GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2021

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SENATE BILL 505

Short Title:	Medical Billing Transparency.	(Public)
Sponsors:	Senators Krawiec, Burgin, and Perry (Primary Sponsors).	
Referred to:	Rules and Operations of the Senate	

April 6, 2021

A BILL TO BE ENTITLED

AN ACT TO PREVENT NORTH CAROLINIANS FROM BECOMING VICTIMS OF SURPRISE BILLING BY OUT-OF-NETWORK HEALTH CARE PROVIDERS THAT HAVE RENDERED HEALTH CARE SERVICES AT HEALTH SERVICES FACILITIES THAT ARE IN-NETWORK WITH AN INDIVIDUAL'S HEALTH BENEFIT PLAN.

Whereas, insureds receiving health care services in North Carolina have been placed in the untenable position of receiving surprise bills from certain health care provider types even though the insureds have chosen to utilize a health care facility that is in-network as a participating provider with their health benefit plan; and

Whereas, in those cases, insureds in North Carolina often do not have a choice of which health care provider by whom they will be treated while at their chosen in-network health services facility; and

Whereas, it is in the best interest of North Carolinians to retain the choice and control over their finances which are impacted by choice of health services facilities and to avoid becoming victims of surprise billing by out-of-network health care providers rendering health care services at in-network health services facilities; Now therefore,

The General Assembly of North Carolina enacts:

SECTION 1. Article 3 of Chapter 58 of the General Statutes is amended by adding a new section to read:

"**§ 58-3-295. Contract requirements for limitations on billing by in-network health services facilities.**

(a) The following definitions apply in this section:

(1) Health care provider. – Any individual licensed, registered, or certified under Chapter 90 of the General Statutes, or under the laws of another state, to provide health care services in the ordinary care of business or practice, as a profession, or in an approved education or training program in any of the following:

a. Anesthesia or anesthesiology.
b. Emergency services, as defined under G.S. 58-3-190(g).
c. Pathology.
d. Radiology.
e. Rendering assistance to a physician performing any of the services listed in this subdivision.

(2) Health services facility. – As defined in G.S. 131E-176(9b) and including any office location.

(3) Out-of-network provider. – A health care provider that has not entered into a contract or agreement with an insurer to participate in one of the insurer's provider networks for the provision of health care services at a pre-negotiated rate.

(b) All contracts or agreements for participation as an in-network health services facility between an insurer offering health benefit plans in this State and a health services facility at which there are out-of-network providers who may be part of the provision of services to an insured while receiving care at the health services facility shall require that an in-network health services facility shall give at least 72 hours' advanced written notification to an insured that has scheduled an appointment at that health services facility of any out-of-network provider who will be part of the provision of the insured's health care services. If there is not at least 72 hours between the scheduling of the appointment and the appointment, then the in-network health services facility shall give the written notice to the insured on the day the appointment is scheduled. In the case of emergency services, the health services facility shall give written notice to the insured as soon as reasonably possible. The written notice required by this subsection shall include all of the following:

(1) All of the health care providers that will be rendering services to the insured that are not participating as in-network health care providers in the applicable insurer's network.

(2) The estimated cost to the insured of the services being rendered by the out-of-network providers identified in subdivision (1) of this subsection.

(c) Subject to the time lines required under G.S. 58-3-225, an insurer may recover overpayments made to any health care provider or health services facility under this section by making demands for refunds from the insured, the health care provider, or health services facility, as applicable. Any recoveries may also include related interest payments as required by G.S. 58-3-225. Not less than 30 calendar days before an insurer seeks an overpayment recovery or offsets future payments, the insurer shall give written notice to the responsible party that is accompanied by adequate information to identify the specific claim and specific reason for the overpayment recovery or offset of future payment.

(d) If any provision of this section conflicts with the federal Consolidated Appropriations Act, 2021, P.L. 116-260, and any amendments to that act or regulations promulgated pursuant to that act, then the provisions of P.L. 116-260 will be applied."

SECTION 2. This act becomes effective January 1, 2022, and applies to contracts entered into, amended, or renewed on or after that date.