GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2009

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SENATE DRS15150-LN-110 (3/6)

Short Title:	Health Benefit Plan Provider Contracts.	(Public)
Sponsors:	Senator Clodfelter.	
Referred to:		

A BILL TO BE ENTITLED

AN ACT TO REQUIRE CONTRACTS BETWEEN HEALTH BENEFIT PLANS AND HEALTH CARE PROVIDERS TO CONTAIN CERTAIN TERMS AND CONDITIONS.

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 Part to read:

"Part 7. Contracts between health benefit plans and health care providers.

"**§ 58-50-270. Purpose; contract provisions.**

(a) The purpose of this Part is to require that certain provisions be included in contracts between health plans and heath care providers. These requirements are in addition to any other requirements of contract provisions applicable to health benefit plans under this Chapter.

(b) The main body of the contract must include provisions of North Carolina General Statutes and regulations which materially affect the business relationship between physicians and health plans. Those provisions shall be identified by the Commissioner.

(c) Contract attachments or addenda may supplement but not amend the main body of the contract.

(d) In addition to the applicable statutory and regulatory provisions required under this Chapter, the following items must be addressed in contracts:

(1) Contract term,
(2) Termination process,
(3) Amendment process,
(4) Contact person for notices (both parties),
(5) Types of products and specific lists of all product names applicable to the contract,
(6) All rental networks and affiliated payers eligible to access the contracted network,
(7) All vendored authorization programs and delegated entities, including radiology benefit managers, vision programs, and mental health vendors, must be listed in the contract or its attachments,
(8) Conflict resolution mechanisms,
(9) Complete list, title, and order of attachments, and
(10) Specific payment provisions containing specific information as required under G.S. 58-50-276.

(e) When a new contract is executed, the contract effective date must be entered on the contract, and copies of dually signed contracts with an accurate effective date must be provided by the health plan.

(f) New physicians added to an existing contract must be provided an effective date coterminous with this credentialing effective date.

(g) The language of the contract must be clear and reasonably understandable to a health professional doing business in North Carolina.

"**§ 58-50-271. Definitions.**

Unless the context clearly requires otherwise, the following definitions apply in this Part.

(1) "Affiliated payers" – Payers eligible to access the contracted network.

(2) "Amendment" includes the following:

a. Changes in the terms of the contract, or

b. Additions or deletions in products, affiliated vendors, or rental networks, or

c. Changes in fee schedules.

(3) "Authorization vendor" – A vendor contracted by the payer to manage certain benefits within the contract. Examples include radiology benefit managers, vision programs, and mental health vendors.

(4) "Contract" – the contract between a health plan and one or more health care providers.

(5) "Delegated entity" – An entity, other than a health maintenance organization authorized to engage in business itself, or through subcontracts with one or more entities, undertakes to arrange for or provide medical care or health care to an enrollee in exchange for a predetermined payment and that accepts responsibility for performing on behalf of the health maintenance organization specific functions as applicable to a health maintenance organization.

(6) "EOB" – Explanation of Benefits provided to the individual covered under the health plan.

(7) "Health plan" – Health benefit plans as defined in G.S. 58-3-167. All fair contracting requirements apply to insurers, health benefit plans, and the State Health Plan for Teachers and State Employees.

(8) "Insurer" – as that term is defined in G.S. 58-3-167.

(9) "Rental network" –

"**§ 58-50-272. Contract termination clauses.**

(a) The contract must include a mutual termination without cause provision with 90 days' prior written notice after an initial one-year term. The termination may be coincident with the expiration of the one-year term.

(b) Termination must not be linked to a specific date or an anniversary date. Termination without cause may be at any time after the initial one-year term.

(c) The 90-day termination without cause and anniversary date provisions may be varied by mutual agreement only if the term of the agreement is three years or greater.

(d) Compensation terms, or requirements to continue to provide services, whichever term applies, will not survive termination of a contract. Continuation of coverage required by G.S. 58-67-88 shall be paid at billed charges.

(e) If the contract provides for termination for cause by either party, the contract shall state:

(1) The specific reasons that may be cited for termination for cause, which shall not be unreasonable, and

(2) The time frame and notice contact must also be specified.

