

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2019

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HOUSE BILL 555
Committee Substitute Favorable 5/2/19
Senate Health Care Committee Substitute Adopted 8/21/19
Senate Finance Committee Substitute Adopted 8/22/19
Fifth Edition Engrossed 8/27/19

Short Title: Medicaid Transformation Implementation.

(Public)

Sponsors:

Referred to:

April 3, 2019

1 A BILL TO BE ENTITLED
2 AN ACT TO APPROPRIATE FUNDS FOR THE IMPLEMENTATION OF MEDICAID
3 TRANSFORMATION AND TO MAKE OTHER MEDICAID
4 TRANSFORMATION-RELATED CHANGES.

5 The General Assembly of North Carolina enacts:

6
7 **PART I. IMPLEMENTATION IN CONJUNCTION WITH STATUTORY**
8 **PROCEDURES FOR BUDGET CONTINUATION**

9 **SECTION 1.1.** The provisions of this act shall be implemented in conjunction with
10 the procedures for budget continuation specified in G.S. 143C-5-4(b). If the provisions of this
11 act and G.S. 143C-5-4(b) are in conflict, the provisions of this act shall prevail.

12 **SECTION 1.2.** If House Bill 966, 2019 Regular Session, becomes law, then Section
13 9D.14, Section 9D.15A, Section 9D.16, Section 9D.17, Section 9D.18, and Section 9D.19 of
14 House Bill 966, 2019 Regular Session, are repealed.

15 **SECTION 1.3.** If House Bill 966, 2019 Regular Session, becomes law, then Section
16 2.1, Section 2.2, and Part III of this act are repealed.

17
18 **PART II. FUNDS FOR OPERATION OF THE MEDICAID PROGRAM**

19 **SECTION 2.1.(a)** There is appropriated from the General Fund the sum of
20 thirty-three million seven hundred fifty-eight thousand one hundred thirty-six dollars
21 (\$33,758,136) in recurring funds for the 2019-2020 fiscal year to the Department of Health and
22 Human Services, Division of Health Benefits, to be used for the Medicaid and NC Health Choice
23 programs rebase.

24 **SECTION 2.1.(b)** There is appropriated from the General Fund the sum of one
25 hundred ninety-nine million seven hundred eighty-four thousand two hundred thirty-eight dollars
26 (\$199,784,238) in recurring funds for the 2020-2021 fiscal year to the Department of Health and
27 Human Services, Division of Health Benefits, to be used for the Medicaid and NC Health Choice
28 programs rebase.

29 **SECTION 2.2.(a)** There is appropriated from the General Fund the sum of
30 twenty-eight million six hundred seventeen thousand six hundred fifty-five dollars (\$28,617,655)
31 in recurring funds for the 2019-2020 fiscal year to the Department of Health and Human Services,
32 Division of Health Benefits, for the purpose of transitioning to Medicaid managed care.



1 **SECTION 2.2.(b)** There is appropriated from the General Fund the sum of forty
2 million one hundred sixty-seven thousand six hundred fifty-five dollars (\$40,167,655) in
3 recurring funds for the 2020-2021 fiscal year to the Department of Health and Human Services,
4 Division of Health Benefits, for the purpose of transitioning to Medicaid managed care.

5 **SECTION 2.3.** Departmental receipts received as a result of this act are appropriated
6 in each year of the 2019-2021 biennium for the purposes specified in this act.

7
8 **PART III. USE OF MEDICAID TRANSFORMATION FUND FOR MEDICAID**
9 **TRANSFORMATION NEEDS**

10 **SECTION 3.1.(a)** The State Controller shall transfer the sum of one hundred
11 ninety-three million dollars (\$193,000,000) for the 2019-2020 fiscal year from funds available
12 in the Medicaid Transformation Reserve in the General Fund to the Medicaid Transformation
13 Fund established under Section 12H.29 of S.L. 2015-241.

14 **SECTION 3.1.(b)** The State Controller shall transfer the sum of twenty-four million
15 dollars (\$24,000,000) for the 2020-2021 fiscal year from funds available in the Medicaid
16 Transformation Reserve in the General Fund to the Medicaid Transformation Fund established
17 under Section 12H.29 of S.L. 2015-241.

18 **SECTION 3.2.(a) Claims Run Out.** – Funds from the Medicaid Transformation Fund
19 may be transferred to the Department of Health and Human Services, Division of Health Benefits
20 (DHB), as needed for the purpose of paying claims related to services billed under the
21 fee-for-service payment model for recipients who are being, or have been, transitioned to
22 managed care, otherwise known as "claims run out." Funds may be transferred to DHB as the
23 need to pay claims run out arises and need not be transferred in one lump sum. To the extent that
24 any funds are transferred under this subsection, the funds are appropriated for the purpose set
25 forth in this subsection.

26 **SECTION 3.2.(b) Non-Claims Run Out Medicaid Transformation Needs.** – Subject
27 to the fulfillment of conditions specified in subsection (c) of this section, the sum of twenty-seven
28 million two hundred eighty thousand nine hundred forty-seven dollars (\$27,280,947) in
29 nonrecurring funds for the 2019-2020 fiscal year and the sum of ten million nine hundred
30 eighty-three thousand five hundred forty-eight dollars (\$10,983,548) in nonrecurring funds for
31 the 2020-2021 fiscal year from the Medicaid Transformation Fund may be transferred to the
32 Department of Health and Human Services, Division of Health Benefits (DHB), for the sole
33 purpose of providing the State share for nonrecurring qualifying needs directly related to
34 Medicaid transformation, as required by S.L. 2015-241, as amended. Funds may be transferred
35 to DHB as nonrecurring qualifying needs arise during the 2019-2021 fiscal biennium and need
36 not be transferred in one lump sum. To the extent that any funds are transferred under this
37 subsection, the funds are appropriated for the purpose set forth in this subsection.

