GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 1995

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SENATE BILL 784
Judiciary II/Election Laws Committee Substitute Adopted 6/13/95

Short Title: Health Care Reform/HPC. (Public)

Sponsors:

Referred to: Appropriations

April 24, 1995

A BILL TO BE ENTITLED

AN ACT TO IMPLEMENT CERTAIN HEALTH CARE REFORM RECOMMENDATIONS OF THE NORTH CAROLINA HEALTH PLANNING COMMISSION.

The General Assembly of North Carolina enacts:

PART I. – INSURANCE REFORM

Section 1.1. Article 3 of Chapter 58 of the General Statutes is amended by adding a new section to read:

"**§ 58-3-173. Guaranteed renewability; provisions.**

(a) As used in this section:

(1) 'Health benefit plan' means a plan covering a group of persons and in the form of: an accident and health insurance policy or certificate; a nonprofit hospital or medical service corporation contract; a health maintenance organization subscriber contract; a plan provided by a multiple employer welfare arrangement; or a plan provided by another benefit arrangement, to the extent permitted by the Employee Retirement Income Security Act of 1974, as amended, or by other

federal law or regulation. 'Health benefit plan' does not mean any of the following kinds of insurance:

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

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

(b) An insurer shall not modify any health benefit plan with respect to any insured through riders, endorsements, or otherwise, in order to restrict or exclude coverage for certain diseases or medical conditions otherwise covered by the health benefit plan.

(c) Renewal of the health benefit plans shall be guaranteed by the insurer except:

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

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

(3) When the insurer ceases providing health benefit plans, provided notice of the decision to cease providing health benefit plans is given to the Commissioner and to the policyholder or contract holder six months before the renewal of the health benefit plan would have taken effect."

Sec. 1.2. G.S. 58-50-130(a)(2) reads as rewritten:

"(2) In determining whether a preexisting-conditions provision applies to an eligible employee or to a dependent, all health benefit plans shall credit the time the person was covered under a previous group health benefit plan if the previous coverage was continuous to a date not more than 60 days before the effective date of the new coverage, exclusive of any applicable waiting period under the plan. As used in this subdivision with respect to previous coverage, 'health benefit plan' is not limited to plans subject to this act under G.S. 58-50-115."

Sec. 1.3. G.S. 58-51-80(b)(3) reads as rewritten:

"(3) Policies may contain a provision limiting coverage for preexisting conditions. Preexisting conditions must be covered no later than 12 months after the effective date of coverage. Preexisting conditions are

defined as 'those conditions for which medical advice or treatment was received or recommended or which could be medically documented within the 12-month period immediately preceding the effective date of the person's coverage.' Preexisting conditions exclusions may not be implemented by any successor plan as to any covered persons who have already met all or part of the waiting period requirements under any ~~prior group~~ previous plan. Credit must be given for that portion of the waiting period which was met under the ~~prior~~ previous plan. As used in this subdivision, a 'previous plan' includes any health benefit plan provided by a health insurer, as those terms are defined in G.S. 58-51-115, or any government plan or program providing health benefits or health care. For employer groups of 50 or more ~~persons:~~ persons and for groups under subdivision (1a) of this subsection and under G.S. 58-51-81: In determining whether a preexisting condition provision applies to an eligible ~~employee~~ employee, association member, student, or to a dependent, all health benefit plans shall credit the time the person was covered under a previous ~~group health benefit~~ plan if the previous plan's coverage was continuous to a date not more than 60 days before the effective date of the new coverage, exclusive of any applicable waiting period under the new coverage."

Sec. 1.4. G.S. 58-51-80(h) reads as rewritten:

"(h) Nothing contained in this section ~~shall be deemed applicable~~ applies to any contract issued by any corporation defined in ~~Articles~~ Article 65 ~~and 66~~ of this Chapter. Subdivision (b)(3) of this section applies to MEWAs, as defined in G.S. 58-49-30(a)."

Sec. 1.5. G.S. 58-65-60(e)(2) reads as rewritten:

"(2) Employer master group contracts may contain a provision limiting coverage for preexisting conditions. Preexisting conditions must be covered no later than 12 months after the effective date of coverage. Preexisting conditions are defined as 'those conditions for which medical advice or treatment was received or recommended or which could be medically documented within the 12-month period immediately preceding the effective date of the person's coverage.' Preexisting conditions exclusions may not be implemented by any successor plan as to any covered persons who have already met all or part of the waiting period requirements under any ~~prior group~~ previous plan. Credit must be given for that portion of the waiting period which was met under the ~~prior~~ previous plan. As used in this subdivision, a 'previous plan' includes any health benefit plan provided by a health insurer, as those terms are defined in G.S. 58-51-115, or any government plan or program providing health benefits or health care. For employer groups of 50 or more persons: In determining whether a preexisting condition provision applies to an eligible employee or to a dependent, all health benefit plans shall credit the time the person was

covered under a previous ~~group health benefit~~ plan if the previous plan's coverage was continuous to a date not more than 60 days before the effective date of the new coverage, exclusive of any applicable waiting period under the new coverage."

