GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 1993

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SENATE BILL 554*
House Committee Substitute Favorable 6/17/93

Short Title: Fletcher-Jeralds Health Reform Act. (Public)

Sponsors:

Referred to:

March 24, 1993

A BILL TO BE ENTITLED

AN ACT TO ENACT THE FLETCHER-JERALDS OMNIBUS HEALTH REFORM ACT OF 1993.

Whereas, a health care crisis is at hand in North Carolina; and

Whereas, the crisis is eroding the social and economic vitality of many of our cities, towns, and rural areas; and

Whereas, the crisis has arisen from the difficulty communities all over North Carolina face in meeting the fundamental need to provide citizens with access to health and medical services; and

Whereas, the move toward national health system reform is rapidly gaining momentum; and

Whereas, minority persons are twice as likely to be uninsured as white persons; and

Whereas, lack of health insurance means less access to health care; and

Whereas, minority communities are especially likely to suffer from a shortage of primary care providers; and

Whereas, minorities' lack of access to health care results in poor health status, including a disproportionately high rate of infant mortality, diabetes, cancer, and cardiovascular disease, and leads to a shortened life expectancy; Now, therefore,

The General Assembly of North Carolina enacts:

TITLE I. HEALTH REFORM.

Section 1. Chapter 143 of the General Statutes is amended by adding the following new Article to read:

"**ARTICLE 64.**

"**THE NORTH CAROLINA HEALTH PLANNING COMMISSION.**

"**§ 143-590. Short title; legislative findings and intent.**

(a) This act shall be known as the Fletcher-Jeralds Health Reform Act.

(b) The General Assembly makes the following findings:

(1) Given the scope and complexity of health reform, the General Assembly expects the necessary changes to take years, and for the results to extend well into the next century.

(2) In order to improve the health status of every North Carolinian, it is necessary for each citizen to have access to appropriate health services delivered by a broad range of health providers who are either licensed or certified in North Carolina.

(3) Appropriate health services can be provided most effectively within each of several local health communities.

(4) Within each health community every citizen shall be able to select the primary care provider of choice and, in return, every citizen shall be held accountable for a healthy lifestyle.

(5) The health providers in each of the several communities shall be held accountable for the health of that community and shall cooperate and collaborate to that end.

(6) In order to ensure that each local health community can address its unique health problems adequately, the State shall provide assessment, assurance, and assistance.

(7) The State's support of local health communities shall be through a State Department of Health whose principal role is to assist local health communities to develop individual solutions to health problems.

(c) It is the intent of the General Assembly to do the following:

(1) Reorganize North Carolina's health system in order to assist the citizenry in improving its health.

(2) Focus health reform upon improving health status and the included health care.

(3) Encourage local communities to develop local solutions to health problems which will require local communities to create a board, representative of the citizenry, which shall guide the health affairs of the community, assign health priorities, and allocate health resources.

(4) Ensure that the reform mechanisms implemented recognize the roles of all health professionals who are either licensed or certified in North Carolina in improving the health status of the citizenry of North Carolina.

(5) Ensure that the reform mechanisms implemented recognize that a comprehensive view of health care must include, as an integral part,

dental health, mental health, and health issues associated with substance abuse.

(6) Raise as rapidly as possible the percentage of primary care physicians to at least fifty percent (50%) of the total number of physicians in the State.

(7) Restructure health insurance in North Carolina to phase in community rating by the year 2000.

"**§ 143-591. Commission established; members; terms of office; quorum; compensation.**

(a) Establishment. – There is established the North Carolina Health Planning Commission with the powers and duties specified in this Article. It is the intent of the General Assembly that after the Department of Health is established, the Commission shall be within the Office of the Secretary of Health for organizational, budgetary, and administrative purposes. Until the Department is established, for organizational, budgetary, and administrative purposes, the Commission shall reside in the Office of the Secretary, Department of Human Resources.

(b) Membership and Terms. – The Commission shall consist of 18 members who shall be appointed as follows:

(1) Six persons appointed by the Governor, one of whom shall represent the labor force, one of whom shall be a hospital administrator, one of whom shall be a public health professional, one of whom shall be an environmentalist, one of whom shall be a representative of a business with 50 or more employees, and one of whom shall be a consumer who is knowledgeable about the problems of low-income persons or a consumer whose annual income does not exceed the federal poverty guidelines. Two of the persons initially appointed under this subdivision shall serve a five-year initial term; two shall serve a three-year initial term; and one shall serve a one-year initial term; thereafter, the terms of the Governor's appointees shall be through June 30, 1999.

(2) Six persons appointed by the General Assembly upon the recommendation of the Speaker of the House of Representatives, one of whom shall be a primary care physician, one of whom shall be a consumer who is knowledgeable about the problems of the uninsured and underinsured or who is uninsured or underinsured, one of whom shall represent a business with under 50 employees, one of whom shall be a nurse licensed under Chapter 90 of the General Statutes, one of whom shall represent a prepaid health plan, and one of whom is a health professional. Two of the persons initially appointed under this subdivision shall serve a six-year initial term; two shall serve a four-year initial term; and one shall serve a two-year initial term; thereafter, the terms of appointees under this subdivision shall be through June 30, 1999; and

(3) Six persons appointed by the General Assembly upon the recommendation of the President Pro Tempore of the Senate, one of

whom represents a business which is a multistate employer of more than 500 employees, one of whom is a trustee of a not-for-profit hospital, one of whom shall be a physician with a specialty, one of whom represents an insurance company authorized to do business in this State, one consumer who is knowledgeable about the problems of persons with disabilities or who is considered 'medically uninsurable', and one representative of a nonprofit rural or community health clinic. Two of the persons initially appointed under this subdivision shall serve a six-year initial term; two shall serve a four-year initial term; and one shall serve a two-year initial term; thereafter, the terms of appointees under this subdivision shall be through June 30, 1999.

No member may be appointed to serve more than two consecutive terms. A member whose term has expired may serve until his or her successor is appointed.

When making appointments to the Commission, the Governor and the General Assembly shall ensure that the membership fairly represents the regions of the State, minority persons, women, membership of the political party to which the largest minority of the membership of the General Assembly belongs, and the broad range of health providers who are licensed or certified in North Carolina. Appointments to the Commission shall be made to provide knowledge and experience in a diverse range of interests. The members of the Commission shall serve and act on the Commission solely for the best interests of the public and public trust and shall bring their particular knowledge and experience to the Commission for that end alone.

(c) Compensation. – The Commission members shall receive no salary as a result of serving on the Commission but shall receive necessary subsistence and travel expenses in accordance with the provisions of G.S. 120-3.1, 138-5, and 138-6, as applicable.

(d) Officers. – The Commission shall have a chair and vice-chair. The chair shall be appointed by the Governor from among the membership. The vice-chair shall be elected by the members. The terms of officers shall be for two years.

(e) Meetings. – Meetings may be called by the chair or by the vice-chair in the case of incapacity of the chair or with the consent of the chair. The Commission shall meet as often as necessary, but not less than six times a year.

(f) Quorum. – Ten members of the Commission shall constitute a quorum for the transaction of business. The affirmative vote of a majority of the members present at meetings of the Commission shall be necessary for action to be taken by the Commission.

"§ 143-592. Powers and duties of the Commission.

(a) The Commission shall have the following powers and duties:

(1) Employ such staff as it deems necessary and fix their compensation. Staff employed by the Commission shall be subject to the State Personnel Act.

(2) Establish one or more advisory panels as the Commission deems appropriate for the effective and timely conduct of its duties.

