GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2017

H **D**

HOUSE BILL 156
Senate Health Care Committee Substitute Adopted 6/22/17
Proposed Conference Committee Substitute H156-PCCS40774-TR-22

Short Title: Medicaid PHP Licensure & Transformation Mods. (Public)

Sponsors:

Referred to:

February 22, 2017

A BILL TO BE ENTITLED

AN ACT TO REQUIRE MEDICAID PREPAID HEALTH PLANS TO OBTAIN A LICENSE FROM THE DEPARTMENT OF INSURANCE AND TO MAKE OTHER CHANGES PERTAINING TO MEDICAID TRANSFORMATION AND THE DEPARTMENT OF INSURANCE.

The General Assembly of North Carolina enacts:

SECTION 1.(a) Chapter 58 of the General Statutes is amended by adding a new Article to read:

"Article 93.

"Prepaid Health Plan Licensing Act.

"**§ 58-93-1. Short title.**

This Article may be cited as the Prepaid Health Plan Licensing Act.

"**§ 58-93-2. Definitions.**

The following definitions apply in this Article:

(1) Commercial Plan. – Any person, entity, or organization, profit or nonprofit, that (i) 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 (ii) is not a provider-led entity.

(2) DHHS. – The North Carolina Department of Health and Human Services.

(3) Enrollee. – A beneficiary enrolled to receive Medicaid or NC Health Choice services through a prepaid health plan.

(4) Governing body. – The board of directors, trustees, partners, managers, or other individuals who are legally responsible for the governance of an entity.

(5) Health care services. – Medicaid or NC Health Choice services provided by a prepaid health plan under a capitated contract with DHHS.

(6) Insolvent or insolvency. – A circumstance that occurs when a prepaid health plan has been declared insolvent and is placed under an order of liquidation by a court of competent jurisdiction.

(7) Licensed health organization. – A licensed health organization includes all of the following:

a. A health maintenance organization licensed under Article 67 of this Chapter.

b. A full service corporation licensed under Article 65 of this Chapter.

c. An insurer under this Chapter that is required by the Commissioner to use the NAIC Health Annual Statement Blank when filing the annual statement in accordance with G.S. 58-2-165.

The term "licensed health organization" does not include an insurer that (i) is licensed under this Chapter as either a life or health insurer or as a property or casualty insurer and (ii) is otherwise subject to either life or property and casualty risk-based capital requirements.

(8) Prepaid health plan or PHP. – A commercial plan or provider-led entity holding a license under this Article for the purposes of operating a capitated contract for the delivery of services under the North Carolina Medicaid and NC Health Choice programs. For the purposes of 11 U.S.C. § 109(b)(2) and 11 U.S.C. § 109(d) only, a PHP is a domestic insurance company.

(9) Provider-led entity. – An entity that meets all of the following criteria:

a. A majority of the entity's ownership is held by (i) an individual or entity that has as its primary business purpose the ownership or operation of one or more capitated contracts under the North Carolina Medicaid and NC Health Choice programs or (ii) Medicaid and NC Health Choice providers.

b. A majority of the entity's governing body is composed of individuals who (i) are licensed in the State as physicians, physician assistants, nurse practitioners, or psychologists and (ii) have experience treating beneficiaries of the North Carolina Medicaid program.

(10) Working capital. – The excess of current assets over current liabilities. The only borrowed funds that may be included in working capital must be funds that are repayable only from net earned income and must be repayable only with the advance permission of the Commissioner.

"**§ 58-93-3. Maximize federal reimbursement.**

The Commissioner shall work with DHHS to maximize federal reimbursement of the Department's expenses in administering this Article to the extent that federal reimbursement is allowed under federal law.

"**§ 58-93-4. Commissioner use of consultants and other professionals.**

(a) The Commissioner may contract with consultants and other professionals to expedite and complete the application process, examinations, and other regulatory activities required under this Article. Costs of contracts entered into under this section shall be reimbursed by the applicant or licensee.

(b) Contracts under this section for financial, legal, examination, and other services shall not be subject to any of the following:

(1) G.S. 114-2.3.

(2) G.S. 147-17.

(3) Articles 3, 3C, and 8 of Chapter 143 of the General Statutes and any rules and procedures adopted under those Articles concerning procurement, contracting, and contract review.

"**§ 58-93-5. Licensing.**

(a) Any commercial plan or provider-led entity may apply to the Commissioner for a license to operate as a PHP in compliance with this Article.

(b) Each license application shall be verified by an officer or authorized representative of the applicant, shall be in a form prescribed by the Commissioner, and shall be set forth or be accompanied, at a minimum, by all of the following:

(1) A copy of the organizational documents, if any, of the applicant, such as the articles of incorporation, articles of association, partnership agreement, trust agreement, or other applicable documents, and all amendments.

(2) A copy of the bylaws, rules and regulations, or similar documents, if any, regulating the conduct of the internal affairs of the applicant.

(3) A list of the names, addresses, official positions, and biographical affidavits of the persons who are to be responsible for the conduct of the affairs of the applicant, including all members of the governing body, the principal officers in the case of a corporation, the partners or members in the case of a partnership or association, or the managers in the case of a limited liability company. This list shall be accompanied by a completed release of information for each of these individuals on forms acceptable to the Commissioner.

(4) A disclosure identifying all affiliates, including a description of any management, service, or cost-sharing arrangement between an affiliate and the applicant.

(5) The name and address of the registered agent of the applicant.

(6) A detailed plan of operation.

(7) The names and addresses of the applicant's qualified actuary and external auditors.

(8) Financial statements showing the applicant's assets, liabilities, and sources of financial support. If the applicant's financial affairs are audited by independent certified public accountants, a copy of the applicant's most recent regular certified financial statement shall satisfy this requirement unless the Commissioner directs that additional or more recent financial information is required for the proper administration of this Article.

(9) A financial feasibility study that includes (i) detailed enrollment projections, (ii) a projection of balance sheets, (iii) cash flow statements that show any capital expenditures, purchases and sales of investments, and deposits with the State, (iv) anticipated income and anticipated expense statements covering the start of operations through the period in which the applicant is anticipated to have had net income for at least one year, and (v) a statement as to the sources of working capital as well as any other sources of funding.

