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GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2025

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SENATE BILL DRS45310-NH-20

Short Title:	Protect North Carolinians from Medical Debt.	(Public)
Sponsors:	Senator Burgin (Primary Sponsor).	
Referred to:		

A BILL TO BE ENTITLED

AN ACT TO ADOPT THE PRO-FAMILY, PRO-CONSUMER MEDICAL DEBT PROTECTION ACT TO LIMIT THE ABILITY OF LARGE MEDICAL FACILITIES TO CHARGE UNREASONABLE INTEREST RATES AND EMPLOY UNFAIR TACTICS IN DEBT COLLECTION.

The General Assembly of North Carolina enacts:

PART I. MEDICAL DEBT PROTECTION ACT

SECTION 1. Chapter 131E of the General Statutes is amended by adding a new Article to read:

"Article 11C.

"Medical Debt Protection Act.

"**§ 131E-214.21. Short title and purpose.**

This Article may be cited as the "Medical Debt Protection Act." The purpose of this Article is to reduce burdensome medical debt and to protect patients in their dealings with medical creditors, medical debt buyers, and medical debt collectors with respect to such debt. This Article is a consumer protection statute and shall be liberally and remedially construed to effectuate its purposes.

"**§ 131E-214.22. Definitions.**

The following definitions apply in this Article:

(1) Consumer. – A natural person who has incurred a debt or alleged debt for primarily personal, family, or household purposes.

(2) Consumer reporting agency. – Any person, which, for monetary fees, dues, or on a cooperative nonprofit basis, regularly engages in whole or in part in the practice of assembling or evaluating consumer credit information or other information on consumers for the purpose of furnishing consumer reports to third parties.

(3) External review. – Review of an adverse benefit determination, including a final internal adverse benefit determination, conducted pursuant to an applicable State external review process as described in Part 4 of Article 50 of Chapter 58 of the General Statutes, a federal external review process as described in 42 U.S.C. § 300gg-19, a review pursuant to 29 U.S.C. § 1133, a Medicare appeals process, a Medicaid appeals process, or another applicable appeals process.

(4) Extraordinary collection action. – An extraordinary collection action includes any of the following:

a. Selling an individual's debt to another party, except if prior to the sale, the medical creditor enters into a legally binding written agreement with the medical debt buyer which includes the following provisions:
1. The medical debt buyer or collector is prohibited from engaging in any extraordinary collection actions to obtain payment for the care.
2. The medical debt buyer is prohibited from charging interest on the debt in excess of that described in G.S. 131E-214.35.
3. The debt is returnable to or recallable by the medical creditor upon a determination by the medical creditor or medical debt buyer that the individual is eligible for financial assistance.
4. If the individual is determined to be eligible for financial assistance for emergency or medically necessary care and the debt is not returned to or recalled by the medical creditor, the medical debt buyer is required to adhere to procedures which ensure that the individual does not pay, and has no obligation to pay, the medical debt buyer and the medical creditor together more than he or she is personally responsible for paying in compliance with this Article. Such procedures shall be specified in any agreement between a medical creditor and a medical debt buyer.

b. Taking a confession of judgment or allowing a borrower to execute a power of attorney to confess a judgment.

c. Actions that require a legal or judicial process, including, but not limited to:
1. Attaching or seizing an individual's bank account or any other personal property.
2. Commencing a civil action or arbitration against an individual.

(5) Gross charges. – A covered health care provider's full, established price for health care services that the covered health care provider charges uninsured patients before applying any contractual allowances, discounts, or deductions.

(6) Health care services. – Services for the diagnosis, prevention, treatment, cure, or relief of a physical, dental, behavioral, substance use disorder or mental health condition, illness, injury, or disease. These services include, but are not limited to, any procedures, products, devices, or medications.

(7) Household income. – Income calculated by using the methods used to calculate Medicaid eligibility, as set forth in 42 C.F.R. 435.603.

(8) Internal review or internal appeal. – Review by a health insurance plan or other insurer of an adverse benefit determination.

(9) Large health care facility. – Includes any of the following entities:
a. Any hospital licensed under this Chapter or Chapter 122C of the General Statutes, whether a nonprofit subject to 26 U.S.C. § 501(c)(3), a hospital owned by a county, municipality, the State, or a for-profit entity.
b. Any outpatient clinic or facility affiliated with a hospital or operating under the license of a hospital described in sub-subdivision a. of this subdivision.
c. Any ambulatory surgical center licensed under this Chapter.
d. Any practice which provides outpatient medical, behavioral, optical, radiology, laboratory, dental, or other health care services with revenues of at least twenty million dollars ($20,000,000) annually and

is licensed under this Chapter or has medical providers performing health care services pursuant to a license issued under Chapter 90 of the General Statutes.

e. Any licensed health care professional who provides health care services in one or more of the settings listed in sub-subdivisions a. through d. of this subdivision and bills patients independently.

