GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2025

H.B. 1175
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HOUSE PRINCIPAL CLERK

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HOUSE BILL DRH30588-MRa-130D

Short Title:	Affordability in Healthcare Act.	(Public)
Sponsors:	Representative Cervania.	
Referred to:		

A BILL TO BE ENTITLED

AN ACT TO LOWER HEALTHCARE COSTS, INCREASE COMPETITION IN THE HEALTH INSURANCE MARKET, AND IMPROVE VALUE AND TRANSPARENCY BY LEVERAGING THE STATE'S PURCHASING POWER; TO ESTABLISH A LOW-COST, AFFORDABLE HEALTH PLAN OPTION ON THE AFFORDABLE CARE ACT HEALTH INSURANCE MARKETPLACE; TO CREATE A HEALTHCARE PURCHASING CONSORTIUM TO ALIGN PUBLIC PROCUREMENT; TO APPROPRIATE FUNDS FOR IMPLEMENTATION; TO CONTINUE AND EXPAND HEALTHY OPPORTUNITIES ACTIVITIES TO PROMOTE CHRONIC DISEASE PREVENTION; TO ELIMINATE CERTIFICATE OF NEED REVIEW FOR INPATIENT REHABILITATION SERVICES, REHABILITATION FACILITIES, AND REHABILITATION BEDS; TO PROVIDE GREATER PROTECTION FOR ESSENTIAL RURAL HEALTH SERVICES; AND TO PRESERVE COMPETITION IN HEALTHCARE BY REGULATING THE CONSOLIDATION AND CONVEYANCE OF HOSPITALS.

Whereas, the people of North Carolina are entitled to timely, affordable, and high-quality healthcare as a matter of human dignity, public welfare, and fundamental fairness; and

Whereas, healthcare is not a luxury but a necessity, and the inability to obtain needed care or coverage endangers the lives, well-being, and economic security of individuals, families, and communities across this State; and

Whereas, in 2026, the cost of healthcare in North Carolina remains too high for too many residents, employers, and taxpayers, driven in part by market consolidation, opaque pricing, administrative burdens, avoidable chronic disease, barriers to meaningful competition, and billing and facility practices that increase costs without commensurate improvement in patient outcomes or access to care; and

Whereas, excessive healthcare costs force North Carolinians to delay treatment, forgo preventive care, accumulate medical debt, and remain uninsured or underinsured, thereby worsening illness, increasing long-term system costs, and deepening inequality; and

Whereas, high healthcare prices also impose substantial burdens on small businesses, local governments, North Carolina State Health Plan for Teachers and State Employees, and other public purchasers, diverting resources away from wages, education, infrastructure, and other public needs; and

Whereas, many North Carolinians remain uninsured or lack access to coverage they can reasonably afford, and the State has a compelling interest in expanding access to dependable, affordable health benefit plans so that residents may obtain needed care before medical conditions become more severe and more costly; and

Whereas, chronic disease is a major driver of suffering, preventable death, and rising medical expenditures, and public health initiatives that prevent, mitigate, and better manage chronic illness are necessary both to improve quality of life and to reduce long-term healthcare costs; and

Whereas, consumers and patients should be protected from healthcare practices that increase prices, obscure the true cost of care, delay or complicate treatment, or impose charges unrelated to improvements in quality, safety, or clinical outcomes; and

Whereas, it is in the interest of the State to lower healthcare costs by increasing competition, leveraging public purchasing power, expanding access to affordable coverage, encouraging public health strategies that reduce chronic disease, and protecting patients and consumers from practices that inflate costs without improving care; Now, therefore,

The General Assembly of North Carolina enacts:

PART I. INCREASING COMPETITION AND LOWERING HEALTHCARE COSTS THROUGH MARKETPLACE INNOVATION AND PURCHASING ALIGNMENT

SECTION 1.1.(a) The General Assembly finds that rising healthcare costs continue to place significant financial strain on individuals, families, employers, and taxpayers across North Carolina. It is in the public interest to promote affordability, expand consumer choice, improve transparency, and strengthen health outcomes by increasing competition in the individual health insurance market and leveraging the State's purchasing power more effectively. The General Assembly further finds all of the following:

(1) In many regions of North Carolina, limited competition in the individual health insurance market contributes to higher premiums and fewer affordable coverage options for consumers. Establishing a lower-cost, State-supported health plan option offered on the Affordable Care Act Health Insurance Marketplace can increase competition, expand access to affordable coverage, and improve price transparency for consumers and the State.

(2) North Carolina's public employers and public programs purchase health coverage and health care services at scale, yet procurement and contracting are fragmented across public entities, diluting negotiating leverage, increasing administrative costs, and limiting the State's ability to align purchasing strategies toward affordability and value.

(3) Coordinating public purchasers through a consortium can support aligned procurement standards, common performance guarantees and data standards, and shared analytics to improve competition, transparency, and affordability while respecting voluntary participation by local governments and other public entities.

(4) Investments in evidence-based interventions that address health-related social needs can reduce avoidable healthcare utilization, improve health outcomes, and support chronic disease prevention when coordinated with Medicaid managed care and other State initiatives to the extent permitted by federal law.

SECTION 1.1.(b) Chapter 58 of the General Statutes is amended by adding a new Article to read:

"Article 94.

"Low-Cost Health Plan Option.

"**§ 58-94-1. Definitions.**

The following definitions apply in this Article:

(1) DHHS. – The Department of Health and Human Services.

(2) Exchange. – The health benefit exchange serving North Carolina pursuant to 42 U.S.C. § 18031 or any successor law.

(3) Reserved for future codification purposes.

(4) Low-Cost Health Plan Option. – A qualified health plan, or group of qualified health plans, made available through a State-facilitated arrangement and ordered on the Exchange in accordance with this Article for the purpose of increasing competition, improving affordability, and expanding consumer choice.

(5) Participating carrier. – An insurer licensed under this Chapter that contracts with the State to offer the Low-Cost Health Plan Option.

(6) Reference-based rate. – A reimbursement rate benchmarked to Medicare or another objective schedule adopted pursuant to this Article.

"**§ 58-94-5. Establishment of Low-Cost Health Plan Option.**

(a) DHHS shall, in consultation with the Department and the State Treasurer, establish and administer the North Carolina Low-Cost Health Plan Option.

(b) The Low-Cost Health Plan Option shall be offered on the Exchange statewide.

(c) DHHS may procure one or more participating carriers or third-party administrators to underwrite, administer, and operate the Low-Cost Health Plan Option, including provider network contracting, claims administration, utilization management, and customer service.

(d) The Low-Cost Health Plan Option shall comply with applicable federal law for qualified health plans.

"**§ 58-94-10. Standards for affordability and value.**

(a) Procurement Requirements. – DHHS shall set procurement requirements intended to reduce premiums and out-of-pocket costs, including reasonable administrative expense limits, quality metrics, and reporting requirements.

(b) Participating Carrier Requirements. – DHHS may require participating carriers to use value-based payment, tiered networks, advanced primary care models, or other designs consistent with affordability and quality.

(c) Reference-Based Rates. – To the extent permitted by federal law, the DHHS may set reference-based rates for provider reimbursement under the Low-Cost Health Plan Option, including rates expressed as a percentage of Medicare, with adjustments for rural access, critical access hospitals, and other essential providers.

(d) Affordability Outcomes. – Beginning with the initial plan year and for each plan year thereafter, DHHS shall ensure that the Low-Cost Health Plan Option meets the following affordability outcomes:

(1) Premium benchmark. – For each rating area in which the Low-Cost Health Plan Option is offered, DHHS shall procure and administer at least one standard-design silver Low-Cost Health Plan Option plan with a premium that is no greater than ninety-five percent (95%) of the premium for the lowest-premium available silver qualified health plan offered in the same rating area, excluding the Low-Cost Health Plan Option, for the same age and tobacco status, as determined using a methodology specified by DHHS.

(2) Administrative expense cap. – DHHS shall require participating carriers and third-party administrators to meet a reasonable administrative expense limit that shall not exceed twelve percent (12%) of premium, except that DHHS may allow a higher limit for the first plan year of operation if the DHHS finds that a temporary adjustment is necessary for implementation and consumer protections and reports the finding to the Joint Legislative Oversight Committee on Health and Human Services.

(3) Out-of-pocket affordability standard. – DHHS shall require standardized benefit designs for at least one silver plan and shall set cost-sharing parameters intended to reduce out-of-pocket costs relative to comparable silver plans, including lower deductibles or copayments for primary care, behavioral

health, and generic prescription drugs, consistent with federal law for qualified health plans.

(4) Corrective action. – If DHHS determines that an affordability outcome required by this subsection cannot be met in a rating area due to network adequacy requirements, provider participation, federal restrictions, or other constraints outside the reasonable control of DHHS, then DHHS shall do all of the following:

a. Document the constraint and the steps taken to address it.

b. Implement procurement or design changes reasonably expected to improve affordability in the subsequent plan year.

c. Report the determination and corrective action plan in the annual report required by G.S. 58-94-25.

"**§ 58-94-15. Provider participation and network adequacy.**

(a) Network adequacy requirements for the Low-Cost Health Plan Option shall be consistent with State and federal standards.

(b) DHHS may include provisions to encourage broad provider participation, including prompt pay protections and standardized contracting terms.

(c) Nothing in this Article shall be construed to mandate a healthcare provider to contract with a participating carrier.

"**§ 58-94-20. Financing; no State guarantee.**

(a) The Low-Cost Health Plan Option shall be financed primarily through premiums and other revenues associated with plan operations.

(b) The State does not guarantee premiums, liabilities, or obligations of a participating carrier.

(c) Appropriations may be requested for plan start-up costs, systems integration, actuarial services, and procurement expenses.

"**§ 58-94-25. Reporting.**

DHHS shall report annually to the Joint Legislative Oversight Committee on Health and Human Services and the Fiscal Research Division on enrollment, premiums, claims, administrative costs, network adequacy, consumer satisfaction, quality outcomes, and any recommended statutory changes."

SECTION 1.2.(a) The Low-Cost Health Plan Option shall be offered on the Federally Facilitated Marketplace, or Exchange, beginning with the plan year 2028, unless the Department of Health and Human Services certifies in writing to the Joint Legislative Oversight Committee on Health and Human Services that an earlier plan year is feasible.

SECTION 1.2.(b) This Part is effective when it becomes law, and the Department of Health and Human Services shall begin planning, procurement, and implementation of this Part when this Part becomes effective.

PART II. POOLING PUBLIC PURCHASING POWER/PUBLIC HEALTH PURCHASING CONSORTIUM

SECTION 2.1. Chapter 143 of the General Statutes is amended by adding a new Article to read:

"Article 85.

"Public Health Purchasing Consortium.

"**§ 143-820. Establishment.**

(a) There is established the Public Health Purchasing Consortium, also known as the Consortium, to coordinate, aggregate, and strategically align the healthcare purchasing power of public entities in North Carolina.

(b) The Consortium shall be chaired by the State Treasurer or the Treasurer's designee and shall include, at a minimum, the following members:

(1) The Department of Health and Human Services.
(2) The Department of Insurance.
(3) The Office of State Human Resources.
(4) The University of North Carolina System.
(5) The North Carolina Community College System.
(6) A representative of another public entity designated by the chair.

(c) Local governments may elect to participate in the Consortium pursuant to G.S. 143-823.

"**§ 143-821. Powers and duties.**

The Consortium shall do all of the following:

(1) Develop model procurement standards for carriers, Third-Party Administrators, Pharmacy Benefit Managers, and other vendors.
(2) Pursue joint or aligned procurements where practicable, including common performance guarantees and data standards.
(3) Establish common definitions and reporting for price, quality, and utilization metrics.
(4) Coordinate strategies to improve competition, transparency, and affordability.
(5) Recommend statutory or budget changes to implement purchasing reforms.
(6) Support implementation of the Low-Cost Health Plan Option created under Article 94 of Chapter 58 of the General Statutes.

