2017-2018 General Assembly

HOUSE BILL 156: Medicaid PHP Licensure & Transformation Mods.

Committee:		**Date:**	June 28, 2018
Introduced by:		**Prepared by:**	Jennifer Hillman
Analysis of:	S.L. 2018-49		Staff Attorney

OVERVIEW: S.L. 2018-49 does the following:

- ***Creates a Prepaid Health Plan (PHP) Licensure Act governing the Department of Insurance's licensure of Medicaid PHPs as part of Medicaid transformation.***
- ***Makes various changes to laws pertaining to health insurance and Medicaid transformation.***

This act became effective June 22, 2018. The sections pertaining to the lock-in program for certain controlled substances apply to health benefit plan contracts issued, renewed, or amended on or after June 22, 2018.

CURRENT LAW: S.L. 2015-245, An Act to Transform and Reorganize North Carolina's Medicaid and NC Health Choice Programs, as amended by S.L. 2016-121, Sec. 11H.17 of S.L. 2017-57, Sec. 4 of S.L. 2017-186, Sec. 11H.10 of S.L. 2018-5, S.L. 2018-48, and Secs. 4-7 of S.L. 2018-49, provides a legislative framework for the transformation of North Carolina's Medicaid program with the stated purpose of providing budget predictability for the taxpayers of the State while ensuring quality care to those in need. S.L. 2015-245 requires transition of the current Medicaid and NC Health Choice programs to capitated contracts with Prepaid Health Plans (PHPs) under an 1115 waiver to be approved by the Centers for Medicare and Medicaid Services (CMS). S.L. 2015-245 requires PHPs to hold a PHP license in order to operate.

BILL ANALYSIS:

PREPAID HEALTH PLAN LICENSURE ACT: Sections 1 through 3 pertain to the licensure of Medicaid PHPs by the Department of Insurance.

Section 1 enacts Article 93 of Chapter 58 of the General Statutes – the Prepaid Health Plan Licensing Act (PHP Licensing Act). The PHP Licensing Act provides the requirements for obtaining a PHP license as well as requirements for maintaining that license. Licenses will be granted by the Commissioner of the Department of Insurance. Key components of the new Article 93 include the following:

- In order to obtain a license, an entity is required to make an application to the Department of Insurance and pay an application fee not to exceed $2,000. In order for an entity to apply for a license, the entity must be a commercial plan or provider-led entity, as those terms are used in the Medicaid transformation legislation.
- Licensed health organizations are not required to file an application or pay the application fee but may obtain a PHP license upon showing that the licensed health organization meets the

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requirements of Article 93 of the General Statutes. The new Article 93 defines a licensed heath organization as one of the following:

- A health maintenance organization licensed under Article 67 of Chapter 58.
- A full service corporation licensed under Article 65 of Chapter 58.
- An insurer under Chapter 58 that is required by the Commissioner of Insurance 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 Chapter 58 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.
- PHP licenses are issued on an annual basis. The fee for continuing a license can be no more than $5,000.
- The new Article 93 prescribes the investments a PHP may make, the approval requirements for exclusive management or custodial agreements, and the examinations that may be made by the Commissioner of Insurance.
- The new Article 93 requires PHPs to have a plan for protection against insolvency, as well as a plan for handling insolvency, approved by the Commissioner of Insurance. PHPs also must maintain a minimum capital and surplus equal to the greater of $1 million or the amount required under the risk-based capital provisions of Chapter 58. All PHPs must make a deposit of at least $500,000 to be administered in accordance with Article 5 of Chapter 58. The amount may be higher, as determined by the Commissioner of Insurance.
- The new Article 93 outlines actions the Commissioner of Insurance may take if a PHP is in a hazardous financial condition. The new Article 93 also outlines the circumstances under which the Commissioner may suspend or revoke a PHP license, or take any other action against a PHP described in Article 93, and requires the Commissioner to consult with the Secretary of DHHS before taking such actions.
- The new Article 93 also addresses the confidentiality of information shared between the Department of Insurance and DHHS.
- The new Article 93 specifies the other provisions of Chapter 58 that are applicable to the operation of PHPs.

Sections 2(a) and 2(b) make conforming changes in Chapter 58 related to the PHP Licensing Act.

