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S **D**

SENATE BILL DRS35386-MRxfa-140C

Short Title:	Medicaid Transformation Necessities.	(Public)
Sponsors:	Senators Brown, Harrington, and B. Jackson (Primary Sponsors).	
Referred to:		

A BILL TO BE ENTITLED

AN ACT TO APPROPRIATE FUNDS FOR THE IMPLEMENTATION OF MEDICAID TRANSFORMATION AND TO MAKE OTHER NECESSARY MEDICAID TRANSFORMATION-RELATED CHANGES.

The General Assembly of North Carolina enacts:

PART I. INTRODUCTION

SECTION 1.1. The provisions of the State Budget Act, Chapter 143C of the General Statutes, are reenacted and shall remain in full force and effect and are incorporated in this act by reference.

SECTION 1.2. Departmental receipts, as defined in G.S. 143C-1-1, are appropriated for the 2020-2021 fiscal year up to the amounts needed to implement the provisions in this act for the 2020-2021 fiscal year.

SECTION 1.3. Except where expressly repealed or amended by this act, the provisions of any other legislation enacted during the 2019 Regular Session expressly appropriating funds to an agency, a department, or an institution covered under this act, shall remain in effect.

PART II. DELAY IMPLEMENTATION OF MEDICAID TRANSFORMATION

SECTION 2.1. Subdivision (4) of Section 3 of S.L. 2015-245, as amended by Section 4 of S.L. 2018-49, reads as rewritten:

"(4) ~~Eighteen months after the date that CMS approves the 1115 demonstration waiver request submitted as required by this act on June 1, 2016, as amended.~~ No later than January 1, 2021. – Capitated contracts shall 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."

PART III. FUNDS FOR OPERATION OF THE MEDICAID PROGRAM

SECTION 3.1. There is appropriated from the General Fund a sufficient sum in recurring funding for the 2020-2021 fiscal year to the Department of Health and Human Services, Division of Health Benefits, to be used for the Medicaid and NC Health Choice programs rebase.

SECTION 3.2. There is appropriated from the General Fund a sufficient sum in recurring funding for the 2020-2021 fiscal year to the Department of Health and Human Services, Division of Health Benefits, for contracts, personnel, and projects related to transitioning to Medicaid managed care.

PART IV. USE OF MEDICAID TRANSFORMATION FUND FOR MEDICAID TRANSFORMATION NEEDS

SECTION 4.1. The State Controller shall transfer a sufficient sum for the nonrecurring Medicaid transformation needs in the 2020-2021 fiscal year from funds available in the Medicaid Transformation Reserve in the General Fund to the Medicaid Transformation Fund established under Section 12H.29 of S.L. 2015-241.

SECTION 4.2. Funds from the Medicaid Transformation Fund may be transferred to the Department of Health and Human Services, Division of Health Benefits (DHB), as needed for the purpose of paying claims related to services billed under the fee-for-service payment model for recipients who are being, or have been, transitioned to managed care, otherwise known as "claims run out." Funds may be transferred to DHB as the need to pay claims run out arises and need not be transferred in one lump sum. To the extent that any funds are transferred under this section, the funds are appropriated for the purpose set forth in this section.

SECTION 4.3.(a) Subject to the fulfillment of conditions specified in subsection (b) of this section, nonrecurring funds for the 2020-2021 fiscal year from the Medicaid Transformation Fund may be transferred to the Department of Health and Human Services, Division of Health Benefits (DHB), for the sole purpose of providing the State share for nonrecurring qualifying needs directly related to Medicaid transformation, as required by S.L. 2015-241, as amended. Funds may be transferred to DHB as nonrecurring qualifying needs arise during the 2020-2021 fiscal year and need not be transferred in one lump sum. To the extent that any funds are transferred under this subsection, the funds are appropriated for the purpose set forth in this subsection.

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

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

SECTION 4.3.(b) A request by the Department of Health and Human Services, Division of Health Benefits (DHB), for the transfer of funds pursuant to this section shall be made to the Office of State Budget and Management (OSBM) and shall include the amount requested and the specific nonrecurring qualifying need for which the funds are to be used. None of the funds identified in this section shall be transferred to DHB until OSBM verifies all of the following information:

(1) The amount requested is to be used for a nonrecurring qualifying need in the 2020-2021 fiscal year.
(2) The amount requested provides a State share that will not result in total requirements that exceed one hundred forty million dollars ($140,000,000) in nonrecurring funds for the 2020-2021 fiscal year.

SECTION 4.3.(c) Any federal funds received in any fiscal year by the Department of Health and Human Services, Division of Health Benefits (DHB), that represent a return of State share already expended on a qualifying need related to the funds received by DHB under this section shall be deposited into the Medicaid Transformation Fund.

