LEGISLATIVE RESEARCH COMMISSION

PREVENTATIVE MEDICINE

REPORT TO THE 1987 GENERAL ASSEMBLY OF NORTH CAROLINA

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STATE OF NORTH CAROLINA

LEGISLATIVE RESEARCH COMMISSION

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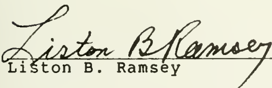
December 12, 1986

TO THE MEMBERS OF THE 1987 GENERAL ASSEMBLY:

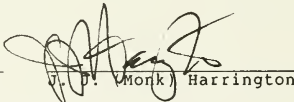
The Legislative Research Commission herewith reports to the 1987 General Assembly on the matter of Preventative Medicine. The report is made pursuant to Chapter 790 of the 1985 Session Laws.

This report was prepared by the Legislative Research Commission's Committee on Preventative Medicine and is transmitted by the Legislative Research Commission for your consideration.

Respectfully submitted,



Liston B. Ramsey



J. J. (Monk) Harrington

Cochairmen

Legislative Research Commission

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TABLE OF CONTENTS

Letter of Transmittal.. i

Legislative Research Commission Membership.................... ii

PREFACE... 1

COMMITTEE PROCEEDINGS... 3

1. First Meeting -- December 18, 1985 3
2. Second Meeting -- January 30, 1986 3
3. Third Meeting -- March 6, 1986 3
4. Fourth Meeting -- April 17, 1986 4
5. Fifth Meeting -- August 27, 1986 4
6. Sixth Meeting -- September 30, 1986 5
7. Seventh Meeting -- November 14, 1986 5

FINDINGS AND RECOMMENDATIONS 6

APPENDICES

Authorizing Legislation .... A
Chapter 790 of the 1985 Session Laws A-1
House Bill 1052 .... A-2

Committee Membership .... B

Budget for Health Promotion/Disease Prevention
in North Carolina
Department of Human Resources C

Presentation of Economic Potentials
of the Preventive Approach
Department of Human Resources .... D

Letter from Insurance Commissioner James E. Long
August 27 meeting .... E

Statement of North Carolina Nurses Association
September 30 meeting .... F

A BILL TO BE ENTITLED AN ACT TO ESTABLISH A STATEWIDE
HEALTH PROMOTION AND DISEASE PREVENTION PROGRAM .... G

A BILL TO BE ENTITLED AN ACT TO AUTHORIZE
THE LEGISLATIVE RESEARCH COMMISSION TO STUDY
REIMBURSEMENT FOR PREVENTIVE HEALTH CARE .... H

PREFACE

The Legislative Research Commission, authorized by Article 6B of Chapter 120 of the General Statutes, is a general purpose study group. The Commission is co-chaired by the Speaker of the House and the President Pro Tempore of the Senate and has five additional members appointed from each house of the General Assembly. Among the Commission's duties is that of making or causing to be made, upon the direction of the General Assembly, "such studies of and investigation into governmental agencies and institutions and matters of public policy as will aid the General Assembly in performing its duties in the most efficient and effective manner" G.S. 120-30.17(1).

At the direction of the 1985 General Assembly, the Legislative Research Commission has undertaken studies of numerous subjects. These studies were grouped into broad categories and each member of the Commission was given responsibility for one Commission, under the authority of General Statute 120-30.10(b) and (c), appointed committees consisting of members of the General Assembly and the public to conduct the studies. Co-chairmen, one from each house of the General Assembly were designated for each committee.

The study of preventive health was authorized by Section 1(8) of Chapter 790 of the 1985 Session Laws (1985 Session). That act states that the Commission may consider House Bill 1052 in determining

the nature, scope and aspects of the study. Section 1 of House Bill 1052 reads: "The Legislative Research Commission may study innovative ways to finance a comprehensive health promotion, disease prevention, education program throughout North Carolina." Relevant portions of Chapter 790 and House Bill 1052 are included in Appendix A.

The Legislative Research Commission grouped this study in its Human Resources area under the direction of Senator Ollie Harris. The Committee was chaired by Representative Jeff H. Enloe, Jr. and Senator William N. Martin. The full membership of the Committee is listed in Appendix B of this report.

COMMITTEE PROCEEDINGS

The Committee's study proceeded in this order:

* from the State's problems in preventable causes of death and disability,

* to the efficacy of health promotion and disease prevention in attacking those problems,

* to the design of a State-wide program of health promotion and disease prevention,

* to methods to finance such a program.

A fuller discussion of the early work of the Committee is to be found in the Committee's interim report to the 1985 General Assembly, 1986 Session. That report has more detailed accounts than will be found here of the first four meetings of the Committee. It contains an outline of the proposals made to the Committee. And it has appendices that include presentations to the Committee on the above topics.

First Meeting -- December 18, 1985

At its first meeting, the Committee heard a presentation from the Department of Human Resources about the problem of preventable causes of death and disability and about the solution of health promotion. Senator William N. Martin, one of the co-chairmen, and Rep. Sidney Locks, a Committee member who introduced the bill that led to the study, asked for a presentation at the next meeting about the current effort to promote health and prevent illness and injury, particularly cardiovascular disease, cancer, and accidents.

Second Meeting -- January 30

At the second meeting, the Department of Human Resources made a presentation about the health promotion efforts of State government. The Capital Health Systems Agency made a presentation about such efforts outside State government. In addition, speakers from various groups stated their interest in health promotion and made recommendations. The staff was directed to collect all the recommendations made to the Committee, from members and non-members, and present them to the Committee at the next meeting.

Third Meeting -- March 6

At the third meeting, the staff presented the requested outline of proposals (see interim report, pp. 7-12). The Division of Health Services of the Department of Human Resources proposed a $5 million program (see interim report, Appendices VII,

A-C). And officials of the Departments of Human Resources and Insurance reported on and answered questions about a premium tax proposal suggested by Rep. Jeff H. Enloe Jr., one of the Committee's cochairmen. That proposal was to finance the program by a 2/3 percent increase in the premium tax on non-profit health plans and a 1 percent premium tax imposed for the first time on Health Maintenance Organizations. After discussion, the Committee directed the staff to draft a report for the next meeting that would include recommendations of the following: 1) the program proposed by the Department of Human Resources, 2) the premium tax plan suggested by Rep. Enloe, 3) an amendment to the Teachers' and State Employees' Comprehensive Health Benefits Plan to pay for cardiac rehabilitation in all State certified centers, not just in hospitals, and 4) direct reimbursement of nurses. The staff was asked to draft bills for the first three recommendations, and to leave the nurses proposal as an abstract recommendation. The Committee members present when the staff was so directed were Enloe, Martin, Locks, Rep. James Richardson, Rep. Bradford Ligon, Dr. Joseph Holliday, and Dr. Louis Smith.

Fourth Meeting -- April 17, 1986

At its fourth meeting, the Committee heard from representatives of Blue Cross-Blue Shield and two HMOs. After a staff presentation of part of the draft report that had been requested, and after Committee discussion, the members voted to make an interim report to the 1986 Session with no recommendations and no findings. The members present for the vote were Enloe, Martin, Ligon, Smith, Holliday, Senator A.D. Guy, Senator Ollie Harris, and Senator Weldon Price.

Fifth Meeting -- August 27, 1986

The fifth meeting was devoted to a discussion of the premium tax proposal. James E. Long, the State Commissioner of Insurance, told the Committee he favored placing an equal premium-tax burden on commercial insurance companies, Blue Cross and HMOs to the extent that they provide equivalent coverage. But he did not endorse earmarking any premium tax revenue to the health promotion program, because he said any additional premium tax revenue would be needed to make up for a shortfall that is estimated to result from the premium tax changes made in the 1986 Session. (See **Appendix** E of this report.) Blue Cross and HMO representatives repeated their opposition to the premium tax proposal. Senator Martin asked the staff to send to the members copies of the draft findings prepared for the April 17 meeting so that, before the September 30 meeting, they could edit those findings as an exercise to reach Committee consensus for a final report. Rep. Locks asked the Department of Human Resources for an estimate of how much money the proposed health promotion program would save.

Sixth Meeting -- September 30, 1986

At the sixth meeting, the Department of Human Resources presented a revised, phased-in version of the program first put forth in March. (See Appendix C of this report.) The Department also offered figures in answer to Rep. Locks' call for a cost-saving estimate. (See Appendix D of this report.) The North Carolina Nurses Association and a representative of physicians' groups spoke pro and con on the benefits of direct reimbursement of nurses, one of the issues that remained from the spring. After discussion, the Committee members present voted to:

1. Recommend to the 1987 General Assembly the community-based health promotion/disease prevention program presented at the September 30 meeting by the Department of Human Resources, to be financed from the General Fund.

2. Recommend that the 1987 General Assembly appoint a committee to study the reimbursement of health care providers for preventive health-care services.

