

**GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2019**

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SENATE BILL 386

Short Title: Greater Transparency in Health Care Billing. (Public)

Sponsors: Senators Hise and Krawiec (Primary Sponsors).

Referred to: Rules and Operations of the Senate

March 28, 2019

1 A BILL TO BE ENTITLED
2 AN ACT TO PROVIDE GREATER TRANSPARENCY IN HEALTH CARE SERVICES
3 BILLING AND REDUCE BILLING WHICH COMES AS A SURPRISE TO THE
4 PATIENT.

5 The General Assembly of North Carolina enacts:

6 **SECTION 1.(a)** G.S. 58-3-200(a) is repealed.

7 **SECTION 1.(b)** G.S. 58-2-200 is amended by adding a new subsection to read:

8 "(a1) Definitions. – 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 (2) Health care provider. – Any health services facility or any person who is
13 licensed, registered, or certified under Chapter 90 or Chapter 90B of the
14 General Statutes, or under the laws of another state, to provide health care
15 services in the ordinary care of business or practice, or as a profession, or in
16 an approved education or training program, except that this term shall not
17 include a pharmacy.

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

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

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

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



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

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

6 **"§ 58-3-201. Limitation on balance billing.**

7 (a) For the purposes of this section, the term "health care provider" shall be as defined in
8 G.S. 58-3-200(a1).

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

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

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

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

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

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

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

31 **SECTION 2.** Chapter 131E of the General Statutes is amended by adding a new
32 Article to read:

33 "Article 11B.

34 "Transparency in Health Services Billing Practices.

35 **"§ 131E-214.25. Definitions.**

36 The following definitions apply in this Article:

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

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

43 (3) Health services facility. – A facility that is licensed under this Chapter or
44 Chapter 122C of the General Statutes or under the licensing laws of another
45 state for the provision of the same services in the ordinary course of business
46 or practice as would require the facility to be licensed under this Chapter or
47 Chapter 122C of the General Statutes were the facility located in this State.

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

49 **"§ 131E-214.26. Fair notice requirements.**

50 (a) Services Provided at Participating Health Services Facilities or by Health Care
51 Providers. – At the time a health services facility or a health care provider participating in an

1 insurer's health care provider network (i) treats an insured individual for anything other than
2 screening and stabilization in accordance with G.S. 58-3-190, (ii) admits an insured individual
3 to receive emergency services, (iii) schedules a procedure for nonemergency services for an
4 insured individual, or (iv) seeks prior authorization from an insurer for the provision of
5 nonemergency services to an insured individual, the health services facility or health care
6 provider shall provide the insured individual with a written disclosure containing the following
7 information:

- 8 (1) Services may be provided at the health services facility by the health services
9 facility itself as well as by health care providers who may separately bill the
10 insured individual.
- 11 (2) Certain health care providers may be called upon to render care to the insured
12 individual during the course of treatment and may not have contracts with the
13 insured's insurer and are therefore considered to be nonparticipating health
14 care providers in the insurer's health care provider network. The
15 nonparticipating health care providers shall be identified in the written
16 disclosure using the individual's health care provider's name and practice
17 name as used on the applicable health services facility or health care providers
18 credentials or name badge.
- 19 (3) The insurer and the insured individual, individually or collectively, have no
20 legal obligation to pay any more than the benchmark amount, as calculated
21 under G.S. 58-3-201, for services provided by nonparticipating health care
22 providers.
- 23 (4) Receipt by the health care provider of payment for services to the insured
24 individual by the insurer and any third party, individually or collectively, of
25 the benchmark amount calculated under G.S. 58-3-201 forecloses a
26 nonparticipating health services facility or health care provider from
27 collecting any additional amount from the insurer, insured individual, or any
28 third party with the exception of any applicable deductible, co-payment, or
29 coinsurance in the insured's health benefit plan with the insurer.
- 30 (5) Text, using a bold or other distinguishable font, that states that certain
31 consumer protections available to the insured individual when services are
32 rendered by a health services facility or health care provider participating in
33 the insurer's health care provider network may not be applicable when services
34 are rendered by a nonparticipating health services facility or health care
35 provider.

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

- 41 (1) The health services facility does not have a health care provider network
42 contract with the applicable insurer and is considered to be a nonparticipating
43 health care provider.
- 44 (2) The insurer, the insured individual, and any third party, individually or
45 collectively, have no legal obligation to pay any more than the benchmark
46 amount, as calculated under G.S. 58-3-201, for services provided by
47 nonparticipating health care providers or health service facilities.
- 48 (3) Payment by the insurer, the insured individual, or any third party, individually
49 or collectively, of the benchmark amount calculated under G.S. 58-3-201
50 forecloses a nonparticipating health services facility or health care provider
51 from collecting any additional amount from the insurer, insured individual, or

1 any third party with the exception of any applicable deductible, co-payment,
2 or coinsurance in the insured's health benefit plan.

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

9 **"§ 131E-214.27. Fair billing and collection practices.**

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

- 17 (1) Services rendered by a health care provider who is not participating in an
18 insurer's health care provider network at a health services facility that does
19 participate in an insurer's health care provider network if a participating health
20 care provider is unavailable.
21 (2) Services rendered by a health care provider who is nonparticipating in an
22 insurer's provider network without the insured individual's prior knowledge,
23 as evidenced by the fair notice requirements under G.S. 131E-214.26.
24 (3) All emergency services, as defined by G.S. 58-3-190.
25 (4) Services rendered by a health care provider who is not participating in an
26 insurer's health care provider network if the services were referred by a
27 participating provider to the nonparticipating health care provider without an
28 explicit written explanation of the differences in cost, certification of delivery
29 of the written disclosure under G.S. 131E-214.26, and written consent of the
30 insured individual acknowledging that the participating health care provider
31 is referring the insured individual to a nonparticipating health care provider
32 and that the referral may result in costs not covered by the insured's health
33 benefit plan.

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

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

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

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

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

9 **"§ 131E-214.28. Penalties.**

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

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

16 "Article 41A.

17 "Transparency in Health Care Provider Billing Practices.

18 **"§ 90-705. Definitions.**

19 The following definitions shall apply in this Article:

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

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

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

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

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

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

32 **"§ 90-706. Fair notice requirement.**

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

39 **"§ 90-707. Fair billing and collection practices.**

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

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

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

8 **"§ 90-708. Penalties.**

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

13 **SECTION 4.** This section becomes effective October 1, 2019, and applies to health
14 care services provided to insured individuals on or after that date.