

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2025

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1

HOUSE BILL 1175

Short Title: Affordability in Healthcare Act. (Public)

Sponsors: Representatives Cervania, Crawford, Ball, and Belk (Primary Sponsors).
For a complete list of sponsors, refer to the North Carolina General Assembly web site.

Referred to: Rules, Calendar, and Operations of the House

May 4, 2026

A BILL TO BE ENTITLED

1
2 AN ACT TO LOWER HEALTHCARE COSTS, INCREASE COMPETITION IN THE
3 HEALTH INSURANCE MARKET, AND IMPROVE VALUE AND TRANSPARENCY
4 BY LEVERAGING THE STATE'S PURCHASING POWER; TO ESTABLISH A
5 LOW-COST, AFFORDABLE HEALTH PLAN OPTION ON THE AFFORDABLE CARE
6 ACT HEALTH INSURANCE MARKETPLACE; TO CREATE A HEALTHCARE
7 PURCHASING CONSORTIUM TO ALIGN PUBLIC PROCUREMENT; TO
8 APPROPRIATE FUNDS FOR IMPLEMENTATION; TO CONTINUE AND EXPAND
9 HEALTHY OPPORTUNITIES ACTIVITIES TO PROMOTE CHRONIC DISEASE
10 PREVENTION; TO ELIMINATE CERTIFICATE OF NEED REVIEW FOR INPATIENT
11 REHABILITATION SERVICES, REHABILITATION FACILITIES, AND
12 REHABILITATION BEDS; TO PROVIDE GREATER PROTECTION FOR ESSENTIAL
13 RURAL HEALTH SERVICES; AND TO PRESERVE COMPETITION IN HEALTHCARE
14 BY REGULATING THE CONSOLIDATION AND CONVEYANCE OF HOSPITALS.

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

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

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

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

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

33 Whereas, many North Carolinians remain uninsured or lack access to coverage they
34 can reasonably afford, and the State has a compelling interest in expanding access to dependable,



1 affordable health benefit plans so that residents may obtain needed care before medical
2 conditions become more severe and more costly; and

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

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

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

14 The General Assembly of North Carolina enacts:

15
16 **PART I. INCREASING COMPETITION AND LOWERING HEALTHCARE COSTS**
17 **THROUGH MARKETPLACE INNOVATION AND PURCHASING ALIGNMENT**

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

- 24 (1) In many regions of North Carolina, limited competition in the individual
25 health insurance market contributes to higher premiums and fewer affordable
26 coverage options for consumers. Establishing a lower-cost, State-supported
27 health plan option offered on the Affordable Care Act Health Insurance
28 Marketplace can increase competition, expand access to affordable coverage,
29 and improve price transparency for consumers and the State.
- 30 (2) North Carolina's public employers and public programs purchase health
31 coverage and health care services at scale, yet procurement and contracting
32 are fragmented across public entities, diluting negotiating leverage, increasing
33 administrative costs, and limiting the State's ability to align purchasing
34 strategies toward affordability and value.
- 35 (3) Coordinating public purchasers through a consortium can support aligned
36 procurement standards, common performance guarantees and data standards,
37 and shared analytics to improve competition, transparency, and affordability
38 while respecting voluntary participation by local governments and other
39 public entities.
- 40 (4) Investments in evidence-based interventions that address health-related social
41 needs can reduce avoidable healthcare utilization, improve health outcomes,
42 and support chronic disease prevention when coordinated with Medicaid
43 managed care and other State initiatives to the extent permitted by federal law.

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

46 "Article 94.

47 "Low-Cost Health Plan Option.

48 **"§ 58-94-1. Definitions.**

49 The following definitions apply in this Article:

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

- 1 (2) Exchange. – The health benefit exchange serving North Carolina pursuant to
2 42 U.S.C. § 18031 or any successor law.
- 3 (3) Reserved for future codification purposes.
- 4 (4) Low-Cost Health Plan Option. – A qualified health plan, or group of qualified
5 health plans, made available through a State-facilitated arrangement and
6 ordered on the Exchange in accordance with this Article for the purpose of
7 increasing competition, improving affordability, and expanding consumer
8 choice.
- 9 (5) Participating carrier. – An insurer licensed under this Chapter that contracts
10 with the State to offer the Low-Cost Health Plan Option.
- 11 (6) Reference-based rate. – A reimbursement rate benchmarked to Medicare or
12 another objective schedule adopted pursuant to this Article.

13 **"§ 58-94-5. Establishment of Low-Cost Health Plan Option.**

- 14 (a) DHHS shall, in consultation with the Department and the State Treasurer, establish
15 and administer the North Carolina Low-Cost Health Plan Option.
- 16 (b) The Low-Cost Health Plan Option shall be offered on the Exchange statewide.
- 17 (c) DHHS may procure one or more participating carriers or third-party administrators to
18 underwrite, administer, and operate the Low-Cost Health Plan Option, including provider
19 network contracting, claims administration, utilization management, and customer service.
- 20 (d) The Low-Cost Health Plan Option shall comply with applicable federal law for
21 qualified health plans.

22 **"§ 58-94-10. Standards for affordability and value.**

- 23 (a) Procurement Requirements. – DHHS shall set procurement requirements intended to
24 reduce premiums and out-of-pocket costs, including reasonable administrative expense limits,
25 quality metrics, and reporting requirements.
- 26 (b) Participating Carrier Requirements. – DHHS may require participating carriers to use
27 value-based payment, tiered networks, advanced primary care models, or other designs consistent
28 with affordability and quality.
- 29 (c) Reference-Based Rates. – To the extent permitted by federal law, the DHHS may set
30 reference-based rates for provider reimbursement under the Low-Cost Health Plan Option,
31 including rates expressed as a percentage of Medicare, with adjustments for rural access, critical
32 access hospitals, and other essential providers.
- 33 (d) Affordability Outcomes. – Beginning with the initial plan year and for each plan year
34 thereafter, DHHS shall ensure that the Low-Cost Health Plan Option meets the following
35 affordability outcomes:
- 36 (1) Premium benchmark. – For each rating area in which the Low-Cost Health
37 Plan Option is offered, DHHS shall procure and administer at least one
38 standard-design silver Low-Cost Health Plan Option plan with a premium that
39 is no greater than ninety-five percent (95%) of the premium for the
40 lowest-premium available silver qualified health plan offered in the same
41 rating area, excluding the Low-Cost Health Plan Option, for the same age and
42 tobacco status, as determined using a methodology specified by DHHS.
- 43 (2) Administrative expense cap. – DHHS shall require participating carriers and
44 third-party administrators to meet a reasonable administrative expense limit
45 that shall not exceed twelve percent (12%) of premium, except that DHHS
46 may allow a higher limit for the first plan year of operation if the DHHS finds
47 that a temporary adjustment is necessary for implementation and consumer
48 protections and reports the finding to the Joint Legislative Oversight
49 Committee on Health and Human Services.
- 50 (3) Out-of-pocket affordability standard. – DHHS shall require standardized
51 benefit designs for at least one silver plan and shall set cost-sharing parameters

intended to reduce out-of-pocket costs relative to comparable silver plans, including lower deductibles or copayments for primary care, behavioral health, and generic prescription drugs, consistent with federal law for qualified health plans.

- (4) Corrective action. – If DHHS determines that an affordability outcome required by this subsection cannot be met in a rating area due to network adequacy requirements, provider participation, federal restrictions, or other constraints outside the reasonable control of DHHS, then DHHS shall do all of the following:
 - a. Document the constraint and the steps taken to address it.
 - b. Implement procurement or design changes reasonably expected to improve affordability in the subsequent plan year.
 - c. Report the determination and corrective action plan in the annual report required by G.S. 58-94-25.

