NORTH CAROLINA GENERAL ASSEMBLY

HOUSE SELECT COMMITTEE ON HEALTH CARE

Co-chairs:
Representative Nye
Representative Wright
Representative England

INTERIM REPORT TO THE GENERAL ASSEMBLY

MAY, 2006

The House Select Committee on Health Care respectfully submits the following interim report.

Edd Nye
Representative Nye
Co-Chair

Thom E. Wright
Representative Wright
Co-Chair

Representative England
Co-Chair

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Representative Edd Nye, Co-Chair

Representative Thomas Wright, Co-Chair

Representative Bob England, Co-Chair

Subcommittee on Medicaid : Rep. Nye, Rep. Earle, Co-chairs

Representative Dickson

Representative Owens

Representative Sutton

Representative Culp

Representative Howard

Representative Rapp

Representative Walend

Subcommittee on the Cost of Health Care and Health Insurance for Employees and Employers

Representative Holliman, Co-Chair

Representative Faison

Representative Goforth

Representative Sherrill

Representative Bordsen

Representative Underhill, Co-Chair

Representative Grady

Representative McGee

Representative Bell

Subcommittee on Safety, Quality, Accountability

Representative L. Allen, Co-chair

Representative Tucker

Representative Justus

Representative Warren

Representative Brubaker

Representative Justice

Representative Ross

Subcommittee on Healthcare Workforce

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Representative Clary

Representative Farmer-Butterfield

Representative McLawhorn

Representative Adams

Representative Carney, Co-Chair

Representative Current

Representative Hollo

Representative Wilkins

Subcommittee on Access

Representative England, Co-Chair
Representative Insko, Co-Chair
Representative Fisher
Representative Pate
Representative Setzer
Representative Weiss
Representative Williams
Representative Womble
Representative Barnhart
Representative Coates
Representative McAllister
Representative Walker

Subcommittee on the State Health Plan

Representative Wright, Chair
Representative Church
Representative Coleman
Representative Crawford
Representative Eddins
Representative Folwell
Representative Gulley
Representative Michaux
Representative Haire

COMMITTEE PROCEEDINGS

The House Select Committee on Health Care, met three times from November 30, 2005 through April 11, 2006.

The first meeting was held on November 30, 2005, to review the duties and responsibilities of the Committee as outlined in the Speaker's Authorization effective November 9, 2005, as subsequently revised. (See Appendix I)

The second meeting was held on March 7, 2006, to hear from subcommittee chairs on the topics being reviewed and progress being made by subcommittees.

The final meeting was held on April 11, 2006. At this meeting the Committee heard a presentation entitled "An Analysis of Premium Assistance under North Carolina Medicaid." Premium assistance is a state funding strategy that allows a state government to offer premium subsidies for employer-sponsored insurance premiums to Medicaid and Medicaid-eligible individuals. The presentation was made by students from Duke University: Kate Abramson, Andrew Bye, Katie Owen, Hirsh Sandesara, and Catherine Wu. The students presented an overview of the premium assistance concept, the impact of premium assistance on coverage and health, equity concerns raised by premium assistance, the impact on Medicaid costs and financing, and the students' conclusions and policy implications. Based on their analysis, the students recommended (1) case-by-case subsidies, (2) wrap-around coverage, (3) no waiting periods for premium assistance, and (4) no mandatory enrollment. (See Appendix II)

Also at the final meeting prior to the 2006 Regular Session, subcommittee chairs made reports to the Committee on their work, findings, recommendations, and legislative proposals. The Committee voted to accept the subcommittee reports, as amended, and adopted this Committee Report encompassing each subcommittee's report.

FINDINGS AND RECOMMENDATIONS

BASED ON SUBCOMMITTEE REPORTS PRESENTED TO THE HOUSE SELECT COMMITTEE ON HEALTH CARE ("COMMITTEE") ON APRIL 11, 2006, THE COMMITTEE ADOPTS THE FOLLOWING FINDINGS AND RECOMMENDATIONS:

I. SUBCOMMITTEE ON MEDICAID

FINDING: Ever increasing costs to cover county Medicaid expenditures are severely burdening county budgets, often at the expense of vital programs such as public education. Although Medicaid services are in large part local expenses, the House Select Committee on Health Care finds that without financial assistance from the State other essential county services, especially in counties with low growth, high Medicaid populations, and limited resources, will have to absorb cuts in order to meet Medicaid obligations.

RECOMMENDATION: the State should provide financial assistance to counties on a fair and reasonable basis to assist in the cost of covering locally incurred Medicaid expenditures. Financial assistance should be provided in accordance with legislation proposed in this report: "AN ACT TO PROVIDE THAT THE COUNTY SHARE OF THE NONFEDERAL SHARE OF MEDICAID COSTS FOR THE 2006-2007 FISCAL YEAR SHALL NOT EXCEED THE COUNTY SHARE PAID BY EACH COUNTY FOR THE 2005-2006 FISCAL YEAR; TO APPROPRIATE FUNDS TO COVER THE COST TO THE GENERAL FUND OF CAPPING THE COUNTY SHARE; TO APPLY THE CAP BEGINNING WITH THE 2006-2007 FISCAL YEAR AND THEREAFTER; AND TO PROVIDE FOR FURTHER REDUCTION IN THE COUNTY SHARE ON A TARGETED BASIS USING SAVINGS REALIZED FROM THE MEDICARE PART D PROGRAM."

II. SUBCOMMITTEE ON COST OF HEALTH CARE AND HEALTH INSURANCE FOR EMPLOYEES AND EMPLOYERS

FINDING 1:

Information provided by the North Carolina Institute of Medicine included average employee insurance premiums for small firms (fewer than 50 employees) and large firms (50 or more employees) in North Carolina, and a breakdown of average premiums for family coverage by firm size in North Carolina. From the year 2000 to 2003, total premiums rose nearly $900 per employee for small firms and $700 per employee for large firms. The increase for small firms is slightly more than the national average, while the increase for large

firms is slightly less than the national average. Total premiums for family coverage rose nearly $2500 per year for small firms and $1700 per year for large firms. The increase for small firms is comparable to the national average, while the increase for large firms is less than the national average. Over three fifths of employees of small (fewer than 10 employees) firms are not offered health insurance through their employer. Additionally, there was a decline in employer-based insurance coverage from 66.3% in 2000 to 59.1% in 2004. During this timeframe there was an increase in the percentage of individuals that were uninsured and an increase in the percentage of individuals covered by Medicaid. The information provided by NC IOM also indicated that the uninsured rates vary widely by industry, from 3% in government to over 50% in construction, and that research suggests that the increase in the uninsured is more a result of within-group changes than changes in the demographic composition. National research has concluded the number one driver of increasing rates of uninsurance is premium cost.

RECOMMENDATION 1: TAX CREDIT TO SMALL BUSINESSES

The House Select Committee on Health Care encourages the General Assembly to enact legislation to provide a tax credit to small businesses that provide health benefits to all eligible employees.

FINDING 2:

Information provided by Dr. Silberman and Dr. Holmes with the NC Institute of Medicine (NC IOM), pertained also to a high risk pool for people with pre-existing conditions. Blue Cross & Blue Shield of North Carolina is the only insurer to voluntarily offer health insurance coverage to any individual regardless of health status. People with pre-existing health problems are the ones most in need of health insurance to pay for care, but premiums make this coverage unaffordable in the non-group market. For illustration purposes, non-group health insurance coverage for a 35-year old man with a major health problem could cost more than $800 per month (with a $1,000 deductible, 30% coinsurance plan), or more than $1,800 per month for a 55-year old man. Coverage for women is generally more expensive.

According to the NC IOM presentation, 33 other states have high-risk pools to help subsidize the costs of insurance provided to high-cost individuals. The federal Deficit Reduction Act makes some federal funds available to help support a high-risk pool. The NC IOM recommends that the NC General Assembly enact legislation to implement a high-risk pool. The NC IOM suggests that eligibility for the high-risk pool be limited to individuals who are ineligible for Medicaid or Medicare, and are unable to purchase a policy except with a premium that is higher than that offered through the pool, or have been rejected from another insurer due to pre-existing health problems.

House Bill 1535 Establish NC Health Insurance Risk Pool was introduced in the House and referred to the House Committee on Insurance on April 21, 2005. A subcommittee of the House Committee on Insurance has reviewed the bill and has recommended modifications.

RECOMMENDATION 2: HIGH-RISK POOL

The House Select Committee on Health Care encourages the General Assembly to enact legislation to implement a health insurance high-risk pool.

FINDING 3:

Information was provided on a proposal for a Healthy North Carolina program, based on the Healthy New York model. This concept represents a publicly subsidized health insurance targeted to certain small employers, sole proprietors, and working individuals who have not had health insurance coverage in the last 12 months. The Healthy New York model had 106,944 members as of December 2005. Additional information on the New York model can be found in the, "Report on the Healthy NY Program 2005," prepared for the State of New York Insurance Department on December 31, 2005.

The NC IOM, based on the work of the NC IOM Task Force on Covering the Uninsured, recommends that the North Carolina General Assembly create a lower-cost health insurance product available to certain small employers, self-employed individuals, and low-income workers that had not had coverage in the prior 12 months. Additionally, the State should provide publicly funded reinsurance to help reduce the premium costs by 30% of what is available in the private market. The recommendation from the NC IOM for a Healthy North Carolina program would limit eligibility for coverage to:

- Small employers with 25 or fewer workers, with at least 30% of the workforce as low-income (less than $12/hour),
    - Must have 75% participation of eligible employees without other coverage, the
    - Employer must pay 50% of the employees premium, the
    - State would provide additional tax credit if: greater than 75% participation, employer pays more than 50% of employee premium, or employer contributes toward dependents premium;
- Self employed individuals with a family income of less than 250% FPG (federal poverty guideline); and
- Working individuals that have no access to employer-sponsored insurance with family incomes of less than 250% FPG (federal poverty guideline).

RECOMMENDATION 3: HEALTHY NORTH CAROLINA PROGRAM

The House Select Committee on Health Care encourages the General Assembly to enact legislation to create a program offering affordable health insurance to North Carolina small employers and working individuals, similar to the Healthy New York model.

FINDING 4:

A presentation on NC Stroke Systems of care was made by Dr. Larry B. Goldstein, MD, FAAN, FAHA, Professor of Medicine (Neurology); Director, Center for Cerebrovascular Disease; Senior Fellow, Center for Clinical Health Policy Research, Duke University and Durham VAMC. Data indicate that 27,000 North Carolinians have strokes annually, 14,000 North Carolinians are disabled by stroke each year, and that stroke is the third leading cause of death. With regard to costs associated with a stroke: 36% are indirect costs - lost productivity-mortality (25%) and lost productivity-morbidity (11%), and 64% are direct costs - hospitalization (27%), nursing home/rehabilitation (25%), physician/other (5%), drugs/durable (2%), home health (5%). Dr. Goldstein indicated that stroke systems serve three critical functions: ensure the effective interaction and collaboration between all entities involved in the prevention, treatment and rehabilitation of stroke patients; promote standardized science-supported practices; and monitor performance.

On March 23, 2006, the Subcommittee also discussed House Bill 1396 Statewide Stroke Care System. This bill was introduced and on April 21, 2005 and was referred to the House Committee on Health. (See Appendices for House Bill 1396.)

RECOMMENDATION 4: STATEWIDE STROKE CARE SYSTEM

The House Select Committee on Health Care encourages the General Assembly to enact legislation, to provide for the identification of primary stroke centers, to disseminate information to the general public and emergency care providers about the location of primary stroke centers, and to facilitate appropriate emergent stroke centers: "AN ACT TO PROVIDE FOR THE IDENTIFICATION OF PRIMARY STROKE CENTERS; TO DISSEMINATE INFORMATION TO THE GENERAL PUBLIC AND EMERGENCY CARE PROVIDERS ABOUT THE LOCATION OF PRIMARY STROKE CENTERS; AND TO FACILITATE APPROPRIATE EMERGENCY STROKE CARE, AS RECOMMENDED BY THE HOUSE SELECT COMMITTEE ON HEALTH CARE.

FINDING 5: SMALL GROUP EMPLOYER HEALTH PLANS

A presentation on the Small Employer Group Health Reform Act was made by Barbara Morales Burke, Chief Deputy Commissioner at the Department of Insurance. Ms. Morales Burke presented recommended changes to North Carolina's Small Employer Group Health Coverage Reform Act. The content of her presentation originated with the work of the Department of Insurance's Small Group Informal Discussion Group. This work group made a report to the Department of Insurance. On behalf of the Department, Ms. Morales Burke presented five of the six recommendations that originated with the Discussion Group. The recommendations included:

Recommendation #1: Allow small group insurers to offer self-employed individuals two popular plans instead of the Basic and Standard Plans.

Recommendation #2:	Replace the demographic factor for geographic location with factor for medical care system.
Recommendation #3:	Allow a rating factor for an industry, up to 10%.
Recommendation #4:	Expand the risk band from 20% to 25%.
Recommendation # 5:	Eliminate the Reinsurance Pool for small group carriers.

In conclusion Ms. Morales Burke pointed out the following:

- Allowing carriers alternatives to Basic and Standard Plans would increase the choice of plans and prices for self-employed individuals and may make NC more attractive to carriers.
- Eliminating the Reinsurance Pool for small group carriers would end unnecessary, bureaucratic construct that provides no value.
- Revising the rating to: allow an industry factor, recognize medical care systems instead of county lines, and expand the risk band, would maintain significant subsidy but reduce and recalibrate it to produce short-term and long-term benefits to the market.
    - Groups with lower medical risks and using less-costly systems would see immediate reduction in rates. This would keep some of these groups from losing coverage and bring in some new groups.
    - Groups with higher medical risks would see increases in rates. But, over time, these same groups would see lower rate increase as a result of more groups with lower medical risks in the small group pool.

RECOMMENDATION 5: SMALL EMPLOYER GROUP HEALTH COVERAGE

The House Select Committee on Health Care encourages the General Assembly to enact legislation to allow small group insurers to offer self-employed individuals two popular plans instead of the Basic and Standard Plans; to replace demographic factor for geographic location with a factor for medical care system; to allow a rating factor for the industry, up to 10%; to expand the risk band from 20% to 25%; and to eliminate the Reinsurance Pool for small group carriers: AN ACT TO MAKE CHANGES TO THE STATUTORY BASIC AND STANDARD HEALTH PLANS FOR SMALL EMPLOYERS, AS RECOMMENDED BY THE HOUSE SELECT COMMITTEE ON HEALTH CARE."

III. SUBCOMMITTEE ON SAFETY, QUALITY, ACCOUNTABILITY

FINDING 1:

Patient safety is enhanced when physicians and others authorized to practice medicine are held accountable for their actions. The North Carolina Medical Board is the State board charged with the responsibility of licensing and disciplining those engaged in the practice of medicine in the State.

The Subcommittee on Patient Safety, Quality, and Accountability heard presentations from representatives of the Medical Board on the Board's increasing focus on patient safety issues and more vigorous enforcement of licensure requirements. The Board, in particular, has increased its efforts to identify physicians and others authorized to practice medicine who are practicing below standards and either force them to improve or remove their license. The Medical Board asked the Subcommittee to consider legislation that would assist the Board in its efforts to discipline its licensees including providing additional disciplinary tools to the Board beyond the current options of license denial, revocation or suspension, allowing the Board to use three member panels to hear disciplinary cases, and providing sanctions for hospitals and insurance companies who do not comply with the statutory reporting requirements when a physician's hospital privileges are amended or a malpractice claim has been paid.

The Subcommittee finds that the limited disciplinary options available to the Medical Board under G.S. 90-14 impede its ability to appropriately oversee and discipline its licensees and others authorized to practice medicine. Providing the Board additional disciplinary options such as probation, conditional licensing, public reprimand, monetary fines, and remedial training will help the Board in its efforts to ensure that those practicing medicine in this State are competent and of good character. The Subcommittee also finds that allowing the Board to appoint its members to panels to hear disciplinary cases will improve the functioning of the Board and the increase the speed at which cases may be disposed of as the number of actions against licensees grows. Finally, the Subcommittee finds that the Medical Board's efforts to supervise those practicing medicine can be hampered by the failure of hospitals and medical malpractice insurance companies to timely provide information that would help the Board in identifying those practitioners who may pose a threat to patients through the provision of substandard care. Providing monetary penalties for failure to provide timely reports to the Board should encourage the timely flow of information to the Medical Board for investigation and thus improve patient safety.

RECOMMENDATION 1: INCREASE AUTHORITY OF THE NORTH CAROLINA MEDICAL BOARD

The House Select Committee on Health Care encourages the General Assembly to enact legislation to broaden the authority of the North Carolina Medical Board to assure that those persons practicing medicine in the State meet the standards of competence and character: "AN ACT TO STRENGTHEN THE AUTHORITY OF THE NORTH CAROLINA MEDICAL BOARD TO DISCIPLINE PHYSICIANS AND CERTAIN OTHERS AUTHORIZED TO PRACTICE MEDICINE IN ORDER TO IMPROVE PATIENT SAFETY, AS RECOMMENDED BY THE HOUSE SELECT COMMITTEE ON HEALTH CARE."

FINDING 2:

Hospital acquired infections occur in approximately 5% of all persons hospitalized and are estimated to add over $6.5 billion dollars a year to health care costs. North Carolina began addressing this problem in 1980 through the Statewide Program for Infection Control and Epidemiology (SPICE). SPICE personnel conduct educational programs for hospitals, nursing homes, and other health care providers. They offer workshops through area heath education centers, provide investigative and consulting

services to hospitals and actively teach infection control courses at the UNC School of Medicine. SPICE is currently funded by an annual appropriation of $163,000. Representatives from SPICE presented the Subcommittee with an overview of current projects and an outline of what could be accomplished in the way of reducing the number of infections and concomitant health care costs if the program received expanded funding. The Subcommittee finds that an appropriation of $663,000 per year would allow SPICE to expand its services in several ways. Additional funding would allow SPICE to provide assistance to hospitals that are implementing the new infection control interventions recommended by the Institute for Healthcare Improvement. The funding would also provide for regular visitation by SPICE personnel at individual hospitals, the conduct of on-site infection control rounds, and the development of ideal infection control protocols and their publication on the internet for ready access by health care facilities. The Study of the Efficacy of Nosocomial Infection Control showed that high quality infection control programs have helped reduce the number of hospital acquired infections by 7 to 48%. The same study also indicated that those facilities without effective programs saw an increase in infections of 9 to 31%. The Subcommittee finds that the potential reduction in numbers of persons developing infections and resulting reduction in health care costs attributed to such infections warrants the additional funding for SPICE.

RECOMMENDATION 2: FUNDS FOR THE STATEWIDE PROGRAM ON INFECTION CONTROL AND EPIDEMIOLOGY

The House Select Committee on Health Care encourages the General Assembly to enact legislation to increase the funding for the Statewide Program on Infection Control and Epidemiology: "AN ACT TO APPROPRIATE FUNDS FOR THE STATEWIDE PROGRAM ON INFECTION CONTROL AND EPIDEMIOLOGY, AS RECOMMENDED BY THE HOUSE SELECT COMMITTEE ON HEALTH CARE."

IV. SUBCOMMITTEE ON HEALTHCARE WORKFORCE

FINDING 1: NURSING SHORTAGE

Based on information provided in the subcommittee report, the House Select Committee on Health Care makes the following findings:

- There is an emerging shortage of nurses. This demand is driven by increased demand, exacerbated by an aging workforce, and complicated by limitations in educational capacity, including the small percentage of Registered Nurses with graduate work preparation.
- In order to assure optimal nursing resources, the number of new nursing graduates will need to increase by 25% over the 2002-03 number of graduates.
- The North Carolina Center for Nursing is projecting a shortage of 9,000 registered nurses in 2015, and about 18,000 in 2020. The State will not be able to provide all the needed nurses and in fact, by 2020, the State will only be able to provide 81% of the needed nurses.

- One of the primary issues that must be addressed to assure sufficient qualified nurses in the future is the nursing faculty shortage. In North Carolina, the full-time nurse faculty vacancy rates for 2003 were 5.3% in Associate Programs and 7.4% in Baccalaureate Programs. The 2003 part-time nurse faculty vacancy rates were 11.4% and 11.7% respectively. Potential nurse educators are being enticed from teaching by higher compensation in other areas of nursing, especially clinical settings.

- There are 55 Associate Degree Nursing program and 37 Licensed Practical Nursing programs available at 56 of the State's community colleges. The greatest challenge facing the community colleges is the shortage of qualified faculty. Several key factors that are causing the nursing faculty shortage include: "salary, an aging faculty, a lack of MSN programs with an education track/major, lack of access to MSN programs in some geographical areas of the state, and a shortage of flexible and innovative approaches to MSN and higher education including RN to MSN programs in our state.

- Another factor impacting the nursing faculty shortage in the Community College System is that the North Carolina Board of Nursing has decided that all nursing programs must be accredited by a national accrediting agency in nursing by 2015. This means that all nursing faculty in the community colleges will be required to hold a minimum of a master's degree including the part-time faculty in clinical settings. Less than 10% of the nurses in the State today hold a master's, or higher, degree in nursing. Traditionally, the community colleges have employed experienced nurses with a bachelor of science degree in nursing or a master's in other fields as instructors in the classroom and clinical settings.

RECOMMENDATION 1: NURSING FACULTY FELLOWS PROGRAM

The House Select Committee on Health Care encourages the General Assembly to enact a Proposed Committee Substitute for House Bill 1718 Nursing Faculty Fellows Program/Funds, which establishes a scholarship loan program enabling recipients to become full-time nursing teaching faculty: "AN ACT TO ESTABLISH A NURSING FACULTY FELLOWS PROGRAM AND TO APPROPRIATE FUNDS FOR THAT PURPOSE, AS RECOMMENDED BY THE HOUSE SELECT COMMITTEE ON HEALTH CARE."

FINDINGS 2: HEALTH CARE WORKERS/NOVA

Direct care workers are essential to the provision of care and an enhanced quality of life for long-term care consumers, whether they are receiving services provided in a home or community setting, or in an residential or institutional setting; and that North Carolina faces a challenge of attracting and retaining employees to these jobs. "Direct care workers" is a nationally recognized term referring to those paraprofessionals that are employed as nurse aides, personal care aides, personal care attendants, home health aides, in-home aides, habilitation aides, and other assistive personnel who provide hands-on care to individuals.

The 10 fastest growing industries in the State are service producing, and the health services segment was projected to have a fifty-seven percent (57%) increase from 2000-2010. North Carolina Occupational Trends data on Healthcare Support Occupations indicate that the category of Nursing Aides, Orderlies, and Attendants showed 50,120 individuals in 2002, but growth is anticipated to reach 64,760 in 2012. Home Health Aides totaled 22,550 in 2002, and is expected to total 32,720 in 2012.

According to the North Carolina New Organizational Visition Award Project (NOVA), average annual turnover rates for direct care workers in 2004 were as follows: 106% in adult care homes, 107% in nursing homes, and 41% in home care agencies. However, direct care jobs are among the occupations with the largest projected job growth - it is anticipated that North Carolina will need 30,590 additional direct care workers from 2002 to 2012.