38 For the purposes of this section, the term "qualifying need" shall be limited to
39 information technology, time-limited staffing, and contracts related to the following Medicaid
40 transformation needs:

- 41 (1) Program design.
- 42 (2) Beneficiary experience.
- 43 (3) NC FAST upgrades related to Medicaid transformation.
- 44 (4) Data management tools.
- 45 (5) Program integrity.
- 46 (6) Technical and operational integration.
- 47 (7) Other nonrecurring needs identified by DHB, as determined in consultation
48 with the Office of State Budget and Management.

49 **SECTION 3.2.(c) Requests for Transfer of Funds for Qualifying Need.** – A request
50 by the Department of Health and Human Services, Division of Health Benefits (DHB), for the
51 transfer of funds pursuant to subsection (b) of this section shall be made to the Office of State

1 Budget and Management (OSBM) and shall include the amount requested and the specific
2 nonrecurring qualifying need for which the funds are to be used. None of the funds identified in
3 subsection (b) of this section shall be transferred to DHB until OSBM verifies the following
4 information:

- 5 (1) The amount requested is to be used for a nonrecurring qualifying need in the
6 2019-2021 fiscal biennium.
- 7 (2) The amount requested provides a State share that will not result in total
8 requirements that exceed one hundred ninety million dollars (\$190,000,000)
9 in nonrecurring funds for the 2019-2021 fiscal biennium.

10 **SECTION 3.2.(d) Federal Fund Receipts.** – Any federal funds received in any fiscal
11 year by the Department of Health and Human Services, Division of Health Benefits (DHB), that
12 represent a return of State share already expended on a qualifying need related to the funds
13 received by DHB under this section shall be deposited into the Medicaid Transformation Fund.
14

15 **PART V. REPEAL OF PAST DIRECTIVE TO ELIMINATE GME TO ALIGN WITH** 16 **MEDICAID TRANSFORMATION**

17 **SECTION 5.1.** Section 12H.12(b) of S.L. 2014-100 and Section 12H.23 of S.L.
18 2015-241, as amended by Section 88 of S.L. 2015-264, are repealed.
19

20 **PART VI. MEDICAID TRANSFORMATION HOTLINE OPTION**

21 **SECTION 6.1.** The Department of Health and Human Services shall ensure that the
22 existing DHHS Customer Service hotline is responsive to questions posed by a Medicaid
23 beneficiary or provider or by the general public that are related to the rollout of Medicaid
24 Transformation during the 2019-2020 fiscal year.
25

26 **PART VII. TRIBAL OPTION/MEDICAID TRANSFORMATION**

27 **SECTION 7.1.(a)** The Department of Health and Human Services may contract with
28 an Indian managed care entity (IMCE) or an Indian health care provider (IHCP), as defined under
29 42 C.F.R. § 438.14(a), to assist in the provision of health care or health care–related services to
30 Medicaid and NC Health Choice beneficiaries who are members of federally recognized tribes
31 or who are eligible to enroll in an IMCE. Contracts may include health care or health care–related
32 services as agreed upon with the IMCE or IHCP, as approved by the Secretary of the Department
33 of Health and Human Services and as allowed by the Centers for Medicare and Medicaid Services
34 (CMS), including, but not limited to, the following services:

- 35 (1) Primary care case management as a primary care case managed system or
36 entity, as described in 42 C.F.R. § 438.2.
- 37 (2) Utilization management and referrals.
- 38 (3) The management or provision of home- and community-based services under
39 a 1915(c) waiver.
- 40 (4) The management or provision of specialized services covered by a BH IDD
41 Tailored Plan in accordance with subdivision (10) of Section 4 of S.L.
42 2015-245, as amended by S.L. 2018-48.

43 Coverage provided by the IMCE or IHCP may be more permissive, but no more
44 restrictive, than Medicaid or NC Health Choice medical coverage policy adopted or amended by
45 the Department of Health and Human Services; however, the coverage shall be in compliance
46 with federal regulations and policies related to the receipt of federal funding for these health care
47 or health care–related services.

48 **SECTION 7.1.(b)** Subdivision (5) of Section 4 of S.L. 2015-245, as amended by
49 subsection 2(b) of S.L. 2016-121, S.L. 2018-48, Section 5 of S.L. 2018-49, and Section 12 of
50 S.L. 2019-81, reads as rewritten:

"(5) Populations covered by PHPs. – Capitated PHP contracts shall cover all Medicaid and NC Health Choice program aid categories except for the following categories:

...

e. Members of federally recognized tribes. Members of federally recognized tribes shall have the option to enroll voluntarily in PHPs.

e1. Eligible recipients who are enrolled in a DHHS-contracted Indian managed care entity, as defined in 42 C.F.R. § 438.14(a).

...."

SECTION 7.1.(c) Subdivision (9) of Section 4 of S.L. 2015-245, as amended by S.L. 2018-48 and Section 12 of S.L. 2019-81, reads as rewritten:

"(9) LME/MCOs. – Beginning on the date that capitated contracts begin, LME/MCOs shall cease managing Medicaid services for all Medicaid recipients other than recipients described in sub-subdivisions a., d., e., e1., f., g., j., k., l., and m. of subdivision (5) of this section. Until BH IDD Tailored Plans become operational, all of the following shall occur:

a. LME/MCOs shall continue to manage the Medicaid services that are covered by the LME/MCOs under the combined 1915(b) and (c) waivers for Medicaid recipients described in sub-subdivisions a., d., e., e1., f., g., j., k., l., and m. of subdivision (5) of this section.

b. The Division of Health Benefits shall negotiate actuarially sound capitation rates directly with the LME/MCOs based on the change in composition of the population being served by the LME/MCOs.

c. Capitation payments under contracts between the Division of Health Benefits and the LME/MCOs shall be made directly to the LME/MCO by the Division of Health Benefits.

