H 1039 - Medical Debt De-Weaponization Act-AB
Bill Description from the NC Department of State Treasurer

Overview

The Medical Debt De-Weaponization Act would be a pro-family, anti-poverty consumer protection law that sets parameters around the provision of charity care and limits the ability of large medical facilities to charge unreasonable interest rates and employ unfair tactics in debt collection.

To accomplish that, the new law would require health care facilities to develop a Medical Debt Mitigation Policy (MDMP). The MDMP that would build on an existing framework of financial assistance plans under the federal Affordable Care Act by:

- Establishing a set of steps that must be followed before someone is billed, including:
    - Screening patients for eligibility for public assistance programs;
    - Posting and publicizing the MDMP; and
    - Posting prices online in a usable format using plain language labels.
- Mandating charity care for patients at 200% of federal poverty level (FPL) or below.
- Using a clear pricing structure to offer a transparent sliding scale of MDMP discounts for patients between 200% and 400% of FPL and a predictable maximum amount that could be charged during a twelve-month period for those patients.
- Prohibiting interest charges to patients who receive the MDMP discounts.
- Protecting underinsured patients by:
    - Holding debt collections in abeyance during insurance appeals; and
    - Clarifying that it cannot violate an insurance company's contract with a health care provider for the provider to provide charity or discounted care.
- Providing protections from unreasonable debt collection practices by:
    - Shielding family members from medical and nursing home debts incurred by a spouse or parent;
    - Requiring detailed receipts of payments;
    - Prohibiting credit reporting of unpaid debts within one year after a patient is billed; and
    - Pegging interest rates to U.S. Treasury yields with a maximum allowable rate of 5 percent.
- Enhancing legal remedies for patients by:
    - Creating a new private right of action with treble damages; and
    - Requiring the Attorney General to write rules to enforce the provisions of the act.

Detailed Section by Section Explanation

Section One:

This section of the bill creates a new statute that treats medical debt differently than other types of consumer debt in North Carolina. The new statute is placed under the chapter of the North Carolina General Statutes (NCGS) governing health care facilities and licensure. This document attempts to describe each new section of statute being created by the Medical Debt De-Weaponization Act-AB and to provide context for the proposed language when useful.

NCGS 131E-214.21 Purpose
This introductory section for the new statute sets out the purpose of the "Medical Debt Protection Act" that would be created by the legislation to reduce medical debt and protect vulnerable patients and families by requiring medical debt mitigation policies to help financially eligible patients, setting forth specific financial guidelines for charity care and discounted care, and adding procedural safeguards to protect patients from aggressive or unfair debt collection practices.

NCGS 131E-214.22 Definitions
The definitions section establishes the meaning of terms used in the act. Most definitions in this section are based on those found in other state or federal laws. A few examples of this are:

- The definition of "consumer reporting agency" is based on the definition from the Fair Credit Reporting Act at 15 U.S.C. § 1681a(f).
- The definitions of "external review" and "internal review or internal appeal" are generally based on the definitions used at 45 C.F.R. § 147.136(a)(2), which implements Section 2917 of the Public Service Health Act. They also reflect the requirements of 42 U.S.C. § 300gg-19147.136 and 29 U.S.C. § 1133, which govern different types of health insurance appeals. In general, an internal review is the first step that a patient takes to challenge an insurer's decision to deny a claim. An external review, which is a further appeal to an independent reviewer, may be available to the patient in certain insurance disputes. In addition, Medicare and Medicaid plans offer different appeal rights which are set forth in state law (for Medicaid) and federal law (for both Medicaid and Medicare). The definitions of internal and external review are needed because the Medical Debt De-Weaponization Act contains a protection which pauses any collection or credit reporting activity while the patient exercises appeal rights.
- The definition of "extraordinary collection action" lists the types of collection activities that are regulated by the Medical Debt De-Weaponization Act-AB and is based on those listed at 26 C.F.R. § 1.501(r)-6(b), as set forth at 79 Fed. Reg. 78953-79016 (Dec. 31, 2014), which the IRS promulgated to implement the financial assistance and debt collection provisions of the ACA.
- The definition of "medical debt mitigation policy (MDMP)" is closely based on 26 U.S.C. § 501(r)(4), which the IRS promulgated to implement the financial assistance and debt collection provisions of the ACA. In many other state statutes, this is referred to as the "financial assistance policy."
- The definition of "gross charges" is based on the definition at 26 C.F.R. § 1.501(r)-1, which the IRS promulgated to implement the financial assistance and debt collection provisions of the ACA. Gross charges may also be referred to as chargemaster rates. While chargemaster rates are more commonly found in hospitals, this definition includes the gross charges of any covered health care provider. Gross charges are often several times the rates paid by third party insurers (such as Medicare or private insurers) and also several times the provider's cost of services. See National Consumer Law Center, Collection Actions § 9.1.3 (4th ed. 2017) (discussion of chargemaster pricing).
- The definition of "health care services" is a general one, which is similar to the Massachusetts insurance law definition at Mass. Gen. Laws ch. 176O, § 1.
- "Household income" is defined as income calculated by using the federal modified adjusted gross income (MAGI) method that is used to determine Medicaid eligibility. In the alternative, a state may choose to adopt a state law definition of household income.
- "Large health care facilities" are defined to include nonprofit and for-profit hospitals, outpatient practices which are affiliated with hospitals, ambulatory surgical centers, and large outpatient