3. Direct the Co-chairmen and staff to draft bills establishing the program in #1 and the study in #2.

4. Incorporate in the Committee's final report findings on the community-based program, the premium tax, expanded reimbursement for cardiac rehabilitation, and direct reimbursement of nurses. The staff was directed to make certain that the findings on premium taxes and nurses reimbursement would not appear to be endorsements. Indeed, the Committee voted not to endorse direct reimbursement of nurses, but instead to recommend the study described in #2 above. And the discussion of premium taxes made clear that the members did not intend to endorse the premium-tax financing method in the report, but instead to endorse financing the program with a General Fund appropriation. The findings on expanded cardiac rehabilitation were to recognize that the proposal made in the spring was enacted by the 1986 General Assembly in the summer.

The Committee members present for the voting at the sixth meeting were Enloe, Martin, Guy, Ligon, and Smith.

Seventh Meeting -- November 14, 1986

At the seventh meeting, the Committee approved this report.

FINDINGS AND RECOMMENDATIONS

I. FINDINGS

The Committee on Preventative Medicine makes the following findings:

A. Health Promotion/Disease Prevention Program

(1) North Carolina's age-adjusted mortality rates for cerebrovascular disease, motor vehicle accidents, other accidents and heart disease are substantially above those for the nation,

(2) North Carolina's age-adjusted cancer mortality rate is increasing faster than that for the nation.

(3) One-third of North Carolina's annual deaths are premature adult deaths occurring to persons between the ages of 18 and 64,

(4) The cost of these premature deaths has been estimated at two billion one hundred million dollars ($2,100,000,000) in taxes to the federal and state governments, and an inestimable amount in lost human life.

(5) In addition to death, the above-mentioned diseases and accidents cause sickness and disability that are responsible for untold loss and suffering.

(6) An estimated fifty percent (50%) of deaths are due to causes that can be traced to unhealthy lifestyles: smoking, overeating, poor nutrition, stress, physical inactivity, and alcohol and drug abuse.

(7) Programs that focus on inducing currently healthy people to avoid unhealthy lifestyles and adopt healthy lifestyles have been shown to reduce death, sickness and disability. Such programs will in the long run reduce health insurance claims as well as the myriad of other public and private costs that flow from premature death, sickness and disability.

(8) The "health promotion/disease prevention" movement, spurred on by the Surgeon General's Healthy People report in 1979, has produced around the nation an abundance of approaches to inducing healthy lifestyles.

(9) Some of those approaches are to be found in North Carolina, but the effort in this state lacks the scope and coordination needed to seriously address the problem.

(10) To be effective, a state promotion/prevention strategy must take aim at the top preventable causes of death and home in on the lifestyle causes that can be prevented. The strategy must tailor its methods of outreach to the needs, wants and sociological patterns of the different peoples of North Carolina.

(11) The state's existing public health system is the logical framework on which to hang a comprehensive health promotion/disease prevention program. Already, 30 local health departments have small grants for risk-reduction efforts under the Preventive Health Block Grant enacted by Congress.

(12) All 100 counties have unmet promotion/prevention needs. Concentrations of population, however, and geographical pockets of disease necessitate a sensitive but fair formula of distributing funds among the local health departments or other local coordinating agencies.

(13) In some instances, organizations outside the public health system in both public and private sectors may be better suited by experience or community status for executing certain portions of the promotion/prevention program than are the local health departments. An effective strategy would encourage the local health department or other local coordinating agency to coordinate promotion/prevention services rather than try to deliver every service on its own, and to contract out those parts of the program that can best be done by others.

(14) In delivering and coordinating the promotion/prevention program, the local health departments or other local coordinating agencies are most likely to be effective if they are given discretion in program design, but held to strict standards of performance as a condition for maintaining their status as nuclei of the local programs. There are experts in evaluation of promotion/prevention programs at the University of North Carolina and elsewhere whose services can be employed.

B. Financing Program With Premium Taxes

(1) The comprehensive health promotion/disease prevention program the state needs will cost up to five million dollars ($5,000,000) a year, according to an estimate of the Division of Health Services, State Department of Human Resources.

(2) For its present risk reduction program, the State of North Carolina relies on the federal Preventive Health Block Grant. The State also uses the Preventive Health Block Grant for other programs. Changes in the federal-state financing picture, such as the Gramm-Rudman-Hollings Act, make it a questionable policy to rely on federal funding for new health programs beyond Fiscal Year 1986-87.

(3) The State of North Carolina places a tax of 1.75 percent on premiums paid to domestic health insurance companies licensed under Chapter 58 of the General Statutes, a tax of .33 percent on non-profit health care plans established under Chapter 57, and no premium tax at all on health maintenance organizations licensed under Chapter 57B.

(4) If the premium tax on Chapter 57 plans were increased from .33 percent to 1 percent, and a premium tax of 1 percent were placed on Chapter 57B HMOs, the estimated revenue would be $4,245,490 per year based on premium volume for 1985, not far from the amount DHR estimates is needed for the program.

(5) Increasing the premium tax on Chapter 57 plans to one percent (1%) and imposing a premium tax of one percent (1%) on HMOs would continue to give Chapter 57 plans and HMOs a tax advantage over Chapter 58 commercial plans.

(6) If both Chapter 57 and Chapter 57B corporations were taxed at the rate of 1.75%, based on premium volume for 1985, the resulting gain in revenue would be $8,664,227.52.

(7) The gain in revenue would be greater if the 1.75% rate were based on 1986, rather than 1985, because of the increase in HMO business during 1986. Three of the 12 HMOs now operating in North Carolina did not begin operations until 1986.

(8) The 1986 General Assembly made changes in the premium tax law which legislative fiscal analysts predict will reduce General Fund revenues by $1 million in 1987-88 and by $16.5 million in 1988-89.

(9) James E. Long, the State Insurance Commissioner, has proposed setting premium tax rates of 1.75% on both Chapter 57 and Chapter 57B companies. He has said he wants to use the revenue to offset the loss in General Fund revenues expected because of the 1986 changes in the premium tax laws. Therefore, he has cautioned against earmarking revenues from Chapter 57 or Chapter 57B premium taxes to health programs.

(10) Commissioner Long has taken the position that the State should treat equally all competing forms of health care payment -- whether Chapter 57 companies, HMOs, or commercial health insurance companies -- as long as they provide equal services. But he has suggested that it might be prudent policy for the State to provide more favorable tax treatment to companies willing to write risky or unavailable lines of insurance. As examples, he suggested exempting from taxation small or non-group health insurance, medical malpractice insurance, or companies that are willing to underwrite all comers without restriction.

(11) The long-run effect of a health promotion/disease prevention program will be to reduce claims against health insurance and the service demands on HMOs.

(12) The questions about the premium-tax method of financing the program and the opposition to that method indicate that other approaches should be pursued at this time.

C. Cardiac Rehabilitation for State Employees

(1) Cardiac Rehabilitation Centers help people with heart problems reduce their risk of death and serious disability.

(2) The General Assembly has recognized the worth of Cardiac Rehabilitation Centers and has sought to guarantee their quality by establishing a certification program in the Department of Human Resources (General Statute 131E-165 through -170).

(3) By mid-1986, the Department had certified 27 Cardiac Rehabilitation Centers and expected to certify perhaps 10 more within a year. These certified Centers were distributed all over the State.

(4) Until 1986, the Teachers and State Employees Comprehensive Major Medical Plan reimbursed for cardiac rehabilitation if the charges were incurred "in a hospital." General Statute 135-40.6 (8) (m).

(5) The diagnostic work of Cardiac Rehabilitation Centers normally occurs in hospitals and therefore was covered before 1986 by the Teachers and State Employees Plan.

(6) The actual rehabilitative treatment the Centers perform, however, normally does not occur "in a hospital." It normally occurs in a gym or a physician's office. Therefore before 1986 the patient could not rely on his Teachers and State Employees Plan to reiumburse for it.

(7) Few of the certified Centers in North Carolina did their rehabilitative work "in a hospital." Before 1986, only in such an "in-hospital" Center could a patient who is a teacher or State employee be assured that his health plan will cover his treatment.

(8) Since the Cardiac Rehabilitation Centers program entails a thrice-weekly exercise program, geographical access is an important factor in participation. Distance prevented most teachers and State employees from attending the "in-hospital" programs. Equity was not served by allowing reiumbursement to those who live close to the in-hospital programs and not to those who lived elsewhere. Nor was medical judgment or economy served by encouraging other Centers to re-arrange their programs so that

rehabilitation work was done in a hospital rather than in a gym or a physician's office.

(9) Although cardiac rehabilitation should reduce acute-care costs in the long run, nonetheless the short-run cost increase to the State could be expected to result from a change in the Teachers and State Employees Plan to include coverage in all certified cardiac rehabilitation centers.

(10) The 1985 General Assembly, 1986 Session, changed the Teachers and State Employees Plan to include within its reimbursement policy cardiac rehabilitation in all State-certified centers, not just that conducted in hospitals.

D. Direct Reimbursement of Nurse Practitioners

(1) The nursing profession has many members who specialize in areas that emphasize prevention of disease rather than cure or treatment. Among the specialists are: nurse practitioners of various types, nurse midwives, nurse anesthetists, and psychiatric-mental health nurses.

(2) Because nurses have close contact with their patients, they can be particularly effective in counseling, educational and prevention work.

(3) Encouraging the use of specialty nurses in educational and preventive work will likely result in the promotion of health and the prevention of disease.