...."

SECTION 7.1.(d) The Department of Health and Human Services is authorized to seek approval from CMS and submit any necessary State Plan Amendments and waivers, or any amendments thereto, to implement the provisions of this section.

SECTION 7.1.(e) Subsections (b) and (c) of this section become effective October 1, 2019.

PART VIII. REVISE AND RENAME THE SUPPLEMENTAL PAYMENT PROGRAM FOR ELIGIBLE MEDICAL PROFESSIONAL PROVIDERS

SECTION 8.1.(a) The Department of Health and Human Services shall revise the supplemental payment program for eligible medical professional providers described in the Medicaid State Plan, Attachment 4.19-B, Section 5, Pages 2 and 3, as required by this section. This payment program shall be called the Average Commercial Rate Supplemental and Directed Payment Program. Effective October 1, 2019, the following two changes to the program shall be implemented:

(1) The program shall no longer utilize a limit on the number of eligible medical professional providers that may be reimbursed through the program and instead shall utilize a limit on the total payments made under the program.

(2) Payments under the program shall consist of two components: (i) supplemental payments that increase reimbursement to the average commercial rate under the State Plan and (ii) directed payments that increase reimbursement to the average commercial rate under the managed care system.

SECTION 8.1.(b) The limitation on total payments made under the Average Commercial Rate Supplemental and Directed Payment Program for eligible medical professional

1 providers shall apply to the combined amount of payments made as supplemental payments under
2 the State Plan and payments made as directed payments under the managed care system and shall
3 be based on the amount of supplemental payments for services provided during the 2018-2019
4 fiscal year as follows:

5 (1) For services provided during the period October 1, 2019, through June 30,
6 2020, the total annual supplemental and directed payments made under the
7 Average Commercial Rate Supplemental and Directed Payment Program shall
8 not exceed seventy-five percent (75%) of the gross supplemental payments
9 for services provided by eligible medical providers during the 2018-2019
10 fiscal year.

11 (2) For services provided on or after July 1, 2020, the total annual supplemental
12 and directed payments made under the Average Commercial Rate
13 Supplemental and Directed Payment Program shall not exceed one hundred
14 percent (100%) of the gross supplemental payments for services provided by
15 eligible medical providers during the 2018-2019 fiscal year, increased at the
16 start of each State fiscal year by an inflation factor determined by the
17 Department of Health and Human Services, Division of Health Benefits.

18 **SECTION 8.1.(c)** Consistent with the existing supplemental payment program for
19 eligible medical professional providers, the Department of Health and Human Services shall limit
20 the total amount of supplemental and directed payments that may be received by the eligible
21 providers affiliated with East Carolina University Brody School of Medicine and University of
22 North Carolina at Chapel Hill Health Care System. Average commercial rate supplemental
23 payments and directed payments shall not be made for services provided in Wake County.

24 **SECTION 8.1.(d)** The Department of Health and Human Services is not authorized
25 to make any modifications to the supplemental payment program for eligible medical
26 professional providers, except as authorized by this section.

27 **SECTION 8.1.(e)** Effective October 1, 2019, Section 12H.13(e) of S.L. 2013-360
28 and Sections 12H.13(b) and 12H.13A of S.L. 2014-100 are repealed.

30 PART IX. MEDICAID CONTINGENCY RESERVE CODIFICATION

31 **SECTION 9.1.** Article 4 of Chapter 143C of the General Statutes is amended by
32 adding a new section to read:

33 "§ 143C-4-11. Medicaid Contingency Reserve.

34 (a) Medicaid Contingency Reserve. – The Medicaid Contingency Reserve is established
35 as a reserve to be used only for budget shortfalls in the Medicaid or NC Health Choice programs.

36 (b) Funds from the Medicaid Contingency Reserve may be allocated or expended only if
37 all of the following criteria are met:

38 (1) There is an act of appropriation by the General Assembly.

39 (2) After the State Controller has verified that all Medicaid and NC Health Choice
40 program receipts are being used appropriately, the Director of the Budget has
41 found that additional funds are needed to cover a shortfall in the Medicaid or
42 NC Health Choice budget for the State fiscal year.

43 (3) The Director of the Budget has reported immediately to the Fiscal Research
44 Division on the amount of the shortfall found in accordance with subdivision
45 (2) of this subsection. This report shall include an analysis of the causes of the
46 shortfall, such as (i) unanticipated enrollment and mix of enrollment, (ii)
47 unanticipated growth or utilization within particular service areas, (iii) errors
48 in the data or analysis used to project the Medicaid or NC Health Choice
49 budget, (iv) the failure of the program to achieve budgeted savings, (v) other
50 factors and market trends that have impacted the price of or spending for
51 services, (vi) variations in receipts from prior years or from assumptions used

1 to prepare the Medicaid and NC Health Choice budget for the current fiscal
2 year, or (vii) other factors. The report shall also include data in an electronic
3 format that is adequate for the Fiscal Research Division to confirm the amount
4 of the shortfall and its causes.

