

11

Health

The 1998 legislative session seems likely to prove extremely important for the health of North Carolina's vulnerable populations. First, the state managed, at the last minute, to qualify for \$80 million of federal money to provide broad health coverage for low-income children. Second, an agreement was reached to ensure that the state receives full value of its investment from Blue Cross/Blue Shield (BC/BS) should it convert to for-profit status. If this happens, BC/BS assets will be deposited in a foundation to meet the health needs of North Carolinians, presumably including the many residents now without health insurance. The same theme, mending the safety net, appears in other significant legislation: expanded Medicaid coverage for elderly and disabled persons, expanded health insurance coverage for teachers and state employees, a state income tax credit for long-term care insurance, a large one-time appropriation for AIDS prescription drugs, and the curbing of state regulation of out-of-state pharmacy deliveries. Another concern, apparent throughout the 1998 Appropriations Act, is the General Assembly's interest in efficiency and accountability from state, local, and private organizations using state funds.

Children's Health Care

Health Insurance Program for Uninsured Children

Whatever the reality, it certainly appeared as if the General Assembly's acceptance of \$80 million from the federal government for this program was not a sure thing. [Additional background on the 1998 extra session that enacted this program is provided in Chapter 1 (The General Assembly).] With little time remaining before the federal deadline, the state agreed to provide \$15.6 million in state matching funds for the remainder of 1998 (the state's share of the cost for the new program is about \$27 million for a complete year) to qualify for the federal funds to provide health insurance for 71,000 children whose family incomes are low but not low enough for Medicaid. S.L. 1998-1 (Ex. Sess.) (S 2). The legislature did not create an entitlement but did expect to be able to cover all who try to enroll. (However, it may be hard to reach eligible children. State officials estimate that 67,000 children eligible for Medicaid are not enrolled in that program.)

For previously uninsured children under age nineteen, the new program (known as Health Choice) covers hospital and outpatient care; immunizations; checkups; surgery; drugs; mental health and substance abuse treatment; equipment; hospice and home health; nursing and lab work; dental, vision, and hearing services; and additional services if a child has special needs. Families with incomes up to 150 percent of the federal poverty level pay nothing; those with incomes between 150 and 200 percent of the poverty level pay an annual enrollment charge (\$50 for one child, \$100 for two or more children), \$5 per doctor visit, and \$6 per prescription.

S.L. 1998-1 also added two members to the Joint Legislative Health Care Oversight Committee (JLHCOC) and established (in art. 71, G.S. Ch. 143) a Commission on Children with Special Needs to “monitor and evaluate services” provided under the program. Section 12.12 of S.L. 1998-212 (S 1366) added a second parent member, to allow representation for both chronically ill children and children with developmental disabilities or behavioral disorders.

Finally, the compromise needed to enact the Health Choice program also created a state income tax credit (estimated cost \$64 million) for middle- to upper-income families (\$60,000 income for a single parent, \$100,000 for a couple) for the cost of health insurance premiums for dependent children. The credit is \$300 for taxpayers with incomes up to 225 percent of the federal poverty level and \$100 for other eligible taxpayers. The state income tax credit for children’s health insurance premiums is also discussed in Chapter 26 (State Taxation).

Continued Medicaid Coverage

Section 12.7 of S.L. 1998-212 (S 1366) provides that “categorically needy” families with children will remain eligible for Medicaid for one year after enrollment, regardless of change in their income or assets. This legislation is discussed in more detail in Chapter 24 (Social Services).

Standards for Access to Health Care

The North Carolina Department of Health and Human Services (DHHS) has until May 1, 1999, to propose to the General Assembly standards for offering all North Carolinians, “especially children,” access to “quality and affordable health care.” S.L. 1998-212, sec. 12.

Maternal and Child Health Pilot Programs

DHHS may let as many as six local health departments create their own maternal and child health pilot programs, using federal block grant funds and state funds from six program sources. A program may focus on improving the health of women of childbearing age, reducing infant deaths and illness, or helping children with chronic handicapping conditions. A health department must still track the money by its original program sources and report on how the added flexibility improves administrative processes, the program and health outcomes. S.L. 1998-212, sec. 12.43.

Teen Pregnancy Prevention

Section 5 of S.L. 1998-212 appropriates \$2 million from the federal Temporary Assistance to Needy Families Block Grant to the DHHS Women’s and Children’s Health Division for teen pregnancy prevention. The division may fund initiatives on adolescent parenting, pregnancy prevention, teen care coordination, and a media campaign to raise awareness in teens and their parents.