Sec. 1.6. G.S. 58-67-85(c) reads as rewritten:

"(c) Employer master group contracts may contain a provision limiting coverage for preexisting conditions. Preexisting conditions must be covered no later than 12 months after the effective date of coverage. Preexisting conditions are defined as 'those conditions for which medical advice or treatment was received or recommended or which could be medically documented within the 12-month period immediately preceding the effective date of the person's coverage.' Preexisting conditions exclusions may not be implemented by any successor plan as to any covered persons who have already met all or part of the waiting period requirements under any ~~prior group~~ previous plan. Credit must be given for that portion of the waiting period which was met under the ~~prior~~ previous plan. As used in this subsection, a 'previous plan' includes any health benefit plan provided by a health insurer, as those terms are defined in G.S. 58-51-115, or any government plan or program providing health benefits or health care. ~~For employer groups of 50 or more persons:~~ In determining whether a preexisting condition provision applies to an eligible employee or to a dependent, all health benefit plans shall credit the time the person was covered under a previous ~~group health benefit~~ plan if the previous plan's coverage was continuous to a date not more than 60 days before the effective date of the new coverage, exclusive of any applicable waiting period under the new coverage."

Sec. 1.7. Article 3 of Chapter 58 of the General Statutes is amended by adding a new section to read:

"**§ 58-3-185. Excess or stop loss coverage.**

Insurance against the risk of an economic loss assumed by a plan sponsor under a less than fully underwritten employee health benefit plan is subject to the following:

(1) The policy must be issued by a licensed insurer to the employer, trustee, other sponsor of the plan, or the plan itself for the purpose of insuring the purpose or plan but not for the purpose of insuring the employees, members, or participants;

(2) Payment by the insurer must be made to the employer, to the trustee or other sponsor of the plan, or to the plan itself, but not to the employees, members, participants, or health care providers;

(3) If the policy establishes an aggregate attaching point or retention, the point or retention may not be less than the greater of:

a. One hundred twenty percent (120%) of the expected claims against the health benefit plan; or

b. One hundred fifty thousand dollars ($150,000) for one plan year; and

(4) If the policy establishes an attaching point or retention applicable to each individual, the point or retention must not be less than twenty-five thousand dollars ($25,000)."

Sec. 1.8. G.S. 58-51-15(a)(2)b. reads as rewritten:

"b. ~~No claim for loss incurred or disability (as defined in the policy) commencing after two years from the date of issue of this policy shall be reduced or denied on the ground that a disease or physical condition not excluded from coverage by name or specific description effective on the date of loss had existed prior to the effective date of coverage of this policy.~~ This policy contains a provision limiting coverage for preexisting conditions. Preexisting conditions must be covered no later than one year after the effective date of coverage. Preexisting conditions are defined as 'those conditions for which medical advice or treatment was received or recommended or that could be medically documented within the one-year period immediately preceding the effective date of the person's coverage.' Preexisting conditions exclusions may not be implemented by any successor plan as to any covered persons who have already met all or part of the waiting period requirements under any previous plan. Credit must be given for that portion of the waiting period that was met under the previous plan. As used in this policy, the term 'previous plan' includes any health benefit plan provided by a health insurer, as those terms are defined in G.S. 58-51-115, or any government plan or program providing health benefits or health care. In determining whether a preexisting condition provision applies to an insured person, all health benefit plans must credit the time the person was covered under a previous plan if the previous plan's coverage was continuous to a date not more than 60 days before the effective date of the new coverage, exclusive of any applicable waiting period under the new coverage."

Sec. 1.9. (a) **Standardized benefit plans required.** Effective January 1, 1997, all entities licensed to provide group and nongroup health insurance or health benefit plans, hereinafter "health insurer", in this State shall offer on a guarantee-to-issue and guaranteed renewability basis at least three different health benefit plan products standardized according to coverage and premium rating structure.

(b) **Committee to design and evaluate standardized plans.** The Commissioner of Insurance shall appoint a committee to design the three standardized health insurance products required under subsection (a) of this section. Membership on the Committee shall include, in relatively equal proportions, representatives of business, health insurers, health care providers, and consumers. The Committee shall periodically review the products offered and shall eliminate and replace those that have proven to be unmarketable. The review shall be conducted annually during the first three years of implementation and biannually thereafter.

