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SENATE BILL 321
Health Care Committee Substitute Adopted 4/20/23
Third Edition Engrossed 5/1/23

Short Title: Medical Debt De-Weaponization Act. (Public)

Sponsors:

Referred to:

March 20, 2023

A BILL TO BE ENTITLED

AN ACT TO ADOPT THE PRO-FAMILY, PRO-CONSUMER MEDICAL DEBT PROTECTION ACT TO LIMIT THE ABILITY OF LARGE MEDICAL FACILITIES TO CHARGE UNREASONABLE INTEREST RATES AND EMPLOY UNFAIR TACTICS IN DEBT COLLECTION AND TO LIMIT THE ABILITY OF NON-HOSPITAL HEALTH CARE FACILITIES TO CHARGE FACILITY FEES.

The General Assembly of North Carolina enacts:

PART I. MEDICAL DEBT PROTECTION ACT

SECTION 1. Chapter 131E of the General Statutes is amended by adding a new Article to read:

"Article 11C.

"Medical Debt Protection Act.

"**§ 131E-214.21. Short title and purpose.**

This Article may be cited as the "Medical Debt Protection Act." The purpose of this Article is to reduce burdensome medical debt and to protect patients in their dealings with medical creditors, medical debt buyers, and medical debt collectors with respect to such debt. This Article is a consumer protection statute and shall be liberally and remedially construed to effectuate its purposes.

"**§ 131E-214.22. Definitions.**

The following definitions apply in this Article:

(1) Consumer. – A natural person who has incurred a debt or alleged debt for primarily personal, family, or household purposes.

(2) Consumer reporting agency. – Any person, which, for monetary fees, dues, or on a cooperative nonprofit basis, regularly engages in whole or in part in the practice of assembling or evaluating consumer credit information or other information on consumers for the purpose of furnishing consumer reports to third parties.

(3) External review. – Review of an adverse benefit determination, including a final internal adverse benefit determination, conducted pursuant to an applicable State external review process as described in Part 4 of Article 50 of Chapter 58 of the General Statutes, a federal external review process as described in 42 U.S.C. § 300gg-19, a review pursuant to 29 U.S.C. § 1133, a Medicare appeals process, a Medicaid appeals process, or another applicable appeals process.

(4) Extraordinary collection action. – An extraordinary collection action includes any of the following:
a. Selling an individual's debt to another party, except if prior to the sale, the medical creditor enters into a legally binding written agreement with the medical debt buyer which includes the following provisions:
1. The medical debt buyer or collector is prohibited from engaging in any extraordinary collection actions to obtain payment for the care.
2. The medical debt buyer is prohibited from charging interest on the debt in excess of that described in G.S. 131E-214.23.
3. The debt is returnable to or recallable by the medical creditor upon a determination by the medical creditor or medical debt buyer that the individual is eligible for financial assistance.
4. If the individual is determined to be eligible for financial assistance for emergency or medically necessary care and the debt is not returned to or recalled by the medical creditor, the medical debt buyer is required to adhere to procedures which shall be specified in the agreement that ensure that the individual does not pay, and has no obligation to pay, the medical debt buyer and the medical creditor together more than he or she is personally responsible for paying in compliance with this Article.
b. Reporting adverse information about the patient to a consumer reporting agency.
c. Actions that require a legal or judicial process, including, but not limited to:
1. Placing a lien on an individual's property.
2. Attaching or seizing an individual's bank account or any other personal property.
3. Commencing a civil action against an individual.
4. Garnishing an individual's wages.
(5) Gross charges. – A covered health care provider's full, established price for health care services that the covered health care provider charges uninsured patients before applying any contractual allowances, discounts, or deductions.
(6) Health care services. – Services for the diagnosis, prevention, treatment, cure, or relief of a physical, dental, behavioral, substance use disorder or mental health condition, illness, injury, or disease. These services include, but are not limited to, any procedures, products, devices, or medications.
(7) Internal review or internal appeal. – Review by a health insurance plan or other insurer of an adverse benefit determination.
(8) Large health care facility. – Includes any of the following entities:
a. Any hospital licensed under this Chapter or Chapter 122C of the General Statutes, whether a nonprofit subject to 26 U.S.C. § 501(c)(3), a hospital owned by a county, municipality, the State, or a for-profit entity.
b. Any outpatient clinic or facility affiliated with a hospital or operating under the license of a hospital described in sub-subdivision a. of this subdivision.
c. Any ambulatory surgical center licensed under this Chapter.
d. Any practice which provides outpatient medical, behavioral, optical, radiology, laboratory, dental, or other health care services with