Medicaid

Legislation affecting North Carolina's Medicaid program is also discussed in Chapter 24 (Social Services).

Dental Services

Section 12.12C of S.L. 1998-212 (S 1366) requires DHHS, cooperating with the state dental society, to take steps to expand access to dental care for Medicaid patients and report to the House and Senate Appropriations Subcommittees on Human Resources by April 30, 1999.

Elderly and Disabled Persons

Section 12.12D of S.L. 1998-212 directs DHHS to provide Medicaid coverage for elderly and disabled people whose incomes are no greater than the federal poverty level. Expanded Medicaid coverage of low-income elderly and disabled persons is also discussed in Chapter 22 (Senior Citizens) and Chapter 24 (Social Services).

Slowing the Growth of the Medicaid Program

Section 12.5 of S.L. 1998-212 requires DHHS to report to the House and Senate Human Resources Appropriations Committees by February 1, 1999, on how to restrict the growth of the Medicaid program to no more than an 8 percent annual increase by 2001.

Required Fingerprinting

Section 12.26A of S.L. 1998-212 provides that anyone [other than institutionalized adults and persons under the age of eighteen (other than minor parents)] who applies for or receives Medicaid benefits must be fingerprinted and makes fingerprinting a condition of eligibility for these Medicaid applicants, recipients, and all members of their households. The fingerprinting requirements for Medicaid and other public assistance programs are also discussed in Chapter 24 (Social Services).

Oversight of Health Agencies

Medicare PSOs

S.L. 1998-227 (H 74) adds a new Article 17 to G.S. Ch. 131E to create a licensing process for provider sponsored organizations (PSOs) that offer care to Medicare enrollees under the federal government's Medicare Plus Choice program. The most significant aspect of the process approved by the act is that the PSOs, run by doctors and hospitals, will be supervised by the DHHS Division of Medical Assistance (DMA) rather than by the Department of Insurance (DOI), which supervises health maintenance organizations (HMOs). DMA must apply federal standards on solvency and consumer protection, however, and if there are none, the standards applicable to HMOs in North Carolina will apply. In addition, DMA must report quarterly to the Joint Legislative Health Care Oversight Committee on how it regulates PSOs, how its requirements differ from those the DOI imposes on HMOs, the DOI's comments on the solvency of PSO license applicants, PSO efforts to improve community health status, and the development of measurements of health outcomes. (The content of this act first appeared in H 1455 and S 1278.)

Blue Cross/Blue Shield Conversion

The 1997 General Assembly consigned to a commission the highly controversial issue of how BC/BS assets should be handled in the event of a conversion to for-profit status and prevented a conversion's occurring before August 1, 1998. S.L. 1997-483. [For a discussion of this issue in the 1997 legislative session, see Anne Dellinger, "Health," Chapter 11 in *North Carolina Legislation 1997* (Chapel Hill, N.C.: Institute of Government, The University of North Carolina at Chapel Hill, 1997).] S.L. 1998-3 (S 993) incorporates the commission's recommendations, which apply to any medical, dental, or hospital service corporation.

The commission, chaired by Senator Tony Rand and Representative Leo Daughtry, met early in April and agreed, first, that the mission of the foundation to be formed in the event of a conversion would be to "promote the health of the people of North Carolina" and, second, on the selection process for foundation board members. The Attorney General will name the eleven board members from a list of twenty-two candidates produced by an advisory committee consisting of three representatives of business, chosen by N.C. Citizens for Business and Industry; three representatives of medical schools, chosen by the University of North Carolina (UNC) Board of Governors; three representatives of foundations and other nonprofits, chosen by the N.C. Center for Nonprofits; one representative of the N.C. Medical Society; and another representative of the Association of Hospitals and Health Care Networks.

The foundation's assets will equal 100 percent of the fair market value of the nonprofit corporation at the time of conversion. (BC/BS assets are currently estimated at \$1 to \$2 billion.) The foundation must disburse all income, less operating expenses, to further its mission. If the conversion occurred now the foundation would be the second largest in the state and, according to the *News and Observer* (April 8, 1998), one of the twenty-five largest in the United States.

