

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2023

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SENATE BILL 321
PROPOSED COMMITTEE SUBSTITUTE S321-CSBC-8 [v.10]
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Short Title: Medical Debt Consumer Protection Act.

(Public)

Sponsors:

Referred to:

March 20, 2023

A BILL TO BE ENTITLED

AN ACT TO ADOPT THE PRO-FAMILY, PRO-CONSUMER MEDICAL DEBT PROTECTION ACT TO LIMIT THE ABILITY OF LARGE MEDICAL FACILITIES TO CHARGE UNREASONABLE INTEREST RATES AND EMPLOY UNFAIR TACTICS IN DEBT COLLECTION, AND TO LIMIT THE ABILITY OF NON-HOSPITAL HEALTH CARE FACILITIES TO CHARGE FACILITY FEES.

The General Assembly of North Carolina enacts:

PART I: MEDICAL DEBT PROTECTION ACT

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

"Article 11C.

"Medical Debt Protection Act.

"§ 131E-214.21. Short title and purpose.

This Article may be cited as the "Medical Debt Protection Act." The purpose of this Article is to reduce burdensome medical debt and to protect patients in their dealings with medical creditors, medical debt buyers, and medical debt collectors with respect to such debt. This Article is a consumer protection statute and shall be liberally and remedially construed to effectuate its purposes.

"§ 131E-214.22. Definitions.

The following definitions apply in this Article:

- (1) Consumer. – A natural person who has incurred a debt or alleged debt for primarily personal, family, or household purposes.
- (2) Consumer reporting agency. – Any person, which, for monetary fees, dues, or on a cooperative nonprofit basis, regularly engages in whole or in part in the practice of assembling or evaluating consumer credit information or other information on consumers for the purpose of furnishing consumer reports to third parties.
- (3) External review. – Review of an adverse benefit determination, including a final internal adverse benefit determination, conducted pursuant to an applicable State external review process as described in Part 4 of Article 50 of Chapter 58 of the General Statutes, a federal external review process as described in 42 U.S.C. § 300gg-19, a review pursuant to 29 U.S.C. § 1133, a Medicare appeals process, a Medicaid appeals process, or another applicable appeals process.
- (4) Extraordinary collection action. – An extraordinary collection action includes any of the following:



- 1 a. Selling an individual's debt to another party, except if prior to the sale,
2 the medical creditor enters into a legally binding written agreement
3 with the medical debt buyer which includes the following provisions:
4 1. The medical debt buyer or collector is prohibited from
5 engaging in any extraordinary collection actions to obtain
6 payment for the care.
7 2. The medical debt buyer is prohibited from charging interest on
8 the debt in excess of that described in G.S. 131E-214.23.
9 3. The debt is returnable to or recallable by the medical creditor
10 upon a determination by the medical creditor or medical debt
11 buyer that the individual is eligible for financial assistance.
12 4. If the individual is determined to be eligible for financial
13 assistance for emergency or medically necessary care and the
14 debt is not returned to or recalled by the medical creditor, the
15 medical debt buyer is required to adhere to procedures which
16 shall be specified in the agreement that ensure that the
17 individual does not pay, and has no obligation to pay, the
18 medical debt buyer and the medical creditor together more than
19 he or she is personally responsible for paying in compliance
20 with this Article.
21 b. Reporting adverse information about the patient to a consumer
22 reporting agency.
23 c. Actions that require a legal or judicial process, including, but not
24 limited to:
25 1. Placing a lien on an individual's property.
26 2. Attaching or seizing an individual's bank account or any other
27 personal property.
28 3. Commencing a civil action against an individual.
29 4. Garnishing an individual's wages.
30 (5) Gross charges. – A covered health care provider's full, established price for
31 health care services that the covered health care provider charges uninsured
32 patients before applying any contractual allowances, discounts, or deductions.
33 (6) Health care services. – Services for the diagnosis, prevention, treatment, cure,
34 or relief of a physical, dental, behavioral, substance use disorder or mental
35 health condition, illness, injury, or disease. These services include, but are not
36 limited to, any procedures, products, devices, or medications.
37 (7) Internal review or internal appeal. – Review by a health insurance plan or other
38 insurer of an adverse benefit determination.
39 (8) Large health care facility. – Includes any of the following entities:
40 a. Any hospital licensed under this Chapter or Chapter 122C of the
41 General Statutes, whether a nonprofit subject to 26 U.S.C. § 501(c)(3),
42 a hospital owned by a county, municipality, the State, or a for-profit
43 entity.
44 b. Any outpatient clinic or facility affiliated with a hospital or operating
45 under the license of a hospital described in sub-subdivision a. of this
46 subdivision.
47 c. Any ambulatory surgical center licensed under this Chapter.
48 d. Any practice which provides outpatient medical, behavioral, optical,
49 radiology, laboratory, dental, or other health care services with
50 revenues of at least twenty million dollars (\$20,000,000) annually and
51 is licensed under this Chapter or has medical providers performing