5 (c) Nothing in this section shall be construed to limit the authority of the Governor to
6 carry out the Governor's duties under the Constitution."

8 **PART X. REVISE AND UPDATE HOSPITAL ASSESSMENTS**

9 **SECTION 10.1.(a)** Effective October 1, 2019, Article 7 of Chapter 108A of the
10 General Statutes is repealed.

11 **SECTION 10.1.(b)** Effective October 1, 2019, Chapter 108A of the General Statutes
12 is amended by adding a new Article to read:

13 "Article 7A.

14 "Hospital Assessment Act.

15 "Part 1. General.

16 **"§ 108A-130. Short title and purpose.**

17 This Article shall be known as the "Hospital Assessment Act." This Article does not authorize
18 a political subdivision of the State to license a hospital for revenue or impose a tax or assessment
19 on a hospital.

20 **"§ 108A-131. Definitions.**

21 The following definitions apply in this Article:

22 (1) Base assessment. – The assessment payable under G.S. 108A-142.

23 (2) CMS. – Centers for Medicare and Medicaid Services.

24 (3) Critical access hospital. – As defined in 42 C.F.R. § 400.202.

25 (4) Department. – The Department of Health and Human Services.

26 (5) Prepaid health plan. – As defined in G.S. 108D-1.

27 (6) Public hospital. – A hospital that certifies its public expenditures to the
28 Department pursuant to 42 C.F.R. § 433.51(b) during the fiscal year for which
29 the assessment applies.

30 (7) Secretary. – The Secretary of Health and Human Services.

31 (8) State's annual Medicaid payment. – An amount equal to one hundred ten
32 million dollars (\$110,000,000) for State fiscal year 2019-2020, increased each
33 year over the prior year's payment by the percentage specified as the Medicare
34 Market Basket Index less productivity most recently published in the Federal
35 Register.

36 (9) Supplemental assessment. – The assessment payable under G.S. 108A-141.

37 (10) Total hospital costs. – The costs as calculated using the most recent available
38 Hospital Cost Report Information System's cost report data available through
39 CMS or other comparable data, including both inpatient and outpatient
40 components, for all hospitals that are not exempt from the applicable
41 assessment.

42 **"§ 108A-132. Due dates and collections.**

43 (a) Beginning October 1, 2019, assessments under this Article are due quarterly in the
44 time and manner prescribed by the Secretary and shall be considered delinquent if not paid within
45 seven calendar days of this due date.

46 (b) With respect to any hospital owing a past due assessment amount under this Article,
47 the Department may withhold the unpaid amount from Medicaid or NC Health Choice payments
48 otherwise due or impose a late payment penalty. The Secretary may waive a penalty for good
49 cause shown.

1 (c) In the event the data necessary to calculate an assessment under this Article is not
2 available to the Secretary in time to impose the quarterly assessments for a payment year, the
3 Secretary may defer the due date for the assessment to a subsequent quarter.

4 **"§ 108A-133. Assessment appeals.**

5 A hospital may appeal a determination of the assessment amount owed through a
6 reconsideration review. The pendency of an appeal does not relieve a hospital from its obligation
7 to pay an assessment amount when due.

8 **"§ 108A-134. Allowable costs; patient billing.**

9 (a) Assessments paid under this Article may be included as allowable costs of a hospital
10 for purposes of any applicable Medicaid reimbursement formula, except that assessments paid
11 under this Article shall be excluded from cost settlement.

12 (b) Assessments imposed under this Article may not be added as a surtax or assessment
13 on a patient's bill.

14 **"§ 108A-135. Rule-making authority.**

15 The Secretary may adopt rules to implement this Article.

16 **"§ 108A-136. Repeal.**

17 If CMS determines that an assessment under this Article is impermissible or revokes approval
18 of an assessment under this Article, then that assessment shall not be imposed and the
19 Department's authority to collect the assessment is repealed.

20 "Part 2. Supplemental and Base Assessments.

21 **"§ 108A-140. Applicability.**

22 (a) The assessments imposed under this Part apply to all licensed North Carolina
23 hospitals, except as provided in this section.

24 (b) The following hospitals are exempt from both the supplemental assessment and the
25 base assessment:

26 (1) Critical access hospitals.

27 (2) Freestanding psychiatric hospitals.

28 (3) Freestanding rehabilitation hospitals.

29 (4) Long-term care hospitals.

30 (5) State-owned and State-operated hospitals.

31 (6) The primary affiliated teaching hospital for each University of North Carolina
32 medical school.

33 (c) Public hospitals are exempt from the supplemental assessment.

34 **"§ 108A-141. Supplemental assessment.**

35 (a) The supplemental assessment shall be a percentage, established by the General
36 Assembly, of total hospital costs.

37 (b) The Department shall propose the rate of the supplemental assessment to be imposed
38 under this section when the Department prepares its budget request for each upcoming fiscal
39 year. The Governor shall submit the Department's proposed supplemental assessment rate to the
40 General Assembly each fiscal year.

41 (c) The Department shall base the proposed supplemental assessment rate on all of the
42 following factors:

43 (1) The percentage change in aggregate payments to hospitals subject to the
44 supplemental assessment for Medicaid and NC Health Choice enrollees,
45 excluding hospital access payments made under 42 C.F.R. § 438.6, as
46 demonstrated in data from prepaid health plans and the State, as determined
47 by the Department.

48 (2) Any changes in the federal medical assistance percentage rate applicable to
49 the Medicaid or NC Health Choice programs for the applicable year.

50 (d) The rate for the supplemental assessment for each taxable year shall be the percentage
51 rate set by law by the General Assembly.

