GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 1993

H 1

HOUSE BILL 572

Short Title: Family Health Care Program. (Public)

Sponsors: Representatives Gottovi; Easterling, Kuczmarski, and Luebke.

Referred to: Health and Human Services.

March 25, 1993

1 A BILL TO BE ENTITLED
2 AN ACT TO ENACT THE NORTH CAROLINA FAMILY HEALTH CARE ACT,
3 TO INDICATE THE GENERAL ASSEMBLY'S INTENT TO RAISE REVENUE
4 TO IMPLEMENT THE ACT, TO REQUIRE NONBINDING ARBITRATION OF
5 MEDICAL MALPRACTICE ACTIONS, AND TO MAKE CONFORMING
6 CHANGES TO THE GENERAL STATUTES.
7 The General Assembly of North Carolina enacts:
8 **TITLE I. FAMILY HEALTH CARE PROGRAM.**
9 Section 1. Chapter 58 of the General Statutes is amended by adding the
10 following new Article to read:
11 **"ARTICLE 68A.**
12 "North Carolina Family Health Care Act .
13 **"PART 1. NORTH CAROLINA FAMILY** Health Care Program.
14 **"§ 58-68A-22. SHORT TITLE; legislative findings and intent.**
15 **(a) This act shall be known as the North Carolina Family Health Care**
16 **Act.**
17 (b) The General Assembly makes the following findings:
18 (1) North Carolinians have a responsibility to themselves, their family,
19 and society to act in a manner that promotes good personal health and
20 well-being.
21 (2) All North Carolinians have a right to medically necessary health care,
22 including preventive, primary, and long-term services.

(3) During the course of one year, approximately 1.3 million North Carolinians do not have health insurance and approximately 865,000 are underinsured with respect to their health insurance coverage.

(4) Over the last five years the cost of obtaining health insurance has more than doubled; cost increases are reflected in premium rates, cost-shifting, and reductions in benefits covered.

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

(6) Between 1990 and 1991 North Carolina was one of only four states where the state's uninsured population increased by over 100,000 people.

(7) 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 Carolinians without containing health care costs.

(8) It has been documented that the lack of access to medically necessary and affordable health care leads to a decline in health status, including birth defects, lifelong disabilities, uncontrolled diabetes, hypertension, and untreated chronic conditions.

(9) Lack of access to health care also results in unnecessary pain and suffering and premature death, and often leads to overuse of expensive health care services.

(10) Providing preventive health care will efficiently and effectively improve the health of all North Carolinians and can significantly reduce the need for more expensive health care services and long-term care later in life.

(11) The health and well-being of individuals are directly related to their ability to obtain necessary and affordable preventive and primary medical care and health related support services for emergency, chronic, and long-term conditions.

(12) The integration of long-term care services with comprehensive health coverage is cost-effective, protects persons with disabilities from being impoverished by the cost of nursing facility care, and allows maximum independence for those who can remain safely at home.

(c) It is the intent of the General Assembly to do the following:

(1) Enact a comprehensive health care program to provide medically necessary care specific to individual needs, including preventive, primary, and long-term care, for all residents of North Carolina.

(2) Enact a means and method for financing the program that better utilizes the money that is now being spent on health care by the public and private sectors.

(3) Ensure that the burden of financing the program is allocated equitably among citizens based on ability to pay, and that administration of the

program and the allocation of moneys under it are carried out in a manner that is efficient, equitable, and effective.

"**§ 58-68A-23. Definitions .**

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

(1) 'Accountable Health Plan' means any health maintenance or preferred provider organization, independent practice association, or any other mode of delivery of care approved by the Commission to provide health care services to individuals in exchange for a prescribed capitated payment from the Program.

(2) 'Commission' means the North Carolina Family Health Care Planning Commission established under Article 64 of Chapter 143 of the General Statutes.

(3) 'Director' means the health care director of the North Carolina Family Health Care Program.

(4) '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

a. Obtaining a North Carolina motor vehicle operator's license, or
b. Registering to vote in North Carolina, or
c. Filing a North Carolina income tax return, or
d. Obtaining a North Carolina identification card from the North Carolina Division of Motor Vehicles.

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 other disability or circumstance 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.

(5) '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.

(6) 'Fund' means the North Carolina Family Health Care Trust Fund established under this Article.

(7) 'Global budget' or 'global health budget' means a comprehensive, binding annual budget setting forth in advance the aggregate compensation all health care providers will receive from the Program for provision of all covered services.

(8) 'Health Plan Purchasing Cooperative' means an organization established to implement the Program in geographic areas of the State.

(9) 'Program' means the North Carolina Family Health Care Program.

1 (10) 'Provider' means a health care provider participating in the Program
2 through the State Plan or through an Accountable Health Plan.
3 (11) 'State Plan' means that portion of the Program in which eligible
4 persons may elect to receive services either from a private or public
5 provider on a fee-for-service basis or from a hospital or long-term care
6 institution based on a negotiated annual budget.
7 "**§ 58-68A-24. North Carolina Family Health Care Program established; purpose;**
8 **components; administration.**
9 (a) There is established the North Carolina Family Health Care Program. The
10 purpose of the Program is to provide all eligible residents with access to health care
11 services by enabling them to enroll in one of the health services plans established under
12 the Program.
13 (b) The Program shall be comprised of the following health services plans:
14 (1) A State Plan providing health care services to eligible residents
15 wherein providers are paid on a fee-for-service or negotiated budget
16 basis; and
17 (2) An Accountable Health Plan providing health care services wherein
18 providers are paid on a capitated payment basis.
19 (c) The Program shall be administered by the North Carolina Family Health Care
20 Planning Commission established under Article 64 of Chapter 143 of the General
21 Statutes.
22 "**§ 58-68A-25. Program eligibility; coverage secondary and supplemental to certain**
23 **other coverage; transfer of retiree coverage; expenditure limitations;**
24 **nonresident eligibility.**
25 (a) Eligibility. – Any eligible resident of this State may receive health care
26 services under the Program.
27 (b) Coverage Secondary to Certain Other Coverage. – Program benefits shall be
28 secondary to any health care benefits for which the following persons are eligible or to
29 which they are entitled:
30 (1) Residents eligible for the federal Medicare program, as defined by the
31 federal Social Security Act (42 U.S.C. § 1395, **et seq.**); and
32 (2) Persons on active military duty or otherwise receiving benefits under
33 the CHAMPUS program (10 U.S.C.A. § 1071, **et seq.**) and their
34 dependents; and
35 (3) Federal employees entitled to health care benefits, and their
36 dependents.
37 The health care benefits provided under the Program shall be supplemental to
38 benefits provided under Medicare Parts A and B and shall include health care benefits
39 not provided by Medicare Parts A and B, including long-term care, prescription drugs,
40 preventive care, and Medigap benefits.
41 Coverage provided under the Program shall be secondary to any retirement health
42 coverage for which a resident or the resident's dependents are eligible. The
43 Commission shall hold public hearings regarding the integration of benefits provided
44 under the Program with retirement health benefit plans in the private and public sectors.