- 1 health care services pursuant to a license issued under Chapter 90 of
2 the General Statutes.
- 3 e. Any licensed health care professional who provides health care
4 services in one or more of the settings listed in sub-subdivisions a.
5 through d. of this subdivision and bills patients independently.
- 6 (9) Medical creditor. – Any entity that provides health care services and to whom
7 the consumer owes money for health care services, or the entity that provided
8 health care services and to whom the consumer previously owed money if the
9 medical debt has been purchased by one or more debt buyers.
- 10 (10) Medical debt. – A debt arising from the receipt of health care services.
- 11 (11) Medical debt buyer. – A person or entity that is engaged in the business of
12 purchasing medical debts for collection purposes, whether it collects the debt
13 itself or hires a third party for collection or an attorney-at-law for litigation in
14 order to collect such debt.
- 15 (12) Medical debt collector. – Any person that regularly collects or attempts to
16 collect, directly or indirectly, medical debts originally owed or due or asserted
17 to be owed or due another. A medical debt buyer is considered to be a medical
18 debt collector for all purposes.
- 19 (13) Medical debt mitigation policy (MDMP). – A written financial assistance
20 policy which includes:
- 21 a. The basis for calculating amounts charged to patients.
- 22 b. The method for applying for financial assistance for emergency or
23 medically necessary care.
- 24 c. The billing and collections policy containing the actions the covered
25 health care provider may take in the event of nonpayment, including
26 collections action and reporting to credit agencies.
- 27 d. Measures to widely publicize the policy within the community to be
28 served by the covered health care provider in accordance with G.S.
29 131E-214.25.
- 30 (14) Patient. – The person who received health care services and, for the purposes
31 of this Article, shall include a parent if the patient is a minor or a legal guardian
32 if the patient is an adult under guardianship.
- 33 **§ 131E-214.23. Medical debt mitigation policy for large health care facilities.**
- 34 (a) All large health care facilities are required to develop a written MDMP that complies
35 with this Article and any implementing rules. This requirement shall apply whether or not the
36 large health care facility is required to develop a financial assistance policy under 26 U.S.C. §
37 501(r)(4) and implementing regulations.
- 38 (b) The MDMP must, at a minimum, include the following:
- 39 (1) A written financial assistance policy that applies to all emergency and other
40 medically necessary health care services offered by the covered health care
41 provider.
- 42 (2) A plain language summary of the financial assistance policy, which shall not
43 exceed two pages in length.
- 44 (3) The eligibility criteria for financial assistance and a summary of the type of
45 assistance that is available as set forth in this Article.
- 46 (4) The method and application process that patients are to use to apply for
47 financial assistance.
- 48 (5) The information and documentation the large health care facility may require
49 an individual to provide as part of the application.
- 50 (6) The reasonable steps that the provider will take to determine whether a patient
51 is eligible for financial assistance.

1 (7) The billing and collections policy, including the actions that may be taken in
2 the event of nonpayment, which shall comply with all applicable parts of this
3 Article and other applicable municipal, State, or federal laws.

