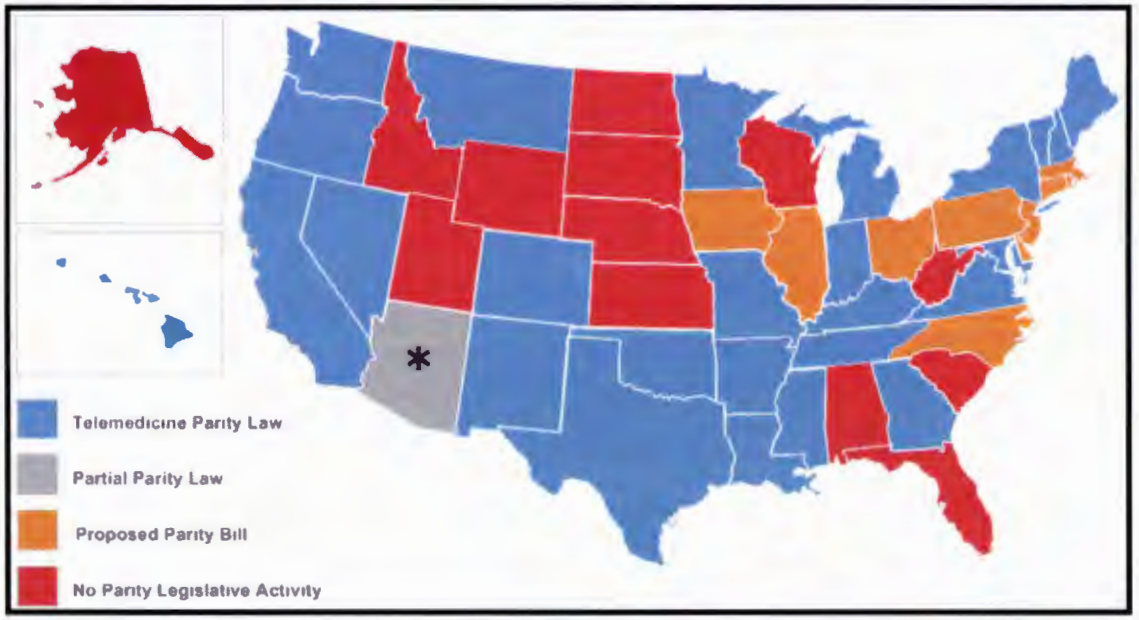
To date, the growth of telehealth in NC has been "Home Grown" and grant or state funded with limited concern for sustainability or infrastructure/interoperability.

Elements to consider to catalyze expansion of telehealth in NC

- **Physician/provider engagement**: This requires telemedicine programs to be sustainable as a clinical tool.
- **Technology selection and interoperability** are achievable today with broad choices of for individual providers or programs. A state resource for providers to aid in selection of appropriate equipment and hardware to initiate telehealth programs promote interoperability would be valuable. Accessible health information exchange mechanisms are very important to successful telehealth.
- **Reimbursement for appropriate telemedicine services** should be available from all payers for medical care including Medicaid, State Health Plan, and commercial insurers. In many states this has been achieved through legislation to assure telemedicine services equivalent to face to face services are reimbursed the same.

State by state view of telehealth parity legislation

States with Parity Laws for Private Insurance Coverage of Telemedicine (2015)



28 states and the District of Columbia have Parity legislation in place

States with the year of enactment: Arizona (2013)*, **Arkansas (2015)**, California (1996), Colorado (2001), Georgia (2006), Hawaii (1999), **Indiana (2015)**, Kentucky (2000), Louisiana (1995), Maine (2009), Maryland (2012), Michigan (2012), **Minnesota (2015)**, Mississippi (2013), Missouri (2013), Montana (2013), **Nevada (2015)**, New Hampshire (2009), New Mexico (2013), New York (2014), Oklahoma (1997), Oregon (2009), Tennessee (2014), Texas (1997), Vermont (2012), Virginia (2010), **Washington (2015)** and the District of Columbia (2013)

States with proposed/pending legislation: In 2015, **Arkansas (ENACTED)**, Connecticut, Delaware, Illinois, **Indiana (ENACTED)**, Iowa, Massachusetts, **Minnesota (ENACTED)**, **Nevada (ENACTED)**, New Jersey, North Carolina, Ohio, Pennsylvania, Rhode Island, and **Washington (ENACTED)**

**Coverage applies to certain health services and/or rural areas only*

Wider use of telehealth will aid in delivery of care, access to care, efficiency and cost of care, and compliance of patients with care plans, all needed to improve the health of North Carolinians

Telemedicine

Created: Jul 1, 2010
Modified:
November 2014

"Telemedicine" is the practice of medicine using electronic communication, information technology or other means between a licensee in one location and a patient in another location with or without an intervening health care provider.

The Board recognizes that technological advances have made it possible for licensees to provide medical care to patients who are separated by some geographical distance. As a result, telemedicine is a potentially useful tool that, if employed appropriately, can provide important benefits to patients, including: increased access to health care, expanded utilization of specialty expertise, rapid availability of patient records, and the reduced cost of patient care.

The Board cautions, however, that licensees practicing via telemedicine will be held to the same standard of care as licensees employing more traditional in-person medical care. A failure to conform to the appropriate standard of care, whether that care is rendered in-person or via telemedicine, may subject the licensee to potential discipline by this Board. It is the Board's position that there is not a separate standard of care applicable to telemedicine. Telemedicine providers will be evaluated according to the standard of care applicable to their area of specialty. Additionally, telemedicine providers are expected to adhere to current standards for practice improvement and monitoring of outcomes

The Board provides the following considerations to its licensees as guidance in providing medical services via telemedicine:

Training of Staff — Staff involved in the telemedicine visit should be trained in the use of the telemedicine equipment and competent in its operation.

Evaluations and Examinations — Licensees using telemedicine technologies to provide care to patients located in North Carolina must provide an appropriate evaluation prior to diagnosing and/or treating the patient. This evaluation need not be in-person if the licensee employs technology sufficient to accurately diagnose and treat the patient in conformity with the applicable standard of care.

Other evaluations may also be considered appropriate if the licensee is at a distance from the patient, but a licensed health care professional is able to provide various physical findings that the licensee needs to complete an adequate assessment. On the other hand, a simple questionnaire without an appropriate evaluation may be a violation of law and/or subject the licensee to discipline by the Board. (1)

Licensee-Patient Relationship —The Board stresses the importance of proper patient identification in the context of the telemedicine encounter. Failure to verify the patient's identity may lead to fraudulent activity or the improper disclosure of confidential patient information. The licensee using telemedicine should verify the identity and location of the patient and should be prepared to inform the patient of the licensee's name, location and professional credentials. A diagnosis should be established through the use of accepted medical practices, i.e., a patient history, mental status evaluation, physical examination and appropriate diagnostic and laboratory testing. Licensees using telemedicine should also ensure the availability for appropriate follow-up care and maintain a complete medical record that is available to the patient and other treating health care providers.

Prescribing — Licensees are expected to practice in accordance with the Board's Position Statement "Contact with patients before prescribing." It is the position of the Board that prescribing controlled substances for the treatment of pain by means of telemedicine is not consistent with the standard of care. Licensees prescribing controlled substances by means of telemedicine for other conditions should obey all relevant federal and state laws and are expected to participate in the Controlled Substances Reporting System. (2)

Medical Records — The licensee treating a patient via telemedicine must maintain a complete record of the telemedicine patient's care according to prevailing medical record standards. The medical record serves to document the analysis and plan of an episode of care for future reference. It must reflect an appropriate evaluation of the patient's presenting symptoms, and relevant components of the electronic professional interaction must be documented as with any other encounter.

The licensee must maintain the record's confidentiality and disclose the records to the patient consistent with state and federal law. If the patient has a primary care provider and a telemedicine provider for the same ailment, then the primary care provider's medical record and the telemedicine provider's record constitute one complete patient record. Licensees practicing via telemedicine will be held to the same standards of professionalism concerning medical records transfer and communication with the primary care provider and medical home as those licensees practicing via traditional means.

Licensure — The practice of medicine is deemed to occur in the state in which the patient is located. Therefore, any licensee using telemedicine to regularly provide medical services to patients located in North Carolina should be licensed to practice medicine in North Carolina. (3) Licensees need not reside in North Carolina, as long as they have a valid, current North Carolina license.

North Carolina licensees intending to practice medicine via telemedicine technology to treat or diagnose patients outside of North Carolina should check with other state licensing boards. Most states require physicians to be licensed, and some have enacted limitations to telemedicine practice or require or offer a special registration. A directory of all U.S. medical boards may be accessed at the Federation of State Medical Boards website: http://www.fsmb.org/directory_smb.html.

(1) See also the Board's Position Statement entitled "Contact with Patients before

Prescribing."
(2) See Ryan Haight Act
(3) N.C. Gen. Stat. § 90-18(c)(11) exempts from the requirement for licensure: "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."

The Board also notes that the North Carolina General Statutes define the practice of medicine as including, "The performance of any act, within or without this State, described in this subdivision by use of any electronic or other means, including the Internet or telephone." N.C. Gen. Stat. § 90-1.1(5)

Select Language Powered by **Translate**

Stricken language would be deleted from and underlined language would be added to present law.

State of Arkansas *As Engrossed: S3/3/15 S3/12/15*
90th General Assembly **A Bill**
Regular Session, 2015 SENATE BILL 133

By: Senator Bledsoe
By: Representative D. Ferguson

For An Act To Be Entitled

AN ACT TO ENCOURAGE THE USE OF TELEMEDICINE; TO REDUCE HEALTHCARE DISPARITIES; TO IMPROVE ACCESS TO CARE; TO ADDRESS GEOGRAPHIC MALDISTRIBUTION OF PRIMARY CARE AND SPECIALTY CARE; TO AUTHORIZE REIMBURSEMENT AND REGULATION OF SERVICES PROVIDED THROUGH TELEMEDICINE; TO DECLARE AN EMERGENCY; AND FOR OTHER PURPOSES.

Subtitle

TO ENCOURAGE THE USE OF TELEMEDICINE; AND TO DECLARE AN EMERGENCY.

BE IT ENACTED BY THE GENERAL ASSEMBLY OF THE STATE OF ARKANSAS:

SECTION 1. DO NOT CODIFY. Title.
This act shall be known and may be cited as the "Telemedicine Act".

SECTION 2. DO NOT CODIFY. Legislative findings.
The General Assembly finds and declares that:

(1) The advancements and continued development of medical and communications technology have had a profound impact on the practice of medicine and offer opportunities for improving the delivery and accessibility of health care, particularly in the area of telemedicine;

(2) Geography, weather, availability of specialists, transportation, and other factors can create barriers to accessing appropriate health care, and a way to provide, ensure, or enhance access to

health care, given these barriers, is through the appropriate use of technology to allow healthcare consumers access to qualified healthcare professionals; and

(3) There is a need in this state to embrace efforts that will encourage:

(A) Health insurers and healthcare professionals to support the use of telemedicine; and

(B) All state agencies to evaluate and amend their policies and rules to remove regulatory barriers prohibiting the use of telemedicine.

SECTION 3. Arkansas Code Title 17, Chapter 80, Subchapter 1, is amended to add an additional section to read as follows:

17-80-117. Telemedicine.

(a) As used in this section:

(1) "Distant site" means the location of the healthcare professional delivering services through telemedicine at the time the services are provided;

(2) "Healthcare professional" means a person who is licensed, certified, or otherwise authorized by the laws of this state to administer health care in the ordinary course of the practice of his or her profession;

(3) "Originating site" means:

(A) The offices of a healthcare professional or a licensed healthcare entity where the patient is located at the time services are provided by a healthcare professional through telemedicine; and

(B) The home of a patient in connection with treatment for end-stage renal disease;

(4) "Professional relationship" means at minimum a relationship established between a healthcare professional and a patient when:

(A) The healthcare professional has previously conducted an in-person examination and is available to provide appropriate follow-up care, when necessary, at medically necessary intervals;

(B) The healthcare professional personally knows the patient and the patient's relevant health status through an ongoing personal or professional relationship, and is available to provide appropriate follow-up care, when necessary, at medically necessary intervals;

(C) The treatment is provided by a healthcare professional in consultation with, or upon referral by, another healthcare professional who has an ongoing relationship with the patient and who has agreed to *supervise the patient's treatment, including follow-up care;*

(D) An on-call or cross-coverage arrangement exists with the patient's regular treating healthcare professional;

(E) A relationship exists in other circumstances as defined by rule of the Arkansas State Medical Board for healthcare professionals under its jurisdiction and their patients; or

(F) A relationship exists in other circumstances as defined by rule of a licensing or certification board for other healthcare professionals under the jurisdiction of the appropriate board and their patients if the rules are no less restrictive than the rules of the Arkansas State Medical Board;

(5) "Store and *forward technology*" means the transmission of a patient's medical information from an originating site to the provider at the distant site without the patient being present; and

(6) "Telemedicine" means the medium of delivering clinical healthcare services by means of real-time two-way electronic audio-visual communications, including without limitation the application of secure video conferencing, to provide or support healthcare delivery that facilitates the assessment, diagnosis, *consultation, or treatment* of a patient's health care while the patient is at an originating site and the healthcare professional is at a distant site.

(b)(1) The standards of appropriate practice in traditional healthcare professional-patient settings shall govern the licensed healthcare professional's treatment recommendations made via electronic means, including issuing a prescription via telemedicine.

(2) This section does not alter existing state law or rules governing a healthcare professional's scope of practice.

(3) This section does not authorize drug-induced, chemical, or surgical abortions performed through telemedicine.

(4)(A) Store and forward technology shall not be considered telemedicine.

(B) This subchapter does not restrict the use of store and forward technology.

(c) A healthcare professional shall follow applicable state and federal law, rules, and regulations for:

(1) Informed consent;

(2) Privacy of individually identifiable health information;

(3) Medical recordkeeping and confidentiality; and

(4) Fraud and abuse.

(d)(1) A healthcare professional who is treating patients in Arkansas through telemedicine shall be fully *licensed or certified* to practice in Arkansas and is subject to the rules of the appropriate state *licensing or certification* board.

(2) The requirement in subdivision (d)(1) of this section does not apply to the acts of a healthcare professional located in another jurisdiction who provides only episodic consultation services.

(e)(1) A healthcare professional at a distant site shall not utilize telemedicine with respect to a patient located in Arkansas unless a professional relationship exists between the healthcare professional and the *patient or the healthcare professional otherwise meets the requirements of professional relationship as defined in § 17-80-117(a)(4).*

(2) The existence of a professional relationship is not required in the following circumstances:

(A) Emergency situations where the life or health of the patient is in danger or imminent danger; or

(B) Simply providing information of a generic nature, not meant to be specific to an individual patient.

(f) State licensing and certification boards for a healthcare professional shall amend their rules where necessary to comply with this section.

SECTION 4. Arkansas Code Title 23, Chapter 79, is amended to add an additional subchapter to read as follows:

Subchapter 16 — Coverage for Services Provided Through Telemedicine

23-79-1601. Definitions.

As used in this subchapter:

(1) "Distant site" means the location of the healthcare

professional delivering healthcare services through telemedicine at the time the services are provided;

(2)(A) "Health benefit plan" means:

(i) An individual, blanket, or group plan, policy, or contract for healthcare services issued or delivered by an insurer, health maintenance organization, hospital medical service corporation, or self-insured governmental or church plan in this state; and

(ii) Any health benefit program receiving state or federal appropriations from the State of Arkansas, including the Arkansas Medicaid Program and the Health Care Independence Program, commonly referred to as the "Private Option", or any successor program.

(B) "Health benefit plan" includes:

(i) Indemnity and managed care plans; and

(ii) *Non-federal governmental plans* as defined in 29 U.S.C. § 1002(32), as it existed on January 1, 2015.

(C) "Health benefit plan" does not include:

(i) Disability income plans;

(ii) Credit insurance plans;

(iii) Insurance coverage issued as a supplement to liability insurance;

(iv) Medical payments under automobile or homeowners insurance plans;

(v) Health benefit plans provided under Arkansas Constitution, Article 5, § 32, the Workers' Compensation Law, § 11-9-101 et seq., or the Public Employee Workers' Compensation Act, § 21-5-601 et seq.;

(vi) Plans that provide only indemnity for hospital confinement;

(vii) Accident only plans;

(viii) Specified disease plans; or

(ix) Long-term care only plans;

(3) "Healthcare professional" means a person who is licensed, certified, or otherwise authorized by the laws of this state to administer health care in the ordinary course of the practice of his or her profession;

(4) "Originating site" means:

(A) The offices of a healthcare professional or a licensed healthcare entity where the patient is located at the time services are

provided by a healthcare professional through telemedicine; and

(B) The home of a patient in connection with treatment for end-stage renal disease; and

(5) "Telemedicine" means the medium of delivering clinical healthcare services by means of real-time two-way electronic audio-visual communications, including without limitation the application of secure video conferencing, to provide or support healthcare delivery that facilitates the assessment, diagnosis, *consultation, or treatment* of a patient's health care while the patient is at an originating site and the healthcare professional is at a distant site.

23-79-1602. Coverage for telemedicine.

(a)(1) This subchapter shall apply to all health benefit plans delivered, issued for delivery, reissued, or extended in Arkansas on or after January 1, 2016, or at any time when any term of the health benefit plan is changed or *any premium adjustment is made thereafter.*

(2) Notwithstanding subdivision (a)(1) of this section, this subchapter shall apply to the Arkansas Medicaid Program on and after July 1, 2016.

(b) A healthcare service provided through telemedicine shall comply with the requirements of § 17-80-117.

(c)(1) A health benefit plan shall cover the services of a physician who is licensed by the Arkansas State Medical Board for healthcare services through telemedicine on the same basis as the health benefit plan provides coverage for the same healthcare services provided by the physician in person.

(2) Subject to subdivision (d)(1) of this section, a health benefit plan shall reimburse a physician licensed by the board for healthcare services provided through telemedicine on the same basis as the health benefit plan reimburses a physician for the same healthcare services provided in person.

(d)(1) The combined amount of reimbursement that a health benefit plan allows for the compensation to the distant site physician and the originating site shall not be less than the total amount allowed for healthcare services provided in person.

(2) Payment for healthcare services provided through

telemedicine shall be provided to the distant site physician and the originating site upon submission of the appropriate procedure codes.

(3) This section does not:

(A) Prohibit:

(i) A health benefit plan from reimbursing other healthcare professionals; or

(ii) A health benefit plan from paying a facility fee to a provider at the distant site in addition to a fee paid to the healthcare professional; or

(B) Require an insurer to pay more for a healthcare service provided through telemedicine than would have been paid if the healthcare service was delivered in person.

(e) A health benefit plan shall not impose on coverage for healthcare services provided through telemedicine:

(1) An annual or lifetime dollar maximum on coverage for services provided through telemedicine other than an annual or lifetime dollar maximum that applies to the aggregate of all items and services covered;

(2) A deductible, copayment, coinsurance, benefit limitation, or maximum benefit that is not equally imposed upon all healthcare services covered under the health benefit plan; or

(3) A prior authorization requirement for services provided through telemedicine that exceeds the prior authorization requirement for in-person healthcare services under the health benefit plan.

(f) This subchapter does not prohibit a health benefit plan from:

(1) Limiting coverage of healthcare services provided through telemedicine to medically necessary services, subject to the same terms and conditions of the covered person's health benefit plan that apply to services provided in person; or

(2)(A) Undertaking utilization review, including prior authorization, to determine the appropriateness of healthcare services provided through telemedicine, provided that:

(i) The determination of appropriateness is made in the same manner as determinations are made for the treatment of any illness, condition, or disorder covered by the health benefit plan whether the service was provided in-person or through telemedicine; and

(ii) All adverse determinations are made by a physician who possesses a current and valid unrestricted license to practice medicine in Arkansas.

(B) Utilization review shall not require prior authorization of emergent telemedicine services.

(g)(1) A health benefit plan may adopt policies to ensure that healthcare services provided through telemedicine submitted for payment comply with the same coding, documentation, and other requirements necessary for payment *an in-person service other than the in-person requirement.*

(2) If deemed necessary, the State Insurance Department may promulgate rules containing additional standards and procedures for the utilization of telemedicine to provide healthcare service through health benefit plans if the additional standards and procedures do not conflict with this subchapter or § 17-80-117, and are applied uniformly by all health benefit plans.

SECTION 5. Arkansas Code Title 23, Chapter 86, Subchapter 1, is amended to add an additional section to read as follows:

23-86-123. Prior authorization by physician.

(a) As used in this section:

(1) "Prior authorization" means the process by which a health carrier determines the medical necessity or eligibility for coverage of a healthcare service before a covered person receives the healthcare service in order to provide coverage and reimbursement for the healthcare service; and

(2) "Telemedicine" means the medium of delivering clinical healthcare services by means of real-time two-way electronic audiovisual communications, including without limitation the application of secure video conferencing, to provide or support healthcare delivery that facilitates the assessment, diagnosis, consultation, treatment, education, care management, or self-management of a patient's health care while the patient is at an originating site and the healthcare professional is at a distant site.

(b) When conducting prior authorization, whether for healthcare services provided through telemedicine or provided in person, a physician who possess a current and unrestricted license to practice medicine in the State of Arkansas shall make all adverse determinations.

SECTION 6. EMERGENCY CLAUSE. It is found and determined by the General Assembly of the State of Arkansas that Arkansas is experiencing a healthcare professional maldistribution resulting in medically underserved areas throughout the state; that allowing healthcare professionals to provided healthcare services through telemedicine will ease the burden on medically underserved areas; and that this act is immediately necessary because the citizens of Arkansas and the healthcare professionals of Arkansas need immediate direction about the law regarding healthcare services provided through telemedicine. Therefore, an emergency is declared to exist, and this act being immediately necessary for the preservation of the public peace, health, and safety shall become effective on:

(1) The date of its approval by the Governor;

(2) If the bill is neither approved nor vetoed by the Governor, the expiration of the period of time during which the Governor may veto the bill; or

(3) If the bill is vetoed by the Governor and the veto is overridden, the date the last house overrides the veto.

/s/Bledsoe

Telehealth: A Tool for clinical care in NC today

Alan Stiles, MD
Sr. VP Network Development and Strategic Affiliations
UNC Health Care
Professor of Pediatrics

UNC HEALTH CARE SYSTEM

Telerehabilitation

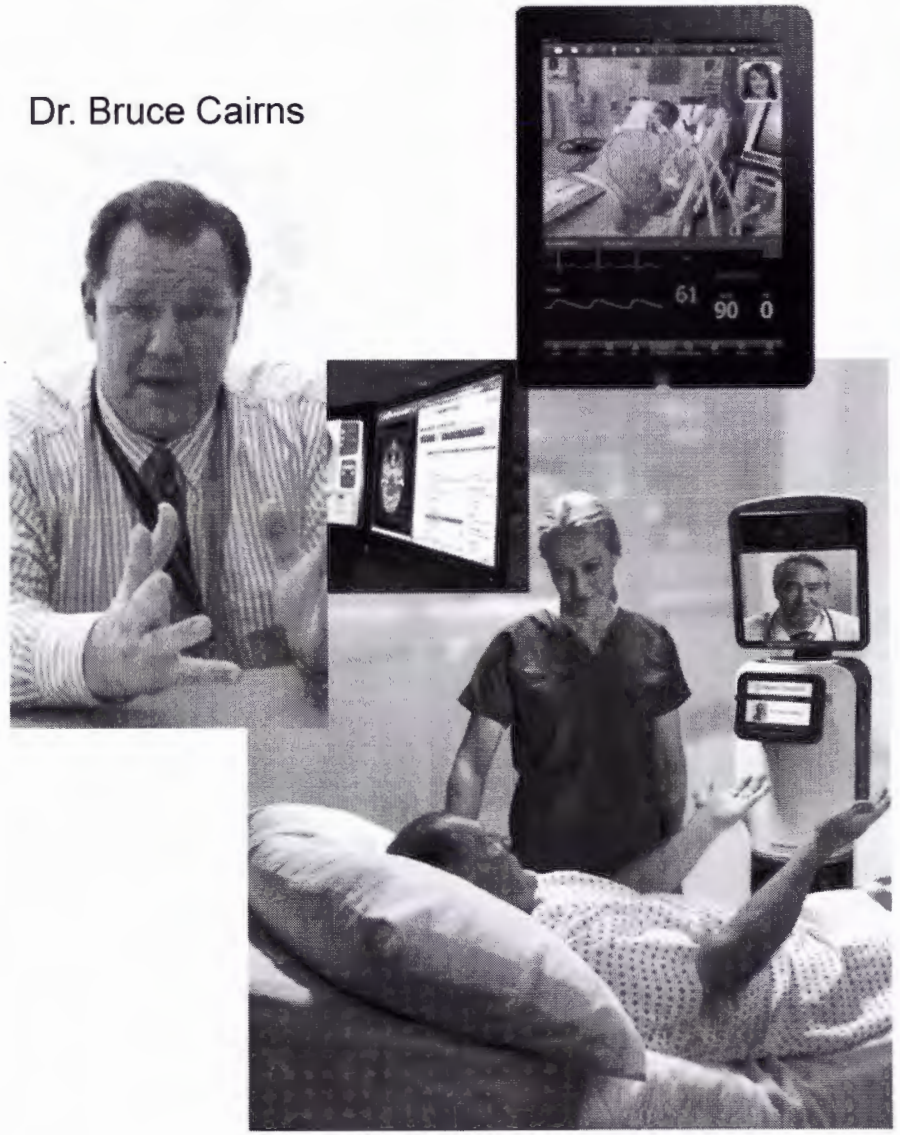
Dr. Josh Alexander

TelAbility is an innovative, community oriented, interdisciplinary program from the UNC Department of Physical Medicine and Rehabilitation that uses telecommunications to improve the lives of children with disabilities. Using real time video-conferencing and internet technologies, TelAbility provides comprehensive, coordinated, family centered care to children with disabilities and the people who care for them. This saves families travel time and expense, school and work absences, and challenges of moving a child with disabilities and equipment from a local clinic to the medical center at Chapel Hill.

UNC HEALTH CARE SYSTEM

Teleburn: Specialists at the Jaycee Burn Center at UNC connect to NC community emergency rooms

- 24/7 Telehealth access to burn specialists for Emergency room physicians and burn victims
- Allows direct assessment of a burn, an immediate management plan jointly developed with the physician in the emergency room and the burn specialist
- This program will substantially reduce transfers of patients from community hospitals to higher levels of care. For those patients needing higher levels of care, decisions and facilitation of transfer to a hospital that can provide the needed care will occur.
- Follow-up care for patients post-burn can be provided using these tools to avoid travel by patients and loss of time at work or school.
- This same technology can be used for
  - Stroke care
  - ED coverage by specialists (e.g., cardiology)
  - Clinical collaboration via multisite video collaboration (e.g., surgical consultations)



UNC HEALTH CARE SYSTEM

What is Telehealth in 2015?

Telehealth: a clinical tool for patient care

- **Definition: The use of technology to interact with patients or facilitate patient care at a distance**
- **Telehealth has been proven through multiple studies to: 1) deliver health care or health related information, 2) improve access to medical care, 3) reduce costs of care (direct and indirect), and 4) improve compliance of patients with care plans**
- **Applications include:**
  - **Provider to patient* (video conference patient care delivery including examination, patient-provider contact, e.g. email or video conference progress checks)**
  - **Store/forward* (data transfer for interpretation, e.g. radiology studies, echocardiograms)**
  - **Provider to provider consultation (e.g. tumor board, primary care to specialist consultation)**
  - **Provider to patient group care* (e.g. diabetes education, mental health support groups, telepsychiatry)**
  - **Hybrids of these systems* (e.g. prenatal ultrasound data transfer followed by patient visit with Maternal-Fetal Medicine-patient visit, E-ICUs)**
  - **Home monitoring of patients (including device reporting to providers and extension of independent living for at risk patients [elderly with motion sensors or video monitoring])**
  - **M-Health or E-Health (wellness or health care prompts pushed out (and in some cases bi-directionally communicating information) through mobile devices**

Patients acceptance telehealth is rapid with appreciation for the convenience

* Billable activities under current payer models; others, although not billable have the "halo" effect of impacting referrals or providing greater "value" in care.

UNC HEALTH CARE SYSTEM

Is the environment right to expand telehealth in NC now?

- **NC is a "rural" state with geographic challenges for patient access through traditional face to face health care encounters**
- **NC is a "wired" state for internet, the platform for much of telehealth.**
- **Supportive legislature and leadership seeking innovation and leveraging technology for better access to health care and improved health of NC citizens**
- **Long history of NC engagement with telehealth including developers and early adopters in NC medical teaching institutions**
- **NC health care systems are under pressure to expand population care with changes to value based payments and care delivery using limited manpower**
- **Multiple vendors of telehealth equipment and software have resulted in rapidly decreasing costs for the needed technology**
- **Medical care insurers are recognizing telehealth as a "legitimate" health delivery model.**
- **There is a growing appetite for telehealth in NC from patients, hospitals, physicians and other medical professionals as efficiency of care and easier connections with care are sought**

UNC HEALTH CARE SYSTEM

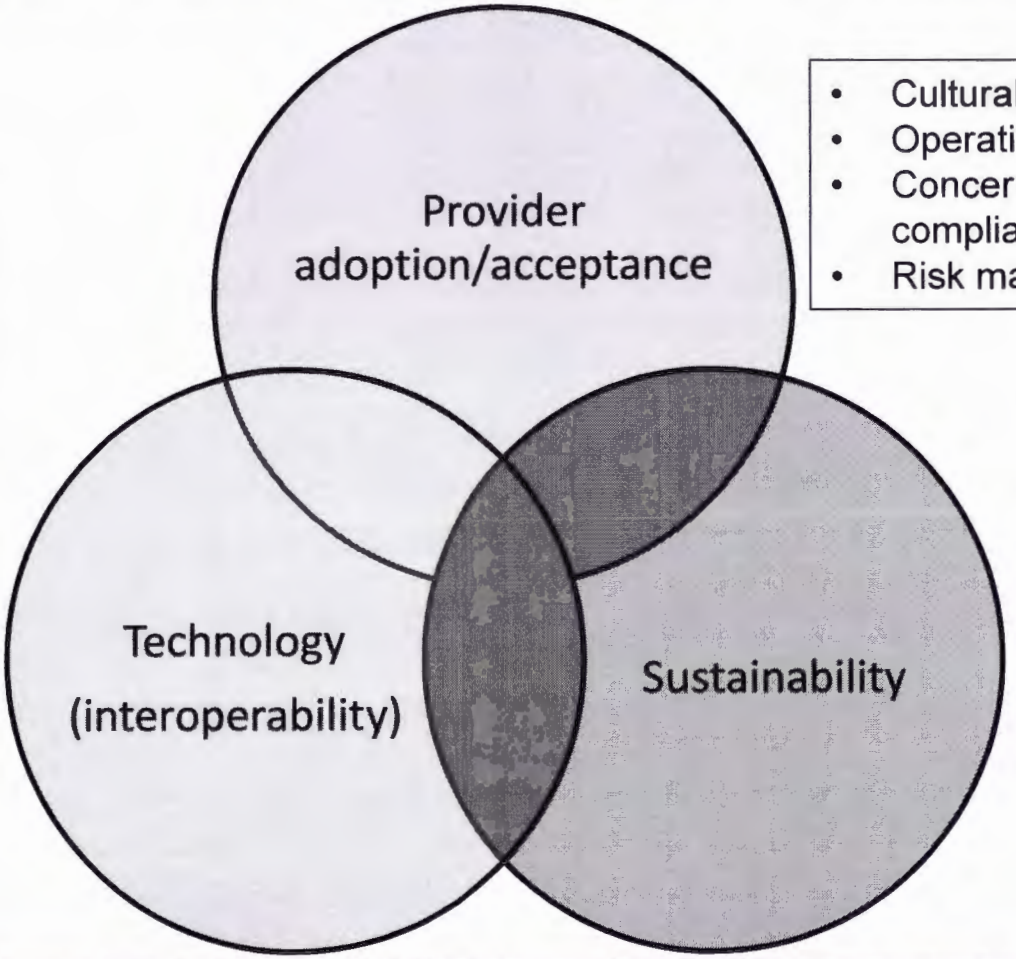
What is happening with telehealth in NC over the three years?

