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**INTERIM REPORT
TO THE**

1977

**GENERAL ASSEMBLY OF NORTH CAROLINA
SECOND SESSION 1978**

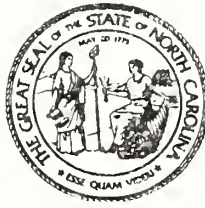
LEGISLATIVE COMMISSION

on

MEDICAL COST

CONTAINMENT

RALEIGH, NORTH CAROLINA



MEDICAL COST CONTAINMENT COMMISSION

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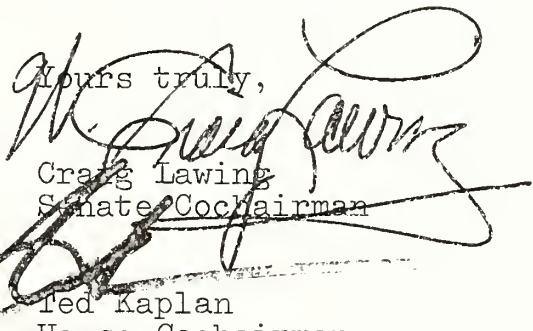
Dear Sirs:

On behalf of the members of the Legislative Commission on Medical Cost Containment, it is our pleasure to present to you our findings and recommendations. The Interim Report contains the findings and conclusions of this Commission after the first year of extensive study and hearings.

The Report contains sections with appropriate headings so that you may examine a part or all of the Report. Within each section are the Commission's findings of the trends across the country, the circumstances in North Carolina, and the recommendations for change. In addition, there is an Executive Summary for your review. Where necessary, proposed legislation has been prepared for your consideration. In our final report to the 1979 General Assembly more legislation will follow.

The Commission members are available to you if you have questions. We thank you for the opportunity to serve you and the people of North Carolina.

Yours truly,


Craig Lawing
Senate Cochairman


Ted Kaplan
House Cochairman



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ENABLING LEGISLATION

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 1977
RATIFIED BILL

CHAPTER 968

HOUSE BILL 630

AN ACT TO CREATE THE LEGISLATIVE COMMISSION ON MEDICAL COST
CONTAINMENT.

Whereas, the General Assembly of North Carolina is currently faced with large cost increases in the State's Medicaid Program in the 1977-1979 biennium; and

Whereas, the problem of rising Medicaid costs has been compounded by severe management problems within the program; and

Whereas, rising costs of Medicaid coverage for the State's poor have been paralleled by increases in the cost of health insurance coverage for employees in the public and private sector; and

Whereas, the General Assembly of North Carolina believes that the spiraling costs of health care imperils the continued access to appropriate medical services by all citizens of the State; and

Whereas, the General Assembly recognizes that while certain short-range options may be exercised during this legislative session no plan exists to deal with the broader issue of rising health care costs for all citizens of the State; Now, therefore,

The General Assembly of North Carolina enacts:

Section 1. There is hereby created the Legislative Commission on Medical Cost Containment.

Sec. 2. Duties of the commission. The commission shall study the present health care system in North Carolina and the cost trends associated with that system. The commission shall review North Carolina's Medicaid program and the cost trends associated with that program. The commission shall review medical cost containment programs that have been established in North Carolina and in other states. In the course of its hearings the commission shall receive testimony from consumers, providers of medical services, or their representative State agencies involved in the delivery and the regulation of medical services, representatives of the health insurance industry, and representatives of private industry.

In its reports the commission shall make recommendations on cost containment options for the State's Medicaid program, and any other medical service or reimbursement programs operated by the State. The commission shall also make recommendations on medical cost containment proposals that will impact on all people of the State of North Carolina.

Sec. 3. Organization of the commission.

(a) The commission shall consist of six members appointed by the President of the Senate from that body and six members appointed by the Speaker of the House of Representatives from that body. The members of the commission shall be appointed within 30 days of ratification of this act and they shall serve until termination of the commission.

(b) If a vacancy occurs in the membership of the commission, it shall be filled by action of the officer who appointed the former member who is to be replaced, and the person

then appointed shall serve for the remainder of the term of the member whom he succeeds.

(c) The Speaker of the House of Representatives and the President of the Senate shall appoint cochairman for the commission.

Sec. 4. Staff support for the commission. In executing its duties the commission is authorized to hire such professional assistance and secretarial support as it deems necessary. The commission is also authorized to utilize the staff of the Fiscal Research Division and the General Research Division as it deems appropriate. Commission members are authorized to receive subsistence and mileage at the statutory rates in lieu of compensation.

Sec. 5. Appropriations to the commission. There is hereby appropriated to the General Assembly for the Legislative Commission on Medical Cost Containment from the General Fund of the State fifteen thousand dollars (\$15,000) in fiscal year 1977-78. These funds shall be used in the performance of the duties set forth in this act.

Sec. 6. Reports by the commission. The commission shall file an interim report with the President of the Senate and the Speaker of the House of Representatives by April 1, 1978. The commission shall file its final report with the President of the Senate and the Speaker of the House of Representatives by April 1, 1979. The final report of the commission shall summarize the information obtained in the course of its inquiry, set forth any findings and conclusions, and recommend such administrative actions or legislative actions that may be

necessary to contain rising medical costs. If legislation is recommended, the commission shall prepare and submit with its report appropriate bills. Upon termination of the commission, the chairman shall transmit to the Legislative Library for preservation the records and papers of the commission. The commission shall terminate upon the filing of its report.

Sec. 7. This act shall become effective upon ratification.

In the General Assembly read three times and ratified, this the 1st day of July, 1977.

JAMES C. GREEN, SR.

James C. Green
President of the Senate

CARL J. STEWART, JR.

Carl J. Stewart, Jr.
Speaker of the House of Representatives

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Mr. David McCombs	Duke University Graduate Student
Professor David Warren	Duke University

The Commission would also like to extend its thanks to all those who aided the Commission in carrying out its duties. A special thanks goes to Dr. Sarah Morrow and staff from the Department of Human Resources who participated in the drafting of many of the recommended bills.

EXECUTIVE SUMMARY

EXECUTIVE SUMMARY

In 1977, the Legislature established the Commission on Medical Cost Containment to study the present health care system in North Carolina and the cost trends associated with that system. The Commission was directed to make recommendations for containing health care costs which would impact both the State's Medicaid Program and individuals in North Carolina. (Page 1)

BACKGROUND AND FINDINGS

The evidence and testimony of over 65 individuals appearing before the Medical Cost Containment Commission cited instance after instance of gross and unnecessary cost inflation in the health care sector. Since 1950, for example, price increases and growth in total expenditures for medical care have significantly outpaced increases for other consumer goods and services. Even more alarming, since 1965 double digit inflation has become the rule rather than the exception for health services. The rate of inflation in the State of North Carolina is somewhat, but not substantially, lower than nationwide figures. (Page 4)

In its discussion, the Commission divided medical care into

five service components; Hospitals, Physicians, Technology, Long Term Care and Medicaid. While the Commission found the most dramatic inflationary trends in Hospital Services, each component clearly showed some symptoms of inflation. The (Page 8) acceleration in expenditures for Long Term Care Services were given special attention in this report. (Page 28)

The Commission found that, in general, rising costs and expenditures for health care reflected fundamental changes -- growth -- in the availability of care, the utilization of care and the intensity of that care. Not only has there been an increase in the number of facilities available to consumers, but the number of services within health care facilities has also grown through advances in medical technology. While it is clear that increases in the intensity and availability of care raises cost, the Commission concluded that it is not always known whether new services improve health status or for that matter to what extent new facilities improve access to health care. Increasing expenditures, for example, have not solved the nation's problems regarding access to care since some

individuals still do not have even basic health services

available to them.

(Page 42)

Is the public getting its money's worth in health care?

The Commission concluded no. Because of the implications of

the conclusion, a great deal of time was spent examining the

causes of inflation in the health care sector.

(Page 44)

No complex problem has a simple cause, nor for that matter a simple solution. Rising health care costs are no exception.

The Commission, in the course of its hearings, however, identified

two primary factors--health care economics and medical education

which in combination appear to determine the pattern and cost of

care. First, there is considerable evidence that competitive

market forces which serve to hold down price and enhance effi-

ciency are largely absent from the economic structure of health

care. The absence of such forces appears to be a direct conse-

quence of widespread insurance and financing arrangements between

providers and insurers. In the health care transaction, the patient con-

sumes a service and payment for that service is made to the health

care facility on his/her behalf. Because there is no direct

payment, the consumer need not consider the price of that service and consequently, he tends to consume more and more expensive services. Since coverage is frequently greatest for high-cost care such as hospitalization and nursing home care, the consumer also tends to use the more expensive setting. Insurance protects him/her from the financial consequences of this behavior. Furthermore, under insurance coverage, the seller-provider need not be concerned about the price consumers are (Page 49) willing to pay for his/her service. The provider knows that the third-party insurer will reimburse him/her for the care delivered typically retrospectively or after the care. (Page 54)

Without price considerations, then, the inflationary cycle continues. Consumers demand more care; providers deliver more care; utilization of services increases; availability of services increases; intensity of services increases; and correspondingly cost goes up. (Page 56)

This is not the whole story. The Commission found that medical education also plays a significant role since it produces the physicians who are the central figures in health care decisions,

economic or otherwise. Increasingly, the new physician is highly specialized and accustomed to a style of medical practice requiring expensive equipment and procedures. The new physician contributes to the inflationary cycle, then, by adding an expensive practice to the limitless financing (Page 57) provided by third-party insurance.

SOLUTIONS AND RECOMMENDATIONS

The Commission reviewed three general strategies for dealing with medical cost inflation. The first can be termed the private market strategy which includes both attempts at (Page 60) voluntary price control and attempts to restore competition to health care economics. The second strategy encompasses various forms of public regulation at the state and Federal level. A (Page 68) third strategy, and the one the Commission favors, requires a careful balance between private market and public regulatory solutions. A review of cost containment activities in other (Page 73) states suggested that the latter alternative was the most successful. Consequently the following recommendations reflect the Commission's commitment to combining private and public plans.

Medicaid

Very early in its discussions, the Medical Cost Containment Commission realized that growth in the Medicaid budget was in large part symptomatic of a deeper problem with health care (Page 36) generally. However, an intensive study of the North Carolina Medicaid program by Peat, Marwick and Mitchell yielded two cost

containment proposals specific to that program. Both should add stability to the administration of the Medicaid Program; the first, by allowing the State to contract on a long term basis for claims processing and the second by reducing the fragmentation of management responsibility in the program. The Secretary of the Department of Human Resources has taken steps to create a separate division responsible solely for Medicaid. Legislative action, however, is required to remove the current rule-making authority for the program from the Division of Social Services and to place it with the new division. It is therefore recommended that the Legislature

Repeal the present provision in G.S. 108-60 that prevents the State from contracting for Medicaid claims processing beyond December 31, 1979. (Page 75 and Appendix B)

Remove rule-making authority for Medicaid from the Social Services Commission. (Page 76 and Appendix C)

Long Term Care

Throughout its report, the Commission notes the special problems associated with long term care services for the elderly and disabled. The report reviews the fragmentation of long term care programs in the State of North Carolina and the over-utilization of high cost institutional skilled nursing and

intermediate care facilities. Because of the changing age distribution of the population and the enormous cost of institutionalization the problem is of critical importance.

The Medical Cost Containment Commission believes four actions can be taken to help alleviate these problems. The first addresses the issue of fragmentation and the remaining options are directed at increasing the utilization of lower cost alternatives (home health and rest homes) to SNF and ICF care. It is recommended that the Legislature move to

Develop a Comprehensive Long Term Care Plan for North Carolina.

(Page 77)

Require that Home Health Services be Available in All Counties of North Carolina.

(Page 78 and Appendix D)

Change the Current State-County Matching Formula for Skilled Nursing, Intermediate Care, and Rest Homes. Eliminate the Present Financial Incentive to Place Medicaid Patients in the High Levels of Care.

(Page 79 and Appendix E)

That the Department of Human Resources Request a Waiver from the Department of Health, Education, and Welfare to Implement a "Swing-Bed Experiment" in the Medicaid Program.

(Page 80)

Certificate of Need

It is clear from all the evidence that much of the increase in spending within the current unregulated health care industry has been for the addition of new health care facilities and expensive equipment. It is clear that some of these additions go beyond the needs of communities. It is estimated, for example,

that North Carolina currently has between 2700 and 3300 excess hospital beds. If these excess beds remain empty, each costs \$25 thousand to maintain, or roughly 60 percent of the cost of a filled bed. As a result, the citizens of North Carolina could spend between \$68 and \$84 million each year to maintain empty beds.

The Certificate of Need program is designed to control (Page 69) rising health care costs by asking health care facilities to establish real need before the purchasing of new equipment or construction of new facilities. In this fashion, Certificate of Need will both encourage health planning and reduce the number of duplicated services. Under the program, health care institutions desiring to build or purchase new equipment in a particular geographic area must obtain a Certificate of Need from the State Health Planning and Development Agency before the project is continued. In granting or denying a certificate, the Department must consider existing health resources such as the number of hospital or long term care beds per 1000 population, and the utilization rates of current facilities or equipment such as Cat Scanners, burn, or cardiac care units. If a particular area, some rural communities for example, has inadequate health services, a Certificate of Need will be granted. On the other hand, if a community has too many health services, the

certificate may be denied.

For these reasons and since North Carolina could lose \$55 million if such a program is not enacted, one of the most important recommendations of the Medical Cost Containment Commission is for the

Passage of a Certificate of Need Act in 1978

(Page 80 and
Appendix F)

Appropriations for the Commission

Since a number of matters still remain before the Commission, a full meeting schedule will be necessary for the next six months. Consequently, the Commission requests

That the 1978 Legislative Session provide funds in the amount of \$15,000 for FY 1978-1979 to continue the activities of the Medical Cost Containment Commission.

(Page 81 a
Appendix

Legislative Action to Encourage Private Market Competition

While the initiative to restore competition to the health care market must come from the private sector, two legislative actions could enable such initiative. The Commission found, for example, that the absence of licensing procedures for lower cost ambulatory surgical facilities prevented them from taking advantage of insurance coverage for their services. As a result, these facilities have not been developed to an adequate degree. The Commission recommends, therefore, that the Legislature

Provide for the licensing of free-standing ambulatory surgical facilities in North Carolina.

(Page 82 and Appendix H)

The Commission found that many of the market forces which serve to enhance competition were absent under third party insurance coverage. Testimony by several witnesses, however, suggested that these market forces are present in the Prepaid Group Practice System (PPGP) where the provider is the insurer and hence no third party is involved. Because the PPGP is not currently available to most North Carolinians, the Commission recommends

That the 1978 Legislative Session provide funds to establish the Commission on Prepaid Health Plans

(Page 82 and Appendix I)

REPORT

INTRODUCTION

The Legislative Commission on Medical Cost Containment was established by the General Assembly in Chapter 968 of the 1977 Session Laws. The Commission is composed of six Senators appointed by the President of the Senate, and six Representatives appointed by the Speaker of the House of Representatives.

Chapter 968 charged the Commission with the following duties:

Duties of the Commission. The Commission shall study the present health care system in North Carolina and the cost trends associated with that system. The Commission shall review medical cost containment programs that have been established in North Carolina and in other states. In the course of its hearings the Commission shall receive testimony from consumers, providers of medical services, or their representative State agencies involved in the delivery and the regulation of medical services, representatives of the health insurance industry, and representatives of private industry.

In its reports the Commission shall make recommendations

on cost containment options for the State's Medicaid program, and any other medical service or reimbursement programs operated by the State. The Commission shall also make recommendations on medical cost containment proposals that will impact on all people of the State of North Carolina.

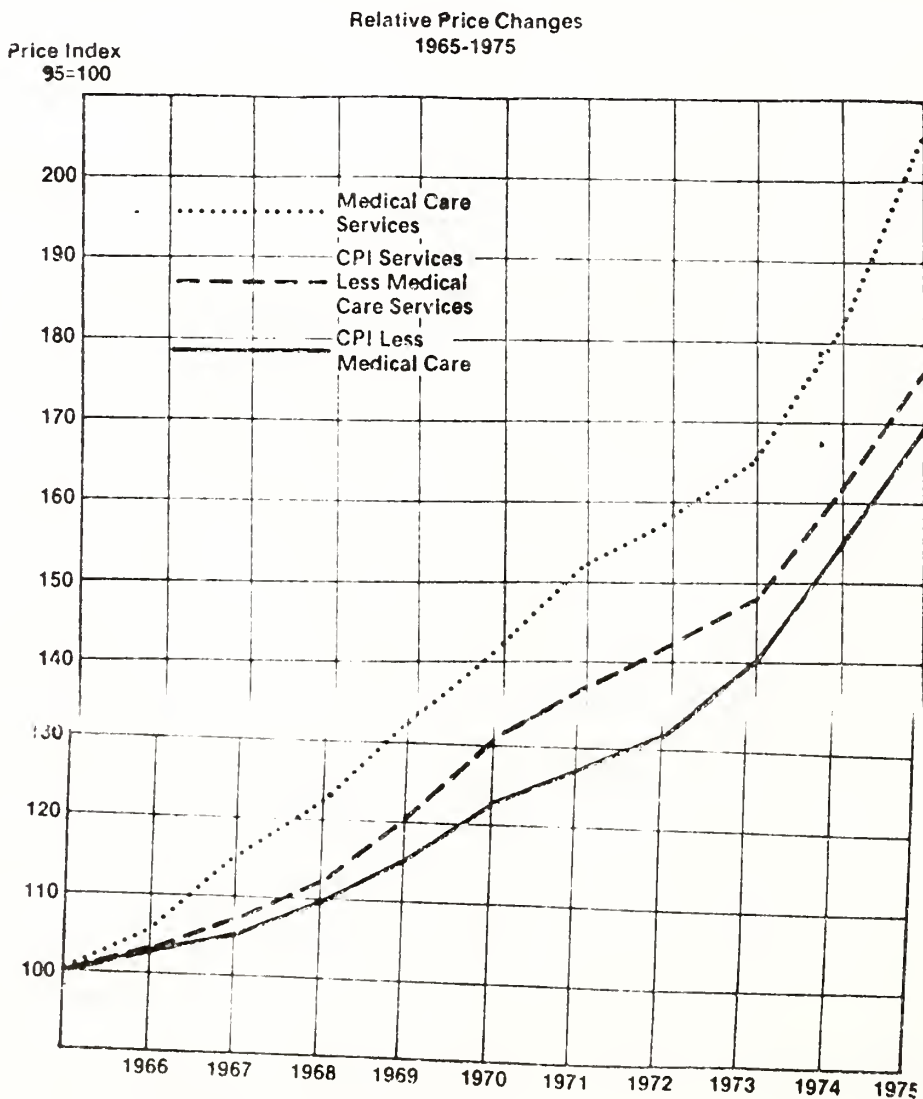
The Commission began its meetings in September and examined at great length the issue of rising health care costs and options that might contain these costs. Persons appearing before the Commission included Medicaid recipients, doctors, dentists, economists, insurance executives, and representatives of the State's Medicaid program. A list of persons appearing before the Commission is contained in Appendix A. During the course of its meetings the Commission received testimony from more than 65 individuals.