revenues of at least twenty million dollars ($20,000,000) annually and is licensed under this Chapter or has medical providers performing health care services pursuant to a license issued under Chapter 90 of the General Statutes.

e. Any licensed health care professional who provides health care services in one or more of the settings listed in sub-subdivisions a. through d. of this subdivision and bills patients independently.

(9) Medical creditor. – Any entity that provides health care services and to whom the consumer owes money for health care services, or the entity that provided health care services and to whom the consumer previously owed money if the medical debt has been purchased by one or more debt buyers.

(10) Medical debt. – A debt arising from the receipt of health care services.

(11) Medical debt buyer. – A person or entity that is engaged in the business of purchasing medical debts for collection purposes, whether it collects the debt itself or hires a third party for collection or an attorney-at-law for litigation in order to collect such debt.

(12) Medical debt collector. – Any person that regularly collects or attempts to collect, directly or indirectly, medical debts originally owed or due or asserted to be owed or due another. A medical debt buyer is considered to be a medical debt collector for all purposes.

(13) Medical debt mitigation policy (MDMP). – A written financial assistance policy which includes:

a. The basis for calculating amounts charged to patients.

b. The method for applying for financial assistance for emergency or medically necessary care.

c. The billing and collections policy containing the actions the covered health care provider may take in the event of nonpayment, including collections action and reporting to credit agencies.

d. Measures to widely publicize the policy within the community to be served by the covered health care provider in accordance with G.S. 131E-214.25.

(14) Patient. – The person who received health care services and, for the purposes of this Article, shall include a parent if the patient is a minor or a legal guardian if the patient is an adult under guardianship.

"**§ 131E-214.23. Medical debt mitigation policy for large health care facilities.**

(a) All large health care facilities are required to develop a written MDMP that complies with this Article and any implementing rules. This requirement shall apply whether or not the large health care facility is required to develop a financial assistance policy under 26 U.S.C. § 501(r)(4) and implementing regulations.

(b) The MDMP must, at a minimum, include the following:

(1) A written financial assistance policy that applies to all emergency and other medically necessary health care services offered by the covered health care provider.

(2) A plain language summary of the financial assistance policy, which shall not exceed two pages in length.

(3) The eligibility criteria for financial assistance and a summary of the type of assistance that is available as set forth in this Article.

(4) The method and application process that patients are to use to apply for financial assistance.

(5) The information and documentation the large health care facility may require an individual to provide as part of the application.

(6) The reasonable steps that the provider will take to determine whether a patient is eligible for financial assistance.

(7) The billing and collections policy, including the actions that may be taken in the event of nonpayment, which shall comply with all applicable parts of this Article and other applicable municipal, State, or federal laws.

(c) The MDMP must be approved by the owners or governing body of a health care provider and shall be reviewed by the owners or governing board annually.

"**§ 131E-214.24. Implementation of the medical debt mitigation policy.**

(a) In addition to any other actions required by applicable municipal, State, or federal law, large health care facilities must take the following steps before seeking payment for any emergency or medically necessary care:

(1) Determine whether the patient has health insurance.

(2) If the patient is uninsured, offer to screen the patient for public or private insurance eligibility and offer assistance if the patient chooses to apply for public or private insurance, however, a patient's refusal to be screened shall not be grounds for denying financial assistance.

(3) Offer to screen the patient for other public programs which may assist with health care costs; however, a patient's refusal to be screened shall not be grounds for denying financial assistance.

(4) If the patient submits an application for financial assistance, determine the patient's eligibility for the financial assistance plan within 30 days after the patient applies for financial assistance, suspending any billing or collections actions while eligibility is being determined.