- Rapid growth in specific telehealth programs (e.g. Telestroke for evaluation of interventions for patients in the emergency room at presentation) and programs that operate under hospital contracts for professional services.
- The Board of Medicine has revised the Telehealth Guidelines to allow broader use of telehealth within the scope of practice for NC physicians
- An "Ad Hoc" State Telehealth Work Group including representatives from all the NC academic medical centers, MCNC, NCHICA, NCHIE, AHEC, and other interested stakeholders has been meeting to identify means to accelerate adoption and use of telehealth in NC. Some of the identified areas needing attention ilnclude:
  - Continued expansion of high speed (and large capacity) internet connectivity across the state
  - Developing consensus for collaboration across health systems for telehealth deployment to promote inter-connectivity
  - Evolving interest in development of a "state" telehealth resource center housed in a "neutral" site to aid with technology selection and collaboration on operational issues among users
  - Advocacy for reimbursement reform to promote telehealth adoption and state regulation reform through Board of Medicine and Board of Pharmacy to moderate practice barriers for telehealth

UNC HEALTH CARE SYSTEM

Challenges slowing expansion of telehealth in North Carolina

- Selection of technology has been erratic with limited consideration of interoperability, connection to EMRs, or broad connectivity issues.
- Would a "neutral" state Resource Center for NC help?



- Cultural issues
- Operational concerns
- Concerns with regulatory compliance issues
- Risk management

- Reimbursement for telehealth is not standard among NC insurers.
- Nationally "telehealth parity legislation" state by state is occurring

To date, the growth of telehealth in NC has been "Home Grown" and grant or state funded with limited concern for sustainability or infrastructure/interoperability.

UNC HEALTH CARE SYSTEM

Elements to consider to catalyze expansion of telehealth in NC

- **Physician/provider engagement**: This requires telemedicine programs to be sustainable as a clinical tool.
- **Technology selection and interoperability** are achievable today with broad choices of for individual providers or programs. A state resource for providers to aid in selection of appropriate equipment and hardware to initiate telehealth programs promote interoperability would be valuable. Accessible health information exchange mechanisms are very important to successful telehealth.
- **Reimbursement for appropriate telemedicine services** should be available from all payers for medical care including Medicaid, State Health Plan, and commercial insurers. In many states this has been achieved through legislation to assure telemedicine services equivalent to face to face services are reimbursed the same.

UNC HEALTH CARE SYSTEM

State by state view of telehealth parity legislation

States with Parity Laws for Private Insurance Coverage of Telemedicine (2015)

28 states and the District of Columbia have Parity legislation in place

States with the year of enactment: Arizona (2013)*, **Arkansas (2015)**, California (1996), Colorado (2001), Georgia (2006), Hawaii (1999), **Indiana (2015)**, Kentucky (2000), Louisiana (1995), Maine (2009), Maryland (2012), Michigan (2012), **Minnesota (2015)**, Mississippi (2013), Missouri (2013), Montana (2013), **Nevada (2015)**, New Hampshire (2009), New Mexico (2013), New York (2014), Oklahoma (1997), Oregon (2009), Tennessee (2014), Texas (1997), Vermont (2012), Virginia (2010), **Washington (2015)** and the District of Columbia (2013)

States with proposed/pending legislation: In 2015, **Arkansas (ENACTED)**, Connecticut, Delaware, Illinois, **Indiana (ENACTED)**, Iowa, Massachusetts, **Minnesota (ENACTED)**, **Nevada (ENACTED)**, New Jersey, North Carolina, Ohio, Pennsylvania, Rhode Island, and **Washington (ENACTED)**

**Coverage applies to certain health services and/or rural areas only.*

Wider use of telehealth will aid in delivery of care, access to care, efficiency and cost of care, and compliance of patients with care plans, all needed to improve the health of North Carolinians

Wednesday, June 24	Room	Time
HEALTH	643	10:00 am

Name	County	Sponsor
Brooklyn Breedlove	Rutherford	Mike Hager
Davis Jones	Guilford	Jon Hardister
Chris Norris	Rowan	Harry Warren
Andrew Akins	Guilford	Jon Hardister
Gabby Banks	Franklin	Bobbie Richardson
Hayley Kaplan	Wake	Jason Saine

Committee Sergeants at Arms

NAME OF COMMITTEE House Comm. on Health

DATE: 06/24/15 Room: 643

House Sgt-At Arms:

1. Name: Young Bae
2. Name: Bill Morris
3. Name: Jim Moran
4. Name: David Leighton
5. Name: _____

Senate Sgt-At Arms:

1. Name: _____
2. Name: _____
3. Name: _____
4. Name: _____
5. Name: _____

VISITOR REGISTRATION SHEET

House Comm. on Health 06/24/15

Name of Committee Date

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Caroline Anderson	NC GA
Sarah Thomas	House District 8
Lindaman Edgar	
Pauline Holbrook	NCSBA
Skye David	KLG

VISITOR REGISTRATION SHEET

House Comm. on Health — 06/24/15

Name of Committee — Date

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Tom Friedman	SHP
Elizabeth Thomas	UNC
Susan DeLaney	NCANP
	NCANP
Thom Mansfield	NCMB
Amy Jo Johnson	NCMB
Elizabeth Meredith	NCMB
JW Joyner	New Frame
Bubba White	New Frame
Scott Kirby	NCMB

VISITOR REGISTRATION SHEET

House Comm. on Health — 06/24/15

Name of Committee — Date

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Elizabeth Hodges	NCPeds
Kay Castillo	NASW-NC
Phoebe Landon	Brooks Pierce
Dirk Taylor	Ha-Ofa/KHK
Tim Bycek	Novartis
Dana Sykes	SA
Jeff Barnhart	MWC
Val Procopio	
Mike Jones	NCP
Fi Bristin	AHP
Andy Chase	KMA

VISITOR REGISTRATION SHEET

House Comm. on Health 06/24/15

Name of Committee Date

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Ellen Vick	NCBOP
[signature]	NP
[signature]	BAYER
Michelle Frazier	MFTS
Rivan Menwald	WM
Joyce Peters	CSS
[signature]	CSS
Erica Nelson	NCHA
[signature]	DPSNC
DOUG HERON	DUKE
[signature]	FWA
Henry Capers	ATT

VISITOR REGISTRATION SHEET

House Comm. on Health 06/24/15

Name of Committee Date

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Joanna Spruill	NCAFP
Allison Stewart	Cardinal
Christine Craig	WakeMed
Lex Morgan	NCRMA
Heather Jones	Jordan Price

VISITOR REGISTRATION SHEET

House Comm. on Health 06/24/15

Name of Committee Date

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
MaHGross	NCK

VISITOR REGISTRATION SHEET

House Comm. on Health — 06/24/15

Name of Committee — Date

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Brianne Gill	Carney
Courtney Johnson	NP
TJ Bugbee	NP
Sarah Wolfe	MMC
Jennifer Willis	UNC-CH
Alex Bowen	CCS
Colleen Kochanek	KLG
Chris Kahler	Nelson Mullins
Elizabeth Schab	NCMHA
Jane Bielak	
Amanda McQuade	NC Child

HEALTH
House Standing Committee

2016 Short Session

Co-Chairs

Representative Justin Burr
Representative Bert Jones
Representative Donny Lambeth
Representative Gary Pendleton

NORTH CAROLINA GENERAL ASSEMBLY

HEALTH
2015-2016 SESSION

Rep. Justin Burr
Co-Chair

Rep. Bert Jones
Co-Chair

Rep. Donny Lambeth
Co-Chair

Rep. Gary Pendleton
Co-Chair

Rep. Marilyn Avila
Vice-Chair

Rep. William Brisson
Vice-Chair

Rep. Nelson Dollar
Vice-Chair

Rep. Beverly Earle
Vice-Chair

Rep. Jean Farmer-Butterfield
Vice-Chair

Rep. Gale Adcock

Rep. Dan Bishop

Rep. Hugh Blackwell

Rep. Bill Brawley

Rep. Rayne Brown

Rep. Becky Carney

Rep. Tricia Cotham

Rep. Josh Dobson

Rep. Carl Ford

Rep. Ken Goodman

NORTH CAROLINA GENERAL ASSEMBLY

HEALTH
2015-2016 SESSION

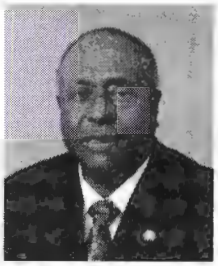
Rep. Mike Hager

Rep. Larry Hall

Rep. Kelly Hastings

Rep. Verla Insko

Rep. David Lewis


Rep. Marvin Lucas

Rep. Susan Martin

Rep. Gregory Murphy

Rep. Jason Saine

Rep. Mitchell Setzer

Rep. John Szoka

Rep. Ken Waddell

Rep. Michael Wray

Rep. Larry Yarborough

ATTENDANCE

COMMITTEE on HEALTH

2015-2016 SESSION

DATES	May 11 2016	May 25 '16 June 1st '16	June 8, 16 AM	June 8, 16 PM										
BURR, Justin CHAIR	✓	✓		✓										
JONES, Bert CHAIR	✓	✓	✓	✓	✓									
LAMBETH, Donny CHAIR		✓	✓	✓	✓									
PENDLETON, Gary CHAIR	✓	✓	✓	✓										
AVILA, Marilyn VICE-CHAIR	✓	✓	✓	✓	✓									
BRISSON, William VICE-CHAIR		✓	✓	✓										
DOLLAR, Nelson VICE-CHAIR		✓	✓											
EARLE, Beverly VICE-CHAIR	✓	✓	✓	✓	✓									
FARMER-BUTTERFIELD, Jean VICE-CHAIR			✓	✓	✓									
ADCOCK, Gale (04/08/2015)	✓	✓	✓	✓	✓									
BISHOP, Dan		✓	✓		✓									
BRAWLEY, Bill (04/20/2015)	✓													
BLACKWELL, Hugh	✓	✓	✓		✓									
BROWN, Rayne	✓		✓	✓										
CARNEY, Becky	✓	✓	✓											
COTHAM, Tricia														
DOBSON, Josh	✓		✓	✓	✓									
FORD, Carl	✓	✓	✓	✓										
GOODMAN, Ken	✓	✓	✓	✓	✓									
HAGER, Mike (04/20/2015)	✓	✓	✓	✓	✓									
HALL, Larry														
HASTINGS, Kelly	✓			✓										
INSKO, Verla	✓	✓	✓	✓	✓									

ATTENDANCE

COMMITTEE on HEALTH

2015-2016 Session

DATES	5-11-2016	May 25 '16	June 1 '16	June 8, '16	6-8-16 PM										
LEWIS, David															
LUCAS, Marvin	✓	✓	✓	✓											
MARTIN, Susan		✓	✓	✓											
MURPHY, Greg	✓	✓	✓	✓	✓										
SAINE, Jason		✓													
SETZER, Mitchell	✓														
SZOKA, John		✓		✓	✓										
WADDELL, Ken		✓	✓	✓											
WRAY, Michael	✓				✓										
YARBOROUGH, Larry	✓	✓	✓	✓	✓										
Committee Clerks															
LONG, Dina	✓	✓	✓	✓	✓										
OLLS, Brenda	✓	✓	✓	✓	✓										
Peters, Kathy	✓	✓	✓	✓	✓										

Corrected #2: Remove HB 1047

NORTH CAROLINA HOUSE OF REPRESENTATIVES
COMMITTEE MEETING NOTICE
AND
BILL SPONSOR NOTIFICATION
2015-2016 SESSION

You are hereby notified that the **House Committee on Health** will meet as follows:

DAY & DATE: Wednesday, May 11, 2016
TIME: **10:00 AM**
LOCATION: **643 LOB**
COMMENTS: **Remove HB 1047**

The following bills will be considered:

BILL NO.	SHORT TITLE	SPONSOR
HB 1012	Study Allocation of CC Subsidies/Waitlist.	Representative Dobson Representative Horn Representative Jeter Representative Earle
HB 1013	Study Alignment of CC Services Applications.	Representative Dobson Representative S. Martin Representative Horn Representative Malone
HB 1014	NC-PreK Conforming Change.	Representative Dobson Representative Jeter Representative Malone Representative Earle
HB 1040	Study Costs Associated With NC Pre-K Slots.	Representative Dobson Representative Horn Representative Earle Representative Malone

Respectfully,

Representative Justin P. Burr, Co-Chair
Representative Bert Jones, Co-Chair
Representative Donny Lambeth, Co-Chair
Representative Brig Gen (Ret) Gary Pendleton, Co-Chair

I hereby certify this notice was filed by the committee assistant at the following offices at 1:49 PM on Tuesday, May 10, 2016.

___ Principal Clerk
___ Reading Clerk – House Chamber

Brenda Olls (Committee Assistant)

Corrected #1: Add HB 1040, HB 1047

NORTH CAROLINA HOUSE OF REPRESENTATIVES
COMMITTEE MEETING NOTICE
AND
BILL SPONSOR NOTIFICATION
2015-2016 SESSION

You are hereby notified that the **House Committee on Health** will meet as follows:

DAY & DATE: Wednesday, May 11, 2016
TIME: **10:00 AM**
LOCATION: **643 LOB**

The following bills will be considered:

BILL NO.	SHORT TITLE	SPONSOR
HB 1012	Study Allocation of CC Subsidies/Waitlist.	Representative Dobson Representative Horn Representative Jeter Representative Earle
HB 1013	Study Alignment of CC Services Applications.	Representative Dobson Representative S. Martin Representative Horn Representative Malone
HB 1014	NC-PreK Conforming Change.	Representative Dobson Representative Jeter Representative Malone Representative Earle
HB 1040	Study Costs Associated With NC Pre-K Slots.	Representative Dobson Representative Horn Representative Earle Representative Malone
HB 1047	Welfare Reform/Food and Nutrition Benefits.	Representative Jones Representative Blackwell Representative Hager

Respectfully,

Representative Justin P. Burr, Co-Chair
Representative Bert Jones, Co-Chair
Representative Donny Lambeth, Co-Chair
Representative Brig Gen (Ret) Gary Pendleton, Co-Chair

I hereby certify this notice was filed by the committee assistant at the following offices at 9:18 AM on Tuesday, May 10, 2016.

___ Principal Clerk
___ Reading Clerk – House Chamber

Brenda Olls (Committee Assistant)

NORTH CAROLINA HOUSE OF REPRESENTATIVES
COMMITTEE MEETING NOTICE
AND
BILL SPONSOR NOTIFICATION
2015-2016 SESSION

You are hereby notified that the **House Committee on Health** will meet as follows:

DAY & DATE: Wednesday, May 11, 2016
TIME: **10:00 AM**
LOCATION: **643 LOB**

The following bills will be considered:

BILL NO.	SHORT TITLE	SPONSOR
HB 1012	Study Allocation of CC Subsidies/Waitlist.	Representative Dobson Representative Horn Representative Jeter Representative Earle
HB 1013	Study Alignment of CC Services Applications.	Representative Dobson Representative S. Martin Representative Horn Representative Malone
HB 1014	NC-PreK Conforming Change.	Representative Dobson Representative Jeter Representative Malone Representative Earle

Respectfully,

Representative Justin P. Burr, Co-Chair
Representative Bert Jones, Co-Chair
Representative Donny Lambeth, Co-Chair
Representative Brig Gen (Ret) Gary Pendleton, Co-Chair

I hereby certify this notice was filed by the committee assistant at the following offices at 11:57 AM on Thursday, May 05, 2016.

___ Principal Clerk
___ Reading Clerk – House Chamber

Brenda Olls (Committee Assistant)

House Committee on Health
Wednesday, May 11, 2016, 10:00 AM
643 Legislative Office Building

AGENDA

Welcome and Opening Remarks

Introduction of Pages

Bills

BILL NO.	SHORT TITLE	SPONSOR
HB 1012	Study Allocation of CC Subsidies/Waitlist.	Representative Dobson Representative Horn Representative Jeter Representative Earle
HB 1013	Study Alignment of CC Services Applications.	Representative Dobson Representative S. Martin Representative Horn Representative Malone
HB 1014	NC-PreK Conforming Change.	Representative Dobson Representative Jeter Representative Malone Representative Earle
HB 1040	Study Costs Associated With NC Pre-K Slots.	Representative Dobson Representative Horn Representative Earle Representative Malone

Presentations

Other Business

Adjournment

House Committee on Health
Wednesday, May 11, 2016 at 10:00 AM
Room 643 of the Legislative Office Building

MINUTES

The House Committee on Health met at 10:00 AM on May 11, 2016 in Room 643 of the Legislative Office Building. Representatives Burr, Jones, Pendleton, Avila, Earle, Adcock, Brawley, Blackwell, Brown, Carney, Dobson, Ford, Goodman, Hager, Hastings, Insko, Lucas, Murphy, Setzer, Wray, and Yarborough attended.

Representative Bert Jones, Chair, presided.

The following bills were considered:

HB 1012 Study Allocation of CC Subsidies/Waitlist. (Representatives Dobson, Horn, Jeter, Earle)
Representative Dobson presented the bill. Jennifer Johnson, DHHS, answered questions. Representative Earle motioned for a favorable report, unfavorable to the original, favorable to the PCS.

HB 1013 Study Alignment of CC Services Applications. (Representatives Dobson, S. Martin, Horn, Malone)
Representative Dobson presented the bill. Representative Brawley motioned for a favorable report, unfavorable to the original, favorable to the PCS.

HB 1014 NC Pre-K Conforming Change/Taylor's Law. (Representatives Dobson, Jeter, Malone, Earle)
Representative Dobson presented the bill. Representative Setzer motioned for a favorable report, unfavorable to the original, favorable to the PCS.

HB 1040 Study Costs Associated With NC Pre-K Slots. (Representatives Dobson, Horn, Earle, Malone)
Representative Dobson presented the bill. Representative Adcock motioned for a favorable report, unfavorable to the original, favorable to the PCS.

Representative Pendleton was welcomed as a new Chair of the Health Committee. Representative Murphy was welcomed to the committee as a new member.

The meeting adjourned at 10:26.

Bert Jones
Representative Bert Jones, Chair

Brenda Ollis
Brenda Ollis, Committee Clerk

HOUSE BILL 1012:
Study Allocation of CC Subsidies/Waitlist.

2016-2017 General Assembly

Committee:	House Health	**Date:**	May 10, 2016
Introduced by:	Reps. Dobson, Horn, Jeter, Earle	**Prepared by:**	Jason Moran-Bates Committee Co-Counsel
Analysis of:	PCS to First Edition H1012-CSTY-8		

SUMMARY: ***House Bill 1012 directs the Division of Child Development and Early Education (DCDEE) in the Department of Health and Human Services to study and report on the allocation of child care subsidies, as recommended by the Joint Legislative Oversight Committee on Health and Human Services.***

The Proposed Committee Substitute requires DCDEE to seek input from the North Carolina Partnership for Children, Inc.

[As introduced, this bill was identical to S796, as introduced by Sen. Pate, which is currently in Senate Rules and Operations of the Senate.]

BILL ANALYSIS: House Bill 1012 requires the Division of Child Development and Early Education to study the allocation of child care subsidies for families that move from one county to another. The Division is directed to make recommendations on a statewide approach to allocating funds for the subsidized child care program, the impact of a statewide allocation on children on the waitlist for the program, mechanisms for allowing funds to follow eligible children who move from one county to another, and provisions to protect the funding for children who remain in counties into which other eligible children move. The PCS amends the bill to require the Division to seek input from the North Carolina Partnership for Children, Inc. The Division must report findings to the Joint Legislative Oversight Committee on Health and Human Services on or before December 1, 2016.

EFFECTIVE DATE: This bill is effective when it becomes law.

BACKGROUND: This study was recommended by the Joint Legislative Oversight Committee's Subcommittee on Statewide Early Education and Family Support Programs in its April 2016 report. The Joint Legislative Oversight Committee on Health and Human Services recommended enactment of this bill in its report to the General Assembly.

Karen Cochrane-Brown
Director

Legislative Analysis Division
919-733-2578

This bill analysis was prepared by the nonpartisan legislative staff for the use of legislators in their deliberations and does not constitute an official statement of legislative intent.

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2015

H D

HOUSE BILL 1012
PROPOSED COMMITTEE SUBSTITUTE H1012-CSSH-64 [v.1]
05/10/2016 11:00:21 AM

Short Title: Study Allocation of CC Subsidies/Waitlist. (Public)

Sponsors:

Referred to:

May 2, 2016

A BILL TO BE ENTITLED

AN ACT TO DIRECT THE DIVISION OF CHILD DEVELOPMENT AND EARLY EDUCATION WITHIN THE DEPARTMENT OF HEALTH AND HUMAN SERVICES TO STUDY AND REPORT ON THE ALLOCATION OF CHILD CARE SUBSIDIES, AS RECOMMENDED BY THE JOINT LEGISLATIVE OVERSIGHT COMMITTEE ON HEALTH AND HUMAN SERVICES.

The General Assembly of North Carolina enacts:

SECTION 1. The Department of Health and Human Services, Division of Child Development and Early Education, shall study the allocation of child care subsidies, in particular for families that move from one county to another. While conducting this study, the Division shall seek input from the North Carolina Partnership for Children, Inc. The Division shall evaluate and make recommendations on the following:

(1) A statewide approach to the funding allocation for the subsidized child care program.

(2) The impact of a statewide funding approach to funding on children who are on the waiting list.

(3) Mechanisms by which funding may follow an eligible child who moves from one county to another such that the child has uninterrupted child care and is not relegated to the bottom of the new county's child care subsidy waiting list.

(4) Provisions to protect the funding for eligible children who receive child care subsidies in counties in which new eligible children move, as described in subdivision (3) of this section.

(5) Any other relevant issues the Division deems appropriate.

SECTION 2. The Division shall report its findings and recommendations, including any legislative proposals, to the Joint Legislative Oversight Committee on Health and Human Services on or before December 1, 2016.

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

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2015

H D

HOUSE BILL 1012
PROPOSED COMMITTEE SUBSTITUTE H1012-PCS40614-SH-64

Short Title: Study Allocation of CC Subsidies/Waitlist. (Public)

Sponsors:

Referred to:

May 2, 2016

A BILL TO BE ENTITLED

AN ACT TO DIRECT THE DIVISION OF CHILD DEVELOPMENT AND EARLY EDUCATION WITHIN THE DEPARTMENT OF HEALTH AND HUMAN SERVICES TO STUDY AND REPORT ON THE ALLOCATION OF CHILD CARE SUBSIDIES, AS RECOMMENDED BY THE JOINT LEGISLATIVE OVERSIGHT COMMITTEE ON HEALTH AND HUMAN SERVICES.

The General Assembly of North Carolina enacts:

SECTION 1. The Department of Health and Human Services, Division of Child Development and Early Education, shall study the allocation of child care subsidies, in particular for families that move from one county to another. While conducting this study, the Division shall seek input from the North Carolina Partnership for Children, Inc. The Division shall evaluate and make recommendations on the following:

(1) A statewide approach to the funding allocation for the subsidized child care program.

(2) The impact of a statewide funding approach to funding on children who are on the waiting list.

(3) Mechanisms by which funding may follow an eligible child who moves from one county to another such that the child has uninterrupted child care and is not relegated to the bottom of the new county's child care subsidy waiting list.

(4) Provisions to protect the funding for eligible children who receive child care subsidies in counties in which new eligible children move, as described in subdivision (3) of this section.

(5) Any other relevant issues the Division deems appropriate.

SECTION 2. The Division shall report its findings and recommendations, including any legislative proposals, to the Joint Legislative Oversight Committee on Health and Human Services on or before December 1, 2016.

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

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2015

H 1

HOUSE BILL 1012*

Short Title:	Study Allocation of CC Subsidies/Waitlist.	(Public)
Sponsors:	Representatives Dobson, Horn, Jeter, and Earle (Primary Sponsors). *For a complete list of sponsors, refer to the North Carolina General Assembly web site.*	
Referred to:	Health	

May 2, 2016

A BILL TO BE ENTITLED

AN ACT TO DIRECT THE DIVISION OF CHILD DEVELOPMENT AND EARLY EDUCATION WITHIN THE DEPARTMENT OF HEALTH AND HUMAN SERVICES TO STUDY AND REPORT ON THE ALLOCATION OF CHILD CARE SUBSIDIES, AS RECOMMENDED BY THE JOINT LEGISLATIVE OVERSIGHT COMMITTEE ON HEALTH AND HUMAN SERVICES.

The General Assembly of North Carolina enacts:

SECTION 1. The Department of Health and Human Services, Division of Child Development and Early Education, shall study the allocation of child care subsidies, in particular for families that move from one county to another. In the conduct of its study, the Division shall evaluate and make recommendations on the following:

(1) A statewide approach to the funding allocation for the subsidized child care program.

(2) The impact of a statewide funding approach to funding on children who are on the waiting list.

(3) Mechanisms by which funding may follow an eligible child who moves from one county to another such that the child has uninterrupted child care and is not relegated to the bottom of the new county's child care subsidy waiting list.

(4) Provisions to protect the funding for eligible children who receive child care subsidies in counties in which new eligible children move, as described in subdivision (3) of this section.

(5) Any other relevant issues the Division deems appropriate.

SECTION 2. The Division shall report its findings and recommendations, including any legislative proposals, to the Joint Legislative Oversight Committee on Health and Human Services on or before December 1, 2016.

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

HOUSE BILL 1013:
Study Alignment of CC Services Applications.

2016-2017 General Assembly

Committee:	House Health	**Date:**	May 9, 2016
Introduced by:	Reps. Dobson, S. Martin, Horn, Malone	**Prepared by:**	Jennifer Mundt Committee Analyst
Analysis of:	PCS to First Edition H1013-CSTA-17 [v.3]		

SUMMARY: ***House Bill 1013 would direct the Division of Child Development and Early Education (Division) in the Department of Health and Human Services to study and report on the feasibility and desirability of developing a streamlined process for eligible families to apply for and obtain available services.***

The Proposed Committee Substitute (PCS) for House Bill 1013 specifically names the North Carolina Partnership for Children, Inc. as a stakeholder with which the Division must consult on the study.

[As introduced, this bill was identical to S797, as introduced by Sen. Pate, which is currently in Senate Rules and Operations of the Senate.]

BILL ANALYSIS: A recommendation of the Joint Legislative Oversight Committee on Health and Human Services (HHS Oversight Committee), the PCS for House Bill 1013 would direct the Division, in consultation with the North Carolina Partnership for Children (Partnership) and other stakeholders, to study the efficacy and desirability of developing a statewide application process for families to apply for and obtain available child care, early education, and health support services at one time. The Division must evaluate and make recommendations to the HHS Oversight Committee by December 1, 2016, on a statewide streamlined process and technology that improves the ability of agencies to match families and children to programs and services, and supports:

1. NC Pre-K
2. Title I
3. Child Care Subsidy
4. Head Start
5. Management of waiting lists for the aforementioned programs
6. Any other relevant programs or services the Division, Partnership, and stakeholders deem appropriate.

EFFECTIVE DATE: This act is effective when it becomes law.

BACKGROUND: The HHS Oversight Committee's Subcommittee on Statewide Early Education and Family Support Programs studied and made recommendations on early childhood and family support programming in the State. The Subcommittee's final report is available here and House Bill 1013 is an outgrowth of one of the Subcommittee's recommendations to the full HHS Oversight Committee.

Karen Cochrane-Brown
Director

Legislative Analysis Division
919-733-2578

This bill analysis was prepared by the nonpartisan legislative staff for the use of legislators in their deliberations and does not constitute an official statement of legislative intent.

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2015

H D

HOUSE BILL 1013
PROPOSED COMMITTEE SUBSTITUTE H1013-CSTA-17 [v.3]
05/10/2016 11:30:28 AM

Short Title: Study Alignment of CC Services Applications. (Public)

Sponsors:

Referred to:

May 2, 2016

A BILL TO BE ENTITLED

AN ACT TO DIRECT THE DIVISION OF CHILD DEVELOPMENT AND EARLY EDUCATION IN THE DEPARTMENT OF HEALTH AND HUMAN SERVICES TO STUDY AND REPORT ON THE FEASIBILITY AND DESIRABILITY OF DEVELOPING A STATEWIDE STREAMLINED APPLICATION PROCESS BY WHICH ELIGIBLE FAMILIES MAY APPLY FOR AND OBTAIN AVAILABLE SERVICES, AS RECOMMENDED BY THE JOINT LEGISLATIVE OVERSIGHT COMMITTEE ON HEALTH AND HUMAN SERVICES.

The General Assembly of North Carolina enacts:

SECTION 1. The Division of Child Development and Early Education in the Department of Health and Human Services, in consultation with the North Carolina Partnership for Children, Inc. (Partnership) and other stakeholders, shall study the efficacy and desirability of developing a statewide streamlined application process by which eligible families may apply for and obtain available child care, early education, and health support services at one time. In the conduct of this study, the Division shall evaluate and make recommendations on a statewide streamlined application process and technology that improves the ability of agencies to match families and children to programs and services, and supports:

(1) NC Pre-K.
(2) Title I.
(3) Child Care Subsidy.
(4) Head Start.
(5) Management of waiting lists for the programs identified in subdivisions (1) through (4) of this section.
(6) Any other relevant programs or services the Division, Partnership, and stakeholders deem appropriate.

SECTION 2. The Division shall report its findings and recommendations, including any legislative proposals, to the Joint Legislative Oversight Committee on Health and Human Services on or before December 1, 2016.