The purpose of the Commission's interim report is to provide the legislature and the public with a general overview of the factors that have contributed to rising health care costs, and the kinds of solutions that might be employed by the State and Federal Government. Several pieces of legislation are recommended by the Commission for

consideration during the 1978 legislative session. These recommendations are designed to strike a balance between the necessity for additional regulation and the introduction of competitive forces into the health care market place. In our final report in 1979 we hope to provide a more comprehensive range of cost containment options for legislative consideration.

RIISING COSTS OF HEALTH SERVICES -- THE CRISIS OF THE 1970s.

Since 1950 and particularly in the last ten years, both the Nation and the citizens of North Carolina have witnessed alarming increases in the costs of medical services. Price increases for medical care have significantly outpaced increases for other consumer goods and services. Figure One shows the disparity between



Source: U.S. Department of Labor, Bureau of Labor Statistics

the increases in medical costs and the increase in the Consumer Price Index (CPI) nationwide since 1966. Both the public and legislators are concerned. In a nationwide Gallup poll, for example, the public placed limiting costs as the number one health care priority. An independent survey of North Carolina's legislators, sponsored by this Commission, showed similar concern with 70 percent selecting inflation as the most significant problem associated with health care today. In the fall of 1977, the Department of Administration conducted the North Carolina Tomorrow Scientific Survey and found that health care costs ranked fourth among those problems facing North Carolina that respondents would most like State Government to correct.

The concern expressed in these surveys is justified. Per capita costs for medical services have risen dramatically. Total health expenditures made by or on behalf of an individual averaged \$78 in 1950, \$198 in 1965, and \$638 in 1976. As one would expect, the overall national health care bill has correspondingly increased from \$12 billion in 1950, to \$38.9 billion in 1965, and finally to \$139.3 billion in 1976 (Council on Wage and Price Stability, 1968).

The overall health care expenditure increase amounts to 1,060 percent between 1950 and 1976. It should be noted that although this 1,060 percent increase includes both price inflation and costs of new facilities and services, it is still twice as much as the 510 percent increase in the Gross National Product (GNP). In 1950, health care expenditures accounted for 4.5 percent of the GNP. In 1978 it is estimated that they will account for 9.3 percent of the GNP.

It is clear that health care costs are consuming more and more of this nation's financial resources (Council on Wage and Price Stability, 1978).

The phenomenal increase in medical costs is not solely the result of inflation. Price increases, in fact, make up only a portion of total expenditures. The bulk of expenditure growth has been for other factors including increases in utilization of medical services, and increases in the number of services and procedures that are available to health care consumers through advances in medical technology. Not only has there been a rapid increase in the number of facilities available and in their

utilization, but the number of services offered within health care facilities has also grown. Today health care is more intensive in that it involves more treatments, more tests, more personnel, etc., and, hence, is more expensive.

The following sections detail the Commission's findings on the relationships between availability, intensity, and utilization in determining health care expenditures. Since individual factors in the health care delivery system such as hospitals, physicians, additional equipment acquisitions, and long term care respond to different economic incentives and disincentives, each is considered separately.

HOSPITAL SERVICES

Expenditures for hospital care are the single largest component of national health expenditures, reaching about \$55.4 billion in fiscal year 1976 (or about 40 percent of total health care expenditures). Table One presents the annual increases in hospital care expenditures since fiscal year 1950. Since 1950, hospital expenditures have increased 1,400 percent compared to 1,060 percent for total health expenditures and 510 percent for the GNP.

Table One

Expenditures for Hospital Care, Selected Fiscal Years 1950-76

<u>Fiscal Year</u>	<u>Total Expenditures (billions)</u>	<u>Annual Percent Increase</u>	<u>Percent of Total Health Expenditures</u>
1950	\$ 3.7	9.0	30.1
1960	8.5	9.1	32.8
1965	13.2	14.5	33.9
1970	25.9	12.3	37.4
1975	48.2	14.9	39.4
1976	55.4	14.3	39.7

Source: Gibson, R.M. and Muller, M.S. National Health Expenditures, Fiscal Year 1976. Social Security Bulletin, April 1977.

Much of the increase in total expenditures for hospitals is accounted for by increases in the number of hospitals and the expansion of existing facilities funded largely through the Hill-Burton program. Clearly some of this construction was needed. There is evidence, however, that construction exceeded the needs of many communities. While it is easy to demonstrate growth in the number of hospitals, such figures do not include expansion of existing facilities. A somewhat better measure is the number of hospital beds per 1000 population. National studies suggest that a population will have adequate hospital coverage if for every 1000 persons, four hospital beds are available at an 80 percent patient occupancy rate. Some experts who have carefully studied the problem believe that a high standard of health care can be maintained at approximately 3.5 beds per 1000. In 1960 there were 3.53 beds per 1000 population nationwide. Today the ratio has risen to 4.4 beds per 1000. Based on this figure and other criteria such as need for specific types of hospitals, it is estimated that there are between 70,000 and 200,000 excess beds in the United States.

Using the 4/1000 population formula, the North Carolina State

Health Planning and Development Agency calculated that 4.29/1000 were currently available or under construction in this State as compared to 3.62/1000 in 1970. Using a standard of 4 beds per 1000 and a bed occupancy of 80 percent, the State Health Planning Agency estimates that there are 3,263 excess beds across the State. In his testimony before the Commission, Mr. Thomas A. Rose, President of North Carolina Blue Cross/Blue Shield, projected the actual number at a somewhat lower figure of 2,696 excess beds. There is a direct relationship between bed availability and cost according to Blue Cross/Blue Shield. Each excess empty bed, according to Blue Cross, costs \$25,550 annually in North Carolina or 60 percent of the cost of an occupied bed. If the number of excess beds in this State is in the range of 2700-3300, then the cost is \$68.9 to \$84.3 million annually.

While there is overall excess bed capacity, some areas of North Carolina and the United States have larger excesses than others and in some areas bed availability is still too low. The tendency has been for hospitals to locate in urban settings, leaving rural settings underserved. The health planning region

(HSA IV) including Raleigh, Durham, and Chapel Hill, reports a 5.44/1000 ratio, substantially higher than the 4.29 state average. HSA V, located in southeastern North Carolina, however, reports a 3.62/1000 ratio. While this latter figure may not reflect an inadequate number of beds, it does point out the uneven distribution of beds in North Carolina.

The proliferation of hospitals in certain urban settings has led to under-utilization of facilities in those areas. Federal guidelines suggest that an optimum occupancy rate for hospitals is 80 percent. This rate takes into account both economic efficiency and the necessary occupancy required to maintain a high quality of service. Hospital staffs must perform some procedures fairly often in order to maintain high standards of care. According to testimony presented to the Commission by the Director of the State Health Planning Agency, by the time all hospital beds existing and under construction are available the estimated occupancy rate will be 68.7 percent. This assumes that demand remains the same, however, we know from experience that hospitals require a greater occupancy rate than 68.7 percent in order to remain financially secure.

To make up this difference, utilization will unnecessarily increase, leading to over-utilization by certain populations. This has led to the adage " a built bed is a filled bed" (Roemer, 1961). Past experience also shows that utilization as measured by patient days per 1000 population has steadily increased along with the growth in hospitals and expenditures. In 1970 the United States bed ratio was 4.16 per 1000 population and patient days were 1,177 per 1000 population. By 1975, the number of beds had increased to 4.4 per 1000 population and the number of patient days had increased to 1,212 days per 1000 population. Several studies suggest that holding other factors constant, a 10 percent increase in bed availability will be associated with a 4 or 5 percent increase in utilization.

Testimony presented before the Commission indicates that total expenditures for hospital care have grown as a consequence of expanding availability and utilization. Both inflation and ~~increases~~ in the intensity of service have driven up the cost per day and cost per admission of hospital care as well. A detailed picture of the trends in these costs is shown in Table Two, based on American Hospital Association data.

Table Two

Community Hospital Expenses in the United States and North Carolina
Patient Day and Per Admission 1965 - 1975

	<u>Expenses Per Patient Day</u>	<u>Expenses Per Admission</u>
1965	\$ 40.56	\$ 310.79
1966	43.66	337.54
1967	49.46	409.04
1968	55.80	471.30
1969	64.26	329.25
1970	73.73	610.10
1971	83.43	675.01
1972	94.87	749.47
1973	102.44	799.03
1974	113.55	885.69
1975	133.81	1,026.79

North Carolina

1970	59.21	N/A
1975	100.97	N/A
1976	116.17	767.40

Both the per patient expense and the expense per admission increased by 230 percent over the ten year period between 1965 and 1975. While the North Carolina figures fall below the national average, increases from 1970-76 alone amount to 96 percent. (Testimony before this Commission, Mr. Thomas A. Rose, President, North Carolina Blue Cross/Blue Shield, 1977).

Another measure of the growth in hospital prices is the Consumer Price Index. Table Three summarizes the trends in the CPI from 1960-76. While earlier hospital data was not available, the semi-private room pattern is illustrative. Inflation for the room service

was significantly higher than the combined medical services component and the CPI for "goods and services" except during the economic stabilization period.

Table Three

Annual Rates of Increase in Consumer Price Index and Selected Medical Care Components, Selected Periods 1960-76.

	<u>Fiscal 1960-66</u>	<u>Fiscal 1966-71</u>	<u>Economic Stabilization Program, Aug. 1971-April 1974</u>	<u>Post Control Period-April 1974 to Dec. 1976</u>
CPI, All Items	1.4	4.5	6.4	7.5
CPI, All Services	2.2	6.0	5.1	8.9
Medical Care, Total	2.6	6.5	4.3	11.0
Medical Care Services	3.2	7.7	4.9	11.6
Hospital Service Chg.	N/A	N/A	4.6	13.4
Semi-private Rm. Chg.	6.0	14.6	5.7	15.4

Since 1974 the Department of Administration has prepared "North Carolina Cost of Living Indicators." Table Four presents trends in selected items since 1974.

Table Four

Price Indexes Seasonally Unadjusted for Selected Cost-of-Living Indicators for North Carolina

(Base: April, 1974 = 100.0)

<u>Category</u>	<u>April 1974</u>	<u>October 1974</u>	<u>April 1975</u>	<u>October 1975</u>	<u>April 1976</u>	<u>October 1976</u>	<u>April 1977</u>	<u>October 1977</u>
Food	100.0	105.5	107.7	113.5	112.0	113.0	119.0	120.7
Restaurant Meals	100.0	106.1	111.4	115.9	119.7	123.6	132.1	137.0
Homeownership	100.0	109.9	108.7	111.7	112.8	116.8	117.9	121.5
Fuel and Utilities	100.0	109.9	119.8	128.9	130.5	135.2	151.0	158.6
Public Trans- portation	100.0	104.9	116.1	116.1	123.5	128.1	130.2	135.7
Motels and Hotels	100.0	102.0	103.2	103.4	108.6	109.5	113.0	117.2
Medical Care	100.0	109.6	112.4	118.9	122.2	128.6	134.7	143.8

Over this three and one-half year period medical care costs increased by 43.8 percent exceeded only by fuel and utilities that increased at the rate of 58.6 percent. During this same period the hospital portion of the cost-of-living indicators in North Carolina increased by the following:

	<u>April</u> <u>1974</u>	<u>October</u> <u>1974</u>	<u>April</u> <u>1975</u>	<u>October</u> <u>1975</u>	<u>April</u> <u>1976</u>	<u>October</u> <u>1976</u>	<u>April</u> <u>1977</u>	<u>October</u> <u>1977</u>
Hospital Services	100.0	104.6	109.7	118.2	121.5	132.5	137.1	150.3

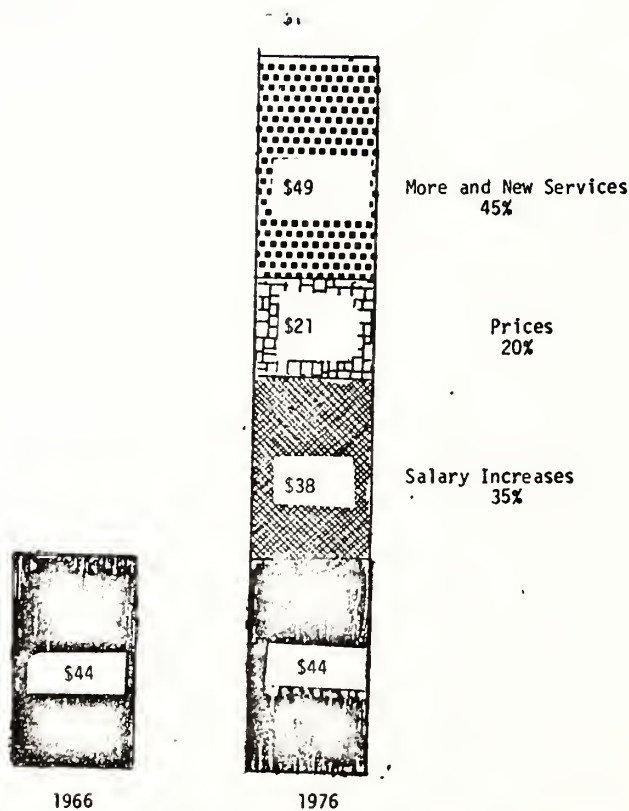
This represents a 50.3 percent increase in the cost of hospital services in North Carolina since 1974.

Cost increases, to a large extent, reflect increases in the intensity of care. For example, consider the rise in the cost per day for hospital care. In a paper presented by Mr. Thomas Rose, President of North Carolina Blue Cross/Blue Shield, to the Commission, the following statement appears:

Is the product bought in 1970, a day of hospital care, the same product bought in 1976? Clearly, the answer is no. The cost of hospital care has risen not only because the cost of individual service components has increased, but also because more components are packed into a single day of hospital care. Today's hospital stay involves more lab tests, more physical and inhalation therapy, more drugs, etc. Renal dialysis,

open-heart surgery, organ transplants, cardiac care units and CAT scanners are all relatively new services which have changed the product we call hospital care. Not only is it expensive to install such services, but the day-to-day operating costs are quite high.

This relationship between cost increases and intensity of service is described in Figure Two. Forty-five percent of the increases in cost per patient day since 1966 are a direct result of more and new services -- intensity. Twenty percent of the per day costs is pure inflation and the remaining portion is accounted for by salary increases.



Source: Office of the Deputy Assistant Secretary for Planning and Evaluation Health, Department of Health, Education and Welfare

PHYSICIAN SERVICES

The second largest single component of total health expenditures are monies spent for physician services. Physicians themselves play a central role in all types of medical care decisions. They determine, for example, who uses hospital care, the types of treatment prescribed, lab testing, and what equipment will be used. It has been estimated by the President's Council on Wage and Price Stability that 70 percent of all health care expenditures are under the direction of physicians; that the physician services component is second in total expenditures, then, underemphasizes their role. As Table Five indicates, both aggregate and per capita spending for these services have increased sharply since 1950.

Table Five

Aggregate and Per Capita Expenditures for Physician Services in the United States, 1950 - 1977

<u>Year</u>	<u>Expenditures in Billions</u>	<u>Percent of Total Health Expenditures</u>	<u>Annual Per Capita Expenditures for Physician Services</u>
1950	2.7	22.5	\$ 18
1960	5.6	21.6	31
1965	8.4	21.6	43
1970	13.4	19.3	65
1975	22.9	18.7	106
1977	26.4	19.0	121

Source: Gibson and Mueller, National Health Expenditures, Fiscal Year 1976; Social Security Bulletin, April, 1977.

Over the 1950-1976 period aggregate spending for physician services increased 880 percent, somewhat less than aggregate increases in hospital services. It is estimated that 60 percent of this increase is due to increases in prices, with the remaining 40 percent reflecting increases in the quantity of services purchased.

Consistent with the overall and hospital services patterns, the inflationary trends for physician services have exceeded those of other goods and services. Since 1950, for example, prices for goods and services less medical care, rose an average of 3.5 percent a year as compared with 5.0 percent for physician services. Table Six details this discrepancy for selected years. It should be noted that a recent Council on Wage and Price Stability report suggests that costs of physician services are significantly understated by the Consumer Price Index.

Table Six

Annualized Rates of Change in CPI, 1950-1977

	<u>CPI (All Items Less Medical Care)</u>	<u>CPI Physician Services</u>
1950-1955	2.1	3.5
1955-1960	2.0	3.3
1960-1965	1.2	2.8
1965-1970	4.1	6.6
1970-1977	<u>6.5</u>	<u>7.8</u>
Total Percentage Change	150	273

Source: Consumer Price Index, Bureau of Labor Statistics, U.S. Department of Labor, Washington, D. C.

Cost-of-living data for the State of North Carolina show a similar pattern; costs of professional physician services are increasing more rapidly than other goods and services (excepting fuel and utilities). Prices for other items over a three and one-half year period beginning in 1974 and ending in October, 1977 appear in Table Four. The professional services component of this North Carolina index includes physicians, surgeons, and dentists. The cost-of-living indicators for professional services during the same time period were as follows:

	<u>April 1974</u>	<u>October 1974</u>	<u>April 1975</u>	<u>October 1975</u>	<u>April 1976</u>	<u>October 1976</u>	<u>April 1977</u>	<u>October 1977</u>
Professional Services	100.00	112.9	116.1	121.7	128.1	131.8	137.9	145.8

While the 45.8 percent increase during this period is somewhat lower

than the 50.3 percent increase observed for hospital services, it is still considerable in comparison to other indicators.

In general, expenditures for professional services reflect increasing availability of doctors and intensity of physician care. According to Federal recommendations adequate medical care requires 1.3 doctors per 1000 population. In 1960 there were actually 1.39 doctors nationwide. Today the figure is estimated at 1.77 per 1000. By 1990, the Department of Health, Education and Welfare projects that the Nationwide average will be 2.3 doctors for every 1000 persons. (McClure Testimony, 1977). Needed or not each new physician adds cost. Data from the U.S. Department of Commerce suggests that the median physician income at \$63,000 is higher and has increased more rapidly than any other profession. In fact there has been a 50 percent increase since 1970 when income level was \$43,000. Furthermore, one study estimates that each additional doctor generates more than \$200,000 annually in health care expenditures in the form of treatment, drugs, hospitalization, etc.

As with hospital services, availability of physicians varies from area to area with some areas overserved and others underserved.

