



INTRODUCTION

After working on the budget for 8 months and at times seeing no end in sight, the budget was rolled out last Monday night around 10:30 p.m. with over 670 pages of numbers, detail, explanation and policy. Amazingly the budget was then debated and voted on less than 75 hours later (over the strong objections of the Democrats)! Despite all the battles, negotiations and harsh words, the House and Senate leadership congratulated each other and had high praise for the final product. The budget even drew some bi-partisan support with a handful of Democrats in the Senate and about 10 in the House voting for the measure. The Governor signed the Budget on Friday morning making sure the spending plan was in place before the end of the continuing budget resolution that was set to expire at the end of the day.

One of the reasons that the budget stalled is that the negotiations were tied into policy decisions so that if agreement could not be reached on Medicaid Reform, Tax Reform, and Economic Incentives, each chamber was threatening to hold up the budget. The document has several "poison pills" included to make sure that if the policy deals are not done, that something drastic happens that would provide an incentive to complete the deal.

Now that the budget is completed, both Chambers are saying that they will work through next weekend and would like to adjourn by September 30th. There seems to be a real push to get out before October (not many sessions have lasted that long so they want to avoid that label). The last couple weeks of session are always dangerous as there is very little time to stop things that come up and there are always surprises. Despite knowing how busy it will be it is nice that there is light at the end of the tunnel!

We have provided a general summary of the budget below and a few details that may affect you directly. We will provide a more complete summary of the budget in your final legislative report.



NORTH CAROLINA COLLEGE OF EMERGENCY PHYSICIANS



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BUDGET

There are a wide variety of Emergency Medicine related items in the budget, and we will touch on them here briefly:

- A new HIE (Health Information Exchange) will be done by the State with over \$1.4 million provided. All hospitals and Medicaid Providers will be required to provide information.
- A pilot program to focus on the expanding the role of paramedics to allow for community-based initiatives that result in providing care that avoids nonemergency use of emergency rooms and 911 services and avoids unnecessary admissions into health care facilities is provided \$225,000.
- Paramedicine Pilot Program would require NCOEMS to create educational standards and provides \$350,000.
- The budget restricts any funding to be provided to an organization that also provides abortion services (this is clearly targeted at Planned Parenthood) and will stop several successful programs around the state targeting teen pregnancy.
- Inmate health care costs will be paid at 70% of the provider's standard rate or 2 times the Medicaid rate.
- New local inpatient psych beds for those not covered by insurance, Medicare, or Medicaid would be provided \$40 million.
- The funds from the sale of Dorothea Dix would be used to provide 150 new behavioral health inpatient beds.
- There will be a Joint Study of the intersection of behavioral health and the justice and public safety system by the oversight committees on Justice and Public Safety and Health and Human Services.
- Law Enforcement and the Harm Reduction Coalition will receive \$50,000 to distribute Narcan for opioid overdoses.
- The budget included a provision that was opposed by NCCEP to require one hour of continuing Medical Education for licensees of the North Carolina Medical Board and several other professional Boards, including Nursing, Dental and Podiatry. The course will focus on controlled substance prescribing.
- The Controlled Substance Reporting System will be improved by making the connectivity interstate.
- There will be created a prescription drug abuse advisory committee to assist in creating a strategic plan to combat prescription drug abuse.
- The Medicaid provider application and re-credentialing fee is \$100 and must be done every three years.
- No Medicaid provider may receive reimbursement for Graduate Medical Education (GME) in addition to their DRG Unit Value (Base) rate under the methodology as defined in the current Medicaid State Plan.

The budget also:

- Spends \$21.735 billion which is a 3.1 percent spending increase.
- Provides \$600 million to the rainy day and repair renovation fund.
- New Teachers starting pay will increase from \$33 to \$35 thousand and experienced-based step raises will be provided to teachers, assistant principals, principals, state highway patrol troopers, clerks and magistrates.