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

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2015

H D

HOUSE BILL 1013
PROPOSED COMMITTEE SUBSTITUTE H1013-PCS30498-TA-17

Short Title: Study Alignment of CC Services Applications. (Public)

Sponsors:

Referred to:

May 2, 2016

A BILL TO BE ENTITLED

AN ACT TO DIRECT THE DIVISION OF CHILD DEVELOPMENT AND EARLY EDUCATION IN THE DEPARTMENT OF HEALTH AND HUMAN SERVICES TO STUDY AND REPORT ON THE FEASIBILITY AND DESIRABILITY OF DEVELOPING A STATEWIDE STREAMLINED APPLICATION PROCESS BY WHICH ELIGIBLE FAMILIES MAY APPLY FOR AND OBTAIN AVAILABLE SERVICES, AS RECOMMENDED BY THE JOINT LEGISLATIVE OVERSIGHT COMMITTEE ON HEALTH AND HUMAN SERVICES.

The General Assembly of North Carolina enacts:

SECTION 1. The Division of Child Development and Early Education in the Department of Health and Human Services, in consultation with the North Carolina Partnership for Children, Inc., (Partnership) and other stakeholders, shall study the efficacy and desirability of developing a statewide streamlined application process by which eligible families may apply for and obtain available child care, early education, and health support services at one time. In the conduct of this study, the Division shall evaluate and make recommendations on a statewide streamlined application process and technology that improves the ability of agencies to match families and children to programs and services, and supports:

(1) NC Pre-K.
(2) Title I.
(3) Child Care Subsidy.
(4) Head Start.
(5) Management of waiting lists for the programs identified in subdivisions (1) through (4) of this section.
(6) Any other relevant programs or services the Division, Partnership, and stakeholders deem appropriate.

SECTION 2. The Division shall report its findings and recommendations, including any legislative proposals, to the Joint Legislative Oversight Committee on Health and Human Services on or before December 1, 2016.

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

HOUSE BILL 1013*

Short Title:	Study Alignment of CC Services Applications.	(Public)
Sponsors:	Representatives Dobson, S. Martin, Horn, and Malone (Primary Sponsors). *For a complete list of sponsors, refer to the North Carolina General Assembly web site.*	
Referred to:	Health	

May 2, 2016

A BILL TO BE ENTITLED

AN ACT TO DIRECT THE DIVISION OF CHILD DEVELOPMENT AND EARLY EDUCATION IN THE DEPARTMENT OF HEALTH AND HUMAN SERVICES TO STUDY AND REPORT ON THE FEASIBILITY AND DESIRABILITY OF DEVELOPING A STATEWIDE STREAMLINED APPLICATION PROCESS BY WHICH ELIGIBLE FAMILIES MAY APPLY FOR AND OBTAIN AVAILABLE SERVICES, AS RECOMMENDED BY THE JOINT LEGISLATIVE OVERSIGHT COMMITTEE ON HEALTH AND HUMAN SERVICES.

The General Assembly of North Carolina enacts:

SECTION 1. The Division of Child Development and Early Education in the Department of Health and Human Services, in consultation with stakeholders, shall study the efficacy and desirability of developing a statewide streamlined application process by which eligible families may apply for and obtain available child care, early education, and health support services at one time. In the conduct of its study, the Division shall evaluate and make recommendations on a statewide streamlined application process and technology that improves the ability of agencies to match families and children to programs and services, and supports:

(1) NC Pre-K.
(2) Title I.
(3) Child Care Subsidy.
(4) Head Start.
(5) Management of waiting lists for the programs identified in subdivisions (1) through (4) of this section.
(6) Any other relevant programs or services the Division and stakeholders deem appropriate.

SECTION 2. The Division shall report its findings and recommendations, including any legislative proposals, to the Joint Legislative Oversight Committee on Health and Human Services on or before December 1, 2016.

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

HOUSE BILL 1014:
NC-PreK Conforming Change/Taylor's Law.

2016-2017 General Assembly

Committee:	House Health	**Date:**	May 9, 2016
Introduced by:	Reps. Dobson, Jeter, Malone, Earle	**Prepared by:**	Jason Moran-Bates Committee Co-Counsel
Analysis of:	PCS to First Edition H1014-CSSH-63		

SUMMARY: The Proposed Committee Substitute (PCS) for House Bill 1014 makes technical and conforming changes to replace references to "More at Four" with "NC Pre-K" in the General Statutes and retitles Part 6 of Article 1B of Chapter 130A of the General Statutes to "Taylor's Law Establishing the Advisory Council on Rare Diseases."

[As introduced, this bill was identical to S799, as introduced by Sens. Pate, Robinson, which is currently in Senate Education/Higher Education.]

BILL ANALYSIS:

Sections 1 and 2 of the original bill make technical and conforming changes by replacing "More at Four" with "NC Pre-K" in two statutes.

Section 3 of the PCS amends the title of Part 6 of Article 1B of Chapter 130A of the General Statutes by renaming it "Taylor's Law Establishing the Advisory Council on Rare Diseases." Session Law 2015-199 established the Advisory Council on Rare Diseases.

EFFECTIVE DATE: This bill is effective when it becomes law.

BACKGROUND:

The Advisory Council on Rare Diseases was established in 2015 within the School of Medicine of the University of North Carolina at Chapel Hill to provide advice on research, diagnosis, treatment, and education relating to rare diseases.

Taylor King is a seventeen-year-old resident of Charlotte who was diagnosed with Batten Disease, an extremely rare neurodegenerative disorder, when she was seven. Batten Disease causes the buildup of fatty substances called lipopigments in the body's tissues. This buildup leads to the death of neurons in the retina, brain, and central nervous system. Batten Disease is always fatal, and there is no known treatment or cure. Taylor's Tale is a volunteer organization dedicated to the fight against Batten Disease and other rare diseases.

Karen Cochrane-Brown
Director

Legislative Analysis Division
919-733-2578

This bill analysis was prepared by the nonpartisan legislative staff for the use of legislators in their deliberations and does not constitute an official statement of legislative intent.

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2015

H D

HOUSE BILL 1014
PROPOSED COMMITTEE SUBSTITUTE H1014-CSSH-63 [v.3]
05/09/2016 01:59:19 PM

Short Title: NC-PreK Conforming Change/Taylor's Law. (Public)

Sponsors:

Referred to:

May 2, 2016

A BILL TO BE ENTITLED

AN ACT TO MAKE CONFORMING CHANGES BY REMOVING OBSOLETE REFERENCES TO THE MORE AT FOUR PROGRAM IN THE GENERAL STATUTES, AS RECOMMENDED BY THE JOINT LEGISLATIVE OVERSIGHT COMMITTEE ON HEALTH AND HUMAN SERVICES, AND TO RENAME PART 6 OF ARTICLE 1B OF CHAPTER 130A TO TAYLOR'S LAW ESTABLISHING THE ADVISORY COUNCIL ON RARE DISEASES.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 115C-242 reads as rewritten:

"**§ 115C-242. Use and operation of school buses.**

Public school buses may be used for the following purposes only, and it shall be the duty of the superintendent of the school of each local school administrative unit to supervise the use of all school buses operated by such local school administrative unit so as to assure and require compliance with this section:

(1) A school bus may be used for the transportation of pupils enrolled in and employees in the operation of the school to which such bus is assigned by the superintendent of the local school administrative unit. Except as otherwise herein provided, such transportation shall be limited to transportation to and from such school for the regularly organized school day, and from and to the points designated by the principal of the school to which such bus is assigned, for the receiving and discharging of passengers. No pupil or employee shall be so transported upon any bus other than the bus to which such pupil or employee has been assigned pursuant to the provisions of this Article: Provided, that children enrolled in a Headstart program or any ~~More at Four~~NC Pre-K program may be transported on public school buses, and any additional costs associated with such contractual arrangements shall be incurred by the benefitting Head Start or ~~More at Four~~NC Pre-K program: Provided further, that children with disabilities may be transported to and from the nearest appropriate private school having a special education program approved by the State Board of Education if the children to be transported are or have been placed in that program by a local school administrative unit as a result of the State or the unit's duty to provide such children with a free appropriate public education.

...."

SECTION 2. G.S. 143B-168.12(a)(1)n. reads as rewritten:

"**§ 143B-168.12. North Carolina Partnership for Children, Inc.; conditions.**

(a) In order to receive State funds, the following conditions shall be met:

(1) The North Carolina Partnership shall have a Board of Directors consisting of the following 26 members:

...

n. The Director of the ~~More at Four Pre-Kindergarten~~NC Pre-K Program, or the Director's designee."

SECTION 3. Part 6 of Article 1B of Chapter 130A reads as rewritten:

"Part 6. Taylor's Law Establishing the Advisory Council on Rare Diseases.

§ 130A-33.65. Advisory Council on Rare Diseases; membership; terms; compensation; meetings; quorum.

(a) There is established the Advisory Council on Rare Diseases within the School of Medicine of the University of North Carolina at Chapel Hill to advise the Governor, the Secretary, and the General Assembly on research, diagnosis, treatment, and education relating to rare diseases. This Part shall be known as Taylor's Law Establishing the Advisory Council on Rare Diseases. For purposes of this Part, "rare disease" has the same meaning as provided in 21 U.S.C. § 360bb.

...."

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

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2015

H D

HOUSE BILL 1014
PROPOSED COMMITTEE SUBSTITUTE H1014-PCS40615-SH-63

Short Title: NC Pre-K Conforming Change/Taylor's Law. (Public)

Sponsors:

Referred to:

May 2, 2016

A BILL TO BE ENTITLED

AN ACT TO MAKE CONFORMING CHANGES BY REMOVING OBSOLETE REFERENCES TO THE MORE AT FOUR PROGRAM IN THE GENERAL STATUTES, AS RECOMMENDED BY THE JOINT LEGISLATIVE OVERSIGHT COMMITTEE ON HEALTH AND HUMAN SERVICES, AND TO RENAME PART 6 OF ARTICLE 1B OF CHAPTER 130A OF THE GENERAL STATUTES TO TAYLOR'S LAW ESTABLISHING THE ADVISORY COUNCIL ON RARE DISEASES.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 115C-242 reads as rewritten:

"**§ 115C-242. Use and operation of school buses.**

Public school buses may be used for the following purposes only, and it shall be the duty of the superintendent of the school of each local school administrative unit to supervise the use of all school buses operated by such local school administrative unit so as to assure and require compliance with this section:

(1) A school bus may be used for the transportation of pupils enrolled in and employees in the operation of the school to which such bus is assigned by the superintendent of the local school administrative unit. Except as otherwise herein provided, such transportation shall be limited to transportation to and from such school for the regularly organized school day, and from and to the points designated by the principal of the school to which such bus is assigned, for the receiving and discharging of passengers. No pupil or employee shall be so transported upon any bus other than the bus to which such pupil or employee has been assigned pursuant to the provisions of this Article: Provided, that children enrolled in a Headstart program or any ~~More at Four~~ NC Pre-K program may be transported on public school buses, and any additional costs associated with such contractual arrangements shall be incurred by the benefitting Head Start or ~~More at Four~~ NC Pre-K program: Provided further, that children with disabilities may be transported to and from the nearest appropriate private school having a special education program approved by the State Board of Education if the children to be transported are or have been placed in that program by a local school administrative unit as a result of the State or the unit's duty to provide such children with a free appropriate public education.

…."

SECTION 2. G.S. 143B-168.12(a)(1)n. reads as rewritten:

"**§ 143B-168.12. North Carolina Partnership for Children, Inc.; conditions.**

(a) In order to receive State funds, the following conditions shall be met:

(1) The North Carolina Partnership shall have a Board of Directors consisting of the following 26 members:

...

n. The Director of the ~~More at Four Pre-Kindergarten~~ NC Pre-K Program, or the Director's designee."

SECTION 3. Part 6 of Article 1B of Chapter 130A of the General Statutes reads as rewritten:

"Part 6. Taylor's Law Establishing the Advisory Council on Rare Diseases.

"**§ 130A-33.65. Advisory Council on Rare Diseases; membership; terms; compensation; meetings; quorum.**

(a) There is established the Advisory Council on Rare Diseases within the School of Medicine of the University of North Carolina at Chapel Hill to advise the Governor, the Secretary, and the General Assembly on research, diagnosis, treatment, and education relating to rare diseases. This Part shall be known as Taylor's Law Establishing the Advisory Council on Rare Diseases. For purposes of this Part, "rare disease" has the same meaning as provided in 21 U.S.C. § 360bb.

...."

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

HOUSE BILL 1014*

Short Title:	NC-PreK Conforming Change.	(Public)
Sponsors:	Representatives Dobson, Jeter, Malone, and Earle (Primary Sponsors). *For a complete list of sponsors, refer to the North Carolina General Assembly web site.*	
Referred to:	Health	

May 2, 2016

A BILL TO BE ENTITLED

AN ACT TO MAKE CONFORMING CHANGES BY REMOVING OBSOLETE REFERENCES TO THE MORE AT FOUR PROGRAM IN THE GENERAL STATUTES, AS RECOMMENDED BY THE JOINT LEGISLATIVE OVERSIGHT COMMITTEE ON HEALTH AND HUMAN SERVICES.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 115C-242 reads as rewritten:

"**§ 115C-242. Use and operation of school buses.**

Public school buses may be used for the following purposes only, and it shall be the duty of the superintendent of the school of each local school administrative unit to supervise the use of all school buses operated by such local school administrative unit so as to assure and require compliance with this section:

(1) A school bus may be used for the transportation of pupils enrolled in and employees in the operation of the school to which such bus is assigned by the superintendent of the local school administrative unit. Except as otherwise herein provided, such transportation shall be limited to transportation to and from such school for the regularly organized school day, and from and to the points designated by the principal of the school to which such bus is assigned, for the receiving and discharging of passengers. No pupil or employee shall be so transported upon any bus other than the bus to which such pupil or employee has been assigned pursuant to the provisions of this Article: Provided, that children enrolled in a Headstart program or any ~~More at Four~~NC Pre-K program may be transported on public school buses, and any additional costs associated with such contractual arrangements shall be incurred by the benefitting Head Start or ~~More at Four~~NC Pre-K program: Provided further, that children with disabilities may be transported to and from the nearest appropriate private school having a special education program approved by the State Board of Education if the children to be transported are or have been placed in that program by a local school administrative unit as a result of the State or the unit's duty to provide such children with a free appropriate public education.

...."

SECTION 2. G.S. 143B-168.12(a)(1)n. reads as rewritten:

"**§ 143B-168.12. North Carolina Partnership for Children, Inc.; conditions.**

(a) In order to receive State funds, the following conditions shall be met:

(1) The North Carolina Partnership shall have a Board of Directors consisting of the following 26 members:

...

n. The Director of the ~~More at Four Pre-Kindergarten~~NC Pre-K Program, or the Director's designee."

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

HOUSE BILL 1040:
Study Costs Associated With NC Pre-K Slots.

2016-2017 General Assembly

Committee:	House Health	**Date:**	May 10, 2016
Introduced by:	Reps. Dobson, Horn, Earle, Malone	**Prepared by:**	Jennifer Mundt
Analysis of:	PCS to First Edition H1040-CSTA-18 [v.1]		Committee Analyst

SUMMARY: ***House Bill 1040 would direct the Division of Child Development and Early Education (Division) in the Department of Health and Human Services to study and report on the costs associated with the slots for the NC Pre-K Program.***

[As introduced, this bill was identical to S800, as introduced by Sens. Pate, Robinson, which is currently in Senate Health Care.]

BILL ANALYSIS: A recommendation of the Joint Legislative Oversight Committee on Health and Human Services, House Bill 1040 would direct the Division to study and report its findings and recommendations, including any legislative proposals on the costs associated with funding slots for the NC Pre-K program to the chairs of the House and Senate Appropriations Committees on Health and Human Services and the Fiscal Research Division by February 1, 2017. In the conduct of its study, the Division must:

1. Review the total cost to fund a NC Pre-K slot, including local costs. The ***Proposed Committee Substitute*** adds the review of administration of the program to the evaluation of the total slot cost.
2. Review the State share needed to fund a NC Pre-K slot by each setting.
3. Review the amount of funds needed to maintain the current number of NC Pre-K slots if the per slot cost were increased to the amount recommended by the study.
4. Recommend how often NC Pre-K slot costs should be evaluated and reported to the General Assembly.

EFFECTIVE DATE: This act is effective when it becomes law.

BACKGROUND: The HHS Oversight Committee's Subcommittee on Statewide Early Education and Family Support Programs studied and made recommendations on early childhood and family support programming in the State. The Subcommittee's final report is available here and House Bill 1040 is an outgrowth of one of the Subcommittee's recommendations to the full HHS Oversight Committee.

Karen Cochrane-Brown
Director

H1040-SMTA-71 CSTA-18 -V-1

Legislative Analysis Division
919-733-2578

This bill analysis was prepared by the nonpartisan legislative staff for the use of legislators in their deliberations and does not constitute an official statement of legislative intent.

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2015

H D

HOUSE BILL 1040
PROPOSED COMMITTEE SUBSTITUTE H1040-CSTA-18 [v.1]

05/10/2016 01:19:29 PM

Short Title: Study Costs Associated With NC Pre-K Slots. (Public)

Sponsors:

Referred to:

May 5, 2016

A BILL TO BE ENTITLED

AN ACT TO DIRECT THE DIVISION OF CHILD DEVELOPMENT AND EARLY EDUCATION WITHIN THE DEPARTMENT OF HEALTH AND HUMAN SERVICES TO STUDY AND REPORT ON THE COSTS ASSOCIATED WITH SLOTS FOR THE NC PRE-K PROGRAM, AS RECOMMENDED BY THE JOINT LEGISLATIVE OVERSIGHT COMMITTEE ON HEALTH AND HUMAN SERVICES.

The General Assembly of North Carolina enacts:

SECTION 1. The Department of Health and Human Services, Division of Child Development and Early Education, shall study the costs associated with funding slots for the NC Pre-K program. In conducting the study, the Division shall review and determine the following:

(1) The total cost to fund a NC Pre-K slot, including administration and any local costs.

(2) The State share needed to fund a NC Pre-K slot by each setting, including public schools, child care facilities, and Head Start.

(3) The amount of funds needed to maintain the current number of NC Pre-K slots if the per slot cost were increased to the amount recommended by the study.

(4) Recommendations on how often the NC Pre-K slot costs should be evaluated and reported to the General Assembly.

(5) Any other relevant issues the Division deems appropriate.

SECTION 2. The Division shall report its findings and recommendations, including any legislative proposals, to the chairs of the House Appropriations Committee on Health and Human Services and the Senate Appropriations Committee on Health and Human Services and the Fiscal Research Division on or before February 1, 2017.

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

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2015

H D

HOUSE BILL 1040
PROPOSED COMMITTEE SUBSTITUTE H1040-PCS10526-TA-18

Short Title: Study Costs Associated With NC Pre-K Slots. (Public)

Sponsors:

Referred to:

May 5, 2016

A BILL TO BE ENTITLED

AN ACT TO DIRECT THE DIVISION OF CHILD DEVELOPMENT AND EARLY EDUCATION WITHIN THE DEPARTMENT OF HEALTH AND HUMAN SERVICES TO STUDY AND REPORT ON THE COSTS ASSOCIATED WITH SLOTS FOR THE NC PRE-K PROGRAM, AS RECOMMENDED BY THE JOINT LEGISLATIVE OVERSIGHT COMMITTEE ON HEALTH AND HUMAN SERVICES.

The General Assembly of North Carolina enacts:

SECTION 1. The Department of Health and Human Services, Division of Child Development and Early Education, shall study the costs associated with funding slots for the NC Pre-K program. In conducting the study, the Division shall review and determine the following:

(1) The total cost to fund a NC Pre-K slot, including administration and any local costs.

(2) The State share needed to fund a NC Pre-K slot by each setting, including public schools, child care facilities, and Head Start.

(3) The amount of funds needed to maintain the current number of NC Pre-K slots if the per slot cost were increased to the amount recommended by the study.

(4) Recommendations on how often the NC Pre-K slot costs should be evaluated and reported to the General Assembly.

(5) Any other relevant issues the Division deems appropriate.

SECTION 2. The Division shall report its findings and recommendations, including any legislative proposals, to the chairs of the House Appropriations Committee on Health and Human Services and the Senate Appropriations Committee on Health and Human Services and the Fiscal Research Division on or before February 1, 2017.

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

HOUSE BILL 1040*

Short Title:	Study Costs Associated With NC Pre-K Slots.	(Public)
Sponsors:	Representatives Dobson, Horn, Earle, and Malone (Primary Sponsors). *For a complete list of sponsors, refer to the North Carolina General Assembly web site.*	
Referred to:	Health	

May 5, 2016

A BILL TO BE ENTITLED

AN ACT TO DIRECT THE DIVISION OF CHILD DEVELOPMENT AND EARLY EDUCATION WITHIN THE DEPARTMENT OF HEALTH AND HUMAN SERVICES TO STUDY AND REPORT ON THE COSTS ASSOCIATED WITH SLOTS FOR THE NC PRE-K PROGRAM, AS RECOMMENDED BY THE JOINT LEGISLATIVE OVERSIGHT COMMITTEE ON HEALTH AND HUMAN SERVICES.

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(2) The State share needed to fund a NC Pre-K slot by each setting, including public schools, child care facilities, and Head Start.
(3) The amount of funds needed to maintain the current number of NC Pre-K slots if the per slot cost were increased to the amount recommended by the study.
(4) Recommendations on how often the NC Pre-K slot costs should be evaluated and reported to the General Assembly.
(5) Any other relevant issues the Division deems appropriate.

SECTION 2. The Division shall report its findings and recommendations, including any legislative proposals, to the chairs of the House Appropriations Committee on Health and Human Services and the Senate Appropriations Committee on Health and Human Services and the Fiscal Research Division on or before February 1, 2017.

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

NORTH CAROLINA GENERAL ASSEMBLY
HOUSE OF REPRESENTATIVES

HEALTH COMMITTEE REPORT

Representative Justin P. Burr, Co-Chair
Representative Bert Jones, Co-Chair
Representative Donny Lambeth, Co-Chair
Representative Brig Gen (Ret) Gary Pendleton, Co-Chair

FAVORABLE COM SUB , UNFAVORABLE ORIGINAL BILL

HB **1012** Study Allocation of CC Subsidies/Waitlist.

Draft Number:	H1012-PCS40614-SH-64
Serial Referral:	None
Recommended Referral:	None
Long Title Amended:	No
Floor Manager:	Dobson

HB **1013** Study Alignment of CC Services Applications.

Draft Number:	H1013-PCS30498-TA-17
Serial Referral:	None
Recommended Referral:	None
Long Title Amended:	No
Floor Manager:	Dobson

HB **1040** Study Costs Associated With NC Pre-K Slots.

Draft Number:	H1040-PCS10526-TA-18
Serial Referral:	None
Recommended Referral:	None
Long Title Amended:	No
Floor Manager:	Dobson

TOTAL REPORTED: 3

CMR619-V-1

NORTH CAROLINA GENERAL ASSEMBLY
HOUSE OF REPRESENTATIVES

HEALTH COMMITTEE REPORT

Representative Justin P. Burr, Co-Chair
Representative Bert Jones, Co-Chair
Representative Donny Lambeth, Co-Chair
Representative Brig Gen (Ret) Gary Pendleton, Co-Chair

FAVORABLE COM SUB , UNFAVORABLE ORIGINAL BILL

HB **1014** NC-PreK Conforming Change.

Draft Number:	H1014-PCS40615-SH-63
Serial Referral:	None
Recommended Referral:	None
Long Title Amended:	Yes
Floor Manager:	Dobson

TOTAL REPORTED: 1

HOUSE PAGES
(Health)

Week of May 9-12, 2016

Name:	County:	Sponsor:
CAMPBELL MCLAUCHLAN	WAKE	PAUL STAM
CASSIDY DAVIS	IREDELL	SPEAKER TIM MOORE
NATALIE MONZAVIFAR	MECKLENBURG	SPEAKER TIM MOORE
BRENDA MCWHORTER	UNION	DEAN ARP

VISITOR REGISTRATION SHEET

House Comm. on Heath — 05/11/16

Name of Committee — Date

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Susan Harriss	NCSSWA
[illegible]	SOG
Jacqueline Smith	NCPA
Patricia Knaudt	NCPA
Joy Peters	CSS
J Peters	CSS
Liz Fadhook	UNC / NCPA
Laura Willing	NCPA
Susan Theresa Garrett	NCPA
Samina Aziz	NCPA
Gabriele Morosoff	UNC, NCPA

VISITOR REGISTRATION SHEET

House Comm. on Heath — 05/11/16

Name of Committee — Date

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Nathan Copeland, MD	UNC/NCPA
Lauren Isbell, MD	NCPA / Duke
Weston Geddings, MD	UNC / NCPA
Riah Patterson, MD	UNC/ NCPA
Carson Felkel, MD	Cornerstone Healthcare / WFBH
Brittany Rodgers, MD	NCPA / UNC
Rebecca Taylor, MD	NCPA / UNC
CHRISTIAN BJERKE, MD	NCPA / DUKE
Winfield Tan, MD	NCPA / UNC
CS Hollis	CSH
Wendy Kelly	Focus Carolina

VISITOR REGISTRATION SHEET

House Comm. on Heath — 05/11/16

Name of Committee — Date

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Cory Hand	NCHA
Thomas Meece	HACK
Ryan Blackledge	Professional Hack
Amy McConkey	NC BEV
Fred Bone	Bone & Assoc.
Chip Zoot	NCMS
Duncan	DHHS
Sandy Sands	M
Martha McCarrell	Carolinas HealthCare
TJ Bugbee	NP
Adam Scholar	NCHCFA

VISITOR REGISTRATION SHEET

House Comm. on Heath — 05/11/16

Name of Committee — Date

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Bo Heath	MWC
Keni Burke	NLWC
Rob Lamm	FEA
Laura Mary	UWNC
Michelle Brooks	ECU

VISITOR REGISTRATION SHEET

House Comm. on Heath — 05/11/16

Name of Committee — Date

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
David Kolbacker	NC Board of Nursing
Connie Wilson	Smart Start for Jobs
A. Chase	KMA
NICHOLE KARIM	NAMI NC
Amanda Donovan	TSS
Kevin Rich	OSBM
Chris Broughton	McGuireWoods
David Heinen	NC Center for Nonprofits
Matt Gross	NCPC
Kay Castillo	NASW-NC
Sarah McQuillan	SSO-NC

VISITOR REGISTRATION SHEET

House Comm. on Heath — 05/11/16

Name of Committee — Date

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Sam Hoekstra	NCACC
Hugh Johnson	NCACC
Johanna Reese	NCACC
Courtney Lockamy	Randolph Cloud & Assoc
Heather Laffoon	DHHS - DCIDEE
Jennifer Johnson	"
Brian Perkins	DHHS
Skye David	AMGA
Katy Kirgsburg	BP
Sarah O'Rourke	NC Child
James Peace	citizen

VISITOR REGISTRATION SHEET

House Comm. on Heath — 05/11/16

Name of Committee — Date

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
John Privette	DPI
Robb Jansen	State Board of Education
Amerian Sanchez	Mutual Pharmacy Student
Liz Moody	Mutual Drug - Pharmacy Student
M [redacted]	Rep
Ashley Perkins	Perkinson Law
Matthew Ness	evicore healthcare
Carson Weir	NVA

NORTH CAROLINA HOUSE OF REPRESENTATIVES
COMMITTEE MEETING NOTICE
AND
BILL SPONSOR NOTIFICATION
2015-2016 SESSION

You are hereby notified that the **House Committee on Health** will meet as follows:

DAY & DATE: Wednesday, May 25, 2016
TIME: **10:00 AM**
LOCATION: **643 LOB**

The following bills will be considered:

BILL NO.	SHORT TITLE	SPONSOR
SB 838	Medicaid Transformation Modifications.	Senator Hise
SB 734	Statewide Standing Order/Opioid Antagonist.	Senator Pate Senator Tucker Senator Robinson

Respectfully,

Representative Justin P. Burr, Co-Chair
Representative Bert Jones, Co-Chair
Representative Donny Lambeth, Co-Chair
Representative Brig Gen (Ret) Gary Pendleton, Co-Chair

I hereby certify this notice was filed by the committee assistant at the following offices at 2:21 PM on Tuesday, May 24, 2016.

___ Principal Clerk
___ Reading Clerk – House Chamber

Brenda Olls (Committee Assistant)

House Committee on Health
Wednesday, May 25, 2016, 10:00 AM
643 Legislative Office Building

AGENDA

Welcome and Opening Remarks

Introduction of Pages

Bills

BILL NO.	SHORT TITLE	SPONSOR
SB 838	Medicaid Transformation Modifications.	Senator Hise
SB 734	Statewide Standing Order/Opioid Antagonist.	Senator Pate Senator Tucker Senator Robinson

Presentations

Other Business

Adjournment

House Committee on Health
Wednesday, May 25, 2016 at 10:00 AM
Room 643 of the Legislative Office Building

MINUTES

The House Committee on Health met at 10:00 AM on May 25, 2016 in Room 643 of the Legislative Office Building. Representatives Adcock, Avila, Bishop, Blackwell, Brisson, Burr, Carney, Dollar, Earle, Ford, Goodman, Hager, Insko, Jones, Lambeth, Lucas, S. Martin, Murphy, Pendleton, Saine, Szoka, Waddell, and Yarborough attended.

Representative Donny Lambeth, Chair, presided.

The following bills were considered:

SB 838 Medicaid Transformation Modifications. (Senator Hise)

Representative Dollar explained the bill. Questions followed, which were answered by Staff and by Dave Richard , DHHS. Representative Insko motioned for a favorable report, unfavorable to the original, favorable to the PCS. The motion passed.

SB 734 Statewide Standing Order/Opioid Antagonist. (Senators Pate, Tucker, Robinson)

Senator Pate, along with Dr. Randall Williams, Deputy Secretary of Health Services, with DHHS, explained the bill. Discussion followed. Representative Avila motioned for a favorable report, with referral to Judiciary 1. The motion passed.

The meeting adjourned at10:30.

Representative Donny Lambeth, Chair
Presiding

Brenda Olls, Committee Clerk

SENATE BILL 838:
Medicaid Transformation Modifications.

2016-2017 General Assembly

Committee:	House Health	**Date:**	May 25, 2016
Introduced by:	Sen. Hise	**Prepared by:**	Jennifer Hillman
Analysis of:	PCS to Second Edition S838-CSTR-9		Staff Attorney

SUMMARY: ***The PCS to Senate bill 838 would require additional reporting on the status of Medicaid transformation planning and implementation and would make modifications proposed by the Department of Health and Human Services (DHHS) to the 2015 Medicaid Transformation session law.***

CURRENT LAW: S.L. 2015-245, An Act to Transform and Reorganize North Carolina's Medicaid and NC Health Choice Programs, became law on September 23, 2015, and provided a legislative framework for the transformation of North Carolina's Medicaid program to provide budget predictability for the taxpayers of the State while ensuring quality care to those in need. S.L. 2015-245 requires transition of the current Medicaid and NC Health Choice programs to capitated contracts with Prepaid Health Plans (PHPs) under an 1115 waiver approved by the Centers for Medicare and Medicaid Services (CMS). S.L. 2015-245 also created the Division of Health Benefits (DHB) within the Department of Health and Human Services (DHHS) to plan for and implement for transformation established by the General Assembly.

