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SENATE BILL DRS35129-MR-39

Short Title: Greater Transparency in Health Care Billing. (Public)

Sponsors: Senators Hise, Krawiec, and Burgin (Primary Sponsors).

Referred to:

1 A BILL TO BE ENTITLED  
2 AN ACT TO PROVIDE GREATER TRANSPARENCY IN HEALTH CARE SERVICES  
3 BILLING AND TO REDUCE BILLING THAT COMES AS A SURPRISE TO THE  
4 PATIENT.

5 The General Assembly of North Carolina enacts:

6 **SECTION 1.(a)** G.S. 58-3-200(a) is repealed.

7 **SECTION 1.(b)** G.S. 58-3-200 is amended by adding a new subsection to read:

8 "(a1) Definitions. – The following definitions apply in this section:

9 (1) Clinical laboratory. – An entity in which services are performed to provide  
10 information or materials for use in the diagnosis, prevention, or treatment of  
11 disease or assessment of a medical or physical condition.

12 (2) Health care provider. – Any health services facility or any person who is  
13 licensed, registered, or certified under Chapter 90 or Chapter 90B of the  
14 General Statutes, or under the laws of another state, to provide health care  
15 services in the ordinary care of business or practice, or as a profession, or in  
16 an approved education or training program, except that this term shall not  
17 include a pharmacy.

18 (3) Health services facility. – A hospital; long-term care hospital; psychiatric  
19 facility; rehabilitation facility; nursing home facility; adult care home; kidney  
20 disease treatment center, including freestanding hemodialysis units;  
21 intermediate care facility; home health agency office; chemical dependency  
22 treatment facility; diagnostic center; hospice office; hospice inpatient facility;  
23 hospice residential care facility; ambulatory surgical facility; urgent care  
24 facility; freestanding emergency facility; and clinical laboratory."

25 **SECTION 1.(c)** G.S. 58-3-200(d) reads as rewritten:

26 "(d) Services Outside Provider Networks. – No insurer shall ~~penalize an insured or~~ subject  
27 an insured to the out-of-network benefit levels offered under the insured's approved health benefit  
28 plan, including an insured receiving an extended or standing referral under G.S. 58-3-223, unless  
29 contracting health care providers able to meet health needs of the insured are reasonably available  
30 to the insured without unreasonable delay. Upon notice from the insured, the insurer shall  
31 determine whether a health care provider able to meet the needs of the insured is reasonably  
32 available to the insured without unreasonable delay by reference to the insured's location and the  
33 specific medical needs of the insured.

34 Unless otherwise agreed to by the health care provider and the insurer, the amount allowed  
35 for services provided under this subsection shall be calculated using the benchmark amount under  
36 G.S. 58-3-201. Nothing herein shall require an insurer to make any direct payment to a health



1 care provider. Prior to services being rendered to an insured, no health care provider shall subject  
2 an insured to, or otherwise require prior payment of, an amount in excess of the applicable  
3 reasonable payment amount under G.S. 58-3-201."

4 **SECTION 1.(d)** Article 3 of Chapter 58 of the General Statutes is amended by  
5 adding a new section to read:

6 **"§ 58-3-201. Limitation on balance billing.**

7 (a) For the purposes of this section, the term "health care provider" shall be as defined in  
8 G.S. 58-3-200.

9 (b) Reasonable Payment. – A health care provider's total payment for services provided  
10 outside an insurer's health care provider network pursuant to G.S. 58-3-200(d), or for emergency  
11 care services provided pursuant to G.S. 58-3-190, shall be presumed to be reasonable if the  
12 payment is equal to or higher than the benchmark amount.

13 (c) Benchmark Amount Calculation. – The benchmark amount shall be calculated at least  
14 annually and shall be the lesser of the following:

15 (1) One hundred percent (100%) of the current Medicare payment rate for the  
16 same or similar services.

17 (2) The health care provider's actual charges.

18 (3) The median contracted rate in the insurer's health care provider network for  
19 the same or similar services.

20 (d) Application of Benchmark Amount. – The applicable benchmark amount that is  
21 applied to an insured's deductible, copayment, or coinsurance is considered payment for the  
22 purposes of this section. Receipt by the health care provider of payment for services to the insured  
23 from all payers, individually or collectively, of the benchmark amount shall foreclose the health  
24 care provider from collecting any additional amount from the insured or any third party. Nothing  
25 in this section shall require an insurer to make payment of any amount owed under this section  
26 directly to a health care provider.