4 (c) The MDMP must be approved by the owners or governing body of a health care
5 provider and shall be reviewed by the owners or governing board annually.

6 **§ 131E-214.24. Implementation of the medical debt mitigation policy.**

7 (a) In addition to any other actions required by applicable municipal, State, or federal
8 law, large health care facilities must take the following steps before seeking payment for any
9 emergency or medically necessary care:

10 (1) Determine whether the patient has health insurance.

11 (2) If the patient is uninsured, offer to screen the patient for public or private
12 insurance eligibility and offer assistance if the patient chooses to apply for
13 public or private insurance, however, a patient's refusal to be screened shall
14 not be grounds for denying financial assistance.

15 (3) Offer to screen the patient for other public programs which may assist with
16 health care costs; however, a patient's refusal to be screened shall not be
17 grounds for denying financial assistance.

18 (4) If the patient submits an application for financial assistance, determine the
19 patient's eligibility for the financial assistance plan within 30 days after the
20 patient applies for financial assistance, suspending any billing or collections
21 actions while eligibility is being determined.

22 (b) If a large health care facility receives an application for financial assistance from a
23 patient, the facility shall notify the patient in writing within 30 days whether it has approved or
24 denied the application. The large health care facility shall provide a copy of any recalculated bill
25 and calculation of financial assistance provided to the patient.

26 (c) A large health care facility shall accept and consider a patient's application for
27 financial assistance if it is submitted within one year of the date of the first bill after the provision
28 of the health care services. However, if the patient is the subject of collection activity by the
29 facility or a medical debt collector, including a lawsuit to collect a medical debt or negative credit
30 reporting regarding a medical debt, and submits an application for financial assistance, the large
31 health care facility shall accept and process the application at any time. If the patient submits a
32 financial assistance application to a medical debt collector, the medical debt collector shall
33 forward the application to the large health care facility within two business days and shall cease
34 collection activity until notified by the large health care facility of the outcome of the application
35 and any debt forgiven or new repayment terms.

36 (d) For a patient who has been found to be eligible for financial assistance, no initial
37 payment on a monthly payment plan shall be due within the first 90 days after the health care
38 services were provided.

39 **§ 131E-214.25. Medical debt mitigation policy: public education and information.**

40 (a) A large health care facility must publicize its MDMP widely by:

41 (1) Making the policy and the financial assistance application form easily
42 accessible online, through the large health care facility's website and through
43 any patient portal or other online communication portal used by patients of
44 the health care provider.

45 (2) In addition to any other requirements in this Article, making paper copies of
46 the MDMP and application form available upon request and without charge,
47 both by mail and in the large health care facility's office. For hospitals, copies
48 should be available, at a minimum, in the emergency room, if any, and
49 admissions areas.

50 (3) Notifying and informing members of the community served by the large
51 health care facility about the MDMP in a manner reasonably calculated to

1 reach those members who are most likely to require financial assistance with
2 such efforts commensurate to the size and income of the provider.

3 (4) Notifying and informing individuals who receive care from the large health
4 care facility about the MDMP by:

5 a. Offering a paper copy of the MDMP to patients as part of the patient's
6 first visit, or in the case of a hospital facility, during the intake and
7 discharge process.

8 b. Including a conspicuous written notice on billing statements, whether
9 sent by the large health care facility or a medical debt collector, that
10 notifies and informs recipients about the availability of financial
11 assistance and includes the telephone number of the large health care
12 facility's office or department that can provide information about the
13 financial assistance policy and application process and the direct
14 website address where copies of the MDMP and application may be
15 obtained.

16 c. Setting up conspicuous public displays or other measures reasonably
17 calculated to attract patients' attention that notify and inform patients
18 about the MDMP in public locations in the large health care facility's
19 office. For hospitals, displays should be posted in the emergency room,
20 if any, and admissions areas, at a minimum.