(10) If not domiciled in this State, a power of attorney duly executed by the applicant appointing the Commissioner, the Commissioner's successors in office, and duly authorized deputies as the true and lawful attorney of the applicant in and for this State, upon whom all lawful process in any legal action or proceeding against the applicant on a cause of action arising in this State may be served.

(11) A description of the procedures to be implemented to meet the protection against insolvency requirements of G.S. 58-93-50.

(12) The plan for handling an insolvency as required by G.S. 58-93-55.

(13) Other information as the Commissioner may require in order to make the determinations required in G.S. 58-93-10.

(c) Any person that is already a licensed health organization in this State under this Chapter shall be recognized as a PHP under this Article and shall be issued a PHP license upon the licensed health organization's demonstration to the Commissioner compliance with this Article. A licensed health organization shall not be required to file a PHP application, pay a PHP application fee, or provide the notice required by subsection (d) of this section as a condition of receipt of a PHP license. Unless otherwise exempted, a licensed health organization shall be subject to the remaining requirements of this Article, including deposit, minimum capital and surplus, and working capital requirements.

(d) A PHP shall file a notice describing any significant modification of the operation set out in the information required by subsection (b) of this section for approval by the Commissioner

prior to the modification. If the Commissioner does not disapprove within 90 days after the filing, the modification shall be deemed to be approved. Every PHP shall file with the Commissioner all subsequent changes in the information or forms that are required by this Article to be filed with the Commissioner.

(e) The Commissioner shall regularly provide DHHS with information and documentation related to its licensing and regulation of PHPs, including licenses, examination results, penalties imposed, or other actions taken in regards to PHPs.

"**§ 58-93-10. Issuance and continuation of license.**

(a) Before issuing or continuing any PHP license, the Commissioner of Insurance may make any examination as the Commissioner deems expedient. Except as otherwise provided in subsection (c) of G.S. 58-93-5, the Commissioner shall issue a license upon the payment of the application fee prescribed in G.S. 58-93-14 and upon being satisfied on all of the following points:

(1) The applicant has complied with the application requirements of G.S. 58-93-5.

(2) The applicant has a minimum capital and surplus equal to or greater than that required by G.S. 58-93-50(b).

(3) The amounts provided as working capital are repayable only out of earned income in excess of amounts paid and payable for operating expenses and expenses of providing services and such reserve as the Department deems adequate.

(4) The amount of money actually available for working capital is sufficient to carry all acquisition costs and operating expenses for a reasonable period of time from the date of the issuance of the license and that the applicant is financially responsible and may reasonably be expected to meet its obligations to enrollees and prospective enrollees. Such working capital shall initially be a minimum of one million five hundred thousand dollars ($1,500,000) or a higher amount as the Commissioner shall determine to be adequate.

(5) The person or persons who will manage the PHP have adequate expertise, experience, and character.

(b) A license shall be denied only after compliance with the requirements of G.S. 58-93-75.

"**§ 58-93-14. Fees.**

The Commissioner shall establish an application fee not to exceed two thousand dollars ($2,000) for entities filing an application to be licensed as a PHP under this Article. The Commissioner shall establish an annual PHP license continuation fee not to exceed five thousand dollars ($5,000). The PHP license shall continue in full force and effect subject to timely payment of the annual PHP license continuation fee in accordance with G.S. 58-6-7(c) and subject to any other provisions of this Chapter applicable to PHPs.

"**§ 58-93-15. Deposits.**

(a) All deposits required by this section shall be administered in accordance with the provisions of Article 5 of this Chapter.

(b) The Commissioner shall require a minimum deposit of five hundred thousand dollars ($500,000) or such higher amount as the Commissioner determines to be necessary for the protection of enrollees.

(c) For licensed health organizations, the deposit required by this section is in addition to any other deposit required by the Commissioner.

(d) All deposits made pursuant to this section shall not be subject to G.S. 58-62-95.

"**§ 58-93-20. Management and exclusive agreements; custodial agreements.**

(a) No PHP shall enter into an exclusive management or custodial agreement unless the agreement is first filed with the Commissioner and approved under this section within (i) 45 days

after filing or (ii) a reasonable extended period as specified by notice from the Commissioner given within a 45-day period after filing.

(b) The Commissioner shall disapprove an agreement submitted under subsection (a) of this section if the Commissioner determines that the agreement does any of the following:

(1) Subjects the PHP to excessive charges.

(2) Extends for an unreasonable period of time.

(3) Does not contain fair and adequate standards of performance.

(4) Enables persons under the contract to manage the PHP who are not sufficiently trustworthy, competent, experienced, and free from conflict of interest to manage the PHP with due regard for the interests of its enrollees, creditors, or the public.

(5) Contains provisions that impair the interests of the PHP's enrollees, creditors, or the public.

"**§ 58-93-25. Fiduciary responsibilities.**

Any director, officer, trustee, manager, or partner of a PHP who receives, collects, disburses, or invests funds in connection with the activities of the PHP shall be responsible for those funds in a fiduciary relationship to the enrollees and to the State.

"**§ 58-93-30. Statements filed with Commissioner.**

Every PHP subject to this Article is subject to G.S. 58-2-165.

"**§ 58-93-35. Investments.**

(a) With the exception of investments made in accordance with subsection (b) of this section, the funds of a PHP shall be invested or maintained only in securities, other investments, or other assets permitted by the laws of this State for the investment of assets constituting the legal reserves of life insurance companies or such other securities or investments as the Commissioner may permit.

(b) A PHP may, with the Commissioner's prior approval, do any of the following:

(1) Invest its funds to purchase, lease, construct, renovate, operate, or maintain (i) a hospital, (ii) a medical facility, (iii) ancillary equipment of a hospital or medical facility, or (iv) any property as may reasonably be required for its principal office or for other purposes as may be necessary in the transaction of the business of the PHP.

(2) Make loans to a medical group under contract with the PHP in furtherance of the PHP's program or the making of loans to a corporation or corporations under the PHP's control for the purpose of acquiring or constructing medical facilities and hospitals or in furtherance of a program providing health care services to enrollees.

(c) The Commissioner shall not allow any investment if the Commissioner determines the investment would substantially and adversely affect the financial soundness of the PHP and endanger its ability to meet its obligations.