1 **"§ 108A-142. Base assessment.**

2 (a) The base assessment shall be a percentage, established by the General Assembly, of
3 total hospital costs.

4 (b) The Department shall propose the rate of the base assessment to be imposed under
5 this section when the Department prepares its budget request for each upcoming fiscal year. The
6 Governor shall submit the Department's proposed base assessment rate to the General Assembly
7 each fiscal year.

8 (c) The Department shall base the proposed base assessment rate on all of the following
9 factors:

10 (1) The change in the State's annual Medicaid payment for the applicable year.

11 (2) The percentage change in aggregate payments to hospitals subject to the base
12 assessment for Medicaid and NC Health Choice enrollees, excluding hospital
13 access payments made under 42 C.F.R. § 438.6, as demonstrated in data from
14 prepaid health plans and the State, as determined by the Department.

15 (3) Any changes in the federal medical assistance percentage rate applicable to
16 the Medicaid or NC Health Choice programs for the applicable year.

17 (4) Any changes as determined by the Department in (i) reimbursement under the
18 Medicaid State Plan, (ii) managed care payments authorized under 42 C.F.R.
19 § 438.6 for which the nonfederal share is not funded by General Fund
20 appropriations, and (iii) reimbursement under the NC Health Choice program.

21 (d) The rate for the base assessment for each taxable year shall be the percentage rate set
22 by law by the General Assembly.

23 **"§ 108A-143. Payment from other hospitals.**

24 If a hospital that is exempt from both the base and supplemental assessments under this Part
25 (i) makes an intergovernmental transfer to the Department to be used to draw down matching
26 federal funds and (ii) has acquired, merged, leased, or managed another hospital on or after March
27 25, 2011, then the exempt hospital shall transfer to the State an additional amount. The additional
28 amount shall be a percentage of the amount of funds that (i) would be transferred to the State
29 through such an intergovernmental transfer and (ii) are to be used to match additional federal
30 funds that the exempt hospital is able to receive because of the acquired, merged, leased, or
31 managed hospital. That percentage shall be calculated by dividing the amount of the State's
32 annual Medicaid payment by the total amount collected under the base assessment under
33 G.S. 108A-142.

34 **"§ 108A-144. Use of funds.**

35 The proceeds of the assessments imposed under this Part, and all corresponding matching
36 federal funds, must be used to make the State's annual Medicaid payment to the State, to fund
37 payments to hospitals made directly by the Department, to fund a portion of capitation payments
38 to prepaid health plans attributable to hospital care, and to fund the nonfederal share of graduate
39 medical education payments."

40 **SECTION 10.1.(c)** The percentage rate to be used in calculating the supplemental
41 assessment under G.S. 108A-141, as enacted in subsection (b) of this section, is two and
42 twenty-six hundredths percent (2.26%) for the taxable year October 1, 2019, through September
43 30, 2020.

44 **SECTION 10.1.(d)** The percentage rate to be used in calculating the base assessment
45 under G.S. 108A-142, as enacted in subsection (b) of this section, is one and seventy-seven
46 hundredths percent (1.77%) for the taxable year October 1, 2019, through September 30, 2020.

47 **SECTION 10.2.** Notwithstanding G.S. 143C-4-11, as enacted by Section 9.1 of this
48 act, the State Controller shall transfer funds from the Medicaid Contingency Reserve to the
49 Department of Health and Human Services, Division of Health Benefits (DHB), only upon
50 request by DHB as needed to cover any shortfall in receipts from the supplemental or base

1 assessments under G.S. 108A-141 and G.S. 108A-142, enacted by subsection (b) of Section 10.1
2 of this act, and only if the following two conditions are met:

- 3 (1) The Office of State Budget and Management (OSBM) has certified that there
4 will be a shortfall in receipts from the supplemental or base assessments.
- 5 (2) OSBM has certified that the amount requested by DHB does not exceed the
6 shortfall in receipts certified by OSBM under subdivision (1) of this
7 subsection.

8 Upon making the request to the State Controller for the transfer of funds pursuant to
9 this section, DHB shall notify the Fiscal Research Division and the Joint Legislative Oversight
10 Committee on Medicaid and NC Health Choice of the request and the amount of the request. To
11 the extent any funds are transferred under this section, the funds are hereby appropriated for the
12 purpose set forth in this section. The authority set forth in this section expires June 30, 2020.

13 **SECTION 10.3.(a)** The Department of Health and Human Services, Division of
14 Health Benefits (DHB), shall establish a new fund code entitled "Hospital Assessment Fund" in
15 Budget Code 24445. When setting the supplemental assessment and base assessment rates in
16 accordance with G.S. 108A-141(d) and G.S. 108A-142(d) for the 2020-2021 taxable year, funds
17 in the Hospital Assessment Fund shall be used to support a decrease in the supplemental
18 assessment or base assessment rates submitted by the Governor under G.S. 108A-141(b) and
19 G.S. 108A-142(b) that corresponds with the amount in the Hospital Assessment Fund.