"**§ 143-822. Data sharing and analysis.**

(a) The Consortium may establish a secure data sharing framework for claims, encounter, and pharmacy data among participating public purchasers for purposes of analytics, fraud detection, payment reform, and evaluation of procurement performance, subject to HIPAA and State privacy laws.

(b) Data disclosed under this section shall be used only for public purchasing purposes and shall not be publicly disclosed in a manner that reveals protected health information or proprietary pricing terms, except as otherwise required by law.

"**§ 143-823. Voluntary participation by local governments and other public entities.**

(a) A county, municipality, or other political subdivision may elect to participate in Consortium initiatives, including joint procurements and shared analytics, upon approval by its governing board and execution of a participation agreement.

(b) Participation agreements may address cost-sharing, governance, data use, vendor selection, and opt-out procedures.

"**§ 143-824. Reports.**

The Consortium shall submit an annual report to the Joint Legislative Oversight Committee on General Government and the Joint Legislative Oversight Committee on Health and Human Services detailing activities, savings estimates, procurement outcomes, and recommendations."

PART III. IMPLEMENTATION AND APPROPRIATION FOR THE LOW-COST HEALTH PLAN OPTION AND THE PUBLIC HEALTH PURCHASING CONSORTIUM

SECTION 3.1.(a) The Department of Health and Human Services, the Department of Insurance, and the Department of State Treasurer shall enter into any interagency agreements necessary to implement Parts I and II of this act.

SECTION 3.1.(b) The Department of Health and Human Services may issue requests for information and requests for proposals and may take other actions necessary to ensure the Low-Cost Health Plan Option under Part I of this act is operational by the date required in this act.

SECTION 3.2. Effective July 1, 2026, there is appropriated from the General Fund to the Department of Health and Human Services the sum of twenty-five million dollars

($25,000,000) in recurring funds and the sum of ten million dollars ($10,000,000) in nonrecurring funds for the 2026-2027 fiscal year to implement the Low-Cost Health Plan Option under Part I of this act and the Public Health Purchasing Consortium under Part II of this act, including Consortium analytics and procurement coordination, actuarial services, information technology, contracting support, and outreach.

PART IV. HEALTHY OPPORTUNITIES CONTINUATION FOR CHRONIC DISEASE PREVENTION

SECTION 4.1.(a) There is appropriated from the General Fund to the Department of Health and Human Services, Division of Health Benefits (DHB), the sum of one hundred seventy-five million dollars ($175,000,000) in recurring funds and associated receipts for the 2026-2027 fiscal year to continue and expand Healthy Opportunities Pilots activities to promote chronic disease prevention, reduce avoidable healthcare utilization, and improve health outcomes through evidence-informed interventions addressing health-related social needs, including, as applicable, nutrition supports, housing-related supports, transportation supports, interpersonal safety supports, and other services authorized by DHHS consistent with federal requirements.

SECTION 4.1.(b) Funds appropriated by this section may be used for any of the following purposes related to Healthy Opportunities Pilots:

(1) Payments to participating entities, network leads, human service organizations, and other contractors or grantees to deliver covered interventions.

(2) Administrative costs necessary to operate the program, including contracting, compliance, data collection, evaluation, quality improvement, and program integrity activities.

(3) Information technology, referral platforms, community resource connectivity, and related infrastructure needed to support screening, referral, service delivery, and reporting.

(4) Technical assistance, provider engagement, beneficiary outreach, and training necessary for effective implementation.

SECTION 4.1.(c) DHB shall prioritize the use of funds under this section for interventions and program designs that are expected to reduce the incidence or severity of chronic disease, including diabetes, cardiovascular disease, asthma, and other conditions identified by DHB. DHB shall coordinate implementation with Medicaid managed care and other relevant State initiatives to the extent permitted by federal law.

SECTION 4.1.(d) Funds appropriated by this section shall not be used to supplant existing State funding for substantially similar purposes unless expressly authorized by an act of the General Assembly.

SECTION 4.2. The Department of Health and Human Services, Division of Health Benefits (DHB), shall submit a report by March 1, 2027, and annually thereafter while funds remain available, to the Joint Legislative Oversight Committee on Medicaid, the Joint Legislative Oversight Committee on Health and Human Services, and the Fiscal Research Division on all of the following items related to the Healthy Opportunities Pilots:

(1) Annual expenditures by category and region.

(2) Number of beneficiaries served and services delivered within the previous calendar year.

(3) Outcome measures, including utilization impacts where measurable.

(4) Recommendations for continuation, modification, or expansion of the Healthy Opportunities Pilots.

SECTION 4.3. This Part is effective July 1, 2026.

PART V. GREATER TRANSPARENCY IN HOSPITAL AND AMBULATORY SURGICAL FACILITY HEALTHCARE COSTS

SECTION 5.1. Article 11B of Chapter 131E of the General Statutes reads as rewritten:

"Article 11B.

"Transparency in Health Care Costs.

"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.

…

"**§ 131E-214.13. Disclosure of prices for most frequently reported DRGs, CPTs, and HCPCSs.**

(a) Definitions. – The following definitions apply in this ~~Article:~~Part:

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

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

(2a) CPT. – Current Procedural Terminology.

(2b) DRG. – Diagnostic Related Group.

(2c) HCPCS. – The Healthcare Common Procedure Coding System.

(3) Health insurer. – An entity that writes a health benefit plan and is one of the following:

a. An insurance company under Article 3 of Chapter 58 of the General Statutes.

b. A service corporation under Article 65 of Chapter 58 of the General Statutes.

c. A health maintenance organization under Article 67 of Chapter 58 of the General Statutes.

d. A third-party administrator of one or more group health plans, as defined in section 607(1) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. § 1167(1)).

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

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

(6) Statewide data processor. – As defined in G.S. 131E-214.1.

(b) ~~Beginning with the reporting period ending September 30, 2015, and annually thereafter,~~ Quarterly Report on Most Frequently Reported DRGs for Inpatients. – On a quarterly basis, each hospital shall provide to the ~~Department of Health and Human Services~~ statewide data processor, utilizing electronic health records software, the following information about the 100 most frequently reported admissions by DRG for inpatients as established by the Department:

(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. In calculating this amount, each hospital shall include charges for each billable item and service associated with the DRG regardless of whether the health service is performed by a physician or nonphysician practitioner employed by the hospital.

(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 amount of Medicaid reimbursement for each DRG, including claims and pro rata supplemental payments.
(4) The amount of Medicare reimbursement for each DRG.
(5) For each of the five largest health insurers providing payment to the hospital on behalf of insureds and teachers and State employees, the range and the average of the amount of payment made for each DRG. Prior to providing this information to the ~~Department~~ statewide data processor, each hospital shall redact the names of the health insurers and any other information that would otherwise identify the health insurers.

A hospital shall not be required to report the information required by this subsection for any of the 100 most frequently reported admissions where the reporting of that information reasonably could lead to the identification of the person or persons admitted to the hospital in violation of the federal Health Insurance Portability and Accountability Act of 1996 (HIPAA) or other federal law.

~~(c) The Commission shall adopt rules on or before March 1, 2016, to ensure that subsection (b) of this section is properly implemented and that hospitals report this information to the Department in a uniform manner. The rules shall include all of the following:~~

~~(1) The method by which the Department shall determine 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 reporting period ending September 30, 2015, and annually thereafter,~~ Quarterly Report on Total Costs for the Most Common Surgical and Imaging Procedures. – On a quarterly basis, each hospital and ambulatory surgical facility shall provide to the ~~Department,~~ statewide data processor, 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. In providing information on total costs, each hospital and ambulatory surgical facility shall include the costs for each billable item and service associated with the procedure regardless of whether the health service is performed by a physician or nonphysician practitioner employed by the hospital or ambulatory surgical facility. Hospitals and ambulatory surgical facilities shall report this information in the same manner as required by subdivisions (b)(1) through (5) of this section, provided that hospitals and ambulatory surgical facilities shall not be required to report the information required by this subsection where the reporting of that information reasonably could lead to the identification of the person or persons admitted to the hospital in violation of the federal Health Insurance Portability and Accountability Act of 1996 (HIPAA) or other federal law.

~~(e) The Commission shall adopt rules on or before March 1, 2016, 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 method by which the Department shall determine the 20 most common surgical procedures and the 20 most common imaging procedures for which the hospitals and ambulatory surgical facilities must provide the data set out in subsection (d) of this section.~~

~~(e1) The Commission shall adopt rules to establish and define no fewer than 10 quality measures for licensed hospitals and licensed ambulatory surgical facilities.~~

(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.

(f1) Commission Rules. – The Commission shall adopt rules to accomplish all of the following:

(1) To ensure that subsection (b) of this section is properly implemented and that hospitals report this information to the statewide data processor in a uniform manner. The rules shall include the method by which the statewide data processor shall determine the 100 most frequently reported DRGs for inpatients for which hospitals must provide the data set out in subsection (b) of this section and the specific categories by which hospitals shall be grouped for the purpose of disclosing this information to the public on the Department's website.

(2) To ensure that subsection (d) of this section is properly implemented and that hospitals and ambulatory surgical facilities report this information to the statewide data processor in a uniform manner. The rules shall include the method by which the statewide data processor shall determine the 20 most common surgical procedures and the 20 most common imaging procedures for which the hospitals and ambulatory surgical facilities must provide the data set out in subsection (d) of this section.

(3) To establish and define no fewer than 10 quality measures for licensed hospitals and licensed ambulatory surgical facilities.

(4) To establish procedures for the statewide data processor to receive the data required by subsections (b) and (d) of this section and submit that data to the Department for publication on the Department's website.

(g) G.S. 150B-21.3 does not apply to rules adopted under ~~subsections (c) and (e)~~ subdivision (f1)(1) or subdivision (f1)(2) of this section. A rule adopted under ~~subsections (c) and (e)~~ subdivision (f1)(1) or subdivision (f1)(2) of this section becomes effective on the last day of the month following the month in which the rule is approved by the Rules Review Commission.

…

"**§ 131E-214.18. Penalty for noncompliance.**

The Department may impose a civil penalty on any hospital or ambulatory surgical facility that fails to comply with the requirements of this Part. For each day of violation, the amount of the civil penalty shall not be (i) less than one hundredth of one percent (.01%) of the annual salary of the chief executive officer of the noncompliant hospital or ambulatory surgical facility or (ii) greater than two thousand dollars ($2,000). This civil penalty shall be in addition to any fine or civil penalty that the Centers for Medicare and Medicaid Services or other federal agency may choose to impose on the facility. The Department shall remit the clear proceeds of civil penalties assessed pursuant to this section to the Civil Penalty and Forfeiture Fund in accordance with G.S. 115C-457.2."

SECTION 5.2. G.S. 131E-214.4(a) reads as rewritten:

"(a) A statewide data processor shall perform the following duties:

…

(8) Receive data required to be submitted by hospitals under G.S. 131E-214.13(b) and by hospitals and ambulatory surgical facilities under G.S. 131E-214.13(d) and submit that data to the Department of Health and Human Services (Department) for publication on the Department's website."

SECTION 5.3. This Part becomes effective on the later of January 1, 2027, or the date the rules adopted by the North Carolina Medical Care Commission under G.S. 131E-214.13(f1)(2) take effect, and G.S. 131E-214.18, as enacted by this Part, applies to

acts occurring on or after that date. The Commission shall notify the Revisor of Statutes when the rules required under G.S. 131E-214.13(f1)(1) and (f1)(2) take effect.

PART VI. GREATER TRANSPARENCY IN HEALTH CARE PROVIDER BILLING PRACTICES

SECTION 6.1. Article 11B of Chapter 131E of the General Statutes, as amended by Part V of this act, is amended by adding a new Part to read:

"Part 2. Transparency in 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, or under the laws of another state or the federal government.

