GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2013

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SENATE BILL 473
Health Care Committee Substitute Adopted 4/25/13
PROPOSED COMMITTEE SUBSTITUTE S473-PCS75319-RF-19

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 MAKE IT UNLAWFUL FOR HEALTH CARE PROVIDERS TO CHARGE FOR PROCEDURES OR COMPONENTS OF PROCEDURES THAT WERE NOT PROVIDED OR SUPPLIED; TO PROVIDE FOR FAIR HEALTH CARE FACILITY BILLING AND COLLECTIONS PRACTICES; AND TO PROVIDE GUIDANCE ON THE GOVERNANCE OF ENTITIES TO MANAGE CARE AND CONTROL COSTS STATEWIDE.

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

"Article 1B.

"Transparency in Health Care Costs.

"**§ 131E-214.5. Purpose; Department to publish price information.**

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

(b) The Department of Health and Human Services shall make available to the public on its internet Web site the most current price information it receives from hospitals and ambulatory surgical facilities pursuant to G.S. 131E-214.6. The Department 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-214.6.

(2) Information for each hospital outpatient department and each ambulatory surgical facility shall be listed separately.

(c) Any data disclosed to the Department 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 pursuant to this act, including a consolidation or analysis of the data, shall be and will remain the sole property of the State. The Department shall not allow proprietary information it receives pursuant to this act to be used by any person or entity for commercial purposes.

"**§ 131E-214.6. Disclosure of prices for most frequently reported DRGs, CPTs, and HCPCSs.**

(a) The following definitions apply in this Article:

(1) Ambulatory surgical facility. – A facility licensed under Part 4 of Article 6 of this Chapter.

(2) Commission. – The North Carolina Medical Care Commission.

(3) Hospital. – A medical care facility licensed under Article 5 of this Chapter or under Article 2 of Chapter 122C of the General Statutes.

(4) 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.

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

(b) Beginning with the quarter ending March 31, 2014, and quarterly thereafter, each hospital shall provide to the Department of Health and Human Services, utilizing electronic health records software, the following information about the 100 most frequently reported admissions by DRG for inpatients as established by the Commission:

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

(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 DRG, including claims and pro rata supplemental payments.

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

(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 DRG. Prior to providing this information to the Department, 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 DRG.

(c) The Commission shall adopt rules to ensure that subsection (b) of this section is properly implemented on January 1, 2014, and that hospitals report this information to the Department in a uniform manner. The rules shall include all of the following:

(1) The 100 most frequently reported DRGs for inpatients for which hospitals must provide the data set out in subsection (b) of this section.

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

(d) Beginning with the quarter ending June 30, 2014, and quarterly thereafter, each hospital and ambulatory surgical facility shall provide to the Department, utilizing electronic health records software, information on the total costs for the 20 most common surgical procedures and the 20 most common imaging procedures, by volume, performed in hospital outpatient settings or in ambulatory surgical facilities, along with the related CPT and HCPCS codes. Hospitals and ambulatory surgical facilities shall report this information in the same manner as required by subdivisions (b)(1) through (6) of this section.

(e) The Commission shall adopt rules on or before March 31, 2014, to ensure that subsection (d) of this section is properly implemented and that hospitals and ambulatory surgical facilities report this information to the Department in a uniform manner. The rules shall include the list of the 20 most common surgical procedures and the 20 most common imaging procedures, by volume, performed in a hospital outpatient setting and those performed in an ambulatory surgical facility, along with the related CPT and HCPCS codes.

(f) Upon request of a patient for a particular DRG, imaging procedure, or surgery procedure reported in this section, a hospital or ambulatory surgical facility shall provide the information required by subsection (b) or subsection (d) of this section to the patient in writing, either electronically or by mail, within three business days after receiving the request.

"**§ 131E-214.7. Disclosure of charity care policy and costs.**

(a) Requirements. – A hospital or ambulatory surgical facility required to file Schedule H, federal form 990, under the Code must provide the public access to its financial assistance policy and its annual financial assistance costs reported on its Schedule H, federal form 990. The information must be submitted annually to the Department in the time, manner, and format required by the Department. The Department must post the information on its Internet Web site. The information must also be displayed in a conspicuous place in the organization's place of business.

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

(1) Code. – Defined in G.S. 105-228.90.

(2) Financial assistance costs. – The information reported on Schedule H, federal form 990, related to the organization's financial assistance at cost and the amounts reported on that schedule related to the organization's bad debt expense and the estimated amount of the organization's bad debt expense attributable to patients eligible under the organization's financial assistance policy.

(3) Financial assistance policy. – A policy that meets the requirements of section 501(r) of the Code."

SECTION 3. Not later than July 1, 2013, the Department of Health and Human Services shall communicate the requirements of Section 2 of this act to all hospitals licensed pursuant to Article 5 of Chapter 131E of the General Statutes, Article 2 of Chapter 122C of the General Statutes, and to all ambulatory surgical facilities licensed pursuant to Part 4 of Article 6 of Chapter 131E of the General Statutes.

