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S **D**

SENATE BILL DRS35129-MR-39

Short Title:	Greater Transparency in Health Care Billing.	(Public)
Sponsors:	Senators Hise, Krawiec, and Burgin (Primary Sponsors).	
Referred to:		

A BILL TO BE ENTITLED

AN ACT TO PROVIDE GREATER TRANSPARENCY IN HEALTH CARE SERVICES BILLING AND TO REDUCE BILLING THAT COMES AS A SURPRISE TO THE PATIENT.

The General Assembly of North Carolina enacts:

SECTION 1.(a) G.S. 58-3-200(a) is repealed.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

"Article 11B.

"Transparency in Health Services Billing Practices.

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

"**§ 131E-214.11. Title.**

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

…

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

"**§ 131E-214.25. Definitions.**

The following definitions apply in this Part:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

"**§ 131E-214.28. Penalties.**

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

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

"Article 41A.

"Transparency in Health Care Provider Billing Practices.

"**§ 90-705. Definitions.**

The following definitions shall apply in this Article:

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

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

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

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

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

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

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

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

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

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

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

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

"**§ 90-708. Penalties.**

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

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

"(a) It is the intent of this ~~Article~~ Part 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."

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

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

…."

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