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

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

"**§ 131E-214.30. Fair notice requirements; health service facilities.**

(a) Services Provided at a Participating Health Service Facility. – At the time a health service facility participating in an insurer's 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 service facility shall provide the insured individual with a written disclosure containing all of the following information:

(1) Services may be provided at the health service facility for which the insured individual may receive a separate bill.

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

(3) 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 service facility or provider participating in the insurer's provider network may not be applicable when services are rendered by a nonparticipating provider.

(b) Emergency Services Provided at Nonparticipating Health Service Facilities. – As soon as practicable after a health service facility begins the provision of emergency services to an insured individual, if the facility does not have a contract with the applicable insurer, then the health service facility shall provide the insured individual with a written disclosure containing all of the following:

(1) A statement that the health service facility does not have a provider network contract with the applicable insurer and is considered to be a nonparticipating provider.

(2) 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 service 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 service facility.

"**§ 131E-214.31. Fair notice requirements.**

At the time a health care provider not participating in an insurer's provider network (i) treats an insured individual for anything other than screening and stabilization in accordance with G.S. 58-3-190, (ii) schedules an appointment or procedure for nonemergency services for an insured individual, or (iii) seeks prior authorization from an insurer for the provision of nonemergency services to an insured individual, the provider shall provide the insured individual with a written disclosure containing all of the following information:

(1) A statement that the provider is not in the insurer's health care provider network applicable to the individual.

(2) 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 care provider participating in the insurer's health care provider network may not be applicable when services are rendered by a nonparticipating provider.

"**§ 131E-214.35. Penalties.**

The repeated failure to comply with this Article shall indicate a general business practice that is deemed an unfair and deceptive trade practice and is actionable under Chapter 75 of the General Statutes. Nothing in this Article forecloses other remedies available under law or equity."

SECTION 6.2.(a) G.S. 58-3-200(a)(1) and G.S. 58-3-200(a)(2) are repealed.

SECTION 6.2.(b) G.S. 58-3-200(a), as amended by subsection (a) of this section, reads as rewritten:

"(a) Definitions. – ~~As used~~ The following definitions apply in this section:

…

(3) 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.

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

SECTION 6.2.(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 or request from the insured, the insurer shall determine whether a provider able to meet the needs of the insured is available to the insured without unreasonable delay by reference to the insured's location and the specific medical needs of the insured."

SECTION 6.3. This Part becomes effective October 1, 2026, and applies to healthcare services provided on or after that date and to contracts issued, renewed, or amended on or after that date.

PART VII. GREATER FAIRNESS IN BILLING AND COLLECTIONS PRACTICES FOR HOSPITALS AND AMBULATORY SURGICAL FACILITIES

SECTION 7.1.(a) Chapter 131E of the General Statutes is amended by adding a new Article 11C to be entitled "Fair Billing and Collections Practices for Hospitals and Ambulatory Surgical Facilities."

SECTION 7.1.(b) G.S. 131E-91 is recodified as G.S. 131E-214.50 under Article 11C of Chapter 131E of the General Statutes, as created by subsection (a) of this section.

SECTION 7.1.(c) G.S. 131E-214.50(d) reads as rewritten:

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

…

(1a) A hospital or ambulatory surgical facility shall not refer a patient's unpaid bill to a collections agency, entity, or other assignee unless it has first presented an itemized list of charges to the patient detailing, in language comprehensible to an ordinary layperson, the specific nature of the charges or expenses incurred by the patient.

…."

SECTION 7.2. Article 11C of Chapter 131E of the General Statutes, as created by Section 7.1(a) of this act, is amended by adding a new section to read:

"**§ 131E-214.52. Patient's right to a good-faith estimate.**

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

(1) CMS. – The federal Centers for Medicare and Medicaid Services.

(2) Facility. – A hospital or ambulatory surgical facility licensed under this Chapter.

(3) Items and services. – All items and services, including individual items and services and service packages, that could be provided by a facility to a patient in connection with an inpatient admission or an outpatient visit for which the facility has established a standard charge. Examples include, but are not limited to, all of the following:

a. Supplies and procedures.

b. Room and board.

c. Fees for use of the facility or other items.

d. Professional charges for services of physicians and nonphysician practitioners who are employed by the facility.

e. Professional charges for services of physicians and nonphysician practitioners who are not employed by the facility.

f. Any other items or services for which a facility has established a standard charge.

(4) Service package. – An aggregation of individual items and services into a single service with a single charge.

(5) Shoppable service. – A non-urgent service that can be scheduled by a patient in advance. The term includes all CMS-specified shoppable services plus as many additional facility-selected shoppable services as are necessary for a combined total of at least 300 shoppable services.

(b) Good-Faith Estimate. – Upon request of any patient for a good-faith estimate for a shoppable service, the facility shall provide to the patient, in writing, at least three business days prior to the date the patient schedules the shoppable service, an itemized list of expected charges, in language comprehensible to an ordinary layperson, that the patient will be obligated to pay for all items and services related to the shoppable service. The good-faith estimate shall include the Diagnostic Related Group (DRG), Current Procedural Terminology (CPT), or Healthcare Common Procedure Coding System (HCPCS) code for each expected charge.

(c) In any case in which a patient has requested a good-faith estimate from a facility for a shoppable service, the patient's final bill for that shoppable service shall not exceed more than five percent (5%) of the good-faith estimate provided to the patient pursuant to this section.

(d) The Department shall adopt rules to implement this section."

SECTION 7.3. This Part becomes effective on the later of January 1, 2027, or the date the rules adopted by the Department under G.S. 131E-214.52 take effect and applies to acts occurring on or after that date. The Department shall notify the Revisor of Statutes when the rules required under G.S. 131E-214.52 take effect.

PART VIII. GREATER PROTECTION FOR HEALTHCARE CONSUMERS FROM FACILITY FEES

SECTION 8.1.(a) Article 11C of Chapter 131E of the General Statutes, as created by Section 7.1(a) of this act, is amended by adding a new section to read:

"**§ 131E-214.54. Facility fees.**

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

(1) Ambulatory surgical facility. – As defined in G.S. 131E-176.

(2) Campus. – Any of the following:

a. The main building of a hospital.

b. The physical area immediately adjacent to a hospital's main building.

c. Other structures not contiguous to the main building of a hospital that are within 250 yards of the main building.

d. Any other area that has been determined to be part of a hospital's campus by the Centers for Medicare and Medicaid Services.

(3) 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.

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

(5) 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.

(6) Hospital. – Any hospital as defined in G.S. 131E-76 and any facility licensed under Chapter 122C of the General Statutes.

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

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

(9) Remote location of a hospital. – A hospital-based facility that is created, acquired, or purchased by a hospital or health system for the purpose of furnishing inpatient services under the name, ownership, and financial and administrative control of the hospital.

(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, at a remote location of a hospital, at a facility that includes an emergency department, or at an ambulatory surgical facility.

(2) Regardless of where the services are provided, no health care provider shall charge, bill, or collect a facility fee for 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 this section constitutes an unfair or deceptive trade practice in violation of G.S. 75-1.1 and is subject to all of the enforcement and penalty provisions of an unfair or deceptive trade practice under 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."

SECTION 8.1.(b) No later than January 1, 2027, the Department of Health and Human Services shall adopt rules necessary to implement G.S. 131E-214.54, as enacted by subsection (a) of this section.

SECTION 8.2. G.S. 131E-214.54, as enacted by Section 8.1(a) of this Part, becomes effective on the later of January 1, 2027, or the date the rules adopted by the Department of Health and Human Services pursuant to Section 8.1(b) of this Part become effective, and applies to healthcare services provided on or after that date. The Department shall notify the Revisor of Statutes when the rules required under Section 8.1(b) of this Part become effective.

PART IX. STATE AUDITOR REVIEW OF HEALTH SERVICE FACILITY PRICES

SECTION 9.1. G.S. 147-64.6(c) reads as rewritten:

"(c) Responsibilities. – The Auditor is responsible for the following acts and activities:

…

(25) The Auditor shall periodically examine (i) health service facilities, as defined in G.S. 131E-176, that are recipients of State funds and (ii) facilities licensed under Chapter 122C of the General Statutes that are recipients of State funds and report findings to the Joint Legislative Oversight Committee on Health and Human Services on April 1, 2027, and periodically thereafter. The report must include at least the following:
a. The prices that the health service facility charges patients whose insurance is out-of-network or who are uninsured.
b. To what extent the health service facility is transparent about the prices described in sub-subdivision a. of this subdivision."

PART X. ENHANCEMENTS TO EMPLOYEE SAFETY BY ALLOWING FOR THE REMOVAL OF CERTAIN EMPLOYEE DETAILS FROM HEALTH INSURANCE APPEALS AND GRIEVANCE REVIEWS

SECTION 10.1.(a) G.S. 58-50-61(k) reads as rewritten:

"(k) Nonexpedited Appeals. – Within three business days after receiving a request for a standard, nonexpedited appeal, the insurer or its URO shall provide the covered person with ~~the name, address, and telephone number of the coordinator and~~ information on how and where to submit written ~~material.~~ material for the appeal, including contact information for the insurer. For standard, nonexpedited appeals, the insurer or its URO shall give written notification of the decision, in clear terms, to the covered person and the covered person's provider within 30 days after the insurer receives the request for an appeal. If the decision is not in favor of the covered person, the written decision shall ~~contain:~~contain all of the following information:

(1) The professional qualifications and licensure of the person or persons reviewing the appeal.

(2) A statement of the ~~reviewers' understanding of the reason for the covered person's~~ basis of the appeal.

(3) The ~~reviewers'~~ insurer's or URO's decision in clear terms and the medical rationale in sufficient detail for the covered person to respond further to the insurer's position.

…."

SECTION 10.1.(b) G.S. 58-50-62(e) reads as rewritten:

"(e) First-Level Grievance Review. – A covered person or a covered person's provider acting on the covered person's behalf may submit a grievance. All of the following shall apply to a first-level grievance review:

(1) The insurer ~~does not have~~ is not required to allow a covered person to attend the first-level grievance review. A covered person may submit written material. Except as provided in subdivision (3) of this subsection, within three business days after receiving a grievance, the insurer shall provide the covered person with ~~the name, address, and telephone number of the coordinator and~~ information on where and how to submit written ~~material.~~material for the first-level grievance review, including contact information for the insurer.

(2) An insurer shall issue a written decision, in clear terms, to the covered person and, if applicable, to the covered person's provider, within 30 days after receiving a grievance. The person or persons reviewing the grievance shall not be the same person or persons who initially handled the matter that is the subject of the grievance and, if the issue is a clinical one, at least one of whom shall be a medical doctor with appropriate expertise to evaluate the matter. Except as provided in subdivision (3) of this subsection, if the decision is not in favor of the covered person, the written decision issued in a first-level grievance review shall ~~contain:~~contain all of the following information:

a. The professional qualifications and licensure of the person or persons reviewing the grievance.

b. A statement of the ~~reviewers' understanding~~ basis of the grievance.

c. The ~~reviewers'~~ insurer's decision in clear terms and the contractual basis or medical rationale in sufficient detail for the covered person to respond further to the insurer's position.

…."

SECTION 10.1.(c) G.S. 58-50-62(f) reads as rewritten:

"(f) Second-Level Grievance Review. – An insurer shall establish a second-level grievance review process for covered persons who are dissatisfied with the first-level grievance review decision or a utilization review appeal decision. A covered person or the covered person's

provider acting on the covered person's behalf may submit a second-level grievance. All of the following shall apply to a second-level grievance review:

(1) An insurer shall, within 10 business days after receiving a request for a second-level grievance review, ~~make known to~~ provide the covered ~~person:~~person all of the following information:

a. ~~The name, address, and telephone number of a person designated to coordinate the grievance review for the insurer.~~Information on how and where to submit written material for the second-level grievance review, including contact information for the insurer.

…."

SECTION 10.2. This Part is effective when it becomes law.