(10) Medical creditor. – Any entity that provides health care services and to whom the consumer owes money for health care services, or the entity that provided health care services and to whom the consumer previously owed money if the medical debt has been purchased by one or more debt buyers.

(11) Medical debt. – A debt arising from the receipt of health care services.

(12) Medical debt buyer. – A person or entity that is engaged in the business of purchasing medical debts for collection purposes, whether it collects the debt itself or hires a third party for collection or an attorney-at-law for litigation in order or other collection activity to collect such debt.

(13) Medical debt collector. – Any person that regularly collects or attempts to collect, directly or indirectly, medical debts originally owed or due or asserted to be owed or due another. A medical debt buyer is considered to be a medical debt collector for all purposes.

(14) Medical debt mitigation policy (MDMP). – A financial assistance policy which shall be written in accordance with this Article.

(15) Patient. – The person who received health care services and, for the purposes of this Article, as context requires, the person legally obligated to pay for the provision of the health care services.

"**§ 131E-214.23. Medical debt mitigation policy for large health care facilities.**

(a) All large health care facilities are required to develop a written MDMP that complies with this Article and any implementing rules. This requirement shall apply whether or not the large health care facility is required to develop a financial assistance policy under 26 U.S.C. § 501(r)(4) and implementing regulations.

(b) The MDMP must, at a minimum, include the following:

(1) A written financial assistance policy that applies to all emergency and other medically necessary health care services offered by the covered health care provider.

(2) The basis for calculating amounts charged to patients.

(3) A plain language summary of the financial assistance policy, which shall not exceed two pages in length.

(4) The eligibility criteria for financial assistance including when such assistance includes free or discounted care.

(5) A summary of the type of financial assistance that is available as set forth in this Article.

(6) The method and application process that patients are to use to apply for financial assistance.

(7) The information and documentation the large health care facility may require an individual to provide as part of the application.

(8) The reasonable steps that the provider will take to determine whether a patient is eligible for financial assistance.

(9) The billing and collections policy, including the actions that may be taken in the event of nonpayment, which shall comply with all applicable parts of this Article and other applicable municipal, State, or federal laws.

(10) Information about available payment plans for patients, including available time periods for repayment and caps on payment amount.

(11) Measures the facility will take to widely publicize the policy within the community to be served by the facility in accordance with G.S. 131E-214.27.

(c) The MDMP must be approved by the owners or governing body of a health care provider and shall be reviewed by the owners or governing board annually.

"**§ 131E-214.24. Implementation of the medical debt mitigation policy.**

(a) In addition to any other actions required by applicable municipal, State, or federal law, large health care facilities must take the following steps before seeking payment for any emergency or medically necessary care:

(1) Determine whether the patient has health insurance.

(2) If the patient is uninsured, offer to screen the patient for public or private insurance eligibility and offer assistance if the patient chooses to apply for public or private insurance, however, a patient's refusal to be screened shall not be grounds for denying financial assistance.

(3) Offer to screen the patient for other public programs which may assist with health care costs; however, a patient's refusal to be screened shall not be grounds for denying financial assistance.

(4) If available, use information in the possession of the large health care facility to determine if the patient is qualified for free or discounted care as set forth in G.S. 131E-214.25.

(5) Determine whether the patient is eligible for assistance under the large health care facility's Presumptive Eligibility Policy adopt pursuant to G.S. 131-214.26(b).

(6) If a patient submits an application or eligibility documentation pursuant to G.S. 131E-214.26(c), the large health care facility shall issue a determination of eligibility on the application or eligibility documentation within 14 days of receipt of the application or eligibility documentation. The facility shall suspend all billing and collection actions while an eligibility determination is pending.

(7) A large health care facility shall provide a patient all of the following notifications:

a. When an application for financial assistance is received.

b. During review of the application, if the application is found to be missing any components or needs to be updated. This notice shall include details about the information the patient needs to provide to complete the application.

c. If the application is denied, a notice of the denial including the basis for the denial and information on how to appeal the decision.

d. If the application is approved, notice of the approval including a detailed explanation of the costs charged to the patient, how the financial aid policy has been applied to the costs charged to the patient, and a detailed explanation of what the patient does or will owe. This notice shall also explain how to apply for additional financial assistance for any remaining balance.

