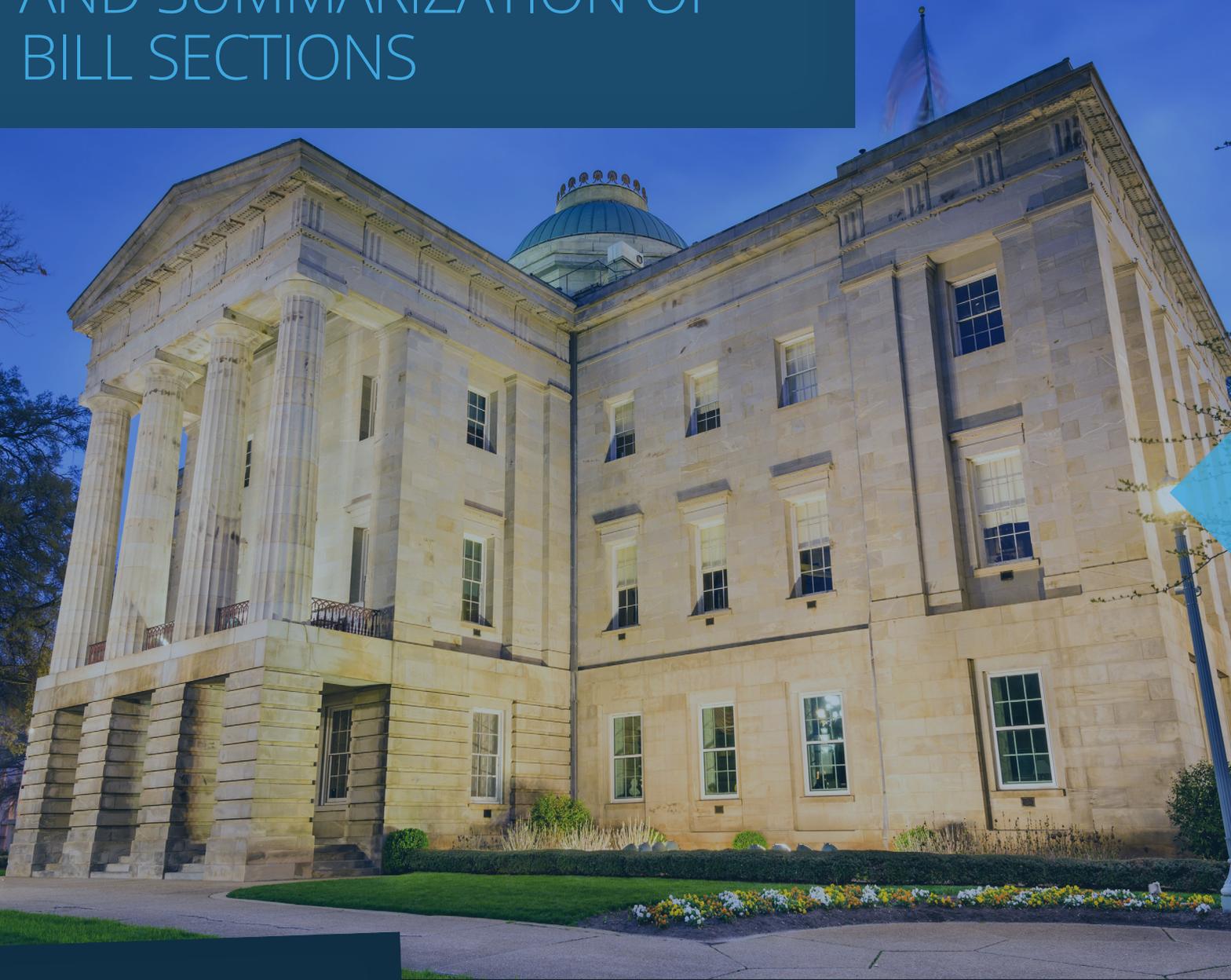


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HOUSE BILL 149, TAKEAWAYS AND SUMMARIZATION OF BILL SECTIONS



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Introduction

On June 2nd, 2022, the North Carolina Senate voted 44-2 to pass House Bill 149 Expanding Access to Healthcare. While H.B. 149 has gotten significant media coverage related to the Medicaid expansion component, the bill includes several significant changes that will impact state health policy and the business of health in North Carolina. H.B. 149 is composed of five sections: Medicaid expansion, work requirements for certain beneficiaries, certificate of need reform, modernization of nursing regulations, and health insurance reforms.

This CBOH Insight will break down each section of H.B. 149. While Medicaid expansion is vitally important for the state and has received the most attention, we will highlight important takeaways and provide context for why specific sections of the bill remain contentious for both consumers and providers of healthcare services.

