GENERAL ASSEMBLY OF NORTH CAROLINA
1993 SESSION

CHAPTER 529
HOUSE BILL 729

AN ACT TO PROVIDE FOR HEALTH CARE REFORM PLANNING, SMALL EMPLOYER PURCHASING GROUPS, REORGANIZATION OF STATE HEALTH FUNCTIONS INTO A STATE DEPARTMENT OF HEALTH, THE CREATION OF COMMUNITY HEALTH DISTRICTS, UNIFORM HEALTH CLAIM FORMS, HOSPITAL COOPERATION AGREEMENTS, AND HEALTH DELIVERY IMPROVEMENTS.

The General Assembly of North Carolina enacts:

PART I.–HEALTH CARE REFORM PLANNING

Section 1. (a) This act shall be known as the "Jeralds - Ezzell - Fletcher Health Care Reform Act of 1993".

(b) The General Assembly makes the following findings:

(1) More than 1,000,000 North Carolina citizens are uninsured on an average day, and an additional number are underinsured.

(2) North Carolina citizens who are uninsured and underinsured lack access or have limited access to health care, especially to cost-effective primary and preventive care, which may result in poor health, illness, and death.

(3) The health care received by uninsured and underinsured individuals is obtained primarily through public programs, and is financed by cost shifting which places an unfair financial burden on those who can pay, especially on employers who provide health care coverage for their employees.

(4) Health care costs in North Carolina and nationwide are rising much more rapidly than incomes, and the disparity will continue to grow over time unless health care reform is enacted.

(5) The increasing numbers of uninsured and underinsured individuals in North Carolina and the escalating costs of health care are so interrelated that it is not possible to guarantee access to health care for all North Carolina citizens without containing health care costs.

(6) Given the scope and complexity of health reform, the General Assembly expects the necessary changes to take years, and for the results to extend well into the next century. Purchasing alliances for small employers should provide accessibility and affordability of

health care in an employer-based system as the General Assembly plans for these changes.

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

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

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

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

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

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

Sec. 1.1. Chapter 58 of the General Statutes is amended by adding the following new Article to read:

"ARTICLE 68A.

"Health Care Reform Planning.

"§ 58-68-21. Short title; legislative intent.

The General Assembly finds that in order to provide access and contain costs it is necessary to plan for the restructuring of the financing and delivery of health care in this State. It is the intent of the General Assembly to:

(1) Develop a universal health care program to provide all North Carolina residents access to quality health care that is comprehensive and affordable.

(2) Implement the universal health care program only when:

a. A national mandate for universal coverage takes effect; or

b. Waivers have been obtained exempting North Carolina from ERISA and if necessary, from Medicaid and Medicare; or

c. The General Assembly has determined that it can implement a universal health care program within existing law and determines it would not adversely affect the economy and the business climate in North Carolina.

(3) Establish a commission to reorganize North Carolina's citizenry in improving its health and to develop the universal health care program.

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

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

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

"§ 58-68-22. Definitions.

As used in this Article, unless the context clearly requires otherwise, the following definitions apply:

(1) 'Community health plan' means any privately administered health service plan or any other mode of delivery of health care that is certified by a regional health plan purchasing cooperative and that provides health care services to eligible residents in exchange for a prescribed charge paid pursuant to the program of universal health coverage established by this Article.

(2) 'Commission' means the North Carolina Health Planning Commission established pursuant to Article 65 of Chapter 143 of the General Statutes.

(3) 'Eligible resident' means an individual who has been legally domiciled in this State for a period of 30 days. For purposes of this Article, legal domicile is established by living in this State and obtaining a North Carolina motor vehicle operator's license, registering to vote in North Carolina, or filing a North Carolina income tax return. A child is legally domiciled in this State if the child lives in this State and if at least one of the child's parents or the child's guardian is legally domiciled in this State for a period of 30 days. A person with a developmental disability or another disability which prevents the person from obtaining a North Carolina motor vehicle operator's license, registering to vote in North Carolina, or filing a North Carolina income tax return, is legally domiciled in this State by living in the State for 30 days.

(4) 'Federal poverty income level' means the federal official poverty line, as defined by the Federal Office of Management and Budget, based on Bureau of Census data, and revised annually by the Secretary of Health and Human Services pursuant to section 9902(2) of Title 42 of the United States Code.

(5) 'Plan' means the North Carolina Health Plan described in this Article.

(6) 'Regional health plan purchasing cooperative' means an organization established to administer the Plan in a geographic area of the State.

"§ 58-68-23. North Carolina Health Plan.

The Commission may design a plan for a system of universal health care coverage to be known as the North Carolina Health Plan. The Plan, when implemented, will provide

all eligible residents the same guaranteed package of comprehensive, medically necessary health care services, including primary and preventive care. These health care services will be provided through community health plans that will accept all eligible residents regardless of health status, and without individual medical underwriting, preexisting condition exclusions, or waiting periods. The Plan shall address the following elements:

(1) Financing. – A method or methods of financing the Plan shall be recommended by the Commission. The system which will ensure that every North Carolina citizen has access to affordable health care, regardless of the resources of the community in which he resides.

(2) Cost Containment. – Costs shall be contained by encouraging competition among community health plans on the basis of price and quality, reducing administrative costs, providing incentives for health care providers to participate in managed-care systems, ensuring appropriate growth in medical technology, and through any other methods that will contain health care costs without impairing the quality of services.

(3) Provider Fees and Practice Parameters. – The Plan shall address the following aspects of provider fees and practice parameters:

a. Global per case reimbursement including both professional and institutional providers;

b. Resource-Based Relative Value Scale (RBRVS) fee schedules for all other physician reimbursement; and

c. The use of physician practice guidelines for reimbursement and utilization review purposes only.

(4) Benefit Package. – A benefit package shall be developed by the Commission similar to the most commonly purchased Health Maintenance Organization (HMO) benefit package in the State. The Commission's benefit package shall include patient cost-sharing, except there shall be full coverage with no deductible and no copayments for prenatal care, well child care, periodic physical examinations, and other health screenings and services as recommended by the U.S. Preventive Services Task Force 'Guide to Clinical Preventive Services'. Cost-sharing for eligible residents below one hundred percent (100%) of the federal poverty income level shall not exceed Medicaid-allowable amounts. Cost-sharing for eligible residents between one hundred percent (100%) and two hundred fifty percent (250%) of poverty shall be based on a sliding scale. The Commission shall develop maximum out-of-pocket limits.

(5) Administration. – The Plan may be administered through regional health plan purchasing cooperatives that will:

a. Certify private health plans as community health plans for participation in the system of universal health coverage on the basis of ability to deliver the State-guaranteed package of

comprehensive, medically necessary health services in accordance with criteria defined by the Commission for quality and service. All community health plans meeting certification requirements will be certified.

b. Pay each community health plan the same risk-adjusted per capita amount for all eligible persons, except that the Commission shall have the authority to ensure accessibility to health care in rural and medically underserved areas by enhancing provider payments, requiring an accountable health plan to provide services throughout the area, or by any other reasonable means.

c. Ensure that no community health plan that charges an additional premium shall charge an eligible resident a higher premium than that charged to any other eligible resident for the same accountable health plan.

d. Except in underserved areas in which the regional health plan purchasing cooperative determines that there are insufficient providers to support more than one community health plan, ensure that all eligible residents have a choice of at least two community health plans that will provide the State-guaranteed package of comprehensive, medically necessary health services for no additional premium above that paid on their behalf by the regional health plan purchasing cooperative.

e. Assist eligible residents in choosing among community health plans by providing consumer education, including uniform information about all the community health plans available through the health plan purchasing cooperative such as quality indicators and choice of providers.

f. Provide a mechanism for enrolling all eligible residents in their chosen community health plans and for automatically enrolling in a community health plan all eligible residents who fail to choose such a plan.

g. The number, organization, and geographic areas of the regional health plan purchasing cooperatives to be established, which will include at least six geographic areas. Each area is to be defined so that it is self-sufficient in providing comprehensive health care including most tertiary services, thus allowing for a large enough population to support community rating.

h. Monitor and enforce standards concerning access, consumer satisfaction, and quality of care in all community health plans.

i. Jointly with the Commission and the North Carolina Medical Database Commission, collect data from all community health plans and sponsor research into health outcomes and practice guidelines.

j. Jointly with the Commission and where necessary to meet the needs of underserved areas or special populations, organize the delivery of health care.

k. Receive bids annually from private health plans to provide the benefit package established by the Commission to enrolled eligible residents. A health plan purchasing cooperative may reject any or all bids, and may request that revised bids be submitted.

(6) Large Groups. – In order to preserve employer-based and other group health care coverage, the Plan may provide, notwithstanding any other provision of this Article, for the direct marketing by community health plans to an employer with 100 or more employees and to any other group with 100 or more members, provided that the employer or group is eligible under G.S. 58-51-80 for group accident, group health, or group accident and health insurance. If the Plan provides for direct marketing of insurance to large groups as defined in this subsection, it shall also address the extent to which those groups and self-insured plans (prior to obtaining an ERISA waiver) should be subject to the certification requirements for community health plans, whether exemptions, tax credits, or other means are necessary and appropriate to provide for equitable treatment of large groups and self-insured groups under any tax-financed system of universal health care coverage, and other issues involving the use of large group coverage with universal coverage. The regional health plan purchasing cooperatives would be responsible for marketing community health plans to individuals and all other groups. Before the plan provides for direct marketing to large groups, the Commission shall study whether there are any adverse affects to the purchasing arrangements in effect for other residents, the impact on portability of coverage, and the role large employers play in financing coverage for the uninsured and indigent populations."

Sec. 1.2. Chapter 143 of the General Statutes is amended by adding the following new Article to read:

"ARTICLE 65.

"North Carolina Health Planning Commission.

"§ 143-610. Definitions.

As used in this Article, unless the context clearly requires otherwise, the following definitions apply:

(1) 'Community health plan' means any privately administered health service plan or any other mode of delivery of health care that is certified by a regional health plan purchasing cooperative and that provides health care services to eligible residents in exchange for a prescribed charge paid pursuant to the program of universal health coverage established by this Article.

(2) 'Commission' means the North Carolina Health Planning Commission.

(3) 'Eligible resident' means an individual who has been legally domiciled in this State for a period of 30 days. For purposes of this Article, legal domicile is established by living in this State and obtaining a North Carolina motor vehicle operator's license, registering to vote in North Carolina, or filing a North Carolina income tax return. A child is legally domiciled in this State if the child lives in this State and if at least one of the child's parents or the child's guardian is legally domiciled in this State for a period of 30 days. A person with a developmental disability or another disability which prevents the person from obtaining a North Carolina motor vehicle operator's license, registering to vote in North Carolina, or filing a North Carolina income tax return, is legally domiciled in this State by living in the State for 30 days.

(4) 'Federal poverty income level' means the federal official poverty line, as defined by the Federal Office of Management and Budget, based on Bureau of Census data, and revised annually by the Secretary of Health and Human Services pursuant to section 9902(2) of Title 42 of the United States Code.

(5) 'Plan' means the North Carolina Health Plan described in this Article.

(6) 'Regional health plan purchasing cooperative' means an organization established to administer the Plan in a geographic area of the State.

"§ 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;

(2) The Lieutenant Governor;

(3) The Speaker of the House of Representatives;

(4) The President Pro Tempore of the Senate;

(5) Five members of the House of Representatives appointed by the Speaker of the House of Representatives;

(6) Five members of the Senate 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.

(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.

"§ 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, 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;
(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) 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 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;

(26) Mechanisms to provide for the continuing education and training of health care 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.

(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.

"§ 143-614. Reports.

(a) The Commission shall submit to the General Assembly, no later than April 1, 1994, the following:

(1) An outline for the development of a Health Care Reform Plan.
(2) The implementation plan for Phases I and II, as required under Section 1.4 of this act.
(3) A progress report on the study of issues on Health Care Reform pursuant to G.S. 143-612(c).

(b) The Commission shall submit to the General Assembly, no later than April 1, 1995, the following:

(1) A progress report on the development of a Health Care Reform Plan.
(2) The implementation plan for Phase III, as required under Section 1.4 of this act.
(3) Recommendations resulting from the study of issues on Health Care Reform pursuant to G.S. 143-612(c).

(c) The Commission shall thereafter report annually to the General Assembly on its activities, findings, and recommendations. Reports shall be submitted no later than April 1 of each year."