PART XI-A. ELIMINATION OF CERTIFICATE OF NEED REVIEW FOR INPATIENT REHABILITATION SERVICES, REHABILITATION FACILITIES, AND REHABILITATION BEDS

SECTION 11A.1. G.S. 131E-176 reads as rewritten:

"**§ 131E-176. Definitions.**

The following definitions apply in this Article:

…

(9a) Health service. – An organized, interrelated activity that is medical, diagnostic, therapeutic, ~~rehabilitative,~~ or a combination ~~thereof~~ of these and that is integral to the prevention of disease or the clinical management of an individual who is sick or injured or who has a disability. "Health service" does not include administrative and other activities that are not integral to clinical management.

(9b) Health service facility. – A hospital; long-term care hospital; ~~rehabilitation facility;~~ nursing home facility; adult care home; kidney disease treatment center, including freestanding hemodialysis units; intermediate care facility for individuals with intellectual disabilities; home health agency office; diagnostic center; hospice office, hospice inpatient facility, hospice residential care facility; and ambulatory surgical facility.

(9c) Health service facility bed. – A bed licensed for use in a health service facility in the categories of (i) acute care beds; ~~(iii) rehabilitation beds; (iv)~~ (ii) nursing home beds; ~~(v)~~ (iii) intermediate care beds for individuals with intellectual disabilities; ~~(vii)~~ (iv) hospice inpatient facility beds; ~~(viii)~~ (v) hospice residential care facility beds; ~~(ix)~~ (vi) adult care home beds; and ~~(x)~~ (vii) long-term care hospital beds.

…

(13) Hospital. – A public or private institution ~~which~~ that is primarily engaged in providing to inpatients, by or under supervision of physicians, diagnostic services and therapeutic services for medical diagnosis, treatment, and care of injured, disabled, or sick ~~persons, or rehabilitation services for the rehabilitation of injured, disabled, or sick~~ persons. The term includes all facilities licensed pursuant to G.S. 131E-77, except rehabilitation facilities and long-term care hospitals.

…

(17a) Nursing care. – Any of the following:

a. Skilled nursing care and related services for residents who require medical or nursing care.

b. Rehabilitation ~~services~~ services, other than those provided at an inpatient rehabilitation facility, for the rehabilitation of individuals who are injured or sick or who have disabilities.

c. Health-related care and services provided on a regular basis to individuals who because of their mental or physical condition require care and services above the level of room and board, which can be made available to them only through institutional facilities.

These are services which are not primarily for the care and treatment of mental diseases.

…

(22) Rehabilitation facility. – ~~A public or private inpatient facility which is operated for the primary purpose of assisting in the rehabilitation of individuals with disabilities through an integrated program of medical and other services which are provided under competent, professional supervision.~~A facility that has been classified and designated as an inpatient rehabilitation facility by the Centers for Medicare and Medicaid Services pursuant to Part 412 of Subchapter B of Chapter IV of Title 42 of the Code of Federal Regulations.

…."

PART XI-B. ESSENTIAL RURAL HEALTH SERVICES PROTECTION

SECTION 11B.1. Chapter 131E of the General Statutes is amended by adding a new Article to read:

"Article 9B.

"Essential Rural Health Services Protection Act.

"**§ 131E-193.1. Title.**

This Article shall be known and may be cited as the "Essential Rural Health Services Protection Act."

"**§ 131E-193.3. Definitions.**

The following definitions apply in this Article:

(1) Department. – The Department of Health and Human Services.

(2) Essential rural health services. – Any of the following services when provided in a rural county or when reasonably necessary to maintain access for residents of a rural county:

a. Emergency services.

b. Obstetrical services, including labor and delivery.

c. Inpatient services.

d. Surgical services necessary for emergency stabilization or urgent intervention.

e. Behavioral health services, including inpatient psychiatric services.

f. Dialysis services.

g. Diagnostic imaging or laboratory services necessary for emergency diagnosis or treatment.

h. Primary care services, if the Department determines that loss or material reduction of the service would likely leave a rural county without reasonable local access.

i. Any other service designated by the Department by rules adopted pursuant to this Article as essential to preserving access to care in rural counties.

(3) Essential rural provider. – A hospital, facility, practice, clinic, or other provider located in a rural county, or regularly serving residents of a rural county, that provides one or more essential rural health services.

(4) Material change. – Any of the following:

a. The closure of an essential rural health service.

b. A reduction in the hours, staffing, call coverage, bed capacity, operating capacity, or service capability of an essential rural health service that is reasonably likely to materially reduce access for residents of a rural county.

c. The relocation of an essential rural health service in a manner reasonably likely to materially reduce access for residents of a rural county.

d. A change in ownership, control, governance, management, operations, or contracting that is reasonably likely to materially reduce access to an essential rural health service for residents of a rural county.

e. The opening or expansion of a service, facility, practice, or line of business that is reasonably likely to materially impair (i) the ability of an essential rural provider to maintain one or more essential rural health services in a rural county or (ii) the financial viability of an essential rural provider.

(5) Person. – An individual, corporation, limited liability company, partnership, hospital authority, unit of local government, or any other legal entity.

(6) Rural county. – A county with a population density of 250 or fewer persons per square mile, using the most recent data published by the Office of State Budget and Management.

"**§ 131E-193.5. Notice required for material changes affecting essential rural health services.**

(a) A person shall not implement a material change affecting essential rural health services unless the person provides written notice to the Department at least 120 days before the proposed effective date of the material change.

(b) Notice under this section shall also be provided to any known essential rural provider reasonably likely to be materially affected by the proposed change. The notice shall include all of the following:

(1) A description of the proposed material change.

(2) The proposed effective date.

(3) The service area affected by the proposed material change.

(4) The essential rural health services affected.

(5) The reason for the proposed material change.

(6) The projected effect of the proposed material change on service availability, staffing, hours, bed capacity, call coverage, patient travel time, payor mix, and service to Medicaid recipients, uninsured persons, and underserved populations.

(7) Any management, services, affiliation, referral, transfer, payor, contracting, or other operational arrangement reasonably likely to affect access to care in a rural county.

(8) Any other information required by the Department to evaluate the proposed material change under this Article.

"**§ 131E-193.7. Review process.**

(a) Upon receipt of a notice that is determined by the Department to meet the requirements of G.S. 131E-193.5, the Department shall evaluate whether the proposed material change is reasonably likely to do one or more of the following:

(1) Materially reduce access to an essential rural health service for residents of a rural county.
(2) Result in the closure, conversion, relocation, or reduction of hours or capacity of an essential rural health service.
(3) Reduce the availability of emergency services, obstetrical services, behavioral health services, primary care, inpatient services, or other essential rural health services in a rural county.
(4) Change staffing, call coverage, on-call specialty availability, or service capability in a manner that materially impairs timely access to clinically appropriate care.
(5) Materially impair the financial viability of an essential rural provider in a manner likely to jeopardize continued access to one or more essential rural health services. In evaluating whether this condition has been satisfied, the Department may consider whether the change is reasonably likely to remove or divert profitable or commercially sustainable service lines, patient volume, or payor mix necessary to support essential rural health services.
(6) Increase patient travel times or care delays beyond levels reasonably consistent with maintaining meaningful rural access.
(7) Create or worsen discriminatory admission, transfer, referral, staffing, or contracting practices that shift disproportionate burdens to essential rural providers.

(b) In conducting its review under this section, both of the following apply:
(1) The Department shall consider the totality of the circumstances, including current service availability, travel times, payor mix, levels of uncompensated care, workforce availability, service interdependence, community health needs, and whether a reasonable substitute for the affected service exists within the affected service area.
(2) The Department shall determine if public input as specified by G.S. 131E-193.13 is necessary to complete its evaluation of the proposed material change. Upon a determination that public input is necessary, the Department shall conduct it within the time period specified by G.S. 131E-193.11.

"**§ 131E-193.9. Rural financial viability review.**

(a) The Department shall adopt rules establishing one or more financial viability thresholds for essential rural providers.

(b) If an essential rural provider falls below any of the thresholds established by the rules adopted under subsection (a) of this section, the Department shall initiate a rural financial viability review. The rural financial viability review shall include an assessment of whether recent or proposed market entry, service expansion, referral patterns, contracting arrangements, payor shifts, or other conduct is reasonably likely to contribute to the essential rural provider's financial distress in a manner that jeopardizes continued access to essential rural health services.

(c) If the Department finds that continued access to essential rural health services is reasonably likely to be materially impaired as a result of an essential rural provider's financial viability status, the Department may impose reporting requirements on the essential rural provider, impose a mitigation plan as provided by G.S. 131E-193.11, or take other enforcement action authorized by this Article.

"**§ 131E-193.11. Determinations; mitigation plans; extensions of time.**

(a) Within 60 days after determining that a notice meets the requirements of G.S. 131E-193.5, the Department shall do one of the following:
(1) Issue a written notice that no further action is required by the Department.

(2) Approve the proposed material change subject to a mitigation plan that satisfies the criteria specified in subsection (b) of this section.

(3) Issue a written determination prohibiting the proposed material change if the Department finds that, even with a mitigation plan, (i) essential rural health services would not be adequately protected in the affected service area or (ii) the proposed material change is reasonably likely to materially destabilize the financial viability of an essential rural provider.

(b) A mitigation plan may include one or more of the following:

(1) A requirement to maintain specified service lines, service levels, staffing levels, call coverage, or operating hours for a defined period.

(2) A requirement to phase in the proposed material change over time.

(3) A requirement to maintain Medicaid participation.

(4) A requirement to maintain a financial assistance policy for uninsured and underinsured patients.

(5) Transfer, referral, and admission protections, including nondiscriminatory clinical criteria.

(6) Reporting and monitoring requirements.

(7) Community engagement, patient notice, or coordination requirements.

(8) Other conditions reasonably necessary to prevent material impairment of access to essential rural health services.

(c) The Department may extend the period of time for making a determination under subsection (a) of this section by not more than 30 additional days with written notice to the person that submitted notice under G.S. 131E-193.5 on the grounds that public input as specified by G.S. 131E-193.13 is necessary or that additional information is reasonably necessary to complete the review, or both.

(d) A person shall not implement a material change while a review is pending under this Article.

"**§ 131E-193.13. Public input.**

For any proposed material change that (i) involves a hospital or a hospital authority or (ii) is reasonably likely to materially affect essential rural health services in a rural county, the Department shall provide an opportunity for public comment and may conduct one or more public hearings or public meetings in the affected service area. The Department shall adopt rules establishing procedures for public comment periods, public hearings, and public meetings under this section.

"**§ 131E-193.15. Prohibited conduct.**

No person subject to this Article shall do any of the following:

(1) Engage in any pattern or practice of admission, transfer, referral, staffing, contracting, or operational behavior that has the purpose or effect of materially undermining an essential rural provider's ability to maintain essential rural health services.

(2) Selectively retain lower-acuity or better-insured patients, or shift disproportionate numbers of higher-acuity, uninsured, underinsured, or Medicaid patients, in a manner reasonably likely to materially destabilize access to essential rural health services in a rural county.

(3) Knowingly fail to provide the notice required under G.S. 131E-193.5.

(4) Knowingly submit materially false information to the Department.

"**§ 131E-193.17. Reporting requirements.**

(a) Any person subject to a mitigation plan under this Article shall file annual reports with the Department for the period specified by the Department, not to exceed five years, regarding compliance with the mitigation plan and the continuing availability of affected essential rural health services.

(b) The Department shall report annually by November 1 to the Joint Legislative Oversight Committee on Health and Human Services and the Fiscal Research Division regarding all notices received under this Article, determinations made, mitigation plans required, enforcement actions taken, and observed effects on rural access to essential health services.