(c) **Three types of standardized plans.** The purpose of standardized plan offerings is to enable consumers and payers to make like comparisons of costs and benefits among different plans. To this end, two of the three types of standardized products required to be offered by each health insurer are as follows:

(1) The small group standard product, developed in accordance with G.S. 58-50-125.

(2) One plan which shall include coverage of preventive primary, acute and chronic care, and mental health and substance abuse services. Mental health and substance abuse services shall be subject to case management and the same cost-sharing requirements as other nonpreventive medical services but without dollar or day limits. Preventive services shall be covered as recommended by the U.S. Preventive Services Task Force, with a periodicity schedule listed in "Preventive Services in the Clinical Setting, What Works and What It Costs", U.S. Department of Health and Human Services, Public Health Service, May 1993, with no cost-sharing.

Sec. 1.10. G.S. 58-50-130(a)(5) reads as rewritten:

"(5) Notwithstanding any other provision of this Chapter, no small employer carrier, insurer, subsidiary ~~or~~ of an insurer, or controlled individual of an insurance holding company shall act as an administrator or claims paying agent, as opposed to an insurer, on behalf of small groups which, if they purchased insurance, would be subject to this section. ~~No small employer carrier, insurer, subsidiary of an insurer, or controlled individual of an insurance holding company shall provide stop loss, catastrophic, or reinsurance coverage to small employers that does not comply with the underwriting, rating, and other applicable standards in this Act.~~"

Sec. 1.11. Chapter 1 of the General Statutes is amended by adding the following new Article to read:

"**ARTICLE 24A.**

"**ENFORCEMENT OF ASSIGNMENTS.**

"**§ 1-246.1. Assignment of proceeds of personal injury claims.**

No assignment of the proceeds of a claim for personal injury shall be enforceable against any payor of any sums paid as damages for personal injury unless the assignment is signed by the injured person and served upon the payor by certified mail, return receipt requested."

PART II. – MALPRACTICE CASES/ALTERNATIVE DISPUTE RESOLUTION

Sec. 2.1. The Administrative Office of the Courts shall study the efficiency and effectiveness of requiring that parties to medical malpractice actions attempt to resolve their dispute through alternative dispute resolution proceedings before proceeding to trial. The study shall specifically address whether mandatory alternative dispute resolution is appropriate for all medical malpractice cases.

The Administrative Office of the Courts shall report its findings and recommendations to the General Assembly not later than May 1, 1996. The AOC shall indicate in its report whether legislation is necessary to carry out its recommendations.

PART III. – LOAN GUARANTEES/RURAL HEALTH CARE FACILITIES

Sec. 3.1. G.S. 131A-4 is amended by inserting a new subdivision to read:

"(8a) To provide at its discretion, loan guarantees of principal and interest in an aggregate amount not exceeding seventy-five percent (75%) of the principal amount borrowed by any public or nonprofit agency for rural hospitals and other health care facilities in underserved areas for the development, expansion, renovation, or equipping of physical facilities for other uses approved by the Commission. The total amount of such guarantees shall not exceed the amount of funds appropriated for this purpose, including any interest earnings thereon, plus any other funds the Commission receives and designates for this purpose. For purposes of this subdivision, the term 'rural hospitals and other health care facilities in underserved areas' means any health care facilities located in a county with a population, according to the latest federal census, of less than fifty thousand (50,000)."

PART IV. – NORTH CAROLINA HEALTH PLANNING COMMISSION REORGANIZATION

Sec. 4.1. G.S. 143-611 reads as rewritten:

"**§ 143-611. Commission established; members; terms of office; quorum; compensation.**

(a) Establishment. – There is established the North Carolina Health Planning Commission with the powers and duties specified in this Article. The Commission shall be located within the Office of the Secretary, Department of Human Resources, for organizational, budgetary, and administrative purposes.

(b) Membership and Terms. – The Commission shall consist of 16 members, as follows:

(1) The ~~Governor;~~ Governor or the Governor's designee;
(2) The Lieutenant Governor;
(3) The Speaker of the House of Representatives;
(4) The President Pro Tempore of the Senate;
(5) ~~Five~~ Four members appointed by the Speaker of the House of Representatives, at least two of whom are members of the House of Representatives at the time of appointment; ~~appointed by the Speaker of the House of Representatives;~~
(6) ~~Five~~ Four members appointed by the President Pro Tempore of the Senate, at least two of whom are members of the Senate at the time of the appointment; and ~~appointed by the President Pro Tempore of the Senate; and~~

~~(7) The following nonvoting members, ex officio:~~
~~a. The Secretary of the Department of Environment, Health, and Natural Resources; and~~
~~b. The Secretary of the Department of Human Resources.~~
(7a) Four members appointed by the Governor, two of whom shall be members of the majority party in this State and two of whom shall be members of the minority party in this State.

