NORTH CAROLINA GENERAL ASSEMBLY

2025 Session

Legislative Fiscal Note

Short Title: Affordability in Healthcare Act.
Bill Number: House Bill 1175 (First Edition)
Sponsor(s): Rep. Cervania, Rep. Crawford, Rep. Ball, and Rep. Belk

SUMMARY TABLE

FISCAL IMPACT OF H.B. 1175, V.1 ($ in millions)

	FY 2026-27	FY 2027-28	FY 2028-29	FY 2029-30	FY 2030-31
State Impact					
General Fund Revenue	-	- to -	- to -	- to -	- to -
Less Expenditures	213	139 to 203	139 to 203	139 to 203	139 to 203
General Fund Impact	**(213)**	**(139) to (203)**	**(139) to (203)**	**(139) to (203)**	**(139) to (203)**
NET STATE IMPACT	**(213)**	**(139) to (203)**	**(139) to (203)**	**(139) to (203)**	**(139) to (203)**

FISCAL IMPACT SUMMARY

Parts I and II of H.B. 1175 establish the North Carolina Low-Cost Health Plan Option and the Public Health Purchasing Consortium to be implemented by multiple agencies. Part III appropriates $25 million recurring and $10 million nonrecurring to implement the Low-Cost Health Plan Option and the Consortium. Once established, the Low-Cost Health Plan shall be supported by member premiums and should have no further fiscal impact on the State.

Part IV continues and expands the Healthy Opportunities Pilots (HOP) program, which addresses health-related social needs to reduce avoidable healthcare utilization and prevent chronic disease. Section 4.1(a) appropriates $175 million recurring from the General Fund and associated federal receipts in FY 2026-27 to the Department of Health and Human Services (DHHS), Division of Health Benefits (DHB), for this purpose. Previously, independent actuaries linked FY 2023-24 HOP spending to a reduction in Medicaid capitation rates in FY 2024-25, which indicates possible savings from this appropriation beginning in FY 2027-28, but this analysis does not assume future savings at the same rate.

Part V establishes a civil penalty for hospitals and ambulatory surgical facilities that fail to comply with pricing transparency and reporting requirements. Revenue generated from this penalty is required by the North Carolina Constitution to be deposited into the Civil Penalty and Forfeiture Fund and therefore would result in no direct General Fund impact.

Part VIII restricts facility fee billing by hospitals and ambulatory surgical facilities and establishes reporting and penalty provisions for noncompliance. This may affect State expenditures if the

State Health Plan and Medicaid currently pay facility fees for services that would no longer be billable under the new restrictions and may generate penalty revenue for the Civil Penalty and Forfeiture Fund from noncompliant providers; however, the fiscal impact cannot be estimated because current billing data does not separately identify facility fee components as defined in the bill.

Part IX requires the Office of State Auditor (OSA) to report on the price transparency of health service facilities who receive State funds. OSA should be able to produce this report using available staff; therefore, this section has no fiscal impact on the State.

Part XI-A amends the definitions in G.S. 131E-176 to remove inpatient rehabilitation facilities, services, and beds from the Certificate of Need (CON) regulatory framework, which would have no direct fiscal impact on the State.

Part XI-B amends G.S. 131E by adding Article 9B, which creates a set of requirements applying to providers of essential rural health services. The requirements center around DHHS managing the viability of essential rural health services through the oversight of providers and by taking actions authorized by the Article. A low-end estimate for the cost to carry out the requirements in this Article is $2.6 million recurring.

Part XIII directs the State Auditor, Attorney General, and State Treasurer to review ownership transactions of hospital entities and establishes a fee on acquiring entities to support the review of each proposed transaction. The fee is sufficient to support the review process. No additional fiscal impact on the State is expected.

FISCAL ANALYSIS

Part I. Low-Cost Health Plan Option

Part I of H.B. 1175 directs DHHS, in consultation with the State Treasurer, to establish and administer the Low-Cost Health Plan Option, a health insurance plan meeting certain affordability standards as defined in the bill. The Low-Cost Health Plan Option shall be offered statewide on the Federally Facilitated Marketplace (health benefit exchange website) beginning in 2028. Section 3.2 appropriates $25 million recurring for DHHS to employ one or more participating carriers or a third-party administrator for this purpose. Once established, the Low-Cost Health Plan Option shall be financed primarily through premiums, however DHHS may request additional appropriations for start-up costs, systems integration, actuarial services, and procurement expenses as outlined in the bill. This analysis concludes that the initial appropriation and the collection of premiums should be sufficient to establish this program. There is no additional expected fiscal impact on the State to support the Low-Cost Health Plan Option.