"**§ 131E-193.19. Enforcement.**

(a) The Department may assess a civil penalty not to exceed ten thousand dollars ($10,000) per day for each violation of this Article, each violation of an order issued by the Department under this Article, and each violation of a mitigation plan implemented by the Department under this Article. The clear proceeds of civil money penalties imposed pursuant to this section shall be remitted to the Civil Penalty and Forfeiture Fund in accordance with G.S. 115C-457.2.

(b) The Department may seek injunctive relief in Wake County Superior Court or in the superior court of any county affected by the violation to enforce this Article, to prevent implementation of a prohibited material change, or to enforce any mitigation plan or order issued under this Article.

(c) The remedies provided in this Article are cumulative and do not limit any other remedy available under law.

"**§ 131E-193.21. Rules.**

In addition to the rules expressly authorized by this Article, the Department may adopt any other rules that are necessary to implement this Article."

SECTION 11B.2.(a) The first report under G.S. 131E-193.17 is due by November 1, 2027.

SECTION 11B.2.(b) This Part becomes effective January 1, 2027, and applies to material changes affecting essential rural health services proposed, announced, or implemented on or after that date. As used in this section, the term "material change" has the same meaning as in G.S. 131E-193.3, as enacted by Section 11B.1 of this Part.

PART XII. UPDATED HEALTH INSURER PRIOR AUTHORIZATION REQUIREMENTS

SECTION 12.1.(a) G.S. 58-50-61 reads as rewritten:

"**§ 58-50-61. Utilization review.**

(a) Definitions. – ~~As used~~ The following definitions apply in this section, in G.S. 58-50-62, and in Part 4 of this ~~Article, the term:~~Article:

…

(2a) "Course of treatment" means a prescribed order or ordered treatment protocol for a specific covered person with a specific condition that is outlined and decided upon ahead of time with the covered person and health care provider and approved by the insurer or utilization review organization when prospective review is applicable.

…

(8) "Health care provider" ~~means any person who is licensed, registered, or certified under Chapter 90 of the General Statutes or the laws of another state to provide health care services in the ordinary care of business or practice or a profession or in an approved education or training program; a health care facility as defined in G.S. 131E-176(9b) or the laws of another state to operate as a health care facility; or a pharmacy.~~has the same meaning as in G.S. 90-410.

…

(14a) "Prior authorization" means the process by which insurers and UROs determine coverage on the basis of medical necessity and/or covered benefits prior to the rendering of those services.

…

(16a) "Urgent health care service" means a health care service, including mental and behavioral health care services and dental care services, with respect to which the application of the time periods for making an urgent care determination that, in the opinion of a health care provider with knowledge of the covered person's medical condition, meets either of the following criteria:

a. Could seriously jeopardize the life or health of the covered person or the ability of the covered person to regain maximum function.

b. Would subject the covered person to severe pain that cannot be adequately managed without the care or treatment that is the subject of the utilization review.

…

(c) Scope and Content of Program. – Every insurer shall prepare and maintain a utilization review program document that describes all delegated and nondelegated review functions for covered services ~~including:~~including all of the following:

(1) Procedures to evaluate the clinical necessity, appropriateness, efficacy, or efficiency of health care services.

…

(d) ~~Program Operations.~~ Clinical Review Criteria, Generally. – In every utilization review program, an insurer or URO shall use documented clinical review criteria that are based on sound clinical evidence and that are periodically evaluated to assure ongoing efficacy. An insurer may develop its own clinical review criteria or purchase or license clinical review criteria.

(d1) Clinical Review Criteria, Substance Use Treatment. – Criteria for determining when a patient needs to be placed in a substance abuse treatment program shall be either (i) the diagnostic criteria contained in the most recent revision of the American Society of Addiction Medicine Patient Placement Criteria for the Treatment of Substance-Related Disorders or (ii) criteria adopted by the insurer or its URO. The Department, in consultation with the Department of Health and Human Services, may require proof of compliance with this subsection by ~~a plan~~ an insurer or its URO.

(d2) Administration of Program. – All of the following shall apply in the administration of a utilization review program under this section:

(1) Qualified health care professionals shall administer the utilization review program and oversee review decisions for health care services under the direction of a medical doctor. A medical doctor licensed to practice medicine in this State shall evaluate the clinical appropriateness of ~~noncertifications.~~ noncertifications under this subdivision.

(2) Compensation to persons involved in utilization review shall not contain any direct or indirect incentives for them to make any particular review decisions.

(3) Compensation to utilization reviewers shall not be directly or indirectly based on the number or type of noncertifications they render.

(4) In issuing a utilization review decision, an insurer or its URO shall: obtain all information required to make the decision, including pertinent clinical information; employ a process to ensure that utilization reviewers apply clinical review criteria consistently; and issue the decision in a timely manner pursuant to this section.

…

(f) Time Lines for Prospective and Concurrent ~~Reviews.~~ Utilization Reviews Based Upon Type of Health Care Service. – As used in this subsection, the term "necessary information" includes the results of any patient examination, clinical evaluation, or second opinion that may be required. ~~Prospective and concurrent determinations shall be communicated to~~ The time line for completion of a prospective or concurrent utilization review is as follows:

(1) Non-urgent health care services. – If an insurer requires a prior authorization review of a health care service, then the insurer or its URO shall both (i) render a prior authorization review determination or noncertification and (ii) notify the covered person and the covered person's provider within three business days after the insurer obtains all necessary information ~~about the admission, procedure, or health care service.~~ to make the prior authorization review determination or noncertification.

(2) Urgent health care services. – An insurer or its URO shall both (i) render a utilization review determination or noncertification concerning urgent health care services and (ii) notify the covered person and the covered person's provider of that utilization review determination or noncertification not later than 24 hours after receiving all necessary information needed to complete the review of the requested services. If the covered person's provider and the insurer, or the insurer's URO, do not both have access to the electronic health records of the covered person, then this subdivision shall not apply and the utilization review will be subject to the time line under subdivision (1) of this subsection.

(f1) Prior Authorization Determination Notifications. – If an insurer or its URO certifies a health care service, ~~the insurer shall notify~~ notification shall be sent to the covered person's provider. ~~For~~ If an insurer or its URO issues a noncertification, ~~the insurer shall notify the covered person's provider and send~~ then written or electronic confirmation of the noncertification that is in compliance with subsection (h) of this section shall be sent to the covered person's provider and the covered person. ~~In~~

(f2) Concurrent Review Liability. – For concurrent reviews, the insurer shall remain liable for health care services until the covered person has been notified of the noncertification.

…

(i) Requests for Informal Reconsideration. – An insurer may establish procedures for informal reconsideration of noncertifications and, if established, the procedures shall be in writing. After a written notice of noncertification has been issued in accordance with subsection (h) of this section, then the reconsideration shall be conducted between the covered person's provider and a medical doctor licensed to practice medicine in this State designated by the insurer. An insurer shall not require a covered person to participate in an informal reconsideration before the covered person may appeal a noncertification under subsection (j) of this section. If, after informal reconsideration, the insurer upholds the noncertification decision, then the insurer shall issue a new notice in accordance with subsection (h) of this section. If the insurer is unable to render an informal reconsideration decision within 10 business days after the date of receipt of the request for an informal reconsideration, ~~it~~ the insurer shall treat the request for informal reconsideration as a request for an ~~appeal; provided that~~ appeal and the requirements of subsection (k) of this section for acknowledging the request shall apply beginning on the day the insurer determines an informal reconsideration decision cannot be made before the tenth business day after receipt of the request for an informal reconsideration.

(j) Appeals of Noncertifications. – Every insurer shall have written procedures for appeals of noncertifications by covered persons or their providers acting on their behalves, including expedited review to address a situation where the time frames for the standard review procedures set forth in this section would reasonably appear to seriously jeopardize the life or health of a covered person or jeopardize the covered person's ability to regain maximum function. Each appeal shall ~~be evaluated by a medical doctor licensed to practice medicine in this State who was not involved in the noncertification.~~meet the requirements of subsection (j1) of this section.

(j1) Requirements Applicable to Appeals Reviews. – All of the following requirements apply to an appeals review:

(1) Except as otherwise provided, all appeals shall be reviewed by a licensed physician who meets all of the following criteria:
a. Possesses a current and valid non-restricted license to practice medicine in any United States jurisdiction.
b. Has practiced for a period of at least three consecutive years in the same or similar specialty as a licensed physician who typically manages the medical condition or disease for which prior authorization review is required or whose training and experience meets all of the following criteria:
1. Includes treatment of the same condition as the condition of the covered person.
2. Includes treatment of complications that may result from the service or procedure that is the subject of the appeal.
3. Is sufficient for the licensed physician to determine if the service or procedure is medically necessary or clinically appropriate.
c. Had no direct involvement in making the prior adverse determination or noncertification that is the subject of the appeal.
d. Has no financial interest, or other conflict of interest, in the outcome of the appeal.
(2) Appeals initiated by a licensed mental health professional for a service provided by a licensed mental health professional may be reviewed by a licensed mental health professional rather than a licensed physician. The requirements of subdivision (1) of this subsection shall apply to the reviewing licensed mental health professional in the same manner that they apply to a licensed physician.
(3) The licensed physician or licensed mental health professional shall consider all known clinical aspects of the health care service under review, including all pertinent medical records and any medical literature that have been provided by the covered person's provider or by a health care facility.

…

(*l*) Expedited Appeals. – An expedited appeal of a noncertification may be requested by a covered person or ~~his or her~~ the provider acting on the covered person's behalf only when a nonexpedited appeal would reasonably appear to seriously jeopardize the life or health of a covered person or jeopardize the covered person's ability to regain maximum function. All of the following apply to expedited appeals:
(1) The insurer may require documentation of the medical justification for the expedited appeal.~~The~~
(2) For expedited appeals related to health care services, the review shall be provided by the insurer ~~shall,~~ in consultation with a medical doctor licensed to practice medicine in this ~~State, provide expedited review, and the~~ State.
(3) The insurer or its URO shall communicate ~~its~~ the expedited appeal decision in writing to the covered person and ~~his or her~~ the covered person's provider as soon as possible, but not later than four days after receiving the information justifying expedited review. The written decision shall contain the provisions specified in subsection (k) of this section.
(4) If the expedited review is a concurrent review determination, then the insurer shall remain liable for the coverage of the applicable health care services until the covered person has been notified of the determination.
(5) An insurer is not required to provide an expedited review for retrospective noncertifications.

(m) Disclosure of Utilization Review Requirements. – All of the following apply to an insurer's responsibility to disclose any utilization review procedures:

(1) Coverage and member handbook. – In the certificate of coverage and member handbook provided to covered persons, an insurer shall include a clear and comprehensive description of its utilization review procedures, including the procedures for appealing noncertifications and a statement of the rights and responsibilities of covered persons, including the voluntary nature of the appeal process, with respect to those procedures. An insurer shall also include in the certificate of coverage and the member handbook information about the availability of assistance from the Department's Health Insurance Smart NC, including the telephone number and address of the ~~Program.~~ program.

(2) Prospective materials. – An insurer shall include a summary of its utilization review procedures in materials intended for prospective covered persons.

(3) Membership cards. – An insurer shall print on its membership cards a toll-free telephone number to call for utilization review purposes.

(4) Website. – An insurer shall make any current prior authorization requirements and restrictions readily accessible on its website.

(m1) Changes to Prior Authorization. – If an insurer intends either to implement a new prior authorization review requirement or restriction or to amend an existing requirement or restriction, then the new or amended requirement shall not be in effect unless and until the insurer's website has been updated to reflect the new or amended requirement or restriction. A claim shall not be denied for failure to obtain a prior authorization if the prior authorization requirement or amended requirement was not in effect on the date of service of the claim.

…

(n1) Prior Authorization Determination Validity. – All of the following apply to the length of time an approved prior authorization shall remain valid under certain circumstances:

(1) If a covered person enrolls in a new health benefit plan offered by the same insurer under which the prior authorization was approved, then the previously approved prior authorization remains valid for the initial 90 days of coverage under the new health benefit plan. This section does not require coverage of a service if it is not a covered service under the new health benefit plan.

