GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2007

H **1**

HOUSE BILL 447

Short Title:	Health Care Provider/Balance Billing.	(Public)
Sponsors:	Representatives Faison, Coleman, Blue (Primary Sponsors); and Wainwright.	
Referred to:	Health, if favorable, Judiciary III.	

March 5, 2007

A BILL TO BE ENTITLED

AN ACT TO PROHIBIT BALANCE BILLING BY HEALTH CARE PROVIDERS UNDER CERTAIN CIRCUMSTANCES.

The General Assembly of North Carolina enacts:

SECTION 1. Article 50 of Chapter 58 of the General Statutes is amended by adding the following new section to read:

"**§ 58-50-248. Balance billing restrictions; definitions.**

(a) A facility-based physician or health care provider may not, in connection with the provision of health care services to a covered person, bill the covered person for any amount above the applicable co-payment, coinsurance, or deductible for the health care services if the facility-based physician or health care provider accepts the usual and customary rate under the health benefit plan.

(b) As used in this section:

(1) 'Covered person'. – An individual who receives health benefits from an insurer under a health benefit plan.

(2) 'Facility'. – A hospital or ambulatory surgical center licensed under Chapter 131E of the General Statutes.

(3) 'Facility-based physician or health care provider'. – Includes:

a. A radiologist, an anesthesiologist, a pathologist, a neonatologist, or an emergency department physician or provider to whom the facility has granted clinical privileges and who provides services to patients of the facility under those clinical privileges.

b. A physician or provider who provides physician or provider services to a facility's patients in a clinical area if the facility grants clinical privileges on a closed staff basis for the clinical area.

c. A person other than a facility, physician, or provider that provides health care services or supplies directly to patients under an agreement with the facility.

(3) 'Health benefit plan'. – As defined under G.S. 58-3-167.

(4) 'Insurer'. – As defined under G.S. 58-3-167.

(c) For purposes of this section, a member of the medical staff of a health care facility is not a 'facility-based provider' as defined in this section solely because the member is appointed to the facility's medical staff and granted clinical privileges by the facility."

SECTION 2. G.S. 58-65-2 reads as rewritten:

"**§ 58-65-2. Other laws applicable to service corporations.**

The following provisions of this Chapter are applicable to service corporations that are subject to this Article:

G.S. 58-2-125.	Authority over all insurance companies; no exemptions from license.
G.S. 58-2-150.	Oath required for compliance with law.
G.S. 58-2-155.	Investigation of charges.
G.S. 58-2-160.	Reporting and investigation of insurance and reinsurance fraud and the financial condition of licensees; immunity from liability.
G.S. 58-2-162.	Embezzlement by insurance agents, brokers, or administrators.
G.S. 58-2-185.	Record of business kept by companies and agents; Commissioner may inspect.
G.S. 58-2-190.	Commissioner may require special reports.
G.S. 58-2-195.	Commissioner may require records, reports, etc., for agencies, agents, and others.
G.S. 58-2-200.	Books and papers required to be exhibited.
G.S. 58-3-50.	Companies must do business in own name; emblems, insignias, etc.
G.S. 58-3-100(c), (e).	Insurance company licensing provisions.
G.S. 58-3-115.	Twisting with respect to insurance policies; penalties.
G.S. 58-7-46.	Notification to Commissioner for president or chief executive officer changes.
G.S. 58-50-35.	Notice of nonpayment of premium required before forfeiture.
G.S. 58-51-25.	Policy coverage to continue as to mentally retarded or physically handicapped children.
G.S. 58-51-95(h), (i),(j).	Approval by Commissioner of forms, classification and rates; hearings; exceptions.
G.S. 58-50-248.	Balance billing restrictions."

SECTION 3. Article 67 of Chapter 58 of the General Statutes is amended by adding the following new section to read:

"**§ 58-67-43. Balance billing restrictions; definitions.**

(a) For purposes of health care plans provided by a Health Maintenance Organization, if a limited provider network or delegated entity provides or arranges to provide services to enrollees through a facility-based physician or provider who is not a member of the HMO delivery network, on payment by the HMO of the usual and customary rate as defined under the health care plan or an agreed rate for health care services, the enrollee is not liable for any further payments to the facility-based physician or provider except for payment of any applicable co-payments, coinsurance, or deductibles for the covered services.

(b) As used in this section:

(1) 'Facility'. – A hospital or ambulatory surgical center licensed under Chapter 131E of the General Statutes.

(2) 'Facility-based physician or health care provider'. – Includes:

a. A radiologist, an anesthesiologist, a pathologist, a neonatologist, or an emergency department physician or provider to whom the facility has granted clinical privileges and who provides services to patients of the facility under those clinical privileges.

b. A physician or provider who provides physician or provider services to a facility's patients in a clinical area if the facility grants clinical privileges on a closed staff basis for the clinical area.

c. A person other than a facility, physician, or provider that provides health care services or supplies directly to patients under an agreement with the facility.

(3) 'Health care plan'. – As defined under G.S. 58-67-5.

(4) 'Health care services'. – As defined under G.S. 58-67-5.

(5) 'Limited provider network'. – A subnetwork within a health maintenance organization delivery network in which contractual relationships exist between physicians, certain providers, independent physician associations, or physician groups that limit an enrollee's access to physicians and providers to those physicians and providers in the subnetwork.

(c) For purposes of this section, a member of the medical staff of a health care facility is not a 'facility-based provider' as defined in this section solely because the member is appointed to the facility's medical staff and granted clinical privileges by the facility."

SECTION 4.(a) G.S. 58-50-56(a) is amended by adding the following new definitions, in alphabetical order:

"**§ 58-50-56. Insurers, preferred provider organizations, and preferred provider benefit plans.**

(a) Definitions. – As used in this section:

…

(5) 'Facility'. – A hospital or ambulatory surgical center licensed under Chapter 131E of the General Statutes.

(6) 'Facility-based physician or health care provider'. – Includes:

a. A radiologist, an anesthesiologist, a pathologist, a neonatologist, or an emergency department physician or provider to whom the facility has granted clinical privileges and who provides services to patients of the facility under those clinical privileges.

b. A physician or provider who provides physician or provider services to a facility's patients in a clinical area if the facility grants clinical privileges on a closed staff basis for the clinical area.

c. A person other than a facility, physician, or provider that provides health care services or supplies directly to patients under an agreement with the facility."

SECTION 4.(b) G.S. 58-50-56 is amended by adding the following new subsection to read:

"(l) If health care services are provided to an insured in a facility that is part of the preferred provider network by a facility-based physician or health care provider who is not a preferred provider, on payment to the physician or provider by the insurer of the usual and customary rate as defined by the health insurance policy or the agreed rate for covered services, the insured is not liable for further payments to the facility-based physician or health care provider except for payment of any applicable co-payments, coinsurance, or deductibles owed by the insured for the covered services."

SECTION 5. This act becomes effective January 1, 2008, and applies to plans, policies, or certificates issued or renewed on or after that date.