20 **SECTION 10.3.(b)** For the 2019-2020 fiscal year only, if the amount of receipts
21 collected, in aggregate, from the supplemental and base assessments under G.S. 108A-141 and
22 G.S. 108A-142 is more than the amount, in aggregate, anticipated in the Governor's proposed
23 base budget for the 2019-2020 fiscal year for the Department of Health and Human Services,
24 Division of Health Benefits, as adjusted by Section 2.1(a) of this act, from the supplemental and
25 base assessments, then the amount of those over-realized receipts shall be transferred as follows:

- 26 (1) Forty-five million dollars (\$45,000,000) shall be transferred to the Hospital
27 Assessment Fund created under subsection (a) of this section. If the total
28 amount of over-realized receipts is less than forty-five million dollars
29 (\$45,000,000), then the full amount of over-realized receipts shall be
30 transferred to the Hospital Assessment Fund.
- 31 (2) The remaining amount of over-realized receipts not transferred under
32 subdivision (1) of this subsection shall be transferred to the Medicaid
33 Transformation Reserve.
- 34 (3) Prior to transferring any amount of over-realized receipts under this
35 subsection, the Office of State Budget and Management shall certify that (i)
36 there will be, in aggregate, over-realized receipts for the 2019-2020 fiscal year
37 from the supplemental and base assessments and (ii) the amounts to be
38 transferred are in compliance with this subsection.

39 **SECTION 10.4.** If House Bill 966, 2019 Regular Session, becomes law, then Section
40 10.3(b) of this act reads as rewritten:

41 "**SECTION 10.3.(b)** For the 2019-2020 fiscal year only, if the amount of receipts collected,
42 in aggregate, from the supplemental and base assessments under G.S. 108A-141 and G.S. 108A-
43 142 is more than the amount, in aggregate, anticipated in ~~the Governor's proposed base budget~~
44 ~~for the 2019-2020 fiscal year for the Department of Health and Human Services, Division of~~
45 ~~Health Benefits, as adjusted by Section 2.1 of this act,~~ House Bill 966, 2019 Regular Session,
46 from the supplemental and base assessments, then the amount of those over realized receipts shall
47 be transferred as follows:

48"

50 PART XI. GROSS PREMIUMS TAX/PREPAID HEALTH PLANS

1 SECTION 11.(a) The title of Article 8B of Chapter 105 of the General Statutes reads
2 as rewritten:

3 "Article 8B.

4 "Taxes Upon Insurance ~~Companies~~-Companies and Prepaid Health Plans."

5 SECTION 11.(b) G.S. 105-228.3 reads as rewritten:

6 "§ 105-228.3. Definitions.

7 The following definitions apply in this Article:

8 (1) Article 65 corporation. – A corporation subject to Article 65 of Chapter 58 of
9 the General Statutes, regulating hospital, medical, and dental service
10 corporations.

11 (2) Capitation payment. – Amounts paid by the Department of Health and Human
12 Services to prepaid health plans under capitated contracts for the delivery of
13 Medicaid and NC Health Choice services in accordance with Article 4 of
14 Chapter 108D of the General Statutes.

15 ~~(1a)~~(3) Captive insurance company. – Defined in G.S. 58-10-340.

16 ~~(1b)~~(4) Foreign captive insurance company. – A captive insurance company as
17 defined in G.S. 58-10-340(9), except that such company is not formed or
18 licensed under the laws of this State but is formed and licensed under the laws
19 of any jurisdiction within the United States other than this State.

20 ~~(2)~~(5) Insurer. – An insurer as defined in G.S. 58-1-5 or a group of employers who
21 have pooled their liabilities pursuant to G.S. 97-93 of the Workers'
22 Compensation Act.

23 (6) Prepaid health plan. – As defined in G.S. 108D-1.

24 ~~(3)~~(7) Self-insurer. – An employer that carries its own risk pursuant to G.S. 97-93 of
25 the Workers' Compensation Act."

26 SECTION 11.(c) G.S. 105-228.5 reads as rewritten:

27 "§ 105-228.5. Taxes measured by gross premiums.

28 (a) Tax Levied. – A tax is levied in this section on insurers, Article 65 corporations, health
29 maintenance organizations, prepaid health plans, and self-insurers. An insurer, health
30 maintenance organization, prepaid health plan, or Article 65 corporation that is subject to the tax
31 levied by this section is not subject to franchise or income taxes imposed by Articles 3 and 4,
32 respectively, of this Chapter.

33 (b) Tax Base. –

34 (1) Insurers. – The tax imposed by this section on an insurer or a health
35 maintenance organization shall be measured by gross premiums from business
36 done in this State during the preceding calendar year.

37 (2) Repealed by Session Laws 2006-196, effective for taxable years beginning on
38 or after January 1, 2008.

39 (3) Article 65 Corporations. – The tax imposed by this section on an Article 65
40 corporation shall be measured by gross collections from membership dues,
41 exclusive of receipts from cost plus plans, received by the corporation during
42 the preceding calendar year.

43 (4) Self-insurers. – The tax imposed by this section on a self-insurer shall be
44 measured by the gross premiums that would be charged against the same or
45 most similar industry or business, taken from the manual insurance rate then
46 in force in this State, applied to the self-insurer's payroll for the previous
47 calendar year as determined under Article 36 of Chapter 58 of the General
48 Statutes modified by the self-insurer's approved experience modifier.

49 (5) Prepaid health plans. – The tax imposed by this section on a prepaid health
50 plan shall be measured by gross capitation payments received by the prepaid
51 health plan from the Department of Health and Human Services for services

1 provided to enrollees in the State Medicaid program or NC Health Choice
2 program in the preceding calendar year.

3 (b1) Calculation of Tax Base. – In determining the amount of gross premiums from
4 business in this State, all gross premiums received in this State, credited to policies written or
5 procured in this State, or derived from business written in this State shall be deemed to be for
6 contracts covering persons, property, or risks resident or located in this State unless one of the
7 following applies:

8 (1) The premiums are properly reported and properly allocated as being received
9 from business done in some other nation, territory, state, or states.

10 (2) The premiums are from policies written in federal areas for persons in military
11 service who pay premiums by assignment of service pay.