practices. These entities and health care professionals are to be covered by the provisions of the Medical Debt De-Weaponization Act-AB as a condition of their licensure by the state. These covered health care providers are a subcategory of "medical creditor," which includes large and small health care providers. The Medical Debt De-Weaponization Act-AB regulates the activities of all medical creditors, but places special responsibilities on large health care facilities, such as the development of financial assistance policies.

- The definition of "large health care facility" includes any outpatient practice which receives at least $20,000,000 in annual revenues. This definition would include large group practices that might not otherwise fall into any of the other categories but does not include solo or smaller practices. The threshold of $20 million is a sufficiently high figure to define large group practice, as it even encompasses small hospitals. For examples of the revenues received by one state's large health care providers, see Center for Health Information and Analysis, Hospital and Health System Financial Performance. Patients who are treated in hospitals may not anticipate bills which are sent not by the hospital, but by health care professionals who treat patients within a hospital building or other facility but are not part of the hospital staff. Bills from anesthesiologists, surgeons and other specialists often come as a surprise to patients who believed that only the hospital itself would bill for their care. In some instances, the specialist may not be part of the patient's insurance network, even though the hospital itself is within the insurer's network. The IRS regulations implementing the financial assistance provisions of the Affordable Care Act made a limited attempt to address this issue by requiring nonprofit hospitals to list any providers who were not covered by the hospital's financial assistance plan. See, 26 C.F.R. §1.501(r)-4 (b)(iii)(F). In addition to expanding the scope of this IRS requirement to for-profit hospitals and other large providers, the Medical Debt De-Weaponization Act-AB directs that any health care professional who provides services in a large health care facility must also provide financial assistance and follow the facility's medical debt mitigation policy. There is no requirement that such providers themselves be part of a large group, to prevent evasion by structuring their practices to technically be solo or a small group, but in reality practicing in a hospital or large facility. High medical bills at gross charges for such providers would be financially devastating for the low- and moderate- income patients who are eligible for financial assistance.
- "Medical creditor" is broadly defined as a health care provider to whom a patient owes money.
- The definition of "medical debt" is based on the definition used by the Fair Credit Reporting Act at 15 U.S.C. § 1681b(g)(1)(C).
- The definition of "medical debt buyer" is a modified version of the definition of debt buyer used in the North Carolina Consumer Economic Protection Act of 2009, codified at N.C. Gen. Stat. Ann. § 58-70-15(b)(4).
- The definition of "medical debt collector" is a simplified version of the definition of debt collector used in the Fair Debt Collection Practices Act, at 15 U.S.C. § 1692a(6), slightly modified to make it explicit that the term covers medical debt buyers.

NCGS 131E-214.23. Medical debt mitigation policy for large health care facilities.

This section requires all large health care facilities to develop a "medical debt mitigation policy (MDMP)," which some states call a "financial assistance policy." The requirements for a MDMP are based on those set forth in the Affordable Care Act provisions governing financial assistance by nonprofit hospitals at 26 U.S.C. § 501(r)(4), and implementing regulations promulgated by the U.S. Department of Treasury regarding such policies. However, the Medical Debt De-Weaponization Act-AB applies the MDMP requirements to all large healthcare facilities and takes the additional step of setting

forth eligibility standards and minimum levels of financial assistance. As noted earlier, the definition of MDMP is also based on the language of 26 U.S.C. § 501(r)(4).

NCGS 131E-214.24. Implementation of the medical debt mitigation policy.