Based on the hearings, the Commission shall conduct a comparison of the benefits available to residents under the Program with those typically available to retirees and their dependents and shall adopt rules defining benefits under the Program which residents with retiree health coverage are entitled to receive. In adopting rules, the Commission shall consider establishing a maintenance of effort for private and public retiree health benefit plans in order to avoid creating incentives for private and public employers to reduce retiree health benefits.

(c) Transfer of Benefits. – The Commission may negotiate with private and public employers for the transfer of responsibility for providing health benefits to retirees and their dependents from the employer to the Commission. Any private or public employer may negotiate with the Commission for the transfer of the responsibility for providing retiree health benefits to the Commission to the extent allowed by retiree health benefit agreements.

(d) Expenditure Limitations. – The amount that shall be used for the baseline for setting limits on expenditures for the first year of the operation of the Program shall be the amount spent in North Carolina for health care covered under this Article during the most recent calendar year in which data is available.

(e) Nonresident Eligibility. – Persons who are not residents of this State but who work in North Carolina may receive benefits under the Program, including benefits for dependents, if all payments, surcharges, and premiums required to be paid by or on behalf of residents under the Program have been paid to the Program by or on behalf of such nonresidents.

If a person who is not a resident of this State and is not eligible for Program benefits pursuant to this subsection receives medical treatment in North Carolina, such person is subordinated to the State of North Carolina for reimbursement from a third-party payer for such medical treatment.

(f) The Commission shall estimate the expenditures and revenues required to provide services under the Program and shall report that information to the General Assembly on or before January 1, 1995, and annually thereafter.

(g) Coverage and benefits provided under the Program shall be secondary to any coverage provided under workers' compensation, automobile insurance, or liability insurance policy.

"**§ 58-68A-26. Copayments .**

(a) The Director may require copayments for services under the State Plan of not more than ten percent (10%) of the cost of the services, not to exceed two hundred fifty dollars ($250.00) per year in copayments for individuals, and not to exceed five hundred dollars ($500.00) per year in copayments for families.

(b) Persons who have income below two hundred fifty percent (250%) of the federal poverty income level shall not be required to pay any copayments under the State Plan or under an Accountable Health Plan.

(c) No copayments may be required that create a barrier to medically necessary care under the State Plan or under an Accountable Health Plan.

(d) An Accountable Health Plan may impose copayments from its members no greater than five percent (5%) of the cost of services, and not more than one hundred

1 dollars ($100.00) per year per individual or two hundred fifty dollars ($250.00) per year
2 per family.
3 (e) No individual enrolled in either the State Plan or an Accountable Health Plan
4 shall be required to meet a deductible as a condition for receiving health care services.
5 (f) No copayments may be required under the State Plan or under an
6 Accountable Health Plan for prenatal care, well-child care, periodic physical
7 examinations, and other health screenings and services as recommended by the U.S.
8 Preventive Services Task Force 'Guide to Clinical Preventive Services'.
9 "Part 2. Program Benefits .
10 "**§ 58-68A-27. General benefits.**
11 **(a) The benefits listed in this section shall be covered benefits** under this
12 Article. The Program shall provide all of the following:
13 (1) Comprehensive medical care benefits specified in this Article,
14 including preventive care, primary and tertiary health care for acute
15 and chronic conditions, rehabilitative care, and long-term services.
16 (2) Limited mental health services, dental care, and prescription drugs, as
17 specified in this Article.
18 The Program shall provide the benefits specified in this Article through the State Plan or
19 the Accountable Health Plan.
20 "**§ 58-68A-28. Medical benefits .**
21 **(a) Covered benefits in this section shall include, but are** not limited to, the
22 following when determined to be medically necessary:
23 (1) Inpatient and outpatient hospital services;
24 (2) Inpatient and outpatient professional provider services, including
25 home health care;
26 (3) Diagnostic X ray and laboratory services;
27 (4) Family planning, perinatal, and maternity care;
28 (5) Children's preventive care, including, but not limited to, well-child
29 care, routine dental, hearing, and vision checkups, and immunizations;
30 (6) Adult preventive care including, but not limited to, periodic
31 mammograms and pap smears;
32 (7) Durable medical equipment;
33 (8) Podiatry;
34 (9) Unreplaced blood;
35 (10) Dialysis;
36 (11) Emergency transportation;
37 (12) Rehabilitative care;
38 (13) Alcohol and drug abuse or addiction treatment, or both;
39 (14) Prescription drugs;
40 (15) Periodic physical examinations, and other health screenings and
41 services as recommended by the U.S. Preventive Services Task Force
42 'Guide to Clinical Preventive Services';
43 (16) Chiropractic.

1 (b) Nothing in this subsection shall preclude the direct reimbursement of
2 physician assistants, certified clinical social workers, nurse practitioners, or other
3 advanced practice nurses in providing covered services or benefits within the scope of
4 their practice.
5 "**§ 58-68A-29. Long-term services benefits .**
6 **(a) Long-term services which are necessary for the health, social,** and
7 personal needs of individuals with limited self-care capabilities are covered benefits
8 under the Program as provided in this section. Long-term benefits shall include all of
9 the following:
10 (1) Institutional and residential care;
11 (2) Home health care;
12 (3) Hospice care;
13 (4) Home and community-based services, including personal assistance
14 and attendant care.
15 (b) Individual needs shall be determined through a standardized assessment of
16 the individual's abilities for self-care and shall include all of the following:
17 (1) Medical examinations necessary to determine what, if any, level of
18 medical care is required.
19 (2) Environmental and psychosocial evaluations to determine what the
20 individual can and cannot do for himself or herself physically, as well
21 as mentally.
22 (3) Services, service coordination, or case management, to ensure that
23 necessary services are provided to enable the individual to remain
24 safely in the least restrictive setting.
25 (c) Services may be provided in the individual's home, or through community-
26 based, residential, or institutional programs.
27 (d) Reassessment shall be conducted at appropriate intervals, but not less than
28 once a year.
29 (e) In providing long-term services under this section, the Commission shall, to
30 save Program funds, encourage and reimburse noninstitutional long-term services where
31 appropriate, as determined pursuant to the assessment process required under subsection
32 (b) of this section, to allow persons needing long-term services to remain safely in their
33 homes to the maximum extent possible.
34 "**§ 58-68A-30. Mental health benefits .**
35 (a) The following mental health benefits are covered benefits under the
36 Program:
37 (1) Fifty-two outpatient visits per year; and
38 (2) Inpatient care, other than for substance abuse, not exceeding 45 days
39 per year.
40 (b) The Commission shall encourage the use of services, service coordination,
41 and case management which will enable the individual to remain in the least restrictive
42 setting. Services may be provided through community-based, residential, or
43 institutional programs.