(4) North Carolina's statutes that provide for commercial health insurance (Chapter 58) and non-profit health plans (Chapter 57) guarantee to an insured the right to choose among several groups of health care providers who engage in overlapping areas of service. G.S. 57-1 and 58-160. Those statutes prohibit insurers from denying payment or reimbursement to the insured on the basis of the kind of provider chosen, so long as the service provided is within the scope of the practice for which the provider is licensed.

(5) Nurses are not among the providers against whom reimbursement discrimination is prohibited in G.S. 57-1 and 58-160.

(6) Two other provisions, G.S. 57-3.2 and 58-259.2, prohibit denial of payment or reimbursement to an insured because the work was done by a registered nurse acting within the rules of the Board of Medical Examiners and the Board of Nursing. Each of those statutes, however, contains a disclaimer that "nothing herein shall be construed to authorize contracting with or making payments directly to a nurse not otherwise permitted."

(7) Chapter 135 of the General Statutes, which sets out the Teachers and State Employees Comprehensive Major Medical Plan, does not deal with the question of direct reimbursement of nurses.

(8) Chapter 108A of the General Statutes, which governs the Medicaid program, empowers the Department to authorize payment "to pharmacies, physicians, dentists, optometrists or other providers of health-related services authorized by the Department." G.S. 108A-55. The Appropriations Act of 1985, which governs the Medicaid program in more detail, does not mention reimbursement of nurses.

(9) The current statutory scheme does not require that nurses must be directly reimbursed for their work. The scheme has given rise to dispute as to whether nurses may be directly reimbursed for their work.

(10) The ramifications and complexities of the issue of direct reimbursement of nurses are such that the matter requires fuller study.

The Committee recommends the following to the 1987 General Assembly:

(1) That legislation be enacted establishing a comprehensive, community-based program of health promotion/disease prevention for North Carolina, using the public health system as a framework; with base allocations for each of the 100 counties, formula grants according to population and other special needs, and additional competitive grants for worthy community programs; and with evaluation and accountability for performance. The program should be financed from the General Fund. (See draft bill at Appendix G.)

(2) That the Legislative Research Commission be authorized to study issues related to having health care delivery professionals and those in related professions (such as vocational rehabilitation specialists and dieticians) receive direct reimbursement from third parties for preventive health care. (See draft bill at Appendix H.)

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 1985
RATIFIED BILL

CHAPTER 790
SENATE BILL 636

AN ACT AUTHORIZING STUDIES BY THE LEGISLATIVE RESEARCH COMMISSION, MAKING TECHNICAL AMENDMENTS THERETO, AND TO MAKE OTHER AMENDMENTS.

The General Assembly of North Carolina enacts:

Section 1. Studies Authorized. The Legislative Research Commission may study the topics listed below. Listed with each topic is the 1985 bill or resolution that originally proposed the issue or study and the name of the sponsor. The Commission may consider the original bill or resolution in determining the nature, scope and aspects of the study. The topics are:

(1) Continuation of the Study of Revenue Laws (H.J.R. 17-Lilley),

(2) Continuation of the Study of Water Pollution Control (H.J.R. 141-Evans),

(3) Adolescent Sexuality Teaching (H.J.R. 275-Jeralds),

(4) Continuation of the Study on the Problems of the Aging (H.J.R. 322-Greenwood),

(5) Continuation of the Study of Municipal Incorporations (H.J.R. 389-Greenwood),

(6) School Discipline (H.J.R. 861-Colton),

(7) Bail Bondsmen and Bail Bond Forfeiture (H.B. 967-Watkins),

(8) Preventative Medicine (H.B. 1052-Locks),

(9) Life Care Arrangements (H.B. 1053-Locks),

(10) State Personnel System (H.B. 1064-Wiser),

(11) Long-Term Health Care Insurance (H.B. 1103-Locks),

(12) Itinerant Merchants (H.B. 1170-Lancaster),

(13) Manufactured Housing Zoning (H.B. 1178-Ballance; S.B. 636-Plyler),

(14) Interest Rate Regulation (H.J.R. 1227-Evans),

(15) Underground Storage Tank Leakage Hazards and other ground water hazards (H.B. 1281-Locks),

(16) Mental Patient Commitments (H.J.R. 1313-Miller),

(17) High-Level Radioactive Waste Disposal (H.B. 1373-Diamont; S.B. 655-Hipps),

(18) Stun Guns (H.J.R. 1390-McDowell),

(19) Continuation of the Study of Water Quality in Haw River and B. Everett Jordan Reservoir (H.J.R. 1393-Hackney),

(20) Authority of Boards of County Commissioners in Certain Counties over Commissions, Boards and Agencies (H.J.R. 1405-Holroyd),

(21) Superintendent of Public Instruction and State Board of Education (H.J.R. 1412-Nye),

(22) Rental Referral Agencies (H.B. 1421-Stamey),

(23) Child Abuse Testimony Study (S.B. 165-Hipps),

(24) Home Schooling Programs (S.J.R. 224-Winner),

(25) Pretrial Release (S.J.R. 297-Winner),

(26) Inmate Substance Abuse Therapy Program (S.J.R. 317-Plyler),

(27) Inmate Work-Release Centers (S.B. 406-Swain),

(28) Community College System (S.B. 425-Martin),

(29) Community Service Alternative Punishment and Restitution (S.B. 495-Swain),

(30) State Employee Salaries and Benefits (S.B. 514-Jordan),

(31) State Infrastructure Needs (S.B. 541-Royall),

(32) Commercial Laboratory Water Testing (S.B. 573-Taft),

(33) Outdoor Advertising (S.B. 611-Thomas, R.P.),

(34) Premium Tax Rate on Insurance Companies (S.B. 633-Hardison)

(35) Continuation of the Study of Child Support (S.B. 638-Marvin),

(36) Local Government Financing (S.B. 670-Rauch),

(37) Medical Malpractice and Liability (S.B. 703-Taft),

(38) Marketing of Perishable Food (S.B. 718-Basnight),

(39) Child Protection (S.B. 802-Hipps),

(40) Legislative Ethics and Lobbying (S.B. 829-Rauch),

(41) Satellite Courts (S.B. 850-Barnes),

(42) Substantive Legislation in Appropriations Bills (S.B. 851-Rand),

(43) School Finance Act (S.B. 848-Taft).

Sec. 2. Transportation Problems at Public Facilities. The Legislative Research Commission may identify and study transportation problems at public transportation facilities in North Carolina.

Sec. 2.1. The Legislative Research Commission may study the feasibility of the prohibition of investment by the State Treasurer of stocks of the retirement systems listed in G.S. 147-69.2(b)(6), or of the assets of the trust funds of The University of North Carolina and its constituent institutions deposited with the State Treasurer pursuant to G.S. 116-36.1 and G.S. 147-69.2(19) in a financial institution that has outstanding loans to the Republic of South Africa or in stocks, securities, or other obligations of a company doing business in or with the Republic of South Africa.

Sec. 3. Reporting Dates. For each of the topics the Legislative Research Commission decides to study under this act or pursuant to G.S. 120-30.17(1), the Commission may report its findings, together with any recommended legislation, to the 1987 General Assembly, or the Commission may make an interim report to the 1986 Session and a final report to the 1987 General Assembly.

Sec. 4. Bills and Resolution References. The listing of the original bill or resolution in this act is for reference purposes only and shall not be deemed to have incorporated by reference any of the substantive provisions contained in the original bill or resolution.

Sec. 5. The last sentence of G.S. 120-19.4(b) is amended by deleting the citation "G.S. 5-4" and inserting in lieu thereof the following: "G.S. 5A-12 or G.S. 5A-21, whichever is applicable".

Sec. 6. G.S. 120-99 is amended by adding a new paragraph to read:

"The provisions of G.S. 120-19.1 through G.S. 120-19.8 shall apply to the proceedings of the Legislative Ethics Committee as if it were a joint committee of the General Assembly, except that the chairman shall sign all subpoenas on behalf of the Committee.

Sec. 7. G.S. 120-30.17 is amended by adding a new subsection to read:

"(9) For studies authorized to be made by the Legislative Research Commission, to request another State agency, board, commission or committee to conduct the study if the Legislative Research Commission determines that the other body is a more appropriate vehicle with which to conduct the study. If the other body agrees, and no legislation specifically provides otherwise, that body shall conduct the study as if the original authorization had assigned the study to that body and shall report to the General Assembly at the same time other studies to be conducted by the Legislative Research Commission are to be reported. The other agency shall conduct the transferred study within the funds already assigned to it."

Sec. 8. This act is effective upon ratification.

In the General Assembly read three times and ratified, this the 18th day of July, 1985.

ROBERT B. JORDAN III

Robert B. Jordan III
President of the Senate

LISTON B. RAMSEY

Liston B. Ramsey
Speaker of the House of Representatives

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 1985

H | 1

HOUSE BILL 1052

Short Title: LRC Health Study. (Public)

Sponsors: Representatives Locks; Ballance, Barnhill, Beard, Blue,*

Referred to: Appropriations.

May 15, 1985

1 A BILL TO BE ENTITLED

2 AN ACT TO AUTHORIZE THE LEGISLATIVE RESEARCH COMMISSION TO STUDY
3 INNOVATIVE APPROACHES TO FINANCE THE HEALTH PROMOTION, DISEASE
4 PREVENTION EFFORT IN NORTH CAROLINA.

