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## Health

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The General Assembly did not ignore health issues this session. A number of areas were tidied up, and certain steps were taken. However, action on a major issue—limitations on the managed care industry—was largely postponed. Another important matter, the details of distribution of tobacco settlement funds to health programs, also was left to the future.

Public health fared reasonably well in the state budget, sustaining no major cuts and making progress in some areas. The Healthy Carolinians program, which helps communities identify the health needs most important to them, received its first state funding—\$1 million. The period for continuation of Medicaid coverage for people leaving public assistance was doubled, from twelve to twenty-four months. Medicaid physician-reimbursement rates were raised to those of Medicare, which should improve access to health care for low-income residents. Preventive dental care was added as a benefit of the Health Choice program for children in low-income families, and school health clinics are now eligible to serve these children. Last session people with AIDS received \$8 million in one-time funding to purchase medication. This time they were awarded continuing funding of \$7 million plus additional federal funding. Low-income elderly residents with cardiovascular disease or diabetes were given a \$.5 million prescription drug subsidy. \$6 million was set aside to relieve families caring for people with developmental disabilities who are waiting for admission to the Community Alternative program, and \$1 million was allocated to improve the level of immunization in the state.

This summary groups the session's activities in the following categories: managed care, prescription drugs, the regulation of health providers, facilities, financing and insurance, medical information, women's health status, and communicable disease. Numerous items identified for further study also are noted.

### **Managed Care**

Several new requirements for managed care were adopted in 1999. S.L. 1999-219 (H 306) includes managed care entities (health benefit plans or health plans) among insurers that may not deny coverage or benefits solely on the basis of handicap. The definition of "health benefit plan" is standardized for purposes of application of state laws, and managed care organizations are required to acknowledge claims within thirty days or risk civil penalties. S.L. 1999-294 (S 594).

Hospital, medical and dental service corporations, and health maintenance organizations (HMOs) are made subject to numerous aspects of state insurance regulation, including the provisions about licensure and the Commissioner of Insurance's investigation of fraud and embezzlement [S.L. 1999-244 (S 766)]. S.L. 1999-168 (S 344) allows certain enrollees quicker access to specialists within their plan. The ability to bypass a gatekeeper through what is called continuing referral is available to those with a "serious or chronic degenerative, disabling, or life-threatening" condition. Under S.L. 1999-391 (S 345), a health plan's coverage denials and decisions on appeal must be approved by a North Carolina-licensed physician.

However, the managed care proposals that failed were even more significant. They included the imposition of malpractice liability on plans (H 1133); limitations on patients' waiting time for appointments and distance from providers, protection for providers who want to participate in plans, complaint mechanisms for providers and patients, giving the latter the right to sue, and required settlement of health insurance claims within thirty days (H 1282); disclosure requirements about providers and benefits, access to eye care, and transition coverage for people disenrolling (H 736); and besides much of the foregoing, direct access to certain specialists and the right of parents to select a pediatrician as the primary physician for their children (H 285).

## **Prescription Drugs**

As the U.S. population ages, prescription drugs move to the front row of significant health issues. Many health plans establish "closed" or exclusive formularies, that is, a list of the only drugs for which they will reimburse enrollees. The General Assembly required health plans to cover "medically necessary and appropriate" nonformulary drugs and devices [S.L. 1999-178 (S 347)], as long as they are for a covered condition (S.L. 1999-294).

S.L. 1999-290 (H 1095) establishes a new class of provider, the clinical pharmacist practitioner. These pharmacists will be jointly approved by the boards of medicine and pharmacy to cooperate with physicians on drug therapy. They may order drug therapy, tests, devices, or medication.

S.L. 1999-246 (S 59) allows mobile pharmacies to deliver free or reduced-price drugs to low-income uninsured individuals. S.L. 1999-343 (S 513) requires a uniform prescription drug card for all plans' enrollees by July 1, 2000. By 2003 the card must be able to be read electronically.

Several provisions of the state budget, S.L. 1999-237 (H 168) (hereafter, the budget act), address the need for drugs. Section 11.55 contains the additional AIDS funding mentioned in the introduction. Section 28.28 reduces what some state employees pay for drugs. (See the "Health Insurance" section of this chapter for details.) Section 11.1 covers some drug costs for low-income elderly people with cardiovascular disease or diabetes who are not fully covered by Medicaid and invites further study before next session.

The most controversial pharmacy bill (H 1277) did not pass, although it had considerable support. The bill allowed pharmacies to charge customers more than the co-payment established by their health plans. Another unsuccessful proposal (S 783) required out-of-state pharmacies to fill prescriptions written by North Carolina providers, even if the provider class could not have prescribed in the pharmacy's state of incorporation.

See the "Women's Health" section of this chapter for a discussion of coverage of contraceptive drugs and devices.