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

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

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

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

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

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

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

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

"§ 58-94-25. Reporting.

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

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

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

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

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

"Article 85.

"Public Health Purchasing Consortium.

"§ 143-820. Establishment.

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

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

3 **(1)** The Department of Health and Human Services.

4 **(2)** The Department of Insurance.

5 **(3)** The Office of State Human Resources.

6 **(4)** The University of North Carolina System.

7 **(5)** The North Carolina Community College System.

8 **(6)** A representative of another public entity designated by the chair.

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

11 **"§ 143-821. Powers and duties.**

12 The Consortium shall do all of the following:

13 **(1)** Develop model procurement standards for carriers, Third-Party
14 Administrators, Pharmacy Benefit Managers, and other vendors.

15 **(2)** Pursue joint or aligned procurements where practicable, including common
16 performance guarantees and data standards.

17 **(3)** Establish common definitions and reporting for price, quality, and utilization
18 metrics.

19 **(4)** Coordinate strategies to improve competition, transparency, and affordability.

20 **(5)** Recommend statutory or budget changes to implement purchasing reforms.

21 **(6)** Support implementation of the Low-Cost Health Plan Option created under
22 Article 94 of Chapter 58 of the General Statutes.

23 **"§ 143-822. Data sharing and analysis.**

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

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

31 **"§ 143-823. Voluntary participation by local governments and other public entities.**

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

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

37 **"§ 143-824. Reports.**

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

41
42 **PART III. IMPLEMENTATION AND APPROPRIATION FOR THE LOW-COST**
43 **HEALTH PLAN OPTION AND THE PUBLIC HEALTH PURCHASING**
44 **CONSORTIUM**

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

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

1 **SECTION 3.2.** Effective July 1, 2026, there is appropriated from the General Fund
2 to the Department of Health and Human Services the sum of twenty-five million dollars
3 (\$25,000,000) in recurring funds and the sum of ten million dollars (\$10,000,000) in nonrecurring
4 funds for the 2026-2027 fiscal year to implement the Low-Cost Health Plan Option under Part I
5 of this act and the Public Health Purchasing Consortium under Part II of this act, including
6 Consortium analytics and procurement coordination, actuarial services, information technology,
7 contracting support, and outreach.

8
9 **PART IV. HEALTHY OPPORTUNITIES CONTINUATION FOR CHRONIC DISEASE**
10 **PREVENTION**

11 **SECTION 4.1.(a)** There is appropriated from the General Fund to the Department
12 of Health and Human Services, Division of Health Benefits (DHB), the sum of one hundred
13 seventy-five million dollars (\$175,000,000) in recurring funds and associated receipts for the
14 2026-2027 fiscal year to continue and expand Healthy Opportunities Pilots activities to promote
15 chronic disease prevention, reduce avoidable healthcare utilization, and improve health outcomes
16 through evidence-informed interventions addressing health-related social needs, including, as
17 applicable, nutrition supports, housing-related supports, transportation supports, interpersonal
18 safety supports, and other services authorized by DHHS consistent with federal requirements.

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

- 21 (1) Payments to participating entities, network leads, human service
22 organizations, and other contractors or grantees to deliver covered
23 interventions.
- 24 (2) Administrative costs necessary to operate the program, including contracting,
25 compliance, data collection, evaluation, quality improvement, and program
26 integrity activities.
- 27 (3) Information technology, referral platforms, community resource connectivity,
28 and related infrastructure needed to support screening, referral, service
29 delivery, and reporting.
- 30 (4) Technical assistance, provider engagement, beneficiary outreach, and training
31 necessary for effective implementation.

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

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

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

- 45 (1) Annual expenditures by category and region.
- 46 (2) Number of beneficiaries served and services delivered within the previous
47 calendar year.
- 48 (3) Outcome measures, including utilization impacts where measurable.
- 49 (4) Recommendations for continuation, modification, or expansion of the Healthy
50 Opportunities Pilots.

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

1
2 **PART V. GREATER TRANSPARENCY IN HOSPITAL AND AMBULATORY**
3 **SURGICAL FACILITY HEALTHCARE COSTS**

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

6 "Article 11B.

7 "Transparency in Health Care Costs.

8 "Part 1. Health Care Cost Reduction and Transparency Act of 2013.

9 "**§ 131E-214.11. Title.**

10 This ~~article~~ Part shall be known as the Health Care Cost Reduction and Transparency Act of
11 2013.

12 ...

13 "**§ 131E-214.13. Disclosure of prices for most frequently reported DRGs, CPTs, and**
14 **HCPCSs.**

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

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

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

19 (2a) CPT. – Current Procedural Terminology.

20 (2b) DRG. – Diagnostic Related Group.

21 (2c) HCPCS. – The Healthcare Common Procedure Coding System.

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

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

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

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

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

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

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

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

39 (b) ~~Beginning with the reporting period ending September 30, 2015, and annually~~
40 ~~thereafter, Quarterly Report on Most Frequently Reported DRGs for Inpatients. – On a quarterly~~
41 ~~basis, each hospital shall provide to the Department of Health and Human Services statewide~~
42 ~~data processor, utilizing electronic health records software, the following information about the~~
43 ~~100 most frequently reported admissions by DRG for inpatients as established by the~~
44 ~~Department:~~

45 (1) The amount that will be charged to a patient for each DRG if all charges are
46 paid in full without a public or private third party paying for any portion of
47 the charges. In calculating this amount, each hospital shall include charges for
48 each billable item and service associated with the DRG regardless of whether
49 the health service is performed by a physician or nonphysician practitioner
50 employed by the hospital.

- 1 (2) The average negotiated settlement on the amount that will be charged to a
2 patient required to be provided in subdivision (1) of this subsection.
- 3 (3) The amount of Medicaid reimbursement for each DRG, including claims and
4 pro rata supplemental payments.
- 5 (4) The amount of Medicare reimbursement for each DRG.
- 6 (5) For each of the five largest health insurers providing payment to the hospital
7 on behalf of insureds and teachers and State employees, the range and the
8 average of the amount of payment made for each DRG. Prior to providing this
9 information to the ~~Department statewide data processor~~, each hospital shall
10 redact the names of the health insurers and any other information that would
11 otherwise identify the health insurers.

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

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

- 20 (1) ~~The method by which the Department shall determine the 100 most frequently~~
21 ~~reported DRGs for inpatients for which hospitals must provide the data set out~~
22 ~~in subsection (b) of this section.~~
- 23 (2) ~~Specific categories by which hospitals shall be grouped for the purpose of~~
24 ~~diselosing this information to the public on the Department's Internet Web~~
25 ~~site.~~

26 ~~(d) Beginning with the reporting period ending September 30, 2015, and annually~~
27 ~~thereafter, Quarterly Report on Total Costs for the Most Common Surgical and Imaging~~
28 ~~Procedures. – On a quarterly basis, each hospital and ambulatory surgical facility shall provide~~
29 ~~to the Department, statewide data processor, utilizing electronic health records software,~~
30 ~~information on the total costs for the 20 most common surgical procedures and the 20 most~~
31 ~~common imaging procedures, by volume, performed in hospital outpatient settings or in~~
32 ~~ambulatory surgical facilities, along with the related CPT and HCPCS codes. In providing~~
33 ~~information on total costs, each hospital and ambulatory surgical facility shall include the costs~~
34 ~~for each billable item and service associated with the procedure regardless of whether the health~~
35 ~~service is performed by a physician or nonphysician practitioner employed by the hospital or~~
36 ~~ambulatory surgical facility. Hospitals and ambulatory surgical facilities shall report this~~
37 ~~information in the same manner as required by subdivisions (b)(1) through (5) of this section,~~
38 ~~provided that hospitals and ambulatory surgical facilities shall not be required to report the~~
39 ~~information required by this subsection where the reporting of that information reasonably could~~
40 ~~lead to the identification of the person or persons admitted to the hospital in violation of the~~
41 ~~federal Health Insurance Portability and Accountability Act of 1996 (HIPAA) or other federal~~
42 ~~law.~~