(c) A large health care facility shall accept and consider a patient's application for financial assistance if it is submitted within one year of the date of the first bill after the provision of the health care services. However, if the patient is the subject of collection activity by the facility or a medical debt collector, including a lawsuit to collect a medical debt, and the patient submits, or updates by providing eligibility documentation for, an application for financial assistance, the large health care facility shall accept and process the application at any time. If the patient submits a financial assistance application to a medical debt collector, the medical debt collector shall forward the application to the large health care facility within two business days

and shall cease collection activity until notified by the large health care facility of the outcome of the application and any debt forgiven or new repayment terms.

(d) For a patient who has been found to be eligible for financial assistance, no initial payment on a monthly payment plan shall be due within the first 90 days after the health care services were provided.

(e) The large health care facility shall create an appeals process under which it will evaluate denials of financial assistance upon request of a patient. Any denial of financial assistance shall inform a patient of the right to appeal the denial.

"**§ 131E-214.25. Eligibility for medical debt mitigation policy financial assistance.**

(a) A large health care facility's financial assistance policy adopted as required by this Article shall be available, at a minimum, to any patient meeting the eligibility criteria in this section.

(b) The following patients shall qualify for financial assistance under the MDMP in accordance with the following terms, which applies to any charges for health care services that are not covered by insurance and would otherwise be billed to the patient:

(1) Patients with household income of zero percent (0%) to three hundred percent (300%) of the federal poverty level shall receive free care.

(2) Patients with household income of more than three hundred percent (300%) up to four hundred percent (400%) of the federal poverty level shall be charged no more than an amount calculated in the following manner:

a. Recalculate the patient's bill using the Medicare reimbursement rate applicable on the dates of service.

b. The patient shall be charged no more than twenty-five percent (25%) of the recalculated bill.

(3) Patients with household income of more than four hundred percent (400%) up to six hundred percent (600%) of the federal poverty level shall receive the same discount listed in subdivision (2) of subsection (b) of this section if the patient or the patient's household has incurred medical expenses during the previous 12 months which in total exceed tfive percent (5%) of the household's income. For purposes of this section, medical expenses includes all bills for medically necessary health care services received by a household member during the previous 12 months, including the bill the large health care facility is currently seeking payment on.

(4) In addition to other financial assistance provided under this Article, no patient with household income at or below four hundred percent (400%) of the federal poverty level shall be required to pay more than two thousand three hundred dollars ($2,300) in cumulative medical bills to large health care facilities in any 12 month period. Upon patient request and documentation, any health care services that have been delivered by one or more large health care facilities after the two thousand three hundred dollar ($2,300) limit has been met must be provided as free care. A large health care facility may require a patient to provide proof of payment showing the payment cap has been reached except for payments made to that large health care facility which should have record of the payment.

(c) If a patient is approved for financial assistance, the patient shall remain qualified for the same level of financial assistance for at least one year from the date the financial assistance is approved, with the opportunity to renew.

"**§ 131E-214.26 Determining eligibility for medical debt mitigation policy financial assistance.**

(a) As part of a large health care facility's MDMP, the facility shall adopt a process to screen for presumptive eligibility for financial assistance and establish a process for determining

non-presumptive eligibility. The facility shall not issue a bill to a patient until the patient has been screened for presumptive eligibility and notified if found presumptively eligible.

(b) The presumptive eligibility screening policy shall comply with all of the following:

(1) Shall not require a patient to provide documentation or other verification of meeting presumptive eligibility criteria.

(2) Shall require patients to be screened for presumptive eligibility prior to or at check-in for non-emergency services and as soon as reasonably possible and prior to discharge, if feasible, for emergency services.

(3) Shall allow patients to attest to their qualifications for Medicaid, with an understanding that the patient will not be financially penalized for misreporting qualifications if the report was made in good faith and the patient is later determined to be ineligible.

(4) Shall deem a patient presumptively eligible for financial assistance if the patient meets any one or more of the following criteria:

a. Experiencing homelessness.

b. Is mentally incapacitated with no legal guardian to act on their behalf.

c. The patient or someone in the patient's household is enrolled in Medicaid.

d. The patient or someone in the patient's household is enrolled in any means-tested public assistance program, including Supplemental Security Income, Medicare Low Income Subsidy, Low Income Energy Assistance Program, Temporary Assistance to Needy Families, Women, Infants and Children Nutrition Program, or Supplemental Nutrition Assistance Program.

e. The patient is enrolled in an organized community-based program providing access to medical care that assesses and documents limited low-income financial status as criteria.

f. By income. A large health care facility may use third-party software tools or services to determine patient eligibility for income-based presumptive eligibility only if they are unable to determine a patient's eligibility through other means. If the facility is unable to determine a patient's eligibility through other means, it may choose to use a consumer report, as defined in section 603(a) of the Fair Credit Reporting Act, 15 U.S.C.1681a(d), or any score or rating based on a consumer report information. Before obtaining any consumer information to determine income eligibility, a facility must obtain consent for the credit check from the patient. The patient's consent must be given in writing on a standalone document and shall be effective for no more than 30 days.