## **Health Providers**

In addition to recognizing clinical pharmacist practitioners as a new provider group, the General Assembly considered the boundaries among existing groups. S.L. 1999-226 (H 1193) lets physician's assistants or nurse practitioners perform any physical examination that state law requires be performed by a physician. S.L. 1999-210 (S 685) requires reimbursement for a

physician's assistant's services if a physician performing the service would have been reimbursed. S.L. 1999-292 (S 793) expands psychologists' scope of practice to include the diagnosis and treatment of the "neuropsychological aspects of physical illness" and the diagnosis of mental and emotional disorders.

North Carolina joined the Interstate Compact on Nursing Licensure [S.L. 1999-245 (S 194)], which gives a nurse licensed by any one of the party states the ability to practice in another party state. The compact also coordinates a licensure information system for recording disciplinary actions. Another measure to improve discipline is the requirement that, before employing health providers, health facilities must consult the state's Health Care Personnel Registry. The facilities also must report to the registry all substantiated allegations of misconduct and the disciplinary actions taken [S.L. 1999-159 (S 1258)]. S.L. 1999-430 (S 732) limits ownership of chiropractic practices to chiropractors, as of January 1, 2000, and makes a chiropractor accused of misconduct responsible for the cost of a disciplinary hearing in which he or she asserted a dilatory defense or one not based in good faith.

Three acts addressed the problem of impaired providers. S.L. 1999-81 (H 906) allows the Board of Pharmacy to contract for the identification and treatment of impaired pharmacists. The contractors are made state agencies and are given good faith immunity. S.L. 1999-382 (H 1470) gives similar contracting authority to the Board of Dental Examiners. S.L. 1999-291 (S 160) authorizes the Board of Nursing to adopt its own programs.

All direct health care providers will soon be identifiable by patients and families. By October 1, 1999, all must wear name badges. By October 1, 2001, the badge must also state the wearer's license, certification, or registration, unless the category of provider is exempt through rules of its licensing board. S.L. 1999-320 (S 951).

In order to improve information on cancer in North Carolina, S.L. 1999-22 (S 273) extends the allowable time for reporting a case to six months after diagnosis and requires reporting by all providers and facilities that detect, diagnose, or treat cancer. The Central Cancer Registry may collect the data from any site that fails to report and charge the provider or facility.

Two interesting bills failed. H 996 would have prevented any provider (including physicians) with fewer than 1,200 hours of training in spinal manipulation from adjusting the spine. H 1049 would have made a physician's review of services for reimbursement or precertification for reimbursement the practice of medicine. The effect would have been that only North Carolina-licensed physicians could perform these acts for a health plan. The bill also made the unlicensed practice of medicine a felony, proposed several new grounds for physician discipline, and conferred good faith immunity on those (other than the person charged) involved in disciplinary proceedings.

## **Health Facilities**

### **Long-Term Care Facilities**

The 1999 General Assembly addressed long-term care in two enactments. Section 11.7A of the budget act directs the Department of Health and Human Services (DHHS) to lead state and local agencies and consumer and provider organizations in developing a "system that provides a continuum of long-term care for elderly and disabled individuals and their families." By April 15, 2000, the department is to submit a progress report to the General Assembly and other bodies that includes a proposed budget and a budget management plan for "all publicly financed long-term care services available to older North Carolinians." By January 1, 2001, the system is to track expenditures, services, and consumer profiles and preferences and to develop a coordinated system to minimize administrative costs and improve access to services. The system is to emphasize public-private partnerships and personal responsibility for long-term care. The second session law [S.L. 1999-334 (S 10)] addresses current concerns in long-term care. It changes supervision of adult care homes from the Division of Social Services to the Medical Care Commission and places

greater emphasis on professional and medical services in the homes. Adult care homes may apply for licensure as providers of special care for Alzheimer's disease and other conditions. The department may refuse to renew a license if a home has a history of noncompliance with state law, or it may reduce a full license to provisional status. The rights of residents to remain in a home are set out, as is the obligation of local departments of social services to investigate complaints and remedy inadequacies.

### **Other**

Local hospitals operating under G.S. 131-4 received authority to hold a new referendum on a tax levy for the hospital. S.L. 1999-377 (S 279). S.L. 1999-386 (H 1120) lets public hospitals use installment purchase financing and issue revenue anticipation notes. Under S.L. 1999-307 (S 34) the Division of Facility Services may waive rules applicable to health care facilities, home care agencies, and adult homes so they may function as temporary shelters in an emergency. For legislation on required cancer reporting and ownership of chiropractic facilities, see the preceding section.

