NORTH CAROLINA GENERAL ASSEMBLY

HOUSE SELECT COMMITTEE ON HEALTH CARE

Co-chairs:
Representative Rep. Edd Nye
Representative Rep. Thomas Wright
Representative England

FINAL REPORT
TO THE
HOUSE OF REPRESENTATIVES

DECEMBER, 2006

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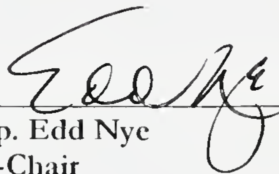
The House Select Committee on Health Care respectfully submits the following final report.



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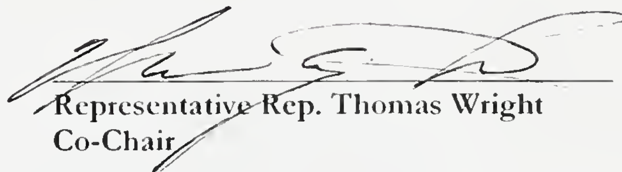
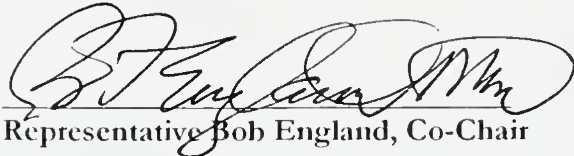


Representative Rep. Thomas Wright
Co-Chair



Representative Bob England, Co-Chair

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PREFACE

In a declaration effective November 3, 2005, the Speaker of the House of Representatives established the House Select Committee on Health care. The Speaker appointed 56 members of the House of Representatives to serve on the Committee and its subcommittees, as established by the Speaker. Six subcommittees of the Select Committee were established, as follows: Medicaid; Cost of Health Care and Health Insurance for Employees and Employers; Safety, Quality, Accountability; Healthcare Workforce; Access; and the State Health Plan. The Select Committee and its appropriate subcommittees were directed to study specific issues pertaining to health care.

This final report represents the work of the Select Committee and its Subcommittees from the time of establishment to the convening of the 2007 General Assembly. The Select Committee met on for the purpose of reviewing its charge, hearing progress reports from subcommittees, considering subcommittee reports, and adopting an interim report. The number of meetings, topics of discussion, and recommendations of subcommittee can be found in the Committee Proceedings Part of this Report.

EXECUTIVE SUMMARY

Health care costs and health care quality are pressing issues facing North Carolina citizens, businesses, and all levels of government. Moreover, affordable access to health care is a growing concern for many North Carolina families, and many communities in rural and urban North Carolina lack reliable access to physicians and other health care providers. A shortage of health care professionals is also a growing concern across the State.

In addition to health care access for all State citizens, the North Carolina Teachers' and State Employees' Comprehensive Major Medical Plan (State Health Plan) is the primary vehicle for providing health care services for thousands of State employees. For this and other reasons, the effectiveness of the State Health Plan is critically important for many North Carolina families and North Carolina taxpayers.

A primary method of providing basic health care treatment to qualified elderly, poor, and disabled North Carolina citizens is the State Medical Assistance Program (Medicaid), a Program that is a growing component of the State's budget.

Promoting quality health care for every North Carolinian is essential for out State's economic growth; and all parties involved in the delivery of health care need to address the issues affecting patient safety in health care delivery.

COMMITTEE MEMBERSHIP

Representative Edd Nye, Co-Chair
Representative Thomas Wright, Co-Chair
Representative Bob England, Co-Chair

Subcommittee on Medicaid

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

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

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

Subcommittee on the State Health Plan

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

COMMITTEE PROCEEDINGS

In addition to its meetings prior to the 2006 Regular Session, the House Select Committee on Health Care met on August 29, 2006 and November 29, 2006. At the August meeting the Committee heard a presentation by Patrice Roesler, NC Association of County Commissioners, on the allocation of the reduction in county Medicaid share of the nonfederal share for the fiscal year 2006-2007. Discussion ensued about the allocation and whether it met the intent of the budget special provision appropriating funds for the one-time reduction in the county share. The Committee requested that the Joint Committee on Governmental Operations review the legislation and the subsequent allocation to determine if it meets the intent of the General Assembly. The Co-chairs directed subcommittee chairs to begin meeting on their subject areas and to report to the Committee on November 29 each subcommittee's findings and recommendations.

At the November 29 meeting the full Committee heard the findings and recommendations of each of the six subcommittees. Those findings and recommendations were adopted by the full Committee, as amended, and are reported herein as the findings and recommendations of the full Committee. Committee Proceedings, appendices, and legislative proposals of each of the subcommittee reports are attached to this report. Copies of the Interim Report of the House Select Committee on Health Care, May 2006, may be found in the Legislative Library.

FINDINGS AND RECOMMENDATIONS

I. SUBCOMMITTEE ON MEDICAID

FINDING 1:

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 subcommittee 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.

The North Carolina General Assembly recognized the Medicaid burden on counties during the 2006 session by capping the county share of the Medicaid program at the FY 2005-06 county expenditure level and providing a $26.4 million one-time appropriation to cover the cost of the cap for FY 2006-07.

RECOMMENDATION 1:

The State should continue capping the county share of Medicaid at the FY 2005-06 expenditure level until a methodology for eliminating all of the county share of Medicaid is identified and funded. The estimated cost of continuing the cap on county Medicaid expenditures for FY 2007-08 is $70,000,000 and $115,000,000 for FY 2008-09.

FINDING 2:

The following language has appeared in the Medicaid special provision in every current operations appropriations bill since 1996:

"The Division of Medical Assistance, Department of Health and Human Services, may provide incentives to counties that successfully recover fraudulently spent Medicaid funds by sharing State savings with counties responsible for the recovery of the fraudulently spent funds."

Providing incentives to counties that successfully investigate Medicaid fraud assists the State in reducing fraudulent Medicaid expenditures.

RECOMMENDATION 2:

The North Carolina General Assembly should continue language in the Medicaid special provision in the FY 2007-2009 current operations appropriations bills that authorize the Department of Health and Human Services, Division of Medical Assistance, to provide incentives to counties that successfully recover fraudulently spent Medicaid funds by sharing State savings with counties responsible for the recovery of the fraudulently spent funds.

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

FINDING 1:

During the March 2, 2006 subcommittee meeting, Dr. Silberman and Dr. Holmes with the NC Institute of Medicine (NC IOM), shared information on a high risk pool for people with pre-existing conditions. According to their presentation, Blue Cross & Blue Shield of North Carolina is the only insurer to voluntarily offer health insurance coverage to any individual regardless of health status. The presenters indicated that ironically, 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, they indicated that 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. The presenters also noted that 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. Dr. Silberman and Dr. Holmes indicated that the Deficit Reduction Act makes some federal funds available to help support a high-risk pool. The NC IOM concluded their presentation on this topic with a recommendation 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.

In 2005, House Bill 1535 Establish NC Health Insurance Risk Pool was introduced in the House and referred to the House Committee on Insurance. A subcommittee of the House Committee on Insurance reviewed the bill and recommended modifications, but the bill was not enacted.

During a meeting on March 23, 2006, the Subcommittee adopted a recommendation to encourage the General Assembly to enact legislation to implement a health insurance high-risk pool and this recommendation was contained in the Subcommittee's interim report. The House Select Committee on Health Care endorsed the Subcommittee's recommendation.

In 2006, House Bill 1895 Establish High-Risk Pool was introduced. Upon introduction, HB 1895 was referred to and reported favorably out of the House Committee on Insurance and the House Committee on Finance. House Bill 1895 passed the House of Representatives on July 17, 2006, by a vote of 95-11, and crossed over to the Senate, where it was referred to the Senate Committee on Health Care and remained at the close of session. House Bill 1895, if enacted, would have established the North Carolina Health Insurance Risk Pool, which would have enabled individuals with high-risk health conditions to obtain health insurance at premium rates that are more affordable than rates that are currently available. Pool financing would have been achieved through a combination of premiums and assessments with an initial federal grant award to fund Board operating expenses and Pool start-up costs.

Consistent with the recommendation contained in the interim report, the Subcommittee continues to support the establishment of a high-risk pool.

RECOMMENDATION 1: HIGH-RISK POOL

The Subcommittee on the Cost of Health Care and Health Insurance for Employees and Employers recommends that the House Select Committee on Health Care encourage the General Assembly to enact legislation to implement a health insurance high-risk pool.

FINDING 2:

During its November 14, 2006 meeting, the Subcommittee heard from a wide range of parties interested in the issue of secondhand smoke. Agencies and individuals participating in the meeting included the following: the Chronic Disease Section of the Division of Public Health of the Department of Health and Human Services, the American Lung Association of North Carolina, the University of North Carolina at Chapel Hill School of Medicine Tobacco Prevention and Evaluation Program, the Wake County Health Director, and the University of North Carolina at Chapel Hill, School of Government, among others.

Major points raised by the speakers included findings of linkages between secondhand smoke exposure and sudden infant death syndrome (SIDS), acute respiratory infections, ear problems, asthma, coronary heart disease, and lung cancer. An Elon University poll conducted of North Carolina residents September 24 through September 28 showed that 86% of those surveyed either agreed or strongly agreed that employees in North Carolina should be able to work in a smoke-free environment and that 65% of those surveyed supported a Statewide law that would prohibit smoking in public places. As such, the Subcommittee notes the growing public awareness of health complications associated with secondhand smoke.

RECOMMENDATION 2: PROHIBIT SMOKING IN PUBLIC PLACES

The Subcommittee on the Cost of Health Care and Health Insurance for Employees and Employers recommends that the House Select Committee on Health Care encourage the General Assembly to enact legislation to prohibit smoking in public places and places of employment.

FINDING 3:

During the meeting on October 10, 2006, the Subcommittee heard a presentation from Mr. Tom Vitaglione, Senior Fellow, Health and Safety, Action for Children North Carolina. Mr. Vitaglione stressed the need to expand health care and insurance coverage for children in the State. By focusing on children, the State would have an impact on the number of uninsured through methods that are easily attainable. For example, the majority of the 300,000 uninsured children are already eligible for Medicaid or Health Choice, and are less costly to cover than adults. Mr. Vitaglione pointed out that providing consistent, continuous preventive and primary care for children enhances their health status, school readiness, and success. He also stated that an additional advantage may be the production of a savings to employers in their efforts to provide dependent coverage.

As Mr. Vitaglione noted, the number of uninsured children increased from 10.1% in 2000 to 11.9% in 2005. Because of the loss of employer-based dependent coverage, the number of uninsured children increased despite an increase in the number of children covered by Medicaid and Health Choice from 581,000 to 842,000 from 2000 to 2005.

Mr. Vitaglione listed several issues to be considered by the Subcommittee when examining options to expand children's access to health coverage and insurance including: (1) enhancing enrollment in Medicaid and Health Choice through increased outreach efforts; (2) examining the use of insurance programs (versus coverage programs such as Medicaid and Health Choice) that give premium subsidies based on poverty levels; and (3) requiring an "uninsured period" before allowing enrollment in insurance programs to address the possibility of a large, sudden enrollment in subsidized insurance programs. This issue must be balanced with the need to make enrollment in insurance programs as accessible as possible.

The Subcommittee supports enhancing access to health coverage and insurance for children in North Carolina.

RECOMMENDATION 3: ENHANCE CHILDREN'S ACCESS TO HEALTH COVERAGE AND INSURANCE

The Subcommittee on the Cost of Health Care and Health Insurance for Employees and Employers recommends that the House Select Committee on Health Care encourage the General Assembly to enhance children's access to health coverage and insurance.

III. SUBCOMMITTEE ON SAFETY, QUALITY, AND ACCOUNTABILITY

FINDING 1:

The Subcommittee finds that tissue banks render an invaluable service to the citizens of North Carolina. Properly recovered, transported, processed and stored, human tissues have helped millions of people to see, walk, and recover from serious illness and injury. Nationally, more than 25,000 donations are made annually which provide for in excess of one million transplants.

Tissue banks in North Carolina are regulated by the Food and Drug Administration. There is no State regulation. The primary purpose of the FDA's regulatory program is to ensure the safety of tissue transplants. The FDA requires tissue banks to register with the FDA within 5 days of beginning operations and to comply with extensive regulations regarding donor consent, screening, testing, and current good tissue practices. 21 CFR 1271. According to the FDA, there are 45 tissue banks operating in North Carolina. Tissue banks are also subject to inspection by the FDA, however, federal inspections have been limited to date. An inspection is not required prior to an establishment beginning operations.

Tissue banks also may voluntarily seek accreditation by the American Association of Tissue Banks (AATB) or, in the case of ocular tissues, the Eye Bank Association of America (EBAA). According to the data provided by the AATB, 95 % of the human tissue distributed for human transplant in the United States comes from AATB accredited tissue banks. Standards for tissue banks promulgated by the AATB and EBAA are more stringent than those required by the FDA. AATB requires the establishment of standard operating procedures and

an independent inspection prior to accreditation being granted. At this time, none of the tissue banks operating in North Carolina are accredited by the AATB. Most of the eye banks in the State are, however, accredited by the EBAA.

Over 90% of tissue donations come from hospitals. The balance comes from funeral homes, law enforcement authorities and medical examiners. By law in North Carolina, hospitals are required to establish protocols that require that only the organ procurement organization (OPO) designated by the federal Secretary of Health and Human Services be notified of all deaths. G.S. 130A-412.1. Federally designated OPO's, therefore, are the recovery agents for most human tissue recovered for human transplant in North Carolina. Federally designated OPO's must meet the certification standards set by the federal Secretary of Health and Human Services and be registered as a tissue bank with the FDA in order to recover human tissue for human transplant.

The Subcommittee finds that Donor Referral Services, the Raleigh based tissue bank shut down by the FDA in August of 2006, was conducting its recovery operations primarily from funeral homes. Donor Referral Services was not accredited by either the AATB or the EBAA. Further, it appears that the individual associated with Donor Referral Services had been involved with questionable tissue bank operations in other states prior to locating in North Carolina. Under the current federal regulatory framework, Donor Referral Services was only required to provide notification to the FDA before beginning operations.

The Subcommittee finds that State regulation of tissue banks is necessary to ensure the safety of human tissue transplants in the State. Specifically, tissue banks, other than federally designated OPO's, that are engaged in the recovery of human tissues outside of a hospital setting should be accredited by AATB or EBAA. Such a requirement would mandate that these tissue banks had established satisfactory operating procedures, including provisions for proper donor consent, screening and testing, before beginning operations. Concomitant with this requirement, the statutes governing funeral establishments should also be amended to prohibit a funeral establishment from allowing an unaccredited tissue bank to conduct recovery operations at the funeral establishment. These requirements should discourage "fly-by-night" tissue banking operations in the State and reduce the risk that compromised human tissues enter the health care system

RECOMMENDATION 1:

The Subcommittee recommends that the House Select Committee on Health encourage the General Assembly to enact legislation (1) requiring tissue banks, other than federally designated OPO's, that recover human tissue from locations other than a hospital, be accredited by the AATB or EBAA and (2) prohibiting funeral establishments from allowing unaccredited tissue banks to recover tissues from their facilities.

FINDING 2:

The Subcommittee finds that the Statewide Program on Infection Control and Epidemiology (SPICE) provides expertise in infection prevention that is not available in most North Carolina hospitals. With recurring funds, SPICE would be able to fund the ongoing employment of the professionals it is hiring to assist hospitals in the implementation of the Institute for Healthcare Improvement (IHI) processes. SPICE would also be able to implement

other initiatives such as the new Centers for Disease Control and Prevention guideline on management and prevention of multi-drug resistant pathogens to prevent hospital-acquired infections (HAIs.) In summary, recurring funding would allow SPICE to support expanded implementation of proven, evidence-based infection control programs. These programs save lives by preventing HAIs. They result in substantial cost savings to hospitals and health care payers. And, most importantly, they improve the health care of North Carolina's citizens.

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

The Subcommittee on Patient Safety, Quality, and Accountability recommends that the House Select Committee on Health Care encourage the General Assembly to enact legislation to appropriate funds, on a recurring basis, for the Statewide Program on Infection Control and Epidemiology.

RECOMMENDATION 3:

Due to time constraints, the Subcommittee was unable to address many issues relating to the safety and quality of health care available in the State. Some of these issues include enhancing safety for patients in the nursing care and assisted living venues, developing and implementing health information technologies to reduce medical errors and improve the quality of care, and reducing hospital infection rates. The Subcommittee recommends that the House Select Committee on Health Care encourage the General Assembly to establish a study commission to continue to investigate patient safety and quality of care issues and make recommendations for legislative action.

IV. SUBCOMMITTEE ON HEALTHCARE WORKFORCE

FINDING 1:

On October 25, 2006, the Subcommittee heard from a number of presenters on the subject of School Nurses.