BILL ANALYSIS: **Section 1** of the PCS would require DHHS to submit a report to the Joint Legislative Oversight Committee on Medicaid and NC Health Choice (Medicaid Oversight Committee) by October 1, 2016 containing an update on the status of the 1115 waiver submission and responses received from CMS, a detailed Work Plan identifying key milestones, tasks, and events necessary to the transition of the programs, and a description of any other changes relevant to successful implementation of the Medicaid and NC Health Choice transformation. The language in this section was recommended by the Medicaid Oversight Committee in its April 2016 report.

Section 2 of the PCS makes changes proposed by DHHS in its March 1, 2016 report to the Medicaid Oversight Committee. Throughout Section 2, the PCS strikes references that DHHS must act "through the DHB" in conducting activities related to Medicaid transformation. Certain references to the DHB alone are replaced with references to DHHS, clarifying that authority and responsibility in those instances are at the Department level. **Section 2(b)** amends subdivisions (4), (5), and (6) of Section 4 of S.L. 2015-245 to add certain services to the list of services excluded from PHP coverage, add populations to the list of populations excluded from PHP coverage, and increase the maximum number of provider-led entities (PLEs) allowed to enter into a regional PHP contract from 10 to 12. **Section 2(e1)** adds a new Section 9A to S.L. 2015-245 authorizing DHHS to seek approval from CMS through the 1115 waiver to allow parents to retain Medicaid eligibility while their child is being served temporarily by the foster care program and expressing the General Assembly's intent to expand eligibility to cover this population if coverage under the waiver is approved by CMS. **Section 2(f)** clarifies that, until the procedures for appointing the Director of the Division of Health Benefits in G.S. 143B-216.85 become effective in 2021, DHHS has authority to hire the Director of the Division of

This bill analysis was prepared by the nonpartisan legislative staff for the use of legislators in their deliberations and does not constitute an official statement of legislative intent.

Health Benefits. **Sections 2(g) and 2(h)** codify language that was uncodified in S.L. 2015-245 and move language that was previously codified in G.S. 108A-54(g) to G.S. 143B-216.80. **Section 2(i)** clarifies the definition of "administration of a contract" and "former employee of the Department" in G.S. 143B-139.6C, which was enacted as part of S.L. 2015-245 and imposes a cooling-off period for certain Department employees.

EFFECTIVE DATE: The bill is effective when it becomes law.

BACKGROUND: As required by S.L. 2015-245, DHHS, through the DHB, submitted a report to the Medicaid Oversight Committee on March 1, 2016 that described its proposed statutory changes necessary to implement the Medicaid transformation plan. In its April 2016 report, the Medicaid Oversight Committee recommended that the General Assembly consider the legislative changes proposed in DHHS's report and further requested in a special provision to the 2016 Governor's Budget. A copy of the report is available at: http://www.ncleg.net/documentsites/committees/BCCI-6660/Final%20LOC%20Reports%20to%20the%20GA/Medicaid%20Oversight%20Committee%20Report%20April%202016_FINAL.pdf

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2015

S D

SENATE BILL 838
Health Care Committee Substitute Adopted 5/17/16
PROPOSED HOUSE COMMITTEE SUBSTITUTE S838-CSTR-9 [v.7]
05/24/2016 08:20:59 PM

Short Title: Medicaid Transformation Modifications. (Public)

Sponsors:

Referred to:

May 11, 2016

A BILL TO BE ENTITLED

AN ACT TO REQUIRE FURTHER REPORTING FROM THE DEPARTMENT OF HEALTH AND HUMAN SERVICES RELATED TO TRANSFORMATION OF THE MEDICAID AND NC HEALTH CHOICE PROGRAMS AND TO MODIFY CERTAIN PROVISIONS OF THE MEDICAID TRANSFORMATION LEGISLATION.

The General Assembly of North Carolina enacts:

SECTION 1. No later than October 1, 2016, the Department of Health and Human Services shall submit a report to the Joint Legislative Oversight Committee on Medicaid and NC Health Choice and the Fiscal Research Division containing the following items:

(1) The status of the 1115 waiver submission to the Centers for Medicare and Medicaid Services (CMS), as well as any other submissions to CMS related to the transition of Medicaid and NC Health Choice from fee for service to capitation. The report shall specifically address the timeliness of the submission or submissions to CMS, responses received from CMS, and strategies necessary to ensure approval of a waiver for Medicaid transformation.

(2) A detailed Work Plan for the implementation of the transformation of Medicaid and NC Health Choice programs. The Work Plan shall provide sufficient detail to allow the Joint Legislative Oversight Committee on Medicaid and NC Health Choice to monitor progress and identify challenges and impediments to the implementation of the transformation of Medicaid and NC Health Choice programs. The detailed Work Plan shall identify key milestones, tasks, and events necessary to the transition of the programs. For each milestone, task, and event, the Work Plan shall specify the expected completion dates and identify the individual who is assigned responsibility for accomplishing or ensuring the accomplishment of the milestone, task, or event.

(3) A sufficiently detailed description of any developments or changes during the planning process to enable the General Assembly to address any barriers to successful implementation of the Medicaid and NC Heath Choice transformation.

SECTION 2.(a) Section 3 of S.L. 2015-245 reads as rewritten:

"**SECTION 3.** Time Line for Medicaid Transformation. – The following milestones for Medicaid transformation shall occur no later than the following dates:

(1) When this act becomes law. –

a. The Division of Health Benefits of the Department of Health and Human Services (DHHS) is created pursuant to Section 10 of this act.

b. The Joint Legislative Oversight Committee on Medicaid and NC Health Choice is created pursuant to Section 15 of this act to oversee the Medicaid and NC Health Choice programs.

c. ~~The Division of Health Benefits~~ DHHS shall begin development of the 1115 waiver and any other State Plan amendments and waiver amendments necessary to effectuate the Medicaid transformation required by this act.

(2) March 1, 2016. – ~~The DHHS, through the Division of Health Benefits,~~ DHHS shall report its plans and progress on Medicaid transformation, including recommended statutory changes, to the Joint Legislative Oversight Committee on Medicaid and NC Health Choice, as required by subdivision (12) of Section 5 of this act.

(3) On or before June 1, 2016. – ~~The DHHS, through the Division of Health Benefits~~DHHS shall submit the waivers and State Plan amendments required by this act to the Centers for Medicare & Medicaid Services (CMS).

(4) Eighteen months after approval of all necessary waivers and State Plan amendments by CMS. – Capitated contracts shall begin and initial recipient enrollment shall be complete."

SECTION 2.(b) Section 4 of S.L. 2015-245 reads as rewritten:

"**SECTION 4.** Structure of Delivery System. – The transformed Medicaid and NC Health Choice programs described in Section 1 of this act shall be organized according to the following principles and parameters:

(1) DHHS authority. – The Department of Health and Human Services (DHHS) shall have full authority to manage the State's Medicaid and NC Health Choice programs provided that the total expenditures, net of agency receipts, do not exceed the authorized budget for each program, except the General Assembly shall determine eligibility categories and income thresholds. DHHS ~~through the Division of Health Benefits, created in Section 10 of this act,~~ shall be responsible for planning and implementing the Medicaid transformation required by this act.

...

(4) Services covered by PHPs. – Capitated PHP contracts shall cover all Medicaid and NC Health Choice services, including physical health services, prescription drugs, long-term services and supports, and behavioral health services for NC Health Choice recipients, except as otherwise provided in this subdivision. The capitated contracts required by this subdivision shall not cover:

a. Behavioral health services for Medicaid recipients currently covered by the local management entities/managed care organizations (LME/MCOs) ~~shall be excluded from the capitated contracts until~~for at least four years after the date capitated contracts begin.

b. ~~The capitated contracts required by this subdivision shall not cover dental~~Dental services.

c. Services provided through the Program of All-Inclusive Care for the Elderly (PACE).

d. Audiology, speech therapy, occupational therapy, physical therapy, nursing, and psychological services prescribed in an Individualized Education Program (IEP) and performed by schools or individuals contracted with Local Education Agencies.

e. Services provided directly by a Children's Developmental Services Agency (CDSA) or by a provider under contract with a CDSA if the

service is authorized through the CDSA and is included on the child's Individualized Family Service Plan.

f. Services for Medicaid program applicants during the period of time prior to eligibility determination.

(5) Populations covered by PHPs. – Capitated PHP contracts shall cover all Medicaid and NC Health Choice program aid categories except ~~recipients~~ for the following categories:

a. Recipients who are dually eligible for Medicaid and Medicare. Recipients in the aged program aid category that are eligible for Medicare shall be considered recipients who are dually eligible for Medicaid and Medicare. The Division of Health Benefits shall develop a long-term strategy to cover dual eligibles through capitated PHP contracts, as required by subdivision (11) of Section 5 of this act.

b. Qualified aliens subject to the 5-year bar for means-tested public assistance under 8 U.S.C. § 1613 who qualify for emergency services under 8 U.S.C. § 1611.

c. Undocumented aliens who qualify for emergency services under 8 U.S.C. § 1611.

d. Medically needy Medicaid recipients.

e. Members of federally-recognized tribes. Members of federally-recognized tribes shall have the option to enroll voluntarily in PHPs.

f. Presumptively eligible recipients, during the period of presumptive eligibility.

g. Recipients who participate in the North Carolina Health Insurance Premium Payment (NC HIPP) program.

(6) Number and nature of capitated PHP contracts. – The number and nature of the contracts required under subdivision (3) of this section shall be as follows:

a. Three contracts between the Division of Health Benefits and PHPs to provide coverage to Medicaid and NC Health Choice recipients statewide (statewide contracts).

b. Up to ~~10~~12 contracts between the Division of Health Benefits and PLEs for coverage of regions specified by the Division of Health Benefits pursuant to subdivision (2) of Section 5 of this act (regional contracts). Regional contracts shall be in addition to the three statewide contracts required under sub-subdivision a. of this subdivision. Each regional contract shall provide coverage throughout the entire region for the Medicaid and NC Health Choice services required by subdivision (4) of this section. A PLE may bid for more than one regional contract, provided that the regions are contiguous.

c. Initial capitated PHP contracts may be awarded on staggered terms of three to five years in duration to ensure against gaps in coverage that may result from termination of a contract by the PHP or the State.

...."

SECTION 2.(c) Section 5 of S.L. 2015-245 reads as rewritten:

"**SECTION 5.** Role of DHHS. – The role and responsibility of ~~DHHS, through the Division of Health Benefits,~~ DHHS during Medicaid transformation shall include the following activities and functions:

...

(6) Enter into capitated PHP contracts for the delivery of the Medicaid and NC Health Choice services described in subdivision (4) of Section 4 of this act. All

contracts shall be the result of requests for proposals (RFPs) issued by DHHS and the submission of competitive bids by PHPs. ~~DHHS, through the Division of Health Benefits,~~ DHHS shall develop standardized contract terms, to include at a minimum, the following:

a. Risk-adjusted cost growth for its enrollees must be at least two percentage (2%) points below national Medicaid spending growth as documented and projected in the annual report prepared for CMS by the Office of the Actuary for nonexpansion states.

b. A requirement that PHP spending for prescribed drugs, net of rebates, ensures the State realizes a net savings for the spending on prescription drugs. All PHPs shall be required to use the same drug formulary, which shall be established by ~~DHHS, through the Division of Health Benefits.~~DHHS.

c. Until final federal regulations are promulgated governing medical loss ratio, a minimum medical loss ratio of eighty-eight percent (88%) for health care services, with the components of the numerator and denominator to be defined by ~~DHHS, through the Division of Health Benefits.~~DHHS.

d. A requirement that PHPs develop and maintain provider networks that meet access to care requirements for their enrollees. PHPs may not exclude providers from their networks except for failure to meet objective quality standards or refusal to accept network rates. Notwithstanding the previous sentence, PHPs must include all providers in their geographical coverage area that are designated essential providers by DHHS pursuant to subdivision (13) of this section, unless DHHS approves an alternative arrangement for securing the types of services offered by the essential providers.

e. A requirement that all PHPs assure that enrollees who do not elect a primary care provider will be assigned to one.

...

(11) Develop a Dual Eligibles Advisory Committee, which must include at least a reasonably representative sample of the populations receiving long-term services and supports covered by Medicaid. ~~The Division of Health Benefits,~~DHHS, upon the advice of the Dual Eligibles Advisory Committee, shall develop a long-term strategy to cover dual eligibles through capitated PHP contracts and report the strategy to the Joint Legislative Oversight Committee on Medicaid and NC Health Choice by January 31, 2017.

...

(13) Designate Medicaid and NC Health Choice providers as essential providers if the provider either offers services that are not available from any other provider within a reasonable access standard or provides a substantial share of the total units of a particular service utilized by Medicaid and NC Health Choice recipients within the region during the last three years, and the combined capacity of other service providers in the region is insufficient to meet the total needs of the Medicaid and NC Health Choice enrollees. DHHS shall not classify physicians and other practitioners as essential providers. At a minimum, providers in the following categories shall be designated essential providers:

a. Federally qualified health centers.

b. Rural health centers.

c. Free clinics.

d. Local health departments.
e. State Veterans Homes."

SECTION 2.(d) Section 8 of S.L. 2015-245 reads as rewritten:

"**SECTION 8.** Innovations Center. – DHHS shall submit a program design and budget proposal no later than May 1, 2016, to the Joint Legislative Oversight Committee on Medicaid and NC Health Choice that will create a Medicaid and NC Health Choice Transformation Innovations Center ~~within the Division of Health Benefits~~ with the purpose of assisting Medicaid and NC Health Choice providers in achieving the ultimate goals of better health, better care, and lower costs for North Carolinians. The center should be designed to support providers through technical assistance and learning collaboratives that foster peer-to-peer sharing of best practices. DHHS shall use the Oregon Health Authority's Transformation Center as a design model and shall consider at least the following features:

(1) Learning collaboratives, peer-to-peer networks.
(2) Clinical standards and supports.
(3) Innovator agents.
(4) Council of Clinical Innovators.
(5) Community and stakeholder engagement.
(6) Conferences and workshops.
(7) Technical assistance.
(8) Infrastructure support."

SECTION 2.(e) Section 9 of S.L. 2015-245 reads as rewritten:

"**SECTION 9.** Maintain Funding Mechanisms. – In developing the waivers and State Plan amendments necessary to implement this act, ~~the Department of Health and Human Services, through the Division of Health Benefits created in Section 10 of this act,~~DHHS shall work with the Centers for Medicare & Medicaid Services (CMS) to attempt to preserve existing levels of funding generated from Medicaid-specific funding streams, such as assessments, to the extent that the levels of funding may be preserved. If such Medicaid-specific funding cannot be maintained as currently implemented, then ~~the Division of Health Benefits~~DHHS shall advise the Joint Legislative Oversight Committee on Medicaid and NC Health Choice, created in Section 15 of this act, of any modifications necessary to maintain as much revenue as possible within the context of Medicaid transformation. If such Medicaid-specific funding streams cannot be preserved through the transformation process or if revenue would decrease, it is the intent of the General Assembly to modify such funding streams so that any supplemental payments to providers are more closely aligned to improving health outcomes and achieving overall Medicaid goals."

SECTION 2.(e1) S.L. 2015-245 is amended by adding a new section to read:

"**SECTION 9A.** Eligibility for Parents of Children in Foster Care. – DHHS is authorized to seek approval from CMS through the 1115 waiver required by subdivision (1) of Section 5 of this act to allow parents to retain Medicaid eligibility while their child is being served temporarily by the foster care program. It is the intent of the General Assembly to expand Medicaid eligibility to cover this population upon implementation of the 1115 waiver, if CMS approves this coverage in the waiver."

SECTION 2.(f) Section 10 of S.L. 2015-245 reads as rewritten:

"**SECTION 10.** Creation of the Division of Health Benefits. – The Division of Health Benefits is established as a new division of the Department of Health and Human Services. ~~The Department of Health and Human Services, through the Division of Health Benefits, shall be responsible for implementing Medicaid transformation required by this act and shall administer and operate all functions, powers, duties, obligations, and services related to the transformed Medicaid and NC Health Choice programs.~~ The Division of Medical Assistance shall continue to operate the current Medicaid and NC Health Choice programs until the Division of Medical Assistance is eliminated. Upon the elimination of the Division of Medical Assistance, all

functions, powers, duties, obligations, and services vested in the Division of Medical Assistance of the Department of Health and Human Services are vested in the Division of Health Benefits. The Department of Health and Human Services shall remain the Medicaid single State ~~agency.~~ agency and shall be responsible for implementing Medicaid transformation required by this act and shall administer and operate all functions, powers, duties, obligations, and services related to the transformed Medicaid and NC Health Choice programs. Prior to the effective date of G.S. 143B-216.85, the Secretary of DHHS may appoint a Director of the Division of Health Benefits."

SECTION 2.(g) G.S. 143B-216.80 reads as rewritten:

"**§ 143B-216.80. Division of Health Benefits – creation and organization.**

(a) There is hereby established the Division of Health Benefits of the Department of Health and Human Services. The Director shall be the head of the Division of Health Benefits. Upon the elimination of the Division of Medical Assistance, the Division of Health Benefits shall be vested with all functions, powers, duties, obligations, and services previously vested in the Division of Medical Assistance. The Department of Health and Human ~~Services, through the Division of Health Benefits,~~ Services shall have the powers and duties described in ~~G.S. 108A-54(e). The Director shall be the head of the Division of Health Benefits.~~ G.S. 108A-54(e) in addition to the powers and duties already vested in the Department.

(b) Although generally subject to the laws of this State, the following exemptions, limitations, and modifications apply to the Division of Health Benefits of the Department of Health and Human Services, notwithstanding any other provision of law:

(1) Employees of the Division of Health Benefits shall not be subject to the North Carolina Human Resources Act, except as provided in G.S. 126-5(c1)(31).

(2) The Secretary may retain private legal counsel and is not subject to G.S. 114-2.3 or G.S. 147-17(a) through (c).

(3) The Division of Health Benefits' employment contracts offered pursuant to G.S. 108A-54(e)(2) are not subject to review and approval by the Office of State Human Resources.

(4) If the Secretary establishes alternative procedures for the review and approval of contracts, then the Division of Health Benefits is exempt from State contract review and approval requirements but still may choose to utilize the State contract review and approval procedures for particular contracts."

SECTION 2.(h) G.S. 108A-54 reads as rewritten:

"**§ 108A-54. Authorization of Medical Assistance Program; administration.**

...

(e) The Department of Health and Human Services shall continue to administer and operate the Medicaid and NC Health Choice programs through the Division of Medical Assistance until the Division of Medical Assistance is eliminated at which time all functions, powers, duties, obligations, and services vested in the Division of Medical Assistance are vested in the Division of Health Benefits. Prior to and following the exchange of powers and duties from the Division of Medical Assistance to the Division of Health Benefits, and in addition to the powers and duties already vested in the Secretary of the Department of Health and Human Services, the Secretary of the Department of Health and Human ~~Services, through the Division of Health Benefits,~~ Services shall have the following powers and duties:

(1) Administer and operate the Medicaid and NC Health Choice programs, provided that the total expenditures, net of agency receipts, do not exceed the authorized budget for ~~each program.~~the Medicaid program and NC Health Choice program. None of the powers and duties enumerated in the other subdivisions of this subsection shall be construed to limit the broad grant of authority to administer and operate the Medicaid and NC Health Choice programs.

(2) Employ clerical and professional staff of the Division of Health Benefits, including consultants and legal counsel, necessary to carry out the powers and duties of the division. In hiring staff for the Division of Health Benefits, the Secretary may offer employment contracts for a term and set compensation for the employees, which may include performance-based bonuses based on meeting budget or other targets.

(3) Notwithstanding G.S. 143-64.20, enter into contracts for the administration of the Medicaid and NC Health Choice programs, as well as manage such contracts, including contracts of a consulting or advisory nature.

(4) Establish and adjust all program components, except for eligibility categories and income thresholds, of the Medicaid and NC Health Choice programs within the appropriated and allocated budget.

(5) Adopt rules related to the Medicaid and NC Health Choice programs.

(6) Develop midyear budget correction plans and strategies and then take midyear budget corrective actions necessary to keep the Medicaid and NC Health Choice programs within budget.

(7) Approve or disapprove and oversee all expenditures to be charged to or allocated to the Medicaid and NC Health Choice programs by other State departments or agencies.

(8) Develop and present to the Joint Legislative Oversight Committee on Medicaid and NC Health Choice and the Office of State Budget and Management by January 1 of each year, beginning in 2017, the following information for the Medicaid and NC Health Choice programs:

a. A detailed four-year forecast of expected changes to enrollment growth and enrollment mix.

b. What program changes will be made by the Department in order to stay within the existing budget for the programs based on the next fiscal year's forecasted enrollment growth and enrollment mix.

c. The cost to maintain the current level of services based on the next fiscal year's forecasted enrollment growth and enrollment mix.

(9) Publish on its Web site and update on at least a monthly basis, at a minimum, the following information about the Medicaid and NC Health Choice programs:

a. Enrollment by program aid category by county.

b. Per member per month spending by category of service.

c. Spending and receipts by fund along with a detailed variance analysis.

d. A comparison of the above figures to the amounts forecasted and budgeted for the corresponding time period.

(f) The General Assembly shall determine the eligibility categories and income thresholds for the Medicaid and NC Health Choice programs. The Department of Health and Human ~~Services, through the Division of Health Benefits,~~ Services is expressly authorized to adopt temporary and permanent rules regarding eligibility requirements and determinations, to the extent that they do not conflict with the parameters set by the General Assembly.

~~(g) Although generally subject to the laws of this State, the following exemptions, limitations, and modifications apply to the Division of Health Benefits of the Department of Health and Human Services, notwithstanding any other provision of law:~~

~~(1) Employees of the Division of Health Benefits shall not be subject to the North Carolina Human Resources Act, except as provided in G.S. 126-5(c1)(31).~~

~~(2) The Secretary may retain private legal counsel and is not subject to G.S. 114-2.3 or G.S. 147-17(a) through (c).~~

~~(3) The Division of Health Benefits' employment contracts offered pursuant to G.S. 108A-54(e)(2) are not subject to review and approval by the Office of State Human Resources.~~

~~(4) If the Secretary establishes alternative procedures for the review and approval of contracts, then the Division of Health Benefits is exempt from State contract review and approval requirements but may still choose to utilize the State contract review and approval procedures for particular contracts.~~"

SECTION 2.(i) G.S. 143B-139.6C reads as rewritten:

"**§ 143B-139.6C. Cooling-off period for certain Department employees.**

(a) Ineligible Vendors. – The Secretary of the Department of Health and Human Services shall not contract for goods or services with a vendor that employs or contracts with a person who is a former employee of the Department and uses that person in the administration of a contract with the Department.

(b) Vendor Certification. – The Secretary shall require each vendor submitting a bid or contract to certify that the vendor will not use a former employee of the Department in the administration of a contract with the Department in violation of the provisions of subsection (a) of this section.

(c) A violation of the provisions of this section shall void the contract.

(d) Definitions. – As used in this section, the following terms mean:

(1) Administration of a contract. – ~~Oversight~~The former employee's duties and responsibilities for the vendor include oversight of the performance of a contract, or authority to make decisions regarding a contract, including interpretation of a contract, ~~or participation in the~~ development of specifications or terms of a ~~contract or in the preparation~~ contract, or award of a contract.

(2) Former employee of the Department. – A person who, for any period within the preceding six months, was employed as an employee or contract employee of the Department of Health and Human ~~Services, and in the six months immediately preceding termination of State employment, participated personally in either the award or management of a Department contract with the vendor, or made regulatory or licensing decisions that directly applied to the vendor.~~ Services and personally participated in any of the following:

a. The award of a contract to the vendor.

b. An audit, decision, investigation, or other action affecting the vendor.

c. Regulatory or licensing decisions that applied to the vendor."

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

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2015

S D

SENATE BILL 838
Health Care Committee Substitute Adopted 5/17/16
PROPOSED HOUSE COMMITTEE SUBSTITUTE S838-PCS45503-TR-9

Short Title: Medicaid Transformation Modifications. (Public)

Sponsors:

Referred to:

May 11, 2016

A BILL TO BE ENTITLED

AN ACT TO REQUIRE FURTHER REPORTING FROM THE DEPARTMENT OF HEALTH AND HUMAN SERVICES RELATED TO TRANSFORMATION OF THE MEDICAID AND NC HEALTH CHOICE PROGRAMS AND TO MODIFY CERTAIN PROVISIONS OF THE MEDICAID TRANSFORMATION LEGISLATION.

The General Assembly of North Carolina enacts:

SECTION 1. No later than October 1, 2016, the Department of Health and Human Services shall submit a report to the Joint Legislative Oversight Committee on Medicaid and NC Health Choice and the Fiscal Research Division containing the following items:

(1) The status of the 1115 waiver submission to the Centers for Medicare and Medicaid Services (CMS), as well as any other submissions to CMS related to the transition of Medicaid and NC Health Choice from fee for service to capitation. The report shall specifically address the timeliness of the submission or submissions to CMS, responses received from CMS, and strategies necessary to ensure approval of a waiver for Medicaid transformation.

(2) A detailed Work Plan for the implementation of the transformation of Medicaid and NC Health Choice programs. The Work Plan shall provide sufficient detail to allow the Joint Legislative Oversight Committee on Medicaid and NC Health Choice to monitor progress and identify challenges and impediments to the implementation of the transformation of Medicaid and NC Health Choice programs. The detailed Work Plan shall identify key milestones, tasks, and events necessary to the transition of the programs. For each milestone, task, and event, the Work Plan shall specify the expected completion dates and identify the individual who is assigned responsibility for accomplishing or ensuring the accomplishment of the milestone, task, or event.

(3) A sufficiently detailed description of any developments or changes during the planning process to enable the General Assembly to address any barriers to successful implementation of the Medicaid and NC Health Choice transformation.

SECTION 2.(a) Section 3 of S.L. 2015-245 reads as rewritten:

"**SECTION 3.** Time Line for Medicaid Transformation. – The following milestones for Medicaid transformation shall occur no later than the following dates:

(1) When this act becomes law. –

a. The Division of Health Benefits of the Department of Health and Human Services (DHHS) is created pursuant to Section 10 of this act.

b. The Joint Legislative Oversight Committee on Medicaid and NC Health Choice is created pursuant to Section 15 of this act to oversee the Medicaid and NC Health Choice programs.

c. ~~The Division of Health Benefits~~ DHHS shall begin development of the 1115 waiver and any other State Plan amendments and waiver amendments necessary to effectuate the Medicaid transformation required by this act.

(2) March 1, 2016. – ~~The DHHS, through the Division of Health Benefits,~~ DHHS shall report its plans and progress on Medicaid transformation, including recommended statutory changes, to the Joint Legislative Oversight Committee on Medicaid and NC Health Choice, as required by subdivision (12) of Section 5 of this act.

(3) On or before June 1, 2016. – ~~The DHHS, through the Division of Health Benefits~~ DHHS shall submit the waivers and State Plan amendments required by this act to the Centers for Medicare & Medicaid Services (CMS).

(4) Eighteen months after approval of all necessary waivers and State Plan amendments by CMS. – Capitated contracts shall begin and initial recipient enrollment shall be complete."

SECTION 2.(b) Section 4 of S.L. 2015-245 reads as rewritten:

"**SECTION 4.** Structure of Delivery System. – The transformed Medicaid and NC Health Choice programs described in Section 1 of this act shall be organized according to the following principles and parameters:

(1) DHHS authority. – The Department of Health and Human Services (DHHS) shall have full authority to manage the State's Medicaid and NC Health Choice programs provided that the total expenditures, net of agency receipts, do not exceed the authorized budget for each program, except the General Assembly shall determine eligibility categories and income thresholds. DHHS ~~through the Division of Health Benefits, created in Section 10 of this act,~~ shall be responsible for planning and implementing the Medicaid transformation required by this act.

...

(4) Services covered by PHPs. – Capitated PHP contracts shall cover all Medicaid and NC Health Choice services, including physical health services, prescription drugs, long-term services and supports, and behavioral health services for NC Health Choice recipients, except as otherwise provided in this subdivision. The capitated contracts required by this subdivision shall not cover:

a. Behavioral health services for Medicaid recipients currently covered by the local management entities/managed care organizations (LME/MCOs) ~~shall be excluded from the capitated contracts until~~ for at least four years after the date capitated contracts begin.

b. ~~The capitated contracts required by this subdivision shall not cover dental~~ Dental services.

c. Services provided through the Program of All-Inclusive Care for the Elderly (PACE).

d. Audiology, speech therapy, occupational therapy, physical therapy, nursing, and psychological services prescribed in an Individualized Education Program (IEP) and performed by schools or individuals contracted with Local Education Agencies.

e. Services provided directly by a Children's Developmental Services Agency (CDSA) or by a provider under contract with a CDSA if the

service is authorized through the CDSA and is included on the child's Individualized Family Service Plan.

f. Services for Medicaid program applicants during the period of time prior to eligibility determination.

(5) Populations covered by PHPs. – Capitated PHP contracts shall cover all Medicaid and NC Health Choice program aid categories except ~~recipients~~ for the following categories:

a. Recipients who are dually eligible for Medicaid and Medicare. Recipients in the aged program aid category that are eligible for Medicare shall be considered recipients who are dually eligible for Medicaid and Medicare. The Division of Health Benefits shall develop a long-term strategy to cover dual eligibles through capitated PHP contracts, as required by subdivision (11) of Section 5 of this act.

b. Qualified aliens subject to the five-year bar for means-tested public assistance under 8 U.S.C. § 1613 who qualify for emergency services under 8 U.S.C. § 1611.

c. Undocumented aliens who qualify for emergency services under 8 U.S.C. § 1611.

d. Medically needy Medicaid recipients.

e. Members of federally recognized tribes. Members of federally recognized tribes shall have the option to enroll voluntarily in PHPs.

f. Presumptively eligible recipients, during the period of presumptive eligibility.

g. Recipients who participate in the North Carolina Health Insurance Premium Payment (NC HIPP) program.

(6) Number and nature of capitated PHP contracts. – The number and nature of the contracts required under subdivision (3) of this section shall be as follows:

a. Three contracts between the Division of Health Benefits and PHPs to provide coverage to Medicaid and NC Health Choice recipients statewide (statewide contracts).

b. Up to ~~10~~12 contracts between the Division of Health Benefits and PLEs for coverage of regions specified by the Division of Health Benefits pursuant to subdivision (2) of Section 5 of this act (regional contracts). Regional contracts shall be in addition to the three statewide contracts required under sub-subdivision a. of this subdivision. Each regional contract shall provide coverage throughout the entire region for the Medicaid and NC Health Choice services required by subdivision (4) of this section. A PLE may bid for more than one regional contract, provided that the regions are contiguous.

c. Initial capitated PHP contracts may be awarded on staggered terms of three to five years in duration to ensure against gaps in coverage that may result from termination of a contract by the PHP or the State.

...."

SECTION 2.(c) Section 5 of S.L. 2015-245 reads as rewritten:

"**SECTION 5.** Role of DHHS. – The role and responsibility of ~~DHHS, through the Division of Health Benefits,~~ DHHS during Medicaid transformation shall include the following activities and functions:

...

