NORTH CAROLINA GENERAL ASSEMBLY

2023 Session

Legislative Fiscal Note

Short Title: Access to Healthcare Options.
Bill Number: House Bill 76 (Third Edition)
Sponsor(s): Rep. Lambeth, Rep. White, Rep. Wray, and Rep. Humphrey

SUMMARY TABLE

FISCAL IMPACT OF H.B. 76, V.3 ($ in millions)

	FY 2022-23	FY 2023-24	FY 2024-25	FY 2025-26	FY 2026-27
State Impact					
General Fund Revenue					
Gross Premiums Tax	-	124.1	185.2	175.0	171.3
Certificate of Need Fees	-	(0.2)	(0.2)	(0.6)	(0.7)
Departmental Receipts	1,262.3	8,233.7	10,087.0	10,072.0	10,305.3
Less Expenditures	1,262.3	8,215.8	10,115.4	10,132.5	10,358.0
General Fund Impact	**-**	**141.8**	**156.5**	**113.9**	**118.0**
Special Fund Revenues	-	1,373.8	1,409.9	723.5	750.9
Less Expenditures	-	516.5	649.0	720.2	741.7
Special Fund Impact	**-**	**857.3**	**760.9**	**3.3**	**9.2**
NET STATE IMPACT	**-**	**$999.1**	**$917.4**	**$117.2**	**$127.2**
Local Impact					
Local Revenue	-	48.0	59.2	62.4	63.4
Less Local Expenditures	-	48.0	59.2	62.4	63.4
NET LOCAL IMPACT	**-**	**-**	**-**	**-**	**-**

FISCAL IMPACT SUMMARY

Part I of the bill establishes NC Health Works to extend Medicaid coverage to individuals ages 18 through 64 who are not already eligible for Medicaid and have household incomes equal to or less than 133% of the federal poverty level. (In 2023, 133% of the federal poverty level is an annual salary of $19,391 for an individual or $33,064 for a family of 3.) In addition, it requires the Department of Health and Human Services (DHHS) to request federal approval for a new directed payment program, the Healthcare Access and Stabilization Program (HASP), that will increase Medicaid hospital reimbursements for services provided to Medicaid managed care enrollees. HASP would be funded entirely with new receipts from hospital assessments and transfers, and NC Health Works would be funded with a combination of departmental receipts from a new hospital assessment structure and increased gross premiums tax revenues resulting from the implementation of NC Health Works.

In addition to the new revenue and receipts that would fund the initiatives, the State would realize a total of approximately $1.6 billion in Medicaid savings over 2 years due to a federal incentive for expanding Medicaid coverage. The State would also realize ongoing Medicaid savings of $17 million to $25 million annually due to the elimination of an eligibility category that would be redundant with the implementation of NC Health Works. In addition, HASP would net an estimated $90 million to $100 million annually in additional gross premiums tax collections that would represent new General Fund revenue for the State.

A Health Advancement Receipts Special Fund is established to hold departmental receipts generated through a new hospital assessment structure, the Health Advancement Assessments, and would be used to pay the nonfederal share of all costs for NC Health Works. A second special fund, the ARPA Temporary Savings Fund, is established to hold Medicaid savings generated through the federal Medicaid expansion incentive.

County departments of social services (DSSs), which perform Medicaid eligibility determinations, would incur additional costs with the implementation of NC Health Works, but a combination of federal Medicaid receipts and transfers from the Health Advancement Receipts Special Fund would reimburse counties for these costs on an ongoing basis.

HASP is effective when the bill becomes law. NC Health Works is effective on the later of the date the FY 2023-24 State budget is enacted or the date the Centers for Medicare and Medicaid Services (CMS) approves implementation. If a State budget is not enacted by June 30, 2024, the NC Health Works provisions in the bill would expire without taking effect. This memo assumes that the initial HASP payments are made during the final quarter of FY 2022-23 and NC Health Works begins July 1, 2023.

Part II of the bill is not expected to have a significant impact on State finances. Part III of the bill implements Certificate of Need (CON) reforms and is expected to result in a loss of up to $700,000 per year in CON fees.