1 (c) Not later than January 1, 1994, the Commission shall appoint an independent
2 advisory board of mental health experts and representatives of health care consumers to
3 develop a plan for providing all necessary mental health care through the Program.
4 "**§ 58-68A-31. Dental benefits .**
5 (a) Dental benefits are covered benefits under the Program as follows:
6 (1) All necessary dental care, including preventive care, shall initially be
7 provided for individuals up to 18 years of age.
8 (2) Each year the Program is operational the age limit for dental benefits
9 shall be increased by one year.
10 (3) For persons over age 65, immediate coverage for full and partial
11 dentures once every 10 years.
12 "**§ 58-68A-32. Expansion of benefits .**
13 **The benefits provided under this Article may be expanded by the Commission**
14 **when the** expansion meets the intent of this Article and when there are sufficient
15 revenues to cover expansion costs.
16 "Part 3. Program Providers .
17 "**§ 58-68A-33. Choice of health care providers; enrollment periods.**
18 (a) Any eligible resident may choose to receive services from the Program either
19 from a private or public health care provider or from a hospital through enrollment in
20 the State Plan or in an Accountable Health Plan.
21 (b) An Accountable Health Plan may use any of the following methods of health
22 care service delivery:
23 (1) A staff model, in which services are provided by salaried health care
24 professionals;
25 (2) A group model, in which a professional group is paid for services
26 rendered at a capitation rate;
27 (3) An independent practice association model, in which health care
28 professionals are paid fees; or
29 (4) Any other model for delivery of care approved by the Director.
30 (c) Individuals enrolled in an Accountable Health Plan are entitled to an open
31 enrollment period of not less than one month, during which period an individual may
32 enroll in another Accountable Health Plan or may change to the State Plan option. The
33 open enrollment period for an Accountable Health Plan shall be offered annually.
34 (d) Individuals enrolled in the State Plan may enroll in any available Accountable
35 Health Plan at any time.
36 "**§ 58-68A-34. Accountable Health Plan requirements .**
37 (a) Any Accountable Health Plan providing services under, and receiving
38 payment from, the Program shall do all of the following:
39 (1) Allow any eligible resident to enroll in order of time of application, up
40 to a reasonable limit determined by capacity of the Accountable Health
41 Plan to provide services;
42 (2) As a condition of approval to participate in the Program, demonstrate
43 that the Accountable Health Plan will provide, or arrange and pay for,

all of the benefits required for the capitation payment set by the Commission;

(3) If an Accountable Health Plan does not have its own hospital facility, that Accountable Health Plan shall contract with a hospital or hospitals for the provisions of care for those enrolled in that Accountable Health Plan;

(4) Demonstrate that the Accountable Health Plan will do all of the following:

a. Provide, or arrange and pay for, all the benefits required for the payment set by the Program;

b. Provide services of a level of quality acceptable to the Commission;

c. Charge no additional fees, premiums, or copayments other than those allowed by the Commission for the provision of benefits under this Article;

d. Provide a grievance procedure that allows patient complaints pertaining to coverage under the Program to be heard, and appeals from the decision regarding those complaints to be heard by the Health Plan Purchasing Cooperative;

e. Make reports as required by the Commission; and

f. Meet any other requirements the Commission determines to be necessary to ensure that the Accountable Health Plans participating in the Program are financially viable and will provide quality health care to enrollees in the Accountable Health Plans.

(b) As a condition of participation in the Program, no Accountable Health Plan may refuse to enroll or serve any eligible individual because of that individual's economic status, health history, preexisting health condition, age, sex, race, national origin, ancestry, sexual orientation, disability, ethnicity, or religion.

(c) Nothing in this section shall prohibit an Accountable Health Plan from offering additional benefits beyond those set forth in this Article. The additional benefits shall be clearly set forth in disclosure and Accountable Health Plan description materials provided to persons eligible to enroll in the Program.

"Part 4. Program Administration .

"§ 58-68A-35. Program administered by Commission; implementation; monitoring.

(a) Administration. – The Commission shall administer the Program in accordance with this Article and with Article 64 of Chapter 143 of the General Statutes. The Commission shall ensure that the Program is structured and administered in the most efficient and effective manner possible.

(b) Implementation. – The Program shall be implemented through health plan purchasing cooperatives in accordance with an implementation schedule established by the Commission. Implementation shall be phased in beginning not later than July 1, 1996. In developing the phase-in schedule, the Commission shall ensure that services

are expanded for underserved populations. Implementation of the Program shall be carried out only to the extent that funds are available for this purpose.

(c) Monitoring. – The Commission, in consultation with such other experts as it deems appropriate, shall develop an evaluation and monitoring system which considers, at a minimum, the quality of care and access to care provided by the Program. Monitoring and evaluation shall include the geographic distribution of health care resources under the Program, and the extent to which the needs of special populations including low income persons, persons living in medically underserved areas, and persons with disabilities or chronic or unusual medical needs will be met.

"**§ 58-68A-36. Duties of health plan purchasing cooperative .**

Health plan purchasing cooperatives shall implement the Program in each cooperative's geographic area, and in carrying out the implementation, shall do the following:

(1) Certify private health plans as Accountable 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.
(2) Pay each Accountable 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.
(3) Ensure that no Accountable Health Plan charges an additional premium.
(4) Jointly with the Commission and where necessary to meet the needs of underserved areas or special populations, organize the delivery of health care to ensure that every individual has a choice of Accountable Health Plans.
(5) Assist eligible residents in choosing among Accountable Health Plans by providing consumer education, including uniform information about all the Accountable Health Plans available through the health plan purchasing cooperative such as quality indicators and choice of providers.
(6) Provide a mechanism for enrolling all eligible residents in their chosen Accountable Health Plans and for automatically enrolling in the State Plan all eligible residents who fail to choose a plan.
(7) Monitor and enforce standards concerning access, consumer satisfaction, and quality of care in all Accountable Health Plans.
(8) Jointly with the Commission and the North Carolina Medical Database Commission, collect data from all Accountable Health Plans and sponsor research into health outcomes and practice guidelines.

"**§ 58-68A-37. Efficiency of Program operations .**

(a) The Director shall set standards and conduct retrospective review of the utilization of Program benefits to ensure that health care services are rendered in an effective, cost-efficient, and appropriate manner.

(b) The Director shall make timely payments to providers, including Accountable Health Plans and hospitals, and shall establish a payment system which is efficient for health care providers and the Commission to administer and which eliminates unnecessary administrative costs. Administration costs shall not exceed the limits set under G.S. 58-68A-37.