"**§ 58-93-40. Examinations.**

The Commissioner may make an examination of the affairs of any PHP as often as the Commissioner determines it to be necessary for the protection of the interests of the enrollees or the State but not less frequently than once every five years. Examinations shall otherwise be conducted under G.S. 58-2-131 through G.S. 58-2-134.

"**§ 58-93-45. Hazardous financial condition.**

(a) Whenever the financial condition of any PHP indicates a condition such that the continued operation of the PHP might be hazardous to its enrollees, creditors, the general public, or the State, the Commissioner may order the PHP to take action as may be reasonably necessary to rectify the existing condition, including one or more of the following steps:

(1) Reduce the total amount of present and potential liability for health care services by reinsurance.

(2) Reduce the volume of new business being accepted.
(3) Reduce the expenses by specified methods.
(4) Suspend or limit the writing of new business for a specified period of time.
(5) Require an increase to the PHP's capital and surplus by contribution.

(b) The Commissioner may consider any or all of the standards in G.S. 58-30-60(b) when determining whether the continued operation of a PHP is hazardous to its enrollees, creditors, the general public, or the State.

(c) The remedies under subsection (a) of this section are in addition to, and not in lieu of, the remedies and measures available to the Commissioner under the provisions of Article 30 of this Chapter.

(d) The Commissioner shall notify the Secretary of DHHS prior to taking any action against a PHP under this section.

"**§ 58-93-50. Protection against insolvency.**

(a) The Commissioner shall require deposits in accordance with the provisions of G.S. 58-93-15.

(b) Each PHP shall maintain a minimum capital and surplus equal to the greater of one million dollars ($1,000,000) or the amount required under the risk-based capital provisions of Article 12 of this Chapter.

(c) Every PHP shall have and maintain at all times an adequate plan for protection against insolvency acceptable to the Commissioner. In determining the adequacy of such a plan, the Commissioner may consider all of the following:

(1) A reinsurance agreement preapproved by the Commissioner covering excess loss, stop loss, or catastrophes. The agreement must provide that the Commissioner will be notified no less than 60 days prior to cancellation or reduction of coverage.
(2) Any other arrangements offering protection against insolvency that the Commissioner may require.

"**§ 58-93-55. Continuation of health care services.**

The Commissioner shall require that each PHP have a plan for handling insolvency. The plan must allow for health care services to be provided to enrollees until the PHP's enrollees whose enrollment in a PHP is not voluntary are enrolled in another PHP. In considering the plan, the Commissioner may require any of the following:

(1) Insurance to cover the expenses to be paid for enrollee health care services after an insolvency.
(2) Provisions in provider contracts that obligate the provider to provide services for the duration of the period after the PHP's insolvency until the PHP's enrollees whose enrollment in a PHP is not voluntary are enrolled in another PHP.
(3) Insolvency reserves.
(4) Letters of credit acceptable to the Commissioner.
(5) Any other arrangements to assure that health care services are provided to enrollees as specified in this section.

"**§ 58-93-60. Incurred but not reported claims.**

(a) Every PHP shall, when determining liability, include an amount estimated in the aggregate to provide for (i) any unearned capitation payment, (ii) the payment of all claims for health care expenditures that have been incurred, whether reported or unreported, that are unpaid and for which the PHP is or may be liable, and (iii) the expense of adjustment or settlement of these claims.

(b) Liabilities shall be computed in accordance with rules adopted by the Commissioner based upon rules applicable to health maintenance organizations adjusted for reasonable consideration of the ascertained experience and character of the PHP.

"**§ 58-93-65. Suspension or revocation of license.**

(a) The Commissioner may suspend or revoke a PHP license if the Commissioner finds that a PHP meets any of the following:

(1) Is operating significantly in contravention of its organizational document, or in a manner contrary to that described in and reasonably inferred from any other information submitted under G.S. 58-93-5, unless amendments to such submissions have been filed with and approved by the Commissioner.

(2) Is no longer financially responsible and may reasonably be expected to be unable to meet its obligations to enrollees or prospective enrollees.

(3) Is operating in a manner that would be hazardous to its enrollees or to the State.

(4) Knowingly or repeatedly fails or refuses to comply with any law or rule applicable to the PHP or with any order issued by the Commissioner after notice and opportunity for a hearing.

(5) Has knowingly published or made to the Department, to DHHS, or to the public any false statement or report.

(b) A license shall be suspended or revoked only after compliance with G.S. 58-93-75.

(c) When a PHP license is suspended, the PHP shall not, during the suspension, enroll any additional enrollees, except newborn children or other newly acquired dependents of existing enrollees, and shall not engage in any advertising or solicitation.

(d) When a PHP license is revoked, the PHP shall proceed, immediately following the effective date of the order of revocation, to wind up its affairs and shall conduct no further business except as may be essential to the orderly conclusion of the affairs of the PHP. The PHP shall engage in no advertising or solicitation. The Commissioner may, by written order, permit such further operation of the PHP as the Commissioner may find to be in the best interest of enrollees and the State of North Carolina.

(e) The Commissioner shall consult with the Secretary of DHHS prior to taking any action against a PHP under this section.

"**§ 58-93-70. Rehabilitation or liquidation of PHP.**

Any rehabilitation or liquidation of a PHP shall be deemed to be the rehabilitation or liquidation of an insurance company and shall be conducted under the supervision of the Commissioner pursuant to Article 30 of this Chapter. The Commissioner may apply for an order directing the rehabilitation or liquidation of a PHP upon one or more grounds set out in Article 30 of this Chapter or when it is the opinion of the Commissioner that the continued operation of the PHP would be hazardous either to the enrollees or to the State. Priority shall be given to DHHS's claims over all other claims in G.S. 58-30-220, except for claims in G.S. 58-30-220(1).

"**§ 58-93-75. Administrative procedures.**

(a) When the Commissioner has cause to believe that grounds for the denial of an application for a license exist, or that grounds for the suspension or revocation of a license exist, notification shall be given to the PHP in writing. This notice shall specifically state the grounds for denial, suspension, or revocation and shall set a date for a hearing on the matter at least 30 days after notice is given.

(b) After such hearing, or upon the failure of the PHP to appear at such hearing, the Commissioner shall take action as is deemed advisable and issue written findings that shall be mailed to the PHP. The Commissioner shall provide DHHS with an explanation of the action taken and a copy of the written findings.