Part I: Medicaid

What is Medicaid expansion?

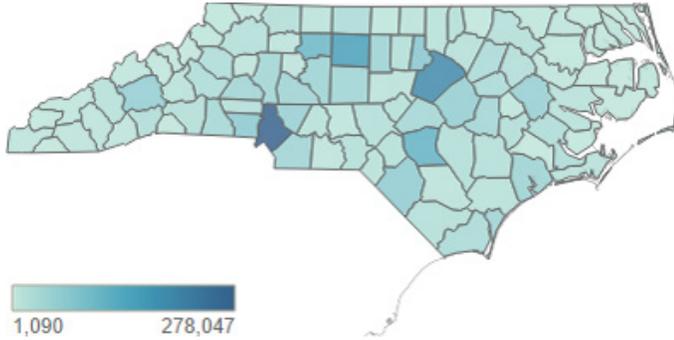
The Affordable Care Act (ACA) included sections concerning Medicaid expansion. Medicaid is now available to individuals with incomes up to 138% of the Federal Poverty Level (FPL). This is approximately \$17,900 per individual. As of 2022, 39 states had adopted Medicaid expansion.¹

What is Medicaid and what is NC Medicaid?

Medicaid is both a federal and state program that aids in covering healthcare costs for low-income and limited resource individuals. As of June 2022, North Carolina Medicaid had 2,804,809 individuals enrolled to receive services. Figure 1 shows current Medicaid enrollment across NC by county. Approximately 20% of current enrollees reside in the most populous counties in North Carolina: Mecklenburg, Wake, and Guilford. Upper range estimates show up to 600,000 new individuals will be eligible for Medicaid due to H.B. 149; this is approximately a 20% increase in current enrollment.

¹ <https://www.kff.org/medicaid/issue-brief/status-of-state-medicaid-expansion-decisions-interactive-map/>

Figure 1



Takeaways

- The Medicaid expansion will be funded by the State in part through adjustments to the current hospital assessment. Hospital assessments are a fee imposed on hospitals (exempt are critical access and State-owned/operated hospitals).
 - Each hospital licensed in North Carolina is subject to a fee of 0.044% of its hospital costs.
 - Starting January 1st, 2023, the fee is 0.539% of hospital costs.
 - Starting July 1st, 2023, the fee is 0.555% of hospital costs.
- Assessment fees are used to reimburse county departments and their social services for additional costs incurred during the determination of eligibility for new individuals.
- If the State cannot fund the expanded coverage, the Department of Health and Human Services (DHHS) can end the expanded coverage immediately.
- Each October the DHHS will generate a new annual report, starting in 2024, for legislative oversight, budget, and fiscal research purposes.
- Increased Medicaid reimbursement to hospitals will not go into effect until the General Assembly ensures the increased hospital assessment fully funds the State's portion of the expanded access.

Part II: Work Requirements for Certain NC Health Works Beneficiaries

What are work requirements for Medicaid?

Certain states have included in their Medicaid expansion bills a section that requires individuals to meet certain work requirements in order to be eligible for services. This has been a long-standing partisan debate in North Carolina. Previous Medicaid expansion attempts in 2017 and 2019 included work requirement mandates. Some NC representatives have stated inclusion of work requirements for Medicaid expansion is necessary for their support. While work requirements had previously been imposed by several states, a January 2021 federal executive order initiated a review of all 13 previously approved state work requirement waivers. The Centers for Medicare and Medicaid Services (CMS) are responsible for approving work requirement waivers, and subsequently after the January 2021 executive order all waivers were withdrawn by CMS. The current administration continues to block work requirements for Medicaid expansions, and in April 2022 the U.S. Supreme Court stated it will not review the arguments and appeals by the states that had tried to impose work requirements via waiver.²

There are arguments that work requirements limit and cause loss of access to Medicaid. Proponents of work requirements suggest expansion without work requirements disincentivizes recipients to pursue jobs. Proponents also suggest working can lead to improved health outcomes. Inversely, those opposed to work requirements believe these policies could prevent access

to coverage by those unable to work. Work requirements remain a contentious aspect of Medicaid expansion, and it is likely laws and regulations will change yearly depending on the current administration.

Takeaways

- H.B. 149 currently includes work requirements.
- Those exempt from work requirements include individuals who:
 - Have been certified unfit for employment for physical or mental reasons.
 - Those whose disability significantly impairs their ability to perform daily activities of living.
 - Those in substance abuse and rehabilitation programs.
 - Parents or caretakers of a dependent child <1 year old.
 - Parents or caretakers with a dependent child with a serious medical condition or disability.
 - Participants of NC HIPP.
 - Inmates of a prison.
- H.B. 149 acknowledges that DHHS of NC must submit a waiver to CMS in order to implement a work requirement. While the bill acknowledges work requirements may not be approved by CMS, the DHHS will continue to “monitor developments on the federal level” in order to impose work requirements in order for individuals to receive Medicaid.