Sec. 1.3. Section 78 of Chapter 321 of the 1993 Session Laws reads as rewritten:

"Sec. 78. (a) Funds appropriated in this act to the Board of Governors of The University of North Carolina for continuation of financial assistance to the medical schools of Duke University and Wake Forest University shall be disbursed on certifications of the respective schools of medicine that show the number of North Carolina residents as first-year, second-year, third-year, and fourth-year students in the medical school as of November 1, 1993, and November 1, 1994. Disbursement to Wake Forest University shall be made in the amount of eight thousand dollars ($8,000) for each medical student who is a North Carolina resident, one thousand dollars ($1,000) of which shall be placed by the school in a fund to be used to provide financial aid to needy North Carolina students who are enrolled in the medical school. The maximum aid given to any student from this fund in a given year may not exceed the amount of the difference in tuition and academic fees charged by the school and those charged at the School of Medicine at the University of North Carolina at Chapel Hill.

Disbursement to Duke University shall be made in the amount of five thousand dollars ($5,000) for each medical student who is a North Carolina resident, five hundred dollars ($500.00) of which shall be placed by the school in a fund to be used to provide student financial aid to financially needy North Carolina students who are enrolled in the medical school. No individual student may be awarded assistance from this fund in excess of two thousand dollars ($2,000) each year. In addition to this basic disbursement for each year of the biennium, a disbursement of one thousand dollars ($1,000) shall be made for each medical student who is a North Carolina resident in the

first-year, second-year, third-year, and fourth-year classes to the extent that enrollment of each of those classes exceeds 30 North Carolina students.

The Board of Governors shall establish the criteria for determining the eligibility for financial aid of needy North Carolina students who are enrolled in the medical schools and shall review the grants or awards to eligible students. The Board of Governors shall adopt rules for determining which students are residents of North Carolina for the purposes of these programs. The Board of Governors shall also make any regulations as necessary to ensure that these funds are used directly for instruction in the medical programs of the schools and not for religious or other nonpublic purposes.

(a1) 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. The Board of Governors shall report to the Joint Legislative Education Oversight Committee by May 15, 1994, 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 ~~fifty~~ sixty percent ~~(50%)~~ (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. The Board of Governors shall report to the Joint Legislative Education Oversight Committee by May 15, 1994, 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.

(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 to ensure that larger proportions of medical students seek residencies 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 programs have sufficient medical residency positions for medical school graduates in these primary care specialties.

(d) The progress of the private and public medical 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,

and (ii) the specialty practices by a physician as of a date five years after graduation. The Board of Governors shall certify data on graduates, their residencies, 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 education.

(f) Subsection (a1) of this section shall be codified as G.S. 143-613(a). Subsection (b) of this section shall be codified as G.S. 143-613(b). Subsection (c) of this section shall be codified as G.S. 143-613(c). Subsection (d) of this section shall be codified as G.S. 143-613(d). Subsection (e) of this section shall be codified as G.S. 143-613(e). The catch line of G.S 143-613 shall read as follows:

'§ 143-613. Medical education; primary care physicians.'"

Sec. 1.4. (a) It is the intent of the General Assembly that the North Carolina Health Planning Commission develop a Health Care Reform Plan and that a new commission be appointed in the future to oversee implementation of the Plan. The new Commission would be a seven-member panel appointed by the Governor, subject to confirmation by the General Assembly, and would be appointed at least six months prior to the Plan's effective date.

(b) The North Carolina Health Planning Commission, in preparing for this transition, shall develop (i) a phased implementation program for the Plan to coincide with a mandate or anticipated mandate for universal coverage, a federal preemption for North Carolina, or the date established by the General Assembly after it has determined that it can implement a universal health care program within existing laws, and (ii) a phased implementation plan for insurance reforms. The Plan shall incorporate the following structure for implementation. Phases I and II are interim measures until the General Assembly enacts a universal health coverage plan. Phase III is to be implemented in accordance with G.S. 58-68-21(2).

Phase I: The Small Employer Group Health Insurance Coverage Reform Act is expanded from employers with up to 25 employees to employers of up to 49 employees, pursuant to Chapter 408 of the 1993 Session Laws. Rating band restrictions for the individual market would also be instituted, to be phased in over a period of time.

Phase II: The Small Employer Group Health Insurance Coverage Reform Act would be expanded to employers with up to 99 employees. Community rating would begin to be implemented, with incremental implementation of rating bands. All carriers would be required to implement community health plan qualifications.

Phase III: Rating bands would be removed to fully implement adjusted community rating. Cost-containment measures would be implemented.

Sec. 1.5. The Department of Insurance and the Executive Administrator and the Board of Trustees of the Teachers' and State Employees' Comprehensive Major Medical Plan shall provide technical assistance to the North Carolina Health Planning Commission upon request, including assistance on statutory changes required in Chapters 58 and 135 of the General Statutes in order to effectuate the Plan.

Sec. 1.6. Of the funds appropriated to the Reserve for Health Care Initiatives in Chapter 321 of the 1993 Session Laws, the sum of one million five hundred thousand dollars ($1,500,000) for the 1993-94 fiscal year and the sum of one million five hundred thousand dollars ($1,500,000) for the 1994-95 fiscal year shall be used for the operation of the North Carolina Health Planning Commission and for other activities related to the duties and responsibilities of the Commission pursuant to this Act.

Sec. 1.7. Nothing in this Part shall be construed to give the North Carolina Health Planning Commission authority to implement any Plan for health care reform developed under this Part. A Plan developed under this Part shall not be implemented without additional authorizing legislation from the General Assembly.

Sec. 1.8. Section 1.6 of this act becomes effective July 1, 1993.

PART II.–DEPARTMENT OF HEALTH AND COMMUNITY HEALTH DISTRICTS

Sec. 2.1. (a) From the least fortunate to those with greatest wealth in this State, there is near universal concern over the current health system. Strong and effective preventive health services must not only be designed but implemented. The people in this State, wherever they happen to reside, shall have access to comparable levels of health services at reasonable costs. Lack of access for hundreds of thousands of North Carolinians, and a host of unacceptable health indices, require a carefully constructed plan for reform. If the State is to face this responsibility, it will require consolidation of planning and oversight of many presently scattered health programs. Fundamental health reform demands clear accountability. Accountability is impossible when many different departments and divisions of government have responsibility.

(b) The Governor shall present to the General Assembly no later than April 1, 1994, a plan for consolidating all of the State health functions into one State Department of Health. The plan shall be based upon and shall address the principles and elements outlined in subsections (c) and (d) of this section.

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

(1) Improved health status - not health care - should be the ultimate goal;
(2) Health status must be improved primarily through locally developed initiatives;
(3) The appropriate role of the State is to assure a framework by which health services can be delivered in local communities;
(4) While State and local governments should provide the framework for the delivery of health services, they should not interpret this responsibility as a requirement to directly provide all of these services;
(5) In order for a new health system to be effective, there must be cooperative and collaborative efforts in place throughout the State. Hospitals, health departments, individual health providers, provider organizations, and others must find new and innovative ways to work together effectively.

(d) The Plan required under subsection (b) of this section shall be based on the following elements:

(1) A Department of Health encompassing at least all health functions now residing in the Department of Human Resources, Department of Environment, Health, and Natural Resources, the North Carolina Medical Database Commission, and any other functions assigned by the General Assembly or Governor to State agencies relating to health care.

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

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

(4) The State Health Department and Commission for Health Services shall establish scientifically based indicators of health quality. The Community Health District shall be responsible for implementation of disease prevention, local health regulation, and health care delivery for the community pursuant to broad guidelines established by the Commission for Health Services.

(5) A "Community Health Status Assessment" shall be performed on a regular basis in each Community Health District in order to provide the information needed to implement the purposes and programs of the Board. The assessment shall include, but not be limited to:

a. Epidemiological research of community including age, sex, racial, and geographic factors.

b. Environmental health risk factors.

c. Availability, access, and utilization of prevention programs (medical, dental, educational).

d. Mental health and substance abuse factors.

e. Outcomes of health care programs and services in the District.

f. An estimate of the total private and public financial resources necessary to meet health needs within the District.

g. A survey of the health facilities available to meet the needs of hospitals, community clinics, school clinics, and high technology treatment facilities available outside hospitals.
h. A survey of the health care personnel and related human resources available to meet the health care needs of the District.
i. Priorities for improving community health status.

PART III.–SMALL EMPLOYER PURCHASING GROUPS

Sec. 3.1. Chapter 143 of the General Statutes is amended by adding a new Article to read:

"ARTICLE 66.

"Health Care Purchasing Alliance Act.

"§ 143-621. Purpose and intent.

The purpose and intent of this Article is to increase the affordability, efficiency, and fairness of health coverage for small employers.

The Article promotes the development of voluntary purchasing Alliances to provide affordable health care coverage for self-employed individuals and employees of participating small employers in the manner of large employer groups. The Alliances will allow members to benefit from the contracting expertise and the administrative savings that can result from the pooling of small employers and self-employed individuals.

These Alliances will make available through their contracting processes a choice of Accountable Health Carriers that arrange for quality health services in a cost-effective manner. The Article establishes rules for fair competition among competing Accountable Health Carriers. These rules include the offering of comparable benefits by competing Accountable Health Carriers, risk assessment, and risk adjustment to assure competition based on a fair allocation of risk among Accountable Health Carriers, and the providing of data that measures clinical outcomes and other valid areas of Accountable Health Carrier performance.

Carriers throughout the health coverage market for small employers are required to use adjusted community rating, guarantee the continuity of coverage, adhere to limitations on the use of preexisting conditions, abolish individual medical underwriting, and follow rules limiting the use of participation requirements.

"§ 143-622. Definitions.

As used in this Article:

(1) 'Accountable Health Carrier' means a carrier registered with the Board pursuant to G.S. 143-626.
(2) 'Adjusted community rating' means a method used to develop carrier premiums which spreads financial risk across a large population and allows adjustments only for the following demographic factors: age, gender, number of family members covered, and geographic areas, as determined pursuant to G. S. 58-50-130(b).

(3) 'Alliance' means a State-chartered, nonprofit organization that provides health insurance purchasing services to member small employers in a market area regarding qualified health care plans offered by Accountable Health Carriers established pursuant to G.S. 143-629.
(4) 'Alliance Board' means the Alliance Board of Directors for a market area established pursuant to G.S. 143-627.
(5) 'Antitrust laws' means federal and State laws intended to protect commerce from unlawful restraints, monopolies, and unfair business practices.
(6) 'Board' means the State Health Plan Purchasing Alliance Board.
(7) 'Carrier' means that as defined in G.S. 58-50-110(5).
(8) 'Community sponsor' means an organization that assumes responsibility for serving as the host for an Alliance in a market area.
(9) 'Dependent' means that as defined in G.S. 58-50-110(9).
(10) 'Eligible employee' means that as defined in G.S. 58-50-110(10).
(11) 'Employee enrollee' means an eligible employee or dependent of an eligible employee who is enrolled in a qualified health care plan.
(12) 'Fund' means the State Health Plan Purchasing Alliance Fund established under G.S. 143-635.
(13) 'Grievance procedure' means an established set of rules that specify a process for appeal of an organizational decision.
(14) 'Health benefit plan' means that as defined in G.S. 58-50-110(11).
(15) 'Late enrollee' means an eligible employee or a dependent of an eligible employee who requests enrollment in a qualified health care plan after the initial enrollment period for a member small employer, provided the enrollment is consistent with the Alliance's rules for initial enrollment and provided that the initial enrollment period shall extend for at least 30 consecutive calendar days. However, an eligible employee or dependent shall not be considered a late enrollee if:
a. The individual was covered under a public or private health benefit plan that provided at least the minimum level of benefits in qualified health care plans established pursuant to G.S. 58-50-120 at the time the individual was eligible to enroll and either:
1. Lost coverage under another health plan as a result of termination of employment, the termination of coverage under another health plan, or the death of a spouse or divorce and requests enrollment in a qualified health care plan within 30 days after termination of coverage; or
2. Stated, in writing, during the enrollment period that coverage under another employer's health benefit plan was the reason for declining coverage;
b. The individual elects a different health plan offered through an Alliance during an open enrollment period;

c. An eligible employee requests enrollment within 30 days of becoming an employee of a member small employer;

d. A court has ordered that coverage be provided for a spouse or minor child under a covered employee's health benefit plan and the request for enrollment is made within 30 days after issuance of the court order; or

e. The individual or employee enrollee makes a request for enrollment of the spouse or child within 30 days of his or her marriage or the birth or adoption of a child.

