

119TH CONGRESS
2D SESSION

H. R. 8585

To require the Secretary of Health and Human Services to award grants to support community-based coverage entities to carry out a comprehensive coverage program that provides qualifying individuals and small businesses health coverage and integrated health-related social need services to small business workers that promote improved health, long-term economic self-sufficiency, employment and retention, and for other purposes.

IN THE HOUSE OF REPRESENTATIVES

APRIL 29, 2026

Mr. MOOLENAAR (for himself and Mr. HUIZENGA) introduced the following bill; which was referred to the Committee on Energy and Commerce, and in addition to the Committee on Education and Workforce, for a period to be subsequently determined by the Speaker, in each case for consideration of such provisions as fall within the jurisdiction of the committee concerned

A BILL

To require the Secretary of Health and Human Services to award grants to support community-based coverage entities to carry out a comprehensive coverage program that provides qualifying individuals and small businesses health coverage and integrated health-related social need services to small business workers that promote improved health, long-term economic self-sufficiency, employment and retention, and for other purposes.

1 *Be it enacted by the Senate and House of Representa-*
2 *tives of the United States of America in Congress assembled,*

3 **SECTION 1. SHORT TITLE.**

4 This Act may be cited as the “Community Multi-
5 Share Coverage Program Act of 2026”.

6 **SEC. 2. GRANTS TO ESTABLISH COMMUNITY MULTI-SHARE**
7 **COVERAGE PROGRAMS TO ENABLE SMALL**
8 **BUSINESSES TO PROVIDE AFFORDABLE**
9 **HEALTH COVERAGE AND SUPPORT SERVICES**
10 **TO EMPLOYEES WITH LIMITED INCOME AND**
11 **ASSETS.**

12 (a) IN GENERAL.—Not later than 180 days after the
13 date of the enactment of this Act, the Secretary of Health
14 and Human Services shall award at least 3 and not more
15 than 5 grants to support Community Multi-Share Cov-
16 erage programs. Such programs shall—

17 (1) reduce the number of uninsured individuals
18 through hospital-community partnership initiatives
19 that provide an affordable health coverage option for
20 such individuals and provide a coverage transition
21 for those limited to coverage through government-
22 sponsored programs;

23 (2) promote workforce development for small
24 businesses by addressing the psycho-social barriers
25 that directly impact employment success and create

1 barriers to exiting Medicaid, resulting in better
2 health and workplace success; and

3 (3) support small business economic recovery by
4 allowing small businesses to be competitive in their
5 hiring, and to provide high quality, affordable health
6 coverage to workers who are otherwise hesitant to
7 lose Medicaid eligibility.

8 (b) COMMUNITY MULTI-SHARE COVERAGE PROGRAM
9 REQUIREMENTS.—For purposes of this section, the term
10 “Community Multi-Share Coverage Program” means a
11 program that satisfies each of the following program re-
12 quirements:

13 (1) PHYSICAL PRESENCE IN THE COMMU-
14 NITY.—The program maintains a physical presence
15 within close geographic proximity to the enrollees it
16 is serving, with a focus on mitigating barriers to en-
17 gagement by enabling face-to-face interactions be-
18 tween the program staff, enrollees, and community
19 organizations.

20 (2) HEALTH COVERAGE.—The program pro-
21 vides enrolled qualifying individuals with health cov-
22 erage that satisfies the following:

23 (A) SERVICES COVERED.—Provides cov-
24 erage for the following categories of services

1 when furnished by network providers and com-
2 munity resources:

3 (i) Physician services.

4 (ii) Inpatient and outpatient hospital
5 services.

6 (iii) Behavioral health services, includ-
7 ing services for substance use disorder pre-
8 vention and treatment.

9 (iv) Preventative services.

10 (v) Diagnostic laboratory tests and x-
11 rays.

12 (vi) Prescription drugs.

13 (vii) Emergency ambulance services
14 that are provided by ground transpor-
15 tation.

16 (viii) Emergency services (as defined
17 in section 2719A(b)(2)(B) of the Public
18 Health Service Act (42 U.S.C. 300gg-
19 1719a(b)(2)(B))).

20 (ix) Population health improvement
21 services.

22 (B) COST-SHARING.—Imposes no deduct-
23 ible on covered services provided by network
24 providers and community resources, and limits
25 co-payments for in-network covered services to

1 levels that do not create a barrier to patient ac-
2 cess.

3 (C) NETWORK PROVIDERS.—Establishes
4 agreements with hospitals and health care pro-
5 viders located within the community to provide
6 care for qualifying individuals.

7 (3) COMMUNITY COLLABORATION AND ALIGN-
8 MENT.—The program is carried out in partnership
9 with, or in formal coordination with, an existing
10 community-based collaborative, intermediary, or co-
11 ordinating entity that—

12 (A) has demonstrated experience aligning
13 safety-net health, human service, and work-
14 force-related services within the community;

15 (B) supports the identification of commu-
16 nity-defined needs, priorities, and service gaps
17 through ongoing engagement with community
18 stakeholders; and

19 (C) facilitates coordination among partici-
20 pating health care providers, community-based
21 organizations, employers, and other relevant
22 partners to avoid duplication and promote effec-
23 tive use of community resources.