43 ~~(e) The Commission shall adopt rules on or before March 1, 2016, to ensure that~~
44 ~~subsection (d) of this section is properly implemented and that hospitals and ambulatory surgical~~
45 ~~facilities report this information to the Department in a uniform manner. The rules shall include~~
46 ~~the method by which the Department shall determine the 20 most common surgical procedures~~
47 ~~and the 20 most common imaging procedures for which the hospitals and ambulatory surgical~~
48 ~~facilities must provide the data set out in subsection (d) of this section.~~

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

1 (f) Upon request of a patient for a particular DRG, imaging procedure, or surgery
 2 procedure reported in this section, a hospital or ambulatory surgical facility shall provide the
 3 information required by subsection (b) or subsection (d) of this section to the patient in writing,
 4 either electronically or by mail, within three business days after receiving the request.

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

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

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

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

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

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

32 ...

33 **"§ 131E-214.18. Penalty for noncompliance.**

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

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

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

45 ...

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

50 **SECTION 5.3.** This Part becomes effective on the later of January 1, 2027, or the
 51 date the rules adopted by the North Carolina Medical Care Commission under

1 G.S. 131E-214.13(f1)(2) take effect, and G.S. 131E-214.18, as enacted by this Part, applies to
2 acts occurring on or after that date. The Commission shall notify the Revisor of Statutes when
3 the rules required under G.S. 131E-214.13(f1)(1) and (f1)(2) take effect.
4

5 **PART VI. GREATER TRANSPARENCY IN HEALTH CARE PROVIDER BILLING** 6 **PRACTICES**

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

9 "Part 2. Transparency in Provider Billing Practices.

10 **"§ 131E-214.25. Definitions.**

11 The following definitions apply in this Part:

- 12 (1) Health benefit plan. – As defined in G.S. 58-3-167, or under the laws of
13 another state or the federal government.
- 14 (2) Health care provider. – As defined in G.S. 90-410.
- 15 (3) Insurer. – As defined in G.S. 58-3-167.

16 **"§ 131E-214.30. Fair notice requirements; health service facilities.**

17 (a) Services Provided at a Participating Health Service Facility. – At the time a health
18 service facility participating in an insurer's provider network (i) treats an insured individual for
19 anything other than screening and stabilization in accordance with G.S. 58-3-190, (ii) admits an
20 insured individual to receive emergency services, (iii) schedules a procedure for nonemergency
21 services for an insured individual, or (iv) seeks prior authorization from an insurer for the
22 provision of nonemergency services to an insured individual, the health service facility shall
23 provide the insured individual with a written disclosure containing all of the following
24 information:

- 25 (1) Services may be provided at the health service facility for which the insured
26 individual may receive a separate bill.
- 27 (2) Certain health care providers may be called upon to render care to the insured
28 individual during the course of treatment and those providers may not have
29 contracts with the insured's insurer and are considered to be nonparticipating
30 providers in the insurer's provider network. Any nonparticipating providers
31 shall be identified in the written disclosure using the individual provider's
32 name and practice name, as used on the applicable health service facility's or
33 provider's credentials or name badge.
- 34 (3) Text, using a bold or other distinguishable font, that states that certain
35 consumer protections available to the insured individual when services are
36 rendered by a health service facility or provider participating in the insurer's
37 provider network may not be applicable when services are rendered by a
38 nonparticipating provider.

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

- 44 (1) A statement that the health service facility does not have a provider network
45 contract with the applicable insurer and is considered to be a nonparticipating
46 provider.
- 47 (2) Text, using a bold or other distinguishable font, that states that certain
48 consumer protections available to the insured individual when services are
49 rendered by a health service facility or health care provider participating in
50 the insurer's health care provider network may not be applicable when services
51 are rendered by a nonparticipating health service facility.

1 **"§ 131E-214.31. Fair notice requirements.**

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

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

10 (2) Text, using a bold or other distinguishable font, that states that certain
11 consumer protections available to the insured individual when services are
12 rendered by a health care provider participating in the insurer's health care
13 provider network may not be applicable when services are rendered by a
14 nonparticipating provider.

15 **"§ 131E-214.35. Penalties.**

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

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

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

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

23 ...

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

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

28 **SECTION 6.2.(c)** G.S. 58-3-200(d) reads as rewritten:

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

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

40
41 **PART VII. GREATER FAIRNESS IN BILLING AND COLLECTIONS PRACTICES**
42 **FOR HOSPITALS AND AMBULATORY SURGICAL FACILITIES**

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

46 **SECTION 7.1.(b)** G.S. 131E-91 is recodified as G.S. 131E-214.50 under Article
47 11C of Chapter 131E of the General Statutes, as created by subsection (a) of this section.

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

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

51 ...

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

6 "

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

9 **"§ 131E-214.52. Patient's right to a good-faith estimate.**

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

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

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

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

19 a. Supplies and procedures.

20 b. Room and board.

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

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

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

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

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

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

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

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

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

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

49
50 **PART VIII. GREATER PROTECTION FOR HEALTHCARE CONSUMERS FROM**
51 **FACILITY FEES**

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

3 **"§ 131E-214.54. Facility fees.**

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

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

6 (2) Campus. – Any of the following:

7 a. The main building of a hospital.

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

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

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

13 (3) Facility fee. – Any fee charged or billed by a health care provider for
14 outpatient services provided in a hospital-based facility that is (i) intended to
15 compensate the health care provider for the operational expenses of the health
16 care provider, (ii) separate and distinct from a professional fee, and (iii)
17 charged regardless of the modality through which the health care services
18 were provided.

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

20 (5) Health systems. – A parent corporation of one or more hospitals and any entity
21 affiliated with that parent corporation through ownership, governance,
22 membership, or other means, or a hospital and any entity affiliated with that
23 hospital through ownership, governance, membership, or other means.

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

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

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

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

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

36 (1) No health care provider shall charge, bill, or collect a facility fee unless the
37 services are provided on a hospital's main campus, at a remote location of a
38 hospital, at a facility that includes an emergency department, or at an
39 ambulatory surgical facility.

40 (2) Regardless of where the services are provided, no health care provider shall
41 charge, bill, or collect a facility fee for outpatient evaluation and management
42 services, or any other outpatient, diagnostic, or imaging services identified by
43 the Department.