New physicians are being drawn away from primary care settings toward the practice of specialized medicine in urban hospitals. Since hospitals are urban (or suburban) based, one would expect physicians to follow that pattern. Certain geographic locations, primarily rural, and certain populations, the poor and the aged, are and probably will be underserved since the current health care planning system provides no incentives to encourage surplus physician manpower to move in these directions. Several areas, principally rural, in the State of North Carolina have too few or no physicians. For example, of the 100 counties in this State, 30-40 are defined as physician shortage areas. The situation is intensified by the especially small proportion of primary care physicians per 1000 population. Primary care is defined as services provided by physicians trained in family or general practice, internal medicine or pediatrics. Twenty-eight counties in North Carolina have only one primary care provider per 3,000 population, or more. One result of the lack of primary care physicians is that people tend to seek these services in hospital emergency rooms at much expense. This tends to drive up the overall costs of medical care.

Perhaps the best indicator of increasing intensity in physician care is the remarkable change from a preponderance of general practice in 1949 to specialization in 1977. In 1949 roughly 60 percent of physicians were general practitioners. Today roughly 80 percent are specialists, all of whom are presumably better able to treat illness using sophisticated procedures. The direct economic impact of this change is that the cost of specialized care is significantly more expensive than General Practice Care. For example, The Wage and Price Council has reported that nationwide, the initial office visit for specialists ran 63 percent higher than the same General Practice fee, and follow-up office visits were 34 percent higher among specialists. Total income received by specialists is correspondingly higher as well. The influence of medical specialization is discussed in more detail in later sections.

Not only has intensity of care increased in terms of physician training, but also in terms of the number of services that physicians offer, and the professional staff physicians must hire to assist in providing those services. The American Medical Association reports, for example, that the number of ancillary personnel per physician rose from 1.83 to 2.29 between 1970 and 1975, or roughly 4.6 percent a year.

Finally, along with increasing expenditures, availability and intensity of services, overall utilization of physician services has steadily risen as well. Utilization has increased 201 percent between 1950 and 1976.

TECHNOLOGY: EQUIPMENT AND TREATMENT PROCEDURES

In recent years public attention has been focused on the cost of new high technology medical services. Traditionally these specialized services, such as body scanners, have been available only in the hospital setting, but advances in technology have more recently made them available at the outpatient level. Presently there are no accurate cost projections for the amount spent each year on technological innovations. It is clear, however, that in recent years medical innovation and technological change have shifted from pharmaceutical (i.e. antibiotics) development to the development of complex diagnostic and therapeutic techniques usually requiring hospitalization and expensive equipment. Unlike "normal" business, very few of these innovations have been cost-saving. Many are cost-rising. Examples include open-heart surgery, renal dialysis, burn units, CAT scanners, etc. It should be noted that, unlike a new "drug", such technologies may be used before they have been thoroughly tested. There is, consequently, some question concerning the appropriateness and in some cases the efficacy of these costly treatments (Testimony before the Commission, Rice, Exhibit A, October, 1977).

Nevertheless, hospital administrators and staff tend to measure their prestige by the availability of such sophisticated equipment and strongly favor its acquisition. This is a particular problem in small rural hospitals, for example, which in order to attract physicians must provide these expensive tools of the trade. Acquisition of a new technology or care-unit serves as a signal to other hospitals in the area to acquire the facilities as well, rather than a recognition that one such service may sufficiently serve the community.

The so-called CAT scanner is the most popular example of the equipment drive. At a cost of \$350,000 to \$500,000 apiece, plus high operating costs, hospitals in Southern California are reported to have installed more scanners than are needed to serve the entire western United States (Council on Wage and Price Stability, 1976). Megavoltage radiation therapy units are another example. While not as dramatic as the California example, North Carolina has had similar experiences. Recently, the State Health Planning and Development Agency estimated, "liberally" according to its director, the need for CAT scanners on a regional basis. According to these estimates

two regions out of six already have too many scanners for population need.

Along with increasing availability of these intensive technologies, utilization patterns have also shifted. That is, the utilization of laboratory and diagnostic tests, surgical procedures, etc. has steadily risen. Overuse of surgery, for example, was demonstrated in a recent HEW study which compared surgery patterns in hospitals with those in a health maintenance organization.

The results showed that surgery rates were 44 percent to 54 percent higher for the hospital group. A Social Security Administration study of Medicaid recipients reached similar results. There is some controversy, then, over the necessity of some surgery performed in this country (research by McCarthy & Widmer, 1974). Dr. Walter McClure suggested to the Commission that 80 percent of all tonsilectomies could be eliminated by an equally effective treatment. Recently there has been a trend toward second opinion for surgery procedures aimed at reducing unnecessary surgery. The State of Massachusetts now requires second opinions for certain elective surgeries for all Medicaid patients.

The Commission found that utilization of laboratory tests (i.e., multiphasic blood screening) and radiology equipment in hospitals has dramatically increased. It is estimated that the number of laboratory tests performed increased from 2.9 billion in 1971 to 5.0 billion in 1975, reflecting an 8 percent annual increase in tests per admission since 1970. Laboratory and diagnostic tests now account for more than 10 percent of total national health care expenditures. The cost impact of new medical technologies has rarely been considered.

LONG TERM CARE: THE CRISIS OF THE 1980s

The long term care service consists of health and social services provided to the chronically disabled, usually elderly persons. These services range from highly skilled nursing and therapy to occasional visits by a home health aide or social worker. During its hearings, the Medical Cost Containment Commission focused primarily on the higher levels of care, principally skilled nursing homes and intermediate care facilities.

Since the growth of such long term care services as nursing homes has occurred only within the last 15 years adequate information is not always available on utilization and costs. The advent of Medicaid/Medicare and the gradual aging of the population have both contributed to the rapid increases in the demand for long term care. While we may want to call cost growth in physician services and hospital services the crisis of the '70s, long term care is likely to become the health crisis of the 1980s.

It is estimated, for example, that total expenditures for long term care, approximately \$13.4 billion in 1975, will more than double by 1980 from \$25.8 to \$31.0 billion. Of these expenditures,

the greatest proportion, approximately 55 percent, come from families and friends of the disabled.

More detailed estimates of the remaining expenditures which are provided by public programs are available. The majority of public expenditures, roughly 90 percent go for nursing home care including skilled nursing and intermediate care facilities. Only a small portion of expenditures go to home-based or day-care services for the elderly. Nationwide and in North Carolina, Medicaid is the primary source of financing for these nursing home services. While the Medicare program pays for some portion of the stay in a skilled nursing home for most people over 65, Medicaid still pays for the great majority of this type of care. The Congressional Budget Office estimates of public expenditures for skilled nursing (SNF) and intermediate care facilities (ICF) are shown in Table Seven. Between 1976 and 1980, the amounts nationwide for SNFs and ICFs are projected to rise from \$5.8 billion to \$10.7 billion in 1980. The \$5.8 billion figure for 1976 was 200 percent higher than the same figure for 1970.

Table Seven

Estimated Expenditures for Skilled Nursing Facilities and Intermediate Care Facilities: 1976 and 1980 (All dollar figures are in billions)

	<u>1976</u>	<u>1980</u>
Skilled Nursing Facilities		
Federal		
1. Medicare	.3	.6
2. Medicaid	2.1	4.0
3. V.A.	.1	.1
State		
1. Medicaid	1.7	3.1
2. Other	.2	.3
Total SNFs	4.4	8.1
Intermediate Care Facilities		
Federal		
1. Medicare	.0	0
2. Medicaid	.7	1.2
3. V.A.	.1	.3
State		
1. Medicaid	.5	1.0
2. Other	.1	.1
Total SNFs and ICFs	<u>5.8</u>	<u>10.7</u>

Source: Congressional Budget Office, "Long-Term Care Actuarial Estimates," 1978.

For the State of North Carolina no estimates are readily available for the costs of all types of long term care. Data is available, however, on the costs of skilled nursing and intermediate care facilities to the Medicaid program and the overall growth trends in skilled and intermediate care beds in the State. Table Eight

gives the costs of skilled nursing and intermediate care in North Carolina since the first full year of the Medicaid program in FY 70-71. SNF expenditures grew more than 115 percent during this eight year period. More dramatic, however, is the 1700 percent increase in ICF expenditures over a three year period.

The present average per day costs to the Medicaid program for skilled nursing and intermediate care are approximately \$30.57 and \$23.35 respectively. Costs to private paying patients often run several dollars per day higher. At a cost of \$900 per month in skilled care and \$700 per month for intermediate care private payment for nursing care is well beyond the financial means of most North Carolina families.

Table Eight
Costs of Skilled Nursing and Intermediate Care Facilities
 FY 1970-71 - 1976-77

	<u>Skilled Nursing Facilities</u>	<u>Intermediate Care Facilities</u>
FY 1970-71	\$ 16,328,631	\$ -
FY 1971-72	17,798,096	-
FY 1972-73	20,148,988	-
FY 1973-74	22,943,562	3,419,727
FY 1974-75	26,093,778	23,735,329
FY 1975-76	25,070,905	32,462,325
FY 1976-77	34,148,368	58,096,479
FY 1977-78 (estimated)	35,233,806	64,292,975

Several explanations exist for why the North Carolina Medicaid program now pays more in total dollars for intermediate care than

for skilled nursing care. The first is that only Medicaid pays for the intermediate level of care. Medicare and Blue Cross will pay for some skilled care, but only for a limited number of days, thus reducing the burden on Medicaid. The second reason has been the rapid expansion of ICF beds in North Carolina. Most observers believe that this expansion was the result of a Medicaid reimbursement system that provided strong financial incentives for the construction of privately owned ICFs. Third is the expansion of intermediate care in State-owned facilities, especially in centers for the mentally retarded. Of the estimated \$64.2 million that will be spent in FY 77-78 on intermediate care, over 30 percent or \$20.3 million will go to State-owned facilities. Finally, the average length of stay in ICFs is longer than in the SNF, thus Medicaid must pay for more days per year at the ICF level.

The Commission found evidence that in North Carolina, as well as most other states, there is no comprehensive policy on long term care, and Medicaid will pay for both levels. The result of this policy is to place a heavy burden on the states to fund nursing home costs through Medicaid.

Neither Medicaid nor Medicare, however, will pay for a stay in a convalescent home (rest home), but rather the cost of this form of long term care must be borne by the individual, state or local governments. In North Carolina rest homes are paid for exclusively from State and County sources. Home health care, while available in 90 counties of North Carolina, is still not available statewide. Other services, such as chore providers, that might help to avoid a placement in a nursing home are not available in sufficient quantity statewide. The result is an increasing use and availability of nursing homes for the state's older citizens. The Commission found that there is a definite need for a comprehensive state policy on long term care and a closer coordination between Title XX, Medicaid and the Special Assistance for Adults Program.

In 1970-71 there were 7,505 SNF licensed beds in North Carolina and only 156 ICF beds. By February, 1978, the SNF beds totaled 7,649, a net increase of only 144 beds. The number of ICF beds, however, had increased to 8,570 over this same period. In only one year, March 1977 to February 1978, the number of ICF beds increased

by 1,132. In addition to the 8,570 ICF beds in private facilities an additional 2,119 beds are certified as ICF in the four mental and retardation centers. This brings the current total of SNF and ICF in North Carolina to 18,338 beds.

It should be noted that the gradual aging of the population is also a factor in ICF growth. By 1980 the Congressional Budget Office estimates that the nursing home population will have risen to 1.8 million compared to .7 million in 1970 and 1.56 million in 1976. North Carolina, the Commission found, has experienced a dramatic increase in its over 65 population since 1970, with a continuation of this trend through the 1980s. The following table compares the growth of North Carolina's total population with its over 65 population.

Table Nine
North Carolina Population Over 65

	<u>1970</u>	<u>1978</u>	<u>1980</u>	<u>1985</u>
Total State Population	5,084,411	5,678,621	5,813,773	6,240,622
Population Over 65	412,038	554,280	583,783	681,678
Percentage	8.1%	9.7%	10%	10.9%

In the period 1970-1985 the total state population is projected to grow by 22.7 percent, while the increase in the over 65 population

is 65.4 percent.

Maldistribution of services is not limited to physician and hospital components of health care. The same pattern holds in long term care. As of August 1977, the Commission was told, 21 counties in the State of North Carolina had no long term care facilities. Based on projected 1982 bed need, however, 24 counties in the state will have long term care beds exceeding the maximum 42/1000 recommended in the State health facilities plan.

Overutilization of services and equipment is also not limited to hospitals but can be seen in nursing home settings as well. A Congressional Budget Office report found that nationally a substantial number of persons in Skilled Nursing Facilities and Intermediate Care Facilities either do not need the presumably high level or degree of care provided, or could be maintained at home if adequate home care services were available. According to the CBO report, a conservative estimate is that 20 to 30 percent of SNF patients and 20 to 40 percent of ICF patients are receiving unnecessarily high levels of care. A number of physicians testified to the Commission that this same pattern of overutilization existed in North Carolina.

MEDICAID IN NORTH CAROLINA

Medicaid is an integral part of the health care delivery system. Recipients of Medicaid receive treatment from the same hospitals and physicians, purchase drugs in the same pharmacies, and ultimately become residents in the same long term care facilities as other consumers of health care. It is therefore difficult if not impossible to control Medicaid costs without dealing with the broader issue of costs throughout the health care system.

Table Ten illustrates cost increases in Medicaid since North Carolina entered the program in 1970. It is easy to see that Medicaid costs have expanded at an uncontrollable rate since the program began. These cost increases reflect four issues: increased cost of services, increased number of services, increased utilization of services, and increased number of ways services can be provided. Not only have total costs increased in the Medicaid program but at the same time the percentage of Federal participation in North Carolina's program has decreased. As a result, State costs have increased by a total of 359 percent since the program began, and over the same period, total costs have increase

by only 271 percent.

Table Ten

	<u>Total Cost</u>	<u>State Cost (Approx.)</u>	<u>State Percent</u>
1970-71	\$ 98,168,145	\$ 21,729,000	22.13
1971-72	109,542,847	25,289,000	23.09
1972-73	129,999,107	30,012,000	23.09
1973-74	148,917,537	37,961,000	25.49
1974-75	193,157,785	49,239,000	25.49
1975-76	221,519,891	60,197,000	27.17
1976-77	281,599,179	76,523,000	27.17
1977-78 (Estimated)	303,185,000	82,956,000	27.36
1978-79 (Estimated)	364,557,000	99,748,000	27.36

Price inflation in Medicaid has resulted from the same basic factors that have increased costs throughout the health care delivery system: increased technological sophistication and the absence of effective market forces (See later sections). Since most health care providers provide services to both Medicaid and non-Medicaid patients, any cost increases in non-Medicaid services will rapidly spread to Medicaid.

More services are available through Medicaid now than were available at the time the program began. As new services are added, they are not only utilized by current recipients but also tend to attract new recipients. For example, Intermediate Care was added in 1973 as a new service in an attempt to provide a less expensive alternative to Skilled Nursing Care. Since that time, more than

6,000 intermediate care beds have been added in North Carolina.

Instead of decreasing skilled nursing has actually increased over the same time period. Obviously, new recipients have been attracted to the new service.

Increased utilization has had a major impact on Medicaid costs over the past several years. Utilization increases are caused by an increase in the number of services. Increased utilization occurs both as a result of increased availability of services and as a result of increased eligibility. Table Eleven displays increases in eligibility since 1970. Two major factors are responsible for most of the increased eligibility since 1970.

Table Eleven

Medicaid Eligibility by Program

<u>Date</u>	<u>AFDC</u>	<u>SAA</u>	<u>SSI</u>	<u>Medically Needy</u>	<u>Total</u>
(1) July, 1970	134,129	4,452	62,799	19,538	220,918
July, 1971	159,095	3,797	65,176	34,489	262,557
July, 1972	167,933	3,361	68,274	44,832	284,400
July, 1973	149,247	1,722	63,475	47,970	262,414
(2) May, 1974	154,183	(included	79,057	27,801	261,041
May, 1975	178,405	in SSI	88,990	21,030	288,425
May, 1976	187,422	data)	92,735	16,976	297,133
May, 1977	198,579		94,954	17,597	311,130

Note: These data do not include persons who are declared retroactive eligible and as a result may significantly understate the number of persons actually receiving service.

1. Public Assistance - Trends in North Carolina. Special Report No. 31, March 1975 (1970-1973 data)
2. Statistical Journal - published quarterly by Dept. of Human Resources 1974-1977 data)

1. In January 1974, most of the recipients of categorical aid to the aged, blind and disabled were shifted to the Federal Supplemental Security Income (SSI) program. Eligibility criteria for SSI were more liberal than the State program. As a result, more people became eligible under SSI.

2. In 1976, the State experienced a severe recession. One of the side effects of that recession was a significant increase in the Aid to Families with Dependent Children (AFDC) program.

Another factor responsible for cost increases is that there are an increased number of ways in which a service can be provided. For example, when the Medicaid program began in 1970, the only allowable outpatient services were hospital outpatient services. By 1975, outpatient services were being provided in health departments, free standing clinics, migrant health clinics, and rural health clinics in addition to hospitals. One of the major reasons that methods of service provisions were expanded was to make services more available and that, obviously, increased utilization and therefore costs.

MEDICAID ELIGIBILITY

Federal law requires that all categorical recipients of money payments are automatically eligible for Medicaid. These include recipients of Aid to Families with Dependent Children (AFDC), and Supplemental Security Income (SSI) where 100 percent of income is from SSI.

In addition to categorical eligibility, the State has elected to provide medical services to the medically needy. Generally speaking a medically needy recipient is defined as both: 1) A person who has been determined to be permanently disabled, over 65 years of age, or blind, and; 2) A person whose net family income, after paying medical expenses, does not exceed the amounts shown in Table Twelve.

If the family income of a potential medically needy recipient exceeds the amount shown in Table Twelve, the surplus must be expended on medical costs before the recipient actually becomes eligible for Medicaid.

Table Twelve
Medically Needy Income Scales

<u>Family Size</u>	<u>Net Income (Annual)</u>
1 .	\$ 1700
2	2200
3	2500
4	2800

(For each additional family member add \$200)

CAUSES OF HEALTH CARE COST INCREASES: THE ECONOMIC STRUCTURE OF THE HEALTH CARE INDUSTRY

That the inflationary trends for medical services differ, both in terms of price and total growth from those for other consumer goods and services, reflects in large part differences in the economic structure of the health care industry and free market systems. The free market system assumes that where commodity or service supply and demand are unrestricted, competitive forces arise as "an incentive to lower prices, better service, and more efficient management." Such competitive forces do, in fact, occur in ordinary businesses where the producer in control of supply responds to consumer wants through demand signals in the marketplace.