21 (b) In all attempts, whether written or oral, by a medical creditor or debt collector to
22 collect a medical debt for health care services provided by a large health care facility, the patient
23 must be informed of any financial assistance policy available through the large health care
24 facilities.

25 **§ 131E-214.26. Medical debt mitigation policy; language access.**

26 (a) An MDMP shall include a notice that states: "This document contains important
27 information about financial assistance for your bill. Contact [insert name and phone number of
28 large health care facility] for translation assistance," translated in the 10 languages most
29 frequently spoken by limited English proficient households as determined by U.S. Census Bureau
30 data in the large health care facility's service area.

31 (b) A large health care facility must accommodate all significant populations that have
32 limited English proficiency by translating the MDMP and application form into the primary
33 languages spoken by such populations. A large health care facility will satisfy this translation
34 requirement if it makes available translations of its MDMP and application form in the language
35 spoken by each limited English proficiency language group that constitutes the lesser of 1,000
36 individuals or five percent (5%) of the community served by the large health care facility or the
37 population likely to be affected or encountered by the large health care facility. A large health
38 care facility may determine the percentage or number of limited English proficiency individuals
39 in the large health care facility's community or likely to be affected or encountered by the hospital
40 facility.

41 (c) A large health care facility must accommodate any patient with limited English
42 proficiency, who is part of a population which falls below the numerical thresholds established
43 in subsection (b) of this section, by providing oral interpretation services to the patient upon
44 request and at no cost to the patient to explain the MDMP and its application.

45 (d) A large health care facility must accommodate any patient with limited English
46 proficiency to answer questions from the patient regarding the MDMP, the application form, any
47 written determination of eligibility, and any other communication regarding financial assistance
48 from the large health care facility. A large health care facility may accommodate these patients
49 by providing oral interpretation services to the patient upon request and at no cost to the patient.

50 **§ 131E-214.27. Billing and collections rules; limits on creditors.**

1 (a) The following prohibited collection actions may not be used by any medical creditor
2 or medical debt collector to collect debts owed for health care services:

3 (1) Causing an individual's arrest.

4 (2) Causing an individual to be held in civil contempt or imprisoned under
5 G.S. 5A-21 or G.S. 1-302 if the only reason supporting the contempt is the
6 debtor's failure to pay a judgment for medical debt.

7 (3) Foreclosing on an individual's real property.

8 (4) Garnishing wages or State income tax refunds.

9 (b) No medical creditor or medical debt collector shall engage in any permissible
10 extraordinary collection actions until 180 days after the first bill for a medical debt has been sent.

11 (c) At least 30 days before taking any extraordinary collection actions, a medical creditor
12 or medical debt collector must provide to the patient a notice containing the following:

13 (1) In the case of large health care facilities and medical debt collectors collecting
14 debt for health care services provided by such facilities, stating that financial
15 assistance is available for eligible individuals and providing a plain-language
16 summary of the MDMP.

17 (2) Identifying the extraordinary collection actions that will be initiated in order
18 to obtain payment.

19 (3) Providing a deadline after which such extraordinary collection actions will be
20 initiated, which date is no earlier than 30 days after the date of the notice.

21 (d) A large health care facility or a medical debt collector collecting debt for health care
22 services provided by such a facility shall not use any extraordinary collection actions unless these
23 actions are described in the large health care facility's billing and collections policy.

24 (e) If a large health care facility or a medical debt collector collecting debt for health care
25 services provided by such a facility bills or initiates collection activities and the patient is later
26 found eligible for financial assistance, the large health care facility or medical debt collector shall
27 reverse any extraordinary collection actions, including:

28 (1) Deleting any negative reports to consumer reporting agencies.

29 (2) Dismissing or vacating any collection lawsuits over the medical debt.

30 (3) Removing any wage garnishment orders.

31 If the patient has paid any part of the medical debt or any of the patient's funds have been seized
32 or levied in excess of the amount that the patient owes after application of financial assistance,
33 the large health care facility or medical debt collector shall refund any excess amount to the
34 patient.