- Medicaid is provided \$225 million to begin the process of restructuring and reforming Medicaid
- Class size in the first grade is reduced to a 1:16 teacher-student ratio.
- Expands the Read to Achieve summer reading camps to first and second grades.
- Increases the funding to the controversial opportunity scholarships (vouchers to private schools) by \$14 million.
- Assists the School Connectivity initiative to bring better broadband and WiFi access to all North Carolina schools.
- Cuts the personal tax rate to 5.499 beginning in 2017.
- Exempts the first \$15,500 of income for taxpayers married and filing jointly.
- Fully restores the state tax deduction for medical expenses, which was part of the tax reform package in 2013.
- Moves to calculate corporate income tax on the basis of a single sales factor over the next three years like many of our neighbor states - this will actually decrease the revenue to the state as the tax will be based on how much a business sells, rather than how big their payroll is or how much equipment they own and use.
- Extends the historic preservation tax credits for four years.
- Maintains the existing system for allocation of local sales tax revenue, where 75 percent is allocated based on the county where a sale takes place and 25 percent is based on population.
- Increases funding for essential court needs like interpreters, expert witnesses and juror fees and also increases funding for operations at the Administrative Office of the Courts.
- Lays the groundwork to give voters the opportunity to pass a \$2 billion bond referendum for improvements across the state.
- Increases fees for a variety of services at the Department of Motor Vehicles.
- Creates a new Department of Information Technology for all state agencies.
- The state will charge Sales Tax on previously untaxed services such as repairs to cars, installation of personal property and warranties connected to new purchases. The new sales tax expansion won't apply to people who operate as a contractor or people and businesses that provide services but do not sell anything. For example, a lawnmower repair shop that sells lawnmower parts will likely have to charge sales tax for servicing your equipment, but the person who mows your lawn will not have to charge you tax. These new taxes on services will take effect March 1, 2016.
- North Carolina's corporate tax rate will drop to 4 percent this year and could drop to 3 percent in future years depending of certain income triggers for the state.

MEDICAID REFORM

HOUSE BILL 372, Medicaid Transformation and Reorganization. This bill is the final version of Medicaid Reform that will be voted on by the House and Senate this week. This conference committee report is the culmination of many months and really years of negotiations between the House and the Senate and advocacy efforts by every healthcare provider group, healthcare advocacy group and insurance company in the State. Although the bill contains a general framework for the new Medicaid Reform - many issues and decisions will be made later by the waiver to CMS drafted by DHHS, the RFP that will go out to the "prepaid health plans" and the new department created in DHHS to manage the new system. The waiver to CMS is expected to take at least 2 years and then the implementation of the plan another 18 months so there will be lots of work to do in the interim to try to protect emergency medicine. The Legislature will also

remain involved so many of these issues will continue to be worked on in Raleigh. Here is a summary of the final compromise.

PART I. TRANSFORMATION OF MEDICAID AND NC HEALTH CHOICE PROGRAMS

- state the intent of the General Assembly to transform the State's current Medicaid and NC Health Choice programs to programs that provide budget predictability for the taxpayers of this State while ensuring quality care to those in need;
 - design the new Medicaid and NC Health Choice programs to achieve the following goals:
 - budget predictability through shared risk and accountability;
 - balanced quality, patient satisfaction, and financial measures;
 - efficient and cost-effective administrative systems and structures; and
 - a sustainable delivery system;
 - provide that the General Assembly will have the following roles and responsibilities in Medicaid and NC Health Choice transformation and governance:
 - define the overall goals of transformation and the structure of the delivery system for the programs;
 - monitor the development of transformation plans and implementation through the Joint Legislative Oversight Committee on Medicaid and NC Health Choice;
 - **define and approve eligibility and income standards for the programs, including which populations will be covered by Prepaid Health Plans (PHPs);**
 - appropriate the annual budget for the Medicaid and NC Health Choice programs; and
 - confirm the Director of the Division of Health Benefits.
 - include the following time line for Medicaid transformation:
 - when this act becomes law:
 - create the Division of Health Benefits of DHHS;
 - create the Joint Legislative Oversight Committee on Medicaid and NC Health Choice to oversee the Medicaid and NC Health Choice programs;
 - require the Division of Health Benefits to begin development of the 1115 waiver and any other State Plan amendments and waiver amendments necessary to effectuate the Medicaid transformation;
 - March 1, 2016 – require DHHS, through the Division of Health Benefits, to report its plans and progress on Medicaid transformation, including recommended statutory changes, to the Joint Legislative Oversight Committee on Medicaid and NC Health Choice;
 - on or before June 1, 2016 – require DHHS, through the Division of Health Benefits to submit the required waivers and State Plan amendments to the Centers for Medicare & Medicaid Services (CMS); and
 - eighteen months after approval of all necessary waivers and State Plan amendments by CMS – require capitated contracts to begin and initial recipient enrollment to be complete.
 - require the transformed Medicaid and NC Health Choice programs to be organized according to specified principles and parameters:
 - provide that DHHS will have full authority to manage the State's Medicaid and NC Health Choice programs provided that the total expenditures, net of agency receipts, do not exceed the authorized budget for each program, except the
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General Assembly shall determine eligibility categories and income thresholds. DHHS through the Division of Health Benefits, will be responsible for planning and implementing the Medicaid transformation;

