GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2013

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SENATE BILL 473
PROPOSED COMMITTEE SUBSTITUTE S473-PCS75292-RF-9

Short Title: HealthCare Cost Reduction & Transparency. (Public)

Sponsors:

Referred to:

March 28, 2013

A BILL TO BE ENTITLED

AN ACT TO IMPROVE TRANSPARENCY IN THE COST OF HEALTH CARE PROVIDED BY HOSPITALS AND AMBULATORY SURGICAL FACILITIES; TO TERMINATE SET-OFF DEBT COLLECTION BY CERTAIN STATE AGENCIES PROVIDING HEALTH CARE TO THE PUBLIC; TO PROHIBIT HOSPITALS AND AMBULATORY SURGICAL FACILITIES FROM CHARGING MULTIPLE TIMES FOR OUTPATIENT RADIOLOGY SERVICES RENDERED ONLY ONCE; TO PROVIDE FOR FAIR HEALTH CARE FACILITY BILLING AND COLLECTIONS PRACTICES; AND TO ENCOURAGE COMMUNITY CARE OF NORTH CAROLINA TO ADJUST ITS CORPORATE GOVERNANCE.

The General Assembly of North Carolina enacts:

PART I. TITLE

SECTION 1. This act shall be known as the Health Care Cost Reduction and Transparency Act of 2013.

PART II. TRANSPARENCY IN HEALTH CARE COSTS

SECTION 2. G.S. 90-413.2 reads as rewritten:

"**§ 90-413.2. Purpose.**

This Article is intended to improve the quality of health care delivery within this State by facilitating and regulating the use of a voluntary, statewide health information exchange network for the secure electronic transmission of individually identifiable health information among health care providers, health plans, and health care clearinghouses in a manner that is consistent with the Health Insurance Portability and Accountability Act, Privacy Rule and Security Rule, 45 C.F.R. §§ 160, 164. This Article is also intended to improve transparency in health care costs by providing information to the public on the cost of the 50 most common episodes of care in hospitals subject to the North Carolina Hospital Licensure Act and ambulatory surgical facilities subject to the North Carolina Ambulatory Surgical Facility Licensure Act."

SECTION 3. Article 29A of Chapter 90 of the General Statutes is amended by adding a new section to read:

"**§ 90-413.9. Disclosure of prices for most common episodes of care.**

(a) The NC HIE shall publish on its Internet Web site available to the public in a conspicuous manner the most current information it receives from hospitals and ambulatory surgical facilities pursuant to G.S. 131E-91.1 and G.S. 131E-153. The NC HIE shall provide

this information in a manner that is easily understood by the public and meets the following minimum requirements:

(1) Information for each hospital shall be listed separately, and hospitals shall be listed in groups by category, as determined by the North Carolina Medical Care Commission in rules adopted pursuant to G.S. 131E-91.1.

(2) Information for each ambulatory surgical facility shall be listed separately.

(3) Information concerning the most common episodes of care for each hospital shall include a separate listing of the facility fees charged by health care providers affiliated with the hospital.

(4) Information concerning the most common episodes of care for each ambulatory surgical facility shall include a separate listing of the facility fees charged by health care providers affiliated with the facility.

(b) Any data disclosed to the North Carolina Health Information Exchange by a hospital or ambulatory surgical facility pursuant to the Health Care Cost Reduction and Transparency Act of 2013 shall be and will remain the sole property of the facility that submitted the data. Any data or product derived from the data disclosed to the NC HIE pursuant to the Health Care Cost Reduction and Transparency Act of 2013, including a consolidation or analysis of the data, shall be and will remain the sole property of the State. The NC HIE, North Carolina Community Care Networks, Inc., (CCNC), and all other entities that directly or indirectly receive any data disclosed to the NC HIE by a hospital or an ambulatory surgical facility pursuant to the Health Care Cost Reduction and Transparency Act of 2013 or that are involved in any other CCNC information technology initiative are prohibited from disclosing, selling, or exchanging the data, or any consolidation, analysis, or product derived from the data, for a fee or other consideration of any kind."