(b) If a large health care facility receives an application for financial assistance from a patient, the facility shall notify the patient in writing within 30 days whether it has approved or denied the application. The large health care facility shall provide a copy of any recalculated bill and calculation of financial assistance provided to the patient.

(c) A large health care facility shall accept and consider a patient's application for financial assistance if it is submitted within one year of the date of the first bill after the provision of the health care services. However, if the patient is the subject of collection activity by the facility or a medical debt collector, including a lawsuit to collect a medical debt or negative credit reporting regarding a medical debt, and submits an application for financial assistance, the large health care facility shall accept and process the application at any time. If the patient submits a financial assistance application to a medical debt collector, the medical debt collector shall forward the application to the large health care facility within two business days and shall cease collection activity until notified by the large health care facility of the outcome of the application and any debt forgiven or new repayment terms.

(d) For a patient who has been found to be eligible for financial assistance, no initial payment on a monthly payment plan shall be due within the first 90 days after the health care services were provided.

"**§ 131E-214.25. Medical debt mitigation policy: public education and information.**

(a) A large health care facility must publicize its MDMP widely by:

(1) Making the policy and the financial assistance application form easily accessible online, through the large health care facility's website and through any patient portal or other online communication portal used by patients of the health care provider.

(2) In addition to any other requirements in this Article, making paper copies of the MDMP and application form available upon request and without charge, both by mail and in the large health care facility's office. For hospitals, copies should be available, at a minimum, in the emergency room, if any, and admissions areas.

(3) Notifying and informing members of the community served by the large health care facility about the MDMP in a manner reasonably calculated to reach those members who are most likely to require financial assistance with such efforts commensurate to the size and income of the provider.

(4) Notifying and informing individuals who receive care from the large health care facility about the MDMP by:

a. Offering a paper copy of the MDMP to patients as part of the patient's first visit, or in the case of a hospital facility, during the intake and discharge process.

b. Including a conspicuous written notice on billing statements, whether sent by the large health care facility or a medical debt collector, that notifies and informs recipients about the availability of financial assistance and includes the telephone number of the large health care facility's office or department that can provide information about the financial assistance policy and application process and the direct website address where copies of the MDMP and application may be obtained.

c. Setting up conspicuous public displays or other measures reasonably calculated to attract patients' attention that notify and inform patients about the MDMP in public locations in the large health care facility's office. For hospitals, displays should be posted in the emergency room, if any, and admissions areas, at a minimum.

(b) In all attempts, whether written or oral, by a medical creditor or debt collector to collect a medical debt for health care services provided by a large health care facility, the patient must be informed of any financial assistance policy available through the large health care facilities.

"**§ 131E-214.26. Medical debt mitigation policy: language access.**

(a) An MDMP shall include a notice that states: "This document contains important information about financial assistance for your bill. Contact [insert name and phone number of large health care facility] for translation assistance," translated in the 10 languages most frequently spoken by limited English proficient households as determined by U.S. Census Bureau data in the large health care facility's service area.

(b) A large health care facility must accommodate all significant populations that have limited English proficiency by translating the MDMP and application form into the primary languages spoken by such populations. A large health care facility will satisfy this translation requirement if it makes available translations of its MDMP and application form in the language spoken by each limited English proficiency language group that constitutes the lesser of 1,000 individuals or five percent (5%) of the community served by the large health care facility or the population likely to be affected or encountered by the large health care facility. A large health care facility may determine the percentage or number of limited English proficiency individuals in the large health care facility's community or likely to be affected or encountered by the hospital facility.

(c) A large health care facility must accommodate any patient with limited English proficiency, who is part of a population which falls below the numerical thresholds established in subsection (b) of this section, by providing oral interpretation services to the patient upon request and at no cost to the patient to explain the MDMP and its application.

(d) A large health care facility must accommodate any patient with limited English proficiency to answer questions from the patient regarding the MDMP, the application form, any written determination of eligibility, and any other communication regarding financial assistance from the large health care facility. A large health care facility may accommodate these patients by providing oral interpretation services to the patient upon request and at no cost to the patient.

"**§ 131E-214.27. Billing and collections rules; limits on creditors.**

(a) The following prohibited collection actions may not be used by any medical creditor or medical debt collector to collect debts owed for health care services:

(1) Causing an individual's arrest.