(c) In addition to other duties assigned by the Commission and by this Article and Article 64 of Chapter 143 of the General Statues, the Director shall do the following to ensure efficiency of Program operation:

(1) Establish uniform reporting requirements for all health care providers participating in the Program;
(2) To the extent permitted by federal law, develop and implement standardized claims, reporting methods, and utilization review criteria under the Program;
(3) Require all recipients of funds under the Program to periodically report information which the Director determines to be necessary for the planning, budgeting, and quality assurance of care provided under the Program; and
(4) Make any information and reports submitted pursuant to this section, including the analysis of data contained in those reports, available to the public.

"**§ 58-68A-38. Confidentiality of records.**

The confidentiality of communications between a recipient of services under the Program and the health care provider, and the confidentiality of medical records and communications between the patient and the health care provider, shall remain confidential to the same extent that such records and communications are protected as confidential under other provisions of law of this State.

"Part 5. Allocation of Funds and Provider Reimbursement.

"**§ 58-68A-39. ALLOCATION OF PROGRAM funds.**

(a) Not more than seven percent (7%) of the funds appropriated for the Program may be used for Program administration.

(b) That amount of funds appropriated for the Program remaining after allocation for administrative costs and reserves, shall be divided based on the proportion of individuals enrolled in the State Plan or an Accountable Health Plan, adjusted for health risk variations, and may be increased to encourage providers to practice in medically underserved areas.

(c) The cost of any necessary research and education related to medicine and health, other than patient and consumer education, shall not be paid from Program funds.

"**§ 58-68A-40. Provider reimbursement.**

(a) An Accountable Health Plan may reimburse providers by any method authorized under G.S. 58-68A-33.

1 (b) Providers may not charge any fee for services covered under
2 Part 2 of this Article which exceeds the rate set or negotiated under the Program.
3 (c) Providers shall be reimbursed for services provided under the Program as
4 follows:
5 (1) The Program shall reimburse individual providers, other than
6 hospitals, for the provision of covered services in the State Plan
7 pursuant to a resource-based relative value fee schedule established by
8 the Director, based on the total amount of funds available in the State
9 Plan.
10 (2) The Commission may adjust downward the increase in fees for any
11 procedure or service or group of procedures for the year following any
12 year in which the expenditure target for that procedure is exceeded and
13 this excess cannot be accounted for by increases in epidemics,
14 disasters, other changes in the health status of the covered population,
15 or other factors deemed relevant by the Commission and occurring
16 after the establishment of the expenditure target.
17 (3) As a condition of providing services under the Program, providers
18 shall accept the fees established by the Commission as payment in full
19 and shall not bill patients for any additional charges.
20 (4) Hospitals shall be reimbursed on the basis of an annual budget for all
21 covered services rendered under the Program to eligible residents,
22 based on the hospital's census, location, the acuity of its patient
23 population, and other relevant factors.
24 (5) The Director shall negotiate the budget specified in subdivision (4) of
25 this subsection with each participating hospital on an annual basis,
26 with adjustments made for epidemics and other unforeseen
27 catastrophic changes in the general health status of a patient
28 population, and adjustments that take into account the number of
29 persons enrolled in Accountable Health Plans.
30 (6) The Director shall reimburse Accountable Health Plans on a capitated
31 basis, for each patient, based on the following:
32 a. Total funds available to all Accountable Health Plans
33 reimbursed under the Program,
34 b. The number of persons enrolling in the Accountable Health
35 Plan, adjusted for health risk variations of enrollees, and
36 c. Adjustments to encourage providers to serve in medically
37 underserved areas.
38 (7) Accountable Health Plans shall be responsible for covering the costs of
39 its enrollees through negotiated fee for service, prospective annual
40 budget, or any other means negotiated between the parties.
41 (d) The Commission may impose reimbursement mechanisms which have as
42 their purpose reducing unnecessary referrals and utilization of health benefits and long-
43 term care services among providers in the State Plan, including, but not limited to, all of
44 the following:

(1) Payment incentives to limit patient self-referrals to specialists and to encourage greater review and screening of those referrals by primary care providers.
(2) Capitation payments to groups or associations of providers.
(3) Targeted case management for high-cost or high-risk cases.
(4) Use of expenditure targets.
(5) Retrospective utilization review.
(6) Enhanced payments to primary care providers whose services result in reductions in inpatient admissions and superior health outcomes.
(7) Other mechanisms which, upon deliberation, the Commission deems to be appropriate to control unnecessary utilization of services.

"Part 6. Reserves .

"**§ 58-68A-41. Reserves.**

(a) The Director shall establish and retain a reserve account of one percent (1%) of the total revenues collected for the support of the Program during budgetary shortfalls or epidemics as defined by the Commission.

(b) Whenever the Director determines that the reserve account exceeds one percent (1%) of the total revenues collected for the support of the Program, the Director shall report to the Commission and the General Assembly on the appropriate options available, which shall include but are not limited to:
(1) Increasing benefits,
(2) Adjusting rates of reimbursement,
(3) Improving access to the Program,
(4) Reducing surcharges and taxes imposed and earmarked for the purpose of supporting the Program, and
(5) Expanding the reserve.

(c) The Commission shall review and adjust its budget, fee schedules, and capitation rates on a regular basis, according to a review schedule established by the Commission, to ensure that the Program remains solvent and that the payments to providers are equitable, prompt, and within the Program budget.

"Part 7. Family Health Care Trust Fund .

"**§ 58-68A-42. FUND ESTABLISHED .**

(a) Effective January 1, 1996, there is established in the State Treasurer's Office the North Carolina Family Health Care Trust Fund. The Fund shall consist of the following:
(1) All revenues collected from taxes and other sources enacted for the purpose of funding the Program.
(2) 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
(3) All moneys appropriated by the North Carolina General Assembly for carrying out the purposes of the Program.