(3) Conduct investigations and inquiries and compel the submission of information and records the Commission deems necessary.
(4) Assist the Governor in describing Community Health Districts.
(5) Develop a financing system which will ensure that by 1998 every North Carolina citizen has access to affordable health care, regardless of the resources of the District in which he resides.
(6) Develop the benefits to be included in the State-guaranteed package of comprehensive medically necessary health services.
(7) Assist the Community Health Districts to identify additional benefits and population-based services to be offered in the community, based on the established priorities for improving community health status in the District.
(8) Assist the Community Health Districts to establish budgets to address the priorities for improving health status in the District.
(9) Investigate payer systems that can operate through Community Health Districts to provide the financial resources necessary to meet each community's health needs.
(10) Assist Community Health Districts to develop plans for capital and health professional needs in their community.
(11) Develop a statewide plan to address the capital needs and health professional needs identified by the Community Health Districts.
(12) Establish a mechanism to provide for the continuing education and training of health care personnel and Community Health District Boards.
(13) Annually review the Community Health District Board Advisory Committee's report and establish priorities for programs and financing to address Community Health District needs.
(14) Analyze and report to the Governor and General Assembly the availability, training, and production needs of primary care advanced practice nurses, physician assistants, and social workers.
(15) Such other duties as are required for the effective and efficient implementation of this Article.

(b) The Commission shall appoint such advisory technical and professional panels as it deems necessary to advise it on the performance and administration of its functions. Each panel shall consist of experts drawn from the health professions, from health education institutions, from providers of services, or from other sources, and consumers to advise the Commission. At least one panel shall be established to advise, consult with, and make recommendations to the Commission on the development, maintenance, funding, evaluation, and priorities of community health services. Each Community Health District Board may appoint a member to serve on this panel.

(c) The State Board of Education, the State Board of Community Colleges, the Board of Governors of The University of North Carolina, and proprietary schools and private colleges and universities throughout the State shall advise and assist the Commission to develop a plan for the coordination of educational systems related to the

production of primary care providers. The Commission shall report its plan to the General Assembly prior to the convening of the 1995 General Assembly.

(d) The Commission shall study the feasibility and desirability of increasing the number of mobile health care units that provide services to communities that are underserved with respect to health care. The Commission shall include its recommendations in this regard in its report to the General Assembly required under this section.

(e) The Commission shall study the impact on health care cost and efficiency of rule changes made by State and local government agencies pertaining to health care services. The study shall include the impact of the frequency of such rule changes. The Commission shall include its finding and recommendations in this regard in its report to the General Assembly required under this section.

(f) The Commission may accept grants, contributions, devises, bequests, and gifts for the purpose of providing financial support to the Commission. Such funds shall be retained by the Commission.

(g) The Commission shall submit a written report annually by March 1 to the General Assembly on its activities and recommend any changes to improve health care for all persons within this State.

"**§ 143-593. Health Care Director.**

(a) The Commission shall appoint a Director, who shall function as the chief executive officer for the North Carolina Health Planning Commission.

(b) The Director shall be exempt from the State Personnel Act."

Sec. 2. It is the intent of the General Assembly that the State educational systems be coordinated to facilitate the process by which people working as primary health care providers can receive education and training to become higher level primary health care providers. This coordination would:

(1) Provide extended tracks to licensure or certification as primary health care providers to people who do not have access to the current fast tracks;

(2) Ensure that people receive credit towards a higher level of licensure or certification for prior education, training, and experience in primary health care;

(3) Allow people to work and receive education and training at the same time;

(4) Provide visible, achievable steps that a person could aspire to and work towards;

(5) Give people the opportunity to continue education and training at any point during their careers.

Sec. 3. The Governor shall, not later than July 1, 1998, recommend to the General Assembly the organizational structure of the North Carolina Health Care Planning Commission to take effect July 1, 1999.

Sec. 4. Chapter 116 of the General Statutes is amended by adding a new section to read:

"**§ 116-11.3. Production of primary care physicians.**

(a) It is the policy of the General Assembly to provide financial assistance for medical education to medical schools and university-based and community hospital-based medical residency programs within the State in order to ensure an appropriate supply of physicians to serve the needs of the State. Statistics relating to current physician supply and projected health care needs point to a continued shortage of primary care physicians. The specific mechanism by which the General Assembly supports the production of physicians is through appropriations to both public and private medical schools and to university-based and community hospital-based medical residency programs within the State. Therefore, it is the intent of the General Assembly to appropriate funds in such a fashion that medical schools and university-based and community hospital-based medical residency programs within the State are rewarded financially for producing an adequate number of primary care physicians to satisfy the State's needs.

(b) For the purposes of this section, the term 'primary care physician' is defined as a licensed physician whose practice is limited to the specialties of: family medicine, general medicine, general internal medicine, obstetrical and gynecological medicine, and general pediatric medicine, and the term 'primary care specialty' is defined as family practice, general internal medicine, obstetrics/gynecology, and general pediatrics.

(c) The Board of Governors shall ensure that each and every medical school receiving State appropriations for medical education of North Carolina residents complies with the requirements that by the year 2001 (for the 1996 graduating class) the percentage of graduates entering primary care specialties shall be no less than fifty percent (50%), and that by the year 2006 (the 2001 graduating class) and each year thereafter, the percentage of graduates entering primary care specialties shall be no less than sixty percent (60%). For the purposes of this section, the term 'percentage of graduates entering primary care specialties' shall mean the percentage of graduates of each medical school class that are practicing in a primary care specialty five years after their year of graduation. Private medical schools which receive less than two million dollars ($2,000,000) each year for providing medical school opportunities for North Carolina students shall develop a plan by December 1, 1993, with the goal of encouraging at least fifty percent (50%) of the North Carolina graduates to be engaged in the practice of primary care medicine five years after graduation for review by the Board of Governors.

(d) The Board of Governors, in conjunction with the State's medical schools, shall develop a plan for medical schools and residency programs to achieve the requirements established in subsection (c) of this section. The Board of Governors shall submit this plan to the 1994 Regular Session of the 1993 General Assembly. The plan shall include interim goals for the General Assembly to use to gauge the progress of the medical schools prior to the 2001 date for full compliance. The Board of Governors shall conduct an analysis in the year 2001 to assess the need for primary care physicians and recommended to the General Assembly appropriate adjustments to the requirements of subsection (c).

(e) The Board of Governors, in conjunction with the State's medical schools, shall submit a report to the State Health Director on or before October 1, 1994, and each

year thereafter, in which it certifies data regarding medical school graduates and medical residencies. Such data shall include information relating to the production of primary care physicians by medical schools and university-based and community-based medical residency programs receiving State assistance for medical education. Specifically, such data shall include: the percentage of first-year medical school enrollees who have been identified as likely to become primary care physicians; the percentage of each graduating class that selects residencies in primary care specialties; the percentage of each graduating class that accepts in-State residencies in primary care specialties; the number of physicians completing residencies who enter into the practice of primary care medicine in the State; and the percentage of physicians completing in-State residencies who enter into practice in a medically underserved area. The State Health Director shall report to the General Assembly and to the Office of State Budget and Management as to whether the requirements established in this section have been met. If a medical school does not meet the requirements established in subsection (c) of this section, the Office of State Budget and Management shall reduce the amount of State funds appropriated to that medical school by an amount equal to the amount reached by multiplying the annual cost to the State of preparing a medical student by the number of graduates by which the school fails to meet the goals. In all cases in which the Office of State Budget and Management acts to reduce the appropriations to a school or program due to the failure of the school or program to meet a goal established in this section, reductions shall be made so as to principally impact nonprimary care physician training. Funds attributable to such reductions may be shifted to other medical school programs on a pro rata basis that have met or exceeded the requirements of subsection (c) of this section."

Sec. 5. (a) Article 1 of Chapter 130A of the General Statutes is amended by adding the following new section to read:

"**§ 130A-3.1. Duties of the State Health Director.**

The State Health Director shall have the following authority and duties in addition to those assigned by the Secretary pursuant to G.S. 130A-3:

(1) To receive from the Board of Governors of The University of North Carolina certified data collected pursuant to G.S. 116-11.3 relating to the production of primary care physicians by medical schools and university-based and community-based medical residency programs receiving State assistance for medical education.

(2) To report to the General Assembly by March 1 of each year, the following:

a. Percentage of first year medical school enrollees who have been identified as likely to become primary care physicians;

b. The percentage of each graduating class that select residencies in primary care specialties;

c. The percentage of each graduating class that accept in-State residencies;

d. The number of physicians completing residencies who enter into primary care practice in the State;

e. The percentage of physicians completing in-State residencies who enter into practice in a medically underserved area;
f. The number of in-State medical school graduates practicing medicine within the State five years after graduation;
g. The percent of graduates practicing primary care medicine within the State five years after graduation;
h. The percent of graduates accepting in-State residencies; and
i. Other pertinent information bearing on physician supply.