(a) This subsection sets forth the steps that a large health care facility must follow before billing any patient who has received health care services. In summary, the large health care facility must offer to check insurance status and offer to help uninsured patients to apply for health insurance. This type of screening is modeled on a requirement in California law, see Cal. Health & Safety Code § 127420. The large health care facility will also be directed to refer patients to other publicly funded programs which may provide assistance. These programs could include Catastrophic Illness in Children Relief Funds, which operate in about 11 states, or other funds such as the Massachusetts Health Safety Net and Medical Hardship programs, which provide assistance to low-income patients for certain types of health care expenses. A patient may choose not to be screened for insurance eligibility, and this refusal to be screened will not adversely impact the patient's eligibility for the facility's MDMP.

(b) This subsection mandates minimum levels of discounts that must be offered by large health care facilities. Several states have established similar guidelines, although the discounts in the H 1039 Medical Debt De-Weaponization Act-AB are more substantial as proposed than most other states to address the pervasive problems of medical debt caused by the high cost of health care in North Carolina resulting from excessive consolidation.

Other states which currently mandate discounts for low-income patients include the following:

- California: Sets minimum eligibility criteria, discounted care for uninsured patients or patients with high medical costs who have incomes at or below 350% of the federal poverty level. Cal. Health & Safety Code §§127400, 127405.
- Connecticut: Discounted care for uninsured patients who do not qualify for Medicaid, Medicare, or other coverage and with income at or below 250% FPL. C.G.S.A. §19a-673.
- Illinois: Free care for most patients with a family income at or below 200% FPL (care at rural or critical access hospitals must be free for patients at or below 125% FPL); discounted care for uninsured patients with income and assets at or below 600% FPL (or 300% FPL for rural or critical access hospitals). 210 Ill. Comp. Stat. Ann. 89/10.
- Maryland: Free care for patients at or below 200% FPL, reduced cost care for patients with income between 200%-500% FPL. Md. Code Ann., Health-Gen. §19-214.1; Md. Code Regs. 10.37.10.26.
- New Jersey: Free care for patients at or below 200% FPL, and discounts for patients with income between 200%-300% FPL. N.J. Admin. Code § 10:52-11.8.
- New York: Hospitals may charge no more than a nominal fee to patients with incomes at or below 100% FPL and are to provide discounted care on a sliding scale basis to patients with incomes between 100%-300% FPL. N.Y. Pub. Health Law §2807-k(9-a).
- Washington: Free care for uninsured patients at or below 100% FPL and discounts of 75% to 25% for patients between 100% and 200% FPL. Wash. Rev. Code Ann. § 70.170.060; Wash. Admin. Code 246-453-010; 246-453-020; 246-453-050.

Under the Medical Debt De-Weaponization Act-AB, a family with income between 201%-400% of the federal poverty level, or a family with slightly higher income that is experiencing a financial hardship as defined in this section, could be charged no more than $1,150 for a medical bill depending on the cost of

the health care services received. This amount would be subject to a payment plan as noted below. In addition, if a family of this income level is subject to multiple medical bills, paragraph (b)(4) limits the overall cumulative amount that the family can be charged to $2,300 in one year. Health care facilities would be free to deviate from this structure to provide additional assistance, such as providing free care for patients up to 300% of the federal poverty level without financial contribution from the patient. The following chart describes the financial assistance which is to be made available to a patient with household income that is between 201-400% of FPL (generally to be administered as is typical using the federal poverty guidelines instead of FPL cut offs.)

Amounts to be paid by patients with incomes of 201-400% FPL (Patient pays up to this amount)	
50% of the first $1,000	$500
10% of amounts between $1,001-$5,000	$400
5% of amounts between $5,001-$10,0000	$250
Full forgiveness of amounts over $10,000	----
Maximum amount for patient to pay per bill	$1150

The provision includes assistance for moderate-income families with incomes between 401- 600% of FPL, under certain circumstances. These families are included since they may also suffer economic harm from medical debt when large health care costs are incurred. The Medical Debt De-Weaponization Act extends a discount to these families when annual out-of-pocket expenses exceed 5% of the patient's family income. The patient must provide documentation of the patient's medical expenses paid by the patient or the patient's family in the prior 12 months.

A critical question for any medical debt or charity care law is how to set the reimbursement rate from which financial assistance is calculated. Financial assistance should not be calculated from gross or chargemaster rates, which are highly inflated. The Medical Debt De-Weaponization Act-AB uses the Medicare reimbursement rate to determine the amount that can be charged for care, and then applies the appropriate discount to the Medicare amount.