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

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

PART VI. MEDICAID TRANSFORMATION HOTLINE OPTION

SECTION 6.1. The Department of Health and Human Services shall ensure that the existing DHHS Customer Service hotline is responsive to questions posed by a Medicaid beneficiary or provider or by the general public that are related to the rollout of Medicaid Transformation.

PART VII. TRIBAL OPTION/MEDICAID TRANSFORMATION

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

(1) Primary care case management as a primary care case managed system or entity, as described in 42 C.F.R. § 438.2.
(2) Utilization management and referrals.
(3) The management or provision of home- and community-based services under a 1915(c) waiver.
(4) The management or provision of specialized services covered by a BH IDD Tailored Plan in accordance with G.S. 108D-60(8).

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

SECTION 7.1.(b) G.S. 108D-40(a) reads as rewritten:

"(a) Capitated PHP contracts shall cover all Medicaid and NC Health Choice program aid categories except for the following categories:

…

(5a) 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) G.S. 122C-115(e) reads as rewritten:

"(e) Beginning on the date that capitated contracts under Article 4 of Chapter 108D of the General Statutes begin, LME/MCOs shall cease managing Medicaid services for all Medicaid recipients other than recipients described in G.S. 108D-40(a)(1), (4), (5), (5a), (6), (7), (10), (11), (12), and (13). Until BH IDD tailored plans become operational, all of the following shall occur:

(1) 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 G.S. 108D-40(a)(1), (4), (5), (5a), (6), (7), (10), (11), (12), and (13).
(2) 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.

(3) 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.

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 January 1, 2021, 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 providers shall apply to the combined amount of payments made as supplemental payments under the State Plan and payments made as directed payments under the managed care system and shall be based on the amount of supplemental payments for services provided during the 2018-2019 fiscal year as follows:

(1) For services provided during the period January 1, 2021, through June 30, 2021, the total annual supplemental and directed payments made under the Average Commercial Rate Supplemental and Directed Payment Program shall not exceed fifty percent (50%) of the gross supplemental payments for services provided by eligible medical providers during the 2018-2019 fiscal year increased by an inflation factor determined by the Department of Health and Human Services, Division of Health Benefits.

(2) For services provided on or after July 1, 2021, the total annual supplemental and directed payments made under the Average Commercial Rate Supplemental and Directed Payment Program shall not exceed one hundred percent (100%) of the gross supplemental payments for services provided by eligible medical providers during the 2018-2019 fiscal year, increased at the start of each State fiscal year by an inflation factor determined by the Department of Health and Human Services, Division of Health Benefits.

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

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

SECTION 8.1.(e) Effective January 1, 2021, Section 12H.13(e) of S.L. 2013-360 and Sections 12H.13(b) and 12H.13A of S.L. 2014-100 are repealed.

PART IX. MEDICAID CONTINGENCY RESERVE CODIFICATION

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

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

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

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

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

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

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

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

PART X. REVISE AND UPDATE HOSPITAL ASSESSMENTS

SECTION 10.1.(a) Effective January 1, 2021, Article 7 of Chapter 108A of the General Statutes is repealed.

SECTION 10.1.(a1) Notwithstanding any provision of Article 7 of Chapter 108A of the General Statutes to the contrary, the equity assessment, UPL assessment, equity payments, and UPL payments required under that Article for the partial year beginning October 1, 2020, and ending December 31, 2020, shall be carried out in accordance with this subsection. For the annual period beginning October 1, 2020, the equity payment amount and the UPL payment amount required by G.S. 108A-124 shall be calculated to exclude services rendered after December 31, 2020. In order to account for these partial-year payment amounts, the Secretary of the Department of Health and Human Services may adjust the quarterly equity payments and UPL payments required by G.S. 108A-124. In order to account for any partial-year adjustments to the equity payments or UPL payments, the Secretary of the Department of Health and Human Services may make any necessary adjustments to the equity assessment percentage rate, the UPL assessment percentage rate, any quarterly equity assessment, and any UPL assessment required under G.S. 108A-122 and G.S. 108A-123.

SECTION 10.1.(a2) Subsection (a) of this section does not affect the rights or liabilities of the State, a hospital subject to the equity assessment or the UPL assessment, or another person arising under a statute repealed by subsection (a) of this section or arising under subsection (a1) of this section before the effective date of its repeal.

SECTION 10.1.(b) Effective January 1, 2021, Chapter 108A of the General Statutes is amended by adding a new Article to read:

"Article 7A.

"Hospital Assessment Act.

"Part 1. General.