"**§ 58-50-273. Notice contact provisions.**

(a) All contracts must contain a "notice contact" provision listing the name or title and address of the person to whom all contracts, administrative policies, policies and procedures, notices of material changes, termination notices, amendments, and other matters pertaining to the contractual relationship must be sent.

(b) The notice contact will be designated by the physician practice and may include a business manager, billing company, or other person as designated by the contract.

(c) There will also be a health plan notice contact designated by the health plan in the contract.

(d) Date of receipt for all notices will be calculated as five business days after the date the amendment is placed, first-class postage prepaid, in the United States mail.

"**§ 58-50-274. Contract amendments.**

(a) All contract amendments must be sent at least 90 days in advance of the amendment effective date and mailed to the notice contact designated in the contract.

(b) The amendment will be dated, labeled "Amendment," signed by the party initiating the amendment, and will include an amendment effective date.

(c) Date of receipt will be calculated as five business days after the date the amendment is placed, first-class postage prepaid, in the United States mail.

(d) The recipient of the amendment will have at least 60 days from the date of receipt to accept an amendment. Acceptance will be by signing the amendment and returning it to the initiating party.

(e) If the amendment is not accepted within 60 days, the initiating party will be entitled to terminate the agreement with 90 days' advance written notice.

(f) Additions or deletions of products or additions or deletions of affiliated payers or rental networks able to access the health plan network.

"**§ 58-50-275. Policies and procedures.**

(a) An insurer shall provide a copy of the insurer's policies and procedures to the health care provider concurrently with contracts under negotiation and new contracts, and annually to all network physician practices. The policies and procedures may be provided to the health care provider in hard copy, CD, or other electronic format, and may also be provided by posting the policies and procedures on the insurer's Web site.

(b) Policies and procedures shall not conflict with or override contract language. In the event of a conflict, the contract language will prevail.

(c) Policies and procedures shall not negatively change payment provisions of the contract or adversely affect payment amounts.

"**§ 58-50-276. Fee schedule, bundling, and contract disclosures.**

(a) Fee schedule disclosures required under G.S. 58-3-227 shall include at a minimum:

(1) The description of the service, primary fee source, or reference schedule including:

a. The version, edition or publication date, description of the payment methodology, and

b. The actual payment amount or percentage of the primary fee source or reference schedule.

(2) When payment or compensation is based on a publicly available relative value unit system (RVU system) such as the Medicare RBRVS, the contract shall identify the specific RVU system, its version, edition or publication date, any applicable conversion or geographic factors used.

(3) When payment or compensation is based on an insurer-determined fee schedule, the entire fee schedule including professional, facility, and global charges shall be identified.

(b) Health plans shall make available on their Web site a preadjudication tool that provides information to physicians regarding the manner in which its claim system adjudicates claims for specific CPT® codes or combinations of such codes.

(c) Fee schedules, methodologies, and adjudication rules under the health plan shall be provided to the health care provider within 30 days of request or concurrently during a contract negotiation.

(d) Copies of contracts and all attachments shall be provided within 30 days of request or concurrently during a contract negotiation.

(e) Lists of affiliated payers and rental networks eligible to access the contracted network shall be provided with 30 days of request or concurrently during a contract negotiation.

(f) Lists of delegated entities and authorization vendors doing business with the health plan shall be provided within 30 days of request or concurrently during a contract negotiation.

"**§ 58-50-277. Material adverse changes.**

(a) Material adverse changes to the business relationship include the following:

(1) A change in an existing reimbursement policy that decreases the physician's payment or compensation,

(2) Changes in the administrative procedures that can be expected to increase the physician's administrative expense, and

(3) Changes in authorization vendors or delegated entities.

(b) Material adverse changes also include reimbursement policy changes.

(c) An insurer shall provide 90 days' advance notice of all material adverse changes to the contract as required by G.S. 58-3-227.

"**§ 58-50-278. Accessibility standards.**

(a) Health plans must adhere to specific accessibility standards as follows:

(1) Specialty Care Services: Access to care shall be within 60 minutes in urban areas, and 90 minutes in rural areas.