(c) This subsection sets out the documentation requirements to be used for financial assistance determinations. It allows large health care facilities to grant assistance even if there is missing documentation. It also permits a large health care facility to grant financial assistance based on a determination of presumptive eligibility based on other information, such as the fact that the patient receives public benefits or is eligible for another income-based program but prohibits the facility from denying financial assistance using a presumptive determination. If a large health care facility uses credit scores or other scoring models when determining eligibility, the Medical Debt De-Weaponization Act-AB requires patient consent and that the facility comply with the federal Fair Credit Reporting Act, 15 U.S.C. §1681 et seq.

(d) This subsection requires the large health care facility to give the patient written notice within 30 days that the patient’s application for financial assistance was approved or denied, and in the case of a successful application to issue a revised bill explaining how much the patient is expected to pay. This notice is to provide clear information to the patient about their financial obligations after the receipt of financial assistance.

(e) This subsection requires that any large health care facility must accept and process applications for financial assistance for a full year after the first bill for the health care services that generated the medical debt. In addition, if the large health care facility or medical debt collector

(including medical debt buyers) engages in collection activity over the debt, including suing the patient for the debt or reporting it to a credit reporting agency, then the patient may submit the financial assistance application at any time, and the large health care facility must determine if the patient is eligible. If the patient is eligible based on the most recent financial information, then the large health care facility must provide financial assistance.

(f) Prohibits the charging of interest, late fees and prepayment penalty fees for MDMP-eligible patients and ensures that payments do not exceed 5% of the patient's gross monthly income.

(g) Payments on monthly payment plans would not commence until at least 90 days after health care services were provided.

NCGS 131E-214.25. Medical debt mitigation policy: public education and information

This subsection lists the notice and publicity requirements for the medical debt mitigation policy and is based on the regulations at 26 C.F.R. §1.501(r)-4. These requirements are included in the Act given the difficulty of predicting changes to or repeal of the federal regulations. With any attempt to collect the debt by the large health care facility or a medical creditor or debt collector, the patient must be notified again of the large health care facility's MDMP.

NCGS 131E-214.26. Medical debt mitigation policy: language access

The Medical Debt De-Weaponization Act-AB includes language accessibility requirements for the MDMP, which are based on similar requirements found in the IRS regulations, at 26 C.F.R. § 1.501(r)-4(b)(5)(ii). The MDMP must also include a "Babel notice," or a tagline notice written in different languages to inform the patient that the document is important, and the patient may seek translation assistance.

A large health care facility must provide a written translation of its MDMP to patients. In addition, the health care facility must provide oral translation services to other patients who speak less commonly used languages about the MDMP, and to any patients who have questions about the MDMP and its application. The large health care facility may provide oral translation services by using a telephone language line service.

NCGS 131E-214.27. Billing and collections rules; limits on creditors

(a) This subsection prohibits certain collection actions by medical creditors or debt collectors: arrest, body attachment, and foreclosure. It also prohibits them from garnishing the wages or state tax refunds of patients eligible for financial assistance. With respect to arrests and body attachments, also sometimes called a "capias," this usually occurs because the consumer supposedly has failed to show up to a court-mandated hearing, such as the debtor's examination in which the debtor is required to reveal his or her assets to pay a judgment. Despite being ostensibly issued as a form of civil contempt, such arrest warrants are often actually used as an in terrorem tactic by collectors to coerce payment. The Act prohibits medical creditors or debt collectors from seeking an arrest or body attachment; however, the court always has the inherent authority to issue them. As for foreclosures, a medical creditor or debt collector has the ability to place a lien on a home but cannot foreclose on that lien under this section. Instead, they must wait until the home is sold to collect the amount.

(b) Of the permissible extraordinary collection actions, a medical creditor or medical debt collector (including a medical debt buyer) may take those allowable extraordinary collection actions only after 180 days have passed since sending the first bill for a medical debt. This protection is based on a similar prohibition (albeit only 120 days) in the Internal Revenue Service regulations at 26 C.F.R. §1.501(r)-6. The purpose of this 180-day period is to give the patient time to resolve billing disputes and questions, or insurance documentation requests and appeals, before being subject to extraordinary collection actions.