Part II. Public Health Purchasing Consortium

Section 2.1 establishes the Public Health Purchasing Consortium to coordinate, aggregate, and strategically align the healthcare purchasing power of public entities in North Carolina. The State Treasurer shall chair the consortium which will include representatives from the following:

- The Department of Health and Human Services,
- The Department of Insurance,
- The Office of State Human Resources,
- The University of North Carolina System,
- The North Carolina Community College System,
- A representative of another public entity designated by the chair.

The Consortium shall use the $10 million nonrecurring appropriated in Section 3.2 to establish a secure data sharing framework for claims, encounter, and pharmacy data among public purchases for analytics, fraud detection, payment reform, and evaluation of procurement performance. Using this data, within HIPAA and State privacy laws, the Consortium shall submit an annual report to the Joint Legislative Oversight Committee on General Government and the Joint Legislative Oversight Committee on Health and Human Services detailing its activities, savings estimates, procurement outcomes, and statutory or budget recommendations. The initial appropriation of $10 million nonrecurring should be sufficient for establishing the data sharing framework needed for the Consortium to produce its annual report indefinitely, therefore the Consortium is not expected to have any additional substantial and recurring costs for the State.

Part IV. Healthy Opportunities Pilots

Section 4.1(a) appropriates $175 million in recurring funds and associated receipts to DHB for the 2026-27 fiscal year to resume HOP. Prior to the 2025 discontinuation of HOP, DHB's contracted actuary (Mercer Government) linked HOP spending to reductions in Medicaid capitation rates in a subsequent fiscal year, reflecting fewer emergency department visits and hospitalizations among participants. Specifically, approximately $80 million in HOP spending in FY 2023-24 was linked to a $45.5 million reduction in Medicaid managed care Standard Plan capitation rates in FY 2024-25 (both numbers inclusive of federal and nonfederal shares). Scaling this relationship proportionally and adjusting for the State's current Federal Medicaid Assistance Percentage (FMAP), the $175 million net General Fund appropriated under this section, paired with federal matching receipts, would suggest potential offsetting net General Fund savings to Medicaid of approximately $63.9 million beginning as early as FY 2027-28.

This analysis includes a range of the anticipated costs of Part IV, with the low end incorporating $63.9 million net General Fund savings per year, beginning in FY 2027-28, and the high end incorporating no General Fund savings from HOP. There are several reasons for including the possibility of no savings. HOP program authorizations ended in FY 2024-25, effective July 1, 2025, interrupting the spend-to-savings relationship reflected in the FY 2024-25 capitation adjustment; the effect of resuming the program after this gap on that relationship is unknown. The appropriation for HOP under this section is substantially larger than the appropriation in any year prior to FY 2026-27 and would likely extend the program to additional counties and populations. It is not guaranteed that prior results would scale proportionally to a larger, broader program in areas with no history of HOP spending on services or infrastructure. Finally, the pairing of FY 2023-24 HOP spending to FY 2024-25 capitation rate savings is the only documented instance of this relationship to date, and whether this pattern would continue, grow, or plateau over additional years of operation cannot be determined from the data currently available.

A one-time, nonrecurring appropriation for HOP of $9 million from the General Fund, plus associated receipts, for FY 2026-27 was separately enacted under S.L. 2026-41, 2026 Appropriations Act. The relationship between that appropriation and this section, including whether the two would overlap or duplicate funding for the same fiscal year, is unknown and would depend on the implementation strategy of DHB.

Part V. Greater Transparency in Hospital and Ambulatory Surgical Facility Healthcare Costs

Section 5.1 of the bill enacts G.S. 131E-214.18, which authorizes a civil penalty of not less than 0.01% of a facility's CEO's annual salary or no more than $2,000 per day of violation if that facility fails to comply with pricing transparency and reporting requirements. Proceeds of any penalty assessed are remitted to the Civil Penalty and Forfeiture Fund under G.S. 115C-457.2. Three variables required for an estimate are unknown: the number of facilities that will fail to comply, the number of days any individual violation will continue before correction, and where within the statutory range an assessed penalty would fall. In addition, because the penalty is intended to deter noncompliance rather than generate revenue, current rates of noncompliance would not provide a reliable basis for projecting future penalty amounts under the new requirement.