FISCAL ANALYSIS

Part I. Medicaid

American Rescue Plan Act Medicaid Expansion Incentive

For a state that expands Medicaid after March 11, 2021, the federal American Rescue Plan Act (ARPA) offers an additional 5 percentage points on the state's federal Medicaid match to be applied to the existing Medicaid population for 2 years. Implementation of NC Health Works would qualify North Carolina for the higher federal match, which would result in approximately $912 million per year in additional federal Medicaid receipts for 2 years. The incentive would begin when NC Health Works begins and would continue for 2 years. The increased federal Medicaid match would also reduce State costs for the Medicare Part D program. The additional federal receipts and Part D savings would be partially offset by a decrease in receipts from the State's existing Modernized Hospital Assessments formula and receipts from other providers that pay a portion of the State's nonfederal share of Medicaid costs.

The State savings generated by the incentive, approximately $1.6 billion in total, would be placed in an ARPA Temporary Savings Fund and could only be expended through an appropriation by the General Assembly. *Table 1* estimates deposits into the ARPA Temporary Savings Fund assuming a July 1, 2023 start date for NC Health Works.

Table 1. ARPA Temporary Savings Fund

($ in millions)	FY23-24	FY24-25	Total
Federal Medicaid Receipts	$912	$912	$1,824
Medicare Part D Savings	65	65	130
Modernized Assessment Receipts	(127)	(125)	(252)
Other Provider Receipts	(68)	(68)	(136)
Net State Savings	**$782**	**$784**	**$1,566**

Healthcare Access and Stabilization Program

If approved by the federal Centers for Medicare and Medicaid Services (CMS), HASP would increase Medicaid hospital reimbursements in accordance with the approved limits. Funds for the additional reimbursements would be allocated to Medicaid prepaid health plans (PHPs) to make managed care "directed payments" to hospitals in their networks.

HASP reimbursements to hospitals can begin at the start of the fiscal quarter following the bill's enactment if CMS has approved the State's plan, so initial HASP payments would be based on hospital services provided to the State's current Medicaid population. The bill requires DHHS to request at least $3.2 billion in HASP reimbursement increases for FY 2023-24, but if the bill is enacted and DHHS has secured federal approval, HASP payments could begin in FY 2022-23 for hospital services provided to Medicaid managed care enrollees since July 1, 2022. HASP payments made for hospital utilization prior to the start of behavioral health and intellectual/developmental

disabilities tailored plans (Tailored Plans) will likely be lower than the minimum of $3.2 billion identified for FY 2023-24.

The nonfederal share of HASP directed payments for the State's current Medicaid program would be fully funded by a new HASP component in the existing Modernized Hospital Assessments formula. Hospital receipts would be collected and matched with federal Medicaid receipts to make the directed payments to PHPs. *Table 2* estimates HASP payments for the current Medicaid population.

Table 2. Healthcare Access and Stabilization Program/Current Medicaid Population

($ in millions)	**FY22-23**	**FY23-24**	**FY24-25**	**FY25-26**	**FY26-27**
Total Requirements					
HASP directed payments to PHPs	$1,262	$2,735	$3,366	$3,366	$3,366
Receipts					
Federal Medicaid receipts	918	1,976	2,387	2,219	2,219
Additional hospital receipts	344	759	979	1,147	1,147
Net General Fund Appropriation	**$0**	**$0**	**$0**	**$0**	**$0**

The figures in *Table 2* are based on the following assumptions.

- HASP is approved by CMS for payments dating back to July 1, 2022.
- HASP reimbursements would be paid on a 2-quarter lag, whereby reimbursements delivered in one quarter would be based on utilization of hospital services in the second prior fiscal quarter. Payments for the first 2 quarters of FY 2022-23 would be made by June 30, 2023.
- Tailored Plans begin as scheduled on October 1, 2023.
- HASP reimbursements for hospital utilization prior to the start of Tailored Plans are estimated at $2.5 billion on an annualized basis. Once Tailored Plans are implemented, HASP reimbursements for the traditional Medicaid population would total $3.3 billion annually. With the 2-quarter lag, the first payment that includes Tailored Plan HASP reimbursements would be made in the final quarter of FY 2023-24.
- When making HASP directed payments to PHPs, 2% would be added to HASP hospital reimbursements. The additional 2% would be funded with hospital receipts and federal Medicaid receipts and would be retained by PHPs to pay the State's gross premiums tax.

Because the HASP directed payments pass through PHPs, they are subject to the State's 1.9% gross premiums tax. Additional gross premiums tax collections generated by HASP payments represent new General Fund revenue for the State. Based on the assumptions described above, the additional revenue for the current Medicaid population would level off at approximately $64 million per year.