(6) Enter into capitated PHP contracts for the delivery of the Medicaid and NC Health Choice services described in subdivision (4) of Section 4 of this act. All contracts shall be the result of requests for proposals (RFPs) issued by DHHS

and the submission of competitive bids by PHPs. ~~DHHS, through the Division of Health Benefits,~~ DHHS shall develop standardized contract terms, to include at a minimum, the following:

a. Risk-adjusted cost growth for its enrollees must be at least two percentage (2%) points below national Medicaid spending growth as documented and projected in the annual report prepared for CMS by the Office of the Actuary for nonexpansion states.

b. A requirement that PHP spending for prescribed drugs, net of rebates, ensures the State realizes a net savings for the spending on prescription drugs. All PHPs shall be required to use the same drug formulary, which shall be established by ~~DHHS, through the Division of Health Benefits.~~DHHS.

c. Until final federal regulations are promulgated governing medical loss ratio, a minimum medical loss ratio of eighty-eight percent (88%) for health care services, with the components of the numerator and denominator to be defined by ~~DHHS, through the Division of Health Benefits.~~DHHS.

d. A requirement that PHPs develop and maintain provider networks that meet access to care requirements for their enrollees. PHPs may not exclude providers from their networks except for failure to meet objective quality standards or refusal to accept network rates. Notwithstanding the previous sentence, PHPs must include all providers in their geographical coverage area that are designated essential providers by DHHS pursuant to subdivision (13) of this section, unless DHHS approves an alternative arrangement for securing the types of services offered by the essential providers.

e. A requirement that all PHPs assure that enrollees who do not elect a primary care provider will be assigned to one.

...

(11) Develop a Dual Eligibles Advisory Committee, which must include at least a reasonably representative sample of the populations receiving long-term services and supports covered by Medicaid. ~~The Division of Health Benefits,~~DHHS, upon the advice of the Dual Eligibles Advisory Committee, shall develop a long-term strategy to cover dual eligibles through capitated PHP contracts and report the strategy to the Joint Legislative Oversight Committee on Medicaid and NC Health Choice by January 31, 2017.

...

(13) Designate Medicaid and NC Health Choice providers as essential providers if the provider either offers services that are not available from any other provider within a reasonable access standard or provides a substantial share of the total units of a particular service utilized by Medicaid and NC Health Choice recipients within the region during the last three years, and the combined capacity of other service providers in the region is insufficient to meet the total needs of the Medicaid and NC Health Choice enrollees. DHHS shall not classify physicians and other practitioners as essential providers. At a minimum, providers in the following categories shall be designated essential providers:

a. Federally qualified health centers.

b. Rural health centers.

c. Free clinics.

d. Local health departments.

e. State Veterans Homes."

SECTION 2.(d) Section 8 of S.L. 2015-245 reads as rewritten:

"**SECTION 8.** Innovations Center. – DHHS shall submit a program design and budget proposal no later than May 1, 2016, to the Joint Legislative Oversight Committee on Medicaid and NC Health Choice that will create a Medicaid and NC Health Choice Transformation Innovations Center ~~within the Division of Health Benefits~~ with the purpose of assisting Medicaid and NC Health Choice providers in achieving the ultimate goals of better health, better care, and lower costs for North Carolinians. The center should be designed to support providers through technical assistance and learning collaboratives that foster peer-to-peer sharing of best practices. DHHS shall use the Oregon Health Authority's Transformation Center as a design model and shall consider at least the following features:

(1) Learning collaboratives, peer-to-peer networks.
(2) Clinical standards and supports.
(3) Innovator agents.
(4) Council of Clinical Innovators.
(5) Community and stakeholder engagement.
(6) Conferences and workshops.
(7) Technical assistance.
(8) Infrastructure support."

SECTION 2.(e) Section 9 of S.L. 2015-245 reads as rewritten:

"**SECTION 9.** Maintain Funding Mechanisms. – In developing the waivers and State Plan amendments necessary to implement this act, ~~the Department of Health and Human Services, through the Division of Health Benefits created in Section 10 of this act,~~DHHS shall work with the Centers for Medicare & Medicaid Services (CMS) to attempt to preserve existing levels of funding generated from Medicaid-specific funding streams, such as assessments, to the extent that the levels of funding may be preserved. If such Medicaid-specific funding cannot be maintained as currently implemented, then ~~the Division of Health Benefits~~DHHS shall advise the Joint Legislative Oversight Committee on Medicaid and NC Health Choice, created in Section 15 of this act, of any modifications necessary to maintain as much revenue as possible within the context of Medicaid transformation. If such Medicaid-specific funding streams cannot be preserved through the transformation process or if revenue would decrease, it is the intent of the General Assembly to modify such funding streams so that any supplemental payments to providers are more closely aligned to improving health outcomes and achieving overall Medicaid goals."

SECTION 2.(e1) S.L. 2015-245 is amended by adding a new section to read:

"**SECTION 9A.** Eligibility for Parents of Children in Foster Care. – DHHS is authorized to seek approval from CMS through the 1115 waiver required by subdivision (1) of Section 5 of this act to allow parents to retain Medicaid eligibility while their child is being served temporarily by the foster care program. It is the intent of the General Assembly to expand Medicaid eligibility to cover this population upon implementation of the 1115 waiver, if CMS approves this coverage in the waiver."

SECTION 2.(f) Section 10 of S.L. 2015-245 reads as rewritten:

"**SECTION 10.** Creation of the Division of Health Benefits. – The Division of Health Benefits is established as a new division of the Department of Health and Human Services. ~~The Department of Health and Human Services, through the Division of Health Benefits, shall be responsible for implementing Medicaid transformation required by this act and shall administer and operate all functions, powers, duties, obligations, and services related to the transformed Medicaid and NC Health Choice programs.~~ The Division of Medical Assistance shall continue to operate the current Medicaid and NC Health Choice programs until the Division of Medical Assistance is eliminated. Upon the elimination of the Division of Medical Assistance, all functions, powers, duties, obligations, and services vested in the Division of Medical Assistance of

the Department of Health and Human Services are vested in the Division of Health Benefits. The Department of Health and Human Services shall remain the Medicaid single State ~~agency.~~agency and shall be responsible for implementing Medicaid transformation required by this act and shall administer and operate all functions, powers, duties, obligations, and services related to the transformed Medicaid and NC Health Choice programs. Prior to the effective date of G.S. 143B-216.85, the Secretary of DHHS may appoint a Director of the Division of Health Benefits."

SECTION 2.(g) G.S. 143B-216.80 reads as rewritten:

"**§ 143B-216.80. Division of Health Benefits – creation and organization.**

(a) There is hereby established the Division of Health Benefits of the Department of Health and Human Services. The Director shall be the head of the Division of Health Benefits. Upon the elimination of the Division of Medical Assistance, the Division of Health Benefits shall be vested with all functions, powers, duties, obligations, and services previously vested in the Division of Medical Assistance. The Department of Health and Human ~~Services, through the Division of Health Benefits,~~ Services shall have the powers and duties described in ~~G.S. 108A-54(e). The Director shall be the head of the Division of Health Benefits.~~G.S. 108A-54(e) in addition to the powers and duties already vested in the Department.

(b) Although generally subject to the laws of this State, the following exemptions, limitations, and modifications apply to the Division of Health Benefits of the Department of Health and Human Services, notwithstanding any other provision of law:

(1) Employees of the Division of Health Benefits shall not be subject to the North Carolina Human Resources Act, except as provided in G.S. 126-5(c1)(31).

(2) The Secretary may retain private legal counsel and is not subject to G.S. 114-2.3 or G.S. 147-17(a) through (c).

(3) The Division of Health Benefits' employment contracts offered pursuant to G.S. 108A-54(e)(2) are not subject to review and approval by the Office of State Human Resources.

(4) If the Secretary establishes alternative procedures for the review and approval of contracts, then the Division of Health Benefits is exempt from State contract review and approval requirements but still may choose to utilize the State contract review and approval procedures for particular contracts."

SECTION 2.(h) G.S. 108A-54 reads as rewritten:

"**§ 108A-54. Authorization of Medical Assistance Program; administration.**

...

(e) The Department of Health and Human Services shall continue to administer and operate the Medicaid and NC Health Choice programs through the Division of Medical Assistance until the Division of Medical Assistance is eliminated at which time all functions, powers, duties, obligations, and services vested in the Division of Medical Assistance are vested in the Division of Health Benefits. Prior to and following the exchange of powers and duties from the Division of Medical Assistance to the Division of Health Benefits, and in addition to the powers and duties already vested in the Secretary of the Department of Health and Human Services, the Secretary of the Department of Health and Human ~~Services, through the Division of Health Benefits,~~ Services shall have the following powers and duties:

(1) Administer and operate the Medicaid and NC Health Choice programs, provided that the total expenditures, net of agency receipts, do not exceed the authorized budget for ~~each program.~~the Medicaid program and NC Health Choice program. None of the powers and duties enumerated in the other subdivisions of this subsection shall be construed to limit the broad grant of authority to administer and operate the Medicaid and NC Health Choice programs.

(2) Employ clerical and professional staff of the Division of Health Benefits, including consultants and legal counsel, necessary to carry out the powers and duties of the division. In hiring staff for the Division of Health Benefits, the Secretary may offer employment contracts for a term and set compensation for the employees, which may include performance-based bonuses based on meeting budget or other targets.

(3) Notwithstanding G.S. 143-64.20, enter into contracts for the administration of the Medicaid and NC Health Choice programs, as well as manage such contracts, including contracts of a consulting or advisory nature.

(4) Establish and adjust all program components, except for eligibility categories and income thresholds, of the Medicaid and NC Health Choice programs within the appropriated and allocated budget.

(5) Adopt rules related to the Medicaid and NC Health Choice programs.

(6) Develop midyear budget correction plans and strategies and then take midyear budget corrective actions necessary to keep the Medicaid and NC Health Choice programs within budget.

(7) Approve or disapprove and oversee all expenditures to be charged to or allocated to the Medicaid and NC Health Choice programs by other State departments or agencies.

(8) Develop and present to the Joint Legislative Oversight Committee on Medicaid and NC Health Choice and the Office of State Budget and Management by January 1 of each year, beginning in 2017, the following information for the Medicaid and NC Health Choice programs:

a. A detailed four-year forecast of expected changes to enrollment growth and enrollment mix.

b. What program changes will be made by the Department in order to stay within the existing budget for the programs based on the next fiscal year's forecasted enrollment growth and enrollment mix.

c. The cost to maintain the current level of services based on the next fiscal year's forecasted enrollment growth and enrollment mix.

(9) Publish on its Web site and update on at least a monthly basis, at a minimum, the following information about the Medicaid and NC Health Choice programs:

a. Enrollment by program aid category by county.

b. Per member per month spending by category of service.

c. Spending and receipts by fund along with a detailed variance analysis.

d. A comparison of the above figures to the amounts forecasted and budgeted for the corresponding time period.

(f) The General Assembly shall determine the eligibility categories and income thresholds for the Medicaid and NC Health Choice programs. The Department of Health and Human ~~Services, through the Division of Health Benefits,~~ Services is expressly authorized to adopt temporary and permanent rules regarding eligibility requirements and determinations, to the extent that they do not conflict with the parameters set by the General Assembly.

~~(g) Although generally subject to the laws of this State, the following exemptions, limitations, and modifications apply to the Division of Health Benefits of the Department of Health and Human Services, notwithstanding any other provision of law:~~

~~(1) Employees of the Division of Health Benefits shall not be subject to the North Carolina Human Resources Act, except as provided in G.S. 126-5(c1)(31).~~

~~(2) The Secretary may retain private legal counsel and is not subject to G.S. 114-2.3 or G.S. 147-17(a) through (c).~~

~~(3) The Division of Health Benefits' employment contracts offered pursuant to G.S. 108A-54(e)(2) are not subject to review and approval by the Office of State Human Resources.~~

~~(4) If the Secretary establishes alternative procedures for the review and approval of contracts, then the Division of Health Benefits is exempt from State contract review and approval requirements but may still choose to utilize the State contract review and approval procedures for particular contracts.~~"

SECTION 2.(i) G.S. 143B-139.6C reads as rewritten:

"**§ 143B-139.6C. Cooling-off period for certain Department employees.**

(a) Ineligible Vendors. – The Secretary of the Department of Health and Human Services shall not contract for goods or services with a vendor that employs or contracts with a person who is a former employee of the Department and uses that person in the administration of a contract with the Department.

(b) Vendor Certification. – The Secretary shall require each vendor submitting a bid or contract to certify that the vendor will not use a former employee of the Department in the administration of a contract with the Department in violation of the provisions of subsection (a) of this section.

(c) A violation of the provisions of this section shall void the contract.

(d) Definitions. – As used in this section, the following terms mean:

(1) Administration of a contract. – ~~Oversight~~ The former employee's duties and responsibilities for the vendor include oversight of the performance of a contract, or authority to make decisions regarding a contract, including interpretation of a contract, ~~or participation in the~~ development of specifications or terms of a ~~contract or in the preparation~~ contract, or award of a contract.

(2) Former employee of the Department. – A person who, for any period within the preceding six months, was employed as an employee or contract employee of the Department of Health and Human ~~Services, and in the six months immediately preceding termination of State employment, participated personally in either the award or management of a Department contract with the vendor, or made regulatory or licensing decisions that directly applied to the vendor.~~Services and personally participated in any of the following:

a. The award of a contract to the vendor.

b. An audit, decision, investigation, or other action affecting the vendor.

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

SENATE BILL 838*
Health Care Committee Substitute Adopted 5/17/16

Short Title: Medicaid Transformation Modifications. (Public)

Sponsors:

Referred to:

May 11, 2016

A BILL TO BE ENTITLED

AN ACT TO REQUIRE FURTHER REPORTING FROM THE DEPARTMENT OF HEALTH AND HUMAN SERVICES RELATED TO TRANSFORMATION OF THE MEDICAID AND NC HEALTH CHOICE PROGRAMS AND TO MODIFY CERTAIN PROVISIONS OF THE MEDICAID TRANSFORMATION LEGISLATION.

The General Assembly of North Carolina enacts:

SECTION 1. No later than October 1, 2016, the Department of Health and Human Services shall submit a report to the Joint Legislative Oversight Committee on Medicaid and NC Health Choice and the Fiscal Research Division containing the following items:

(1) The status of the 1115 waiver submission to the Centers for Medicare and Medicaid Services (CMS), as well as any other submissions to CMS related to the transition of Medicaid and NC Health Choice from fee for service to capitation. The report shall specifically address the timeliness of the submission or submissions to CMS, responses received from CMS, and strategies necessary to ensure approval of a waiver for Medicaid transformation.

(2) A detailed Work Plan for the implementation of the transformation of Medicaid and NC Health Choice programs. The Work Plan shall provide sufficient detail to allow the Joint Legislative Oversight Committee on Medicaid and NC Health Choice to monitor progress and identify challenges and impediments to the implementation of the transformation of Medicaid and NC Health Choice programs. The detailed Work Plan shall identify key milestones, tasks, and events necessary to the transition of the programs. For each milestone, task, and event, the Work Plan shall specify the expected completion dates and identify the individual who is assigned responsibility for accomplishing or ensuring the accomplishment of the milestone, task, or event.

(3) A sufficiently detailed description of any developments or changes during the planning process to enable the General Assembly to address any barriers to successful implementation of the Medicaid and NC Health Choice transformation.

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"**SECTION 3.** Time Line for Medicaid Transformation. – The following milestones for Medicaid transformation shall occur no later than the following dates:

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b. The Joint Legislative Oversight Committee on Medicaid and NC Health Choice is created pursuant to Section 15 of this act to oversee the Medicaid and NC Health Choice programs.

c. ~~The Division of Health Benefits~~ DHHS shall begin development of the 1115 waiver and any other State Plan amendments and waiver amendments necessary to effectuate the Medicaid transformation required by this act.

(2) March 1, 2016. – ~~The DHHS, through the Division of Health Benefits,~~ DHHS shall report its plans and progress on Medicaid transformation, including recommended statutory changes, to the Joint Legislative Oversight Committee on Medicaid and NC Health Choice, as required by subdivision (12) of Section 5 of this act.

(3) On or before June 1, 2016. – ~~The DHHS, through the Division of Health Benefits~~DHHS shall submit the waivers and State Plan amendments required by this act to the Centers for Medicare & Medicaid Services (CMS).

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SECTION 2.(b) Section 4 of S.L. 2015-245 reads as rewritten:

"**SECTION 4.** Structure of Delivery System. – The transformed Medicaid and NC Health Choice programs described in Section 1 of this act shall be organized according to the following principles and parameters:

(1) DHHS authority. – The Department of Health and Human Services (DHHS) shall have full authority to manage the State's Medicaid and NC Health Choice programs provided that the total expenditures, net of agency receipts, do not exceed the authorized budget for each program, except the General Assembly shall determine eligibility categories and income thresholds. DHHS ~~through the Division of Health Benefits, created in Section 10 of this act,~~ shall be responsible for planning and implementing the Medicaid transformation required by this act.

...

(4) Services covered by PHPs. – Capitated PHP contracts shall cover all Medicaid and NC Health Choice services, including physical health services, prescription drugs, long-term services and supports, and behavioral health services for NC Health Choice recipients, except as otherwise provided in this subdivision. The capitated contracts required by this subdivision shall not cover:

a. Behavioral health services for Medicaid recipients currently covered by the local management entities/managed care organizations (LME/MCOs) ~~shall be excluded from the capitated contracts~~ until four years after the date capitated contracts begin.

b. ~~The capitated contracts required by this subdivision shall not cover dental~~Dental services.

c. Services provided through the Program of All-Inclusive Care for the Elderly (PACE).

d. Audiology, speech therapy, occupational therapy, physical therapy, nursing, and psychological services prescribed in an Individualized Education Program (IEP) and performed by schools or individual contracted with Local Education Agencies.

e. Services provided pursuant to a contract with Children's Developmental Services Agencies.

f. Services for Medicaid program applicants during the three-month retroactive eligibility period authorized by 42 U.S.C. § 1396a(a)(34). Services provided during a prospective, 12-month continuous enrollment period shall be covered by the capitated contracts.

(5) Populations covered by PHPs. – Capitated PHP contracts shall cover all Medicaid and NC Health Choice program aid categories except ~~recipients~~ for the following categories:

a. Recipients who are dually eligible for Medicaid and Medicare. Recipients in the aged program aid category that are eligible for Medicare shall be considered recipients who are dually eligible for Medicaid and Medicare. The Division of Health Benefits shall develop a long-term strategy to cover dual eligibles through capitated PHP contracts, as required by subdivision (11) of Section 5 of this act.

b. Qualified aliens subject to the 5-year bar for means-tested public assistance under 8 U.S.C. § 1613 who qualify for emergency services under 8 U.S.C. § 1611.

c. Undocumented aliens who qualify for emergency services under 8 U.S.C. § 1611.

d. Medically needy Medicaid recipients.

e. Members of federally-recognized tribes. Members of federally-recognized tribes shall have the option to enroll voluntarily in PHPs.

f. Presumptively eligible recipients, during the period of presumptive eligibility. Presumptively eligible recipients who submit a full Medicaid application and are determined eligible for the Medicaid program shall be covered by capitated contracts during the prospective, 12-month continuous enrollment period after they have been determined eligible.

(6) Number and nature of capitated PHP contracts. – The number and nature of the contracts required under subdivision (3) of this section shall be as follows:

a. Three contracts between the Division of Health Benefits and PHPs to provide coverage to Medicaid and NC Health Choice recipients statewide (statewide contracts).

b. Up to ~~10~~12 contracts between the Division of Health Benefits and PLEs for coverage of regions specified by the Division of Health Benefits pursuant to subdivision (2) of Section 5 of this act (regional contracts). Regional contracts shall be in addition to the three statewide contracts required under sub-subdivision a. of this subdivision. Each regional contract shall provide coverage throughout the entire region for the Medicaid and NC Health Choice services required by subdivision (4) of this section. A PLE may bid for more than one regional contract, provided that the regions are contiguous.

c. Initial capitated PHP contracts may be awarded on staggered terms of three to five years in duration to ensure against gaps in coverage that may result from termination of a contract by the PHP or the State.

...."

SECTION 2.(c) Section 5 of S.L. 2015-245 reads as rewritten:

"**SECTION 5.** Role of DHHS. – The role and responsibility of ~~DHHS, through the Division of Health Benefits,~~ DHHS during Medicaid transformation shall include the following activities and functions:

...

(6) Enter into capitated PHP contracts for the delivery of the Medicaid and NC Health Choice services described in subdivision (4) of Section 4 of this act. All contracts shall be the result of requests for proposals (RFPs) issued by DHHS and the submission of competitive bids by PHPs. ~~DHHS, through the Division of Health Benefits,~~ DHHS shall develop standardized contract terms, to include at a minimum, the following:

a. Risk-adjusted cost growth for its enrollees must be at least two percentage (2%) points below national Medicaid spending growth as documented and projected in the annual report prepared for CMS by the Office of the Actuary for nonexpansion states.

b. A requirement that PHP spending for prescribed drugs, net of rebates, ensures the State realizes a net savings for the spending on prescription drugs. All PHPs shall be required to use the same drug formulary, which shall be established by ~~DHHS, through the Division of Health Benefits.~~DHHS.

c. Until final federal regulations are promulgated governing medical loss ratio, a minimum medical loss ratio of eighty-eight percent (88%) for health care services, with the components of the numerator and denominator to be defined by ~~DHHS, through the Division of Health Benefits.~~DHHS.

d. A requirement that PHPs develop and maintain provider networks that meet access to care requirements for their enrollees. PHPs may not exclude providers from their networks except for failure to meet objective quality standards or refusal to accept network rates. Notwithstanding the previous sentence, PHPs must include all providers in their geographical coverage area that are designated essential providers by DHHS pursuant to subdivision (13) of this section, unless DHHS approves an alternative arrangement for securing the types of services offered by the essential providers.

e. A requirement that all PHPs assure that enrollees who do not elect a primary care provider will be assigned to one.

...

(11) Develop a Dual Eligibles Advisory Committee, which must include at least a reasonably representative sample of the populations receiving long-term services and supports covered by Medicaid. ~~The Division of Health Benefits.~~DHHS, upon the advice of the Dual Eligibles Advisory Committee, shall develop a long-term strategy to cover dual eligibles through capitated PHP contracts and report the strategy to the Joint Legislative Oversight Committee on Medicaid and NC Health Choice by January 31, 2017.

...

(13) Designate Medicaid and NC Health Choice providers as essential providers if the provider either offers services that are not available from any other provider within a reasonable access standard or provides a substantial share of the total units of a particular service utilized by Medicaid and NC Health Choice recipients within the region during the last three years, and the combined capacity of other service providers in the region is insufficient to meet the total needs of the Medicaid and NC Health Choice enrollees. DHHS shall not classify physicians and other practitioners as essential providers. At a minimum, providers in the following categories shall be designated essential providers:

a. Federally qualified health centers.

b. Rural health centers.
c. Free clinics.
d. Local health departments.
e. State Veterans Homes."

SECTION 2.(d) Section 8 of S.L. 2015-245 reads as rewritten:

"**SECTION 8.** Innovations Center. – DHHS shall submit a program design and budget proposal no later than May 1, 2016, to the Joint Legislative Oversight Committee on Medicaid and NC Health Choice that will create a Medicaid and NC Health Choice Transformation Innovations Center ~~within the Division of Health Benefits~~ with the purpose of assisting Medicaid and NC Health Choice providers in achieving the ultimate goals of better health, better care, and lower costs for North Carolinians. The center should be designed to support providers through technical assistance and learning collaboratives that foster peer-to-peer sharing of best practices. DHHS shall use the Oregon Health Authority's Transformation Center as a design model and shall consider at least the following features:

(1) Learning collaboratives, peer-to-peer networks.
(2) Clinical standards and supports.
(3) Innovator agents.
(4) Council of Clinical Innovators.
(5) Community and stakeholder engagement.
(6) Conferences and workshops.
(7) Technical assistance.
(8) Infrastructure support."

SECTION 2.(e) Section 9 of S.L. 2015-245 reads as rewritten:

"**SECTION 9.** Maintain Funding Mechanisms. – In developing the waivers and State Plan amendments necessary to implement this act, ~~the Department of Health and Human Services, through the Division of Health Benefits created in Section 10 of this act,~~DHHS shall work with the Centers for Medicare & Medicaid Services (CMS) to attempt to preserve existing levels of funding generated from Medicaid-specific funding streams, such as assessments, to the extent that the levels of funding may be preserved. If such Medicaid-specific funding cannot be maintained as currently implemented, then ~~the Division of Health Benefits~~DHHS shall advise the Joint Legislative Oversight Committee on Medicaid and NC Health Choice, created in Section 15 of this act, of any modifications necessary to maintain as much revenue as possible within the context of Medicaid transformation. If such Medicaid-specific funding streams cannot be preserved through the transformation process or if revenue would decrease, it is the intent of the General Assembly to modify such funding streams so that any supplemental payments to providers are more closely aligned to improving health outcomes and achieving overall Medicaid goals."

SECTION 2.(f) Section 10 of S.L. 2015-245 reads as rewritten:

"**SECTION 10.** Creation of the Division of Health Benefits. – The Division of Health Benefits is established as a new division of the Department of Health and Human Services. ~~The Department of Health and Human Services, through the Division of Health Benefits, shall be responsible for implementing Medicaid transformation required by this act and shall administer and operate all functions, powers, duties, obligations, and services related to the transformed Medicaid and NC Health Choice programs.~~ The Division of Medical Assistance shall continue to operate the current Medicaid and NC Health Choice programs until the Division of Medical Assistance is eliminated. Upon the elimination of the Division of Medical Assistance, all functions, powers, duties, obligations, and services vested in the Division of Medical Assistance of the Department of Health and Human Services are vested in the Division of Health Benefits. The Department of Health and Human Services shall remain the Medicaid single State ~~agency.~~ agency and shall be responsible for implementing Medicaid transformation required by this act and shall administer and operate all functions, powers, duties, obligations, and services related to the

transformed Medicaid and NC Health Choice programs. Prior to the effective date of G.S. 143B-216.85, the Secretary of DHHS may appoint a Director of the Division of Health Benefits."

SECTION 2.(g) G.S. 143B-216.80 reads as rewritten:

"**§ 143B-216.80. Division of Health Benefits – creation and organization.**

(a) There is hereby established the Division of Health Benefits of the Department of Health and Human Services. The Director shall be the head of the Division of Health Benefits. Upon the elimination of the Division of Medical Assistance, the Division of Health Benefits shall be vested with all functions, powers, duties, obligations, and services previously vested in the Division of Medical Assistance. The Department of Health and Human ~~Services, through the Division of Health Benefits,~~ Services shall have the powers and duties described in ~~G.S. 108A-54(e). The Director shall be the head of the Division of Health Benefits.~~ G.S. 108A-54(e) in addition to the powers and duties already vested in the Department.

(b) Although generally subject to the laws of this State, the following exemptions, limitations, and modifications apply to the Division of Health Benefits of the Department of Health and Human Services, notwithstanding any other provision of law:

(1) Employees of the Division of Health Benefits shall not be subject to the North Carolina Human Resources Act, except as provided in G.S. 126-5(c1)(31).

(2) The Secretary may retain private legal counsel and is not subject to G.S. 114-2.3 or G.S. 147-17(a) through (c).

(3) The Division of Health Benefits' employment contracts offered pursuant to G.S. 108A-54(e)(2) are not subject to review and approval by the Office of State Human Resources.

(4) If the Secretary establishes alternative procedures for the review and approval of contracts, then the Division of Health Benefits is exempt from State contract review and approval requirements but still may choose to utilize the State contract review and approval procedures for particular contracts."

SECTION 2.(h) G.S. 108A-54 reads as rewritten:

"**§ 108A-54. Authorization of Medical Assistance Program; administration.**

...

(e) The Department of Health and Human Services shall continue to administer and operate the Medicaid and NC Health Choice programs through the Division of Medical Assistance until the Division of Medical Assistance is eliminated at which time all functions, powers, duties, obligations, and services vested in the Division of Medical Assistance are vested in the Division of Health Benefits. Prior to and following the exchange of powers and duties from the Division of Medical Assistance to the Division of Health Benefits, and in addition to the powers and duties already vested in the Secretary of the Department of Health and Human Services, the Secretary of the Department of Health and Human ~~Services, through the Division of Health Benefits,~~ Services shall have the following powers and duties:

(1) Administer and operate the Medicaid and NC Health Choice programs, provided that the total expenditures, net of agency receipts, do not exceed the authorized budget for each program. None of the powers and duties enumerated in the other subdivisions of this subsection shall be construed to limit the broad grant of authority to administer and operate the Medicaid and NC Health Choice programs.

(2) Employ clerical and professional staff of the Division of Health Benefits, including consultants and legal counsel, necessary to carry out the powers and duties of the division. In hiring staff for the Division of Health Benefits, the Secretary may offer employment contracts for a term and set compensation for the employees, which may include performance-based bonuses based on meeting budget or other targets.

(3) Notwithstanding G.S. 143-64.20, enter into contracts for the administration of the Medicaid and NC Health Choice programs, as well as manage such contracts, including contracts of a consulting or advisory nature.

(4) Establish and adjust all program components, except for eligibility categories and income thresholds, of the Medicaid and NC Health Choice programs within the appropriated and allocated budget.

(5) Adopt rules related to the Medicaid and NC Health Choice programs.

(6) Develop midyear budget correction plans and strategies and then take midyear budget corrective actions necessary to keep the Medicaid and NC Health Choice programs within budget.

(7) Approve or disapprove and oversee all expenditures to be charged to or allocated to the Medicaid and NC Health Choice programs by other State departments or agencies.

(8) Develop and present to the Joint Legislative Oversight Committee on Medicaid and NC Health Choice and the Office of State Budget and Management by January 1 of each year, beginning in 2017, the following information for the Medicaid and NC Health Choice programs:

a. A detailed four-year forecast of expected changes to enrollment growth and enrollment mix.

b. What program changes will be made by the Department in order to stay within the existing budget for the programs based on the next fiscal year's forecasted enrollment growth and enrollment mix.

c. The cost to maintain the current level of services based on the next fiscal year's forecasted enrollment growth and enrollment mix.

(9) Publish on its Web site and update on at least a monthly basis, at a minimum, the following information about the Medicaid and NC Health Choice programs:

a. Enrollment by program aid category by county.

b. Per member per month spending by category of service.

c. Spending and receipts by fund along with a detailed variance analysis.

d. A comparison of the above figures to the amounts forecasted and budgeted for the corresponding time period.

(f) The General Assembly shall determine the eligibility categories and income thresholds for the Medicaid and NC Health Choice programs. The Department of Health and Human ~~Services, through the Division of Health Benefits,~~ Services is expressly authorized to adopt temporary and permanent rules regarding eligibility requirements and determinations, to the extent that they do not conflict with the parameters set by the General Assembly.