The first presentation was from Steve Cline, Deputy State Health Director, Division of Public Health, North Carolina Department of Health and Human Services. Mr. Cline presented information on School Nurse Services from the North Carolina Annual School Health Services Report for Public Schools. The Executive Summary of the report is included in Appendix III-B. Mr. Cline reported that the average school nurse to student ratio in the State had improved slightly from 1:1593 in 2004-2005 to 1:1571 in 2005-2006.

He further reported that this ratio remains more than double the ratio of 1:750 recommended by the American Academy of Pediatricians, the Centers for Disease Control and Prevention, and the National Association of School Nurses. Mr. Cline further explained that funding for school nurse positions comes from a variety of sources including local and state funds, federal block grants and categorical funds, and public and private foundations.

The second presentation was from Jennifer Garrett, President, of the School Nurse Association of North Carolina. Ms. Garrett described her work as a school nurse and urged the Subcommittee to support moving toward the recommended ratio.

Finally, the Subcommittee heard about two different school health service models. First, Anthony Bucci, Assistant Superintendent, Student, Family and Community Services, Charlotte-Mecklenburg Schools, discussed the Coordinated School Health Model. Next, Dana McNeilly, RN, BSN, School Health Supervisor, and Linda Kiser, RN, former School Health Supervisor, described the School Based Health Centers model in Cleveland County. Each of the presenters recommended moving toward the recommended school nurse to student ratio of 1:750.

RECOMMENDATION 1: LOWER SCHOOL NURSE TO STUDENT RATIO

The Subcommittee on Healthcare Workforce recommends that the House Select Committee on Health Care encourage the General Assembly to continue to support initiatives that would lower the school nurse to student ratio in public schools to 1:750 or lower.

FINDING 2:

At the meeting on October 25, 2006, the Subcommittee on Healthcare Workforce heard a report from Erin Fraher with the Cecil G. Sheps Center for Health Services Research, University of North Carolina at Chapel Hill. The report was entitled "The Supply and Distribution of Psychiatrists in North Carolina: Pressing Issues in the Context of Mental Health Reform."

According to the report, the need for mental health services in the State is increasing. One reason that many individuals with mental health disorders cannot access treatment is because of the inadequate supply and poor distribution of psychiatrists and primary care physicians in certain areas of the State.

The report notes that expanding the supply of other mental health care providers will help address this problem. New educational programs could be developed that put more focus on training nurse practitioners and physician assistants in providing mental health services. Select slides from the presentation on the supply and distribution of psychiatrists in North Carolina are included in Appendix III-B.

RECOMMENDATION 2: INCREASE MENTAL HEALTH TRAINING FOR PRIMARY CARE PHYSICIANS, NURSE PRACTITIONERS, AND PHYSICIAN ASSISTANTS

The Subcommittee on Healthcare Workforce recommends that the House Select Committee on Health Care encourage the General Assembly to support and to adequately fund a more comprehensive and integrated approach to addressing the shortage of mental health professionals in underserved areas of the state. Specifically, the Subcommittee recommends increased mental health training for primary care physicians, nurse practitioners, physician assistants, and other primary care providers, and encourages a more effective use of these primary care professionals in working collaboratively with psychiatrists, psychologists, social workers and other mental health professionals to address the mental health needs of underserved areas of North Carolina.

FINDING 3:

The Subcommittee on Healthcare Workforce recognizes the workforce shortages in Allied Health. Severe gaps are projected among registered nurses, licensed practical nurses, emergency medical technicians, dental assistants, respiratory therapists, and medical and clinical lab technicians. The North Carolina Community College System plays an important role in training these professionals. On November 13, 2006, President Martin Lancaster discussed the funding requirements for Allied Health Programs during his presentation. The Executive Summary of the 2007-09 Consensus Budget Request and other items covered during this presentation are contained in Appendix III-B. To address the shortages in Allied Health, the Community College System needs additional funding in three important areas.

First, there are instructional costs. The Community College System needs funding to supplement and sustain Allied Health Programs. These funds are necessary to recruit and retain faculty, grant salary increases, add enrollment slots to students, and purchase supplies.

Second, nursing programs in the community colleges need additional funding to address accreditation expenses. By 2015, the State Board of Nursing intends to have all of the State's nursing programs accredited by the National League for Nursing (NLN). Obtaining NLN accreditation has a fiscal impact because (1) there is a salary differential between faculty that hold the Masters credential and those that do not, (2) there are costs associated with moving faculty from the BSN to MSN credential, and (3) the accreditation process has costs of its own.

Finally, the Community College System must update their equipment. This will ensure that Allied Health professionals receive the training on the proper equipment before entering the workforce.

RECOMMENDATION 3: SUPPORT FOR ALLIED HEALTH PROGRAMS

The Subcommittee on Healthcare Workforce recommends that the House Select Committee on Health Care encourage the General Assembly to provide additional financial support for instructional costs, accreditation expenses for nursing programs, and equipment for the allied health programs in the North Carolina Community College System.

V. SUBCOMMITTEE ON ACCESS

FINDINGS 1:

At the meeting on November 9, 2006, Committee staff gave an overview of the legislative history of the Subcommittee's recommendation, introduced during the 2006 Session, to expand Community Health Care Grants. The General Assembly appropriated $5 million for Community Health Grants, which includes an increase of $3 million in non-recurring funds. The grants are to be allocated to federally qualified health centers and those health centers that meet the requirements 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.

Also at this meeting, Mr. Torlen Wade, Office of Rural Health and Community Care, Department of Health and Human Services, discussed the status of awarding the grants. He

said that 102 requests, totaling $5.6 million, had been received. The final decision about grant awards was not available until after November 17 but preliminary data indicated that 59 of the requests (58%) were going to be awarded to fund "safety net organizations" in 49 counties. The average amount of the grant is expected to be $70,000. Mr. Wade stated that more individuals could be reached with more funding.

Connie Parker, President of the North Carolina Association for School-Based and School-Linked Health Centers, readdressed the subcommittee and discussed the role of School-based and School- linked Health Centers as "safety net organizations". There are 52 school-based and school-linked centers located in 22 counties across the State. The centers were founded in communities of high-risk populations with an identified need for access to adolescent and child health care. State funding has remained stagnant at around $1.5 million since the early 1990's with only one increase in 2001. Ms. Parker also mentioned to the Committee that the school-based and school-linked health centers had not been informed about the grants and therefore none will be recipients of the grants.

The Subcommittee adopted the following recommendations below during the meeting on November 28, 2006:

RECOMMENDATION 1: EXPAND COMMUNITY HEALTH CARE GRANTS

The Subcommittee on Access recommends that the House Select Committee on Health Care encourage the General Assembly to appropriate fifteen million ($15,000,000) in recurring funds to the Department of Health and Human Services, Office of Research, Demonstrations, and Rural Health Development to increase the number and/or the amount of the grants awarded to assist federally qualified health centers, rural health centers, free clinics, public health departments, school-based and school-linked health centers, and other non-profit organizations that provide primary or preventive medical services to uninsured or medically indigent patients. The Subcommittee also encourages the House Select Committee on Health Care to direct the Department of Health and Human Services, Office of Research, Demonstrations, and Rural Health Development to ensure that all of the eligible "safety net organizations" are informed about the opportunity to apply for the grants.

FINDING 2:

At the meeting on November 9, 2006, Committee staff gave an overview of the legislative history of the Subcommittee's recommendation, introduced during the 2006 Session, to implement a health insurance high-risk pool. House Bill 1895 "Establish a High Risk Pool" passed the House of Representatives on July 17, 2006 by a vote of 95-11 and crossed over to the Senate, where it was referred to the Senate Committee on Health Care and remained at the close of session.

Barbara Morales Burke, Chief Deputy Commissioner of the NC Department of Insurance, provided the Subcommittee with an update of progress made with its application for grant funding from the Centers for Medicare and Medicaid Services (CMS) to study the establishment of a high risk pool in the State. CMS approved the DOI application in the amount of $150,000, which DOI will use to hire an outside actuarial firm to conduct a study of the many factors and issues relating to creation of a high-risk pool in North Carolina. Ms. Burke

told the Subcommittee that the Request for Proposals was issued by the DOI in early November and she anticipates the contract being awarded in early December. The final results of the actuarial analysis should be reported to the DOI by the end of February and will be shared with interested parties at that time.

The North Carolina Institute of Medicine Task Force on Covering the Uninsured – April 2006 Report Recommendation 6.5 sets forth a range of factors to be incorporated into legislation implementing a high-risk pool in the State. The following includes methods for financing the costs of the high-risk pool as well as other aspects of pool operations: offering participants the choice of different insurance products, with different levels of deductibles and cost sharing; providing a State-funded premium subsidy to low-income enrollees, to provide coverage for as many North Carolinians as possible; including a sliding scale annual limit on out-of-pocket expenses, based on family income; conducting broad-based assessments on covered lives (to apply to all health insurers, reinsurers, Third Party Administrators (TPAs), and Administrative Service Organizations (ASOs)); and limiting provider reimbursements to Medicare reimbursement rates.

The Subcommittee on Access made the following recommendation on November 28, 2006.

RECOMMENDATION 2: ESTABLISH A HIGH RISK POOL

The Subcommittee on Access recommends that the House Select Committee on Health Care urge the General Assembly to enact legislation establishing a health insurance high-risk pool funded primarily through a broad based assessment on private health insurance policies. The Subcommittee supports an appropriation to cover the cost of covering eligible State employees, teachers, retirees and their dependents. The Subcommittee supports an appropriation to subsidize premiums for low-income individuals who would otherwise qualify for the pool in order to expand pool coverage to an estimated 18,000 eligible persons. The Subcommittee supports expanding this subsidy to cover dependents of State employees and teachers with incomes that fall below 300% of the federal guidelines.

FINDING 3:

During its October 25, 2006 meeting, the Subcommittee on Access heard a presentation from Mr. Tom Vitaglione from Action for Children North Carolina. Appendix III-A. Mr. Vitaglione stressed the need to expand health care and insurance coverage for children in the State. By focusing on children, the State would have an impact on the number of uninsured through methods that are easily attainable. Mr. Viatglione stated of the 264,000 uninsured children, 177,000 are currently eligible for Medicaid or Health Choice, and are less costly to cover than adults. Moreover, by providing health care a child's school readiness and success is enhanced and savings are produced for employers.

As Mr. Vitaglione noted, the number of uninsured children increased from 10.1% in 2000 to 11.9% in 2005. Because of the loss of employer-based dependent coverage, the number of uninsured children increased despite an increase in the number of children covered by Medicaid and Health Choice from 581,000 to 842,000 from 2000 to 2005.

Mr. Vitaglione proposed several issues to be considered by the Subcommittee when examining options to expand children's access to health coverage and insurance, including: (1)

enhancing outreach efforts by both Medicaid and NC Health Choice to increase participation in those programs; (2) implementing a health insurance coverage program for children in families with incomes between 200%-300% of the Federal Poverty Guidelines (FPG) by requiring these families to pay premiums, co-payments and deductibles on a sliding scale depending on family income; and that public subsidies be made available for families in the lower-income ranges and (3) allowing families with incomes above 300% FPG to buy into an expanded Health Choice Program by paying full premiums for their children.

The Subcommittee discussed the need to look into dependents of State employees who fall within 200%-300% of the Federal Poverty Guidelines and determine how the State Health Plan can increase enrollment of these children.

The Subcommittee on Access made the following recommendation on November 28, 2006.

RECOMMENDATION 3: ENHANCE CHILDREN'S ACCESS TO HEALTH COVERAGE AND INSURANCE

The Subcommittee on Access recommends that the House Select Committee on Health Care encourages the General Assembly to enact legislation that would enhance children's access to health benefits coverage and insurance as recommended by the group "Action for Children North Carolina".

FINDING 4:

Presentations given to the Subcommittee by the various individuals and agencies that participated in the Subcommittee proceedings clarified the fragmented nature of the health care delivery system currently in place in North Carolina and the need for some form of systemic change to improve the healthcare outcomes for all in the State. Almost 1.4 million North Carolinians now have no form of health insurance coverage. Under the present system, the uninsured are left out of the medical expense bargaining process and are required to pay for health care services at higher rates than the insured. The current system leads the uninsured to receive services in hospital emergency departments while proven, more cost effective, early intervention models are overlooked and struggle for funding.

North Carolinians overwhelmingly believe the General Assembly should assure all North Carolinians have access to health care. 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 healthcare outcomes and will make North Carolina's business climate more appealing while making North Carolina businesses more competitive in the global market.

The Subcommittee on Access made the following recommendation on November 28, 2006.

RECOMMENDATION 4: CREATE A BOARD TO TRANSITION FROM CURRENT HEALTH CARE SYSTEM

The Subcommittee on Access recommends that the House Select Committee on Health Care encourage the General Assembly to support the creation of a permanent health care planning board to transition from the current system of delivering health care to a system that covers all North Carolinians and report on its progress annually to the General Assembly.

VI. SUBCOMMITTEE ON THE STATE HEALTH PLAN

FINDINGS AND RECOMMENDATIONS

The Subcommittee did not have any specific recommendations at this time. Topics discussed at subcommittee meetings may be found in the Subcommittee Proceedings Section, Appendix II-6, page 45 of this report.

PROPOSED LEGISLATION

LEGISLATIVE PROPOSAL I – SUBCOMMITTEE ON SAFETY, QUALITY, AND ACCOUNTABILITY

1 A BILL TO BE ENTITLED
2 AN ACT TO REQUIRE CERTAIN TISSUE BANKS OPERATING IN NORTH CAROLINA
3 TO BE ACCREDITED BY THE AMERICAN ASSOCIATION OF TISSUE BANKS OR
4 THE EYE BANK ASSOCIATION OF AMERICA.
5 The General Assembly of North Carolina enacts:
6 **SECTION 1.** Chapter 131E of the General Statutes is amended by adding a new
7 Article to read:
8 "**ARTICLE 8A**
9 "**Regulation of Tissue Banks**
10 "**§ 131E- 171. Registration and accreditation requirements.**
11 (a) Any tissue bank that recovers human tissue at a location outside of a hospital, when
12 such tissue is intended for human transplantation, shall be registered with the Food and Drug
13 Administration and accredited by the American Association of Tissue Banks (AATB), or
14 accredited by the Eye Bank Association of America (EBAA), unless the establishment is an
15 organ procurement organization that has been designated by the federal Secretary for Health
16 and Human Services and is registered with the Food and Drug Administration as a tissue bank.
17 (b) For purposes of this Article, 'human tissue' means musculoskeletal tissue, including
18 bone, tendons, ligaments, fascia, cartilage, and related soft tissues, skin, cardiac tissue, dura
19 mater, and ocular tissue. Human tissue in this Article shall not include oocytes, semen,
20 embryos or stem cells from peripheral blood or umbilical cord blood sources.
21 "**§ 131E-172. Inspection, Enforcement, Penalties.**
22 (a) The Department is authorized to inspect the records of any tissue bank engaged in the
23 recovery of human tissue for human transplantation in the State to ascertain compliance with
24 the registration and accreditation requirements of this Article.
25 (b) Notwithstanding the existence or pursuit of any other remedy, the Department may
26 maintain an action in the name of the State for injunctive relief or other process against any
27 tissue bank to restrain or prevent recovery of human tissue for human transplantation without
28 the required registration or accreditation or otherwise restrain or prevent substantial
29 noncompliance with this Article or the rules adopted pursuant to it.
30 (c) If any person hinders the proper performance of duty of the Department in carrying out
31 the provisions of this Article, the Department may institute an action in the superior court of the
32 county in which the hindrance occurred for injunctive relief against the continued hindrance.
33 (d) Any person who knowingly and willfully engages in the recovery of human tissue for
34 human transplantation without registration with the Food and Drug Administration or
35 accreditation by the AATB or EBAA as required by this Article is guilty of a Class 3
36 misdemeanor and upon conviction is liable only for a fine of not more than five hundred dollars

1 ($500.00) for the first offense and not more than one thousand dollars ($1,000.00) for each
2 subsequent offense.
3 **SECTION 2.** G.S. 90-210.25 is rewritten by adding a new subsection to read:
4 "(e1) No funeral establishment shall permit the recovery of human tissue from a dead
5 human body in its custody and control except in accordance with Article 8A of Chapter 131 E."
6 **SECTION 3.** This act becomes effective December 1, 2007 and applies to tissue
7 banks engaged in the recovery of human tissue or cells for human transplantation on or after
8 that date.