(5) A large health care facility may grant financial assistance based on a determination of presumptive eligibility relying on any information obtained by the facility or in the facility's possession, but shall not use that information to deny financial assistance.

(c) If a patient is found to not be presumptively eligible for financial assistance after being screened in accordance with subsection (b) of this section, then the large health care facility must provide a process for patients to apply for financial assistance that complies with all of the following:

(1) Allows patients to apply by phone, online, by mail, or in-person.

(2) May require patients to provide proof of income. Patients may prove income by submitting any of the following:

a. Most recent tax return.

b. A pay stub.
c. Documentation of public assistance or participation in any means-tested program, including those listed in sub-subdivision (4) of subsection (b) of this section.
d. Any documentation of household income which the Office of the State Treasurer has identified as a valid form of documentation for the purposes of this Article.

(3) A large health care facility may grant financial assistance notwithstanding a patient's failure to provide proof of income and may rely on, but not require other evidence of eligibility.

"**§ 131E-214.27 Medical debt mitigation policy public education and information.**

(a) A large health care facility must publicize its MDMP widely by:

(1) Making the policy and the financial assistance application form easily accessible online, through the large health care facility's website and through any patient portal or other online communication portal used by patients of the health care provider. As part of the information available online related to the MDMP, the large health care facility shall also identify prohibited collection actions and unlawful debt collection practices that the medical creditor or medical debt collector cannot take under state and federal law, including causing an individual's arrest, holding a spouse liable for an individual's medical debt, foreclosing on an individual's real property, and garnishing wages or state income tax refunds and shall provide information about filing a complaint with the Attorney General if the patient's rights are violated.

(2) In addition to any other requirements in this Article, making paper copies of the MDMP and application form available upon request and without charge, both by mail and in the large health care facility's office. For hospitals, copies should be available, at a minimum, in the emergency room, if any, billing and financial assistance application areas, and admissions areas.

(3) Notifying and informing members of the community served by the large health care facility about the MDMP in a manner reasonably calculated to reach those members who are most likely to require financial assistance with such efforts commensurate to the size and income of the provider.

(4) Notifying and informing individuals who receive care from the large health care facility about the MDMP by:

a. Offering a paper copy of the MDMP to patients as part of the patient's first visit, or in the case of a hospital facility, during the intake and discharge process.
b. Including a conspicuous written notice on billing statements, whether sent by the large health care facility or a medical debt collector, that notifies and informs recipients about the availability of financial assistance and payment plans and includes the telephone number of the large health care facility's office or department that can provide information about the financial assistance policy and application process and the direct website address where copies of the MDMP and application may be obtained.
c. Setting up conspicuous public displays or other measures reasonably calculated to attract patients' attention that notify and inform patients about the MDMP in public locations in the large health care facility's office. For hospitals, displays should be posted in the emergency room,

if any, billing and financial assistance application areas, and admissions areas, at a minimum.

(b) In all written attempts by a medical creditor or medical debt collector to collect a medical debt for health care services provided by a large health care facility, the patient must be informed of any financial assistance policy available through the large health care facility and given the same information about prohibited debt collection practices as required under subdivision (a)(1) of this section.

(c) In all oral attempts by a medical creditor or debt collector to collect a medical debt for health care services provided by a large health care facility, the patient must be informed of any financial assistance policy available through the large health care facility and the website address where the information on prohibited debt collection practices required under subdivision (a)(1) of this section, and given the same information about prohibited debt collection practices as required under subdivision (a)(1) of this section, as well as the phone number and website address where such information can be accessed.

(d) Medical creditors and medical debt collectors shall notify all patients about the risks of paying for medical services with a credit card, including at the point of transaction when a patient attempts to pay a medical creditor or debt collector with a credit card. The notification must inform the patient that by using a credit card to pay for medical services, the patient may be forgoing state and federal protections regarding medical debt and financial assistance policies. Before accepting a credit card payment from a patient, a medical creditor or medical debt collector shall obtain a signed, written waiver from the patient acknowledging that the patient has received the notice required by this subsection.