(c) Requires medical creditors, medical debt buyers, and medical debt collectors to notify the patient 30 days before taking any of the permissible extraordinary collection actions. This notice requirement is based on the 30-day notice that is provided in the Internal Revenue Service regulations at 26 C.F.R. §1.501(r)-6 (c)(4)(i)(A). If the debt originates from a large health care facility, this notice informs the patient about the availability of financial assistance, including a plain language summary of the MDMP.

(d) Prohibits a large health care facility or a medical debt collector collecting its debts from taking an extraordinary collection action unless it is listed in the large health care medical debt mitigation policy.

(e) Directs a large health care facility or a medical debt collector collecting its debts to make refunds to the patient in some circumstances if the patient is found to qualify for financial assistance. A refund to the patient may be needed to resolve the patient's debt where the patient has paid the medical debt with a credit card, has borrowed other funds to pay the medical debt, or has had his or her wages or bank account funds seized to pay the debt.

NCGS 131E-214.28. Price information

Information about the health care provider's gross charges and applicable Medicare reimbursement rates can help patients to make health care decisions or address problems with medical debt that has already accrued. Patients eligible for financial assistance can see what their bill should be based on. Patients who do not qualify for financial assistance but who lack the resources to pay a large medical bill promptly may be able to use this information to negotiate reasonable discounts on a bill. Although the purpose of this section is to encourage fair resolution of debt (rather than health care cost containment or shopping), this section is also consistent with the growing attention to price transparency as a tool to help individuals and to slow the growth of health care costs.

As announced by the Center for Medicaid and Medicare Services (CMS), as of January 1, 2019, all hospitals must post standard or chargemaster prices for their health care services. 42 U.S.C.A. § 300gg-18; 83 FR 20164-01 at 20548-20549 ("Requirements for Hospitals To Make Public a List of Their Standard Charges via the Internet"). This provision augments these requirements by also requiring disclosure of Medicare rates and requiring a plain language title or description of the health care services.

NCGS 131E-214.29. Liability for medical debt

This section clarifies the financial responsibility for medical debt. It also removes application of the common law "doctrine of necessaries" to medical debt. That doctrine makes spouses liable for each other's "necessaries," which almost always includes medical bills. The doctrine originated to require a husband to pay for certain necessary expenses incurred by his wife back when married women were not permitted to own property. The doctrine has been abolished in some states. See, e.g., Ark. Code Ann. § 9-11-516 (abolishing doctrine of necessaries); Connor v. Sw. Florida Reg'l Med. Ctr., Inc., 668 So. 2d 175, 177 (Fla. 1995) (abrogating the doctrine of necessaries on equal protection grounds).

The language in this section of the Medical Debt De-Weaponization Act-AB would exempt medical bills in North Carolina from this doctrine. This would provide protection for the non-debtor spouse and may help to prevent situations in which the spouse is burdened with overwhelming medical debt for the patient's medical care, including expensive end-of-life treatment, resulting in severe financial hardship to elderly widows and widowers.

NCGS 131E-214.30. Verification
The information that must be provided pursuant to this section will help patients and creditors resolve disputes around the amounts that are owed.

NCGS 131E-214.31. Medical debt and consumer reporting agencies
These consumer protections would allow for a one year waiting period between the initial billing of a patient and when the debt could be reported to a consumer reporting agency. This one-year period allows "breathing room" to resolve insurance issues (appeals, disputes), billing errors, and other complications that arise from having a third-party payor (the insurer) involved in financial transactions. This section would codify a stronger version of one of the protections for medical debtors in the 2015 settlement reached between thirty-one state attorneys general and the three major credit bureaus, which included a six month period before a medical debt could appear on a credit report, and that has been incorporated into statute in some states (for example, Maine enacted a 180 day waiting period at Me. Rev. Stat. Ann. Tit. 10 § 1310-H(4) (2019), and Washington state enacted a similar consumer protection at RCW 19.16.250(27)(c)). In 2017, the Fair Credit Reporting Act was amended to exclude certain medical debts of military veterans from their credit reports for one year. 15 U.S.C.A. § 1681c(a)(7). A similar provision that would extend a one year waiting period to all consumers was introduced in Congress in 2019 as Section 103 of H.R.3622, the "Restoring Unfairly Impaired Credit and Protecting Consumers Act."

In addition, this section mandates that medical debt collectors (including medical debt buyers) must provide the notice of the right to validate a debt, which is required under the Fair Debt Collection Practices Act, before reporting a medical debt to a consumer reporting agency. This prevents the practice of passive collection or "parking," in which a medical debt collector will not actively dun a consumer for a debt but will simply report it on the consumer's credit report and then wait until the consumer applies for credit and then must address the debt urgently.