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

47 (d) Reporting Requirements. – Each hospital and health system shall submit a report to
48 the Department annually on July 1. The report shall be published on the Department's website
49 and shall contain the following:

- 1 (1) The name and full address of each facility owned or operated by the hospital
- 2 or health system that provides services for which a facility fee is charged or
- 3 billed.
- 4 (2) The number of patient visits at each such hospital-based facility for which a
- 5 facility fee was charged or billed.
- 6 (3) The number, total amount, and range of allowable facility fees paid at each
- 7 facility by Medicare, Medicaid, and private insurance.
- 8 (4) For each hospital-based facility and for the hospital or health system as a
- 9 whole, the total amount billed, and the total revenue received from facility
- 10 fees.
- 11 (5) The top 10 procedures or services, identified by Current Procedural
- 12 Terminology (CPT) category I codes, provided by the hospital or health
- 13 system that generated the greatest amount of facility fee gross revenue; the
- 14 number of each of these 10 procedures or services provided; the gross and net
- 15 revenue totals for each such procedure or service; and the total net amount of
- 16 revenue received by the hospital or health system derived from facility fees
- 17 for each procedure or service.
- 18 (6) Any other information the Department may require.
- 19 (e) Enforcement. – This section shall be enforced as follows:
- 20 (1) Any violation of this section constitutes an unfair or deceptive trade practice
- 21 in violation of G.S. 75-1.1 and is subject to all of the enforcement and penalty
- 22 provisions of an unfair or deceptive trade practice under Article 1 of Chapter
- 23 75 of the General Statutes.
- 24 (2) In addition to the remedies described in subdivision (1) of this subsection, any
- 25 health care provider who violates any provision of this section shall be subject
- 26 to an administrative penalty of not more than one thousand dollars (\$1,000)
- 27 per occurrence."

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

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

36
 37 **PART IX. STATE AUDITOR REVIEW OF HEALTH SERVICE FACILITY PRICES**

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

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

- 40 ...
- 41 (25) The Auditor shall periodically examine (i) health service facilities, as defined
- 42 in G.S. 131E-176, that are recipients of State funds and (ii) facilities licensed
- 43 under Chapter 122C of the General Statutes that are recipients of State funds
- 44 and report findings to the Joint Legislative Oversight Committee on Health
- 45 and Human Services on April 1, 2027, and periodically thereafter. The report
- 46 must include at least the following:
- 47 a. The prices that the health service facility charges patients whose
- 48 insurance is out-of-network or who are uninsured.
- 49 b. To what extent the health service facility is transparent about the prices
- 50 described in sub-subdivision a. of this subdivision."
- 51

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

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

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

- 13 (1) The professional qualifications and licensure of the person or persons
 14 reviewing the appeal.
 15 (2) A statement of the ~~reviewers' understanding of the reason for the covered~~
 16 ~~person's basis of the~~ appeal.
 17 (3) The ~~reviewers' insurer's or URO's~~ decision in clear terms and the medical
 18 rationale in sufficient detail for the covered person to respond further to the
 19 insurer's position.

20"

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

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

- 25 (1) The insurer ~~does not have~~ is not required to allow a covered person to attend
 26 the first-level grievance review. A covered person may submit written
 27 material. Except as provided in subdivision (3) of this subsection, within three
 28 business days after receiving a grievance, the insurer shall provide the covered
 29 person with ~~the name, address, and telephone number of the coordinator and~~
 30 ~~information on~~ where and how to submit written material. material for the
 31 first-level grievance review, including contact information for the insurer.
 32 (2) An insurer shall issue a written decision, in clear terms, to the covered person
 33 and, if applicable, to the covered person's provider, within 30 days after
 34 receiving a grievance. The person or persons reviewing the grievance shall not
 35 be the same person or persons who initially handled the matter that is the
 36 subject of the grievance and, if the issue is a clinical one, at least one of whom
 37 shall be a medical doctor with appropriate expertise to evaluate the matter.
 38 Except as provided in subdivision (3) of this subsection, if the decision is not
 39 in favor of the covered person, the written decision issued in a first-level
 40 grievance review shall ~~contain~~ contain all of the following information:
 41 a. The professional qualifications and licensure of the person or persons
 42 reviewing the grievance.
 43 b. A statement of the ~~reviewers' understanding~~ basis of the grievance.
 44 c. The ~~reviewers' insurer's~~ decision in clear terms and the contractual
 45 basis or medical rationale in sufficient detail for the covered person to
 46 respond further to the insurer's position.

47"

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

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

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

- 3 (1) An insurer shall, within 10 business days after receiving a request for a
 4 second-level grievance review, ~~make known to provide~~ the covered
 5 ~~person;~~ person all of the following information:
 6 a. ~~The name, address, and telephone number of a person designated to~~
 7 ~~coordinate the grievance review for the insurer.~~ Information on how
 8 and where to submit written material for the second-level grievance
 9 review, including contact information for the insurer.

10"

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

12
 13 **PART XI-A. ELIMINATION OF CERTIFICATE OF NEED REVIEW FOR INPATIENT**
 14 **REHABILITATION SERVICES, REHABILITATION FACILITIES, AND**
 15 **REHABILITATION BEDS**

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

17 **"§ 131E-176. Definitions.**

18 The following definitions apply in this Article:

- 19 ...
- 20 (9a) Health service. – An organized, interrelated activity that is medical,
 21 diagnostic, therapeutic, ~~rehabilitative,~~ or a combination ~~thereof~~ of these and
 22 that is integral to the prevention of disease or the clinical management of an
 23 individual who is sick or injured or who has a disability. "Health service" does
 24 not include administrative and other activities that are not integral to clinical
 25 management.
- 26 (9b) Health service facility. – A hospital; long-term care hospital; ~~rehabilitation~~
 27 ~~facility;~~ nursing home facility; adult care home; kidney disease treatment
 28 center, including freestanding hemodialysis units; intermediate care facility
 29 for individuals with intellectual disabilities; home health agency office;
 30 diagnostic center; hospice office, hospice inpatient facility, hospice residential
 31 care facility; and ambulatory surgical facility.
- 32 (9c) Health service facility bed. – A bed licensed for use in a health service facility
 33 in the categories of (i) acute care beds; ~~(iii) rehabilitation beds;~~ ~~(iv)~~ ~~(ii)~~ nursing
 34 home beds; ~~(v)~~ ~~(iii)~~ intermediate care beds for individuals with intellectual
 35 disabilities; ~~(vii)~~ ~~(iv)~~ hospice inpatient facility beds; ~~(viii)~~ ~~(v)~~ hospice
 36 residential care facility beds; ~~(ix)~~ ~~(vi)~~ adult care home beds; and ~~(x)~~ ~~(vii)~~
 37 long-term care hospital beds.
- 38 ...
- 39 (13) Hospital. – A public or private institution ~~which that~~ is primarily engaged in
 40 providing to inpatients, by or under supervision of physicians, diagnostic
 41 services and therapeutic services for medical diagnosis, treatment, and care of
 42 injured, disabled, or sick ~~persons, or rehabilitation services for the~~
 43 ~~rehabilitation of injured, disabled, or sick persons.~~ The term includes all
 44 facilities licensed pursuant to G.S. 131E-77, except rehabilitation facilities
 45 and long-term care hospitals.
- 46 ...
- 47 (17a) Nursing care. – Any of the following:
 48 a. Skilled nursing care and related services for residents who require
 49 medical or nursing care.

- b. Rehabilitation services—services, other than those provided at an inpatient rehabilitation facility, for the rehabilitation of individuals who are injured or sick or who have disabilities.
- c. Health-related care and services provided on a regular basis to individuals who because of their mental or physical condition require care and services above the level of room and board, which can be made available to them only through institutional facilities.

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

...

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

...."

PART XI-B. ESSENTIAL RURAL HEALTH SERVICES PROTECTION

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

Article to read:

"Article 9B.

"Essential Rural Health Services Protection Act.

"§ 131E-193.1. Title.

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

"§ 131E-193.3. Definitions.

