GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2025

S **4**

SENATE BILL 316
Health Care Committee Substitute Adopted 3/19/25
Judiciary Committee Substitute Adopted 3/25/25
Fourth Edition Engrossed 3/27/25

Short Title: Lower Healthcare Costs. (Public)

Sponsors:

Referred to:

March 18, 2025

A BILL TO BE ENTITLED

AN ACT LOWERING HEALTHCARE COSTS AND INCREASING PRICE TRANSPARENCY.

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 40 percent 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, employers are burdened with the increasing costs of providing health insurance for employees, leading to higher premiums, deductibles, and out-of-pocket expenses; 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; and

Whereas, the absence of price transparency in the healthcare system leads to market inefficiencies, less awareness of price difference, less competition, and higher prices, with consumers often unable to identify the most cost-effective providers; and

Whereas, transparency in healthcare pricing allows consumers to shop for affordable healthcare services and encourages competition among healthcare providers to offer more competitive pricing; and

Whereas, providing consumers with clear, understandable, and accessible information about the costs of healthcare services will foster a more competitive and patient-centered healthcare market; and

Whereas, requiring healthcare providers and insurers to disclose their prices in advance, including all providers and services a patient may need, both in-network and out-of-network, will enable consumers to make more informed choices about their care, leading to better healthcare outcomes at lower costs; and

Whereas, price transparency will incentivize hospitals and healthcare providers to improve the quality of care while reducing prices, to the benefit of patients and employers; and

Whereas, clear pricing and competition among healthcare providers will encourage innovation in healthcare delivery and improve overall efficiency within the system; and

Whereas, empowering patients and employers with pricing information will help create a healthcare system that prioritizes affordability, access, and choice; and

Whereas, President Trump recently signed an Executive Order to make healthcare prices transparent, "empower[ing] patients with clear, accurate, and actionable healthcare pricing information," also "ensur[ing] hospitals and insurers disclose actual prices, not estimates, and take action to make prices comparable across hospitals and insurers, including prescription drug prices; Now, therefore,

The General Assembly of North Carolina enacts:

PART I. GREATER TRANSPARENCY IN HOSPITAL AND AMBULATORY SURGICAL FACILITY HEALTHCARE COSTS

SECTION 1.1. Article 11B of Chapter 131E of the General Statutes reads as rewritten:

"Article 11B.

"Transparency in Health Care Costs.

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

"**§ 131E-214.11. Title.**

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

…

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

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

(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.

…

"**§ 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 Part. 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 1.1A. 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 1.2. This Part becomes effective on the later of January 1, 2026, 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.

PART II. GREATER TRANSPARENCY IN HEALTHCARE PROVIDER BILLING PRACTICES

SECTION 2.1. Article 11B of Chapter 131E of the General Statutes, as amended by Part I of this act, is amended by adding a new Part to read:

"Part 2. Transparency in Healthcare Provider Billing Practices.

"**§ 131E-214.25. Definitions.**

The following definitions apply in this Part:

(1) Health benefit plan. – As defined in G.S. 58-3-167, or under the laws of another state or the federal government.

(2) Healthcare provider. – As defined in G.S. 90-410.

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

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

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

(1) Services may be provided at the health service facility for which the insured individual may receive a separate bill.

(2) Certain healthcare providers may be called upon to render care to the insured individual during the course of treatment and those healthcare providers may not have contracts with the insured's insurer and are considered to be nonparticipating healthcare providers in the insurer's healthcare provider network. Any nonparticipating healthcare providers shall be identified in the written disclosure using the individual's healthcare provider's name and practice name as used on the applicable health service facility's or healthcare provider's credentials or name badge.

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

(b) Emergency Services Provided at Nonparticipating Health Service Facilities. – As soon as practicable after a health service facility begins the provision of emergency services to an insured individual, if the facility does not have a contract with the applicable insurer, then the

health service facility shall provide the insured individual with a written disclosure containing all of the following:

(1) A statement that the health service facility does not have a provider network contract with the applicable insurer and is considered to be a nonparticipating provider.

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

"**§ 131E-214.31. Fair notice requirements; healthcare providers.**

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

(1) A statement that the healthcare provider is not in the insurer's healthcare provider network applicable to the individual.