There is considerable evidence, however, that the economic structure of the health care industry, particularly the way it is financed, significantly alters the "normal" relationship between supply and demand such that competitive forces do not appear. This position was supported in testimony before the Commission by Drs. McClure and Klar, and in the literature reviewed by the Commission

As John O'Connell, a representative of Bethlehem Steel explains,

It is estimated that the health care industry is a \$120 billion a year industry. I find it absolutely mind-boggling that an industry of this size ... operates in our economy almost completely immune to the forces most basic to the economy: the forces of supply and demand ... It seems, however, that the health care industry because of its very nature tends to control both supply and demand. (p. 7, Council on Wage-Price Stability, 1976).

Health Care Economics

Traditionally, the existence of a competitive market is thought to require:

1. That all resources be completely mobile. In other words, each resource must be able to enter or leave the market, and switch from one use to another;
2. That each participant in the market, whether buyer or seller, be so small, in relation to the entire market, that he cannot affect the product's price;
3. That the product of any one seller be perceived by consumers to be the same as the product of any other seller;

4. That consumers, firms, and resource owners have perfect knowledge of the relevant economic and technological data.

No industry or market meets all these criteria perfectly. Deviations from this ideal model in the health care system, however, are more severe. In fact, there is reason to believe that the market for health care fails to meet all four assumptions of competition.

First, there is considerable evidence that since 1910 organized medicine (through the American Medical Association) has quite successfully restricted entry into the medical profession, primarily through its control of state licensure and the system of medical school accreditation. While the AMA's original motivation was to improve the quality of the profession, the restrictions in physician supply, consistent with economic theory, have led to higher prices. It should be noted that trends in physician supply are changing. Since 1965, for example, medical school enrollment jumped dramatically from 32,000 to 56,000 in 1976. Unfortunately, this increasing supply has not, as economic theory suggests it should, led to lower prices.

The second requirement, that participants be so small that they cannot individually affect price, is also violated. The bias in health care today is toward large institutional facilities, hospitals, skilled nursing homes, and intermediate care facilities. Even within these institutions there are substantial variations in size. Large institutional or corporate providers are quite capable of affecting price since they clearly dominate the market.

It is also the case that the health care product delivered by one provider is perceived by consumers as different from another. Consider, for example, the current preference for a specialist's care rather than a general practitioner's. Or, consider the preference for hospitalization in the "up-to-date" teaching facility rather than the community hospital even at a substantially higher cost. Or, consider a woman's trust in or reluctance to change her obstetrician.

The health system deviates most radically from the fourth and final requirement that consumers and providers have knowledge of the relevant economic and technological data. First, consumers are not well-informed concerning medical technology and treatment

efficacy. Furthermore, neither consumers nor providers are well informed with regard to price primarily because third-party payment and financing arrangements obscure or hide this information from the market. This fundamental lack of information creates the peculiar economics of health care that prevent competition and encourage inflation.

Because medical knowledge is so complex, the information possessed by the physician as to the effectiveness of particular treatments is necessarily very much greater than that of the patients. In ordinary business often the consumer knows less concerning the methods of production than the producer, but in most cases the consumer has as good or nearly as good an understanding of the utility of the product as the producer. That consumers lack this knowledge effectively moves demand decisions concerning the nature and level of service required to the supplier-provider. The physician is the key decision-maker. His/her diagnosis determines the extent to which their own services are required as well as utilization of diagnostic tests, therapeutic drugs, and hospital services. The patient has little information

available to question or seek alternatives and, hence, this creates a peculiar economic situation where "supply creates its own demand " (Arrow, 1963; Testimony before the Commission, Klar, November 1977). The result is that physicians are able to command certain amounts of resources and income regardless of the total number of physicians. This runs directly counter to the usual expectations of lower cost with increased supply.

Perhaps more important than the lack of knowledge for treatment evaluation is the inherent uncertainty of illness or accident faced by consumers. For most types of goods and services, a family can predict its annual expenses. For health care, only a few costs (i.e., immunization, check-ups, etc.) are so predictable. This uncertainty and desire to avoid financial disaster have created a demand for health insurance, particularly the third-party type.

The purchase of health care services as a consequence typically differs from the ordinary business transaction where the consumer pays business directly for goods or services. In the health care transaction, the patient consumes a service and payment for that service is made to the health care facility on his behalf by a

third party (private insurers, state or federal governments). According to the Council on Wage and Price Stability in fiscal year 1975, such third-party payments accounted for 67.4 percent of all health care expenditures, 92 percent of all hospital services, 65.5 percent of all physician fees and 80 percent of all nursing home services in North Carolina. The large percentage of coverage for hospital services reflects the strong incentive by consumers to reduce the risk of potentially large medical bills. The same incentive is evident in the physician fees category in that insurance coverage is much more complete for large surgical expenses, specialists care, and ambulatory diagnostics than it is for primary care.

The absence of direct payments by consumers is an important feature of the health care industry. There has been considerable analysis of the impact of widespread insurance coverage on demand and prices, and the consensus is that third-party payments significantly affect decision making by consumers and providers by obscuring price considerations. Economic theory suggests that consumers demand more service when out-of-pocket costs are small or none and

demand correspondingly less service when out-of-pocket costs more closely reflect the full cost of providing that service. The increase in intensity of service per hospital stay is a good example of this increased demand.

The third-party system not only impacts the quantity of demand but it also biases health care delivery toward more expensive settings where coverage is more complete (hospitals, specialists, etc.). It is common sense that consumers desiring care will choose that setting which involves the least out-of-pocket expense. This is true even if that care could be delivered in an overall less costly setting with equal efficiency, but involving a greater patient contribution. Such contributions are often in the form of deductibles. For example, an individual may be asked to pay the first \$100 for care and only then will the insurer begin payment.

While it is true that consumers ultimately feel rising health care charges in premium payments, those payments in most cases are lower than the true costs. Even substantial raises in premiums are often "hidden" from the consumer in employee benefit packages which are not counted directly as employee income. Eighty percent of all

private insurance premiums are, in fact, paid in this fashion. The true cost of health care is further obscured by the Federal and State tax structure which allows a 50 percent exemption for health insurance premiums paid by the individual. In the case of an employee benefit package, the tax advantage is more substantial. Group type policies often are not included in wages and salaries and, hence, are not taxed at all. This is not to suggest that employee benefits or tax incentives are not good, but to point out that both serve to reduce the consumer's knowledge of price information.

While the principal impact of third-party payments appears to be on the demand side, i.e. creating more in number and more expensive demands, third-party payments also appear to alter supply variables in that physicians are more willing to use expensive and varied treatment when patients are not involved in payment.

One influence of insurance on supply has been clearly demonstrated. Fee discounting, the practice of setting fees according to the financial means of patients has declined inversely with the growth of insurance. The notion is that particularly with the adven

of Medicare and Medicaid the number of charity patients dropped and thus lessened the need for discounting. It should be noted that in its day, fee discounting was anti-inflationary.

Under widespread insurance coverage, then, the economics of health care, and to some extent supply, deviate from the "normal" market model. These deviations the Commission found are one cause of the rising cost of medical care. If this is correct, then where insurance coverage is most complete, inflation and growth in expenditures should be the greatest. This is, in fact, the case. Insurance coverage is most complete for hospital services, and it is hospital services where inflation has been the highest. Insurance coverage biases demand toward delivering services in a hospital setting thus stimulating growth of these types of facilities. With Medicaid providing reimbursement for nursing home care this same trend is now present in the area of long term care. In North Carolina this has been most evident in the construction of intermediate care facilities.

One would also expect the most growth in areas where insurance coverage for physician services is greatest. Those with the most coverage are anesthesiologists, radiologists, surgeons, and

obstetricians-gynecologists. Insurance generally pays for fewer services provided by pediatricians, psychiatrists, and general practitioners. As we noted previously the actual number of specialists has grown from 40 percent to 80 percent since 1950.

It appears then that third-party payments obscure price considerations from consumers and to some small extent providers. Not only do consumers lack clear information regarding the cost of health care decisions, but the availability of insurance protects them from the financial consequences. This means that the fourth requirement of a free market system, that is that consumers and providers have perfect knowledge of the relevant economic and technological data, does not always exist in health care.

Unlike a free market system where the seller must be concerned about the price consumers are willing to pay for his product, third party insurance, coupled with present retrospective reimbursement principles, insulates the health care provider from most price considerations. The health care provider operates in a system where the demand for his service is virtually unlimited. In the practice of medicine additional service can always be justified on the basis

that it will improve the health status of individuals. The existing financing system (insurance, Medicaid, Medicare) provides the dollars to meet this limitless demand, however marginal the value of the health service. An example of this may be found in the system of usual, customary, and reasonable charges that most insurance companies and Medicaid and Medicare use to base payment to physicians. This approach is of particular significance since its widespread use is only a recent development, since 1966. Under the UCR approach, the insurer agrees to pay some portion (between 70-100 percent) of the physician fee. The maximum allowable fee is that which does not exceed the UCR charge for that particular locality. Curiously, maximum charges within the UCR system are typically higher than those allowed under a fee schedule. It appears that the higher rate with UCR financing may, at least in part, result from the physicians' awareness of the UCR fees. In some cases, for example, it may take only a few physicians raising their fees to increase the UCR maximum.

Whatever the cost-reimbursement method, the present system has few incentives for cost-efficient service. Instead, retro-

active reimbursement encourages greater quantity and cost of service since the higher the charge, generally, the higher the payment and the more charges the more payment. Added expenses from additional beds, for example, may be offset in this fashion. The normal supply and demand forces do not operate to bring the system back into balance. In an important way then, financing arrangements permit hospitals and physicians to meet increasing consumer demands under insurance coverage.

The health care industry resulting from these characteristics is unique in its economic properties. It does not reward economic behavior on the supply or demand side, nor does it penalize for uneconomic behavior. Indeed, savings from cost-efficient behavior created by one participant do not accrue to that participant. For example, if a hospital is efficient any accrued savings go to the insurance company or patient, but not the hospital. The result is a failure of cost accountability in the health care sector and the removal of competitive forces which serve to lower cost and encourage efficiency (Testimony Klar and McClure, 1977).

MEDICAL EDUCATION

The issue of increasing specialization in the training of physicians has been noted on several occasions. This trend coupled with the economics of health care have determined the pattern and cost of care. Specialization provides the expensive practice, and third-party insurance pays for it. Specialization has resulted in greater fee inflation since specialists tend to charge higher fees than general practitioners for the same services. A recent American Medical Association study, for example, suggests that specialists fees average 25 to 63 percent higher than fees for General Practitioners (Council on Wage and Price Stability, 1978). The production of specialists in medical schools also biases the physician toward practice in the hospital settings since he/she depends on the new technologies as tools of the trade. Again this bias is inflationary.

The issue surrounding medical education is not simply specialization. Rather it concerns a style of practice. Walt McClure in his testimony before this Commission aptly described this style issue:

"There are many styles of medical practice, good style, equally effective style and some of them cost a lot more than others. Some doctors make very aggressive use of the hospital, some doctors make very conservative use of the hospital. You can do well either way but you will spend a lot more money doing one than the other. For example, consider tonsillectomies. There are at least two ways to treat tonsil disease; one is you put the patient in the hospital and yank the tonsils, the other way is to send the child home, you medicate, you prescribe rest, you observe, and if the problem is still there, then you yank the tonsils. According to some of my pediatric friends, the latter, of course, is actually the better preferred course but obviously a lot of practicing doctors don't agree with them because tonsillectomy is the most common procedure in the land and obviously a lot of mothers who have to put up with these squalling brats for a year don't agree with the doctors either. Nevertheless, we can say there are at least two ways to treat tonsil disease that are equally medically accepted. They are not equally financially accepted. If we did the second course, home rest and observation, we could eliminate 80 percent of the tonsillectomies. While these styles of practice are equally acceptable medically, they are not equally acceptable financially. You can multiply these examples by thousands and you will understand that medical care is not a precise thing--we can save enormous amounts of money without denying anybody adequate medical care. "

Educationally, we train doctors in diagnosis and treatment. Patients requiring primary care are not seen frequently in the course of this educational process. (Some programs such as family medicine are obvious exceptions.) It is unreasonable to expect that the new physician accustomed to sophisticated treatments and tools will not use them. This expensive style is further encouraged by defensive medicine in response to malpractice suits.

SOLUTIONS TO THE HEALTH CARE COST CRISIS

Inflation in the cost of medical care has spurred much discussion not only of its causes, but of possible cures. The Commission reviewed three general strategies for dealing with inflation which fall out of these discussions. The first can be termed the private market strategy which includes both attempts at voluntary price control and attempts to restore competitive forces to the health care industry. The second strategy encompasses various forms of public regulation at the state and Federal level. A third strategy, and the one the Commission favors, is a combination of private market and public solutions.

PRIVATE MARKET AND VOLUNTARY COST CONTAINMENT SOLUTIONS

Private market solutions are aimed at the restoration of price considerations to the health care marketplace. Some of these solutions, however, can work within the health care system as it now exists and others require a restructuring of the current delivery system. As discussed earlier, there is some evidence that competitive forces are absent in the health care industry principally because suppliers and consumers do not have sufficient

knowledge to make cost effective health decisions. As we noted in the previous section, such knowledge is a prerequisite for competition to arise. One possible solution then is to increase the amount of information available to providers and consumers. In practice, we have seen educational efforts aimed at suppliers and consumers.

Hospital associations, medical societies, and insurance carriers are currently involved in voluntary efforts to improve supplier information and thus, hold down the costs of medical care. Several state hospital associations, for example, have developed programs which provide technical assistance to member hospitals on the implementation of cost-saving managerial techniques.

Recently, the North Carolina Hospital Association and the North Carolina Medical Society approved a resolution to educate member providers. The resolution was as follows:

In order to increase physician awareness of medical care costs, samples of patients' bills should be submitted to each appropriate physician at monthly or other appropriate intervals. A listing of the various costs of drugs, laboratory, diagnostic, therapeutic and other ancillary services should be posted in physician work areas in hospitals.

While some of these voluntary cost containment programs have had demonstrable success, some have been confronted by serious

problems in gaining compliance of member providers. The nation-wide voluntary effort, in fact, was dealt a serious blow in April when the Labor Department's CPI showed that hospital and medical costs continued to surpass the price of other consumer goods and services in February. The 1.3 percent increase for February equates to about 14 percent annually which is not lower than previous years. It is, however, still too early to tell whether North Carolina efforts will be successful.

Consumer education efforts have also been undertaken by many employers, labor unions and insurance carriers. While some of these education programs provide individuals with cost information, most focus on providing information on the prevention of illness or accident and promotion of good health (i.e. through exercise, etc.) One such program was described by Mr. Thomas A. Rose, President of North Carolina Blue Cross/Blue Shield.

We have fostered and are currently involved in a pilot program in the Cabarrus County School System known as Health and Education United (HEED), which is designed to provide the child with sufficient information to aid his making appropriate choices in his lifestyle as an adult.

While it is assumed that such programs have important cost-saving

consequences, no real economic evaluation of them is available principally because their effects are extremely long-term.

It should be noted that insurance carriers are involved in other programs which have consequences for premium costs. These include improved claims review for fraud and abuse, coordination of benefits, etc. Most of these programs, however, do not deal with the root problems of cost containment. Rather, they simply lower the cost of coverage to groups of subscribers.

The second group of private market solutions propose some restructuring of the present health delivery system. Those involving the least change focus mainly on the restructuring of insurance coverage. As noted previously, insurance coverage is currently most complete for expensive care, i.e., hospitalization. In terms of their own out-of-pocket expense, then, individuals have a good incentive to use hospital facilities. Presumably, one could lower overall costs if incentives were introduced for patients to use less costly alternatives to inpatient care. One way to encourage these latter forms of care is to broaden insurance coverage of these services, perhaps with lower copayments on lower cost

services than on inpatient care.

What are less costly alternatives to inpatient care? There are actually several different types including ambulatory primary care facilities, free-standing surgical facilities, home health programs, etc. The problem is that the current insurance incentives have biased care toward hospitals. As a consequence, we have many hospitals and few of these alternative delivery systems. If we change the insurance incentives then we will have to build more of these alternative systems involving substantial revamping of the current health care system. Nevertheless, the cost consequences would be enormous. Ambulatory surgical facilities, for example, can perform minor surgery for significant cost reduction. While quality of care is an issue here, no data is available which suggests differences. It should be noted that if more of these facilities were available and the incentives for their use changed, we would expect a reduction in hospitalization. If home health alternatives were increased and reimbursement provided, we might also see a decrease in utilization of nursing homes among the elderly and disabled.

While changing the insurance coverage would operate principally by altering demand, there are two other proposals which would alter supply considerations. As we noted in the previous section, the current system of financing on a retrospective, UCR or cost basis essentially gives providers a "blank" check and thus has been partially responsible for the proliferation of equipment and enormous cost increases. Presumably, a change in these financing arrangements would improve the inflationary situation. For example, if prospective budgeting were used, providers would know how much money they had and would have an incentive to operate within that budget. Several witnesses before this Commission recommended moving to a prospective reimbursement system, or returning to the use of fee schedules. Many large insurance carriers have moved to prospective systems, but an economic evaluation is not currently available. There does not appear to be any trend toward the "fee schedule," which we noted earlier is associated with lower costs.

The final private market solution is an alternative delivery system that changes both the incentives for consumers and providers.

It is especially promising in its potential to restore competition to the health care marketplace and, hence, is considered separately. This alternative is the Health Maintenance Organization (HMO) or some variation of the prepaid practice (PPGP). While the PPGP alternative may exist in a variety of forms, all share four important characteristics. First, they eliminate third-party payment by making the provider directly the insurer, bringing him/her closer to the financial decisions involved in health care. Secondly, they require prepayment for health services. Rather than a "blank check," providers have a defined budget and must deliver health services to a particular population within that budget. Third, prepaid group practices generally offer a comprehensive set of services, which typically include outpatient and inpatient care, maternity, drugs, home visits, etc. These services are provided without additional out-of-pocket expense to consumers. Hence, the consumer has no more incentive to use hospital facilities than to use ambulatory care. Finally, and most important, each prepaid group practice essentially draws a circle around a group of providers which distinguishes them from other

groups. Because of this identifiable delivery unit the provider can be held accountable by consumers for both his economic and medical decisions. For example, the consumer can associate particular rates, services and quality with a particular prepaid practice. From the perspective of the provider the prepaid structure can encourage efficiency by rewarding such behavior financially. If one prepaid group practice is more efficient than another and less costly, the profits return to that provider. Incentives of this type are absent within the existing third-party insurance system.

One important result of changing these incentives is a significantly lower utilization of hospital services. In 1977, the National HMO Census survey found that across all types of prepaid group practices hospital utilization averaged 488 days per 1000 persons. This ratio is more than 50 percent lower than the nationwide utilization rate of 1212/1000. In addition, there are apparently no differences in health status for enrollees in prepaid practices, but the data on health status are not adequate to make final conclusions. These low utilization rates have been

confirmed in a number of studies throughout the United States.