NC Health Works

The bill establishes NC Health Works to extend Medicaid coverage to individuals ages 18 through 64 who are not currently eligible for full Medicaid benefits and have household incomes no more than 133% of the federal poverty level. Medicaid coverage for NC Health Works enrollees would begin once a FY 2023-24 budget is enacted and CMS has authorized implementation of NC Health

Works. Assuming HASP has also been approved by CMS, the cost of NC Health Works services would include costs for the additional HASP directed payments to PHPs.

Federal Medicaid receipts would cover 90% of the service costs and 50% to 75% of the administrative costs for NC Health Works. A one-time hospital assessment would be imposed in October 2023 to generate funds for the nonfederal share of State start-up costs and initial operational costs for DHHS and county DSSs. The initial assessment would collect $12.8 million, with $8.8 million designated for State costs and $4.0 million to be allocated to counties. Beginning at the approved start date for NC Health Works, the nonfederal share of NC Health Works costs would be paid from a new Health Advancement Receipts Special Fund (HAR SF) created to hold hospital receipts from the new Health Advancement Assessments established in the bill.

The Health Advancement Assessments structure would begin generating hospital receipts with the start of NC Health Works, and most of the receipts generated by the new structure would be deposited into HAR SF. A reconciliation component in the assessments realigns the amount collected each quarter to ensure that hospitals get credit for any overpayments or make additional payments to replace any shortfalls relative to the actual cost of NC Health Works. Once NC Health Works begins to generate additional gross premiums tax revenues, the bill includes intent language to appropriate a portion of the new General Fund revenue resulting from NC Health Works to DHHS for deposit in HAR SF.

The Health Advancement Assessments formula is expected to initially over-collect hospital receipts, resulting in a balance being retained in HAR SF. Estimates of deposits into HAR SF and spending from HAR SF are provided in *Table 3*.

Table 3. Health Advancement Receipts Special Fund

($ in millions)	**FY23-24**	**FY24-25**	**FY25-26**	**FY26-27**
Starting Balance	$0	$75	$52	$56
Deposits into HAR SF				
Health Advancement hospital receipts	592	580	638	675
Gross premiums tax appropriation	0	46	86	76
Transfer to pay NC Health Works costs	(517)	(649)	(720)	(742)
FY Ending Balance	**$75**	**$52**	**$56**	**$65**

In addition to the financing structure for new NC Health Works costs, other changes to the current Medicaid program are made in the bill to align with NC Health Works. The changes are described briefly below and generate savings for the current Medicaid program.

- The cost of extending postpartum coverage, as enacted in S.L. 2021-180, would be reduced with the implementation of NC Health Works, and the bill makes a corresponding reduction in the hospital assessments used to fund the nonfederal share of the postpartum extension.
- A budget provision from S.L. 2021-180 that allows the parents of children placed in the foster care system to retain Medicaid benefits is repealed. The initiative would not be needed with implementation of NC Health Works.

With the savings generated by these changes, NC Health Works nets a small amount of savings for DHHS, as shown in *Table 4.*

Table 4. Impact of NC Health Works

($ in millions)	**FY23-24**	**FY24-25**	**FY25-26**	**FY26-27**
NC Health Works average monthly enrollees	500,100	607,500	660,900	667,600
Total Requirements				
NC Health Works services, including HASP	$4,805	$6,034	$6,729	$6,939
State administration	62	47	47	47
Transfers to county DSSs	48	59	62	63
Medicaid savings	(151)	(155)	(158)	(134)
Requirements Total	**$4,764**	**$5,985**	**$6,681**	**$6,916**
Receipts				
Federal Medicaid receipts	$4,280	$5,381	$6,015	$6,220
Start-up hospital assessment	13	0	0	0
Modern assmts/postpartum component	(27)	(28)	(29)	(22)
Transfer from HAR SF	517	649	720	742
Receipts Total	**$4,782**	**$6,002**	**$6,706**	**$6,939**
Net General Fund Savings to State	**$18**	**$17**	**$25**	**$24**

The figures in *Table 4* are based on the following assumptions.

- Enrollment in NC Health Works will begin July 1, 2023 and ramp up over the first 2 years of implementation. After then, enrollment will increase with North Carolina population growth (approximately 1% per year).
- HASP reimbursements for NC Health Works will phase up with enrollment to reach $1.2 billion annually. Like HASP payments for the current Medicaid population, reimbursements will be made quarterly based on utilization from the second prior quarter and directed payments to PHPs will include a 2% add-on to the reimbursements to enable PHPs to pay the gross premiums tax on the payments they receive.

