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SENATE BILL DRS45217-MR-51 (02/21)

Short Title: Health Care Services Billing Transparency. (Public)

Sponsors: Senators Hise and Meredith (Primary Sponsors).

Referred to:

1 A BILL TO BE ENTITLED
2 AN ACT TO PROVIDE FOR GREATER TRANSPARENCY IN HEALTH CARE
3 SERVICES BILLING.

4 The General Assembly of North Carolina enacts:

5 SECTION 1. G.S. 58-3-200 reads as rewritten:

6 "§ 58-3-200. **Miscellaneous insurance and managed care coverage and network**
7 **provisions.**

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

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

12 ~~(1)(2)~~ "Health benefit plan" means any Health benefit plan. – Any of the following
13 if written by an insurer: an accident and health insurance policy or
14 certificate; a nonprofit hospital or medical service corporation contract; a
15 health maintenance organization subscriber contract; or a plan provided by a
16 multiple employer welfare arrangement. "Health benefit plan" does not mean
17 any plan implemented or administered through the Department of Health and
18 Human Services or its representatives. "Health benefit plan" also does not
19 mean any of the following kinds of insurance:

20 a. Accident.

21 b. Credit.

22 c. Disability income.

23 d. Long-term or nursing home care.

24 e. Medicare supplement.

25 f. Specified disease.

26 g. Dental or vision.

27 h. Coverage issued as a supplement to liability insurance.

28 i. Workers' compensation.

29 j. Medical payments under automobile or homeowners insurance.

30 k. Hospital income or indemnity.

31 l. Insurance under which benefits are payable with or without regard to
32 fault and that is statutorily required to be contained in any liability
33 policy or equivalent self-insurance.

34 (3) Health care provider. – Any health care services facility or any person who
35 is licensed, registered, or certified under Chapter 90 or Chapter 90B of the
36 General Statutes, or under the laws of another state, to provide health care



1 services in the ordinary care of business or practice, or as a profession, or in
 2 an approved education or training program, except that this term shall not
 3 include a pharmacy.

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

11 (2)(5) "Insurer" means an Insurer. – An entity that writes a health benefit plan and
 12 that is an insurance company subject to this Chapter, a service corporation
 13 under Article 65 of this Chapter, a health maintenance organization under
 14 Article 67 of this Chapter, or a multiple employer welfare arrangement under
 15 Article 49 of this Chapter.

16 ...

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

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

29"

30 **SECTION 2.** Article 3 of Chapter 58 of the General Statutes is amended by adding
 31 a new section to read:

32 **"§ 58-3-201. Limitation on balance billing.**

33 (a) The following definitions shall apply in this Article:

34 (1) Health care provider. – As defined in G.S. 58-3-200(a).

35 (2) Insurer. – As defined in G.S. 58-3-200(a).

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

40 (c) Benchmark Amount Calculation. – The benchmark amount shall be calculated as
 41 the lesser of the following:

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

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

45 (3) The median contracted rate for the same or similar services in the same or
 46 similar geographic areas.

47 (d) Application of Benchmark Amount. – A benchmark amount that is applied to an
 48 insured's deductible, co-payment, or coinsurance is considered payment for the purposes of this
 49 section. An insurer's and insured's total payment, individually or collectively, of the benchmark
 50 amount shall foreclose the health care provider from collecting any additional amount from the

1 insured or any third party. Nothing in this section shall require an insurer to make any direct
2 payment to a health care provider.

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

7 **SECTION 3.** Chapter 131E of the General Statutes is amended by adding a new
8 Article to read:

9 "Article 11B.

10 "Transparency in Health Services Billing Practices.

11 **"§ 131E-214.25. Definitions.**

12 The following definitions apply in this section:

- 13 (1) Health care provider. – As defined in G.S. 58-3-200(a).
14 (2) Health services facility. – As defined in G.S. 58-2-200(a).
15 (3) Insurer. – As defined in G.S. 58-3-200(a).
16 (4) Provider. – A health care provider.

17 **"§ 131E-214.26. Fair notice requirements.**

18 (a) Services Provided at Participating Health Services Facilities. – At the time a health
19 services facility participating in an insurer's health care provider network (i) admits to receive
20 emergency services, (ii) schedules a procedure for nonemergency services for, or (iii) seeks
21 prior authorization from an insurer for the provision of nonemergency services to an insured
22 individual, the health services facility shall provide the insured individual with a written
23 disclosure containing the following information:

- 24 (1) Services may be provided at the health services facility by the health
25 services facility itself as well as by other health care providers who may
26 separately bill the insured.
27 (2) Certain health care providers may be called upon to render care to the
28 insured during the course of treatment and may not have contracts with the
29 insured's insurer and are therefore considered to be nonparticipating health
30 care providers. The nonparticipating health care providers shall be identified
31 in the written disclosure.
32 (3) The insurer and the insured, individually or collectively, have no legal
33 obligation to pay for any more than the benchmark amount under
34 G.S. 58-3-201 for services provided by nonparticipating health care
35 providers.
36 (4) Payment by the insurer or insured, individually or collectively, of the
37 benchmark amount under G.S. 58-3-201 forecloses a nonparticipating health
38 care provider from collecting any additional amount from the insured or any
39 third party with the exception of any applicable deductible, co-payment, or
40 coinsurance.
41 (5) Certain consumer protections available to the insured when services are
42 rendered by a health care provider participating in the insurer's health care
43 provider network may not be applicable when services are rendered by a
44 nonparticipating health care provider.