SECTION 4. 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 and ambulatory surgical facilities are required to report under G.S. 131E-214.6. 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 5. G.S. 131E-99 reads as rewritten:

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

~~The~~ Except for the information a hospital or an ambulatory surgical facility is required to report under G.S. 131E-214.6, 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. CERTAIN CHARGES/PAYMENTS PROHIBITED

SECTION 6. Article 16 of Chapter 131E of the General Statutes is amended by adding a new section to read:

"**§ 131E-273. Certain charges/payments prohibited.**

It shall be unlawful for any provider of health care services to charge or accept payment for any health care procedure or component of any health care procedure that was not performed or supplied."

PART IV. HOSPITAL DEBT COLLECTION

SECTION 7. 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 8.(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.~~patients detailing in language comprehensible to an ordinary layperson the specific nature of the charges or expenses incurred by the patient. Patient bills that are not itemized shall include notification to the patient 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. Each hospital and ambulatory surgical facility shall establish a method for patients to inquire about or dispute a bill.

(b) 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, and the overpayment is not in dispute or on appeal, the hospital or ambulatory surgical facility shall provide the patient with a refund within 45 days of receiving notice of the overpayment.

(c) 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.

(d) 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) For debts arising from the provision of care by a hospital or ambulatory surgical center, the doctrine of necessaries as it existed at common law shall apply equally to both spouses, except where they are permanently living separate and apart, but shall in no event create any liability between the spouses as to each other. No lien arising out of a judgment for a debt owed a hospital or ambulatory surgical facility under this section shall attach to the judgment debtors' principal residence held by them as tenants by the entireties or that was held by them as tenants by the entireties prior to the death of either spouse where the tenancy terminated as a result of the death of either spouse.

(6) For debts arising from the provision of care by a hospital or ambulatory surgical center to a minor, there shall be no execution on or otherwise forced sale of the principal residence of the custodial parent or parents for a judgment obtained for the outstanding debt until such time as the minor is either no longer residing with the custodial parent or parents or until the minor reaches the age of majority, whichever occurs first.

(e) 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~~ subsection are being met.

SECTION 8.(b) Article 2A of Chapter 131E of the General Statutes is repealed.

SECTION 8.(c) Part 4 of Article 6 of Chapter 131E of the General Statutes is amended by adding a new section 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 8.(d) 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. GOVERNANCE OF ENTITIES TO MANAGE CARE AND CONTROL COSTS STATEWIDE

SECTION 9.(a) The General Assembly finds that the internal governance of entities contracting with the State to provide centralized care coordination, cost containment, or management of care on a statewide basis for the Medicaid program is of significant importance to the State, its taxpayers, and its Medicaid recipients, especially given the considerable amount of public funds expended on such contracts. The General Assembly further finds that the public has a profound interest in ensuring the quality of the entities' internal governance and,

therefore, it is appropriate that the public should have an influence in the entities' internal governance.

SECTION 9.(b) Based on the legislative findings of subsection (a) of this section, the Department of Health and Human Services shall not enter into a new contract with an entity to provide cost containment or management of care on a statewide basis for the Medicaid program unless the entity adheres to the following governance provisions related to the entity's governing board:

(1) The board shall contain individuals with experience in health care, including the following:
   a. A health actuary.
   b. Someone with expertise in health information technology, informatics, or provider performance measurement.
   c. Two representatives of the provider community.
   d. A representative of the health insurance industry.

(2) The board shall provide for public, voting members to be appointed as follows:
   a. Two persons appointed by General Assembly on the recommendation of the President Pro Tempore of the Senate.
   b. Two persons appointed by the General Assembly on the recommendation of the Speaker of the House of Representatives.
   c. Two persons appointed by the Governor.

(3) No more than two members on the board may directly benefit from any per member per month (PMPM) payments or incentive payments that are distributed or administered by the entity.

(4) No more than twenty-five percent (25%) of the members of the board may be providers or come from the provider community.

(5) No member of the board, or immediate family of a member of the board, may be a registered lobbyist or be employed by an entity that lobbies on behalf of a health care provider association.

(6) The board size may not exceed twice the number of persons to be appointed under subdivision (2) of this section plus one.

SECTION 9.(c) Subsection (b) of this section shall not apply to existing contracts or renewals under existing contracts when the renewal is at the option of one party.

PART VII. EFFECTIVE DATE

SECTION 10. Sections 4 and 5 of this act become effective January 1, 2014. Section 6 of this act becomes effective December 1, 2013, and applies to health care procedures and services rendered on or after that date. Section 7 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 8 of this act becomes effective October 1, 2013, and applies to hospital and ambulatory surgical facility billings and collections practices occurring on or after that date. The remainder of this act is effective when it becomes law.