Members shall serve two-year terms. Vacancies in membership shall be filled by the appointing authority in accordance with this section.

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

(d) Meetings. – The Governor shall convene the Commission. Meetings shall be held as often as necessary, but not less than six times a year.

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

Sec. 4.2. G.S. 143-612 reads as rewritten:

"**§ 143-612. Powers and duties of the Commission.**

(a) Administrative Powers. – The Commission shall have the following administrative powers:

(1) To appoint a director, who shall be exempt from the State Personnel Act, and to employ other staff as it deems necessary, subject to the State Personnel Act, and to fix their compensation;
(2) To enter into contracts to carry out the purposes of this Article;
(3) To conduct investigations and inquiries and compel the submission of information and records the Commission deems necessary; and
(4) To accept grants, contributions, devises, bequests, and gifts for the purpose of providing financial support to the Commission. Such funds shall be retained by the Commission.

(b) Plan Development. – The Commission may develop a Plan for submission to the General Assembly. If the Commission develops a Plan in accordance with G.S. ~~58-68-23,~~ 58-68A-10, the Plan may incorporate the following:

~~(1) Annual review of the benefits package;~~
~~(2) Annual budget targets;~~
(3) Cost-containment ~~measures to meet established annual budget targets;~~ measures;
~~(4) Independent actuarial cost estimates for the recommended benefit package;~~
(5) The amount of appropriations needed to finance the Plan;
(6) The methodology to be used in making risk-adjusted payments to the community health plans;

(7) The standards for eligibility for the Plan in addition to those contained in G.S. ~~58-68-22(3)~~ 58-68A-5(3) and G.S. 143-610(3);

(8) Accessibility to health care in rural and medically underserved areas through the enhancement of provider payments, requiring community health plans to provide services throughout their area, or by any other reasonable means;

(9) Supplemental health benefits for all eligible residents including employees of business entities; and

(10) The economic impacts of implementing the Plan, including overall costs to the State economy, costs to the State's business economy, costs to the State, impact on future State economic development, immediate effects on the job market in the State, and a 10-year projection of these items if the Plan is not implemented.

(c) Plan Study. – The Commission ~~shall~~ may also study the following issues and may recommend to the General Assembly actions to address these issues:

(1) The steps necessary to include the populations served by Medicaid, including a statement of any necessary federal waivers;

(2) The steps necessary to obtain an exemption from the federal Employee Retirement and Income Security Act (ERISA);

(3) Examine the roles of other existing publicly financed systems of health coverage such as Medicare, federal employee health benefits, health benefits for armed services members, the Veterans Administration, the CHAMPUS program (10 U.S.C. § 1071 et seq.), and any other health benefits currently mandated by State or federal law or funded by State agencies;

(4) Whether existing retirement health benefits may be included in the Plan;

(5) The mechanisms for ensuring that the Plan will provide appropriate access to quality medical services for all eligible residents;

(6) The means by which the Plan will ensure that the needs of special populations of eligible residents such as low-income persons, people living in rural and underserved areas, and people with disabilities and chronic or unusual medical needs will be met;

(7) The role of the existing county health care system in the Plan;

(8) Proposals for consolidation of the health care components of workers' compensation and automobile insurance with the health coverage provided under the Plan to avoid duplication of coverage;

(9) The appropriate means of financing medical education and medical research;

(10) The appropriate method of collecting data for both quality assurance and cost containment, and in guiding the proliferation of new medical technologies;

(11) The means by which North Carolina's need for long-term care services can best be met, including an examination of the appropriateness and availability of home and community-based services;

~~(12) Whether medical malpractice tort reforms are needed, and, if so, the tort reforms needed;~~

~~(13) The development of medical practice parameters;~~

(14) The need for rate-setting in areas where sufficient competition does not exist;

(15) The need for the collection of data prior to implementation of the Plan and develop, if necessary, recommendations for the collection of such data;

(16) The impact of the Plan on small businesses and methods to alleviate undue financial burdens on small businesses, including, but not limited to, a specified monthly level of payroll upon which no assessment is made;

(17) The impact of the Plan on continued group health insurance for large groups;

(18) The use of licensed insurance agents and producers in the enrollment, education, and provision of service to eligible residents;

(19) The need for and methods to accomplish global budgeting;

(20) Methods to ensure adequate primary care for all eligible residents, and appropriate compensation for primary care services to achieve that end;

(21) Methods to increase the number of mobile health care units that provide services to communities that are underserved with respect to health care;

(22) The impact on health care cost and efficiency of rule changes made by State and local government agencies pertaining to health care services. The study shall include the impact of the frequency of such rule changes;

(23) The relationship between the Plan, regional health plan purchasing cooperatives, ~~community health districts,~~ a Department of Health, the Commission, and the Health Care Purchasing Alliances established under G.S. 143-627;

(24) The establishment of a health care trust fund in the State Treasurer's Office to serve as a depository for the following:

a. All revenues collected from taxes and other sources enacted for the purpose of funding the Plan;

b. All federal payments received as a result of any waiver of requirements granted by the United States Secretary of Health and Human Services under health care programs established under Title XIX of the Social Security Act, as amended; and

c. All moneys appropriated by the North Carolina General Assembly for carrying out the purposes of the Plan.