(3) To evaluate actions taken by other states that have faced similar problems attracting primary care providers which could be implemented in North Carolina.

(4) To study funding strategies to increase to at least sixty percent (60%) the number of in-State medical school graduates that enter and remain in primary care.

(5) To study the expansion of repayment programs in which physicians may have their medical school loans forgiven for practicing in primary care.

(6) To study the need and feasibility of establishing a scholarship program for primary care physicians.

(7) To study and recommend legislative action to increase reimbursement rates for primary care physicians.

(8) To monitor any legislation passed by the General Assembly that establishes a plan for increasing the supply of primary care physicians in North Carolina.

(9) To conduct any other studies or evaluations necessary to effectuate the duties specified herein.

(10) To report these and any other matters relevant to the health of the citizens of North Carolina to the General Assembly by February 1, of each year."

(b) It is the intent of the General Assembly that these duties be transferred to the Secretary for Health when that office is created.

Sec. 6. (a) From the least fortunate to those with greatest wealth in this State, there is near universal concern over the current health system. Strong and effective preventive health services must not only be designed but implemented. The people in this State, wherever they happen to reside, shall have access to comparable levels of health services at reasonable costs. Lack of access for hundreds of thousands of North Carolinians, and a host of unacceptable health indices, require a carefully constructed plan for reform. If the State is to face this responsibility, it will require consolidation of planning and oversight of many presently scattered health programs. Fundamental health reform demands clear accountability. Accountability is impossible when many different departments and divisions of government have responsibility.

(b) The Governor shall present to the General Assembly no later than May 1, 1994, a plan for consolidating all of the State health functions into one State Department

of Health. The plan shall be based upon and shall address the principles and elements outlined in subsections (c) and (d) of this section.

(c) The Governor's plan as required under subsection (b) of this section shall be based on the following principles:

(1) Improved health status - not health care - should be the ultimate goal;

(2) Health status must be improved primarily through locally developed initiatives;

(3) The appropriate role of the State is to assure a framework by which health services can be delivered in local communities;

(4) While State and local governments should provide the framework for the delivery of health services, they should not interpret this responsibility as a requirement to directly provide all of these services;

(5) In order for a new health system to be effective, there must be cooperative and collaborative efforts in place throughout the State. Hospitals, health departments, individual health providers, provider organizations, and others must find new and innovative ways to work together effectively. Statutes must be amended as necessary to encourage these cooperative and collaborative efforts.

(d) The Governor's plan as required under subsection (b) of this section shall be based on the following elements:

(1) A Department of Health encompassing at least all health functions now residing in the Departments of Human Resources, Environment, Health, and Natural Resources, all licensing boards that relate to health, and any other functions assigned by the General Assembly or Governor related to health care reform.

(2) Expansion of the Commission for Health Services to include a membership comprised of health experts, business leaders, and consumers. The Governor would appoint a State Health Secretary who would act as chief executive officer of the Department of Health. Such an expanded Commission may be developed and created before the Department comes into existence. Such a Commission should be placed within the Department of Human Resources until such time as the Department of Health is created.

(3) The Department of Health shall promote and organize "Community Health Districts". Community Health Districts shall represent the locus of health policy and delivery for the designated communities they serve. All governmental health related activities will be conducted under the auspices of the District. Each District shall have a local District Board of Health whose members shall be appointed by the County Boards of Commissioners of each county within the District.

(4) The State Health Department and Commission for Health Services shall establish scientifically based indicators of health quality. The District Board of Health shall be responsible for implementation of

disease prevention, local health regulation, and health care delivery for the community pursuant to broad guidelines established by the Commission for Health Services.

(e) The Governor shall recommend to the General Assembly the method for dividing the State into Community Health Districts for delivery of public and private services needed to improve the health status of the citizens of each District in the most cost-effective and beneficial manner possible. The Community Health District structure shall be organized as follows:

(1) The State Health Director shall recommend to the Governor, by April 1, 1994, the Community Health Districts to be included in the Governor's report as required in subsections (c) and (d) of this section. Community Health Districts shall be defined by such factors as population, secondary and tertiary health institution use patterns, economic conditions, political boundaries (counties, current local public health department districts,) geographical areas, transportation patterns, and/or shopping patterns. Community Health Districts shall be large enough to allow for complete community rating for insurance purposes.

(2) A "Community Health District Director", who shall be a person with a background in health planning and the implementation of community health systems, shall serve as executive director of the Community Health District Board, and shall oversee the implementation of State and local health programs.

(3) The county commissioners in each Community Health District shall establish a Community Health District Board which shall be the local policy-making body for each Community Health District. The Community Health District Board shall be an independent, broadly representative body made up of payers, consumers, primary care providers and others appointed by the Boards of County Commissioners in each Community Health District. The purposes of the Community Health District Board are to advise the Community Health District Director on District health policy issues and programs, after being informed by objective research and giving consideration to all interests, and to establish cooperative and collaborative programs with provider groups within the District in order to improve health status throughout the community. In effectuating these purposes, the Board shall act in such a manner as to:

a. Improve access to and ensure the quality of health care for all residents of the District, rural and urban.

b. Improve access and assure the quality of health care for low-income persons and the currently uninsured and reduce nonfinancial barriers to health services such as cultural, language, and transportation barriers.

c. Ensure the affordability of health care by developing safe and appropriate cost-effective substitutions for costly forms of care while constraining the supply of these costly forms of care.
d. Carry out the State's health education and personal responsibility program so that all persons including low-income and rural residents will have access to the program in the District.
e. Reduce the environmental health risks in the District.
f. Carry out a disease prevention program based on primary care and environmental health initiatives.

(4) A "District Health Status Assessment" shall be performed on a regular basis in each Community Health District in order to provide the information needed to implement the purposes and programs of the Board. The assessment shall include, but not be limited to:
a. Epidemiological research of community including age, sex, racial, and geographic factors.
b. Environmental health risk factors.
c. Availability, access, and utilization of prevention programs (medical, dental, educational).
d. Mental health and substance abuse factors.
e. Outcomes of health care programs and services in the District.
f. An estimate of the total private and public financial resources necessary to meet health needs within the District.
g. A survey of the health facilities available to meet the health needs of the District, including tertiary hospitals, community hospitals, community clinics, school clinics, and high technology treatment facilities available outside hospitals.
h. A survey of the health care personnel and related human resources available to meet the health care needs of the District.
i. Priorities for improving community health status.

Sec. 7. The School of Public Health of the University of North Carolina at Chapel Hill shall reconsider its mission and name and shall report its findings and recommendations by February 1, 1995, to the 1995 General Assembly.

Sec. 8. (a) Medical Practice Parameter Advisory Committee. – There is established within the Board of Medical Examiners a Medical Practice Parameter Advisory Committee. The purpose of the Advisory Committee is to oversee the development of practice parameters by specialty area subcommittees established pursuant to subsection (b) of this section, and to make recommendations to the Board for its report to the General Assembly. The Advisory Committee shall be composed of 13 members appointed by the Governor as follows:

(1) Eight physicians, one of whom practices emergency medicine, and seven of whom are board certified in one of each of the following specialty areas: anesthesiology, family medicine, general internal medicine, pediatric medicine, obstetrics-gynecology, general surgical

medicine, and specialty surgical medicine; of the seven board certified appointees, at least one shall be a physician providing services in an HMO;

(2) One nurse practitioner as recommended by the North Carolina Nurses Association;

(3) One hospital administrator as recommended by the North Carolina Hospital Association;

(4) One representative of the insurance industry as recommended by the Health Insurance Association of America;

(5) One consumer not affiliated with any health care profession; and

(6) One attorney with expertise in representing plaintiffs in civil cases relating to medical malpractice, as recommended by the North Carolina Academy of Trial Lawyers.

The Governor shall appoint the chair of the Advisory Committee. To the extent possible, the Governor shall ensure that appointments to the Advisory Committee include persons who have experience in developing medical practice parameters. The Governor shall make appointments to the Advisory Committee within 60 days of the date of ratification of this act. The Advisory Committee shall convene its initial meeting within 90 days of the date of ratification of this act.