24 (4) INTEGRATED CONTINUOUS HEALTH IM-
25 PROVEMENT SERVICES.—The program provides, ei-

ther directly or through contract, integrated continuous health improvement services that satisfy the following:

(A) Regular assessments of community factors and resources that potentially impact enrollees' physical, emotional, and economic health.

(B) A community-based planning process to identify and address any negative influences identified pursuant to subparagraph (A), and promote well-being through partnerships and alignment efforts between the community-based coverage entity and—

(i) local small employers;

(ii) entities that provide educational and occupational training (including classes, workshops, mentorships, and apprenticeships) designed to enhance preparation for work and support economic self-sufficiency;

(iii) community health and health-related social need initiatives;

(iv) investors;

(v) local, State, and Federal governmental agencies; and

(vi) organizations described in section 501(c)(3) of the Internal Revenue Code of 1986 that focuses on human service needs relating to physical health, behavioral health, poverty, education, access to health care, and safety.

(C) Individualized assessment of each enrollee to identify any negative influences on their physical, emotional, and economic health, and ability to achieve economic self-sufficiency, which shall include—

(i) an assessment of any of the enrollee's psycho-social barriers, health risks, barriers to long-term employment, and barriers to increasing income; and

(ii) a determination of the enrollee's health domain score, which is a measurement of specific influences of physical, emotional, and financial health with respect to a qualifying individual.

(D) Establishment of an individualized plan to support each enrollee in achieving better health and economic self-sufficiency, which shall—

1 (i) identify community resources that
2 will support the enrollee in improving their
3 physical, behavioral, or economic health,
4 which may include—

5 (I) group classes that address
6 barriers to physical, emotional, and
7 economic health; and

8 (II) educational and occupational
9 training opportunities that enhance
10 work preparedness and support eco-
11 nomic self-sufficiency; and

12 (ii) contain engagement milestones,
13 with a goal of identifying and overcoming
14 obstacles to engagement in personal health
15 improvement and mitigation of root-cause
16 barriers, which shall include—

17 (I) participation in individualized
18 health coaching services to address
19 the enrollee's health-related social
20 needs and to support their physical,
21 emotional, and financial health; and

22 (II) engagement with community
23 resources, such as participating in
24 group classes, as recommended by the
25 health coach.

1 (5) FUNDING STRUCTURE.—

2 (A) IN GENERAL.—The direct costs of the
3 program are shared among the following enti-
4 ties, each of which makes a direct financial con-
5 tribution:

6 (i) The public sector.

7 (ii) Local health care providers.

8 (iii) Enrollees.

9 (iv) Enrollees' employers or skilled
10 trade organizations.

11 (B) SHARED FINANCIAL RESPONSIBILITY
12 AND LONG-TERM SUSTAINABILITY.—The pro-
13 gram shall be structured to support long-term
14 financial sustainability through a shared finan-
15 cial responsibility framework that—

16 (i) relies on coordinated and ongoing
17 contributions from multiple levels of gov-
18 ernment, local resources, and hospital com-
19 munity benefit investment;

20 (ii) avoids dependence on a single
21 funding source by establishing a defined,
22 multi-year transition toward a stable allo-
23 cation of financial responsibility across
24 participating sectors; and

1 (iii) demonstrates measurable
2 progress toward a mature financing struc-
3 ture in which Federal support is supple-
4 mented by sustained contributions from
5 State and local government and hospital
6 community benefit resources.

7 (6) ENROLLEES.—

8 (A) In the event that a Program is unable
9 to provide services to all qualifying individuals
10 in its catchment area, the Program has a pub-
11 licly available written policy for determining
12 which qualifying individuals are offered enroll-
13 ment.

14 (B) The program may rescind a qualifying
15 individual's enrollment due to sustained failure
16 to meet minimum engagement and personal
17 growth thresholds, which shall be participatory
18 and not health-contingent, and provide for rea-
19 sonable alternatives, in their individual plan de-
20 scribed in subsection (b)(2)(D).

21 (7) EVALUATION.—The program formally eval-
22 uates its impact on enrollees' employment status,
23 physical and behavioral health, income, and eco-
24 nomic self-sufficiency.

1 (c) QUALIFYING INDIVIDUAL.—The term “qualifying
2 individual” means an individual who—

3 (1) resides or works within the catchment area
4 of a partner hospital described in subsection
5 (e)(1)(A);

6 (2) subject to any modification made by such
7 program to narrow the income eligibility range, has
8 a household income that exceeds the Medicaid eligi-
9 bility limit applicable to the qualifying individual in
10 their State of residence but does not exceed 400 per-
11 cent of the Federal poverty line applicable to their
12 household size;

13 (3) is not enrolled in a qualified health plan
14 during the 180-day period preceding the date on
15 which such qualifying individual seeks to enroll in
16 the Community Multi-Share Coverage Program, un-
17 less a such coverage is terminated due to a quali-
18 fying special event;

19 (4) is ineligible for enrollment in a Federal
20 health care program, including ineligibility to receive
21 health services through the Indian Health Service or
22 Veterans Administration;

23 (5) works for a small employer which does not
24 offer its employees coverage in a qualified health
25 plan under which the combined premium plus de-

1 ductible cost to cover the employee's household is
2 less than seven percent of the employee's household
3 income; and

4 (6) meets other requirements the Secretary de-
5 termines appropriate.