(2) Causing an individual to be held in civil contempt or imprisoned under G.S. 5A-21 or G.S. 1-302 if the only reason supporting the contempt is the debtor's failure to pay a judgment for medical debt.

(3) Foreclosing on an individual's real property.

(4) Garnishing wages or State income tax refunds.

(b) No medical creditor or medical debt collector shall engage in any permissible extraordinary collection actions until 180 days after the first bill for a medical debt has been sent.

(c) At least 30 days before taking any extraordinary collection actions, a medical creditor or medical debt collector must provide to the patient a notice containing the following:

(1) In the case of large health care facilities and medical debt collectors collecting debt for health care services provided by such facilities, stating that financial assistance is available for eligible individuals and providing a plain-language summary of the MDMP.

(2) Identifying the extraordinary collection actions that will be initiated in order to obtain payment.

(3) Providing a deadline after which such extraordinary collection actions will be initiated, which date is no earlier than 30 days after the date of the notice.

(d) A large health care facility or a medical debt collector collecting debt for health care services provided by such a facility shall not use any extraordinary collection actions unless these actions are described in the large health care facility's billing and collections policy.

(e) If a large health care facility or a medical debt collector collecting debt for health care services provided by such a facility bills or initiates collection activities and the patient is later found eligible for financial assistance, the large health care facility or medical debt collector shall reverse any extraordinary collection actions, including:

(1) Deleting any negative reports to consumer reporting agencies.

(2) Dismissing or vacating any collection lawsuits over the medical debt.

(3) Removing any wage garnishment orders.

If the patient has paid any part of the medical debt or any of the patient's funds have been seized or levied in excess of the amount that the patient owes after application of financial assistance, the large health care facility or medical debt collector shall refund any excess amount to the patient.

"**§ 131E-214.28. Price information.**

All large health care facilities must post price information on their internet websites. This information must be accessible via a link from the website's homepage and at a minimum must include the following:

(1) A list of gross charges for all health care services.

(2) Next to the relevant gross charge, a list of the amounts that Medicare would reimburse for the health care service.

(3) Plain-language titles or descriptions of health care services that can be understood by the average consumer.

"**§ 131E-214.29. Liability for medical debt.**

No spouse or other person shall be liable for the medical debt or nursing home debt of any other person age 18 or older. A person may voluntarily consent to assume liability, but such consent shall:

(1) Be on a separate standalone document signed by the person.

(2) Not be solicited in an emergency room or during an emergency situation.

(3) Not be required as a condition of providing any emergency or nonemergency health care services.

"**§ 131E-214.30. Verification.**

Upon written or oral request and without fee, a medical creditor or medical debt collector shall provide an itemized bill to the patient within 60 days of the request. The itemized bill shall state:

(1) The name and address of the medical creditor.
(2) The dates of service.
(3) The dates the medical debts were incurred, if different from the dates of service.
(4) A detailed list of the specific health care services provided to the patient.
(5) A list of all health care professionals who treated the patient.
(6) The amount of principal for any medical debts incurred.
(7) Any adjustment to the bill, including negotiated insurance rates or other discounts.
(8) The amount of any payments received, whether from the patient or any other party.
(9) Any interest or fees.
(10) Whether the patient was screened for financial assistance.
(11) Whether the patient was found eligible for financial assistance and, if so, the amount due after all financial assistance has been applied to the itemized bill.

"**§ 131E-214.31. Medical debt and consumer reporting agencies.**

(a) No medical creditor or medical debt collector may communicate with or report any information to any consumer reporting agency regarding a consumer's medical debt for a period of one year beginning on the date when the consumer was first given a bill for the medical debt.

(b) After the one-year period described in subsection (a) of this section, medical creditors and medical debt collectors must give consumers at least one additional bill before reporting a medical debt to any consumer reporting agency. The amount reported to the consumer reporting agency must be the same as the amount stated in the bill, and the bill shall state that the debt is being reported to a consumer reporting agency. Medical debt collectors shall also provide the notice required by 15 U.S.C. § 1692g before reporting a debt to a consumer reporting agency.