5 Whereas, the North Carolina age-adjusted mortality rates
6 for cerebrovascular disease, motor vehicle accidents, other
7 accidents and heart disease are substantially above those for the
8 nation; and

9 Whereas, the State's age-adjusted cancer mortality rate
10 is increasing faster than that for the nation; and

11 Whereas, one-third of North Carolina annual deaths are
12 premature adult deaths occurring to persons between the ages of
13 18 and 64, equivalent to approximately 16,500 deaths per year or
14 43 deaths per day; and

15 Whereas, these deaths rob North Carolina of valuable
16 resources because they occur during the productive years of life,
17 and cause hardship on family and friends; and

18 Whereas, 194,555 person years were lost prematurely to
19 those in the adult working population of North Carolina in 1981;
20 and

21

1 Whereas, the economic impact of these deaths in terms of
2 loss of potential income, state, federal and general sales tax
3 loss, is an estimated two billion one hundred million dollars
4 ($2,100,000,000); and
5 Whereas, morbidity and disability from chronic diseases
6 and accidents are responsible for substantial medical care costs
7 and lost productivity among the work force, not to mention the
8 personal loss, grief, and financial disruption experienced by
9 families; and
10 Whereas, it is estimated that more than fifty percent
11 (50%) of mortality is related to causes that are preventable; and
12 Whereas, efforts to prevent morbidity and mortality from
13 chronic diseases and accidents require the active involvement of
14 communities, including public health, the medical community,
15 business, industry, and voluntary agencies; and
16 Whereas, the prevention of unnecessary morbidity and
17 mortality require comprehensive, planned, and systematically
18 implemented health promotion and education efforts directed at
19 the community and individuals; and
20 Whereas, the North Carolina Public Health System has
21 responsiblity for the public health but lacks the financial
22 resources to undertake a comprehensive health promotion and
23 disease prevention effort; and
24 Whereas, a comprehensive health promotion and disease
25 prevention effort can improve the health status of North
26 Carolinians and can provide affordable economic return to the
27 State; Now, therefore,
28 The General Assembly of North Carolina enacts:

1 Section 1. The Legislative Research Commission may
2 study innovative ways to finance a comprehensive health
3 promotion, disease prevention, education program throughout North
4 Carolina. The Legislative Research Commission may make an
5 interim report to the 1985 General Assembly, Regular Session, and
6 may make a final report to the 1987 General Assembly.
7 Sec. 2. This act is effective upon ratification.
8 ---------------
9 *Additional Sponsors: Bowman, DeVane, Edwards, Fitch, Hasty,
10 Holt, Jeralds, Jones, Kennedy, Nye, Pool, Richardson, Tyson, E.
11 Warren, C.D. Woodard.
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PREVENTATIVE MEDICINE

1985 - 1986

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Franklin, N. C. 28734

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LRC Member responsible for study: Senator Ollie Harris

Staff: William Gilkeson, Legislative Services Office

Jean W. Mims, Committee Clerk

North Carolina Department of Human Resources
Division of Health Services
P.O. Box 2091 • Raleigh, North Carolina 27602-2091

James G. Martin, Governor
Phillip J. Kirk, Jr., Secretary

Ronald H. Levine, M.D., M.P.H.
State Health Director

September 25, 1986

MEMORANDUM

TO: Senator William N. Martin, Co-chairmen and
Representative Jeff H. Enloe, Jr.

FROM: Ronald H. Levine, M.D., M.P.H. Ronald H. Levine | m w

SUBJECT: Budget for Health Promotion/Disease
Prevention in North Carolina

As you requested, I have reduced the budget delineated in our March 5, 1986, memo to the Committee and have accordingly scaled down the requirements of our response of February 17, 1986, entitled "Structuring the Solution: A Public Health Approach to Health Promotion/Disease Prevention in North Carolina." To implement a program of this nature, $4,453,188 would be needed. During the first twelve months of operation, $3,283,995 would be needed. A budget breakdown and narrative are specified in Attachment A. Overall goals are shown in Attachment B. My staff is continuing its work with assistance from various experts to detail the program plans.

Last week, Dr. Stoodt and I, as well as health directors from the other states, participated in the First National Conference on Chronic Disease Prevention held at the Centers for Disease Control in Atlanta. Detailed presentations with sound evaluations of several projects including some which I presented to your Committee, were made. Efforts in other states are showing positive results. North Carolina could benefit from similar approaches.

RHL/GS:jwc

Attachments

ATTACHMENT A

Budget for Statewide Health Promotion/Disease Prevention Program

	Proposed March 5, 1986	Revised September 24, 1986 YEAR 1	YEAR 2
I. COMMUNITY-BASED HP/DP ACTIVITIES			
A. Grants to Local Public Health Agencies	$3,000,000	$2,800,000	$3,000,000
[o Base Allocation	2,000,000]	[2,000,000]	[2,000,000]
[o Formula Distribution	1,000,000]	[800,000]	[800,000]
B. Awards to Governmental and Non-Governmental Agencies and Organizations	$1,223,500	-0-	1,000,000
SUBTOTAL	$4,223,500	$2,800,000	$3,800,000
II. PROGRAM ADMINISTRATION			
A. Staff Salaries and Fringe Benefits This includes in Year One: a Central Program Supervisor and 4 Regional Health Promotion Specialists In Year Two: 4 Regional Fitness/ Nutrition Consultants and a Clerk Typist		A.$ 144,995	A.$ 281,188
B. Related expenses including travel, telephone, office supplies and equipment		B.$ 92,000	B.$ 92,000
SUBTOTAL	$ 496,500	$ 236,995	$ 373,188
III. TRAINING	$ 110,000	$ 55,000	$ 110,000
IV. MASS MEDIA	$ 80,000	$ 40,000	$ 80,000
V. EVALUATION	$ 90,000	$ 60,000	$ 90,000
TOTALS	$5,000,000	$3,283,995	$4,453,188

SGS#5: char

A-1

Community-Based Health Promotion Disease Prevention Activities

In order to support the community-based health promotion/disease prevention activities of a statewide program, $3.8 million dollars would be needed; $2.8 million in the first year. Of this amount, $2 million would be allocated such that each of North Carolina's 100 county health departments would be entitled to receive $20,000 to support the assessment of the county's needs and resources for prevention of cardiovascular disease, cancer, and injuries; to coordinate resources; to develop a coordinated plan of action to prevent cardiovascular disease, cancer and injuries; and to implement direct services or interventions as appropriate.

An additional $800,000 would be allocated to local health departments on the basis of a formula which considers need of the county population relative to the prevention of these health problems and other current state and federal funding levels for relevant programs.

The local level budget would vary according to the need and the type of project undertaken. Health promotion by its nature is labor intensive as it is dependent largely upon "people skills." It is anticipated that 85-90% of funds allocated to local health departments would be spent for personnel support. The Division of Health Services (DHS) would be responsible for providing or securing current information and expertise in both the content and process of health promotion and disease prevention. A variety of process and content packages or modules are available for community and worksite health promotion program planning, implementation, and evaluation. The particular modules or program segments which might be needed by local projects would be determined by the local assessment of health related need and the priority assigned by corresponding goals and objectives. Thus, it would be the responsibility of the Division's staff to help match appropriate resources with local needs.

The ($2,800,000) described above would be distributed utilizing the Adult Health Funding Guidelines. Submission of a plan as described in 10 NCAC 8A .1005, Item b, would be required of all health departments. Further, they are subject to 10 NCAC 8A .1006 and .1007, "Monitoring and Reporting Program Performance" and "Use of Program Funds" which provide the basis by which the Division of Health Services can ensure necessary accountability. In particular, "A contractor that consistently fails to meet acceptable levels of performance as determined through site visits, review of performance reports,..., and has been offered program consultation and technical assistance, may have program funds reduced or discontinued."

During the second year, on a competitive basis using criteria set forth in 10 NCAC 8A .1005, "Applications for Program Funds" $1,000,000 would be allocated to community-based endeavors. These funds would provide incentives to coordinate local efforts to meet unmet needs in the prevention of the leading causes of death. Local health departments, as well as other agencies and organizations would be eligible to apply for these funds. As noted therein, it is particularly important that coordination of efforts with local health departments be demonstrated by other agencies and organizations. These competitive funds would be allocated for use in the second year of program operation, the first year being used to plan the program and develop the Request for Proposals process.

Program Administration:

Administrative costs related to the program would be approximately 8% of the total budget, or $373,188. Approximately 12% of these administrative costs would support personnel in the central and 63% in the four regional offices. Over 83% of these personnel costs would support technically trained persons such as health promotion specialists, and fitness/nutrition consultants who would provide technical assistance and consultation to local project staff. Less than 17% would support management and clerical personnel. Approximately 25% of program administrative costs would support operating expenses including travel, equipment, postage, telephone, supplies, and data processing for administration and program evaluation. Staff would be phased in (see Attachment A, page 1); therefore $236,995 would be needed for administrative costs for the first year.