27 (e) Failure to Comply. – A health care provider's repeated failure to comply with this  
28 section shall indicate a general business practice that is deemed an unfair and deceptive trade  
29 practice and shall be actionable under Chapter 75 of the General Statutes. Nothing in this section  
30 shall foreclose other remedies available under law or equity."

31 **SECTION 2.** Article 11B of Chapter 131E of the General Statutes reads as rewritten:

32 "Article 11B.

33 "Transparency in Health Services Billing Practices.

34 "Part 1. Health Care Cost Reduction and Transparency Act of 2013.

35 **"§ 131E-214.11. Title.**

36 This ~~article-Part~~ shall be known as the Health Care Cost Reduction and Transparency Act of  
37 2013.

38 ...

39 "Part 2. Transparency in Health Care Provider Billing Practices.

40 **"§ 131E-214.25. Definitions.**

41 The following definitions apply in this Part:

42 (1) Health benefit plan. – As defined in G.S. 58-3-167.

43 (2) Health care provider. – Any person who is licensed, registered, or certified  
44 under Chapter 90 or Chapter 90B of the General Statutes, or under the laws of  
45 another state, to provide health care services in the ordinary care of business  
46 or practice, or as a profession, or in an approved education or training  
47 program, except that this term shall not include a pharmacy.

48 (3) Health services facility. – A facility that is licensed under this Chapter or  
49 Chapter 122C of the General Statutes or under the licensing laws of another  
50 state for the provision of the same services in the ordinary course of business

1 or practice as would require the facility to be licensed under this Chapter or  
2 Chapter 122C of the General Statutes were the facility located in this State.

3 (4) Insurer. – As defined in G.S. 58-3-167.

4 **"§ 131E-214.26. Fair notice requirements.**

5 (a) Services Provided at Participating Health Services Facilities or by Health Care  
6 Providers. – At the time a health services facility or a health care provider participating in an  
7 insurer's health care provider network (i) treats an insured individual for anything other than  
8 screening and stabilization in accordance with G.S. 58-3-190, (ii) admits an insured individual  
9 to receive emergency services, (iii) schedules a procedure for nonemergency services for an  
10 insured individual, or (iv) seeks prior authorization from an insurer for the provision of  
11 nonemergency services to an insured individual, the health services facility or health care  
12 provider shall provide the insured individual with a written disclosure containing the following  
13 information:

14 (1) Services may be provided at the health services facility by the health services  
15 facility itself as well as by health care providers who may separately bill the  
16 insured individual.

17 (2) Certain health care providers may be called upon to render care to the insured  
18 individual during the course of treatment and may not have contracts with the  
19 insured's insurer and are therefore considered to be nonparticipating health  
20 care providers in the insurer's health care provider network. The  
21 nonparticipating health care providers shall be identified in the written  
22 disclosure using the individual's health care provider's name and practice  
23 name as used on the applicable health services facility or health care provider's  
24 credentials or name badge.

25 (3) The insurer and the insured individual, individually or collectively, have no  
26 legal obligation to pay more than the benchmark amount, as calculated under  
27 G.S. 58-3-201, for services provided by nonparticipating health care  
28 providers.

29 (4) Receipt by the health care provider of payment for services to the insured  
30 individual by the insurer and any third party, individually or collectively, of  
31 the benchmark amount calculated under G.S. 58-3-201 forecloses a  
32 nonparticipating health services facility or health care provider from  
33 collecting any additional amount from the insurer, insured individual, or any  
34 third party with the exception of any applicable deductible, copayment, or  
35 coinsurance in the insured's health benefit plan with the insurer.

36 (5) Text, using a bold or other distinguishable font, that states that certain  
37 consumer protections available to the insured individual when services are  
38 rendered by a health services facility or health care provider participating in  
39 the insurer's health care provider network may not be applicable when services  
40 are rendered by a nonparticipating health services facility or health care  
41 provider.

42 (b) Emergency Services Provided at Nonparticipating Health Services Facilities or  
43 Health Care Providers. – At the time a health services facility begins the provision of emergency  
44 services to an insured individual, but the facility does not have a contract with the applicable  
45 insurer, the health services facility shall provide the insured individual with a written disclosure  
46 that contains the following information:

47 (1) The health services facility does not have a health care provider network  
48 contract with the applicable insurer and is considered to be a nonparticipating  
49 health care provider.