Wage data for direct care workers, as of November 2004, follows:

Home Health Aides:	$8.22	(median hourly wage)
Nurse Aides, Orderlies, Attendants:	$9.59	(median hourly wage)
Personal and Home Care Aides:	$8.06	(median hourly wage)
	$8.83	(weighted median hourly wage across categories)

The weighted median hourly wage across the same three categories for 2004 was $8.83, and for 2003, it was $8.67.

The NC NOVA project is a voluntary special licensing award for home care agencies, adult care homes, and nursing homes. It has been funded thus far by The Robert Wood Johnson Foundation and The Atlantic Philanthropies. The focus of NC NOVA is workforce development and retention for direct care workers through a comprehensive, raise the bar, culture change program. Direct care workers include nurse aides, in-home aides/home health aides, and personal care aides/attendants.

The NC NOVA project is an incentive/reward based program with uniform criteria across long-term care settings. NC NOVA is currently being piloted in 60 sites: 20 adult care homes, 20 nursing homes, and 20 home health agencies. The pilot phase lasts from July 2005 until May 2006. Review will be conducted by the Carolinas Center for Medical Excellence, and a special license will be issued for entities meeting the rigorous criteria for the NC NOVA designation. It is anticipated that NC NOVA will benefit providers, workers, and consumers. Legislation is needed to allow statewide implementation in early 2007. State funds are not needed to implement the legislation as the grant contains sufficient funds for operation in FY 2006-2007.

RECOMMENDATION 2: SUPPORT NC NOVA

The House Select Committee on Health Care supports the North Carolina New Organizational Vision Award Program in an effort to address the shortage of direct care workers.

FINDING 3: SHORTAGE OF ALLIED HEALTH PRACTITIONERS/DESIGNATION OF HIGH COST PROGRAMS IN COMMUNITY COLLEGES

There is a shortage of allied health practitioners, including in the areas of physical therapy, speech language pathology, health information management, respiratory care, radiological care, clinical lab sciences, and other allied health professions.

The North Carolina General Assembly directed the State Board of Community Colleges to consider modifications to its funding formulas to ensure that adequate funding is provided for high cost programs. The State Board of Community Colleges submitted the results of its study on January 15, 2005.

A high-cost program is one that is funded apart from the funding formula. The North Carolina Community College System designates two truck driving programs, one marine science program, and one heavy equipment program as high-cost. There is a need to adequately fund high-cost programs and because the Allied Health field is so important in today's economy to designate allied health programs as high-cost.

RECOMMENDATION 3: SUPPORT ALLIED HEALTH AND NURSING PROGRAMS

The House Select Committee on Health Care encourages the General Assembly to support proposals from the North Carolina Community College System to designate allied health and nursing training programs as "high-cost" programs in an effort to assure hiring and retention of qualified faculty and the acquisition of appropriate facilities, equipment, and technology.

FINDING 4: AHEC

The mission of the North Carolina Area Health Education Centers (AHEC) is to meet the State's health workforce needs by providing educational programs through partnerships with academic institutions and health care agencies.

One of AHEC's priorities is improved access to mental health services through five initiatives aimed at achieving this goal: (1) supporting psychiatry residents in public community settings, (2) offering continuing education for mental health professionals, (3) providing an evidence-based practices training center, (4) offering library and information resources for mental health professionals, and (5) presenting new programs to link behavioral health providers to primary care physicians and others. AHEC's future plans also include expanding residency training in the area of psychiatry.

RECOMMENDATION 4: SUPPORT AHEC FUNDING PRIORITIES REGARDING MENTAL HEALTH

The House Select Committee on Health Care encourages the General Assembly to support the funding priorities proposed by the North Carolina Area Health Education Centers (AHEC) with regard to developing new models for preparing mental health professionals to practice in the reformed mental health system, and linking primary care professionals to behavioral health professionals in new models of care at the community level.

V. SUBCOMMITTEE ON ACCESS

FINDING 1:

Federally Qualified Health Centers are community and migrant health centers that receive federal funds to provide health care to underserved populations.

- 279,000 patients were served at 74 service delivery sites in 54 counties (2004)

Rural Health Centers through the Office of Research, Demonstrations, and Rural Health assist underserved rural communities and populations by providing access to primary medical services for all persons regardless of their ability to pay.

- 84 centers (32 centers funded by the State)
- 124,144 unduplicated users of state-funded rural health centers

Local Health Departments provide quality health care services when not otherwise available.

- 85 local health departments (79 single counties)
- Served 641,601 patients of which 260,603 were uninsured (2003)
- 58 have capacity to provide comprehensive primary care

Free Clinics are private, non-profit organizations supported primarily by cash and in-kind contributions.

- Over 8,000 volunteers including 2000 MDs, 1500 RNs, 350 DDS
- Over 60 free clinics or free pharmacies serving 48 communities both rural and urban
- Over 81,000 patients served (2004)

School-based or School linked health centers were founded in communities with high at-risk populations as a direct result of identified needs for access to adolescent and child health care.

- 50 centers in 22 counties
- State funds 28 centers which reported 14,709 enrolled student patients with 105,774 service visits provided (2005)

Area Health Education Centers (AHEC) improve access to healthcare by supporting primary care residency programs, student training in communities, programs to improve the diversity of the health workforce, programs to keep health professionals current, programs to take clinical services to North Carolina communities.

- Trained 430 Family Physicians in AHEC Residencies
- Over 35,400 uninsured patients were seen as outpatients in AHEC clinics (2003)

Hospitals by mission provide services necessary, within available resources, for the community.

- 130 general acute care hospitals operating 109 emergency rooms (ER)
- Required by law to screen anyone who request treatment at the ER, regardless of ability to pay
- Survey of hospitals found 22% of patients seeking care in the ER were uninsured (2003)

RECOMMENDATION 1: EXPAND COMMUNITY HEALTH CARE GRANTS

The House Select Committee on Health Care encourages the General Assembly to appropriate fifteen million dollars ($15,000,000) to the Department of Health and Human Services, Office of Research, Demonstrations, and Rural Health Development for a grant program to assist federally qualified health centers, rural health centers, free clinics, public health departments, and other non-profit organizations that provide primary or preventive medical services to uninsured or medically indigent patients: "AN ACT TO APPROPRIATE FUNDS TO THE DEPARTMENT OF HEALTH AND HUMAN SERVICES, OFFICE OF RESEARCH, DEMONSTRATIONS, AND RURAL HEALTH DEVELOPMENT, FOR A GRANT PROGRAM TO ASSIST IN THE PROVISION OF PRIMARY AND PREVENTIVE MEDICAL SERVICES TO UNINSURED OR MEDICALLY INDIGENT PATIENTS, AS RECOMMENDED BY THE HOUSE SELECT COMMITTEE ON HEALTH CARE."

FINDINGS 2:

During the March 16, 2006 Subcommittee meeting, Dr. Mark Holmes with the North Carolina Institute of Medicine (NC IOM) , shared information on establishing a high risk insurance pool for people with pre-existing conditions. According to Dr. Holmes presentation, Blue Cross and Blue Shield of North Carolina is the only insurer to voluntarily offer health insurance coverage to any individual regardless of health status.

According to the NC IOM presentation, 33 other states have high-risk pools to help subsidize the cost of insurance provided to high-cost individuals. Dr. Holmes indicated that the Deficit Reduction Act makes some federal funds available to help support a high-risk pool. The NC IOM recommends that the North Carolina General Assembly enact legislation to implement a high risk pool.

House Bill 1525 Establish NC Health Insurance Risk Pool was introduced in the House and referred to the House Committee on Insurance on April 21, 2005. A subcommittee of the House Committee on Insurance has reviewed the bill and has recommended modifications.

RECOMMENDATION 2: HIGH-RISK POOL

The House Select Committee on Health Care encourages the General Assembly to enact legislation to implement a health insurance high-risk pool: "AN ACT TO ESTABLISH THE NORTH CAROLINA HEALTH INSURANCE RISK POOL AND TO APPROPRIATE FUNDS THEREFOR, AS RECOMMENDED BY THE HOUSE SELECT COMMITTEE ON HEALTH CARE."

FINDING 3: HEALTH CARE SYSTEM

During the March 28, 2006 Subcommittee meeting, with information based on comments and presentations from previous meeting, Co-chair Verla Insko shared the following resolution:

Whereas:

Nations that assure health care for all spend significantly less per capita and as a percentage of GDP on healthcare than the U.S., and

In many of these nations a basic healthcare plan for all residents effectively coexists with supplemental private sector plans, and

These same nations have health care systems that achieve better healthcare outcomes than those achieved in the U.S., and

The healthcare outcomes in North Carolina are considered at or below average when compared to other states in the nation, and

Investing in a healthcare model that covers all North Carolinians and includes early intervention and personal responsibility will reduce state health expenditures while improving healthcare outcomes and will make North Carolina's business climate more appealing while making North Carolina Businesses more competitive in the global market, and,

Our current system leads hospitals to spend millions of dollars on emergency department improvements that lead to higher hospital admissions while proven, more cost effective, early intervention models struggle for funding, and

The large and growing numbers of the uninsured are left out of the medical expense bargaining process,

Our current healthcare system requires the uninsured to pay at higher rates than the insured, and

North Carolinians overwhelmingly believe the General Assembly should assure all North Carolinians have access to health care, and

We have a unique opportunity where creating a just health care system will provide significant economic advantages to the State, it's residents and to North Carolina businesses.

RECOMMENDATION 3: HEALTH CARE FOR NORTH CAROLINIANS

The House Select Committee on Health Care encourages the General Assembly to study the establishment of a formal plan for transitioning from our current fragmented system of delivering health care to a system that covers all North Carolinians: "AN ACT TO CREATE A JOINT COMMISSION TO STUDY ESTABLISHING A FORMAL PLAN FOR TRANSITIONING FROM THE CURRENT SYSTEM OF DELIVERING HEALTH CARE TO A SYSTEM THAT COVERS ALL NORTH CAROLINIANS, AS RECOMMENDED BY THE HOUSE SELECT COMMITTEE ON HEALTH CARE."

VI. SUBCOMMITTEE ON THE STATE HEALTH PLAN

FINDING 1: STATE HEALTH PLAN OVERVIEW

The Teachers' and State Employees Comprehensive Health Plan (State Health Plan) is an approximately $2 billion a year health benefit plan operation that provides health benefit coverage to some 590,000 active employees and retired employees of State Agencies, Universities, Local Public Schools, and Local Community College institutions. The Plan also covers eligible dependents active and retired employees. The Plan, similar to other public and private employer sponsored health benefit plans, has been experiencing annual double digit growth in medical claims costs in recent years due to increasing utilization of medical care by plan members and rising costs particularly in the area of outpatient prescription drugs and outpatient medical services.

During the 2005 Session the Plan reported to the General Assembly that it was facing a $483 million shortfall for the 2005-2007 biennium. The 2005 Session of the General Assembly overcame this shortfall by raising premium rates by 12.3% ($383 million) and reduced plan member benefits ($100 million) by increasing out-of-pocket requirements to plan members.

The growth rate in medical claims costs is currently projected by the Plan to be 11% annually. Increasing costs and utilization for medical services and prescription drugs continue to drive overall claims trends. The Plan's current demographics are weighted toward members requiring greater utilization of medical care. Data from the Plan indicates that the costliest age groups under the Plan are growing the fastest in terms of enrollment growth and claims costs. Rising premiums for dependent coverage paid fully by the employee or retired employee is causing younger and/or healthier plan members to select alternative health benefit coverage outside the Plan at lesser premium rates. The resulting adverse selection is thought to be leaving the Plan with more costly plan members in terms of utilization of care and causing the Plan to lose "good risk" over time.

In response to legislation enacted by the 2005 General Assembly, the Executive Administrator of the Plan was authorized to explore offering health benefit coverage under alternative programs to the self-insured indemnity program. The Executive Administrator

of the Plan, George C. Stokes has reported that the Plan intends to offer members a three option preferred provider network alternative beginning in the Fall of 2006.

FINDING 2: INTEGRATED HEALTH MANAGEMENT INITIATIVE

The State Health Plan reports that it is adopting a strategy to proactively improve the long-term health of plan members by lessening the estimated $1.1 billion financial impact of chronic disease on the Plan as estimated by the Plan's Executive Administrator. The Plan is implementing the "Health Smart Initiative." This initiative is designed to empower plan members to stay healthy and to help those with chronic disease or disease risk factors better manage their health care.

According to Plan staff, every 1% decline in healthy plan members results in an additional $68 million of health care expenses to the Plan and that the percent of healthy plan members is decreasing by almost 2% a year. Moreover, this decline is driving increases in medical claims for chronic illness and rising pharmacy costs and utilization. The Plan also claims that worsening these trends is the lack of primary care coordination for chronic disease and preventive services, and lifestyle choices in the form of poor nutrition, physical inactivity, and tobacco use.

FINDING 3: STAKEHOLDER GROUPS

The Committee makes the following findings based on information provided by major associations representing the State Health Plan's employees and retired employees:
NCAE: It is cost prohibitive for many staff members who make salaries below the poverty level to cover their children and families through the State Health Plan.

NCAE suggested the following recommendations based on feedback from its membership:

- Continue to creatively find ways to lower premiums;
- Minimize out-of-pocket increases to plan members in the form of deductibles, co-insurance, and co-payments for office visits and prescription drugs;
- Consider lower co-payments on drugs;
- Consider a "Spouse only" premium rate category;
- Improve wellness benefits offered;
- Continue to develop the Preferred Provider Option (PPO);
- Maintain annual autumn open enrollment period for self-insured indemnity program and establish the same open enrollment timeframe for the PPO program;
- Maintain the self-insured indemnity program as a plan member option;
- Maintain full funding of employee and retired employee premiums.

SEANC: The State Health Plan is second in importance only to salary as part of an employee's total compensation. Further, the Plan is critical to the State's ability to compete

with the private sector in recruiting and retaining a professional work force to serve our State's citizens.

SEANC's recommendations included:

- Funding: The State Health Plan is under funded and needs additional appropriations because health care costs have increasingly been shifted to employees;

- Dependent Coverage: The State pays nothing toward dependent coverage and employees of the state pay over 50% more for dependent coverage than their counterparts in the Southeast. (Source: Office of State Personnel).

- Dental and Vision Benefits: The State Health Plan does not offer dental or vision benefits, which are frequently included in plans offered by large employers.

- Health Maintenance: A wellness benefit of $150 added to the State Health Plan about eight years ago has never been adjusted for medical inflation averaging 8-10% annually. This benefit should be increased to $300 per year and could be modified to provide each employee with $300 annually to purchase dental and/or vision care.

- Maximum Out-of-Pocket (Stop-Loss): An absolute cap inclusive of co-pays is needed to ensure that total expenses in any given year do not exceed a specified limit. Due to the numerous co-pays, one SEANC member in Morganton spent more than $12,000 out-of-pocket for medical care after an accident, while a cancer patient in Wayne County spent more than $5,000 in out-of-pocket expenses.

- Eligibility for Health Benefit Coverage as a Retired Employee: Current plan provisions allow a person to work only five years for the state, leave for private employment and retire at age 60 with free health insurance for life, the same benefit as those who dedicate their entire career to state service.

- Plan Year: The State Health Plan year needs to be changed to a calendar year. Currently, Medicare-eligible retirees must keep two different sets of books to track deductibles and co-pays, one for Medicare and one for the State Health Plan. This is an unnecessary burden for seniors.

RGEA: Approximately 70% of the members are retired teachers or state employees who are covered by the State Heath Plan. The majority of the members is age 65 or older and, therefore, has Medicare for their primary health insurance coverage. However, the State Health Plan provides secondary coverage, picking up as much as 80% of the eligible health care costs that are not paid by Medicare. More important for State retirees is the fact that the State Health Plan provides primary prescription drug coverage even for members who are age 65 or older. As a result, our state retirees have not had to enroll in the recently implemented Medicare Part D Prescription Drug Plan thereby saving an average of $35 per month in Medicare premiums.

Maintaining the benefits of the State Health Plan has become the top priority issue during the past few years for our members who are retired teachers and state employees. While our members take a keen interest in pension benefit increases, we now receive more calls and questions from members about legislative actions affecting the State Health Plan.

RGEA recommendations include:

- Provide a "Spouse Only" premium category under dependent coverage;
- Non-Preferred Prescription Drugs -- expedite the approval for inclusion on the preferred drug list any commonly used prescription drugs.
- Avoid increasing level of Annual Deductible
- Include Medicare eligible retired employees and their dependents under the Plan's Health Smart Initiative.

RECOMMENDATION FOR FINDING NO. 3:

The House Select Committee on Health Care recommends that the General Assemblly review the State's policy of allowing current employees who retire with a minimum of 5 years of contributory retirement service to be eligible for non-contributory health benefit coverage by the State. The Committee further recommends that the General Assembly review the option of changing eligibility for non-contributory health benefit coverage as a retired employee, for those future employees first hired on or after October 1, 2006, to a schedule that requires a retired employee participating in a State sponsored health benefit plan to be eligible for a State contribution toward the premium required for health benefit coverage on the following schedule:

Years of Service Contributory Retirement Svc.	Percent State Contribution To Premium	Percent Employee Contribution To Premium
5 up to 10 years	0%	100%
10 up to 20 years	50%	50%
20 years +	100%	0%

The Committee recommends that review of this potential policy change include the actuarial analysis of bills currently proposing a similar policy change and also any available information on the potential financial effect changing this policy may have on the reporting of liabilities associated with the cost of retired employee health benefits as specified in coming Governmental Accounting Standards Boards guidelines.

FINDING 4: <u>Private Sector Approaches</u>

Many companies in the private sector are addressing the delivery of employer-sponsored health benefits to their employees. Information provided by three of North Carolina's most

prominent private corporate sector companies, BB&T, Capitol Broadcasting, and SAS Institute, indicate that each company has progressively incorporated some form of wellness and disease management activity effort for over twenty years. Capitol Broadcasting and BB&T representatives discussed financial incentives provided to employees to encourage them to be screened for chronic diseases and to participate in programs designed to manage those diseases. The SAS Institute representative spoke extensively on their efforts to reduce absenteeism and improve productivity of its employees by giving them comprehensive primary care and wellness management at the worksite. Following are excerpts from each company representative:

BB&T Corp

- A voluntary wellness initiative, called "LifeForce," which has been in effect nearly 20 years. Under this program, which 75% of BB&T workers participate in, employees get a basic physical examination from a nurse practitioner twice a year. Also, once a year very comprehensive blood panels are done. The bank pays for the cost of LifeForce (except for the blood work, which is paid for by the employee) and workers get their physicals on company time. Mr. Sapp said that the program focuses on diet/weight, cardiovascular health, early detection and substance abuse (especially smoking; a smoker can enter the program but can not reach its highest levels without quitting – as a result many employees have given up smoking). Mr. Sapp said that BB&T has found that LifeForce participants "incur about 20% lower medical costs and less absenteeism from medically related reasons than the rest of our employees." The bank passes these lower costs on to its workers. Mr. Sapp stated that an individual employee saves about $500 a year and families about $1,000 in health costs. He noted that, even with this "significant economic incentive" and even with many attempts by the company to reach 100% participation, 25% of company employees do not participate.

- A disease management program for employees not participating in LifeForce. Mr. Sapp said that all workers not in the wellness program "must complete a health questionnaire and have a blood panel to remain in the bank's health plan" (BB&T pays the full cost of the blood work). This information is sent to an outside vendor, independent of the bank. If warranted by the results of the questionnaire and/or blood panel, the vendor contacts the employee and suggests a course of treatment (e.g., see a doctor). If the employee fails to follow the recommended course of treatment, their health benefits insurance deductible is raised, but they are not removed from the bank's health plan.

- "Shifting costs to those who use the system the most." Mr. Sapp referred to studies that show that "about 15% of BB&T employees account for 80% of medical costs." He said that these "high cost users" fall into three categories: (1) "Over users or abusers who do not personally manage their health care costs"; (2) "Early under users who become later heavy users" because they do not get medical care soon enough"; and (3) "People that get sick" – which BB&T can not do anything to

prevent. While nothing can be done about the last category, Mr. Sapp said that the "first two deserve management." To reduce overuse of health care services, Mr. Sapp said that BB&T has raised insurance co-payments to $30 for a doctor's visit and $40 for specialists, while also increasing prescription drug co-pays and adding significant incentives to use generics. The result: "People cut down health care costs on their own," Mr. Sapp said, and this has reduced the bank's costs - $10 million in savings have been generated by these cost shifts. He added: "A number of people waste medical services when they are 'free."

- Creating Health Savings Accounts (HSAs). Mr. Sapp referred to a preliminary study which he said indicates that BB&T employees "with higher deductibles incur less medical expenses and less medically related absenteeism." He acknowledged that this may be partly caused by selection, but he added that it also suggests that "people will manage their health care costs rationally when they have to incur the cost personally."

SAS Institute: Established in 1980, SAS has a self-funded indemnity plan. They added a PPO option in 2004. The PPO has lower cost sharing. If the employee stays in the network the employee pays no deductible – there is a "heavy deductible" if the employee goes outside of the network. SAS pays the employee's share of the premium for both plans. Employees pay a specified amount ($100 to $150/month for the indemnity plan; $75/$110 for the PPO) for dependent/family coverage plus 20% co-insurance for the indemnity plan and $10/$20 co-pays for the PPO. Both plans have out-of-pocket maximums of $500 for individuals and $1,000 for dependents/families. Both plans offer 100% coverage (no co-pays or co-insurance) of wellness benefits, including well-child exams for the first 14 months.

The SAS employee prescription drug plan has no formulary. SAS believes that "the provider is the best judge of what medications a patient needs," said Ms. Adcock. There is limited use of prior authorization and medical necessity verification. SAS gives financial incentives for employees to choose generic drugs and use mail order.

SAS also covers chiropractic, massage therapy and acupuncture services (SAS pays 80% after the deductible is met; there is a combined $3,600 annual limit for these 3 services).

Central to the SAS health care benefit system is their Health Care Center (HCC) (opened in 1984, recently expanded to 34,000 square feet). The HCC has a staff of 59, including 4 physicians, 10 nurse practitioners, other nurses, a psychologist, and lab technicians. 65% of the 4,200 SAS employees (and 6,000 dependents) who work in the Cary headquarters receive their primary care through the HCC. The other 35% receive complementary or wraparound care there. SAS accepts the fact that an employee will have to leave his or her desk to go to the HCC, said Ms. Adcock, but they usually have a round trip of only 30 minutes for a visit. SAS provides numerous disease management and health education programs through the HCC. "It is always cheaper to prevent illness and disability than to treat it," she added.

Capitol Broadcasting Corporation: Offers more choices for coverage. Currently, employees have PPO, HMO and point-of-service (POS) options.

- Providing employees with a "health advocate" who is available to help them "maneuver through a complex medical system." The health advocate gives employees advice on finding health care services, including identifying appropriate specialists or facilities.