Section 1.2 of the bill requires termination of NC Health Works if the federal contribution for NC Health Works coverage drops below 90% or if the nonfederal share of the cost of NC Health Works cannot be fully funded through the sources identified in the bill. If either of these scenarios occur, then coverage would end as expeditiously as possible. DHHS would report to the Joint Legislative Oversight Committee on Medicaid annually on the nonfederal share of the cost of NC Health Works coverage compared to the funding available from sources identified in the bill.

Gross Premiums Tax Revenue

Separate from the budgetary impact on DHHS, HASP and NC Health Works would also impact General Fund revenue collected through the gross premiums tax. Medicaid payments to PHPs are taxed at 1.9%, the same tax rate used for the premiums paid to other insurance providers in the State. With the additional HASP directed payments and the new managed care population from NC Health Works, total Medicaid payments to PHPs would increase significantly. While the additional revenue collected from Medicaid PHPs would be partially offset by the loss of revenue

from some commercial insurers who would lose clients to NC Health Works, an overall increase in gross premiums tax collections is anticipated. The additional revenue associated with NC Health Works would be appropriated to DHHS to deposit in HAR SF, while the portion of gross premiums tax collections related to HASP would represent additional unassigned General Fund availability.

Based on the assumptions in this memo, HASP payments are expected to generate $90 million to $100 million annually once they reach a steady state. FY 2023-24 and FY 2024-25 gross premiums tax revenue could be higher due to the timing of collections. The projected net increase in General Fund revenue is shown in *Table 5*.

Table 5. NC Health Works and HASP Gross Premiums Tax Impact

($ in millions)	**FY23-24**	**FY24-25**	**FY25-26**	**FY26-27**
Gross Premiums Tax/GF Revenue	$124	$185	$175	$171
GF appropriation to DHHS to deposit in HAR SF	0	(46)	(86)	(76)
Net Increase in General Fund Availability	**$124**	**$139**	**$89**	**$95**

Disproportionate Share Hospital (DSH) Payments

Federal disproportionate share hospital (DSH) funding is used to support hospitals that serve higher proportions of uninsured and Medicaid patients. If HASP or NC Health Works is implemented, hospitals in North Carolina will not be eligible for as much DSH funding as they currently receive. Any reduction in hospital DSH payments would be replaced with increased hospital reimbursements from Medicaid, but the State would lose $43 million that it currently uses to support the rest of the Medicaid program. In response, the Health Advancement Assessments structure collects an additional $43 million annually from hospitals. Unlike other Health Advancement Assessments revenue, this funding would not be deposited in HAR SF and would instead be used by the Medicaid program in place of the federal DSH receipts.

6% Medicaid Assessment Limit

Federal law prohibits states from taxing providers more than 6% of net patient revenues for use in generating a federal Medicaid match. The combination of hospital assessments used in this bill to fund HASP and NC Health Works would likely put the State very close to the 6% limit within a few years. If the combination of assessments would result in the State exceeding the cap, HASP payments to hospitals would be decreased to account for the amount of nonfederal funds available within the 6% limit. The State's current Modernized Hospital Assessments and the assessments needed to fund the non-HASP costs of NC Health Works would remain unchanged.

Local Impact

County DSSs are responsible for conducting Medicaid eligibility determinations, and their costs would increase with the implementation of NC Health Works. DHHS is directed to use $4.0 million from the October 2023 one-time assessment, and all corresponding federal receipts, to reimburse the counties for costs incurred due to NC Health Works. In addition, factors in the Health Advancement Assessments produce receipts from hospitals that are placed in HAR SF for distribution to counties. Section 1.8 of the bill authorizes use of the federally facilitated

marketplace to make Medicaid eligibility determinations for a temporary period of up to 12 months after NC Health Works coverage begins. The use of the federal marketplace should reduce some of the burden on counties.

The anticipated impact of the bill on counties is shown in *Table 6*. DHHS must report annually on the allocation of funds to the county DSSs.