Training

$110,000 of program resources would be used for training and for resource development and acquisition. Training would target community-based health promotion/disease prevention staff. This training and continuing education would be planned and implemented by DHS technical staff with assistance from the university community. Resources for program development and delivery include planning and implementation materials and curricula that are flexible enough to be adapted to specific local needs. For example, an existing workbook on fitness might be of excellent technical quality, but be written at too high a reading level. It would need to be modified for effective use. It is anticipated that development of some of these resources would require expertise from the university community. $55,000 would be needed to develop training plans and activities for the first year.

Mass Media

An additional $80,000 would support a mass media initiative, heightening awareness of health problems and local resources to address them. This program component would be developed by DHS staff with expertise provided from the university community as well as other technical resources. Approximately $40,000 would be needed the first year to plan and undertake the initial phase of a mass media initiative that would be supportive of program goals and activities.

Program Evaluation

Program evaluation would best be handled by contract to a leading center of health promotion and disease prevention, with some of this data collection being centered in the State Center for Health Statistics. The independent agency would develop the evaluation design and methodology in consultation with the Division of Health Services. It would provide technical assistance and training to the state program in developing evaluation priorities and strategies, developing and implementing program evaluation designs for funded projects, developing data collection instruments and a data management plan, and providing technical assistance and training for local health departments in the implementation of program evaluation plans and in the production of evaluation reports. Approximately $90,000 would be needed for these evaluation efforts with $60,000 needed for the first year. If desired, these could be reported to the General Assembly, perhaps in the form of a biennial report.

Attachment B

Health Promotion/Disease Prevention
Program Development in North Carolina

We are focusing on the implementation of model programs that will address the known preventable and modifiable risk factors for cardiovascular disease, cancer and injuries (see the table below). This effort will be centrally administered, centrally financed and locally operated. A description follows of anticipated interventions, as well as outcomes, both state and local, that would be expected of such a program.

RISK FACTORS, SURROUNDING INFLUENCES AND
LEADING CAUSES OF DEATH

	Heart Disease	Cancer	Stroke	Accidents (non-auto)	Accidents (auto)
Smoking	*	*		*	
High blood pressure	*		*		
High cholesterol	*				
Diet	*	*			
Obesity	*				
Lack of exercise	*				
Stress	*			*	
Alcohol misuse		*		*	*
Drug misuse	*			*	*
Seat belts					*
Mass media	*	*	*	*	*
Social norms regarding:					
smoking	*	*			
exercise	*				
diet	*	*			
stress	*			*	
Seat belt laws					*
Smoking policies	*	*			
Food labeling	*	*			
Home hazards					*
Accessibility of low fat high fiber foods	*	*			
Product design				*	
Automobile design					*
Roadway design					*
Speed limits					*
Environmental factors					
physical		*		*	
chemical		*		*	

B-1

Anticipated Interventions:

* appropriate, effective screening programs for cardiovascular disease, and certain cancers

* coordinating treatment, referral and follow-up for those individuals identified by screening to be at risk

* group and self-help programs to increase skills and knowledge in order to reduce behavioral risk factors. Programs include smoking cessation, nutrition education, weight management, stress management, fitness, injury control, and where appropriate, substance abuse education, defensive driving, and worker safety education

* community-wide education and media programs to influence social norms and attitudes which contribute to positive health behaviors

Local Outcomes:

* to identify those who are at high risk for cardiovascular disease, cancer and/or accidents

* at a minimum, to reduce one or more of the risk factors for cardiovascular disease, cancer, or injuries which are carefully defined, measurable, modifiable and prevalent among the members of a chosen target group

* to deliver interventions that will clearly and effectively reduce these risks within an appropriate setting

* to plan and implement programs cooperatively with other key local providers and community resources

Statewide Outcomes:

* to reduce known modifiable and preventable risk factors for cardiovascular disease, cancer and injuries, North Carolina's three leading causes of death

* to document and share effective models of planning, implementation and evaluation of health promotion/disease prevention programs

* to demonstrate the effectiveness of certain planned health promotion/disease prevention interventions through evaluation of impact and process

* to demonstrate the effective institutionalization of priority health promotion/disease prevention efforts within a county, a community, or a system

B-2

Evaluations to include:

* monitoring - a short-term evaluation technique to assure program accountability

* process evaluation - an analysis of factors associated with program success or failure

* impact evaluation - the extent to which the programs actually achieved the desired objectives. Emphasis will be placed on measurement of change in known behavioral risk factors, and in surrounding influences.

* outcome evaluation - longer range evaluation based on health status indicators such as mortality, morbidity, and/or functional status of populations will be explored with academic experts.

Presentation to the Legislative Research Commission's
Study Committee on Preventive Medicine

Dr. Georjean Stoodt, Chief
Adult Health Services Section
Division of Health Services
Department of Human Resources

September 30, 1986

Senator Martin, Representative Enloe, Mr. Gilkeson and Members of the Committee. I appreciate the opportunity to be with you today.

My tasks today are two:

- o first, as you requested at your last meeting, to provide you with some assessment of the economic potentials which might accrue should you invest in a statewide Health Promotion/Disease Prevention Program targeting cardiovascular disease, cancer, and injuries;
- o second, to review with you our recommendations of what such a program would look like and projected costs.

Let me begin:

Handout: Attachment A

- o Data is for 18-64 year old N. C. population only.
- o About 75% of deaths due to 3 leading causes.
- o Note relationships between # deaths, years of life lost, and indirect costs.
- o No medical care costs shown in these figures.

Considerations in Cost-Benefit or Cost Savings:

- o Difficulty assigning and determining costs, both at the input and the output ends.
- o Does Not include intangible benefits such as functional senior citizens, grandparents, and so on.
- o Requires assumption that what you spent your money for is what made the difference (causation).
- o Usually, it is assumed that the "savings" derived accrue to those who make the investment.
- o I would, therefore, caution you re using monetary figures alone to guide you as to what is the right thing to do, and implore you not to enter into this arena on the basis of cost savings alone, but to create a healthier North Carolina, where health is a means to a productive, worthwhile life, enriching our families and communities throughout the state.

In general the measurements of costs and benefits can be described as one of the following:

- o Indirect Costs
- o Direct - (Med) Costs
- o Human suffering costs.

In preparing the information I am sharing with you today, I have tried to be conservative with cost/benefit extrapolations, so as not to overstate the benefits. But, as we all know, the real test will come in the actual doing, and the results will be borne out in several years' time.

Let me suggest that perhaps a part of an evaluation of this program might examine the impacts such a program would have on the costs to the state for care for its Medicaid-eligible, for example. In reviewing some unofficial 8-month figures from 1985-86 recently, I noticed some slightly over 3 million dollars in 8 months paid for hospitalizations for Medicaid patients for heart attacks, hypertension, heart failure and other cardiovascular disease related conditions. On an annual basis, this shows an estimated Medicaid cost of roughly $5 million for only some of the CVD-related hospitalizations. (Caution: rough figures need further analysis.)

What have cost assessments elsewhere shown?

We've told you of many successful programs, but as I've indicated, Cost Benefit Evaluation is very difficult, and conclusions are hard to make with confidence. Many assumptions must be made in applying findings in one study to another setting. Nonetheless, with these cautions in mind let me share what we found and provide some estimates of how these observations might apply in North Carolina.

AT&T's Total Life Concept

- o AT&T in 1983 began a Total Life Concept program with some 1400 employees, and after 1 year projected a savings over the next 10 years of $22.4 million for heart attacks alone if they applied this to all 110,000 employees, a conservative figure since they only considered medical costs ($60,000 per heart attack). During their first year they had observed a decrease in their projected 10-year heart attack incidence, or 374 less heart attacks occurring among their 110,000 employees in the next 10 years. At a medical cost of $60,000/heart attack, these 374 totalled $22.4 million. This was as of 1984. (They estimated indirect costs were $250,000 to $1 million per case if the person became disabled. For a cancer case medical costs were $67,000/case.) In a 1986 issue of the Journal of Occupational Medicine, favorable health results had been shown, but cost-benefits, using Medical Costs minus Operating Costs, are being analyzed under contract to an outside agency. These will be determined annually for the next 3 - 5 years.

Seat Belts Pay Off in Chapel Hill:

- o They accomplished a seatbelt usage increase from 24 to 41% in 6 months, then 6 months after the program the usage decreased to 36%.

  - o Costs were:

$189,000 total:	$70,000 grant
	$15,000 time donated
	$34,000 prizes donated by business
	$70,000 donated advertising

- o Remember this was a research project so more of the budget was likely directed toward evaluation than would be devoted to a project taking this approach - already shown to be successful by this research - and applying it in a similar project.

- o So, the cost to do an intervention project without the evaluation and research aspects would probably be less than $70,000 to the sponsoring agency.

  Several points:

  - o Note voluntary participation and contributions.
  - o **Noting the decline in usage after the demonstration project ended, we would want to assess the lasting influence of one-time demonstrations.**

Maine's Ambulatory Diabetes Education and Follow-Up Program:

They observed a decrease of 32% in the number of hospitalizations as well as a 32% decrease in length of stay, equivalent to a $293 savings per patient participating in the program.