(b) Specialty Area Subcommittees. – The Advisory Committee shall establish and the Advisory Committee chair shall appoint at least five specialty area subcommittees, not less than one of which shall be in each of the following areas: primary care, OB-GYN, surgical specialty, and medical specialty. The Advisory Committee shall select medical specialty areas based upon the areas of medical practice that have the greatest variation in practice procedures as indicated by a significant incidence of malpractice lawsuits, or that are specialty areas with relatively high expenditures for care, and based upon other such indicators as the Committee deems appropriate.

The task of each subcommittee shall be to develop practice parameters in that subcommittee's specialty area. Subcommittees may adopt or modify nationally approved practice parameters. The chair of the Advisory Committee shall make subcommittee appointments not later than four months following the initial meeting of the Advisory Committee. To the extent possible, the chair of the Advisory Committee shall ensure that appointments to the subcommittees include persons who have experience in developing medical practice parameters. The chair of each subcommittee shall be elected by the members of the subcommittee.

The Advisory Committee shall ensure that persons appointed to each subcommittee include the following:

(1) At least four board-certified physicians recommended by the North Carolina Medical Society, one of whom practices in an urban area, one of whom practices in a rural area, and one of whom practices in an HMO;

(2) At least one specialist physician who serves on the Advisory Committee; provided that the specialist physician from the Advisory

Committee shall be appointed to a subcommittee specialty area other than that physician's area of professional practice or expertise;

(3) At least one consumer who is not affiliated with any health care profession;

(4) At least one representative of the insurance industry as recommended by the Health Insurance Association of America;

(5) At least one licensed or certified health care professional who practices in the subcommittee's area of specialty and who is not a physician; and

(6) One attorney with expertise in representing plaintiffs in civil cases relating to medical malpractice, as recommended by the North Carolina Academy of Trial Lawyers.

(c) Practice Parameters. – In overseeing the development of the practice parameters, the Advisory Committee shall ensure that:

(1) The medical procedures for which parameters are established are limited to a reasonable number based on volume, cost, and risks for inappropriate utilization and inconsistency in quality of care;

(2) Parameters developed are useful for risk management, and define appropriate clinical indications and methods of treatment within the subcommittee's specialty area;

(3) Parameters are consistent with appropriate standards of care and levels of quality, and take into account resources available to physicians practicing in various geographic areas of the State; and

(4) Each subcommittee reports the parameters developed to the Advisory Committee together with any recommendations the subcommittee may have, and any other information deemed appropriate by the Advisory Committee.

(d) Advisory Committee Review. – The Advisory Committee shall review each subcommittee's parameters and recommendations, and shall report the parameters adopted by the Advisory Committee to the Board of Medical Examiners for its review and recommendations. The Advisory Committee shall complete its task and make its report to the Board in sufficient time for the Board to review the Advisory Committee's recommendations and make the Board's final report to the General Assembly.

(e) Report to General Assembly. – On or before February 1, 1995, the Board of Medical Examiners shall make a final report and recommendations on the practice parameters to the 1995 General Assembly and to the Governor. The report shall include recommendations for developing a system for monitoring compliance with the practice parameters, for ongoing review of existing practice parameters, and for expanding the development of practice parameters to other medical specialty areas.

(f) The Board of Medical Examiners may accept funds from outside sources to help finance the work of the Practice Parameters Advisory Committee and the medical specialty subcommittees.

Sec. 9. The Commissioner of Insurance shall survey the work being done on establishing: practice guidelines and parameters, quality measures, and effectiveness outcomes in the delivery of health care. The survey may include the efforts and

products of the federal government; other state governments; leading medical, clinical, and academic centers; the AMA and related specialty colleges and boards; nation and state associations, societies, colleges, and boards relating to the practice of chiropractic, podiatry, optometry and osteopathy; private third-party payors; larger employer benefit plans/coalitions; benefit consulting companies; respected managed care, quality assurance, and utilization review firms; national accreditation bodies (including URAC, NCQA, AAPI, HEDIS, JCAHO).

The Commissioner shall report back to the 1995 General Assembly the results of such an annotated survey, along with its recommendations as to the appropriateness and feasibility of adopting uniform practice parameters for the purposes of improved quality assurance, reduced unnecessary and/or defensive medicine, and for limiting third-party reimbursement to only the most cost efficacious care.

The Commissioner shall effectuate the purposes of this section solely through the solicitation of grants and the use of working arrangements with academic or research organizations. General Insurance Department budget appropriations shall not be used to effectuate the purposes of this section.

TITLE II. HEALTH PROVIDER COOPERATION AND COLLABORATION.

Sec. 10. Chapter 131E of the General Statutes is amended by adding the following new Article to read:

"ARTICLE 9A.

"CERTIFICATE OF PUBLIC ADVANTAGE.

"§ 131E-192.1. Findings.

The General Assembly of North Carolina makes the following findings:

(1) That technological and scientific developments in hospital care have enhanced the prospects for further improvement in the quality of care provided by North Carolina hospitals to North Carolina citizens.

(2) That the cost of improved technology and improved scientific methods for the provision of hospital care contributes substantially to the increasing cost of hospital care. Cost increases make it increasingly difficult for hospitals in rural areas of North Carolina to offer care.

(3) That changes in federal and State regulations governing hospital operation and reimbursement have constrained the ability of hospitals to acquire and develop new and improved machinery and methods for the provision of hospital-related care.

(4) That cooperative agreements among hospitals and between hospitals and others for the provision of health care services may foster improvements in the quality of health care for North Carolina citizens, moderate increases in cost, improve access to needed services in rural areas of North Carolina, and enhance the likelihood that smaller hospitals in North Carolina will remain open in beneficial service to their communities.

(5) That hospitals are often in the best position to identify and structure cooperative arrangements that enhance quality of care, improve access, and achieve cost-efficiency in the provision of care.

(6) That federal and State antitrust laws may prohibit or discourage cooperative arrangements that are beneficial to North Carolina citizens despite their potential for or actual reduction in competition and that such agreements should be permitted and encouraged.

(7) That competition as currently mandated by federal and State antitrust laws should be supplanted by a regulatory program to permit and encourage cooperative agreements between hospitals, or between hospitals and others, that are beneficial to North Carolina citizens when the benefits of cooperative agreements outweigh their disadvantages caused by their potential or actual adverse effects on competition.

(8) That regulatory as well as judicial oversight of cooperative agreements should be provided to ensure that the benefits of cooperative agreements permitted and encouraged in North Carolina outweigh any disadvantages attributable to any reduction in competition likely to result from the agreements.

"**§ 131E-192.2. Definitions.**

The following definitions apply in this Article:

(1) 'Attorney General' means the Attorney General of the State of North Carolina or any attorney on his or her staff to whom the Attorney General delegates authority and responsibility to act pursuant to this Article.

(2) 'Cooperative agreement' means an agreement among two or more hospitals, or between a hospital and any other person, for the sharing, allocation, or referral of patients, personnel, instructional programs, support services and facilities, or medical, diagnostic, or laboratory facilities or equipment, or procedures or other services traditionally offered by hospitals. Cooperative agreement shall not include any agreement by which ownership over substantially all of the stock, assets, or activities of one or more previously licensed and operating hospitals is transferred nor any agreement that would permit self-referrals of patients by a health care provider that is otherwise prohibited by law.

(3) 'Department' means the Department of Human Resources.

(4) 'Hospital' means any hospital required to be licensed under Chapters 131E or 122C of the General Statutes.

(5) 'Person' means any individual, firm, partnership, corporation, association, public or private institution, political subdivision, or government agency.

(6) 'Federal or State antitrust laws' means any and all federal or State laws prohibiting monopolies or agreements in restraint of trade, including the federal Sherman Act, Clayton Act, Federal Trade Commission Act, and North Carolina laws codified in Chapter 75 of the General Statutes that prohibit restraints on competition.