SECTION 4. Article 5 of Chapter 131E of the General Statutes is amended by adding a new Part to read:

"Part 4A. Transparency in Health Care Costs.

"**§ 131E-91.1. Disclosure of prices for most common episodes of care.**

(a) The following definitions apply in this section:

(1) Episode of care. – All acute care hospital services related to a health condition with a given diagnosis, from the three-day period preceding a patient's first admission to a hospital, including readmissions, through the 30-day period following the patient's discharge from the hospital, for treatment of the health condition. The term includes acute care hospital services, services by health care providers employed by the hospital, facility use by health care providers affiliated with the hospital, ancillary services, room and board, and pharmaceuticals dispensed by the hospital pharmacy or by a pharmacy owned or controlled by, or under contract with, the hospital.

(2) Health insurer. – As defined in G.S. 108A-55.4, provided that "health insurer" shall not include self-insured plans and group health plans as defined in section 607(1) of the Employee Retirement Income Security Act of 1974.

(3) Public or private third party. – Includes the State, the federal government, employers, health insurers, third-party administrators, and managed care organizations.

(b) Beginning on March 31, 2014, and quarterly thereafter, each hospital licensed pursuant to this Article shall provide to the North Carolina Health Information Exchange, utilizing electronic health records software, the following information about the 50 most common episodes of care established by the Commission:

(1) The amount that will be charged to a patient for each episode of care if all charges are paid in full without a public or private third party paying for any

portion of the charges, along with a separate listing of the facility fees charged by health care providers affiliated with the hospital for each episode of care.

(2) The average negotiated settlement on the amount that will be charged to a patient required to be provided in subdivision (1) of this subsection.

(3) The total amount of Medicaid reimbursements for each episode of care, including claims and pro rata supplemental payments.

(4) The total amount of Medicare reimbursements for each episode of care.

(5) For the five largest health insurers providing payment to the hospital on behalf of insureds, the range of the total amount of payments made for each episode of care. Prior to providing this information to the NC HIE, each hospital shall redact the names of the health insurers and any other information that would otherwise identify the health insurers.

(6) The total amount of payments made by the State Health Plan for Teachers and State Employees for each episode of care.

(c) Upon request of a patient, a hospital shall provide the information required by subsection (b) of this section to the patient, in writing, within 24 hours after receiving the request.

(d) The disclosure requirements of this section shall not be construed to require a hospital licensed pursuant to this Article to participate in the voluntary statewide health information exchange network overseen and administered by the North Carolina Health Information Exchange.

(e) The Commission shall adopt rules to ensure that this section is properly implemented on January 1, 2014, and that hospitals report this information to the North Carolina Health Information Exchange in a uniform manner. The rules shall include all of the following:

(1) The 50 most common episodes of care on which the hospitals must report. The Commission shall identify a cross section of medical and surgical specialty areas from which to draw the 50 most common episodes of care.

(2) Specific categories by which hospitals shall be grouped for the purpose of disclosing this information to the public on the NC HIE Internet Web site.

"**§ 131E-91.2. Disclosure of uncompensated care, charity care, and bad debt information.**

(a) The following definitions apply in this section:

(1) "Bad debt" is the cost of care provided for which a hospital expected, but cannot obtain, reimbursement either because a patient is unable to pay the bill but did not apply for charity care or because the patient was unwilling to pay the bill.

(2) "Charity care" is the cost of care for which a hospital never expected reimbursement because of a determination that the patient was unable to pay for the services rendered.

(3) "Uncompensated care" is the total cost of care provided for which a hospital did not receive payment.

(b) Beginning on January 1, 2014, and annually thereafter, each operator of a hospital shall conspicuously post the hospital policy on charity care, and the amounts spent by the hospital on uncompensated care, charity care, and bad debt during the preceding calendar year, in the following locations:

(1) On the licensed premises in an area accessible to the public.

(2) On an Internet Web site established and maintained by the hospital and made available to the general public."