Rural Kentucky Hypertension Program:

You heard Dr. Levine present this previously and we heard the project director report in Atlanta recently. She reported that the total cost to initiating agency was $30,000. Again, note the approach of mobilizing and coordinating existing systems. (Review Attachment B)

- o Another source which reveiwed cost savings from cardiovascular disease prevention, if applied to our own N. C. data, could result in significant reductions of medical costs. (Review Attachment C)

BC/BS of Indiana's Health Promotion Program

Finally, a report from Blue Cross-Blue Shield of Indiana points out an impressive result (Review Attachment D) usirg $36,000 to start, and serving 2400 employees plus spouses and retirees, their final equation over a 5-year period was that they put in $98.96 and got back $143.60 per employee. This is a savings to cost ratio of 1.45, i.e., $1.45 returned on every dollar spent.

- If the $3.8 million we propose for North Carolina local activities resulted in a savings/cost ratio of 1.45 over 5 years, this would mean over $5.5 million in savings. (Note that an initial temporary increase of utilization occurred as e.g., conditions such as hypertension were discovered and controlled.)

In conclusion, the preponderance of this information leads me to conclude that the investment you might choose to make could derive a meaningful financial benefit over time, and most importantly, a benefit to the health and well-being of people in communities throughout North Carolina through doing what we know can be done to prevent the preventable.

Questions?

Now, let me ask you to turn to the Budget for Health Promotion/Disease Prevention in North Carolina and call upon Leslie Brown, Assistant Section Chief for Adult Health Services in the Division of Health Services to review it with you.

GS:em:Asst Chief 01:SpeechGS

NORTH CAROLINA TOTAL DEATHS AND
YEARS OF LIFE LOST (AGES 18-64 ONLY), WITH
LIFETIME ATTRIBUTABLE LOST WAGES, LOST STATE INCOME TAX
AND LOST GENERAL SALES TAX
BY CAUSE OF DEATH

CAUSE OF DEATH	1985 TOTAL NUMBER OF DEATHS (AGES 18-64)	1985 YEARS OF LIFE LOST (BELOW AGE 65)	LIFETIME LOST WAGES [2]	LIFETIME LOST STATE INCOME TAX [3]	LIFETIME LOST GENERAL SALES TAX [4]
Cardio-vascular Disease	5,436	52,941	$ 725,291,700	$ 36,254,585	$ 9,317,616
Cancer	4,475	47,353	$ 648,736,100	$ 32,436,805	$ 8,334,128
All Accidents	2,013	58,943	$ 807,519,100	$ 40,375,955	$ 10,373,968
SUBTOTAL	11,924	159,237	$2,181,546,900	$109,077,345	$ 28,025,712
All Other Causes[1]	4,679	79,351	$1,087,138,700	$ 54,355,435	$ 13,965,776
TOTAL	16,603	238,588	$3,268,685,600	$163,432,780	$ 41,991,488

(1) Includes diabetes mellitus, pneumonia/influenza, chronic obstructive pulmonary disease; chronic liver disease/cirrhosis; nephritis/nephrosis; suicide; homicide; all other causes.

(2) Based on 1982 average yearly income of $13,700. Statistical Abstract for State Government, 1984. Figures in this column represent what could have been contributed if these persons had lived until age 65.

(3) 5% derived from net income and net income tax paid, 1982. Ibid. Figures in this column represent what could have been contributed if these persons had lived until age 65.

(4) For a family of 3 (avg. in NC, 1980), $176 is the estimated sales tax paid, 1982. (Federal Income Tax Form) Figures in this column represent what could have been contributed if these persons had lived until age 65.

Total population in North Carolina ages 18-64 is 3,928,097 based on extrapolation from 70-80 census data, N. C. Office of State Budget and Management.

SGS#5:hpdpchart

DEPARTMENT OF INSURANCE

State of North Carolina

P. O. BOX 26387

RALEIGH, N C. 27611

JAMES E. LONG
COMMISSIONER OF INSURANCE

LEGAL DIVISION
(919) 733-4700

August 25, 1986

Representative Jeff H. Enloe, Jr.
Senator William N. Martin
Co-Chairmen
Legislative Research Commission's Study Committee on
Preventative Medicine

Gentlemen:

I have read with interest your Committee's Interim Report and applaud the Committee's efforts to institute a statewide wellness program.

I am interested in this concept for two reasons. First, as Insurance Commissioner, I oversee the commercial health insurance market in North Carolina and must be aware of what is being offered in the marketplace, as well as the continually rising costs of health care. Second, as Acting Executive Administrator of the State Health Plan (which is the second largest health insuring entity in North Carolina), I am also acutely aware of rising health care costs.

I will always be supportive of ways to save on health care costs, particularly when we can do so in a positive manner by encouraging wellness--to say nothing of the prospect of saving lives or improving the quality of the lives of North Carolina citizens.

I note in your Interim Report the recommendation (I. I. 1.) to write into the Teachers and State Employees Health Care Plan benefits for services to heart patients in all state-certified Cardiac Rehabilitation Clinics, not just those in hospitals. I recommended this to the General Assembly and it was accomplished in House Bill 2131 (C. 1020, 1985 S.L., Sec. 13) by an amendment to G.S. 135-40.6 (8)m allowing up to $650 per fiscal year for cardiac testing and exercise therapy.

The recommendation of routine physical examinations in your report (I. I. 2.) is provided for state health plan participants

who opted for HMO's effective July 1, 1986. Many traditional insurers believe that annual exams may not be cost effective below certain age levels. They believe that depending upon age, sex and other factors biennial exams or even triennial exams might be more cost effective, while for other groups annual exams may indeed be better. I would welcome the Committee's examination of this issue and sharing the results of your survey of the literature or studies on this question.

One of the Committee's recommendations for financing a comprehensive health promotion/disease prevention program statewide particularly concerns me. It has been proposed that a new premium tax of 1% be placed on Health Maintenance Organizations (HMO's), which are currently not taxed, and that the current tax on Chapter 57 nonprofit health plans be increased, from 1/3 of 1% to 1%. Apparently, $5,000,000 of the revenues collected from this taxation will be earmarked for use by the Department of Human Resources for this statewide program each fiscal year.

A recent United States General Accounting Office report raised questions as to the justification of continuing a different federal tax treatment for Blue Cross and Blue Shield Plans. I note with some interest that a similar question was not raised about HMO's. Whether there was a significant reason for this difference I cannot say. In the GAO report, however, several questions are raised as to whether health insurance, an already expensive (and increasingly expensive) item, should indeed be taxed at all. Perhaps more to the point, a question was posed as to whether increased taxation of those (few) insurers who try to provide non-group and small group coverage (business not always sought by many larger companies), might provide disincentives enough to dry up these markets--ultimately making it more difficult for individuals and small employers to obtain coverage. Before we move too aggressively into increased taxation of health insurers--of any kind--I think we need to explore the impact of same on the affordability and the availability of needed coverages.

During the Short Session of the Legislature this summer, when the subject of premium taxation was being debated, I proposed that both Chapter 57 and Chapter 57B corporations should be taxed at the same rate as all other insurance companies--1.75%--assuming similar marketplace conduct and services. The revenue gain from this taxation would help reduce the deficit in the General Fund which results over the next two years from the revisions in the premium tax law which became effective on July 16, 1986, for taxable years beginning on and after January 1, 1986 (House Bill 2103). A Fiscal Report from the Fiscal Research Division, dated July 10, 1986,

reflected that for the fiscal year 1987-88 the net effect on the General Fund, after passage of H.B. 2103, would be a reduction by approximately one million dollars. The effect on 1988-89 would be a $16.5 million reduction. This effect on the General Fund greatly concerns me.

According to figures which have been projected by the Financial Evaluation Division of the Department of Insurance, taxation of Chapter 57 corporations at a 1% rate would result in an increase in revenues of $3,991,895.77. This amount is based on premium volume for 1985, the latest year for which accurate premium volume is available. Taxation of Chapter 57B corporations at a 1% rate, based on premium volume for 1985, would result in an increase in revenues of $217,970.70. The total increase in revenues if Chapter 57 and Chapter 57B corporations were taxed at a rate of 1% would be $4,209,866.47. The gain in revenue from taxation of Chapter 57B corporations would be more significant for the 1986 tax year. Of the twelve HMO's currently operating in North Carolina, three commenced operations during the first half of 1986. As of June 30, 1986, one of the recently admitted HMO's had a premium volume of almost $3 million dollars.

If both Chapter 57 and Chapter 57B corporations were taxed at the rate of 1.75%, based on premium volume for 1985, the resulting gain in revenue would be $8,864,227.52.

I noticed from the Interim Report of your Committee that several other recommendations were considered for financing the wellness program. I would urge the Committee to give serious consideration to these other recommendations instead of attempting to earmark taxes levied on health insurance premiums. It is my belief that the Committee's proposal concerning such taxes would jeopardize any attempts to offset the future anticipated deficit in the General Fund by taxation of Chapter 57 and 57B corporations at 1.75%, the same rate placed on all other insurance companies (with the exception of Workers' Compensation insurance, which is at 2.5%.)