The following definitions apply in this Article:

- (1) Department. – The Department of Health and Human Services.
- (2) Essential rural health services. – Any of the following services when provided in a rural county or when reasonably necessary to maintain access for residents of a rural county:
 - a. Emergency services.
 - b. Obstetrical services, including labor and delivery.
 - c. Inpatient services.
 - d. Surgical services necessary for emergency stabilization or urgent intervention.
 - e. Behavioral health services, including inpatient psychiatric services.
 - f. Dialysis services.
 - g. Diagnostic imaging or laboratory services necessary for emergency diagnosis or treatment.
 - h. Primary care services, if the Department determines that loss or material reduction of the service would likely leave a rural county without reasonable local access.
 - i. Any other service designated by the Department by rules adopted pursuant to this Article as essential to preserving access to care in rural counties.

- 1 (3) Essential rural provider. – A hospital, facility, practice, clinic, or other
2 provider located in a rural county, or regularly serving residents of a rural
3 county, that provides one or more essential rural health services.
- 4 (4) Material change. – Any of the following:
5 a. The closure of an essential rural health service.
6 b. A reduction in the hours, staffing, call coverage, bed capacity,
7 operating capacity, or service capability of an essential rural health
8 service that is reasonably likely to materially reduce access for
9 residents of a rural county.
10 c. The relocation of an essential rural health service in a manner
11 reasonably likely to materially reduce access for residents of a rural
12 county.
13 d. A change in ownership, control, governance, management, operations,
14 or contracting that is reasonably likely to materially reduce access to
15 an essential rural health service for residents of a rural county.
16 e. The opening or expansion of a service, facility, practice, or line of
17 business that is reasonably likely to materially impair (i) the ability of
18 an essential rural provider to maintain one or more essential rural
19 health services in a rural county or (ii) the financial viability of an
20 essential rural provider.
- 21 (5) Person. – An individual, corporation, limited liability company, partnership,
22 hospital authority, unit of local government, or any other legal entity.
- 23 (6) Rural county. – A county with a population density of 250 or fewer persons
24 per square mile, using the most recent data published by the Office of State
25 Budget and Management.

26 **"§ 131E-193.5. Notice required for material changes affecting essential rural health**
27 **services.**

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

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

- 34 (1) A description of the proposed material change.
35 (2) The proposed effective date.
36 (3) The service area affected by the proposed material change.
37 (4) The essential rural health services affected.
38 (5) The reason for the proposed material change.
39 (6) The projected effect of the proposed material change on service availability,
40 staffing, hours, bed capacity, call coverage, patient travel time, payor mix, and
41 service to Medicaid recipients, uninsured persons, and underserved
42 populations.
43 (7) Any management, services, affiliation, referral, transfer, payor, contracting,
44 or other operational arrangement reasonably likely to affect access to care in
45 a rural county.
46 (8) Any other information required by the Department to evaluate the proposed
47 material change under this Article.

48 **"§ 131E-193.7. Review process.**

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

- 1 (1) Materially reduce access to an essential rural health service for residents of a
2 rural county.
- 3 (2) Result in the closure, conversion, relocation, or reduction of hours or capacity
4 of an essential rural health service.
- 5 (3) Reduce the availability of emergency services, obstetrical services, behavioral
6 health services, primary care, inpatient services, or other essential rural health
7 services in a rural county.
- 8 (4) Change staffing, call coverage, on-call specialty availability, or service
9 capability in a manner that materially impairs timely access to clinically
10 appropriate care.
- 11 (5) Materially impair the financial viability of an essential rural provider in a
12 manner likely to jeopardize continued access to one or more essential rural
13 health services. In evaluating whether this condition has been satisfied, the
14 Department may consider whether the change is reasonably likely to remove
15 or divert profitable or commercially sustainable service lines, patient volume,
16 or payor mix necessary to support essential rural health services.
- 17 (6) Increase patient travel times or care delays beyond levels reasonably
18 consistent with maintaining meaningful rural access.
- 19 (7) Create or worsen discriminatory admission, transfer, referral, staffing, or
20 contracting practices that shift disproportionate burdens to essential rural
21 providers.
- 22 (b) In conducting its review under this section, both of the following apply:
- 23 (1) The Department shall consider the totality of the circumstances, including
24 current service availability, travel times, payor mix, levels of uncompensated
25 care, workforce availability, service interdependence, community health
26 needs, and whether a reasonable substitute for the affected service exists
27 within the affected service area.
- 28 (2) The Department shall determine if public input as specified by
29 G.S. 131E-193.13 is necessary to complete its evaluation of the proposed
30 material change. Upon a determination that public input is necessary, the
31 Department shall conduct it within the time period specified by
32 G.S. 131E-193.11.

33 **"§ 131E-193.9. Rural financial viability review.**

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

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

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

47 **"§ 131E-193.11. Determinations; mitigation plans; extensions of time.**

48 (a) Within 60 days after determining that a notice meets the requirements of
49 G.S. 131E-193.5, the Department shall do one of the following:

- 50 (1) Issue a written notice that no further action is required by the Department.

- 1 (2) Approve the proposed material change subject to a mitigation plan that
2 satisfies the criteria specified in subsection (b) of this section.
- 3 (3) Issue a written determination prohibiting the proposed material change if the
4 Department finds that, even with a mitigation plan, (i) essential rural health
5 services would not be adequately protected in the affected service area or (ii)
6 the proposed material change is reasonably likely to materially destabilize the
7 financial viability of an essential rural provider.
- 8 (b) A mitigation plan may include one or more of the following:
- 9 (1) A requirement to maintain specified service lines, service levels, staffing
10 levels, call coverage, or operating hours for a defined period.
- 11 (2) A requirement to phase in the proposed material change over time.
- 12 (3) A requirement to maintain Medicaid participation.
- 13 (4) A requirement to maintain a financial assistance policy for uninsured and
14 underinsured patients.
- 15 (5) Transfer, referral, and admission protections, including nondiscriminatory
16 clinical criteria.
- 17 (6) Reporting and monitoring requirements.
- 18 (7) Community engagement, patient notice, or coordination requirements.
- 19 (8) Other conditions reasonably necessary to prevent material impairment of
20 access to essential rural health services.
- 21 (c) The Department may extend the period of time for making a determination under
22 subsection (a) of this section by not more than 30 additional days with written notice to the person
23 that submitted notice under G.S. 131E-193.5 on the grounds that public input as specified by
24 G.S. 131E-193.13 is necessary or that additional information is reasonably necessary to complete
25 the review, or both.

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

28 **"§ 131E-193.13. Public input.**

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

35 **"§ 131E-193.15. Prohibited conduct.**

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

- 37 (1) Engage in any pattern or practice of admission, transfer, referral, staffing,
38 contracting, or operational behavior that has the purpose or effect of materially
39 undermining an essential rural provider's ability to maintain essential rural
40 health services.
- 41 (2) Selectively retain lower-acuity or better-insured patients, or shift
42 disproportionate numbers of higher-acuity, uninsured, underinsured, or
43 Medicaid patients, in a manner reasonably likely to materially destabilize
44 access to essential rural health services in a rural county.
- 45 (3) Knowingly fail to provide the notice required under G.S. 131E-193.5.
- 46 (4) Knowingly submit materially false information to the Department.

47 **"§ 131E-193.17. Reporting requirements.**

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

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

5 **"§ 131E-193.19. Enforcement.**

6 (a) The Department may assess a civil penalty not to exceed ten thousand dollars
7 (\$10,000) per day for each violation of this Article, each violation of an order issued by the
8 Department under this Article, and each violation of a mitigation plan implemented by the
9 Department under this Article. The clear proceeds of civil money penalties imposed pursuant to
10 this section shall be remitted to the Civil Penalty and Forfeiture Fund in accordance with
11 G.S. 115C-457.2.