LEGISLATIVE PROPOSAL 2 – SUBCOMMITTEE ON SAFETY, QUALITY, AND AFFORDABILITY

1 A BILL TO BE ENTITLED
2 AN ACT TO APPROPRIATE FUNDS TO THE BOARD OF GOVERNORS OF THE
3 UNIVERSITY OF NORTH CAROLINA FOR THE STATEWIDE PROGRAM FOR
4 INFECTION CONTROL AND EPIDEMIOLOGY.
5 The General Assembly of North Carolina enacts:
6 **SECTION 1.** There is appropriated from the General Fund to the Board of
7 Governors of The University of North Carolina the sum of four hundred fifty thousand dollars
8 ($450,000) for the 2007-2008 fiscal year and the sum of four hundred fifty thousand dollars
9 ($450,000) for the 2008-2009 fiscal year. These funds shall be allocated to the School of
10 Medicine at the University of North Carolina at Chapel Hill for support of the Statewide
11 Program for Infection Control and Epidemiology. It is the intent of the General Assembly that
12 these funds become part of the continuation budget.
13 **SECTION 2.** This act becomes effective July 1, 2007.

LEGISLATIVE PROPOSAL 3. - SUBCOMMITTEE ON COST OF HEALTHCARE AND HEALTH INSURANCE FOR EMPLOYEES AND EMPLOYERS

1 A BILL TO BE ENTITLED
2 AN ACT TO ESTABLISH THE NORTH CAROLINA HEALTH INSURANCE RISK POOL.
3 The General Assembly of North Carolina enacts:
4 **SECTION 1.1.** Article 50 of Chapter 58 of the General Statutes is amended by
5 adding a new Part to read:
6 "Part 7. North Carolina Health Insurance Risk Pool.
7 "**§ 58-50-245. Definitions.**
8 For the purposes of this Part:
9 (1) "Administrator" means the Pool Administrator selected by the Executive
10 Director in accordance with this Part.
11 (2) "Benefit plan" means coverage offered by the Pool to eligible individuals.
12 (3) "Board" means the Board of Directors of the Pool.
13 (4) "Commissioner" means the Commissioner of Insurance.
14 (5) "Covered person" means any individual resident of this State, excluding
15 dependents, who is eligible to receive health benefits from any insurer.

1 (6) "Church plan" has the meaning given that term under section 3(33) of the
2 Employee Retirement Income Security Act of 1974.
3 (7) "Creditable coverage" has the same meaning as prescribed in
4 G.S. 58-68-30(c)(1).
5 (8) "Dependent" means a resident spouse or unmarried child under the age of 19
6 years, a child who is a full-time student under the age of 23 years and who is
7 financially dependent upon the parent, a child who is over 18 years of age
8 and for whom a person may be obligated to pay child support, or a child of
9 any age who is disabled and dependent upon the parent.
10 (9) "Executive Director" means the Executive Administrator of the Teachers'
11 and State Employees' Comprehensive Major Medical Plan.
12 (10) "Family member" means a parent, grandparent, brother, sister, or child of a
13 dependent residing with the insured.
14 (11) "Federally defined eligible individual" has the same meaning as "eligible
15 individual" as prescribed in G.S. 58-68-60(b).
16 (12) "Governmental plan" has the same meaning as prescribed in
17 G.S. 58-68-60(h)(2).
18 (13) "Group health plan" means an employee welfare benefit plan as defined in
19 section 3(1) of the Employee Retirement Income Security Act of 1974 to the
20 extent that the plan provides medical care, including items and services paid
21 for as medical care to employees or their dependents, as defined under the
22 terms of the plan directly or through insurance, reimbursement, or otherwise.
23 (14) "Health insurance coverage" shall have the same meaning as prescribed in
24 G.S. 58-68-25(a)(5). Health insurance coverage does not include benefits
25 described in G.S. 58-68-25(b).
26 (15) "Insurance arrangement" means a plan, program, contract, or other
27 arrangement through which health care services are provided by an employer
28 to its officers or employees but does not include health care services covered
29 through an insurer.
30 (16) "Insured" means an individual who is eligible to receive benefits from the
31 Pool. The term "insured" includes dependents and family members, as
32 applicable.
33 (17) "Insurer" means any entity that provides health insurance coverage in this
34 State. For the purposes of this Part, insurer includes:
35 a. An insurance company;
36 b. A hospital or medical service corporation;
37 c. A health maintenance organization;
38 d. A multiple employer welfare arrangement;
39 e. A third-party administrator or claims processor;
40 f. An administrative service organization;
41 g. Any other nongovernmental entity providing a health benefit plan
42 subject to State insurance regulation; and
43 (18) "Medical care" means amounts paid for:
44 a. The diagnosis, cure, mitigation, treatment, or prevention of disease,
45 or amounts paid for the purpose of affecting any structure or function
46 of the body;

1 b. Transportation primarily for and essential to medical care referred to in sub-subdivision a. of this subdivision; and
3 c. Insurance covering medical care referred to in sub-subdivisions a. and b. of this subdivision.
5 (19) "Plan of Operation" means the articles, bylaws, and operating rules and procedures adopted by the Board in accordance with this Part.
7 (20) "Pool" means the North Carolina Health Insurance Risk Pool.
8 (21) "Resident" means an individual who is in the country legally and who:
9 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;
12 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
15 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.
18 (22) "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.
22 (23) "State Health Plan" means the Teachers' and State Employees' Comprehensive Major Medical Plan as set forth in Parts 1, 2, and 3 of Article 3 of Chapter 135 of the General Statutes.
25 (24) "Trade Adjustment Assistance Program" (TAA) means Title II of the Trade Act of 2002, P.L. 107-210.
27 "**§ 58-50-250. Risk Pool established; board of directors; plan of operation.**
28 (a) High-Risk Pool Established. – There is hereby created within the Teachers' and State Employees' Comprehensive Major Medical Plan the North Carolina Health Insurance Risk Pool. The Pool shall operate under the supervision and control of the Board of Directors of the Pool.
32 (b) Board Appointment; Membership. – The Board 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 11 members appointed as follows:
35 (1) One member who represents an insurer, as appointed by the Governor.
36 (2) 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 as follows:
42 a. One member upon the recommendation of the President Pro Tempore of the Senate.
44 b. One member upon the recommendation of the Speaker of the House of Representatives.

1 (3) Eight members appointed by the Commissioner, as follows:
2 a. One insurer who sells individual health insurance policies.
3 b. One insurer who covers the largest number of persons in the State.
4 c. One who is licensed to sell health insurance in this State.
5 d. Two who represent the medical provider community, one as
6 recommended by the North Carolina Medical Society and one as
7 recommended by the North Carolina Hospital Association.
8 e. One who represents business, as recommended by the North Carolina
9 Citizens for Business and Industry.
10 f. One who represents small business, as recommended by the National
11 Federation of Independent Business.
12 g. One who is either a health policy researcher or a health economist
13 with experience relating to the operation of high-risk insurance pools.
14 (c) Board; Terms of Appointment; Vacancies; Compensation. – The initial Board
15 members shall be appointed as follows: three of the members to serve a term of three years;
16 four of the members to serve a term of one year; and four of the members to serve a term of
17 two years. Subsequent Board members shall serve for terms of three years. A Board member's
18 term shall continue until the member's successor is appointed. The Commissioner shall appoint
19 a chair to serve for the initial two years of the Plan's operation. Subsequent chairs shall be
20 elected by a majority vote of the Board members and shall serve for two-year terms. The
21 Commissioner shall fill vacancies in membership and may remove members from the Board for
22 cause. Board members shall not be compensated in their capacity as Board members but shall
23 be reimbursed for reasonable expenses incurred in the necessary performance of their duties.
24 (d) Plan of Operation. – The Executive Director shall submit to the Board a Plan of
25 Operation for the Pool and any amendments necessary or suitable to assure the fair, reasonable,
26 and equitable administration of the Plan of Operation. The Plan of Operation shall become
27 effective upon approval by the majority of the Board consistent with the date on which the
28 coverage under this Part must be made available. The Executive Director shall submit a
29 suitable Plan of Operation within 180 days after the appointment of the Board. The Plan of
30 Operation shall:
31 (1) Establish procedures for operation of the Pool.
32 (2) Establish procedures for selecting a Pool Administrator in accordance with
33 G.S. 58-50-255.
34 (3) Establish procedures to create a fund for administrative expenses, which
35 shall be managed by the Board.
36 (4) Establish procedures for the collection, handling, disbursing, accounting,
37 assessing, and auditing of assets, monies, and claims of the Pool and the
38 Pool Administrator.
39 (5) Develop and implement a program to publicize the existence of the Pool, the
40 eligibility requirements, procedures for enrollment, and availability of State
41 premium subsidies, and to maintain public awareness of the Pool.
42 (6) Establish procedures under which applicants and participants may have
43 grievances reviewed by a grievance committee appointed by the Executive
44 Director in accordance with G.S. 58-50-295.

1 (7) Establish procedures for identifying and confirming income levels of
2 applicants for Pool coverage who are eligible to receive a State premium
3 subsidy, if a State premium subsidy is available.
4 (8) Provide for other matters as may be necessary and proper for the execution
5 of the Executive Director's powers, duties, and obligations under this Part.
6 (e) The Pool shall have the general powers and authority granted under the laws of this
7 State to health insurers and the specific authority to do all of the following:
8 (1) Enter into contracts as are necessary or proper to carry out the provisions
9 and purposes of this Part, including the authority, with the approval of the
10 Executive Director in collaboration with the Board, to enter into contracts
11 with similar plans of other states for the joint performance of common
12 administrative functions or with persons or other organizations for the
13 performance of administrative functions.
14 (2) Sue or be sued, including taking any legal actions necessary or proper to
15 recover or collect assessments due the Pool.
16 (3) Take legal action as necessary to:
17 a. Avoid the payment of improper claims against the Pool or the
18 coverage provided by or through the Plan.
19 b. Recover any amounts erroneously or improperly paid by the Plan.
20 c. Recover any amounts paid by the Pool as a result of mistake of fact
21 or law.
22 d. Recover other amounts due the Pool.
23 (4) Establish rates and rate schedules in accordance with this Part.
24 (5) Issue policies of insurance in accordance with the requirements of this Part.
25 (6) Appoint appropriate legal, actuarial, and other committees as necessary to
26 provide technical assistance in the operation of the Pool, policy, and other
27 contract design, and any other function within the Pool's authority.
28 (7) Borrow money to effect the purposes of the Pool. Any notes or other
29 evidence of indebtedness of the Pool not in default are legal investments for
30 insurers and may be carried as admitted assets.
31 (8) Establish policies, conditions, and procedures for reinsuring risks of
32 participating insurers desiring to issue Pool coverage in their own name.
33 Provision of reinsurance shall not subject the Pool to any of the capital or
34 surplus requirements, if any, otherwise applicable to reinsurers.
35 (9) Employ and fix the compensation of employees.
36 (10) Prepare and distribute certificate of eligibility forms and enrollment
37 instruction forms to insurance producers and to the general public.
38 (11) Provide for reinsurance of risks incurred by the Pool.
39 (12) Issue additional types of health insurance policies to provide optional
40 coverage, including Medicare supplemental insurance coverage.
41 (13) Provide for and employ cost containment measures and requirements
42 including preadmission screening, second surgical opinion, concurrent
43 utilization review, disease management, individual case management, and
44 other commonly used benefit plan design features for the purpose of making
45 health insurance coverage offered by the Pool more cost-effective.

1 (14) Design, utilize, contract, or otherwise arrange for the delivery of
2 cost-effective health care services, including establishing or contracting with
3 preferred provider organizations, health maintenance organizations, and
4 other limited network provider arrangements.
5 (15) Adopt bylaws, policies, and procedures as may be necessary or convenient
6 for the implementation of this Part and the operation of the Pool.
7 (16) Assess all insurers and the State Health Plan in accordance with
8 G.S. 58-50-290.
9 (f) The Executive Director, with the approval of the Board, shall operate the Pool in a
10 manner so that the estimated cost of providing health insurance coverage during any fiscal year
11 is not anticipated to exceed the total income the Pool expects to receive from policy premiums
12 and other revenue available to the Pool. The Board may impose a cap on enrollment or may
13 suspend enrollment for an indefinite period if the Board finds that estimated costs are
14 anticipated to exceed income, except that any enrollment cap or suspension shall not apply to
15 federally defined eligible individuals who are eligible to enroll in the Pool pursuant to
16 G.S. 58-50-265(5).
17 (g) The Executive Director shall make an annual report to the Speaker of the House of
18 Representatives, the President Pro Tempore of the Senate, the Joint Legislative Health Care
19 Oversight Committee, and the Committee on Employee Hospital and Medical Benefits. The
20 report shall summarize the activities of the Pool in the preceding calendar year, including the
21 net written and earned premiums, benefit plan enrollment, the expense of administration, and
22 the paid and incurred losses.
23 (h) Neither the Board nor the employees of the Pool are liable for any obligations of the
24 Pool. There shall be no liability on the part of and no cause of action of any nature shall arise
25 against the Pool or its agents or employees, the Board, the Executive Director, the
26 Commissioner, or his representatives for any action taken by them in good faith in the
27 performance of their powers and duties under this Part. The Pool and the Teachers' and State
28 Employees' Comprehensive Major Medical Plan may provide in their bylaws or rules for
29 indemnification of, and legal representation for, their members and employees.
30 (i) The members of the Board shall comply with the provisions of G.S. 14-234
31 prohibiting conflicts of interest.
32 "**§ 58-50-255. Administrator.**
33 (a) The Executive Director, in collaboration with the Board, shall select through a
34 competitive bidding process one or more authorized insurers or a third-party administrator to
35 administer the Pool. The Executive Director shall evaluate bids submitted based on criteria
36 established by the Board. The criteria shall allow for the comparison of information about each
37 bidding administrator and selection of a Pool Administrator based on at least the following:
38 (1) Proven ability to handle health insurance coverage to individuals.
39 (2) Efficiency and timeliness of the claim processing procedures.
40 (3) Estimated total charges for administering the Pool.
41 (4) Ability to apply effective cost containment programs and procedures and to
42 administer the Pool in a cost-efficient manner.
43 (5) Financial condition and stability.
44 (b) The Administrator shall serve for a period specified in the contract between the Pool
45 and the Administrator subject to removal for cause and subject to any terms, conditions, and
46 limitations of the contract between the Pool and the Administrator. At least one year before the

1 expiration of each period of service by an Administrator, the Executive Director shall invite
2 eligible entities, including the current Administrator, unless the current Administrator was
3 removed for cause, to submit bids to serve as the Administrator. Selection of the Administrator
4 for the succeeding period shall be made at least six months before the end of the current period.
5 (c) The Administrator shall perform such functions relating to the Pool as may be
6 assigned to it, including:
7 (1) Verification of eligibility.
8 (2) Payment of claims.
9 (3) Establishment of a premium billing procedure for collection of premiums
10 from individuals covered under the Pool.
11 (4) Other necessary functions to assure timely payment of benefits to covered
12 persons under the Pool.
13 (d) The Administrator shall submit regular reports to the Executive Director and the
14 Board regarding the operation of the Pool. The contract between the Pool and the Administrator
15 shall specify the frequency, content, and form of the report.
16 (e) Following the close of each calendar year, the Administrator shall determine net
17 written and earned premiums, the expense of administration, and the paid and incurred losses
18 for the year and report this information to the Executive Director and the Board on a form
19 prescribed by the Executive Director.
20 (f) The Administrator shall be paid as provided in the contract between the Pool and the
21 Administrator.
22 "**§ 58-50-260. Risk Pool rates and policy forms.**
23 (a) The Pool shall adopt and modify, as appropriate, rates, rate schedules, rate
24 adjustments, expense allowances, agents' referral fees, claim reserve formulas, and any other
25 actuarial function appropriate to the operation of the Pool. Rates and rate schedules may be
26 adjusted for appropriate factors such as age, sex, and geographic variation in claim cost and
27 shall take into consideration appropriate rating factors in accordance with established actuarial
28 and underwriting practices.
29 (b) The Pool shall determine the standard risk rate by considering the premium rates
30 charged by other insurers offering health insurance coverage to individuals. The standard risk
31 rate shall be established using reasonable actuarial techniques and shall reflect anticipated
32 experience and expenses for the coverage. Pool rates shall be one hundred fifty percent (150%)
33 of rates established as applicable for individual standard rates.
34 (c) The Executive Director, with the approval of the Board and the Commissioner, shall
35 have the authority to develop incentive programs with premium discounts. The Pool may
36 provide for premium surcharges for covered individuals who are smokers. Premium surcharge
37 rates shall be established by the Executive Director, in collaboration with the Board, subject to
38 the approval of the Commissioner.
39 (d) Provider reimbursement rates under Pool coverage shall be limited to the rates
40 allowed for providers under the Medicare Program.
41 (e) The Pool shall submit all rates and rate schedules and amendments thereto to the
42 Commissioner for approval, and the Commissioner shall approve the rates and rate schedules
43 before the Pool may use them. The Commissioner, in evaluating the rates and rate schedules,
44 shall consider the factors provided in this section. The Pool shall provide all individuals
45 enrolled in the Pool with at least 45 days' notice of any change in Pool rates or rate schedules.

