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SENATE BILL DRS45451-MGa-178

Short Title: Reduce Healthcare Costs & Protect Patients. (Public)

Sponsors: Senator Grafstein (Primary Sponsor).

Referred to:

1 A BILL TO BE ENTITLED  
2 AN ACT REDUCING HEALTHCARE COSTS AND PROTECTING PATIENTS.

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

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

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

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

13 Whereas, patients and employers are often unable to compare the costs of medical  
14 services due to a lack of clear and accessible pricing information, hindering their ability to make  
15 informed decisions; Now, therefore,  
16 The General Assembly of North Carolina enacts:

17  
18 **PART I. PRESCRIPTION DRUG AFFORDABILITY**

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

21 **"§ 58-3-182. Limits on cost-sharing.**

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

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

28  
29 **PART II. SURPRISE BILLING AND EMERGENCY PROTECTION**

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

32 **"§ 58-3-182. Limits on cost-sharing.**

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



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

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

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

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

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

### 23 24 **PART III. MEDICAL DEBT PREVENTION**

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

28       **SECTION 3.1.(b)** G.S. 131E-91 is recodified as G.S. 131E-214.50 under Article  
29 11C of Chapter 131E of the General Statutes, as created by subsection (a) of this section.

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

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

34       ...

35       (1a) A hospital or ambulatory surgical facility shall not refer a patient's unpaid bill  
36 to a collections agency, entity, or other assignee unless it has first made an  
37 informed decision, based on a screening of the patient, that the patient is not  
38 eligible for charity care or financial assistance under the hospital's or  
39 ambulatory surgical facility's charity care or financial assistance policies.

40       (1b) A hospital or ambulatory surgical facility shall not report a patient's unpaid  
41 bill to a credit reporting agency until the unpaid bill is at least 180 days past  
42 due.

43       ...."

### 44 45 **PART IV. PRICE TRANSPARENCY IN HEALTHCARE**

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

47       "**§ 131E-214.13. Disclosure of prices for most frequently reported DRGs, CPTs, and**  
48 **HCPCSs.**

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

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

- 1 (2) Commission. – The North Carolina Medical Care Commission.  
 2 (2a) CPT. – Current Procedural Terminology.  
 3 (2b) DRG. – Diagnostic Related Group.  
 4 (2c) HCPCS. – The Healthcare Common Procedure Coding System.  
 5 (3) Health insurer. – An entity that writes a health benefit plan and is one of the  
 6 following:  
 7 a. An insurance company under Article 3 of Chapter 58 of the General  
 8 Statutes.  
 9 b. A service corporation under Article 65 of Chapter 58 of the General  
 10 Statutes.  
 11 c. A health maintenance organization under Article 67 of Chapter 58 of  
 12 the General Statutes.  
 13 d. A third-party administrator of one or more group health plans, as  
 14 defined in section 607(1) of the Employee Retirement Income Security  
 15 Act of 1974 (29 U.S.C. § 1167(1)).  
 16 (4) Hospital. – A medical care facility licensed under Article 5 of this Chapter or  
 17 under Article 2 of Chapter 122C of the General Statutes.  
 18 (5) Public or private third party. – Includes the State, the federal government,  
 19 employers, health insurers, third-party administrators, and managed care  
 20 organizations.  
 21 (6) Statewide data processor. – As defined in G.S. 131E-214.1.  
 22 (b) ~~Beginning with the reporting period ending September 30, 2015, and annually~~  
 23 ~~thereafter, Quarterly Report on Most Frequently Reported DRGs for Inpatients. – On a quarterly~~  
 24 ~~basis, each hospital shall provide to the Department of Health and Human Services statewide~~  
 25 ~~data processor, utilizing electronic health records software, the following information about the~~  
 26 ~~100 most frequently reported admissions by DRG for inpatients as established by the~~  
 27 ~~Department:~~  
 28 (1) The amount that will be charged to a patient for each DRG if all charges are  
 29 paid in full without a public or private third party paying for any portion of  
 30 the charges. In calculating this amount, each hospital shall include charges for  
 31 each billable item and service associated with the DRG regardless of whether  
 32 the health service is performed by a physician or nonphysician practitioner  
 33 employed by the hospital.  
 34 (2) The average negotiated settlement on the amount that will be charged to a  
 35 patient required to be provided in subdivision (1) of this subsection.  
 36 (3) The amount of Medicaid reimbursement for each DRG, including claims and  
 37 pro rata supplemental payments.  
 38 (4) The amount of Medicare reimbursement for each DRG.  
 39 (5) For each of the five largest health insurers providing payment to the hospital  
 40 on behalf of insureds and teachers and State employees, the range and the  
 41 average of the amount of payment made for each DRG. Prior to providing this  
 42 information to the ~~Department statewide data processor~~, each hospital shall  
 43 redact the names of the health insurers and any other information that would  
 44 otherwise identify the health insurers.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

17 **"§ 131E-214.18. Penalty for noncompliance.**

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

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

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

29 ...

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

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

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

41 **"§ 131E-214.52. Patient's right to a good-faith estimate.**

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

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

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

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

51 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.