"**§ 131E-214.32. Prohibition against collection of medical debt during health insurance appeals.**

(a) A medical creditor or medical debt collector that knows or should have known about an internal review, external review, or other appeal of a health insurance decision that is pending now or was pending within the previous 60 days shall not do any of the following:

(1) Provide information relative to unpaid charges for health care services to a consumer reporting agency.
(2) Communicate with the consumer regarding the unpaid charges for health care services for the purpose of seeking to collect the charges.
(3) Initiate a lawsuit or arbitration proceeding against the consumer relative to unpaid charges for health care services.

(b) If a medical debt has already been reported to a consumer reporting agency and the medical creditor or medical debt collector who reported the information learns of an internal review, external review, or other appeal of a health insurance decision that is pending now or was pending within the previous 60 days, that person shall instruct the consumer reporting agency to delete the information about the debt.

(c) No medical creditor that knows or should have known about an internal review, external review, or other appeal of a health insurance decision that is pending now or was pending within the previous 60 days shall refer, place, or send the unpaid charges for health care services to a medical debt collector, including by selling the debt to a medical debt buyer.

"**§ 131E-214.33. Interest on medical debt.**

(a) Interest on medical debt shall be limited to the rate of interest equal to the weekly average one-year constant maturity Treasury yield, but not less than two percent (2%) per annum nor more than five percent (5%) per annum, as published by the Board of Governors of the Federal Reserve System, for the calendar week preceding the date when the consumer was first provided with a bill. The Office of the State Treasurer shall incorporate a reporting on this interest rate into the interest matters report required by the Council of State. If the Board of Governors of the Federal Reserve System ceases to publish this interest rate, then the Office of the State Treasurer shall substitute another measure that will result in a reasonable interest rate of no more than five percent (5%) per annum. Patients eligible for financial assistance shall not be charged any interest or late fees.

(b) The rate of interest provided in subsection (a) of this section shall also apply to any judgments on medical debt, notwithstanding any other provision of law or agreement to the contrary.

"**§ 131E-214.34. Medical debt payment plans.**

(a) Any medical creditor or medical debt collector that agrees to a payment plan for a medical debt shall provide a written copy of the payment plan to the consumer within five business days of entering into the payment plan. This plan shall prominently disclose the rate of any interest being applied to the debt in compliance with G.S. 131E-214.33 and the date by which the account will be paid off in full, assuming the payments set by the schedule are made without interruption.

(b) A consumer need not make a payment on the payment plan until the written copy has been provided.

(c) A medical debt payment plan may be accelerated or declared in default or no longer operative due to nonpayment only after the patient fails to make scheduled payments on the payment plan for at least three consecutive months. Before declaring the payment plan no longer operative, the medical creditor or medical debt collector shall make at least three reasonable attempts to contact the patient by telephone or other method preferred by the patient. Additionally, notice must be provided in writing that the payment plan may become inoperative and informing the patient of the opportunity to renegotiate the payment plan. Prior to the payment plan being declared inoperative, the medical creditor shall attempt to renegotiate the terms of the defaulted payment plan, if requested by the patient. The medical creditor shall not report adverse information to a consumer credit reporting agency or commence a civil action against the patient or responsible party for nonpayment until at least 60 days after the payment plan is declared to be no longer operative. For purposes of this section, the notice and telephone call to the patient may be made to the last known telephone number and address of the patient.

"**§ 131E-214.35. Receipts for payments.**

Within 10 business days of receipt of a payment on a medical debt, the medical creditor or medical debt collector, or any of their agents receiving the payment, shall furnish a receipt to the person that made the payment. All receipts shall include the following information:

(1) The amount paid.
(2) The date payment was received.
(3) The account's balance before the most recent payment.
(4) The new balance after application of the payment.
(5) The interest rate and interest accrued since the consumer's last payment.
(6) The consumer's account number.
(7) The name of the current owner of the debt and, if different, the name of the medical creditor.
(8) Whether the payment is accepted as payment in full of the debt.