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

"**§ 131E-214.35. Penalties.**

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

SECTION 2.2.(a) G.S. 58-3-200(a)(1) and G.S. 58-3-200(a)(2) are repealed.

SECTION 2.2.(b) G.S. 58-3-200(a), as amended by subsection (a) of this section, reads as rewritten:

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

…

(3) 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.

(4) Healthcare provider. – As defined in G.S. 90-410."

SECTION 2.2.(c) 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 2.3. This Part 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.

PART III. GREATER FAIRNESS IN BILLING AND COLLECTIONS PRACTICES FOR HOSPITALS AND AMBULATORY SURGICAL FACILITIES

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) 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 presented an itemized list of charges to the patient detailing, in language comprehensible to an ordinary layperson, the specific nature of the charges or expenses incurred by the patient.

…."

SECTION 3.2. 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 3.3. This Part becomes effective on the later of January 1, 2026, or the date the rules adopted by the Department under G.S. 131E-214.52 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 IV. GREATER PROTECTION FOR HEALTHCARE CONSUMERS FROM FACILITY FEES

SECTION 4.1.(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-214.54. Facility fees.**

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

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

(2) Campus. – Any of the following:

a. The main building of a hospital.

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

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

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

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

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

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

(6) Hospital. – Any hospital as defined in G.S. 90-176(13) and any facility licensed under Chapter 122C of the General Statutes.

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

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

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

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

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

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

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

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

(1) The name and full address of each facility owned or operated by the hospital or health system that provides services for which a facility fee is charged or billed.

(2) The number of patient visits at each such hospital-based facility for which a facility fee was charged or billed.

(3) The number, total amount, and range of allowable facility fees paid at each facility by Medicare, Medicaid, and private insurance.

(4) For each hospital-based facility and for the hospital or health system as a whole, the total amount billed, and the total revenue received from facility fees.

(5) The top 10 procedures or services, identified by Current Procedural Terminology (CPT) category I codes, provided by the hospital or health system that generated the greatest amount of facility fee gross revenue; the number of each of these 10 procedures or services provided; the gross and net revenue totals for each such procedure or service; and the total net amount of revenue received by the hospital or health system derived from facility fees for each procedure or service.

(6) Any other information the Department may require.

(e) Enforcement. – This section shall be enforced as follows:

(1) Any violation of this section constitutes an unfair or deceptive trade practice in violation of G.S. 75-1.1 and is subject to all of the enforcement and penalty provisions of an unfair or deceptive trade practice under Article 1 of Chapter 75 of the General Statutes.

(2) In addition to the remedies described in subdivision (1) of this subsection, any health care provider who violates any provision of this section shall be subject to an administrative penalty of not more than one thousand dollars ($1,000) per occurrence."

SECTION 4.1.(b) No later than January 1, 2026, the Department of Health and Human Services shall adopt rules necessary to implement G.S. 131E-214.54, as enacted by subsection (a) of this section.

SECTION 4.2. G.S. 131E-214.54, as enacted by Section 4.1(a) of this Part, becomes effective January 1, 2026, or on the date the rules adopted by the Department of Health and Human Services pursuant to Section 4.1(b) of this Part become effective, whichever is later, and applies to healthcare services provided on or after that date. The Department shall notify the Revisor of Statutes when the rules required under Section 4.1(b) of this Part become effective.

PART V. STATE AUDITOR REVIEW OF HEALTH SERVICE FACILITY PRICES

SECTION 5.1. G.S. 147-64.6(c) reads as rewritten:

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

…

(24) The Auditor shall periodically examine (i) health service facilities, as defined in G.S. 131E-176, that are recipients of State funds and (ii) facilities licensed under Chapter 122C of the General Statutes that are recipients of State funds and report findings to the Joint Legislative Oversight Committee on Health and Human Services on April 1, 2026, and periodically thereafter. The report must include at least the following:

a. The prices that the health service facility charges patients whose insurance is out-of-network or who are uninsured.

b. To what extent the health service facility is transparent about the prices described in sub-subdivision a. of this subdivision."