The difficult part of the commission's work was, first, deciding when a conversion takes place triggering the creation of the foundation. Under S.L. 1998-3, a conversion occurs if (1) the corporation obtains 40 percent of its revenues or has 40 percent of its assets in for-profit enterprises; (2) it transfers 10 percent of assets to an out-of-state for-profit business; or (3) it merges with a for-profit or transfers stock to an outside investor. The commission also debated whether to limit Blue Cross's acquisition of for-profit entities and decided against it.

Governance of UNC Hospitals

The UNC Health Care System, created by Section 11.8 of S.L. 1998-212 (S 1366), merges UNC Hospitals and the clinical operations of the UNC-CH medical school and changes the governance of the entity. [This legislation is also discussed in Chapter 12 (Higher Education).] One issue was whether state rules prevented the hospitals from competing effectively. To provide greater administrative flexibility, the system was freed from state rules on personnel, purchasing, construction, and property acquisition (as was the Medical Faculty Practice Plan of the East Carolina University School of Medicine). Another point of discussion was whether UNC Hospitals should be governed largely as a state institution or as part of the university's Chapel Hill campus. It was decided that the system will have its own board chosen by UNC's president and ratified by the UNC Board of Governors. Nominees are generated by the Health Care System board. The president also chooses the system's CEO from two names presented by the UNC-CH chancellor, board of trustees, and the system's board of directors.

Health Insurance

Teachers' and State Employees' Health Plan

Beginning January 1, 1999, the health plan will cover participation in clinical trials if all of the following conditions are met:

- the medical condition is life-threatening;

- the trial is “clearly superior” to nonexperimental treatment;
- clinical and preclinical data show the trial at least as effective as nonexperimental treatment;
- the trial is approved by one of several federal agencies and by institutional review boards;
- the trial is conducted in excellent facilities and by highly qualified personnel;

- the patient meets “substantially all” protocol requirements and agrees to participate; and
 - the expenses are medically necessary and not “customarily funded” by others.
- S.L. 1998-212 (S 1366), sec. 28.29.

Long-Term Care Insurance

Section 29A.6 of S.L. 1998-212 creates a new state income tax credit of 15 percent of the premium cost, up to \$350 a year, for purchase of a policy insuring long-term care for a taxpayer or the taxpayer’s spouse or dependent. It is effective for tax years beginning January 1, 1999, until the tax year beginning January 1, 2003. This legislation is also discussed in Chapter 26 (State Taxation).

Other Health Legislation

Tobacco Negotiations

Before adjourning, the General Assembly took the precaution of creating a settlement reserve fund to receive money that might come to North Carolina as a result of a federal or state settlement with the tobacco companies, legislation, or a court order. S.L. 1998-191 (H 1248). The legislation also states that the General Assembly intends to enact “appropriate tax relief” for payments to tobacco farmers and others who depend on tobacco for their livelihood.

AIDS

The 1998 Appropriations Act, S.L. 1998-212 (S 1366), appropriates \$8 million in one-time funding for the AIDS Drug Assistance Program (ADAP). Section 12.46A of the act directs DHHS to explore several avenues for serving more people through the ADAP and to report on that point and on patient medication usage patterns and compliance with doctors’ recommendations to the House and Senate Human Resources Appropriations Committees by March 15, 1999.

Another provision (S.L. 1998-212, sec. 12.51) requires organizations that contract with the DHHS Division of Epidemiology to provide services to people at high risk of HIV or sexually transmitted disease to report quarterly and provide an annual financial statement and audit report. A nonprofit contractor must also report quarterly to the local health department. DHHS is required to adopt standards and sanctions for grantees. It must adopt standards by April 1, 1999, must include the standards in contracts after 2000, and may not award a contract after 2000 unless a grantee meets the standards. DHHS is required to report to the House and Senate Human Resources Appropriations Committees by May 1, 1999, on the standards, current grantees, and their performance.

Prescription Drug Delivery

Section 12.3B of S.L. 1998-212 amends the Pharmacy Practice Act, Article 4A of G.S. Ch. 90, to allow the Board of Pharmacy to waive pharmacy practice requirements in emergencies declared by the Governor or local authorities so that the public may obtain drugs, devices, and pharmacists’ services. The same section, however, curbs the board’s powers in another regard. The board may not impose restrictions on deliveries from mail-order pharmacies doing business in North Carolina that are greater than those imposed by federal statutes and regulations.