(c) The action of the Commissioner taken under subsection (b) of this section shall be subject to review by the Superior Court of Wake County. The court may, in disposing of the issue before it, modify, affirm, or reverse the order of the Commissioner in whole or in part.

(d) The provisions of Chapter 150B of the General Statutes of this State shall apply to proceedings under this section to the extent that they are not in conflict with this section.

"**§ 58-93-80. Penalties and enforcement.**

(a) The Commissioner may, in addition to or in lieu of suspending or revoking a license under G.S. 58-93-65, proceed under G.S. 58-2-70, provided that the PHP has reasonable time to remedy the defect in its operations that gave rise to the procedure under G.S. 58-2-70.

(b) Violation of this Article or any other provision of this Chapter that expressly applies to PHPs is a Class 1 misdemeanor.

(c) If the Commissioner shall for any reason have cause to believe that any violation of this Article or any other provision of this Chapter that expressly applies to PHPs has occurred or is threatened, the Commissioner may give notice to the PHP and to the representatives or other persons who appear to be involved in such suspected violation to arrange a conference with the alleged violators or their authorized representatives for the purpose of attempting to ascertain the facts relating to the suspected violation and, in the event it appears that any violation has occurred or is threatened, to arrive at an adequate and effective means of correcting or preventing the violation. If notice is given under this subsection, a copy of the notice shall be provided to the Secretary of DHHS. The Secretary of DHHS or the Secretary's designee may be present at any proceedings under this subsection.

Proceedings under this subsection shall not be governed by any formal procedural requirements and may be conducted in such manner as the Commissioner may deem appropriate under the circumstances.

(d) The Commissioner may issue an order directing a PHP or a representative of a PHP to cease and desist from engaging in any act or practice in violation of the provisions of this Article or any other provision of this Chapter that expressly applies to PHPs.

Within 30 days after service of the cease and desist order, the respondent may request a hearing on the question of whether acts or practices have occurred that are in violation of this Article or any other provision of this Chapter that expressly applies to PHPs. The hearing shall be conducted under Article 3A of Chapter 150B of the General Statutes, and judicial review shall be available as provided by Article 4 of Chapter 150B of the General Statutes.

(e) In the case of any violation of the provisions of this Article or any other provision of this Chapter that expressly applies to PHPs, if the Commissioner elects not to issue a cease and desist order, or in the event of noncompliance with a cease and desist order issued under subsection (d) of this section, the Commissioner may institute a proceeding to obtain injunctive relief, or seek other appropriate relief, in the Superior Court of Wake County.

(f) The Commissioner shall consult with the Secretary of DHHS prior to taking any action against a PHP under this section.

"**§ 58-93-85. Confidentiality of information.**

(a) All applications, filings, and reports required under this Article shall be treated as public documents unless otherwise determined by the Commissioner to be proprietary information.

(b) Information shared between the Department and DHHS under this Article is confidential and not open to public inspection under G.S. 132-6, unless the information is considered a public record under G.S. 132-1 or is otherwise subject to disclosure under the provisions of Chapter 132 of the General Statutes.

(c) Information shared between the Department and DHHS under this Article that is not open to public inspection shall not be disclosed to any person unless otherwise agreed to by both the Commissioner and the Secretary of DHHS.

"**§ 58-93-90. Statutory construction and relationship to other laws.**

(a) Except as otherwise provided in this Article, provisions of this Chapter do not apply to either of the following:

(1) A PHP that is not a licensed health organization.

(2) A PHP that is a licensed health organization in regards to activities that relate solely to the PHP's Medicaid or NC Health Choice operations.

(b) Nothing in this section shall limit the Commissioner's authority over a PHP that is a licensed health organization in relation to any activities that do not relate solely to the PHP's Medicaid or NC Health Choice operations.

"**§ 58-93-91. Rules.**

The Commissioner may adopt rules to carry out the provisions of this Article.

"**§ 58-93-92. Other laws applicable to PHPs.**

The following provisions of this Chapter are applicable to PHPs in the manner in which they are applicable to insurers:

(1) G.S. 58-2-131, Examinations to be made; authority, scope, scheduling, and conduct of examinations.
(2) G.S. 58-2-132, Examination reports.
(3) G.S. 58-2-133, Conflict of interest; cost of examinations; immunity from liability.
(4) G.S. 58-2-134, Cost of certain examinations.
(5) G.S. 58-2-150, Oath required for compliance with law.
(6) G.S. 58-2-155, Investigation of charges.
(7) G.S. 58-2-160, Reporting and investigation of insurance and reinsurance fraud and the financial condition of licensees; immunity from liability.
(8) G.S. 58-2-162, Embezzlement by insurance agents, brokers, or administrators.
(9) G.S. 58-2-165, Annual, semiannual, monthly, or quarterly statements to be filed with Commissioner.
(10) G.S. 58-2-185, Record of business kept by companies and agents; Commissioner may inspect.
(11) G.S. 58-2-190, Commissioner may require special reports.
(12) G.S. 58-2-195, Commissioner may require records, reports, etc., for agencies, agents, and others.
(13) G.S. 58-2-200, Books and papers required to be exhibited.
(14) G.S. 58-2-205, CPA audits of financial statements.
(15) G.S. 58-7-21, Credit allowed a domestic ceding insurer.
(16) G.S. 58-7-26, Asset or reduction from liability for reinsurance ceded by a domestic insurer to an assuming insurer not meeting the requirements of G.S. 58-7-121.
(17) G.S. 58-7-30, Insolvent ceding insurer.
(18) G.S. 58-7-31, Life and health reinsurance agreements.
(19) G.S. 58-7-46, Notification to Commissioner for president or chief executive officer changes.
(20) G.S. 58-7-73, Dissolution of insurers.
(21) G.S. 58-7-160, Investments unlawfully acquired.
(22) G.S. 58-7-162, Allowed or admitted assets.
(23) G.S. 58-7-163, Assets not allowed.
(24) G.S. 58-7-165, Eligible investments.
(25) G.S. 58-7-167, General qualifications.
(26) G.S. 58-7-168, Authorization of investment.
(27) G.S. 58-7-170, Diversification.
(28) G.S. 58-7-172, Cash and deposits.
(29) G.S. 58-7-173, Permitted insurer investments.
(30) G.S. 58-7-179, Mortgage loans.
(31) G.S. 58-7-180, Chattel mortgages.
(32) G.S. 58-7-183, Special consent investments.
(33) G.S. 58-7-185, Prohibited investments and investment underwriting.