(25) Identification of need for additional benefits and population-based services to be offered in the community, based on the established priorities for improving community health status in the community; and

(26) Mechanisms to provide for the continuing education and training of health care personnel. ~~personnel and community health district boards; and~~

~~(27) Review of community health districts' reports and establishment of priorities for programs and financing to address community health district needs.~~

(c1) Other Duties. – In addition to other duties established under this Article, the Commission shall do the following:

(1) Study the quality of care provided in the State and conduct necessary activities to assure that health care provided through the public and private health care systems and by health care providers is of sufficient quality to adequately serve the health needs of the citizenry and to improve overall health status of the State's population;

(2) Determine the feasibility of establishing a procedure for the development and issuance of report cards that are consistent statewide and that enable consumers and payers to compare the quality and value of services provided by different insurance carriers and health plans. The study shall include an examination of information already collected by private organizations providing quality review;

(3) Study ways to maximize employer-based coverage;

(4) Study and report on trends in the numbers of uninsured and underinsured persons and barriers to access by these persons;

(5) Monitor efforts to increase the purchasing power of government health programs;

(6) Study ways to maintain emergency medical services when hospital beds are reconfigured;

(7) Monitor how closely health expenditures for both the public and private sectors relate to the rate of real economic growth and determine the cumulative effect of the State's and private sector's various cost containment measures. The Commission shall develop cost assessments for the following:

a. Total expenditures,

b. Public expenditures (State, local, federal), including Medicaid and State Health Plan benefits,

c. Private expenditures, including amounts for traditional insurance, HMOs, individual out-of-pocket and uncompensated care, and

d. Types of service, including primary, secondary, or tertiary care, physician or hospital care.

These cost assessment categories, as well as others deemed appropriate by the responsible agency, should be crosscut by

both public and private source of payment and type of service provider.

In evaluating the data, the Commission shall determine the sectors of the health care system that are growing the fastest and shall educate the public and government leaders about the real cost of delivering health care to North Carolinians.

(8) Review current conflict-of-interest laws;

(9) Assess the impact of locum tenens programs;

(10) Review proposals on collaborative practice;

(11) Study effectiveness of different types of preventive health services;

(12) Develop other ways to expand coverage to uninsured persons; and

(13) Monitor the number of persons who lack access to primary care providers.

(d) Notwithstanding any other provision in this Article or Article 68A of Chapter 58 of the General Statutes, the Commission may develop its own health care proposals or plans or make any other recommendations to the General Assembly.

(e) The Commission shall appoint such advisory, technical, and professional panels as it deems necessary to advise it on the performance and administration of its functions. Each panel shall consist of experts drawn from the health professions, health educational institutions, providers of services, insurers, and other sources, including consumers. ~~At least three panels shall be established to advise, consult with, and make recommendations to the Commission on the development, maintenance, funding, evaluation, and priorities of community health services.~~"

Sec. 4.3. The Commission shall include in its reports to the General Assembly proposed legislation needed to implement recommendations of the Commission.

Sec. 4.4. (a) The North Carolina Health Planning Commission shall evaluate and report on how governmental programs could become more prudent purchasers and arrangers of health care.

(b) The Fiscal Research Division of the Legislative Services Office shall identify total health care dollars spent for services provided under the following:

(1) Medicaid program,

(2) Teachers' and State Employees' Comprehensive Major Medical Plan,

(3) Mental Health, Developmental Disabilities, and Substance Abuse Services program,

(4) Local and statewide public health programs,

(5) Health services provided through public school programs and the Department of Correction, and

(6) Other publicly funded health programs.

(c) Using the information provided under subsection (b) of this section, as well as other information obtained by the Commission, the Commission shall report its findings and recommendations to the Governor, the Joint Legislative Commission on Governmental Operations, and the North Carolina Health Planning Commission, not later than May 1, 1996.