1 (f) The Pool shall submit all policy forms to the Commissioner for approval, and the
2 Commissioner shall approve the forms before the Pool may use them. Except for any
3 provisions that are specifically treated otherwise under this Part, the provisions of this Chapter
4 that apply to benefit plans and policy forms of health insurers generally shall apply to the
5 benefit plans offered and policy forms used by the Pool.
6 "**§ 58-50-265. Eligibility for Pool coverage.**
7 (a) Any individual who is and continues to be a resident of this State is eligible for Pool
8 coverage if evidence is provided of:
9 (1) A notice of rejection or refusal to issue substantially similar health insurance
10 coverage for health reasons by an insurer. A rejection or refusal by an
11 insurer offering only stop-loss, excess loss, or reinsurance coverage with
12 respect to the applicant is not sufficient evidence of eligibility;
13 (2) An offer to issue health insurance coverage only with a conditional rider that
14 limits coverage for the individual's high-risk medical condition;
15 (3) A refusal by an insurer to issue health insurance coverage except at a rate
16 exceeding the Pool rate;
17 (4) A diagnosis of the individual with one of the medical or health conditions
18 listed by the Board in accordance with this section. An individual diagnosed
19 with one or more of these conditions is eligible for Pool coverage without
20 applying for other health insurance coverage;
21 (5) In the case of a federally defined eligible individual, the individual's
22 maintenance of health insurance coverage, of which the most recent
23 coverage was through an employer-sponsored plan, for the previous 18
24 months with no gap in coverage greater than 63 days and exhaustion of any
25 available COBRA or State continuation benefits; or
26 (6) An individual who is legally domiciled in this State and is eligible for the
27 credit for health insurance costs under the Trade Adjustment Assistance
28 Reform Act of 2002, section 35 of the Internal Revenue Code of 1986.
29 (b) The Board, upon approval of the Executive Director, shall adopt a list of medical or
30 health conditions for which a person shall be eligible for Pool coverage without applying for
31 health insurance pursuant to subsection (a) of this section. The Board may amend the list as the
32 Board considers appropriate.
33 (c) Each dependent of an individual who is eligible for Pool coverage shall also be
34 eligible for Pool coverage.
35 (d) An individual is not eligible for coverage under the Pool if:
36 (1) The individual has or obtains health insurance coverage substantially similar
37 to or more comprehensive than a Pool policy, or would be eligible to have
38 coverage if the person elected to obtain it, except that:
39 a. An individual may maintain other coverage for the period of time the
40 individual is satisfying any preexisting condition waiting period
41 under a Pool policy; and
42 b. An individual may maintain Pool coverage for the period of time the
43 individual is satisfying a preexisting condition waiting period under
44 another health insurance policy intended to replace the Pool policy.
45 (2) The individual is determined to be eligible for enrollment in the State
46 Medical Assistance Plan.

1 (3) The individual has previously terminated Pool coverage unless 12 months
2 have lapsed since the termination, except that this subdivision shall not apply
3 with respect to an applicant who is a federally defined eligible individual or
4 to an applicant eligible for or receiving benefits under the Trade Adjustment
5 Assistance Program.
6 (4) The individual is an inmate or resident of a public institution, except that this
7 subdivision shall not apply with respect to an applicant who is a federally
8 defined eligible individual.
9 (5) The individual's premiums are paid for or reimbursed under any
10 government-sponsored program or by any government agency or health care
11 provider, except as an otherwise qualifying full-time employee, or dependent
12 thereof, of a government agency or health care provider. This subdivision
13 shall not apply for individuals receiving benefits under the Trade Adjustment
14 Assistance Program or to individuals receiving premium subsidies made
15 available by the State based on individual income levels.
16 (6) The individual has in effect on the date Pool coverage takes effect health
17 insurance coverage from an insurer or insurance arrangement.
18 (e) Coverage under the Pool shall cease:
19 (1) On the date an individual is no longer a resident of this State.
20 (2) On the date an individual requests coverage to end.
21 (3) Upon the death of the covered individual.
22 (4) On the date State law requires cancellation of the Pool policy.
23 (5) At the option of the Pool, 30 days after the Pool makes any inquiry
24 concerning the individual's eligibility or residence to which the individual
25 does not reply.
26 (6) Because the individual has failed to make the payments required under this
27 Part.
28 (f) Except as provided in subsection (e) of this section, an individual who ceases to
29 meet the eligibility requirements of this section may be terminated at the end of the Pool period
30 for which the necessary premiums have been paid.
31 "**§ 58-50-270. Unfair referral to Pool.**
32 It is an unfair trade practice under Article 63 of this Chapter for an insurer, insurance
33 producer, as defined in G.S. 58-33-10(7), or third-party administrator to refer an individual
34 employee to the Pool or arrange for an individual employee to apply to the Pool for the purpose
35 of separating that employee from group health insurance coverage provided in connection with
36 the employee's employment or for the purpose of separating an individual covered by health
37 insurance offered in the individual market.
38 "**§ 58-50-275. Minimum Pool benefits.**
39 (a) The Pool shall offer at least two types of health insurance coverage for individuals
40 eligible under G.S. 58-50-265, including preferred provider organizations with different levels
41 of deductibles and cost-sharing, and at least one choice of a health savings account. The
42 covered services and benefit levels may vary between the types of coverage, but at least two
43 types of coverage must, at a minimum, cover the benefits and services outlined in the National
44 Association of Insurance Commissioners' (NAIC) Model Health Pool for Uninsurable
45 Individuals Act and be consistent with comprehensive coverage generally available to persons

1 who are eligible for health insurance other than Medicare. All health insurance products offered
2 by the Pool shall include disease or case management services.
3 (b) Health insurance products offered by the Pool shall include not less than one million
4 dollars ($1,000,000) lifetime limit and an annual limit of up to five thousand dollars ($5,000)
5 on out-of-pocket expenses. The Board, upon recommendation of the Executive Director, shall
6 adjust limitations at least once every five years to reflect changes in the medical component of
7 the Consumer Price Index.
8 "**§ 58-50-280. Preexisting conditions.**
9 (a) Except as otherwise provided by law, Pool coverage shall exclude charges or
10 expenses incurred during the first 12 months following the effective date of coverage as to any
11 condition for which medical advice, care, or treatment was recommended or received as to such
12 conditions during the 12-month period immediately preceding the effective date of coverage,
13 except that no preexisting condition exclusion shall be applied to a federally defined eligible
14 individual.
15 (b) Subject to subsection (a) of this section, the preexisting condition exclusions shall
16 be waived to the extent that similar exclusions, if any, have been satisfied under any prior
17 health insurance coverage that was involuntarily terminated, provided that:
18 (1) Application for Pool coverage is made not later than 63 days following the
19 involuntary termination, and in such case coverage in the Pool shall be
20 effective from the date on which the prior coverage was terminated; and
21 (2) The applicant is not eligible for continuation or conversion rights that would
22 provide coverage substantially similar to Pool coverage.
23 "**§ 58-50-285. Nonduplication of benefits.**
24 (a) The Pool shall be payor of last resort of benefits whenever any other benefit or
25 source of third-party payment is available. Benefits otherwise payable under coverage shall be
26 reduced by all amounts paid or payable through any other health insurance coverage and by all
27 hospital and medical expense benefits paid or payable under any workers' compensation
28 coverage, automobile medical payment, or liability insurance, whether provided on the basis of
29 fault or no-fault, and by any hospital or medical benefits paid or payable under or provided
30 pursuant to any State or federal law or program.
31 (b) The Pool shall have a cause of action against an eligible person for the recovery of
32 the amount of benefits paid that are not for covered expenses. Benefits due from the Pool may
33 be reduced or refused as a setoff against any amount recoverable under this subsection.
34 "**§ 58-50-290. Assessments.**
35 (a) For the purposes of providing the funds necessary to carry out the powers and duties
36 of the Pool, the Pool shall assess all insurers and the State Health Plan at such time and for such
37 amounts as the Board finds necessary. Assessments shall be due in not less than 30 days after
38 prior written notice to the insurers and shall accrue interest at twelve percent (12%) per annum
39 on and after the due date.
40 (b) Except with respect to special assessments authorized under this section, the Pool
41 shall assess each insurer and the State Health Plan in an amount not to exceed two dollars
42 ($2.00) per covered individual insured or reinsured by each insurer or the State Health Plan per
43 month. The assessment shall be based on actual and expected losses, actuarially appropriate
44 reserves, and administrative expenses in excess of expected and collected premiums and federal
45 loss reimbursements, if any, received by the Pool. Each insurer and the State Health Plan shall

not be assessed an amount exceeding eight dollars ($8.00) per family policy for each family insured or reinsured per month.

In addition to the assessment, the Pool may impose on each insurer and the State Health Plan a special assessment only when enrollment in the Pool has been capped or suspended. A special assessment may be made to cover only the additional losses of the Pool that are expected to result from the continued entry into the Pool by federally defined eligible individuals during the time that enrollment is closed to all other individuals eligible under G.S. 58-50-265. The special assessment shall be based on actual and expected losses, actuarially appropriate reserves, and administrative expenses in excess of expected and collected premiums for the federally defined eligible individuals who enrolled or are expected to enroll while the suspension of enrollment is in effect.

(b1) Except with respect to special assessments authorized under this section, the Pool shall assess each insurer and the State Health Plan an amount not to exceed the following limitations for each covered individual insured per month:

(1) Seventy cents (70¢) for the 2008-2009 fiscal year.
(2) One dollar ($1.00) for the 2009-2010 fiscal year.
(3) One dollar and thirty cents ($1.30) for the 2010-2011 fiscal year.
(4) One dollar and seventy cents ($1.70) for the 2011-2012 fiscal year.
(5) Two dollars ($2.00) for the 2012-2013 fiscal year and all years thereafter.

(c) The Pool shall make reasonable efforts designed to ensure that each covered individual is counted only once with respect to any assessment. For that purpose, the Pool 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, except that lives covered under the Pool and reinsured or administered by a third-party administrator shall not be included in the count. The Pool shall allow a reinsurer to exclude from its number of covered individuals those individuals 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 Pool may verify each insurer's assessment based on annual statements and other reports deemed to be necessary by the Pool. The Pool 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 exceed the actual losses and administrative expenses of the Pool, the excess shall be held at interest and used by the Pool to offset future losses or to reduce Pool premiums. Future losses include reserves for claims incurred but not reported.

(f) The Commissioner may suspend or revoke, after notice and hearing, the license to transact insurance in this State of any insurer that fails to pay an assessment. As an alternative, the Commissioner may levy a forfeiture on any 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 Executive Director. 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 Executive Director shall retain all written complaints regarding

1 the Pool at least until the third anniversary of the date the Pool received the complaint. An
2 applicant or participant may file for external review of the applicant's grievance after having
3 exhausted the Pool's internal grievance procedure. External review, including eligibility
4 determinations, shall be conducted in accordance with Part 4 of this Article.
5 "**§ 58-50-300. Audit.**
6 An audit of the Pool shall be conducted annually under the oversight of the State Auditor.
7 The cost of the audit shall be reimbursed to the State Auditor from the Special Reserve for the
8 North Carolina Health Insurance Risk Pool.
9 "**§ 58-50-305. Taxation.**
10 The Pool established under this Part is exempt from any and all taxes.
11 "**§ 58-50-310. Rules.**
12 The Executive Director, in collaboration with the Board, may adopt rules, including
13 temporary rules, to implement this Part. The Executive Director, in collaboration with the
14 Board, and the Commissioner may adopt rules to carry out their respective powers and duties
15 under this Part.
16 "**§ 58-50-315. Collective action.**
17 The establishment of rates, forms, or procedures, and any other joint or collective action
18 required by this Part may not be the basis of any legal action or criminal or civil liability or
19 penalty against the Pool or any insurer."
20 **SECTION 1.2.** On or before January 1, 2008, the Executive Director shall notify
21 the Centers for Medicare and Medicaid Services that the State has established the North
22 Carolina Health Insurance Risk Pool and shall request that the North Carolina Health Insurance
23 Risk Pool be approved as an acceptable "alternative mechanism" under the federal Health
24 Insurance Portability and Accountability Act in accordance with 45 C.F.R. § 148.128(e).
25 **SECTION 1.3.** The Board of Directors of the North Carolina Health Insurance
26 Risk Pool, as appointed under Section 1.1 of this act, shall monitor methods of financing the
27 Pool to ensure a stable funding source and allow for its continued operation. This monitoring
28 shall include supplementary sources of funding, such as funds obtained from public and private
29 not-for-profit foundations, insurer assessments including special assessments, or other
30 appropriate and available State or non-State funds. The Board shall also review on a regular
31 basis:
32 (1) The number of individuals in this State who are uninsured as of a date
33 certain because of high-risk conditions.
34 (2) The number of uninsured individuals who would qualify for coverage under
35 the Pool based on G.S. 58-50-265 and its Plan of Operation.
36 (3) The cost of coverage under each of the health insurance plans developed by
37 the Board, including administrative costs.
38 (4) The extent to which assessments meet or exceed amounts necessary for
39 coverage and Board operations.
40 (5) The status of a request by the State to the Centers for Medicare and
41 Medicaid Services for approval of the North Carolina Health Insurance Risk
42 Pool to be considered an acceptable "alternative mechanism" under the
43 federal Health Insurance Portability and Accountability Act in accordance
44 with 45 C.F.R. § 148.128(e).
45 The Board shall report its findings and recommendations to the General Assembly
46 on March 1, 2008, and annually thereafter.

1 **SECTION 1.4.** The North Carolina Health Insurance Risk Pool Administrator shall
2 study methods for encouraging healthy behaviors and report its findings to the Board and to the
3 General Assembly not later than one year after initial implementation of the Pool.
4 **SECTION 1.5.** Notwithstanding G.S. 58-50-280(a), individuals enrolling in the
5 North Carolina Health Insurance Risk Pool within six months of the date that enrollment into
6 the Pool first begins shall be subject to a six-month preexisting condition waiting period.
7 **SECTION 1.6.** G.S. 135-38 is amended by adding a new subsection to read:
8 "(e) The Executive Administrator shall routinely report to the Committee and shall
9 provide the Committee with any information or assistance requested by the Committee as
10 relates to the North Carolina Health Insurance Risk Pool, as established under Part 7 of Article
11 50 of Chapter 58 of the General Statutes."
12 **SECTION 1.7.** G.S. 120-70.111(a) reads as rewritten:
13 "(a) The Joint Legislative Health Care Oversight Committee shall review, on a
14 continuing basis, the provision of health care and health care coverage to the citizens of this
15 State, in order to make ongoing recommendations to the General Assembly on ways to improve
16 health care for North Carolinians. To this end, the Committee shall study the delivery,
17 availability, and cost of health care in North Carolina. The Committee shall also review, on a
18 continuing basis, the implementation of the State Health Insurance Program for Children
19 established under Part 8 of Article 2 of Chapter 108A of the General Statutes. As part of its
20 review, the Committee shall advise and consult with the Department of Health and Human
21 Services as provided under G.S. 108A-70.21. The Committee shall review, on a continuing
22 basis, the implementation of the North Carolina Health Insurance Risk Pool established under
23 Part 7 of Article 50 of Chapter 58 of the General Statutes. As part of its review, the Committee
24 shall advise and consult with the Executive Director of the North Carolina Health Insurance
25 Risk Pool as provided under G.S. 58-50-250. The Committee may also study other matters
26 related to health care and health care coverage in this State."
27 **SECTION 2.** There is established in the Teachers' and State Employees'
28 Comprehensive Major Medical Plan the Reserve for the North Carolina Health Insurance Risk
29 Pool ("Reserve"). The sum of one million dollars ($1,000,000) is transferred from the Public
30 Employee Health Benefit Fund ("Fund") to the Reserve for the 2007-2008 fiscal year. These
31 funds may be used to support reasonable expenses for personnel to carry out the Board's
32 responsibilities under the North Carolina Health Insurance Risk Pool and shall be allocated for
33 the reasonable expenses of the Board in conducting its duties under Section 1 of this act that are
34 incurred on or before July 1, 2009. The Reserve is subject to the Executive Budget Act, except
35 that Article 3C of Chapter 143 of the General Statutes does not apply to G.S. 58-50-250(e).
36 Transfer of the funds from the Fund to the Reserve is contingent upon successful
37 application for and award of federal grant funds to implement the North Carolina Health
38 Insurance Risk Pool. Federal funds received for this purpose shall be deposited to the Reserve.
39 Upon receipt of the federal funds, the Board shall, from Reserve funds, reimburse the Fund in
40 the amount of one million dollars ($1,000,000). It is the intent of the General Assembly that in
41 the event the State is not awarded the federal funds anticipated, the Fund shall be held
42 harmless.
43 **SECTION 3.** Section 2 of this act becomes effective July 1, 2007. The remainder
44 of this act is effective when it becomes law. G.S. 58-50-290(b1), as enacted by Section 1.1 of
45 this act, is repealed January 1, 2014. Enrollment in the North Carolina Health Insurance Risk
46 Pool shall commence no later than January 1, 2009.