Table 6. NC Health Works County Impact

($ in millions)	**FY23-24**	**FY24-25**	**FY25-26**	**FY26-27**
Total additional county expenditures	$48	$59	$62	$63
Federal receipts	24	30	31	32
Start-up assessment	4	0	0	0
State receipts from HAR SF	20	30	31	32
Net County Impact	**$0**	**$0**	**$0**	**$0**

Part II. Creating Seamless Workforce Development Opportunities

Section 2.1 of the bill requires the Secretary of the Department of Commerce (Secretary) to develop a plan to create a comprehensive statewide workforce development program. The plan must identify currently existing workforce development programs for unemployed and low-wage workers, the specific labor force needs within the State, particularly in healthcare, and the specific needs of current and potential future workforce development participants. The plan must address job training assistance, career paths and job readiness, job placement, resources for job seekers, recruiting services, and healthcare workforce support, and must include measures to determine the success of the workforce development programs.

By December 1, 2024, the Secretary must report to various committees within the General Assembly on the plan, the workforce needs of North Carolina employers, existing workforce development gaps and opportunities for improvement, workforce training infrastructure and needs, and any cost to the State to implement the plan.

The Department of Commerce houses the Division of Workforce Solutions (DWS). DWS manages a statewide system of workforce programs that prepare North Carolinians for employment, with services for adults, veterans, and youth. DWS is funded through the federal Workforce Innovation and Opportunity Act, Wagner-Peyser Act, and the Trade Adjustment Act. DWS has a budget of $142.9 million and 674.75 FTE.

There is no cost associated with developing the plan per Section 2.1 of the bill. The Department of Commerce can use existing personnel and resources to complete the plan.

Section 2.2 directs DHHS, in collaboration with the Department of Commerce, to develop a referral plan that includes consultation with a workforce development case manager to assist Medicaid and other social service beneficiaries with accessing workforce development services. Section 2.3 requires the DHHS Division of Health Benefits (DHB) to provide Medicaid applicants with information about the Health Insurance Marketplace. Finally, Section 2.4 directs DHB to negotiate with CMS for approval to add work requirements to Medicaid if there is an indication that work

requirements could be authorized. These requirements can be accomplished with existing DHHS staff and resources.

Part III. Certificate of Need Reforms

Part III makes changes to the State's Certificate of Need (CON) requirements. It removes psychiatric beds and facilities, chemical dependency treatment beds and facilities, Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) services for children under age 21 receiving care from home health agencies, and the first $3 million worth of replacement equipment in any health facility from certificate of need review. Individual pieces of equipment in diagnostic centers that exceed a value of $10,000 are exempted up to an aggregate value of $3 million. The changes include indexing the $3 million limit for replacement equipment to inflation.

Effective 2 years after the first HASP payment is made, the section would also exempt ambulatory surgical centers located in a county with a population larger than 125,000 from CON review. Effective 3 years after the first HASP payment is made, Magnetic Resonance Imaging (MRI) machines located in a county with a population larger than 125,000 would also be exempt from CON review.

Applicants for a CON must include an application filing fee with the CON application. The base fee is $5,000 with an additional fee of $0.003 for every dollar of the projected capital cost of the project greater than $1,000,000. The maximum filing fee is $50,000, and the fee is not refundable even if the application is denied.

Collected CON application fees are credited to the General Fund as nontax revenue. To the extent that expansions of health services that currently require a CON application will no longer require one, the changes in Part III will impact nontax revenue. Based on historical data, the net reduction in nontax revenue from each of these changes is estimated in *Table 7*.

Table 7. Projected Loss of CON Fee Revenue

($ in millions)	FY23-24	FY24-25	FY25-26	FY26-27
Net Decrease in General Fund Revenue	**($0.2)**	**($0.2)**	**($0.6)**	**($0.7)**

Note: Fees are based on project cost. The calculations assume that project costs increase by 5% per year due to inflation.

TECHNICAL CONSIDERATIONS

N/A.

DATA SOURCES

DEPARTMENT OF HEALTH AND HUMAN SERVICES; NORTH CAROLINA HEALTHCARE ASSOCIATION; CERTIFICATE OF NEED APPLICATION LOGS.

LEGISLATIVE FISCAL NOTE – PURPOSE AND LIMITATIONS

This document is an official fiscal analysis prepared pursuant to Chapter 120 of the General Statutes and rules adopted by the Senate and House of Representatives. The estimates in this analysis are based on the data, assumptions, and methodology described in the Fiscal Analysis section of this document. This document only addresses sections of the bill that have projected direct fiscal impacts on State or local governments and does not address sections that have no projected fiscal impacts.

CONTACT INFORMATION

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Signed copy located in the NCGA Principal Clerk's Offices