131E-214.32. Prohibition against collection of medical debt during health insurance appeals.
This section requires that all health care providers, whether required to have an MDMP or not, shall refrain from any credit reporting, debt collection activities, or selling medical debt to a debt buyer while a patient appeals the denial of coverage by a health insurance payor. This section also requires the medical creditor or medical debt collector that has reported a medical debt to a consumer reporting agency to remove that information if it learns of an appeal. As a practical matter, a patient may need to inform the health care provider of an appeal to invoke the protections of this section, since the health care provider may not otherwise be aware of the appeal.

NCGS 131E-214.33. Interest on medical debt
This section ensures that interest on medical debts is charged at a reasonable rate. It allows medical creditors and debt collectors an interest rate that is the same as permitted under federal law for civil judgments, 28 U.S.C. § 1961, but with a floor of 2% and ceiling of 5% per annum. Reasonable interest rates will also apply to any judgments obtained in court.

NCGS 131E-214.34. Medical debt payment plans
This section sets forth requirements for payment plans to resolve medical debt, requiring the medical creditor, or medical debt collector (including a medical debt buyer) to provide a copy of the plan in writing to the patient. The section recognizes that financial hardships may interfere with a patient's ability to make every payment on schedule and allows a patient who has missed payments during a 90-day period to renegotiate the payment plan.

NCGS 131E-214.35. Receipts for payments
This section directs medical creditors and debt collectors to provide receipts to patients who have made payments on medical debts. In addition to confirming that payment was received, the receipts will be helpful to patients if they are later dunned or charged for a debt that was already paid.

NCGS 131E-214.36. Debt forgiven by medical center
This section addresses a concern that had been raised by health care providers in the past. Some hospitals and health care providers were concerned that their contracts with insurance companies prevented them from waiving or reducing patient copayments or other patient cost sharing. This section clarifies that forgiveness of copayments and other cost sharing will be permitted and will not be construed to violate insurance contracts. New York has adopted a similar state law and directs hospitals that receive funds from the hospital indigent care pool to establish financial aid policies which allow for "…reducing or discounting the collection of co- pays and deductible payments from those individuals who can demonstrate an inability to pay such amounts." N.Y. Pub. Health Law § 2807-k (McKinney). This section is also consistent with principles of medical ethics that encourage the waiver of patient copayments for financial hardship. AMA Principles of Medical Ethics, Ch. 11, § 11.1.4 Financial Barriers to Health Care Access (June 2016).

NCGS 131E-214.37. Private remedy
All states have adopted laws to protect consumers from unfair or deceptive acts or practices (UDAP laws). See National Consumer Law Center, Unfair and Deceptive Acts and Practices, § 1.1. This section makes any violation of the Medical Debt De-Weaponization Act subject to private enforcement through the North Carolina's UDAP law, in addition to any other applicable consumer protections law, such as a our equivalent of the Fair Debt Collection Practices Act.

NCGS 131E-214.38. Prohibition of waiver of rights.
This section is included to preserve the rights established in the Medical Debt De-Weaponization Act-AB. A patient would not be able to sign away their rights under this act when a health care facility asks them to sign a stack of paperwork.

NCGS 131E-214.39. Enforcement
This section designates the Office of the Attorney General, to enforce the Medical Debt De-Weaponization. Enforcement activities would include promulgating rules, accepting and resolving complaints, public reporting of complaints, litigation, and other enforcement actions.

NCGS 131E-214.40. Annual reports and database
Hospitals must file an annual report in which they provide a copy of their MDMP and provide data on, among other things, the number of patients who applied for and were approved for financial assistance, and the amount of financial assistance they provided. This information will be compiled NC Department

of Health and Human Services and made available to the public, the governor, and the legislature. This information is critical in determining if the Act serves the purposes for which it is intended.

NCGS 131E-214.41. Severability
Provides that the components of the act are severable. If any part is invalidated by the courts, the remainder of the act survives.

Section Two:
Provides that if the provisions of certain other Sections of Chapter 131E conflict with the Medical Debt De-Weaponization Act, then the new law prevails.

Section Three:
Provides for a $100,000 recurring appropriation to the Department of Health and Human Services for the purpose of administering the collection of reports required under the act.

Section Four:
The act would be effective October 22, 2022.

Source Acknowledgement: *This document and the proposed bill are adapted from the Model Medical Debt Protection Act developed by the National Consumer Law Center.*