1 (b) Monies shall be deposited in the Fund beginning with the 1995-96 fiscal year.
2 (c) Monies held in the Fund are not subject to appropriation or allotment by the
3 State or any political subdivision of the State, except to the Commission for
4 administration and implementation of the Program.
5 (d) The Fund shall include a preventive care account for the purpose of ensuring
6 that monies are allocated for community-based disease prevention and health promotion
7 efforts. These efforts shall be targeted to population groups with the greatest unmet
8 needs and shall emphasize programs to reduce or eliminate causes of illnesses and to
9 provide outreach to underserved populations. The Fund shall also contain such other
10 discrete accounts as the Commission deems appropriate for the effective and efficient
11 administration of the Program.
12 (e) The State Treasurer shall administer and invest Fund monies in accordance
13 with his authority under State law.
14 "Part 8. General Provisions .
15 "**§ 58-68A-43. Reporting requirements.**
16 **(a) Commencing January 1, 1998, the Commission shall make** a report to the
17 general public, to the General Assembly, and to the Governor. The report shall be made
18 every five years and shall contain a comprehensive evaluation of the Program. The
19 report shall include all of the following:
20 (1) A description of the Commission's evaluation and monitoring of the
21 Program.
22 (2) A description of the successes and problems in the areas of quality of
23 and access to health care.
24 (3) The results of surveys of consumer and provider satisfaction with the
25 Program.
26 (b) The Commission shall report annually to the General Assembly and to the
27 Governor summarizing information about health needs, health services, health
28 expenditures, revenues, and other issues relevant to the efficient and effective
29 administration and operation of the Program. The Commission's annual report shall
30 also contain any recommendations it has for legislation necessary to maintain or
31 improve the Program's performance.
32 "**§ 58-68A-44. Waivers from federal requirements; options for additional federal**
33 **participation.**
34 (a) The Commission shall seek all necessary federal waivers, exemptions,
35 agreements, or legislation which will allow that all federal payments for health, mental
36 health, and long-term care made to this State will be paid directly to the Fund for the
37 purposes of the Program, and for the assumption, by the Program, of the responsibility
38 for all benefits previously paid for by the federal government.
39 (b) The Commission shall, in all cases, seek to maximize federal contributions
40 and payments for health, mental health, and long-term care services provided in this
41 State, and, in obtaining the waivers, exemptions, agreements, or legislation required
42 under subsection (a) of this section, the Commission shall ensure that the contributions
43 of the federal government for health, mental health, and long-term care services in

North Carolina will not decrease in relation to other states as a result of the waivers, exemptions, agreements, or legislation.

(c) When directed to do so by the Commission, the Director shall petition the federal government for a waiver pursuant to section 1315 of Title 42 of the United States Code for the purpose of providing medical services to Medicaid beneficiaries. The State shall, at a minimum, continue to match federal financial participation at the same rate at which the match was made during the 1995-96 fiscal year.

(d) The Department of Human Resources shall report to the Commission, not later than January 1, 1994, regarding all of the following:

(1) All federal Medicaid options and other federal options which the State has not exercised but would allow greater federal participation in the provision of health care services pursuant to this Article.
(2) The amount of potential federal participation relating to each option.
(3) The amount of expanded federal participation which could be expected if outreach and other efforts were initiated to expand participation to present programs, including the medically needy program.

(e) The Commission shall implement the report of the Department of Human Resources to take advantage of all federal Medicaid options to maximize eligibility and services, and shall take steps to maximize participation in all programs with federal participation as soon as possible after the issuance of the Department's report. Payment for services under this subsection shall come from the Fund.

(f) The Department of Human Resources shall conduct a vigorous outreach campaign to notify potentially eligible persons, including medically needy persons, of their eligibility.

"**§ 58-68A-45. Private coverage may not duplicate Program benefits.**

Insurance companies may sell, subject to the approval of the Commissioner of Insurance, health insurance to cover benefits not provided by the Program. However, no private insurance may be sold to cover benefits which eligible residents are entitled to receive from the Program. Not later than January 1, 1998, the Commissioner of Insurance shall report to the General Assembly on the need for community rating and limitations on medical underwriting under the Program."

Sec. 2. Chapter 143 of the General Statutes is amended by adding the following new Article to read:

"**ARTICLE 64.**

"THE NORTH CAROLINA FAMILY HEALTH CARE PLANNING COMMISSION.

"**§ 143-590. Purpose .**

The purpose of this Article is to establish the North Carolina Family Health Care Planning Commission. The Commission will administer the North Carolina Family Health Care Program established under Article 68A of Chapter 58 of the General Statutes.

"**§ 143-591. Definitions .**

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

(1) 'Accountable Health Plan' means any health maintenance organization, independent practice association, or any other mode of delivery of care approved by the Commission to provide health care services to individuals in exchange for a prescribed capitated payment from the Program.

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

(3) 'Director' means the health care director of the North Carolina Family Health Care Program.

(4) '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

a. Obtaining a North Carolina motor vehicle operator's license, or
b. Registering to vote in North Carolina, or
c. Filing a North Carolina income tax return, or
d. Obtaining a North Carolina identification card issued by the North Carolina Division of Motor Vehicles.

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 other 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.

(5) '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.

(6) 'Fund' means the North Carolina Family Health Care Trust Fund established under this Article.

(7) 'Global budget' or 'global health budget' means a comprehensive, binding annual budget setting forth in advance the aggregate compensation all health care providers will receive from the Program for provision of all covered services.

(8) 'Health plan purchasing cooperative' means an organization established to implement the Program in geographic areas of the State.

(9) 'Program' means the North Carolina Family Health Care Program.

(10) 'Provider' means a health care provider participating in the Program through the State Plan or an Accountable Health Plan.

(11) 'State Plan' means that portion of the Program in which eligible persons may elect to receive services either from a private or public

provider on a fee-for-service basis or from a hospital, based on a negotiated annual budget.

"**§ 143-592. Commission established; members; terms of office, quorum; compensation.**

(a) Establishment. – Effective July 1, 1993, there is established the North Carolina Family Health Care Planning Commission with the powers and duties specified in this Article and in Article 68A of Chapter 58 of the General Statutes, and with the power to adopt, amend, and repeal rules necessary to carry out this Article. The Commission shall be a commission within the Department of Insurance for organizational, budgetary, and administrative purposes only. The Commission shall be responsible for the development, implementation, and administration of the North Carolina Family Health Care Program established under Article 68A of Chapter 58 of the General Statutes.

(b) Membership and Terms. – The Commission shall consist of 15 members who shall be appointed as follows:

(1) Five persons appointed by the Governor, one of whom shall represent the labor force, one of whom shall be a physician licensed to practice medicine in this State, one of whom shall be a representative of a business with 50 or more employees, and one of whom is a consumer. Two of the persons initially appointed under this subdivision shall serve a five-year initial term; two shall serve a three-year initial term; and one shall serve a one-year initial term; thereafter, the terms of the Governor's appointees shall be for six years.

(2) Five persons appointed by the General Assembly upon the recommendation of the Speaker of the House of Representatives, two of whom shall represent the beneficiaries whose right to health care under the Program is guaranteed pursuant to this act, one of whom is a nurse licensed under Chapter 90 of the General Statutes, one of whom represents a prepaid health plan, and one of whom is an academic expert in the field of health care. Two of the persons initially appointed under this subdivision shall serve a six-year initial term; two shall serve a four-year initial term; and one shall serve a two-year initial term; thereafter, the terms of appointees under this subdivision shall be for six years; and

(3) Five persons appointed by the General Assembly upon the recommendation of the President Pro Tempore of the Senate, one of whom represents a business with less than 50 employees, one of whom is a hospital administrator, one of whom represents an insurance company authorized to do business in this State, one consumer, and one representative of a nonprofit community health clinic. Two of the persons initially appointed under this subdivision shall serve a six-year initial term; two shall serve a four-year initial term; and one shall serve a two-year initial term; thereafter, the terms of appointees under this subdivision shall be for six years.

