GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2025

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SENATE BILL 976

Short Title:	Reduce Healthcare Costs & Protect Patients.	(Public)
Sponsors:	Senator Grafstein (Primary Sponsor).	
Referred to:	Rules and Operations of the Senate	

May 4, 2026

A BILL TO BE ENTITLED

AN ACT REDUCING HEALTHCARE COSTS AND PROTECTING PATIENTS.

Whereas, rising healthcare costs place a significant financial burden on individuals, families, employers, and taxpayers; greatly contribute to inflation; and make it increasingly difficult for residents to access essential healthcare services; and

Whereas, North Carolina has intolerably high healthcare costs, with recent studies ranking the State 50th out of 50 in the United States; and

Whereas, skyrocketing healthcare costs have resulted in over forty percent (40%) of Americans reporting some type of healthcare debt, according to one study; and

Whereas, many patients face unexpected medical bills due to a lack of disclosure about out-of-network providers and a general lack of transparency in healthcare pricing, resulting in financial strain and hardship; and

Whereas, patients and employers are often unable to compare the costs of medical services due to a lack of clear and accessible pricing information, hindering their ability to make informed decisions; Now, therefore,

The General Assembly of North Carolina enacts:

PART I. PRESCRIPTION DRUG AFFORDABILITY

SECTION 1.1.(a) Article 3 of Chapter 58 of the General Statutes is amended by adding a new section to read:

"**§ 58-3-182. Limits on cost-sharing.**

Prescription Drugs. – The cost-sharing for any health benefit plan for the coverage of prescription drugs shall not exceed the annual amount of two thousand dollars ($2,000) per covered person. Cost-sharing includes copayments, deductibles, and any other out-of-pocket expense for a prescription drug paid by the covered individual."

SECTION 1.1.(b) This section is effective October 1, 2026, and applies to insurance contracts entered into, renewed, or amended on or after that date.

PART II. SURPRISE BILLING AND EMERGENCY PROTECTION

SECTION 2.1.(a) G.S. 58-3-182, as enacted by Section 1.1(a) of this act, reads as rewritten:

"**§ 58-3-182. Limits on cost-sharing.**

(a) Prescription Drugs. – The cost-sharing for any health benefit plan for the coverage of prescription drugs shall not exceed the annual amount of two thousand dollars ($2,000) per covered person. Cost-sharing includes copayments, deductibles, and any other out-of-pocket expense for a prescription drug paid by the covered individual.

(b) In-Network Facilities. – All nonemergency care provided at a facility that is part of the health benefit plan's provider network shall be charged to the covered individual at an in-network rate. No health benefit plan shall allow for any cost-sharing at an out-of-network rate so long as the facility in which the care is provided is in the health benefit plan's provider network."

SECTION 2.1.(b) G.S. 58-3-200(d) reads as rewritten:

"(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~~ healthcare providers able to meet health needs of the insured are reasonably available to the insured without unreasonable delay. Upon notice or request from the insured, the insurer shall determine whether a healthcare provider able to meet the needs of the insured is available to the insured without unreasonable delay by reference to the insured's location and the specific medical needs of the insured."

SECTION 2.1.(c) This section becomes effective October 1, 2026, and applies to healthcare services provided on or after that date and to contracts issued, renewed, or amended on or after that date.

SECTION 2.2. Beginning with the 2027 calendar year, emergency ground ambulance services shall be considered part of the essential health benefit package under 45 C.F.R. § 147.150(a). The Commissioner of the Department of Insurance shall communicate this change to the federal Centers for Medicare and Medicaid Services and to all insurers offering a health benefit plan in North Carolina on the federally facilitated marketplace.

PART III. MEDICAL DEBT PREVENTION

SECTION 3.1.(a) Chapter 131E of the General Statutes is amended by adding a new Article 11C to be entitled "Fair Billing and Collections Practices for Hospitals and Ambulatory Surgical Facilities."

SECTION 3.1.(b) G.S. 131E-91 is recodified as G.S. 131E-214.50 under Article 11C of Chapter 131E of the General Statutes, as created by subsection (a) of this section.

SECTION 3.1.(c) G.S. 131E-214.50(d), as recodified by subsection (b) of this section, reads as rewritten:

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

…

(1a) A hospital or ambulatory surgical facility shall not refer a patient's unpaid bill to a collections agency, entity, or other assignee unless it has first made an informed decision, based on a screening of the patient, that the patient is not eligible for charity care or financial assistance under the hospital's or ambulatory surgical facility's charity care or financial assistance policies.

(1b) A hospital or ambulatory surgical facility shall not report a patient's unpaid bill to a credit reporting agency until the unpaid bill is at least 180 days past due.

…."