For 20 years, CBC has sponsored employee health fairs to actively encourage healthier lifestyles for its employees. The health fair is administered by WakeMed and has three phases:

- Phase I – employees complete a health risk assessment and get tested to measure cholesterol, triglycerides, glucose, height/weight, blood pressure, etc.
- Phase II – WakeMed compiles the test results and meets with the employee to discuss what lifestyle changes the employee needs to make. The employee's wellness profile results are sent to the employee's primary care provider.
- Phase III – employees go to WakeMed for a full physical examination, including mammograms and other screenings and fitness and nutrition work.

To improve employee participation CBC offers a financial incentive. CBC pays the employees' health insurance premium if the employee participates in a health fair. If the employee does not participate, they must pay 20% of the premium cost. CBC also pays nearly 2/3 of the cost of dependent coverage.

FINDINGS 5: HEALTH SAVINGS ACCOUNTS AND HEALTH REIMBURSEMENT ACCOUNTS

Health Savings Accounts (HSAs) and Health Reimbursement Accounts(HRAs) are ways to provide health benefits at a lower cost. One of the advantages of an HSA is its portability. HSAs make "individuals responsible for more of their own care," making people smarter consumers of health care services.

Unlike HSAs, which emphasize employee control of health benefits, HRAs are an option that gives more control to employers. An HRA is a "consumer-directed health plan (CDHP)" in which a business can give employees financial incentives to encourage employees to get health risk assessments and then make the lifestyle changes necessary to improve health and reduce the utilization of medical services. HRAs are modeled after flexible spending accounts – except that in an HRA unused funds may be rolled forward to future years. HSAs use the employees' money (although employers can contribute). Only employers contribute to an HRA and the employer designs the benefit plan.

According to Aon Consulting, there were 3 million plan participants in 2005 and that number is expected to double in 2006. Several states are offering HSA options to state and

local government employees. Aon further states that health care costs are growing at a slower rate in HSAs than in traditional PPOs.

FINDING 6: UNC-SYSTEM COMMENTS

According to Ms. Kitty McCollum, Associate Vice President of Human Resources of University of North Carolina – General Administration, The UNC system has made efforts to improve health benefits coverage for its employees. UNC wants to give new State Health Plan Executive Administrator George Stokes "a chance to improve" the Plan. So far, they are impressed with Mr. Stokes' efforts, including the professionals he has added to the Plan's staff and the outreach that he and his staff have made to Plan "customers," including UNC, to get input. UNC hopes that Mr. Stokes will take what it has learned and use it to improve the State Health Plan.

VII. OTHER COMMITTEE RECOMMENDATIONS

1. The House Select Committee on Health Care recommends that the General Assembly enact "AN ACT TO REENACT THE LONG TERM CARE INSURANCE TAX CREDIT, AS RECOMMENDED BY THE HOUSE SELECT COMMITTEE ON HEALTH CARE."
2. The House Select Committee on Health Care recommends that the General Assembly enact "AN ACT TO PROVIDE FOR THE REPORTING OF DETAILS OF SETTLEMENTS OF MEDICAL MALPRACTICE CLAIMS, AS RECOMMENDED BY THE HOUSE SELECT COMMITTEE ON HEALTH CARE."
3. The House Select Committee on Health Care recommends that the General Assembly enact "AN ACT TO ALLOW FOR PAYMENT OF FUTURE EXPENSES ARISING FROM MEDICAL MALPRACTICE ACTIONS TO BE BY PERIODIC PAYMENTS, AS RECOMMENDED BY THE HOUSE SELECT COMMITTEE ON HEALTH CARE."
4. The House Select Committee on Health Care recommends that the General Assembly enact "AN ACT TO MODIFY APPEAL BONDS IN MEDICAL MALPRACTICE ACTIONS, AS RECOMMENDED BY THE HOUSE SELECT COMMITTEE ON HEALTH CARE."
5. The House Select Committee on Health Care recommends that the General Assembly enact "AN ACT TO ALLOW FOR BIFURCATION OF ISSUES OF LIABILITY AND DAMAGES IN MEDICAL MALPRACTICE ACTIONS, AS RECOMMENDED BY THE HOUSE SELECT COMMITTEE ON HEALTH CARE."

PROPOSED LEGISLATION

Following are the legislative proposals recommended by the subcommittees and accepted by the House Select Committee on Health Care at its April 11, 2006 meeting. The House Select Committee recommends that the General Assembly consider the following legislative proposals:

"AN ACT TO PROVIDE THAT THE COUNTY SHARE OF THE NONFEDERAL SHARE OF MEDICAID COSTS FOR THE 2006-2007 FISCAL YEAR SHALL NOT EXCEED THE COUNTY SHARE PAID BY EACH COUNTY FOR THE 2005-2006 FISCAL YEAR; TO APPROPRIATE FUNDS TO COVER THE COST TO THE GENERAL FUND OF CAPPING THE COUNTY SHARE; TO APPLY THE CAP BEGINNING WITH THE 2006-2007 FISCAL YEAR AND THEREAFTER; AND TO PROVIDE FOR FURTHER REDUCTION IN THE COUNTY SHARE ON A TARGETED BASIS USING SAVINGS REALIZED FROM THE MEDICARE PART D PROGRAM, AS RECOMMENDED BY THE HOUSE SELECT COMMITTEE ON HEALTH CARE."

"AN ACT TO PROVIDE FOR THE IDENTIFICATION OF PRIMARY STROKE CENTERS; TO DISSEMINATE INFORMATION TO THE GENERAL PUBLIC AND EMERGENCY CARE PROVIDERS ABOUT THE LOCATION OF PRIMARY STROKE CENTERS; AND TO FACILITATE APPROPRIATE EMERGENCY STROKE CARE, AS RECOMMENDED BY THE HOUSE SELECT COMMITTEE ON HEALTH CARE."

"AN ACT TO MAKE CHANGES TO THE STATUTORY BASIC AND STANDARD HEALTH PLANS FOR SMALL EMPLOYERS, AS RECOMMENDED BY THE HOUSE SELECT COMMITTEE ON HEALTH CARE.

"AN ACT TO STRENGTHEN THE AUTHORITY OF THE NORTH CAROLINA MEDICAL BOARD TO DISCIPLINE PHYSICIANS AND CERTAIN OTHERS AUTHORIZED TO PRACTICE MEDICINE IN ORDER TO IMPROVE PATIENT SAFETY, AS RECOMMENDED BY THE HOUSE SELECT COMMITTEE ON HEALTH CARE."

"AN ACT TO APPROPRIATE FUNDS FOR THE STATEWIDE PROGRAM ON INFECTION CONTROL AND EPIDEMIOLOGY, AS RECOMMENDED BY THE HOUSE SELECT COMMITTEE ON HEALTH CARE."

"AN ACT TO ESTABLISH A NURSING FACULTY FELLOWS PROGRAM AND TO APPROPRIATE FUNDS FOR THAT PURPOSE, AS RECOMMENDED BY THE HOUSE SELECT COMMITTEE ON HEALTH CARE."

"AN ACT TO APPROPRIATE FUNDS TO THE DEPARTMENT OF HEALTH AND HUMAN SERVICES, OFFICE OF RESEARCH, DEMONSTRATIONS, AND RURAL HEALTH DEVELOPMENT, FOR A GRANT PROGRAM TO ASSIST IN THE PROVISION OF PRIMARY AND PREVENTIVE MEDICAL SERVICES TO UNINSURED OR MEDICALLY INDIGENT PATIENTS, AS RECOMMENDED BY THE HOUSE SELECT COMMITTEE ON HEALTH CARE."

"AN ACT TO ESTABLISH THE NORTH CAROLINA HEALTH INSURANCE RISK POOL AND TO APPROPRIATE FUNDS THEREFOR, AS RECOMMENDED BY THE HOUSE SELECT COMMITTEE ON HEALTH CARE."

"AN ACT TO CREATE A JOINT COMMISSION TO STUDY ESTABLISHING A FORMAL PLAN FOR TRANSITIONING FROM THE CURRENT SYSTEM OF DELIVERING HEALTH CARE TO A SYSTEM THAT COVERS ALL NORTH CAROLINIANS, AS RECOMMENDED BY THE HOUSE SELECT COMMITTEE ON HEALTH CARE."

"AN ACT TO REENACT THE LONG-TERM CARE INSURANCE TAX CREDIT, AS RECOMMENDED BY THE HOUSE SELECT COMMITTEE ON HEALTH CARE."

"AN ACT TO PROVIDE FOR THE REPORTING OF DETAILS OF SETTLEMENTS OF MEDICAL MALPRACTICE CLAIMS, AS RECOMMENDED BY THE HOUSE SELECT COMMITTEE ON HEALTH CARE."

"AN ACT TO ALLOW FOR PAYMENT OF FUTURE EXPENSES ARISING FROM MEDICAL MALPRACTICE ACTIONS TO BE BY PERIODIC PAYMENTS, AS RECOMMENDED BY THE HOUSE SELECT COMMITTEE ON HEALTH CARE."

"AN ACT TO MODIFY APPEAL BONDS IN MEDICAL MALPRACTICE ACTIONS , AS RECOMMENDED BY THE HOUSE SELECT COMMITTEE ON HEALTH CARE."

"AN ACT TO ALLOW FOR BIFURCATION OF ISSUES OF LIABILITY AND DAMAGES IN MEDICAL MALPRACTICE ACTIONS , AS RECOMMENDED BY THE HOUSE SELECT COMMITTEE ON HEALTH CARE."

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2005

H D

HOUSE DRH30399-LNz-228 (3/28)

Short Title: Cap Medicaid County Share. (Public)

Sponsors:

Referred to:

A BILL TO BE ENTITLED

AN ACT TO PROVIDE THAT THE COUNTY SHARE OF THE NONFEDERAL SHARE OF MEDICAID COSTS FOR THE 2006-2007 FISCAL YEAR SHALL NOT EXCEED THE COUNTY SHARE PAID BY EACH COUNTY FOR THE 2005-2006 FISCAL YEAR; TO APPROPRIATE FUNDS TO COVER THE COST TO THE GENERAL FUND OF CAPPING THE COUNTY SHARE; TO APPLY THE CAP BEGINNING WITH THE 2006-2007 FISCAL YEAR AND THEREAFTER; AND TO PROVIDE FOR FURTHER REDUCTION IN THE COUNTY SHARE ON A TARGETED BASIS USING SAVINGS REALIZED FROM THE MEDICARE PART D PROGRAM, AS RECOMMENDED BY THE HOUSE SELECT COMMITTEE ON HEALTH CARE.

The General Assembly of North Carolina enacts:

SECTION 1. Notwithstanding any other provision of law to the contrary, each county's portion of the nonfederal share of Medical Assistance Program costs, excluding administrative costs, for the 2006-2007 fiscal year and thereafter, shall not exceed the amount paid by the county for the nonfederal share of Medical Assistance Program costs, excluding administrative costs, for the 2005-2006 fiscal year. The limitation on the county share shall be in effect regardless of growth in Medical Assistance Program expenditures for the 2007-2008 fiscal year and thereafter.

SECTION 1.(a) There is appropriated from the General Fund to the Department of Health and Human Services, Division of Medical Assistance, the sum of thirty million three hundred ninety thousand dollars ($30,390,000) for the 2006-2007 fiscal year to cover the increased cost to the State resulting from the cap on county share required by this section. These funds shall be allocated from savings realized in the State Medical Assistance program from the Medicare Part D federal program for the 2006-2007 fiscal year.

The General Assembly recognizes that in future years there will not be sufficient savings from Medicare Part D to cover the increased costs to the State resulting from capping the county share at the 2005-2006 fiscal year level. It is the intent of the General Assembly to appropriate additional funds to cover these costs in future fiscal years.

SECTION 2. There is appropriated from the General Fund to the Department of Health and Human Services, Division of Medical Assistance, the sum of thirty-four million six hundred ten thousand dollars ($34,610,000) for the 2006-2007 fiscal year. These funds shall be allocated from savings realized from the Medicare Part D federal program for the 2006-2007 fiscal year. The Department shall allocate these funds to reduce the county share of the nonfederal share of Medical Assistance Program expenditures, as follows:

(1) Forty percent (40%) shall be allocated among counties with a Medicaid eligible population of twenty-five percent (25%) or greater of the total county population. The allocation shall be based on a county's percentage of the total Medicaid budget for all counties with a Medicaid eligible population of twenty-five percent (25%) or greater.

(2) Fifty-five percent (55%) shall be allocated among counties with a Medicaid eligible population of at least fifteen percent (15%) but less than twenty-five percent (25%) of the total county population. The allocation shall be based on a county's percentage of the total Medicaid budget for all counties with a Medicaid population of at least fifteen percent (15%) but less than twenty-five percent (25%).

(3) Five percent (5%) shall be allocated to counties with a Medicaid population of less than fifteen percent (15%) of the total county population. The allocation shall be based on a county's percentage of the total Medicaid budget for all counties with a Medicaid population of less than fifteen percent (15%).

Funds allocated under this section may be increased to reflect growth in Medicaid expenditures for the preceding fiscal year. It is the intent of the General Assembly to appropriate additional funds to cover these costs in future fiscal years.

SECTION 3. This act becomes effective July 1, 2006.

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2005

H D

HOUSE DRH30403-LNz-234 (4/13)

Short Title:	Primary Stroke Centers.	(Public)
Sponsors:	Representatives	
Referred to:		

A BILL TO BE ENTITLED

AN ACT TO PROVIDE FOR THE IDENTIFICATION OF PRIMARY STROKE CENTERS; TO DISSEMINATE INFORMATION TO THE GENERAL PUBLIC AND EMERGENCY CARE PROVIDERS ABOUT THE LOCATION OF PRIMARY STROKE CENTERS; AND TO FACILITATE APPROPRIATE EMERGENT STROKE CARE, AS RECOMMENDED BY THE HOUSE SELECT COMMITTEE ON HEALTH CARE.

Whereas, stroke is one of the leading causes of long-term disability; and

Whereas, as many as twenty-five percent of stroke survivors are permanently disabled; and

Whereas, stroke is the third leading cause of death in North Carolina; and

Whereas, North Carolina is situated in the country's "Stroke Belt," with North Carolina ranking fourth in the nation for stroke-related death; and

Whereas, 5,000 North Carolinians die of stroke each year; and

Whereas, nearly thirty percent of all people who have strokes are younger than 65 years of age; and

Whereas, as the population of North Carolina ages, death and disability from stroke will increase dramatically if this State does not implement strategies based on sound research that will improve the outcomes of stroke victims across this State; and

Whereas, the Institute of Medicine of the National Academy of Science has recommended the establishment of coordinated systems of care as a means of improving the level of medical treatment that patients receive; and

Whereas, in agreement with the Institute of Medicine report, national medical experts from a wide range of disciplines have concluded that improving the organization of stroke care through the development of statewide stroke care systems offers one means of reducing the burden of stroke on a community basis; and

Whereas, there has not been an appreciable change in the organization of stroke care in the State over recent years; Now, therefore,

The General Assembly of North Carolina enacts:

SECTION 1. Chapter 131E of the General Statutes is amended by adding the following new Article to read:

"Article 18.

"North Carolina Stroke Systems Act.

"**§ 131E-318. Scope and definitions.**

(a) Nothing in this act limits or otherwise impairs the authority of a hospital licensed in this State to provide services it is licensed or otherwise authorized to provide under this Chapter or other applicable State or federal law.

(b) As used in this Article, the term:

(1) 'Primary stroke center' means a hospital in this State that is recognized by a national medical accreditation association as a primary stroke center and includes a hospital identified by the Department as a primary stroke center.

(2) 'Emergency medical dispatcher' has the same meaning as in G.S. 131E-155.

(3) 'Emergency medical services systems' means providers of emergency medical services as described in G.S. 143-507.

(4) 'Peer review committee' means an emergency medical services peer review committee as defined in G.S. 131E-155.

"**§ 131E-319. Identification of primary stroke center hospitals.**

(a) The Department shall implement a system for identifying and disseminating information about the location of hospitals in this State that are recognized as primary stroke centers by a national medical accreditation association such as the Joint Commission on Accreditation of Healthcare Organizations ('JCAHO'). In implementing the identification system, the Department shall do the following:

(1) Develop a procedure for a hospital to apply for identification as a primary stroke center. The Department may develop materials designed to assist a hospital in qualifying for identification as a primary stroke center.

(2) Identify a hospital as a primary stroke center if the hospital has applied for identification, has current JCAHO Certificate of Distinction as a primary stroke center, or its equivalent, and has otherwise complied with this act and rules of the Department. The Department shall not limit the number of hospitals that may be identified as primary stroke centers.

(b) A hospital may use the term 'primary stroke center' in its published materials only if the Department has identified the hospital as a primary stroke center in accordance with this Article.

(c) The Department may publish a list of identified primary stroke centers on the Department's Web site. A primary stroke center identified by the Department may decline to be listed on the Department's Web site. If the Department publishes the list on

its Web site, then the Department shall also publish a list of all hospitals in the State that have an established stroke plan as provided in G.S. 131E-320, but that are not primary stroke centers and notify all hospitals in the State:

(1) Of the qualifications necessary for a hospital to be identified as a primary stroke center;

(2) Of the procedure for applying for identification as a primary stroke center; and

(3) That the identified hospital has a right but is not required to be listed on the Department's Web site as a primary stroke center.

(d) The Department shall send a list of primary stroke centers and their locations to all emergency medical services providers.

(e) Except as otherwise provided in this subsection, identification of a hospital as a primary stroke center terminates on the date the hospital ceases to qualify for the identification in accordance with rules adopted by the Department. A hospital identified as a primary stroke center that ceases to qualify for identification may continue to use the identification if the hospital:

(1) Reasonably expects to qualify for the identification within six months after the date the hospital ceases to qualify for identification; and

(2) Notifies the Department and each emergency medical services provider located in the region for which the hospital provides primary stroke services of the temporary lapse in qualification and the expected date of qualification as a primary stroke center.

(f) A hospital whose identification as a primary stroke center has terminated shall notify the Department and each emergency medical services provider in the region that the hospital serves that the hospital's qualification as a primary stroke center has terminated. A hospital that loses identification as a primary stroke center may reapply for identification.

"**§ 131E-320. Hospitals not identified as primary stroke centers.**

A hospital that is not identified as a primary stroke center shall develop a plan indicating the hospital's procedures for providing emergent care for stroke patients. The plan shall include the circumstances under which a stroke patient may be transferred to a primary stroke center for emergent care and shall identify primary stroke centers available to advise the hospital upon its request regarding stroke patient management.

"**§ 131E-321. Prehospital medical services for stroke victims.**

(a) Emergency medical services systems that utilize emergency medical dispatchers shall use written diagnostic algorithms and protocols to facilitate the rapid identification of possible stroke victims and the rapid dispatch of appropriate prehospital providers.

(b) Emergency medical services systems shall adopt written policies and procedures to facilitate the identification and transport of suspected stroke victims to an appropriate health care facility. To the extent possible, development of the policies and procedures should include input and assistance from a primary stroke center. The policies and procedures shall provide for, at a minimum:

(1) Training of first responders on stroke recognition and treatment, including emergency screening procedures, per certification cycle or per another period based upon recommendations by the peer review committee;

(2) Protocols for rapid transport to a primary stroke center when rapid transport to a primary stroke center is appropriate; and

(3) Response, on-site, and transport times should be monitored to minimize delays in the initiation of hospital-based treatment.

"**§ 131E-322. Rule-making authority.**

The Department may adopt rules to implement this Article."

SECTION 2. This act becomes effective January 1, 2007.

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2005

H D

HOUSE DRH10409-LNz-241 (4/24)

Short Title: Health Plans/Changes to Basic and Std. (Public)

Sponsors: Representatives

Referred to:

A BILL TO BE ENTITLED

AN ACT TO MAKE CHANGES TO THE STATUTORY BASIC AND STANDARD HEALTH PLANS FOR SMALL EMPLOYERS, AS RECOMMENDED BY THE HOUSE SELECT COMMITTEE ON HEALTH CARE.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 58-50-125(a) reads as rewritten:

"(a) To improve the availability and affordability of health benefits coverage for small employers, the Committee shall recommend to the Commissioner two plans of coverage, one of which shall be a basic health care plan and the second of which shall be a standard health care plan. Each plan of coverage shall be in two forms, one of which shall be in the form of insurance and the second of which shall be consistent with the basic method of operation and benefit plans of HMOs, including federally qualified HMOs. On or before January 1, 1992, the Committee shall file a progress report with the Commissioner. The Committee shall submit the recommended plans to the Commissioner for approval within 180 days after the appointment of the Committee under G.S. 58-50-120. The Committee shall take into consideration the levels of health benefit plans provided in North Carolina, and appropriate medical and economic factors, and shall establish benefit levels, cost sharing, exclusions, and limitations. On or after October 1, 2006, both plans may have optional deductible and co-payment levels as may be determined by the small employer carrier, including high deductible options. A small employer carrier shall file such changes with the Commissioner for the Commissioner's approval prior to implementing the changes in this State. The Commissioner may periodically review and update the benefits provided by these plans to address trends in the small group market. The Commissioner shall consult with small employer carriers and representatives of the insurance agent and small employer communities as part of that periodic review. Notwithstanding subsection (c) of this

section, in developing and approving the plans, the Committee and the Commissioner shall give due consideration to cost-effective and life-saving health care services and to cost-effective health care providers. The Committee shall file with the Commissioner its findings and recommendations, and reasons for the findings and recommendations, if it does not provide for coverage by any type of health care provider specified in G.S. 58-50-30. The recommended plans may include cost containment features such as, but not limited to: preferred provider provisions; utilization review of medical necessity of hospital and physician services; case management benefit alternatives; or other managed care provisions."

SECTION 2. G.S. 58-50-125(d) reads as rewritten:

"(d) ~~Within 180 days after the Commissioner's approval under subsection (b) of this section, every small employer carrier shall, as~~

As a condition of transacting business as a small employer carrier in this State, the carrier shall either offer small employers at least one basic and one standard health care ~~plan.~~ plan or the alternative coverages as provided in subsection (d1) of this section.

Every small employer that elects to be covered under such a plan and agrees to make the required premium payments and to satisfy the other provisions of the plan shall be issued such a plan by the small employer carrier. The premium payment requirements used in connection with basic and standard health care plans may address the potential credit risk of small employers that elect coverage in accordance with this subsection by means of payment security provisions that are reasonably related to the risk and are uniformly applied.

If a small employer carrier offers coverage to a small employer, the small employer carrier shall offer coverage to all eligible employees of a small employer and their dependents. A small employer carrier shall not offer coverage to only certain individuals in a small employer group except in the case of late enrollees as provided in G.S. 58-50-130(a)(4). A small employer carrier shall not modify any health benefit plan with respect to a small employer, any eligible employee, or dependent through riders, endorsements, or otherwise, in order to restrict or exclude coverage for certain diseases or medical conditions otherwise covered by the health benefit plan. In the case of an eligible employee or dependent of an eligible employee who, before the effective date of the plan, was excluded from coverage or denied coverage by a small employer carrier in the process of providing a health benefit plan to an eligible small employer, the small employer carrier shall provide an opportunity for the eligible employee or dependent of an eligible employee to enroll in the health benefit plan currently held by the small employer."