35 **"§ 131E-214.28. Price information.**

36 All large health care facilities must post price information on their internet websites. This
37 information must be accessible via a link from the website's homepage and at a minimum must
38 include the following:

39 (1) A list of gross charges for all health care services.

40 (2) Next to the relevant gross charge, a list of the amounts that Medicare would
41 reimburse for the health care service.

42 (3) Plain-language titles or descriptions of health care services that can be
43 understood by the average consumer.

44 **"§ 131E-214.29. Liability for medical debt.**

45 No spouse or other person shall be liable for the medical debt or nursing home debt of any
46 other person age 18 or older. A person may voluntarily consent to assume liability, but such
47 consent shall:

48 (1) Be on a separate standalone document signed by the person.

49 (2) Not be solicited in an emergency room or during an emergency situation.

50 (3) Not be required as a condition of providing any emergency or nonemergency
51 health care services.

"§ 131E-214.30. Verification.

Upon written or oral request and without fee, a medical creditor or medical debt collector shall provide an itemized bill to the patient within 60 days of the request. The itemized bill shall state:

- (1) The name and address of the medical creditor.
- (2) The dates of service.
- (3) The dates the medical debts were incurred, if different from the dates of service.
- (4) A detailed list of the specific health care services provided to the patient.
- (5) A list of all health care professionals who treated the patient.
- (6) The amount of principal for any medical debts incurred.
- (7) Any adjustment to the bill, including negotiated insurance rates or other discounts.
- (8) The amount of any payments received, whether from the patient or any other party.
- (9) Any interest or fees.
- (10) Whether the patient was screened for financial assistance.
- (11) Whether the patient was found eligible for financial assistance and, if so, the amount due after all financial assistance has been applied to the itemized bill.

"§ 131E-214.31. Medical debt and consumer reporting agencies.

(a) No medical creditor or medical debt collector may communicate with or report any information to any consumer reporting agency regarding a consumer's medical debt for a period of one year beginning on the date when the consumer was first given a bill for the medical debt.

(b) After the one-year period described in subsection (a) of this section, medical creditors and medical debt collectors must give consumers at least one additional bill before reporting a medical debt to any consumer reporting agency. The amount reported to the consumer reporting agency must be the same as the amount stated in the bill, and the bill shall state that the debt is being reported to a consumer reporting agency. Medical debt collectors shall also provide the notice required by 15 U.S.C. § 1692g before reporting a debt to a consumer reporting agency.

"§ 131E-214.32. Prohibition against collection of medical debt during health insurance appeals.

(a) A medical creditor or medical debt collector that knows or should have known about an internal review, external review, or other appeal of a health insurance decision that is pending now or was pending within the previous 60 days shall not do any of the following:

- (1) Provide information relative to unpaid charges for health care services to a consumer reporting agency.
- (2) Communicate with the consumer regarding the unpaid charges for health care services for the purpose of seeking to collect the charges.
- (3) Initiate a lawsuit or arbitration proceeding against the consumer relative to unpaid charges for health care services.

(b) If a medical debt has already been reported to a consumer reporting agency and the medical creditor or medical debt collector who reported the information learns of an internal review, external review, or other appeal of a health insurance decision that is pending now or was pending within the previous 60 days, that person shall instruct the consumer reporting agency to delete the information about the debt.

(c) No medical creditor that knows or should have known about an internal review, external review, or other appeal of a health insurance decision that is pending now or was pending within the previous 60 days shall refer, place, or send the unpaid charges for health care services to a medical debt collector, including by selling the debt to a medical debt buyer.

"§ 131E-214.33. Interest on medical debt.

1 (a) Interest on medical debt shall be limited to the rate of interest equal to the weekly
2 average one-year constant maturity Treasury yield, but not less than two percent (2%) per annum
3 nor more than five percent (5%) per annum, as published by the Board of Governors of the
4 Federal Reserve System, for the calendar week preceding the date when the consumer was first
5 provided with a bill. The Office of the State Treasurer shall incorporate a reporting on this interest
6 rate into the interest matters report required by the Council of State. If the Board of Governors
7 of the Federal Reserve System ceases to publish this interest rate, then the Office of the State
8 Treasurer shall substitute another measure that will result in a reasonable interest rate of no more
9 than five percent (5%) per annum. Patients eligible for financial assistance shall not be charged
10 any interest or late fees.