PART IV. PRICE TRANSPARENCY IN HEALTHCARE

SECTION 4.1.(a) G.S. 131E-214.13 reads as rewritten:

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

(a) The following definitions apply in this Article:

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

(2) Commission. – The North Carolina Medical Care Commission.
(2a) CPT. – Current Procedural Terminology.
(2b) DRG. – Diagnostic Related Group.
(2c) HCPCS. – The Healthcare Common Procedure Coding System.
(3) Health insurer. – An entity that writes a health benefit plan and is one of the following:
a. An insurance company under Article 3 of Chapter 58 of the General Statutes.
b. A service corporation under Article 65 of Chapter 58 of the General Statutes.
c. A health maintenance organization under Article 67 of Chapter 58 of the General Statutes.
d. A third-party administrator of one or more group health plans, as defined in section 607(1) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. § 1167(1)).
(4) Hospital. – A medical care facility licensed under Article 5 of this Chapter or under Article 2 of Chapter 122C of the General Statutes.
(5) Public or private third party. – Includes the State, the federal government, employers, health insurers, third-party administrators, and managed care organizations.
(6) Statewide data processor. – As defined in G.S. 131E-214.1.

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

(1) The amount that will be charged to a patient for each DRG if all charges are paid in full without a public or private third party paying for any portion of the charges. In calculating this amount, each hospital shall include charges for each billable item and service associated with the DRG regardless of whether the health service is performed by a physician or nonphysician practitioner employed by the hospital.
(2) The average negotiated settlement on the amount that will be charged to a patient required to be provided in subdivision (1) of this subsection.
(3) The amount of Medicaid reimbursement for each DRG, including claims and pro rata supplemental payments.
(4) The amount of Medicare reimbursement for each DRG.
(5) For each of the five largest health insurers providing payment to the hospital on behalf of insureds and teachers and State employees, the range and the average of the amount of payment made for each DRG. Prior to providing this information to the ~~Department~~ statewide data processor, each hospital shall redact the names of the health insurers and any other information that would otherwise identify the health insurers.

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

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

~~(1) The method by which the Department shall determine the 100 most frequently reported DRGs for inpatients for which hospitals must provide the data set out in subsection (b) of this section.~~

~~(2) Specific categories by which hospitals shall be grouped for the purpose of disclosing this information to the public on the Department's Internet Web site.~~

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

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

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

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

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

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

(2) To ensure that subsection (d) of this section is properly implemented and that hospitals and ambulatory surgical facilities report this information to the statewide data processor in a uniform manner. The rules shall include the

method by which the statewide data processor shall determine the 20 most common surgical procedures and the 20 most common imaging procedures for which the hospitals and ambulatory surgical facilities must provide the data set out in subsection (d) of this section.

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

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

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

SECTION 4.1.(b) Article 11B of Chapter 131E of the General Statutes is amended by adding a new section to read:

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

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

SECTION 4.1.(c) G.S. 131E-214.4(a) reads as rewritten:

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

…

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

SECTION 4.1.(d) This section becomes effective on the later of January 1, 2027, or the date the rules adopted by the North Carolina Medical Care Commission under G.S. 131E-214.13(f1)(2) take effect, and G.S. 131E-214.18, as enacted by this Part, applies to acts occurring on or after that date. The Commission shall notify the Revisor of Statutes when the rules required under G.S. 131E-214.13(f1)(1) and (f1)(2) take effect.

SECTION 4.2.(a) Article 11C of Chapter 131E of the General Statutes, as created by Section 3.1(a) of this act, is amended by adding a new section to read:

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

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

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

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

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

a. Supplies and procedures.

b. Room and board.
c. Fees for use of the facility or other items.
d. Professional charges for services of physicians and nonphysician practitioners who are employed by the facility.
e. Professional charges for services of physicians and nonphysician practitioners who are not employed by the facility.
f. Any other items or services for which a facility has established a standard charge.

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

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

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

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

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

SECTION 4.2.(b) This section becomes effective on the later of January 1, 2027, or the date the rules adopted by the Department under G.S. 131E-214.52, as enacted by subsection (a) of this section, take effect and applies to acts occurring on or after that date. The Department shall notify the Revisor of Statutes when the rules required under G.S. 131E-214.52 take effect.

PART V. APPROPRIATIONS

SECTION 5.1. Effective July 1, 2026, there is appropriated from the General Fund to the Department of Insurance the sum of two million five hundred thousand dollars ($2,500,000) in recurring funds beginning in the 2026-2027 fiscal year to implement and enforce Part I and Part II of this act.

SECTION 5.2. Effective July 1, 2026, there is appropriated from the General Fund to the Department of Health and Human Services the sum of two million five hundred thousand dollars ($2,500,000) in recurring funds beginning in the 2026-2027 fiscal year to implement and enforce Parts III and IV of this act.

PART VI. EFFECTIVE DATE

SECTION 6.1. Except as otherwise provided, this act is effective when it becomes law.