12 Gross premiums from business done in this State in the case of life insurance contracts,
13 including supplemental contracts providing for disability benefits, accidental death benefits, or
14 other special benefits that are not annuities, means all premiums collected in the calendar year,
15 other than for contracts of reinsurance, for policies the premiums on which are paid by or credited
16 to persons, firms, or corporations resident in this State, or in the case of group policies, for
17 contracts of insurance covering persons resident within this State. The only deductions allowed
18 shall be for premiums refunded on policies rescinded for fraud or other breach of contract and
19 premiums that were paid in advance on life insurance contracts and subsequently refunded to the
20 insured, premium payer, beneficiary or estate. Gross premiums shall be deemed to have been
21 collected for the amounts as provided in the policy contracts for the time in force during the year,
22 whether satisfied by cash payment, notes, loans, automatic premium loans, applied dividend, or
23 by any other means except waiver of premiums by companies under a contract for waiver of
24 premium in case of disability.

25 Gross premiums from business done in this State in the case of prepaid health plans means
26 all capitation payments received by a prepaid health plan from the Department of Health and
27 Human Services for the delivery of services to enrollees in the State Medicaid program or NC
28 Health Choice program in the calendar year. Capitation payments refunded by a prepaid health
29 plan to the State are the only allowable deductions.

30 Gross premiums from business done in this State for all other health care plans and contracts
31 of insurance, including contracts of insurance required to be carried by the Workers'
32 Compensation Act, means all premiums written during the calendar year, or the equivalent
33 thereof in the case of self-insurers under the Workers' Compensation Act, for contracts covering
34 property or risks in this State, other than for contracts of reinsurance, whether the premiums are
35 designated as premiums, deposits, premium deposits, policy fees, membership fees, or
36 assessments. Gross premiums shall be deemed to have been written for the amounts as provided
37 in the policy contracts, new and renewal, becoming effective during the year irrespective of the
38 time or method of making payment or settlement for the premiums, and with no deduction for
39 dividends whether returned in cash or allowed in payment or reduction of premiums or for
40 additional insurance, and without any other deduction except for return of premiums, deposits,
41 fees, or assessments for adjustment of policy rates or for cancellation or surrender of policies.

42 (c) Exclusions. – Every insurer, in computing the premium tax, shall exclude all of the
43 following from the gross amount of premiums, and the gross amount of excluded premiums is
44 exempt from the tax imposed by this section:

45 (1) All premiums received on or after July 1, 1973, from policies or contracts
46 issued in connection with the funding of a pension, annuity, or profit-sharing
47 plan qualified or exempt under section 401, 403, 404, 408, 457 or 501 of the
48 Code as defined in G.S. 105-228.90.

49 (2) Premiums or considerations received from annuities, as defined in
50 G.S. 58-7-15.

- 1 (3) Funds or considerations received in connection with funding agreements, as
2 defined in G.S. 58-7-16.
- 3 (4) The following premiums, to the extent federal law prohibits their taxation
4 under this Article:
- 5 a. Federal Employees Health Benefits Plan premiums.
6 b. ~~Medicaid or Medicare~~ premiums.
7 c. Medicaid or NC Health Choice premiums, other than capitation
8 payments, paid by or on behalf of a Medicaid or NC Health Choice
9 beneficiary.
- 10 (d) Tax Rates; Disposition. –
- 11 (1) Workers' Compensation. – The tax rate to be applied to gross premiums, or
12 the equivalent thereof in the case of self-insurers, on contracts applicable to
13 liabilities under the Workers' Compensation Act is two and five-tenths percent
14 (2.5%). The net proceeds shall be credited to the General Fund.
- 15 (2) Other Insurance Contracts. – The tax rate to be applied to gross premiums on
16 all other taxable contracts issued by insurers or health maintenance
17 organizations and to be applied to gross premiums and gross collections from
18 membership dues, exclusive of receipts from cost plus plans, received by
19 Article 65 corporations is one and nine-tenths percent (1.9%). The net
20 proceeds shall be credited to the General Fund.
- 21 (2a) Prepaid Health Plans. – The tax rate to be applied to gross premiums from
22 capitation payments received by prepaid health plans is one and nine-tenths
23 percent (1.9%). The net proceeds shall be credited to the General Fund.
- 24 (3) Additional Rate on Property Coverage Contracts. – An additional tax at the
25 rate of seventy-four hundredths percent (0.74%) applies to gross premiums on
26 insurance contracts for property coverage. The tax is imposed on ten percent
27 (10%) of the gross premiums from insurance contracts for automobile
28 physical damage coverage and on one hundred percent (100%) of the gross
29 premiums from all other contracts for property coverage. Twenty percent
30 (20%) of the net proceeds of this additional tax must be credited to the
31 Volunteer Fire Department Fund established in Article 87 of Chapter 58 of
32 the General Statutes. Twenty percent (20%) of the net proceeds must be
33 credited to the Department of Insurance for disbursement pursuant to
34 G.S. 58-84-25. Up to twenty percent (20%), as determined in accordance with
35 G.S. 58-87-10(f), must be credited to the Workers' Compensation Fund. The
36 remaining net proceeds must be credited to the General Fund. The additional
37 tax imposed on property coverage contracts under this subdivision is a special
38 purpose assessment based on gross premiums and not a gross premiums tax.
39 The following definitions apply in this subdivision:
- 40 a. Automobile physical damage. – The following lines of business
41 identified by the NAIC: private passenger automobile physical
42 damage and commercial automobile physical damage.
- 43 b. Property coverage. – The following lines of business identified by the
44 NAIC: fire, farm owners multiple peril, homeowners multiple peril,
45 nonliability portion of commercial multiple peril, ocean marine, inland
46 marine, earthquake, private passenger automobile physical damage,
47 commercial automobile physical damage, aircraft, and boiler and
48 machinery. The term also includes insurance contracts for wind
49 damage.
- 50 c. NAIC. – National Association of Insurance Commissioners.