11 (b) The rate of interest provided in subsection (a) of this section shall also apply to any
12 judgments on medical debt, notwithstanding any other provision of law or agreement to the
13 contrary.

14 **"§ 131E-214.34. Medical debt payment plans.**

15 (a) Any medical creditor or medical debt collector that agrees to a payment plan for a
16 medical debt shall provide a written copy of the payment plan to the consumer within five
17 business days of entering into the payment plan. This plan shall prominently disclose the rate of
18 any interest being applied to the debt in compliance with G.S. 131E-214.33 and the date by which
19 the account will be paid off in full, assuming the payments set by the schedule are made without
20 interruption.

21 (b) A consumer need not make a payment on the payment plan until the written copy has
22 been provided.

23 (c) A medical debt payment plan may be accelerated or declared in default or no longer
24 operative due to nonpayment only after the patient fails to make scheduled payments on the
25 payment plan for at least three consecutive months. Before declaring the payment plan no longer
26 operative, the medical creditor or medical debt collector shall make at least three reasonable
27 attempts to contact the patient by telephone or other method preferred by the patient.
28 Additionally, notice must be provided in writing that the payment plan may become inoperative
29 and informing the patient of the opportunity to renegotiate the payment plan. Prior to the payment
30 plan being declared inoperative, the medical creditor shall attempt to renegotiate the terms of the
31 defaulted payment plan, if requested by the patient. The medical creditor shall not report adverse
32 information to a consumer credit reporting agency or commence a civil action against the patient
33 or responsible party for nonpayment until at least 60 days after the payment plan is declared to
34 be no longer operative. For purposes of this section, the notice and telephone call to the patient
35 may be made to the last known telephone number and address of the patient.

36 **"§ 131E-214.35. Receipts for payments.**

37 Within 10 business days of receipt of a payment on a medical debt, the medical creditor or
38 medical debt collector, or any of their agents receiving the payment, shall furnish a receipt to the
39 person that made the payment. All receipts shall include the following information:

40 (1) The amount paid.

41 (2) The date payment was received.

42 (3) The account's balance before the most recent payment.

43 (4) The new balance after application of the payment.

44 (5) The interest rate and interest accrued since the consumer's last payment.

45 (6) The consumer's account number.

46 (7) The name of the current owner of the debt and, if different, the name of the
47 medical creditor.

48 (8) Whether the payment is accepted as payment in full of the debt.

49 **"§ 131E-214.37. Private remedy.**

50 (a) Any medical creditor or medical debt collector who violates this Article, regardless
51 of whether the violation was committed knowingly, shall be liable to the consumer against whom

1 the violation occurred in a private right of action in an amount up to treble the amount fixed by
2 a damages verdict in favor of the plaintiff.

3 (b) Any consumer may sue for injunctive or other appropriate equitable relief to enforce
4 this Article.

5 (c) The remedies provided in this section are not intended to be the exclusive remedies
6 available to a consumer nor must the consumer exhaust any administrative remedies provided
7 under this Article or any other applicable law.

8 (d) No MDMP or agreement between the patient and a large health care provider or
9 medical debt collector shall contain a provision that, prior to a dispute arising, waives or has the
10 practical effect of waiving the rights of a patient to resolve that dispute by obtaining:

11 (1) Injunctive, declaratory, or other equitable relief.

12 (2) Multiple or minimum damages as specified by statute.

13 (3) Attorney's fees and costs as specified by statute or as available at common
14 law.

15 (4) A hearing at which that party can present evidence in person.

16 Any provision in a financial assistance policy or other written agreement violating this
17 subsection shall be void and unenforceable. A court may refuse to enforce other provisions of
18 the financial assistance policy or other written agreement as equity may require.