SECTION 5. Part 4 of Article 6 of Chapter 131E of the General Statutes is amended by adding new sections to read:

"**§ 131E-153. Disclosure of prices for most common episodes of care.**

(a) The following definitions apply in this section:

(1) Episode of care. – All ambulatory surgical services related to a health condition with a given diagnosis, from the three-day period preceding a patient's first admission to an ambulatory surgical facility, including readmissions, through the seven-day period following the patient's discharge from the facility, for treatment of the health condition. The term includes ambulatory surgical services, services by health care providers employed by the facility, facility use by health care providers affiliated with the facility, use of facility operating and recovery rooms, and pharmaceuticals dispensed by the ambulatory surgical facility pharmacy or by a pharmacy owned or controlled by the ambulatory surgical facility.

(2) Health insurer. – As defined in G.S. 108A-55.4, provided that "health insurer" shall not include self-insured plans and group health plans as defined in section 607(1) of the Employee Retirement Income Security Act of 1974.

(3) Public or private third party. – Includes the State, the federal government, employers, health insurers, third-party administrators, and managed care organizations.

(b) Beginning on March 31, 2014, and quarterly thereafter, each ambulatory surgical facility licensed pursuant to this Part shall provide to the North Carolina Health Information Exchange, utilizing electronic health records software, the following information about the facility's 50 most common episodes of care:

(1) The amount that will be charged to a patient for each episode of care if all charges are paid in full without a public or private third party paying for any portion of the charges, along with a separate listing of the facility fees charged by health care providers affiliated with the hospital for each episode of care.

(2) The average negotiated settlement on the amount that will be charged to a patient required to be provided in subdivision (1) of this subsection.

(3) The total amount of Medicaid reimbursements for each episode of care.

(4) The total amount of Medicare reimbursements for each episode of care.

(5) For the five largest health insurers providing payment to the facility on behalf of insureds, the range of the total amount of payments made for each episode of care. Prior to providing this information to the NC HIE, each facility shall redact the names of the health insurers and any other information that would otherwise identify the health insurers.

(6) The total amount of payments made by the State Health Plan for Teachers and State Employees for each episode of care.

(c) Upon request of a patient, an ambulatory surgical facility shall provide the information required by subsection (b) of this section to the patient, in writing, within 24 hours after receiving the request.

(d) The disclosure requirements of this section shall not be construed to require an ambulatory surgical facility licensed pursuant to this Part to participate in the voluntary statewide health information exchange network overseen and administered by the North Carolina Health Information Exchange.

(e) The Commission shall adopt rules to ensure that this section is properly implemented on January 1, 2014, and that ambulatory surgical facilities report this information to the North Carolina Health Information Exchange in a uniform manner. The rules shall include the 50 most common episodes of care on which the ambulatory surgical facilities must

report. The Commission shall identify a cross section of medical and surgical specialty areas from which to draw the 50 most common episodes of care.

"**§ 131E-153.1. Disclosure of uncompensated care, charity care, and bad debt information.**

(a) The following definitions apply in this section:

(1) "Bad debt" is the cost of care provided for which an ambulatory surgical facility expected, but cannot obtain, reimbursement either because a patient is unable to pay the bill but did not apply for charity care or because the patient was unwilling to pay the bill.

(2) "Charity care" is the cost of care for which an ambulatory surgical facility never expected reimbursement because of a determination that the patient was unable to pay for the services rendered.

(3) "Uncompensated care" is the total cost of care provided for which an ambulatory surgical facility did not receive payment.

(b) Beginning on January 1, 2014, and annually thereafter, each operator of an ambulatory surgical facility shall conspicuously post the facility policy on charity care, and the amounts spent by the facility on uncompensated care, charity care, and bad debt during the preceding calendar year, in the following locations:

(1) On the licensed premises in an area accessible to the public.

(2) On an Internet Web site established and maintained by the ambulatory surgical facility and made available to the general public."