- define a Prepaid Health Plan (PHP) as an entity, which may be a commercial plan or provider-led entity, that operates or will operate a capitated contract for the delivery of services. For purposes of this act, the terms "commercial plan" and "provider-led entity" are defined as follows:
 - Commercial plan or CP. – Any person, entity, or organization, profit or nonprofit, that undertakes to provide or arrange for the delivery of health care services to enrollees on a prepaid basis except for enrollee responsibility for copayments and deductibles and holds a PHP license issued by the Department of Insurance.
 - Provider-led entity or PLE. – An entity that meets all of the following criteria:
 - a majority of the entity's ownership is held by an individual or entity that has as its primary business purpose the ownership or operation of one or more Medicaid and NC Health Choice providers;
 - a majority of the entity's governing body is composed of physicians, physician assistants, nurse practitioners, or psychologists; and
 - holds a PHP license issued by the Department of Insurance;
- require the Division of Health Benefits to enter into capitated contracts with PHPs for the delivery of Medicaid and NC Health Choice services. All capitated contracts shall be the result of requests for proposals (RFPs) issued by the Division of Health Benefits and the submission of competitive bids by PHPs;
- provide that capitated PHP contracts will cover all Medicaid and NC Health Choice services, including physical health services, prescription drugs, long-term services and supports, and behavioral health services for NC Health Choice recipients, except as otherwise provided. **Behavioral health services for Medicaid recipients currently covered by the LME/MCOs would be excluded from the capitated contracts until four years after the date capitated contracts begin. The capitated contracts would not cover dental services;**
- require capitated PHP contracts to cover all Medicaid and NC Health Choice program aid categories except recipients who are dually eligible for Medicaid and Medicare. Recipients in the aged program aid category that are eligible for Medicare would be considered recipients who are dually eligible for Medicaid and Medicare, and the Division of Health Benefits would develop a long-term strategy to cover dual eligibles through capitated PHP contracts;
- specify the number and nature of capitated PHP contracts as follows: (1) **three contracts between the Division of Health Benefits and PHPs to provide coverage to Medicaid and NC Health Choice recipients statewide (statewide contracts);** (2) **up to 10 contracts between the Division of Health Benefits and PLEs for coverage of regions specified by the Division of Health Benefits (regional contracts).** Regional contracts would be in addition to the three statewide contracts. Each regional contract shall provide coverage throughout the entire region for the Medicaid and NC Health Choice services. A PLE could bid for more than one regional contract, if the regions are contiguous. Initial capitated PHP contracts could be awarded on staggered terms of three to five years in

duration to ensure against gaps in coverage that may result from termination of a contract by the PHP or the State;