19 **"§ 131E-214.39. Enforcement.**

20 (a) The Attorney General shall have the authority to enforce this Article and may adopt
21 any rules believed to be necessary or appropriate to effectuate the purpose of this Article, to
22 provide for the protection of patients and their families, and to assist market participants in
23 interpreting this Article.

24 (b) The Attorney General shall establish a complaint process allowing an aggrieved
25 patient or any member of the public to file a complaint against a medical creditor or debt collector
26 who violates any provision of this Article. All complaints shall be considered public records
27 pursuant to Chapter 132 of the General Statutes with the exception of the complainant's name,
28 address, or other personal identifying information.

29 **"§ 131E-214.40. Annual reports and database.**

30 (a) On or before July 1 of each year, beginning July 2024, each large health care facility
31 shall file its MDMP and an annual report with the Department of Health and Human Services
32 pursuant to procedures that the Department shall establish. If the health care facility is not
33 required to report to the Department under G.S. 131E-214.14, that health care facility does not
34 need to submit separate reports to satisfy each reporting requirement; the health care facility may
35 submit one report, so long as the report contains all of the information required under this Article
36 and G.S. 131E-214.14.

37 (b) The Department shall post each report and MDMP in a searchable database accessible
38 on the internet.

39 (c) An annual consolidated report shall be prepared by the Department and made
40 available to the public. These reports shall include the following information for the time period
41 of July 1 of the prior year to July of that year:

42 (1) The total number of patients who applied for financial assistance.

43 (2) The total number of patients who received financial assistance.

44 (3) The total amount of financial assistance provided to patients.

45 (d) Any large health care provider that retains or initiates the process to retain a patient's
46 State tax refund through setoff prescribed by Chapter 105A of the General Statutes or other
47 provision of State law shall report no later than July 1 of each year to the Revenue Laws Study
48 Committee the number of patients eligible for setoff, the total debt owed by the eligible patients,
49 the number of pending setoff actions, the amount expected to be recovered, and the amount of
50 debt expected to be charged off.

51 **"§ 131E-214.41. Severability.**

1 Should a court decide that any provision of this Article is unconstitutional, preempted, or
2 otherwise invalid, that provision shall be severed and shall not affect the validity of the Article
3 other than the part severed.

4 **"§ 131E-214.42. Exemptions.**

5 Federally qualified health centers, as defined by section 1396d (i)(2)(B) of Title 42 of the
6 United States Code, are exempt from G.S. 131E-214.23 through 131E-214.26, 131E-214.28, and
7 131E-214.40."

8 **SECTION 2.** Article 11C of Chapter 131E of the General Statutes, as amended by
9 this act, is amended by adding new sections to read:

10 **"§ 131E-214.36. Debt forgiven by medical center.**

11 Forgiveness of any part of an insured patient's copayment, coinsurance, deductible, facility
12 fees, out-of-network charges, or other cost-sharing shall not be a breach of contract or other
13 violation of an agreement between the medical creditor and the insurer or payor.

14 **"§ 131E-214.38. Prohibition of waiver of rights.**

15 Any waiver by any patient or other consumer of any protection provided by or any right of
16 the patient or other consumer under this Article is void and may not be enforced by any court or
17 any other person."

18 **SECTION 3.** To the extent this act is in conflict with G.S. 131E-91, 131E-99, or
19 131E-147.1, this act shall control.

20 **PART II: FACILITY FEES**

21 **SECTION 4.(a)** Article 16 of Chapter 131E of the General Statutes is amended by
22 adding a new section to read:

23 **"§ 131E-274. Facility fees.**

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

25 (1) Campus. – The main building of a hospital, the physical area immediately
26 adjacent to a hospital's main building, other structures not contiguous to the
27 main building of a hospital that are within 250 yards of the main building, or
28 any other area that has been determined to be part of a hospital's campus by
29 the Centers for Medicare and Medicaid Services.