(16) 'Lowest cost plan' means the lowest cost qualified health care plan selected by a member small employer and offered to the employer's employee enrollees.

(17) 'Market area' means a clearly defined, nonoverlapping, and exclusive geographical area determined by the Board for the purpose of defining the region in which an Alliance shall operate.

(18) 'Member small employer' means a small employer who enrolls in an Alliance.

(19) 'Preexisting condition provision' means that as defined in G.S. 58-50-110(17).

(20) 'Premium' means that as defined in G.S. 58-50-110(18).

(21) 'Qualified health care plans' means the basic or standard health care plans offered by an Accountable Health Carrier to member small employers and as authorized by the Small Employer Carrier Committee pursuant to G.S. 58-50-120.

(22) 'Risk adjustment mechanism' means the process established pursuant to G.S. 143-633.

(23) 'Self-employed individual' means that as defined in G.S. 58-50-110(21a).

(24) 'Service area' means a geographic region in which a carrier is licensed to operate.

(25) 'Small employer' means that as defined in G.S. 58-50-110(22).

"§ 143-623. Health benefit plans subject to Article.

A health benefit plan is subject to this Article if it provides health benefits for small employers and if any of the following conditions are met:

(1) Any part of the premiums or benefits is paid by a small employer, or any covered individual is reimbursed, whether through wage or adjustments or otherwise, by a small employer for any portion of the premium;

(2) The health benefit plan is treated by the employer or any of the covered self-employed individuals as part of a plan or program for the purposes of Sections 106, 125, or 162 of the United States Internal Revenue Code; or

(3) The small employer has permitted payroll deductions for the eligible enrollees for the health benefit plans.

"§ 143-624. Jurisdiction of the Department of Insurance.

Nothing in this Article shall be deemed to be in conflict with or in limitation of the duties and powers granted to the Commissioner of Insurance under Chapter 58 of the General Statutes. The Board and Alliances established under this Article shall bring to the attention of the Department of Insurance any suspected or alleged violations of this Article.

"§ 143-625. Establishment of the Board; membership; terms; personnel.

(a) There is established the State Health Plan Purchasing Alliance Board. The Board shall be established within the Department of Administration for administrative, organizational, and budgetary purposes only. The Department of Administration shall provide administrative and staff support to the Board. The Department of Insurance shall provide technical assistance as requested by the Board.

(b) The Board shall consist of 11 members, as follows:

(1) Three appointed by the Governor, at least one of whom shall be an owner or manager of a member small employer of an Alliance operating in North Carolina; and at least one of whom shall be an employee enrollee of an Alliance operating in North Carolina;

(2) Three appointed by the General Assembly upon the recommendation of the Speaker of the House of Representatives, in accordance with G.S. 120-121, at least one of whom shall be an owner or manager of a member small employer of an Alliance operating in North Carolina; and at least one of whom shall be an employee enrollee of an Alliance operating in North Carolina;

(3) Three appointed by the General Assembly upon the recommendation of the President Pro Tempore of the Senate in accordance with G.S. 120-121, at least one of whom shall be an owner or manager of a member small employer of an Alliance operating in North Carolina; and at least one of whom shall be an employee enrollee of an Alliance operating in North Carolina;

(4) The Lieutenant Governor or his or her representative; and

(5) The Commissioner of Insurance or his or her representative.

(c) Members of the Board who are not officers or employees of the State shall receive compensation of two hundred dollars ($200.00) for each day or part of a day of service plus reimbursement for travel and subsistence expenses at the rates specified in G.S. 138-5. Members of the Board who are officers or employees of the State shall receive reimbursement for travel and subsistence at the rates specified in G.S. 138-6.

(d) Appointed members shall serve for four-year terms except that the initial terms of:

(1) Two members appointed by the Governor, two members appointed by the General Assembly upon the recommendation of the President Pro Tempore of the Senate, and one member appointed by the General Assembly upon the recommendation of the Speaker of the House of Representatives, shall expire July 1, 1995; and

(2) One member appointed by the Governor, one member appointed by the General Assembly upon the recommendation of the President Pro Tempore of the Senate, and two members appointed by the General Assembly upon the recommendation of the Speaker of the House of Representatives, shall expire July 1, 1997.

(e) At the end of a term, a member shall continue to serve until a successor is appointed. A member who is appointed after a term has begun serves only for the remainder of the term and until a successor is appointed. A member who serves two consecutive full four-year terms shall not be reappointed until four years after completion of those terms. A vacancy in a legislative appointment shall be filled in accordance with G.S. 120-122.

(f) The Board shall elect officers biennially. Officers shall serve no more than two consecutive terms in an office.

(g) The Board shall appoint an executive director who shall serve at the pleasure of the Board. The executive director shall administer the affairs of the Board. The executive director may employ and direct staff necessary to carry out the provisions of this Article. Staff of the Board shall be covered under the State Personnel Act.

(h) The Board shall meet as needed at the times and places it determines. Such meetings and procedures shall be governed by the procedures and policies set forth in the North Carolina Open Meetings Law, Article 33C of Chapter 143 of the General Statutes. A majority of the fully authorized membership of the Board is a quorum.

(i) No Board members or their spouses shall be employed by, affiliated with an agent of, or otherwise a representative of any carrier or health care provider.

(j) No individual shall be appointed to or remain a member of the Board if the individual, the individual's spouse, or the individual and spouse together, held securities or are otherwise the beneficiaries of securities worth ten thousand dollars ($10,000) or more at fair market value as of December 31 of the preceding year in a single health care business or aggregated among multiple health care businesses. For the purposes of this subsection, the term, 'health care business':

(1) Includes an association, corporation, enterprise, joint venture, organization, partnership, proprietorship, trust, and every other business interest that provides or insures human health care.

(2) Does not include a widely held investment fund, regulated investment company, or pension or deferred compensation plan if neither the individual nor the individual's spouse has the ability to exercise control over the financial interests held by the fund.

"**§ 143-626. Duties of the Board.**

The Board shall:

(1) Establish no less than four and no more than 12 market areas in this State. In establishing such market areas, the Board shall ensure that every location is a part of a market area. To the largest extent possible, the Board should consider metropolitan standard areas and other existing markets. The Board may redefine market areas where it determines there will be insufficient numbers of enrollees, health care

providers, or qualifying Accountable Health Carriers to make such requirements feasible. Any such modifications are subject to annual review by the Board.

(2) Accept applications by carriers to qualify as Accountable Health Carriers, determine the eligibility of carriers to become Accountable Health Carriers according to criteria described in G.S. 143-629, and designate carriers as Accountable Health Carriers.

(3) Establish Alliances with community sponsors pursuant to G.S. 143-627 for each market area determined by the Board.

(4) Conduct annual reviews of the performance of each Alliance to ensure that the Alliance is in compliance with this Article. To assist the Board in its review, each Alliance shall submit data to the Board quarterly including, but not limited to, employer enrollment by employer size; industry sector; previous insurance status and number of employees within each insurance status; number of total eligible employers in the market area participating in the Alliance; number of insured lives by county and insured category, including employees, dependents and other insured categories, represented by Alliance members; profiles of potential employer membership by county; premium ranges for each qualified health care plan for Alliance member categories; type and resolution of member grievances; surcharges; and Alliance financial statements. A summary of this annual review shall be provided to the General Assembly and each Alliance.

(5) Develop standard enrollment procedures to be used in enrolling small employers and their eligible employees.

(6) Establish conditions of participation for small employers and self-employed individuals which shall conform to the requirements of this Article and G. S. 58-50-125(d) and include, but not be limited to, the following:

a. Assurances that the member small employer is a valid small employer group and is not formed for the purpose of securing health benefits coverage. This assurance must include requirements that sole proprietors and self-employed individuals have been in business for a reasonable period of time as established by the Board, have provided filings to verify employment status, and have provided other evidence, in the Board's discretion, to ensure that the individual is working;

b. A member small employer who opts to pay seventy percent (70%) or more of the cost of coverage may choose to offer a single qualified health care plan to its eligible employees. Eligible employees of other member small employers shall have the choice of at least two qualified health care plans. All member small employers may offer the qualified health care

plans of more than one Accountable Health Carrier. The Board and Alliances shall encourage all member small employers to consider offering more than one Accountable Health Carrier;

c. Minimum employer contribution requirements that shall be an amount not less than fifty percent (50%) of the premium for an employee's coverage of the lowest cost plan. The Alliance shall require that the employer contribute the same dollar amount for each employee regardless of the qualified health care plan chosen by the employee;

d. A mechanism that will provide for participation if an employer chooses not to participate but one hundred percent (100%) of the eligible employees who are not covered under a health benefit plan elect to purchase their coverage through the Alliance; and

e. Prepayment of premiums or other mechanisms to assure that payment will be made for coverage.

(7) Ensure that any small employer or any employee of a small employer who meets the requirements established by the Board pursuant to subdivision (6) of this section may purchase health care coverage through an Alliance.

(8) Assure compliance with this Article by Alliances, small employers, and employee enrollees.

(9) Have the authority to request carrier information about the financial condition of the carrier consistent with the financial information required to be submitted by the carrier to the Department of Insurance.

(10) Assure fair and affirmative marketing of the qualified health care plans consistent with standards established by the Department of Insurance, the Small Employer Carrier Committee, and G.S. 143-632.

(11) Adopt rules in compliance with Chapter 150B of the General Statutes as necessary to administer the provisions of this Article.

(12) Appoint advisory committees that shall include persons with expertise in health benefits management and representatives of Accountable Health Carriers.

(13) Develop uniform standards for the data that Alliances collect from Accountable Health Carriers. In formulating such standards, the Board shall strive for consistency with health care data collection activities underway in North Carolina and nationally. Any data collection requirements promulgated by the Board shall be based on a study of their feasibility and cost-effectiveness, including their consistency with national standards for electronic data interchange, and their necessity for supporting the evaluation of Accountable Health Carriers and their provider networks with respect to cost containment, quality, control of expensive technology, and customer satisfaction. All enrollee

satisfaction surveys employed by Alliances shall be in a standardized format promulgated by the Board.

(14) Have the authority to sue or be sued, including taking action necessary for securing legal remedies on behalf of, or against Alliances, member small employers, or employee enrollees and dependants of those employees.

(15) Have the authority to receive and accept grants or funds from any public or private agency and receive and accept contributions from any source of money, property, labor, or any other thing of value.

(16) Develop and implement standardized forms for use by Accountable Health Carriers in conformance with applicable national standards.

(17) Review, and limit if necessary, surcharges charged by each Alliance for administrative costs.

(18) Develop guidelines for any authorized marketing materials to be used in providing member small employers and their eligible employees with information regarding Accountable Health Carriers and their respective qualified health care plans in accordance with G.S. 143-632. Such guidelines shall be consistent with standards established by the Department of Insurance and the Small Employer Carrier Committee.

(19) Develop grievance procedures to be used in resolving disputes between member small employers and Alliances. A member small employer, Alliance or Accountable Health Carrier may appeal to the Board any grievance that is not resolved.

(20) Receive, review, and act on appeals of grievances not resolved.

(21) Analyze information collected from Accountable Health Carriers and other sources and report findings that assist consumers, Alliances, Accountable Health Carriers, or health care providers in improving the delivery or purchase of cost-effective health care.

(22) Report annually on the operation of the Board to the Joint Legislative Commission on Governmental Operations and the Governor.

"§ 143-627. Alliances authorized.

(a) The Board is authorized to create a single Alliance within each designated market area for the benefit of its member small employers. Each Alliance shall be operated as a State-chartered, nonprofit private organization.

(b) Each Alliance shall operate under the supervision of an Alliance Board of Directors, which shall consist of 11 members. The majority of members on each Alliance Board shall be small employers.

(1) The Board shall initially appoint six members for a term of two years. The community sponsor shall initially appoint five members for a term of two years. In so doing, the Board and community sponsor shall consider, among other things, whether all member small employers are fairly represented and assure that a majority of the Alliance Board shall be small employers.

(2) Subsequent members of the Alliance Board of Directors shall be elected pursuant to the Alliance Board's bylaws.

(c) Each Alliance Board shall adopt bylaws that shall include a procedure for the election of Alliance Board members by the Alliance's member small employers.

(d) Of the initially elected members of each Alliance Board, six members shall be designated to serve two-year terms and the remaining five members shall have four-year terms. Thereafter, the term of an elected member shall be four years.