² <https://www.kff.org/medicaid/issue-brief/an-overview-of-medicaid-work-requirements-what-happened-under-the-trump-and-biden-administrations/>

Part III: Certificate of Need Reform

What is a certificate of need?

A certificate of need (CON) is a legal document that is often required in order to create or expand healthcare services and facilities. Federally, CON program requirements ended in 1987, but more than 35 states still have CON laws in effect. An example of CON in practice would be if a county in North Carolina wants to build a new hospital, it must seek approval and receive a certificate of need showing that its locale needs a new hospital either due to a lack of current resources or due to increasing demand. Traditionally, the goal of certificate of need programs is to ensure equal and equitable distribution of health services across a geographic location.³ In limiting construction of facilities too close in proximity to each other, CON laws aim to ensure the spread of facilities across a state to ensure access is available for more individuals than if all facilities were in one location.

There are many arguments for and against certificate of need reform. Eliminating certificates of need for certain types of healthcare services opens the door for competitors to enter a market where they may have been previously restricted from operating. For example, a rural nonprofit hospital may be the only facility with an ambulatory surgery center. If certificate of need reform eliminated ambulatory surgery centers from requiring a certificate of need to open (as is the case in H.B. 149), then new surgery center competitors could enter the region and provide their services near the rural hospital's surgery center.

A retrospective review that analyzed patient mortality data after Pennsylvania's CON law expired in 1996 found that mortality rates actually decreased.⁴ Additionally, other studies have found coronary surgery mortality rates decreased across multiple states when CON laws were removed.⁵ In addition to patient outcome effects, those in favor of eliminating CON laws express that this potentially allows for more options as a healthcare consumer.

Others, including many hospital systems, argue that elimination of certificates of need for certain services would negatively impact their margins and revenue streams, which would adversely impact the ability to provide to the communities they serve.⁶ This may be a particularly impactful change for rural hospitals whose highest-margin services may no longer be protected by the certificate of need regulatory approval process. A 2022 brief by the NC Rural Health Research Program found that "rural hospitals with long-term unprofitability are in particular vulnerable to shifts in the economy and demography of their markets as well as to state and federal policy changes."⁷ Rural hospitals that already suffer from low patient volume or lack of outpatient diagnostic and surgical services may find it difficult to compete with new market entrants in their region that provide similar services.

3 <https://info.ncdhhs.gov/dhsr/coneed/index.html>

4 <https://www.sciencedirect.com/science/article/abs/pii/S2211883719300607>

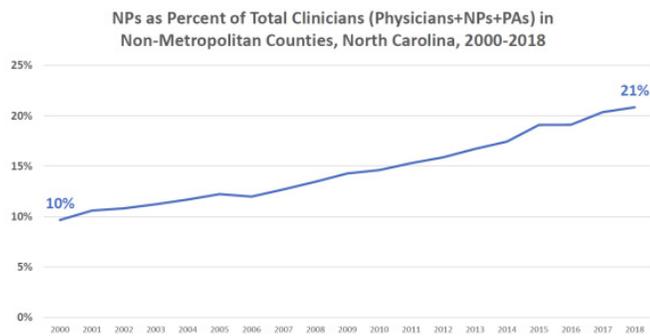
5 <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2677050/>

6 <https://www.ncha.org/2022/06/ncha-statement-on-nc-senate-vote-passing-h149/>

7 https://www.shepscenter.unc.edu/wp-content/uploads/dlm_uploads/2022/03/Rural-Hospital-Profitability-during-the-Global-COVID-19-Pandemic-Requires-Careful-interpretation.pdf