30 (2) Facility fee. – Any fee charged or billed by a health care provider for
31 outpatient services provided in a hospital-based facility that is: (i) intended to
32 compensate the health care provider for the operational expenses of the health
33 care provider, (ii) separate and distinct from a professional fee; and (iii)
34 charged regardless of the modality through which the health care services
35 were provided.

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

37 (4) Health systems. – A parent corporation of one or more hospitals and any entity
38 affiliated with that parent corporation through ownership, governance,
39 membership or other means, or a hospital and any entity affiliated with that
40 hospital through ownership, governance, membership or other means.

41 (5) Hospital. – As defined in G.S. 131E-76.

42 (6) Hospital-based facility. – A facility that is owned or operated, in whole or in
43 part, by a hospital where hospital or professional medical services are
44 provided.

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

47 (b) Limits on facility fees. – The following limitations are applicable to facility fees:

48 (1) No health care provider shall charge, bill, or collect a facility fee unless the
49 services are provided on a hospital's main campus or at a facility that includes
50 an emergency department.

1 (2) Regardless of where the services are provided, no health care provider shall
2 charge, bill, or collect a facility fee to outpatient evaluation and management
3 services, or any other outpatient, diagnostic, or imaging services identified by
4 the Department.

5 (c) Identification of services. – The Department shall annually identify services subject
6 to the limitations on facility fees provided in subdivision (2) of subsection (b) of this section that
7 may reliably be provided safely and effectively in non-hospital settings.

8 (d) Reporting requirements. – Each hospital and health system shall submit a report to
9 the Department annually on July 1. The report shall be published on the Department's website
10 and shall contain the following:

11 (1) The name and full address of each facility owned or operated by the hospital
12 or health system that provides services for which a facility fee is charged or
13 billed.

14 (2) The number of patient visits at each such hospital-based facility for which a
15 facility fee was charged or billed.

16 (3) The number, total amount, and range of allowable facility fees paid at each
17 facility by Medicare, Medicaid, and private insurance.

18 (4) For each hospital-based facility and for the hospital or health system as a
19 whole, the total amount billed and the total revenue received from facility fees.

20 (5) The top ten procedures or services, identified by current procedural
21 terminology (CPT) category I codes, provided by the hospital or health system
22 that generated the greatest amount of facility fee gross revenue; the number of
23 each of these ten procedures or services provided; the gross and net revenue
24 totals for each such procedure or service; and, the total net amount of revenue
25 received by the hospital or health system derived from facility fees for each
26 procedure or service.

27 (6) Any other information the Department may require.

28 (e) Enforcement. – This section shall be enforced as follows:

29 (1) Any violation of any provision of this section shall be considered an unfair
30 and deceptive trade practice and shall be subject to the provisions of Article 1
31 of Chapter 75 of the General Statutes.

32 (2) In addition to the remedies described in subdivision (1), any health care
33 provider who violates any provision of this section shall be subject to an
34 administrative penalty of not more than one thousand dollars (\$1,000) per
35 occurrence.

36 (3) The Department may audit any health care provider for compliance with the
37 requirements of this section. Until the expiration of four years after the
38 furnishing of any services for which a facility fee was charged, billed, or
39 collected, each health care provider shall make available, upon written request
40 of the Department or its designee, copies of any books, documents, records,
41 or data that are necessary for the purposes of completing the audit."

42 **SECTION 4.(b)** No later than October 1, 2023, the Department of Health and Human
43 Services shall adopt rules necessary to implement the provisions of this section.

44 **PART III: EFFECTIVE DATE**

45 **SECTION 5.** Section 1 of this act becomes effective October 1, 2023, and applies to
46 medical debt collection activities occurring after that date. Section 2 of this act becomes effective
47 October 1, 2023, and applies to agreements and contracts entered into, amended, or renewed on
48 or after that date. Section 4(a) of this act becomes effective October 1, 2023, and applies to
49 facility fees charged on or after that date. The remainder of this act is effective when it becomes
50 law.