(2) If a health care service, other than for in-patient care, requires prior authorization and is for the treatment of a covered person's chronic condition, then the prior authorization shall remain valid for no less than six months from the date the health care provider receives notification of the prior authorization approval.

(o) Violation. – ~~A~~ In accordance with this Chapter, a violation of this section subjects an insurer and an agent of the insurer to G.S. 58-2-70.

(p) Federal Rule Alignment. – No later than January 1, 2028, an insurer offering a health benefit plan or a utilization review agent acting on behalf of an insurer offering a health benefit plan shall implement and maintain a prior authorization application programming interface meeting the requirements under 45 C.F.R. § 156.223(b) as it existed on January 1, 2025.

(q) Reserved for future codification purposes.

(r) Reserved for future codification purposes.

(s) Artificial Intelligence. – An artificial intelligence-based algorithm shall not be used as the sole basis to deny a utilization review determination."

SECTION 12.1.(b) In accordance with G.S. 135-48.24(b) and G.S. 135-48.30(a)(7), which require the State Treasurer to implement procedures that are substantially similar to the provisions of G.S. 58-50-61 for the North Carolina State Health Plan for Teachers and State Employees (State Health Plan), the State Treasurer and the Executive Administrator of the State Health Plan shall review all practices of the State Health Plan and all contracts with, and practices

of, any third party conducting any utilization review on behalf of the State Health Plan to ensure compliance with subsection (a) of this section no later than the start of the next plan year.

SECTION 12.1.(c) G.S. 58-50-75(b) reads as rewritten:

"(b) This Part applies to all insurers that offer a health benefit plan and that provide or perform utilization review pursuant to ~~G.S. 58-50-61, the State Health Plan for Teachers and State Employees,~~ G.S. 58-50-61 and any optional plans or programs operating under Part 2 of Article 3A of Chapter 135 of the General Statutes. With respect to second-level grievance review decisions, this Part applies only to second-level grievance review decisions involving noncertification decisions."

SECTION 12.1.(d) G.S. 90-21.52(c)(1) reads as rewritten:

"(1) The liability of the managed care entity is based on an administrative decision to approve or disapprove payment or reimbursement for, or denial, reduction, or termination of coverage, for a health care service and the physician organizations, health care providers, or entities wholly owned by physicians or health care providers or any combination thereof, which have made the decision at issue, have agreed explicitly, in a written addendum or agreement separate from the managed care organization's standard professional service agreement, to assume responsibility for making noncertification ~~decisions~~ decisions, as defined under ~~G.S. 58-50-61(13)~~ G.S. 58-50-61, with respect to certain insureds or enrollees; and"

SECTION 12.1.(e) Subsection (a) of this section becomes effective October 1, 2026, and applies to insurance contracts, including contracts with utilization review organizations, issued, renewed, or amended on or after that date. The remainder of this section is effective when it becomes law.

PART XIII. PRESERVATION OF COMPETITION IN HEALTHCARE BY REGULATING THE CONSOLIDATION AND CONVEYANCE OF HOSPITALS

SECTION 13.1.(a) Chapter 131E of the General Statutes is amended by adding a new Article to read:

"Article 11D.

"Preserving Competition in Healthcare Act.

"**§ 131E-214.60. Definitions.**

The following definitions apply in this Article:

(1) Acquiring entity. – The person or entity that gains ownership or control of a hospital entity as a result of a transaction subject to review under this Article.

(2) Attorney General. – The Attorney General or any employee of the Department of Justice designated by the Attorney General.

(3) Hospital entity. – Any corporation or governmental entity licensed as a hospital under Article 5 of this Chapter, including any entity affiliated with such corporation or governmental entity through ownership, governance, or membership, such as a holding company or subsidiary.

(4) Person. – Any individual, partnership, trust, estate, corporation, association, joint venture, joint stock company, or other organization.

(5) State Auditor. – The State Auditor or any employee of the Office of the State Auditor designated by the State Auditor.

(6) State Treasurer. – The State Treasurer or any employee of the Office of the State Treasurer designated by the State Treasurer.

(7) Transaction. – Includes all of the following, if the value of the assets, control, or governance interest equals or exceeds five million dollars ($5,000,000):

a. The sale, transfer, lease, exchange, optioning, conveyance, or other disposition of no less than fifty percent (50%) of the assets or

operations of any hospital entity to any person or entity other than another hospital entity that controls, is controlled by, or is under common control with such hospital entity.

b. The transfer of control or governance of a hospital entity to a person or entity other than another hospital entity that controls, is controlled by, or is under common control with such hospital entity.

c. Any binding legal obligation between two or more persons that results in a transfer of control, responsibility, or governance of no less than fifty percent (50%) of a hospital entity's assets to an acquiring entity.

d. Any transaction regardless of exact form that, if structured as a purchase, merger, or joint venture, would be subject to review under this Article.

e. Any transaction described in sub-subdivisions a. through d. of this subdivision that is entered into by a hospital entity or by any person or entity that controls, is controlled by, or is under common control with such hospital entity.

f. All sales, transfers, conveyances, or other dispositions of no less than fifty percent (50%) of a hospital entity's assets made in the course of a bankruptcy proceeding.

"**§ 131E-214.61. Actions and decisions by the State Auditor, Attorney General, and State Treasurer.**

Whenever an action or decision is required by the State Auditor, the Attorney General, and the State Treasurer under this Article, they shall act or decide together and the opinion of the majority shall prevail.

"**§ 131E-214.62. Applicability; waived transactions.**

This Article does not apply to a hospital entity if (i) the transaction is in the usual and regular course of its activities and (ii) the State Auditor, Attorney General, and State Treasurer have provided to the hospital entity a written waiver of this Article with respect to the transaction. A determination by the State Auditor, Attorney General, and State Treasurer that a transaction merits review under this Article shall be the final decision of the State and shall not be set aside on judicial review unless found to be arbitrary and capricious.

"**§ 131E-214.64. Written notice and certification requirements for proposed transactions; rules.**

(a) Prior to entering into any transaction subject to review under this Article, a hospital entity shall provide the State Auditor, Attorney General, and State Treasurer with written notice of the proposed transaction. The hospital entity shall simultaneously provide the State Auditor, Attorney General, and State Treasurer with written certification that a copy of this Article in its entirety has been provided to each member of the governing board or board of trustees of the hospital entity.

(b) A hospital entity and an acquiring entity may provide the State Auditor, Attorney General, and State Treasurer with a single written notice of a proposed transaction that meets the requirements of this section; provided, however, that the State Auditor, Attorney General, and State Treasurer may require additional information that the State Auditor, Attorney General, and State Treasurer determines is necessary for a complete review of the proposed transaction from any party.

(c) The written notice required under this section shall not become effective until the State Auditor, Attorney General, and State Treasurer have acknowledged receipt of a complete notice in accordance with subsection (a) of G.S. 131E-214.66.

(d) The State Auditor, Attorney General, and State Treasurer shall adopt rules specifying the required contents of the written notice required by this section and the manner in which the written notice shall be provided to the State Auditor, Attorney General, and State Treasurer in

order to be deemed complete and effective. The rules shall allow for the State Auditor, Attorney General, and State Treasurer, in their discretion, to require additional information about a proposed transaction that is not expressly required in the rules adopted pursuant to this section.

"**§ 131E-214.66. Time line and process for decision to object or take no action.**

(a) When the parties to the proposed transaction have provided the State Auditor, Attorney General, and State Treasurer with all the information expressly required by the rules adopted under G.S. 131E-214.64(d), the State Auditor, Attorney General, and State Treasurer shall provide to the hospital entity and acquiring entity written acknowledgement of having received a complete notice that meets the requirements of G.S. 131E-214.64. Written acknowledgement by the State Auditor, Attorney General, and State Treasurer pursuant to this subsection shall constitute the beginning of a 90-day review period. The State Auditor, Attorney General, and State Treasurer shall not unreasonably withhold a determination that the parties have provided a complete notice that meets the requirements of G.S. 131E-214.64.

(b) If the State Auditor, Attorney General, and State Treasurer have provided to the hospital entity and acquiring entity written acknowledgement of having received a complete notice that meets the requirements of G.S. 131E-214.64, as required by subsection (a) of this section, a request by the State Auditor, Attorney General, and State Treasurer for additional information not expressly required by the rules adopted under G.S. 131E-214.64(d) does not delay the commencement of the 60-day review period under subsection (c) of this section.

(c) The State Auditor, Attorney General, and State Treasurer have a period of 60 days, commencing on the date they provide written acknowledgement to the hospital entity and acquiring entity of having received a complete notice that meets the requirements of G.S. 131E-214.64, to review the proposed transaction and notify the hospital entity, in writing, of their decision to either object to the proposed transaction or to take no action regarding the proposed transaction.

(d) Upon notice, in writing, to all parties to the transaction, the State Auditor, Attorney General, and State Treasurer may extend their 60-day review period for up to an additional 30 days if the extension is necessary to obtain additional information from one or more of the parties to the transaction or to complete any component of the review process specified in G.S. 131E-214.30 through G.S. 131E-214.76.

(e) During the review period, the parties to the proposed transaction are prohibited from consummating the transaction.

"**§ 131E-214.68. Published written notice of proposed transaction; failure to give notice.**

(a) Within 10 days after providing the State Auditor, Attorney General, and State Treasurer with written notice of a proposed transaction pursuant to subsection (a) of G.S. 131E-214.64, without regard to whether or not the State Auditor, Attorney General, and State Treasurer have acknowledged receipt of a complete notice, the hospital entity shall give written notice of the proposed transaction by publication in one or more newspapers of general circulation in every county in which (i) there exists a hospital entity whose control or governance would be altered by the proposed transaction or (ii) there resides a substantial number of patients of a hospital entity whose control or governance would be altered by the proposed transaction. The published written notice shall contain the following:

(1) A brief restatement of the nature of the transaction, as specified in the written notice provided to the State Auditor, Attorney General, and State Treasurer under G.S. 131E-214.64, which shall include the following:
  a. The name of the hospital entity.
  b. The name of the acquiring entity.
  c. The names of any other parties to the proposed transaction.
  d. The nature of the proposed transaction.
  e. The anticipated consideration that will be paid by the acquiring entity.

(2) The following statements:

a. "This notice is provided pursuant to G.S. 131E-214.64."
b. "Any interested party wishing to provide written comments may submit the written comments directly to the Office of the Attorney General, 114 W. Edenton Street, Raleigh, NC 27603."

(3) The time, date, and location of any public hearing required under G.S. 131E-214.30, or the information necessary to access a public hearing using teleconferencing or video-conferencing technology, as permitted under subsection (c) of G.S. 131E-214.30. A public hearing shall not be conducted earlier than 14 days after the publication of a notice pursuant to this section.

(4) In the event the hospital entity is a nonprofit or publicly owned entity, a link to a webpage that allows any member of the public to view a detailed summary of the proposed transaction and copies of all transactional and collateral agreements not otherwise exempt from public disclosure under Chapter 132 of the General Statutes or G.S. 131E-97.3.

(b) A failure by the hospital entity giving notice under G.S. 131E-214.64 to provide a published written notice as required by subsection (a) of this section shall be a sufficient ground for the State Auditor, Attorney General, and State Treasurer to object to the proposed transaction.

(c) This section does not apply to a sale, transfer, conveyance, or other disposition of a substantial portion of a hospital entity's assets made in the course of a bankruptcy proceeding.

"**§ 131E-214.70. Public hearing requirements; responsibility for public hearing costs; exemptions and waivers.**

(a) Within 30 days after providing the State Auditor, Attorney General, and State Treasurer with the written notice required under subsection (a) of G.S. 131E-214.64, without regard to whether or not the State Auditor, Attorney General, and State Treasurer have acknowledged receipt of a complete notice, the hospital entity and the acquiring entity shall conduct one or more public hearings at a convenient time and in a convenient location in a county in which there exists a hospital entity whose control or governance would be altered by the proposed transaction. The public hearing required by this section shall not be conducted earlier than 14 days after publication of the written notice required under G.S. 131E-214.68.

