GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2017

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SENATE BILL 629

Short Title:	Health Care Services Billing Transparency.	(Public)
Sponsors:	Senators Hise, Meredith (Primary Sponsors); and Krawiec.	
Referred to:	Rules and Operations of the Senate	

April 5, 2017

A BILL TO BE ENTITLED

AN ACT TO PROVIDE FOR GREATER TRANSPARENCY IN HEALTH CARE SERVICES BILLING.

The General Assembly of North Carolina enacts:

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

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

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

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

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

a. Accident.
b. Credit.
c. Disability income.
d. Long-term or nursing home care.
e. Medicare supplement.
f. Specified disease.
g. Dental or vision.
h. Coverage issued as a supplement to liability insurance.
i. Workers' compensation.
j. Medical payments under automobile or homeowners insurance.
k. Hospital income or indemnity.
l. Insurance under which benefits are payable with or without regard to fault and that is statutorily required to be contained in any liability policy or equivalent self-insurance.

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

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

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

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

...

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

"Article 11B.

"Transparency in Health Services Billing Practices.

"**§ 131E-214.25. Definitions.**

The following definitions apply in this section:

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

(2) Health services facility. – As defined in G.S. 58-2-200(a).

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

(4) Provider. – A health care provider.

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

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

(1) Services may be provided at the health services facility by the health services facility itself as well as by other health care providers who may separately bill the insured.

(2) Certain health care providers may be called upon to render care to the insured during the course of treatment and may not have contracts with the insured's insurer and are therefore considered to be nonparticipating health care providers. The nonparticipating health care providers shall be identified in the written disclosure.

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

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

(5) Certain consumer protections available to the insured when services are rendered by a health care provider participating in the insurer's health care provider network may not be applicable when services are rendered by a nonparticipating health care provider.

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

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

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

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

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

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

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

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

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

(3) All emergency services.

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

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

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

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

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

"**§ 131E-214.28. Penalties.**

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

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

"Article 41A.

"Transparency in Health Care Provider Billing Practices.

"**§ 90-705. Definitions.**

The following definitions shall apply in this Article:

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

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

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

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

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

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

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

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

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

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

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

"**§ 90-708. Penalties.**

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

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