SECTION 6. Not later than July 1, 2013, the Department of Health and Human Services shall do all of the following:

(1) Communicate the requirements of Sections 3 and 4 of this act to all hospitals licensed pursuant to Article 5 of Chapter 131E of the General Statutes.

(2) Communicate the requirements of Sections 3 and 5 of this act to all ambulatory surgical facilities licensed pursuant to Part 4 of Article 6 of Chapter 131E of the General Statutes.

SECTION 7. G.S. 131E-97.3(a) reads as rewritten:

"**§ 131E-97.3. Confidentiality of competitive health care information.**

(a) For the purposes of this section, competitive health care information means information relating to competitive health care activities by or on behalf of hospitals and public hospital authorities. Competitive health care information does not include any of the information hospitals are required to report under G.S. 131E-91.1 or any of the information ambulatory surgical facilities are required to report under G.S. 131E-153. Competitive health care information shall be confidential and not a public record under Chapter 132 of the General Statutes; provided that any contract entered into by or on behalf of a public hospital or public hospital authority, as defined in G.S. 159-39, shall be a public record unless otherwise exempted by law, or the contract contains competitive health care information, the determination of which shall be as provided in subsection (b) of this section."

SECTION 8. G.S. 131E-99 reads as rewritten:

"**§ 131E-99. Confidentiality of health care contracts.**

~~The~~ Except for the information a hospital is required to report under G.S. 131E-91.1 and the information an ambulatory surgical facility is required to report under G.S. 131E-153, the financial terms and other competitive health care information directly related to the financial terms in a health care services contract between a hospital or a medical school and a managed care organization, insurance company, employer, or other payer is confidential and not a public record under Chapter 132 of the General Statutes. Nothing in this section shall prevent an elected public body which has responsibility for the hospital or medical school from having access to this confidential information in a closed session. The disclosure to a public body does

not affect the confidentiality of the information. Members of the public body shall have a duty not to further disclose the confidential information."

PART III. TRANSPARENCY IN BILLING FOR OUTPATIENT RADIOLOGY SERVICES

SECTION 9. Article 5 of Chapter 131E of the General Statutes is amended by adding a new Part to read:

"Part 4B. Transparency in Billing for Outpatient Radiology Services.

"**§ 131E-91.3. Duplicate charges for certain radiology services prohibited.**

(a) The following definitions apply in this section:

(1) Clinical labor. – Includes all of the following:

a. Greeting the patient.

b. Escorting and positioning the patient for radiology services.

c. Educating the patient about the radiology services to be performed and obtaining the patient's informed consent for the services.

d. Retrieving the patient's prior examinations.

e. Setting up an intravenous line for the patient.

f. Preparing and cleaning the examination room.

g. Operating the radiology equipment.

(2) Multiple radiology session. – A single outpatient session during which multiple radiology imaging procedures are performed.

(3) Provider of radiology services. – A hospital, an ambulatory surgical facility, a freestanding radiology services facility, or a physician's office that provides outpatient radiology services.

(4) Technical components. – The clinical labor and supplies used by a hospital to perform radiology imaging procedures on a patient, including gowns and contrast material. This term does not include X-ray film.

(b) It shall be unlawful for a provider of radiology services to charge a patient, entity, or person more than eighty percent (80%) of the full amount of the technical components of an outpatient radiology imaging procedure for each subsequent radiograph performed on the patient during a multiple radiology session if the provider of radiology services only provides the technical components once during the multiple radiology session.

(c) Any contract provision or other agreement between a health insurer and a provider of radiology services that purports to require a party to pay for charges deemed unlawful under this section is void and unenforceable.

(d) Nothing in this section shall be construed to prohibit a provider of radiology services from doing any of the following:

(1) Charging a patient, entity, or person for the full amount of the technical components of multiple radiology imaging procedures performed on the same day, but not during the same session.

(2) Submitting a corrected bill to a patient, entity, or person.

(3) Requesting the radiology services of more than one radiologist for a second medical opinion on a specimen."