- **require PHPs to comply with the requirements of GS Chapter 58 to the extent allowed by Medicaid federal law and regulations and consistent with the requirements of this act. This requirement would not be construed to require PHPs to cover services that are not covered by the Medicaid program pursuant to federal law and regulations. DHHS, Division of Health Benefits, and the Department of Insurance would jointly review the applicability of provisions of GS Chapter 58 to PHPs, and report to the Joint Legislative Oversight Committee on Medicaid and NC Health Choice by March 1, 2016;**
- **require the new delivery system and capitated PHP contracts to be built on defined measures and goals for risk-adjusted health outcomes, quality of care, patient satisfaction, access, and cost. Each component would be subject to specific accountability measures, including penalties. The Division of Health Benefits could use organizations such as National Committee for Quality Assurance (NCQA), Physician Consortium for Performance Improvement (PCPI), or any others necessary to develop effective measures for outcomes and quality;**
- provide that PHPs are responsible for all administrative functions for recipients enrolled in their plan, including, but not limited to, claims processing, care and case management, grievances and appeals, and other necessary administrative services;
- direct LME/MCOs to continue to manage the behavioral health services currently covered for their enrollees under all existing waivers, including the 1915(b) and (c) waivers, for four years after the date capitated PHP contracts begin;
- specify the role and responsibilities of DHHS, through the Division of Health Benefits, during Medicaid transformation as follows:
 - submit to CMS a demonstration waiver application pursuant to Section 1115 of the Social Security Act and any other waivers and State Plan amendments as necessary to accomplish the requirements of this act within the required time frames;
 - **define six regions comprised of whole contiguous counties that reasonably distribute covered populations across the State to ensure effective delivery of health care and achievement of the goals of Medicaid transformation with every county in the State assigned to a region;**
 - oversee, monitor, and enforce capitated PHP contract performance;
 - ensure sustainability of the transformed Medicaid and NC Health Choice programs;
 - **set rates, including the following: capitation rates that are actuarially sound; appropriate rate floors for in-network primary care physicians, specialist physicians, and pharmacy dispensing fees to ensure the achievement of transformation goals; and rates for services in the remaining fee-for-service programs;**
 - enter into capitated PHP contracts for the delivery of the Medicaid and NC Health Choice services. The Division of Health Benefits would develop standardized contract terms, to include at a minimum, the following:
 - risk-adjusted cost growth for its enrollees must be at least 2% points below national Medicaid spending growth as documented and projected in the annual report prepared for CMS by the Office of the Actuary for nonexpansion states;
 - a requirement that PHP spending for prescribed drugs, net of rebates, ensures the State realizes a net savings for the spending on prescription

drugs. All PHPs shall be required to use the same drug formulary established by DHHS, Division of Health Benefits;

- until final federal regulations are promulgated governing medical loss ratio, a minimum medical loss ratio of 88% for health care services, with the components of the numerator and denominator to be defined by DHHS, Division of Health Benefits;
- a requirement that PHPs develop and maintain provider networks that meet access to care requirements for their enrollees. **PHPs may not exclude providers from their networks except for failure to meet objective quality standards or refusal to accept network rates. PHPs must include all providers in their geographical coverage area that are designated essential providers by DHHS, unless DHHS approves an alternative arrangement for securing the types of services offered by the essential providers;**
- a requirement that all PHPs assure that enrollees who do not elect a primary care provider will be assigned to one;
- consult with the Joint Legislative Oversight Committee on Medicaid and NC Health Choice on the terms and conditions of the requests for proposals (RFPs) for the solicitation of bids for statewide and regional capitated PHP contracts;
- develop and implement a process for recipient assignment to PHPs. Criteria for assignment would include at least the recipient's family unit, including foster family and adoptive placement, quality measures, and primary care physician;
- **define methods to ensure program integrity against provider fraud, waste, and abuse at all levels;**
- **require all PHPs and Medicaid and NC Health Choice providers to submit data through the Health Information Exchange Network;**
- develop a Dual Eligibles Advisory Committee, and the Division of Health Benefits, upon the advice of the Dual Eligibles Advisory Committee, would develop a long-term strategy to cover dual eligibles through capitated PHP contracts and report the strategy to the Joint Legislative Oversight Committee on Medicaid and NC Health Choice by January 31, 2017;
- report to the Joint Legislative Oversight Committee on Medicaid and NC Health Choice by March 1, 2016, on specified items;
- **designate Medicaid and NC Health Choice providers as essential providers if the provider either offers services that are not available from any other provider within a reasonable access standard or provides a substantial share of the total units of a particular service utilized by Medicaid and NC Health Choice recipients within the region during the last three years, and the combined capacity of other service providers in the region is insufficient to meet the total needs of the Medicaid and NC Health Choice enrollees. DHHS could not classify physicians and other practitioners as essential providers. At a minimum, providers in the following categories would be designated essential providers: federally qualified health centers; rural health centers; free clinics; and local health departments;**
- require the Department of Insurance to establish and implement solvency requirements for the licensing of PHPs;
- direct DHHS to renegotiate its contract with North Carolina Community Care Networks, Inc., (NCCCN) by July 1, 2016, to reduce per member per month payments to NCCCN for administration, including informatics, by 15% from the amount of per member per month payments NCCCN received for January 2015. The renegotiated contract would