As a result of reduced hospital use, prepaid practices are able to offer more services such as maternity, office visits, eye examinations, etc. at the same or lower cost than traditional third-party coverage. Among Health Maintenance Organizations participating in the Federal employee's program, for example, the premiums are generally less expensive, yet the services provided are more comprehensive than those available from competing health insurance options. (Perspective, a Blue Cross/Blue Shield publication, 1977): Group Health Association, 1978).

Finally, a 1970 study by Blue Cross offers encouraging evidence that HMO plan premiums are inflating at a substantially lower rate than traditional third-party insurance. While the study looked at premiums over a short period of time and hence must be interpreted with caution, it appears that the inflation rate may be two-thirds lower in some cases for HMO premiums.

PUBLIC REGULATION

There are three regulatory approaches that are currently operating in some states and under consideration by the U. S.

Congress. They are respectively, Certificate of Need, Rate Regulation, and the Carter Administration proposal to cap hospital revenues.

Certificate of Need (CON) programs attempt to control rising health costs by restricting capital expenditures above some dollar amount such as \$100,000 to those which are actually needed within communities. The program is based on the observation that the current unregulated health care market place has permitted the proliferation of facilities and equipment beyond need. These excesses are costly to maintain as well as purchase and lead to unnecessary utilization of those services. By regulating capital expenditures, CON can reduce medical care costs. Health Care institutions desiring to either build or purchase equipment in particular geographic areas (HSAS) must obtain the Certificate of Need from the State Health Planning Department before the project is continued. In granting or denying a CON, the State Planning Authority considers existing health resources such as hospital or long-term beds per 1000 population and the utilization rates of current facilities such as CAT scanners, burn or cardiac

care units, etc. If a particular area, such as a rural community, does not have adequate health services, a Certificate of Need may be granted. If the area has too many facilities the CON may be denied.

On January 4, 1975, President Ford signed into law the National Health Planning and Resources Development Act of 1974. The Act is an attempt to establish a rational and workable mechanism for the development of new health services. On the national level P.L. 93-641 sets out specific National Health Priorities and establishes a 15-member National Council on Health Planning and Development to advise the Secretary of Health, Education, and Welfare on the implementation of the law and programs to achieve its goal. At the state level, the Act requires the designation of a single State Health Planning and Development Agency which is advised by a Statewide Health Coordinating Council. At the local level, the Act provides for the division of the country into approximately 200 Health Service Areas (six in North Carolina) the characteristics of which make them natural areas for health planning and resources development. Once designated, each

of these areas was to establish an area-wide Health Systems (HSA). The six HSAs, the SHCC, and the SHPDA are currently operational in North Carolina.

All Federal funding under this Act, as well as the continuation under other Federal health planning authorities, is contingent upon an HSA playing a role in its state's Certificate of Need program. Implicit in this funding arrangement is the requirement that a state must adopt and enforce a CON program meeting the Federal requirements. Federal funding of the state level agency and council is also tied to this condition.

The State of North Carolina contested P.L. 93-641 in the U.S. District Court, arguing that the Federal law was coercive in attaching the CON requirement to receipt of Federal funds, and that the Act threatened "the integrity of a recognized state government" (State of North Carolina vs. Califano, 1977). The U.S. District Court ruled against the State, and an appeal was made to the U.S. Supreme Court. The U.S. Supreme Court refused to hear the appeal. This places North Carolina in the position

of meeting the Congressional mandate requiring the State to pass a Certificate of Need statute. Beyond the Congressional mandate for Certificate of Need as a requirement for receipt of Federal funds, cost containment is the reason for passing such a bill in North Carolina. Passage of a Certificate of Need law in North Carolina was endorsed by a number of groups testifying before the Commission, including the North Carolina Hospital Association and Blue Cross/Blue Shield of North Carolina.

Hospital and Nursing Home Rate Regulation Commissions currently operate in several states much in the fashion of a utility commission. Typically, a commission reviews the hospital and nursing home budgets and proposed charges for the fiscal year and decides how much of an increase will be approved. The hospital must then operate within that budget. For example, a Connecticut hospital requested a budget increase of 16.9 percent which their rate commission reduced to 10.6 percent. The Legislative Commission on Medical Cost Containment now has a special subcommittee reviewing rate legislation for possible introduction in the 1979 legislative session.

The third public regulatory strategy is the Carter Administration's proposal and similar proposals from Congress to put a ceiling on hospital revenues. The ceiling itself is determined by a complex formula which is tied to the inflation rate of other consumer goods and services. The ceiling for 1979 would allow a 9 percent increase in revenues. Without the ceiling the revenue increase will probably reach 15 percent. There are several hospital cost containment programs now before the Congress but it is unclear that any will pass before adjournment in the fall.

THE THIRD ALTERNATIVE-- COMBINING PRIVATE MARKET SOLUTIONS AND PUBLIC REGULATION

There is nothing which says that private market and public regulatory solutions must be used separately. Rather, because of the severity of the inflation of medical care costs, a judicious combination of the alternatives may be the most sound strategy. There isn't a single simple solution to this complex problem. For example, many of the private market solutions take time to implement. In the meantime, some public regulation

could serve to hold down costs with the idea that once competitive forces were reestablished in the health care industry, regulation could cease. In its recommendations to the General Assembly the Commission has opted for this approach.

RECOMMENDATIONS

RECOMMENDATIONS

Repeal the present provision in G.S. 108-60 that prevents the State from contracting for Medicaid claims processing beyond December 31, 1979.

Present State law (Chapter 537 of the 1977 Session Laws) prevents contracting for Medicaid claims processing beyond December 1, 1979. In their report, Medicaid Program Administration in North Carolina, Peat, Marwick, and Mitchell stated that some of the instability in the Medicaid program occurred because of turnover in claims processors. To reduce this turnover, Peat, Marwick and Mitchell recommended that the State enter into a multi-year contract for claims processing, beginning July 1, 1979. The Commission concurs in this recommendation and recommends that the provision in Appendix B become a part of the 1978 Appropriations Act. Unless this provision is passed by the 1978 legislative session the State will find it impossible to develop a "request for proposals" that would lead to a multi-year contract.

Remove Rule-making Authority for Medicaid from the Social Services Commission

Authority over the Medicaid program has traditionally been divided between several sections within the Division of Social Services of the Department of Human Resources. The Commission believes that this fragmentation of management responsibility has helped to create many of the problems that have occurred in the program over the past several years. Especially it has led to problems in budget forecasting, administration of the claims processing contracts, and eligibility determination. The Commission concurs in the recommendation of Peat, Marwick, and Mitchell that legislative and gubernatorial accountability will be strengthened by creating a separate division within the Department of Human Resources responsible solely for this program. In recent weeks the Secretary has taken steps to implement this recommendation. But, even with the new division, the final rule-making authority over much of the Medicaid program will still lie with the Social Services Commission. This potentially continues the fragmentation of authority

that has plagued the program in the past. Under the statutory revision contained in Appendix C , authority over rules and regulations in the Medicaid program would be vested with the Secretary of Human Resources. Final approval of changes relating to services, rates of payment, and claims processing contracts still are vested in the Governor and the Advisory Budget Commission. The Commission recommends that this become a part of the 1978 Appropriations Act.

Development of a Comprehensive Long Term Care Plan for North Carolina

In the text of this report the Commission has documented the fragmentation of programs in the area of long term care. At the same time we have found overutilization of high cost institutional services. We have also shown that because of the changing age distribution in our State's population and the enormous cost of such care that the problem will simply not go away. Therefore we recommend that the Governor and the General Assembly initiate the development of a comprehensive plan for long term care in North Carolina. While realizing that such a plan cannot be developed overnight it is the first step toward expanding the

services available to our senior citizens and reducing costly overutilization of nursing homes that now occurs.

Require that Home Health Services be Available in All Counties in North Carolina

In the course of its hearings, the Commission was told by a number of individuals that home health care offered an effective alternative to placement in nursing homes. At the present time 90 counties in North Carolina have home health agencies. The 10 counties that do not are Rowan, Union, Anson, Bladen, Stokes, Jones, Pamlico, Hyde, Davidson, and Robeson. Stokes expects to start an agency in April 1978, and Anson is a possibility for 1978. Startup costs are available from the Department of Human Resources for home health agencies. The Department has stated that it has sufficient funds in FY 1978-79 to fund the startup costs in these 10 counties, with additional funds required in the next biennium.

The bill in Appendix D was prepared for the Legislative Research Commission on Aging for introduction in the 1978 legislative session. This Commission endorses that bill and

urges its passage during the May session.

Change the current State-County Matching Formula for Skilled Nursing Care, Intermediate Care, and Rest Homes to Eliminate the Present Financial Incentive to Place Medicaid Patients in the High Levels of Care.

The present matching formulas used to determine the county share of nursing home cost in the Medicaid program, when compared with the cost to the county of a rest home placement, provides a financial incentive for placement in the higher levels of care. The Commission believes that such a change will stimulate the growth of additional rest home beds. The Commission recommends that the matching formulas be revised in the 1978 Appropriations Act to reflect the following:

	<u>Federal</u>	<u>State</u>	<u>County</u>
Skilled Nursing Facilities		65%	35%
Intermediate Care Facilities		65%	35%
Rest Homes		70%	30%

Finally, the Commission recommends that the Depart. of Human Resources

carefully monitor the implementation of this change and report its findings to the Governor and future sessions of the General Assembly. The statutory language necessary to implement this recommendation is contained in Appendix E.

Passage of a Certificate of Need Act in 1978.

The text of this report speaks to why this Commission believes a Certificate of Need law is necessary in North Carolina. This Commission recommends immediate passage of the bill contained in Appendix F of this report with an effective date of January 1, 1979. Postponment of the effective date for over six months allows the Department of Human Resources sufficient time to develop rules and regulations that comply with State and Federal law on this subject.

That the Department of Human Resources Request a Waiver from the Department of Health Education and Welfare to Implement a "Swing-bed experiment" in the Medicaid Program.

Current Federal Medicare and Medicaid rules do not allow the State to reimburse a hospital or a nursing home for a lower level of care unless the patient is physically moved into a part

of that facility designated to provide for those services. For example, if a hospital has a Medicaid patient ready to move from inpatient status to a skilled nursing facility but no skilled bed is available, the hospital cannot be paid for providing skilled care unless it has a unit designated to provide that care. A skilled nursing facility with a patient ready for intermediate level care cannot provide such care unless it has beds distinctly designated for such use. If no beds are available the patient must be moved to another home. The Commission believes that both the State and Federal Government would benefit from a carefully monitored experiment that paid providers by the level of care necessary for the patient, rather than the present more restrictive policy of moving the patient to a separate unit.

That the 1978 Legislative Session Provide Funds in the Amount of \$15,000 for FY 1978-79 to continue the activities of the Legislative Commission on Medical Cost Containment.

Chapter 968 of the 1977 Session Laws requires that this Commission make an interim report to the 1978 legislative session,

with final report in April 1979. Since a number of matters still remain before the Commission, a full meeting schedule will be necessary for the next six months. The funds requested are in the same amounts appropriated for FY 1977-78.

Provide for the Licensing of Free-standing Ambulatory Surgical Facilities in North Carolina

The surgical procedures provided in these free-standing outpatient centers and medical and dental services obtainable at these clinics are often far less expensive to the patient. Since the State does not at this time have licensing procedures established for these types of facilities, the patient is often denied insurance coverage for this lower cost care. The result is that the patient is forced to seek out unneeded and more expensive hospital care.

We recommend that the State set up licensing procedures for free-standing ambulatory surgical centers to the end that they may qualify for full insurance benefits. A bill implementing this recommendation is contained in Appendix H.

That the 1978 Legislative Session Provide Funds to Establish the Commission on Prepaid Health Plans

The Commission found that many of the market forces which serve to enhance competition and keep prices down are absent from the traditional health care system. Testimony by several witnesses, however, suggested that these market forces are present in the Prepaid Group Practice System (see earlier discussion). Because the PPGP is not currently available to most North Carolinians and because of the PPGP's potential to contain health care costs, the Commission recommends that a joint Legislative and Gubernatorial Commission on Prepaid Health Plans be established to study this alternative on a Statewide basis. The bill establishing this Commission appears in Appendix I.

Since the PPGP is a private market solution, this recommendation is of particular importance since it emphasizes the Commission's commitment to the judicious combination of public regulatory and private approaches to cost containment.

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APPENDIX A

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Persons Appearing Before the Legislative Commission on Medical
Cost Containment

10/25/77

- Mr. Bob Ward - Director, Division of Social Services, Department of Human Resources.
- Mr. Jim Gibson - Medical Services, Department of Human Resources
- Mr. Emmett Sellers - Division of Social Services, Department of Human Resources
- Ms. Charlotte Mitchell - Division of Social Services, Department of Human Resources
- Mr. David Mazo - Division of Social Services, Department of Human Resources

10/26/77

- Mr. Todd Carlson - Electronic Data Systems-Federal (EDS-F)
- Mr. Doug Griffiths- EDS-F
- Ms. Norma Martin - EDS-F
- Mr. Hank Betts - EDS-F
- Mr. Bill Cozens - The Computer Company (TCC)
- Mr. Bert Parish - TCC
- Mr. Shelton Brown- TCC
- Mr. Benny Rideout - Division of Social Services, Department of Human Resources
- Dr. Frank Sohmer - President and Medical Director, N.C. Medical Peer Review Foundation

11/3/77

- Mr. Marion Foster - President, N.C. Hospital Association
- Mr. Jack Richardson - Director, Pitt Memorial Hospital, Greenville, N. C.
- Mr. Tom Surratt - President, Carteret County General Hospital, Morehead City, N.C.
- Mr. Harold Coe - President, Forsyth County Hospital Authority, Winston-Salem, N.C.
- Mr. Joseph James - Administrator, Wayne County Memorial Hospital, Goldsboro, N.C.
- Mr. Richard Peck - Administrative Director, Duke Medical Center, Durham, N.C.
- Mr. John Marston - Vice-President, N.C. Hospital Association

11/4/77

- Mr. Paul Karsaras - Past President, N.C. Health Care Facilities Association
- Mr. J.R. Garrett - President, N.C. Health Care Facilities Association
- Mr. Craig Souza - Director, N.C. Health Care Facilities Association

Mr. A.S. Pierce - President, N.C. Association of Long Term Care
Facilities
Mr. W.J. Smith - Executive Director, N.C. Pharmaceutical
Association

11/4/77

Dr. E. Harvey Estes, Jr. - President, N.C. Medical Society
Dr. Frank Sohmer, Jr. - President and Medical Director, N.C.
Medical Peer Review Foundation
Dr. Robert H. Shackelford - Mount Olive, N.C.
Dr. Archie Johnson - President, N.C. Pediatric Society
Dr. Robert B. Litton - President, N.C. Dental Society
Dr. Marvin Block - N.C. Dental Society
Dr. Chuck Malone - N.C. Dental Society
Dr. Mitchell Wallace - N.C. Dental Society

Dr. D.F. Hoard - N.C. Dental Society
Dr. R.B. Barden - N.C. Dental Society
Ms. Joyce Rogers - Executive Director, N.C. Dental Society
Mr. Roy Horwick - Assistant Executive Director, N.C. Dental Society
Dr. Willie Wilkins - President, Old North State Dental Society

11/15/77

Ms. Lark Hayes - Legal Aid Society of Mecklenburg County
Ms. Marcia Stein - Legal Aid Society of Wake County
Mr. Harvey Jordan - Senior Citizen from Charlotte
Ms. Lula Belle Switzer - Medicaid Recipient
Ms. Jennie Chalk - Business Manager of the Health Care Center in
Raleigh
Ms. Carol Spruill - Legal Aid Society of Forsyth County
Ms. Sudie Goldstone - Executive Director of Creative Life Centers,
Winston-Salem
Ms. Carrie Graves - Community Volunteer, Charlotte
Mr. Ken Wing - Professor School of Public Health and U.N.C. Law
School

11/16/77

Mr. Bob Crane - Staff member to the U.S. House of Representatives
Subcommittee on Health and the Environment
Dr. William B. Munier - Director, Office of Quality Standards,
Office of the Assistant Secretary for Health, U.S.
Department of H.E.W.
Dr. Ronald M. Klar - Director, Division of Health, Financing, Office
of the Assistant Secretary for Health, U.S. Depart-
ment of H.E.W.
Mr. George J. Williams - Regional Program Consultant, Health Planning
and Facilities Branch, Region IV, H.E.W., Atlanta,
Georgia

Ms. Virginia M. Smyth - Regional Administrator, Health Care
Financing Administration, Region IV, H.E.W.,
Atlanta, Georgia
Mr. Ed Davis - Regional Medicaid Director, Region IV, H.E.W.,
Atlanta, Georgia
Mr. Bernard Dvoskin - Director, Division of Financing and Health
Economics, Region IV, H.E.W., Atlanta, Georgia

12/6/77

Mr. Jim Johnson - Fiscal Research Division, Legislative Services
Commission
Mr. Larry Burwell - Director of the State Health Planning and
Development Agency
Dr. Walter McClure - Senior Policy Analyst and Director of the
Health Policy and Planning Group of InterStudy,
Minneapolis, Minnesota

12/7/77

Mr. Tom Rose - President, N.C. Blue Cross/Blue Shield
Mr. Eugene M. Heimburg - Vice President, Group Insurance of
Prudential Insurance Company of America
Mr. James Long - Director, Claims for Prudential's Governmental
Health Programs
Mr. Amos Lashley - Director, Prudential's N.C. Medicare Claims
Processing
Mr. George Hider - Vice President, Pilot Life Insurance Company

2/8/78

Dr. Charles Watts - Lincoln Community Health Center, Durham, N.C.
Representative A.J. Howard Clement, III - Durham, N.C.

APPENDIX B

PROPOSED LANGUAGE FOR
THE APPROPRIATIONS BILL

-----MEDICAID CLAIMS PROCESSING

Section . Section 4 of Chapter 123 of the 1975
Session Laws as amended by Section 1 of Chapter 537 of the 1977
Session Laws is further amended to read as follows:

"This act is effective upon ratification."

APPENDIX C

MEDICAID RULES AND REGULATIONS - POWERS OF THE DEPARTMENT OF
HUMAN RESOURCES

Section 1. G. S. 108-7, as the same appears in Part I of Volume 3A of the General Statutes, is hereby amended by adding the following sentence at the end thereof:

"Provided, however, county policies for the program of medical assistance shall be established in conformity with the rules and regulations of the Department of Human Resources."

Sec. 2. G. S. 108-15(5), as the same appears in Part I of Volume 3A of the General Statutes, is hereby amended by adding after the word "Assembly" on line 1 thereof a comma and the words "the Department of Human Resources".

Sec. 3. G. S. 108-19(3), as the same appears in Part I of Volume 3A of the General Statutes, is hereby amended by deleting the period at the end thereof and substituting therefor the following: "under pertinent rules and regulations."

