SENATE BILL 316:
Lower Healthcare Costs/Util. Rev. Efficiency.

2025-2026 General Assembly

Committee:	Senate Judiciary. If favorable, re-refer to Rules and Operations of the Senate	**Date:**	March 25, 2025
Introduced by:	Sens. Burgin, Galey, Sawrey	**Prepared by:**	Jason Moran-Bates Staff Attorney
Analysis of:	Amendment to Second Edition S316-ABC-13		

OVERVIEW: Amendment ABC-13 to 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.***
- ***Eliminate certificate of need review for rehabilitation services, rehabilitation facilities, and rehabilitation beds.***
- ***Establish timelines for insurers to notify insureds of utilization reviews for urgent health care services, require qualified physicians to conduct appeals of initial utilization review denials, require insurers to post utilization review requirements on their websites before those requirements can be effective, and ensure prior utilization review results remained effective if insureds switched to a new plan with the same insurer.***

BILL ANALYSIS: The amendment would combine S316 and S315. Non-technical changes from the Second Edition of S316 and the First Edition of S315 are underlined below.

The definitions of "healthcare provider" and "healthcare facility" in various parts of the original bill have been standardized to include the same provider and entity types throughout the amendment.

Part I 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.

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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 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 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 would prohibit healthcare providers from charging facility fees for any procedures that are not performed at a hospital's main campus, an inpatient facility, an ambulatory surgical 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 would require the State Auditor to periodically 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. The Auditor would be required to report the results of the examination to the Joint Legislative Oversight Committee on Health and Human Services by April 1, 2026, and periodically thereafter.

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 would eliminate certificate of need review for rehabilitative services, rehabilitation facilities, and rehabilitation facility beds.

Part VIII would change the insurance utilization review process regulations in Chapter 58 (Insurance) as follows:

- Insurers must notify insureds and their providers of the utilization review result within 24 hours of receiving all necessary information for urgent services via electronic health records and within 3 days for non-urgent services and urgent services where information is not submitted via electronic health records.
- Utilization review appeals must be reviewed by a (i) licensed physician with three years' experience in the same or a similar specialty as the treating physician or (ii) a licensed physician

with training and experience treating the medical condition at issue. The reviewing physician cannot have any prior involvement with the case or financial interest in the outcome.

- Mental health appeals submitted by a non-physician provider may be reviewed by a licensed non-physician mental health provider.
- All clinical aspects, including literature submitted by the treating physician, must be considered in the utilization review appeals process.
- Utilization review requirements must be readily available on the insurer's website, and utilization review requirement changes may not be effective until they have been posted on the insurer's website.
- Prior authorizations that have been approved will remain in force for 90 days after an insured switches to a new health benefit plan offered by the same insurer. If the authorization is for a chronic condition, the prior authorization will remain in force for at least six months.
- Effective January 1, 2028, insurers must provide utilization review application programming interfaces that comply with the requirements of 45 CFR §156.223(b) as it existed on January 1, 2025.
- Insurers would be prohibited from using an AI-based algorithm as the sole basis for a utilization review denial. The previous version would have also prevented using AI algorithms to modify an insured's services.

The State Treasurer and the Executive Administrator of the State Health Plan would be required to ensure the State Health Plan's compliance with all these provisions by the next plan year.

Part VIII would become effective October 1, 2026, and apply to contracts issued, renewed, or amended on or after that date. The provisions dealing the with the compliance of the State Health Plan would be effective when they become law.

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