Fees

Section 12.16D of S.L. 1998-212 requires the DHHS Division of Facility Services to propose a fee schedule for its processing and reviewing of construction plans for health-care facilities and

for inspecting them and to submit the proposal by December 1, 1998, to the General Assembly and to the Joint Legislative Health Care Oversight Committee.

Effective January 1, 1999, the fee counties pay for autopsies on residents called for by a medical examiner rises from \$400 to \$1,000. S.L. 1998-212, sec. 29A.10.

Regulation of Massage

S.L. 1998-230 (S 916) requires a license to engage in massage or “bodywork therapy”; establishes a seven-member board appointed by the General Assembly and the Governor; and sets licensure fees and qualifications. The board may adopt rules for approving schools. Eleven grounds for discipline are identified. Counties and municipalities retain concurrent jurisdiction to regulate the practice.

Studies

Although no single act authorized interim studies after the session, a number of provisions in the 1998 Appropriations Act, S.L. 1998-212, call for study of a particular health subject.

- Section 12.12 of S.L. 1998-212 requires DHHS to identify programs that might be reduced or eliminated because of overlap with services provided under the new Health Choice Children’s Health Insurance Program and requires the Office of State Budget and Management (OSBM) to look for duplications of the new program’s functions elsewhere in state government or in private agencies funded by the state. DHHS and OSBM must report to the House and Senate Human Resources Appropriations Committees by March 1, 1999.
- Section 12.12C of S.L. 1998-212 requires DHHS to evaluate and recommend steps for increasing dentists’ participation in Medicaid and report to the House and Senate Human Resources Appropriations Committees by April 30, 1999.
- Section 12.13 of S.L. 1998-212 requires the Joint Legislative Health Care Oversight Committee to consider whether the reimbursement Medicaid pays physicians needs to be increased to that paid by Medicare and identify what Medicaid funds could be used for that purpose. The committee must report to the 1999 General Assembly.
- Section 12.45 of S.L. 1998-212 directs that, to assess maternal outreach programs, DHHS gather data from localities receiving maternal outreach funds and report to the House and Senate Human Resources Appropriations Committees and to the Fiscal Research Division by February 1, 1999.
- Section 12.52 of S.L. 1998-212 instructs DHHS to try to improve the immunization program, particularly distribution of vaccine to providers, and report to the House and Senate Human Resources Appropriations Committees by April 1, 1999. Meanwhile, the Commission for Health Services is directed to create temporary rules and sanctions, and as of March 1, 1999, providers must pay to replace vaccines damaged through improper handling.
- Section 12.2 of S.L. 1998-212 directs DHHS to study the advisability of establishing an Office of Strategic Planning and the costs of doing so and report to the House and Senate Human Resources Appropriations Committees by March 15, 1999.
- Section 12.7 of S.L. 1998-212 requires DHHS to study the effect of continuing Medicaid enrollment for categorically needy families with children and file an interim report October 1, 1999, and a final report January 1, 2000, with the House and Senate Human Resources Appropriations Committees.
- Section 25.1 of S.L. 1998-212 directs OSBM to report by April 1, 1999, to the House and Senate General Government Appropriations Subcommittees on the size, locations, and cost of nursing homes needed for veterans and on the feasibility and cost of alternatives.
- Section 29A.6 of S.L. 1998-212 directs the Legislative Research Commission to study the effectiveness of the long-term care tax credit. DHHS Division of Aging will provide data on the effect of the credit on the state’s Medicaid costs, and the Department of

Revenue will profile the taxpayers claiming the credit. The commission must report the results of its study to the General Assembly in 2004.

Bills Not Enacted

Privacy of Medical Records. Interest groups, a study commission, and legislators invested considerable effort in H 1495 and S 1288, which would have revised the law regarding privacy and disclosure of medical information. In the end, however, the bills were not adopted by either chamber. Business interests and consumer advocates disagreed, particularly on the language governing use of health information for research. Most observers expect to see the bill return next session. [Meanwhile, an important issue in this area, the validity of electronic signatures for medical orders and records, was resolved by the enactment of S.L. 1998-127 (H 1356).]

School Health Clinics. Two proposals affecting school health clinics were considered but were not enacted. One would have allowed the use of Healthy Start funds in school-based health clinics. The second would have amended G.S. 115C-81(e), the School Health Education Act, to prevent students from receiving information about where to obtain an abortion unless the school has written parental consent.

Anne Dellinger