"**§ 131E-192.3. Certificate of public advantage; application.**

(a) A hospital and any person who is a party to a cooperative agreement with a hospital may negotiate, enter into, and conduct business pursuant to a cooperative agreement without being subject to damages, liability, or scrutiny under any State antitrust law if a certificate of public advantage is issued for the cooperative agreement, or in the case of activities to negotiate or enter into a cooperative agreement, if an application for a certificate of public advantage is filed in good faith. It is the intention of the General Assembly that immunity from federal antitrust laws shall also be conferred by this statute and the State regulatory program that it establishes.

(b) Parties to a cooperative agreement may apply to the Department for a certificate of public advantage governing that cooperative agreement. The application must include an executed written copy of the cooperative agreement or letter of intent with respect to the agreement, a description of the nature and scope of the activities and cooperation in the agreement, any consideration passing to any party under the agreement, and any additional materials necessary to fully explain the agreement and its likely effects. A copy of the application and all additional related materials shall be submitted to the Attorney General at the same time the application is submitted to the Department.

"**§ 131E-192.4. Procedure for review; standards for review.**

(a) The Department shall review an application in accordance with the standards set forth in subsection (b) of this section and shall hold a public hearing with the opportunity for the submission of oral and written public comments in accordance with rules adopted by the Department. The Department shall determine whether the application should be granted or denied within 90 days of the date the application is filed. The Department may extend the review period for a specified period of time upon notice to the parties.

(b) The Department shall determine that a certificate of public advantage should be issued for a cooperative agreement if it determines that an applicant has demonstrated by clear and convincing evidence that the benefits likely to result from the agreement outweigh the disadvantages likely to result from a reduction in competition from the agreement.

In evaluating the potential benefits of a cooperative agreement, the Department shall consider whether one or more of the following benefits may result from the cooperative agreement:

(1) Enhancement of the quality of hospital and hospital-related care provided to North Carolina citizens.

(2) Preservation of hospital facilities in geographical proximity to the communities traditionally served by those facilities.

(3) Lower costs of, or gains in, the efficiency of delivering hospital services.

(4) Improvements in the utilization of hospital resources and equipment.

(5) Avoidance of duplication of hospital resources.

(6) The extent to which medically underserved populations are expected to utilize the proposed services.

In evaluating the potential disadvantages of a cooperative agreement, the Department shall consider whether one or more of the following disadvantages may result from the cooperative agreements:

(1) The extent to which the agreement may increase the costs or prices of health care at a hospital which is party to the cooperative agreement.

(2) The extent to which the agreement may have an adverse impact on patients in the quality, availability, and price of health care services.

(3) The extent to which the agreement may reduce competition among the parties to the agreement and the likely effects thereof.

(4) The extent to which the agreement may have an adverse impact on the ability of health maintenance organizations, preferred provider organizations, managed health care service agents, or other health care payors to negotiate optimal payment and service arrangements with hospitals, physicians, allied health care professionals, or other health care providers.

(5) The extent to which the agreement may result in a reduction in competition among physicians, allied health professionals, other health care providers, or other persons furnishing goods or services to, or in competition with, hospitals.

(6) The availability of arrangements that are less restrictive to competition and achieve the same benefits or a more favorable balance of benefits over disadvantages attributable to any reduction in competition.

In making its determination, the Department may consider other benefits or disadvantages that may be identified.

"**§ 131E-192.5. Issuance of a certificate.**

If the Department determines that the likely benefits of a cooperative agreement outweigh the likely disadvantages attributable to reduction of competition as a result of the agreement by clear and convincing evidence, and the Attorney General has not stated any objection to issuance of a certificate during the review period, the Department shall issue a certificate of public advantage for the cooperative agreement at the conclusion of the review period. The certificate shall include any conditions of operation under the agreement that the Department, in consultation with the Attorney General, determines to be appropriate in order to ensure that the cooperative agreement and the activities engaged under it are consistent with this Article and its purpose to limit health care costs. The Department shall include conditions to control prices of health care services provided under the cooperative agreement. Consideration shall be given to assure that access to health care is provided to all areas of the State. The Department shall publish its decisions on applications for certificates of public advantage in the North Carolina Register.

"**§ 131E-192.6. Objection by Attorney General.**

If the Attorney General is not persuaded that an applicant has demonstrated by clear and convincing evidence that the benefits likely to result from the agreement outweigh the likely disadvantages of any reduction of competition to result from the agreement as set forth in G.S. 131E-192.4, the Attorney General may, within the review period, state

an objection to the issuance of a certificate of public advantage and may extend the review period for a specified period of time. Notice of the objection and any extension of the review period shall be provided in writing to the applicant, together with a general explanation of the concerns of the Attorney General. The parties may attempt to reach an agreement with the Attorney General on modifications to the agreement or to conditions in the certificate so that the Attorney General no longer objects to issuance of a certificate. If the Attorney General withdraws the objection and the Department maintains its determination that a certificate should be issued, the Department shall issue a certificate of public advantage with any appropriate conditions as soon as practicable following the withdrawal of the objection. If the Attorney General does not withdraw the objection, a certificate shall not be issued.

"**§ 131E-192.7. Record keeping.**

The Department shall maintain on file all cooperative agreements for which certificates of public advantage are in effect and a copy of the certificate, including any conditions imposed in it. Any party to a cooperative agreement who terminates an agreement shall file a notice of termination with the Department within 30 days after termination. These files shall be public records as set forth in Chapter 132 of the General Statutes.

"**§ 131E-192.8. Review after issuance of certificate.**

If at any time following the issuance of a certificate of public advantage, the Department or the Attorney General has questions concerning whether the parties to the cooperative agreement have complied with any condition of the certificate or whether the benefits or likely benefits resulting from a cooperative agreement may no longer outweigh the disadvantages or likely disadvantages attributable to a reduction in competition resulting from the agreement, the Department or the Attorney General shall advise the parties to the agreement and either the Department or the Attorney General shall request any information necessary to complete a review of the matter.

"**§ 131E-192.9. Periodic reports.**

(a) During the time that a certificate is in effect, a report of activities pursuant to the cooperative agreement must be filed every two years with the Department on or before the anniversary date on which the certificate was issued. A copy of the periodic report shall be submitted to the Attorney General at the same time that it is filed with the Department. A report shall include all of the following:

(1) A description of the activities conducted pursuant to the agreement.

(2) Price and cost information.

(3) The nature and scope of the activities pursuant to the agreement anticipated for the next two years, the likely effect of those activities.

(4) A signed certificate by each party to the agreement that the benefits or likely benefits of the cooperative agreement as conditioned continue to outweigh the disadvantages or likely disadvantages of any reduction in competition from the agreement as conditioned.

(5) Any additional information requested by the Department or the Attorney General.

The Department shall give public notice in the North Carolina Register that a report has been received. After notice is given, the public shall have 30 days to file written comments on the report and on the benefits and disadvantages of continuing the certificate of public advantage. Periodic reports, public comments, and information submitted in response to a request shall be public records as set forth in Chapter 132 of the General Statutes.

(b) Failure to file a periodic report required by this section after notice of default or failure to provide information requested pursuant to a review under G.S. 131E-192.8 is grounds for the revocation of the certificate by the Attorney General or the Department.

(c) The Department shall review each periodic report, public comments, and information submitted in response to a request under G.S. 131E-192.8 to determine whether the advantages or likely advantages of the cooperative agreement continue to outweigh the disadvantages or likely disadvantages of any reduction in competition from the agreement, and to determine what, if any, changes in the conditions of the certificate should be made. In the review the Department shall consider the benefits and disadvantages set forth in G.S. 131E-192.4. Within 60 days of the filing of a periodic report, the Department shall determine whether the certificate should remain in effect and whether any changes to the conditions in the certificate should be made. The Department may extend the review period an additional 30 days. If either the Department or the Attorney General determines that the parties to a cooperative agreement have not complied with any condition of the certificate, the Department or the Attorney General shall revoke the certificate and the parties shall be notified. If the Department determines that the certificate should remain in effect and the Attorney General has not stated any objection to the certificate remaining in effect during the review period, the certificate shall remain in effect subject to any changes in the conditions of the certificate imposed by the Department. The parties shall be notified in writing of the Department's decision and of any changes in the conditions of the certificate. The Department shall publish its decision and any changes in the conditions in the North Carolina Register.