~~(g) Although generally subject to the laws of this State, the following exemptions, limitations, and modifications apply to the Division of Health Benefits of the Department of Health and Human Services, notwithstanding any other provision of law:~~

~~(1) Employees of the Division of Health Benefits shall not be subject to the North Carolina Human Resources Act, except as provided in G.S. 126-5(c1)(31).~~

~~(2) The Secretary may retain private legal counsel and is not subject to G.S. 114-2.3 or G.S. 147-17(a) through (c).~~

~~(3) The Division of Health Benefits' employment contracts offered pursuant to G.S. 108A-54(e)(2) are not subject to review and approval by the Office of State Human Resources.~~

~~(4) If the Secretary establishes alternative procedures for the review and approval of contracts, then the Division of Health Benefits is exempt from State contract review and approval requirements but may still choose to utilize the State contract review and approval procedures for particular contracts.~~"

SECTION 2.(i) G.S. 143B-139.6C reads as rewritten:

"**§ 143B-139.6C. Cooling-off period for certain Department employees.**

(a) Ineligible Vendors. – The Secretary of the Department of Health and Human Services shall not contract for goods or services with a vendor that employs or contracts with a person who is a former employee of the Department and uses that person in the administration of a contract with the Department.

(b) Vendor Certification. – The Secretary shall require each vendor submitting a bid or contract to certify that the vendor will not use a former employee of the Department in the administration of a contract with the Department in violation of the provisions of subsection (a) of this section.

(c) A violation of the provisions of this section shall void the contract.

(d) Definitions. – As used in this section, the following terms mean:

(1) Administration of a contract. – ~~Oversight~~The former employee's duties and responsibilities for the vendor include oversight of the performance of a contract, or authority to make decisions regarding a contract, including interpretation of a contract, ~~or participation in the~~ development of specifications or terms of a ~~contract or in the preparation~~ contract, or award of a contract.

(2) Former employee of the Department. – A person who, for any period within the preceding six months, was employed as an employee or contract employee of the Department of Health and Human ~~Services, and in the six months immediately preceding termination of State employment, participated personally in either the award or management of a Department contract with the vendor, or made regulatory or licensing decisions that directly applied to the vendor.~~ Services and personally participated in any of the following:

a. The award of a contract to the vendor.

b. An audit, decision, investigation, or other action affecting the vendor.

c. Regulatory or licensing decisions that applied to the vendor."

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

SENATE BILL 734:
Statewide Standing Order/Opioid Antagonist.

2016-2017 General Assembly

Committee:	House Health	**Date:**	May 24, 2016
Introduced by:	Sens. Pate, Tucker, Robinson	**Prepared by:**	Theresa Matula Committee Staff
Analysis of:	First Edition		

SUMMARY: Senate Bill 734 amends the law on drug-related overdose treatment to authorize the State Health Director to issue a statewide standing order for an opioid antagonist allowing the overdose treatment drug to be more readily accessible. This bill is a recommendation of the Joint Legislative Oversight Committee on Health and Human Services.

CURRENT LAW: As enacted by S.L. 2013-23, and amended by S.L. 2015-94, **G.S. 90-106.2** allows a practitioner to prescribe an opioid antagonist directly, or by standing order, to (i) a person at risk of experiencing an opiate-related overdose or (ii) a family member, friend, or other person in a position to assist a person at risk of experiencing an opiate-related overdose. A more detailed analysis of G.S. 90-106.2 Drug-related overdose treatment; limited immunity, is outlined below.

Opioid Antagonist - Subsection (a) provides that "opioid antagonist" means naloxone hydrochloride.

Practitioner authorized to prescribe directly or by standing order - Subsection (b) authorizes a practitioner acting in good faith and exercising reasonable care to prescribe directly, or by standing order, an opioid antagonist to: (i) a person at risk of experiencing an opiate-related overdose, or (ii) a family member, friend, or other person in a position to assist a person at risk of experiencing an opiate-related overdose.

Dispense - Subsection (b1) allows a pharmacist to dispense an opioid antagonist pursuant to subsection (b).

Administer- Subsection (c) provides that a person who receives an opioid antagonist prescribed pursuant to subsection (b), may administer an opioid antagonist to another person if (i) the person has a good faith belief that the other person is experiencing a drug-related overdose and (ii) the person exercises reasonable care in administering the drug to the other person. Evidence of the use of reasonable care in administering the drug shall include the receipt of basic instruction and information on how to administer the opioid antagonist.

Immunity - Subsection (d) provides that any practitioner who prescribes, pharmacist who dispenses, or person who administers, an opioid antagonist pursuant to this section is immune from any civil or criminal liability for authorized actions.

G.S. 130A-3 requires the State Health Director, appointed by the Secretary of Health and Human Services, to be a physician licensed to practice medicine in this State.

BILL ANALYSIS: Senate Bill 734 amends G.S. 90-106.2(b) to add a new subdivision authorizing the State Health Director to prescribe an opioid antagonist pursuant to current law and by means of a statewide standing order. Subsection (d) of the section is amended to specifically list the State Health Director among those individuals who are statutorily granted immunity from civil or criminal liability for actions authorized by the section.

Karen Cochrane-Brown
Director

S734-SMSH-132 E1 -V-1

Legislative Analysis
Division
919-733-2578

This bill analysis was prepared by the nonpartisan legislative staff for the use of legislators in their deliberations and does not constitute an official statement of legislative intent.

EFFECTIVE DATE: Senate Bill 734 would become effective when it becomes law.

BACKGROUND: The Joint Legislative Oversight Committee on Health and Human Services heard a presentation and received handouts on April 12, 2016, regarding the need for a statewide standing order for naloxone in an effort to make the overdose treatment drug more readily accessible.

Naloxone hydrochloride is an opioid antagonist that reverses the effects of opioids (heroin and prescription drugs such as methadone, oxycodone, and hydrocodone). According to the Department of Health and Human Services (DHHS), "[b]etween 1999 and 2014, the number of unintentional medication or drug overdose deaths increased by over 330 percent in North Carolina." Under State law, a pharmacy cannot dispense naloxone without a prescription or standing order issued by a practitioner. A standing order signed by the North Carolina State Health Director would authorize any pharmacist practicing in the state of North Carolina to dispense naloxone. Routes of naloxone administration include intranasal and intramuscular (shoulder or thigh) and each person dispensed naloxone would receive education regarding use and the risk factors.

Since the enactment of SL 2013-23 and SL 2015-94, entities across the State have established naloxone dispensing programs. In August 2015, local health departments received information on adopting naloxone standing orders. S.L. 2015-241, Sec 12F.15, provided funds to the Division of Mental Health, Developmental Disabilities, and Substance Abuses Services, DHHS, to purchase opioid antagonists for distribution by the NC Harm Reduction Coalition (NCHRC) and for distribution to NC law enforcement agencies. The NCHRC website provides access to Overdose Rescue 101, an information sheet on naloxone, and lists contacts for and locations where overdose rescue kits may be obtained. The DHHS reports that since August 2013, naloxone has been used to reverse more than 1,500 overdoses in North Carolina.

Maryland and Pennsylvania also have a statewide standing order for naloxone.

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2015

S 1*

SENATE BILL 734*

Short Title:	Statewide Standing Order/Opioid Antagonist.	(Public)
Sponsors:	Senators Pate, Tucker, Robinson (Primary Sponsors); and J. Davis.	
Referred to:	Health Care	

April 26, 2016

A BILL TO BE ENTITLED

AN ACT AUTHORIZING THE STATE HEALTH DIRECTOR TO PRESCRIBE OPIOID ANTAGONIST BY MEANS OF A STATEWIDE STANDING ORDER, WITH IMMUNITY FROM CIVIL AND CRIMINAL LIABILITY FOR SUCH ACTION, AS RECOMMENDED BY THE JOINT LEGISLATIVE OVERSIGHT COMMITTEE ON HEALTH AND HUMAN SERVICES.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 90-106.2 reads as rewritten:

"**§ 90-106.2. Treatment of overdose with opioid antagonist; immunity.**

(a) As used in this section, "opioid antagonist" means naloxone hydrochloride that is approved by the federal Food and Drug Administration for the treatment of a drug overdose.

(b) The following individuals may prescribe an opioid antagonist in the manner prescribed by this subsection:

(1) A practitioner acting in good faith and exercising reasonable care may directly or by standing order prescribe an opioid antagonist to (i) a person at risk of experiencing an opiate-related overdose or (ii) a family member, friend, or other person in a position to assist a person at risk of experiencing an opiate-related overdose. As an indicator of good faith, the practitioner, prior to prescribing an opioid under this subsection, may require receipt of a written communication that provides a factual basis for a reasonable conclusion as to either of the following:

~~(1)~~a. The person seeking the opioid antagonist is at risk of experiencing an opiate-related overdose.

~~(2)~~b. The person other than the person who is at risk of experiencing an opiate-related overdose, and who is seeking the opioid antagonist, is in relation to the person at risk of experiencing an opiate-related overdose:

~~a.~~1. A family member, friend, or other person.

~~b.~~2. In the position to assist a person at risk of experiencing an opiate-related overdose.

(2) The State Health Director may prescribe an opioid antagonist pursuant to subdivision (1) of this subsection by means of a statewide standing order.

(b1) A pharmacist may dispense an opioid antagonist to a person described in subsection (b) of this section pursuant to a prescription issued in accordance with subsection (b) of this section. For purposes of this section, the term "pharmacist" is as defined in G.S. 90-85.3.

(c) A person who receives an opioid antagonist that was prescribed pursuant to subsection (b) of this section may administer an opioid antagonist to another person if (i) the person has a

good faith belief that the other person is experiencing a drug-related overdose and (ii) the person exercises reasonable care in administering the drug to the other person. Evidence of the use of reasonable care in administering the drug shall include the receipt of basic instruction and information on how to administer the opioid antagonist.

(d) All of the following individuals are immune from any civil or criminal liability for actions authorized by this section:

(1) ~~Any~~ The State Health Director and any practitioner who prescribes an opioid antagonist pursuant to subsection (b) of this section.

(1a) Any pharmacist who dispenses an opioid antagonist pursuant to subsection (b1) of this section.

(2) Any person who administers an opioid antagonist pursuant to subsection (c) of this section."

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

HOUSE PAGES
(Health)

Week of May 23-26, 2016

Name:	County:	Sponsor:
Brooke Barnhill	Carteret	Rep. Pat McElraft
Natalie Tilley	Lincoln	Rep. Jason Saine
Weston Cregger	Cabarrus	Rep. Linda Johnson
Ethan Ritchie	Franklin	Rep. Bobbie Richardson

Committee Sergeants at Arms

NAME OF COMMITTEE House Committee on Health

DATE: 5/25/16 Room: 643

House Sgt-At Arms:

1. Name: You ng Bae
2. Name: [redacted]
3. Name: Jim Moran
4. Name: Joe Crook
5. Name: Will Crocker

Martha Gadison

Senate Sgt-At Arms:

1. Name: _____
2. Name: _____
3. Name: _____
4. Name: _____
5. Name: _____

VISITOR REGISTRATION SHEET

House Committee on Heallth — 5/25/16

Name of Committee — Date

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Lexi Artnur	NCRMA
Wendy Kelly	Focus Carolina
BILL SCOGGIN	TS
JOE LANIER	TS
Adam Sholar	NCHCFA
DEL MAYNARD	GPM : ASSOC
Katy Kingsbury	BP
Phoebe Landon	MWC
Sarah Smith	ILP
Lanier Hodgson	UNC Health Care
Christine Craig	WakeMed

VISITOR REGISTRATION SHEET

House Committee on Heallth — 5/29/16

Name of Committee — Date

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Cody Hand	North Carolina Hospital Association
Scott Lasater	SSGNC
Kelly Vogel	KV strategies
Andy Ellen	NCRMA
David Board	Tuggle Duggins
Andy Wheeler	SA
Jack Stafford	SA
Matt Grabowski	State Health Plan
Jean McKillop	Nelson Mullins
Penny Hill Peterson	SOG
Ashley Parkinson	Parkinson Law

VISITOR REGISTRATION SHEET

House Committee on Heallth — 5/29/16

Name of Committee — Date

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

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Emily Callen	PPSAT, 100 S. Boylan Ave, Raleigh
Nora Spencer	UNC Ch. Hill School of Social Work, 325 Pittsboro Ch. Hill
Dena Lind	" UNC SSW, 325 Pittsboro St, Chapel Hill "
Olivia Boss	" UNC SSW "
Lydia Short	UNC SSW
Stephanie Miller	UNC SSW
Lao Russell	CYJC
Terrell Morton	UNC SSW
Michelle Jones	NCPHA
Maddie Koines	UNC SSW
Beth Lawder	UNC SSW
Sarah Verbiest	UNC SSW
Roger Hudson	UNC SSW

VISITOR REGISTRATION SHEET

House Committee on Heallth — 5/25/16

Name of Committee — Date

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Kate Torrey	LWV - ODC // PPSA
Jim Foster	LWV - orange/durham/chatham
Mary Parry	LWV - ODC
Janet Hay	LWV - ODC
[illegible]	[illegible]
[illegible]	[illegible]
JEFF BARNHART	MWR
[illegible]	[illegible]
[illegible]	[illegible]
Mary Bocock	Prime Therapeutics
Kaye Gooch	Nat'l MS Society
Jennifer H. Mangum	National MS Society
[illegible]	GSK
Flint Benson	SEANC

VISITOR REGISTRATION SHEET

House Committee on Heallth — 5/22/16

Name of Committee — Date

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Amy Warren	National MS Society
Kathy Goff	National MS Society
David Collins	SEANC
Chelsey Baughard	Nurse of the day
Michelle Brooks	ECU
THOM ILES	JOHN DEERE
GEOFF COWEN	Nelson Mullins
Diane Jordan	NCHFA
Will Parry-Hall	NCHFA
Julia Adams Schmid	Oak City Gov Rel
Ken Melton	K M A
Tim Colvard	H & H
James Norment	Ward and Smith

VISITOR REGISTRATION SHEET

House Committee on Heallth — 5/28/16

Name of Committee — Date

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Lee Hartsell	Duke University Medical Center DUMC 3184 Durham, NC 27710
Andy Chase	KMA
cstolls	cstl
Michelle Frazier	MFS
Jon Carr	Jordan Price Law Firm
Joyce Peters	CJS
J Ohden	Fort Sanford CP
Ann Rodriguez	NC Council of Comm Programs
Kay Castillo	NASW-NC
Sarah Bales	Brubaker & Associates
Johanna Reese	NCACC

VISITOR REGISTRATION SHEET

Health Comm

(Committee Name)

5/25/2016

Date

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

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Mitney Christenson	Ward and Smith, PA
Melissa Robinson	HPE
Madeline Hurley	Ward and Smith, PA
Jonathan Yeomans	OSBM
Sarah Grimsrud	OSBM
Lori Ann Harris	LAHA

09-21-201

VISITOR REGISTRATION SHEET

Health Comm

(Committee Name)

5/25/2016

Date

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
John Lashua	Rep Salmon office
James Pearce	Cynthia for NC
Rhonda Todd	DOA
Ryan Manuel Smith	Intern DOA
Fred Bon	Bon : Assn
Dick Carlton	Law off. of Kitt PLLC
John Bode	BSH6
Rick Zechini	Williams Mullen
Ed Turlington	
John DeStefano	Brubaker & Assoc.

09-21-201

Corrected #1: Room Change

NORTH CAROLINA HOUSE OF REPRESENTATIVES
COMMITTEE MEETING NOTICE
AND
BILL SPONSOR NOTIFICATION
2015-2016 SESSION

You are hereby notified that the **House Committee on Health** will meet as follows:

DAY & DATE: Wednesday, June 1, 2016
TIME: **9:00 AM**
LOCATION: **544 LOB**
COMMENTS: **Review the Submission of the Medicaid Reform Waiver. Secretary Rick Brajer will lead the presentation wilth his staff.**

Respectfully,

Representative Justin P. Burr, Co-Chair
Representative Bert Jones, Co-Chair
Representative Donny Lambeth, Co-Chair
Representative Brig Gen (Ret) Gary Pendleton, Co-Chair

I hereby certify this notice was filed by the committee assistant at the following offices at 10:08 AM on Tuesday, May 31, 2016.

___ Principal Clerk
___ Reading Clerk – House Chamber

Brenda Olls (Committee Assistant)

House Committee on Health
Wednesday, June 1, 2016, 9:00 AM
544 Legislative Office Building

AGENDA

Welcome and Opening Remarks

Introduction of Pages

Presentation

Submission of the Medicaid Reform Waiver.	Rick Brajer, Secretary, Department of Health and Human Services

Other Business

Adjournment

House Committee on Health
Wednesday, June 1, 2016 at 9:00 AM
Room 544 of the Legislative Office Building

MINUTES

The House Committee on Health met at 9:00 AM on June 1, 2016 in Room 544 of the Legislative Office Building. Representatives Adcock, Avila, Bishop, Blackwell, Brisson, R. Brown, Carney, Dobson, Dollar, Earle, Farmer-Butterfield, Ford, Goodman, Hager, Insko, Jones, Lambeth, Lucas, S. Martin, Murphy, Pendleton, Waddell, and Yarborough attended.

Representative Brig Gen (Ret) Gary Pendleton, Chair, presided.

The following bills were considered: Medicaid Reform Presentation

Presentation materials are attached.
Questions were asked to Secretary Rick Brajer, Mr. Trey Sutten and Dave Richard from:

Representative Greg Murphy
Representative Josh Dobson
Representative Hugh Blackwell
Representative Donny Lambeth
Representative Beverly Earle
Representative Gale Adcock
Representative Verla Insko
Representative Nelson Dollar
Representative Marilyn Avila

Final comments were made by Senator Louis Pate

The meeting adjourned at 10:25a.m.

Representative Brig Gen (Ret) Gary Pendleton, Chair Presiding

Kathy Peters, Committee Clerk

Nothing Compares
NORTH CAROLINA

House Health Committee
June 1, 2016

Department of Health and Human Services
Medicaid Reform 1115 Waiver Submission

Agenda

- Overview, milestones and vision
- Alignment with session law
- Public comments
- Waiver changes from 3/1 to 6/1
- Finances
- Proposed legislative changes
- Next steps

Overview

Session Law 2015-245

- Medicaid reform was signed into law by Gov. McCrory in September 2015, after extensive engagement with the General Assembly, providers, beneficiaries and other stakeholders throughout the state.
- Outlined in SL 2015-245 (HB 372), Medicaid reform, once approved by the Centers for Medicare & Medicaid Services (CMS) will transform North Carolina Medicaid and NC Health Choice programs through system-wide innovation for beneficiaries, communities and providers while promoting budget stability.
- SL 2015-245 required DHHS to submit an 1115 Demonstration Waiver to CMS by June 1, 2016, to support reform goals.

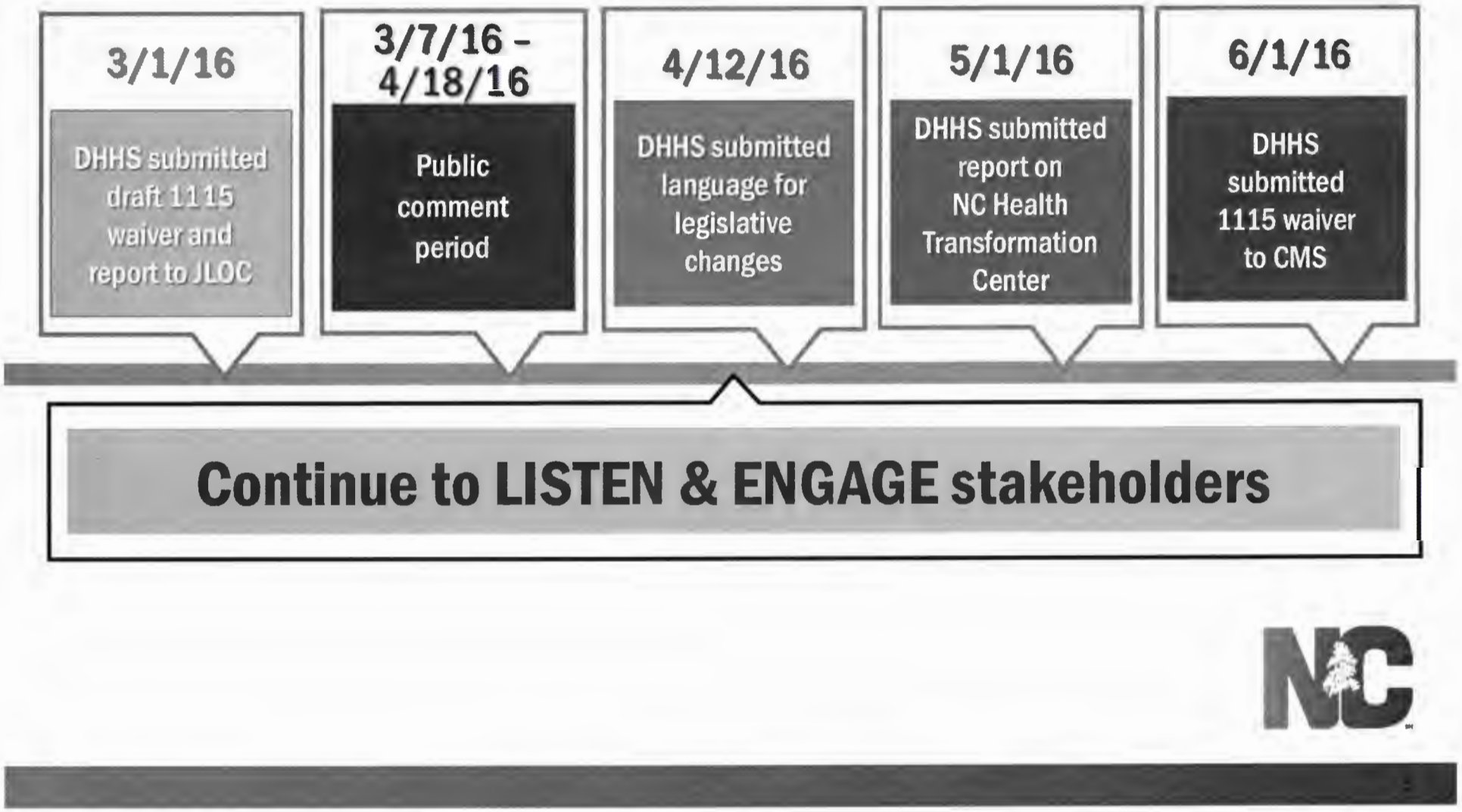
Overview of 1115 demonstration waivers

Section 1115 waivers provide states an avenue to test and implement coverage approaches that do not meet federal program rules

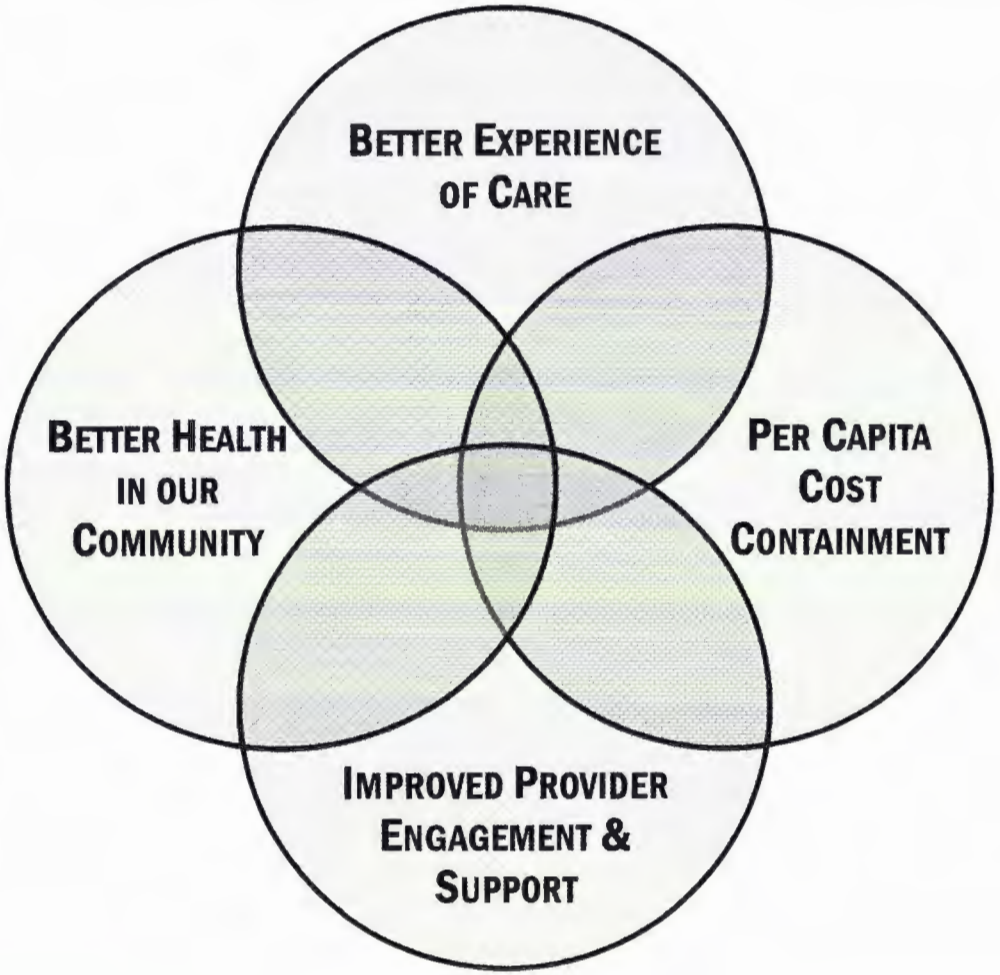
- Secretary of Health and Human Services has authority to waive certain Medicaid requirements and to allow a state to use federal Medicaid funds in ways that are not otherwise allowed under federal rules
- Allow for broad changes in eligibility, benefits, cost sharing and provider payments.
- Intended to be research and demonstration projects to test and learn about new approaches to program design and administration

Milestones

A process built on collaboration



Vision builds on our foundation of innovation



Improve to improve health care access, quality and cost efficiency for our 1.9 million Medicaid and NC Health Choice beneficiaries

North Carolina waiver initiatives

- Build a system of accountability for outcomes
- Create Person-Centered Health Communities (PCHCs)
- Support providers through engagement and innovations
- Connect children and families in the child welfare system to better health
- Implement capitation and care transformation through payment alignment

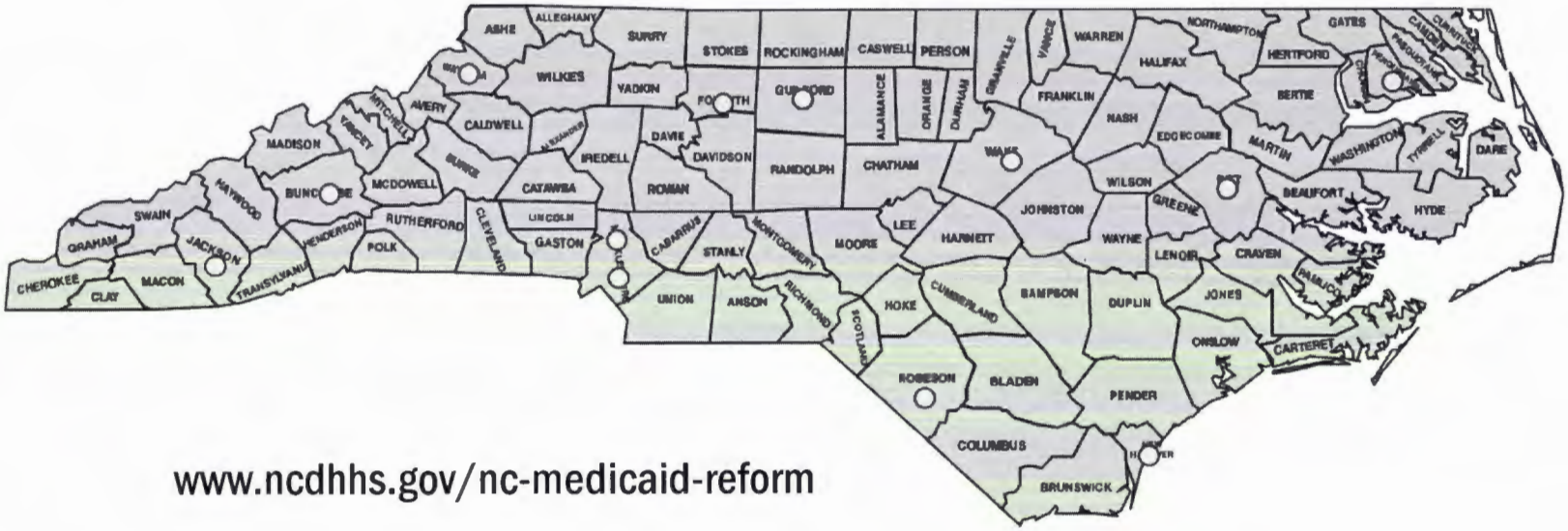
Alignment with session law

S.L. 2015-245 REQUIREMENT	IN WAIVER APPLICATION – Y/N
Part I, Section 4: Structure of Delivery System	
4.1 DHHS authority. DHHS has full authority to manage NC Medicaid and NC Health Choice; DHB is responsible for planning and implementing Medicaid transformation	Yes
4.2 Prepaid health plan. Commercial plans and provider-led entities, which will operate a capitated contract for delivery of services	Yes
4.3 Capitated contracts. DHB will enter into capitated contracts with PHPs, as a result of RFPs and submission of competitive bids	Yes
4.4 Services covered by PHPs. PHP capitated contracts will cover all Medicaid and NC Health Choice services, including physical health services, prescription drugs, LTSS and NC Health Choice behavioral health services; LME/MCOs are excluded until 4 years after capitated contracts begin; dental services are excluded	Yes, with exceptions requested by DHHS
4.5 Populations covered by PHPs. PHP capitated contracts will cover Medicaid and NC Health Choice program aid categories except dually eligible recipients; DHB will develop a dually eligible long-term coverage strategy	Yes, with exceptions requested by DHHS
4.6 Number and nature of PHP contracts. 3 statewide contracts; 10 regional contracts; initial PHP capitated contracts may be staggered in duration of 3-5 years	Yes
4.6a PHPs will comply with General Statutes Chapter 58. Joint review by DHHS, DHB and Department of Insurance	N/A; reflected in 3/1 JLOC report
4.7 Defined measures and goals. Delivery system and contracts will be built on defined measures and goals for health outcomes, quality of care, patient satisfaction, access and cost	Yes
4.8 PHP administrative functions. PHPs are responsible for administrative functions for enrolled recipients, including claims processing, care and case management, and grievances and appeals.	Yes, details will be included in contracts
4.9 LME/MCOs. LME/MCOs will continue to manage behavioral health services for enrollees under existing waivers for 4 years after PHP capitated contracts begin; DHB will negotiate rates and make payments directly to LME/MCOs during the 4-year period	Yes

Alignment with session law

Part 1, Section 5: Role of DHHS	IN WAIVER APPLICATION - Y/N
5.1 Section 1115 waiver application to CMS. Submit 1115 waiver, and any other waivers and plan amendments as necessary	Yes, 1115 has been submitted; plan amendments will be submitted if and when identified
5.2 Regions. Develop 6 regions that reasonably distribute populations across the state	N/A; reflected in 3/1 JLOC report
5.3 PHP contract performance. Oversee, monitor and enforce	N/A; part of PHP contracting
5.4 Transformed Medicaid and NC Health Choice programs. Ensure sustainability	Yes
5.5a-c Set rates. Actuarially sound capitation rates that are risk-adjusted and include a portion at-risk for quality and outcome measures, and value-based payments; appropriate rate floors for in-network primary care physicians, specialist physicians, and pharmacy dispensing fees; fee-for-service rates	N/A; part of program design and PHP contracting
5.6a-e PHP standardized contract terms. Through RFPs and competitive bids, DHB will develop standard contract terms including risk-adjusted cost growth of 2% for enrollees; use of same prescription drug formulary; minimum medical loss ratio of 88%; include providers in coverage area designated as essential providers; assign enrollees a PCP if one is not elected	Yes, with details part of PHP contracting
5.7 RFPs for PHP capitated contracts. Consult with JLOC/Medicaid and NCHC before issuing RFPs	Yes
5.8 Recipient assignment to PHPs. Develop and implement process, including at least family unit, quality measures and primary care physician	Yes
5.9 Program integrity. Define methods against fraud, waste, abuse	N/A; part of program design
5.10 Health Information Exchange. Require PHPs and providers to submit data through HIE	Yes
5.11 Dual eligibles. Develop advisory committee; develop long-term strategy; report strategy to JLOC/Medicaid and NCHC	Yes
5.12a-n JLOC/Medicaid and NCHC reporting. March 1: Provide draft waiver, report, statutory changes, DHB staffing, contract distribution, etc.	N/A; completed
5.13a-d. Designate essential providers. Include federally qualified health centers, rural health centers, free clinics and local health departments	Yes

12 Public Hearings – 1,600 citizens participated



www.ncdhhs.gov/nc-medicaid-reform

March 30 – Raleigh, 6–8 p.m.
March 31 – Monroe, 2–4 p.m.*
March 31 – Huntersville, 6:30–8:30 p.m.
April 5 – Sylva, 4–6 p.m.
April 6 – Boone, 12–2 p.m.
April 6 – Asheville, 6:30–8:30 p.m.
April 7 – Greensboro, 6:30–8:30 p.m.
April 8 – Winston-Salem, 2–4 p.m.
April 13 – Wilmington, 6–8 p.m.
April 14 – Greenville, 2–4 p.m.
April 16 – Elizabeth City, 10–12 p.m.
April 18 – Pembroke, 3:30–5:30 p.m.*

* Dial-in option available.