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

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

"**§ 108A-131. Definitions.**

The following definitions apply in this Article:

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

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

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

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

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

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

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

(8) State's annual Medicaid payment. – An annual amount equal to one hundred ten million dollars ($110,000,000) for the taxable year October 1, 2020, through September 30, 2021, increased each year over the prior year's payment by the percentage specified as the Medicare Market Basket Index less productivity most recently published in the Federal Register.

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

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

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

(a) Assessments under this Article are due quarterly in the time and manner prescribed by the Secretary and shall be considered delinquent if not paid within seven calendar days of this due date.

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

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

"**§ 108A-133. Assessment appeals.**

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

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

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

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

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

The Secretary may adopt rules to implement this Article.

"**§ 108A-136. Repeal.**

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

"Part 2. Supplemental and Base Assessments.

"**§ 108A-140. Applicability.**

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

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

(1) Critical access hospitals.
(2) Freestanding psychiatric hospitals.
(3) Freestanding rehabilitation hospitals.
(4) Long-term care hospitals.
(5) State-owned and State-operated hospitals.
(6) The primary affiliated teaching hospital for each University of North Carolina medical school.

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

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

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

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

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

(1) The percentage change in aggregate payments to hospitals subject to the supplemental assessment for Medicaid and NC Health Choice enrollees, excluding hospital access payments made under 42 C.F.R. § 438.6, as demonstrated in data from prepaid health plans and the State, as determined by the Department.
(2) Any changes in the federal medical assistance percentage rate applicable to the Medicaid or NC Health Choice programs for the applicable year.

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

"**§ 108A-142. Base assessment.**

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

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

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

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

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

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

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

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

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

(a) If a hospital that is exempt from both the base and supplemental assessments under this Part (i) makes an intergovernmental transfer to the Department to be used to draw down matching federal funds and (ii) has acquired, merged, leased, or managed another hospital on or after March 25, 2011, then the exempt hospital shall transfer to the State an additional amount. The additional amount shall be a percentage of the amount of funds that (i) would be transferred to the State through such an intergovernmental transfer and (ii) are to be used to match additional federal funds that the exempt hospital is able to receive because of the acquired, merged, leased, or managed hospital.

(b) Beginning October 1, 2021, the percentage described in subsection (a) of this section shall be calculated by dividing the amount of the State's annual Medicaid payment by the total amount collected under the base assessment under G.S. 108A-142.

(c) For the partial year beginning January 1, 2021, and ending September 30, 2021, the percentage described in subsection (a) of this section shall be calculated by dividing three-fourths of the amount of the State's annual Medicaid payment by the amount collected under the base assessment under G.S. 108A-142.

"**§ 108A-144. Use of funds.**

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

SECTION 10.1.(b1) Notwithstanding any provision of G.S. 108A-131, as enacted by subsection (b) of this section, to the contrary, for the taxable year October 1, 2020, through September 30, 2021, total hospital costs, as defined in G.S. 108A-131(10), shall be calculated based on the Hospital Cost Report Information System's 2016 cost report data available through the Centers for Medicare and Medicaid Services.

SECTION 10.1.(c) The percentage rate to be used in calculating the supplemental assessment under G.S. 108A-141, as enacted in subsection (b) of this section, is two and twenty-six hundredths percent (2.26%) for the taxable year October 1, 2020, through September 30, 2021. The supplemental assessment shall be imposed only for months beginning on or after January 1, 2021. The supplemental assessment imposed during the period January 1, 2021, through September 30, 2021, shall equal three-fourths of the amount of supplemental assessment that would have been imposed for the full taxable year.

SECTION 10.1.(d) The percentage rate to be used in calculating the base assessment under G.S. 108A-142, as enacted in subsection (b) of this section, is one and seventy-seven

hundredths percent (1.77%) for the taxable year October 1, 2020, through September 30, 2021. The base assessment shall be imposed only for months beginning on or after January 1, 2021. The base assessment imposed during the period January 1, 2021, through September 30, 2021, shall equal three-fourths of the amount of base assessment that would have been imposed for the full taxable year.

SECTION 10.2. Notwithstanding G.S. 143C-4-11, as enacted by Section 9.1 of this act, the State Controller shall transfer funds from the Medicaid Contingency Reserve to the Department of Health and Human Services, Division of Health Benefits (DHB), only upon request by DHB as needed to cover any shortfall in receipts from the supplemental or base assessments under G.S. 108A-141 and G.S. 108A-142, enacted by subsection (b) of Section 10.1 of this act, and only if the following two conditions are met:

(1) The Office of State Budget and Management (OSBM) has certified that there will be a shortfall in receipts from the supplemental or base assessments.

(2) OSBM has certified that the amount requested by DHB does not exceed the shortfall in receipts certified by OSBM under subdivision (1) of this subsection.