SECTION 3. G.S. 58-50-125 is amended by adding the following new subsection to read:

"(d1) Alternative Coverage Permitted. –

(1) In general. – In the case of health insurance coverage offered in this State, a small employer carrier may elect to limit the coverage offered under subsection (d) of this section as long as it offers at least two different policy forms of health insurance coverage both of which:

a. Are designed for, made generally available to, and actively marketed to, and enroll self-employed individuals and other small employer groups; and

b. Meet the requirement of subdivision (2) or (3) of this subsection, as elected by the small employer carrier.

(2) Choice of most popular policy forms. – The requirement of this subdivision is met, for health insurance coverage policy forms offered by a small employer carrier, if the small employer carrier offers the policy forms for small group health insurance coverage with the two highest premium volume numbers of all the policy forms offered by the small employer carrier in this State or applicable marketing or service area, as may be prescribed by rules or regulations, by the small employer carrier in the small group market in the period involved.

(3) Choice of two policy forms with representative coverage. –

a. In general. – The requirement of this subdivision is met for health insurance coverage policy forms offered by a small employer carrier in the small group market if the small employer carrier offers a lower-level coverage policy form, as described in sub-subdivision b. of this subdivision, and a higher-level coverage policy form, as described in sub-subdivision c. of this subdivision, each of which includes benefits substantially similar to other small group health insurance coverage offered by the small employer carrier in this State.

b. Lower-level coverage policy form. – A policy form is deemed a lower-level coverage policy form for this subdivision if the actuarial value of the benefits under the coverage is at least eighty-five percent (85%) but not greater than one hundred percent (100%) of a weighted average, as described in sub-subdivision d. of this subdivision.

c. Higher-level coverage policy form. – A policy form is deemed a higher-level coverage policy form for this subdivision if:

1. the actuarial value of the benefits under the coverage is at least fifteen percent (15%) greater than the actuarial value of the coverage described in sub-subdivision b. of this subdivision offered by the small employer carrier; and

2. the actuarial value of the benefits under the coverage is at least one hundred percent (100%) but not greater than one hundred twenty percent (120%) of a weighted average, as described in sub-subdivision d. of this subdivision.

d. Weighted average. – For the purposes of this subdivision, the weighted average described in this sub-subdivision is the

average actuarial value of the benefits provided by all the health insurance coverage issued, as elected by the small employer carrier, either by that small employer carrier or all small employer carriers in this State in the small group market during the previous year, not including coverage issued under this section, weighted by enrollment for the different coverage.

(4) Election. – The small employer carrier elections of the policies to be offered under this subsection shall apply uniformly to all small employers in this State for that small employer carrier. The election shall be effective for a period of not less than two years.

(5) Assumptions. – For the purposes of subdivision (3) of this subsection, the actuarial value of benefits provided under small group insurance coverage shall be calculated based on a standardized population and a set of standardized utilization and cost factors.

(6) If a small employer carrier chooses to offer the plans under this subsection and discontinues coverage under the basic or standard health benefit plans, the carrier shall make available to the insured employer whose coverage is to be discontinued both of the plans offered under this subsection. New coverage made available pursuant to this subsection shall constitute replacement coverage and shall be rated in accordance with G.S. 58-50-130(b)(3).

(7) The Commissioner may adopt rules to carry out the purposes and provisions of this subsection.

For purposes of this subsection only, policy forms that have different cost-sharing arrangements or different riders shall be considered to be different policy forms."

SECTION 4. G.S. 58-68-40(e)(2) reads as rewritten:

"(2) A self-employed individual as defined in G.S. 58-50-110(21a), except as otherwise provided for the basic and standard health care plans or other plans as provided under G.S. 58-50-125(d1) under the North Carolina Small Employer Group Health Coverage Reform Act."

SECTION 5. G.S. 58-50-130(b)(1) reads as rewritten:

"(b) For all small employer health benefit plans that are subject to this section, premium rates for health benefit plans subject to this section are subject to the following provisions:

(1) Small employer carriers shall use an adjusted-community rating methodology in which the premium for each small employer can vary only on the basis of the eligible employee's or dependent's age as determined in accordance with subdivision (6) of this subsection, the gender of the eligible employee or dependent, number of family members covered, or geographic area as determined under subdivision (7) of this ~~subsection.~~subsection, or industry as determined under subdivision (9) of this subsection. Premium rates charged during a rating period to small employers with similar case characteristics for same coverage shall not vary from the adjusted community rate by

more than ~~twenty percent (20%)~~ twenty-five percent (25%) for any reason, including differences in administrative costs and claims experience."

SECTION 6. G.S. 58-50-110(5a) reads as rewritten:

"(5a) 'Case characteristics' means the demographic factors age, gender, family size, ~~and~~ geographic ~~location.~~location, and industry."

SECTION 7. G.S. 58-50-110 is amended by adding the following subdivision to read:

"(12a) 'Industry' means a demographic factor used to reflect the financial risk associated with a specific industry."

SECTION 8. G.S. 58-50-130(b)(2) reads as rewritten:

"(2) Rating factors related to age, gender, number of family members covered, ~~or~~ geographic ~~location~~ location, or industry may be developed by each carrier to reflect the carrier's experience. The factors used by carriers are subject to the Commissioner's review;"

SECTION 9. G.S. 58-50-130(b) is amended by adding the following new subdivision to read:

"(9) In any case where the small employer carrier uses industry as a case characteristic in establishing premium rates, the rate factor associated with any industry classification divided by the lowest rate factor associated with any other industry classification shall not exceed 1.2."

SECTION 10. G.S. 589-50-130(f) reads as rewritten:

"(f) Each small employer carrier shall file with the Commissioner annually on or before March 15 an actuarial certification certifying that it is in compliance with this Act and that its rating methods are actuarially sound. The small employer carrier shall retain a copy of the certification at its principal place of business. The Commissioner may adopt rules to carry out the purposes and provisions of this subsection and subsection (b) of this section, including rules establishing the language, content, and format of actuarial certifications."

SECTION 11. G.S. 58-50-130(b)(7) reads as rewritten:

"(7) For the purposes of subsection (b) of this section, a carrier shall ~~not apply different geographic rating factors to the rates of small employers located within the same county; and~~define geographic area to mean medical care system. Medical care system factors shall reflect the relative differences in expected costs, shall produce rates that are not excessive, inadequate, or unfairly discriminatory in such medical care system areas, and shall be revenue neutral to the small employer carrier; and"

SECTION 12. G.S. 58-50-149 reads as rewritten:

"**§ 58-50-149. Limit on cessions to the Reinsurance Pool.**

In addition to any individual or group previously reinsured in accordance with G.S. 58-50-150(g)(1), the Pool shall only reinsure a health benefit plan issued or delivered for original issue by a reinsuring carrier on or after October 1, 1995, if the health benefit plan provides coverage to a small employer with no more than 25 eligible

employees, including self-employed individuals. Notwithstanding any other provision of law, the Pool shall cease to reinsure any individual or group uless that individual or group is reinsured by the Pool on January 1, 2007."

SECTION 13. Article 50 of Chapter 58 of the General Statutes is amended by adding the following new section to read:

"**§ 58-50-157. Termination of the North Carolina Small Employer Health Reinsurance Pool.**

The Pool shall continue in existence subject to the provisions of G.S. 58-50-149 and to termination in accordance with the requirements of a law or laws of the State of North Carolina or the United States of America. In case of enactment of a law or laws that in the determination of the Board and the Commissioner shall result in the termination of the Pool, the Pool shall terminate and conclude its affairs in a manner to be determined by the Board with the approval of the Commissioner. Any funds or assets of any nature held by the Pool following termination and the payment of all claims and expenses of the Pool shall be distributed to the Pool Member small employer carriers existing at that time in accordance with the then-existing assessment formula found in the Pool's Plan of Operation. The Pool may also assess members in accordance with the then-existing assessment formula should there be claims and expenses of the Pool for which current assessments or funds do not provide adequate resources to cover."

SECTION 14. G.S. 58-50-120, 58-50-125(b), and 58-50-125(e) and (g) are repealed.

SECTION 15. G.S. 58-50-125(f) reads as rewritten:

"(f) Every small employer carrier shall fairly market ~~the basic and standard health care plan~~ all health benefit plans it sells in the small group market to all small employers in the geographic areas in which the carrier makes coverage available or provides benefits."

SECTION 16. This act is effective when it becomes law.

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2005

H D

HOUSE DRH10408-RUqq-39 (03/20)

Short Title:	Strengthen NC Medical Board.	(Public)
Sponsors:	Representatives	
Referred to:		

A BILL TO BE ENTITLED

AN ACT TO STRENGTHEN THE AUTHORITY OF THE NORTH CAROLINA MEDICAL BOARD TO DISCIPLINE PHYSICIANS AND CERTAIN OTHERS AUTHORIZED TO PRACTICE MEDICINE IN ORDER TO IMPROVE PATIENT SAFETY, AS RECOMMENDED BY THE HOUSE SELECT COMMITTEE ON HEALTH CARE.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 90-14 reads as rewritten:

"**§ 90-14. Revocation, suspension, annulment or denial of license.**

(a) The Board shall have the power to place on probation with or without conditions, impose limitations and conditions on, publicly reprimand, assess monetary redress, issue public letters of concern, mandate free medical services, require satisfactory completion of treatment programs or remedial or educational training, fine, deny, annul, suspend, or revoke a license or other authority to practice medicine in this State, issued by the Board to any person who has been found by the Board to have committed any of the following acts or conduct, or for any of the following reasons:

(1) Immoral or dishonorable conduct.

(2) Producing or attempting to produce an abortion contrary to law.

(3) Made false statements or representations to the Board, or who has willfully concealed from the Board material information in connection with an application for a license.

(4) Repealed by Session Laws 1977, c. 838, s. 3.

(5) Being unable to practice medicine with reasonable skill and safety to patients by reason of illness, drunkenness, excessive use of alcohol, drugs, chemicals, or any other type of material or by reason of any physical or mental abnormality. The Board is empowered and

authorized to require a physician licensed by it to submit to a mental or physical examination by physicians designated by the Board before or after charges may be presented against the physician, and the results of the examination shall be admissible in evidence in a hearing before the Board.

(6) Unprofessional conduct, including, but not limited to, departure from, or the failure to conform to, the standards of acceptable and prevailing medical practice, or the ethics of the medical profession, irrespective of whether or not a patient is injured thereby, or the committing of any act contrary to honesty, justice, or good morals, whether the same is committed in the course of the physician's practice or otherwise, and whether committed within or without North Carolina. The Board shall not revoke the license of or deny a license to a person solely because of that person's practice of a therapy that is experimental, nontraditional, or that departs from acceptable and prevailing medical practices unless, by competent evidence, the Board can establish that the treatment has a safety risk greater than the prevailing treatment or that the treatment is generally not effective.

(7) Conviction in any court of a crime involving moral turpitude, or the violation of a law involving the practice of medicine, or a conviction of a felony; provided that a felony conviction shall be treated as provided in subsection (c) of this section.

(8) By false representations has obtained or attempted to obtain practice, money or anything of value.

(9) Has advertised or publicly professed to treat human ailments under a system or school of treatment or practice other than that for which the physician has been educated.

(10) Adjudication of mental incompetency, which shall automatically suspend a license unless the Board orders otherwise.

(11) Lack of professional competence to practice medicine with a reasonable degree of skill and safety for patients. In this connection the Board may consider repeated acts of a physician indicating the physician's failure to properly treat a patient. The Board may, upon reasonable grounds, require a physician to submit to inquiries or examinations, written or oral, ~~by members of the Board or by other physicians licensed to practice medicine in this State,~~ as the Board deems necessary to determine the professional qualifications of such licensee. In order to annul, suspend, deny, or revoke a license of an accused person, the Board shall find by the greater weight of the evidence that the care provided was not in accordance with the standards of practice for the procedures or treatments administered.

(11a) Not actively practiced medicine or practiced as a physician assistant, or having not maintained continued competency, as determined by the Board, for the two-year period immediately preceding the filing of an

application for an initial license from the Board or a request, petition, motion, or application to reactivate an inactive, suspended, or revoked license previously issued by the Board. The Board is authorized to adopt any rules or regulations it deems necessary to carry out the provisions of this subdivision.

(12) Promotion of the sale of drugs, devices, appliances or goods for a patient, or providing services to a patient, in such a manner as to exploit the patient, and upon a finding of the exploitation, the Board may order restitution be made to the payer of the bill, whether the patient or the insurer, by the physician; provided that a determination of the amount of restitution shall be based on credible testimony in the record.

(13) Having a license to practice medicine or the authority to practice medicine revoked, suspended, restricted, or acted against or having a license to practice medicine denied by the licensing authority of any jurisdiction. For purposes of this subdivision, the licensing authority's acceptance of a license to practice medicine voluntarily relinquished by a physician or relinquished by stipulation, consent order, or other settlement in response to or in anticipation of the filing of administrative charges against the physician's license, is an action against a license to practice medicine.

(14) The failure to respond, within a reasonable period of time and in a reasonable manner as determined by the Board, to inquiries from the Board concerning any matter affecting the license to practice medicine.

(15) The failure to complete an amount not to exceed 150 hours of continuing medical education during any three consecutive calendar years pursuant to rules adopted by the Board.

~~For any of the foregoing reasons, the Board may deny the issuance of a license to an applicant or revoke a license issued to a physician, may suspend such a license for a period of time, and may impose conditions upon the continued practice after such period of suspension as the Board may deem advisable, may limit the accused physician's practice of medicine with respect to the extent, nature or location of the physician's practice as the Board deems advisable.~~ The Board may, in its discretion and upon such terms and conditions and for such period of time as it may prescribe, restore a license so revoked or ~~rescinded,~~otherwise acted upon, except that no license that has been revoked shall be restored for a period of two years following the date of revocation.

(b) The Board shall refer to the ~~State Medical Society Physician Health and Effectiveness Committee~~ North Carolina Physicians Health Program all physicians and physician assistants whose health and effectiveness have been significantly impaired by alcohol, drug addiction or mental illness. Sexual misconduct shall not constitute mental illness for purposes of this subsection. A physician or physician assistant shall be limited to two referrals to the North Carolina Physicians Health Program except upon the suspension or revocation of the physician's or physician assistant's license.

(c) A felony conviction shall result in the automatic revocation of a license issued by the Board, unless the Board orders otherwise or receives a request for a hearing from the person within 60 days of receiving notice from the Board, after the conviction, of the provisions of this subsection. If the Board receives a timely request for a hearing in such a case, the provisions of G.S. 90-14.2 shall be followed.

(d) The Board and its members and staff may release confidential or nonpublic information to any health care licensure board in this State or another state about the issuance, denial, annulment, suspension, or revocation of a license, or the voluntary surrender of a license by a Board-licensed physician, including the reasons for the action, or an investigative report made by the Board. The Board shall notify the physician within 60 days after the information is transmitted. A summary of the information that is being transmitted shall be furnished to the physician. If the physician requests, in writing, within 30 days after being notified that such information has been transmitted, he shall be furnished a copy of all information so transmitted. The notice or copies of the information shall not be provided if the information relates to an ongoing criminal investigation by any law-enforcement agency, or authorized Department of Health and Human Services personnel with enforcement or investigative responsibilities.

(e) The Board and its members and staff shall not be held liable in any civil or criminal proceeding for exercising, in good faith, the powers and duties authorized by law.

(f) A person, partnership, firm, corporation, association, authority, or other entity acting in good faith without fraud or malice shall be immune from civil liability for (i) ~~reporting or~~ reporting, investigating or providing an expert medical opinion to the Board regarding the acts or omissions of a licensee or applicant that violate the provisions of subsection (a) of this section or any other provision of law relating to the fitness of a licensee or applicant to practice medicine and (ii) initiating or conducting proceedings against a licensee or applicant if a complaint is made or action is taken in good faith without fraud or malice. A person shall not be held liable in any civil proceeding for testifying before the Board in good faith and without fraud or malice in any proceeding involving a violation of subsection (a) of this section or any other law relating to the fitness of an applicant or licensee to practice medicine, or for making a recommendation to the Board in the nature of peer review, in good faith and without fraud and malice.

(g) Prior to taking action against any licensee who practices integrative medicine for providing care not in accordance with the standards of practice for the procedures or treatments administered, the Board shall consult with a licensee who practices integrative medicine."

SECTION 2. G.S. 90-14.5 reads as rewritten:

"**§ 90-14.5. Use of ~~trial examiner or~~hearing committee and depositions.**

~~Where the licensee requests that the hearing herein provided for be held by the Board in a county other than the county designated for the holding of the meeting of the Board at which the matter is to be heard, the Board may designate in writing one or more of its members to conduct the hearing as a trial examiner or trial committee, to take evidence and report a written transcript thereof to the Board at a meeting where a~~

~~majority of the members are present and participating in the decision. Evidence and testimony may also be presented at such hearings and to the Board in the form of depositions taken before any person designated in writing by the Board for such purpose or before any person authorized to administer oaths, in accordance with the procedure for the taking of depositions in civil actions in the superior court.~~

(a) The Board, in its discretion, may designate in writing three or more of its members to conduct hearings as a hearing committee to take evidence.

(b) Evidence and testimony may be presented at hearings before the Board or a hearing committee in the form of depositions before any person authorized to administer oaths in accordance with the procedure for the taking of depositions in civil actions in the superior court.

(c) The hearing committee shall submit a recommended decision that contains findings of fact and conclusions of law to the Board. Before the Board makes a final decision, it shall give each party an opportunity to file written exceptions to the recommended decision made by the hearing committee, and to present oral arguments to the Board. A quorum of the Board will issue a final decision."

SECTION 3. G.S. 90-14.13 reads as rewritten:

"**§ 90-14.13. Reports of disciplinary action by health care institutions; reports of professional liability insurance awards or settlements; immunity from liability.**

(a) The chief administrative officer of every licensed hospital or other health care institution, including Health Maintenance Organizations, as defined in G.S. 58-67-5, preferred providers, as defined in G.S. 58-50-56, and all other provider organizations that issue credentials to physicians who practice medicine in the State, shall, after consultation with the chief of staff of that institution, report to the Board any revocation, suspension, or limitation of a physician's privileges to practice in that ~~institution.~~institution within 30 days, whether or not the action has been appealed. A hospital is not required to report the suspension of a physician's privileges for failure to timely complete medical records unless the suspension is the third within the calendar year for failure to timely complete medical records. Upon reporting the third suspension, the hospital shall also report the previous two suspensions. The institution shall also report to the Board resignations from practice in that institution by persons licensed under this Article. The Board shall report all violations of this subsection known to it to the licensing agency for the institution involved. The licensing agency for the institution involved is authorized to order the payment of a monetary penalty of not less than five hundred dollars ($500.00) nor more than one thousand dollars ($1,000), for each violation, from any institution that fails to make a report as required.

(b) Any licensed physician who does not possess professional liability insurance shall report to the Board any award of damages or any settlement of any malpractice complaint affecting his or her practice within 30 days of the award or settlement.

(c) The chief administrative officer of each insurance company providing professional liability insurance for physicians who practice medicine in North Carolina, the administrative officer of the Liability Insurance Trust Fund Council created by G.S. 116-220, and the administrative officer of any trust fund or other fund operated or

administered by a hospital authority, group, or provider shall report to the Board within 30 days:

(1) Any award of damages or settlement of any claim or lawsuit ~~affecting or involving~~affecting, involving or in any way implicating the care provided by a ~~physician~~ physician, physician assistant, or nurse practitioner it insures, or

(2) Any cancellation or nonrenewal of its professional liability coverage of a physician, if the cancellation or nonrenewal was for cause.

(d) ~~The Board may request details about any action and the officers shall promptly furnish the requested information. The reports required by this section are privileged and shall not be open to the public.~~ The Board shall report all violations of this paragraph to the Commissioner of Insurance. The Commissioner of Insurance is authorized to order the payment of a monetary penalty of not less than five hundred dollars ($500.00) nor more than one thousand dollars ($1,000), for each violation, from any person or entity that fails to make a report as required.

(e) The Board may request details about any action covered by this section and the officers shall promptly furnish the requested information. The reports required by this section are privileged and shall not be open to the public. Any person making a report required by this section shall be immune from any criminal prosecution or civil liability resulting therefrom unless such person knew the report was false or acted in reckless disregard of whether the report was false."

SECTION 4.(a) The subcommittee of the North Carolina Medical Board and the subcommittee of the Board of Nursing, directed to work jointly to develop rules to govern the performance of medical acts by registered nurses pursuant to G.S. 90-6(b), shall examine adding the provisions of G.S. 90-14(a) to their joint rules that set forth grounds for action against a registered nurse's approval to perform medical acts..

SECTION 4.(b) The subcommittee of the North Carolina Medical Board and the subcommittee of the North Carolina Board of Pharmacy, directed to work jointly to develop rules to govern the performance of medical acts by clinical pharmacist practitioners pursuant to G.S. 90-6(c), shall examine adding the provisions of G.S. 90-14(a) to the joint rules that set forth grounds for action against a clinical pharmacist practitioner's approval to perform medical acts.

SECTION 4.(c) The North Carolina Medical Board, the Board of Nursing and the North Carolina Pharmacy Board shall report to the Chairs of the House Committee on Health, the Senate Committee on Health Care, the House Select Committee on Health Care and the Subcommittee on Patient Safety, Quality and Accountability of the House Select Committee on Health Care on the adoption of the provisions of G.S. 90-14(a) as part of the joint rules governing the practice of medical acts for nurse practitioners and clinical pharmacist practitioners. The boards shall file their reports no later than August 1, 2006.

SECTION 5. Section 4 of this act is effective when it becomes law. The remainder of this act becomes effective October 1, 2006. Section 1 applies to acts or omissions that occur on or after the effective date. Section 2 applies to hearings held on

or after the effective date. Section 3 applies to awards entered or settlements entered into on or after the effective date.

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2005

H D

HOUSE DRH50509-RFz-13 (03/30)

Short Title: Spice Funds. (Public)

Sponsors: Representatives

Referred to:

A BILL TO BE ENTITLED

AN ACT TO APPROPRIATE FUNDS TO THE STATEWIDE PROGRAM FOR INFECTION CONTROL AND EPIDEMIOLOGY, AS RECOMMENDED BY THE HOUSE SELECT COMMITTEE ON HEALTH CARE.