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

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

18 **"§ 131E-193.21. Rules.**

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

21 **SECTION 11B.2.(a)** The first report under G.S. 131E-193.17 is due by November
22 1, 2027.

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

27
28 **PART XII. UPDATED HEALTH INSURER PRIOR AUTHORIZATION**
29 **REQUIREMENTS**

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

31 **"§ 58-50-61. Utilization review.**

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

34 ...

35 (2a) "Course of treatment" means a prescribed order or ordered treatment protocol
36 for a specific covered person with a specific condition that is outlined and
37 decided upon ahead of time with the covered person and health care provider
38 and approved by the insurer or utilization review organization when
39 prospective review is applicable.

40 ...

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

48 ...

49 (14a) "Prior authorization" means the process by which insurers and UROs
50 determine coverage on the basis of medical necessity and/or covered benefits
51 prior to the rendering of those services.

- 1 ...
- 2 (16a) "Urgent health care service" means a health care service, including mental and
- 3 behavioral health care services and dental care services, with respect to which
- 4 the application of the time periods for making an urgent care determination
- 5 that, in the opinion of a health care provider with knowledge of the covered
- 6 person's medical condition, meets either of the following criteria:
- 7 a. Could seriously jeopardize the life or health of the covered person or
- 8 the ability of the covered person to regain maximum function.
- 9 b. Would subject the covered person to severe pain that cannot be
- 10 adequately managed without the care or treatment that is the subject
- 11 of the utilization review.
- 12 ...
- 13 (c) Scope and Content of Program. – Every insurer shall prepare and maintain a
- 14 utilization review program document that describes all delegated and nondelegated review
- 15 functions for covered services ~~including:~~including all of the following:
- 16 (1) Procedures to evaluate the clinical necessity, appropriateness, efficacy, or
- 17 efficiency of health care services.
- 18 ...
- 19 (d) ~~Program Operations.~~ Clinical Review Criteria, Generally. – In every utilization
- 20 review program, an insurer or URO shall use documented clinical review criteria that are based
- 21 on sound clinical evidence and that are periodically evaluated to assure ongoing efficacy. An
- 22 insurer may develop its own clinical review criteria or purchase or license clinical review criteria.
- 23 (d1) Clinical Review Criteria, Substance Use Treatment. – Criteria for determining when
- 24 a patient needs to be placed in a substance abuse treatment program shall be either (i) the
- 25 diagnostic criteria contained in the most recent revision of the American Society of Addiction
- 26 Medicine Patient Placement Criteria for the Treatment of Substance-Related Disorders or (ii)
- 27 criteria adopted by the insurer or its URO. The Department, in consultation with the Department
- 28 of Health and Human Services, may require proof of compliance with this subsection by ~~a plan~~
- 29 an insurer or its URO.
- 30 (d2) Administration of Program. – All of the following shall apply in the administration of
- 31 a utilization review program under this section:
- 32 (1) Qualified health care professionals shall administer the utilization review
- 33 program and oversee review decisions for health care services under the
- 34 direction of a medical doctor. A medical doctor licensed to practice medicine
- 35 in this State shall evaluate the clinical appropriateness of ~~noncertifications.~~
- 36 noncertifications under this subdivision.
- 37 (2) Compensation to persons involved in utilization review shall not contain any
- 38 direct or indirect incentives for them to make any particular review decisions.
- 39 (3) Compensation to utilization reviewers shall not be directly or indirectly based
- 40 on the number or type of noncertifications they render.
- 41 (4) In issuing a utilization review decision, an insurer or its URO shall: obtain all
- 42 information required to make the decision, including pertinent clinical
- 43 information; employ a process to ensure that utilization reviewers apply
- 44 clinical review criteria consistently; and issue the decision in a timely manner
- 45 pursuant to this section.
- 46 ...
- 47 (f) ~~Time Lines for Prospective and Concurrent Reviews.~~ Utilization Reviews Based
- 48 Upon Type of Health Care Service. – As used in this subsection, the term "necessary information"
- 49 includes the results of any patient examination, clinical evaluation, or second opinion that may
- 50 be required. ~~Prospective and concurrent determinations shall be communicated to~~ The time line
- 51 for completion of a prospective or concurrent utilization review is as follows:

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

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

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

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

26 ...

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

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

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

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

31 ...

32 (l) Expedited Appeals. – An expedited appeal of a noncertification may be requested by
 33 a covered person or ~~his or her~~ the provider acting on the covered person's behalf only when a
 34 nonexpedited appeal would reasonably appear to seriously jeopardize the life or health of a
 35 covered person or jeopardize the covered person's ability to regain maximum function. All of the
 36 following apply to expedited appeals:

- 37 (1) The insurer may require documentation of the medical justification for the
- 38 expedited appeal.~~The~~
- 39 (2) For expedited appeals related to health care services, the review shall be
- 40 provided by the insurer ~~shall~~, in consultation with a medical doctor licensed
- 41 to practice medicine in this State, ~~provide expedited review, and the State.~~
- 42 (3) The insurer or its URO shall communicate ~~its~~ the expedited appeal decision
- 43 in writing to the covered person and ~~his or her~~ the covered person's provider
- 44 as soon as possible, but not later than four days after receiving the information
- 45 justifying expedited review. The written decision shall contain the provisions
- 46 specified in subsection (k) of this section.
- 47 (4) If the expedited review is a concurrent review determination, then the insurer
- 48 shall remain liable for the coverage of the applicable health care services until
- 49 the covered person has been notified of the determination.
- 50 (5) An insurer is not required to provide an expedited review for retrospective
- 51 noncertifications.

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

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

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

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

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

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

24 ...

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

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

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

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

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

43 (q) Reserved for future codification purposes.

44 (r) Reserved for future codification purposes.

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

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

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

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

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

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

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

21 **SECTION 12.1.(e)** Subsection (a) of this section becomes effective October 1, 2026,
22 and applies to insurance contracts, including contracts with utilization review organizations,
23 issued, renewed, or amended on or after that date. The remainder of this section is effective when
24 it becomes law.
25

26 **PART XIII. PRESERVATION OF COMPETITION IN HEALTHCARE BY** 27 **REGULATING THE CONSOLIDATION AND CONVEYANCE OF HOSPITALS**

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

30 "Article 11D.

31 "Preserving Competition in Healthcare Act.

32 "§ 131E-214.60. Definitions.