Sec. 4. G. S. 108-23, as the same appears in Part I of Volume 3A of the General Statutes, is hereby amended by designating the current section as subsection (a), by deleting subdivision (4), by renumbering the remaining subdivisions accordingly, and by adding the following subsection at the end thereof:

"(b) The program of medical assistance is hereby established and shall be administered by the county departments of social services under rules and regulations adopted by the Department of Human Resources."

Sec. 5. G. S. 108-24(4), as the same appears in Part I of Volume 3A of the General Statutes, is hereby amended by deleting the words "Social Services Commission" and substituting therefor the words "Department of Human Resources".

Sec. 6. G. S. 108-27(a) and (b), as the same appear in Part I of Volume 3A of the General Statutes, are hereby amended by deleting the periods at the end thereof as well as the words "of the Social Services Commission", inserting between the words "the" and "rules" on line 6 of subsection (a) and line 5 of subsection (b) the word "pertinent", and by adding periods immediately following the word "regulations" at the end of each subsection.

Sec. 7. G. S. 108-42(c) and (d), as the same appear in Part I of Volume 3A of the General Statutes, are hereby amended by inserting after the words "Social Services Commission" the words "or the Department of Human Resources in the case of medical assistance".

Sec. 8. G. S. 108-43, as the same appears in Part I of Volume 3A of the General Statutes, is hereby amended by deleting the period at the end of the first sentence thereof and substituting therefor the following: "or the Department of Human Resources in the case of medical assistance."

Sec. 9. G. S. 108-44(a), as the same appears in Part I of Volume 3A of the General Statutes, is hereby amended by deleting the comma after the word "Commission" on line 6 thereof and substituting the following: "or the Department of Human Resources,".

Sec. 10. G. S. 108-44(b), as the same appears in Part I of Volume 3A of the General Statutes, is hereby amended by deleting the words "of the Social Services Commission" and

inserting between the words "the" and "rules" on line 2 hereof the word "pertinent".

Sec. 11. G. S. 108-44(d), as the same appears in Part I of Volume 3A of the General Statutes, is hereby amended by deleting the period at the end of the first sentence thereof and substituting therefor the following: "or the Department of Human Resources."

Sec. 12. G. S. 108-44(e), as the same appears in Part I of Volume 3A of the General Statutes, is hereby amended by deleting the period at the end of the third sentence thereof and substituting therefor the following: "or the Department of Human Resources."

Sec. 13. G. S. 108-44(f), as the same appears in Part I of Volume 3A of the General Statutes, is hereby amended by inserting between the words "Commission" and "and" on line 9 thereof a comma followed by the words "the Department of Human Resources".

Sec. 14. G. S. 108-45(a), as the same appears in Part I of Volume 3A of the General Statutes, is hereby amended by deleting the period at the end thereof and substituting therefor the following: "or the Department of Human Resources."

Sec. 15. G. S. 108-50, as the same appears in Part I of Volume 3A of the General Statutes, is hereby amended by deleting the comma after the word "Commission" on line 9 thereof and substituting therefor the following: "or the Department of Human Resources,".

Sec. 16. G. S. 108-54, as the same appears in Part I of Volume 3A of the General Statutes, is hereby amended by deleting "Director of the Division of Social Services, as agent for the Department of Human Resources," on lines 9 and 10 thereof and "Director of the Division of Social Services"

on lines 15, 26, 32, and 33 thereof and substituting therefor in each instance the words "Department of Human Resources". G. S. 108-54 is hereby further amended by deleting the word "he" on line 27 thereof and substituting therefor the word "it".

Sec. 17. G. S. 108-54.1(b), as the same appears in Part I of Volume 3A of the General Statutes, is hereby amended by deleting "Director of the Division of Social Services, as agent for the Department of Human Resources," and substituting therefor the words "Department of Human Resources".

Sec. 18. G. S. 108-56(a), as the same appears in Part I of Volume 3A of the General Statutes, is hereby amended by deleting the comma after the word "Commission" on line 4 thereof and substituting therefor the following: "or the Department of Human Resources,".

Sec. 19. G. S. 108-59, as the same appears in Part I of Volume 3A of the General Statutes, is hereby amended by deleting the words "Social Services Commission" on lines 2 and 3 thereof and substituting therefor the words "Department of Human Resources".

Sec. 20. G. S. 108-60, as the same appears in Part I of Volume 3A of the General Statutes, is hereby amended by deleting the words "Social Services Commission" on lines 2, 10, 11, and 13 thereof and substituting therefor in each instance the words "Department of Human Resources".

Sec. 21. G. S. 143B-153, as the same appears in Volume 3C of the General Statutes, is hereby amended by adding the following sentence at the end of the first paragraph:

"Provided, however, the Department of Human Resources shall have the power and duty to adopt rules and regulations to be followed in the conduct of the State's medical assistance program."

Sec. 22. G. S. 143B-153(2)a., as the same appears in Volume 3C of the General Statutes, is hereby amended by deleting the semicolon at the end thereof and substituting therefor the following: "with the exception of the program of medical assistance established by G. S. 108-23(b);"

Sec. 23. All standards, rules, regulations, determinations, and decisions relating to medical assistance and the medical assistance program heretofore adopted by the Social Services Commission and its predecessors shall remain in full force and effect unless and until repealed or superseded by action of the Department of Human Resources.

Sec. 24. This act shall become effective upon ratification.

APPENDIX D

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 1977

HOUSE BILL 1546*

Short Title: Home Health.

(Public)

Sponsors: Representatives Messer, Clarke, Economos, Pickler;

Adams, Beard, Chase, Clement, Cook, Creech, Enloe, Foster,*

Referred to: Aging.

June 1, 1978

A BILL TO BE ENTITLED

AN ACT TO REQUIRE HOME HEALTH SERVICES IN EVERY COUNTY, SO AS TO
IMPLEMENT THE RECOMMENDATIONS OF THE LEGISLATIVE RESEARCH
COMMISSION'S COMMITTEE ON AGING.

The General Assembly of North Carolina enacts:

Section 1. General Statutes Chapter 130 is amended by
adding a new section to read as follows:

"§ 130-170.2. Home health services to be provided in all
counties.--(a) Every county shall provide home health services
as defined in G.S. 130-170.1(a).

(b) For the purpose of this section, home health services
shall be as defined in G.S. 130-170.1(a), except that such
services may be provided by any organization listed in subsection
(c) of this section.

(c) Home health services may be provided by a county health
department, by a district health department, by a home health
agency licensed under G.S. 130-170.1, or by a public agency. The
county may provide home health services by contract with another
health department, or with a home health agency or public agency
in another county."

1 Sec. 2. This act shall become effective July 1, 1979.

2 -----
3 *Additional Sponsors: Gamble, Gregory, Hunter, Hurst, Lutz,
4 Nesbitt, Parnell, Ray, Tally, Henry Tyson, Webb, Wiseman, and B.
5 P. Woodard.

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APPENDIX E

PROPOSED LANGUAGE FOR
THE APPROPRIATIONS BILL

Sec. 23. - 1978 APPROPRIATIONS BILL DRAFT P. 36 - Replaces the language beginning on line 19.

The State shall pay eighty-five percent (85%) and the counties shall pay fifteen percent (15%) of the non-federal costs of all applicable services listed in this section, except as otherwise provided below. The same 85% State and 15% county participation shall be used for any prepaid premium if Medicaid services and related administrative costs are paid for by a health-insuring contractor.

The State shall pay sixty-five percent (65%) and the counties shall pay thirty-five percent (35%) of the non-federal costs of those Skilled Nursing Facilities and Intermediate Care Facilities services which are not owned by the State.

The 85% State and 15% county participation shall remain in effect for all Intermediate Care Facilities for the Mentally Retarded.

Sec. 23.05. The State shall pay seventy percent (70%) and the counties shall pay thirty percent (30%) of the cost of Home for the Aged, and Family Care Homes Services.

-----REPORT ON STATE/COUNTY PARTICIPATION RATE CHANGES

Sec. 23.06. The Department shall submit a preliminary report to the 1979 Session of the General Assembly and a full report to the 1980 and 1981 Sessions of the General

Assembly evaluating the effect of the change in participation rate between the State and the Counties in the provision of Skilled Nursing Services, Intermediate Care Services, Home for the Aged, and Family Care Home Services. This report shall detail changes in the utilization of the various facilities and cost savings, if any, to the State as a result of this change in participation rates.

APPENDIX F

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 1977

HOUSE BILL 1650*

Short Title: Certificate of Need.

(Public)

Sponsors: Representatives Kaplan; and Clement.

Referred to: Appropriations.

June 8, 1978

A BILL TO BE ENTITLED

AN ACT TO PROVIDE A CERTIFICATE OF NEED LAW, SO AS TO IMPLEMENT
THE RECOMMENDATIONS OF THE LEGISLATIVE COMMISSION ON MEDICAL
COST CONTAINMENT.

The General Assembly of North Carolina enacts:

Section 1. This act may be cited as the North Carolina
Health Planning and Resource Development Act of 1978.

Sec. 2. Chapter 131 of the General Statutes is amended
by adding a new Article 18 to read:

"ARTICLE 18.

"Certificate of Need Law.

"§ 131-170. Findings of fact.--The General Assembly of North
Carolina makes the following findings:

(1) That, because of the manner in which health care is
financed, the forces of free market competition are largely
absent and that government regulation is therefore necessary to
control the cost, utilization, and distribution of health
services.

(2) That the continuously increasing cost of health care
services threatens the health and welfare of the citizens of this

1 State in that citizens need assurance of economical, and readily
2 available health care.

3 (3) That the current system of planning for health care
4 facilities and equipment has led to the proliferation of new
5 inpatient acute care facilities and medical equipment beyond the
6 need of many localities in this State and an inadequate supply of
7 health personnel and of recourses for long term, intermediate,
8 and ambulatory care in many localities.

9 (4) That this trend of proliferation of unnecessary health
10 care facilities and equipment results in costly duplication and
11 underuse of facilities, with the availability of excess capacity
12 leading to unnecessary use of expensive resources and
13 overutilization of acute care hospital services by physicians.

14 (5) That a certificate of need law is required by P.L. 93-64,
15 as a condition for receipt of federal funds. If these funds were
16 withdrawn the State of North Carolina would lose in excess of
17 fifty-five million dollars (\$55,000,000).

18 (6) That excess capacity of health facilities places an
19 enormous economic burden on the public who pay for the
20 construction and operation of these facilities as patients,
21 health insurance subscribers, health plan contributors, and
22 taxpayers.

23 (7) That the general welfare and protection of lives, health,
24 and property of the people of this State require that new
25 institutional health services to be offered within this State be
26 subject to review and evaluation as to type, level, quality of
27 care, feasibility, and other criteria as determined by provisions
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1 of this Article or by the North Carolina Department of Human
2 Resources pursuant to provisions of this Article prior to such
3 services being offered or developed in order that only
4 appropriate and needed institutional health services are made
5 available in the area to be served.

6 "§ 131-171. Definitions.--As used in this Article, unless the
7 context clearly requires otherwise, the following terms have the
8 meanings specified:

9 (1) 'Ambulatory surgical facility' means a public or private
10 facility, not a part of a hospital, which provides surgical
11 treatment to patients not requiring hospitalization. Such term
12 does not include the offices of private physicians or dentists,
13 whether for individual or group practice.

14 (2) 'Bed capacity' means space used exclusively for inpatient
15 care, including space designed or remodeled for inpatient beds
16 even though temporarily not used for such purposes. The number
17 of beds to be counted in any patient room shall be the maximum
18 number for which adequate square footage is provided as
19 established by regulations of the department except that single
20 beds in single rooms are counted even if the room contains
21 inadequate square footage.

22 (3) 'Certificate of need' means a written order of the
23 department setting forth the affirmative finding that a proposed
24 project sufficiently satisfies the plans, standards, and criteria
25 prescribed for such projects by this Article and by rules and
26 regulations of the department as provided in G.S. 131-176(a) and
27 affords the person so designated as the legal proponent of the
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1 proposed project the opportunity to proceed with the development
2 of such project.

3 (4) 'Certified cost estimate' means an estimate of the total
4 cost of a project certified by the proponent of the project
5 within 60 days prior to or subsequent to the date of submission
6 of the proposed new institutional health service to the
7 department and which is based on:

- 8 a. plans and specifications,
- 9 b. estimates of the cost of equipment certified by the
10 manufacturer or vendor, and
- 11 c. estimates of the cost of management and
12 administration of the project.

13 (5) 'Change of ownership' means the transfer by purchase,
14 lease or comparable arrangements of the controlling interest of a
15 capital asset or capital stock, or voting rights of a
16 corporation, from one person to another. Such transfer is deemed
17 to occur when fifty percent (50%) or more of an existing capital
18 asset or capital stock or voting rights of a corporation is
19 purchased, leased or acquired by comparable arrangement by one
20 person from another person.

21 (6) 'Commencement of construction' means that all of the
22 following have been completed with respect to a project:

- 23 a. a written contract executed between the applicant
24 and a licensed contractor to construct and complete
25 the project within a designated time schedule in
26 accordance with final architectural plans;
- 27 b. required initial permits and approvals for
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1 commencing work on the project have been issued by
2 responsible governmental agencies; and

3 c. actual construction work on the project has started
4 and a progress payment has been made by the
5 applicant to the licensed contractor under terms of
6 the construction contract.

7 (7) 'Department' means the North Carolina Department of Human
8 Resources.

9 (8) 'To develop' when used in connection with health services,
10 means to undertake those activities which will result in the
11 offering of institutional health service not provided in the
12 previous 12-month reporting period or the incurring of a
13 financial obligation in relation to the offering of such a
14 service.

15 (9) 'Final decision' means an approval, a denial, an approval
16 with conditions, or a deferral.

17 (10) 'Health care facility' means hospitals; psychiatric
18 hospitals; tuberculosis hospitals; skilled nursing facilities;
19 kidney disease treatment centers, including free-standing
20 hemodialysis units; intermediate care facilities; ambulatory
21 surgical facilities; health maintenance organizations; home
22 health agencies; and diagnostic or therapeutic equipment with a
23 value in excess of one hundred thousand dollars (\$100,000)
24 purchased or leased by a 'person', as defined in this section.
25 'Health care facility' does not include a facility operated
26 solely as part of the private medical practice of (i) an
27 independent practitioner, (ii) a partnership, or (iii) a
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1 professional medical corporation, except with respect to
2 acquisitions of diagnostic or therapeutic equipment with a value
3 in excess of one hundred thousand dollars (\$100,000) if with
4 respect to such acquisition either:

- 5 a. the notice required by G.S. 131-173(e) is not filed
6 in accordance with that paragraph with respect to
7 such acquisition, or
8 b. the department finds, within 30 days after the date
9 it receives a notice in accordance with G.S. 131-
10 173(e) with respect to such acquisition, that the
11 equipment will be used to provide services for
12 inpatients or outpatients of a hospital.

13 (II) 'Health Maintenance Organization (HMO)' means a public or
14 private organization which:

- 15 a. provides or otherwise makes available to enrolled
16 participants health care services, including at
17 least the following basic health care services:
18 usual physician services, hospitalization,
19 laboratory, X-ray, emergency and preventive
20 services, and out-of-area coverage;
21 b. is compensated, except for copayments, for the
22 provision of the basic health care services listed
23 in subdivision a. of this section to enrolled
24 participants on a predetermined periodic rate
25 basis; and
26 c. provides physicians' services primarily (i) directly
27 through physicians who are either employees or
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1 partners of such organization, or (ii) through
2 arrangements with individual physicians or one or
3 more groups of physicians organized on a group
4 practice or individual practice basis.

5 (12) 'Health systems agency' means an agency, as defined by
6 P.L. 93-641, as amended, and rules and regulations implementing
7 that act.

8 (13) 'Home health agencies' means a private organization or
9 public agency, whether owned or operated by one or more persons
10 or legal entities, which furnishes or offers to furnish home
11 health services.

12 'Home health services' means items and services furnished to an
13 individual by a home health agency, or by others under
14 arrangements with such others made by the agency, on a visiting
15 basis, and except for subdivision e. of this subsection, in a
16 place of temporary or permanent residence used as the
17 individual's home as follows:

- 18 a. part-time or intermittent nursing care provided by
19 or under the supervision of a registered nurse;
- 20 b. physical, occupational or speech therapy;
- 21 c. medical social services, home health aid services,
22 and other therapeutic services;
- 23 d. medical supplies, other than drugs and biologicals,
24 and the use of medical appliances;
- 25 e. any of the foregoing items and services which are
26 provided on an outpatient basis under arrangements
27 made by the home health agency at a hospital or
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1 nursing home facility or rehabilitation center and
2 the furnishing of which involves the use of
3 equipment of such a nature that the items and
4 services cannot readily be made available to the
5 individual in his home, or which are furnished at
6 such facility while he is there to receive any such
7 item or service, but not including transportation
8 of the individual in connection with any such item
9 or service.

10 (14) 'Hospital' means a public or private institution which is
11 primarily engaged in providing to inpatients, by or under
12 supervision of physicians, diagnostic services and therapeutic
13 services for medical diagnosis, treatment, and care of injured,
14 disabled, or sick persons, or rehabilitation services for the
15 rehabilitation of injured, disabled, or sick persons. Such term
16 does not include psychiatric hospitals, as defined in subdivision
17 (22) of this section, or tuberculosis hospitals, as defined in
18 subdivision (27) of this section.

19 (15) 'To incur a financial obligation in relation to the
20 offering of a new institutional health service' means that in
21 establishing a new institutional health service a person must
22 fulfill the following performance requirements relative to but
23 not limited to the following types of projects:

24 a. new construction or renovation project:

- 25 1. has acquired title or long-term lease to the
26 appropriate site; and
- 27 2. has entered into an enforceable construction

1 contract specifying price and date for
2 commencement of construction within 120 days
3 from the date the contract is entered into;
4 and

5 3. has filed with the appropriate State agency and
6 received approval on the complete set of
7 schematic drawings for the project; and

8 4. has obtained a financial commitment, including
9 an enforceable offer and acceptance from a
10 financial institution to provide adequate
11 capital financing for the project.

12 b. acquisition of equipment: the equipment must either
13 be purchased, the lease agreement must be entered
14 into by the proponent, or if acquired by a
15 comparable arrangement the proponent must have
16 possession of the equipment;

17 c. change of ownership by lease or purchase or
18 comparable arrangement:

19 1. the lease must be entered into; or

20 2. the title to the property or stock must be in
21 the possession of the proponent.

22 (16) 'Intermediate care facility' means a public or private
23 institution which provides, on a regular basis, health-related
24 care and services to individuals who do not require the degree of
25 care and treatment which a hospital or skilled nursing facility
26 is designed to provide, but who because of their mental or
27 physical condition require health-related care and services above
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1 the level of room and board.