Whereas, approximately 200,000 people, or 5% of those hospitalized each year, develop hospital acquired infections; and

Whereas, these infections result in approximately 90,000 deaths and $6.5 billion dollars in additional health care costs annually; and

Whereas, the Statewide Program for Infection Control and Epidemiology (SPICE) provides educational programs for infection control professionals in hospitals and for long-term care personnel, conducts infection control workshops at community hospitals, area health education centers, and other health care facilities in the State, provides investigative and consulting services to health care facilities and professionals, offers instruction at the School of Medicine at the University of North Carolina at Chapel Hill, and develops and publishes State guidelines for disease control for illnesses such as SARS, Avian Influenza, antibiotic resistant organisms, and bioterrorist and chemical agents, and provides other infection control and epidemiological-related services; and

Whereas, high quality infection control programs such as those which SPICE has helped to implement at hospitals and other health care facilities prevent infections, add to patient safety, improve the quality care,and reduce health care costs; and

Whereas, expansion of the SPICE program would help ensure that all North Carolina hospitals and health care facilities have high quality infection control programs and would allow SPICE to provide additional collaborative assistance to hospitals as they implement new infection control interventions, conduct on-site infection control rounds, prepare ideal draft infection control policies and make them available on the

Internet, and provide hospital infection control in-services on a rotating basis; Now, therefore,

The General Assembly of North Carolina enacts:

SECTION 1. There is appropriated from the General Fund to the School of Medicine at the University of North Carolina at Chapel Hill the sum of six hundred sixty-three thousand dollars ($663,000) for fiscal year 2006-2007 to be allocated to the Statewide Program for Infection Control and Epidemiology.

SECTION 2. This act becomes effective July 1, 2006.

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2005

H D

HOUSE BILL 1718
PROPOSED COMMITTEE SUBSTITUTE H1718-CSRJ-31 [v.4]

4/26/2006 4:41:00 PM

Short Title: Nursing Faculty Fellows Program/Funds. (Public)

Sponsors:

Referred to:

May 12, 2005

A BILL TO BE ENTITLED

AN ACT TO ESTABLISH A NURSING FACULTY FELLOWS PROGRAM AND TO APPROPRIATE FUNDS FOR THAT PURPOSE.

The General Assembly of North Carolina enacts:

SECTION 1. Chapter 90 of the General Statutes is amended by adding the following new Article to read:

"Article 9H.

"Nursing Faculty Fellows Program.

"**§ 90-171.97. Nursing Faculty Fellows Program established; administration.**

(a) As used in this Article, unless the context clearly requires otherwise, the following definitions apply:

(1) Commission. – The North Carolina Nursing Scholars Commission established under Article 9D of this Chapter.

(2) Program. – The Nursing Faculty Fellows Program established under this Article.

(b) There is established the Nursing Faculty Fellows Program. The North Carolina Nursing Scholars Commission shall administer the Program in collaboration with the State Education Assistance Authority (SEAA). The purpose of the Program is to provide up to a two-year scholarship loan to selected recipients and extracurricular enhancement activities for scholarship loan recipients. The Commission shall determine selection criteria and methods of selection and shall select recipients of scholarship loans made under the Program. The Director of the State Education Assistance Authority shall coordinate the Program through the Commission.

(c) The Program shall provide a two-year scholarship loan in the amount of eight thousand dollars ($8,000) per year, per recipient, to individuals who may be eligible for selection as nursing faculty in the university, community college, and hospital schools of nursing by completing an approved program that enables the recipient to become a full-time faculty member, as follows:

(1) Approved programs are those programs offered by colleges and universities in this State.

(2) The number of scholarship loan awards per year shall be based on the State's need for nursing faculty and within funds available.

(d) The Commission shall adopt stringent standards to ensure that only the best potential students receive scholarship loans under the Program. The standards may include standardized test scores, undergraduate performance, job experience and performance, leadership abilities, and other standards the Commission deems appropriate. The Commission shall consider the qualifications of all applicants in a manner that is fair and that takes into account the geographic diversity of the State. The Commission may award scholarship loans under the Program only to applicants who meet the Commission's standards, are domiciled in this State, and agree to work as nursing faculty in a North Carolina school of nursing.

(e) The Commission may form regional review committees to assist in identifying the best applicants for the Program. The Commission and the review committees shall make an effort to identify and encourage men and minorities and others who may not otherwise consider a career as a nursing faculty member to apply for the Program.

(f) Upon the naming of recipients of loans from the Program, the Commission shall inform the State Education Assistance Authority (SEAA) of its decisions. The SEAA shall perform all of the administrative functions necessary to implement this Article, which functions shall include: rule making, dissemination of information, disbursement, receipt, liaison with participating educational institutions, determination of the acceptability of service repayment agreements, and all other functions necessary for the execution, payment, and enforcement of promissory notes required under this Article.

"**§ 90-171.98. Terms of loans; receipt and disbursement of funds.**

(a) All scholarship loans shall be evidenced by notes made payable to the State Education Assistance Authority (SEAA) and bear interest at the rate of ten percent (10%) per year beginning 90 days after completion of the Program, or 90 days after termination of the scholarship loan, whichever is earlier. The scholarship loan may be terminated upon the recipient's withdrawal from school or by the recipient's failure to meet the standards of the Commission.

(b) The SEAA shall forgive the loan if, within four years after graduation from an approved program, the recipient teaches in a North Carolina school of nursing for each year a scholarship loan was provided. If the recipient repays the scholarship loan by cash payments, all indebtedness shall be repaid within 10 years.

(c) All funds appropriated to or otherwise received by the Program for scholarships, all funds received as repayment of scholarship loans, and all interest earned on these funds shall be placed in a revolving fund. The revolving fund may be used only for scholarship loans granted under the Program."

SECTION 2. There is appropriated from the General Fund to the State Education Assistance Authority the sum of four hundred thousand dollars ($400,000) for the 2006-2007 fiscal year to provide for 50 nursing faculty scholarships in

accordance with Article 9H of Chapter 90 of the General Statutes, enacted in Section 1 of this act.

SECTION 3. This act becomes effective July 1, 2006.

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2005

H D

HOUSE DRH50510-SQz-3 (03/27)

Short Title: Funds for Community Health Centers. (Public)

Sponsors: Representatives

Referred to:

A BILL TO BE ENTITLED

AN ACT TO APPROPRIATE FUNDS TO THE DEPARTMENT OF HEALTH AND HUMAN SERVICES, OFFICE OF RESEARCH, DEMONSTRATIONS, AND RURAL HEALTH DEVELOPMENT, FOR A GRANT PROGRAM TO ASSIST IN THE PROVISION OF PRIMARY AND PREVENTIVE MEDICAL SERVICES TO UNINSURED OR MEDICALLY INDIGENT PATIENTS, AS RECOMMENDED BY THE HOUSE SELECT COMMITTEE ON HEALTH CARE.

The General Assembly of North Carolina enacts:

SECTION 1.(a) There is appropriated from the General Fund to the Department of Health and Human Services, Office of Research, Demonstrations, and Rural Health Development (Office), the sum of fifteen million dollars ($15,000,000) for the 2006-2007 fiscal year. These funds shall be allocated to federally qualified health centers and those health centers that meet the criteria for federally qualified health centers, State-designated rural health centers, free clinics, public health departments, and other nonprofit organizations that provide primary and preventive medical services to uninsured or medically indigent patients. These funds shall be allocated as grants on a competitive basis to assist in the provision of care to uninsured or medically indigent patients. Grant funds appropriated in this act shall only be used to:

(1) Increase access to preventative and primary care services by uninsured or medically indigent patients in existing or new health center locations;

(2) Establish community health center services in counties where no such services exist;

(3) Create new services or augment existing services provided to uninsured or medically indigent patients, including primary care and preventative medical services, dental services, pharmacy, and behavioral health; and

(4) Increase capacity necessary to serve the uninsured by enhancing or replacing facilities, equipment, or technologies.

Grant funds may not be used to enhance or increase compensation or other benefits of personnel, administrators, directors, consultants, or any other parties. Grant funds may not be used to supplant federal funds traditionally received by federally qualified community health centers and may not be used to finance or satisfy any existing debt.

SECTION 1.(b) The Office shall work with the North Carolina Community Health Center Association (NCCHCA) and the North Carolina Public Health Association (NCPHA) to establish an advisory committee to develop an objective and equitable process for awarding grant funds. The Office shall also develop auditing and accountability procedures. Not more than one percent (1%) of the funds appropriated in this section may be used to reimburse the Office for administering the grant program in collaboration with the NCCHCA and the NCPHA.

SECTION 1.(c) Recipients of grant funds shall provide to the Office annually a written report detailing the number of uninsured and medically indigent patients that are cared for, the types of services that were provided, and any other information requested by the Office as necessary for evaluating the success of the grant program.

SECTION 1.(d) The Office shall work with the NCCHCA and NCPHA to study and present recommendations for continuing funds to support the expansion of community health centers, State-designated rural health centers, free clinics, and public health departments to serve more of the State's uninsured and indigent population. The Department of Health and Human Services shall report on the use of these funds to the House Appropriations Subcommittee on Health and Human Services, the Senate Appropriations Committee on Health and Human Services, and the Fiscal Research Division not later than March 1, 2007.

SECTION 2. This act becomes effective July 1, 2006.

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2005

H D

HOUSE DRH30400-LNz-230 (3/29)

Short Title: Establish High-Risk Pool. (Public)

Sponsors:

Referred to:

A BILL TO BE ENTITLED

AN ACT TO ESTABLISH THE NORTH CAROLINA HEALTH INSURANCE RISK POOL AND TO APPROPRIATE FUNDS THEREFOR.

The General Assembly of North Carolina enacts:

SECTION 1.1. Article 50 of Chapter 58 of the General Statutes is amended by adding a new Part to read:

"Part 7. North Carolina Health Insurance Risk Pool.

"**§ 58-50-245. Definitions.**

For the purposes of this Part:

(1) "Administrator" means the Pool Administrator selected by the Board in accordance with this Part.

(2) "Benefit plan" means coverage offered by the Pool to eligible individuals.

(3) "Board" means the Board of Directors of the Pool.

(4) "Covered person" means any individual resident of this State, excluding dependents, who is eligible to receive health benefits from any insurer.

(5) "Church plan" has the meaning given that term under section 3(33) of the Employee Retirement Income Security Act of 1974.

(6) "Creditable coverage" means, with respect to an individual, coverage of the individual provided under any of the following:

a. A group health plan.

b. Health insurance coverage.

c. Part A or Part B of Title XVIII of the Social Security Act. (Medicare)

d. Title XIX of the Social Security Act, other than coverage consisting solely of benefits under section 1928.(Medicaid)
e. Chapter 55 of Title 10, United States Code.
f. A medical care program of the Indian Health Service or of a tribal organization.
g. A state health benefits risk pool.
h. A health plan offered under Chapter 89 of Title 5, United States Code.
i. A public health plan as defined in federal regulations.
j. A health benefit plan under section 5(e) of the Peace Corps Act (22 U.S.C. § 2504(e)).

A period of creditable coverage shall not be counted, with respect to the enrollment of an individual who seeks coverage under this Part, if, after such period and before the enrollment date, the individual experiences a significant break in coverage.

(7) "Dependent" means a resident spouse or unmarried child under the age of 19 years, a child who is a full-time student under the age of 23 years and who is financially dependent upon the parent, a child who is over 18 years of age and for whom a person may be obligated to pay child support, or a child of any age who is disabled and dependent upon the parent.

(8) "Family member" means a parent, grandparent, brother, sister, or child of a dependent residing with the insured.

(9) "Federally defined eligible individual" means an individual:

a. For whom, as of the date on which the individual seeks coverage under this Part, the aggregate of the periods of creditable coverage is 18 or more months;
b. Whose most recent prior creditable coverage was under a group health plan, governmental plan, church plan, or health insurance coverage offered in connection with such a plan;
c. Who is not eligible for coverage under a group health plan, Part A or Part B of Title XVIII of the Social Security Act (Medicare), or a State plan under Title XIX of the Act (Medicaid), or any successor program, and who does not have other health insurance coverage;
d. With respect to whom the most recent coverage within the period of aggregate creditable coverage was not terminated based on a factor relating to nonpayment of premiums or fraud;
e. Who, if offered the option of continuation coverage under a COBRA continuation provision or under a similar state program, elected this coverage; and
f. Who has exhausted continuation coverage under this provision or program, if the individual elected the continuation coverage described in sub-subdivision e. of this subdivision.

(10) "Governmental plan" has the meaning given under section 3(32) of the Employee Retirement Income Security Act of 1974 and any governmental plan established or maintained for its employees by the government of the United States or by an agency or instrumentality of the government of the United States.

(11) "Group health plan" means an employee welfare benefit plan as defined in section 3(1) of the Employee Retirement Income Security Act of 1974 to the extent that the plan provides medical care, including items and services paid for as medical care to employees or their dependents, as defined under the terms of the plan directly or through insurance, reimbursement, or otherwise.

(12) "Health insurance coverage" means any hospital and medical expense incurred policy, nonprofit health care services contract, health maintenance organization subscriber contract, or any other health care plan or arrangement that pays for or furnishes medical or health care services whether by insurance or otherwise.

"Health insurance coverage" does not include one or more, or any combination of, the following:

a. Coverage only for accident or disability income insurance, or any combination thereof.
b. Coverage issued as a supplement to liability insurance.
c. Liability insurance, including general liability insurance and automobile liability insurance.
d. Workers' compensation or similar insurance.
e. Automobile medical payment insurance.
f. Credit-only insurance.
g. Coverage for on-site medical clinics.
h. Other similar insurance coverage, specified in federal regulations issued pursuant to P.L. 104-191, under which benefits for medical care are secondary or incidental to other insurance benefits.
i. Limited-scope dental or vision benefits.
j. Benefits for long-term care, nursing home care, home health care, community-based care, or any combination thereof.
k. Medicare supplemental health insurance as defined under section 1882(g)(1) of the Social Security Act.
l. Coverage supplemental to the coverage provided under Chapter 55 of Title 10, United States Code (Civilian Health and Medical Program of the Uniformed Services – CHAMPUS).
m. Similar supplemental coverage provided to coverage under a group health plan.

(13) "Insurance arrangement" means a plan, program, contract, or other arrangement through which health care services are provided by an

employer to its officers or employees, but does not include health care services covered through an insurer.

(14) "Insured" means an individual who is eligible to receive benefits from the Pool. The term "insured" includes dependents and family members, as applicable.

(15) "Insurer" means any entity that provides health insurance coverage in this State. For the purposes of this Part, insurer includes an insurance company, a hospital or medical service corporation, a health maintenance organization, a multiple employer welfare arrangement, a third-party administrator or claims processor, an administrative service organization, or any other nongovernmental entity providing a health benefit plan subject to State insurance regulation.

(16) "Medical care" means amounts paid for:

a. The diagnosis, cure, mitigation, treatment, or prevention of disease, or amounts paid for the purpose of affecting any structure or function of the body;

b. Transportation primarily for and essential to medical care referred to in sub-subdivision a. of this subdivision; and

c. Insurance covering medical care referred to in sub-subdivisions a. and b. of this subdivision.

(17) "Plan of operation" means the articles, bylaws, and operating rules and procedures adopted by the Board in accordance with this Part.

(18) "Pool" means the North Carolina Health Insurance Risk Pool.

(19) "Resident" means an individual who:

a. Has been legally domiciled in this State for a period of at least 30 days, except that for a federally defined eligible individual, there shall not be a 30-day requirement;

b. Is legally domiciled in this State on the date of application to the Pool and who is eligible for enrollment in the Pool as a result of the Health Insurance Portability and Accountability Act of 1996; or

c. Is legally domiciled in this State on the date of application to the Pool and is eligible for the credit for health insurance costs under section 35 of the Internal Revenue Code of 1986.

(20) "Significant break in coverage" means a period of 63 consecutive days during all of which the individual does not have any creditable coverage, except that neither a waiting period nor an affiliation period is taken into account in determining a significant break in coverage.

(21) "Trade Adjustment Assistance Program" (TAA) means Title II of the Trade Act of 2002, P.L. 107-210.

"**§ 58-50-250. Risk Pool established; board of directors; plan of operation.**

(a) High-Risk Pool Established. – There is hereby created a nonprofit entity to be known as the North Carolina Health Insurance Risk Pool. The Pool shall operate under the supervision and control of the Board of Directors of the Pool.

(b) Board of Directors Appointment; Membership. – The Board of Directors of the North Carolina Health Insurance Risk Pool shall consist of the Commissioner of Insurance, who shall serve as an ex officio nonvoting member of the Board, and seven members appointed as follows:

(1) Two members of the general public who are not employed by or affiliated with an insurance company or plan, group hospital, or other health care provider, and can reasonably be expected to qualify for coverage in the Pool. Members of the general public include individuals whose only affiliation with health insurance or health care coverage is as a covered member. The two members of the general public shall be appointed by the General Assembly, as follows:

a. One member upon the recommendation of the President Pro Tempore of the Senate.

b. One member upon the recommendation of the Speaker of the House of Representatives.

(2) Five members appointed by the Commissioner of Insurance, as follows:

a. Two who are insurers, at least one of whom covers the largest number of persons in the State.

b. One who is licensed to sell health insurance in this State.

c. One who represents the medical provider community, as recommended by the North Carolina Medical Society.

d. One who represents small business, as recommended by the North Carolina Citizens for Business and Industry.

(c) Board of Directors; Terms of Appointment; Vacancies; Compensation. – The initial Board members shall be appointed as follows: two of the members to serve a term of three years; three of the members to serve a term of one year; and two of the members to serve a term of two years. Subsequent Board members shall serve for terms of three years. A Board member's term shall continue until the member's successor is appointed. The Commissioner shall appoint a chair to serve for the initial two years of the Plan's operation. Subsequent chairs shall be elected by a majority vote of the Board members and shall serve for two-year terms. The Commission shall fill vacancies in membership and may remove members from the Board for cause. Board members shall not be compensated in their capacity as Board members but shall be reimbursed for reasonable expenses incurred in the necessary performance of their duties.

(d) Plan of Operation. – The Board shall submit to the Commissioner a Plan of Operation for the Pool and any amendments necessary or suitable to assure the fair, reasonable, and equitable administration of the Plan of Operation. The Plan of Operation shall become effective upon approval in writing by the Commissioner consistent with the date on which the coverage under this Part must be made available. If the Board fails to submit a suitable Plan of Operation within 180 days after the appointment of the Board of Directors, or at any time thereafter fails to submit suitable amendments to the Plan of Operation, the Commissioner shall adopt temporary rules necessary or advisable to effectuate the provisions of this section. The rules shall

continue in force until modified by the Commissioner or superseded by a Plan of Operation submitted by the Board and approved by the Commissioner. The Plan of Operation shall:

(1) Establish procedures for operation of the Pool.

(2) Establish procedures for selecting a Pool Administrator in accordance with G.S. 58-50-255.

(3) Establish procedures to create a fund for administrative expenses, which shall be managed by the Board.

(4) Establish procedures for the collection, handling, accounting, and auditing of assets, monies, and claims of the Pool and the Pool Administrator.

(5) Develop and implement a program to publicize the existence of the Pool, the eligibility requirements, and procedures for enrollment, availability of State premium subsidies, and to maintain public awareness of the Pool.

(6) Establish procedures under which applicants and participants may have grievances reviewed by a grievance committee appointed by the Board in accordance with G.S. 58-50-295.

(7) Establish procedures for identifying and confirming income levels of applicants for Pool coverage who are eligible to receive a State premium subsidy, if a State premium subsidy is available.

(8) Provide for other matters as may be necessary and proper for the execution of the Board's powers, duties, and obligations under this Part.

(e) The Pool shall have the general powers and authority granted under the laws of this State to health insurers and the specific authority to do all of the following:

(1) Enter into contracts as are necessary or proper to carry out the provisions and purposes of this Part, including the authority, with the approval of the Commissioner, to enter into contracts with similar plans of other states for the joint performance of common administrative functions or with persons or other organizations for the performance of administrative functions.

(2) Sue or be sued, including taking any legal actions necessary or proper to recover or collect assessments due the Pool.

(3) Take legal action as necessary to:

a. Avoid the payment of improper claims against the Pool or the coverage provided by or through the Plan.

b. Recover any amounts erroneously or improperly paid by the Plan.

c. Recover any amounts paid by the Pool as a result of mistake of fact or law.

d. Recover other amounts due the Pool.

(4) Establish rates and rate schedules in accordance with this Part.

(5) Issue policies of insurance in accordance with the requirements of this Part.

(6) Appoint appropriate legal, actuarial, and other committees as necessary to provide technical assistance in the operation of the Pool, policy, and other contract design, and any other function within the Pool's authority.

(7) Borrow money to effect the purposes of the Pool. Any notes or other evidence of indebtedness of the Pool not in default are legal investments for insurers and may be carried as admitted assets.

(8) Establish policies, conditions, and procedures for reinsuring risks of participating insurers desiring to issue Pool coverage in their own name. Provision of reinsurance shall not subject the Pool to any of the capital or surplus requirements, if any, otherwise applicable to reinsurers.

(9) Employ and fix the compensation of employees.

(10) Prepare and distribute certificate of eligibility forms and enrollment instruction forms to insurance producers and to the general public.

(11) Provide for reinsurance of risks incurred by the Pool.

(12) Issue additional types of health insurance policies to provide optional coverage, including Medicare supplemental insurance coverage.

(13) Provide for and employ cost containment measures and requirements including preadmission screening, second surgical opinion, concurrent utilization review, disease management, individual case management, and other commonly used benefit plan design features for the purpose of making health insurance coverage offered by the Pool more cost-effective.

(14) Design, utilize, contract, or otherwise arrange for the delivery of cost-effective health care services, including establishing or contracting with preferred provider organizations, health maintenance organizations, and other limited network provider arrangements.

(15) Adopt bylaws, policies, and procedures as may be necessary or convenient for the implementation of this Part and the operation of the Pool.

(f) The Board shall operate the Pool in a manner so that the estimated cost of providing health insurance coverage during any fiscal year will not exceed the total income the Pool expects to receive from policy premiums and other revenue available to the Pool. The financing mechanisms recommended to and approved by the General Assembly shall provide for a means to adjust those mechanisms annually, or more frequently if necessary, in order to assure that the Pool has the financial capacity to insure the projected number of enrollees.

(g) The Board shall make an annual report to the Commissioner, to the Speaker of the House of Representatives, and to the President Pro Tempore of the Senate. The report shall summarize the activities of the Pool in the preceding calendar year,

including the net written and earned premiums, benefit plan enrollment, the expense of administration, and the paid and incurred losses.

(h) Neither the Board nor its employees are liable for any obligations of the Pool. No current or former member or employee of the Board is liable, and no cause of action of any nature may arise against them, for any act or omission related to the performance of their powers and duties under this Part, unless such act or omission constitutes willful or wanton misconduct. The Board may provide in its bylaws or rules for indemnification of, and legal representation for, its members and employees.

(i) The members of the Board shall comply with the provisions of G.S. 14-234 prohibiting conflicts of interest.

"**§ 58-50-255. Administrator.**

(a) The Board shall select through a competitive bidding process one or more insurers or a third-party administrator to administer the Pool. The Board shall evaluate bids submitted based on criteria established by the Board. The criteria shall allow for the comparison of information about each bidding administrator and selection of a Pool Administrator based on at least the following:

(1) Proven ability to handle health insurance coverage to individuals.
(2) Efficiency and timeliness of the claim processing procedures.
(3) Estimated total charges for administering the Pool.
(4) Ability to apply effective cost containment programs and procedures and to administer the Pool in a cost-efficient manner.
(5) Financial condition and stability.