(e) Vacancies on an Alliance Board shall be filled for the remaining period of the term by a majority vote of the remaining Board members. A member to fill a vacancy may serve for the remainder of the term and until a qualified successor is elected for a new term.

(f) A member who serves two consecutive full four-year terms shall not be reelected for four years after completion of those terms.

(g) Members of the Alliance Board shall be bound by the financial interest restrictions set forth for Board members in G.S. 143-625(i) and (j).

(h) The Alliance Board shall elect officers from among its members every two years. Officers shall not serve more than two consecutive terms in an office.

(i) The Alliance Board shall meet at times and places as it determines necessary to operate the Alliance in accordance with this section and G.S. 143-628. Such meetings shall be governed by the procedures and polices set forth by the North Carolina Open Meetings Law, Article 33C of Chapter 143 of the General Statutes.

(j) There shall be no liability on the part of, and no cause of action of any nature shall arise against any member of the Alliance Board, or its employees or agents, for any action taken in good faith by them in the performance of their powers and duties as defined under G.S. 143-628.

(k) The Alliance Board shall have the powers and duties regarding operation of the Alliance set forth in G.S. 143-628.

"§ 143-628. Powers and duties of the Health Plan Purchasing Alliance.

An Alliance shall have the following powers and duties:

(1) Enter into contracts with Accountable Health Carriers for the provision of qualified health care plans for members of the Alliance pursuant to G.S. 143-629. Each Alliance shall contract with all Accountable Health Carriers which offer qualified health care plans operating in its market area and apply to serve member small employers;

(2) Enter into contracts with small employers pursuant to G.S. 143-630;

(3) Maintain eligibility records as appropriate to carry out the functions of this Article;

(4) Transmit enrollment and eligibility information to Accountable Health Carriers on a timely basis;

(5) Establish procedures for collection of premiums from member small employers, including the share of premiums paid by employee enrollees pursuant to G. S. 143-630;

(6) Pay contracted rates to Accountable Health Carriers on a monthly basis or as otherwise mutually agreed pursuant to G.S. 143-631;

(7) Impose annual surcharges established at the beginning of the fiscal year to be paid monthly by member small employers for necessary costs incurred in connection with the operation of the Alliance. The amount of annual surcharges shall cover any default on insurer premium payments by member small employer.

(8) Provide that in the event a member small employer terminates coverage purchased through the Alliance, the former member small employer shall be ineligible to purchase a qualified health care plan through the Alliance for a period of two years, except as permitted by the Alliance Board and the Board for good cause;

(9) Contract, as authorized by the Alliance Board of Directors, with a qualified third party for any service necessary to carry out the powers and duties as defined in this section, including contracts with agents to assist in contracting with Accountable Health Carriers and small employers and to assist the Alliance in undertaking activities necessary to administer the Alliance, such as marketing and publicizing the availability of the qualified health care plans;

(10) Provide to member small employers clear, standardized information on each Accountable Health Carrier and qualified health care plans offered by each Accountable Health Carrier, including information on price, enrollee costs, quality, patient satisfaction, enrollment, and enrollee responsibilities and obligations; and provide qualified health care plan comparison sheets in accordance with Board rules to be used in providing members and their employees with information regarding coverage that may be obtained through the Accountable Health Carriers;

(11) Appoint an executive director to serve as the chief operating officer of the Alliance, who may employ other staff as needed to administer the Alliance. The executive director shall serve at the pleasure of the Alliance Board;

(12) Establish advisory boards as necessary to assist with carrying out the duties established pursuant to this section;

(13) Establish administrative and accounting procedures for operating the Alliance, providing services to member small employers and employee enrollees, and preparing an annual budget;

(14) Prepare annual reports on the operations of the Alliance, including program and financial operations as required by the Board, and provide for annual internal and independent audits;

(15) Sue or be sued, including taking any legal actions necessary or proper for recovering any penalties for or on behalf of the Alliance;

(16) Maintain records and submit reports to the Board as required; and

(17) Accept and expend funds received through grants, appropriations, or other appropriate and lawful means.

"§ 143-629. Accountable health carriers.

(a) By July 1, 1994, the Board shall establish a process whereby a carrier that fulfills the qualifications of subsection (b) of this section shall be designated as an Accountable Health Carrier.

(b) In order to be eligible to be designated as an Accountable Health Carrier, a carrier must be able to demonstrate the following operating characteristics to the Board:

(1) Licensure and in good standing with the Department of Insurance;
(2) Capacity to administer the qualified health care plans;
(3) In the case of a carrier with a contractual obligation to provide or arrange for the covered health services, the ability to provide enrollees with adequate access to covered services within the carrier's service area;
(4) Grievance procedures, including the ability to respond to enrollees' calls, questions, and complaints;
(5) Established utilization management procedures;
(6) Ability to arrange and pay for the appropriate level and type of health care services;
(7) Ability to monitor and evaluate the quality and cost-effectiveness of care;
(8) Ability to assure enrollees with adequate numbers and types of health care providers;
(9) Ability to provide information on enrollee satisfaction based on standard surveys prescribed by the Board; and
(10) Ability to provide information on the types of treatments and outcomes with respect to the clinical health, functional status, and well-being of the enrollees based on standard data elements prescribed by the Board.

Carriers receiving accreditation by nationally recognized accreditation organizations, including, but not limited to, the National Committee on Quality Assurance (NCQA), the Utilization Review Accreditation Commission (URAC), Joint Commission on Accreditation of Health Care Organizations (JCAHO), or qualification by federal agencies, shall be deemed to be in compliance with the requirements of subdivisions (2) through (10) of this subsection as they pertain to the relevant accreditation activities of the organization.

(c) After notice and hearing, the Board may suspend or revoke the designation as an Accountable Health Carrier of any carrier that fails to maintain compliance with the requirements listed in subsections (b), (d), or (e) of this section.

(d) Each Accountable Health Carrier shall:

(1) Offer qualified health care plans;
(2) Provide for the collection and reporting to the Board and to the appropriate Alliance of information on the performance of Accountable Health Carriers regarding the effectiveness and outcomes in providing selected services; provided, however, that data reporting requirements adopted by the Board shall be consistent with the method of operation of Accountable Health Carriers, shall be consistent with

national standards where available, and shall not impose an unreasonable cost for compliance;

(3) Not deny, limit, or condition coverage under qualified health care plans based on health status, claims experience, receipt of health care, medical history, or lack of evidence of insurability of an eligible employee or dependent pursuant to the provisions of this Article;

(4) Establish premium rates for each qualified health care plan pursuant to the adjusted community rating method described in G.S. 58-50-130(b);

(5) Comply with all rules regarding rating, underwriting, claims handling, sales, solicitation, licensing, unfair trade practices and other provisions in this Article and Chapter 58 of the General Statutes.

(6) Issue a qualified health care plan to any member small employer that elects to be covered under a qualified health care plan offered by an Accountable Health Carrier during the open enrollment period established pursuant to subsection (e) of this section;

(7) Renew each qualified health care plan with respect to any member small employer except in the following cases:

a. Nonpayment of the required premiums;

b. Fraud or material misrepresentation of the member small employer, or the employee enrollee, or a dependent of the member small employer or the employee enrollee;

c. Noncompliance by a small employer with requirements regarding employer contribution or participation as required by the Board;

d. Repeated misuse of a provider network provision including, but not limited to, unreasonable refusal of the enrollee to follow a prescribed course of treatment, or violation of reasonable policies of an Accountable Health Carrier;

e. Election by the Accountable Health Carrier to terminate its contract with an Alliance. In such a case, the Accountable Health Carrier shall:

1. Provide advance notice of its decision in accordance with this sub-subdivision to the Alliance and to the Board;

2. Provide notice of the decision at least 180 days prior to the nonrenewal of any qualified health care plan to the enrollees. Except as provided in sub-subdivision f. of this subdivision an Accountable Health Carrier that elects not to renew a qualified health care plan with an Alliance shall be prohibited from writing new business with the Alliance for a period of three years from the date of notice to the Alliance or until the Alliance invites the carrier to renew participation, whichever is sooner; and

f. Determination by an Alliance, subject to review by the Board, that continuation of coverage would not be in the best interest of the employee enrollees and member small employers or would impair the Accountable Health Carrier's ability to meet its contractual obligations. In this instance, the Alliance shall assist affected employee enrollees in finding replacement coverage;

(8) Provide a procedure for addressing grievances that arise between the Accountable Health Carrier and the Alliance, member small employers, or employee enrollees; and

(e) Each Accountable Health Carrier shall offer an open enrollment period to small employers at the anniversary date of the member small employers' qualified health care plan. The open enrollment period shall be at least 30 consecutive calendar days. Member small employers may choose from the Accountable Health Carriers selected from the qualified health care plans that are offered in the market area in which they reside. An Accountable Health Carrier shall not be required to offer coverage or accept enrollments if:

(1) The eligible employee or dependent does not reside within the Accountable Health Carrier's approved service area;

(2) An Accountable Health Carrier provides 90 days' prior notice that it will not have the capacity to deliver service adequately in a market area to additional enrollees because of its obligations to existing groups and enrollees; or

(3) The Commissioner of Insurance determines that the acceptance of an application or applications would place an Accountable Health Carrier in a financially impaired condition.

(f) An Accountable Health Carrier that cannot offer coverage pursuant to subdivision (2) of subsection (e) of this section shall not offer coverage to or accept applications from a new employer group or an individual until the later of 90 days following such refusal or the date on which the Accountable Health Carrier notifies the Alliance and the Board that it has regained capacity to deliver services to eligible employees and their dependents in the service area. An Accountable Health Carrier that cannot offer coverage pursuant to subdivision (3) of subsection (e) of this section shall not offer coverage or accept applications for any individual or employer group until a determination by the Commissioner of Insurance that acceptance of an application will not put the Accountable Health Carrier in a financially impaired condition.

(g) Nothing in this Article or any other provision of the General Statutes shall prohibit an Accountable Health Carrier from providing a qualified health care plan in an Alliance through a managed-care system, and from contracting with particular health care providers or types, classes, or categories of health care providers.

"§ 143-630. Payment to Alliance by member small employers.

The contracts between Alliances and member small employers and between Accountable Health Carriers and Alliances shall provide that payment of all premiums shall be transmitted by member small employers on their behalf and on behalf of the

employee enrollee, directly to the Alliance for the benefit of the Accountable Health Carrier. Premiums shall be payable on a monthly basis. Alliances may provide for penalties and grace periods for late payment. Nonpayment of premiums by a member small employer or employee enrollee shall constitute a breach of contract and a breach of the insurance policy.

"§ 143-631. Payment by Alliance to Accountable Health Carriers.

(a) Under a contract between an Accountable Health Carrier and an Alliance, the Alliance shall forward to each Accountable Health Carrier with enrollees under a qualified health care plan an amount equal to:

(1) Premiums determined by the Accountable Health Carrier's contracted rates; and

(2) Adjustments in payments, if any, resulting from a risk adjustment mechanism determined in accordance with G.S. 143-633.

(b) The Alliances shall pay the Accountable Health Carrier on a monthly basis.

"§ 143-632. Marketing qualified health care plans.

(a) Each Alliance shall use efficient and standardized means to notify small employers of the availability of sponsored health coverage through the Alliance.

(b) Each Alliance shall make available to member small employers marketing materials accurately summarizing the benefit plans, rates, cost, and accreditation information that its Accountable Health Carriers offer through the Alliance.

(c) If authorized by the Board, an Accountable Health Carrier may provide, directly or through an agent, broker, or contractor, marketing material relating to health plans offered through the Alliance. Accountable Health Carriers shall not need authorization from an Alliance for advertisement to the public at large through the means of mass media.

(d) Nothing in this section shall be construed to or explicitly prohibit an Alliance or Accountable Health Carrier from using the services of an agent or broker in order to assist in marketing. An Accountable Health Carrier shall not vary compensation or commissions to such agents or brokers based, directly or indirectly, on the anticipated or actual claims experience or health status associated with particular small employers to which each plan is sold.

(e) No Accountable Health Carrier, agent of an Accountable Health Carrier or independent insurance agent shall engage, directly or indirectly, in any activity of marketing practices that would encourage member small employers or eligible employees to:

(1) Refrain from enrolling in the Accountable Health Carrier because of their health status or claim experience; or

(2) Seek coverage from other Accountable Health Carriers because of their health status or claim experience.