If the Department determines that the benefits or likely benefits of the agreement and the unavoidable costs of terminating the agreement do not continue to outweigh the disadvantages or likely disadvantages of any reduction in competition from the agreement, or if the Attorney General objects to the certificate remaining in effect based upon a review of the benefits and disadvantages set forth in G.S. 131E-192.4, the Department shall notify the parties to the agreement in writing of its determination or the objections of the Attorney General, and shall provide a summary of any concerns of the Department or Attorney General to the parties.

"**§ 131E-192.10. Right to judicial action.**

(a) Any applicant or other person aggrieved by a decision to issue or not issue a certificate of public advantage is entitled to judicial review of the action or inaction in superior court. Suit for judicial review under this subsection shall be filed within 30 days of public notice of the decision to issue or deny issuance of the certificate. To prevail in any action for judicial review brought under this subsection, the plaintiff or

petitioner must establish that the determination by the Department or the Attorney General was arbitrary or capricious.

(b) Any party or other person aggrieved by a decision to allow a certificate to remain in effect or to make changes in the conditions of a certificate is entitled to judicial review of the decision in superior court. Suit for judicial review under this subsection shall be filed within 30 days of public notice of the decision to allow the certificate to remain in effect or to make changes in the conditions of the certificate. To prevail in any action for judicial review brought under this subsection, the plaintiff or petitioner must establish that the determination by the Department or the Attorney General was arbitrary or capricious.

(c) If the Department or the Attorney General determines that the certificate should not remain in effect, the Attorney General may bring suit in the Superior Court of Wake County on behalf of the Department, or on its own behalf, to seek an order to authorize the cancellation of the certificate. To prevail in the action, the Attorney General must establish that the benefits resulting from the agreement are outweighed by the disadvantages attributable to a reduction in competition resulting from the agreement.

(d) In any action instituted under this section, the work product of the Attorney General or his staff shall not be discoverable or admissible, nor shall the Attorney General or any member of his staff be compelled to be a witness, whether in discovery or at any hearing or trial.

"**§ 131E-192.11. Fees for applications and periodic reports.**

The Department and the Attorney General shall establish a schedule of fees for filing an application for a certificate of public advantage and for filing a periodic report based on the total cost of the project for which the application or periodic report is made. The fee schedule established should generate sufficient revenue to offset the costs of the program. An application filing fee must be paid to the Department at the time an application for a certificate of public advantage is submitted to it pursuant to G.S. 131E-192.3. A periodic report filing fee must be paid to the Department at the time a periodic report is submitted to it pursuant to G.S. 131E-192.9.

"**§ 131E-192.12. Department and Attorney General authority.**

The Department and Attorney General shall have the necessary powers to conduct a review of applications for certificates of public advantage and of periodic reports filed in connection therewith and to bring actions in the Superior Court of Wake County as required under G.S. 131E-192.10. This Article shall not limit the authority of the Attorney General under federal or State antitrust laws.

"**§ 131E-192.13. Effects of certificate of public advantage; other laws.**

(a) Activities conducted pursuant to a cooperative agreement for which a certificate of public advantage has been issued are immunized from challenge or scrutiny under State antitrust laws. In addition, conduct in negotiating and entering into a cooperative agreement for which an application for a certificate of public advantage is filed in good faith shall be immune from challenge or scrutiny under State antitrust laws, regardless of whether a certificate is issued. It is the intention of the General

Assembly that this Article shall also immunize covered activities from challenge or scrutiny under federal antitrust law.

(b) Nothing in this Article shall exempt hospitals or other health care providers from compliance with State or federal laws governing certificate of need, licensure, or other regulatory requirements.

(c) Any dispute among the parties to a cooperative agreement concerning its meaning or terms is governed by normal principles of contract law.

(d) Nothing in this Article shall be construed to exempt from State or federal antitrust laws any solicitation, negotiation, or agreement to fix prices."

Sec. 11. G.S. 131E-7(b) reads as rewritten:

"(b) ~~A municipality may contract with or otherwise arrange with other municipalities of this or other states, federal or public agencies or with any person, private organization or nonprofit association for the provision of hospital, clinical, or similar services. The municipality may pay for these services from appropriations or other moneys available for these purposes.~~ A municipality or a public hospital may contract with or enter into any arrangement with other public hospitals or municipalities of this or other states, the State of North Carolina, federal, or public agencies, or with any person, private organization, or nonprofit corporation or association for the provision of health care. The municipality or public hospital may pay for or contribute its share of the cost of any such contract or arrangement from revenues available for these purposes, including revenues rising from the provision of health care."

Sec. 12. The Department of Human Resources shall prepare and submit a report to the 1999 General Assembly summarizing and analyzing the effects of this act. The report shall include the results of efforts to assure access to health care and to control increases in health care costs and any recommendations the Department may have for amendments to the act.

Sec. 13. G.S. 131E-20(a) reads as rewritten:

"(a) The territorial boundaries of a hospital authority shall include the city or county creating the authority and the area within 10 miles from the territorial boundaries of that city or county. However, a hospital authority may engage in health care activities in a county outside its territorial boundaries pursuant to:

(1) An agreement with a hospital facility if only one hospital currently exists in that county;

(2) An agreement with any hospital if more than one hospital currently exists in that county; or

(3) An agreement with any health care agency if no hospital currently exists in that county.

In no event shall the territorial boundaries of a hospital authority include, in whole or in part, the area of any previously existing hospital authority. All priorities shall be determined on the basis of the time of issuance of the certificates of incorporation by the Secretary of State."

TITLE III. HEALTH INSURANCE REFORM.

Sec. 14. Article 3 of Chapter 58 of the General Statutes is amended by adding a new section to read:

"**§ 58-3-170. Guaranteed health benefit plans; provisions.**

"(a) As used in this section:

(1) 'Health benefit plan' means an accident and health insurance policy or certificate; a nonprofit hospital or medical service corporation contract; a health maintenance organization subscriber contract; a plan provided by a multiple employer welfare arrangement; or a plan provided by another benefit arrangement, to the extent permitted by ERISA. 'Health benefit plan' does not mean any of the following kinds of insurance:

a. Accident;
b. Credit;
c. Disability income;
d. Long-term or nursing home care;
e. Medicare supplement;
f. Specified disease;
g. Dental or vision;
h. Coverage issued as a supplement to liability insurance;
i. Workers' compensation;
j. Medical payments under automobile or homeowners;
k. Hospital income or indemnity; or
l. Insurance under which benefits are payable with or without regard to fault and that is statutorily required to be contained in any liability policy or equivalent self-insurance.

(2) 'Insurer' includes an entity subject to Articles 49, 65, or 67 of this Chapter.

(3) 'Pure community rating' means a system of health benefit plan rating whereby premium rates are charged for the same benefits to all insureds, regardless of differences among the insureds in use or projected use in health care services.

(b) Effective January 1, 1998, notwithstanding any other provision of law, no insurer shall, on account of the physical or mental condition or health of any person:

(1) Refuse to issue, deliver, or renew any health benefit plan.
(2) Have a higher premium rate or charge for any health benefit plan.
(3) Reduce coverages or benefits or charge higher deductibles or copayments on any health benefit plan.
(4) Require evidence of individual insurability.

(c) Any preexisting conditions provision in a health benefit plan may not limit or exclude coverage for a period of more than 12 months after an insured's effective date of coverage; and may only relate to conditions manifesting themselves during the 12 months immediately before the effective date of coverage in a manner that would cause an ordinary, prudent person to seek medical advice, diagnosis, care, or treatment; or conditions for which medical advice, diagnosis, care, or treatment was recommended or received during the 12 months immediately before the effective date of coverage.

(d) In determining whether a preexisting conditions provision applies to any insured, all insurers shall credit the time the insured was covered by a previous insurer if the previous coverage was continuous to a date not more than 60 days before the effective date of the new coverage.