If a member of the Board has submitted a bid to be selected by the Board as Pool Administrator, that bidding member of the Board shall not participate in the selection process or in the Board's final decision on the selection of the Administrator.

(b) The Administrator shall serve for a period specified in the contract between the Pool and the Administrator subject to removal for cause and subject to any terms, conditions, and limitations of the contract between the Pool and the Administrator. At least one year before the expiration of each period of service by an Administrator, the Board shall invite eligible entities, including the current Administrator, to submit bids to serve as the Administrator. Selection of the Administrator for the succeeding period shall be made at least six months before the end of the current period.

(c) The Administrator shall perform such functions relating to the Pool as may be assigned to it, including:

(1) Determination of eligibility.
(2) Payment of claims.
(3) Establishment of a premium billing procedure for collection of premiums from individuals covered under the Pool.
(4) Other necessary functions to assure timely payment of benefits to covered persons under the Pool.

(d) The Administrator shall submit regular reports to the Board regarding the operation of the Pool. The contract between the Board and the Administrator shall specify the frequency, content, and form of the report.

(e) Following the close of each calendar year, the Administrator shall determine net written and earned premiums, the expense of administration, and the paid and incurred losses for the year and report this information to the Board and the Commissioner on a form prescribed by the Commissioner.

(f) The Administrator shall be paid as provided in the contract between the Board and the Administrator.

"**§ 58-50-260. Risk Pool rates.**

(a) The Pool shall adopt and modify, as appropriate, rates, rate schedules, rate adjustments, expense allowances, agents' referral fees, claim reserve formulas, and any other actuarial function appropriate to the operation of the Pool. Rates and rate schedules may be adjusted for appropriate factors such as age, sex, and geographic variation in claim cost and shall take into consideration appropriate factors in accordance with established actuarial and underwriting practices.

(b) The Pool shall determine the standard risk rate by considering the premium rates charged by other insurers offering health insurance coverage to individuals. The standard risk rate shall be established using reasonable actuarial techniques and shall reflect anticipated experience and expenses for the coverage. Pool rates shall be one hundred fifty percent (150%) of rates established as applicable for individual standard rates.

(c) The Pool shall provide for premium discounts for covered individuals who are nonsmokers or who are actively participating in a smoking cessation program. Approval of smoking cessation programs, criteria for active participation in smoking cessation programs, and discount rates shall be established by the Board, subject to the approval of the Commissioner.

(d) Provider reimbursement rates under Pool coverage shall be limited to the rates allowed for providers under the Medicare Program.

(e) The Pool shall submit all rates and rate schedules to the Commissioner for approval, and the Commissioner must approve the rates and rate schedules before the Pool may use them. The Commissioner, in evaluating the rates and rate schedules, shall consider the factors provided in this section.

"**§ 58-50-265. Eligibility for Pool coverage.**

(a) Any individual who is and continues to be a resident of this State and a citizen of the United States is eligible for Pool coverage if evidence is provided of:

(1) A notice of rejection or refusal to issue substantially similar insurance for health reasons by two insurers. A rejection or refusal by an insurer offering only stop-loss, excess loss, or reinsurance coverage with respect to the applicant is not sufficient evidence of eligibility;

(2) Two offers to issue insurance only with conditional riders that limit coverage for the individual's high-risk medical condition;

(3) Refusal by two insurers to issue insurance except at a rate exceeding the Pool rate;

(4) Diagnosis of the individual with one of the medical or health conditions listed by the Board in accordance with this section. An individual diagnosed with one or more of these conditions is eligible

for Pool coverage without applying for other health insurance coverage;

(5) In the case of an individual who is eligible for coverage under the Health Insurance Portability and Accountability Act of 1996, the individual's maintenance of health insurance coverage, of which the most recent coverage was through an employer-sponsored plan, for the previous 18 months with no gap in coverage greater than 63 days and exhaustion of any available COBRA or State continuation benefits; or

(6) An individual who is legally domiciled in this State and is eligible for the credit for health insurance costs under the Trade Adjustment Assistance Reform Act of 2002, section 35 of the Internal Revenue Code of 1986.

(b) The Board shall adopt a list of medical or health conditions for which a person shall be eligible for Pool coverage without applying for health insurance pursuant to subsection (a) of this section. Persons who can demonstrate the existence or history of any medical or health conditions on the list adopted by the Board shall not be required to provide the evidence specified in subsection (a) of this section. The Board may amend the list as the Board considers appropriate.

(c) Each dependent of an individual who is eligible for Pool coverage shall also be eligible for Pool coverage.

(d) An individual is not eligible for coverage under the Pool if:

(1) The individual has or obtains health insurance coverage substantially similar to or more comprehensive than a Pool policy, or would be eligible to have coverage if the person elected to obtain it, except that:

a. An individual may maintain other coverage for the period of time the individual is satisfying any preexisting condition waiting period under a Pool policy; and

b. An individual may maintain Pool coverage for the period of time the individual is satisfying a preexisting condition waiting period under another health insurance policy intended to replace the Pool policy.

(2) The individual is determined to be eligible for enrollment in the State Medical Assistance Plan.

(3) The individual has previously terminated Pool coverage unless 12 months have lapsed since the termination, except that this subdivision shall not apply with respect to an applicant who is a federally defined eligible individual or to an applicant eligible for or receiving benefits under the Trade Adjustment Assistance Program.

(4) The individual is an inmate or resident of a public institution, except that this subdivision shall not apply with respect to an applicant who is a federally defined eligible individual.

(5) The individual's premiums are paid for or reimbursed under any government-sponsored program or by any government agency or health care provider, except as an otherwise qualifying full-time

employee, or dependent thereof, of a government agency or health care provider. This subdivision shall not apply for individuals receiving benefits under the Trade Adjustment Assistance Program or to individuals receiving premium subsidies made available by the State based on individual income levels.

(6) The individual has in effect on the date Pool coverage takes effect health insurance coverage from an insurer or insurance arrangement.

(e) Coverage under the Pool shall cease:

(1) On the date an individual is no longer a resident of this State.

(2) On the date an individual requests coverage to end.

(3) Upon the death of the covered individual.

(4) On the date State law requires cancellation of the Pool policy.

(5) At the option of the Pool, 30 days after the Pool makes any inquiry concerning the individual's eligibility or residence to which the individual does not reply.

(6) Because the individual has failed to make the payments required under this Part.

(f) Except as provided in subsection (e) of this section, an individual who ceases to meet the eligibility requirements of this section may be terminated at the end of the Pool period for which the necessary premiums have been paid.

"**§ 58-50-270. Unfair referral to Pool.**

It is an unfair trade practice under Article 63 of this Chapter for an insurer, insurance producer, as defined in G.S. 58-33-10(7), or third-party administrator to refer an individual employee to the Pool or arrange for an individual employee to apply to the Pool for the purpose of separating that employee from group health insurance coverage provided in connection with the employee's employment, or for the purpose of separating an individual covered by health insurance offered in the individual market.

"**§ 58-50-275. Minimum Pool benefits.**

(a) The Pool shall offer at least two types of health insurance coverage for individuals eligible under G.S. 58-50-265, including preferred provider organizations with different levels of deductibles and cost-sharing, and at least one choice of a health savings account. The covered services and benefit levels may vary between the types of coverage, but at least two types of coverage must, at a minimum, cover the benefits and services outlined in the National Association of Insurance Commissioners' Model Health Pool for Uninsurable Individuals Act and be consistent with comprehensive coverage generally available to persons who are eligible for health insurance other than Medicare. All health insurance products offered by the Pool shall include disease or case management services.

(b) Health insurance products offered by the Pool shall include not less than one million dollars ($1,000,000) lifetime limit and a sliding scale annual limit of two thousand dollars ($2,000) to five thousand dollars ($5,000) on out-of-pocket expenses. The sliding scale shall be based on family income. The Board shall adjust limitations at least once every five years to reflect changes in the medical component of the Consumer Price Index.

"**§ 58-50-280. Preexisting conditions.**

(a) Pool coverage shall exclude charges or expenses incurred during the first 12 months following the effective date of coverage as to any condition for which medical advice, care, or treatment was recommended or received as to such conditions during the 12-month period immediately preceding the effective date of coverage, except that no preexisting condition exclusion shall be applied to a federally defined eligible individual.

(b) Subject to subsection (a) of this section, the preexisting condition exclusions shall be waived to the extent that similar exclusions, if any, have been satisfied under any prior health insurance coverage that was involuntarily terminated, provided that:

(1) Application for Pool coverage is made not later than 63 days following the involuntary termination, and in such case coverage in the Pool shall be effective from the date on which the prior coverage was terminated; and

(2) The applicant is not eligible for continuation or conversion rights that would provide coverage substantially similar to Pool coverage.

"**§ 58-50-285. Nonduplication of benefits.**

(a) The Pool shall be payor of last resort of benefits whenever any other benefit or source of third-party payment is available. Benefits otherwise payable under coverage shall be reduced by all amounts paid or payable through any other health insurance coverage and by all hospital and medical expense benefits paid or payable under any workers' compensation coverage, automobile medical payment, or liability insurance, whether provided on the basis of fault or no-fault, and by any hospital or medical benefits paid or payable under or provided pursuant to any State or federal law or program.

(b) The Pool shall have a cause of action against an eligible person for the recovery of the amount of benefits paid that are not for covered expenses. Benefits due from the Pool may be reduced or refused as a setoff against any amount recoverable under this subsection.

"**§ 58-50-290. Assessments.**

(a) For the purposes of providing the funds necessary to carry out the powers and duties of the Pool, the Board shall assess all insurers at such time and for such amounts as the Board finds necessary. Assessments shall be due in not less than 30 days after prior written notice to the member insurers and shall accrue interest at twelve percent (12%) per annum on and after the due date.

(b) Each insurer shall be assessed in an amount not to exceed two dollars ($2.00) per covered individual insured or reinsured by each insurer per month. The assessment will be based on actual and expected losses, actuarially appropriate reserves, and administrative expenses in excess of expected and collected premiums and federal loss reimbursements, if any, received by the Pool.

(c) The Board shall make reasonable efforts designed to ensure that each covered individual is counted only once with respect to any assessment. For that purpose, the Board shall require each insurer that obtains excess or stop-loss insurance to include in its count of covered individuals all individuals whose coverage is insured (including by

way of excess or stop-loss coverage) in whole or in part. The Board shall allow a reinsurer to exclude from its number of covered individuals those who have been counted by the primary insurer or by the primary reinsurer or primary excess or stop-loss insurer for the purposes of determining its assessment under this section.

(d) The Board may verify each insurer's assessment based on annual statements and other reports deemed to be necessary by the Board. The Board may use any reasonable method of estimating the number of covered individuals of an insurer if the specific number is unknown.

(e) If assessments and other receipts by the Pool, Board, or administering insurer exceed the actual losses and administrative expenses of the plan, the excess shall be held at interest and used by the Board to offset future losses or to reduce plan premiums. Future losses include reserves for claims incurred but not reported.

(f) The Commissioner may suspend or revoke, after notice and hearing, the certificate of authority to transact insurance in this State of any member insurer that fails to pay an assessment. As an alternative, the Commissioner may levy a forfeiture on any member insurer that fails to pay an assessment when due. The forfeiture may not exceed five percent (5%) of the unpaid assessment per month, but no forfeiture shall be less than one hundred dollars ($100.00) per month.

"**§ 58-50-295. Complaint procedures.**

An applicant or participant in coverage from the Pool is entitled to have complaints against the Pool reviewed by a grievance committee appointed by the Board. Members of the Board shall not serve on the grievance committee. The grievance process shall comply with G.S. 58-50-62. The grievance committee shall report to the Board after completion of the review of each complaint. The Board shall retain all written complaints regarding the Pool at least until the third anniversary of the date the Pool received the complaint. An applicant or participant may file for external review of the applicant's grievance after having exhausted the Pool's internal grievance procedure. External review shall be conducted in accordance with Part 4 of this Article.

"**§ 58-50-300. Audit.**

The State Auditor shall conduct annually a special audit of the Pool. The State Auditor's report shall include a financial audit and an economic and efficiency audit. The State Auditor shall report the cost of each audit conducted under this Part to the Board and the Comptroller, and the Board shall remit that amount to the Comptroller for deposit to the General Fund.

"**§ 58-50-305. Taxation.**

The Pool established under this Part is exempt from any and all taxes.

"**§ 58-50-310. Rules.**

The Commissioner may adopt rules, including temporary rules, to implement this Part.

"**§ 58-50-315. Collective action.**

The participation in the Pool as participating insurers, the establishment of rates, forms, or procedures, and any other joint or collective action required by this Part may not be the basis of any legal action or criminal or civil liability or penalty against the Pool or any participating insurer."

SECTION 1.2. The Board of Directors of the North Carolina Health Insurance Risk Pool, as appointed under Section 1 of this act, shall monitor methods of financing the Pool to ensure a stable funding source and allow for its continued operation. This monitoring shall include supplementary sources of funding, such as funds obtained from public and private not-for-profit foundations, or other appropriate and available State or non-State funds. The Board shall also review on a regular basis:

(1) The number of individuals in this State who are uninsured as of a date certain because of high-risk conditions.

(2) The number of uninsured individuals who would qualify for coverage under the Pool based on G.S. 58-50-265 and its Plan of Operation.

(3) The cost of coverage under each of the health insurance plans developed by the Board, including administrative costs.

The Board shall report its findings and recommendations to the General Assembly on March 1, 2007, and annually thereafter.

SECTION 1.3. The North Carolina Health Insurance Risk Pool Administrator shall study methods for encouraging healthy behaviors and report its findings to the Board of Directors of the Pool and to the General Assembly not later than one year after initial implementation of the Pool.

SECTION 1.4. The Board of Directors of the Pool shall apply for grant funds available from the federal government to help support the implementation and ongoing costs of operating a high-risk pool. If federal funds are available for purposes for which funds were appropriated in this act from the General Fund, such federal funds shall be used to reimburse the General Fund, to the maximum extent allowable, for amounts appropriated for this purpose.

SECTION 2. G.S. 58-6-25(d) is amended by adding the following new subdivision to read:

...

"(d) Use of Proceeds. – The Insurance Regulatory Fund is created in the State treasury, under the control of the Office of State Budget and Management. The proceeds of the charge levied in this section and all fees collected under Articles 69 through 71 of this Chapter and under Articles 9 and 9C of Chapter 143 of the General Statutes shall be credited to the Fund. The Fund shall be placed in an interest-bearing account and any interest or other income derived from the Fund shall be credited to the Fund. Moneys in the Fund may be spent only pursuant to appropriation by the General Assembly and in accordance with the line item budget enacted by the General Assembly. The Fund is subject to the provisions of the Executive Budget Act, except that no unexpended surplus of the Fund shall revert to the General Fund. All money credited to the Fund shall be used to reimburse the General Fund for the following:

...

(6) Money appropriated to the Department of Insurance for the Special Reserve for the North Carolina Health Insurance Risk Pool."

SECTION 3.1. There is appropriated from the General Fund to the Department of Insurance the sum of $ for the 2006-2007 fiscal year. These funds shall

be used to support # additional full-time positions in the Department to carry out the Department's responsibilities under the North Carolina Health Insurance Risk Pool.

SECTION 3.2. There is appropriated from the General Fund to the Department of Insurance the sum of two hundred thousand dollars ($200,000) for the 2006-2007 fiscal year. These funds shall be placed in a Special Reserve for the North Carolina Health Insurance Risk Pool in the Department of Insurance and shall be allocated for the reasonable expenses of the Board in conducting its duties under Section 1 of this act. The North Carolina Health Insurance Risk Pool shall not offer or provide coverage under Section 1 of this act until the effective date of an act of the General Assembly that establishes or approves a method or methods for financing the Pool as specified in this act.

SECTION 3.3. There is appropriated to the Special Reserve for the North Carolina Health Insurance Risk Pool the sum of $ for the 2006-2007 fiscal year. These funds shall be used to provide a premium subsidy on a sliding scale basis for individuals with incomes up to three hundred percent (300%) of the federal poverty guidelines who are participating in the North Carolina Health Insurance Risk Pool. The subsidy shall pay for ninety-five percent (95%) of the premium costs for individuals with incomes below one hundred percent (100%) of the federal poverty guidelines, to be phased out when a family's income reaches three hundred percent (300%) of the federal poverty guidelines, and will be based on the lowest cost plan offered through the High-Risk Pool. Individuals who are eligible for a federal premium subsidy under the Trade Adjustment Act (TAA) must apply for premium subsidy under that Act. The amount of the State premium subsidy, if any, shall be reduced by any federal premium subsidy provided. Funds appropriated under this section shall not revert to the General Fund but shall remain in the Special Reserve for the purposes specified in this section.

SECTION 4. Sections 3.1, 3.2, and 3.3 of this act become effective July 1, 2006. The remainder of this act is effective when it becomes law. Enrollment in the North Carolina Health Insurance Risk Pool shall commence no earlier than January 1, 2007.

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2005

H D

HOUSE DRH70573-SQz-7 (04/11)

Short Title:	NC Health Care System Study Commission.	(Public)
Sponsors:	Representatives	
Referred to:		

A BILL TO BE ENTITLED

AN ACT TO CREATE A JOINT COMMISSION TO STUDY ESTABLISHING A FORMAL PLAN FOR TRANSITIONING FROM THE CURRENT SYSTEM OF DELIVERING HEALTH CARE TO A SYSTEM THAT COVERS ALL NORTH CAROLINIANS, AS RECOMMENDED BY THE HOUSE SELECT COMMITTEE ON HEALTH CARE.

Whereas, nations that assure health care for all spend significantly less per capita and as a percentage of Gross Domestic Product on health care than the U.S.; and

Whereas, in many of these nations a basic health care plan for all residents effectively coexists with supplemental private sector plans; and

Whereas, these same nations have health care systems that achieve better health care outcomes than those achieved in the U.S.; and

Whereas, the health care outcomes in North Carolina are considered at or below average when compared to other states in the nation; and

Whereas, investing in a health care model that covers all North Carolinians and includes early intervention and personal responsibility will reduce State health expenditures while improving health care outcomes and will make North Carolina's business climate more appealing while making North Carolina businesses more competitive in the global market; and

Whereas, our current system leads hospitals to spend millions of dollars on emergency department improvements that lead to higher hospital admissions while proven, more cost-effective, early intervention models struggle for funding; and

Whereas, the large and growing numbers of the uninsured are left out of the medical expense bargaining process; and

Whereas, our current health care system requires the uninsured to pay at higher rates than the insured; and

Whereas, North Carolinians overwhelmingly believe the General Assembly should assure all North Carolinians have access to health care; and

Whereas, we have a unique opportunity where creating a just health care system will provide significant economic advantages to the State, its residents, and to North Carolina businesses; Now, therefore,

The General Assembly of North Carolina enacts:

SECTION 1.(a) Commission Established. – There is established in the General Assembly a Joint Legislative Commission on Transitioning to a Health Care System that Covers All North Carolinians.

SECTION 1.(b) Membership. – The Commission shall consist of eight members as follows:

(1) Four members of the House of Representatives appointed by the Speaker of the House of Representatives.

(2) Four members of the Senate appointed by the President Pro Tempore of the Senate.

SECTION 1.(c) Duties of the Commission. – The Commission shall study the need for a health care system that covers all North Carolinians. The Commission shall establish a formal plan for transitioning from the current fragmented system of delivering health care to a system that covers all North Carolinians and may propose legislation, including constitutional amendments if necessary, to implement the plan.

SECTION 1.(d) Vacancies. – A vacancy shall be filled by the officer who made the original appointment.

SECTION 1.(e) Cochairs. – The Speaker of the House of Representatives and the President Pro Tempore of the Senate shall designate cochairs of the Commission from among their respective appointees. The Commission shall meet upon the call of the cochairs. A quorum of the Commission shall be four members.

SECTION 1.(f) Expenses of Members. – Members of the Commission shall receive per diem, subsistence, and travel allowances in accordance with G.S. 120-3.1, 138-5, or 138-6, as appropriate.

SECTION 1.(g) Staff. – The Legislative Services Commission, through the Legislative Services Officer, shall assign professional staff to assist the Commission in its work. The House of Representatives' and the Senate's Supervisors of Clerks shall assign clerical staff to the Commission, and the expenses related to the clerical employees shall be borne by the Commission.

SECTION 1.(h) Consultants. – The Commission may employ consultants to assist with the study as provided in G.S. 120-32.02. Before expending any funds for a consultant, the Commission shall report to the Joint Legislative Commission on Governmental Operations on the consultant selected, the work products to be provided by the consultant, and the cost of the contract, including an itemization of the cost components.

SECTION 1.(i) Meeting Location. – Subject to the approval of the Legislative Services Commission, the Commission may meet in the State Legislative Building or the Legislative Office Building.

SECTION 1.(j) Report. – The Commission shall submit a final report of its findings and recommendations to the General Assembly no later than December 31, 2006. Upon the filing of its final report, the Commission shall terminate.

SECTION 1.(k) Funds. – Of the funds appropriated to the General Assembly, the Legislative Services Commission shall allocate funds to implement the provisions of this section.

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

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2005

H D

HOUSE DRH70572-LNz-235 (4/13)

Short Title: Reenact Long-Term Care Insurance Tax Credit. (Public)

Sponsors:

Referred to:

A BILL TO BE ENTITLED

AN ACT TO REENACT THE LONG-TERM CARE INSURANCE TAX CREDIT, AS RECOMMENDED BY THE HOUSE SELECT COMMITTEE ON HEALTH CARE.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 105-151.28 is reenacted.

SECTION 2. G.S. 105-160.3(b)(7) is reenacted.

SECTION 3. This act is effective for taxable years beginning on or after January 1, 2006.

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2005

H D

HOUSE DRH80466-RU-41 (04/05)

Short Title:	Medical Malpractice Settlement Reports.	(Public)
Sponsors:	Representatives	
Referred to:		

A BILL TO BE ENTITLED

AN ACT TO PROVIDE FOR THE REPORTING OF DETAILS OF SETTLEMENTS OF MEDICAL MALPRACTICE CLAIMS, AS RECOMMENDED BY THE HOUSE SELECT COMMITTEE ON HEALTH CARE.

The General Assembly of North Carolina enacts:

SECTION 1. Article 1B of Chapter 90 is amended by adding the following new section to read:

"**§ 90-21.18D. Settlements in medical malpractice actions; reporting.**

(a) In any medical malpractice action in which the parties agree to settle the claim, in reporting the claim under G.S. 58-2-170, the insurer shall identify the amount of the settlement attributable to economic damages and provide documentation to substantiate that amount.