(34) G.S. 58-7-188, Time limit for disposal of ineligible property and securities; effect of failure to dispose.
(35) G.S. 58-7-192, Valuation of securities and investments.
(36) G.S. 58-7-193, Valuation of property.
(37) G.S. 58-7-197, Replacing certain assets; reporting certain liabilities.
(38) G.S. 58-7-200, Investment transactions.
(39) G.S. 58-7-205, Derivative transactions.
(40) Article 5, Deposits and Bonds by Insurance Companies.
(41) Part 7 of Article 10, Annual Financial Reporting.
(42) Article 12, Risk-Based Capital Requirements.
(43) Article 13, Asset Protection Act.
(44) Article 19, Insurance Holding Company System Regulatory Act."

SECTION 1.(b) If any provision of this section or its application is held invalid, the invalidity does not affect other provisions or applications of this section that can be given effect without the invalid provisions or application, and, to this end, the provisions of this section are severable.

SECTION 2.(a) G.S. 58-30-220 reads as rewritten:

"**§ 58-30-220. Priority of distribution.**

The priority of distribution of claims from the insurer's estate shall be in accordance with the order in which each class of claims is set forth in this section. Every claim in each class shall be paid in full or adequate funds shall be retained for payment before the members of the next class receive any payment. No subcategories shall be established within the categories in a class. The order of distribution of claims shall be:

(1) The receiver's expenses for the administration and conservation of assets of the insurer.
(2) Claims or portions of claims for benefits under policies and for losses incurred, including claims of third parties under liability policies; claims of HMO enrollees and HMO enrollees' beneficiaries; claims for unearned premiums; claims for funds or consideration held under funding agreements, as defined in G.S. 58-7-16; claims under life insurance and annuity policies, whether for death proceeds, annuity proceeds, or investment values; and claims of domestic and foreign guaranty associations, including claims for the reasonable administrative expenses of domestic and foreign guaranty associations; but excluding claims of insurance pools, underwriting associations, or those arising out of reinsurance agreements, claims of other insurers for subrogation, and claims of insurers for payments and settlements under uninsured and underinsured motorist coverages.
(2a) For HMOs, claims of providers and participating providers, as defined in G.S. 58-67-5(h) and G.S. 58-67-5(1)[(l)], who are obligated by statute, agreement, or court order to hold enrollees harmless from liability for services provided and covered by an HMO.
(2b) For prepaid health plans licensed under Article 93 of this Chapter, claims of providers who are obligated by statute, agreement, or court order to hold enrollees harmless, except for copayments and deductibles, from liability for health care services provided and covered by a prepaid health plan.
(3) Claims of the federal or any state or local government or taxing authority, including claims for taxes.
(4) Compensation actually owing to employees other than officers of the insurer for services rendered within three months before the commencement of a delinquency proceeding against the insurer under this Article, but not exceeding one thousand dollars ($1,000) for each employee. In the discretion

of the Commissioner, this compensation may be paid as soon as practicable after the proceeding has been commenced. This priority is in lieu of any other similar priority that may be authorized by law as to wages or compensation of those employees.

(5) Claims of general creditors, including claims of insurance pools, underwriting associations, or those arising out of reinsurance agreements; claims of other insurers for subrogation; and claims of insurers for payments and settlements under uninsured and underinsured motorist coverages."

SECTION 2.(b) G.S. 58-62-21 reads as rewritten:

"**§ 58-62-21. Coverage and limitations.**

…

(c) This Article does not provide coverage for:

…

(11) A policy or contract providing any hospital, medical, prescription drug, or other health care benefits under the State's Medicaid program or NC Health Choice program.

…."

SECTION 2.(c) Article 67 of Chapter 58 of the General Statutes is amended by adding a new section to read:

"**§ 58-67-12. Commissioner use of consultants and other professionals.**

(a) The Commissioner may contract with consultants and other professionals to expedite and complete the application process, examinations, and other regulatory activities required under this Article. Costs of contracts entered into under this section shall be reimbursed by the applicant or licensee.

(b) Contracts under this section for financial, legal, examination, and other services shall not be subject to any of the following:

(1) G.S. 114-2.3.

(2) G.S. 147-17.

(3) Articles 3, 3C, and 8 of Chapter 143 of the General Statutes and any rules and procedures adopted under those Articles concerning procurement, contracting, and contract review."

SECTION 2.(d) G.S. 58-67-95 read as rewritten:

"**§ 58-67-95. Powers of ~~insurers and hospital and~~insurers, hospitals, prepaid health plans, and medical service corporations.**

(a) ~~An~~Upon demonstration to the Commissioner of compliance with this Article, an insurance company licensed in this State, a prepaid health plan licensed to do business in this State, or a hospital or medical service corporation authorized to do business in this State, may either directly or through a subsidiary or affiliate organize and operate a health maintenance organization under the provisions of this Article. Notwithstanding any other law which may be inconsistent herewith, any two or more such insurance companies, hospital or medical service corporations, prepaid health plans, or subsidiaries or affiliates thereof, may jointly organize and operate a health maintenance organization. The business of insurance is deemed to include the arranging of health care by a health maintenance organization owned or operated by an insurer or a subsidiary thereof.

(b) Notwithstanding any provision of the insurance and hospital or medical service corporation laws contained in Articles 1 through 66 of this Chapter, an insurer or a hospital or medical service corporation may contract with a health maintenance organization to provide insurance or similar protection against the cost of care provided through health maintenance organizations and to provide coverage in the event of the failure of the health maintenance organization to meet its obligations. The enrollees of a health maintenance organization constitute a permissible group under such laws. Among other things, under such contracts, the

insurer or hospital or medical service corporation may make benefit payments to health maintenance organizations for health care services rendered by providers pursuant to the health care plan."