(e) A large healthcare provider may not require a credit card pre-authorization or for a patient to have a credit card on file prior to providing emergency or medically necessary services to a patient.

"**§ 131E-214.28. Medical debt mitigation policy language access.**

(a) Notices sent by large health care facilities shall include the following language: "This document contains important information about financial assistance for your bill. Contact [insert name and phone number of large health care facility] for free translation assistance," translated in the 15 languages most frequently spoken by limited English proficient households as determined by U.S. Census Bureau data in the large health care facility's service area. This language is required to be included on all of the following:

(1) The large health care facility's MDMP.

(2) Financial assistance application forms, documents, and notices required under G.S. 131E-214.24.

(3) Any document seeking payment from a patient, including bills, invoices, and collections communications.

(4) Any document or notice related to a credit card payment under G.S. 131E-214.27.

(5) Any document or notice related to a facility fee, including those described in G.S. 131E-274.

(b) A large health care facility must accommodate all significant populations that have limited English proficiency by translating the MDMP, application form, and related documents into the primary languages spoken by such populations. A large health care facility will satisfy this translation requirement if it makes available translations of these documents in the language spoken by each limited English proficiency language group that constitutes the lesser of 1,000 individuals or five percent (5%) of the community served by the large health care facility or the population likely to be affected or encountered by the large health care facility. A large health care facility may determine the percentage or number of limited English proficiency individuals in the large health care facility's community or likely to be affected or encountered by the hospital facility.

(c) A large health care facility must accommodate any patient with limited English proficiency, who is part of a population which falls below the numerical thresholds established in subsection (b) of this section, by providing oral interpretation services to the patient upon request and at no cost to the patient to explain the MDMP and its application.

(d) A large health care facility must accommodate any patient with limited English proficiency to answer questions from the patient regarding the MDMP, the application form, any written determination of eligibility, any communication regarding financial assistance from the large health care facility, and any notice sent to patients. A large health care facility may accommodate these patients by providing oral interpretation services to the patient upon request and at no cost to the patient.

"**§ 131E-214.29. Prohibited acts in collecting medical debt.**

(a) The following prohibited collection actions may not be used by any medical creditor or medical debt collector to collect debts owed for health care services:

(1) Causing an individual's arrest.

(2) Causing an individual to be held in civil contempt or imprisoned under G.S. 5A-21 or G.S. 1-302 if the only reason supporting the contempt is the debtor's failure to pay a judgment for medical debt.

(3) Foreclosing on an individual's real property.

(4) Placing a lien on an individual's real property or engaging in any action that would result in a lien being placed on an individual's real property.

(5) Acquiring a security interest or lien in the individual's real property, by agreement or otherwise.

(6) Garnishing wages or State income tax refunds.

(b) No medical creditor or medical debt collector may communicate with or report any information to any consumer reporting agency regarding a consumer's medical debt, unless the communication is made to resolve an erroneous reporting.

(c) Any medical debt or portion of medical debt that is reported to a consumer reporting agency in violation of this section shall be void.

(d) Nothing in this Article shall be construed as exempting a medical creditor or medical debt collector from the provisions of Chapter 75 or Chapter 58 of the General Statutes, as those Chapters are applicable.

"**§ 131E-214.30. Limitations on extraordinary collection actions.**

(a) No medical creditor or medical debt collector shall engage in any permissible extraordinary collection actions until 180 days after the first bill for a medical debt has been sent.

(b) If a patient is eligible for financial assistance under the large health care facility's MDMP, a medical creditor or medical debt collector shall not engage in any extraordinary collection actions against the eligible patient.

(c) Medical creditors and medical debt collectors shall not engage in any extraordinary collection actions during a state or federally declared state of emergency or a public health emergency in the area where the patient lives.

(d) At least 30 days before taking any extraordinary collection actions, a medical creditor or medical debt collector must provide to the patient a notice containing the following:

(1) In the case of large health care facilities and medical debt collectors collecting debt for health care services provided by such facilities, stating that financial assistance and payment plans are available for eligible individuals and providing a plain-language summary of the MDMP.

(2) Identifying the extraordinary collection actions that will be initiated in order to obtain payment.

(3) Providing a deadline after which such extraordinary collection actions will be initiated, which date is no earlier than 30 days after the date of the notice.

(4) Identifying unlawful debt collection actions and practices that the medical creditor or debt collector are barred from taking or conducting under state and federal law, including causing an individual's arrest, holding a spouse liable for an individual's medical debt, foreclosing on an individual's property, and garnishing wages or state income tax refunds and shall provide information about filing a complaint with the Attorney General if a patient's rights are violated.