provide for greater efficiencies and facilitate a smooth transition of features of the enhanced primary care case management program, including case management, informatics center operations, and practice supports, to the primary care medical home model or other care management model that will be utilized by PHPs, consistent with the plan reported to the Joint Legislative Oversight Committee on Medicaid and NC Health Choice. The renegotiated contract would also include performance measures and consequences for failing to meet those performance measures. **DHHS would continue to utilize NCCCN to perform existing functions until capitated PHP contracts begin.** When capitated PHP contracts begin, any contract with NCCCN existing on that date would terminate. Funds equal to the amount of any savings achieved on or after August 1, 2015, by the Division of Medical Assistance as a result of the contract renegotiation required by this section would be transferred to the Division of Health Benefits to be used for the transition to capitated PHP contract;

- direct DHHS to submit a program design and budget proposal no later than May 1, 2016, to the Joint Legislative Oversight Committee on Medicaid and NC Health Choice that will create a Medicaid and NC Health Choice Transformation Innovations Center within the Division of Health Benefits to assist Medicaid and NC Health Choice providers in achieving the ultimate goals of better health, better care, and lower costs for North Carolinians. **The center should be designed to support providers through technical assistance and learning collaboratives that foster 3 peer-to-peer sharing of best practices; and**
- require DHHS, in developing the waivers and State Plan amendments necessary to implement this act, to work with the Centers for Medicare & Medicaid Services (CMS) to attempt to preserve existing levels of funding generated from Medicaid-specific funding streams, such as assessments, to the extent that the levels of funding may be preserved. If such Medicaid-specific funding cannot be maintained as currently implemented, then the Division of Health Benefits would advise the Joint Legislative Oversight Committee on Medicaid and NC Health Choice of any modifications necessary to maintain as much revenue as possible within the context of Medicaid transformation. If such Medicaid-specific funding streams cannot be preserved through the transformation process or if revenue would decrease, it is the intent of the General Assembly to modify such funding streams so that any supplemental payments to providers are more closely aligned to improving health outcomes and achieving overall Medicaid goals.

PART II. REORGANIZATION OF MEDICAID AND NC HEALTH CHOICE PROGRAMS

- establish the Division of Health Benefits as a new division of the Department of Health and Human Services. The Department of Health and Human Services, through the Division of Health Benefits, would be responsible for implementing Medicaid transformation and would administer and operate all functions, powers, duties, obligations, and services related to the transformed Medicaid and NC Health Choice programs. The Division of Medical Assistance would continue to operate the current Medicaid and NC Health Choice programs until the Division of Medical Assistance is eliminated. Upon the elimination of the Division of Medical Assistance, all functions, powers, duties, obligations, and services vested in the Division of Medical Assistance of the Department of Health and Human Services are vested in the Division of Health Benefits. The Department of Health and Human Services would remain the Medicaid single State agency;

- eliminate the Division of Medical Assistance and all positions remaining in the Division of Medical Assistance twelve months after capitated PHP contracts begin, or at an earlier time as determined by the Secretary of the Department of Health and Human Services;
- provide that the Director of the Division of Health Benefits will be appointed by the Governor for a term of four years subject to confirmation by the General Assembly by joint resolution; and include the procedures for appointment, filling a vacancy, and removal of the director;
- specify the powers and duties of the Secretary of the Department of Health and Human Services, through the Division of Health Benefits;
- establish the 14-member Joint Legislative Oversight Committee on Medicaid and NC Health Choice to examine budgeting, financing, administrative, and operational issues related to the Medicaid and NC Health Choice programs administered by DHHS. The Committee could make periodic reports, including recommendations, to the General Assembly on issues related to Medicaid and NC Health Choice programs;
- transfer jurisdiction for legislative oversight of the Medicaid and NC Health Choice programs from the Joint Legislative Oversight Committee on Health and Human Services to the Joint Legislative Oversight Committee on Medicaid and NC Health Choice. However, both Committees would have concurrent jurisdiction over issues related to mental health, developmental disabilities, and substance abuse services covered by the Medicaid and NC Health Choice programs; and
- provide that no provision in the Medicaid State Plan or in a Medicaid Waiver may expand or otherwise alter the scope or purpose of the Medicaid program from that authorized by law enacted by the General Assembly. The Department of Health and Human Services would be expressly authorized and required to take any and all necessary action to amend the State Plan and waivers in order to keep the program within the certified budget, except as provided in G.S. 108A-54(f).