(e) Effective January 1, 1998, every insurer that is licensed to write any kind of health benefit plan under this Chapter and that is actually writing one or more health benefit plans shall, as a condition of transacting business in this State, offer all of its health benefit plans to the general public. Every person who accepts such offer, elects to be covered under a plan, and agrees to make the required premium payments and to satisfy the other provisions of the plan, shall be guaranteed the issuance of the plan by the insurer. Renewal of the plan shall be guaranteed by the insurer except:

(1) For nonpayment of the required premium by the policyholder or contract holder.

(2) For fraud or material misrepresentation by the policyholder or contract holder.

(3) When the insurer ceases providing health benefit plans in compliance with subsection (f) of this section.

The premium payment requirements used in connection with the plan may address the potential credit risk of persons 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. Whenever an insurer offers group coverage to an employer, the insurer shall offer coverage to all eligible employees of an employer and their dependents.

(f) Insurers that provide health benefit plans on and after January 1, 1998, that intend to cease doing business in the health benefit plan market must comply with all of the following requirements:

(1) Notice of the decision to cease doing business in the health benefit plan market must be provided to the Commissioner and to the policyholder or contract holder six months before nonrenewal of the health benefit plan.

(2) Insurers that cease to write new business in the health benefit plan market continue to be governed by this subsection.

(3) Insurers that cease to write new business in the health benefit plan market are prohibited from writing new business in that market for a period of five years after the date of the notice to the Commissioner.

(g) Effective January 1, 1998, an insurer shall modify any health benefit plan with respect to any insured 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.

(h) Effective January 1, 1994, every insurer subject to this section shall establish a six-year conversion plan by which to convert its current rating structure to a pure community rating structure. Initially, the conversion plan shall take the form of capping the ratio, within each health benefit plan, of the lowest premium charged or that could be charged any insured to the highest premium charged or that could be charged any

insured. At the end of the six-year conversion period, ending on January 1, 2000, every insurer shall have an individual and family community rate for each health benefit plan. During the conversion period all insurers subject to this section shall achieve the following ratios on the stated dates:

(1) The ratio shall not exceed 18:1 on January 1, 1994.
(2) The ratio shall not exceed 15:1 on January 1, 1995.
(3) The ratio shall not exceed 12:1 on January 1, 1996.
(4) The ratio shall not exceed 9:1 on January 1, 1997.
(5) The ratio shall not exceed 6:1 on January 1, 1998.
(6) The ratio shall not exceed 3:1 on January 1, 1999.
(7) The ratio shall not exceed 1:1 on January 1, 2000.

Every insurer writing health benefit plans subject to this subsection must file the insurer's community rates and any formulas and factors used to adjust those rates with the Commissioner. The Commissioner shall adopt rules to provide that the conversion required by this subsection will be accomplished in an actuarially sound manner.

(i) In addition to the rule-making authority granted in subsection (h) of this section, the Commissioner may adopt other rules to effectuate the provisions of this section."

Sec. 14.1. Effective January 1, 1997, G.S. 58-3-170(c) reads as rewritten:

"(c) ~~Any~~ Effective January 1, 1997, any ~~pre-existing~~ preexisting conditions provision in a health benefit plan may not limit or exclude coverage for a period of more than ~~12~~ 6 months after an insured's effective date of coverage; and may only relate to conditions manifesting themselves during the ~~12~~ 6 months immediately before the effective date of coverage in a manner that would cause an ordinary, prudent person to seek medical advice, diagnosis, care, or treatment; or conditions for which medical advice, diagnosis, care, or treatment was recommended or received during the ~~12~~ 6 months immediately before the effective date of coverage."

Sec. 14.2. Effective January 1, 2000, G.S. 58-3-170(c) reads as rewritten:

"(c) Effective January 1, ~~1997,~~ 2000, any ~~pre-existing~~ preexisting conditions provision in a health benefit plan may not limit or exclude coverage for a period of more than ~~6 months~~ 90 days after an insured's effective date of coverage; and may only relate to conditions manifesting themselves during the ~~6 months~~ 90 days immediately before the effective date of coverage in a manner that would cause an ordinary, prudent person to seek medical advice, diagnosis, care, or treatment; or conditions for which medical advice, diagnosis, care, or treatment was recommended or received during the ~~6 months~~ 90 days immediately before the effective date of coverage."

Sec. 14.3. The various effective dates in Sections 14 through 14.2 of this act are applicable to all health benefit plans that are delivered, issued for delivery, or renewed on and after those stated effective dates. For the purposes of this section, renewal of a health benefit plan is presumed to occur on each anniversary of the date on which coverage was first effective on the person or persons covered by the health benefit plan.

Sec. 14.4. The Commissioner of Insurance shall evaluate the provisions of Sections 14 through 14.3 of this act and report his findings and recommendations as to

those provisions and their effects on the State's insurance marketplace, health care delivery system, and general economy. The Commissioner shall also evaluate the feasibility of establishing a residual market mechanism for high-risk individuals. The Commissioner shall make reports to the 1993 General Assembly, 1994 Regular Session, the 1995 General Assembly, 1995 and 1996 Regular Sessions, and the 1997 General Assembly; and may make a report to any Extra Session of the General Assembly. The reports shall be directed to the Speaker of the House of Representatives and the President Pro Tempore of the Senate. The Commissioner shall effectuate the purposes of this section solely through the solicitation of grants and the use of working arrangements with academic and research organizations. General Insurance Department budget appropriations, other receipts, or federal grants for specific programs shall not be used to effectuate the purposes of this section.

Sec. 15. Effective October 1, 1993, G.S. 58-50-10 reads as rewritten:

"**§ 58-50-10. Claim forms.**

(a) All forms used by policyholders, beneficiaries, hospitals and physicians to report information relative to the nature and extent of loss or disability for which claim is being made under any type of ~~accident or health policy~~ health benefit plan must conform to certain standard language approved by the Commissioner.

(b) The Commissioner shall prescribe, and all insurers providing health benefit plans in this State shall accept, a standard claims form to be submitted by health care providers, or by persons receiving services, as appropriate, for reimbursement for health care services provided or received. To the extent possible, the form shall be a single-page form and shall be designed to provide all of the information necessary for the claim to be paid as soon as possible upon receipt of the completed form by the insurer. An insurer may request from the provider or from the insured additional claim-related information, but the insurer may not delay payment of that claim pending receipt of the additional information. Nothing in this subsection shall be construed to prohibit an insurer or State agency from accepting any other health insurance claim form for services provided or received, provided that such form meets the requirements of this section.

(c) As used in this section, 'health benefit plan' and 'insurer' have the same meaning as in G.S. 58-3-170(a)(1) and (2)."

Sec. 16. Article 2 of Chapter 58 of the General Statutes is amended by adding a new section to read:

"**§ 58-2-235. Health Education and Personal Responsibility Program.**

(a) Findings. – The General Assembly finds that health care reform should embody and emphasize personal responsibility as a significant factor in the cost of health care and health insurance.

(b) Program. – The Commissioner, in consultation with the State Health Director, shall develop and implement a Health Education and Personal Responsibility Program whereby each individual who voluntarily participates in a health education and personal responsibility curriculum certified by the State Health Director, receives credit in the form of an amount to be applied against the annual deductible, coinsurance, or

maximum out-of-pocket limit or the total premium of the health insurance program or plan under which the individual is covered.

(c) Report. – The Commissioner shall report annually on the Health Education and Personal Responsibility Program to the Joint Legislative Commission on Governmental Operations."

TITLE IV. HEALTH DELIVERY IMPROVEMENTS.

Sec. 17. G.S. 58-50-50 reads as rewritten:

"**§ 58-50-50. Preferred provider; definition.**

The term 'preferred provider' as used in Articles 1 through 64 of this Chapter with respect to contracts, organizations, policies or otherwise means a person, who has contracted for, or a provider of health care services who has agreed to accept special reimbursement or other terms for health care services from any person; or an insurer subject to the provisions of Articles 1 through 64 of this Chapter or other applicable law for health care services on a fee for service basis, or in exchange for providing health care services to beneficiaries of a plan administered pursuant to Articles 1 through 64 of this ~~Chapter.~~ Chapter, except that the term 'preferred provider' as used in Articles 1 through 64 of this Chapter does not apply to any prepaid health service or capitation arrangement implemented or administered by the Department of Human Resources or its representatives, pursuant to 42 U.S.C. § 1396n or Chapter 108A of the General Statutes, or to any provider of health care services participating in such a prepaid health service or capitation arrangement. Except where specifically prohibited either by G.S. 58-50-55 or by regulations promulgated by the Department of Insurance, not inconsistent with Articles 1 through 64 of this Chapter, the contractual terms and conditions for special reimbursements shall be those which the insurer, health care provider and the preferred provider find to be mutually agreeable."