"**§ 131E-214.37. Private remedy.**

(a) Any medical creditor or medical debt collector who violates this Article, regardless of whether the violation was committed knowingly, shall be liable to the consumer against whom the violation occurred in a private right of action in an amount up to treble the amount fixed by a damages verdict in favor of the plaintiff.

(b) Any consumer may sue for injunctive or other appropriate equitable relief to enforce this Article.

(c) The remedies provided in this section are not intended to be the exclusive remedies available to a consumer nor must the consumer exhaust any administrative remedies provided under this Article or any other applicable law.

(d) No MDMP or agreement between the patient and a large health care provider or medical debt collector shall contain a provision that, prior to a dispute arising, waives or has the practical effect of waiving the rights of a patient to resolve that dispute by obtaining:

(1) Injunctive, declaratory, or other equitable relief.

(2) Multiple or minimum damages as specified by statute.

(3) Attorney's fees and costs as specified by statute or as available at common law.

(4) A hearing at which that party can present evidence in person.

Any provision in a financial assistance policy or other written agreement violating this subsection shall be void and unenforceable. A court may refuse to enforce other provisions of the financial assistance policy or other written agreement as equity may require.

"**§ 131E-214.39. Enforcement.**

(a) The Attorney General shall have the authority to enforce this Article and may adopt any rules believed to be necessary or appropriate to effectuate the purpose of this Article, to provide for the protection of patients and their families, and to assist market participants in interpreting this Article.

(b) The Attorney General shall establish a complaint process allowing an aggrieved patient or any member of the public to file a complaint against a medical creditor or debt collector who violates any provision of this Article. All complaints shall be considered public records pursuant to Chapter 132 of the General Statutes with the exception of the complainant's name, address, or other personal identifying information.

"**§ 131E-214.40. Annual reports and database.**

(a) On or before July 1 of each year, beginning July 2024, each large health care facility shall file its MDMP and an annual report with the Department of Health and Human Services pursuant to procedures that the Department shall establish. If the health care facility is not required to report to the Department under G.S. 131E-214.14, that health care facility does not need to submit separate reports to satisfy each reporting requirement; the health care facility may submit one report, so long as the report contains all of the information required under this Article and G.S. 131E-214.14.

(b) The Department shall post each report and MDMP in a searchable database accessible on the internet.

(c) An annual consolidated report shall be prepared by the Department and made available to the public. These reports shall include the following information for the time period of July 1 of the prior year to July of that year:

(1) The total number of patients who applied for financial assistance.

(2) The total number of patients who received financial assistance.

(3) The total amount of financial assistance provided to patients.

(d) Any large health care provider that retains or initiates the process to retain a patient's State tax refund through setoff prescribed by Chapter 105A of the General Statutes or other provision of State law shall report no later than July 1 of each year to the Revenue Laws Study Committee the number of patients eligible for setoff, the total debt owed by the eligible patients,

the number of pending setoff actions, the amount expected to be recovered, and the amount of debt expected to be charged off.

"**§ 131E-214.41. Severability.**

Should a court decide that any provision of this Article is unconstitutional, preempted, or otherwise invalid, that provision shall be severed and shall not affect the validity of the Article other than the part severed.

"**§ 131E-214.42. Exemptions.**

Federally qualified health centers, as defined by section 1396d (i)(2)(B) of Title 42 of the United States Code, are exempt from G.S. 131E-214.23 through 131E-214.26, 131E-214.28, and 131E-214.40."

SECTION 2. Article 11C of Chapter 131E of the General Statutes, as enacted by this act, is amended by adding the following new sections to read:

"**§ 131E-214.36. Debt forgiven by medical center.**

Forgiveness of any part of an insured patient's copayment, coinsurance, deductible, facility fees, out-of-network charges, or other cost-sharing shall not be a breach of contract or other violation of an agreement between the medical creditor and the insurer or payor.

"**§ 131E-214.38. Prohibition of waiver of rights.**

Any waiver by any patient or other consumer of any protection provided by or any right of the patient or other consumer under this Article is void and may not be enforced by any court or any other person."

SECTION 3. To the extent this act is in conflict with G.S. 131E-91, 131E-99, or 131E-147.1, this act shall control.