(f) An Alliance shall notify the Board of any marketing practices or materials that it finds contrary to the fair and affirmative marketing requirements of this Article. Furthermore, the Board shall monitor compliance with this section, including the conduct of Accountable Health Carriers and their agents, brokers, or contractors, and shall report to the Department of Insurance any unfair trade practices and misleading or

unfair conduct that has been reported to the Board by Alliances, agents, consumers, or any other individual. The Department of Insurance shall investigate all reports and, upon a finding of noncompliance with this section or of unfair and misleading practices, shall take action against violators as permitted under Chapter 58 of the General Statutes or this Article. The Board shall forward all reports of cases or abuse to the Department of Insurance for investigation.

"§ 143-633. Risk adjustment mechanism.

(a) The Board shall establish a payment mechanism to adjust for the amount of risk covered by each qualified health care plan offered by an Accountable Health Carrier. Risk adjustment shall be based on prospectively determined factors that predict utilization of health care services.

(b) On an annual basis, the Board shall establish a factor that represents the difference between the average risk of persons covered through the Alliance and the risk covered by each qualified health care plan offered by each Accountable Health Carrier through the Alliance. The Board shall apply that factor in determining amounts received by Accountable Health Carriers. This may be done directly or it may be done indirectly by adjusting quoted premiums. The mechanism by which the adjustment is made shall be established after consultation with a technical advisory committee.

(c) In addition to the risk adjustment mechanism described in subsections (a) and (b) of this section, the Board may develop a list of a limited number of high cost diagnoses. The Board may develop a mechanism to protect an Accountable Health Carrier that has a disproportionate share of one or more of the listed diagnoses.

(d) Any payments to Accountable Health Carriers under this section shall be determined on an annual basis. No payments under this section shall be based on claims or the health care costs of an Accountable Health Carrier.

"§ 143-634. Antitrust protection.

In addition to the duties described in G.S. 143-626, the Board shall actively supervise the Alliances to ensure that actions affecting market competition are not for private interests, but accomplish the legislative intent of this Article. The Board shall also monitor conduct throughout the small employer market to ensure that the legislative intent of this Article to improve the competitiveness of the small employer health coverage market is not impeded.

"§ 143-635. State Health Plan Purchasing Alliance Fund.

(a) There is established in the Office of the State Treasurer, the State Health Plan Purchasing Alliance Fund. The Fund shall be placed in an interest-bearing account and any interest or other income derived from the Fund shall be credited to the Fund. Moneys in the Fund shall be spent only in accordance with subsection (b) of this section. The Fund shall be administered in accordance with the Executive Budget Act.

(b) All money credited to the Fund shall be used as set forth by the Board.

(c) Moneys appropriated by the General Assembly shall be deposited in the Fund and shall become part of the continuation budget of the Department of Administration.

"§ 143-636. Continuation and conversion of coverage.

(a) For member small employers not covered by Subtitle B of Title III, Public Law 100-647 (26 U.S.C. § 4980B), enrollees who lose their health care coverage due to

loss of employment shall be offered the option of continuing health care coverage for one year, provided such enrollee pays the entire required premium charged to the enrollee's former employer and remains a resident of the State. An enrollee shall transmit payment of premium payments through the enrollee's former employer, who shall submit it to the respective Alliance.

(b) At the end of one year of continuation coverage, such enrollees shall be offered a conversion option if such option, where available, is available for former group enrollees."

Sec. 3.2. G.S. 58-50-130(b) reads as rewritten:

"(b) Premium rates for health benefit plans subject to this Act are subject to the following provisions:

(1) The index rate for a rating period for any class of business shall not exceed the index rate for any other class of business by more than twenty-five percent (25%), twelve and one-half percent (12.5%), adjusted pro rata for any rating period of less than one year.

(2) For a class of business, the premium rates charged during a rating period to small employers with similar case characteristics for the same or similar coverage, or the rates that could be charged to those employers under the rating system for that class of business shall not vary from the index rate by more than thirty-five percent (35%) twenty-five percent (25%) of the index rate, adjusted pro rata for any rating period of less than one year.

(3) The percentage increase in the premium rate charged to a small employer for a new rating period, adjusted pro rata for any rating period of less than one year, may not exceed the sum of the following:

a. The percentage change in the new business premium rate measured from the first day of the prior rating period to the first day of the new rating period. If a small employer carrier is not issuing any new policies, but is only renewing policies, the carrier shall use the percentage change in the base premium rate.

b. Any adjustment, not to exceed fifteen percent (15%) annually and adjusted pro rata for any rating period of less than one year, due to the claim experience, health status, or duration of coverage of the employees or dependents of the small employer as determined from the small employer carrier's rate manual for the class of business.

c. Any adjustment because of a change in coverage or change in the case characteristics of the small employer as determined from the small employer carrier's rate manual for the class of business.

(4) Any adjustment in rates charged by a small employer carrier electing to be a reinsuring carrier that is caused by reinsurance is subject to the rating limitations set forth in this section.

(5) Premium rates for health benefit plans shall comply with the requirements of this section notwithstanding any reinsurance premiums and assessments paid or payable by small employer carriers in accordance with G.S. 58-50-150.

(6) In any case where a small employer carrier uses industry as a case characteristic in establishing premium rates, the rate factor associated with any industry classification may not vary from the arithmetic average of the rate factors associated with all industry classifications by greater than ~~fifteen percent (15%)~~ seven and one-half percent (7 ½%) of coverage.

(7) In the case of health benefit plans issued before January 1, 1992, a premium rate for a rating period, adjusted pro rata for any rating period of less than one year, may exceed the ranges set forth in subdivisions (b)(1) and (2) of this section for a period of three years after January 1, 1992. In that case, the percentage increase in the premium rate charged to a small employer in such a class of business for a new rating period may not exceed the sum of the following:

a. The percentage change in the new business premium rate measured from the first day of the prior rating period to the first day of the new rating period. If a small employer carrier is not issuing any new policies, but is only renewing policies, the small employer carrier shall use the percentage change in the base premium rate.

b. Any adjustment because of a change in coverage or change in the case characteristics of the small employer as determined from the carrier's rate manual for the class of business.

(8) Small employer carriers shall apply rating factors including case characteristics, consistently with respect to all small employers in a class of business. Adjustments in rates for claims experience, health status, and duration from issue may not be applied individually. Any such adjustment must be applied uniformly to the rate charged for all participants of the small employer."

Sec. 3.3. G.S. 58-50-110, as amended by Chapter 408 of the 1993 Session Laws, reads as rewritten:

"§ 58-50-110. Definitions.

As used in this Act:

(1) 'Actuarial certification' means a written statement by a member of the American Academy of Actuaries or other individual acceptable to the Commissioner that a small employer carrier is in compliance with the provisions of G.S. 58-50-130, based upon the person's examination, including a review of the appropriate records and of the actuarial assumptions and methods used by the small employer carrier in establishing premium rates for applicable health benefit plans.

(1a) 'Accountable Health Carrier' means that as defined in G.S. 143-622(1).

(1b) 'Adjusted community rating' means a method used to develop carrier premiums which spreads financial risk across a large population and allows adjustments for the following demographic factors: age, gender, family composition, and geographic areas, as determined pursuant to G.S. 58-50-130(b).

~~(2) 'Base premium rate' means for each class of business as to a rating period, the lowest premium rate charged or that could have been charged under a rating system for that class of business, by the small employer carrier to small employers with similar case characteristics for health benefit plans with the same or similar coverage.~~

(3) 'Basic health care plan' means a health care plan for small employers that is lower in cost than a standard health care plan and is required to be offered by all small employer carriers pursuant to G.S. 58-50-125 and approved by the Commissioner in accordance with G.S. 58-50-125.

(4) 'Board' means the board of directors of the Pool.

(5) 'Carrier' means any person that provides one or more health benefit plans in this State, including a licensed insurance company, a prepaid hospital or medical service plan, a health maintenance organization (HMO), and a multiple employer welfare arrangement.

~~(6) 'Case characteristics' means demographic or other objective characteristics of a small employer, as determined by a small employer carrier, that are considered by the small employer carrier in the determination of premium rates for the small employer; but does not mean claim experience, health status, and duration of coverage since issue.~~

~~(7) 'Class of business' means all or a distinct grouping of small employers as shown on the records of a small employer carrier.~~

(8) 'Committee' means the Small Employer Carrier Committee as created by G.S. 58-50-120.

(9) 'Dependent' means the spouse or child of an eligible employee, subject to applicable terms of the health care plan covering the employee.

(10) 'Eligible employee' means an employee who works for a small employer on a full-time basis, with a normal work week of 30 or more hours, including a sole proprietor, a partner or a partnership, or an independent contractor, if included as an employee under a health care plan of a small employer; but does not include employees who work on a part-time, temporary, or substitute basis.

(11) 'Health benefit plan' means any accident and health insurance policy or certificate; nonprofit hospital or medical service corporation contract; health, hospital, or medical service corporation plan contract; HMO subscriber contract; plan provided by a MEWA or plan provided by another benefit arrangement, to the extent permitted by ERISA, subject to G.S. 58-50-115. Health benefit plan does not mean accident only,

specified disease only, fixed indemnity, credit, or disability insurance; coverage of Medicare services pursuant to contracts with the United States government; Medicare supplement or long-term care insurance; dental only or vision only insurance; coverage issued as a supplement to liability insurance; insurance arising out of a workers' compensation or similar law; automobile medical payment insurance; or insurance under which benefits are payable with or without regard to fault and that is statutorily required to be contained in any liability insurance policy or equivalent self-insurance.

(12) 'Impaired insurer' has the same meaning as prescribed in G.S. 58-62-20(6) or G.S. 58-62-16(8).

~~(13) 'Index rate' means, for each class of business as to a rating period for small employers with similar case characteristics, the arithmetic average of the applicable base premium rate and the corresponding highest premium rate.~~

(14) 'Late enrollee' means an eligible employee or dependent who requests enrollment in a health benefit plan of a small employer after the end of the initial enrollment period provided under the terms of the health benefit plan in effect at the time the employee first became eligible; provided that the initial enrollment period shall be a period of at least 30 consecutive calendar days. However, an eligible employee or dependent shall not be considered a late enrollee if:

a. The ~~individual:~~

~~1.~~ ~~Was~~ individual was covered under ~~another employer~~ a public or private health benefit plan that provided, at the time the individual was eligible to ~~enroll;~~ enroll, the same required level of benefits in the basic and standard health care plans adopted pursuant to G.S. 58-50-120 and either the individual:

1. Lost coverage under another health plan as a result of termination of employment, termination of a spouse's health plan coverage, or the death of a spouse or divorce and requests enrollment in a basic or standard health care plan within 30 days after termination of coverage provided under another health plan; or

2. Stated, ~~at the time of the initial enrollment,~~ in writing, during the enrollment period that coverage under another employer health benefit plan was the reason for declining ~~enrollment;~~ coverage;

~~3. Has lost coverage under another employer health benefit plan as a result of termination of employment, the termination of the other plan's coverage, death of a spouse, or divorce; and~~

~~4. Requests enrollment within 30 days after termination of coverage provided under another employer health benefit plan;~~

~~b. The individual is employed by an employer that offers multiple health benefit plans and the individual elects a different plan during an open enrollment period; or~~

b. The individual elects a different health plan offered through the Alliance during an open enrollment period;

c. An eligible employee requests enrollment within 30 days of becoming an employee of a member small employer;

~~c.~~d. A court has ordered coverage be provided for a spouse or minor child under a covered employee's health benefit plan and the request for enrollment is made within 30 days after issuance of the court ~~order.~~ order; or

e. The individual or employee enrollee makes a request for enrollment of the spouse or child within 30 days of the individual or employee's marriage or the birth or adoption of a child.

~~(15) 'New business premium rate' means, for each class of business as to a rating period, the lowest premium rate charged, offered, or that could have been charged by a small employer carrier to small employers with similar case characteristics for newly issued health benefit plans with the same or similar coverage.~~

(16) 'Pool' means the North Carolina Small Employer Health Reinsurance Pool created in G.S. 58-50-150.

(17) 'Preexisting-conditions provision' means a policy provision that limits or excludes coverage for charges or expenses incurred during a specified period following the insured's effective date of coverage, for a condition that, during a specified period immediately preceding the effective date of coverage, had manifested itself in a manner that would cause an ordinary prudent person to seek diagnosis, care, or treatment, or for which medical advice, diagnosis, care, or treatment was recommended or received as to that condition or as to pregnancy existing on the effective date of coverage.

(18) 'Premium' includes insurance premiums or other fees charged for a health benefit plan, including the costs of benefits paid or reimbursements made to or on behalf of persons covered by the plan.