6 (d) GRANT TERMS.—

7 (1) DURATION.—A grant awarded under this
8 section shall be made for a period of 4 years.

9 (2) AMOUNT.—The Secretary shall determine
10 the maximum amount of each grant awarded under
11 subsection (a).

12 (3) NUMBER.—At least one award must be
13 made to a Community Multi-Share Coverage Pro-
14 gram that is operating at the time that this section
15 is enacted.

16 (e) APPLICATIONS.—

17 (1) IN GENERAL.—To be eligible to be awarded
18 a grant under subsection (a), an applicant must—

19 (A) be a non-profit entity with documented
20 commitments from local partner hospitals and
21 small employers to participate in a Community
22 Multi-Share Coverage Plan; and

23 (B) submit to the Secretary an application
24 at such time, in such manner, and containing
25 the certification described in paragraph (2) and

1 such other information as the Secretary may re-
2 quire.

3 (2) CERTIFICATION.—To eligible for funding
4 under this section, an application described in para-
5 graph (1) shall include certifications that the pro-
6 gram—

7 (A) will not impose any preexisting condi-
8 tion exclusion (as such term is defined in sec-
9 tion 2704(b)(1)(A)) of the Public Health Serv-
10 ice Act (42 U.S.C. 300gg–3(b)(1)(A)) with re-
11 spect to the health coverage described in sub-
12 section (b)(1);

13 (B) has or will establish a network of
14 health care providers and community resources
15 sufficient to provide services to qualifying indi-
16 viduals enrolled under the health coverage de-
17 scribed in subsection (b)(2);

18 (C) will seek to enroll individuals whose
19 household income is less than the basic cost of
20 living (as determined in a manner consistent
21 with the “Asset Limited, Income Constrained,
22 Employed” or “ALICE” methodology);

23 (D) select an entity to carry out adminis-
24 trative and accounting responsibilities (includ-
25 ing monthly billing, verification of eligibility of

1 qualifying individuals, enrollment of qualifying
2 individuals, maintenance of a list of active en-
3 rollees, and operation of a benefit utilization
4 management program) necessary with respect
5 to the health insurance coverage described in
6 subsection (b)(2); and

7 (E) shall submit written reports to the
8 Secretary on an annual basis evaluating the
9 progress on advancing access to health care, in-
10 creasing economic self-sufficiency, and other
11 elements that the Secretary requires.

12 (f) DEFINITIONS.—In this section:

13 (1) AGENCY.—The term “agency” means a
14 local, State, or Federal agency.

15 (2) FEDERAL HEALTH CARE PROGRAM.—The
16 term “Federal health care program” has the mean-
17 ing given such term in section 1128B(f) of the So-
18 cial Security Act (42 U.S.C. 1320a–7b(f)).

19 (3) HEALTH COACH.—The term “health coach”
20 means an individual who is a member of the staff
21 of the community-based coverage entity that has re-
22 ceived training to provide health coaching services
23 (including health improvement program services).

24 (4) HOSPITAL.—The term “hospital” means an
25 institution that—

1 (A) meets the requirements of section
2 1861(e) of the Social Security Act (42 U.S.C.
3 31395x(e)); and

4 (B) is an organization described in sub-
5 sections (c)(3) and (r)(3) of section 501 of the
6 Internal Revenue Code of 1986 and is exempt
7 from taxation under section 501(a) of such
8 code.

9 (5) QUALIFIED HEALTH PLAN.—The term
10 “qualified health plan” has the meaning given such
11 term in section 1301(a) of the Patient Protection
12 and Affordable Care Act (42 U.S.C. 18021(a)).

13 (6) SECRETARY.—The term “Secretary” means
14 the Secretary of Health and Human Services.

15 (7) SMALL EMPLOYER.—The term “small em-
16 ployer” has the meaning given such term in section
17 1304(b)(2) of the Patient Protection and Affordable
18 Care Act (42 U.S.C. 18024(b)(2)).

19 (8) HEALTH-RELATED SOCIAL NEEDS.—The
20 term “health-related social needs” has the meaning
21 given such term by the Director of the Centers for
22 Disease Control and Prevention.

23 (g) AUTHORIZATION OF APPROPRIATIONS.—There is
24 authorized to be appropriated to carry out this section—

25 (1) \$4,800,000 for fiscal year 2026;

- 1 (2) \$7,200,000 for fiscal year 2027; and
- 2 (3) \$12,000,000 for each of fiscal years 2028
- 3 and 2029.