(b) At least seven days prior to the date of any public hearing, the hospital entity and the acquiring entity shall give written notice to the State Auditor, Attorney General, and State Treasurer of the time, date, and location of the public hearing. In addition, the hospital entity and the acquiring entity shall give written notice to the governing bodies of both the county and the municipality in which the hospital entity that is the subject of the proposed transaction is located, as applicable.

(c) With written notice to, and approval by, the State Auditor, Attorney General, and State Treasurer, the hospital entity and the acquiring entity may conduct a public hearing required by this section via online teleconferencing and video-conferencing technology; provided, however, that doing so does not meaningfully limit the opportunity for public input concerning the proposed transaction.

(d) At a hearing required by this section, the hospital entity and the acquiring entity shall provide the following information:

(1) The extent to which the proposed transaction is expected to impact the cost, availability, accessibility, and quality of healthcare services.

(2) The process involved in reaching a fair sales price for the hospital entity, including whether any director, officer, agent, or employee of the hospital entity will benefit directly or indirectly from the proposed transaction.

(e) At a hearing required by this section, the hospital entity and the acquiring entity may make such presentations as they deem appropriate and shall provide a meaningful opportunity for public input. The hospital entity and the acquiring entity shall also communicate to attendees how interested parties may provide written comments about the proposed transaction, which shall

be identical to the statement required by sub-subdivision (2)b. of subsection (a) of G.S. 131E-214.68.

(f) In any transaction in which the hospital entity is a nonprofit or publicly owned entity, the hospital entity and the acquiring entity shall provide information regarding the extent to which the proposed transaction is expected to impact the nonprofit or community benefit activities of the hospital entity, including a description of the resources that will be committed to the nonprofit or community benefit activities after the consummation of the transaction.

(g) In addition to any hearing required under this section, the State Auditor, Attorney General, and State Treasurer may conduct a public hearing regarding a proposed transaction. At least seven days prior to the public hearing, the State Auditor, Attorney General, and State Treasurer shall notify the hospital entity and the acquiring entity of the time, date, and location of any hearing to be conducted by the State Auditor, Attorney General, and State Treasurer or of the information necessary to access a public hearing to be conducted by the State Auditor, Attorney General, and State Treasurer via teleconferencing or video-conferencing technology. At least 14 days prior to the public hearing, the State Auditor, Attorney General, and State Treasurer shall also give written notice of the hearing by publication in one or more newspapers of general circulation in any county in which there exists a hospital entity whose control or governance would be altered by the proposed transaction. At a hearing conducted by the State Auditor, Attorney General, and State Treasurer, the State Auditor, Attorney General, and State Treasurer shall provide a meaningful opportunity for public input that includes opportunities for questions and answers and comments.

(h) The parties to the proposed transaction shall pay for all costs associated with the public hearing conducted in accordance with subsection (a) of this section.

(i) The provisions of this section do not apply to the sale, transfer, conveyance, or other disposition of a substantial portion of a hospital entity's assets made in the course of a bankruptcy proceeding.

"**§ 131E-214.72. Required considerations by the State Auditor, Attorney General, and State Treasurer.**

(a) The State Auditor, Attorney General, and State Treasurer shall consider all of the following criteria in making a decision about any transaction subject to the provisions of this Article:

(1) Whether the fair market value of any asset to be transferred from the hospital entity to the acquiring entity has been manipulated by the actions of the parties in a manner that causes the fair market value of the asset to decrease.

(2) Whether healthcare providers will be offered the opportunity to invest or own an interest in the acquiring entity or a related party, and whether procedures or safeguards are in place to avoid healthcare providers' conflicts of interest with respect to patient referrals.

(3) Whether the terms of any management or services contract negotiated in conjunction with the proposed transaction are reasonable.

(4) Whether the proposed transaction may have a significant effect on the cost, availability, accessibility, or quality of healthcare services for any affected community. In making this determination, the State Auditor, Attorney General, and State Treasurer shall consider all of the following:

a. Whether sufficient safeguards are included to ensure that the affected community will have continued access to affordable healthcare services.

b. Whether the proposed transaction creates or has the likelihood of creating an adverse effect on the cost, availability, accessibility, or quality of healthcare services within the affected community.

c. Whether the acquiring entity has made a commitment to provide (i) free care to individuals whose income is three hundred percent (300%) or less of the federal poverty guidelines, (ii) free or discounted healthcare to other individuals who are disadvantaged, uninsured, or underinsured, and (iii) other benefits to the affected community to promote improved healthcare. In determining whether the level of commitment by the acquiring entity will have a significant effect on the availability, accessibility, or quality of healthcare services for any affected community if the proposed transaction is approved, the State Auditor, Attorney General, and State Treasurer shall consider the number of programs and activities and the amount of funding dedicated by the acquiring entity, as compared to the hospital entity or their affiliated foundations, to:

1. The delivery of healthcare services to individuals who are uninsured or underinsured.
2. The delivery of other services or benefits to the affected community to promote improved healthcare.
3. Medical education and teaching programs.
4. Medical research programs.

d. Whether the proposed transaction would result in the revocation of hospital privileges for any healthcare provider.

e. Whether sufficient safeguards are included to maintain appropriate capacity for health science research and healthcare provider education.

f. Whether the proposed transaction serves the public interest by promoting the availability and accessibility of safe, essential, and quality healthcare services and treatment.

(5) Whether the proposed transaction complies with all applicable State and federal laws and regulations, including antitrust laws.

(6) Whether the proposed transaction will significantly harm competition in any part of this State among healthcare providers.

(7) Whether the State Auditor, Attorney General, and State Treasurer have received all the information required by the rules adopted under G.S. 131E-214.64(d) and timely responses to any additional requests for information necessary to adequately evaluate the proposed transaction; provided, however, that this subdivision shall not be a ground for disapproving the proposed transaction, unless the State Auditor, Attorney General, and State Treasurer have notified the hospital entity and the acquiring entity of any inadequacy of information or data and has provided each with a reasonable opportunity to remedy the inadequacy.

(8) Any objection to the transaction raised in comments submitted to the Attorney General.

(b) In addition to the considerations specified in subsection (a) of this section, the State Auditor, Attorney General, and State Treasurer shall also consider all of the following criteria in making a decision about any proposed transaction subject to the provisions of this Article that would alter the control or governance of a tax-exempt or publicly owned hospital entity:

(1) Whether the hospital entity would receive fair market value for its charitable assets or social welfare assets. For the purpose of this subdivision, "social welfare assets" means the average yearly monetary value of the benefits the hospital entity provided to the community during the preceding five calendar years.

(2) Whether the proceeds of the proposed transaction would be used in a manner consistent with the trust under which the assets are held by the hospital entity.

(3) Whether the proceeds of the proposed transaction would be used by a county or municipality for general or special revenue obligations not expressly provided for when the hospital was established.

(4) Whether any proceeds of the proposed transaction would be controlled as funds independently of the acquiring entity or related entities; provided, however, that the proceeds of a proposed transaction may not be returned to any county or municipal government except to the extent necessary to pay lawful obligations to such county or municipal government.

(5) Whether the proposed transaction would result in a breach of fiduciary duty, as determined by the Attorney General, including conflicts of interest related to payments or benefits to officers, directors, board members, executives, or experts employed or retained by the parties.

(6) Whether the governing body of the hospital entity exercised due diligence in deciding to dispose of the hospital entity's assets, selecting the acquiring entity, and negotiating the terms and conditions of the disposition.

(7) Whether the proposed transaction would result in private inurement to any person.

(8) Whether any foundation established to hold the proceeds of the proposed transaction would be broadly based in the community and be representative of the affected community, taking into consideration the structure and governance of the foundation.

(c) For any proposed transaction subject to the provisions of this Article that involves a hospital owned by a municipality, as defined in G.S. 131E-6, or a hospital authority, as defined in G.S. 131E-16, the State Auditor, Attorney General, and State Treasurer shall also consider whether the transaction complies with the provisions of Article 2 of this Chapter governing the sale or conveyance of any rights of ownership the municipality or hospital authority has in a hospital entity.

"**§ 131E-214.74.** Reserved for future codification purposes.

"**§ 131E-214.76. Contract authority for reviewing proposed transactions; assistance from the Department of Health and Human Services; fees to recover costs incurred in conducting reviews.**

(a) Within the time periods prescribed by G.S. 131E-214.66, the State Auditor, Attorney General, or State Treasurer may do any of the following to assist in the review of a proposed transaction covered by this Article:

(1) Contract with, consult, and receive advice from any agency of the State or the United States on such terms and conditions as the State Auditor, Attorney General, and State Treasurer deem appropriate.

(2) At the sole discretion of the State Auditor, Attorney General, and State Treasurer, contract with experts or consultants the State Auditor, Attorney General, and State Treasurer deem appropriate to assist them in reviewing the proposed transaction.

Notwithstanding the provisions of this subsection, the State Auditor, Attorney General, and State Treasurer shall not incur contract costs that exceed an amount that is reasonable and necessary for a review of the proposed transaction.

(b) In exercising the authority to enter into contracts pursuant to this section, the State Auditor, Attorney General, and State Treasurer are exempt from Article 3 of Chapter 143 of the General Statutes.

(c) The State Auditor, Attorney General, and State Treasurer may request from the Department of Health and Human Services a report on the anticipated effects of any proposed

transaction on access to, or the pricing of, healthcare services in any part of the State. If the State Auditor, Attorney General, and State Treasurer did not unreasonably delay in requesting such a report, the review period prescribed by G.S. 131E-214.66 may be extended an additional 30 days to allow for the completion of such a report; provided, however, that the total review period for the State Auditor, Attorney General, and State Treasurer may not exceed 180 days from the date they notify the parties to the transaction that they have submitted a complete notice pursuant to subsection (a) of G.S. 131E-214.66.

(d) The State Auditor, Attorney General, and State Treasurer may impose upon the acquiring entity a fee of up to fifty thousand dollars ($50,000) to cover one or more of the following:

(1) The cost of all contracts entered into by the State Auditor, Attorney General, and State Treasurer pursuant to subsection (a) of this section.

(2) Actual costs incurred by the State Auditor, Attorney General, and State Treasurer in reviewing any proposed transaction under this Article, including (i) costs incurred by the State Auditor, Attorney General, and State Treasurer for conducting a public hearing pursuant to subsections (f) and (g) of G.S. 131E-214.70 and (ii) attorneys' fees at the maximum billing rate used by the Attorney General to bill State agencies for legal services.

(3) Actual costs incurred by the Department of Health and Human Services for preparing a report for the State Auditor, Attorney General, and State Treasurer pursuant to subsection (c) of this section. Upon receipt of this fee from the acquiring entity, the State Auditor, Attorney General, and State Treasurer shall reimburse the Department of Health and Human Services for the actual cost of preparing the report. Reimbursement of these costs shall receive priority over any reimbursement of costs that will ultimately inure to the State Auditor, Attorney General, and State Treasurer.

(e) The acquiring entity may object to paying any fee imposed under this section. If the acquiring entity objects, it may seek an order from a court of competent jurisdiction to limit the acquiring entity's liability for the fee. In determining whether to issue an order, the court shall consider the reasonableness of any contract the State Auditor, Attorney General, and State Treasurer entered into with any expert and the cost of contracting with the expert relative to the value of the proposed transaction. If the court declines to enter the acquiring entity's proposed order, the acquiring entity shall reimburse the State Auditor, Attorney General, and State Treasurer for costs associated with the litigation and such reimbursement shall not count against the maximum allowed fee of fifty thousand dollars ($50,000) specified in subsection (d) of this section.