(19) 'Rating period' means the calendar period for which premium rates established by a small employer carrier are assumed to be in effect, as determined by the small employer carrier.

(20) 'Risk-assuming carrier' means a small employer carrier electing to comply with the requirements set forth in G.S. 58-50-140.

(21) 'Reinsuring carrier' means a small employer carrier electing to comply with the requirements set forth in G.S. 58-50-145.

(21a) 'Self-employed individual' means an individual or sole proprietor who derives a majority of his or her income from a trade or business carried on by the individual or sole proprietor which results in taxable income as indicated on IRS form 1040, Schedule C or F and which generated taxable income in one of the two previous years.

(22) 'Small employer' means any ~~person~~ individual actively engaged in business that, on at least fifty percent (50%) of its working days during the preceding ~~year,~~ calendar quarter, employed no more than 49 eligible ~~employees and not less than two eligible employees,~~ employees, the majority of whom are employed within this ~~State.~~ State, and is not formed primarily for purposes of buying health insurance and in which a bona fide employer-employee relationship exists. ~~Small employer includes companies that are affiliated companies, as defined in G.S. 58-19-5(1) or that are eligible to file a combined tax return under Chapter 105 of the General Statutes or under the Internal Revenue Code.~~ In determining the number of eligible employees, companies that are affiliated companies, or that are eligible to file a combined tax return for purposes of taxation by this State, shall be considered one employer. Subsequent to the issuance of a health benefit plan to a small employer and for the purpose of determining eligibility, the size of a small employer shall be determined annually. Except as otherwise specifically provided, the provisions of this Act that apply to a small employer shall continue to apply until the plan anniversary following the date the small employer no longer meets the requirements of this ~~section.~~ definition. For purposes of this Act, the term small employer includes self-employed individuals.

(23) 'Small employer carrier' means any carrier that offers health benefit plans covering eligible employees of one or more small employers.

(24) 'Standard health care plan' means a health care plan for small employers required to be offered by all small employer carriers under G.S. 58-50-125 and approved by the Commissioner in accordance with G.S. 58-50-125."

Sec. 3.4. G.S. 58-50-113 is repealed.

Sec. 3.5. G.S. 58-50-115 reads as rewritten:

"**§ 58-50-115. Health benefit plans subject to Act.**

~~(a)~~ A health benefit plan is subject to this Act if it provides health benefits for small employers or self-employed individuals and if any of the following conditions are met:

(1) Any part of the premiums or benefits is paid by a small employer or any covered individual is reimbursed, whether through wage or adjustments or otherwise, by a small employer for any portion of the premium; ~~or for which the small employer has permitted payroll deduction for the covered individual, whether or not the coverage is~~

~~issued through a group or individual policy of insurance, and whether or not the small employer pays any part of the premium.~~

(2) The health benefit plan is treated by the employer or any of the covered self-employed individuals as part of a plan or program for the purpose of ~~section 162 or section 106~~ sections 106, 125, or 162 of the United States Internal Revenue ~~Code.~~ Code; or

(3) The small employer or self-employed individuals have permitted payroll deductions for the eligible enrollees for the health benefit plans.

~~(b) The provisions of G.S. 58-51-95(f) do not apply to individual accident and health insurance policies or contracts to the extent subject to the provisions of this Act~~."

Sec. 3.6. G.S. 58-50-125 reads as rewritten:

"**§ 58-50-125. Health care plans; formation; approval; offerings.**

(a) To improve the availability and affordability of health benefits coverage for small employers, the Committee shall recommend to the Commissioner two plans of coverage, one of which shall be a basic health care plan and the second of which shall be a standard health care plan. Each plan of coverage shall be in two forms, one of which shall be in the form of insurance and the second of which shall be consistent with the basic method of operation and benefit plans of HMOs, including federally qualified HMOs. On or before January 1, 1992, the Committee shall file a progress report with the Commissioner. The Committee shall submit the recommended plans to the Commissioner for approval within 180 days after the appointment of the Committee under G.S. 58-50-120. The Committee shall take into consideration the levels of health benefit plans provided in North Carolina, and appropriate medical and economic factors, and shall establish benefit levels, cost sharing, exclusions, and limitations. Notwithstanding subsection (c) of this section, in developing and approving the plans, the Committee and the Commissioner shall give due consideration to cost-effective and life-saving health care services and to cost-effective health care providers. The Committee shall file with the Commissioner its findings and recommendations, and reasons for the findings and recommendations, if it does not provide for coverage by any type of health care provider specified in G.S. 58-50-30. The recommended plans may include cost containment features such as, but not limited to: preferred provider provisions; utilization review of medical necessity of hospital and physician services; case management benefit alternatives; or other managed care provisions.

(b) After the Commissioner's approval of the plans submitted by the Committee under subsection (a) of this section and in lieu of any contrary procedure established by this Chapter, any small employer carrier may certify to the Commissioner, in the form and manner prescribed by the Commissioner, that the basic and standard health care plans filed by the carrier are in substantial compliance with the provisions of the corresponding approved Committee plans. Upon receipt by the Commissioner of the certification, the carrier may use the certified plans unless their use is disapproved by the Commissioner.

(c) The plans developed under this section are not required to provide coverage that meets the requirements of other provisions of this Chapter that mandate either

coverage or the offer of coverage by the type or level of health care services or health care provider.

(d) Within 180 days after the Commissioner's approval under subsection (b) of this section, every small employer carrier shall, as a condition of transacting business in this State, offer small employers at least one basic and one standard health care plan. Every small employer that elects to be covered under such a plan and agrees to make the required premium payments and to satisfy the other provisions of the plan shall be issued such a plan by the small employer carrier. The premium payment requirements used in connection with basic and standard health care plans may address the potential credit risk of small employers that elect coverage in accordance with this subsection by means of payment security provisions that are reasonably related to the risk and are uniformly applied.

<u>If a small employer carrier offers coverage to a small employer, the small employer carrier shall offer coverage to all eligible employees of a small employer and their dependents. A small employer carrier shall not offer coverage to only certain individuals in a small employer group except in the case of late enrollees as provided in G.S. 58-50-130(a)(4). A small employer carrier shall not modify any health benefit plan with respect to a small employer, any eligible employee, or dependent 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. In the case of an eligible employee or dependent of an eligible employee who, before the effective date of the plan, was excluded from coverage or denied coverage by a small employer carrier in the process of providing a health benefit plan to an eligible small employer, the small employer carrier shall provide an opportunity for the eligible employee or dependent of an eligible employee to enroll in the health benefit plan currently held by the small employer.</u>

(e) No small employer carrier is required to offer coverage or accept applications under subsection (d) of this section:

(1) From a group already covered under a health benefit plan except for coverage that is to begin after the group's anniversary date, but this subsection shall not be construed to prohibit a group from seeking coverage or a small employer carrier from issuing coverage to a group before its anniversary date; or

(2) If the Commissioner determines that acceptance of an application or applications would result in the carrier being declared an impaired <u>insurer.</u> ~~insurer; or~~

~~(3) To groups of fewer than five eligible employees where the small employer carrier does not use preexisting-conditions provisions in all health benefit plans it issues to any small employers.~~

~~If a small employer carrier who does not use preexisting conditions chooses to market to groups of less than five, then it shall immediately notify the Commissioner and the Board, and it shall do so consistently and equally to all such small employer groups.~~

(f) Every small employer carrier shall fairly market the basic and standard health care plan to all small employers in the geographic areas in which the carrier makes coverage available or provides benefits.

(g) No HMO operating as either a risk-assuming carrier or a reinsuring carrier is required to offer coverage or accept applications under subsection (d) of this section in the case of any of the following:

(1) To a ~~group, where the~~ group that is not physically located in the HMO's approved service areas;

(2) To an ~~employee, where the~~ employee who does not reside within the HMO's approved service areas;

(3) Within an area, where the HMO can reasonably ~~anticipates,~~ anticipate, and ~~demonstrates~~ demonstrate, to the Commissioner's satisfaction, that it will not have the capacity within that area and its network of providers to deliver services adequately to the enrollees of those groups because of its obligations to existing group contract holders and enrollees.

An HMO that does not offer coverage pursuant to subdivision (3) of this subsection may not offer coverage in the applicable area to new employer groups with more than ~~25~~ 49 eligible employees until the later of 90 days after that closure or the date on which the carrier notifies the Commissioner that it has regained capacity to deliver services to small employers.

(h) The provisions of subsections (b), (d), and (g) and subdivision (e)(2) of this section apply to every health benefit plan delivered, issued for delivery, renewed, or continued in this State or covering persons residing in this State on or after the date the plan becomes operational, as determined by the Commissioner. For purposes of this subsection, the date a health benefit plan is continued is the anniversary date of the issuance of the health benefit plan."

Sec. 3.7. G.S. 58-50-130, as rewritten by Section 3.2 of this act and by Section 6 of Chapter 408 of the 1993 Session Laws, reads as rewritten:

"**§ 58-50-130. Required health care plan provisions.**

"(a) Health benefit plans covering small employers are subject to the following provisions:

(1) Except in the case of a late enrollee, any preexisting-conditions provision may not limit or exclude coverage for a period beyond 12 months following the insured's initial effective date of coverage and must define preexisting conditions as 'those conditions for which medical advice or treatment was received or recommended or that could be medically documented within the 12-month period immediately preceding the effective date of the person's coverage'.

(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.

(3) The health benefit plan is renewable with respect to all eligible employees or dependents at the option of the policyholder or contract holder except:

a. For nonpayment of the required premiums by the policyholder or contract holder;

b. For fraud or misrepresentation of the policyholder or contract holder or, with respect to coverage of individual enrollees, the enrollees, or their representatives;

c. For noncompliance with plan provisions that have been approved by the Commissioner;

d. When the number of enrollees covered under the plan is less than the number of insureds or percentage of enrollees required by participation requirements under the plan; or

e. When the policyholder or contract holder is no longer actively engaged in the business in which it was engaged on the effective date of the plan.

f. When the small employer carrier stops writing new business in the small employer market, if:

1. It provides notice to the Department and either to the policyholder, contract holder, or employer, of its decision to stop writing new business in the small employer market; and

2. It does not cancel health benefit plans subject to this Act for 180 days after the date of the notice required under paragraph 1; and for that business of the carrier that remains in force, the carrier shall continue to be governed by this Act with respect to business conducted under this Act.

A small employer carrier that stops writing new business in the small employer market in this State after January 1, 1992, shall be prohibited from writing new business in the small employer market in this State for a period of five years from the date of notice to the Commissioner. In the case of an HMO doing business in the small employer market in one service area of this State, the rules set forth in this subdivision shall apply to the HMO's operations in the service area, unless the provisions of G.S. 58-50-125(g) apply.

(4) Late enrollees may be excluded from coverage for the greater of 18 months or an 18-month preexisting-condition exclusion; however, if both a period of exclusion from coverage and a preexisting-condition exclusion are applicable to a late enrollee, the combined period shall not exceed 18 months. If a period of exclusion from coverage is

applied, a late enrollee shall be enrolled at the end of such period in the health benefit plan currently held by the small employer.

~~(5) A carrier may continue to enforce reasonable employer participation and contribution requirements on small employers applying for coverage; however, participation and contribution requirements may vary among small employers only by the size of the small employer group, and the minimum participation for a small employer group must be the greater of two or twenty-five percent (25%) of eligible employees. In applying minimum participation requirements with respect to a small employer, a small employer carrier shall not consider employees or dependents who have qualifying existing coverage in determining whether the applicable percentage of participation is met. 'Qualifying existing coverage' means benefits or coverage provided under: (i) Medicare or Medicaid; or (ii) an employer-based health insurance or health benefit arrangement that provides benefits similar to or exceeding benefits provided under the basic health care plan.~~

(5) Notwithstanding any other provision of this Chapter, no small employer carrier, insurer, subsidiary of an insurer, or controlled individual of a 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 a holding company shall provide stop loss, catastrophic, or reinsurance coverage to small groups which, if they were purchased, would be subject to this section.

(6) If a small employer carrier offers coverage to a small employer, the small employer carrier shall offer coverage to all eligible employees of a small employer and their dependents. A small employer carrier shall not offer coverage to only certain individuals in a small employer group except in the case of late enrollees as provided in G.S. 58-50-130(a)(4).

(7) A small employer carrier shall not modify any health benefit plan with respect to a small employer, any eligible employee, or dependent 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.