PART V. – HEALTH PROFESSIONAL LICENSING BOARD REPORTING

Sec. 5.1. Effective October 1, 1995, Chapter 93B of the General Statutes is amended by adding the following new section to read:

"**§ 93B-12. Information from licensing boards having authority over health care providers.**

(a) Every occupational licensing board having authority to license physicians, physician assistants, nurse practitioners, and nurse midwives in this State shall modify procedures for license renewal to include the collection of information specified in this section for each board's regular renewal cycle. The purpose of this requirement is to assist the State in tracking the availability of health care providers to determine which areas in the State suffer from inequitable access to specific types of health services and to anticipate future health care shortages which might adversely affect the citizens of this State. Occupational licensing boards, in consultation with the North Carolina Health Planning Commission, shall collect, report, and update the following information:

(1) Area of health care specialty practice;

(2) Address of all locations where the licensee practices; and

(3) Other information the occupational licensing board in consultation with the North Carolina Health Planning Commission deems relevant to assisting the State in achieving the purpose set out in this section.

(b) Every occupational licensing board required to collect information pursuant to subsection (a) of this section shall report and update the information on an annual basis to the North Carolina Health Planning Commission. Information provided by the occupational licensing board pursuant to this subsection may be provided in such form as to omit the identity of the health care licensee."

PART VI. – PRIMARY CARE PROVIDERS

Sec. 6.1. G.S. 143-613 reads as rewritten:

"**§ 143-613. Medical education; primary care ~~physicians.~~ physicians and other providers.**

(a) In recognition of North Carolina's need for primary care physicians, Bowman Gray School of Medicine and Duke University School of Medicine shall each prepare a plan with the goal of encouraging North Carolina residents to enter the primary care disciplines of general internal medicine, general pediatrics, family medicine, obstetrics/gynecology, and combined medicine/pediatrics and to strive to have at least fifty percent (50%) of North Carolina residents graduating from each school entering these disciplines. These schools of medicine shall present their plans to the Board of Governors of The University of North Carolina by April 15, ~~1994.~~ 1996, and shall update and present their plans every two years thereafter. The Board of Governors shall report to the Joint Legislative Education Oversight Committee by May 15, ~~1994,~~ 1996, and every two years thereafter on the status of these efforts to strengthen primary health care in North Carolina.

(b) The Board of Governors of The University of North Carolina shall set goals for the Schools of Medicine at the University of North Carolina at Chapel Hill and the School of Medicine at East Carolina University for increasing the percentage of graduates who enter residencies and careers in primary care. A minimum goal should be at least sixty percent (60%) of graduates entering primary care disciplines. Each school shall submit a plan with strategies to reach these goals of increasing the number of graduates entering primary care disciplines to the Board by April 15, ~~1994.~~ 1996, and shall update and present the plans every two years thereafter. The Board of Governors shall report to the Joint Legislative Education Oversight Committee by May 15, ~~1994,~~ 1996, and every two years thereafter on the status of these efforts to strengthen primary health care in North Carolina.

Primary care shall include the disciplines of family medicine, general pediatric medicine, general internal medicine, internal medicine/pediatrics, and obstetrics/gynecology.

(b1) The Board of Governors of The University of North Carolina shall set goals for State-operated health professional schools that offer training programs for licensure or certification of physician assistants, nurse practitioners, and nurse midwives for increasing the percentage of the graduates of those programs who enter clinical programs and careers in primary care. Each State-operated health professional school shall submit a plan with strategies for increasing the percentage to the Board by April 15, 1996, and shall update and present the plan every two years thereafter. The Board of Governors shall report to the Joint Legislative Education Oversight Committee by May 15, 1996, and every two years thereafter on the status of these efforts to strengthen primary health care in North Carolina.

(c) The Board of Governors of The University of North Carolina shall further initiate whatever changes are necessary on admissions, advising, curriculum, and other policies for State-operated medical schools and health professional schools to ensure that larger proportions of ~~medical~~ students seek residencies and clinical training in primary care disciplines. The Board shall work with the Area Health Education Centers and other entities, adopting whatever policies it considers necessary to ensure that residency and clinical training programs have sufficient ~~medical~~ residency and clinical positions for ~~medical school~~ graduates in these primary care specialties. As used in this subsection, health professional schools are those schools or institutions that offer training for licensure or certification of physician assistants, nurse practitioners, and nurse midwives.

(d) The progress of the private and ~~public~~ State-operated medical schools and State-operated health professional schools towards increasing the number and proportion of graduates entering primary care shall be monitored annually by the Board of Governors of The University of North Carolina. Monitoring data shall include (i) the entry of State-supported ~~medical~~ graduates into primary care ~~residencies,~~ residencies and clinical training programs, and (ii) the specialty practices by a physician and each midlevel provider who were State-supported graduates as of a date five years after graduation. The Board of Governors shall certify data on graduates, their ~~residencies,~~ residencies and clinical training programs, and subsequent careers by October 1 of each

calendar year, beginning in October of 1995, to the Fiscal Research Division of the Legislative Services Office and to the Joint Legislative Education Oversight Committee.