No member may be appointed to serve more than two consecutive terms. A member whose term has expired may serve until his or her successor is appointed.

When making appointments to the Commission, the Governor and the General Assembly shall ensure that the membership fairly represents the regions of the State and also fairly represents minority persons, women, and membership of the political party to which the largest minority of the membership of the General Assembly belongs.

(c) Member Association. – No person may be appointed to or remain a member of the Commission if the person or the person's spouse is associated with a health care business in either of the following ways:

(1) As a director, employee, officer, owner, or partner; or
(2) As a holder, either individually or collectively, of securities worth ten thousand dollars ($10,000) or more at fair market value as of December 31 of the preceding year, or constituting five percent (5%) or more of the outstanding stock of the business.

For purposes of this subsection, the term 'health care business':

(1) Does not include a widely held investment fund, regulated investment company, or pension or deferred compensation plan if the prospective employee or member or spouse neither exercises nor has the authority to exercise control over the financial interests held by the fund, and the fund is publicly traded or the fund assets are widely diversified;
(2) Includes an association, corporation, enterprise, joint venture, organization, partnership, proprietorship, trust, and every other business interest that provides or insures human health care or that depends upon a provider or insurer of human health care for twenty-five percent (25%) or more of its annual income.

(d) Compensation. – The salary of Commission members shall be set by the General Assembly.

(e) Officers. – The Commission shall have a chair and vice-chair. The chair shall be appointed by the Governor from among the membership. The vice-chair shall be elected by the members. The terms of officers shall be for two years.

(f) Meetings. – Meetings may be called by the chair or vice chair. The Commission shall meet as often as necessary, but not less than six times a year.

(g) Quorum. – Eight 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.

"**§ 143-593. Powers and duties of the Commission .**

(a) The Commission shall have the following powers and duties:

(1) Employ such staff as it deems necessary and fix their compensation. Staff employed by the Commission shall be subject to the State Personnel Act;
(2) Enter into contracts to carry out the purposes of this Article and Article 68A of Chapter 58 of the General Statutes;

(3) Conduct investigations and inquiries and compel the submission of information and records the Commission deems necessary;
(4) Adopt rules necessary for administration of the Program;
(5) Annual preparation of a budget for the administration of the Program, including personnel costs;
(6) Act directly, or through one or more contractors, as the single payor for all claims for services provided under the Program;
(7) Establish global budgeting and rate-setting mechanisms with annual review of the effectiveness and sufficiency of budgets and rates. Global budgets shall be tied to the consumer price index and may be adjusted upward to account for increases in epidemics, disasters, other changes in the health status of the covered population, or other factors deemed relevant by the Commission and occurring after establishment of the global budget;
(8) Establish an enrollment system which ensures that all eligible persons are aware of their right to health care and are formally enrolled;
(9) Investigate and implement annual cost-containment measures, within the Commission's authority, to meet established global budgets;
(10) Recommend annually to the General Assembly the amount of any appropriation needed to finance the Program;
(11) Develop methodology to be used in making risk-adjusted payments to Accountable Health Plans;
(12) Establish one or more advisory panels as the Commission deems appropriate for the effective and timely conduct of its duties;
(13) Appoint a director of the Program who shall perform such duties as the Commission may assign;
(14) Ensure accessibility to health care in rural and medically underserved areas by enhancing provider payments, requiring services of an Accountable Health Plan to be provided throughout a geographic area, or by any other reasonable means;
(15) Ensure that supplemental health benefits are available to all eligible residents including employees of business entities;
(16) Determine the economic impacts of implementing the Program, including overall costs to the State economy, costs to the State's business economy, costs to the State, impact on real wages of employees, 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 Program is not implemented;
(17) Study and make recommendations to the General Assembly concerning the following:
    a. Options for financing the Program;
    b. Legislation needed to finance the Program;

c. The mechanisms for ensuring that the State Plan and all Accountable Health Plans available to eligible residents will provide appropriate access to quality medical services;
d. The means by which the Program 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;
e. The appropriate means of financing medical education and medical research;
f. Whether medical malpractice tort reforms are needed, and, if so, the tort reforms needed; and
g. Methods to ensure adequate primary care for all eligible residents, and appropriate compensation for primary care services to achieve that end;

(18) Exercise administrative authority over Certificate of Need Requirements under Article 9 of Chapter 131E of the General Statutes and the Medical Database Commission as established under Article 11 of Chapter 131E of the General Statutes, as amended; and

(19) Such other duties as are required for the effective and efficient implementation of the Program.

(b) The Commission may contract with nonrisk-bearing intermediaries for services related to administering the Program, including, but not limited to, the dissemination of materials and information about the Program and coverage choices and options, enrollment of persons eligible for services in the Program, selection and designation of primary care providers, utilization review, and payment of claims.

(c) The Commission may accept grants, contributions, devises, bequests, and gifts for the purpose of providing financial support to the Program. Such funds shall be deposited by the Commission into the Fund.

(d) The Commission shall periodically study the impact of migration to the State on the ability of the Program to provide necessary health and long-term care for beneficiaries of the Program. If the Commission finds, based on credible evidence, that migration to the State is imposing a significant financial burden on the Program, the Commission shall make recommendations to the General Assembly on mitigating the financial burden.

(e) On or before January 1, 1995, the Commission shall identify health, mental health, and long-term health care programs administered by State and local governments whose benefits and services substantially duplicate those provided under the Program and shall make recommendations to the General Assembly for phasing out those programs and transferring funding for them to the Fund.

(f) The Commission shall study the feasibility of integrating health benefits provided under workers' compensation, automobile, homeowners', and other liability coverages with the benefits provided under the Program and shall submit a report of its findings to the General Assembly on or before January 1, 1995.

(g) The Commission shall establish an ongoing system for monitoring patterns of practice. The Commission shall establish a system of peer education for providers responsible for aberrant patterns of practice. If the Commission determines that peer educational efforts have failed, the Commission may refer the matter to the appropriate professional licensing board.

(h) The Commission shall review and adopt professional practice guidelines developed by the State and national medical and specialty organizations, the National Institute of Health, the United States Agency for Health Care Policy and Research, and other organizations as it deems necessary to promote the quality and cost-effectiveness of services provided under the Program.

"**§ 143-594. Health Care Director .**

(a) The Commission shall appoint a Health Care Director, who shall function as the chief executive officer for the administration of the Program.

(b) The Director shall serve a minimum of four years, unless he or she receives a vote of no confidence by not less than two-thirds of the membership of the Commission.

(c) The Director shall be exempt from the State Personnel Act."