OTHER CHANGES PERTAINING TO HEALTH INSURANCE: Sections 2(c) and 2(d) make changes to Article 67 of Chapter 58 of the General Statutes, pertaining to health maintenance organizations (HMOs). **Section 2(c)** allows the Commissioner of Insurance to contract with consultants and other professionals to carry out regulatory activities related to HMOs. **Section 2(d)** allows licensed PHPs to operate HMOs.

Section 3 authorizes PHPs and other health insurers to develop a lock-in program requiring certain enrollees or insureds to select a single prescriber and a single pharmacy for obtaining specified covered substances under Medicaid, NC Health Choice, or a health benefit plan. The substances that can be covered by a lock-in program include any controlled substance identified as an opioid or benzodiazepine, excluding benzodiazepine sedative-hypnotics, consistent with the substances covered by the Medicaid

Beneficiary Management Lock-In Program for outpatient pharmacy services. Individuals who may be subject to the lock-in program include individuals who: (i) have filled six or more prescriptions for covered substances in a period of two consecutive months, (ii) have received prescriptions for covered substances from three or more health care providers in a period of two consecutive months, or (iii) are recommended as a candidate for the program by a health care provider.

OTHER CHANGES PERTAINING TO MEDICAID TRANSFORMATION: Sections 4 through 10 pertain to the Medicaid transformation required by S.L. 2015-245, as amended. These changes include the following:

- DHHS may phase in recipient enrollment in PHPs by regions over the first five months that capitated contracts operate. (**Section 4**)
- The population of Medicare and Medicaid dual eligibles who are excluded from PHP coverage is limited to dual eligibles for whom Medicaid covers only Medicare premiums and cost sharing. (**Section 5**)
- The following populations will be phased in to PHP coverage within five years from the date capitated contracts begin: long-term residents of a nursing facility and dual eligibles for whom Medicaid coverage is not limited to Medicare premiums and cost-sharing. (**Section 5**)
- Any withhold arrangements in the capitated PHP contracts cannot begin during the first 18 months of the contract and cannot withhold more than 3.5% of the PHP's capitation payment. (**Section 6(b)**)
- DHHS cannot require community reinvestment as a condition for any at-risk portion of the PHP's capitation rate. (**Section 6(b)**)
- DHHS must set a minimum medical loss ratio in the capitated PHP contracts that is 88% and cannot require community reinvestment if a PHP does not meet the minimum medical loss ratio. (**Section 6(b)**)
- DHHS must incorporate requirements from specified sections of Chapter 58 of the General Statutes, pertaining to insurance, into the terms of the capitated PHP contracts. (**Section 6(b)**)
- PHPs must implement an Advanced Medical Home care management program but may contract with any entity to serve as an Advanced Medical Home and may create an Advanced Medical Home care management program. (**Section 7**)
- **Section 8** expresses the intent of the General Assembly to enact legislation ensuring that the premium tax levied under G.S. 105-228.5 applies to capitation payments received by PHPs in the same manner in which the tax applies to gross premiums. DHHS must plan for Medicaid transformation with the assumption that such legislation will be enacted until March 15, 2019. If the legislation has not been enacted by that date, then DHHS must no longer assume the legislation will be enacted and must take corrective action. By October 1, 2018, DHHS must submit a report to the Joint Legislative Oversight Committee on Medicaid and NC Health Choice with proposed changes to be included in this legislation.
- **Section 9** expresses the intent of the General Assembly to enact legislation to replace the Hospital Provider Assessment Act in Article 7 of Chapter 108A of the General Statutes with a similar hospital provider assessment that present existing levels of funding generated by the current assessment and will result in similar overall payment levels to hospitals. DHHS must submit a report to the Joint Legislative Oversight Committee on Medicaid and NC Health Choice by October 1, 2018 with proposed changes to be included in this legislation.
- **Section 10** requires DHHS to issue requests for proposals for capitated PHP contracts within a specified deadline that is between 60 and 90 days after the act became law on June 22, 2018.

EFFECTIVE DATE: This act became effective June 22, 2018. Section 3(b) and 3(c) apply to health benefit plan contracts issued, renewed, or amended on or after June 22, 2018.

**Amy Jo Johnson, Staff Attorney in the Legislative Drafting Division, substantially contributed to this summary.*