1 A BILL TO BE ENTITLED
2 AN ACT TO PROHIBIT SMOKING IN PUBLIC PLACES AND PLACES OF
3 EMPLOYMENT.
4 The General Assembly of North Carolina enacts:
5 **SECTION 1.** Chapter 130A of the General Statutes is amended by adding a new
6 Article to read:
7 "Article 23.
8 "Clean Indoor Air.
9 "**130A-491. Legislative intent.**
10 It is the intent of the General Assembly to protect the health of individuals in public places
11 and places of employment from the risks related to secondhand smoke.
12 "**130A-492. Definitions.**
13 The following definitions shall apply to this Article:
14 (1) "Enclosed area" means all space between a floor and ceiling that is enclosed
15 on all sides by solid walls or windows (exclusive of doorways), which
16 extend from the floor to the ceiling.
17 (2) "Lodging establishment" means an establishment that provides lodging for
18 pay to the public.
19 (3) "Place of employment" means an enclosed area under the control of a public
20 or private employer that employees normally frequent during the course of
21 employment.
22 (4) "Private club" shall have the same meaning as prescribed by
23 G.S. 18B-1000(5).
24 (5) "Public place" means an enclosed area that is accessible to or shared by all
25 persons.
26 (6) "Retail tobacco shop" means any place dedicated to or predominantly for the
27 retail sale of tobacco, tobacco products, and accessories for such products.
28 (7) "Smoking" mean use or possession of any lighted cigar, cigarette, pipe, or
29 other lighted tobacco product.
30 "**130A-493. Smoking in public places and places of employment prohibited.**
31 (a) Notwithstanding Article 64 of Chapter 143 of the General Statutes, smoking is
32 prohibited in public places and places of employment, except as provided in subsection (c)
33 below.
34 (b) Notwithstanding Article 64 of Chapter 143 of the General Statutes, smoking is
35 prohibited within 50 feet of entrances, operable windows, and ventilation systems of enclosed
36 areas where smoking is prohibited.
37 (c) Smoking may be permitted in the following places:
38 (1) A private residence, except when being used commercially to provide child
39 care or adult care services.
40 (2) A retail tobacco shop.
41 (3) A tobacco manufacturing or processing facility.

1 (4) A designated smoking guest room in a lodging establishment.
2 (5) A private club when being used for a function to which the general public is
3 not invited.
4 (6) An age-restricted bar or club in which no food is available for purchase.
5 (7) A place of employment used for medical or scientific research to the extent
6 that smoking is an integral part of the research.
7 "**130A-494. Implementation.**
8 (a) A person who owns, manages, operates, or otherwise controls a public place or
9 place of employment shall conspicuously post signs clearly stating that smoking is prohibited.
10 The signs may include the international "No Smoking" symbol, which consists of a pictorial
11 representation of a burning cigarette enclosed in a red circle with a red bar across it.
12 (b) The Commission shall adopt rules to implement the provisions of this Article.
13 "**130A-495. Violations; penalties.**
14 (a) Notwithstanding G.S. 130A-25, a person who owns, manages, operates, or
15 otherwise controls a public place or place of employment and who fails to comply with the
16 provisions of this Article shall be guilty of an infraction, punishable by:
17 (1) A fine of not more than one hundred dollars ($100.00) for a first violation.
18 (2) A fine of not more than two hundred dollars ($200.00) for a second violation
19 within one (1) year.
20 (3) A fine of not more than five hundred dollars ($500.00) for each additional
21 violation within one (1) year.
22 (b) Each day on which a violation of this Article occurs shall be considered a separate
23 and distinct violation.
24 "**130A-496 through 130A-500:** Reserved for future codification purposes."
25 **SECTION 2.** This act becomes effective January 1, 2008 and applies to acts
26 committed on or after that date.

APPENDICES

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

Heath Care – 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

Health Care – Subcommittee on Safety, Quality, Accountability

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

Following are the Committee Proceedings section contained in each of the subcommittee final reports submitted on November 29, 2006

I. Subcommittee on Medicaid

The House Select Committee on Health Care, Subcommittee on Medicaid, met eight times from December 21, 2005 until November 9, 2006. At these meetings subcommittee members heard presentations on the following topics:

December 21, 2005

Overview of the Medicaid Program was presented 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 was 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 was 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..

September 26, 2006

Topics presented at this meeting included:

Summary of 2006 Legislation and Budget Actions – Presentation was made by Carol Shaw of the North Carolina General Assembly, Fiscal Research Division. Carol Shaw also provided summary information on Medicaid Services provided in North Carolina.

Updates from the Department of Health and Human Services, Division of Medical Assistance (DMA) -- Presenters were Mr. Mark Benton, Senior Deputy Director of DMA; Dr. William Lawrence, Deputy Director of DMA, and Mr. Tom D'Andrea, Chief of Pharmacy and Ancillary Services, DMA. Topics addressed included Overview of 2005-05 Medicaid Expenditures, and an Overview of New Pharmacy Initiatives.

October 10, 2006

The October meeting focused on Medicaid fraud:

Report from the DMA Program Integrity Section – Presenters were Mr. Mark Benton, Senior Deputy Director of DMA and Lynn Testa, Assistant Director of Program Integrity Section. The Program Integrity Section is responsible for detecting and preventing Medicaid fraud in North Carolina, and the presentation included information on the activities of the Section.

Recipient Fraud Detection by County Departments of Social Services -- Ms. Millie Brown, Director of the Duplin County Department of Social Services, presented information describing how the county departments of social services detect and prevent recipient Medicaid fraud.

Report from the Attorney General's Medicaid Fraud Investigation Unit – Mr. Charlie Hobgood, Special Deputy Attorney General and Director of the Medicaid Investigations Unit presented information describing how his program investigates and prosecutes Medicaid fraud and assists with obtaining recoveries.

Using Technology to Prevent Medicaid Fraud – Texas Medicaid Program -- Mr. Jerry Lozano, Senior Project Manager of Sagem Morpho, Inc. presented information on how technology developed by his company was assisting the Texas Medicaid Program with reducing provider and recipient fraud.

November 9, 2006

Topics discussed at this meeting include:

Highlights of the CAP-DA Report Submitted to the Legislature in November 2006 – Tracy Colvard, CAP-DA and PCS Unit Manager in the Division of Medical Assistance summarized the report.

Medicare 646 Waiver and Medicaid Transformation Grant – Ms Mona Moon, Senior Health Policy Advisor and SPART Team Leader of the Division of Medical Assistance presented a report on the two DMA initiatives.

"Money Follow the Person" Grant – Ms. Tara Larson, Assistant Director for Clinical Policies and Programs of the Division of Medical Assistance presented a report on DMA's application for a grant through the federal "Money Follows the Person" grant program.

As a result of the information provided and ensuing discussion among subcommittee members at each of these meetings, the Medicaid Subcommittee respectfully submits the following finding and recommendation for consideration by the House Select Committee on Health Care

II. Subcommittee on 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 until April 4, 2006. The Subcommittee submitted an interim report to the House Select Committee on Health Care containing five recommendations.

The Subcommittee met six times between September 12, 2006 and November 28, 2006 and heard from the following individuals:

- Edmund Haislmaier, Research Fellow, Heritage Foundation Health Policy Studies Center, on Massachusetts Health Reform: Implications for Other States.
- Kala Ladenheim, PhD, Program Director, Forum for State Health Policy Leadership, National Conference of State Legislatures, on State Approaches to Universal Coverage
- Alan Dobson, Assistant Secretary for Health Policy and Medical Assistance, Division of Medical Assistance, North Carolina Department of Health and Human Services, on Controlling the Rising Cost of Health Care.
- Tom Vitaglione, Senior Fellow, Health and Safety, Action for Children North Carolina, on Insuring all North Carolina Children.
- Subcommittee Staff and Pam Silberman, President, North Carolina Institute of Medicine, on NC Fair Share Health Insurance Access Program (HB2860).
- Dr. Marcus Plescia, Chief, Chronic Disease and Injury Section, Division of Public Health, DHHS, Deborah Bryan, President and Executive Director, American Lung

Association of North Carolina, Dr. Adam Goldstein, family doctor and UNC researcher, Gibbie Harris, Wake County Health Director, and Aimee Wall, Assistant Professor of Public Law and Government, UNC School of Government, on Smoking in Public Places.

III. Subcommittee on Safety, Quality, and Affordability

The House Select Committee on Health Care, Subcommittee on Safety, Quality, and Accountability met four times from September 19, 2006 until November 29, 2006.

The Subcommittee's first meeting after adjournment sine die of the 2006 General Assembly was held on September 19, 2006. That meeting addressed a wide array of topics Tom Mansfield, Legal Director, North Carolina Medical Board, David Kalbacker, Public Information Officer, North Carolina Nursing Board, and the North Carolina Board of Pharmacy reported on the adoption of joint rules governing the practice of medical acts as requested by legislation recommended by the Subcommittee and enacted by the General Assembly. The rules adopted by the three boards include a list of grounds for disciplinary action by the Boards and provide for an expanded range of disciplinary action that may be taken against a licensee.

Tom Mansfield also spoke about legislation expanding the authority of the North Carolina Medical Board enacted by the legislature that had been recommended by the Subcommittee to the House Select Committee on Health. In addition to the provisions recommended by the Subcommittee, the Medical Board also received authority to use outside experts to review quality of care cases and enhanced the Medical Board's ability to cooperate with local law enforcement.

Other speakers at the September 19th meeting included Jeffrey Horton, Chief Operating Officer, Division of Facility Services, who spoke on patient safety in nursing homes and adult care homes. Mr. Horton also provided the Subcommittee with a report on the Adult Care Homes Medication Testing Program. The medication testing program for medication aides working in adult care homes has resulted in a decrease in the average medication error rate from 20% to 9%. Jesse Goodman, Chief of the Health Care Personnel Registry Section, Division of Facility Services, spoke on the funding needs for expansion of the Health Care Personnel Registry. Alice Watkins, Executive Director, Eastern North Carolina Chapter of the Alzheimers's Association also addressed the Subcommittee.

At its October 17, 2006 meeting, the Subcommittee began investigating whether the State should play a role in the regulation of tissue banks. A tissue bank is an establishment involved in the recovery, processing, storage, or delivery of human tissue for human transplantation. Tissue includes musculoskeletal tissues such as bones and ligaments, skin, ocular tissues, heart valves, dura mater, reproductive cells, and other cells. Tissue banks are primarily regulated at the federal level by the Food and Drug Administration (FDA). Three states, however, have their own regulatory program and several others require additional accreditation in order to operate in those states. The genesis for the Subcommittee's interest in tissue banking was the federal regulatory action against Donor Referral Services (DRS), a Raleigh based company engaged in the recovery of human tissue. Although the FDA

required DRS to cease its activities, no action was taken against the firm at the State level as North Carolina does not regulate tissue banking.

P. Robert Rigney, Jr., Chief Executive Officer of the American Association of Tissue Banks (AATB) provided the Subcommittee with an overview of tissue banking, including the history of tissue donation, the process of tissue recovery and processing, and the numbers and use of tissues for transplant. Mr. Rigney also addressed the regulatory oversight of the tissue banking industry and the role of the AATB in ensuring the quality and safety of tissue available for transplant. AATB is a nonprofit, scientific, and educational organization that was started in 1976 to promote the exchange of information, increase donations and develop a code of ethics for tissue banking. In 1977 it issued draft guidelines for tissue banking. AATB has established standards for the donation and manufacture of human tissues for transplantation to prevent disease transmission and to ensure optimal performance of transplanted cells and tissues. It also provides both accreditation of tissue banks and training and certification of tissue banking specialists. AATB is the only national tissue banking organization.

The AATB standards for accreditation are more rigorous than the federal regulatory requirements. The standards include a requirement that the facility have a medical director who is a licensed physician. They also require detailed donor consent standards, donor screening and testing requirements for disease, age criteria for specific tissues, and the use of current good tissue practices (cGTP's). The accreditation process requires an application, development and implementation of standard operating procedures, and independent inspections for compliance with standards. The process takes about 9 months for a tissue bank to complete the accreditation process. According to Mr. Rigney, approximately 95% of the tissue transplanted in the United States comes from AATB accredited tissue banks.

Dr. Ruth Solomon, Director of the Division of Human Tissues, Office of Cellular, Tissue and Gene Therapies, Center for Biologics Evaluation and Regulation, FDA, spoke to the Subcommittee via teleconference. Dr. Solomon reviewed for the Subcommittee the FDA regulation of tissue banking. All establishments involved in the "manufacture" of human tissue or cells for human transplantation must register with the FDA within 5 days of beginning operations and annually thereafter. Manufacturing includes the recovery, processing, testing, transportation, storage, and distribution of cells and tissues. The FDA regulations, 21 CFR §1271, govern donor eligibility, screening, and testing, and cGTP's. CGTP's include methods, facilities, and controls for manufacturing to prevent disease transmission in tissue transplantation. In addition, the federal regulations require adverse reaction reporting, reporting of deviations from standards and unexpected events, and proper labeling of human tissues and cells for transplant. Finally, the FDA has significant enforcement authority including inspection of establishments with or without notice, and the power to issue orders for the recall or destruction of cells and tissue and the cessation of manufacturing activities.

The third meeting of the Subcommittee was held on November 15, 2006. The Subcommittee invited representatives from a number of establishments involved in tissue banking in the State to comment on a proposal that the State regulate tissue banking by requiring that a tissue bank operating in North Carolina be accredited by the AATB or

requiring that all tissue for human transplants in North Carolina come from establishments accredited by the AATB, or both.

Lloyd Jordan, Chief Executive Officer of Carolina Donor Services (CDS) spoke at length about the various services provided by his organization and the extensive federal regulations with which CDS must comply. CDS is a federally designated Organ Procurement Organization (OPO). An OPO's primary mission relates to the donation and recovery of vascularized organs, such as the heart, kidney, liver or lungs, for human transplant. Incident to organ recovery, OPO's also act as tissue banks, and recover musculoskeletal and other tissue as part of the recovery process. As a federally designated OPO, CDS is required by law to be notified by hospitals within its region of hospital deaths so that the families of potential organ donors may be contacted for permission to recover organs and tissue from the deceased.

Mr. Jordan was opposed to any State requirement that would require a federally designated OPO to obtain accreditation from the AATB. OPO's have a long history of being regulated and must be certified by the federal Secretary of Health and Human Services. They are also subject to FDA regulation as tissue banks due to their tissue recovery operations. Mr. Jordan had no strong opinion on requiring tissue for human transplant in North Carolina to come from AATB accredited processors. Finally, Mr. Jordan noted that the three tissue banks that CDS currently uses to process the tissues it recovers are all AATB accredited.

Hugh Hensleigh, PhD. from the North Carolina Center for Reproductive Medicine, spoke at length about the work of his laboratory, which focuses on in vitro fertilization. Dr. Hensleigh indicated that he considered their operations to be adequately regulated. AATB accreditation would be appropriate only for establishments processing, storing or distributing sperm, ova, or embryos on a commercial basis.

Jeannette Poole, Director of Hospital Development with the Eye Bank of North Carolina, spoke about the history of eye banking. She noted that the first home of the Eye Bank Association of America (EBAA) was in Winston-Salem, North Carolina. The EBAA is the national organization for accreditation of establishments that recover, process, and otherwise manufacture ocular tissue such as corneas and sclera. She indicated that most, but not all, eye banking establishments in North Carolina are EBAA accredited.

Dr. Betsy E. Tuttle-Newhall, Assistant Professor of Surgery and Director of the Liver Transplant Program at Duke University Medical Center also spoke to the Subcommittee and addressed physicians concerns about requiring them to use tissues for transplantation that come from an AATB accredited processor.