Sec. 18. G.S. 58-67-10(b) reads as rewritten:

"(b) (1) It is specifically the intention of this section to permit such persons as were providing health services on a prepaid basis on July 1, 1977, or receiving federal funds under Section 254(c) of Title 42, U.S. Code, as a community health center, to continue to operate in the manner which they have heretofore operated.

(2) Notwithstanding anything contained in this Article to the contrary, any person can provide health services on a fee for service basis to individuals who are not enrollees of the organization, and to enrollees for services not covered by the contract, provided that the volume of services in this manner shall not be such as to affect the ability of the health maintenance organization to provide on an adequate and timely basis those services to its enrolled members which it has contracted to furnish under the enrollment contract.

(3) This Article shall not apply to any employee benefit plan to the extent that the Federal Employee Retirement Income Security Act of 1974 preempts State regulation thereof.

(3a) This Article does not apply to any prepaid health service or capitation arrangement implemented or administered by the Department of

Human Resources or its representatives, pursuant to 42 U.S.C. § 1396n or Chapter 108A of the General Statutes, or to any provider of health care services participating in such a prepaid health services or capitation arrangement.

(4) Except as provided in paragraphs (1), (2), ~~and (3)~~ (3), and (3a) of this subsection, the persons to whom these paragraphs are applicable shall be required to comply with all provisions contained in this Article."

Sec. 19. G.S. 108A-55(b) reads as rewritten:

"(b) Payments shall be made only to intermediate care facilities, hospitals and nursing homes licensed and approved under the laws of the State of North Carolina or under the laws of another state, or to pharmacies, physicians, dentists, optometrists or other providers of health-related services authorized by the Department. Payments may also be made to such fiscal intermediaries and to ~~such~~ the capitation or prepaid health service contractors as may be authorized by the Department. Arrangements under which payments are made to capitation or prepaid health services contracts are not subject to the provisions of Chapter 58 of the General Statutes or of Article 3 of Chapter 143 of the General Statutes."

Sec. 20. Chapter 143 of the General Statutes is amended by adding the following new section to read:

"**§ 143-48.1. Medicaid program exemption.**

(a) This Article shall not apply to any capitation arrangement or prepaid health service arrangement implemented or administered by the North Carolina Department of Human Resources or its delegates pursuant to the Medicaid waiver provisions of 42 U.S.C. 1396n, or to the Medicaid program authorizations under Chapter 108A of the General Statutes.

(b) As used in this section, the following definitions apply:

(1) 'Capitation arrangement' means an agreement whereby the Department of Human Resources pays a periodic per enrollee fee to a contract entity that provides medical services to Medicaid recipients during their enrollment period.

(2) 'Prepaid health services' means services provided to Medicaid recipients that are paid on the basis of a prepaid capitation fee, pursuant to an agreement between the Department of Human Resources and a contract entity."

Sec. 21. Section 136(e) of Chapter 900 of the 1991 Session Laws reads as rewritten:

"(e) To the maximum extent possible, Area Mental Health Authorities are encouraged to develop service implementation plans in accordance with the long-range plans of the Mental Health Study Commission and with the involvement of local affected organizations. These plans may be used as the basis for future budget requests submitted by the Division.

Criteria for development and content of these plans shall be developed by the Department of Human Resources and the members of Coalition 2001 and presented to the Mental Health Study Commission for consideration by November 1, 1992. The

plans themselves shall be ready for review by the Department and the Mental Health Study Commission by ~~November 1, 1993.~~ November 1, 1993, February 1, 1994, and May 1, 1994."

Sec. 22. Chapter 131E of the General Statutes is amended by adding a new Article to read:

"**ARTICLE 13.**

"**DISPOSAL OF SURPLUS PROPERTY TO AID OTHER COUNTRIES.**

"**§ 131E-231. Disposition of surplus property by public and State hospitals.**

(a) As used in this section, 'public hospital' has the same meaning as in G.S. 159-39. A State hospital is any hospital operated by the State.

(b) A public hospital or a State hospital may donate medical equipment it determines is no longer needed by the hospital to any:

(1) Corporation which is exempt from taxation under section 501(c) of the Internal Revenue Code of 1986;

(2) The United States or any agency thereof;

(3) Government of a foreign country or any political subdivision of that country;

(4) The United Nations or an agency of it; or to

(5) Other eleemosynary institutions and groups

if the property so donated is to be used by a hospital or medical facility in another country."

Sec. 23. G.S. 90-85.29 reads as rewritten:

"**§ 90-85.29. Prescription label.**

The prescription label of every drug product dispensed shall contain the brand name of any drug product dispensed, or in the absence of a brand name, the established name. The prescription drug label of every drug product dispensed shall:

(1) Contain the discard date when dispensed in a container other than the manufacturer's original container. The discard date shall be the earlier of one year from the date dispensed or the manufacturer's expiration date, whichever is earlier, and

(2) Not obscure the expiration date and storage statement when the product is dispensed in the manufacturer's original container.

As used in this section, 'expiration date' means the expiration date printed on the original manufacturer's container, and 'discard date' means the date after which the drug product dispensed in a container other than the original manufacturer's container shall not be used. Nothing in this section shall impose liability on the dispensing pharmacist or the prescriber for damages related to or caused by a drug product that loses its effectiveness prior to the expiration or disposal date displayed by the pharmacist or prescriber."

Sec. 24. Chapter 131E of the General Statutes is amended by adding a new section to read:

"**§ 131E-79.1. Counseling patients regarding prescriptions.**

(a) Any hospital or other health care facility licensed pursuant to this Chapter or Chapter 122C of the General Statutes, health maintenance organization, local health

department, community health center, medical office, or facility operated by a health care provider licensed under Chapter 90 of the General Statutes, providing patient counseling by a physician, a registered nurse, or any other appropriately trained health care professional shall be deemed in compliance with the rules adopted by the North Carolina Board of Pharmacy regarding patient counseling.

(b) As used in this section, 'patient counseling' means the effective communication of information to the patient or representative in order to improve therapeutic outcomes by maximizing proper use of prescription medications and devices."

TITLE V. MISCELLANEOUS.

Sec. 25. The Legislative Research Commission shall study the Fletcher-Jeralds Omnibus Health Reform Act of 1993, including:

(1) Production of primary care physicians;
(2) Added duties to the State Health Director relative to data collected on primary care physician production;
(3) Community rating for health insurance;
(4) Simplified health claim forms;
(5) Consumer personal responsibility in health care reform;
(6) Practice parameters and practice outcomes;
(7) Regulated health care provider arrangements;
(8) Consolidation of State health functions and the creation of the Secretary of Health;
(9) Governor's recommendation regarding Community Health Districts;
(10) The creation, composition, and duties of the Health Care Planning Commission;
(11) Parity between in-State and out-of-State pharmacies in prescription drug counseling;
(12) The issue of the provision of long-term care in North Carolina including long-term care insurance; and
(13) Any other issues arising from this study.

The Legislative Research Commission shall make its final report to the 1994 Session of the 1993 General Assembly.

Sec. 26. The provisions of this act are severable. If any provision of this act is held invalid by a court of competent jurisdiction, the invalidity does not affect other provisions of the act that can be given effect without the invalid provision.

Sec. 27. The headings to the titles and sections of this act are a convenience to the reader and are for reference only. The headings do not expand, limit, or define the text of this act.

Sec. 28. Section 10 of this act becomes effective October 1, 1993. Section 21 of this act becomes effective June 30, 1993. Section 23 of this act becomes effective July 1, 1994. The remainder of this act becomes effective July 1, 1993. Sections 17, 18, 19, and 20 of this act apply to arrangements implemented or administered on or after July 1, 1993. Section 1 of this act expires July 1, 1999.