2 (17) 'New institutional health services' means:

- 3 a. the construction, development, or other
4 establishment of a new health care facility;
- 5 b. any expenditure by or on behalf of a health care
6 facility in excess of one hundred thousand dollars
7 (\$100,000) which, under generally accepted
8 accounting principles consistently applied, is a
9 capital expenditure; except that this Article shall
10 not apply to expenditures solely for the
11 termination or reduction of beds or of a health
12 service, but shall apply to expenditures for site
13 acquisitions and acquisition of existing health
14 care facilities. Where a person makes an
15 acquisition by or on behalf of a health care
16 facility under lease or comparable arrangement, or
17 through donation, which would have required review
18 if the acquisition had been by purchase, such
19 acquisition shall be deemed a capital expenditure
20 subject to review. The value of the transaction
21 shall be deemed to be the fair market value of the
22 asset and not necessarily the actual dollar amount
23 of the transaction. Donations shall include
24 bequests. A change in a proposed capital
25 expenditure project which in itself meets the
26 criteria set forth herein shall be considered a
27 capital expenditure, as well as a change in
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1 ownership of in excess of fifty percent (50%) of an
2 existing health care facility or the acquisition of
3 in excess of fifty percent (50%) of the assets or
4 capital stock of a health care facility.

5 c. a change in bed capacity of a health care facility
6 which increases the total number of beds, or which
7 distributes beds among various categories, or
8 relocates such beds from one physical facility or
9 site to another. Such bed capacity change is
10 subject to review regardless of whether a capital
11 expenditure is made;

12 d. health services, including home health services,
13 which are offered in or through a health care
14 facility and which were not offered on a regular
15 basis in or through such health care facility
16 within the 12-month period prior to the time such
17 services would be offered;

18 e. a formal internal commitment of funds by a facility
19 for a project undertaken by the facility as its own
20 contractor;

21 f. any expenditure by or on behalf of a health care
22 facility in excess of one hundred thousand dollars
23 (\$100,000) made in preparation for the offering or
24 development of a new institutional health service
25 and any arrangement or commitment made for
26 financing the offering or development of a new
27 institutional health service;

1 g. any conversion or upgrading of a facility such that
2 it is converted from a type of facility not covered
3 by this Article to any of the types of health care
4 facilities which are covered by this Article as
5 defined in this section;

6 h. a project which substantially expands a service
7 currently offered or which provides a service not
8 offered in the previous 12-month reporting period
9 by the facility, including a change in type of
10 license of five or more beds. Such substantial
11 change of service is subject to review regardless
12 of whether a capital expenditure is made;

13 i. the purchase or lease by a person or health care
14 facility of diagnostic or therapeutic equipment,
15 regardless of location, with a value in excess of
16 one hundred thousand dollars (\$100,000), except it
17 shall not include purchase or lease of such
18 equipment with a value in excess of one hundred
19 thousand dollars (\$100,000) for use in a facility
20 operated solely as part of the private medical
21 practice of (i) an independent practitioner, (ii) a
22 partnership, or (iii) a professional medical
23 corporation unless either,

- 24 1. the notice required by G.S. 131-173(e) is not
25 filed in accordance with that subsection, or
- 26 2. the department finds, within 30 days after it
27 receives a notice under G.S. 131-173(e), that
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1 the equipment will be used to provide services
2 for inpatients or outpatients of a hospital;
3 for purposes of this subdivision, the acquisition of one or more
4 items of functionally related diagnostic or therapeutic equipment
5 shall be considered as one project. Purchase or lease shall
6 include purchases, contracts, encumbrances of funds, lease
7 arrangements, conditional sales or a comparable arrangement that
8 purports to be a transfer of ownership in whole or in part.
9 Diagnostic or therapeutic equipment shall include units of
10 equipment and all accessories functionally related and used in
11 the diagnosis and treatment of patients, excluding mechanical and
12 electrical equipment related to basic operation and maintenance
13 of the facility. Functionally related means that pieces of
14 equipment are interdependent to the extent that one piece of
15 equipment is unable to function in the absence of or without the
16 functioning piece, or that one piece of equipment performs the
17 same function as another piece, or that pieces of equipment are
18 normally used together in the provision of a single health care
19 facility service.

20 (18) 'North Carolina State Health Coordinating Council' means
21 the council as defined by P.L. 93-64, as amended, and rules and
22 regulations implementing that act.

23 (19) 'To offer', when used in connection with health services,
24 means that the health care facility or health maintenance
25 organization holds itself out as capable of providing, or as
26 having the means for the provision of, specified health services.

27 (20) 'Person' means an individual, a trust or estate, a
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1 partnership, a corporation, including associations, joint stock
2 companies, and insurance companies; the State, or a political
3 subdivision or agency or instrumentality of the State.

4 (21) 'Project' or 'capital expenditure project' means a
5 proposal to undertake a capital expenditure that results in the
6 offering of a new institutional health service as defined by this
7 act. A project, or capital expenditure project, or proposed
8 project may refer to the project from its earliest planning
9 stages up through the point at which the specified new
10 institutional health service may be offered. In the case of
11 facility construction, the point at which the new institutional
12 health service may be offered must take place after the facility
13 is capable of being fully licensed and operated for its intended
14 use, and at that time it shall be considered a health care
15 facility.

16 (22) 'Psychiatric hospital' means a public or private
17 institution which is primarily engaged in providing to
18 inpatients, by or under the supervision of a physician,
19 psychiatric services for the diagnosis and treatment of mentally
20 ill persons.

21 (23) 'Skilled nursing facility' means a public or private
22 institution or a distinct part of an institution which is
23 primarily engaged in providing to inpatients skilled nursing care
24 and related services for patients who require medical or nursing
25 care, or rehabilitation services for the rehabilitation of
26 injured, disabled, or sick persons.

27 (24) 'State Medical Facilities Plan' means a plan prepared by
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1 the Department of Human Resources and the North Carolina State
2 Health Coordinating Council, as required by P.L. 93-641, as
3 amended, and rules and regulations implementing that act.

4 (25) 'State Health Plan' means the plan required by P.L. 93-
5 641, as amended, and rules and regulations implementing that act.

6 (26) 'State Mental Health Plan' means the plan prepared by the
7 Department of Human Resources under P.L. 94-63 for the purposes
8 of providing an inventory of existing mental health and mental
9 retardation services, and of establishing priorities for the
10 development of new services to adequately meet the identified
11 needs.

12 (27) 'Tuberculosis hospital' means a public or private
13 institution which is primarily engaged in providing to
14 inpatients, by or under the supervision of a physician, medical
15 services for the diagnosis and treatment of tuberculosis.

16 (28) 'Undertake', with reference to a project or capital
17 expenditure project, means:

- 18 a. constructing, remodeling, installing, or proceeding
19 with a project or any part of a project which
20 exceeds one hundred thousand dollars (\$100,000) in
21 the current fiscal year or can exceed a total of
22 one hundred thousand dollars (\$100,000) in three
23 consecutive fiscal years;
- 24 b. the expenditure or commitment of funds, which
25 exceeds one hundred thousand dollars (\$100,000) in
26 the current fiscal year or can exceed a total of
27 one hundred thousand dollars (\$100,000) in three
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1 subsequent fiscal years, for a project which shall
2 include but not be limited to:

- 3 1. construction and financing of the project;
- 4 2. equipment orders, purchases, leases or
5 acquisition through other comparable
6 arrangements or donations;
- 7 3. development of studies, surveys, reports,
8 working drawings, plans and specifications;
- 9 4. acquisitions, purchases, leases, or contracts
10 for necessary developmental services
11 respecting an existing or proposed health
12 facility;
- 13 5. promotion, sponsorship, solicitation or
14 representation or holding out to the public
15 for donations or a fund raising drive for a
16 specified project;
- 17 6. obtaining or securing bonds for a specified
18 project;
- 19 7. executing contracts for the project;
- 20 8. cost of legal fees.

21 c. The expenditure or commitment of funds to develop
22 applications, studies, reports, schematics, long-
23 range planning or preliminary plans and
24 specifications certified to cost one hundred
25 thousand dollars (\$100,000) or less shall not be
26 considered to be the undertaking of a project.

27 "§ 131-172. Department of Human Resources is designated State
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1 Health Planning and Development Agency; powers and duties.--The
2 Department of Human Resources is designated as the State Health
3 Planning and Development Agency for the State of North Carolina,
4 and is empowered to fulfill responsibilities defined in P.L. 93-
5 641.

6 The department shall exercise the following powers and duties:

7 (1) to establish standards and criteria or plans required to
8 carry out the provisions and purposes of this Article and to
9 adopt rules and regulations pursuant to G.S. Chapter 150A;

10 (2) adopt, amend, and repeal such rules and regulations,
11 consistent with the laws of this State, as may be required by the
12 federal government for grants-in-aid for health care facilities
13 and health planning which may be made available by the federal
14 government. This section shall be liberally construed in order
15 that the State and its citizens may benefit from such grants-in-
16 aid;

17 (3) define, by regulation, procedures for submission of
18 periodic reports by persons or health facilities subject to
19 agency review under this Article;

20 (4) develop policy, criteria, and standards for health care
21 facilities planning, conduct statewide inventories of and make
22 determinations of need for health care facilities, and develop a
23 State plan coordinated with other plans of health systems
24 agencies with other pertinent plans and with the State health
25 plan of the department;

26 (5) implement, by regulation, criteria for project review;

27 (6) have the power to grant, deny, suspend, or revoke a
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1 certificate of need;

2 (7) solicit, accept, hold and administer on behalf of the
3 State any grants or bequests of money, securities or property to
4 the department for use by the department or health systems
5 agencies in the administration of this Article;

6 (8) develop procedures for appeals of decisions to approve or
7 deny a certificate of need, as provided by G.S. 131-180;

8 (9) the Secretary of Human Resources shall have final
9 decision-making authority with regard to all functions described
10 in this section.

11 "§ 131-173. Services and facilities requiring certificates of
12 need.--(a) No person shall undertake new institutional health
13 services or health care facilities without first having obtained
14 a certificate of need as provided by this Article.

15 (b) Projects subject to certificate of need review shall
16 include 'new institutional health services' as defined by this
17 Article.

18 (c) Where the estimated cost of a proposed project is
19 certified by a licensed architect or engineer to be one hundred
20 thousand dollars (\$100,000) or less, such expenditure shall be
21 deemed not to exceed one hundred thousand dollars (\$100,000) and
22 shall not require review as a capital expenditure regardless of
23 the actual cost of the project, provided that the following
24 conditions are met:

25 (1) The estimated cost is certified to the department
26 within 60 days of the date of submission of the
27 project upon which the obligation for such
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1 expenditure is incurred. Such certified cost
2 estimates shall be available for inspection at the
3 facility and sent to the department upon its
4 request.

5 (2) The facility on whose behalf the expenditure was
6 made notifies the department in writing within 30
7 days of the date on which such expenditure is made,
8 if such expenditure exceeded one hundred thousand
9 dollars (\$100,000). Such notice shall include a
10 copy of a certified cost estimate.

11 (d) The department may grant a certificate of need which
12 permits expenditures only for predevelopment activities, but does
13 not authorize the offering or development of a new institutional
14 health service with respect to which such predevelopment
15 activities are proposed. Expenditures in preparation for the
16 offering of a new institutional health service shall include
17 expenditures for architectural designs, plans, working drawings,
18 and specifications. Such expenditures shall also include those
19 for site acquisition and preliminary plans, studies, and surveys.

20 (e) Before any person enters into a contractual arrangement to
21 acquire diagnostic or therapeutic equipment with a value in
22 excess of one hundred thousand dollars (\$100,000), which will not
23 be owned by or located in a health care facility, such person
24 shall notify the department of such person's intent to acquire
25 such equipment. Such notice shall be made in writing on such
26 form as the department shall prescribe and shall be made at least
27 30 days before contractual arrangements are entered into to
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1 acquire the equipment with respect to which the notice is given.
2 For the purposes of this subsection, health care facility does
3 not include a facility operated solely as part of the private
4 medical practice of (i) an independent practitioner, (ii) a
5 partnership, or (iii) a professional medical corporation.

6 (f) Any local health department under Article 3 of Chapter 130
7 of the General Statutes which provides a new institutional health
8 service as defined in G.S. 131-171(17) is subject to the
9 provisions of this Article.

10 "§ 131-174. Nature of certificate of need.--(a) A certificate
11 of need shall be valid only for the defined scope, physical
12 location, and person named in the application. A certificate of
13 need shall not be transferable or assignable nor shall a project
14 or capital expenditure project be transferred from one person to
15 another. A certificate of need shall be valid for the period of
16 time specified therein.

17 (b) A certificate of need shall be issued for a 12-month
18 period, or such other lesser period as specified by the
19 department, effective on the date of the department's action.
20 Within the effective period, the legal proponent of the proposed
21 project must perform on the project by fulfilling the specific
22 performance requirements set forth by this act for incurring a
23 financial obligation in relation to the offering of a new
24 institutional health service.

25 (c) By regulation, the department may define the extent, not
26 to exceed six months, for which a certificate of need may be
27 renewed, provided the applicant by petition makes a good faith
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1 showing that, within a reasonable time, he will complete the
2 establishment, construction, or modification of the health care
3 facility, and that he will incur the financial obligation within
4 the extended approval period.

5 (d) The department shall adopt rules pertaining to the
6 requirement of filing for a certificate of need based on a change
7 of ownership of a health care facility. Any substantial change
8 as to the person who or the partnership which is the operator of
9 a health care facility shall be subject to approval by the
10 department. The department shall adopt rules which shall state,
11 at a minimum, that any transfer, assignment or other disposition
12 or change of ownership or control of fifty percent (50%) or more
13 of the capital stock or voting rights thereunder of a corporation
14 which is the operator of a health care facility in the State, or
15 any transfer, assignment, or other disposition of the stock or
16 voting rights thereunder of such corporation which results in the
17 ownership or control of more than fifty percent (50%) of the
18 stock or voting rights thereunder of such corporation by any
19 person shall be subject to approval by the department in
20 accordance with procedures for filing a certificate of need
21 application. In the absence of such approval, the enforcement
22 provisions of G.S. 131-182 may be invoked.

23 "§ 131-175. Application.--All persons or health care
24 facilities subject to review, as defined in G.S. 131-171 must
25 file an application for a certificate of need with the
26 department. An application for a certificate of need shall be
27 made on the forms provided by the department. This application
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1 shall contain such information as the department, by regulation,
2 deems necessary to conduct the review. Such application shall
3 include affirmative evidence on which the department shall make
4 the findings required under this Article, and upon which the
5 department shall make its final decision on the application.

6 "§ 131-176. Review criteria.--(a) The department shall
7 promulgate rules implementing criteria outlined in this
8 subsection to determine whether an applicant is to be issued a
9 certificate for the proposed project. Criteria so implemented
10 are to be consistent with federal law and regulations and shall
11 cover:

- 12 (1) The relationship of the proposed project to the
13 State Medical Facilities Plan, the State Health
14 Plan, and the State Mental Health Plan.
- 15 (2) The relationship of services reviewed to the long-
16 range development plan of the persons providing or
17 proposing such services.
- 18 (3) The need that the population served or to be served
19 by such services has for such services.
- 20 (4) The availability of less costly or more effective
21 alternative methods of providing such services.
- 22 (5) The immediate and long-term financial feasibility
23 of the proposal, as well as the probable impact of
24 the proposal on the costs of and charges for
25 providing health services.
- 26 (6) The relationship of the services proposed to be
27 provided to the existing health care system of the
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1 area in which such services are proposed to be
2 provided.

3 (7) The availability of resources, including health
4 manpower, management personnel, and funds for
5 capital and operating needs, for the provision of
6 the services proposed to be provided and the
7 availability of alternative uses of such resources
8 for the provision of other health services.

9 (8) The relationship, including the organizational
10 relationship, of the health services proposed to be
11 provided to ancillary or support services.

12 (9) Special needs and circumstances of those entities
13 which provide a substantial portion of their
14 services or resources, or both, to individuals not
15 residing in the health service areas in which the
16 entities are located or in adjacent health service
17 areas. Such entities may include medical and other
18 health professions schools, multidisciplinary
19 clinics and specialty centers.

20 (10) The special needs and circumstances of health
21 maintenance organizations for which assistance may
22 be provided under Title XIII of the Public Health
23 Service Act. Such needs and circumstances include
24 the needs of and costs to members and projected
25 members of the health maintenance organization in
26 obtaining health services and the potential for a
27 reduction in the use of inpatient care in the
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1 community through an extension of preventive health
2 services and the provision of more systematic and
3 comprehensive health services. The consideration
4 of a new institutional health service proposed by a
5 health maintenance organization shall also address
6 the availability and cost of obtaining the proposed
7 new institutional health service from the existing
8 providers in the area that are not health
9 maintenance organizations.

10 (11) The special needs and circumstances of biomedical
11 and behavioral research projects which are designed
12 to meet a national need and for which local
13 conditions offer special advantages.

14 (12) In the case of a construction project, the costs
15 and methods of the proposed construction, including
16 the costs and methods of energy provision, and the
17 probable impact of the construction project
18 reviewed on the costs of providing health services
19 by the person proposing the construction project.

20 (13) The need that the medically underserved portion of
21 the population, especially those people located in
22 rural or economically depressed areas, has for such
23 services, and the extent to which the project under
24 review proposes to meet that need.

25 (b) Criteria adopted for reviews in accordance with subsection
26 (a) of this section may vary according to the purpose for which a
27 particular review is being conducted or the type of health
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service reviewed.

"§ 131-177. Review process.--(a) Except as provided in subsection (c) of this section there shall be a time limit of 90 days for review of the project beginning on the day the department declares the application 'complete for review', as established by departmental regulations.

(1) The appropriate Health Systems Agency shall review each application for a certificate of need in accord with its adopted plans, standards, criteria, and procedures, and shall submit its comments thereon to the department within 60 days after receipt of a complete application by the department. The comments may include a recommendation to approve the application, to approve the application with conditions, to defer the application, or to deny the application. Suggested modifications, if any, shall relate directly to the project under review.

(2) The appropriate Health Systems Agency shall, during the course of its review, provide an opportunity for a public meeting at which interested persons may introduce testimony and exhibits.

(3) Any person may file written comments and exhibits concerning a proposal under review with the appropriate Health Systems Agency and the department.

(b) The department shall issue as provided in this Article a

1 certificate of need with or without conditions or reject the
2 application within the review period. If the department fails to
3 act within such period, the failure to act shall constitute
4 denial of the application.

5 (c) The department shall promulgate rules establishing
6 criteria for determining when it would not be practicable to
7 complete a review within 90 days from receipt of a completed
8 application. If the department finds that these criteria are met
9 for a particular project, it may extend the review period for a
10 period not to exceed 60 days and provide notice of such extension
11 to all affected persons.