(e) The information provided in subsection (d) of this section shall be made available to the Appropriations Committees of the General Assembly for their use in future funding decisions on medical and health professional education."

PART VII. – PUBLIC HEALTH STUDY COMMISSION

Sec. 7.1. (a) G.S. 120-196 reads as rewritten:

"**§ 120-196. Commission duties.**

The Commission shall study the availability and accessibility of public health services to all citizens throughout the State. In conducting the study the Commission shall:

(1) Determine whether the public health services currently available in each county or district health department conform to the mission and essential services established under G.S. 130A-1.1;

(2) Study the workforce needs of each county or district health department, including salary levels, professional credentials, and continuing education requirements, and determine the impact that shortages of public health professional personnel have on the delivery of public health services in county and district health departments;

(3) Review the status and needs of local health departments relative to facilities, and the need for the development of minimum standards governing the provision and maintenance of these facilities;

(4) Propose a long-range plan for funding the public health system, which plan shall include a review and evaluation of the current structure and financing of public health in North Carolina and any other recommendations the Commission deems appropriate based on its study activities; ~~and~~

(5) Conduct any other studies or evaluations the Commission considers necessary to effectuate its ~~purpose.~~ purpose; and

(6) Study the capacity of small counties to meet the core public health functions mandated by current State and federal law. The Commission shall consider whether the current county and district health departments should be organized into a network of larger multidistrict community administrative units. In making its recommendations on this study, the Commission shall consider whether the State should establish minimum populations for local health departments, and if so, shall recommend the number of and configuration for these multicounty administrative units and shall recommend a series of incentives to ease county transition into these new arrangements."

(b) Section 8.1 of Chapter 771 of the 1993 Session Laws reads as rewritten:

"Sec. 8.1. This act is effective upon ratification. ~~Part II of this act is repealed on June 30, 1995.~~"

PART VIII. – APPROPRIATIONS

Sec. 8.1. Primary Care Funds. (a) The Department of Human Resources may combine and allocate funds appropriated for the Office of Rural Health and Resource Development for recruitment and retention of primary care providers in medically underserved areas into one Provider Incentive Fund. Funds in the Provider Incentive Fund may be allocated for purposes of enhancing recruitment and retention of primary care providers in medically underserved areas and for other purposes related to the enhancement of health services to medically underserved communities.

(b) There is appropriated from the General Fund to the Department of Human Resources, Office of Rural Health and Resource Development, the sum of five hundred thousand dollars ($500,000) for the 1995-96 fiscal year and the sum of five hundred thousand dollars ($500,000) for the 1996-97 fiscal year for the development and implementation of a locum tenens program in the Office of Rural Health and Resource Development. Funds shall be used to provide interim clinical services to patients in medically underserved areas during the period that the physicians and other health care providers who serve these patients are away from their practice because of illness, continuing medical education, or vacation.

(c) The Department of Human Resources, Office of Rural Health and Resource Development, shall award grants from the Aid for Clinic Construction Program and the Operational Subsidy Program. Grant funds awarded from these programs shall be used to assist medically underserved communities in constructing and operating health centers in communities where no health centers currently exist, and for capital improvements and operating expenses for existing rural health centers. Funds allocated for capital expenditures shall be matched by local funds.

(d) There is appropriated from the General Fund to the Department of Human Resources, Office of Rural Health and Resource Development, the sum of two million dollars ($2,000,000) for the 1995-96 fiscal year and the sum of two million dollars ($2,000,000) for the 1996-97 fiscal year for the allocation of grant funds for the construction and operation of new health centers and for the expansion of existing health centers in medically underserved communities. Of the funds appropriated under this subsection, not more than one million dollars ($1,000,000) may be allocated in each fiscal year for grants from the Aid for Clinic Construction Program and not more than one million dollars ($1,000,000) in each fiscal year may be allocated for grants from the Operational Subsidy Program.

