# SENATE BILL 316:
# Lower Healthcare Costs.

*2025-2026 General Assembly*

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| **Committee:** | Senate Health Care. If favorable, re-refer to Judiciary. If favorable, re-refer to Rules and Operations of the Senate | **Date:** | March 19, 2025 |
| **Introduced by:** | Sens. Burgin, Galey, Sawrey | **Prepared by:** | Jason Moran-Bates<br>Committee Staff |
| **Analysis of:** | First Edition | | |

***OVERVIEW: Senate Bill 316 would do the following:***

- ***Direct hospitals to file quarterly reports with the Department of Health and Human Services on cost data for common inpatient admissions, surgical procedures, and diagnostic procedures.***
- ***Require out-of-network healthcare facilities and providers to provide information to insureds seeking treatment.***
- ***Require healthcare facilities to provide good faith estimates and not send unpaid amounts to collections unless a line-item bill has been provided.***
- ***Prohibit facility fees from being charged in many circumstances.***
- ***Require the State Auditor to examine cost and billing transparency at health service facilities.***
- ***Allow insurers to provide utilization review office contact information rather than the name, address, and phone number of the reviewers.***
- ***Clarify that the establishment of management fees by dental management companies is not the practice of dentistry.***
- ***Eliminate certificate of need review for rehabilitation services, rehabilitation facilities, and rehabilitation beds.***

**BILL ANALYSIS:**

**Part I** of the bill would require hospitals to provide a quarterly report to DHHS with the self-pay amount charged for each procedure for 100 most frequently reported admissions by Diagnostic Related Group number. The amount must be computed based on each billable item, regardless of whether it was provided by a physician or non-physician.

Part I would also require each hospital and ambulatory surgical facility to provide a quarterly report to DHHS with the costs for the 20 most common surgical procedures and 20 most common imaging procedures by Current Procedure Terminology (CPT) or Healthcare Common Procedure Coding System (HCPCS) number. The amount must be computed based on each billable item, regardless of whether it was provided by a physician or non-physician.

Under current law, hospitals must annually report to DHHS on the 100 most frequently reported admissions by Diagnostic Related Group (DRG) code. The report must also include (1) the self-pay cost for each DRG, (2) the average negotiated settlement that will be charged to a patient, (3) the Medicaid

reimbursement rate for procedure, (4) the Medicare reimbursement rate for each procedure, and (5) the average payment made by each of the five largest insurers in the state. The same information must also be provided for the 20 most common surgical procedures and 20 most common imaging procedures.

The North Carolina Healthcare Commission would be authorized to adopt rules to determine the 100 most frequently reported admissions, 20 most common surgical procedures, 20 most common imaging procedures, and 10 quality measures for hospitals and ambulatory surgical facilities. Rules adopted by the Commission would be effective after approval by the Rules Review Commission and would not be subject to the objection provisions of the rule-making process.

DHHS would be able to impose a daily civil penalty of at least .01% of the hospital CEO's annual salary and not more than $2,000 for violations.

Part I becomes effective January 1, 2026, or on the date the required rules are adopted, whichever is later.

**Part II** of the bill would require in-network hospitals to provide the following information when an insured (1) schedules a procedure, (2) seeks preauthorization for a procedure, (3) is treated for anything other than screening or stabilization, or (4) is admitted for emergency services:

- That the insured may receive separate bills for some of the services provided.
- Certain healthcare providers may not be in the insured's network. These out-of-network providers must be identified by name.
- That certain consumer protections may not be available when services are provided by an out-of-network provider.

If the insured is seeking emergency services at an out-of-network facility, a statement that the facility is out-of-network and that certain consumer protections may not be available when services are provided by an out-of-network provider must be provided when the facility begins to provide the services. If the insured seeks treatment from an individual out-of-network provider, the same information must be provided.

Upon request of an insured, insurers must notify the insured whether there are in-network providers reasonably able to meet the insured's needs without unreasonable delay.

Failure to comply with any of these provisions would be an unfair trade practice under Chapter 75.

Part II becomes effective October 1, 2026, and applies to healthcare services provided and contracts issued, renewed, or amended on or after that date.

**Part III** of the bill would prohibit hospitals and ambulatory surgical facilities from sending unpaid bills to collections with first providing a plain language, itemized list of the charges. The healthcare facilities would be required to provide good faith estimates, in plain language, listing the DRG, CPT, or HCPCS code for each expected charge when requested by a patient scheduling a non-urgent service. The final bill for the services may not exceed the good faith estimate by more than 5%. DHHS would have the authority to adopt rules enforcing these provisions.

Part III becomes effective January 1, 2026, or on the date the required rules are adopted, whichever is later.

**Part IV** of the bill would prohibit healthcare providers from charging facility fees for any procedures that are not performed at a hospital's main campus, an inpatient facility, or a facility that includes an emergency department. Facility fees would also be prohibited, regardless of where the procedure is performed, for outpatient evaluation and management services or for any other outpatient, diagnostic, or imaging services identified by DHHS. Hospitals and health systems would have to report annually to DHHS on the facility fees they charged. The charging of a facility fee that should have been prohibited would be considered an unfair and deceptive trade practice under Chapter 75. DHHS would be able to audit facilities for compliance and assess an administrative penalty not to exceed $1,000 for each violation. DHHS must adopt rules to enforce these provisions.

Part IV becomes effective January 1, 2026, or on the date the required rules are adopted, whichever is later.

**Part V** of the bill would require the State Auditor to examine the prices health service facilities that receive state funds charge out-of-network and uninsured patients and to what extent the facilities are transparent about those prices.

**Part VI** of the bill amend the insurance utilization review procedures in Chapter 58 to clarify that insurers or their utilization review officers must provide insureds with (1) information on where insureds can send information for an appeal and (2) contact information for the insurer. Insurers would no long be required to furnish the name, address, and phone number of the individual conducting the review.

**Part VII** of the bill would clarify that the practice of dentistry does not include the mechanism by which a dentist and a dental management company establish a management arrangement fee.

**Part IX** of the bill would eliminate certificate of need review for rehabilitative services, rehabilitation facilities, and rehabilitation facility beds.

**EFFECTIVE DATE:** Unless otherwise provided, the bill would be effective when it becomes law.