50 (2) The insurer, the insured individual, and any third party, individually or  
51 collectively, have no legal obligation to pay more than the benchmark amount,

1 as calculated under G.S. 58-3-201, for services provided by nonparticipating  
2 health care providers or health service facilities.

3 (3) Payment by the insurer, the insured individual, or any third party, individually  
4 or collectively, of the benchmark amount calculated under G.S. 58-3-201  
5 forecloses a nonparticipating health services facility or health care provider  
6 from collecting any additional amount from the insurer, insured individual, or  
7 any third party with the exception of any applicable deductible, copayment,  
8 or coinsurance in the insured's health benefit plan.

9 (4) Text, using a bold or other distinguishable font, that states that certain  
10 consumer protections available to the insured individual when services are  
11 rendered by a health services facility or health care provider participating in  
12 the insurer's health care provider network may not be applicable when services  
13 are rendered by a nonparticipating health services facility or health care  
14 provider.

15 **§ 131E-214.27. Fair billing and collection practices.**

16 (a) Billing and Collections. – No health services facility or health care provider shall  
17 collect an amount from the insurer, the insured, or any third party, for services in excess of the  
18 benchmark amount as calculated under G.S. 58-3-201 unless the insurer does not have contracted  
19 health care providers or health services facilities in its health care provider network that are able  
20 to meet the needs of the insured individual and that are reasonably available to the insured without  
21 unreasonable delay, as determined by the insurer pursuant to G.S. 58-3-200(d). For the purposes  
22 of this subsection, the term "services" includes all of the following:

23 (1) Services rendered by a health care provider who is not participating in an  
24 insurer's health care provider network at a health services facility that does  
25 participate in an insurer's health care provider network if a participating health  
26 care provider is unavailable.

27 (2) Services rendered by a health care provider who is nonparticipating in an  
28 insurer's provider network without the insured individual's prior knowledge,  
29 as evidenced by the fair notice requirements under G.S. 131E-214.26.

30 (3) All emergency services, as defined by G.S. 58-3-190.

31 (4) Services rendered by a health care provider who is not participating in an  
32 insurer's health care provider network if the services were referred by a  
33 participating provider to the nonparticipating health care provider without an  
34 explicit written explanation of the differences in cost, certification of delivery  
35 of the written disclosure under G.S. 131E-214.26, and written consent of the  
36 insured individual acknowledging that the participating health care provider  
37 is referring the insured individual to a nonparticipating health care provider  
38 and that the referral may result in costs not covered by the insured's health  
39 benefit plan.

40 The term "services" shall not include a bill received for health care services if a health care  
41 provider participating in an insurer's health care provider network is available and the insured  
42 individual has elected to obtain services from a health care provider not contracted in the insurer's  
43 health care provider network.

44 (b) Reasonable Payments. – A health services facility's total payment for services  
45 provided outside an insurer's health care provider network pursuant to G.S. 58-3-200(d), or if the  
46 payment is equal to or higher than the benchmark amount under G.S. 58-3-201.

47 (c) Total Payment. – A benchmark amount under G.S. 58-3-201 that is applied to an  
48 insured individual's deductible, copayment, or coinsurance is considered payment for the  
49 purposes of this section. An insurer's, insured individual's, or any third party's total payment,  
50 individually or collectively, of the benchmark amount shall foreclose the health services facility  
51 or the health care provider from collecting any additional amount from the insured or any third

1 party, including the insurer, individually or collectively. Nothing in this section shall require an  
2 insurer to make payment of any amount owed under this section directly to a health services  
3 facility or health care provider.

4 (d) Contracting. – A health services facility must require through its contracts with health  
5 care providers that do not participate in an insurer's health care provider network that the  
6 nonparticipating health care providers comply with the requirements of this section.

7 (e) Overpayments. – Subject to the time lines required under G.S. 58-3-225, an insurer  
8 may recover overpayments made to any health care provider or health services facility under this  
9 section by making demands for refunds from the insured individual, the health care provider, or  
10 the health services facility, as applicable. Any recoveries may also include related interest  
11 payments that were under the requirements of G.S. 58-3-225. Not less than 30 calendar days  
12 before an insurer seeks an overpayment recovery or offsets future payments, the insurer shall  
13 give written notice to the responsible party that is accompanied by adequate information to  
14 identify the specific claim and specific reason for the recovery.