PART II. FACILITY FEES

SECTION 4.(a) Article 16 of Chapter 131E of the General Statutes is amended by adding a new section to read:

"**§ 131E-274. Facility fees.**

(a) Definitions. – The following definitions apply in this section:

(1) Campus. – The main building of a hospital, the physical area immediately adjacent to a hospital's main building, other structures not contiguous to the main building of a hospital that are within 250 yards of the main building, or any other area that has been determined to be part of a hospital's campus by the Centers for Medicare and Medicaid Services.

(2) Facility fee. – Any fee charged or billed by a health care provider for outpatient services provided in a hospital-based facility that is (i) intended to compensate the health care provider for the operational expenses of the health care provider, (ii) separate and distinct from a professional fee, and (iii) charged regardless of the modality through which the health care services were provided.

(3) Health care provider. – As defined in G.S. 90-410.

(4) Health systems. – A parent corporation of one or more hospitals and any entity affiliated with that parent corporation through ownership, governance, membership or other means, or a hospital and any entity affiliated with that hospital through ownership, governance, membership or other means.

(5) Hospital. – As defined in G.S. 131E-76.

(6) Hospital-based facility. – A facility that is owned or operated, in whole or in part, by a hospital where hospital or professional medical services are provided.

(7) Professional fee. – Any fee charged or billed by a provider for professional medical services provided in a hospital-based facility.

(b) Limits on Facility Fees. – The following limitations are applicable to facility fees:

(1) No health care provider shall charge, bill, or collect a facility fee unless the services are provided on a hospital's main campus or at a facility that includes an emergency department.

(2) Regardless of where the services are provided, no health care provider shall charge, bill, or collect a facility fee to outpatient evaluation and management services, or any other outpatient, diagnostic, or imaging services identified by the Department.

(c) Identification of Services. – The Department shall annually identify services subject to the limitations on facility fees provided in subdivision (2) of subsection (b) of this section that may reliably be provided safely and effectively in non-hospital settings.

(d) Reporting Requirements. – Each hospital and health system shall submit a report to the Department annually on July 1. The report shall be published on the Department's website and shall contain the following:

(1) The name and full address of each facility owned or operated by the hospital or health system that provides services for which a facility fee is charged or billed.

(2) The number of patient visits at each such hospital-based facility for which a facility fee was charged or billed.

(3) The number, total amount, and range of allowable facility fees paid at each facility by Medicare, Medicaid, and private insurance.

(4) For each hospital-based facility and for the hospital or health system as a whole, the total amount billed and the total revenue received from facility fees.

(5) The top 10 procedures or services, identified by current procedural terminology (CPT) category I codes, provided by the hospital or health system that generated the greatest amount of facility fee gross revenue; the number of each of these 10 procedures or services provided; the gross and net revenue totals for each such procedure or service; and, the total net amount of revenue received by the hospital or health system derived from facility fees for each procedure or service.

(6) Any other information the Department may require.

(e) Enforcement. – This section shall be enforced as follows:

(1) Any violation of any provision of this section shall be considered an unfair and deceptive trade practice and shall be subject to the provisions of Article 1 of Chapter 75 of the General Statutes.

(2) In addition to the remedies described in subdivision (1) of this subsection, any health care provider who violates any provision of this section shall be subject to an administrative penalty of not more than one thousand dollars ($1,000) per occurrence.

(3) The Department may audit any health care provider for compliance with the requirements of this section. Until the expiration of four years after the furnishing of any services for which a facility fee was charged, billed, or collected, each health care provider shall make available, upon written request of the Department or its designee, copies of any books, documents, records, or data that are necessary for the purposes of completing the audit."

SECTION 4.(b) No later than January 1, 2024, the Department of Health and Human Services shall adopt rules necessary to implement the provisions of this section.

PART III. EFFECTIVE DATE

SECTION 5. Section 1 of this act becomes effective January 1, 2024, and applies to medical debt collection activities occurring after that date. Section 2 of this act becomes effective January 1, 2024, and applies to agreements and contracts entered into, amended, or renewed on

or after that date. Section 4(a) of this act becomes effective January 1, 2024, and applies to facility fees charged on or after that date. The remainder of this act is effective when it becomes law.