(b) In any medical malpractice action in which the parties agree to settle the claim, the attorney for the plaintiff shall report the settlement to the Department of Insurance. The report shall include a certification and documentation of the amount of the settlement proceeds received in reimbursement of any costs incurred in prosecution of the case, including separate amounts expended for expert witnesses, exhibits, travel, all other categories of expenses which the attorney charges to the plaintiff, and the amount of the settlement attributable to attorneys' fees.

(c) For purposes of this section, a medical malpractice action is settled if at any time after the claim is made and before, during, or after trial, the parties mutually agree to end the litigation in exchange for monetary payment.

(d) As used in this section, the following terms mean:

(1) Economic damages. – Damages to compensate for present and future medical costs, hospital costs, custodial care, rehabilitation costs, lost earnings, loss of bodily function, and any other pecuniary damages.

(2) Insurer. – Every insurer, self-insurer, and risk retention group, as those terms are defined in Chapter 58 of the General Statutes, that provides professional malpractice insurance to health care providers in this State."

SECTION 2. This act becomes effective October 1, 2006, and applies to settlements entered into on or after that date.

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2005

H D

HOUSE DRH80465-RU-42 (04/05)

Short Title:	Periodic Payments for Medical Malpractice.	(Public)
Sponsors:	Representatives	
Referred to:		

A BILL TO BE ENTITLED

AN ACT TO ALLOW FOR PAYMENT OF FUTURE EXPENSES ARISING FROM MEDICAL MALPRACTICE ACTIONS TO BE BY PERIODIC PAYMENTS, AS RECOMMENDED BY THE HOUSE SELECT COMMITTEE ON HEALTH CARE.

The General Assembly of North Carolina enacts:

SECTION 1. Article 1B of Chapter 90 is amended by adding the following new section to read:

"**§ 90-21.18E. Periodic payment of future economic damages in medical malpractice actions.**

(a) As used in this section, the following terms mean:

(1) Future economic damages. – Damages for future medical treatment, care or custody, loss of future earnings, loss of bodily function, and any other pecuniary damages of the plaintiff following the date of the verdict or award.

(2) Periodic payments. – The payment of money or delivery of other property to the plaintiff at regular intervals.

(b) In any medical malpractice action, the form of the fact finder's verdict or award of damages, if supported by the evidence, shall indicate specifically what amount is awarded for future economic damages.

(c) Upon the award of future economic damages in any medical malpractice action, the presiding judge shall, at the request of either party, enter a judgment ordering that the future economic damages of the plaintiff be paid in whole or in part by periodic payments rather than by a lump-sum payment if the award exceeds one hundred thousand dollars ($100,000) in future economic damages. In entering a judgment ordering the payment of future economic damages by periodic payments, the court shall make a specific finding as to the dollar amount of periodic payments that will

compensate the plaintiff for such future economic damages. The calculation of any attorney contingency fee for representing the plaintiff in connection with the medical malpractice action shall be based upon the present value of such future economic damages.

(d) As a condition to authorizing periodic payments of future economic damages, the court shall require that such payments be made through the establishment of a trust fund or the purchase of an annuity for the life of the plaintiff or during the continuance of the compensable injury or disability of the plaintiff. The establishment of a trust fund or the purchase of an annuity, as required and approved by the court, shall constitute the satisfaction of the defendant's judgment for future economic damages.

(e) The judgment ordering the payment of future economic damages by periodic payments shall specify the recipient of the payments, the dollar amount of the payments, the interval between payments, and the number of payments or the period of time over which payment shall be made. Payments shall only be subject to modification by the court in the event of the death of the plaintiff, as provided in subsection (f) of this section.

(f) In any judgment where future economic damages are payable in periodic payments, liability for payment of future economic damages not yet due shall terminate upon the death of the plaintiff. Provided, however, that the court which rendered the original judgment may modify the judgment to provide that damages awarded for loss of future earnings shall not be reduced or payments terminated by reason of the death of the plaintiff, but shall be paid to persons to whom the plaintiff owed a duty of support, as provided by law, immediately prior to the plaintiff's death if such persons have survived the plaintiff."

SECTION 2. This act becomes effective October 1, 2006, and applies to actions filed on or after that date.

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2005

H D

HOUSE DRH80464-RU-43 (04/05)

Short Title:	Appeal Bond for Medical Malpractice.	(Public)
Sponsors:	Representatives	
Referred to:		

A BILL TO BE ENTITLED

AN ACT TO MODIFY APPEAL BONDS IN MEDICAL MALPRACTICE ACTIONS, AS RECOMMENDED BY THE HOUSE SELECT COMMITTEE ON HEALTH CARE.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 1-289 reads as rewritten:

"**§ 1-289. Undertaking to stay execution on money judgment.**

(a) If the appeal is from a judgment directing the payment of money, it does not stay the execution of the judgment unless a written undertaking is executed on the part of the appellant, by one or more sureties, to the effect that if the judgment appealed from, or any part thereof, is affirmed, or the appeal is dismissed, the appellant will pay the amount directed to be paid by the judgment, or the part of such amount as to which the judgment shall be affirmed, if affirmed only in part, and all damages which shall be awarded against the appellant upon the appeal, except as provided in ~~subsection (b)~~subsections (b) and (b1) of this section. Whenever it is satisfactorily made to appear to the court that since the execution of the undertaking the sureties have become insolvent, the court may, by rule or order, require the appellant to execute, file and serve a new undertaking, as above. In case of neglect to execute such undertaking within twenty days after the service of a copy of the rule or order requiring it, the appeal may, on motion to the court, be dismissed with costs. Whenever it is necessary for a party to an action or proceeding to give a bond or an undertaking with surety or sureties, he may, in lieu thereof, deposit with the officer into court money to the amount of the bond or undertaking to be given. The court in which the action or proceeding is pending may direct what disposition shall be made of such money pending the action or proceeding. In a case where, by this section, the money is to be deposited with an officer, a judge of the court, upon the application of either party, may, at any time before the deposit is made, order the money deposited in court instead of with the officer; and a deposit made

pursuant to such order is of the same effect as if made with the officer. The perfecting of an appeal by giving the undertaking mentioned in this section stays proceedings in the court below upon the judgment appealed from; except when the sale of perishable property is directed, the court below may order the property to be sold and the proceeds thereof to be deposited or invested, to abide the judgment of the appellate court.

(b) If the appellee in a civil action brought under any legal theory obtains a judgment directing the payment or expenditure of money in the amount of twenty five million dollars ($25,000,000) or more, and the appellant seeks a stay of execution of the judgment within the period of time during which the appellant has the right to pursue appellate review, including discretionary review and certiorari, the amount of the undertaking that the appellant is required to execute to stay execution of the judgment during the entire period of the appeal shall be twenty five million dollars ($25,000,000).

(b1) If the appellee in any medical malpractice action, as defined in G.S. 90-21.11, obtains a judgment directing the payment or expenditure of money, and the appellant seeks a stay of execution of the judgment within the period of time during which the appellant has the right to pursue appellate review, including discretionary review and certiorari, the amount of the undertaking that the appellant is required to execute to stay execution of the judgment during the entire period of the appeal shall be the lesser of the amount of the judgment or the amount of the appellant's medical malpractice insurance coverage applicable to the action.

(c) If the appellee proves by a preponderance of the evidence that the appellant for whom the undertaking has been limited under subsection (b) or (b1) of this section is, for the purpose of evading the judgment, (i) dissipating its assets, (ii) secreting its assets, or (iii) diverting its assets outside the jurisdiction of the courts of North Carolina or the federal courts of the United States other than in the ordinary course of business, then the limitation in ~~subsection (b)~~subsections (b) and (b1) of this section shall not apply and the appellant shall be required to make an undertaking in the full amount otherwise required by this section."

SECTION 2. This act becomes effective October 1, 2006, and applies to judgments enter on or after that date.

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2005

H D

HOUSE DRH60554-RU-44 (04/05)

Short Title:	Bifurcation of Medical Malpractice Trials.	(Public)
Sponsors:	Representatives	
Referred to:		

A BILL TO BE ENTITLED

AN ACT TO ALLOW FOR BIFURCATION OF ISSUES OF LIABILITY AND DAMAGES IN MEDICAL MALPRACTICE ACTIONS, AS RECOMMENDED BY THE HOUSE SELECT COMMITTEE ON HEALTH CARE.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 1A-1, Rule 42(b), reads as rewritten:

"(b) Separate trials. –

(1) The court may in furtherance of convenience or to avoid prejudice and shall for considerations of venue upon timely motion order a separate trial of any claim, cross-claim, counterclaim, or third-party claim, or of any separate issue or of any number of claims, cross-claims, counterclaims, third-party claims, or issues.

(2) Upon motion of any party in an action that includes a claim commenced under Article 1G of Chapter 90 of the General Statutes involving a managed care entity as defined in G.S. 90-21.50, the court shall order separate discovery and a separate trial of any claim, cross-claim, counterclaim, or third-party claim against a physician or other medical provider.

(3) Upon motion of any party in a medical malpractice action commenced under Article 1B of Chapter 90 of the General Statutes wherein the plaintiff alleges damages greater than one hundred thousand dollars ($100,000), the court shall order separate trials for the issue of liability and the issue of damages. Evidence relating solely to pecuniary damages shall not be admissible until the trier of fact has determined that the defendant is liable for medical malpractice. The same trier of fact that tried the issues relating to liability shall try the issues relating to damages."

SECTION 2. This act becomes effective October 1, 2006, and applies to actions filed on or after that date.

APPENDICES

I. SPEAKER'S AUTHORIZATION OF THE HOUSE SELECT COMMITTEE ON HEALTH CARE.

II. AN ANALYSIS OF PREMIUM ASSISTANCE UNDER NORTH CAROLINA MEDICAID.

III. CHART OF APPROPRIATIONS REQUESTED IN LEGISLATIVE PROPOSALS

IV. SUBCOMMITTEE PROCEEDINGS

APPENDIX I

James B. Black
Speaker

Office of the Speaker
North Carolina House of Representatives
Raleigh, North Carolina 27601-1096

Revision: November 16, 2005

HOUSE SELECT COMMITTEE ON HEALTH CARE
TO THE HONORABLE MEMBERS OF THE
NORTH CAROLINA HOUSE OF REPRESENTATIVES

WHEREAS, health care costs and health care quality are pressing issues facing North Carolina citizens, businesses, and all levels of government; and

WHEREAS, affordable access to health care is a growing concern for many North Carolina families; and

WHEREAS, many communities in rural and urban North Carolina lack reliable access to physicians and other health care providers and the shortage of health care professionals is a growing concern in the State; and

WHEREAS, the State Health Plan is the primary vehicle for providing health care services for thousands of State employees and teachers and therefore the effectiveness of the State Health Plan is critically important for many North Carolina families and North Carolina taxpayers; and

WHEREAS, promoting quality health care for every North Carolinian is essential for our State's economic growth; and

WHEREAS, all the parties involved in the delivery of health care need to address the issues affecting patient safety in health care delivery; and

WHEREAS, Medicaid remains the primary method by which many elderly, poor, and disabled North Carolina citizens receive basic health care treatment and Medicaid spending is a growing component of the State's Budget;

NOW THEREFORE,

Section 1. The **House Select Committee on Health Care** ("Select Committee") is established by the Speaker of the House of Representatives, effective November 3, 2005, as a select committee of the House pursuant to G.S. 120-19.6(a) and Rule 26(a) of the Rules of the House of Representatives of the 2005 General Assembly.

Section 2. The Select Committee consists of 56 members and six subcommittees. The individuals listed below are appointed as members of the Select Committee and its subcommittees, as indicated. The members of the Select Committee serve at the pleasure of the Speaker of the House. The Speaker of the House may dissolve the Select Committee at any time.

Representative Nye, Co-Chair
Representative Wright, Co-Chair
Representative England, Co-Chair

Health Care – Subcommittee on Medicaid

Representative Nye – Co-Chair	Representative Earle – Co-Chair
Representative Dickson	Representative Howard
Representative Owens	Representative Rapp
Representative Sutton	Representative Walend
Representative Culp	

Heath Care – Subcommittee on the Cost of Health Care and Health Insurance for Employees and Employers

Representative Holliman – Co-Chair	Representative Underhill – Co-Chair
Representative Faison	Representative Grady
Representative Goforth	Representative McGee
Representative Sherrill	Representative Bell
Representative Bordsen	

Health Care – Subcommittee on Safety, Quality, Accountability

Representative Culpepper – Co-Chair	Representative L. Allen – Co-Chair
Representative Brubaker	Representative Tucker
Representative Justice	Representative Justus
Representative Ross	Representative Warren

Health Care – Subcommittee on Healthcare Workforce

Representative Tolson – Co-Chair	Representative Carney – Co-Chair
Representative Clary	Representative Current
Representative Farmer-Butterfield	Representative Hollo
Representative McLawhorn	Representative Wilkins
Representative Adams	

Health Care – Subcommittee on Access

Representative England – Co-Chair	Representative Insko – Co-Chair
Representative Fisher	Representative Pate
Representative Setzer	Representative Weiss
Representative Williams	Representative Womble
Representative Barnhart	Representative Coates
Representative McAllister	Representative Walker

Health Care – Subcommittee on the State Health Plan

Representative Wright – Chair	Representative Church
Representative Coleman	Representative Crawford
Representative Eddins	Representative Folwell
Representative Gulley	Representative Michaux
Representative Haire	

Section 3. The Select Committee and its appropriate subcommittees shall study the following issues:

1. The ability of North Carolina citizens to obtain quality, affordable health care services and to have access to doctors and other health professionals in all areas of the State.
2. The increasing burden of health care costs, including the cost of prescription medications, for individuals, families, and employers.
3. The effectiveness of the State Health Plan in providing State employees and their families with quality health care services and improving their overall health while remaining affordable for employees and the State.
4. Ways to improve the safety and quality of health care services in North Carolina and efforts to enhance the accountability of all parties in the health care field.
5. How individuals transition between Medicaid and Medicare and how that transition affects the individual's health and finances and the State's expenditures on Medicaid.
6. Increasing the number of professionals available to provide dental, pharmacy, and health care services in North Carolina, overcoming barriers contributing to provider shortages, and retaining quality health care providers.
7. Any other issues related to health care as determined by the Co-chairs.

Section 4. In undertaking this study, the Select Committee may review the work and consider any findings and recommendations of previous study commissions, committees, and task forces that relate to the issues outlined above.

Section 5. The Select Committee shall meet upon the call of its Co-chairs. A quorum of the Select Committee shall be a majority of its members. A subcommittee shall meet upon the call of the subcommittee chair. A quorum of a subcommittee shall be a majority of its members.

Section 6. The Select Committee, while in discharge of its official duties, may exercise all powers provided for under G.S. 120-19 and Article 5A of Chapter 120 of the General Statutes.

Section 7. The expenses of the Select Committee including per diem, subsistence, travel allowances for Select Committee members, and contracts for professional or consultant services shall be paid upon the written approval of the Speaker of the House of Representatives pursuant to G.S. 120-32.02(c) and G.S. 120-35 from funds available to the House of Representatives for its operations.

Section 8. The Legislative Services Officer shall assign professional and clerical staff to assist the Select Committee in its work. The House of Representatives' Supervisor of Clerks shall assign clerical support staff to the Committee.

Section 9. The Select Committee may meet at various locations around the State in order to promote greater public participation in its deliberations. The Legislative Services Commission shall grant adequate meeting space to the Select Committee in the State Legislative Building or the Legislative Office Building.

Section 10. Each subcommittee may submit an interim report to the Select Committee on or before April 15, 2006. Each subcommittee shall submit a final subcommittee report to the Select Committee on or before December 1, 2006.

Section 11. The Select Committee may submit an interim report on the results of the study, including any proposed legislation, on or before May 1, 2006, by filing a copy of the report with the Speaker's Office, the House Principal Clerk, and the Legislative Library. The Select Committee shall submit a final report on the results of its study, including any proposed legislation, to the members of the House of Representatives on or before December 31, 2006, by filing the final report with the Speaker's Office, the House Principal Clerk, and the Legislative Library. The Select Committee terminates on December 31, 2006, or upon the filing of its final report, whichever occurs first.

Effective this 9th day of November, 2005.

James B. Black, Speaker

APPENDIX II

An Analysis of Premium Assistance under North Carolina Medicaid

Kate Abramson Andrew Bye Katie Owen Hirsh Sandesara Catherine Wu
Duke University

April 11, 2006

Presentation Outline

- Overview of premium assistance
- Impact on coverage and health
- Equity concerns
- Impact on Medicaid costs and financing
- Conclusions and policy implications

Premium Assistance: Overview

- **Program components:**
  - Subsidy: flat dollar amount vs. case-by-case (A-D)
  - Wraparound coverage (B,D)
  - Waiting period (C,D)

	Premium Assistance Program Option			
	A	B	C	D
Subsidy	X	X	X	X
Wraparound		X		X
Waiting period			X	X

Benefits: Cost Savings and Health Outcomes

- **Cost Savings**
  - Medicaid enrollment
  - Medicaid spending
- **Improved health outcomes**
  - Benefits of insurance
  - Medicaid and ESI: public vs. private

Recommendation: Program B

- Case-by-case subsidies
- Wraparound coverage
  - Maintain health among enrollees
  - Increased enrollment → Increased cost savings
  - Necessary to receive matching federal dollars through potential HHS waivers (1115 HIFA)
- No Waiting periods (C,D)
- No Mandatory enrollment

Total Cost Savings

Premium Assistance (Program B)	$2358
Traditional Medicaid	$2815
Cost Savings	**$457 per person**

Estimated Enrollment	5,800
Total Annual Cost Savings	**$2.65 million**

*See handout for other program options

An Analysis of Premium Assistance under North Carolina Medicaid

Premium Assistance: An Overview

What is premium assistance?

Premium assistance is a state funding strategy that allows a state government to offer premium subsidies for employer-sponsored insurance premiums to Medicaid and Medicaid eligible constituents.

Table 1. Program Options

	Premium Assistance Program Option			
	A	**B**	**C**	**D**
Subsidy	X	X	X	X
Wraparound		X		X
Waiting period			X	X

Why premium assistance?

Other states with premium assistance demonstrated that for existing Medicaid beneficiaries, cost savings to the state can occur. As the cost of Medicaid continues to rise, premium assistance offers cost savings without cutting benefits or limiting eligibility.

Benefits include: expanded health insurance coverage, improved health

Costs include: subsidy, wraparound coverage, administration (program design, outreach/marketing, IT system, staff)

Cost analysis approach:

I) Subsidies = (Average premium cost) x (take-up rate x eligible population)

II) Wrap-around = (Average wrap-around cost) x (take-up rate x eligible population)

III) Administration = (Initial outreach + New IT system) + (Staff salaries + outreach)

Cost Savings = Current Medicaid Costs – (I + II + III)

Table 2. Cost Savings in Other States

State	Cost-Effectiveness Requirements	Data on Savings
Iowa	Paying the ESI premium must save the state at least $5 per month compared to the average cost of Medicaid	State believes it is saving an average of $70.13 per beneficiary-per-month
NJ	Subsidized coverage must realize both a 5% savings in coverage costs and a 5% savings in administrative costs	$203.97 per family per month (this varies from month to month)
RI	Monthly premium share plus the cost of wraparound coverage must be less than the capitation rate for the average Medicaid family	An average of $222.45 per family per month (including administrative costs)
Utah	State's costs controlled by cap on subsidy amount	Subsidy is $50 pmpm, compared to $80 pmpm for direct coverage*

Source: Alker J. Premium Assistance Programs: How Are They Financed and Do States Save Money? Kaiser Family Foundation. Available online http://www.kff.org/medicaid/upload/Premium-Assistance-Programs-How-are-they-Financed-and-do-States-Save-Money-Issue-Brief.pdf

APPENDIX III

HOUSE SELECT COMMITTEE ON HEALTH CARE

APPROPRIATIONS NEEDED FOR LEGISLATIVE PROPOSALS
April 11, 2006

Purpose of Appropriation	Amount Requested	Comment
Medicaid County Share	$30,390,000 – 2006-2007 $34,610,000 – 2006-2007	These funds will come from savings realized pursuant to the Medicare D Program.
Dissemination of Information on Primary Stroke Centers	None	Possible fiscal impact on DHHS for dissemination of information.
Statewide Program on Infection Control and Epidemiology	$663,000 – 2006-2007	
Nursing Faculty Fellows Program	$400,000 – 2006-2007	
Community Health Care Grants	$15,000,000 – 2006-2007	
Health Insurance Risk Pool	$200,000 – 2006-2007	$200,000 for Pool Start-up. Additional funds may be requested for Department of Insurance administrative costs, and for premium subsidies under the Risk Pool.
TOTAL REQUESTED	$81,263,000	This amount does not account for funds that may be needed but are not requested in the legislative proposal.

APPENDIX IV

COMMITTEE PROCEEDINGS OF THE
SUBCOMMITTEES OF
THE HOUSE SELECT COMMITTEE ON HEALTH CARE

Subcommittee on Medicaid

The House Select Committee on Health Care, Subcommittee on Medicaid met five times during the period December 21, 2005 through March 28, 2006. At these meetings subcommittee members heard presentations on the following topics:

December 21, 2005

Overview of the Medicaid Program by Carol Shaw, NC General Assembly Fiscal Research Division. This overview addressed work of the Blue Ribbon Commission on Medicaid Reform, a summary of legislation proposed or enacted in 2005, and the impact of the federal Medicare Part D program on the State Medicaid Program.

Updates from the Department of Health and Human Services, Division of Medical Assistance (DMA). Presenters were Dr. L. Allen Dobson, Jr., M.D., Assistant Secretary for Health Policy and Medical Assistance; Mr. Mark Benton, Senior Deputy Director of DMA; Mr. Tom D'Andrea, Chief of Pharmacy and Ancillary Services, DMA; Lynn Perrin, Chief of Facility and Community Services; and Mr. Jeffrey Simms, Assistant Director for Managed Care. Topics addressed included General Medicaid information and strategic plan, Pharmacy Plan overview, Personal Care Services, Community Care of NC-Management of Aged, Blind, and Disabled Medicaid Recipients, and an update on the NC Health Choice Transition

January 11, 2006

Impact of Medicaid on County Budgets. Presentations on this topic were made by Terry Garrison, North Carolina Association of County Commissioners (NCACC) First Vice-President and Vance County Commissioner; David Cooke, NCACC Medicaid Relief Task Force Chairman and Wake County Manager; Carol Shaw, NCGA Fiscal Research. Ms. Shaw presented the subcommittee with options for reducing the county share of the nonfederal share of Medicaid expenses.

An update on the Federal Budget Reconciliation Act of 2005 was presented by Carol Shaw, NCGA Fiscal Research Division.

The Subcommittee also heard from Dr. Joe Holiday, DHHS, Division of Public Health, Women and Children's Health Section. Dr. Holiday gave a presentation on Implementation of the Family Planning Medicaid Waiver.

The Subcommittee approved a research project by students of the Duke Capstone Project for Health Policy Certificate. The project focuses on the question "Should North Carolina adopt a premium assistance program for existing Medicaid recipients or for low-income uninsured individuals who are employed?" The House Select Committee will hear a presentation from the Duke Capstone Project students at its meeting on April 11, 2006.