SECTION 3.(a) Part 6 of Article 2 of Chapter 108A of the General Statutes is amended by adding a new section to read:

"**§ 108A-68.2. Beneficiary lock-in program for certain controlled substances.**

(a) As used in this section, "covered substances" means any controlled substance identified as an opioid or benzodiazepine, excluding benzodiazepine sedative-hypnotics, contained in Article 5 of Chapter 90 of the General Statutes, unless one of the following conditions are met:

(1) If the Department of Health and Human Services specifically identifies the opioid or benzodiazepine as a substance excluded from coverage by the Medicaid Beneficiary Management Lock-In Program described in its Outpatient Pharmacy Clinical Coverage Policy adopted in accordance with G.S. 108A-54.2, then the opioid or benzodiazepine is not a covered substance under this section.

(2) If the Department of Health and Human Services specifically identifies a controlled substance contained in Article 5 of Chapter 90 of the General Statutes other than an opioid or benzodiazepine as a controlled substance covered by the Medicaid Beneficiary Management Lock-In Program described in its Outpatient Pharmacy Clinical Coverage Policy adopted in accordance with G.S. 108A-54.2, then the controlled substance is a covered substance under this section.

(b) As used in this section, "lock-in program" means a requirement that a Medicaid or NC Health Choice beneficiary select a single prescriber and a single pharmacy for obtaining covered substances.

(c) As used in this section, "Prepaid Health Plan" or "PHP" means an entity holding a PHP license under Article 93 of Chapter 58 of the General Statutes.

(d) This section does not apply to any lock-in program for Medicaid or NC Health Choice beneficiaries who are not enrolled in a Prepaid Health Plan.

(e) A Prepaid Health Plan may develop a lock-in program for Medicaid or NC Health Choice beneficiaries who meet any of the following criteria:

(1) Have filled six or more prescriptions for covered substances in a period of two consecutive months.

(2) Have received prescriptions for covered substances from three or more providers in a period of two consecutive months.

(3) Are recommended as a candidate for the lock-in program by a provider.

(f) A lock-in program developed pursuant to subsection (e) of this section shall comply with all of the following:

(1) A beneficiary shall not be subject to the lock-in program until the Prepaid Health Plan has notified the beneficiary in writing that the beneficiary will be subject to the lock-in program.

(2) A beneficiary subject to the lock-in program shall be given the opportunity to select a single prescriber and a single pharmacy from a list of prescribers and pharmacies in the Prepaid Health Plan's provider network. For any beneficiary who fails to select a single prescriber, the Prepaid Health Plan shall use algorithmic guidelines to assign the beneficiary a single prescriber from a list of prescribers in the Prepaid Health Plan's network. For any beneficiary who fails to select a single pharmacy, the Prepaid Health Plan shall use algorithmic guidelines to assign the beneficiary a single pharmacy from a list of pharmacies in the Prepaid Health Plan's network.

(3) A beneficiary shall not be required to use the single prescriber or single pharmacy selected for the lock-in program to obtain prescriptions drugs covered by the Medicaid program or the Prepaid Health Plan that are not covered substances.

(g) A Prepaid Health Plan's use of a lock-in program developed pursuant to subsection (e) of this section shall not constitute a violation of the terms of a contract between the Prepaid Health Plan and the Department that relate to a beneficiary's ability to utilize a pharmacy of choice."

SECTION 3.(b) Article 51 of Chapter 58 of the General Statutes is amended by adding a new section to read:

"**§ 58-51-37.1. Lock-in program for certain controlled substances.**

(a) As used in this section, "covered substances" means any controlled substance identified as an opioid or benzodiazepine, excluding benzodiazepine sedative-hypnotics, contained in Article 5 of Chapter 90 of the General Statutes, unless one of the following conditions are met:

(1) If the Department of Health and Human Services specifically identifies the opioid or benzodiazepine as a substance excluded from coverage by the Medicaid Beneficiary Management Lock-In Program described in its Outpatient Pharmacy Clinical Coverage Policy adopted in accordance with G.S. 108A-54.2, then the opioid or benzodiazepine is not a covered substance under this section.

(2) If the Department of Health and Human Services specifically identifies a controlled substance contained in Article 5 of Chapter 90 of the General Statutes other than an opioid or benzodiazepine as a controlled substance covered by the Medicaid Beneficiary Management Lock-In Program described in its Outpatient Pharmacy Clinical Coverage Policy adopted in accordance with G.S. 108A-54.2, then the controlled substance is a covered substance under this section.

(b) As used in this section, "lock-in program" means a requirement that an insured select a single prescriber and a single pharmacy for obtaining covered substances under a health benefit plan.

(c) An insurer may develop a lock-in program as part of a health benefit plan for insureds who meet any of the following criteria:

(1) Have filled six or more prescriptions for covered substances in a period of two consecutive months.

(2) Have received prescriptions for covered substances from three or more health care providers in a period of two consecutive months.

(3) Are recommended to the insurer as a candidate for the lock-in program by a health care provider.

(d) A lock-in program developed pursuant to subsection (c) of this section shall comply with all of the following:

(1) An insured shall not be subject to the lock-in program until the insurer has notified the insured in writing that the insured will be subject to the lock-in program.

(2) An insured subject to the lock-in program shall be given the opportunity to select a single prescriber and a single pharmacy from a list of prescribers and pharmacies participating in the health benefit plan provider network. For any insured who fails to select a single prescriber, the insurer shall use algorithmic guidelines to assign the insured a single prescriber from a list of prescribers participating in the health benefit plan provider network. For any insured who fails to select a single pharmacy, the insurer shall use algorithmic guidelines

to assign the insured a single pharmacy from a list of pharmacies participating in the health benefit plan provider network.

(3) An insured shall not be required to use the single prescriber or single pharmacy selected for the lock-in program to obtain prescriptions drugs covered by the health benefit plan that are not covered substances. An insured who is subject to a lock-in program retains all rights under G.S. 58-51-37 to obtain prescription drugs covered by a health benefit plan that are not covered substances.

(e) An insurer's use of a lock-in program developed pursuant to subsection (c) of this section is not a violation under G.S. 58-51-37."

SECTION 3.(c) G.S. 58-51-37 is amended by adding a new subsection to read:

"(*l*) An insurer's use of a lock-in program developed pursuant G.S. 58-51-37 is not a violation of this section."

SECTION 3.(d) This section is effective when it becomes law, and subsections (b) and (c) of this section apply to health benefit plan contracts issued, renewed, or amended on or after that date.