45 (b) Emergency Services Provided Nonparticipating Health Services Facilities. – At the
46 time a health services facility admits an insured individual to receive emergency services but
47 the facility does not have a contract with the individual's insurer, the health services facility
48 shall provide the insured individual with a written disclosure that contains the following
49 information:

- 50 (1) The health care facility does not have a contract with the insured's insurer
51 and is considered to be a nonparticipating health care provider.

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

5 (3) Payment by the insured individual or the insurer, individually or collectively,
6 of the benchmark amount under G.S. 58-3-201 forecloses a nonparticipating
7 health care provider from collecting any additional amount from the insured
8 individual or any third party with the exception of any applicable deductible,
9 co-payment, or coinsurance.

10 (4) Certain consumer protections available to the insured individual when
11 services are rendered by a provider participating in the insurer's provider
12 network may not be applicable when services are rendered by a
13 nonparticipating provider.

14 **"§ 131E-214.27. Fair billing practices.**

15 (a) Billing. – No health services facility shall bill for services at a rate greater than the
16 benchmark amount under G.S. 58-3-201 unless contracting health care providers able to meet
17 the needs of the insured are reasonably available to the insured without unreasonable delay, as
18 determined by the insurer pursuant to G.S. 58-3-200(d). For the purposes of this subsection, the
19 term "services" includes all of the following:

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

23 (2) Services rendered by a provider who is not participating in an insurer's
24 provider network without the insured individual's knowledge.

25 (3) All emergency services.

26 (4) Services rendered by a provider who is not participating in an insurer's
27 provider network if the services were referred by a provider that does
28 participate in an insurer's provider network to the nonparticipating provider
29 without an explicit written explanation of the differences in cost and written
30 consent of the insured individual acknowledging that the participating
31 provider is referring the insured individual to a provider who is not
32 participating in an insurer's provider network and that the referral may result
33 in costs not covered by the health benefit plan.

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

37 (b) Reasonable Payments. – A health care facility's total payment for services provided
38 outside an insurer's health care provider networks pursuant to G.S. 58-3-200(d) or for
39 emergency care services provided pursuant to G.S. 58-3-190 shall be presumed to be
40 reasonable if the payment is equal to or higher than the benchmark amount under
41 G.S. 58-3-201.

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

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

51 **"§ 131E-214.28. Penalties.**

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

5 **SECTION 4.** Chapter 90 of the General Statutes is amended by adding a new
6 Article to read:

7 "Article 41A.

8 "Transparency in Health Care Provider Billing Practices.

9 **"§ 90-705. Definitions.**

10 The following definitions shall apply in this Article:

11 (1) Health care provider. – As defined in G.S. 58-3-200(a).

12 (2) Hospital-based provider. – A health care provider who provides health care
13 services to patients who are in a hospital, including services such as
14 pathology, anesthesiology, emergency room care, radiology, or other
15 services provided in a hospital setting where both of the following occur:

16 a. The health care services are arranged by the hospital by contract or
17 agreement with the hospital-based provider as part of the hospital's
18 general business operations.

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

22 (3) Insurer. – As defined in G.S. 58-3-200(a).

23 **"§ 90-706. Fair notice requirement.**

24 A health care provider that does not participate in the health care provider network of an
25 individual's insurer, including a nonparticipating hospital-based provider, shall include a
26 statement on any billing notice sent to an insured individual that the individual is responsible
27 for paying the applicable in-network cost-sharing amount but has no legal obligation to pay the
28 remaining balance when the benchmark amount in G.S. 58-3-201 applies.

29 **"§ 90-707. Fair billing practices.**

30 (a) Billing. – No health care provider shall bill insured individuals for services at a rate
31 greater than the benchmark amount under G.S. 58-3-201 unless contracting health care
32 providers that are able to meet the health needs of the insureds are reasonably available to the
33 insured without unreasonable delay, as determined by the insurer pursuant to G.S. 58-3-200(d).

34 (b) Reasonable Payments. – A health care provider's total payment for services
35 provided outside an insurer's health care provider networks pursuant to G.S. 58-3-200(d) or for
36 emergency care services provided pursuant to G.S. 58-3-190 shall be presumed to be
37 reasonable if the payment is equal to or higher than the benchmark amount under
38 G.S. 58-3-201.

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

45 **"§ 90-708. Penalties.**

46 A health care provider's willful failure to comply with this section with such frequency as to
47 indicate a general business practice shall be deemed an unfair and deceptive trade practice and
48 shall be actionable under Chapter 75 of the General Statutes. Nothing in this section shall
49 foreclose other remedies available under law or equity."

50 **SECTION 5.** This act becomes effective October 1, 2017, and applies to health
51 care services provided on or after that date.