PART VI. ENHANCEMENTS TO EMPLOYEE SAFETY BY ALLOWING FOR THE REMOVAL OF CERTAIN EMPLOYEE DETAILS FROM HEALTH INSURANCE APPEALS AND GRIEVANCE REVIEWS

SECTION 6.1.(a) G.S. 58-50-61(k) reads as rewritten:

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

(1) The professional qualifications and licensure of the person or persons reviewing the appeal.

(2) A statement of the ~~reviewers' understanding of the reason for the covered person's~~ basis of the appeal.

(3) The ~~reviewers'~~ insurer's or URO's decision in clear terms and the medical rationale in sufficient detail for the covered person to respond further to the insurer's position.

…."

SECTION 6.1.(b) G.S. 58-50-62(e) reads as rewritten:

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

(1) The insurer ~~does not have~~ is not required to allow a covered person to attend the first-level grievance review. A covered person may submit written material. Except as provided in subdivision (3) of this subsection, within three business days after receiving a grievance, the insurer shall provide the covered person with ~~the name, address, and telephone number of the coordinator and~~ information on where and how to submit written ~~material.~~material for the first-level grievance review, including contact information for the insurer.

(2) An insurer shall issue a written decision, in clear terms, to the covered person and, if applicable, to the covered person's provider, within 30 days after receiving a grievance. The person or persons reviewing the grievance shall not be the same person or persons who initially handled the matter that is the subject of the grievance and, if the issue is a clinical one, at least one of whom shall be a medical doctor with appropriate expertise to evaluate the matter. Except as provided in subdivision (3) of this subsection, if the decision is not in favor of the covered person, the written decision issued in a first-level grievance review shall ~~contain:~~contain all of the following information:

a. The professional qualifications and licensure of the person or persons reviewing the grievance.
b. A statement of the ~~reviewers' understanding~~ basis of the grievance.
c. The ~~reviewers'~~ insurer's decision in clear terms and the contractual basis or medical rationale in sufficient detail for the covered person to respond further to the insurer's position.

…."

SECTION 6.1.(c) G.S. 58-50-62(f) reads as rewritten:

"(f) Second-Level Grievance Review. – An insurer shall establish a second-level grievance review process for covered persons who are dissatisfied with the first-level grievance review decision or a utilization review appeal decision. A covered person or the covered person's provider acting on the covered person's behalf may submit a second-level grievance. All of the following shall apply to a second-level grievance review:

(1) An insurer shall, within 10 business days after receiving a request for a second-level grievance review, ~~make known to~~ provide the covered ~~person:~~person all of the following information:

a. ~~The name, address, and telephone number of a person designated to coordinate the grievance review for the insurer.~~Information on how and where to submit written material for the second-level grievance review, including contact information for the insurer.

…."

SECTION 6.2. This Part is effective when it becomes law.

PART VII. ELIMINATION OF CERTIFICATE OF NEED REVIEW FOR INPATIENT REHABILITATION SERVICES, REHABILITATION FACILITIES, AND REHABILITATION BEDS

SECTION 7.1. G.S. 131E-176 reads as rewritten:

"**§ 131E-176. Definitions.**

The following definitions apply in this Article:

…

(9a) Health service. – An organized, interrelated activity that is medical, diagnostic, therapeutic, ~~rehabilitative,~~ or a combination ~~thereof~~ of these and that is integral to the prevention of disease or the clinical management of an individual who is sick or injured or who has a disability. "Health service" does not include administrative and other activities that are not integral to clinical management.

(9b) Health service facility. – A hospital; long-term care hospital; ~~rehabilitation facility;~~ nursing home facility; adult care home; kidney disease treatment center, including freestanding hemodialysis units; intermediate care facility for individuals with intellectual disabilities; home health agency office; diagnostic center; hospice office, hospice inpatient facility, hospice residential care facility; and ambulatory surgical facility.

(9c) Health service facility bed. – A bed licensed for use in a health service facility in the categories of (i) acute care beds; ~~(iii) rehabilitation beds; (iv)~~ (ii) nursing home beds; ~~(v)~~ (iii) intermediate care beds for individuals with intellectual disabilities; ~~(vii)~~ (iv) hospice inpatient facility beds; ~~(viii)~~ (v) hospice residential care facility beds; ~~(ix)~~ (vi) adult care home beds; and ~~(x)~~ (vii) long-term care hospital beds.