Part VIII. Greater Protection for Healthcare Consumers from Facility Fees

Part VIII restricts facility fee billing by hospitals and ambulatory surgical facilities and establishes reporting and penalty provisions for noncompliance. The bill's expenditure impact prohibiting facility fees cannot be determined for Medicaid. Medicaid claims data does not separately itemize a facility fee component as would be defined in G.S. 131E-214.54(a)(3) (created by Section 8.1 of the bill); facility costs are typically included within a bundled claim amount rather than billed as a distinct line item. Without this breakdown, Fiscal cannot reliably estimate the portion of current Medicaid expenditures, if any, that would be affected by the restriction. To the extent that these fees are being charged, removing them would result in a reduction in Medicaid expenditures. However, there is likely a one-time cost associated with adapting NC Tracks, the Medicaid billing system, to implement the changes required by the bill.

The bill also authorizes an administrative penalty of not more than $1,000 per occurrence for violations of the facility fee restrictions, in addition to the civil penalty of up to $5,000 per violation available under G.S. 75-15.2 for unfair or deceptive trade practices, for potential total exposure of up to $6,000 per violation. Proceeds of any penalty assessed are remitted to the Civil Penalty and Forfeiture Fund under G.S. 115C-457.2. This provision has a potential revenue impact that cannot be determined, because three variables required for an estimate are unknown: the number of health care providers that will fail to comply, the number of occurrences per provider, and the amount that would be assessed per occurrence, up to the statutory cap. In addition, because the penalty is intended to deter noncompliance rather than generate revenue, current rates of noncompliance would not provide a reliable basis for projecting future penalty amounts under the new requirement.

Part IX. State Auditor Review of Health Service Facility Prices

Section 9.1 directs the State Auditor to review health service facilities which receive State funds and report findings on the transparency of their prices beginning April 1, 2027, and periodically

thereafter. This work will initially require significant staff time but is not entirely a new responsibility of the Office of State Auditor (OSA) since G.S. 147-64.6(c)(24) allows the Auditor to audit or investigate any publicly funded entity. Any audit or investigation would result in a written product much like the report required in Section 9.1. After the first report is due, OSA may choose when to submit reports based on staff availability and workloads. Given the flexibility of the language after the first report, no additional full-time OSA staff should be needed to fulfill this requirement. OSA should be able to use existing staff or hire temporary staff with existing funds to complete the first report due April 1, 2027.

Part XI-A. Elimination of Certificate of Need Review for Inpatient Rehabilitation Services, Rehabilitation Facilities, and Rehabilitation Beds

Part XI-A amends the definitions in G.S. 131E-176 to remove inpatient rehabilitation facilities, services, and beds from the Certificate of Need (CON) regulatory framework, which would have no direct fiscal impact on the State. However, it should be noted that S.L. 2026-41, 2026 Appropriations Act, exempted these facilities, services, and beds from CON review, thus the enactment of this section would not result in any substantive changes from current law.

Part XI-B. Essential Rural Health Services Protection

Part XI-B amends G.S. 131E by adding Article 9B, which creates a set of requirements applying to essential rural health services (ERHS), a term which this Article defines as various health services when provided in a rural county or otherwise necessary to maintain access to residents of a rural county.

This provision requires providers of ERHS to notify DHHS of any plans to implement a material change affecting ERHS at least 120 days before the change is effective. DHHS must determine within 60 days, or 90 if DHHS provides written notice to the provider, how the proposed change would impact the accessibility of ERHS, and either issue a written notice that no further action is required, approve the change subject to the completion of a mitigation plan, or prohibit the change. If a proposed change involves a hospital or hospital authority, the provision requires DHHS to provide an opportunity for public comment. Any provider subject to a mitigation plan under this Article is required to file annual reports with DHHS for no more than 5 years, and DHHS must report annually to the NCGA regarding all notices, determinations, mitigation plans and other actions, and on observed effects on access to ERHS.

This provision also directs DHSS to measure the financial status of ERHS providers, and gives DHHS the authority to impose reporting requirements, mitigation plans, or other actions on providers if DHHS determines the financial status of providers risks impairing the viability of continued access to ERHS. Furthermore, this provision prohibits any operational practice that materially undermines a provider's ability to maintain ERHS.

For any violation of a requirement of this Article, including those of an order or implementation plan issued by DHHS, then DHHS may assess a civil penalty not to exceed $10,000 per day, the proceeds of which shall be sent to the Civil Penalty and Forfeiture Fund.