Sec. 3. As the first step in implementation of the Program, the Commission shall, on or before the first day of the 1993 General Assembly, Regular Session 1994, produce and deliver to the President Pro Tempore of the Senate and the Speaker of the House of Representatives a detailed report concerning implementation of the Program. The report shall contain the following:

(1) Detailed analysis and recommendations pertaining to Program financing options;
(2) Independent actuarial cost estimates for the benefit package;
(3) Possible options for phasing in the Program;
(4) Whether there is a need to begin immediate data collection and, if so, the data needed and methods to begin data collection;
(5) The economic impacts of implementing the Program, 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 Program is not implemented;
(6) The steps necessary to include the populations served by Medicaid, including a statement of any necessary federal waivers;
(7) The need for and steps necessary to obtain a waiver from the federal Employee Retirement and Income Security Act;
(8) The steps necessary to include the North Carolina Teachers' and State Employees' Comprehensive Major Medical Plan.

TITLE II. FAMILY HEALTH CARE PROGRAM FINANCING.

SUBTITLE 1. HEALTH CARE SURCHARGES.

Sec. 4. The General Assembly intends to enact legislation imposing the following surcharges to take effect January 1, 1995, for the purpose of financing the implementation of the North Carolina Family Health Care Act.

(1) Except as provided in subdivision (2) of this section, a surcharge on employers at the rate of percent (%) on the wages paid by every employer in the State. As used in this subdivision, the term "wages" shall have the same definition as applied to that term under G.S. 96-8.

(2) For employers who have less than 50 employees and who have been in business five years or less, a graduated surcharge on wages paid as follows: at the rate of percent (%) in the first two years of operation, percent (%) in the second two years of operation, and percent (%) in the fifth year of operation.

(3) For self-employed individuals, a surcharge at the rate of percent (%) on the amount of net earnings from self-employment. This surcharge amount shall be deductible as a trade or business expense in determining adjusted gross income.

(4) For all residents, a surcharge at the rate of percent (%) of the sum of the resident's North Carolina adjusted gross income plus social security.

SUBTITLE 2. TAXES.

Sec. 5. The General Assembly intends to enact legislation increasing specified taxes, the revenues from which shall be earmarked for deposit into the preventive care account of the North Carolina Family Health Care Trust Fund.

TITLE III. TORT REFORM.

Sec. 6. Chapter 7A of the General Statutes is amended by adding the following new Article to read:

"ARTICLE 39B.
"MEDICAL MALPRACTICE CLAIMS REVIEW AND ARBITRATION PROGRAM.

"§ 7A-496. Short title.

This act shall be known and may be cited as the Medical Malpractice Claims Review and Arbitration Act.

"§ 7A-497. Definitions.

As used in this Article, unless the context clearly requires otherwise, the term:

(1) 'AOC' means the Administrative Office of the Courts;

(2) 'Arbitration panel' means a panel of persons convened to arbitrate a medical malpractice action pursuant to this Article;

(3) 'Medical malpractice action' means a civil action for damages for personal injury or death arising out of the furnishing or failure to furnish professional services in the performance of medical, dental, or other health care;

(4) 'Program' means the Medical Malpractice Claims Review and Arbitration Program of the Administrative Office of the Courts;

(5) 'Review panel' means the panel of persons convened pursuant to this Article to review a medical malpractice action filed.

"**§ 7A-498. Medical Malpractice Claims Review and Arbitration Program established.**

(a) The Administrative Office of the Courts shall establish a Medical Malpractice Claims Review and Arbitration Program. The purpose of the Program is to provide statewide and uniform review and arbitration services to the parties to medical malpractice actions. The Director of the AOC shall appoint AOC staff support for the planning, implementation, and evaluation of the Program on a statewide basis.

(b) Beginning July 1, 1995, the AOC shall implement a statewide medical malpractice claims review and arbitration program comprised of local district programs to be operative in all judicial districts of the State. Each local district program shall consist of one or more medical malpractice claims review panels to review medical malpractice actions filed in that district.

(c) The AOC shall adopt rules and procedures for the convening of review panels and arbitration panels for the orderly, thorough, and expeditious review and arbitration of medical malpractice claims filed, and for other purposes consistent with the implementation of this act.

(d) Beginning July 1, 1995, all medical malpractice actions filed in the courts of this State that are not the subject of a written arbitration agreement between the parties and executed independent of this Article shall be subject to review by a medical malpractice claims review panel before the action may proceed to trial. If the review panel issues the opinion set forth in G.S. 7A-499(c)(2), the claim or claims will be submitted to arbitration as set forth in G.S. 7A-501. If the review panel issues an opinion set forth in G.S. 7A-499(c)(1) or (c)(3) and the plaintiff wants to proceed with the action, the action may proceed to trial, but, if the plaintiff does not prevail in the action at trial against one or more defendants, then the plaintiff shall be responsible for the reasonable attorneys' fees of such defendant or defendants. If the review panel finds as provided in G.S. 7A-499(c)(4), the action may proceed to trial without arbitration under this Article.

(e) Nothing in this Article shall preclude settlement of the action at any time by mutual agreement of the parties.

"**§ 7A-499. Procedure for review of claims.**

(a) **Within 30 days of service on the defendant that a medical malpractice** action has been filed by the plaintiff, the clerk of superior court in the county where the action was filed shall arrange for the appointment of a medical malpractice review panel and shall schedule a review of the plaintiff's claim by the panel, which review shall commence within 30 days of appointment of the review panel.

(b) The clerk shall provide all parties or their counsel with written notice of the scheduled review date. Evidence to be reviewed by the review panel shall be promptly submitted by the parties to each review panel member in written form. Any party to the action, upon request, shall be granted a hearing before the review panel.

(c) Within 60 days after receiving all of the evidence, the review panel shall, after joint deliberation, render one or more of the following opinions as to each claim and as to each party:

(1) The evidence does not support a conclusion that the defendant health care provider failed to comply with the appropriate standard of care;
(2) The evidence supports a conclusion that the defendant health care provider failed to comply with the appropriate standard of care and that such failure is a proximate cause in the alleged damages;
(3) The evidence supports a conclusion that the defendant health care provider failed to comply with the appropriate standard of care and that such failure is not a proximate cause in the alleged damages; or
(4) The evidence indicates that there is a material issue of fact, not requiring an expert opinion, bearing on liability for consideration by a court or jury.

(d) If the panel's opinion is that set forth in subsection (c)(2) of this section, the panel may determine whether the claimant suffered any disability or impairment and the degree and extent thereof.

(e) An opinion of a majority of the review panel shall be deemed the opinion of the review panel. The review panel's opinion shall be in writing and shall be signed by all review panelists who agree therewith. Any member of the review panel may note his or her dissent from the opinion. The clerk shall mail the review panel's opinion to the plaintiff and the defendant, or their counsel, within five days of the date of the rendering of the opinion. The review panel may also announce the opinion in the presence of the parties or their counsel.

(f) Review panel and arbitration panel members shall have absolute immunity from civil liability for all communications, findings, opinions, and conclusions made in the course and scope of their duties as panel members.