In action taken by the General Assembly this past session, some authority was provided to allow latitude in differentiated taxation for certain kinds of insurers. While there are some constitutional questions inherent in this authority, it might be prudent policy for North Carolina to provide more favorable tax treatment to insurers willing to write risky or unavailable lines of insurance. Under this concept we might not tax at all small or non-group health insurance, or medical malpractice insurance, or

Representative Jeff H. Enloe, Jr.
Senator William N. Martin
August 25, 1986
Page 4

health insurance or HMO's that do not selectively underwrite (that is, take all comers without restriction).

One word of caution is that the higher the premium tax on insurers, the greater is the stimulus for plans to go self-insured--where there are no taxes at all nor any of the regulation designed to protect consumers as we have with insured products. In fact, in some areas as much as 40% of the market is going self-insured. Hence, we very well may be providing an unwarranted stimulus for plans to self-insure and thereby be fostering a further shrinkage of the premium tax base. Recognizing this fact, Utah in 1984 repealed its premium tax on health payers altogether.

One of my concerns related to this issue is my anticipation that gradually a large volume of traditional health insurance premium volume will shift from insurance companies to HMO's. If the tax rate for HMO's is significantly lower than the tax rate for insurance companies selling health insurance, a decrease in revenues from this line of insurance would result. More significantly, I do not feel the State can allow any unequal treatment of competing forms of health care payment. Rather we should treat equally those forms which are providing equal services.

Another concern of mine is an administrative one. Under the current draft of the bill to finance a statewide wellness program, I notice that a quarterly system of filing returns and remitting taxes to the Commissioner of Insurance is provided. If I read this section correctly, the quarterly schedule set forth does not correspond to the quarterly schedule mandated by G.S. 105-228.5, the premium taxation statute. This could cause administrative difficulties for the Department of Insurance.

Thank you for the opportunity to express these concerns. Again, I commend the Committee for its efforts to institute a wellness program in North Carolina.

Sincerely yours,

James E. Long

JEL/SYL:eks

TESTIMONY

of

NORTH CAROLINA NURSES ASSOCIATION

Presented to

LEGISLATIVE RESEARCH COMMISSION'S

STUDY OF PREVENTIVE MEDICINE

TUESDAY, SEPTEMBER 30, 1986

STATE LEGISLATIVE BUILDING

Martha L. Henderson, M.S.N., G.N.P.

I AM MARTHA HENDERSON. I AM A GERIATRIC NURSE PRACTITIONER AND DIRECTOR OF CLINICAL SERVICES PROVIDING PRIMARY HEALTH CARE TO 300 RESIDENTS OF CAROL WOODS, A RETIREMENT COMMUNITY IN CHAPEL HILL. I AM REPRESENTING THE NORTH CAROLINA NURSES ASSOCIATION, THE MEMBERSHIP ORGANIZATION FOR REGISTERED NURSES IN THIS STATE.

WE APPRECIATE THE COMMITTEE'S INVITATION TO ADDRESS AGAIN THE ISSUE OF DIRECT REIMBURSEMENT TO NURSES AS HEALTH CARE PROVIDERS.

THERE IS AMPLE VALID RESEARCH THAT DOCUMENTS THE COST-EFFECTIVENESS OF PRIMARY CARE NURSES AS HEALTH CARE PROVIDERS. THESE STUDIES SHOW THAT WHEN THE PROVIDER OF CARE IS THE PRIMARY CARE NURSE:

- COSTS PER VISIT ARE LOWER;
- THE RATE OF HOSPITALIZATION IS LOWER;
- THERE IS LESS LOST WORK TIME;
- THERE IS GREATER USE OF NON-DRUG THERAPY;
- ACCESS TO HEALTH CARE IS INCREASED FOR UNDERSERVED POPULATION GROUPS WITH HITHERTO UNDETECTED AND UNTREATED HEALTH PROBLEMS;
- GREATER PATIENT AND FAMILY TEACHING TAKES PLACE;
- THERE IS GREATER EMPHASIS ON PREVENTIVE MEASURES, REDUCING NEED FOR LATER EXPENSIVE TREATMENT.

TWENTY-FIVE STATES HAVE ALREADY PASSED SOME FORM OF LEGISLATION THAT PROVIDES FOR REIMBURSEMENT TO QUALIFIED NURSES.

THERE ARE IMPORTANT BILLS PENDING IN CONGRESS THAT WILL PROVIDE REIMBURSEMENT FOR NURSES AND OTHER NON-PHYSICIAN PROVIDERS IN FEDERALLY-FUNDED HEALTH BENEFIT PROGRAMS.

WE CITE A SAMPLING OF THE RESEARCH THAT VALIDATES THE COST-SAVINGS AND FAVORABLE PATIENT OUTCOMES ACHIEVED BY PRIMARY CARE NURSES.

A HOSPITAL CLINIC STUDY OF A NURSE MIDWIFERY SERVICE SHOWED A MARKED DECREASE IN PREMATURE BIRTHS AMONG POOR WOMEN AND REDUCTION BY MORE THAN 50 PERCENT IN NEONATAL MORTALITY. THE SERVICE WAS TERMINATED DESPITE THESE ACHIEVEMENTS. DATA FOR THE TWO YEARS FOLLOWING TERMINATION OF THE SERVICE SHOW THAT PREMATURITY RETURNED TO THE LEVELS EXISTING BEFORE THE NURSE-MIDWIFERY PROGRAM, AND NEONATAL MORTALITY TRIPLED.

A HEALTH MAINTENANCE ORGANIZATION USING NURSE PRACTITIONERS AND OTHER NON-PHYSICIAN PROVIDERS FOUND THAT AVERAGE VISIT COSTS DECREASED BY 20 PERCENT. OTHERS HAVE DOCUMENTED A DECREASE IN USE OF MEDICATION BY PATIENTS AND A 27 PERCENT DECREASE IN LABORATORY AND PRESCRIPTION COSTS.

ANOTHER STUDY DOCUMENTED THAT NURSE PRACTITIONER COSTS PER PATIENTS WERE 39 PERCENT OF THOSE GENERATED BY VISITS WITH PHYSICIANS.

A GROUP HEALTH ASSOCIATION INSTITUTED MIDWIFERY CARE IN A BIRTHING CENTER AS THE STANDARD BENEFIT AS A COST CONTAINMENT EFFORT.

A UNIVERSITY OF CALIFORNIA SURVEY OF 93 PRIMARY CARE PRACTICES CONCLUSIVELY DEMONSTRATES THE COST EFFECTIVENESS OF THE FAMILY NURSE PRACTITIONER IN PRIMARY CARE SETTINGS.

A CHAMPUS STUDY FOUND THAT NEARLY 75 PERCENT OF NURSE PRACTITIONER BILLINGS FOR PROCEDURES STUDIED WERE 31% LESS THAN THE AMOUNT NORMALLY ALLOWED TO COVER PHYSICIAN BILLS.

TWO EXTENSIVE STUDIES (AMA CENTER FOR HEALTH SERVICES RESEARCH, 1976; AND THE MACY COMMISSION, 1976) FOUND THAT THERE IS CONSIDERABLE COST-SAVING POTENTIAL WITH THE USE OF NURSE PRACTITIONERS. GIVEN THE RESULT OF SUCH STUDIES, THE NATIONAL COMMISSION ON COST OF MEDICAL CARE (1977), AND THE MEDICUS SYSTEMS CORPORATION (1980) BOTH RECOMMENDED REIMBURSEMENT FOR NURSES PRACTICING IN AN EXPANDED ROLE TO PROMOTE ECONOMIC EFFICIENCY.

A STUDY BY SYSTEM SCIENCE, INC. FOUND THAT FOR 58 TASKS GROUPED INTO 5 CATEGORIES--PHYSICAL EXAMINATION, OFFICE SURGERY, LAB PROCEDURES, PATIENT EDUCATION AND COUNSELING--THE AVERAGE BILL FOR NURSE PRACTITIONER SERVICES WAS LESS THAN 50% OF CHARGES FOR THE SAME SERVICES PERFORMED BY A PHYSICIAN.

A REVIEW OF 15 STUDIES CONCLUDED THAT BETWEEN 75 AND 80% OF ADULT PRIMARY CARE SERVICES, AND UP TO 90% OF PEDIATRIC PRIMARY CARE SERVICES COULD BE PERFORMED BY NURSE PRACTITIONERS. POTENTIAL COST SAVINGS WITH THE USE OF NURSE PRACTITIONERS WAS ESTIMATED AT $0.5 BILLION TO $1.0 BILLION OR 19 TO 49% OF PRIMARY CARE PROVIDER COSTS.

THE ROBERT WOOD JOHNSON FOUNDATION SPONSORED A 5-YEAR DEMONSTRATION IN 18 SCHOOL DISTRICTS IN SEVERAL STATES. THIS SCHOOL HEALTH SERVICES PROGRAM FOUND THAT NURSE PRACTITIONERS CAN IMPROVE CHILDREN'S ACCESS TO HEALTH CARE BY EXPANDING SERVICES AVAILABLE IN SCHOOLS, AND THEY CAN BE "REMARKABLY SUCCESSFUL" IN IDENTIFYING PREVIOUSLY UNDIAGNOSED MEDICAL PROBLEMS IN CHILDREN.