(f) The failure of an acquiring entity to pay to the State Auditor, Attorney General, and State Treasurer any fee authorized by this section by the applicable deadline specified in this subsection shall be sufficient grounds for the State Auditor, Attorney General, and State Treasurer to object to the proposed transaction:

(1) Absent an objection by the acquiring entity within seven days after the State Auditor, Attorney General, and State Treasurer impose the fee, the fee is payable to the State Auditor, Attorney General, or State Treasurer within 30 days after the date the State Auditor, Attorney General, or State Treasurer imposes the fee.

(2) Upon an objection by the acquiring entity within seven days after the State Auditor, Attorney General, and State Treasurer impose the fee, the fee is payable to the State Auditor, Attorney General, and State Treasurer within 30 days after the date the court issues an order determining that the acquiring entity is liable for the fee.

"**§ 131E-214.78. Objection to proposed transaction.**

(a) The State Auditor, Attorney General, and State Treasurer may object to any transaction covered by this Article by providing written notice to the parties within the time frame prescribed by G.S. 131E-214.66.

(b) If the State Auditor, Attorney General, and State Treasurer object to the transaction, the State Auditor, Attorney General, and State Treasurer shall file an action in either (i) the superior court of any county in which there exists a hospital entity whose control or governance would be altered by the proposed transaction or (ii) the superior court of the county in which the acquiring entity's principal place of business is located, if located within the State. The State Auditor, Attorney General, State Treasurer and the parties to a transaction may mutually agree, in writing, to extend the time period in which the State Auditor, Attorney General, and State Treasurer may file such an action. If the time period for the State Auditor, Attorney General, and State Treasurer to file an action objecting to the transaction is extended by mutual agreement under this subsection, the parties to the transaction are prohibited from consummating the transaction during that time.

(c) If the hospital entity is a nonprofit or publicly owned entity:

(1) The State Auditor, Attorney General, and State Treasurer shall file an action in the name of the State seeking injunctive relief to restrain the parties from taking further action to consummate the transaction or to compel the parties to modify the transaction. The court may issue an order granting such injunctive relief.

(2) The State Auditor, Attorney General, and State Treasurer may apply to the court for temporary or preliminary injunctive relief pending a final determination of the case.

(3) The State Auditor, Attorney General, and State Treasurer shall name as defendants the hospital entity, the governing body of the hospital entity, and the acquiring entity. Additionally, if the State Auditor, Attorney General, and State Treasurer allege a breach of fiduciary duty by an individual director or officer of the hospital entity, the State Auditor, Attorney General, and State Treasurer may name such director or officer as a defendant.

(4) In any action brought pursuant to this subsection, the State Auditor, Attorney General, and State Treasurer bear the burden of establishing by clear and convincing evidence one of the following:

a. A breach of fiduciary duty occurred in the negotiation of the transaction and consummation of the transaction would result in a breach of fiduciary duty.

b. The assets of the hospital entity dedicated to charitable purposes prior to the transaction would not continue to be dedicated to the same or equivalent charitable purposes following consummation of the transaction.

c. Consummation of the transaction would have significant and deleterious effects on the cost, availability, accessibility, and quality of healthcare in the State or any portion of the State, and the negative consequences of the transaction would outweigh any potential benefits. In assessing the disadvantages attributable to a reduction in competition likely to result from consummation of the transaction, the court may rely upon determinations by federal courts and North Carolina courts concerning unreasonable restraint of trade and antitrust violations.

(5) In determining whether the State Auditor, Attorney General, and State Treasurer have met the burden of proof under subdivision (4) of this

subsection, the court should consider evidence of any of the applicable criteria listed in G.S. 131E-214.72.

(6) The court may issue a decision approving the transaction, approving the transaction subject to modification, or disapproving the transaction. Any party may appeal a decision of the court approving the transaction subject to modification, except the State Auditor, Attorney General, and State Treasurer shall not appeal a decision of the court approving the transaction subject to the same modifications initially sought by the State Auditor, Attorney General, and State Treasurer.

(d) If the hospital entity is a for-profit entity:

(1) The State Auditor, Attorney General, and State Treasurer shall file an action in the name of the State seeking injunctive relief to restrain the parties from taking further action to consummate the transaction. The court may issue an order granting such injunctive relief.

(2) The State Auditor, Attorney General, and State Treasurer may apply to the court for temporary or preliminary injunctive relief pending final disposition of the case.

(3) The State Auditor, Attorney General, and State Treasurer shall name as defendants the hospital entity and the acquiring entity.

(4) In any action brought pursuant to this subsection, the State Auditor, Attorney General, and State Treasurer shall have the burden of establishing by clear and convincing evidence that consummation of the transaction would have significant and deleterious effects on cost, availability, accessibility, and quality of healthcare in the State or any portion of the State and that the negative consequences of such a transaction outweigh any potential benefits. In assessing disadvantages attributable to a reduction in competition likely to result from consummation of the transaction, the court may rely upon determinations by federal courts and North Carolina courts concerning unreasonable restraint of trade and antitrust violations.

(5) In determining whether the State Auditor, Attorney General, and State Treasurer have met the burden of proof under subdivision (4) of this subsection, the court should consider evidence of any of the applicable criteria listed in G.S. 131E-214.72.

(6) The court may issue a final determination approving the transaction, approving the transaction subject to modification, or disapproving the transaction. Any party may appeal a decision of the court approving the transaction subject to modification, except the State Auditor, Attorney General, and State Treasurer shall not appeal a decision of the court approving the transaction subject to the same modification the State Auditor, Attorney General, and State Treasurer initially sought.

(e) Any party to a transaction that is subject to review under this Article may decline to enter into a transaction that has been modified by order of the court upon a final determination. However, if the parties agree to enter into a transaction that has been modified by order of the court upon a final determination, then the modified transaction shall not be subject to renewed objection from the State Auditor, Attorney General, and State Treasurer.

"**§ 131E-214.80. Post-transaction reporting; authorization to file further action.**

(a) Following a decision by the State Auditor, Attorney General, and State Treasurer not to object to a transaction subject to review under this Article, or following a final decision in a judicial proceeding brought pursuant to G.S. 131E-214.78, the acquiring entity shall submit to the State Auditor, Attorney General, and State Treasurer an annual report on the acquiring entity's compliance with the terms of the purchase agreement for the transaction, including any

representations made to, or modifications made by, the State Auditor, Attorney General, and State Treasurer. The State Auditor, Attorney General, and State Treasurer shall adopt rules specifying the required contents of the annual report required by this subsection.

(b) If the hospital entity that is a party to the transaction is a nonprofit or publicly owned entity, the acquiring entity or any foundation or charitable trust established pursuant to the transaction shall, in addition to submitting the annual report required by subsection (a) of this section, report annually to the State Auditor, Attorney General, and State Treasurer on its charitable activities and the disposition of its charitable assets in the manner and form prescribed by the State Auditor, Attorney General, and State Treasurer.

(c) If the State Auditor, Attorney General, and State Treasurer deem it reasonable and necessary to do so based on the acquiring entity's failure to comply with the terms of the agreement approved by the State Auditor, Attorney General, and State Treasurer or by a court pursuant to G.S. 131E-214.68, including any modifications to the agreement made by the State Auditor, Attorney General, and State Treasurer, then the State Auditor, Attorney General, and State Treasurer may file an action for relief to restore the benefits of healthcare provider competition in any part of the State, subject to all of the following:

(1) If the transaction was approved only after a final judicial determination pursuant to G.S. 131E-214.78, the State Auditor, Attorney General, and State Treasurer shall file the action in the same court that made the final judicial determination. If the transaction was approved by the State Auditor, Attorney General, and State Treasurer without a final judicial determination pursuant to G.S. 131E-214.78, the State Auditor, Attorney General, and State Treasurer may file an action in either (i) the superior court of any county in which there exists a hospital entity whose control or governance would be altered by the proposed transaction or (ii) the superior court of the county in which the acquiring entity's principal place of business is located, if located within the State.

(2) The State Auditor, Attorney General, and State Treasurer may seek any relief necessary to remedy a violation of the agreement.

(3) The State Auditor, Attorney General, and State Treasurer have the burden of demonstrating by clear and convincing evidence that the benefits of the relief sought to restore the benefits of healthcare provider competition in any part of the State clearly outweigh the costs of doing so, including the transactional costs associated with doing so and any likelihood that the resulting market would not provide the benefits of healthcare provider competition in any part of the State.

(4) No such action may be brought more than five years after the consummation of a transaction.

(d) After consummation of a transaction, an acquiring entity shall not change the financial assistance policy regarding patients who are uninsured or underinsured that were in effect for the hospital entity immediately preceding consummation of the transaction without first providing 120 days' notice, in writing, to the Attorney General; its hospital staff, including physicians in a contractual relationship with the acquiring entity; and patients who have previously benefited from the hospital entity's financial assistance policy. This subsection does not prohibit an acquiring entity from increasing the applicable income limits used to determine patient eligibility for financial assistance at any time following consummation of the transaction, and it does not require an acquiring entity to provide prior notice to the State Auditor, Attorney General, and State Treasurer about the increased income limits. In order to meet the notice requirements of this subsection with respect to patients who have previously benefited from the hospital entity's financial assistance policy, the acquiring entity shall do all of the following:

(1) Provide written notice to both the patient's last known mailing address and to the email address on file for the patient that includes at least all of the following:
a. A description of how the acquiring entity's new financial assistance policy will differ from the hospital entity's financial assistance policy.
b. A description of the process for obtaining financial assistance under the acquiring entity's new financial assistance policy, including a list of (i) all forms a patient would be required to complete in order to be eligible for financial assistance and (ii) all documents a patient would be required to produce as part of the acquiring entity's new financial assistance policy.
c. A link to a webpage that allows members of the public to view the new financial assistance policy and any forms a patient would be required to complete in order to be eligible for financial assistance.
d. A toll-free telephone number for patients to call to ask questions about the acquiring entity's new financial assistance policy.

(2) Educate all physicians affiliated with the acquiring entity, including physicians in a contractual relationship with the acquiring entity, on the new financial assistance policy. Physicians shall verbally inform patients about the new financial assistance policy at appointments occurring during the 120-day notice period required by this subsection.

"**§ 131E-214.82. Violations; penalties; preservation of statutory and common law authority of the State Auditor, Attorney General, and State Treasurer.**

(a) Any transactions entered into in violation of this Article shall be null and void.

(b) Each member of the governing boards and each chief financial officer of the parties to a transaction entered into in violation of this Article are subject to a civil penalty of up to fifty thousand dollars ($50,000) each per transaction, unless the violation was made in wanton disregard of the law, in which case the civil penalty may be up to one million dollars ($1,000,000) each per transaction. The State Auditor, Attorney General, and State Treasurer shall institute proceedings to impose a civil penalty authorized by this section in a court of competent jurisdiction in Wake County, and the court shall determine the amount of the civil penalty to be imposed under this section. The clear proceeds of civil penalties provided for in this subsection shall be remitted to the Civil Penalty and Forfeiture Fund in accordance with G.S. 115C-457.2.

(c) The Department of Health and Human Services shall not issue a new or renewal license to operate a hospital under Article 5 of this Chapter, or any applicable rules, on behalf of any hospital that is a party to a transaction entered into in violation of the notice, public hearing, and review requirements of this Article.

(d) Nothing in this Article shall be construed to limit the statutory or common law authority of the State Auditor, Attorney General, or State Treasurer to protect charitable trusts and assets located in this State. The penalties and remedies set forth in this Article are in addition to, and not a replacement for, any other civil or criminal actions the State Auditor, Attorney General, or State Treasurer is authorized by statute or common law to file, including actions seeking rescission of a transaction, injunctive relief, or any combination of these, and other remedies available under statute or common law."

SECTION 13.1.(b) This Part becomes effective December 1, 2026, and applies to activities occurring on or after that date.

PART XIV. EFFECTIVE DATE

SECTION 14.1. Except as otherwise provided, this act is effective when it becomes law.