15 **"§ 131E-214.28. Penalties.**

16 A health care provider's repeated failure to comply with this Article shall indicate a general  
17 business practice that is deemed an unfair and deceptive trade practice and shall be actionable  
18 under Chapter 75 of the General Statutes. Nothing in this Article shall foreclose other remedies  
19 available under law or equity."

20 **SECTION 3.** Chapter 90 of the General Statutes is amended by adding a new Article  
21 to read:

22 "Article 41A.

23 "Transparency in Health Care Provider Billing Practices.

24 **"§ 90-705. Definitions.**

25 The following definitions shall apply in this Article:

26 (1) Health care provider. – As defined in G.S. 131E-214.25.

27 (2) Health services facility. – As defined in G.S. 131E-214.25.

28 (3) Hospital-based health care provider. – A health care provider who provides  
29 services to patients in a health services facility and where both of the following  
30 occur:

31 a. The services are arranged by the health services facility by contract or  
32 agreement with the health care provider as part of the health services  
33 facility's general business operations.

34 b. An insured individual or the insured's health benefit plan does not  
35 specifically select or have a choice of health care providers from which  
36 to receive such services in the health services facility.

37 (4) Insurer. – As defined in G.S. 58-3-167(a).

38 **"§ 90-706. Fair notice requirement.**

39 A nonparticipating health care provider that does not participate in the health care provider  
40 network of an insured's insurer, including a nonparticipating hospital-based provider, shall  
41 include a statement on any billing notice sent to an insured individual that the insured is not  
42 responsible for paying more than the applicable in-network deductible, copayment, or  
43 coinsurance amounts, and has no legal obligation to pay any remaining balance in excess of the  
44 benchmark amount calculated under G.S. 58-3-201 that applies.

45 **"§ 90-707. Fair billing and collection practices.**

46 (a) Billing and Collection. – No health care provider shall collect an amount from the  
47 insurer, the insured individual, or any third party, individually or collectively, for services in  
48 excess of the benchmark amount under G.S. 58-3-201, unless the insurer has contracted health  
49 care providers in its health care provider network that are able to meet the needs of the insured  
50 and are reasonably available to the insured without unreasonable delay, as determined by the  
51 insurer pursuant to G.S. 58-3-200(d).

1       (b) Reasonable Payments. – A health care provider's total collection from the insurer,  
2 insured, and any third party, individually or collectively, for services provided outside an  
3 insurer's health care provider network pursuant to G.S. 58-3-200(d), or for emergency care  
4 services provided pursuant to G.S. 58-3-190, shall be presumed to be reasonable if the amount  
5 collected from the insurer, insured individual, or any third party, individually and collectively, is  
6 equal to or higher than the benchmark amount under G.S. 58-3-201.

7       (c) Total Payment. – A benchmark amount under G.S. 58-3-201 that is applied to an  
8 insured individual's deductible, copayment, or coinsurance is considered payment or an amount  
9 collected for the purposes of this section. An insurer's, insured individual's, or third party's total  
10 payment, individually or collectively, of the benchmark amount shall foreclose the health care  
11 provider from collecting any additional amount from the insurer, insured, or any third party,  
12 individually or collectively. Nothing in this section shall require an insurer to make any payment  
13 of any amount owed under this section directly to a health care provider.

14 **"§ 90-708. Penalties.**

15       A health care provider's repeated failure to comply with this section shall indicate a general  
16 business practice that is deemed an unfair and deceptive trade practice and shall be actionable  
17 under Chapter 75 of the General Statutes. Nothing in this Article shall foreclose other remedies  
18 available under law or equity."

19       **SECTION 4.(a)** G.S. 131E-214.12(a), as amended by Section 2 of this act, reads as  
20 rewritten:

21       "(a) It is the intent of this ~~Article-Part~~ to improve transparency in health care costs by  
22 providing information to the public on the costs of the most frequently reported diagnostic related  
23 groups (DRGs) for hospital inpatient care and the most common surgical procedures and imaging  
24 procedures provided in hospital outpatient settings and ambulatory surgical facilities."

25       **SECTION 4.(b)** G.S. 131E-214.13(a), as amended by Section 2 of this act, reads as  
26 rewritten:

27       "(a) The following definitions apply in this ~~Article-Part~~:

28       ...."

29       **SECTION 5.** This act becomes effective October 1, 2021, and applies to health care  
30 services provided to insured individuals on or after that date.