February 10, 2006

Medicaid: Options to Expand Health Insurance Coverage to Uninsured Persons, presented by Dr. Pam Silberman, President of the Institute of Medicine. Dr. Silberman reviewed data on persons in NC who are uninsured, and presented the IOM priority recommendations for action by the State: expand the health care safety net through local health departments and clinics; promote healthy lifestyles; adopt Healthy North Carolina, an insurance program modeled after Healthy NY; provide for Medicaid expansion to certain individuals not now eligible for Medicaid; adopt a State High Risk Pool.

Supplementing Medicare Part D Program Coverage: Other States' Responses. Carol Shaw presented information to the subcommittee on how certain other states are addressing Medicare Part D coverage. Ms. Shaw also provided revised estimates of the impact of the Medicare Part D program on the State budget, and reported on the status of the Disproportionate Share Program.

Impact of the Medicare Part D Program on NC Pharmacists. Presentations were made by Mr. Mike James, PPh, Association of Community Pharmacists; Mr. Bill Rustin, Association of Community Pharmacists; and Mr. Andy Ellen, NC Retail Merchants Association.

March 8, 2006

Topics presented at this meeting included:

Utilization Management of Personal Care Services, presented by Tracy Colvard, CAP/DA and PCS Unit Manager in the Division of Medical Assistance; and Sherry Thomas, Senior Vice President, Association for Home & Hospice Care of North Carolina. Ms. Thomas also gave a presentation on Telehomecare.

Presentations from representatives of private health organizations: Health Systems One (Mr. Luis Mosquera, CEO, and Mr. Charles Wilhelm, MD, Chief Medical Officer); The Carolinas Center for Medical Excellence (Mr. Robert R. Weiser, Director of Health Care Assessment); Confidant (Mr. David Jackson, CEO and Chairman, and Mr. Thomas Wall, Vice President for Business Development); and Well Path, A Coventry Health Plan (Mr. Peter Chauncey, Chief Operating Officer, Mr. Bobby L. Jones, Sr., Vice President Medicaid Division, and Mr. J. Pat Browder, MD, Associate Medical Director).

March 28, 2006

This meeting addressed the following:

Options for Reducing the County Share of the nonfederal share of Medicaid expenditures. Presenters for this topic were: Ms. Jennifer Hoffman (NCGA Fiscal Research Division), Ms. Kitty Barnes (President, North Carolina Association of County Commissioners (NCACC) and Catawba County Board Chair), and Mr. David Thompson, NCACC Executive Director.

Update on the Community Care of NC Program – Dr. Allen Dobson, Assistant Secretary for Health Policy and Medical Assistance, DHHS, and Mr. Jeffrey Simms, Assistant Director for Managed Care, DHHS, DMA.

Chronic Kidney Disease in North Carolina, information presented by Mr. William Hyland, Director of Health Care Planning for DaVita, Inc.

Subcommittee on the Cost of Health Care and Health Insurance for Employees and Employers

The House Select Committee on Health Care, Subcommittee on the Cost of Health Care and Health Insurance for Employees and Employers, met seven times from December 6, 2005 to April 4, 2006. The Subcommittee heard presentations from the following:

- Barbara Morales Burke, Chief Deputy Commissioner at the Department of Insurance, made presentations on two occasions. She gave the Subcommittee an overview of the health insurance market including: types of insurance, insurance products, insured vs. self-funded or self-insured plans, product changes, market segments, market concentration, small group reform, premium rate regulation, basic components of costs, and product pricing. She also provided an overview of the Department of Insurance small group law project. Additionally, Ms. Morales Burke made recommendations to the Subcommittee on changes to the Small Employer Group Health Coverage Reform Act.

- Dr. Pam Silberman, President and CEO, North Carolina Institute of Medicine (NC IOM) and Dr. Mark Holmes, Vice President, NC IOM made presentations on two occasions. The first presentation was an overview of the Institute of Medicine; recent trends in health insurance coverage; and the uninsured in North Carolina, including county-level estimates of the uninsured. The second presentation to the Subcommittee provided additional detail on the uninsured in North Carolina; information on a proposed Healthy North Carolina program, based on the Healthy New York model; and information on establishing a high-risk health insurance pool for people with pre-existing conditions.

- Ben Popkin, Subcommittee staff, reviewed recent health insurance legislative proposals during three meetings. These included a public Proposed Committee Substitute for Senate Bill 255 - Small Employer Health Insurance, and Part 1 of House Bill 20 - Health Insurance Credit/Minimum Wage.

- Charles T. Frock, President and CEO of First Health of the Carolinas presented information on a not-for-profit health system serving 15 North Carolina counties.

- Mr. Keith Crisco, President and Chairman of Asheboro Elastics Corporation, presented information regarding an on-site healthcare plan offered to Asheboro Elastics Corporation employees. Mr. Crisco was recommended to the Subcommittee by North Carolina Citizens for Business and Industry (NCCBI).

- Gregg Thompson, State Director of the National Federation of Independent Business North Carolina, spoke to the Subcommittee about the cost of health insurance for small businesses.

- Ches Guinn, Chairman of the North Carolina Health Insurance Innovations Commission (NCHIIC), spoke to the Subcommittee on the responsibilities of the NCHIIC, membership, and potential assistance to the House Select Committee on Health Care.

- Kenneth Wright, Director of State and Federal Relations, and John Friesen, Vice-President of Actuarial and Underwriting, Blue Cross & Blue Shield, spoke to the Subcommittee on health care cost drivers and remedies.

- Dr. Elizabeth Sammis of United Health Care, made a presentation to the Subcommittee on understanding and controlling health care costs.

- John Tote, Executive Director of the Mental Health Association in North Carolina, spoke on the issue of mental health coverage in insurance programs, specifically regarding the issue of equitable coverage between mental and physical health care.

- Dr. Larry B. Goldstein, MD, FAAN, FAHA, Professor of Medicine (Neurology); Director of the Center for Cerebrovascular Disease; Senior Fellow Center for Clinical Health Policy Research at Duke University and Durham Veterans Administration Medical Center (VAMC), shared information with the Subcommittee on North Carolina stroke systems of care.

During several meetings, the Subcommittee heard from representatives of business and industry and their experience or recommendations for providing health insurance coverage. Presenters included: Gregg Thompson with the National Federation of Independent Business (NFIB); Keith Crisco, president and Chairman of Asheboro Elastics Corporation, who spoke at the recommendation of North Carolina Citizens for Business and Industry (NCCBI); and Charles Frock, CEO of First Health of the Carolinas.

The Subcommittee heard from Kenneth Wright and John Friesen with Blue Cross & Blue Shield and from Dr. Elizabeth Sammis with United Health Care. The Subcommittee heard from Ches Guinn, Chairman of the North Carolina Health Insurance Innovations Commission. Staff also provided the Subcommittee with information from the Kaiser Family Foundation's Employer Health Benefits 2005 Annual Survey. During several meetings, the Subcommittee heard from representatives of business and industry and their experience or recommendations for providing health insurance coverage. Presenters included: Gregg Thompson with the National Federation of Independent Business (NFIB); Keith Crisco, president and Chairman of Asheboro Elastics Corporation, who spoke at the recommendation of North Carolina Citizens for Business and Industry (NCCBI); and Charles Frock, CEO of First Health of the Carolinas.

The Subcommittee heard from Kenneth Wright and John Friesen with Blue Cross & Blue Shield and from Dr. Elizabeth Sammis with United Health Care. The Subcommittee heard from Ches Guinn, Chairman of the North Carolina Health Insurance Innovations Commission. Staff also provided the Subcommittee with information from the Kaiser Family Foundation's Employer Health Benefits 2005 Annual Survey. (Excerpts from Kaiser Foundation information are included in the Appendices.) (Additional information on the Kaiser survey may be found at:
http://www.kff.org/insurance/7315/sections/upload/7316.pdf)

The Subcommittee discussed recent legislative proposals during meetings on December 6, 2005, February 9, 2006, and March 2, 2006. This included a review and discussion of Part 1 of House Bill 20 Health Insurance Credit. House Bill 20 passed the third reading in the House on 8/10/05, was received in the Senate on 8/11/05 and referred to the Senate Committee on Finance. During these meetings the Subcommittee also discussed a Proposed Committee Substitute for Senate Bill 255, enacting legislation to create a program offering affordable health insurance to North Carolina small employers and working individuals, similar to the Healthy New York model.

Subcommittee on Patient Safety, Quality, and Accountability

The Subcommittee on Patient Safety, Quality and Accountability has held a total of 6 meetings since its creation in December 2005. Over the course of those meetings, the Subcommittee heard from numerous healthcare organizations and regulatory agencies. The presenters to the Subcommittee included the North Carolina Hospital Association, Duke University Health System (Duke), the Carolinas Center for Medical Excellence, The American Heart Association, the North Carolina Medical Society, the North Carolina Healthcare Facilities Association (nursing homes), the North Carolina Association of Long Term Care Facilities (assisted living), the North Carolina Area Health Education Centers, the State Program on Infection Control and Epidemiology, the Licensure Section of the Division of Facilities Services, the North Carolina Medical Board and the Board of Nursing. The Subcommittee also heard from patient advocacy groups including the AARP, the North Carolina Coalition for Patient's Rights, and the North Carolina Public Interest Research Group (NCPIRG). At its March meeting, the Subcommittee began to examine the role the State should play in advancing the adoption of healthcare information technology and the development of interoperable information systems. The North Carolina Heath Care Information and Communications Alliance (NCHICA) provided the Subcommittee with an extensive overview of efforts at the State and national level to improve access to healthcare information technology for healthcare providers and to develop standards for the interoperability of these information systems.

Improving patient safety and quality of care is of paramount importance within all facets of the healthcare system. The theme of "creating a culture of safety" was repeated throughout the meetings of the Subcommittee. The North Carolina Hospital Association, most of the hospitals in the State, and other health related organizations actively participate in the Institute for Healthcare Improvement's 100,000 Lives Campaign. Initiatives currently underway to reduce medical errors and provide quality care include the adoption of electronic medical records technology, educational programs aimed at decreasing surgical site infections, and the use, in the acute care setting, of rapid response teams to prevent medical crises. Individual hospitals, such as Duke, also are instituting their own programs to enhance patient safety and quality of care. Skilled care and assisted living facilities are focusing their efforts on quality improvement.

The Carolinas Center for Medical Excellence (CCME) is working on patient safety initiatives with a variety of health care providers in the State CCME also is following the implementation of the federal Patient Safety and Quality Improvement Act of 2005. The Act seeks to improve patient safety by providing for health care providers to voluntarily report medical errors to patient safety organizations (PSOs) which will help the providers analyze patient safety issues and quality of care problems. PSOs will be certified by the Secretary of Health and Human Services. The work product of the PSOs will be privileged and confidential.

The Subcommittee also learned that the North Carolina Medical Society has established a Physician and Patient Resource Center devoted to quality and safety issues. One of its initiatives encourages patients to complete a "patient snapshot", a document containing the patient's medical history that may be given to each of the patient's healthcare providers. The North Carolina Medical Board has increased its efforts to ensure that those authorized to practice medicine in the State are meeting the standards of competency and character. The Medical Board has requested changes in its statutory authority to allow the Board greater flexibility in disciplining doctors and ensuring physician competency. The patient advocacy groups called for more public reporting of hospital infection rates and easier access to physicians' disciplinary records.

As a result of its study, the Subcommittee is presenting in this interim report three findings and recommendations to the House Select Committee on Health Care. The Subcommittee looks forward to resuming its work at the completion of the 2006 Session of the General Assembly.

Subcommittee on Healthcare Workforce

The House Select Committee on Health Care, Subcommittee on Healthcare Workforce, met five times from December 15, 2005, until April 7, 2006. The Subcommittee heard presentations from the following:

- Dr. Thomas Ricketts, Deputy Director of the Cecil G. Sheps Center, UNC, made a presentation on physician shortages. Dr. Ricketts noted that there is a disturbing trend suggesting that the supply of physicians is growing more slowly than the population. This trend will create a problem for North Carolina because of our growing population.
- Hugh Tilson, Senior Vice President, North Carolina Hospital Association, discussed the workforce shortages in hospitals. Mr. Tilson noted that in addition to the shortage in physicians and nurses, hospitals are experiencing shortages in allied health fields, such as pharmacy technicians, occupational therapists and physical therapists.
- Brenda Cleary, Executive Director, North Carolina Center for Nursing, and Linda Lacey, Associate Director for Research, North Carolina Center for Nursing, presented an overview of the nursing workforce issues facing North Carolina. Dr. Cleary outlined the factors indicating a growing and future nursing shortage.
- Alan Mabe, Vice President Academic Planning, UNC, and Virginia Adams, Dean of Nursing, UNC Wilmington, reviewed the recommendations from the UNC Board of Governors Task Force on Nursing and the UNC nursing program and goals.
- Delores Parker, Vice President for Academic and Student Services, North Carolina Community Colleges, discussed the efforts of the Community College System in addressing nursing shortages. Dr. Parker noted that there is a severe shortage in nursing faculty that is hampering efforts to train more nurses.
- Dennis Sherrod, President, North Carolina Nurses Association, gave an overview of the workforce issues from the perspective of nurses.
- David Clegg, Deputy Chairman for Communications, North Carolina Employment Security Commission, presented an overview of the State's projected healthcare workforce needs. Mr. Clegg noted that the fastest growing occupations in North Carolina are in the healthcare industry.
- Dr. David Yoder, Executive Director, Council for Allied Health in North Carolina, reviewed the Council's recent report on the projected allied health employment growth in the State.
- Dr. Art Apolinario, North Carolina Medical Society, described his experiences as a member of the Community Practice Program, which engages new doctors for underserved areas of the State.

- Dr. Carol Clayton, Executive Director, North Carolina Council of Community Programs, presented a report on mental health, developmental disabilities, and substance abuse workforce issues. Dr. Clayton advised the Subcommittee that there is currently a critical shortage of child psychiatrists in the State and a growing shortage of psychiatrists and other direct support professionals.

- Dr. Mickey Burnim, Chancellor, Elizabeth City State University, and Dr. Robert Blouin, Dean, School of Pharmacy, UNC-CH, presented a report on the joint pharmacy program between the two institutions.

- Dr. Delores Parker, Vice President for Academic and Student Services, North Carolina Community Colleges, and Dr. Phyllis Horns, Dean, School of Nursing, East Carolina University, reported on the distance education programs leading to a degree in a health-related field offered by their institutions.

- Thomas Bacon, Director, North Carolina Area Health Education Centers, gave an overview of the programs offered by his organization.

- Susan Harmuth, Project Coordinator, North Carolina New Organizational Vision Award (NC NOVA), requested that the subcommittee consider supporting a proposal for addressing the shortage of direct care health workers.

- Sara Kamprath, Subcommittee Staff, Research Division, presented a summary of House Bill 1718 (Nursing Faculty Fellows Program/Funds).

The North Carolina Nurses Association pushed for legislation to establish a nursing faculty fellows program during the 2005 Session. This later became House Bill 1718 which was referred to the House Health Committee on May 12, 2005.

On March 23, 2006, the Subcommittee discussed a Proposed Committee Substitute for House Bill 1718 Nursing Faculty Fellows Program/Funds.

Subcommittee on Access

The House Select Committee on Health Care, Subcommittee on Access, met seven times from November 30, 2005 until March 28, 2006. The Subcommittee heard presentations from the following:

- Dr. Pam Silberman, President and CEO, North Carolina Institute of Medicine presented to the subcommittee that people lack access to needed health services in North Carolina for a variety of reasons including financial barriers (lack of or inadequate insurance coverage) and non-financial barriers (maldistribution of healthcare resources; language and cultural barriers). Dr. Silberman reported that safety net providers exist to serve the underserved populations, but do not exist in every community and generally can not meet all of the healthcare needs of the uninsured.
- Laura Tobler, Health Policy Analyst, National Conference of State Legislatures presented information on a variety of state initiatives for providing access to health care for the uninsured. Ms. Tobler explained state initiatives for covering the uninsured fall into three categories: private market (increasing employer-offered insurance, market reforms); public /private sector (assist via government sponsored

programs, support direct care programs); public sector (assist via government sponsored programs).

- Torlen Wade, Director, Office of Research, Demonstrations, and Rural Health Development provided an overview of the rural health centers program.
- Sonya Bruton, Executive Director, North Carolina Community Health Center Association provided an overview of federally recognized community health centers that receive Section 330 grant funding to assist with caring for the uninsured and the look a like programs that do not receive such funding.
- Mike Darrow, Executive Director, North Carolina Association of Free Clinics provided an overview and history of free clinics in North Carolina.
- Connie Parker, Executive Director, School-Based and School-Linked Health Centers presented an overview of school-based and school-linked health centers as part of the health care safety net.
- Dr. Tom Bacon, Program Director, North Carolina Area Health Education Centers (AHEC) explained improved access to health care is fundamental to AHEC's mission.
- Dr. Leah Devlin, Director, Division of Public Health provided an overview of services provided by local health departments as safety net providers.
- Hugh Tilson, Senior Vice President, North Carolina Hospital Association presented on the role of hospitals as part of the health care safety net.
- Dr. Meg Malloy, Executive Director, North Carolina Prevention Partners presented on potential cost savings related to prevention.
- Dr. Mark Holmes, Vice President, NCIOM made presentation on two occasions. The first presentation provided theory and research evidence on the economics of access to healthcare. The second presentation to the Subcommittee provided detail and information on establishing a high-risk health insurance pool.
- Dr. Frank Sloan, Director, Center for Health Policy, Law and Management, Duke University provided an academic critique of an article published in the Journal of the American Medical Association entitled "Impact of Malpractice Reforms on the Supply of Physicians".
- Dr. Roland Stephen, Assistant Director for Research and Policy, Institute on Emerging Issues, North Carolina State University gave an overview of the North Carolina Best Care Initiative.
- Dr. Steven Hill, Buncombe County Medical Society presented on the topic of medical liability reform and provided information on the increased cost on medical liability insurance and the impact of those cost on a person's ability to access health care in North Carolina.
- Dr. John Faulkner, North Carolina Coalition for Patient Rights presented on promoting patient safety and protecting patient rights.
- Dick Taylor, CEO, North Carolina Academy of Trial Lawyers presented information indicating that litigation and malpractice insurance costs do not affect physician population and access to care in North Carolina.

Subcommittee on the State Health Plan

The House Select Committee on Health Care, Subcommittee on the State Health Plan, met five times from December 13, 2005 until April 4, 2006. The Subcommittee heard presentations from the following"

- George C. Stokes, Executive Administrator, Teachers' and State Employees' Comprehensive Major Medical Plan (State Health Plan), discussed the current health benefits offered under the Plan's self-insured indemnity program, and his efforts to provide other alternative health benefit coverage options through the establishment of a Preferred Provider Option (PPO) under the Plan.

- Eddie Davis, President, North Carolina Association of Educators (NCAE), discussed the Association's support for the State Health Plan, the efforts by the Plan to focus on improving employee health, and to lower plan member's out-of-pocket costs by allowing the Plan the option to adopt a PPO alternative under the authorization provided by the 2005 General Assembly.

- Dana Cope, Executive Director, State Employees' Association of North Carolina (SEANC), noted that the State Health Plan is second in importance only to salary as part of an employee's total compensation and that the Plan is critical to the State's ability to compete with the private sector in recruiting and retaining a professional work force.

- Ed Regan, Retired Governmental Employees' Association, emphasized that maintaining the benefits of the State Health Plan has become the top priority of the Association particularly in the provision of outpatient prescription drugs.

- Lisa Bultman, the then Director of Integrated Health Management for the State Health Plan, provided insight into the Integrated Health Management initiative under way by the Plan.

- John Sapp, Executive Vice President, BB&T Corp, described the concerns that large employers have about employer-sponsored health benefit costs and spoke to his company's efforts with employee wellness programs to abate rising costs and improve employee health.

- Gale Adcock, Nurse Practitioner and Director of Comprehensive Health Services, SAS Institute, Inc., spoke about their company's delivery of primary care at the worksite in order to reduce productivity loss and the numerous disease management and health education programs offered under the theory that: "It is always cheaper to prevent illness and disability than to treat it."

- Jan Sharp, Vice President of Human Resources, Capitol Broadcasting Company, spoke about her company's effort to transition employees from being "passive users" of medical care to "active consumers" in an effort to deliver more cost efficient and effective medical care;

- Barbara Buchwald, Vice President, AON Consulting, spoke about the emerging use of Health Savings Accounts, Health Reimbursement Accounts, and the associated high-deductible health benefit plans typically used with these accounts.

- Kitty McCollum, Associate Vice President for Human Resources and University Benefits Officer, UNC-System General Administration provided insight into the role that employer sponsored health benefits play in recruiting a skilled university workforce and expressed their support for the effort being put forth by the State Health Plan's current Executive Administrator with respect to establishing a Preferred Provider Option.

- Mark Trogdon, Principal Fiscal Analyst, Fiscal Research Division, provided an overview of the State Health Plan's financial scope, plan member demographics, major cost components, and expected claims trends. He also provided a summary of the General Assembly's legislative authorization to the Plan to investigate and implement providing alternative health benefit coverage as currently proposed under a Preferred Provider Option arrangement.

UNC-System Comments

Kitty McCollum, Associate Vice President of Human Resources of University of North Carolina – General Administration spoke about UNC system efforts to improve health benefits coverage for its employees.

A 2004 study, in which UNC participated with 18 other research universities, found that:

UNC pays the full cost of employees' premiums compared to 91% by other universities;

UNC requires employees to cover a higher percentage of out-of-pocket costs (deductibles, co-insurance and co-payments) - 20% - compared to other universities (14%);

UNC pays nothing toward dependent coverage, while, on average, other universities pay 64% of dependent costs.; As a result of the high cost of dependent coverage in the State Health Plan (of which UNC is a part), fewer UNC dependents are enrolled in the Plan compared with the percentage of dependents enrolled in other universities' health plans;

UNC is the only university studied to offer only a straight indemnity plan design;

UNC's employee health care benefit was the "worst" of any university in the study.

Ms. McCollum said that, as a result of this study and meetings with and a survey of UNC employees (where employee dissatisfaction with their State Health Plan coverage was "nearly unanimous"), in 2005 UNC asked the General Assembly for a pilot plan, to be offered to UNC employees in lieu of the State Health Plan, to improve UNC employee benefits and health. The General Assembly did not approve this legislation.

Although this issue continues to be a top priority for UNC, Ms. McCollum said that the health benefits pilot is not on UNC's 2006 legislative agenda. She said that UNC wants to

give new State Health Plan Executive Administrator George Stokes "a chance to improve" the Plan. So far, they are impressed with Mr. Stokes' efforts, including the professionals he has added to the Plan's staff and the outreach that he and his staff have made to Plan "customers," including UNC, to get input. She said that UNC hopes that Mr. Stokes will take what it has learned and use it to improve the State Health Plan.