The bill as amended by the conference committee is scheduled to be heard in the House and Senate on September 22nd.

BILL UPDATES

HOUSE BILL 20, Rural Access to Health Care, was amended in the Senate Rules Committee and on the Senate floor to:

- allow a municipality or hospital authority that has complied with the requirements regarding the sale or lease of a hospital but has not, following good faith negotiations, approved any lease, sale, or conveyance as required to, not less than 120 days following the required public hearing, solicit additional prospective lessees or buyers not previously solicited and approve any lease, sale, or conveyance without the necessity to repeat compliance with the sale or lease requirements, except for the following:
 - before considering any proposal to lease or purchase the hospital facility or part thereof, the municipality or hospital authority must require information on charges, services, and indigent care at similar facilities leased, owned, or operated by the proposed lessee or buyer;
 - the municipality or hospital authority must declare its intent to approve any lease or sale in the manner authorized by this subsection at a regular or special meeting held on 10 days' public notice. Such notice shall state that copies of the lease, sale, or conveyance proposed for approval will be available 10 days prior to the regular or special meeting required by subdivision (3) of this subsection, and that the lease, sale, or conveyance shall be considered for approval at a regular or

- special meeting not less than 10 days following the regular or special meeting required by this subsection. Notice must be given by publication in one or more papers of general circulation in the affected area describing the intent to lease, sell, or convey the hospital facility involved and the potential buyer or lessee;
 - not less than 10 days following the regular or special meeting required by subdivision (2) of this subsection, the municipality or hospital authority shall approve any lease, sale, or conveyance by a resolution at a regular or special meeting; and
 - at least 10 days before the regular or special meeting at which any lease, sale, or conveyance is approved, the municipality or hospital authority must make copies of the proposed contract available to the public;
- define a “Legacy Medical Care Facility” (this provision was included to help Belhaven Hospital re-open) as an institution that meets all of the following requirements:
 - is not presently operating;
 - has not continuously operated for at least the past six months; and
 - within the last 24 months was operated by a person holding a license under G.S. 131E-77, and was primarily engaged in providing to inpatients, by or under supervision of physicians, (i) diagnostic services and therapeutic services for medical diagnosis, treatment, and care of injured, disabled, or sick persons, or (ii) rehabilitation services for the rehabilitation of injured, disabled, or sick persons; and
- require the Department of Health and Human Services to exempt from certificate of need review the acquisition or reopening of a Legacy Medical Care Facility. The person seeking to operate a Legacy Medical Care Facility would have given written notice (1) of its intention to acquire or reopen a Legacy Medical Care Facility, and (2) that the hospital will be operational within 36 months of the notice.

The bill as amended was approved by the Senate Rules Committee and the full Senate. The bill has been assigned to the House Rules Committee to consider the changes made by the Senate.

HOUSE BILL 792, Privacy/Protection From Revenge Postings. In your last legislative report we told you that the House voted not to concur with the Senate’s changes to the bill and a conference committee from each chamber was appointed to work out the differences. The result is the conference report that made the following changes:

- despite some talk of making all first offenses a Class 1 misdemeanor, the penalty language was not changed, and remains a Class H for any offense committed by someone over 18 and for a second/subsequent offenses by those under 18, it will be a Class 1 misdemeanor for first offense by those under 18;
- affirmative consent language was added to clarify that the statute covers all disclosures in which “the person discloses the image without the affirmative consent of the depicted person” and “under circumstances such that the person knew or should have known that the depicted person had a reasonable expectation of privacy” (see below); and
- the statute of limitations for civil cases in the 4th edition (4 years from the most recent disclosure) was changed to 1 year from the initial discovery of the disclosure and no more than 7 years from the most recent disclosure.

As a reminder, “reasonable expectation of privacy” is defined in the bill as: "When a depicted person has consented to the disclosure of an image within the context of a personal relationship and the depicted person reasonably believes that the disclosure will not go beyond that

relationship." **The Conference report was adopted by the House and Senate, and the bill has been sent to the Governor for his signature.**

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