March 25, 2009

S 877. HEALTH BENEFIT PLAN PROVIDER CONTRACTS. Filed 3/25/09. *TO REQUIRE CONTRACTS BETWEEN HEALTH BENEFIT PLANS AND HEALTH CARE PROVIDERS TO CONTAIN CERTAIN TERMS AND CONDITIONS*.

Adds new Part 7 (Contracts between health benefit plans and health care providers) to Article 50 of Chapter 58 of the General Statutes. Adds new GS 58-50-270 to require that certain provisions be included in contracts between health plans and health care providers and specifies those provisions. Directs that the main body of the contract must include provisions of the North Carolina General Statutes and regulations which materially affect the business relationship between physicians and health plans, as identified by the Commissioner of Insurance. Directs that (1) contract attachments or addenda may supplement but not amend the main body of the contract; (2) the contract effective date must be entered on all new contracts, and copies of dually signed contracts with accurate effective dates must be provided by the health plan; (3) new physicians added to an existing contract must be provided an effective date coterminous with the credentialing effective date; and (4) the language of the contract must be clear and reasonably understandable to a health professional doing business in North Carolina.

Adds new GS 58-50-271 to define affiliated payers, amendment, authorization vendor, contract, delegated entity, EOB, health plan, and insurer. Lists rental network among the terms to be defined but does not define it.

Adds new GS 58-50-272 that specifies certain contract termination requirements and limitations.

Adds new GS 58-50-273 that specifies certain notice requirements for the contracts.

Adds new GS 58-50-274 that specifies the effective dates of sending, receiving and accepting contract amendments.

Adds new GS 58-50-275 that requires an insurer to provide to health care providers a copy of the insurer's policies and procedures concurrently with contracts under negotiation and new contracts, and annually to all network physician practices. Specifies the form for the policies and procedures and prohibits the policies and procedures from conflicting with or overriding contract language. Also prohibits polices and procedures from negatively changing payment provisions of the contract or adversely affecting payment amounts.

Adds new GS 58-50-276 that specifies certain fee schedule disclosures. Requires health plans to make available on their Web sites 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. Requires that lists of affiliated payers and rental networks eligible to access the contracted network be provided within 30 days of a request or concurrently with contract negotiations. Requires that lists of delegated entities and authorization vendors doing business with the health plan be provided within 30 days of a request or concurrently during a contract negotiation.

Adds new GS 58-50-277 to define material adverse changes to a contract.

Adds new GS 58-50-278 to specify certain accessibility standards. Prohibits an insurer from imposing cost-sharing on patients treated by emergency nonparticipating physicians to a greater extent than the insurer would impose if the nonparticipating physicians were participating in the health plan. Requires admitting physicians to use best efforts to obtain staff privileges at a local participating hospital at the time the contract is signed or a new physician is added.

Adds new GS 58-50-279 to specify certain information be included on the explanation of benefits (EOBs) and physician remittance statements.

Adds new GS 58-50-280 to specify certain requirements and limitations on authorizations and appeals.

Adds new GS 58-50-281 to (1) require that physicians be permitted to opt out and that physicians not be forced to participate in all health plan products; (2) require that physicians be able to opt out or refuse participation in a rental network or an affiliated payer; (3) specify that contracts may not be assigned to another health plan without the physician's written consent; (4) specify that individual employment contracts, practice financial information, or other proprietary practice information may not be required to be disclosed in a contract; (5) prohibit health plans form requiring most favored nations clauses in contracts requiring a physician practice to contract with it on more favorable payment terms than other health plans; (6) require health plans to

immediately notify the practice notice contact person of the specific action taken and the effective date after credentialing is completed; (7) prohibit any arbitration clauses from requiring that mediation or arbitration be held in a venue outside of North Carolina and prohibit such clauses from being binding; and (8) specifying that physicians must 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.

Adds new GS 58-50-282 requiring health plans to provide a summary of physician contract provisions with certain specified elements.

Adds new GS 58-50-283 affirming the Commissioner of Insurance's authority to enforce the provisions in Chapter 58 of the General Statutes.

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.

Intro. by Clodfelter. GS 58

May 12, 2009

S 877. HEALTH PLAN PROVIDER CONTRACTS/TRANSPARENCY (NEW). Filed 3/25/09. Senate committee substitute makes the following changes to 1st edition. Changes title to *AN ACT RELATING TO CONTRACTS BETWEEN HEALTH BENEFIT PLANS AND HEALTH CARE PROVIDERS*. Makes various changes to the proposed new statutory sections addressing definitions, notice contact provisions, contract amendments, policies and procedures, fee schedule, bundling and contract disclosures and renumbering the sections within the proposed new Part 7 to Article 50 of GS Chapter 58. The committee substitute eliminates those proposed statutory sections dealing with purpose and required contract provisions, contract termination clauses, material adverse changes, physician remittance and EOBs, authorization and appeals, miscellaneous contract provisions, summary disclosure forms, and scope of the Part. Makes organizational and technical changes.

May 13, 2009

S 877. HEALTH PLAN PROVIDER CONTRACTS/TRANSPARENCY. Filed 3/25/09. Senate amendment makes the following changes to 2nd edition. Changes proposed new 58-50-270 by amending the definition of the terms *amendment, contract*, and *insurer*, and by deleting the definitions of the terms *affiliated payer*, *affiliated vendor*, *delegated entity*, and *rental network*. Amends proposed new GS 58-50-272 by replacing subsections (b) and (c) in their entirety. Proposed new subsections (b) and (c) would give a health care provider receiving a proposed amendment to a contract 60 days within which to object to the proposed change before the change becomes effective. Allows the initiating health benefit plan or insurer the right to terminate the contract upon 60 days (was, 90 days) written notice to the health care provider if the provider rejects the amendment within 60 days.

Requires the health benefit plan or insurer to provide a copy of its policies and procedures to a provider prior to execution of a new or amended contract (was, concurrently when initiating negotiation of a new or amended contract).

July 27, 2009

SL 2009-352 (S 877). HEALTH PLAN PROVIDER CONTRACTS/TRANSPARENCY. *AN ACT RELATING TO CONTRACTS BETWEEN HEALTH BENEFIT PLANS AND HEALTH CARE PROVIDERS.* Summarized in *Daily Bulletin* 3/25/09, 5/12/09, and 5/13/09. Enacted July 27, 2009. Effective January 1, 2010.