33 The following definitions apply in this Article:

- 34 (1) Acquiring entity. – The person or entity that gains ownership or control of a
35 hospital entity as a result of a transaction subject to review under this Article.
36 (2) Attorney General. – The Attorney General or any employee of the Department
37 of Justice designated by the Attorney General.
38 (3) Hospital entity. – Any corporation or governmental entity licensed as a
39 hospital under Article 5 of this Chapter, including any entity affiliated with
40 such corporation or governmental entity through ownership, governance, or
41 membership, such as a holding company or subsidiary.
42 (4) Person. – Any individual, partnership, trust, estate, corporation, association,
43 joint venture, joint stock company, or other organization.
44 (5) State Auditor. – The State Auditor or any employee of the Office of the State
45 Auditor designated by the State Auditor.
46 (6) State Treasurer. – The State Treasurer or any employee of the Office of the
47 State Treasurer designated by the State Treasurer.
48 (7) Transaction. – Includes all of the following, if the value of the assets, control,
49 or governance interest equals or exceeds five million dollars (\$5,000,000):
50 a. The sale, transfer, lease, exchange, optioning, conveyance, or other
51 disposition of no less than fifty percent (50%) of the assets or

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

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

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

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

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

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

20 **§ 131E-214.61. Actions and decisions by the State Auditor, Attorney General, and State**
21 **Treasurer.**

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

25 **§ 131E-214.62. Applicability; waived transactions.**

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

32 **§ 131E-214.64. Written notice and certification requirements for proposed transactions;**
33 **rules.**

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

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

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

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

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

4 **"§ 131E-214.66. Time line and process for decision to object or take no action.**

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

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

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

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

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

33 **"§ 131E-214.68. Published written notice of proposed transaction; failure to give notice.**

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

43 (1) A brief restatement of the nature of the transaction, as specified in the written
44 notice provided to the State Auditor, Attorney General, and State Treasurer
45 under G.S. 131E-214.64, which shall include the following:

46 a. The name of the hospital entity.

47 b. The name of the acquiring entity.

48 c. The names of any other parties to the proposed transaction.

49 d. The nature of the proposed transaction.

50 e. The anticipated consideration that will be paid by the acquiring entity.

51 (2) The following statements:

- 1 a. "This notice is provided pursuant to G.S. 131E-214.64."
2 b. "Any interested party wishing to provide written comments may
3 submit the written comments directly to the Office of the Attorney
4 General, 114 W. Edenton Street, Raleigh, NC 27603."
- 5 (3) The time, date, and location of any public hearing required under
6 G.S. 131E-214.30, or the information necessary to access a public hearing
7 using teleconferencing or video-conferencing technology, as permitted under
8 subsection (c) of G.S. 131E-214.30. A public hearing shall not be conducted
9 earlier than 14 days after the publication of a notice pursuant to this section.
- 10 (4) In the event the hospital entity is a nonprofit or publicly owned entity, a link
11 to a webpage that allows any member of the public to view a detailed summary
12 of the proposed transaction and copies of all transactional and collateral
13 agreements not otherwise exempt from public disclosure under Chapter 132
14 of the General Statutes or G.S. 131E-97.3.
- 15 (b) A failure by the hospital entity giving notice under G.S. 131E-214.64 to provide a
16 published written notice as required by subsection (a) of this section shall be a sufficient ground
17 for the State Auditor, Attorney General, and State Treasurer to object to the proposed transaction.
- 18 (c) This section does not apply to a sale, transfer, conveyance, or other disposition of a
19 substantial portion of a hospital entity's assets made in the course of a bankruptcy proceeding.
- 20 **§ 131E-214.70. Public hearing requirements; responsibility for public hearing costs;**
21 **exemptions and waivers.**
- 22 (a) Within 30 days after providing the State Auditor, Attorney General, and State
23 Treasurer with the written notice required under subsection (a) of G.S. 131E-214.64, without
24 regard to whether or not the State Auditor, Attorney General, and State Treasurer have
25 acknowledged receipt of a complete notice, the hospital entity and the acquiring entity shall
26 conduct one or more public hearings at a convenient time and in a convenient location in a county
27 in which there exists a hospital entity whose control or governance would be altered by the
28 proposed transaction. The public hearing required by this section shall not be conducted earlier
29 than 14 days after publication of the written notice required under G.S. 131E-214.68.
- 30 (b) At least seven days prior to the date of any public hearing, the hospital entity and the
31 acquiring entity shall give written notice to the State Auditor, Attorney General, and State
32 Treasurer of the time, date, and location of the public hearing. In addition, the hospital entity and
33 the acquiring entity shall give written notice to the governing bodies of both the county and the
34 municipality in which the hospital entity that is the subject of the proposed transaction is located,
35 as applicable.
- 36 (c) With written notice to, and approval by, the State Auditor, Attorney General, and
37 State Treasurer, the hospital entity and the acquiring entity may conduct a public hearing required
38 by this section via online teleconferencing and video-conferencing technology; provided,
39 however, that doing so does not meaningfully limit the opportunity for public input concerning
40 the proposed transaction.
- 41 (d) At a hearing required by this section, the hospital entity and the acquiring entity shall
42 provide the following information:
- 43 (1) The extent to which the proposed transaction is expected to impact the cost,
44 availability, accessibility, and quality of healthcare services.
- 45 (2) The process involved in reaching a fair sales price for the hospital entity,
46 including whether any director, officer, agent, or employee of the hospital
47 entity will benefit directly or indirectly from the proposed transaction.
- 48 (e) At a hearing required by this section, the hospital entity and the acquiring entity may
49 make such presentations as they deem appropriate and shall provide a meaningful opportunity
50 for public input. The hospital entity and the acquiring entity shall also communicate to attendees
51 how interested parties may provide written comments about the proposed transaction, which shall

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

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

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

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

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

27 **"§ 131E-214.72. Required considerations by the State Auditor, Attorney General, and State**
28 **Treasurer.**

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

- 32 (1) Whether the fair market value of any asset to be transferred from the hospital
33 entity to the acquiring entity has been manipulated by the actions of the parties
34 in a manner that causes the fair market value of the asset to decrease.
- 35 (2) Whether healthcare providers will be offered the opportunity to invest or own
36 an interest in the acquiring entity or a related party, and whether procedures
37 or safeguards are in place to avoid healthcare providers' conflicts of interest
38 with respect to patient referrals.
- 39 (3) Whether the terms of any management or services contract negotiated in
40 conjunction with the proposed transaction are reasonable.
- 41 (4) Whether the proposed transaction may have a significant effect on the cost,
42 availability, accessibility, or quality of healthcare services for any affected
43 community. In making this determination, the State Auditor, Attorney
44 General, and State Treasurer shall consider all of the following:
 - 45 a. Whether sufficient safeguards are included to ensure that the affected
46 community will have continued access to affordable healthcare
47 services.
 - 48 b. Whether the proposed transaction creates or has the likelihood of
49 creating an adverse effect on the cost, availability, accessibility, or
50 quality of healthcare services within the affected community.

- 1 c. Whether the acquiring entity has made a commitment to provide (i)
2 free care to individuals whose income is three hundred percent (300%)
3 or less of the federal poverty guidelines, (ii) free or discounted
4 healthcare to other individuals who are disadvantaged, uninsured, or
5 underinsured, and (iii) other benefits to the affected community to
6 promote improved healthcare. In determining whether the level of
7 commitment by the acquiring entity will have a significant effect on
8 the availability, accessibility, or quality of healthcare services for any
9 affected community if the proposed transaction is approved, the State
10 Auditor, Attorney General, and State Treasurer shall consider the
11 number of programs and activities and the amount of funding
12 dedicated by the acquiring entity, as compared to the hospital entity or
13 their affiliated foundations, to:
- 14 1. The delivery of healthcare services to individuals who are
15 uninsured or underinsured.
- 16 2. The delivery of other services or benefits to the affected
17 community to promote improved healthcare.
- 18 3. Medical education and teaching programs.
- 19 4. Medical research programs.
- 20 d. Whether the proposed transaction would result in the revocation of
21 hospital privileges for any healthcare provider.
- 22 e. Whether sufficient safeguards are included to maintain appropriate
23 capacity for health science research and healthcare provider education.
- 24 f. Whether the proposed transaction serves the public interest by
25 promoting the availability and accessibility of safe, essential, and
26 quality healthcare services and treatment.
- 27 (5) Whether the proposed transaction complies with all applicable State and
28 federal laws and regulations, including antitrust laws.
- 29 (6) Whether the proposed transaction will significantly harm competition in any
30 part of this State among healthcare providers.
- 31 (7) Whether the State Auditor, Attorney General, and State Treasurer have
32 received all the information required by the rules adopted under
33 G.S. 131E-214.64(d) and timely responses to any additional requests for
34 information necessary to adequately evaluate the proposed transaction;
35 provided, however, that this subdivision shall not be a ground for disapproving
36 the proposed transaction, unless the State Auditor, Attorney General, and State
37 Treasurer have notified the hospital entity and the acquiring entity of any
38 inadequacy of information or data and has provided each with a reasonable
39 opportunity to remedy the inadequacy.
- 40 (8) Any objection to the transaction raised in comments submitted to the Attorney
41 General.
- 42 (b) In addition to the considerations specified in subsection (a) of this section, the State
43 Auditor, Attorney General, and State Treasurer shall also consider all of the following criteria in
44 making a decision about any proposed transaction subject to the provisions of this Article that
45 would alter the control or governance of a tax-exempt or publicly owned hospital entity:
- 46 (1) Whether the hospital entity would receive fair market value for its charitable
47 assets or social welfare assets. For the purpose of this subdivision, "social
48 welfare assets" means the average yearly monetary value of the benefits the
49 hospital entity provided to the community during the preceding five calendar
50 years.