### **Health Insurance**

Three budget act provisions affect insurance coverage. Section 11.7 sets income limits for inclusion in state health programs other than Medicaid and allows the Department of Health and Human Services to reimburse providers for those programs at higher than Medicaid rates if necessary to procure their services. Section 28.28 improves coverage for state employees in the traditional indemnity health plan. Beginning January 1, 2000, instead of meeting deductibles and paying co-insurance, they may obtain prescription drugs for a co-payment of \$10 to \$20. Section 11.8 doubles the period, to twenty-four months, in which Work First clients who take jobs may continue to have Medicaid coverage for their children. For fuller coverage of Medicaid, see Chapter 23 (Social Services).

Other acts require health plans to continue to reimburse enrollees for pastoral counseling [S.L. 1999-186 (S 293)] and permit the Children's Health Insurance Program to reimburse school-based health clinics for covered services [S.L. 1999-4 (S 26)]. Under S.L. 1999-134 (H 1119), after January 1, 2000, health plans must cover anesthesia and hospital charges for dental work on children under nine and people with serious mental, physical, and behavioral problems. S.L. 1999-351 (H 294) establishes standards for disability income insurance and family leave credit insurance. This act also requires that policies covering mastectomy and reconstructive surgery cover prostheses and the expenses of physical complications in all stages of a mastectomy. S.L. 1999-425 (S 212) sets out conditions for dealings between mutual burial associations and other insurers, and it exempts certain family-owned graves from the statutory minimum burial depth.

### **Health Financing**

Probably the most important health issue of the session was what portion of the state's settlement with tobacco companies will fund health programs. Two proposals for division, S 969 and H 1431, failed. While some observers think the matter is not entirely settled, S.L. 1999-2 (S 6) expresses a legislative intent that 25 percent of the settlement go to health programs.

## Medical Information

A new requirement of the Joint Commission on Healthcare Organizations is that hospitals report untoward (“sentinel”) events. Facilities fear that the ability to protect such information, for instance, from use in litigation, will be lost by the act of reporting. S.L. 1999-222 (H 190) addresses this concern by providing that information released to an accrediting agency for its use in evaluation retains its confidentiality and is not subject to discovery or use in any civil actions. S.L. 1999-247 (H 957) moves North Carolina away from states with “quill pen” laws, that is, requirements that medical signatures be created by pen on paper. Now facilities and providers may use electronic records exclusively, and physicians may sign orders and death certificates with electronic or facsimile signatures.

## Women’s Health

S.L. 1999-231 (S 90) requires insurers who cover outpatient care or prescription drugs to pay for contraceptive drugs and devices and outpatient contraceptive services. The law allows an exemption for religious employers that oppose contraception.

See the “Health Insurance” section of this chapter for mastectomy coverage amendments.

S.L. 1999-197 (H 314) requires health plans to cover bone mass measurement for osteoporosis.

## Communicable Disease

Several budget act provisions concern communicable disease control. Section 11.53(a) authorizes Health and Human Services to use up to \$1 million annually on outreach efforts and a registry to improve immunization rates in North Carolina. Section 11.55 describes eligibility for and use of AIDS Drug Assistance funds (see the introduction to this chapter), and Section 11.56 outlines the use of HIV/STD prevention funds. S.L. 1999-110 (S 614) requires preschools to enroll only vaccinated (or exempt) children and spells out what documentation of immunization in another state a parent must present upon entry to a North Carolina school or daycare facility.

## Studies

A number of the most significant health issues considered in 1999 were set aside for further study. Section 2.1 of S.L. 1999-395 (H 163) authorizes the Legislative Research Commission to study

- managed care
- health reform issues (including those identified by the 1993 Health Care Planning Commission and its advisory committees)
- pharmacy choice for consumers and competition
- long-term care facilities’ compliance with licensure requirements
- recovery of Medicaid costs from the estates of former recipients
- a central registry for consents to organ donation and living wills
- hunger and nutrition
- spinal manipulation
- defibrillators
- health professionals’ scope of practice
- health effects of fire ants
- the appropriateness of the death penalty for people with mental retardation.

In other provisions of S.L. 1999-395, Section 7.1 instructs the state study commission on aging to consider flu shots for nursing home residents and employees; immunization against pneumococcal disease; and the present allocation of state Medicaid costs. Section 19.1 creates the Legislative Study Commission on Musculoskeletal Disorders and asks it to review the frequency, costs, and means to prevent these conditions. Section 20.1 directs the State Board of Dental Examiners to study licensure by credential (rather than examination) for out-of-state dentists and dental assistants. Section 21B.2 creates the Study Commission on Children with Special Needs to study services for this population.

The budget act also directs several studies. The DHHS is to study the cost of traumatic brain injury (Section 11.2) and medically necessary prosthetics and orthotic devices for adult Medicaid recipients (Section 11.13). The Joint Legislative Oversight Committee will study the need for additional school nurses (Section 8.23).

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