The Subcommittee discussed options for State action that would prevent the reoccurrence of situation like that of DRS, yet not impose an unnecessary regulatory burden on tissue banks operating in the State. The problem presented by DRS occurred at the tissue recovery stage. It may also have involved falsification of records and fraud. Mr. Jordan told the Subcommittee that most human tissue in North Carolina is recovered by federally designated OPO's in a hospital setting. Those OPO's are certified by the federal Secretary of Health and Human Services. FDA regulations, however, do not impose a certification requirement. Tissue banks must only register within 5 days of beginning operations. While tissue banks are required to comply with the regulations regarding donor consent, screening, testing and

current good tissue practices, there are no preliminary certifications or inspections required. This presents a window of opportunity for errors to occur and the less scrupulous to operate. After discussion, the Subcommittee decided to recommend legislation to the House Select Committee on Health Care that would require a tissue bank, other than a federally designated OPO, engaged in the recovery of human tissue outside of a hospital setting, to be AATB or EBAA certified.

The Subcommittee also received a written report from the Statewide Program for Infection Control and Epidemiology (SPICE) summarizing the programs that it has been able to undertake with the expanded funding it received from the General Assembly in 2006. In July of 2006, the North Carolina General Assembly allocated $450,000 to SPICE to help North Carolina hospitals reduce their incidents of healthcare-associated infections (HAIs). HAIs account for an estimated 2 million infections, 90,000 deaths, and $4.5 billion in excess healthcare costs annually. Many, but not all, HAIs are avoidable, and hospitals and other health care providers are undertaking initiatives to reduce the incidents of HAIs. To quicken the pace of preventing avoidable HAIs, SPICE plans to use the appropriated funds to enhance hospital participation in a national initiative led by the Institute for Healthcare Improvement (IHI). The IHI campaign proposes that hospitals implement specified interventions for which efficacy is documented in the peer-review literature. Significant infection control interventions include: preventing central line infections, preventing surgical site infections, and preventing ventilator-associated infections. Recently, a pilot project was completed at a university medical center, and there was significant improvement when implementing the central line IHI bundle. To further this initiative, SPICE will hire several experienced infection control professionals who will be assigned hospitals in their region and charged with offering onsite consultations to acute-care hospitals to facilitate the full implementation of the IHI bundles

At its final meeting on November 29, 2006, the Subcommittee voted to approve and forward its report to the House Select Committee on Health Care.

IV. Subcommittee on 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 submitted an interim report to the House Select Committee on Health Care in April 2006. The status of the House Select Committee's recommendations, resulting from the input of the Subcommittee on Healthcare Workforce, is included in Appendix A as the Recommendation Status Report.

The House Select Committee on Health Care, Subcommittee on Healthcare Workforce met on two occasions from October 25, 2006 to November 29, 2006 and heard presentations from the following:

- Erin Fraher with the Cecil G. Sheps Center for Health Services Research and Thomas J. Bacon, Director, North Carolina Area Health Education Centers (AHEC) on the topic of the supply and distribution of psychiatrists in North Carolina.

- Steve Cline, Deputy State Health Director, Division of Public Health, North Carolina Department of Health and Human Services, and Jennifer Garrett, President of the School Nurse Association of North Carolina on the topic of school nurses.
- Anthony Bucci, Assistant Superintendent of Student, Family and Community Services, Charlotte-Mecklenburg Schools, Dana McNeilly, RN, BSN, School Health Supervisor, Cleveland County Health Department, and Linda Kiser, RN, former School Health Supervisor, Cleveland County Health Department on school health service models.
- President H. Martin Lancaster, North Carolina Community College System on the topic of allied health programs in the community colleges.

V. Subcommittee on Access

The House Select Committee on Health Care, Subcommittee on Access, met eleven times from November 30, 2005 until November 29, 2006. The Subcommittee submitted an interim report to the House Select Committee on Health Care in April 2006. The House Select Committee on Health Care, Subcommittee on Access met on four occasions from September 28, 2006 to November 29, 2006 and heard presentations from the following:

- Edmund Haislmaier with the Heritage Foundation Health Policy Studies Center and Kala Ladenheim, Program Director, Forum for State Health Policy Leadership, from the National Conference of State Legislatures presented on the topic of state approaches to universal coverage and implications from the Massachusetts health plan.
- Barbara Pullen Smith, Executive Director of the North Carolina Office of Minority Health and Health Disparities presented on initiatives from the Department of Health and Human Services to improve access to affordable health care and to limit disparities to care.
- Cathy S. Wright, North Carolina Medical Society provided the Subcommittee an overview of the North Carolina Medical Society Foundation's Community Practitioner Program. The program provides assistance to primary care physicians, physician assistants, and family nurse practitioners in return for service in a target community.
- Tom Vitaglione, senior fellow, Action for Children North Carolina presented on the need to expand health care and insurance coverage to all children in North Carolina.
- Barbara Morales Burke, Chief Deputy Commissioner of the NC Department of Insurance, informed the Subcommittee of grant funding awarded to the DOI by the Centers for Medicare and Medicaid Services to study the establishment of a high risk pool in the State.
- Torlen Wade from the Office of Rural Health and Community Care provided the Subcommittee with an update on the use of funds for Community Health Grants appropriated in S.L. 2006-66 (Sec. 10.16) (SB 1741, Sec. 10.16).

- Connie Parker, President of the NC Association of School-Based/School-Linked Health Centers, gave the Subcommittee information about the services provided by the 52 centers located in 22 counties in the State. These centers function as part of the State healthcare safety net, providing access to care for school-age children in or near school grounds in communities with identified high risk populations.
- Jane M. Foy, Past President, NC Pediatric Society, provided the Subcommittee with an overview of issues relating to children's access to health care in the State from the pediatrician's perspective.
- Dr. Allen Dobson, Assistant Secretary for Health Policy and Medical Assistance, provided the Subcommittee with detail on initiatives implemented by the Division of Medical Assistance to control health care cost while improving utilization of Medicaid.

VI. Subcommittee on the State Health Plan (the Teachers' and State Employees' Comprehensive Major Medical Plan)

The House Select Committee on Health Care, Subcommittee on the State Health Plan, met on September 12, 2006. The Subcommittee heard a presentation from George C. Stokes, Executive Administrator of the Teachers' and State Employees' Comprehensive Major Medical Plan (State Health Plan), who provided an update on the Plan's new Preferred Provider Option (PPO) program.

Mr. Stokes reported to the Subcommittee that 336,000 state employees, teachers and retirees, or over 50% of the Plan's membership have switched from the traditional indemnity plan to one of three PPO benefit programs. Mr. Stokes said that the PPO will save North Carolina taxpayers more than $25 million from October 1, 2006 to October 1, 2007. He outlined major reasons for many plan members choosing the PPO including expanded choice in benefit options and adding the employee/spouse premium tier for more affordable spouse only coverage. He also spoke about the lower costs for participating plan members under the PPO in the form of co-pays only for most in-network physician office visits, lower deductible and coinsurance options, co-pays only for diabetic supplies and co-pays for routine eye exams. Mr. Stokes also mentioned "My Member Services" on the State Health Plan website where members can view claim status, order new ID cards and check their benefit summary. Mr. Stokes stated that he estimates Plan members who switched to one of the three PPO programs will have out-of-pocket savings of $1,500 to $2,000 annually. Mr. Stokes added that the PPO programs are "just a beginning" and that he will be presenting a three-year strategic plan with annual initiatives to the Plan's Board of Trustees.

Mark Trogdon of the General Assembly's Fiscal Research Division provided an overview of House Bill 1059, which made various changes to the Plan. Mr. Trogdon summarized the various provisions of the bill which include the following: authorize coverage of certain over-the-counter drugs; authorize the establishment of incentive programs; require prior approval for Bone Anchored Hearing Aids (BAHA) surgically implanted for the treatment of hearing loss; authorize the Plan to create up to eight new full-time positions; amend G.S. 135-39.5(12) to state that the prompt payment law under Chapter

58 applies to the Plan's Comprehensive Major Medical Plan (also known as the self-insured indemnity program) and the optional plans and programs (currently the Preferred Provider Options) offered under the Plan; and authorized the Executive Administrator and the Board of Trustees to allow up to four additional local governments to participate in the Plan.

Mr. Trogdon was also asked by the Subcommittee to discuss briefly the expected financial impact to the Plan by allowing selected local governments to participate as employing units under the Plan. Mr. Trogdon noted that to date the Plan has not experienced any known financial consequences from the participation of Bladen County, Rutherford County, Washington County, and the Town of Forest City. However, he did note that only long-term experience will determine the true impact on the Plan. He also noted that the authorization in HB 1059 requires the Executive Administrator of the Plan to set criteria prior to selecting up to four additional local governments to participate as employing units under the Plan with the hope that the Executive Administrator will be able to limit any adverse impact to the Plan. Mr. Trogdon stated that interest in joining the Plan by local governments is likely to continue to come from small units who do not have leverage with insurers to negotiate their own favorable insurance agreements. He also noted that participating local governments have been allowed to join the Plan at premium rates offered to State agencies and that if the claims experience does become unfavorable, the Plan may have to consider premium rating participating local governmental units separately so as not to have the State subsidizing local government participation in the Plan.

This report also notes the passage of Senate Bill 837 which modified the eligibility for non-contributory health benefit coverage as a retired employee for future employees first hired on and after October 1, 2006 and members of the General Assembly first taking office on and after February 1, 2007. The enacted bill requires future employees upon retirement to earn a minimum of 20 years of retirement service credit to be eligible for health benefit coverage on a non-contributory basis. The bill further requires future employees upon retirement who earn less than 20 years of retirement service credit to pay a premium contribution for their health benefit coverage under the Plan. Future employees upon retirement who earn 10 up to 20 years of retirement service credit would be required to pay a partially contributory premium equal to 50% of the required premium. Future employees upon retirement with 5 up to 10 years of retirement service credit would be required to pay premiums on a fully contributory basis equal to 100% of the required premium.

The changes enacted in Senate Bill 837 closely match those recommended in the Subcommittee's Interim Report dated April 11, 2006.

APPENDIX III - A

Handouts – Subcommittee on Access

Interim Report to House Select Committee on Health Care

Meeting Dates:

November 30, 2005, 11:00 a.m. – 12:30 p.m.
December 15, 2005, 8:30 a.m. – 11:30 a.m.
January 10, 2006, 9:00 a.m. – 12:30 p.m.
January 25, 2006, 1:00 p.m. – 4:00 p.m.
February 15, 2006, 1:00 p.m. – 4:00 p.m.
March 16, 2006, 10:00 a.m. – 12:00 p.m.
March 28, 2006, 1:00 p.m. – 3:00 p.m.

Presentations:

Health Care Access Issues in North Carolina

Access to Care: Lack of Insurance and Other Access Barriers
Pam Silberman, President, North Carolina Institute of Medicine

Addressing Financial and Geographical Barriers

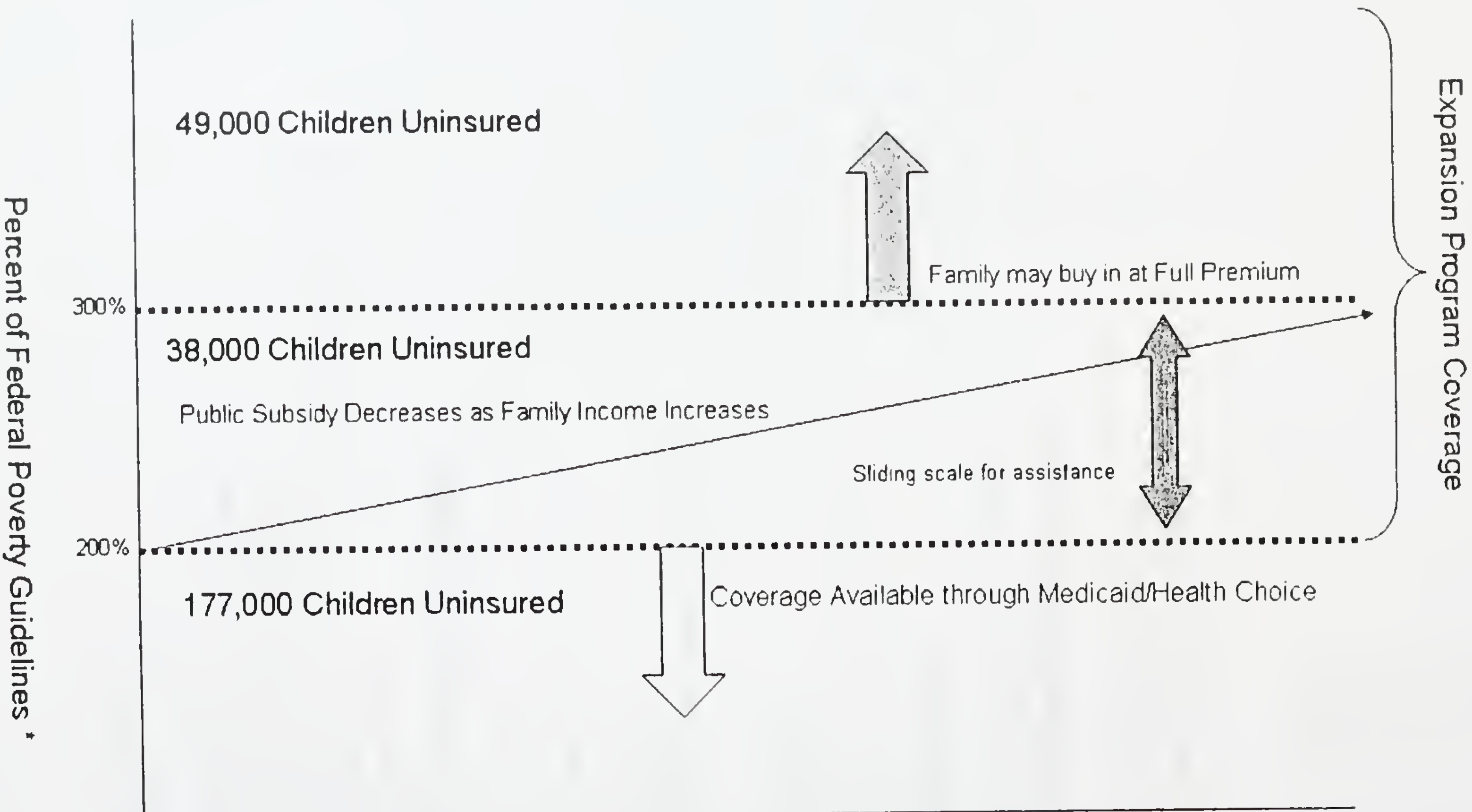
State Options for Providing Access to Health Care
Laura Tobler, Health Policy Analyst, National Confernece of State Legislatures

Overview of Identified Safety Nets

Rural Health Care Centers
Torlen Wade, Office of Research, Demonstrations and Rural Health Development
Community Health Centers
Sonya Bruton, Executive Director, NCCHCA
North Carolina Association of Free Clinics
Mike Darrow, Executive Director
School Based Health Centers
Connie Parker, NC Association of School based and School linked Health Centers
Area Health Education Centers (AHEC)
D r. Tom Bacon, Program Director, NC AHEC
NC Department of Public Health
Dr. Leah Devlin, Director, Division of Public Health
Hospitals
Hugh Tilson, North Carolina Hospital Association

Economic Impacts and Potential Cost Savings

Cost Savings with Health Prevention
Meg Malloy, Executive Director, NC Prevention Partners
The Economics of Access to Healthcare
Dr. Mark Holmes, Vice President, North Carolina Institute of Medicine, Senior Research Fellow, Program on Health Economics and Finance Cecil G. Sheps Center for Health Services Research
Negative Defensive Medicine and Patient Access to Medical Care
Dr. Frank Sloan, Director, Center for Health Policy, Law and Management, Terry Sanford Institute of Public Policy, Duke University
North Carolina "Best Care"
Dr. Roland Stephen, Assistant Director for Research and Policy, North Carolina State University Institute for Emerging Issues



2006 HHS Poverty Guidelines
Base on 4 Persons In Family or Household = $20,000
For each additional /less person, add/subtract $3,400
SOURCE: *Federal Register*, Vol 71, No. 15, January 24, 2006, pp 3848-3849

RECOMMENDATION	RESULT
RECOMMENDATION 1: EXPAND COMMUNITY HEALTH CARE GRANTS The Subcommittee on Access recommends that the House Select Committee on Health Care encourage 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.	• The House Select Committee on Health Care adopted this recommendation. • Upon introduction in 2005, HB 2063 Funds for Community Health Centers was referred to the House Committee on Appropriations. • S.L. 2006-66 (Sec. 10.16) (SB 1741, Sec. 10.16) appropriated $5,000,000 (increase of $3,000,000) for Community Health Grants. The Grants are to be allocated to federally qualified health centers and those health centers that meet the requirements 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 uninsure or medically indigent patients. The funds are to 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. In distributing funds, the Department of Health and Human Services shall consider the availability of other funds for the agency, the incidence of poverty or indigent clients served, arrangements for after-hours care, and collaboration with the applicant's community hospital and other safety net organizations.