(e) A large health care facility or a medical debt collector collecting debt for health care services provided by such a facility shall not use any extraordinary collection actions unless these actions are described in the large health care facility's billing and collections policy.

(f) If a large health care facility or a medical debt collector collecting debt for health care services provided by such a facility bills or initiates collection activities and the patient is later found eligible for financial assistance, within 90 days from the date eligibility is determined the large health care facility or medical debt collector shall reverse any extraordinary collection actions, including dismissing or vacating any collection lawsuits over the medical debt and returning any funds or property taken as part of judgment enforcement.

(g) If the patient has paid any part of the medical debt or any of the patient's funds have been seized or levied in excess of the amount that the patient owes after application of financial assistance, within 90 days from the date eligibility is determined the large health care facility or medical debt collector shall refund any excess amount to the patient with interest. Interest shall accumulate beginning the day eligibility is determined.

"**§ 131E-214.31. Price information.**

(a) All large health care facilities must post price information on their internet websites. This information must be accessible via a link from the website's homepage and at a minimum must include the following:

(1) A list of gross charges for all health care services.

(2) Next to the relevant gross charge, a list of the amounts that Medicare would reimburse for the health care service.

(3) Next to the relevant gross charge, the amount a patient would be required to pay under each level of financial assistance.

(4) Plain-language titles or descriptions of health care services that can be understood by the average patient.

(b) A large health care facility that is not in compliance with this section on the date that items or services were provided to a patient shall not initiate or pursue a collection action against the patient for a debt owed for the items or services.

"**§ 131E-214.32. Liability for medical debt.**

No spouse or other person shall be liable for the medical debt or nursing home debt of any other person age 18 or older, or any other damages related to the collection of the patient's bill. A person may not voluntarily consent to assume liability, and any such agreement shall be unenforceable.

"**§ 131E-214.33. Verification.**

Before requesting payment from a patient, or within 60 days of a patient's written or oral request, a medical creditor or medical debt collector shall provide a patient with an itemized bill at no cost to the patient. The itemized bill shall state:

(1) The name and address of the medical creditor.

(2) The dates of service.

(3) The dates the medical debts were incurred, if different from the dates of service.

(4) A detailed list of the specific health care services provided to the patient.

(5) A list of all health care professionals who treated the patient.

(6) The amount of principal for any medical debts incurred.

(7) Any adjustment to the bill, including negotiated insurance rates or other discounts.

(8) The amount of any payments received, whether from the patient or any other party.

(9) Any interest or fees.

(10) Whether the patient was screened for financial assistance.

(11) Whether the patient was found eligible for financial assistance and, if so, the amount due after all financial assistance has been applied to the itemized bill.

(12) That financial assistance may be available and instructions on how to apply for it.

(13) Information about payment plans available, including the duration of plans and caps on payments.

"**§ 131E-214.34. Prohibition against collection of medical debt during health insurance appeals.**

(a) A medical creditor or medical debt collector that knows or should have known about an internal review, external review, or other appeal of a health insurance decision that is pending now or was pending within the previous 180 days shall not do any of the following:

(1) Communicate with the consumer regarding the unpaid charges for health care services for the purpose of seeking to collect the charges.

(2) Initiate a lawsuit or arbitration proceeding against the consumer relative to unpaid charges for health care services.

(b) No medical creditor that knows or should have known about an internal review, external review, or other appeal of a health insurance decision that is pending now or was pending within the previous 180 days shall refer, place, or send the unpaid charges for health care services to a medical debt collector, including by selling the debt to a medical debt buyer.

"**§ 131E-214.35. Interest on medical debt.**

(a) Interest on medical debt shall be limited to no more than two percent (2%) per annum. Late payments shall not result in a default interest rate. If a patient is charged a late fee, that fee shall not exceed the lesser of twenty-five dollars ($25.00) or one percent (1%). Patients eligible for financial assistance shall not be charged any interest or late fees.

(b) The rate of interest provided in subsection (a) of this section shall also apply to any judgments on medical debt, notwithstanding any other provision of law or agreement to the contrary.

"**§ 131E-214.36. Medical debt payment plans.**

(a) Medical creditors and medical debt collectors shall offer any patient that qualifies for financial assistance or who owes a medical debt over five hundred dollars ($500) a payment plan of not less than 36 months and shall not require the patient to make monthly payments exceeding five percent (5%) of the patient's household income.

(b) Any medical creditor or medical debt collector that agrees to a payment plan for a medical debt shall provide a written copy of the payment plan to the consumer within five business days of entering into the payment plan. This plan shall prominently disclose the rate of any interest being applied to the debt in compliance with G.S. 131E-214.35 and the date by which the account will be paid off in full, assuming the payments set by the schedule are made without interruption.