SECTION 4. Section 3 of S.L. 2015-245, as amended by Section 2(a) of S.L. 2016-121, reads as rewritten:

"**SECTION 3.** Time Line for Medicaid Transformation. – The following milestones for Medicaid transformation shall occur no later than the following dates:

…

(4) Eighteen months after ~~approval of all necessary waivers and State Plan amendments by CMS.~~the date that CMS approves the 1115 demonstration waiver request submitted as required by this act on June 1, 2016, as amended. – Capitated contracts shall ~~begin and initial recipient enrollment shall be complete.~~begin. DHHS may phase recipient enrollment on a regional basis, provided that initial recipient enrollment shall be complete no later than five months after the date capitated contracts are required to begin."

SECTION 5.(a) Sub-subdivision a. of Subdivision (5) of Section 4 of S.L. 2015-245, as amended by Section 2(b) of S.L. 2016-121, reads as rewritten:

"a. Recipients who are ~~dually eligible for Medicaid and Medicare. Recipients in the aged program aid category that are eligible for Medicare shall be considered recipients who are dually eligible for Medicaid and Medicare. The Division of Health Benefits shall develop a long-term strategy to cover dual eligibles through capitated PHP contracts, as required by subdivision (11) of Section 5 of this act.~~ enrolled in both Medicare and Medicaid for whom Medicaid coverage is limited to the coverage of Medicare premiums and cost sharing."

SECTION 5.(b) Subdivision (5) of Section 4 of S.L. 2015-245, as amended by Section 2(b) of S.L. 2016-121, is amended by adding a new sub-subdivision to read:

"m. Recipients in the following categories shall not be covered by PHPs for a period of time to be determined by DHHS that shall not exceed five years after the date that capitated PHP contracts begin:

1. Recipients who (i) reside in a nursing facility and have so resided, or are likely to reside, for a period of 90 days or longer and (ii) are not being served through the Community Alternatives Program for Disabled Adults (CAP/DA). During the period of exclusion from PHP coverage for this population as determined by DHHS in accordance with this sub-subdivision, if an individual enrolled in a PHP resides in a nursing facility for 90 days or more, then that individual shall

be excluded from PHP coverage on the first day of the month following the ninetieth day of the stay in the nursing facility and shall be disenrolled from the PHP.

2. Recipients who are enrolled in both Medicare and Medicaid and for whom Medicaid coverage is not limited to the coverage of Medicare premiums and cost sharing. This sub-sub-subdivision shall not include recipients being served through the Community Alternatives Program for Disabled Adults (CAP/DA)."

SECTION 5.(c) Section 4 of S.L. 2015-245, as amended by Section 2(b) of S.L. 2016-121, Section 11H.17(a) of S.L. 2017-57, Section 4 of S.L. 2017-186, and Section 11H.10(d) of S.L. 2018-5, is amended by adding a new subdivision to read:

"(5a) If a recipient in any of the categories excluded from PHP coverage under subdivision (5) of this section is eligible to receive a service that is not available in the fee-for-service program but is offered by a PHP, the recipient may be enrolled in a PHP."

SECTION 6.(a) Subdivision (6a) of Section 4 of S.L. 2015-245 reads as rewritten:

"(6a) ~~To the extent allowed by Medicaid federal law and regulations and consistent with the requirements of this act, PHPs shall comply with the requirements of Chapter 58 of the General Statutes. This requirement shall not be construed to require PHPs to cover services that are not covered by the Medicaid program pursuant to federal law and regulations.~~ The Department of Health and Human Services, Division of Health Benefits, and the Department of Insurance shall jointly review the applicability of provisions of Chapter 58 of the General Statutes to PHPs, and report to the Joint Legislative Oversight Committee on Medicaid and NC Health Choice by March 1, 2016, on the following:

a. Proposed exceptions to the applicability of Chapter 58 of the General Statutes for PHPs.

b. Recommendations for resolving conflicts between Chapter 58 of the General Statutes and the requirements of Medicaid federal law and regulations.

c. Proposed statutory changes necessary to implement this subdivision."

SECTION 6.(b) Section 5 of S.L. 2015-245, as amended by Section 2(c) of S.L. 2016-121, reads as rewritten:

"**SECTION 5.** Role of DHHS. – The role and responsibility of DHHS during Medicaid transformation shall include the following activities and functions:

…

(5) Set rates, including the following:

a. Capitation rates that are actuarially sound. Actuarial calculations must include utilization assumptions consistent with industry and local standards. Capitation rates shall be risk adjusted and shall include a portion that is at risk for achievement of quality and outcome measures, including value-based ~~payments.~~payments, provided that capitated PHP contracts shall not require any withhold arrangements, as defined in 42 C.F.R. § 438.6, during the first 18 months of the demonstration. Any withhold arrangements required under a capitated PHP contract after the first 18 months of the demonstration shall not withhold an amount of a PHP's capitation payment that exceeds three and one-half percent (3.5%) of the PHP's total capitation payment. DHHS shall not require community reinvestment as a condition for a PHP's receipt of any at-risk portion of the capitation rate.

…

(6) Enter into capitated PHP contracts for the delivery of the Medicaid and NC Health Choice services described in subdivision (4) of Section 4 of this act. All contracts shall be the result of requests for proposals (RFPs) issued by DHHS and the submission of competitive bids by PHPs. DHHS shall develop standardized contract terms, to include at a minimum, the following:

…

c. ~~Until final federal regulations are promulgated governing medical loss ratio, a~~A minimum medical loss ratio of eighty-eight percent (88%) for health care services, with the components of the numerator and denominator to be defined by DHHS. The minimum medical loss ratio shall be neither higher nor lower than eighty-eight percent (88%). DHHS shall not require community reinvestment as a result of a PHP's failure to comply with any minimum loss ratio.