"**§ 7A-500. Composition and appointment of panel.**

(a) Each medical malpractice review panel or arbitration panel shall consist of one practicing plaintiff's attorney, one practicing primary care physician, and three citizens who are not affiliated with the medical profession.

(b) The AOC shall develop and provide to local clerks of court a list of potential attorney and physician review or arbitration panel members which shall contain the names of attorneys recommended by the North Carolina Bar Association and physicians recommended by the North Carolina Medical Society. The chief judge of the judicial district in which a panel is appointed shall appoint the citizen members of the panel for each action, and shall name the chair of the panel from among the members appointed.

(c) The AOC shall establish procedures for the payment of reasonable fees to panel members for services rendered in conducting reviews and arbitration under this Article, and for reimbursement for travel expenses in accordance with G.S. 138-6.

"**§ 7A-501. Nonbinding arbitration of claim.**

(a) If the opinion of the review panel is that set forth in G.S. 7A-499(c)(2), a panel shall be convened to arbitrate the claim that was the subject of the review. The panel convened to arbitrate the claim may be the same panel that reviewed the claim, or, upon request of either party, a different panel appointed by the clerk pursuant to G.S. 7A-500.

1 (b) Upon request of both parties, the Administrative Office of the Courts may
2 arrange for arbitration of the claim to be conducted by professional arbitrators in lieu of
3 an arbitration panel selected in accordance with G.S. 7A-500. Such request must be
4 made to the clerk within 10 days of receipt of the review panel's written decision as set
5 forth in G.S. 7A-499(c)(2). The parties shall be equally responsible for the fees of
6 professional arbitrators and other costs incurred to have the claim arbitrated by
7 professional arbitrators. The clerk shall notify the AOC of the request, and within 30
8 days of receipt of notice from the clerk, the AOC shall appoint three arbitrators, one
9 selected by the Director of the AOC from the American Arbitration Association or other
10 association of professional arbitrators, one selected by the plaintiff, and one selected by
11 the defendant.
12 (c) The arbitration panel may decide the merits of one or more claims reviewed
13 by the review panel, and may make a determination as to damages.
14 (d) All documentary evidence, transcripts of the review panel's hearing, if any,
15 and a copy of the written opinion of the review panel shall be made available to the
16 panel conducting arbitration.
17 (e) The panel convened to arbitrate the claim shall issue its opinion within 60
18 days of completion of the arbitration proceedings. The opinion shall be in writing and
19 shall specify the findings upon which the opinion is based. The opinion of the
20 arbitration panel shall not be binding on the parties.
21 (f) If all parties do not agree to abide by the arbitration panel's decision, the
22 action shall proceed to trial and the opinion of the review panel and the arbitration panel
23 shall be admissible as evidence in the action. Such opinions shall not be conclusive
24 evidence, however, and either party may call, at the party's own expense, a member of
25 the review or arbitration panel as a witness in the action. If called, the panel member
26 shall be required to appear and testify.
27 (g) Any party who does not agree to abide by the arbitration panel's decision
28 shall be responsible for the reasonable attorneys' fees of the party or parties who agree
29 to abide by the arbitration panel's decision and who prevail at trial.
30 "**§ 7A-502. Limitation on length of review and arbitration; statute of limitations**
31 **tolled during review and arbitration period.**
32 (a) Except as otherwise agreed to by both parties, the review and arbitration of a
33 medical malpractice action shall take no longer than one year from the date the action is
34 filed to the date the decision of the arbitration panel is rendered. The chief judge of the
35 district in which the action was filed may extend the one-year limitation if, in the chief
36 judge's opinion, the extension is necessary in order for justice to be served.
37 (b) During the period that a medical malpractice action is under review or
38 arbitration pursuant to this act, any applicable statute of limitations that would bar one
39 or more of the claims of the action from being heard is tolled.
40 "**§ 7A-503. Costs of review and arbitration.**
41 **The AOC shall develop a schedule of fees and costs for the implementation of**
42 **the** Program and for conducting a review or an arbitration under the Program. The
43 parties to an action shall be equally responsible for payment of the costs and fees

established by the AOC. Parties to an action that is being reviewed or arbitrated under this Article shall be responsible for their own attorneys' fees.

"**§ 7A-504. Program administration; advisory committee.**

(a) **The AOC, in cooperation with the chief judge and other court** personnel in the judicial district, shall implement the Program required by this Article.

(b) The AOC shall appoint a Medical Malpractice Review and Arbitration Advisory Committee to advise the AOC in the development and administration of the Program. The Advisory Committee shall have at least five members, one of whom shall be recommended by the North Carolina Academy of Trial Lawyers, and one of whom shall be recommended by the North Carolina Academy of Family Physicians. The members of the Advisory Committee shall receive the same per diem and reimbursement for travel expenses as members of State boards and commissions generally."

TITLE IV. CONFORMING CHANGES, APPROPRIATIONS, OTHER.

SUBTITLE 1. TRANSFER OF CERTIFICATE OF NEED AND MEDICAL DATABASE COMMISSION.

Sec. 7. Effective July 1, 1993, the administration of the Certificate of Need requirements under Article 9 of Chapter 131E are transferred by a Type I transfer in accordance with G.S. 143A-6(a) from the Department of Human Resources to the North Carolina Family Health Care Planning Commission as established under G.S. 143-592. All powers, duties, functions, records, and unexpended balances of appropriations, allocations, or other funds, including the functions of budgeting and purchasing as these elements pertain to administration of Article 9 of Chapter 131E, are transferred from the Department of Human Resources to the North Carolina Family Health Care Planning Commission in accordance with G.S. 143A-6(a).

Sec. 8. Effective July 1, 1993, the Medical Database Commission, established under Article 11 of Chapter 131E of the General Statutes, is transferred by a Type I transfer in accordance with G.S. 143A-6(a) from the Department of Human Resources to the North Carolina Family Health Care Planning Commission established under Article 64 of Chapter 143 of the General Statutes. All powers, duties, functions, records, and unexpended balances of appropriations, allocations, or other funds, including the functions of budgeting and purchasing as these elements pertain to administration of Article 11 of Chapter 131E, are transferred from the Department of Human Resources to the North Carolina Family Health Care Planning Commission in accordance with G.S. 143A-6(a).

Sec. 9. Effective July 1, 1993, the phrase "Department of Human Resources" is deleted and replaced by the phrase "North Carolina Family Health Care Planning Commission" wherever it occurs in Articles 9 and 11 of Chapter 131E of the General Statutes.

Sec. 10. Effective July 1, 1993, the Revisor of Statutes is authorized to correct any reference or citation in the General Statutes to any portion of the General Statutes which is amended by this act by deleting incorrect references and substituting correct references.

1 **SUBTITLE 2. CONFORMING CHANGES.**