A reference point for estimating the cost for DHHS to carry out the functions described in Article 9B is DHHS's Healthcare Planning and Certificate of Need (HPCON) Section under the Division of Health Service Regulation (DHSR). The HPCON Section, with a current authorized budget of $2.6 million, most of which is for costs related to its 20 full-time equivalent positions, is responsible for regulating the expansion of certain health services as a means of curbing excessive healthcare cost growth. This entails reviewing applications to expand certain health services, deciding to approve or deny them, and monitoring post-decision compliance—similar tasks to what Part XI-B would require DHHS to carry out.

While the tasks are comparable, what might not be is the magnitude of the number of proposals DHHS would have to review. The conditions that trigger a notice to DHHS for review under this provision are broader than those for the HPCON Section, and DHHS is also given the task of monitoring the financial viability of providers. Therefore, it is reasonable to assume that the authorized budget for the HPCON section of DHHS, currently $2.6 million, can serve as a low-end estimate of the cost to carry out the responsibilities under Part XI-B of this bill. The bill does not include an appropriation to support this section's estimated costs.

Part XIII. Preservation of Competition in Healthcare

Part XIII directs the State Auditor, the Attorney General, and the State Treasurer to act together in reviewing any transfer or sale of more than 50% of any hospital entity. Before entering into any transaction, hospital entities are to provide written notice to the State Auditor, Attorney General, and State Treasurer of the proposed transaction. Once received, the State Auditor, Attorney General, and State Treasurer are to acknowledge they have received written notice, and a 60-day review period shall begin. During this time, the hospital entity shall hold at least one public hearing on the proposed transaction. The State Auditor, Attorney General, and State Treasurer may also hold a public hearing, the cost of which shall be covered by the parties of the proposed transaction. The State Auditor, Attorney General, and State Treasurer shall review the competitiveness of proposed transaction, may oppose the transaction, and may impose civil penalties on any parties who enter into any transactions without their approval. In making their decisions, the State Auditor, Attorney General, and State Treasurer may impose upon the acquiring entity a fee of up to $50,000 to cover the costs of contracts between the State Auditor, Attorney General, and State Treasurer, the actual costs incurred in contracting experts, and the actual costs incurred in preparing a report. This fee should be sufficient given the proposed quick turnaround of 60 days for a decision. Any opposition to this fee will be grounds for the State Auditor, Attorney General, and State Treasurer to oppose the transaction. As Part XIII creates a fee to support the review of these transactions, there is no expected fiscal impact to the State in this section.

Should hospital entities violate the decision of the State Auditor, Attorney General, and State Treasurer and proceed with the transaction despite their opposition, the State may impose a civil penalty of up to $50,000 on each member of the governing boards and each chief financial officer of the parties to the transaction. If the transaction was made in wanton disregard of the law, the civil penalty may be up to $1 million. Proceedings shall be brought to court by the State Auditor, Attorney General, and State Treasurer. Any revenue generated from this penalty would be deposited into the Civil Penalty and Forfeiture Fund and therefore would result in no General Fund impact.

TECHNICAL CONSIDERATIONS

Part IV. Healthy Opportunities Pilots

North Carolina's FMAP will move to 64.16% on October 1, 2026. While the State's FMAP is adjusted each federal fiscal year by the federal Centers for Medicare & Medicaid Services, this analysis assumes the 64.16% level for the entire five-year analysis and does not project potential future changes in FMAP. As Part IV includes a set appropriation from the General Fund, any decrease in North Carolina's FMAP would result in fewer federal matching dollars for HOP. This lower total spending on HOP would result in a commensurate decrease in potential savings to Medicaid capitation rate spending in the following fiscal year, increasing the high end of the ranges of impacts in the Summary Table beginning in FY 2027-28. Conversely, an increase in the State's FMAP would decrease the high end of the ranges in the Summary Table.

DATA SOURCES

June 2025 BD701 for the Department of Health and Human Services
Mercer Government

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

Questions on this analysis should be directed to the Fiscal Research Division at (919) 733-4910.

ESTIMATE PREPARED BY

Francisco Celis Villagrana, Luke MacDonald, Suma Suswaram, Susie Camilleri, Katherine Tamer

ESTIMATE APPROVED BY

Brian Matteson, Director of Fiscal Research
Fiscal Research Division
September 11, 2026

Official Fiscal Research Division Publication

Signed copy located in the NCGA Principal Clerk's Offices