RECOMMENDATION	RESULT
<u>RECOMMENDATION 2:</u> HIGH-RISK POOL The Subcommittee on Access recommends that the House Select Committee on Health Care encourage the General Assembly to enact legislation to implement a health insurance high-risk pool.	• The House Select Committee on Health Care adopted this recommendation. • Upon introduction in 2006, HB 1895 "Establish High-Risk Pool" was referred to and reported favorably out of the House Committee on Insurance and the House Committee on Finance. HB 1895 passed the House of Representatives on 7/17/2006 by a vote of 95-11 and crossed over to the Senate, where it was referred to the Senate Committee on Health Care and remained at the close of session. • House Bill 1895, if enacted, would have established the North Carolina Health Insurance Risk Pool, the purpose of which would be to enable individuals with high-risk health conditions to obtain health insurance at premium rates that are more affordable than currently available. Pool financing would be achieved through a combination of premiums and assessments with an initial federal grant award to fund Board operating expenses and Pool start-up costs.
<u>RECOMMENDATION 3:</u> HEALTH CARE FOR NORTH CAROLINIANS The Subcommittee on Access recommends that the House Select Committee on Health Care encourage the General Assembly to establish a formal plan for transitioning from our current fragmented system of delivering health care to a system that covers all North Carolinians.	• The House Select Committee on Health Care adopted this recommendation. • Upon introduction in 2005, HB 1894- North Carolina Health Care System Study Commission was referred to the Committee on Rules, Calendar, and Operations of the House. • The bill if enacted, would have established in the General Assembly a Joint Legislative Commission on Transitioning to a Health Care System that Covers All North Carolinians. The bill directs the Commission to study the need for a health care system that covers all North Carolinians. The bill further directs the Commission to establish a formal plan for transitioning from the current fragmented system of delivering health care to a system that covers all North Carolinians.

APPENDIX III-B

Handouts – Subcommittee on Healthcare Workforce

RECOMMENDATION	RESULT
<u>RECOMMENDATION 1:</u> **EXPAND COMMUNITY HEALTH CARE GRANTS** The Subcommittee on Access recommends that the House Select Committee on Health Care encourage 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.	• The House Select Committee on Health Care adopted this recommendation. • Upon introduction in 2005, HB 2063 Funds for Community Health Centers was referred to the House Committee on Appropriations. • S.L. 2006-66 (Sec. 10.16) (SB 1741, Sec. 10.16) appropriated $5,000,000 (increase of $3,000,000) for Community Health Grants. The Grants are to be allocated to federally qualified health centers and those health centers that meet the requirements 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 uninsure or medically indigent patients. The funds are to 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. In distributing funds, the Department of Health and Human Services shall consider the availability of other funds for the agency, the incidence of poverty or indigent clients served, arrangements for after-hours care, and collaboration with the applicant's community hospital and other safety net organizations.

RECOMMENDATION	RESULT
<u>RECOMMENDATION 2:</u> SUPPORT NC NOVA The Subcommittee on Healthcare Workforce recommends that the House Select Committee on Health Care support the North Carolina New Organizational Vision Award Program in an effort to address the shortage of direct care workers.	• The House Select Committee on Health Care adopted this recommendation. • Support for the NC NOVA Program was also a recommendation of the NC Study Commission on Aging. As a result, SB 1277 and HB 2055 were introduced. SB 1277 was enacted and S.L. 2006-104 establishes the North Carolina New Organizational Vision Award (NC NOVA). NC NOVA is a voluntary special licensure designation that will be rewarded to adult care homes, home care agencies, and nursing homes that have been determined through written and on-site review, by an independent review organization, to have met a comprehensive set of workplace related interventions intended to improve the recruitment and retention, quality, and job satisfaction of direct care staff, and the care provided to long-term care clients and residents. The NC NOVA program will be implemented by the Department of Health and Human Services. This act becomes effective January 1, 2007.
<u>RECOMMENDATION 3:</u> SUPPORT ALLIED HEALTH AND NURSING PROGRAMS The Subcommittee on Healthcare Workforce recommends that the House Select Committee on Health Care encourage 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.	• The House Select Committee on Health Care adopted this recommendation. • The General Assembly provided $1,300,000 in non-recurring funds for North Carolina Area Health Education Centers (AHEC) initiative to address health workforce shortages in Allied Health, Dentistry, Nursing, and Pharmacy. In Allied Health, these funds will add new clinical teaching sites throughout the state with an emphasis on physical therapy, speech language pathology, and occupational therapy. The funds will also provide clinical training for PharmD students at Elizabeth City State University, support rural training sites for dental students, and expand the AHEC nursing grants program. • The General Assembly appropriated $1,000,000 in recurring funds to allow the State Board of Community Colleges to fund nursing programs at the colleges on a weighted FTE basis. Colleges may use these funds for nursing equipment and supplies, or to supplement the salaries of nursing faculty. • The General Assembly provided $15,000,000 for grants for community college facilities and equipment needs and $5,000,000 for community college allied health projects. • The General Assembly provided $850,000 in non-recurring funds to provide startup funding for new Bachelor of Science in Nursing programs at Fayetteville State University and UNC-Pembroke and a new RN to BSN program at Appalachian State University. Fayetteville State University will receive $300,000, UNC-Pembroke will receive $300,000, and Appalachian State University will receive $250,000.

RECOMMENDATION	RESULT
RECOMMENDATION 4: SUPPORT AHEC FUNDING PRIORITIES REGARDING MENTAL HEALTH The Subcommittee on Healthcare Workforce recommends that the House Select Committee on Health Care encourage 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.	• The House Select Committee on Health Care adopted this recommendation. • The General Assembly provided $500,000 in recurring funding for the NC Area Health Education Centers (AHEC) program to develop innovative models for educating psychiatry residents/fellows and other mental health professionals in rural and underserved areas of the state in order to improve placement and retention of these professionals in rural communities, and to strengthen the provision of psychiatry services to these communities.

North Carolina Annual School Health Services Report for Public Schools 2005-2006 School Year

Executive Summary

The number of school children in North Carolina grew from 1.3 million in 2004-2005 to 1.4 million in 2005-2006. At the same time, the number of full time school nurse positions increased from 836 to 868, and increase of 32 positions. Together, these caused the school nurse to student ratio to improve slightly from 1:1593 in 2004-2005 to 1:1571 in 2005-2006. This ratio remains more than double the ratio of 1:750 recommended by the American Academy of Pediatrics, the Centers for Disease Control and Prevention, and the National Association of School Nurses.

School nurses in North Carolina are employed by a variety of agencies. Of the 946 school nurses working in public schools, Local Education Agencies employ 490, local health departments employ 303, hospital/healthcare systems employ 98, and alliances or combinations employ 41. Funding for school nurse positions comes from a variety of sources including local and state funds, federal block grants and categorical funds, and public and private foundations.

National certification in school nursing is the standard by which school nurses are judged to have the knowledge and skills necessary to provide health services in the school setting. In the last year, the number of nationally certified school nurses increased from 38% to 43%.

A critical function of school nurses is identifying students with chronic health conditions. The numbers of students with chronic health conditions continues to increase. In 2005-2006, school nurses identified 80,886 students with asthma, an increase of 4,000 students; 4,437 students with diabetes, an increase of 1,600 students; and 18, 386 students with life threatening allergies, an increase of 1,000 students. In addition to identifying these students, school nurses developed individual health care plans, and trained school staff to give necessary medication and perform medical procedures ordered by health care providers.

School nurses provided over 58,000 health counseling sessions to students and staff, and 30,400 health education programs in either one-on-one or group settings. They ensured that vision, hearing, and dental screenings were conducted in their schools. More than 465,000 vision screenings were performed in mostly elementary schools, and more than 37,000 students were referred for comprehensive eye exams. More than 87,000 students were authorized to receive medication at school, an increase of more than 18,000, and school nurses ensured that this was done in a safe manner.

School nurses work with their local School Health Advisory Councils to develop and implement local programs designed to prevent illness and promote health that are mandated by the North Carolina School Board Association Healthy Active Children policy. They also assist with disaster/emergency planning for their communities.

As the health needs of children in school continue to grow, so must the availability of school nurses, until the recommended ratio of 1:750 is reached and there is a school nurse in every school in North Carolina.

The Supply and Distribution of Psychiatrists in North Carolina: Pressing Issues in the Context of Mental Health Reform

Erin Fraher, MPP
Katie Gaul, MA
Thomas C. Ricketts, PhD
Cecil G. Sheps Center for Health Services Research
University of North Carolina at Chapel Hill

Presentation to the House Select Committee on Health Care
Subcommittee on Healthcare Workforce
October 25, 2006

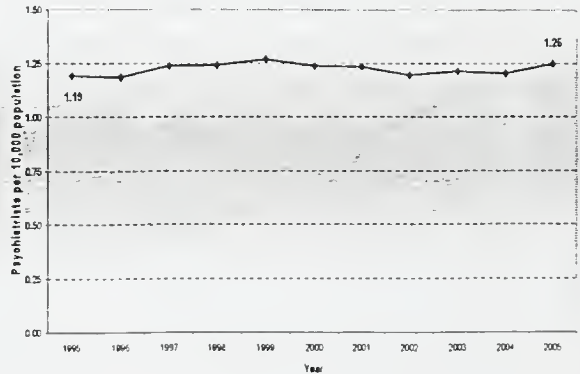
Why examine psychiatrist supply now?

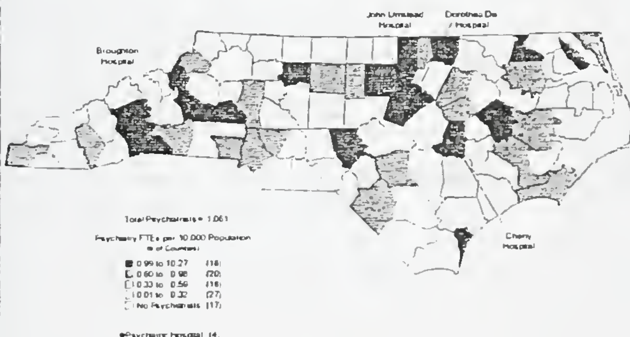
- Potential for a national physician shortage
- North Carolina is a fast population growth state and our supply has slowed
- Psychiatrists are an important specialty group within overall physician workforce
- North Carolina is in the process of redesigning mental health delivery system
- Rising prevalence of common mental health disorders

Rising need for mental health services

- Nearly 1 in 3 non-elderly adults experiences a mental disorder in a given year
- NC pediatricians report 15% of children have behavioral disorder such as attention deficit disorder, anxiety or depression
- Despite need, many adults go untreated due to combination of factors:
  - Inadequate insurance coverage
  - Lack of co-payments
  - Perceived stigma
  - Inadequate supply and distribution of mental health professionals
- This presentation focuses on one component of issue—psychiatrist supply

Physicians with a Primary Specialty in Psychiatry per 10,000 Population, North Carolina, 1995-2004





If there is not an adequate supply of psychiatrists in certain counties, the burden of care will likely fall on primary care physicians. In 2004:

- There were 17 counties in which no psychiatrists claimed a primary, secondary or other practice location, and 7 of these 17 counties were also whole-county primary care HPSAs.
- Of the 19 whole-county primary care HPSAs, 11 face a shortage of psychiatrists
- In counties that are not primary care HPSAs but that have low psychiatrist to population ratios, the burden of mental health care is likely falling upon primary care docs to provide services (such as prescribing, diagnosing and developing treatment plans)

Summary of Findings

- **Psychiatrists**: Issue is less one of overall supply, more an issue of distribution. NC residency programs provide relatively high yield; residency programs need to maintain or increase number of graduates
- **Child Psychiatrists**: There is a critical shortage and maldistribution of child psychiatrists
- **Psychiatrists and Primary Care Providers**: Many counties facing a psychiatrist shortage also face a shortage of primary care providers—may jeopardize access to care for patients with mental disorders

Possible Policy Options

- Create a Psychiatrist Service Corps
- Reduce isolation of providers in rural areas
- Support training in publicly funded settings
- Develop new educational programs for nurse practitioners and physician assistants focused on mental health
- Support and disseminate successful models of care that:
  - Strengthen ties between primary care providers and psychiatrists
  - Provide team-based care and/or consultation models that expand efficiency of existing workforce

THE NORTH CAROLINA COMMUNITY COLLEGE SYSTEM

Executive Summary of the 2007-09 Consensus Budget Request
for the
Health Care Workforce Sub-Committee

H. Martin Lancaster
System President

Kennon D. Briggs
Vice President for Business & Finance

November 2006

House Select Committee on Health Care
Subcommittee on Healthcare Workforce

Introduction

Over the past eighteen months, the North Carolina Community College System (NCCCS) has been through both an internal strategic planning process[1] and an external review process[2]. Both activities have resulted in the identification of critical programmatic and resource issues, the establishment of very specific goals and objectives, and the delivery of important recommendations for System enhancement and improvement. It is the belief of the State Board of Community Colleges, the System President, and all internal stakeholders that an iterative and inclusive process of identifying the educational and personal needs of our student customers leads to a conclusive list of our requirements to address and satisfy those needs. It is also our belief, from an external review of programmatic and economic development needs within the state, that a collaborative relationship with the University of North Carolina System will foster economic transformation in a changing global economy.

Summary of the 2007-09 Consensus Budget Request

The budget request submitted by the North Carolina Community College System for 2007-09 is a reflection of several things. First and foremost, it is a mirror reflection of both an internal System-wide Strategic Planning Process, and an external review of public higher education's educational and programs needs as they relate to economic development. Second, the request reflects the core mission and operations of the System. The core mission of the NCCCS is education and training[3], and the operations thereof include faculty, staff, equipment and facilities. Finally, the request reflects the target population whom the System exists to serve - both students and the state's workforce.

With respect to the market place, this budget asks for funds to weight the funding of programs and activities that, while expensive in nature to deliver, produce graduates that are in extremely high demand. These include all **allied health programs, but especially nursing.**

Both the House Bill 1264 Study and the NCCCS Strategic Planning process identified several important Health Care Issues for the NCCCS. They include:

1. At the Associate Degree, Diploma or Certificate level, respond to employment gaps in EMT, and medical and clinical lab technicians,
2. With UNC, create a special program to produce faculty, especially in allied health fields, particularly nursing, and require all NCCCS nursing programs to be nationally accredited,
3. With UNC, increase the number of nursing graduates and nursing faculty,

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[1] North Carolina Community College System: "Strategic Planning Process - 2007-09.
[2] The Pappas Consulting Group. "Staying a Step Ahead: Higher Education Transforming North Carolina's Economy." July 21, 2006.
[3] General Statute 115D-1

Funding Requirements for Allied Health

There are four funding requirements for the NCCCS that are critical to providing the workforce of the state with the skilled labor that is required. These funding requirements include:

1. **Instructional Costs:**

Funds are requested to supplement and sustain Allied Health Programs. The funds would be used to recruit and retain faculty, grant salary increases thereto, add additional enrollment slots to students, or to purchase supplies and equipment. Enrollment demand for and job opportunities within the allied health industry have never been higher in the state's history. For the reporting period July 1, 2005 through June 30, 2006, enrollment in Associate Degree and Diploma programs in the NCCCS rose to 20,820 full-time equivalent (FTE) students. Severe projected gaps in supplying the workforce in occupations requiring education at NCCCS institutions are for registered nurses, licensed practical nurses, emergency medical technicians, dental assistants, respiratory therapists, and medical and clinical lab technicians.[4] **Therefore, $31,646,400 in recurring funds is requested for weighted funding for Allied Health Programs.**

2. **Accreditation Expenses for Nursing Programs:**

Since the establishment of the "Task Force on the North Carolina Nursing Workforce" in the fall of 2002 by the North Carolina Institute of Medicine (NC IOM), several studies and reports have been issued that focus upon the supply of and demand for both nurses and nursing faculty. In May 2004, the NC IOM published an "Issue Brief" that noted "although North Carolina has yet to experience the extreme shortages of nursing personnel reported in other states, there is little question that without some steps taken in the near term, our state is likely to experience a severe shortage in the next decade."[5] The brief did caution however that labor supply forecasts called for a potential shortfall of 9,000 nurses.

In 2006, the North Carolina Center for Nursing (NC CFN) issued a report on the "Educational Mobility Patterns among Registered Nurses in North Carolina."[6] The report noted that a changing dynamic in nursing education could have a negative consequence for the supply of nursing faculty. Increasingly, a substantial number of entry-level nurses come from Associate Degree (ADN) programs. For ADN nurses to become faculty require completion of two additional degrees: a baccalaureate (BSN) and master's (MSN) degree. New nurses from BSN programs are a declining percentage of entry-level nurses.[7] Also taken

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[4] Pappas Consulting Group. "Staying a Step Ahead: Higher Education Transforming North Carolina's Economy." January 17, 2006. Page 6.