- 1 (2) Whether the proceeds of the proposed transaction would be used in a manner
2 consistent with the trust under which the assets are held by the hospital entity.
3 (3) Whether the proceeds of the proposed transaction would be used by a county
4 or municipality for general or special revenue obligations not expressly
5 provided for when the hospital was established.
6 (4) Whether any proceeds of the proposed transaction would be controlled as
7 funds independently of the acquiring entity or related entities; provided,
8 however, that the proceeds of a proposed transaction may not be returned to
9 any county or municipal government except to the extent necessary to pay
10 lawful obligations to such county or municipal government.
11 (5) Whether the proposed transaction would result in a breach of fiduciary duty,
12 as determined by the Attorney General, including conflicts of interest related
13 to payments or benefits to officers, directors, board members, executives, or
14 experts employed or retained by the parties.
15 (6) Whether the governing body of the hospital entity exercised due diligence in
16 deciding to dispose of the hospital entity's assets, selecting the acquiring
17 entity, and negotiating the terms and conditions of the disposition.
18 (7) Whether the proposed transaction would result in private inurement to any
19 person.
20 (8) Whether any foundation established to hold the proceeds of the proposed
21 transaction would be broadly based in the community and be representative
22 of the affected community, taking into consideration the structure and
23 governance of the foundation.

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

30 "§ 131E-214.74. Reserved for future codification purposes.

31 "§ 131E-214.76. Contract authority for reviewing proposed transactions; assistance from
32 the Department of Health and Human Services; fees to recover costs incurred in
33 conducting reviews.

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

- 37 (1) Contract with, consult, and receive advice from any agency of the State or the
38 United States on such terms and conditions as the State Auditor, Attorney
39 General, and State Treasurer deem appropriate.
40 (2) At the sole discretion of the State Auditor, Attorney General, and State
41 Treasurer, contract with experts or consultants the State Auditor, Attorney
42 General, and State Treasurer deem appropriate to assist them in reviewing the
43 proposed transaction.

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

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

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

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

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

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

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

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

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

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

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

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

51 **"§ 131E-214.78. Objection to proposed transaction.**

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

46 **"§ 131E-214.80. Post-transaction reporting; authorization to file further action.**

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

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

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

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

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

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

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

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

39 (d) After consummation of a transaction, an acquiring entity shall not change the financial
40 assistance policy regarding patients who are uninsured or underinsured that were in effect for the
41 hospital entity immediately preceding consummation of the transaction without first providing
42 120 days' notice, in writing, to the Attorney General; its hospital staff, including physicians in a
43 contractual relationship with the acquiring entity; and patients who have previously benefited
44 from the hospital entity's financial assistance policy. This subsection does not prohibit an
45 acquiring entity from increasing the applicable income limits used to determine patient eligibility
46 for financial assistance at any time following consummation of the transaction, and it does not
47 require an acquiring entity to provide prior notice to the State Auditor, Attorney General, and
48 State Treasurer about the increased income limits. In order to meet the notice requirements of
49 this subsection with respect to patients who have previously benefited from the hospital entity's
50 financial assistance policy, the acquiring entity shall do all of the following:

- 1 (1) Provide written notice to both the patient's last known mailing address and to
 2 the email address on file for the patient that includes at least all of the
 3 following:
 - 4 a. A description of how the acquiring entity's new financial assistance
 5 policy will differ from the hospital entity's financial assistance policy.
 - 6 b. A description of the process for obtaining financial assistance under
 7 the acquiring entity's new financial assistance policy, including a list
 8 of (i) all forms a patient would be required to complete in order to be
 9 eligible for financial assistance and (ii) all documents a patient would
 10 be required to produce as part of the acquiring entity's new financial
 11 assistance policy.
 - 12 c. A link to a webpage that allows members of the public to view the new
 13 financial assistance policy and any forms a patient would be required
 14 to complete in order to be eligible for financial assistance.
 - 15 d. A toll-free telephone number for patients to call to ask questions about
 16 the acquiring entity's new financial assistance policy.
- 17 (2) Educate all physicians affiliated with the acquiring entity, including
 18 physicians in a contractual relationship with the acquiring entity, on the new
 19 financial assistance policy. Physicians shall verbally inform patients about the
 20 new financial assistance policy at appointments occurring during the 120-day
 21 notice period required by this subsection.

22 **"§ 131E-214.82. Violations; penalties; preservation of statutory and common law authority**
 23 **of the State Auditor, Attorney General, and State Treasurer.**

- 24 (a) Any transactions entered into in violation of this Article shall be null and void.
- 25 (b) Each member of the governing boards and each chief financial officer of the parties
 26 to a transaction entered into in violation of this Article are subject to a civil penalty of up to fifty
 27 thousand dollars (\$50,000) each per transaction, unless the violation was made in wanton
 28 disregard of the law, in which case the civil penalty may be up to one million dollars (\$1,000,000)
 29 each per transaction. The State Auditor, Attorney General, and State Treasurer shall institute
 30 proceedings to impose a civil penalty authorized by this section in a court of competent
 31 jurisdiction in Wake County, and the court shall determine the amount of the civil penalty to be
 32 imposed under this section. The clear proceeds of civil penalties provided for in this subsection
 33 shall be remitted to the Civil Penalty and Forfeiture Fund in accordance with G.S. 115C-457.2.
- 34 (c) The Department of Health and Human Services shall not issue a new or renewal
 35 license to operate a hospital under Article 5 of this Chapter, or any applicable rules, on behalf of
 36 any hospital that is a party to a transaction entered into in violation of the notice, public hearing,
 37 and review requirements of this Article.
- 38 (d) Nothing in this Article shall be construed to limit the statutory or common law
 39 authority of the State Auditor, Attorney General, or State Treasurer to protect charitable trusts
 40 and assets located in this State. The penalties and remedies set forth in this Article are in addition
 41 to, and not a replacement for, any other civil or criminal actions the State Auditor, Attorney
 42 General, or State Treasurer is authorized by statute or common law to file, including actions
 43 seeking rescission of a transaction, injunctive relief, or any combination of these, and other
 44 remedies available under statute or common law."

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

47
 48 **PART XIV. EFFECTIVE DATE**

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