Upon making the request to the State Controller for the transfer of funds pursuant to this section, DHB shall notify the Fiscal Research Division and the Joint Legislative Oversight Committee on Medicaid and NC Health Choice of the request and the amount of the request. To the extent any funds are transferred under this section, the funds are hereby appropriated for the purpose set forth in this section. The authority set forth in this section expires June 30, 2021.

PART XI. GROSS PREMIUMS TAX/PREPAID HEALTH PLANS

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

"Article 8B.

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

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

"**§ 105-228.3. Definitions.**

The following definitions apply in this Article:

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

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

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

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

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

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

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

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

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

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

(b) Tax Base. –

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

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

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

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

(5) Prepaid health plans. – The tax imposed by this section on a prepaid health plan shall be measured by gross capitation payments received by the prepaid health plan from the Department of Health and Human Services for services provided to enrollees in the State Medicaid program or NC Health Choice program in the preceding calendar year.

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

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

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

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

Gross premiums from business done in this State in the case of prepaid health plans means all capitation payments received by a prepaid health plan from the Department of Health and Human Services for the delivery of services to enrollees in the State Medicaid program or NC

Health Choice program in the calendar year. Capitation payments refunded by a prepaid health plan to the State are the only allowable deductions.

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

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

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

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

(3) Funds or considerations received in connection with funding agreements, as defined in G.S. 58-7-16.

(4) The following premiums, to the extent federal law prohibits their taxation under this Article:

a. Federal Employees Health Benefits Plan premiums.

b. ~~Medicaid or~~ Medicare premiums.

c. Medicaid or NC Health Choice premiums, other than capitation payments, paid by or on behalf of a Medicaid or NC Health Choice beneficiary.

(d) Tax Rates; Disposition. –

(1) Workers' Compensation. – The tax rate to be applied to gross premiums, or the equivalent thereof in the case of self-insurers, on contracts applicable to liabilities under the Workers' Compensation Act is two and five-tenths percent (2.5%). The net proceeds shall be credited to the General Fund.

(2) Other Insurance Contracts. – The tax rate to be applied to gross premiums on all other taxable contracts issued by insurers or health maintenance organizations and to be applied to gross premiums and gross collections from membership dues, exclusive of receipts from cost plus plans, received by Article 65 corporations is one and nine-tenths percent (1.9%). The net proceeds shall be credited to the General Fund.

(2a) Prepaid Health Plans. – The tax rate to be applied to gross premiums from capitation payments received by prepaid health plans is one and nine-tenths percent (1.9%). The net proceeds shall be credited to the General Fund.

(3) Additional Rate on Property Coverage Contracts. – An additional tax at the rate of seventy-four hundredths percent (0.74%) applies to gross premiums on insurance contracts for property coverage. The tax is imposed on ten percent (10%) of the gross premiums from insurance contracts for automobile physical damage coverage and on one hundred percent (100%) of the gross

premiums from all other contracts for property coverage. Twenty percent (20%) of the net proceeds of this additional tax must be credited to the Volunteer Fire Department Fund established in Article 87 of Chapter 58 of the General Statutes. Twenty percent (20%) of the net proceeds must be credited to the Department of Insurance for disbursement pursuant to G.S. 58-84-25. Up to twenty percent (20%), as determined in accordance with G.S. 58-87-10(f), must be credited to the Workers' Compensation Fund. The remaining net proceeds must be credited to the General Fund. The additional tax imposed on property coverage contracts under this subdivision is a special purpose assessment based on gross premiums and not a gross premiums tax. The following definitions apply in this subdivision:

a. Automobile physical damage. – The following lines of business identified by the NAIC: private passenger automobile physical damage and commercial automobile physical damage.

b. Property coverage. – The following lines of business identified by the NAIC: fire, farm owners multiple peril, homeowners multiple peril, nonliability portion of commercial multiple peril, ocean marine, inland marine, earthquake, private passenger automobile physical damage, commercial automobile physical damage, aircraft, and boiler and machinery. The term also includes insurance contracts for wind damage.

c. NAIC. – National Association of Insurance Commissioners.

…

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

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

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

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

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

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

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

…

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

…

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

…."

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

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

…

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

…

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

…."

SECTION 11.(f) This section is effective 30 days after it becomes law and applies to capitation payments received by prepaid health plans on or after that date.

PART XII. HOSPITAL UNCOMPENSATED CARE FUND

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

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

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

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

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

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

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

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

PART XIII. MEDICAID NONTAX REVENUE

SECTION 13.1. It is the intent of the General Assembly to amend Section 2.3(b) of S.L. 2019-242 to reflect changes to the handling of nontax revenue in the North Carolina Medicaid program in a managed care environment.

PART XIV. EFFECTIVE DATE

SECTION 14.1. Except as otherwise provided, this act is effective when it becomes law.