- 1 (4) Repealed by Session Laws 2006-196, effective for taxable years beginning on
2 or after January 1, 2008.
- 3 (5) Repealed by Session Laws 2003-284, s. 43.1, effective for taxable years
4 beginning on or after January 1, 2004.
- 5 (6) Repealed by Session Laws 2005-276, s. 38.4(a), effective for taxable years
6 beginning on or after January 1, 2007.

7 (e) Report and Payment. – Each taxpayer doing business in this State shall, within the
8 first 15 days of March, file with the Secretary of Revenue a full and accurate report of the total
9 gross premiums as defined in this section, the payroll and other information required by the
10 Secretary in the case of a self-insurer, or the total gross collections from membership dues
11 exclusive of receipts from cost plus plans collected in this State during the preceding calendar
12 year. The taxes imposed by this section shall be remitted to the Secretary with the report.

13 (f) Installment Payments Required. – Taxpayers that are subject to the tax imposed by
14 this section and have a premium tax liability of ten thousand dollars (\$10,000) or more for
15 business done in North Carolina during the immediately preceding year shall remit three equal
16 quarterly installments with each installment equal to at least thirty-three and one-third percent
17 (33 1/3%) of the premium tax liability incurred in the immediately preceding taxable year. The
18 quarterly installment payments shall be made on or before April 15, June 15, and October 15 of
19 each taxable year. The ~~company taxpayer~~ shall remit the balance by the following March 15 in
20 the same manner provided in this section for annual returns.

21 The Secretary may permit an insurance company or prepaid health plan to pay less than the
22 required estimated payment when the insurer or prepaid health plan reasonably believes that the
23 total estimated payments made for the current year will exceed the total anticipated tax liability
24 for the year.

25 An underpayment or an overpayment of an installment payment required by this subsection
26 accrues interest in accordance with G.S. 105-241.21. An overpayment of tax shall be credited to
27 the ~~company taxpayer~~ and applied against the taxes imposed upon the ~~company taxpayer~~ under
28 this Article.

29 (g) Exemptions. – This section does not apply to farmers' mutual assessment fire
30 insurance companies or to fraternal orders or societies that do not operate for a profit and do not
31 issue policies on any person except members. This section does not apply to a captive insurance
32 company taxed under G.S. 105-228.4A."

33 **SECTION 11.(d)** G.S. 58-6-25 reads as rewritten:

34 "**§ 58-6-25. Insurance regulatory charge.**

35 ...

36 (e) Definitions. – The following definitions apply in this section:

37 ...

- 38 (2) Insurance company. – A company or prepaid health plan, as defined in
39 G.S. 58-93-5, that pays the gross premiums tax levied in G.S. 105-228.5 and
40 G.S. 105-228.8.

41"

42 **SECTION 11.(e)** G.S. 105-259 reads as rewritten:

43 "**§ 105-259. Secrecy required of officials; penalty for violation.**

44 ...

45 (b) Disclosure Prohibited. – An officer, an employee, or an agent of the State who has
46 access to tax information in the course of service to or employment by the State may not disclose
47 the information to any other person except as provided in this subsection. Standards used or to
48 be used for the selection of returns for examination and data used or to be used for determining
49 the standards may not be disclosed for any purpose. All other tax information may be disclosed
50 only if the disclosure is made for one of the following purposes:

51 ...

1 (49) To exchange information concerning a tax imposed by Article 8B of this
2 Chapter with the North Carolina Department of Insurance or the North
3 Carolina Department of Health and Human Services when the information is
4 needed to fulfill a duty imposed on the ~~Department~~Department of Revenue.

5"

6 **SECTION 11.(f)** This section is effective October 1, 2019, and applies to capitation
7 payments received by prepaid health plans on or after that date.

8 **PART XII. HOSPITAL UNCOMPENSATED CARE FUND**

9 **SECTION 12.1.** Article 9 of Chapter 143 of the General Statutes is amended by
10 adding a new section to read:

11 **"§ 143C-9-9. Hospital Uncompensated Care Fund.**

12 (a) Creation. – The Hospital Uncompensated Care Fund is established as a nonreverting
13 special fund in the Department of Health and Human Services.

14 (b) Source of Funds. – The Hospital Uncompensated Care Fund shall consist of federal
15 disproportionate share adjustment receipts arising from certified public expenditures.

16 (c) Utilization of Funds. – The Department of Health and Human Services is authorized
17 to utilize funds in the Hospital Uncompensated Care Fund to make the following payments,
18 provided the entity receiving the payment has been determined to be an eligible entity in
19 accordance with subsection (d) of this section:

20 (1) Payments to institutions for mental diseases, as defined in 42 C.F.R. §
21 435.1010.

22 (2) Payments to hospitals to reimburse inpatient services uncompensated care
23 costs or outpatient services uncompensated care costs, or both.

24 (d) Eligibility and Fund Allocations. – The Department of Health and Human Services
25 shall adopt rules for determining eligibility for, and allocations of, Hospital Uncompensated Care
26 Fund payments."

27 **PART XIII. EFFECTIVE DATE**

28 **SECTION 13.1.** Except as otherwise provided, this act is effective when it becomes
29 law.
30
31