[5] North Carolina Institute of Medicine. "Issue Brief: The Task Force on the North Carolina Nursing Workforce Report." Durham, North Carolina. May 2004. Page 1.

[6] Lacey, Linda M. and Jennifer G. Nooney. "Educational Mobility Patterns Among Registered Nurses in North Carolina." Raleigh, North Carolina. March, 2006.

[7] IBID. Page 1.

from a NC CFN "Issue Brief"[8], which examined the supply of and demand for nursing faculty in the state, one conclusion that can be drawn is that if current student-to-faculty ratios are maintained, the demand for faculty already exceeds the supply of faculty.

The process of and annual requirements for NLN accreditation, coupled with a partnership with the University of North Carolina System, could have dramatic positive benefits and effects on the supply of registered nurses and nursing faculty, and community college ADN and PN programs. First, NLN accreditation provides recognition that a nursing education program has been evaluated and periodically re-evaluated by a qualified, independent group of respected and competent peers, who find it to be meeting appropriate higher education purposes. Second, it assures professional development opportunities for community college faculty, by demonstrating their continued professional growth. Third, it assists employers who seek graduates who are produced by accredited programs. Fourth, it facilitates career and education decision-making. Fifth, it promotes educational mobility within the state. Sixth, it will raise the educational attainment level and credentialing of community college faculty, and ultimately their salaries. Finally, it will be consistent with the State Board of Nursing intent to make all the state's nursing programs NLN accredited by 2015.
There are three important factors to consider when developing a cost model to determine the fiscal impact of obtaining NLN accreditation. These factors include:

1. The "salary differential" between faculty that hold the Masters credential and those that do not;
2. The cost of "degree completion", e.g. moving faculty from the BSN to MSN credential; and,
3. The cost of NLN Accreditation.

Funds are requested to provide for the salary differentials, cost of degree completion and actual accreditation expense to move all Associate Degree and Practical Nursing programs in the NCCCS to full accreditation status by the NLN, and to provide annual expenses for those programs already accredited. ***Therefore, $1,157,267 in recurring funds and $6,061,500 in non-recurring funds is requested.***

3. Equipment:

No campus of the NCCCS can accomplish the purpose of education and training a work force in an economy as dynamic as North Carolina's without facilities equipped with the most modern instructional technology as can be afforded. For the last several years, both the Governor and General Assembly have responded favorably to the requests put forth by the NCCCS. In FY 2005-06, $10,000,000 in recurring funds was appropriated for equipment, bringing the annual amount of recurring dollars to $31.3 million the largest recurring amount in the System's history. In FY 2006-07, an additional $10 million in non-recurring funds was appropriated, again increasing the total amount to $41.3 million. The non-recurring nature of the last appropriation is cause for concern going forward.

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[8] Lacey, Linda M. and Jennifer G. Nooney. "Forecasting Supply and Demand of Nursing faculty in North Carolina: 2004-2020." March, 2006.

In the area of Allied Health, the NCCCS currently utilizes $26,843,936 of equipment. Using a five-year replacement cycle, based upon the changes in clinical-based technology, approximately $5,368,787 is needed each year to provide state-of-the-art instructional equipment in Allied Health programs. ***Therefore, $5,368,787 in recurring funds is requested for Allied Health instructional equipment.***

4. Facility Needs:

Both an internal strategic planning process[9] and an external review process[10] recognize the importance of facilities, and the processes of identifying needs for facilities was revamped for 2007-09. No longer an overwhelming process that results in staggering estimates for both capital requirements, the facility requirements have been pared to reflect three renovation and repair projects, one general construction project, and one project per campus each that address state wide labor market needs.

Among the many facility requirements are the needs to plan and construct Allied Health educational facilities. Campus-by-campus evaluations indicate that there is approximately $9.7 million needed to plan these facilities, $210 million to construct them, and another $28.1 million to appropriately equip the facilities.

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[9] North Carolina Community College System: "Strategic Planning Process - 2007-09.

[10] The Pappas Consulting Group. "Staying a Step Ahead: Higher Education Transforming North Carolina's Economy." July 21, 2006.

North Carolina Community College System
Health Sciences Programs[1]
Fiscal year Ended June 30, 2006

Curriculum	Approved Curriculum Code Desc	FTE	Weighted Per Capita Funding 2	Total Funding Cost
A45100	ASSOCIATE DEGREE NURSING (INTEGRATED)	4,290	$ 1,520	$ 6,520,800
A45120	ASSOCIATE DEGREE NURSING(NON-INTEGRATED)	3,042	$ 1,520	$ 4,623,840
A45160	CARDIOVASCULAR SONOGRAPHY	73	$ 1,520	$ 110,960
A45170	CARDIOVASCULAR TECH. (INVASIVE & NON-INV	25	$ 1,520	$ 38,000
A45190	CLINICAL TRIALS RESEARCH ASSOCIATE	67	$ 1,520	$ 101,840
A45260	DENTAL HYGIENE	707	$ 1,520	$ 1,074,640
A45280	DENTAL LABORATORY TECHNOLOGY	46	$ 1,520	$ 69,920
A45310	DIETETIC TECHNICIAN	29	$ 1,520	$ 44,080
A45320	ELECTRONEURODIAGNOSTIC TECHNOLOGY	35	$ 1,520	$ 53,200
A45340	EMERGENCY MEDICAL SCIENCE	721	$ 1,520	$ 1,095,920
A45360	HEALTH INFORMATION TECHNOLOGY	437	$ 1,520	$ 664,240
A45380	HUMAN SERVICES TECHNOLOGY	1,257	$ 1,520	$ 1,910,640
A45400	MEDICAL ASSISTING	1,883	$ 1,520	$ 2,862,160
A45410	INTERVENTIONAL CARDIAC AND VASCULAR TECH	11	$ 1,520	$ 16,720
A45420	MEDICAL LABORATORY TECHNOLOGY	500	$ 1,520	$ 760,000
A45440	MEDICAL SONOGRAPHY	269	$ 1,520	$ 408,880
A45460	NUCLEAR MEDICINE TECHNOLOGY	107	$ 1,520	$ 162,640
A45500	OCCUPATIONAL THERAPY ASSISTANT	148	$ 1,520	$ 224,960
A45560	OPTICIANRY	39	$ 1,520	$ 59,280
A45620	PHYSICAL THERAPIST ASSISTANT (2-YEAR)	144	$ 1,520	$ 218,880
A45640	PHYSICAL THERAPIST ASSISTANT (1+1)	195	$ 1,520	$ 296,400
A45680	RADIATION THERAPY TECHNOLOGY	103	$ 1,520	$ 156,560
A45700	RADIOGRAPHY	1,683	$ 1,520	$ 2,558,160
A45720	RESPIRATORY THERAPY	711	$ 1,520	$ 1,080,720
A45730	SPEECH-LANGUAGE PATHOLOGY ASSISTANT	105	$ 1,520	$ 159,600
A45740	SURGICAL TECHNOLOGY	522	$ 1,520	$ 793,440
A45750	THERAPEUTIC MASSAGE	269	$ 1,520	$ 408,880
A45760	THERAPEUTIC RECREATION	40	$ 1,520	$ 60,800
A45780	VETERINARY MEDICAL TECHNOLOGY	299	$ 1,520	$ 454,480
D45140	CARDIOVASCULAR/VASCULAR INTERVENT. TECH.	19	$ 1,520	$ 28,880
D45200	CT & MRI TECHNOLOGY	73	$ 1,520	$ 110,960
D45220	CYTOTECHNOLOGY	13	$ 1,520	$ 19,760
D45240	DENTAL ASSISTING	718	$ 1,520	$ 1,091,360
D45300	DIALYSIS TECHNOLOGY	20	$ 1,520	$ 30,400
D45510	OPTHTHALMIC MEDICAL ASSISTANT	28	$ 1,520	$ 42,560
D45580	PHARMACY TECHNOLOGY	195	$ 1,520	$ 296,400
D45660	PRACTICAL NURSING	1,997	$ 1,520	$ 3,035,440
		20,820		$ 31,646,400

1 Excludes Certificate programs & A4538A,B,C,D, & E

2 2006-07 Per Capita Instructional Cost - Curriculum = $3,234.74
Weight per FTE = 1.47 **Differential = $1,520**
Nursing Costs Only: $14,180,080

THE TOTAL COST OF MOVING PRACTICAL NURSES FROM ASSOCIATE DEGREE NURSES and COMMUNITY COLLEGE PROGRAMS FROM BSN TO MSN TO NLN ACCREDITATION

Program		Salary Differential A-1 Full-Time Faculty	Salary Differential A-2 Part-Time Faculty	Degree Completion Full-Time Faculty ONLY	Accreditation Expense Non-Recurring	Accreditation Expense Recurring	TOTALS
Practical Nurse	Non-Accredited Program	$ 246,437	$ 13,293	$ 2,508,000	$ 247,500	$ 89,595	$ 3,104,825
Associate Degree Nurses	Accredited Program	$ 20,549	$ 14,506	$ 114,000		$ 24,435	$ 173,490
Associate Degree Nurses	Non-Accredited Program	$ 578,983	$ 66,299	$ 2,907,000	$ 285,000	$ 103,170	$ 3,940,452
TOTAL COSTS		**$ 845,969**	**$ 94,098**	**$ 5,529,000**	**$ 532,500**	**$ 217,200**	**$ 7,218,767**

Budgeting Total Costs		A-1	A-2	Degree Completion	Non-Recurring	Recurring	TOTALS
Recurring Costs		$ 845,969	$ 94,098			$ 217,200	$ 1,157,267
Non-Recurring Costs				$ 5,529,000	$ 532,500		$ 6,061,500
							$ 7,218,767

NORTH CAROLINA COMMUNITY COLLEGE SYSTEM

Allied Health/Health Science Facilities Survey 2006

College	*Description*	*Estimated Cost*	*Advance Planning Cost*	*Equipment Cost*
A-B Tech	Rhododendron Health Center	$16,800,000	$1,000,000	$5,000,000
Beaufort CC	Allied Health Building	$6,000,000	$200,000	$250,000
Bladen CC	Health/Nursing Facility	$5,200,000	$100,000	$450,000
Caldwell CC	Allied Health-Watauga	$8,000,000	$640,000	$1,250,000
Carteret CC	Allied Health/Bio Business Transfer Ctr.	$5,750,000	$250,000	$900,000
Catawba Valley	Simulated Hospital	$2,700,000	$270,000	$1,500,000
Central Carolina CC	Allied Health Building	$8,000,000	$160,000	$1,000,000
Edgecombe CC	Allied Health Building	$4,000,000	$100,000	$100,000
Gaston CC	Health Education (Phase II)	$13,800,000	$938,400	$1,656,000
Isothermal CC	Allied Health/Sciences Facility	$4,500,000	$135,000	$215,000
James Sprunt CC	Medical/General Classroom Bldg.	$4,620,000	$462,000	$0
Martin CC	Allied Health Center	$5,000,000	$120,000	$1,500,000
Montgomery CC	Allied Health & Science Bldg.	$6,400,000	$320,000	$671,000
Nash CC	Allied Health Building	$4,000,000	$100,000	$350,000
Piedmont CC	Allied Health Building	$6,606,000	$370,013	$400,000
Randolph CC	Health Science Addition	$1,026,000	$102,600	$60,800
Roanoke-Chowan CC	Health Sciences Center	$4,500,000	$125,000	$2,000,000
Rockingham CC	Allied Health Building	$6,000,000	$300,000	$660,000
Rowan-Cabarrus CC	Allied Health Building	$10,400,000	$800,000	$1,248,000
Sampson CC	Nursing and Allied Health	$6,000,000	$500,000	$500,000
Southeastern CC	Additional Expansion of Health	$350,000	$30,415	$500,000
Surry CC	Emergency Services Bldg Expansion	$275,000	$3,000	$10,000
Vance-Granville CC	Allied Health Building	$12,000,000	$120,000	$2,000,000
Wake Technical CC	Health Science Bldg B	$45,100,000	$950,000	$5,000,000
Wilkes CC	Allied Health Building	$8,000,000	$125,000	$300,000
Wilson CC	Health & Technology Building	$15,000,000	$1,500,000	$600,000
TOTAL COST		**$210,027,000**	**$9,721,428**	**$28,120,800**

Average Estimated Cost	**$8,077,962**
Average Advance Planning Cost	**$373,901**
Average Equipment Cost	**$1,081,569**

THE NORTH CAROLINA COMMUNITY COLLEGE SYSTEM

Executive Summary
Vacancy Report for Associate Degree Nursing and Practical Nursing Programs
for the
Health Care Workforce Sub-Committee

H. Martin Lancaster
System President

Kim Jernigan
Health Sciences Program Coordinator

Delores A. Parker
Vice President for Academic & Student Services

November 2006

Vacancy Report
Associate Degree Nursing and Practical Nursing Programs
North Carolina Community College System
Executive Summary

Attached are the results of a survey sent to deans and directors at each community college in the North Carolina Community College System. The survey was prepared by Project Health to gather data that might assist in the selection of Project Health fellows awarded to nursing faculty seeking Master of Nursing degrees. The following table reflects the data complied by Diane Steinbeiser, Program Health Coordinator. Forty-two of the 58 community colleges surveyed returned data used in the attached document.

The data reflects the following:

- Total number of Associate Degree Nursing Programs = 55
- Total number of Practical Nursing Programs = 39
- Total number of full-time vacancies in nursing programs = 17
- Total number of part-time vacancies in nursing programs = 50

Faculty Shortages
Associate Degree Nursing (ADN) and Practical Nursing Programs (PN)
North Carolina Community Colleges
November 2006

College	Existing Programs		Faculty Vacancies	
	ADN	PN	Full-Time	Part-time
Alamance Community College	X		N/R	N/R
Asheville-Buncombe Technical Community College	X	X	1	4
Beaufort Community College	X	X	0	1
Bladen Community College	X	X	0	0
Blue Ridge Community College	X		1	0
Brunswick Community College	X	X	0	2
Caldwell Community College	X		2	0
Cape Fear Community College	X	X	0	0
Carteret Community College	X	X	0	0
Catawba Valley Community College	X		1	2
Central Carolina Community College	X	X	1	2
Central Piedmont Community College	X		1	0
Cleveland Community College	X	X	N/R	N/R
Coastal Community College	X	X	0	2
College of the Albemarle	X	X	N/R	N/R
Craven Community College	X	X	0	2
Davidson Community College	X	X	N/R	N/R
Durham Technical Community College	X	X	N/R	N/R
Edgecombe Community College	X	X	1	0
Fayetteville Technical Community College	X	X	0	0
Forsyth Technical Community College	X	X	N/R	N/R
Gaston Community College	X	X	0	0
Guilford Technical Community College	X	X	0	0
Halifax Community College	X	X	0	0
Haywood Community College	X		N/R	N/R
Isothermal Community College	X	X	0	0
James Sprunt Community College	X	X	N/R	N/R
Johnston Community College	X		0	0
Lenoir Community College	X	X	0	0
Martin Community College		X	N/R	N/R
Mayland Community College	X	X	1	0
McDowell Technical Community College	X	X	0	0
Mitchell Community College	X		0	10
Montgomery Community College		X	0	1
Nash Community College	X	X	N/R	N/R

College	Existing Programs		Faculty Vacancies	
	ADN	PN	Full-Time	Part-time
Pamlico Community College			N/R	N/R
Piedmont Community College	X		1	2
Pitt Community College	X		0	0
Randolph Community College	X		0	0
Richmond Community College	X	X	0	0
Roanoke-Chowan Community College	X		2	0
Robeson Community College	X		0	0
Rockingham Community College	X	X	N/R	N/R
Rowan-Cabarrus Community College	X	X	N/R	N/R
Sampson Community College	X	X	0	2
Sandhills Community College	X	X	0	0
South Piedmont Community College	X	X	1	0
Southeastern Community College	X	X	N/R	N/R
Southwestern Community College	X	X	N/R	N/R
Stanly Community College	X		N/R	N/R
Surry Community College	X	X	0	5
Tri-County Community College	X		0	0
Vance-Granville Community College	X	X	0	0
Wake Technical Community College	X		2	14
Wayne Community College	X	X	0	0
Western Piedmont Community College	X		0	0
Wilkes Community College	X		0	0
Wilson Technical Community College	X	X	1	0
Totals	**55**	**39**	**16**	**49**

N/R refers to colleges who did not send a response to the Project Health Survey regarding vacancies in the nursing curriculum.