HOUSE BILL 655:
NC Health Care for Working Families.

2019-2020 General Assembly

Committee:	House Health. If favorable, re-refer to Insurance. If favorable, re-refer to Rules, Calendar, and Operations of the House	**Date:**	July 9, 2019
Introduced by:	Reps. Lambeth, Murphy, Dobson, White	**Prepared by:**	Jennifer Hillman and Amy Jo Johnson, Staff Attorneys
Analysis of:	PCS to First Edition H655-CSMRa-7		

OVERVIEW: Part I of H655 directs the Department of Health and Human Services (DHHS) to design and implement the NC Health Care for Working Families program to provide coverage to certain individuals who are currently ineligible for Medicaid and unable to afford health insurance.

Part II of H655 establishes and appropriates funding to the Rural Access to Healthcare Grant Fund in DHHS's Office of Rural Health to be used to address the health care needs of citizens living in rural areas of the State through the Rural Access to Healthcare Grant Program.

BILL ANALYSIS:

Part I: NC Health Care for Working Families

Section 1 states the General Assembly's intent to facilitate the design of a health care program that addresses the needs of North Carolinians committed to a healthy lifestyle who are currently ineligible for Medicaid and unable to afford health insurance. This section directs DHHS to design the NC Health Care for Working Families program based on the requirements set forth in **Part I** of the PCS. The requirements for the program design include:

- To be eligible, a program participant must be between the ages of 19 and 64, meet federal citizenship and immigration requirements, have income that does not exceed 133% of the federal poverty level, be ineligible for Medicaid under North Carolina's current Medicaid program, and not be covered by Medicare, as described in **Section 2**.
- The program shall cover health care benefits under an alternative benefits plan that provides coverage that is similar to the benefits offered by the North Carolina's current Medicaid program, as described in **Section 3**. Benefits shall be managed by Prepaid Health Plans.
- Program participants must pay an annual premium equal to 2% of the participant's annual income, billed on a monthly basis, as described in **Section 4**. A program participant who fails to make the premium contribution within 90 days of its due date will be suspended from participation in the program, but may have coverage reactivated upon payment of the previously unpaid premiums. Program participants must pay copayments comparable to the current Medicaid copayments, as described in **Section 5**.
- A program participant who meets any of the following criteria is exempt from the premium contribution requirement: has income below 50% of the federal poverty level, is experiencing a

medical or financial hardship, is an Indian Health Services beneficiary, or is a veteran in transition but actively seeking employment, as described in **Section 4**.

- Requires preventative care and wellness activities to be established by DHHS, as described in **Section 5**.
- Requires employment activities for program participants, to be established by DHHS, that adhere to federal guidance and are aligned with the work requirements of the Able-Bodied Adults Without Dependents policy under the Supplemental Nutrition Assistance Program (formerly Food Stamps), as described in **Section 5**. Individuals who are exempt from the employment activities are as follows:
  - Individuals caring for a dependent minor child, an adult disabled child, or a disabled parent.
  - Individuals who are in active treatment for a substance abuse disorder.
  - Individuals determined to be medically frail or with an acute medical condition that would prevent the individual from complying with the employment requirements.
  - Pregnant and post-partum women.
  - Indian Health Services beneficiaries.
  - Any other category of individuals required to be exempt by the Centers for Medicare and Medicaid Services (CMS).
- The program shall be built on defined measures and goals for risk-adjusted health outcomes, quality of care, patient satisfaction, access, and cost, and shall be subject to accountability measures and penalties, as described in **Section 6**.

Funding for the NC Health Care for Working Families program will come from federal funds, program participant contributions, intergovernmental transfers, gross premiums tax revenue, and receipts from an additional hospital assessment, as described in **Section 7**.

The NC Health Care for Working Families program will begin July 1, 2020, or 120 days after approval by CMS, whichever is earlier, under **Section 8**.

Section 9 directs that the program be terminated or not implemented under certain circumstances, including if the program approved by CMS does not substantially comply with the requirements of the bill, if funding is inadequate, of if the federal funding percentage for services costs is less than 90%.

Section 10 requires DHHS to submit a report on the program design to the Joint Legislative Oversight Committee on Medicaid and NC Health Choice by October 1, 2019.

Part II: Rural Access to Healthcare Grant Fund

Section 11 establishes the Rural Access to Healthcare Grant Fund under G.S. 108B-31 as a special fund in DHHS to be used to support the Rural Access Healthcare Grant program, established under G.S. 108B-32. This section directs the Director of the Budget include the following appropriations to the Grant Fund in the base budget:

- For the 2020-2021 fiscal year, $25,000,000.
- For the 2021-2022 fiscal year, $30,000,000.
- For the 2022-2023 fiscal year and every fiscal year thereafter, $50,000,000.

These appropriations are intended to represent a portion of the amount of revenue from the gross premiums tax that is attributable to capitation payments received by prepaid health plans as a result of the implementation of the NC Health Care for Working Families program required by **Part I** of the PCS.

Under the Rural Access to Healthcare Grant program, eligible applicants could apply for a grant, not to exceed $1,000,000, for the following activities:

- Health care provider recruitment to rural areas of the State.
- Loan forgiveness programs or activities for providers practicing in rural areas of the State.
- Rural health care provider retention incentive programs.
- Expansion of telehealth into rural areas of the State.
- Programs that enhance and modernize medical technology utilized in rural areas of the State.
- New clinical patient services for patients in rural areas of the State.
- Activities that address and combat the abuse of opioids by citizens in rural areas of the State.
- Infant mortality reduction efforts.
- Modernization of health information technology systems in rural areas of the State.
- Expansion of mental health services into rural areas of the State, including crisis services.

In determining grant awards, the Office of Rural Health must consider the availability of funds for the applicant, the incidence of poverty in the area addressed by the grant, and the number of individuals impacted by the grant. Grant recipients must report annually on health outcomes. Recipients of grant funds may reapply for additional grants annually but are limited to a reapplication period of five years from the date the first grant award was made to the recipient.

EFFECTIVE DATE: Sections 1 through 12 of the bill are effective only if H966 (the 2019 Current Appropriations Act) becomes law. The remainder of the bill is effective when it becomes law.