…

(13) Hospital. – A public or private institution ~~which~~ that is primarily engaged in providing to inpatients, by or under supervision of physicians, diagnostic

services and therapeutic services for medical diagnosis, treatment, and care of injured, disabled, or sick ~~persons, or rehabilitation services for the rehabilitation of injured, disabled, or sick~~ persons. The term includes all facilities licensed pursuant to G.S. 131E-77, except rehabilitation facilities and long-term care hospitals.

…

(17a) Nursing care. – Any of the following:

a. Skilled nursing care and related services for residents who require 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 VIII. UPDATED HEALTH INSURER PRIOR AUTHORIZATION REQUIREMENTS

SECTION 8.(a) G.S. 58-50-61 reads as rewritten:

"**§ 58-50-61. Utilization review.**

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

…

(2a) Course of treatment. – A prescribed order or ordered treatment protocol for a specific covered person with a specific condition that is outlined and decided upon ahead of time with the covered person and healthcare provider and approved by the insurer or utilization review organization when prospective review is applicable.

…

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

…

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

…

(16a) Urgent health care service. – A health care service, including mental and behavioral health care services, with respect to which the application of the time periods for making an urgent care determination that, in the opinion of a healthcare provider with knowledge of the covered person's medical condition, meets either of the following criteria:

a. Could seriously jeopardize the life or health of the covered person or the ability of the covered person to regain maximum function.

b. Would subject the covered person to severe pain that cannot be adequately managed without the care or treatment that is the subject of the utilization review.

…

(f) Time Lines for Prospective and Concurrent Utilization Reviews Based Upon Type of Health Care Service. – As used in this subsection, the term "necessary information" includes the results of any patient examination, clinical evaluation, or second opinion that may be required. ~~Prospective and concurrent determinations shall be communicated to~~ The time line for completion of a prospective or concurrent utilization review is as follows:

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

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

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

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

…

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

(1) Except as otherwise provided, appeals shall be reviewed by a licensed physician who meets all of the following criteria:

a. Possesses a current and valid non-restricted license to practice medicine in any United States jurisdiction.

b. Has practiced for a period of at least three consecutive years in the same or similar specialty as a medical doctor who typically manages the medical condition or disease for which prior authorization review is required or whose training and experience meets all of the following criteria:

1. Includes treatment of the same condition as the condition of the covered person.

2. Includes treatment of complications that may result from the service or procedure that is the subject of the appeal.

3. Is sufficient for the medical doctor to determine if the service or procedure is medically necessary or clinically appropriate.

c. Had no direct involvement in making the prior adverse determination or noncertification that is the subject of the appeal.

d. Has no financial interest, or other conflict of interest, in the outcome of the appeal.

(2) Appeals initiated by a licensed mental health professional for a service provided by a licensed mental health professional may be reviewed by a licensed mental health professional rather than a medical doctor. The requirements of subdivision (1) of this subsection shall apply to the reviewing licensed mental health professional in the same manner that they apply to a medical doctor.

(3) The medical doctor or licensed mental health professional shall consider all known clinical aspects of the healthcare service under review, including all pertinent medical records and any medical literature that have been provided by the covered person's provider or by a health care facility.

…

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

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

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

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

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

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

…

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

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

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

…

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

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

(q) Reserved for future codification purposes.

(r) Reserved for future codification purposes.

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

SECTION 8.(b) In accordance with G.S. 135-48.24(b) and G.S. 135-48.30(a)(7) which require the State Treasurer to implement procedures that are substantially similar to the provisions of G.S. 58-50-61 for the North Carolina State Health Plan for Teachers and State Employees (State Health Plan), the State Treasurer and the Executive Administrator of the State Health Plan shall review all practices of the State Health Plan and all contracts with, and practices of, any third party conducting any utilization review on behalf of the State Health Plan to ensure compliance with subsection (a) of this section no later than the start of the next plan year.

SECTION 8.(c) Section 8(a) of this act becomes effective October 1, 2026, and applies to insurance contracts, including contracts with utilization review organizations, issued, renewed, or amended on or after that date. The remainder of this section is effective when it becomes law.

PART IX. EFFECTIVE DATE

SECTION 9. Except as otherwise provided, this act is effective when it becomes law.