Sec. 8.2. Medicaid Expansion Funds. There is appropriated from the General Fund to the Department of Human Resources the sum of six million three hundred eight thousand seven hundred twenty-four dollars ($6,308,724) for the 1995-96 fiscal year and the sum of thirteen million four thousand seventy-one dollars ($13,004,071) for the 1996-97 fiscal year to be allocated for coverage to pregnant women and to children as follows:

(1) $4,236,767 for the 1995-96 fiscal year and $8,794,656 for the 1996-97 fiscal year for 12 months' postpartum coverage of women whose family incomes are equal to or less than one hundred thirty-three percent (133%) of the Federal Poverty Level as revised each April 1. On

approval from the Health Care Financing Agency, the Department of Environment, Health, and Natural Resources shall transfer to the Department of Human Resources the sum of three hundred thirty-one thousand six hundred thirty-six dollars ($331,636) in the 1995-96 fiscal year and six hundred sixty-three thousand two hundred seventy-two dollars ($663,272) in the 1996-97 fiscal year. Of the funds allocated under this subdivision for the 1995-97 fiscal biennium, the Department shall allocate to counties as a grant-in-aid sufficient funds to offset the cost of providing benefits to women as a result of this expansion. The grant to each county shall be calculated by a formula that estimates the county's relative share of the statewide total of new eligibles who qualify due to this program expansion. In subsequent years, fifteen percent (15%) of the nonfederal share shall be paid by counties;

(2) $1,971,957 for the 1995-96 fiscal year and $4,209,415 for the 1996-97 fiscal year for children aged 1 through 5 years with family incomes equal to or less than one hundred fifty percent (150%) of the federal poverty guidelines as revised each April 1. The Department of Environment, Health, and Natural Resources shall transfer to the Department of Human Resources the sum of one million eighty-one thousand eight hundred thirty-three dollars ($1,081,833) for the 1995-96 fiscal year and the sum of one million eighty-one thousand eight hundred thirty-three dollars ($1,081,833) for the 1996-97 fiscal year. Of the funds allocated under this subdivision for each year of the 1995-97 biennium, the Department shall allocate to counties as a grant-in-aid, sufficient funds to offset the cost of providing benefits to children as a result of this expansion. The grant to each county shall be calculated by a formula that estimates the county's relative share of the statewide total of new eligibles who qualify due to this program expansion. In subsequent years, fifteen percent (15%) of the nonfederal share shall be paid by the counties.

Sec. 8.3. Public Health Funds. (a) There is appropriated from the General Fund to the Department of Environment, Health, and Natural Resources, the sum of three million dollars ($3,000,000) for the 1995-96 fiscal year and the sum of three million dollars ($3,000,000) for the 1996-97 fiscal year to be allocated to local governments who apply for funds from the Healthy Community Block Grant Program established pursuant to this section.

(b) There is established in the Department of Environment, Health, and Natural Resources, Office of the State Health Director, the North Carolina Healthy Community Block Grant Program (hereinafter referred to as "Program"). The purpose of the Program is to enable county governments to apply for funds to assist them in addressing public health needs in the county. The Program shall be implemented as follows:

(1) In order to be eligible for funds, a county must apply to the Department and include with the application a plan for meeting local health

priorities determined by the results of a community health assessment conducted by the local health department serving the county and indicating the specific health needs for which funds are applied. A county may receive funds for one or more of the following core public health functions:

a. Assessment of community health status, health services, and needs;
b. Prevention, detection, and remediation of environmental health risks;
c. Monitoring the adequacy of health facilities and health providers to meet the needs of the community;
d. Health data collection and evaluation to measure progress toward health outcome objectives;
e. Promulgation of public health policies and regulations necessary to promote and protect the health of individuals and communities;
f. Communicable disease investigation and control;
g. Community education and advocacy for preventive health services;
h. Provision of essential public health services for all citizens;
i. Outreach to assure access to all basic health services; and
j. Provision of clinical health services as needed to assure primary health care for all citizens.

(2) Funds shall be awarded first on a per capita basis to all eligible counties; if there are funds remaining after all eligible counties have been awarded grants, then the remaining funds may be awarded according to rules established by the Health Services Commission.

(c) The Department shall report to the General Assembly and the Fiscal Research Division of the Legislative Services Office the amount of funds allocated to each county including additional funds awarded, and the specific purposes for which the funds were allocated. The Department's initial report shall be submitted on or before April 1, 1996. Thereafter the report shall be submitted on or before April 1 of each year for which funds were appropriated for that fiscal year for the Program.

Sec. 8.4. Loan Guarantee Funds. There is appropriated from the General Fund to the Department of Human Resources the sum of two million dollars ($2,000,000) for the 1995-96 fiscal year and the sum of two million dollars ($2,000,000) for the 1996-97 fiscal year to carry out the loan guarantees authorized for rural health care facilities under Section 3.1 of this act.

PART
IX. – EFFECT OF HEADINGS

Sec. 9.1. The headings to the Parts of this act are a convenience to the reader and are for reference only. The headings do not expand, limit, or define the text of this act.

PART X. – EFFECTIVE DATE

Sec. 10.1. Sections 8.1 through 8.5 of this act become effective July 1, 1995. The remainder of this act is effective upon ratification.