PART IV. HOSPITAL DEBT COLLECTION

SECTION 10. G.S. 105A-2(9) reads as rewritten:

"(9) State agency. – Any of the following:

a. A unit of the executive, legislative, or judicial branch of State ~~government.~~government, except for the following:

1. Any school of medicine, clinical program, facility, or practice affiliated with one of the constituent institutions of The

University of North Carolina that provides medical care to the general public.

2. The University of North Carolina Health Care System and other persons or entities affiliated with or under the control of The University of North Carolina Health Care System.

b. A local agency, to the extent it administers a program supervised by the Department of Health and Human Services or it operates a Child Support Enforcement Program, enabled by Chapter 110, Article 9, and Title IV, Part D of the Social Security Act.

c. A community college."

PART V. FAIR HEALTH CARE FACILITY BILLING AND COLLECTIONS PRACTICES

SECTION 11.(a) G.S. 131E-91 reads as rewritten:

"**§ 131E-91. ~~Itemized charges on discharged patient's bill~~Fair billing and collections practices for hospitals and ambulatory surgical facilities.**

(a) All hospitals and ambulatory surgical facilities licensed pursuant to this Chapter shall, upon request of the ~~patient~~patient, ~~within 30 days of discharge,~~present an itemized list of charges to all discharged patients. Patient bills that are not itemized shall include notification to the patient in large, easy-to-read print, of the right to request, free of charge, an itemized bill. A patient may request an itemized list of charges at any time within three years after the date of discharge or so long as the hospital or ambulatory surgical facility, a collections agency, or another assignee of the hospital or ambulatory surgical facility asserts the patient has an obligation to pay the bill.

(b) All bills and invoices provided to the patient by a hospital or ambulatory surgical facility shall be written so as to be readily understandable by the patient. Where the use of medical codes and terms is unavoidable, clear and understandable definitions of those codes and terms shall be included in large and easy-to-read print.

(c) If a patient has overpaid the amount due to the hospital or ambulatory surgical facility, whether as the result of insurance coverage, patient error, health care facility billing error, or other cause, the hospital or ambulatory surgical facility shall provide the patient with a refund within 60 days of receiving notice of the overpayment.

(d) A hospital or ambulatory surgical facility shall not bill insured patients for charges that would have been covered by their insurance had the hospital or ambulatory surgical facility submitted the claim or other information required to process the claim within the allotted time requirements of the insurer.

(e) Hospitals and ambulatory surgical facilities shall abide by the following reasonable collections practices:

(1) A hospital or ambulatory surgical facility shall not refer a patient's unpaid bill to a collections agency, entity, or other assignee during the pendency of a patient's application for charity care or financial assistance under the hospital's or ambulatory surgical facility's charity care or financial assistance policies.

(2) A hospital or ambulatory surgical facility shall provide a patient with a written notice that the patient's bill will be subject to collections activity at least 30 days prior to the referral being made.

(3) A hospital or ambulatory surgical facility that contracts with a collections agency, entity, or other assignee shall require the collections agency, entity, or other assignee to inform the patient of the hospital's or ambulatory surgical facility's charity care and financial assistance policies when engaging in collections activity.

(4) A hospital or ambulatory surgical facility shall require a collections agency, entity, or other assignee to obtain the written consent of the hospital or ambulatory surgical facility prior to the collections agency, entity, or other assignee filing a lawsuit to collect the debt.

(5) A hospital or ambulatory surgical facility, or a contracted collections agency, entity, or other assignee of the hospital or ambulatory surgical facility, shall not use wage garnishment, a lien on a patient's primary residence, or otherwise force a sale of the patient's primary residence, as a means of collecting an unpaid bill.

(f) The Commission shall adopt rules to ensure that this section is properly ~~implemented~~ implemented. ~~and that patient bills which are not itemized include notification to the patient of his right to request an itemized bill.~~The Department shall not issue~~nor~~ or renew a license under this~~Chapter~~ Article unless the applicant has demonstrated that the requirements of this section are being met."