(c) A consumer need not make a payment on the payment plan until the written copy has been provided.

(d) A medical debt payment plan may be accelerated or declared in default or no longer operative due to nonpayment only after the patient fails to make scheduled payments on the payment plan for at least three consecutive months. Before declaring the payment plan no longer operative, the medical creditor or medical debt collector shall make at least three reasonable attempts to contact the patient by telephone or other method preferred by the patient.

Additionally, notice must be provided in writing that the payment plan may become inoperative and informing the patient of the opportunity to renegotiate the payment plan. Prior to the payment plan being declared inoperative, the medical creditor shall attempt to renegotiate the terms of the defaulted payment plan, if requested by the patient. The medical creditor shall not commence a civil action against the patient or responsible party for nonpayment until at least 90 days after the payment plan is declared to be no longer operative. For purposes of this section, the notice and telephone call to the patient may be made to the last known telephone number and address of the patient.

(e) A payment plan shall not include any penalties or fees for prepayment, early payment, or early payoff.

"**§ 131E-214.37. Receipts for payments.**

Within 10 business days of receipt of a payment on a medical debt, the medical creditor or medical debt collector, or any of their agents receiving the payment, shall furnish a receipt to the person that made the payment. All receipts shall include the following information:

(1) The amount paid.
(2) The date payment was received.
(3) The account's balance before the most recent payment.
(4) The new balance after application of the payment.
(5) The interest rate and interest accrued since the consumer's last payment.
(6) The consumer's account number.
(7) The name of the current owner of the debt and, if different, the name of the medical creditor.
(8) Whether the payment is accepted as payment in full of the debt.
(9) The date of service when the health care services were provided.

"**§ 131E-214.38. Debt forgiven by medical center.**

Forgiveness of any part of an insured patient's copayment, coinsurance, deductible, facility fees, out-of-network charges, or other cost-sharing shall not be a breach of contract or other violation of an agreement between the medical creditor and the insurer or payor.

"**§ 131E-214.39. Private remedy.**

(a) Any medical creditor or medical debt collector who violates this Article, regardless of whether the violation was committed knowingly, shall be liable to the consumer against whom the violation occurred in a private right of action for the greater of (i) up to treble the amount fixed by a damages verdict in favor of the plaintiff, or (ii) civil penalties as the court may allow, but not less than five hundred dollars ($500) nor greater than four thousand dollars ($4,000) for each violation.

(b) If judgment is entered in favor of a plaintiff for a claim for violation of this Article, the defendant shall be liable for the costs of the action together with reasonable attorney fees as determined by the court.

(c) This section applies to any medical creditor or medical debt collector that seeks to avoid its application by any device, subterfuge, or pretense whatsoever.

(d) A consumer may bring an action for violation of this Article within four years from the date on which the violation occurred.

(e) Any consumer may sue for injunctive or other appropriate equitable relief to enforce this Article.

(f) The remedies provided in this section are not intended to be the exclusive remedies available to a consumer nor must the consumer exhaust any administrative remedies provided under this Article or any other applicable law.

(g) No MDMP or agreement between the patient and a large health care provider or medical debt collector shall contain a provision that, prior to a dispute arising, waives or has the practical effect of waiving the rights of a patient to resolve that dispute by obtaining:

(1) Injunctive, declaratory, or other equitable relief.

(2) Multiple or minimum damages as specified by statute.
(3) Attorney's fees and costs as specified by statute or as available at common law.
(4) A hearing at which that party can present evidence in person.

Any provision in a financial assistance policy or other written agreement violating this subsection shall be void and unenforceable. A court may refuse to enforce other provisions of the financial assistance policy or other written agreement as equity may require.

"**§ 131E-214.40. Prohibition of waiver of rights.**

Any waiver by any patient or other consumer of any protection provided by or any right of the patient or other consumer under this Article is void and may not be enforced by any court or any other person.

"**§ 131E-214.41. Enforcement.**

(a) The Attorney General shall have the authority to enforce this Article and may adopt any rules believed to be necessary or appropriate to effectuate the purpose of this Article, to provide for the protection of patients and their families, and to assist market participants in interpreting this Article.

(b) The Attorney General shall establish a complaint process allowing an aggrieved patient or any member of the public to file a complaint against a medical creditor or debt collector who violates any provision of this Article. All complaints shall be considered public records pursuant to Chapter 132 of the General Statutes with the exception of the complainant's name, address, or other personal identifying information.