A NORTH CAROLINA STUDY REPORTED IN 1984 DESCRIBED A LOCAL FURNITURE COMPANY STRUGGLING WITH SPIRALING EMPLOYEE HEALTH CARE COSTS. A FAMILY NURSE PRACTITIONER WAS HIRED TO PERFORM HEALTH SCREENING, ROUTINE TESTING, AND CARE OF MINOR ON-THE-JOB INJURIES. NET SAVINGS TO THE COMPANY IN THE FIRST YEAR TOTALED $203,647.50.

A 1982 STUDY FOUND THAT WHEN COMPARING THE PRACTICES OF NURSE PRACTITIONERS WITH THAT OF PHYSICIANS FOR AN AMBULATORY GERIATRIC POPULATION THE USE OF NURSE PRACTITIONERS LED TO A LOWER NUMBER OF INPATIENT HOSPITAL DAYS AND LESS INTERMEDIATE USE OF NURSING HOME CARE.

A STUDY REPORTED IN THE NEW ENGLAND JOURNAL OF MEDICINE SHOWED THAT THE USE OF THE GERIATRIC NURSE PRACTITIONER FOR HOME AND NURSING HOME CARE FOR THE CHRONICALLY ILL ELDERLY RESULTED IN A DECREASE IN THE FREQUENCY OF HOSPITALIZATION AND ASSOCIATED LENGTHS OF STAY WHEN COMPARING THE PRACTICES OF NURSE PRACTITIONERS WITH THAT OF PHYSICIANS.

SEVERAL STUDIES SHOW THAT THE QUALITY OF CARE PROVIDED BY NURSE PRACTITIONERS IS AS HIGH AS THE CARE RENDERED BY PHYSICIANS FOR THAT RANGE OF SKILLS WHICH THE NURSE PRACTITIONERS ARE TRAINED TO USE. QUALITY OF CARE WAS MEASURED BY DIAGNOSIS AND TREATMENT (AS COMPARED TO THE MD) AND PATIENT OUTCOMES.

THE UNITED STATES CONGRESSIONAL BUDGET OFFICE REPORTS: NURSE PRACTITIONERS HAVE PERFORMED AS WELL AS PHYSICIANS WITH RESPECT TO PATIENT OUTCOMES, PROPER DIAGNOSIS, MANAGEMENT OF SPECIFIED MEDICAL CONDITIONS, AND FREQUENCY OF PATIENT SATISFACTION.

WHILE THE STUDIES WE HAVE CITED ARE NOT SPECIFIC TO NORTH CAROLINA, THEY ARE NONETHELESS VALID RESEARCH.

IT IS THE ARGUMENTS OF OPPONENTS TO REIMBURSEMENT FOR NURSES THAT ARE NOT VALID. THERE IS NO QUESTION OF QUALITY OF CARE. AGAIN, THERE IS AMPLE RESEARCH TO VALIDATE THE SAFETY AND QUALITY OF CARE PROVIDED BY PRIMARY CARE NURSES. THERE IS NO QUESTION OF

PATIENT ACCEPTANCE. THAT ALSO IS VALIDATED BY NUMEROUS STUDIES. THE ARGUMENT THAT RECOGNIZING NURSES AS PROVIDERS ELIGIBLE FOR REIMBURSEMENT WILL INCREASE UTILIZATION (AND THEREBY COSTS) IS REFUTED BY THE U. S. OFFICE OF PERSONNEL MANAGEMENT IN A STUDY RELEASED THIS YEAR.

IN THE FACE OF OVERWHELMING EVIDENCE THAT NURSE PROVIDERS SAVE MONEY, PRACTICE PREVENTIVE HEALTH CARE, AND REACH UNDERSERVED POPULATIONS, ANY SERIOUS EFFORT TO IMPROVE THE PREVENTIVE ASPECTS OF HEALTH CARE IN A COST-EFFECTIVE MANNER REQUIRES OPENING UP THE PAYMENT SYSTEMS TO PROVIDE REIMBURSEMENT FOR NURSE PROVIDERS.

A BILL TO BE ENTITLED
AN ACT TO ESTABLISH
A STATEWIDE HEALTH PROMOTION AND DISEASE PREVENTION PROGRAM

The General Assembly of North Carolina enacts:

Section 1. Chapter 130A of the General Statutes is amended by redesignating G.S. 130A-223(b) as G.S. 130A-223(c) and by adding a new G.S. 130A-223(b) to read as follows:

"(b) As a part of the prevention program, the Department shall establish and administer a Statewide Health Promotion and Disease Prevention Program. In administering the program, the Department shall do, but shall not be limited to doing, the following:

(1) Identify risk factors associated with cardiovascular disease, cancer, accidental injuries, and other leading causes of death or disability.

(2) Identify the prevalence of risk factors among groups, populations, or geographic areas which share patterns of disease, disability, or mortality from cardiovascular disease, cancer, injuries and other leading health problems.

(3) Utilize health education and other methods which do the following:

a. improve the awareness of individuals and communities about controllable risk factors associated with cardiovascular disease, cancer, injuries, and other leading health problems, and

b. promote changes in lifestyle and environment likely to reduce such risk factors.

(4) Establish, finance, coordinate and administer contracts with local health departments or, where appropriate, with other public and private organizations, institutions, and agencies, to plan, develop, coordinate, manage, and provide community-based health promotion and disease prevention services for cardiovascular disease, cancer, accidental injuries, and other leading causes of death or disability. In awarding contracts under this subdivision, the Department shall provide an equal base amount to each county and an additional amount to be allocated based on the needs of the county population.

(5) Establish, finance, coordinate, and administer a system for awarding and monitoring competitive contracts for local health promotion and disease prevention services and activities for cardiovascular disease, cancer, accidental injuries, and other leading causes of death or disability. Local health departments and public and private

organizations, institutions, and agencies shall be eligible to compete for such contracts.

(6) Seek and encourage funding from other public and private sources, including foundations, for the purpose of expanding the nature, scope, and impact of services and activities provided under the program.

(7) Encourage contractors to subcontract parts of local program services and activities to other public and private organizations, institutions, and agencies that can effectively provide such services and activities.

(8) Promote, encourage, and support participation of volunteers in all aspects of the program.

(9) Provide technical assistance, management and program consultation and training to contractors and communities to establish, maintain, and improve health promotion and disease prevention services.

(10) Develop, in cooperation with the university community, a reporting, monitoring, assessment, and performance-evaluation system for the health promotion and disease prevention program. Written reports on these evaluations shall be submitted to the General Assembly on or before March 31 of each year.

Section 2. There is appropriated from the General Fund to the Department of Human Resources the sum of three million, two hundred eighty-four thousand dollars ($3,284,000) for fiscal year 1987-88 and the sum of four million four hundred fifty-three thousand two hunderd dollars ($4,453,200) for fiscal year 1988-89 to establish and administer a community-based program of Health Promotion and Disease Prevention as described under G.S. 130A-223(b) in Section 1 of this Act. Of the amount appropriated in this Act for fiscal year 1988-89, one million dollars shall be awarded for competitive grants under G.S. 130A-223 (b) (5) in Section 1 of this Act.

Section 3. This Act shall become effective July 1, 1987.

APPENDIX H

A BILL TO BE ENTITLED
A JOINT RESOLUTION AUTHORIZING
THE LEGISLATIVE RESEARCH COMMISSION TO STUDY
REIMBURSEMENT FOR PREVENTIVE HEALTH CARE.

Whereas, the top three causes of death and disability in North Carolina are cardiovascular disease, cancer, and accidents; and

Whereas, all three of those conditions have been demonstrated by sound scientific evidence to be preventable to a significant degree; and

Whereas, methods of prevention include primary prevention (promotion of wellness and reduction of health risks), secondary prevention (early diagnosis and prompt treatment of health problems to prevent or limit disability), and tertiary prevention (rehabilitation); and

Whereas, current methods of third-party reimbursement for health services (such as through health insurance) tend to exclude payment for primary and sometimes secondary prevention and, instead, emphasize treatment for diagnosed illnesses; and

Whereas, certain health professionals maintain that the services they provide have a particularly strong emphasis on prevention; and

Whereas, those health professionals oppose laws that discourage or prohibit third parties such as insurors from directly reimbursing for the preventive services they provide to patients, saying that such laws constitute barriers to a well-rounded program of health care; and

Whereas, those health professionals, especially nurse practitioners, maintain that direct reimbursement for their services would result in lower health-care costs without a diminution of quality; and

Whereas, physicians often maintain that direct reimbursement of non-physicians for health services would diminish the quality of health care; and

Whereas, insurors often maintain that mandated coverage of preventive services and expansion of the category of health professionals eligible to receive third-party reimbursement would force insurors to charge higher premiums, causing employers to switch to self-insurance; and

Whereas, preventive health care should be encouraged because it is likely to increase the quality and span of life and

decrease long-run expenditures on treatment of health problems; and

Now, therefore, be it resolved by the House of Representatives, the Senate concurring:

Section 1. The Legislative Research Commission may study issues related to having health care delivery professionals and those in related professions (such as vocational rehabilitation specialists and dieticians) receive direct reimbursement from third parties for preventive health care.

Sec. 2. The Commission shall make a final report of its findings and recommendations to the 1989 General Assembly.

Sec. 3. This resolution is effective upon ratification.

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