SECTION 11.(b) Part 4 of Article 6 of Chapter 131E of the General Statutes is amended to read:

"**§ 131E-147.1. Fair billing and collections practices for ambulatory surgical facilities.**

All ambulatory surgical facilities licensed under this Part shall be subject to the fair billing and collections practices set out in G.S. 131E-91."

SECTION 11.(c) G.S. 58-3-245 reads as rewritten:

"**§ 58-3-245. Provider ~~directories.~~directories; cost tools for insured.**

(a) Every health benefit plan utilizing a provider network shall maintain a provider directory that includes a listing of network providers available to insureds and shall update the listing no less frequently than once a year. In addition, every health benefit plan shall maintain a telephone system and may maintain an electronic or on-line system through which insureds can access up-to-date network information. The health benefit plan shall ensure that a patient is provided accurate and current information on each provider's network status through the telephone system and any electronic or online system. If the health benefit plan produces printed directories, the directories shall contain language disclosing the date of publication, frequency of updates, that the directory listing may not contain the latest network information, and contact information for accessing up-to-date network information.

(b) Each directory listing shall include the following network information:

(1) The provider's name, address, telephone number, and, if applicable, area of specialty.

(2) Whether the provider may be selected as a primary care provider.

(3) To the extent known to the health benefit plan, an indication of whether the provider:

a. Is or is not currently accepting new patients.

b. Has any other restrictions that would limit an insured's access to that provider.

(c) The directory listing shall include all of the types of participating providers. Upon a participating provider's written request, the insurer shall also list in the directory, as part of the participating provider's listing, the names of any allied health professionals who provide primary care services under the supervision of the participating provider and whose services are covered by virtue of the insurer's contract with the supervising participating provider and whose credentials have been verified by the supervising participating provider. These allied health professionals shall be listed as a part of the directory listing for the participating provider upon receipt of a certification by the supervising participating provider that the credentials of the allied health professional have been verified consistent with the requirements for the type of information required to be verified under G.S. 58-3-230.

(d) A health care provider shall provide to a patient or prospective patient, upon request, information on that provider's network status with a particular health benefit plan."

PART VI. COMMUNITY CARE OF NORTH CAROLINA GOVERNANCE

SECTION 12.(a) The Department of Health and Human Services may not enter into a contract with North Carolina Community Care Networks, Inc., (CCNC) unless CCNC has made the governance changes provided in subsection (b) of this section.

SECTION 12.(b) North Carolina Community Care Networks, Inc., is encouraged to make, as soon as practicable, the following governance changes by amending its articles of incorporation, amending its bylaws, or taking other appropriate action:

(1) Adjust the board so as to contain the following:
   a. A health actuary.
   b. Two representatives of the provider community.
   c. One representative of the health insurance industry.
   d. Someone with expertise in health information technology, informatics, or performance measurement.
   e. A business owner or their designee.

(2) Adjust the board so as to provide for the following additional members:
   a. Two persons appointed by General Assembly on the recommendation of the President Pro Tempore of the Senate, at least one of whom shall be a business owner or their designee.
   b. Two persons appointed by the General Assembly on the recommendation of the Speaker of the House of Representatives, at least one of whom shall be a business owner or their designee.
   c. Two persons appointed by the Governor, at least one of whom shall be a business owner or their designee.

(3) Ensure that no more than two members on its board directly benefit from the per member per month (PMPM) payments to participating providers.

(4) Ensure that no more than twenty-five percent (25%) of the members of the board are providers or come from the provider community.

(5) Ensure that no member or immediate family of a member is a registered lobbyist or is employed by an entity that lobbies on behalf of a health care provider association.

(6) Ensure that the board size does not exceed 13 members.

PART VII. EFFECTIVE DATE

SECTION 13. Sections 7 and 8 of this act become effective January 1, 2014. Section 9 of this act becomes effective July 1, 2013, and applies to outpatient radiology services provided, and contracts executed or renewed, on or after that date. Section 10 of this act becomes effective January 1, 2014, and applies to tax refunds determined by the Department of Revenue on or after that date. Section 11 of this act becomes effective October 1, 2013. The remainder of this act is effective when it becomes law.