"**§ 131E-214.42. Annual reports and database.**

(a) On or before July 1 of each year each large health care facility shall file its MDMP and an annual report with the Department of Health and Human Services pursuant to procedures that the Department shall establish. If the health care facility is required to report to the Department under G.S. 131E-214.14, that health care facility does not need to submit separate reports to satisfy each reporting requirement; the health care facility may submit one report, so long as the report contains all of the information required under this Article and G.S. 131E-214.14.

(b) The Department shall post each report and MDMP in a searchable database accessible on the internet.

(c) The Department shall consult with North Carolina's Medical Care Advisory Committee, Beneficiary Advisory Council, and Medicaid Advisory Council to develop materials to inform the public about MDMP policies. The materials shall include, at a minimum, the following information:

(1) How to find a facility's MDMP.
(2) How to apply for financial assistance and appeal assistance decisions.
(3) How to submit a complaint to the Attorney General or the Department.
(4) Any deadlines patients should be aware of related to the MDMP.
(5) The statutory eligibility and requirements for financial assistance and payment plans.

(d) Each large health care facility shall prepare an annual report to submit to the Department no later than August 1 of each year. The report shall include:

(1) The total number of patients who applied for financial assistance.
(2) The total number of patients who received financial assistance.
(3) The total number of patients that were denied financial assistance, categorized by the specific reason for denial.
(4) De-identified demographic information for patients who received financial assistance, including zip code, race, language, gender, and disability status, to the extent such information is available.

(5) The total amount of financial assistance provided to patients based on a cost to charge ratio and Medicare reimbursement rates.
(6) The types of collection practices used by the large health care facility against patients.
(7) The amount of money collected with each of these collection practices, in dollars and by percentage of the large health care provider's annual revenue.

(e) An annual consolidated report shall be prepared by the Department and a copy of the report provided to the Senate Committee on Health Care and the House Committee on Health. The report shall also be made available to the public on the Department's website no later than September 1 of each year. These reports shall include the following information for the time period of July of the prior year to July of the current year, for each large health care provider in aggregate:

(1) The total number of patients who applied for financial assistance.
(2) The total number of patients who received financial assistance.
(3) The total number of patients that were denied financial assistance, categorized by the specific reason for denial.
(4) De-identified demographic information for patients who received financial assistance, including zip code, race, language, gender, and disability status, to the extent such information is available.
(5) The total amount of financial assistance provided to patients based on a cost to charge ratio and Medicare reimbursement rates.
(6) The types of collection practices used by large health care providers against patients.
(7) The amount of money collected with each of these collection practices, in dollars and by percentage of the large health care provider's annual revenue.

"**§ 131E-214.43. Severability.**

Should a court decide that any provision of this Article is unconstitutional, preempted, or otherwise invalid, that provision shall be severed and shall not affect the validity of the Article other than the part severed.

"**§ 131E-214.44. Exemptions.**

Federally qualified health centers, as defined by section 1396d (i)(2)(B) of Title 42 of the United States Code, are exempt from G.S. 131E-214.23 through 131E-214.26, 131E-214.28, and 131E-214.40."

PART II. REMOVE LIENS FOR AMBULANCE SERVICES

SECTION 2. Article 9A and Article 9B of Chapter 44 of the General Statutes are repealed.

PART III. REMOVE UNC ABILITY TO GARNISH TAX REFUNDS FOR MEDICAL DEBT

SECTION 3. G.S. 105A-2(2) reads as rewritten:

"(2) Debt. – Any of the ~~following, except as limited in sub-subdivision (f.) of this subdivision:~~following:

…

~~f. For any school of medicine, clinical program, facility, or practice affiliated with one of the constituent institutions of The University of North Carolina that provides medical care to the general public and for The University of North Carolina Health Care System and other persons or entities affiliated with or under the control of The University of North Carolina Health Care System, the term "debt" is limited to the sum owed to one of these entities by law or by contract~~

~~following adjudication of a claim resulting from an individual's receipt of hospital or medical services at a time when the individual was covered by commercial insurance, Medicaid, Medicare, Medicare Advantage, a Medicare supplement plan, or any other government insurance.~~"

PART IV. CONFLICTS AND EFFECTIVE DATE

SECTION 4.(a) To the extent this act is in conflict with G.S. 131E-91, 131E-99, or 131E-147.1, this act shall control.

SECTION 4.(b) Section 1 of this act becomes effective June 1, 2025, and applies to medical debt collection activities occurring after that date and to agreements and contracts entered into, amended, or renewed on or after that date. The remainder of this act is effective when it becomes law.