(8) In the case of an eligible employee or dependent of an eligible employee who was excluded from or denied coverage by a small employer carrier on or before August 14, 1992, the small employer carrier shall provide an opportunity for such eligible employee or dependent to enroll in the health benefit plan currently held by the small employer not later than the next plan anniversary on or after August 14, 1992.

~~(b) Premium rates for health benefit plans subject to this Act are subject to the following provisions:~~

~~(1) The index rate for a rating period for any class of business shall not exceed the index rate for any other class of business by more than twelve and one half percent (12.5%), adjusted pro rata for any rating period of less than one year.~~

~~(2) For a class of business, the premium rates charged during a rating period to small employers with similar case characteristics for the same or similar coverage, or the rates that could be charged to those employers under the rating system for that class of business shall not vary from the index rate by more than twenty-five percent (25%) of the index rate, adjusted pro rata for any rating period of less than one year.~~

~~(3) The percentage increase in the premium rate charged to a small employer for a new rating period, adjusted pro rata for any rating period of less than one year, may not exceed the sum of the following:~~

~~a. The percentage change in the new business premium rate measured from the first day of the prior rating period to the first day of the new rating period. If a small employer carrier is not issuing any new policies, but is only renewing policies, the carrier shall use the percentage change in the base premium rate.~~

~~b. Any adjustment, not to exceed fifteen percent (15%) annually and adjusted pro rata for any rating period of less than one year, due to the claim experience, health status, or duration of coverage of the employees or dependents of the small employer as determined from the small employer carrier's rate manual for the class of business.~~

~~c. Any adjustment because of a change in coverage or change in the case characteristics of the small employer as determined from the small employer carrier's rate manual for the class of business.~~

~~(4) Any adjustment in rates charged by a small employer carrier electing to be a reinsuring carrier that is caused by reinsurance is subject to the rating limitations set forth in this section.~~

~~(5) Premium rates for health benefit plans shall comply with the requirements of this section notwithstanding any reinsurance premiums and assessments paid or payable by small employer carriers in accordance with G.S. 58-50-150.~~

~~(6) In any case where a small employer carrier uses industry as a case characteristic in establishing premium rates, the rate factor associated with any industry classification may not vary from the arithmetic average of the rate factors associated with all industry classifications by greater than seven and one half percent (7.5%) of coverage.~~

~~(7) In the case of health benefit plans issued before January 1, 1992, a premium rate for a rating period, adjusted pro rata for any rating period of less than one year, may exceed the ranges set forth in subdivisions (b)(1) and (2) of this section for a period of three years after January 1, 1992. In that case, the percentage increase in the premium rate charged to a small employer in such a class of business for a new rating period may not exceed the sum of the following:~~

~~a. The percentage change in the new business premium rate measured from the first day of the prior rating period to the first day of the new rating period. If a small employer carrier is not issuing any new policies, but is only renewing policies, the small employer carrier shall use the percentage change in the base premium rate.~~

~~b. Any adjustment because of a change in coverage or change in the case characteristics of the small employer as determined from the carrier's rate manual for the class of business.~~

~~(8) Small employer carriers shall apply rating factors including case characteristics, consistently with respect to all small employers in a class of business. Adjustments in rates for claims experience, health status, and duration from issue may not be applied individually. Any such adjustment must be applied uniformly to the rate charged for all participants of the small employer.~~

(b) For all small employer health benefit plans that are subject to this section and are issued on or after January 1, 1995, premium rates for health benefit plans subject to this section are subject to the following provisions:

(1) Small employer carriers shall use an adjusted-community rating methodology in which the premium for each small employer can vary on the basis of the eligible employee's or dependent's age as determined in accordance with subdivision (6) of this subsection, the gender of the eligible employee or dependent, number of family members covered, or geographic area as determined under subdivision (7) of this subsection;

(2) Rating factors related to age, gender, number of family members covered, or geographic location may be developed by each carrier to reflect the carrier's experience. The factors used by carriers are subject to the Commissioner's review;

(3) Small employer carriers shall not modify the rate for a small employer for 12 months from the initial issue date or renewal date, unless the composition of the group changed by twenty percent (20%) or more or benefits are changed;

(4) Carriers participating in an Alliance in accordance with the Health Care Purchasing Alliance Act may apply a different community rate to business written in that Alliance;

(5) In the case of health benefit plans issued before January 1, 1995, a premium rate for a rating period, adjusted pro rata for any rating period of less than one year, may vary from the adjusted community rating index line, as determined by the small employer carrier and in accordance with subdivisions (1), (2), (3), and (4) of this subsection, for a period of two years after January 1, 1995, as follows:

a. On January 1, 1995, the premium rates charged during a rating period to small employers with similar case characteristics for the same or similar coverage, or the rates that could be charged to those employers under the rating system for that class of business shall not vary from the adjusted community rate by more than twenty percent (20%) of the index rate, adjusted pro rata for any rating period of less than one year;

b. On January 1, 1996, the premium rates charged during a rating period to small employers with similar case characteristics for the same or similar coverage, or the rates that could be charged to those employers under the rating system for that class of business shall not vary from the adjusted community rate by more than ten percent (10%) of the index rate, adjusted pro rata for any rating period of less than one year; and

c. On January 1, 1997, all small employer benefit plans that are subject to this section and are issued by small employer carriers before January 1, 1997, and that are renewed on or after January 1, 1997, renewal rates shall be based on the same adjusted community rating standard applied to new business.

(6) For the purposes of subsection (b) of this section, a small employer carrier shall not use age brackets of less than five years;

(7) For the purposes of subsection (b) of this section, a carrier shall not apply different geographic rating factors to the rates of small employers located within the same county; and

(8) The Department of Insurance may, by rule, establish regulations to administer this subsection and to assure that rating practices used by small employer carriers are consistent with the purposes of this subsection. Those regulations shall include consideration of differences based on the following:

a. Health benefit plans that use different provider network arrangements may be considered separate plans for the purposes of determining the rating in subdivision (1) of this subsection, provided that the different arrangements are expected to result in substantial differences in claims costs;

b. Except as provided for in sub-subdivision a. above, differences in premium rates charged for different health benefit plans shall be reasonable and reflect objective differences in plan design, but shall not permit differences in premium rates due to the

<u>demographics of groups assumed to select particular health benefit plans; and</u>

<u>c.</u> <u>Small employer carriers shall apply allowable rating factors consistently with respect to all small employers. Adjustments in rates for age, gender, and geography shall not be applied individually. Any such adjustment shall be applied uniformly to the rate charged for all employee enrollees of the small employer.</u>

~~(c) A small employer carrier shall not involuntarily transfer a small employer into or out of a class of business. A small employer carrier shall not offer to transfer a small employer into or out of a class of business unless the carrier offers to transfer all small employers in the class of business without regard to case characteristics, claims experience, health status, or duration of coverage since issue.~~

(d) In connection with the offering for sale of any health benefit plan to a small employer, each small employer carrier shall make a reasonable disclosure, as part of its solicitation and sales materials, of:

~~(1) The extent to which premium rates for a specified small employer are established or adjusted in part based upon the actual or expected variation in claims costs or actual or expected variation in health condition of the eligible employees and dependents of the small employer.~~

(2) Provisions concerning the small employer carrier's right to change premium rates and the factors other than claims experience that affect changes in premium rates.

(3) Provisions relating to renewability of policies and contracts.

(4) Provisions affecting any preexisting conditions provision.

(e) Each small employer carrier shall maintain at its principal place of business a complete and detailed description of its rating practices and renewal underwriting practices, including information and documentation that demonstrate that its rating methods and practices are based upon commonly accepted actuarial assumptions and are in accordance with sound actuarial principles.

(f) Each small employer carrier shall file with the Commissioner annually on or before March 15 an actuarial certification certifying that it is in compliance with this Act and that its rating methods are actuarially sound. The small employer carrier shall retain a copy of the certification at its principal place of business.

(g) A small employer carrier shall make the information and documentation described in subsection (e) of this section available to the Commissioner upon request. Except in cases of violations of this Act, the information is proprietary and trade secret information and is not subject to disclosure by the Commissioner to persons outside of the Department except as agreed to by the small employer carrier or as ordered by a court of competent jurisdiction.

(h) The provisions of subdivisions (a)(1), (3), and (5) and subsections (b) through (g) of this section apply to health benefit plans delivered, issued for delivery, renewed, or continued in this State or covering persons residing in this State on or after January 1,

1992. The provisions of subdivisions (a)(2) and (4) of this section apply to health benefit plans delivered, issued for delivery, renewed, or continued in this State or covering persons residing in this State on or after the date the plan becomes operational, as designated by the Commissioner. For purposes of this subsection, the date a health benefit plan is continued is the anniversary date of the issuance of the health benefit plan."

Sec. 3.8. G.S. 58-53-35 reads as rewritten:

"**§ 58-53-35. Termination of continuation.**

(a) Continuation of insurance under the group policy for any person shall terminate on the earliest of the following dates:

(1) The date ~~three months~~ one year after the date the employee's or member's insurance under the policy would otherwise have terminated because of termination of employment or members;

(2) The date ending the period for which the employee or member last makes his required contribution, if he discontinues his contributions;

(3) The date the employee or member becomes or is eligible to become covered for similar benefits under any arrangement of coverage for individuals in a group, whether insured or uninsured;

(4) The date on which the group policy is terminated or, in the case of a multiple employer plan, the date his employer terminates participating under the group master policy. When this occurs the employee or member shall have the privilege described in G.S. 58-53-45 if the date of termination precedes that on which his actual continuation of insurance under that policy would have been terminated. The insurer that insured the group prior to the date of termination shall make a converted policy available to the employee or member.

(b) Notwithstanding subdivision (a)(4) of this section, if the employer replaces the group policy with another group policy, the employee is entitled to continue under the successor group policy for any unexpired period of continuation to which the employee is entitled."

Sec. 3.9. G.S. 120-123 is amended by adding a new subdivision to read:

"(61) The State Health Plan Purchasing Alliance Board, as established by G.S. 143-625."

Sec. 3.10. The State Health Plan Purchasing Alliance Board shall report not later than January 1, 1995, to the Joint Legislative Commission on Governmental Operations on the following:

(1) The progress achieved in expanding the availability of affordable insurance to employees of small employers;

(2) Employee choice;

(3) The possible need for financial incentives to encourage increased participation;

(4) The demographic factors used to determine the adjusted community rating method;

(5) The possible need to have exclusive purchasing of health insurance through the Alliance for all small employers who choose to purchase health insurance;
(6) Options for including (i) employers with more than 50 employees, and (ii) populations from State and federally financed systems of health coverage;
(7) The need for federal waivers;
(8) Developments in health care reform at the federal level as well as in other states, including, but not limited to, Florida and other states in the southeast region of the United States; and
(9) The need to develop, to the extent feasible and consistent with national standards, standard information to be collected from Accountable Health Carriers on the types of treatments and outcomes with respect to the clinical health, functional status, and well-being of enrollees.

Sec. 3.11. Within 30 days of ratification of this act, the Governor, the General Assembly upon the recommendation of the Speaker of the House of Representatives, and the General Assembly upon the recommendation of the President Pro Tempore of the Senate shall make their appointments to the State Health Care Purchasing Alliance Board. Those appointments restricted by G.S. 143-625(b) shall be drawn from among persons who own, manage, or are employed by a small employer as defined in G.S. 143-622 who would qualify as a member small employer under this act. If initial appointments are not made by the General Assembly prior to August 1, 1993, those positions shall be filled by appointment pursuant to G.S. 120-122.

Sec. 3.12. Of the funds appropriated to the Reserve for Health Care Initiatives in Chapter 321 of the 1993 Session Laws, the sum of four million dollars ($4,000,000) for the 1993-94 fiscal year and the sum of five hundred thousand dollars ($500,000) for the 1994-95 fiscal year shall be used for the initial operation of the Health Care Purchasing Alliance Board and other activities related to the duties and responsibilities of the Alliances and the State Health Purchasing Alliance Board authorized by Section 3.1 of this act.

Sec. 3.13. Section 3.2 of this act becomes effective January 1, 1994. Sections 3.3 through 3.7 of this act become effective January 1, 1995. Alliances shall become operational on or after January 1, 1995. The remainder of this Part is effective upon ratification.

PART IV.–UNIFORM CLAIM FORMS

Sec. 4.1. G.S. 58-50-10 is repealed.