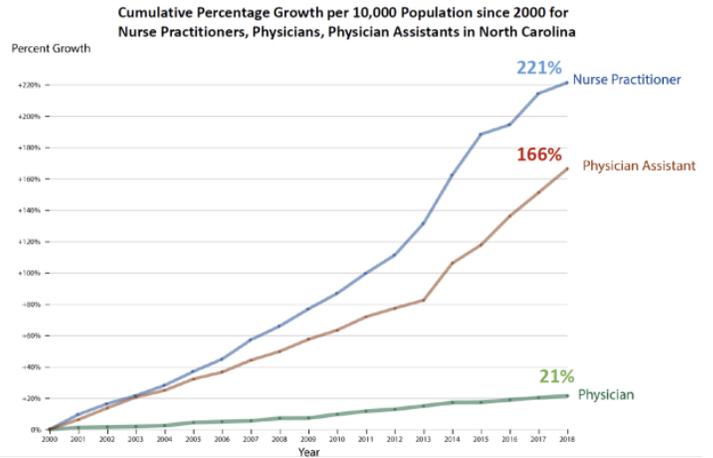
outcomes.⁸ Proponents for granting NPs full practice authority state NPs would be able to fill increasing rural demands for access to healthcare providers without any negative impact on patient outcomes.⁹ Shown in Figure 3, NPs make up an increasing percentage of the health workforce in rural communities. The NP workforce has also seen rapid growth compared with physician growth in NC (Figure 4). Additionally, studies have shown that when SOP laws are relaxed, NPs bill for more services, leading to potential cost savings given that reimbursement rates for NP services are lower than physician services.¹⁰ Prior attempts to pass full practice authority legislation for NPs have been struck down multiple times over the years in NC, often lobbied against by physician groups.

Figure 3



Notes: Data include active, licensed professionals in practice in North Carolina as of October 31 of each year. Data are derived from licensure data from each profession's licensing board. County estimates are based on primary practice location. Metro and nonmetro delineations are from the United States Office of Management and Budget and applied to Census data. According to the 2017 version of the delineation file, which is used for this analysis, North Carolina had 54 nonmetro (rural) counties.

Figure 4



Takeaways

- Whenever a statute or agency requires a medical/physical examination by a physician, the examination can be conducted by an NP without a physician being present.
- The “practice of nursing” consists of collaborating with other healthcare providers in determining the appropriate healthcare for a patient. This subsection removed language that describes prescribing, determining a treatment regimen, and making a diagnosis under the supervision of a licensed physician.
- Oversight of APRNs will be under the Board of Nursing and not dually regulated by the Medical Board and Board of Nursing.

8 [https://www.nursingoutlook.org/article/S0029-6554\(15\)00268-7/fulltext](https://www.nursingoutlook.org/article/S0029-6554(15)00268-7/fulltext)

9 [https://www.nursingoutlook.org/article/S0029-6554\(15\)00268-7/fulltext](https://www.nursingoutlook.org/article/S0029-6554(15)00268-7/fulltext)

10 <https://onlinelibrary.wiley.com/doi/abs/10.1002/heh.4438>

Part V: Health Insurance Reforms

Health insurance reforms within H.B. 149 primarily focus on billing transparency, telehealth access, and consumer protections. The billing transparency components take effect January 1st, 2023, while the telehealth and consumer protections become effective October 1, 2022.

During the COVID-19 pandemic, shifting toward telehealth became vital and necessary for patients and providers. With this shift, many healthcare consumers post-COVID now prefer telehealth options. Per a JAMA Network Open study examining post-COVID preferences, 66.5% of those surveyed preferred to have video as an option for receiving their care. However, when given a choice between in-person and telehealth, approximately 53% preferred an in-person visit.¹¹ Those who had a preference for telehealth options were more sensitive to out-of-pocket expenses. With the reform bill aiding billing transparency efforts, this may continue to shift the percentage of consumers who feel comfortable seeking care via telehealth.

Takeaways

- If an individual is using an in-network health service and has an appointment, the facility has to give at least 72 hours' advance written notice if any out-of-network providers or services might be used.
- If out-of-network services are being rendered, an estimated cost is required.

Telehealth

- An insurer cannot exclude coverage for a service or procedure solely because the service was not provided in-person.
- Insurers are not required to cover out-of-network telehealth services.
- Prior to providing telehealth services, the provider must provide an estimated cost of care.
- Creation of a saved recording of all telehealth encounters is required.

What's Next?

Now that the North Carolina Senate has approved the bill, it will be sent to the North Carolina House for approval. While the House has not voted on H.B. 149, the House did pass S.B. 408 on June 28th, 2022. S.B. 408 seeks to establish a joint committee that will provide recommendations and guidance for a Medicaid expansion plan by December 2022. If there are no delays during this process and the bill receives House approval and is signed into law, the expanded coverage will begin by July 1st, 2023.

S.B. 408, which passed the House on June 28th, did not include Medicaid expansion in the budget discussions. As of July 19th, 2022, Medicaid expansion has not been included in the state fiscal year budget proposals.

¹¹ <https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2786700>

Figures

- 1.** Dashboards | NC Medicaid (ncdhhs.gov)
- 2.** <https://www.aanp.org/advocacy/state/state-practice-environment>
- 3.** Program on Health Workforce Research and Policy - Sheps Center (unc.edu)
- 4.** Program on Health Workforce Research and Policy - Sheps Center (unc.edu)

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