Public comment process

750 commenters

1,700 comments

General public comment themes

- **Beneficiary concerns.** Ensure beneficiaries continue to have a voice through work groups; ensure adequate patient access to providers
- **Provider concerns.** With possibility of working with up to five plans, the state must standardize processes to reduce administrative burden; ensure independent appeals process, rate adequacy, and support for local health departments, HIV specialists and psychiatry
- **Expansion.** Strong advocacy for expansion by attendees
- **Case/care management.** Ensure continuation of care management, provider supports and analytics
- **Supplemental payments.** Ensure levels of funding are maintained for providers (LHD, EMS, hospitals, etc.)
- **Behavioral health.** Favorable feedback around integrated care

Waiver changes based on public comment

March 1 Draft version to June 1 Submission

PUBLIC COMMENT THEME	CHANGE TO DRAFT WAIVER
Medicaid expansion requests	• No change made to waiver.
Provider concerns related to working with multiple PHPs and requests for standardization / centralization	• While no significant changes were made to the waiver, DHHS indicated its intent to work with stakeholders to minimize the administrative burden on providers. This will include working with stakeholders to maximize standardization, centralize functions where feasible, and reduce unnecessary requirements.
Concerns over beneficiary access	• DHHS clarified that network and access standards would comply with new federal regulations with additional details determined as part of program design and PHP contracting.
Cost settlement for public ambulance providers	• Added public ambulance providers and state facilities as eligible for wrap-around cost settlements.
Request to cover community paramedic programs	• Added that DHHS supports the use of cost-effective alternative services by PHPs, such as community paramedic services.
Carved out populations	• Excluded people enrolled in NC Health Insurance Premium Payment (HIPP) program from enrollment in prepaid health plans (PHPs).
Preservation of current patient-centered medical home / enhanced primary care case management model	• Waiver clarifies that these models are the foundation of person-centered health communities. Existing functionality will continue with responsibilities shared by PHPs, providers, and/or DHHS.
Requests for clarification	• Added language regarding Person-centered Health Communities and included a conceptual illustration. • Removed language that S.L. 2015-245 requires integration of physical and behavioral health services within a single capitated system. • Clarified that waiver will change delivery but not coverage of the state plan and Community Alternative Program for Children (CAP/C) or Disabled Adults (CAP/DA) services for Medicaid-only beneficiaries eligible for long-term services and supports (LTSS). • Clarified that provider-led entities are managed care organizations as defined by CMS, and that all PHPs will be required to comply with federal Medicaid managed care requirements. • Clarified that DHHS intends to contract with three statewide plans, as required by SL 2015-245. • Reference to I/DD health homes was removed with clarification that DHHS intends to support I/DD providers to enhance their ability to provide primary care for individuals with I/DD and to increase the capacity of primary care providers to better meet the needs of individuals with I/DD.

Waiver changes based on public comment

March 1 Draft version to June 1 Submission

RATIONALE FOR CHANGE	CHANGE TO DRAFT WAIVER
EBCI requests through tribal consultation	• Clarified that PHPs may include a tribal/Indian managed care entity. • Added EBCI proposal regarding supplemental payments for uncompensated care and alternative services. • Added various assurances requested by EBCI.
CMS Public Notice Requirement	• Added summary of public notice process (e.g., website, public hearings). • Added summary of tribal consultation process. • Added summary of public comments and DHHS responses.
Additional Details Needed for Financing Section	• Added sample Delivery System Reform Incentive Payment (DSRIP) initiatives. • Added information regarding workforce initiatives. • Included projected expenditures for Medicaid Uncompensated Care Payments, DSRIP, workforce initiatives, and tribal supplemental payments for uncompensated care and alternative services.
Budget Neutrality Addition	• Added narrative and completed budget neutrality forms.
Reflection of Medicaid Managed Care Final Rule	• Added provider network standards. • Added requirements for enrollees who need long-term services and supports. • Added beneficiary support system. • Added value-based payments.
North Carolina Health Transformation Center	• Changed "Innovations Center" to North Carolina Health Transformation Center. • Reflected May 1, 2016, report to JLOC/HHS (copy of report will be attached to June 1 waiver application).
Structural Changes to Improve Readability and Flow	• Initiatives are no longer organized by Quadruple Aim elements; however, including an illustration of how each initiative aligns with each aim. • Changed order of some initiatives and items (e.g., foster care proposals included as their own initiative; moved provider administrative ease to first item of provider engagement and support initiative). • Strengthened waiver rationale and executive summary.
Eligibility Chart Required by CMS	• Added a chart of populations included or excluded from waiver and PHPs.

Other waiver changes

March 1 Draft version to June 1 Submission

- Modification to improve flow and readability, and reflect the CMS audience
- DHHS' internal review, discussion and clarifications
- Final Medicaid managed care rule inclusion, as feasible (published May 6, 2016)
- Addition of financing and budget neutrality section, and appendices

Supplemental payments

Trey made comments on this section.

- NC providers currently receive approximately $2 billion annually in payments through a complex set of funding streams
- The transition to reform presents risks to these essential funds
- Waiver proposes supplemental payments be structured in four ways:
  - Uncompensated Care Pools
  - Delivery System Incentive Reform Payments (DSRIP)
  - Direct Payments to certain providers
  - Directed Payments through Base Rates
- Waiver does not reflect payment options provided in recently released final Medicaid managed care rule
- Funding for Disproportionate Share Hospital Payments and Graduate Medical Education will continue outside the waiver

Budget neutrality

- Waiver must cost the federal government no more than what would have been spent otherwise
- Budget neutrality is the basis for negotiations with CMS and is not a calculation that reflects state budget impact
- Preliminary estimates suggest reform will drive over $400M in savings over five years
- DHHS intends to reinvest a significant portion of the savings as incentives payments to improve health outcomes
- Final budget estimates, savings, and reinvestment amounts are subject to negotiations with CMS and OMB

Legislative changes to support program

Changes

Recognize DHHS has operational authority for Medicaid, rather than through Division of Health Benefits

Ease cooling off period requirements for staff without leadership role or contract decision making authority

Enable DHHS to contract with up to 12 Provider Led Entities (PLEs)

Allow members of the Eastern Band of Cherokee Indians (EBCI) to "Opt In" to the managed care program

Maintain eligibility for parents of children placed in foster care system

Changes continued

Include State Veterans Homes as an "essential provider"

Exclude from Prepaid Health Plans:

- Populations with short eligibility spans (e.g., medically needy and populations with emergency only coverage)
- PACE program
- Local Education Agency (LEA) services
- Child Development Service Agencies (CDSAs)
- Periods of retroactivity and presumptive eligibility

Near-term next steps

- Press conference 6/1/16 at 11:00 a.m.
- Submit 1115 demonstration waiver application 6/1/16
- Begin discussions and negotiations with CMS
- Continue stakeholder engagement

Appendix

CMS managed care rule

What is in the Managed Care Final Rule?

- Broad-based changes to the federal rules that will govern PHPs, including:
  - Beneficiary information and support, network adequacy, quality of care, appeals and grievances, LTSS, program integrity, encounter data, medical loss ratio, and capitation/provider payments.
  - July 5, 2016, effective date, with most provisions phased-in between now and 2019; PHPs in 2019 will need to comply.

North Carolina Medicaid Reform – Status Briefing

Overview

Medicaid reform was signed into law by Gov. McCrory in September 2015, after extensive engagement with the General Assembly, providers, beneficiaries and other stakeholders throughout the state. Outlined in SL 2015-245 (HB 372), Medicaid reform, once approved by the Centers for Medicare & Medicaid Services (CMS) will transform North Carolina Medicaid and NC Health Choice programs through system-wide innovation for beneficiaries, communities and providers while promoting budget stability. SL 2015-245 required DHHS to submit an 1115 Demonstration Waiver to CMS by June 1, 2016, to support reform goals.

Milestones

ONGOING	DHHS actively engages and considers feedback from stakeholders across North Carolina
COMPLETED	
March 1, 2016	• Draft Section 1115 demonstration waiver application prepared and presented to the Joint Legislative Oversight Committee on Medicaid and NC Health Choice (JLOC) • Medicaid reform report delivered to JLOC
March 7 – April 18, 2016	• Draft waiver application posted for public comment for 43 days (CMS requires 30 days) • 12 public hearings held across the state to collect public feedback (CMS requires two hearings) • 1,590 individuals attended public hearings, of which 323 attendees spoke • More than 750 commenters provided input through the public hearings, website, postal mail, email, voice mail and two Medical Care Advisory Committee meetings
April 12, 2016	• DHHS submitted requests for General Assembly to modify SL 2015-245
May 1, 2016	• Report on North Carolina Health Transformation Center development provided to JLOC
NEXT	
May 31, 2016	• Section 1115 demonstration waiver application will be filed with the CMS • Press conference with Gov. McCrory, Secretary Brajer; JLO chairs
June 1, 2016	• CMS and DHHS begin to discuss and refine waiver application details (estimated 18 months)
January 2018 (est.)	• Section 1115 demonstration waiver application finalized, and approved by CMS
July 1, 2019 (est.)	• Pre-paid health plans launched

S.L. 2015-245 Requirements

The following table lists S.L. 2015-245 requirements and how they are addressed.

S.L. 2015-245 REQUIREMENT	IN WAIVER APPLICATION – Y/N
Part I, Section 4: Structure of Delivery System	
4.1 DHHS authority. DHHS has full authority to manage NC Medicaid and NC Health Choice; DHB is responsible for planning and implementing Medicaid transformation	Yes
4.2 Prepaid health plan. Commercial plans and provider-led entities, which will operate a capitated contract for delivery of services	Yes
4.3 Capitated contracts. DHB will enter into capitated contracts with PHPs, as a result of RFPs and submission of competitive bids	Yes
4.4 Services covered by PHPs. PHP capitated contracts will cover all Medicaid and NC Health Choice services, including physical health services, prescription drugs, LTSS and NC Health Choice behavioral health services; LME/MCOs are excluded until 4 years after capitated contracts begin; dental services are excluded	Yes, with exceptions requested by DHHS
4.5 Populations covered by PHPs. PHP capitated contracts will cover Medicaid and NC Health Choice program aid categories except dually eligible recipients; DHB will develop a dually eligible long-term coverage strategy	Yes, with exceptions requested by DHHS
4.6 Number and nature of PHP contracts. 3 statewide contracts; 10 regional contracts; initial PHP capitated contracts may be staggered in duration of 3-5 years	Yes
4.6a PHPs will comply with General Statutes Chapter 58. Joint review by DHHS, DHB and Department of Insurance	N/A; reflected in 3/1 JLOC report
4.7 Defined measures and goals. Delivery system and contracts will be built on defined measures and goals for health outcomes, quality of care, patient satisfaction, access and cost	Yes
4.8 PHP administrative functions. PHPs are responsible for administrative functions for enrolled recipients, including claims processing, care and case management, and grievances and appeals.	Yes, details will be included in contracts
4.9 LME/MCOs. LME/MCOs will continue to manage behavioral health services for enrollees under existing waivers for 4 years after PHP capitated contracts begin; DHB will negotiate rates and make payments directly to LME/MCOs during the 4-year period	Yes
Part 1, Section 5: Role of DHHS	
5.1 Section 1115 waiver application to CMS. Submit 1115 waiver, and any other waivers and plan amendments as necessary	Yes, 1115 has been submitted; plan amendments will be submitted if and when identified
5.2 Regions. Develop 6 regions that reasonably distribute populations across the state	N/A; reflected in 3/1 JLOC report
5.3 PHP contract performance. Oversee, monitor and enforce	N/A; part of PHP contracting
5.4 Transformed Medicaid and NC Health Choice programs. Ensure sustainability	Yes
5.5a-c Set rates. Actuarially sound capitation rates that are risk-adjusted and include a portion at-risk for quality and outcome measures, and value-based payments; appropriate rate floors for in-network primary care physicians, specialist physicians, and pharmacy dispensing fees; fee-for-service rates	N/A; part of program design and PHP contracting
5.6a-e PHP standardized contract terms. Through RFPs and competitive bids, DHB will develop standard contract terms including risk-adjusted cost growth of 2% for enrollees; use of same prescription drug formulary; minimum medical loss ratio of 88%; include providers in coverage area designated as essential providers; assign enrollees a PCP if one is not elected	Yes, with details part of PHP contracting
5.7 RFPs for PHP capitated contracts. Consult with JLOC/Medicaid and NCHC before issuing RFPs	Yes
5.8 Recipient assignment to PHPs. Develop and implement process, including at least family unit, quality measures and primary care physician	Yes
5.9 Program integrity. Define methods against fraud, waste, abuse	N/A; part of program design

S.L. 2015-245 REQUIREMENT	IN WAIVER APPLICATION – Y/N
5.10 Health Information Exchange. Require PHPs and providers to submit data through HIE	Yes
5.11 Dual eligibles. Develop advisory committee; develop long-term strategy; report strategy to JLOC/Medicaid and NCHC	Yes
5.12a-n JLOC/Medicaid and NCHC reporting. March 1: Provide draft waiver, report, statutory changes, DHB staffing, contract distribution, etc.	N/A; completed
5.13a-d. Designate essential providers. Include federally qualified health centers, rural health centers, free clinics and local health departments	Yes

Changes to March 1 Draft Waiver Application

DHHS continues its commitment to listen to and engage stakeholders throughout the state. Input to the draft waiver application reflects DHHS review and consideration of:

- Public comments, including tribal consultation with the Eastern Band of Cherokee Indians (EBCI)
- DHHS internal review and discussion
- Final Medicaid managed care rule, as feasible, (published May 6, 2016)
- Modifications to improve flow and readability

Changes made to the March 1 draft waiver application for the final June 1 submission, based on public comments received are summarized below. The June 1 waiver application will include a detailed summary of public comment with DHHS' responses. Many of these comments were related to operational issues that are not addressed in the waiver application. These comments have been reviewed and will be addressed as part of program design and PHP contracting.

Changes to March 1 Draft Waiver Based on Public Comment

PUBLIC COMMENT THEME	CHANGE TO DRAFT WAIVER
Medicaid expansion requests	• No change made to waiver.
Provider concerns related to working with multiple PHPs and requests for standardization / centralization	• While no significant changes were made to the waiver, DHHS indicated its intent to work with stakeholders to minimize the administrative burden on providers. This will include working with stakeholders to maximize standardization, centralize functions where feasible, and reduce unnecessary requirements.
Concerns over beneficiary access	• DHHS clarified that network and access standards would comply with new federal regulations with additional details determined as part of program design and PHP contracting.
Cost settlement for public ambulance providers	• Added public ambulance providers and state facilities as eligible for wrap-around cost settlements.
Request to cover community paramedic programs	• Added that DHHS supports the use of cost-effective alternative services by PHPs, such as community paramedic services.
Carved out populations	• Excluded people enrolled in NC Health Insurance Premium Payment (HIPP) program from enrollment in prepaid health plans (PHPs).
Preservation of current patient-centered medical home / enhanced primary care case management model	• Waiver clarifies that these models are the foundation of person-centered health communities. Existing functionality will continue with responsibilities shared by PHPs, providers, and/or DHHS.
Requests for clarification	• Added language regarding Person-centered Health Communities and included a conceptual illustration. • Removed language that S.L. 2015-245 requires integration of physical and behavioral health services within a single capitated system. • Clarified that waiver will change delivery but not coverage of the state plan and Community Alternative Program for Children (CAP/C) or Disabled Adults (CAP/DA) services for Medicaid-only beneficiaries eligible for long-term services and supports (LTSS). • Clarified that provider-led entities are managed care organizations as defined by CMS, and that all PHPs will be required to comply with federal Medicaid managed care requirements. • Clarified that DHHS intends to contract with three statewide plans, as required by SL 2015-245. • Reference to I/DD health homes was removed with clarification that DHHS intends to support I/DD providers to enhance their ability to provide primary care for individuals with I/DD and to increase the capacity of primary care providers to better meet the needs of individuals with I/DD.
EBCI requests through tribal consultation	• Clarified that PHPs may include a tribal/Indian managed care entity. • Added EBCI proposal regarding supplemental payments for uncompensated care and alternative services. • Added various assurances requested by EBCI.

Other Changes to March 1 Draft Waiver

RATIONALE FOR CHANGE	CHANGE TO DRAFT WAIVER
CMS Public Notice Requirement	• Added summary of public notice process (e.g., website, public hearings). • Added summary of tribal consultation process. • Added summary of public comments and DHHS responses.
Additional Details Needed for Financing Section	• Added sample Delivery System Reform Incentive Payment (DSRIP) initiatives. • Added information regarding workforce initiatives. • Included projected expenditures for Medicaid Uncompensated Care Payments, DSRIP, workforce initiatives, and tribal supplemental payments for uncompensated care and alternative services.
Budget Neutrality Addition	• Added narrative and completed budget neutrality forms.
Reflection of Medicaid Managed Care Final Rule	• Added provider network standards. • Added requirements for enrollees who need long-term services and supports. • Added beneficiary support system. • Added value-based payments.
North Carolina Health Transformation Center	• Changed "Innovations Center" to North Carolina Health Transformation Center. • Reflected May 1, 2016, report to JLOC/HHS (copy of report will be attached to June 1 waiver application).
Structural Changes to Improve Readability and Flow	• Initiatives are no longer organized by Quadruple Aim elements; however, including an illustration of how each initiative aligns with each aim. • Changed order of some initiatives and items (e.g., foster care proposals included as their own initiative; moved provider administrative ease to first item of provider engagement and support initiative). • Strengthened waiver rationale and executive summary.
Eligibility Chart Required by CMS	• Added a chart of populations included or excluded from waiver and PHPs.
Appendices to Provide Additional Background and Public Notice Evidence	Added the following appendices: • Appendix B. Summary of Public Comments and Responses • Appendix C. Tribal Consultation and Assurances • Appendix D. North Carolina Health Care Transformation Center Report • Appendix E. Governor's Press Release • Appendix F. Detailed Public Notice • Appendix G. Website Comment Form • Appendix H. Abbreviated Public Notice (published in newspapers) • Appendix I. Newspaper Notices

Committee Sergeants at Arms

NAME OF COMMITTEE House Committee on Health

DATE: 06/1/2016 Room: 544

House Sgt-At Arms:

1. Name: Warren Hawkins
2. Name: David Leighton
3. Name: Malachi McCullough, Jr
4. Name: Dough Harris
5. Name:

~~Senate Sgt At Arms:~~ House Pages

1. Name: Austin Flores (Rep Nelson Dollar (Wake)
2. Name:
3. Name: Matthew Owens (Rep Holly) (Wake)
4. Name: Thomas Grubb (Speaker Moore) (PiH)
5. Name:

VISITOR REGISTRATION SHEET

House Committee on Health — 06/01/2016

Name of Committee — Date

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
CS Hollis	CSH
Gary Briggs	NCAFP
Robin Huffman	NC Psychiatric Assoc
Sean Moran	UNC
Mike McBrayer	Bryan
Erika Hagensen	NC DD Council + the Arc of NC
Emily Callen	PPSAT
Frank Hill	PSG
Kristen Dubay	NCCHCA
Penny Tomlin	SOG
Elizabeth Hudgins	NC Pediatric Society

VISITOR REGISTRATION SHEET

House Committee on Health — 06/01/2016

Name of Committee — Date

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Mandy Peal	Wellcare
Daniel Baum	Troutman Sanders
John Bode	B & H
Julia Adams Schwinck	Oak City Gov Rel
Martha L McConnell	Cardenas Healthcare
Wendy Kelly	Focus-carolina
[illegible]	[illegible]
Rob Lamm	RA
Michelle Jones	NCHA
Melissa Robins	HPE
Whitney Cherkasov	[illegible] PA

VISITOR REGISTRATION SHEET

House Committee on Health — Name of Committee

06/01/2016 — Date

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Kathy Hawkins	Duke Energy
Ryan Minto	UHG
[illegible]	NVA
[illegible]	[illegible]
Sam Dempsey	N.C. Council of Special Education Admin. Winston-Salem / Forsyth County Sch.
Lanier Hodgson	UNC Health Care
Bruce Thompson	PARKER POE
Kelly Vogel	KV Strategies
Kay Castillo	NASW-NC
Amanda Donovan	TSS
Maddy Thompson	TSS
Bill Scoggin	TSS

VISITOR REGISTRATION SHEET

House Committee on Health — 06/01/2016

Name of Committee — Date

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
J Peters	CSS
Ken Lewis	NCAHP
Jenkins	OAPI
Katey Mode	NCCHCA
Amber Harris	NCICC
Meredith Hermann	Intern @ DHB
Carey Meyer	The Carolinas Center
Adam Sholar	NCHCFA
	MFS

VISITOR REGISTRATION SHEET

House Committee on Health — 06/01/2016

Name of Committee — Date

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Sarah Wolfe	MWC
Rick Zechini	Williams Mullen
James Pesce	Cynthia for NC
Dodie Renfer	CCR
Sophie Sherman	Natl. MS Society
Mary Thyer	NC Council of Community Programs
Kim Mrl	Benchmarks
W. CLARKE LINDLEY	
Ann Marie Williamson	BioDelivery Sciences International
Oluseun Omitoogun	
Oluseyi Omitoogun	

VISITOR REGISTRATION SHEET

House Committee on Health — 06/01/2016

Name of Committee — Date

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Cody Hand	NCHA
KEVIN HUTCHINSON	PCG
James Woodard	DMVA
Christine Weaver	ACS CAN
JERRY COHEN	NM
Ed Turlington	BSC
Donna Sinko	NC Medical Society
Sarah Grimsrud	OSBM
Bonnie Queen	OSBM
ANDY MARSH	SA
Peyton Mann	82

VISITOR REGISTRATION SHEET

House Committee on Health — 06/01/2016

Name of Committee — Date

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Pamela Killian	Nelson Mullins
[signature]	NMRS
Kari Barsness	GCNC

NORTH CAROLINA HOUSE OF REPRESENTATIVES
COMMITTEE MEETING NOTICE
AND
BILL SPONSOR NOTIFICATION
2015-2016 SESSION

You are hereby notified that the **House Committee on Health** will meet as follows:

DAY & DATE: Wednesday, June 8, 2016
TIME: **10:00 AM**
LOCATION: **643 LOB**

The following bills will be considered:

BILL NO.	SHORT TITLE	SPONSOR
HB 1047	Welfare Reform/Food and Nutrition Benefits.	Representative Jones Representative Blackwell Representative Hager
HB 1145	Disapprove Dental Examiners Rule.	Representative Jones

Respectfully,

Representative Justin P. Burr, Co-Chair
Representative Bert Jones, Co-Chair
Representative Donny Lambeth, Co-Chair
Representative Brig Gen (Ret) Gary Pendleton, Co-Chair

I hereby certify this notice was filed by the committee assistant at the following offices at 2:16 PM on Tuesday, June 07, 2016.

___ Principal Clerk
___ Reading Clerk – House Chamber

Brenda Olls (Committee Assistant)

House Committee on Health
Wednesday, June 8, 2016, 10:00 AM
643 Legislative Office Building

AGENDA

Welcome and Opening Remarks

Introduction of Pages

Bills

BILL NO.	SHORT TITLE	SPONSOR
HB 1047	Welfare Reform/Food and Nutrition Benefits.	Representative Jones Representative Blackwell Representative Hager
HB 1145	Disapprove Dental Examiners Rule.	Representative Jones

Presentations

Other Business

Adjournment

House Committee on Health
Wednesday, June 8, 2016 at 10:00 AM
Room 643 of the Legislative Office Building

MINUTES

The House Committee on Health met at 10:00 AM on June 8, 2016 in Room 643 of the Legislative Office Building. Representatives Adcock, Avila, Brown, Brisson, Dobson, Earle, Farmer-Butterfield, Ford, Goodman, Hager, Hastings, Insko, Jones, Lambeth, Lucas, Martin, Murphy, Pendleton, Szoka, Waddell and Yarborough attended.

Representative Donny Lambeth, Chair, presided.

HB 1047 Welfare Reform/Food and Nutrition Benefits was removed from the agenda due to referral error to be corrected in session and placed back on agenda after session.

The motion to hear **HB 1145 Disapprove Dental Examiners Rule** was made by Representative William Brisson.

The following proposed committee substitute was considered:

Proposed Committee Substitute H1145-CSRO-36[v.2]

Representative Bert Jones explained the proposed committee substitute. Questions followed which were answered by Representative Jones. Representative Gale Adcock addressed the title change. Representative Greg Murphy made a motion for a favorable report, unfavorable to original bill, favorable to the PCS. The motion passed.

Representative Lambeth recessed the meeting at 10:15 a.m. to return 15 minutes after session to complete the agenda.

Representative Donny Lambeth, Chair
Presiding

Dina Long, Committee Clerk

HOUSE BILL 1145:
Disapprove Dental Examiners Rule.

2016-2017 General Assembly

Committee:	House Health	**Date:**	June 7, 2016
Introduced by:	Rep. Jones	**Prepared by:**	Theresa Matula Committee Staff
Analysis of:	PCS to First Edition H1145-CSRO-36		

SUMMARY: ***HB 1145 disapproves 21 NCAC 16Q .0101 General Anesthesia and Sedation Definitions, the PCS addresses issues pertaining to rules that should continue to be delayed; rules that could become effective although a delay was previously requested; and rules that became effective April 1, 2016, but the NC Board of Dental Examiners is directed not to enforce.***

CURRENT LAW: Under the Administrative Procedure Act (APA), contained in Chapter 150B, an agency adopting administrative rules must give the public notice of the proposed rules and an opportunity to comment. The agency may then adopt the rule, but the rules must be reviewed by the Rules Review Commission (Commission) before they can go into effect. If the rules are approved, they become effective on the first day of the month following review, unless the Commission receives written objections from 10 or more persons.

G.S. 150B-21.3(b1) Delayed Effective Dates- provides that if the Rules Review Commission received written objections to the rule, the rule becomes effective on the earlier of the thirty-first legislative day or the day of adjournment of the next regular session of the General Assembly that begins at least 25 days after the date the Commission approved the rule, unless a different effective date applies under this section.

If a bill that specifically disapproves the rule is introduced in either house of the General Assembly before the thirty-first legislative day of that session, the rule becomes effective on the earlier of either the day an unfavorable final action is taken on the bill or the day that session of the General Assembly adjourns without ratifying a bill that specifically disapproves the rule. If the agency adopting the rule specifies a later effective date than the date that would otherwise apply under this subsection, the later date applies. A permanent rule that is not approved by the Commission or that is specifically disapproved by a bill enacted into law before it becomes effective does not become effective.

G.S. 150B-21.3(b2) Objection – provides that if the Rules Review Commission receives written objections from 10 or more persons, no later than 5:00 P.M. of the day following the day the Commission approves the rule, clearly requesting review by the legislature in accordance with instructions posted on the agency's Web site and the Commission approves the rule, the rule will become effective as provided in subsection (b1) of this section. The Commission must notify the agency that the rule is subject to legislative disapproval on the day following the day it receives 10 or more written objections. When the requirements of this subsection have been met and a rule is subject to legislative disapproval, the agency may adopt the rule as a temporary rule if the rule would have met the criteria listed in G.S. 150B-21.1(a) at the time the notice of text for the permanent rule was published in the North Carolina Register.

Karen Cochrane-Brown
Director

H1145-SMSH-142 CSRO-36 -V-2

Legislative Analysis
Division
919-733-2578

This bill analysis was prepared by the nonpartisan legislative staff for the use of legislators in their deliberations and does not constitute an official statement of legislative intent.

If the Commission receives objections from 10 or more persons clearly requesting review by the legislature, and the rule objected to is one of a group of related rules adopted by the agency at the same time, the agency that adopted the rule may cause any of the other rules in the group to become effective as provided in subsection (b1) of this section by submitting a written statement to that effect to the Commission before the other rules become effective.

BILL ANALYSIS:

Section 1 of the HB 1145 disapproves 21 NCAC 16Q .0101 (General Anesthesia and Sedation Definitions). This rule was adopted by the North Carolina Board of Dental Examiners on December 12, 2015, and approved by the Rules Review Commission on March 17, 2016. Pursuant to G.S. 150B-21.3(b1), Section 1 of the bill disapproves 21 NCAC 16Q .0101 (General Anesthesia and Sedation Definitions). Because this bill has been introduced the rule is stayed until the end of Session, if no further action is taken, the rule will become effective. If HB 1145 is enacted, the rule is disapproved and will not become effective.

Sections 2, 3, and 4 of the PCS are needed to address issues pertaining to rules that should continue to be delayed, rules that could become effective although a delay was previously requested, and rules that became effective April 1, 2016, but the NC Board of Dental Examiners is directed not to enforce.