…

f. Terms that, to the extent not inconsistent with federal law or regulations, or State law or rule, ensure PHPs will be subject to certain requirements of Chapter 58 of the General Statutes in accordance with this sub-subdivision. Compliance with these requirements shall be overseen and enforced by DHHS. The requirements to be incorporated in the terms of the capitated PHP contracts are in the following sections of Chapter 58, and the requirements in these sections shall be applicable to PHPs in the manner in which these sections are applicable to insurers and health benefits plans, as the context requires:

1. G.S. 58-3-190, Coverage required for emergency care, excluding subdivisions (3) and (4) of subsection (g).
2. G.S. 58-3-191, Managed care reporting and disclosure requirements.
3. G.S. 58-3-200(c), Miscellaneous insurance and managed care coverage and network provisions.
4. G.S. 58-3-221, Access to nonformulary and restricted access prescription drugs.
5. G.S. 58-3-225, Prompt claim payments under health benefit plans.
6. G.S. 58-3-227, Health plans fee schedules.
7. G.S. 58-3-231, Payment under locum tenens arrangements.
8. G.S. 58-50-26, Physician services provided by physician assistants.
9. G.S. 58-50-30, Right to choose services of certain providers.
10. G.S. 58-50-270, Definitions.
11. G.S. 58-50-275, Notice contact provision.
12. G.S. 58-50-280, Contract amendments.
13. G.S. 58-50-285, Policies and procedures.
14. G.S. 58-50-295, Prohibited contract provisions related to reimbursement rates.
15. G.S. 58-51-37, Pharmacy of choice. The requirements of this statute to be incorporated into capitated PHP contracts shall apply to all PHPs regardless of whether a PHP has its own facility, employs or contracts with physicians, pharmacists, nurses, or other health care personnel, and dispenses prescription drugs from its own pharmacy to enrollees.

16. G.S. 58-51-38, Direct access to obstetrician-gynecologists.
17. G.S. 58-67-88, Continuity of care.

This sub-subdivision shall not be construed to require DHHS to utilize contract terms that would require PHPs to cover services that are not covered by the Medicaid program.

g. A requirement that all participation agreements between a PHP and a health care provider incorporate specific terms implementing sub-sub-subdivisions 3, 5, 6, 10, 11, 12, and 13 of sub-subdivision f. of this subdivision.

…."

SECTION 7. S.L. 2015-245, as amended by S.L. 2016-121, Section 11H.17(a) of S.L. 2017-57, Section 4 of S.L. 2017-186, and Section 11H.10.(d) of S.L. 2018-5, is amended by adding a new section to read:

"**SECTION 7A.** Advanced Medical Homes. – PHPs shall be required to implement an Advanced Medical Home care management program but shall not be required to contract with any particular entity as an Advanced Medical Home. A PHP may contract with any entity to serve as an Advanced Medical Home or may create its own Advanced Medical Home care management program."

SECTION 8.(a) It is the intent of the General Assembly to enact legislation, no later than March 15, 2019, that will ensure that the premium tax levied under G.S. 105-228.5 applies to capitation payments received by Prepaid Health Plans, as defined in G.S. 58-93-2, in the same manner in which the tax is applied to the gross premiums from business done in this State for all other health care plans and contracts of insurance provided by insurers or health maintenance organizations subject to the tax.

SECTION 8.(b) Until March 15, 2019, or such earlier date as the legislation described in subsection (a) of this section is enacted, the Department of Health and Human Services shall plan for the implementation of Medicaid transformation with the assumption that such legislation will be enacted. If the General Assembly has not ratified the legislation described in subsection (a) of this section by March 15, 2019, then the Department of Health and Human Services shall plan for the implementation of Medicaid transformation with the assumption that such legislation will be not enacted, and the Department shall correct all actions taken in reliance on the previous assumption, including the reissuance of the requests for proposals for capitated PHP contracts, if necessary.

SECTION 8.(c) By October 1, 2018, the Department of Health and Human Services, in consultation with the Department of Revenue, shall submit a report to the Joint Legislative Oversight Committee on Medicaid and NC Health Choice containing proposed legislative changes necessary to accomplish the intent set forth in subsection (a) of this section. The report shall include the following:

(1) Assurances that the proposed legislative changes do not violate federal Medicaid laws or regulations.
(2) An estimate of the amount of increase in revenue that is anticipated as a result of the proposed legislative changes, and any proposed uses for the increase in revenue.

SECTION 8.(d) G.S. 143C-5-2 does not apply to legislation that is introduced in the 2019 Regular Session of the 2019 General Assembly that contains the legislative changes necessary to accomplish the intent set forth in subsection (a) of this section.

SECTION 9.(a) Consistent with Section 9 of S.L. 2015-245, as amended by Section 2(e) of S.L. 2016-121, it is the intent of the General Assembly to enact legislation during the 2019 Regular Session that will replace the Hospital Provider Assessment Act in Article 7 of Chapter 108A of the General Statutes with a similar hospital provider assessment that will

preserve existing levels of funding generated by the current assessment and will result in similar overall payment levels to hospitals.

SECTION 9.(b) By October 1, 2018, the Department of Health and Human Services shall submit a report to the Joint Legislative Oversight Committee on Medicaid and NC Health Choice containing proposed legislative changes necessary to accomplish the intent set forth in subsection (a) of this section. The report shall include the following:

(1) A description of the new assessment calculation methodology compared to the existing methodology and an estimate of the change in proceeds or revenue from the assessment compared to historical proceeds or revenue from the assessment.

(2) A detailed description of the proposed uses for the proceeds of the tax or assessment.

(3) Assurances that the proposed legislative changes do not violate federal Medicaid laws or regulations and are consistent with federal Medicaid managed care regulations.

SECTION 9.(c) G.S. 143C-5-2 does not apply to legislation that is introduced in the 2019 Regular Session of the 2019 General Assembly that contains the legislative changes necessary to accomplish the intent set forth in subsection (a) of this section.

SECTION 10. The time frame within which the Department of Health and Human Services shall issue the requests for proposals required by subdivision (6) of Section 5 of S.L. 2015-245, as amended by Section 2(c) of S.L. 2016-121 and Section 6(b) of this act, shall be as follows:

(1) If the 1115 demonstration waiver request submitted as required by this act on June 1, 2016, as amended, is not approved before the expiration of the 60 days after this act becomes law, then within 60 days after this act becomes law.

(2) If the 1115 demonstration waiver request submitted as required by this act on June 1, 2016, as amended, is approved before the expiration of the 60 days after this act becomes law, then within 60 days after this act becomes law, or 30 days after the date of the waiver approval, whichever is later.

SECTION 11. Except as otherwise provided, this act is effective when it becomes law.