12 "§ 131-178. Final decision.--The department shall send its
13 decision along with written findings to the person proposing the
14 new institutional health service and to the Health Systems Agency
15 for the health service area in which the new service is proposed
16 to be offered or developed. In the case of a final decision to
17 'approve' or 'approve with conditions' a proposal for a new
18 institutional health service, the department shall issue a
19 certificate of need to the person proposing the new institutional
20 health service.

21 "§ 131-179. Written notice of decision.--The department shall,
22 within 15 days after it makes a final decision on an application,
23 provide in writing to the applicant, to the appropriate Health
24 Systems Agency and, upon request to affected persons, the
25 findings and conclusions on which it based its decision,
26 including but not limited to the criteria used by the department
27 in making such decision.
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1 "§ 131-180. Rights of appeal and judicial review.-- (a) In
2 fulfilling the functions and duties of this Article the
3 department shall comply with the North Carolina Administrative
4 Procedures Act, G.S. Chapter 150A.

5 (b) Any proponent of a new institutional health service or
6 capital expenditure project or any person who qualifies as a
7 'party' or 'person aggrieved' under G.S. 150A-2 shall have all
8 the rights of appeal and judicial review available under Articles
9 3 and 4 of G.S. Chapter 150A.

10 (c) In the instance that the department makes a recommendation
11 on review of a project which is inconsistent with a
12 recommendation made by a particular Health Systems Agency, the
13 department shall submit a written, detailed statement of the
14 reasons for the inconsistency. The Health Systems Agency may
15 request an appeal under the North Carolina Administrative
16 Procedures Act, G.S. Chapter 150A.

17 "§ 131-181. Forfeiture of certificate of need.--The department
18 may revoke a certificate of need, for failure to perform on the
19 certificate of need, based on rules adopted by the department.
20 The department may revoke a certificate of need for, including
21 but not necessarily limited to, the following reasons:

22 (1) For failure to satisfy within 180 days following issuance
23 of the certificate of need any performance requirements that may
24 be set forth by the department.

25 (2) After review, upon 12 months' duration of approval, for
26 failure to incur the financial obligation for a capital
27 expenditure as defined in this Article.
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1 (3) After notice and a fair hearing on proof that a person who
2 has been awarded a certificate of need, and who before completion
3 of the project and operation of the facility, has attempted to or
4 has transferred or conveyed more than five percent (5%) ownership
5 or control in a facility without prior written approval of the
6 department. Transfers resulting from personal illness or other
7 good cause, as determined by the department, may be exempt from
8 this provision based on rules adopted by the department.
9 Transfers resulting from death shall be exempt from this
10 provision.

11 "§ 131-182. Enforcement and sanctions.--(a) Only those new
12 institutional health services which are found by the department
13 to be needed as provided in this Article and granted certificates
14 of need shall be offered or developed within the State.

15 (b) No expenditures in excess of one hundred thousand dollars
16 (\$100,000) in preparation for the offering or development of a
17 new institutional health service shall be made by any person
18 unless a certificate of need for such service or activities has
19 been granted, except as otherwise provided in G.S. 131-173.

20 (c) No formal commitments made for financing, construction, or
21 acquisition regarding the offering or development of a new
22 institutional health service shall be made by any person unless a
23 certificate of need for such service or activities has been
24 granted.

25 (d) Nothing in this Article shall be construed as terminating
26 the P.L. 92-603, Section 1122 capital expenditure program or the
27 contract between the State of North Carolina and the United
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1 States under that program. The sanctions available under that
2 program and contract, with regard to the determination of whether
3 the amounts attributable to an applicable project or capital
4 expenditure project should be included or excluded in determining
5 payments to the proponent under Titles V, XVIII, and XIX of the
6 Social Security Act, shall remain available to the State.

7 (e) If any health care facility proceeds to offer or develop a
8 new institutional health service without having first obtained a
9 certificate of need for such services, the penalty for such
10 violation of this Article and rules and regulations hereunder is
11 the withholding of federal and State funds under Titles V, XVIII,
12 and XIX of the Social Security Act for reimbursement of capital
13 and operating expenses related to the provision of the new
14 institutional health service.

15 (f) If any health care facility proceeds to offer or develop a
16 new institutional health service without having first obtained a
17 certificate of need for such services, the licensure for such
18 facility may be revoked or suspended by the Medical Care
19 Commission, or the Commission for Health Services, as
20 appropriate.

21 (g) A civil penalty of not more than twenty thousand dollars
22 (\$20,000) may be assessed by the department against any person
23 who knowingly offers or develops any new institutional health
24 service within the meaning of this Article without a certificate
25 of need issued under this Article and the rules and regulations
26 pertaining thereto, or in violation of the terms of such a
27 certificate. In determining the amount of the penalty the
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1 department shall consider the degree and extent of harm caused by
2 the violation and the cost of rectifying the damage. The
3 department may assess the penalties provided for in this
4 subsection. Any person assessed shall be notified of the
5 assessment by registered or certified mail, and the notice shall
6 specify the reasons for the assessment. If the person assessed
7 fails to pay the amount of the assessment to the department
8 within 30 days after receipt of notice, or such longer period,
9 not to exceed 180 days, as the department may specify, the
10 department may institute a civil action in the superior court of
11 the county in which the violation occurred or, in the discretion
12 of the department, in the superior court of the county in which
13 the person assessed has its principal place of business, to
14 recover the amount of the assessment. In any such civil action,
15 the scope of the court's review of the department's action (which
16 shall include a review of the amount of the assessment), shall be
17 as provided in Chapter 150A of the General Statutes. For the
18 purpose of this subsection, the word 'person' shall not include
19 an individual in his capacity as an officer, director, or
20 employee of a person as otherwise defined in this Article.

21 (h) No agency of the State or any of its political
22 subdivisions may appropriate or grant funds or financially assist
23 in any way a person, applicant, or facility which is or whose
24 project is in violation of this Article.

25 (i) If any health care facility proceeds to offer or develop a
26 new institutional health service without having first obtained a
27 certificate of need for such services, the Secretary of Human
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1 Resources or any person aggrieved, as defined by G.S. 150A-2(6)
2 may bring a civil action for injunctive relief, temporary or
3 permanent, against the person offering, developing or operating
4 any new institutional health service.

5 "§ 131-183. Venue. -- (a) Any action brought by a 'person
6 aggrieved', as defined by G.S. 150A-2(6), to enforce the
7 provisions of this Article against any health care facility, as
8 defined in G.S. 131-171(10) or its agents or employees, may be
9 brought in the superior court of any county in which the cause of
10 action arose or in the county in which the health care facility
11 is located, or in Wake County.

12 (b) An action brought by a 'party', as defined by G.S. 150A-
13 2(5), who has exhausted all administrative remedies made
14 available to that party by statute or rules and regulations, may
15 be brought in the Superior Court of Wake County at any time after
16 a final decision by the department. Such action must be filed
17 not later than 30 days after a written copy of the final decision
18 by the department is given by personal service or registered or
19 certified mail to the person seeking judicial review."

20 Sec. 3. The provisions of this act are severable, and
21 if any of its provisions shall be held unconstitutional by any
22 court of competent jurisdiction, the decision of such court shall
23 not affect or impair the remaining provisions.

24 Sec. 4. This act shall become effective January 1,
25 1979.

26 This act shall not apply to any project which has
27 received approval under the Section 1122, P.L. 92-603 program
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1 prior to January 1, 1979, as long as construction has commenced
2 before January 1, 1980.

3 This act shall not apply to any project for which
4 application is made under the Section 1122, P.L. 92-603 program
5 between July 1, 1978, and January 1, 1979, if such application is
6 approved, and construction has commenced before January 1, 1980.

7 Rules and Regulations under this act may be issued at
8 any time after the date of ratification of this act, but shall
9 not become effective prior to January 1, 1979.

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GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 1977

HOUSE BILL 1654*

Short Title: Health Planning Appropriation.

(Public)

Sponsors: Representatives Kaplan; and Clement.

Referred to: Appropriations.

June 8, 1978

1 A BILL TO BE ENTITLED
2 AN ACT TO APPROPRIATE FUNDS TO THE DEPARTMENT OF HUMAN RESOURCES
3 TO IMPLEMENT CERTIFICATE OF NEED IN NORTH CAROLINA.
4 The General Assembly of North Carolina enacts:
5 Section 1. There is hereby appropriated from the
6 General Fund to the Department of Human Resources the sum of
7 ninety-nine thousand seven hundred thirty dollars (\$99,730) for
8 fiscal year 1978-79. These funds are to be used to implement the
9 North Carolina Health Planning and Resource Development Act of
10 1978.

11 Sec. 2. This act shall become effective July 1, 1978.
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APPENDIX G

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 1977

HOUSE BILL 1659*

Short Title: Cost Containment Commission App. (Public)

Sponsors: Representatives Kaplan; Clement.

Referred to: Appropriations.

June 9, 1978

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A BILL TO BE ENTITLED

AN ACT TO APPROPRIATE FUNDS TO THE LEGISLATIVE COMMISSION ON
MEDICAL COST CONTAINMENT FOR FISCAL YEAR 1978-79.

The General Assembly of North Carolina enacts:

Section 1. There is hereby appropriated to the General Assembly for the Legislative Commission on Medical Cost Containment from the General Fund of the State fifteen thousand dollars (\$15,000) in fiscal year 1978-79. These funds shall be used in performance of the Commission duties set forth in Chapter 968 of the 1977 Session Laws.

Sec. 2. This act shall become effective July 1, 1978.

APPENDIX H

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 1977

HOUSE BILL 1623

Short Title: Ambulatory Surgical Licensing.

(Public)

Sponsors: Representatives Huskins; Kaplan, B. P. Woodard, Parnell,
Lachot, Gamble, and Clement.

Referred to: Health.

June 6, 1978

A BILL TO BE ENTITLED

AN ACT TO REQUIRE THE LICENSING OF AMBULATORY SURGICAL
FACILITIES, SO AS TO IMPLEMENT THE RECOMMENDATIONS OF THE
LEGISLATIVE COMMISSION ON MEDICAL COST CONTAINMENT.

The General Assembly of North Carolina enacts:

Section 1. The General Statutes of North Carolina are
amended by adding a new Chapter, 131B, to read as follows:

"CHAPTER 131B.

"Licensing of Ambulatory Surgical Facilities.

"§ 131B-1. Definitions.--As used in this Chapter, unless the
context requires otherwise, the following terms have the meanings
specified:

(1) 'Ambulatory Surgical Facility' means a public or private
facility, not a part of a hospital, which provides surgical
treatment to patients not requiring hospitalization. Such term
does not include the offices of private physicians or dentists,
whether for individual or group practice.

(2) 'Department' means the North Carolina Department of Human
Resources.

1 (3) 'Person' means an individual; a trust or estate; a
2 partnership; a corporation, including associations, joint stock
3 companies, and insurance companies; the State, or a political
4 subdivision or instrumentality of the State.

5 "§ 131B-2. Purpose.--The purpose of this Chapter is to provide
6 for the development, establishment and enforcement of basic
7 standards:

8 (a) for the care and treatment of individuals in ambulatory
9 surgical facilities, and

10 (b) for the maintenance and operation of ambulatory surgical
11 facilities so to ensure safe and adequate treatment of such
12 individuals in ambulatory surgical facilities.

13 "§ 131B-3. License requirement.--(a) No person shall operate
14 an ambulatory surgical facility without a license obtained from
15 the department.

16 (b) Applications shall be available from the department and
17 each application filed with the department shall contain all
18 necessary and reasonable information that the department may by
19 rule require. A one-year license shall be granted to the
20 applicant upon a determination by the department that the
21 applicant has complied with the provisions of this Chapter and
22 the rules, regulations, or standards promulgated by the
23 department under this Chapter.

24 (c) A license to operate an ambulatory surgical facility shall
25 be annually renewed upon the filing and departmental approval of
26 a renewal application. The renewal application shall be
27 available from the department and shall contain all necessary and
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1 reasonable information that the department may by rule require.

2 (d) Each license shall be issued only for the premises and
3 persons named in the application and shall not be transferable or
4 assignable except with the written approval of the department.

5 (e) Licenses shall be posted in a conspicuous place on the
6 licensed premises.

7 "§ 13|B-4. Denial, suspension, or revocation of license.--(a)
8 Subject to subsection (b), the department is empowered to deny a
9 new or renewal application for a license, and to suspend or
10 revoke an existing license upon a determination that there has
11 been a substantial failure to comply with the provisions of this
12 Chapter or the rules, regulations or standards promulgated under
13 this Chapter.

14 (b) The provisions of Chapter 150A of the General Statutes
15 shall govern all administrative action and judicial review in the
16 cases where the department has taken the action described in
17 subsection (a).

18 "§ 13|B-5. Rules and regulations.--The Medical Care Commission
19 is empowered to adopt, amend and promulgate all necessary rules,
20 regulations and standards as may be designed to further the
21 accomplishment of this Chapter. These rules, regulations or
22 standards shall be no stricter than those issued by the Medical
23 Care Commission under G.S. 13|-126.7 of the Hospital Licensing
24 Act. The Medical Care Commission shall adopt its rules,
25 regulations and standards within 30 days of the effective date of
26 this act.

27 "§ 13|B-6. Enforcement.--The department shall enforce the
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1 rules, regulations and standards adopted, amended or promulgated
2 by the Medical Care Commission with respect to ambulatory
3 surgical facilities.

4 "§ 13|B-7. Inspections.--The department shall make or cause to
5 be made such inspections of ambulatory surgical facilities as it
6 deems necessary. The department is empowered to delegate to a
7 State officer, agent, board, bureau or division of State
8 government the authority to make such inspections according to
9 the rules, regulations and standards promulgated by the
10 department. The department may revoke such delegated authority
11 in its discretion.

12 "§ 13|B-8. Penalties.--A person who owns (in whole or in part)
13 or operates an ambulatory surgical facility without a license is
14 guilty of a misdemeanor, and upon conviction will be subject to a
15 fine of not more than fifty dollars (\$50.00) for the first
16 offense and not more than five hundred dollars (\$500.00) for each
17 subsequent offense. Each day of continuing violation after
18 conviction is considered a separate offense.

19 "§ 13|B-9. Injunctive relief.--The department may commence an
20 action in the name of the State for an injunction or other
21 process against any person to prevent the operation of an
22 ambulatory surgical facility without a license. Such action
23 shall be brought in the Superior Court of Wake County."

24 Sec. 2. Section 3 of Session Laws 1977 Chapter 712 is
25 amended by adding at the end of that section the following:

26 "G.S. Chapter 13|B, entitled 'Licensing of Ambulatory Surgical
27 Facilities'."

1 Sec. 3. This act is effective 90 days after
2 ratification.

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APPENDIX I

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 1977

HOUSE BILL 1655

Short Title: Study Prepaid Health Care.

(Public)

Sponsors: Representatives Kaplan; Clement.

Referred to: Appropriations.

June 8, 1978

A BILL TO BE ENTITLED

AN ACT TO ESTABLISH A COMMISSION TO PLAN THE DEVELOPMENT OF AN
OPTIONAL PREPAID HEALTH PLAN IN THE RESEARCH TRIANGLE AREA, AND
TO MAKE AN APPROPRIATION, SO AS TO IMPLEMENT THE
RECOMMENDATIONS OF THE LEGISLATIVE COMMISSION ON MEDICAL COST
CONTAINMENT.

The General Assembly of North Carolina enacts:

Section 1. There is hereby established the Commission
on Prepaid Health Plans.

Sec. 2. Duties of the commission. The duties of the
commission shall be:

(1) The development of a prepaid health plan option to
serve teachers and State employees: The plan shall
include:

- a. The number of State employees and teachers to
be served by the plan;
- b. The range of health services to be provided by
the prepaid health plan;
- c. The cost of a prepaid option to the State and

1 the employees based on an actuarial estimate;
2 and

3 d. The health care providers in North Carolina who
4 would participate in a prepaid health care
5 plan. The commission shall consider the
6 special needs of geographical areas of the
7 State, the distribution of medical services
8 making its recommendations, and the type of
9 medical organization that could provide
10 benefits under prepaid health care in making
11 its recommendations for provider
12 participation; and

13 e. The coordination of the State's prepaid option
14 with other such plans available to private
15 industry and federal employees.

16 (2) The development of a pilot prepaid plan in the
17 Research Triangle area to be available to teachers
18 and State employees on an optional basis. The
19 services of the pilot project shall also be
20 available to private and federal employees. In
21 developing the pilot project, the commission is
22 authorized to seek private and public grants.

23 (3) To review other prepaid plans in the public and
24 private sector. It may also visit such plans as
25 part of its investigations and invite
26 representatives and consultants to North Carolina.

27 Sec. 3. Organization of the commission.
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- 1 (a) The commission shall consist of a total of members
2 appointed in the following manner:
- 3 (1) Three shall be appointed by the President of
4 the Senate from that body; and
- 5 (2) Three members shall be appointed by the
6 Speaker of the House of Representatives from
7 that body; and
- 8 (3) The Governor shall appoint the following:
- 9 a. One member with a general background in
10 prepaid plans;
- 11 b. One member to represent State and
12 governmental employees;
- 13 c. One member to represent the North Carolina
14 Hospital Association;
- 15 d. One member to represent the North Carolina
16 Medical Society;
- 17 e. Two members to represent private
18 employers;
- 19 (4) One member from the Board of Trustees of the
20 Capital Area Health Systems Agency.
- 21 The commission members shall be appointed within 30
22 days of ratification of this act and shall serve
23 until termination of the commission.
- 24 (b) If a vacancy occurs in the membership of the
25 commission, it shall be filled by action of the
26 officer or group who made the original appointment,
27 and the person then appointed shall serve for the
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1 remainder of the term of the member whom he
2 succeeds.

3 (c) The commission shall select its chairman from its
4 membership at its first regular meeting.

5 Sec. 4. Staff support for the commission. In executing
6 its duties, the commission is authorized to hire such
7 professional assistance and secretarial support as it deems
8 necessary. Commission members are authorized to receive
9 subsistence and mileage at the statutory rates in lieu of
10 compensation.

11 Sec. 5. Appropriations to the commission. There is
12 hereby appropriated from the General Fund to the Department of
13 Administration for the Commission on Prepaid Health Plans the sum
14 of thirty thousand dollars (\$30,000) for fiscal year 1978-79.
15 These funds shall be used in the performance of the duties set
16 forth in this act.

17 Sec. 6. Reports by the commission. The commission
18 shall file an interim report with the Governor, the President of
19 the Senate, and the Speaker of the House of Representatives by
20 April 1, 1979. The Commission shall file its final report with
21 the Governor, the President of the Senate, and the Speaker of the
22 House of Representatives by February 1, 1980.

23 Sec. 7. This act is effective upon ratification.
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