Section 2 of the PCS pertains to rules that were listed in written statement from the NC Board of Dental Examiners to the Rules Review Commission on March 31, 2016, submitted pursuant to G.S. 150B-21.3(b2). The written statement requested a delay of an additional group of rules because they were related to the rule described in Section 1. The rules included in this section are those rules listed in the written statement minus the rules covered by Section 3 of the bill. The rules covered by this section of the bill are disapproved to the same extent as the rule listed section 1 of the bill, meaning that the rules referenced above are stayed until the end of Session. If no further action is taken, the rule will become effective. If HB 1145 is enacted, the rules are disapproved and will not become effective.

Section 3 of the PCS lists seven rules that were included in the written statement from the NC Board of Dental Examiners to the Rules Review Commission on March 31, 2016. This section of the bill provides that those seven rules are effective April 1, 2016.

Section 4 of the PCS lists three rules that became effective April 1, 2016, but instructs the NC Board of Dental Examiners to continue to enforce these rules as they existed prior to the amendments that became effective on April 1, 2016.

EFFECTIVE DATE: House Bill 1145 would become effective when it becomes law.

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2015

H D

HOUSE BILL 1145
PROPOSED COMMITTEE SUBSTITUTE H1145-CSRO-36 [v.2]
06/07/2016 07:20:43 PM

Short Title: Disapprove Dental Examiners Rule. (Public)

Sponsors:

Referred to:

June 6, 2016

A BILL TO BE ENTITLED

AN ACT TO DISAPPROVE THE GENERAL ANESTHESIA AND SEDATION DEFINITIONS RULE AND CERTAIN RELATED RULES ADOPTED BY THE NORTH CAROLINA BOARD OF DENTAL EXAMINERS AND TO DIRECT THE NORTH CAROLINA BOARD OF DENTAL EXAMINERS NOT TO ENFORCE CERTAIN RULES.

The General Assembly of North Carolina enacts:

SECTION 1. Pursuant to G.S. 150B-21.3(b1), 21 NCAC 16Q .0101 (General Anesthesia and Sedation Definitions), as adopted by the North Carolina Board of Dental Examiners on December 12, 2015, and approved by the Rules Review Commission on March 17, 2016, is disapproved.

SECTION 2. Pursuant to G.S. 150B-21.3(b2), the North Carolina Board of Dental Examiners caused the effective dates of a number of rules that were adopted as part of a group including the rule disapproved by Section 1 of this act to be delayed as provided in G.S. 150B-21.3(b1), by submitting a written statement to the Rules Review Commission on March 31, 2016. Except as provided in Section 3 of this act, the rules listed in the Board's written statement are disapproved to the same extent as 21 NCAC 16Q .0101.

SECTION 3. Notwithstanding G.S. 150B-21.3(b2) and the written statement of the North Carolina Board of Dental Examiners dated March 31, 2016, the following rules are effective April 1, 2016:

21 NCAC 16Q .0204 (Procedure for General Anesthesia Evaluation or Inspection and Re-inspection)
21 NCAC 16Q .0205 (Results of Site Evaluation and Reevaluation)
21 NCAC 16Q.0306 (Procedure for Moderate Conscious Sedation Evaluation or Inspection and Re-inspection)
21 NCAC 16Q .0408 (Procedure for Moderate Pediatric Conscious Sedation Evaluation or Inspection and Re-inspection)
21 NCAC 16Q .0703 (Reports of Adverse Occurrences)
21 NCAC 16Q .0601 (Reports of Adverse Occurrences)
21 NCAC 16Q .0602 (Failure to Report)

SECTION 4. Notwithstanding G.S. 150B-21.3(b), the North Carolina Board of Dental Examiners shall not enforce the following rules which became effective April 1, 2016:

21 NCAC 16O .0301 (Nitrous Oxide Sedation)
21 NCAC 16O .0302 (Nitrous Oxide Monitoring)
21 NCAC 16O .0401 ((Non-Delegable Functions)

The Board shall continue to enforce these rules as they existed prior to the amendments which became effective on April 1, 2016.

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

HOUSE BILL 1145

Short Title:	Disapprove Dental Examiners Rule.	(Public)
Sponsors:	Representative Jones. *For a complete list of sponsors, refer to the North Carolina General Assembly web site.*	
Referred to:	Health	

June 6, 2016

A BILL TO BE ENTITLED

AN ACT TO DISAPPROVE THE GENERAL ANESTHESIA AND SEDATION DEFINITIONS RULE ADOPTED BY THE NORTH CAROLINA BOARD OF DENTAL EXAMINERS.

The General Assembly of North Carolina enacts:

SECTION 1. Pursuant to G.S. 150B-21.3(b1), 21 NCAC 16Q .0101 (General Anesthesia and Sedation Definitions), as adopted by the North Carolina Board of Dental Examiners on December 12, 2015, and approved by the Rules Review Commission on March 17, 2016, is disapproved.

SECTION 2. Notwithstanding G.S. 150B-21.3(b1), the following rules, as adopted by the North Carolina Board of Dental Examiners on December 12, 2015, and approved by the Rules Review Commission on March 17, 2016, are disapproved:

21 NCAC 16O .0301
21 NCAC 16O .0302
21 NCAC 16O .0401
21 NCAC 16Q .0201
21 NCAC 16Q .0202
21 NCAC 16Q .0205
21 NCAC 16Q .0206
21 NCAC 16Q .0207
21 NCAC 16Q .0301
21 NCAC 16Q .0302
21 NCAC 16Q .0304
21 NCAC 16Q .0305
21 NCAC 16Q .0401
21 NCAC 16Q .0402
21 NCAC 16Q .0404
21 NCAC 16Q .0405
21 NCAC 16Q .0406
21 NCAC 16Q .0408
21 NCAC 16Q .0501
21 NCAC 16Q .0502
21 NCAC 16Q .0503
21 NCAC 16Q .0601
21 NCAC 16Q .0602

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

NORTH CAROLINA GENERAL ASSEMBLY
HOUSE OF REPRESENTATIVES

HEALTH COMMITTEE REPORT
Representative Justin P. Burr, Co-Chair
Representative Bert Jones, Co-Chair
Representative Donny Lambeth, Co-Chair
Representative Brig Gen (Ret) Gary Pendleton, Co-Chair

FAVORABLE COM SUB , UNFAVORABLE ORIGINAL BILL

HB **1145** Disapprove Dental Examiners Rule.

Draft Number:	H1145-PCS30517-RO-36
Serial Referral:	None
Recommended Referral:	None
Long Title Amended:	Yes
Floor Manager:	Jones

TOTAL REPORTED: 1

Committee Sergeants at Arms

NAME OF COMMITTEE HOUSE COMMITTEE ON HEALTH

DATE: 6-08-2016 AM Room: 643

House Sgt-At Arms:

1. Name: REGGIE SILLS
2. Name: MARVIN LEE
3. Name: JOE AUSTIN
4. Name: RANDY WALL
5. Name: _____

Senate Sgt-At Arms:

1. Name: _____
2. Name: _____
3. Name: _____
4. Name: _____
5. Name: _____

Please admit the following House Pages to the Health committee meeting:

6/8/16 AM

Annah Bishop, Wake County

Kasey Jackson, Wake County

Seth Laton, Mariette Georgia

Mattheos Meliones, Orange County

Wyatt Schline, Wake County

Thank you,

Carol Waer

Substitute House Page Supervisor

VISITOR REGISTRATION SHEET

Health — 6/8/16 (am)

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Payton Mayo	
Christine Craig	WakeMed
Lexi Arthur	NCRMA
Elizabeth Robinson	NCRMA

VISITOR REGISTRATION SHEET

Health — 6/8/16 (am)

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Allison Pitts	NCDA&CS
Rebecca Eskulis	CFSA
Aaron Oxendine	DACS
Jonathan Babaker	Babaker + Assoc.
Sarah Bales	Babaker + Assoc.
[illegible]	NCEL
Phoebe Landon	mwc
Pat Archibald	NCEL
Bre Hager	NCEL
[illegible]	[illegible]
[illegible]	CSS
[illegible]	Rep. Fisher
ANDY WALSH	SA

VISITOR REGISTRATION SHEET

Health — 6/8/16 (am)

Name of Committee — Date

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Wendy Kelly	Town carolina
Daniel Baum	Daniel Baum
Daphne Snow	Cape Fear Arthritis Care
Constance Moscati	Cape Fear Arthritis Care
J Peters	CSS
Curtis McDonald	DHHS
Joy Peters	CSS
Penny Huffin	SOG
Will Morgan	TNC
[illegible]	P/A
Mike Fox	DOT

VISITOR REGISTRATION SHEET

Health — 6/8/16 (am)

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Cameron Cox, III	MSOC Health
Cameron Nieters	KTS
Lisa Ward	NC Dental Society
Bobby White	NC Dental Board
Molly Masich	OAH
Daniel Jordan	NCHTA
Leah Panaschin	MSOC Health
Lauren Ballew	MSOC Health
Lee Katherine Ayer	MSOC Health
James Pearce	Cynthia for NC
Susan Santaniello	Carolina Endocrine Raleigh

VISITOR REGISTRATION SHEET

Health — Name of Committee

6/8/16 (am) — Date

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
SINEAD INGERSOLL	NORTH CAROLINA EYE, EAR, NOSE + THROAT

VISITOR REGISTRATION SHEET

Health — 6/8/16 (am)

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Ashley Parkinson	Parkinson Law
[illegible]	RAHC
Debbie Clary	NCSP
Lee Dodson	BHADA
[illegible]	[illegible]
Sherea Vodicka	NC Alliance of YMCAs
Matt Gross	NCPC
Amy McConkey	NC Beverage
David Heinen	NC Center for Nonprofits
Geneva Holmes	NC Center for Nonprofits
Jacob Rodman	Raleigh Neurosurgical Clinic

NORTH CAROLINA HOUSE OF REPRESENTATIVES
COMMITTEE MEETING NOTICE
AND
BILL SPONSOR NOTIFICATION
2015-2016 SESSION

You are hereby notified that the **House Committee on Health** will meet as follows:

DAY & DATE: Wednesday, June 8, 2016
TIME: **15 Minutes After Session**
LOCATION: **643 LOB**
COMMENTS: **HB 1047 WELFARE REFORM/FOOD AND NUTRITION BENIFITS will be heard.**

Respectfully,

Representative Justin P. Burr, Co-Chair
Representative Bert Jones, Co-Chair
Representative Donny Lambeth, Co-Chair
Representative Brig Gen (Ret) Gary Pendleton, Co-Chair

I hereby certify this notice was filed by the committee assistant at the following offices at 10:48 AM on Wednesday, June 08, 2016.

___ Principal Clerk
___ Reading Clerk – House Chamber

Brenda Olls (Committee Assistant)

House Committee on Health
Wednesday, June 8, 2016 at 15 Minutes After Session
Room 643 of the Legislative Office Building

MINUTES

The House Committee on Health met 15 Minutes After Session (approximately 4:45pm) on June 8, 2016 in Room 643 of the Legislative Office Building. Representatives Adcock, Avila, Bishop, Blackwell, Dobson, Earle, Farmer-Butterfield, Goodman, Hager, Insko, Jones, Murphy, Pendleton, Szoka, Wray, and Yarborough attended.

Representative Brig Gen (Ret) Gary Pendleton, Chair, presided.

The following bill was considered: HB1047

Representative Gary Pendleton made a motion before the committee to hear PCS H1047-CSSH-68 (v.5)

Representative Bert Jones explained the bill.

There were discussions and questions on the bill by, individuals from Jamie representing the Lottery Commission and David Locklear representing DHHS. Questions were asked from Representatives Adcock, Earle, Insko, Avila, Murphy and Carney.

Representative Insko presented Amendment H1047-ASH-29 (v.1). The amendment passed.

Representative Murphy made a motion to accept the bill.

The final motion was "favorable report to the PCS as amended, rolled into a new PCS."

The meeting adjourned at approximately 5:35pm.

Representative Brig Gen (Ret) Gary Pendleton, Chair Presiding

Kathy Peters, Committee Clerk

HOUSE BILL 1047:
Welfare Reform/Food and Nutrition Benefits.

2016-2017 General Assembly

Committee:	House Health	**Date:**	June 7, 2016
Introduced by:	Reps. Jones, Blackwell, Hager	**Prepared by:**	Theresa Matula
Analysis of:	PCS to First Edition H1047-CSSH-68		Committee Staff

SUMMARY: ***The PCS for House Bill 1047 requires the NC Lottery Commission to provide information on certain lottery winnings to the Division of Social Services, Department of Health and Human Services (DHHS); requires DHHS to review, on at least a monthly basis, the lottery winners and to crosscheck that information with applicants for or recipients of food and nutrition services (FNS) benefits; requires the LRC to study a limitation on categorical eligibility for FNS; and requires the Department to implement disqualification periods for noncompliance with work requirements for FNS benefits.***

CURRENT LAW/ SUPPLEMENTAL INFORMATION

G.S. 18C-114 outlines the powers and duties of the North Carolina State Lottery Commission

G.S. 18C-132 provides the procedures for drawings and claiming prizes; payment of prizes; protection of information concerning certain prize winners.

Food and Nutrition Services (FNS) is a federal program that provides food assistance to low-income households. Benefits are issued on Electronic Benefit Transfer (EBT) cards. Eligibility includes consideration of age and disability and is based on the following criteria: income, household composition, citizenship/immigration status, and resources. The following link provides additional information on income and resource limits: http://www.ncdhhs.gov/assistance/low-income-services/food-nutrition-services-food-stamps. In general, FNS recipients are certified every 6-12 months. Lottery winnings would generally be considered a non-recurring lump-sum payment and the amount available is counted as a resource.

Further, an able-bodied adult without dependent (ABAWD) is defined as a physically and mentally fit individual between the ages of 18 through 49, included in a FNS unit that does not include a person under age 18. A FNS unit that includes an ABAWD must report when the ABAWD stops working an average of 80 hours per month. If an FNS unit member fails to comply with a work requirement, the individual is disqualified from the FNS Program for a period of time. Title 7 of the Code of Federal Regulations (CFR) § 273.7 provides work provisions related to FNS.

G.S. 108A-51 provides that the Department of Health and Human Services is the State agency responsible for supervision of the FNS program. Boards of County Commissioners through county departments of social services are responsible for administration and operation of the program.

BILL ANALYSIS: Section 1 requires the North Carolina State Lottery Commission to report certain cash lottery winnings information to the Department of Health and Human Services, Division of Social Services, who must crosscheck that information with applicants for or recipients of food and nutrition benefits.

Karen Cochrane-Brown
Director

Legislative Analysis Division
919-733-2578

This bill analysis was prepared by the nonpartisan legislative staff for the use of legislators in their deliberations and does not constitute an official statement of legislative intent.

- **Section 1(a)** amends G.S. 18C-114(a) to require the Lottery Commission to provide information to the Department of Health and Human Services (DHHS), Division of Social Services (DSS), regarding persons claiming cash prizes in the amount of $2,500 or more.
- **Section 1(b)** adds section, G.S. 18C-176, to require the Commission to provide the name, prize amount, and any other available identifying information for persons claiming a cash prize of $2,500 or more. The information must be provided on a monthly basis to DHHS, DSS, in order to allow a crosscheck of the information with applicants for or recipients of food and nutrition benefits. An exception is granted under G.S. 18C-132(k) for a prize winner who submits to the Commission a protective order or a valid Address Confidentiality Program Authorization card, in those situations the prize winner's identifying information is treated as confidential information.
- **Section 1(c)** adds a new section, G.S. 108A-52.1, to Part 5, Article 2 of Chapter 108A, pertaining to Food and Nutrition Services requiring the Department of Health and Human Services (DHHS) to review, at least monthly, the cash lottery prize winners as provided by the Lottery Commission. DHHS is specifically required to crosscheck the information with applicants for or recipients of food and nutrition benefits. If DHHS determines that an applicant or recipient has not reported lottery winnings that exceed $2,500, the Department is required to conduct further review to determine possible fraudulent misrepresentation.

Section 2 requires the Legislative Research Commission (LRC) to study limiting categorical eligibility for FNS benefits based on noncash, in-kind, or other benefit unless expressly required by federal law which is contained in Section 2 of the bill as introduced. The LRC is required to report findings and any proposed legislation to the 2017 Regular Session of the 2017 General Assembly.

Section 3 adds a new section, 108A-52.2, to require the DHHS to implement the following disqualification periods for noncompliance under 7 CFR §273.7 unless prohibited by federal law:

- A three month, full household disqualification period for the first instance of noncompliance.
- A six month, full household disqualification period for the second instance of noncompliance.
- A permanent disqualification period for the third instance of noncompliance. If a recipient is subject to disqualification under this subdivision, the recipient's full household is subject to a six month disqualification period.

The section further provides that a recipient of FNS benefits will also be subject to disqualification from receiving FNS benefits for failure to comply with the requirements of any other federal, State or local means-tested public assistance programs unless prohibited by federal law. The Social Services Commission is authorized to adopt rules to implement the section.

Section 4 requires the Lottery Commission to begin providing information under Section 1(b) one month after the act becomes effective.

Section 5 provides that any savings resulting from this bill would be used by the DHHS for services to individuals identified as autistic.

EFFECTIVE DATE: The PCS provides that Sections 2 (LRC Study) and 6 (Effective Date) become effective when the bill becomes law, the remainder of the bill is effective six months after it becomes law.

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2015

H D

HOUSE BILL 1047
PROPOSED COMMITTEE SUBSTITUTE H1047-CSSH-68 [v.5]
06/07/2016 03:09:18 PM

Short Title: Welfare Reform/Food and Nutrition Benefits. (Public)

Sponsors:

Referred to:

May 9, 2016

A BILL TO BE ENTITLED

AN ACT TO REQUIRE THE NORTH CAROLINA LOTTERY COMMISSION TO PROVIDE CERTAIN CASH LOTTERY WINNINGS INFORMATION TO THE DEPARTMENT OF HEALTH AND HUMAN SERVICES, DIVISION OF SOCIAL SERVICES; TO CROSSCHECK WITH THE INFORMATION OF APPLICANTS FOR OR RECIPIENTS OF FOOD AND NUTRITION BENEFITS; TO DIRECT THE LEGISLATIVE RESEARCH COMMISSION TO STUDY THE EXTENT TO WHICH NORTH CAROLINA CAN DISQUALIFY LOTTERY WINNERS FROM RECEIPT OF FOOD AND NUTRITION BENEFITS; AND TO IMPLEMENT CERTAIN DISQUALIFICATION PERIODS FOR NONCOMPLIANCE WITH WORK REQUIREMENTS FOR FOOD AND NUTRITION BENEFITS.

The General Assembly of North Carolina enacts:

SECTION 1.(a) G.S. 18C-114(a) is amended by adding a new subdivision to read:

"(a) The Commission shall have the following powers and duties:

...

(6a) To provide certain information to the Department of Health and Human Services, Division of Social Services, regarding persons claiming cash prizes that equal or exceed two thousand two hundred and fifty dollars ($2,250.00), as required in G.S. 18C-176.

...."

SECTION 1.(b) Article 8 of Chapter 18C of the General Statutes is amended by adding a new section to read:

"**§ 18C-176. Report certain cash lottery winnings information to the Department of Health and Human Services, Division of Social Services.**

In accordance with G.S. 108A-52.1, the Commission shall provide the name, prize amount, and any other available identifying information of a person claiming a cash prize that equals or exceeds two thousand two hundred and fifty dollars ($2,250.00) to the Department of Health and Human Services, Division of Social Services (Division), to crosscheck the information with applicants for or recipients of food and nutrition benefits pursuant to Part 5 of Article 2 of Chapter 108A of the General Statutes. The Commission shall provide the information required by this section to the Division on at least a monthly basis. However, nothing is this section shall be construed as affecting a cash prize winner whose identifying information is otherwise protected under G.S. 18C-132(k)."

SECTION 1.(c) Part 5 of Article 2 of Chapter 108A of the General Statutes is amended by adding a new section to read:

"**§ 108A-52.1. Review of lottery winnings information provided by the North Carolina Lottery Commission.**

The Department shall, on at least a monthly basis, review the information of cash lottery prize winners as provided by the North Carolina Lottery Commission pursuant to G.S. 18C-176. In reviewing the information, the Department shall crosscheck that information with applicants for or recipients of food and nutrition benefits under this Part. If after any monthly review the Department determines that an applicant or recipient has not reported to the Department cash lottery winnings that equal or exceed two thousand two hundred and fifty dollars ($2,250.00), the Department shall conduct further review to determine possible fraudulent misrepresentation by the applicant or recipient as prohibited under G.S. 108A-53. Any information the North Carolina Lottery Commission submits to the Department pursuant to this section is confidential and shall not be disclosed except as otherwise required for the implementation of this section."

SECTION 2. (a) The Legislative Research Commission shall study the determination of eligibility and the limitation on categorical eligibility as provided in G.S. 108A-52 and House Bill 1047, Section 2, as introduced during the 2015 Session.

SECTION 2. (b) The Legislative Research Commission shall report its findings, together with any proposed legislation, to the 2017 Regular Session of the 2017 General Assembly upon its convening.

SECTION 3. Part 5 of Article 2 of Chapter 108A of the General Statutes is amended by adding a new section to read:

"**§ 108A-52.2. Disqualification for noncompliance with work requirements for food and nutrition benefits.**

(a) The Department shall implement the following disqualification periods for any instance of noncompliance under 7 CFR §273.7, unless expressly prohibited by federal law:

(1) A three-month, full-household disqualification period for the first instance of noncompliance.

(2) A six-month, full-household disqualification period for the second instance of noncompliance.

(3) A permanent disqualification period for the third instance of noncompliance. If a recipient is subject to disqualification under this subdivision, the recipient's full household is subject to a six-month disqualification period.

(b) A recipient of food and nutrition benefits shall also be subject to disqualification from receiving food and nutrition benefits under this Part for failure to comply with the requirements of any other federal, State, or local means-tested public assistance programs, unless expressly prohibited by federal law.

(c) The Social Services Commission is authorized to adopt any rules necessary to implement this section."

SECTION 4. The North Carolina Lottery Commission shall begin providing the information required under Section 1(b) of this act one month after this act becomes effective.

SECTION 5. Any future savings resulting from implementation of this act may be reallocated to the Department of Health and Human Services for services to individuals identified as autistic.

SECTION 6. Sections 2 and 6 of this act become effective when it becomes law, the remainder of this act becomes effective six months after it becomes law.

HOUSE BILL 1047

Short Title:	Welfare Reform/Food and Nutrition Benefits.	(Public)
Sponsors:	Representatives Jones, Blackwell, and Hager (Primary Sponsors). *For a complete list of sponsors, refer to the North Carolina General Assembly web site.*	
Referred to:	Health	

May 9, 2016

A BILL TO BE ENTITLED

AN ACT TO REQUIRE THE NORTH CAROLINA LOTTERY COMMISSION TO PROVIDE CERTAIN CASH LOTTERY WINNINGS INFORMATION TO THE DEPARTMENT OF HEALTH AND HUMAN SERVICES, DIVISION OF SOCIAL SERVICES; TO CROSSCHECK WITH THE INFORMATION OF APPLICANTS FOR OR RECIPIENTS OF FOOD AND NUTRITION BENEFITS; TO LIMIT THE MEANS BY WHICH A PERSON MAY BE GRANTED CATEGORICAL ELIGIBILITY FOR PURPOSES OF RECEIVING FOOD AND NUTRITION BENEFITS UNDER THE SUPPLEMENTAL NUTRITION AND ASSISTANCE PROGRAM (SNAP); AND TO IMPLEMENT CERTAIN DISQUALIFICATION PERIODS FOR NONCOMPLIANCE WITH REQUIREMENTS FOR FOOD AND NUTRITION BENEFITS.

The General Assembly of North Carolina enacts:

SECTION 1.(a) G.S. 18C-114(a) is amended by adding a new subdivision to read:

"(a) The Commission shall have the following powers and duties:

...

(6a) To provide certain information to the Department of Health and Human Services, Division of Social Services, regarding persons claiming cash prizes in the amount of six hundred dollars ($600.00) or more as required in G.S. 18C-176.

...."

SECTION 1.(b) Article 8 of Chapter 18C of the General Statutes is amended by adding a new section to read:

"**§ 18C-176. Report certain cash lottery winnings information to the Department of Health and Human Services, Division of Social Services.**

In accordance with G.S. 108A-52.1, the Commission shall provide the name, prize amount, and any other available identifying information of a person claiming a cash prize of six hundred dollars ($600.00) or more to the Department of Health and Human Services, Division of Social Services (Division), to crosscheck the information with applicants for or recipients of food and nutrition benefits pursuant to Part 5 of Article 2 of Chapter 108A of the General Statutes. The Commission shall provide the information required by this section to the Division on at least a monthly basis. However, nothing is this section shall be construed as affecting a cash prize winner whose identifying information is otherwise protected under G.S. 18C-132(k)."

SECTION 1.(c) Part 5 of Article 2 of Chapter 108A of the General Statutes is amended by adding a new section to read:

"**§ 108A-52.1. Review of lottery winnings information provided by the North Carolina Lottery Commission.**

The Department shall, on at least a monthly basis, review the information of cash lottery prize winners as provided by the North Carolina Lottery Commission pursuant to G.S. 18C-176. In reviewing the information, the Department shall crosscheck that information with applicants for or recipients of food and nutrition benefits under this Part. If after any monthly review the Department determines that an applicant or recipient has not reported to the Department cash lottery winnings that exceed an amount corresponding to the resource limit for food and nutrition services set by federal law, the Department shall conduct further review to determine possible fraudulent misrepresentation by the applicant or recipient as prohibited under G.S. 108A-53. Any information the North Carolina Lottery Commission submits to the Department pursuant to this section is confidential and shall not be disclosed except as otherwise required for the implementation of this section."

SECTION 2. G.S. 108A-52 reads as rewritten:

"**§ 108A-52. Determination of ~~eligibility.~~eligibility; limitation on categorical eligibility.**

(a) Any person who believes that he or another person is eligible to receive electronic food and nutrition benefits may apply for such assistance to the county department of social services in the county in which the applicant resides. The application shall be made in such form and shall contain such information as the Social Services Commission may require. Upon receipt of an application for electronic food and nutrition benefits, the county department of social services shall make a prompt evaluation or investigation of the facts alleged in the application in order to determine the applicant's eligibility for such assistance and to obtain such other information as the Department may require. Upon the completion of such investigation, the county department of social services shall, within a reasonable period of time, determine eligibility.

(b) Notwithstanding any provision of law to the contrary, the Department shall not grant a person categorical eligibility under 7 U.S.C. § 2014(a) for the food and nutrition services program based on noncash, in-kind, or other benefit unless expressly required by federal law."

SECTION 3. Part 5 of Article 2 of Chapter 108A of the General Statutes is amended by adding a new section to read:

"**§ 108A-52.2. Disqualification for noncompliance with requirements for food and nutrition benefits.**

(a) The Department shall implement the following disqualification periods for any instance of noncompliance with one or more substantive requirements for food and nutrition benefits, unless expressly prohibited by federal law:

(1) A three-month, full-household disqualification period for the first instance of noncompliance.

(2) A six-month, full-household disqualification period for the second instance of noncompliance.

(3) A permanent disqualification period for the third instance of noncompliance. If a recipient is subject to disqualification under this subdivision, the recipient's full household is subject to a six-month disqualification period.

(b) A recipient of food and nutrition benefits shall also be subject to disqualification from receiving food and nutrition benefits under this Part for failure to comply with the requirements of any other federal, State, or local means-tested public assistance programs, unless expressly prohibited by federal law.

(c) The Social Services Commission is authorized to adopt any rules necessary to implement this section."

SECTION 4. The North Carolina Lottery Commission shall begin providing the information required under Section 1(b) of this act one month after this act becomes effective.

SECTION 5. Any future savings resulting from implementation of this act may be reallocated to the Department of Health and Human Services for services to individuals identified as autistic.

SECTION 6. This act becomes effective six months after it becomes law.

NORTH CAROLINA GENERAL ASSEMBLY
AMENDMENT
House Bill 1047

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

H1047-ASH-29 [v.1]

Amends Title [NO]
H1047-CSSH-68

Date _____,2016

Representative Insko

moves to amend the bill on page 2, lines 40-42, by rewriting the lines to read:

"**SECTION 5.** Any future savings resulting from implementation of this act may be reallocated to the Department of Health and Human Services for services to individuals identified as autistic, mentally ill, intellectually or developmentally delayed, and substance addicted.".

SIGNED _____
Amendment Sponsor

SIGNED _____
Committee Chair if Senate Committee Amendment

ADOPTED _____ FAILED _____ TABLED _____

NORTH CAROLINA GENERAL ASSEMBLY
HOUSE OF REPRESENTATIVES

HEALTH COMMITTEE REPORT
Representative Justin P. Burr, Co-Chair
Representative Bert Jones, Co-Chair
Representative Donny Lambeth, Co-Chair
Representative Brig Gen (Ret) Gary Pendleton, Co-Chair

FAVORABLE COM SUB , UNFAVORABLE ORIGINAL BILL

HB **1047** Welfare Reform/Food and Nutrition Benefits.

Draft Number:	H1047-PCS40657-SH-68
Serial Referral:	None
Recommended Referral:	None
Long Title Amended:	Yes
Floor Manager:	Jones

TOTAL REPORTED: 1

CMR714-V-3

VISITOR REGISTRATION SHEET

House Standing Committee - HEALTH — 6/8/2016 (pm)

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Brian Perkins	DHHS
Jillian Dotman	MUSC/CC
Mark A McConnell	Cardinas Healthcare Sup
Vicki Simmons	NCDPI - Council on Educational Services for Exc. Children
Mary LaCorte	Council on Exc. Services & NC Statewide PTI
Pat Yancey	SHIFT NC
Johanna Reese	NCACC

VISITOR REGISTRATION SHEET

House Standing Committee - HEALTH — 6/8/2016 (pm)

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Stephen Isaacs	CCS
[signature]	NP
TJ Bugbee	NP
[signature]	RLA
David Lacklear	DHHS
Betsy Moore	DHHS
Penny Griffin	SOG
Phoebe Landon	NNJC
Aaron Crenshaw	DHCS
Rebecca Eskalis	CFA
[signature]	NC DHHS

VISITOR REGISTRATION SHEET

House Standing Committee - HEALTH — 6/8/2016 (pm)

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Lexi Arthur	NCRMA
Hayden Robinson	NCRMA
Andy Allen	NCRMA

VISITOR REGISTRATION SHEET

House Standing Committee - HEALTH — 6/8/2016 (pm)

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Jaime King Fogarty	NCEL
Bre Vlooger	NCEL
Pat Archibald	NCEL
Julia Adams Scheurich	Oak City Govt Relations
Cameron Nieters	KTS
Hayden Bauguss	FSP
Sarah Bales	Brubaker & Associates
John Del Giorno	Brubaker & Associates
Hugh Johnson	NCAA
By El	NCHA
Wes Perry-Hill	NCHFA