Sec. 4.2. Article 3 of Chapter 58 of the General Statutes is amended by adding the following new sections to read:

"**§ 58-3-171. Uniform claim forms.**

(a) All claims submitted by health care providers to health benefit plans shall be submitted on a uniform form or format that shall be developed by the Department and approved by the Commissioner. Additional information beyond that contained on the

uniform form or format may be collected subject to rules adopted by the Commissioner. This section applies to the submission of claims in writing and by electronic means.

(b) After consultation with the North Carolina Industrial Commission, the Commissioner may include workers' compensation insurance policies as 'health benefit plans' for the purpose of administering the provisions of this section.

(c) For purposes of this section, 'health benefit plans' means accident and health insurance policies or certificates; nonprofit hospital or medical service corporation contracts; health maintenance organization (HMO) subscriber contracts and other plans provided by managed-care organizations; plans provided by a MEWA or plans provided by other benefit arrangements, to the extent permitted by ERISA; the Teachers' and State Employees' Comprehensive Major Medical Plan; and medical payment coverages under homeowners and automobile insurance policies.

"§ 58-3-172. Notice of claim denied.

(a) For all claims denied for heath care provider services under health benefit plans, written notification of the denied claim shall be given to the insured and to the health care provider submitting the claim if the health care provider would otherwise be eligible for payment.

(b) For purposes of this section, 'health benefit plans' means accident and health insurance policies or certificates; nonprofit hospital or medical service corporation contracts; health, hospital, or medical service corporation plan contracts; health maintenance organization (HMO) subscriber contracts and other plans provided by managed-care organizations; plans provided by a MEWA or plans provided by other benefit arrangements, to the extent permitted by ERISA; and the Teachers' and State Employees' Comprehensive Major Medical Plan."

Sec. 4.3. Chapter 90 of the General Statutes is amended by adding a new Article 28 to read:

"ARTICLE 28.

"Medical Records.

"§ 90-410. Definitions.

As used in this Article:

(1) 'Health care provider' means any person who is licensed or certified to practice a health profession or occupation under this Chapter or Chapters 90B or 90C of the General Statutes, a health care facility licensed under Chapters 131E or 122C of the General Statutes, and a representative or agent of a health care provider.

(2) 'Medical records' means personal information that relates to an individual's physical or mental condition, medical history, or medical treatment, excluding X rays and fetal monitor records.

"§ 90-411. Record copy fee.

A health care provider may charge a reasonable fee to cover the costs incurred in searching, handling, copying, and mailing medical records to the patient or the patient's designated representative. The maximum fee shall be fifty cents (50¢) per page, provided that the health care provider may impose a minimum fee of up to ten dollars ($10.00), inclusive of copying costs. If requested by the patient or the patient's

designated representative, nothing herein shall limit a reasonable professional fee charged by a physician for the review and preparation of a narrative summary of the patient's medical record. This section shall only apply with respect to liability claims for personal injury."

Sec. 4.4. This Part becomes effective January 1, 1994.

PART V.–HOSPITAL COOPERATION

Sec. 5.1. Part V of this act shall be known as the Hospital Cooperation Act of 1993.

Sec. 5.2. Chapter 131E of the General Statutes is amended by adding the following new Article to read:

"ARTICLE 9A.

"Certificate of Public Advantage.

"§ 131E-192.1. Findings.

The General Assembly of North Carolina makes the following findings:

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

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

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

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

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

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

(7) That competition as currently mandated by federal and State antitrust laws should be supplanted by a regulatory program to permit and encourage cooperative agreements between hospitals, or between

hospitals and others, that are beneficial to North Carolina citizens when the benefits of cooperative agreements outweigh their disadvantages caused by their potential or actual adverse effects on competition.

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

"§ 131E-192.2. Definitions.

The following definitions apply in this Article:

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

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

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

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

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

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

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

(a) A hospital and any person who is a party to a cooperative agreement with a hospital may negotiate, enter into, and conduct business pursuant to a cooperative agreement without being subject to damages, liability, or scrutiny under any State antitrust law if a certificate of public advantage is issued for the cooperative agreement, or in the case of activities to negotiate or enter into a cooperative agreement, if an application for a certificate of public advantage is filed in good faith. It is the intention

of the General Assembly that immunity from federal antitrust laws shall also be conferred by this statute and the State regulatory program that it establishes.

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

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

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

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

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

(1) Enhancement of the quality of hospital and hospital-related care provided to North Carolina citizens.
(2) Preservation of hospital facilities in geographical proximity to the communities traditionally served by those facilities.
(3) Lower costs of, or gains in, the efficiency of delivering hospital services.
(4) Improvements in the utilization of hospital resources and equipment.
(5) Avoidance of duplication of hospital resources.
(6) The extent to which medically underserved populations are expected to utilize the proposed services.

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

(1) The extent to which the agreement may increase the costs or prices of health care at a hospital which is party to the cooperative agreement.
(2) The extent to which the agreement may have an adverse impact on patients in the quality, availability, and price of health care services.

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

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

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

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

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

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

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

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

If the Attorney General is not persuaded that an applicant has demonstrated by clear and convincing evidence that the benefits likely to result from the agreement outweigh the likely disadvantages of any reduction of competition to result from the agreement as set forth in G.S. 131E-192.4, the Attorney General may, within the review period, state an objection to the issuance of a certificate of public advantage and may extend the review period for a specified period of time. Notice of the objection and any extension of the review period shall be provided in writing to the applicant, together with a general explanation of the concerns of the Attorney General. The parties may attempt to reach an agreement with the Attorney General on modifications to the agreement or to conditions in the certificate so that the Attorney General no longer objects to issuance of a certificate. If the Attorney General withdraws the objection and the Department

maintains its determination that a certificate should be issued, the Department shall issue a certificate of public advantage with any appropriate conditions as soon as practicable following the withdrawal of the objection. If the Attorney General does not withdraw the objection, a certificate shall not be issued.

"§ 131E-192.7. Record keeping.

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

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

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

"§ 131E-192.9. Periodic reports.

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

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

(2) Price and cost information.

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

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

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

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

(b) Failure to file a periodic report required by this section after notice of default or failure to provide information requested pursuant to a review under G.S. 131E-192.8

is grounds for the revocation of the certificate by the Attorney General or the Department.

(c) The Department shall review each periodic report, public comments, and information submitted in response to a request under G.S. 131E-192.8 to determine whether the advantages or likely advantages of the cooperative agreement continue to outweigh the disadvantages or likely disadvantages of any reduction in competition from the agreement, and to determine what, if any, changes in the conditions of the certificate should be made. In the review the Department shall consider the benefits and disadvantages set forth in G.S. 131E-192.4. Within 60 days of the filing of a periodic report, the Department shall determine whether the certificate should remain in effect and whether any changes to the conditions in the certificate should be made. The Department may extend the review period an additional 30 days. If either the Department or the Attorney General determines that the parties to a cooperative agreement have not complied with any condition of the certificate, the Department or the Attorney General shall revoke the certificate and the parties shall be notified. If the certificate is revoked, the parties shall be entitled to no benefits under this Article, beginning on the date of revocation. If the Department determines that the certificate should remain in effect and the Attorney General has not stated any objection to the certificate remaining in effect during the review period, the certificate shall remain in effect subject to any changes in the conditions of the certificate imposed by the Department. The parties shall be notified in writing of the Department's decision and of any changes in the conditions of the certificate. The Department shall publish its decision and any changes in the conditions in the North Carolina Register.

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

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

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

(b) Any party or other person aggrieved by a decision to allow a certificate to remain in effect or to make changes in the conditions of a certificate is entitled to judicial review of the decision in superior court. Suit for judicial review under this subsection shall be filed within 30 days of public notice of the decision to allow the certificate to remain in effect or to make changes in the conditions of the certificate. To

prevail in any action for judicial review brought under this subsection, the plaintiff or petitioner must establish that the determination by the Department or the Attorney General was arbitrary or capricious.

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

(d) In any action instituted under this section, the work product of the Department, the Attorney General or his staff, is not a public record under Chapter 132, and shall not be discoverable or admissable, nor shall the Attorney General or any member of his staff be compelled to be a witness, whether in discovery or at any hearing or trial.

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

The Department and the Attorney General shall establish a schedule of fees for filing an application for a certificate of public advantage and for filing a periodic report based on the total cost of the project for which the application or periodic report is made. The fee for filing an application may not exceed fifteen thousand dollars ($15,000). The fee for filing a periodic report may not exceed two thousand five hundred dollars ($2,500). The fee schedule established should generate sufficient revenue to offset the costs of the program. An application filing fee must be paid to the Department at the time an application for a certificate of public advantage is submitted to it pursuant to G.S. 131E-192.3. A periodic report filing fee must be paid to the Department at the time a periodic report is submitted to it pursuant to G.S. 131E-192.9.

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

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

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

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

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

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

Sec. 5.3. G.S. 131E-7(b) reads as rewritten:

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

Sec. 5.4. The Department of Human Resources and the Attorney General shall prepare and submit a report to the 1999 General Assembly summarizing and analyzing the effects of this Part. The report shall include the results of efforts to assure access to health care and to control increases in health care costs and any recommendations the Department may have for amendments to this Part.

Sec. 5.5. Sections 5.1, 5.2, and 5.4 are effective upon ratification. Section 5.3 becomes effective October 1, 1993.

PART VI.–HOSPITAL AUTHORITY TERRITORY

Sec. 6.1. G.S. 131E-20(a) reads as rewritten:

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

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

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

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

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

PART VII.–HEALTH DELIVERY IMPROVEMENTS

Sec. 7.1. G.S. 58-50-50 reads as rewritten:

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

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

Sec. 7.2. G.S. 58-67-10(b) reads as rewritten:

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

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

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

(3a) This Article does not apply to any prepaid health service or capitation arrangement implemented or administered by the Department of Human Resources or its representatives, pursuant to 42 U.S.C. § 1396n or Chapter 108A of the General Statutes, or to any provider of health care services participating in such a prepaid health services or capitation arrangement.

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

Sec. 7.3. G.S. 108A-55(b) reads as rewritten:

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

Sec. 7.4. Chapter 143 of the General Statutes is amended by adding the following new section to read:

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

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

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

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

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

Sec. 7.5. G.S. 90-85.29 reads as rewritten:

"**§ 90-85.29. Prescription label.**

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

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

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

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

Sec. 7.6. Chapter 131E of the General Statutes is amended by adding a new Article to read:

"ARTICLE 13A.

"Disposal of Surplus Property to Aid Other Countries.

"**§ 131E-248. Disposition of surplus property by public and State hospitals.**

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

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

(1) Corporation which is exempt from taxation under section 501(c) of the Internal Revenue Code of 1986;
(2) The United States or any agency thereof;
(3) Government of a foreign country or any political subdivision of that country;
(4) The United Nations or an agency of it; or to
(5) Other eleemosynary institutions and groups

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

Sec. 7.7. Chapter 131E of the General Statutes is amended by adding a new section to read:

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

(a) Any hospital or other health care facility licensed pursuant to this Chapter or Chapter 122C of the General Statutes, health maintenance organization, local health department, community health center, medical office, or facility operated by a health care provider licensed under Chapter 90 of the General Statutes, providing patient counseling by a physician, a registered nurse, or any other appropriately trained health care professional shall be deemed in compliance with the rules adopted by the North Carolina Board of Pharmacy regarding patient counseling.

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

Sec. 7.8. Section 136(e) of Chapter 900 of the 1991 Session Laws reads as rewritten:

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

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

Study Commission by ~~November 1, 1993.~~ November 1, 1993, February 1, 1994, and May 1, 1994."

Sec. 7.9. Sections 7.1, 7.2, 7.3, and 7.4 of this act apply to arrangements implemented or administered on or after July 1, 1993. Section 7.7 becomes effective July 1, 1994. Section 7.5 becomes effective January 1, 1994.

PART VIII.–SEVERABILITY AND EFFECTIVE DATE

Sec. 8.1. The provisions of this act are severable. If any provision of this act is held invalid by a court of competent jurisdiction, the invalidity does not affect other provisions of the act that can be given effect without the invalid provision.

Sec. 8.2. The Part headings in this act are for reference only and do not enlarge, define, or restrict the scope of this act unless otherwise expressly indicated.

Sec. 8.3. Except as otherwise specified herein, the provisions of this act are effective upon ratification.

In the General Assembly read three times and ratified this the 24th day of July, 1993.

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Dennis A. Wicker
President of the Senate

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Daniel Blue, Jr.
Speaker of the House of Representatives