(2) Primary Care Services: Access to care shall be within 30 minutes in urban areas, and 60 minutes in rural areas.

(b) The insurer shall not impose cost-sharing on patients treated by emergency nonparticipating physicians to a greater extent than the insurer would impose if the nonparticipating physicians were participating with the health plan.

(c) At the time the contract is signed or a new physician is added to an existing contract, admitting physicians must use best efforts to obtain staff privileges at a local participating hospital consistent with sound medical judgment and reasonable travel times.

"**§ 58-50-279. Physician remittance statement and EOBs for covered persons.**

(a) EOBs must include:

(1) The member name, member number, and the date of service.

(2) Amount of payment for each code for each covered person.

(3) Any adjustment to the bill submitted and an explanation for that adjustment.

(4) For nonparticipating physicians: Accurate patient responsibility amounts defined as the difference between the bill charge amount and the paid amount.

(5) For participating physicians: Accurate patient responsibility amounts defined as the difference between the contracted rate and the paid amount.

(b) Patient/member EOB and physician remittance amount must not show different patient responsibility amounts.

(c) Provider remittance statements must state clearly whether claims have been denied due to benefits, medical necessity, or other reasons.

(d) Health plans shall use standard HIPAA transaction standards re: "reason codes" on the EOB.

"**§ 58-50-280. Authorizations and appeals.**

(a) Health plans shall not deny authorizations for medical necessity and shall permit all appeals if the provider has a reasonable explanation for not obtaining the authorization and medical necessity criteria are otherwise fulfilled.

(b) When a patient is covered by two or more health plans, no secondary payer shall deny payment of any claim for which a physician has previously obtained authorization from a primary payer. If the primary payer does not require authorization, the secondary payer may not condition payment or coverage on preauthorization of such services.

(c) Secondary payers may not condition payment on the amount paid or the contracted rate of a primary payer. Any patient co-pay shall not be deducted by the secondary payer.

(d) Health plans and drug authorization vendors shall provide the name, address, and phone number of a medical director who can be contacted during business hours.

(e) Health plans and authorization vendors shall provide an online process for prior approvals and notifications.

(f) Authorization vendors shall disclose all clinical guidelines used in the decision-making process.

(g) Restate G.S. 58-3-200(c).

"**§ 58-50-281. Miscellaneous contract provisions.**

(a) Physicians shall be permitted to opt out and shall not be required to participate in all health plan products; failure to participate in a particular product cannot be a basis for termination by the health plan.

(b) Physicians may also opt out or refuse participation in a rental network or an affiliated payer; failure to participate in a particular rental network or accept an affiliated payer cannot be a basis for termination by the health plan.

(c) Contracts cannot be assigned to another health plan without the physician's written consent.

(d) Individual employment contracts, practice financial information, or other proprietary practice information shall not be required to be disclosed in a contract.

(e) Health plans cannot require most favored nations clauses in contracts requiring a physician practice to contract with it on more favorable payment terms than other health plans.

(f) After credentialing is completed, health plans shall immediately notify the practice notice contact person of the specific action taken and the effective date, if applicable.

(g) Arbitration clauses, if any, shall not require that mediation or arbitration be held in a venue outside of North Carolina and shall not be binding.

(h) Physicians shall be able to submit retroactive claims commencing from the time the credentialing application is complete if the physician's application for credentialing is accepted by the health plan.

"**§ 58-50-282. Summary disclosure form.**

Health plans shall provide a summary of physician contract provisions. The summary form shall not be part of the contract and shall have no legal effect. Elements of the summary disclosure form included:

(1) Contract duration.
(2) Contract termination provisions.
(3) Responsible party for payment.
(4) List of all affiliated payers able to access the contract.
(5) List of all products applicable to the contract.

"**§ 58-50-283. Scope.**

Nothing in this Part shall be construed to impede, reduce, or otherwise adversely affect the Commissioner's authority to enforce the provisions of this Chapter."

SECTION 2. This act becomes effective January 1, 2010, and applies to health benefit plan contracts between health benefit plan insurers and health care providers delivered, amended, or renewed on and after that date.