**GENERAL ASSEMBLY OF NORTH CAROLINA**
**SESSION 2009**

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# SENATE BILL 877
# PROPOSED COMMITTEE SUBSTITUTE S877-PCS75257-SQ-34

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| Short Title: | Health Plan Provider Contracts/Transparency. | (Public) |
| Sponsors: | | |
| Referred to: | | |

March 26, 2009

A BILL TO BE ENTITLED

AN ACT RELATING TO CONTRACTS BETWEEN HEALTH BENEFIT PLANS AND HEALTH CARE PROVIDERS.

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. Definitions.**

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

(1) "Affiliated payer" – A health benefit plan, employer, or insurer eligible to access contracted network of another health benefit plan or insurer.

(2) "Amendment" – An amendment includes any of the following:

a. Changes in the terms of the contract;

b. Additions or deletions in products, affiliated vendors, or rental networks associated with a contract;

c. Changes in fee schedules;

d. Changes in the policies or procedures of a health plan or insurer that decreases a health care provider's aggregate compensation under a contract;

e. Changes in the policies and procedures of a health plan or insurer that increase administrative expenses for a health care provider.

(3) "Affiliated vendor" – A vendor contracted by a health benefit plan or insurer to manage certain benefits applicable to a health care provider's contract.

(4) "Contract" – An agreement between a health benefit plan or insurer 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, undertaking 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) "Health benefit plan" – A policy, certificate, contract, or plan as defined in G.S. 58-3-167.

(7) "Insurer" – An entity as defined in G.S. 58-3-167.

(8) "Rental network" – Networks of participating providers offered to employers, insurers, and other parties not in direct contractual relationship with participating provider.

"**§ 58-50-271. Notice contact provisions.**

(a) All contracts shall contain a "notice contact" provision listing the name or title and address of the person to whom all correspondence, including proposed amendments and other notices, pertaining to the contractual relationship between parties shall be provided. Each party to a contract shall designate its notice contact under such contract.

(b) Date of receipt for all notices provided under a contract shall be calculated as five business days following the date the notice is placed, first-class postage prepaid, in the United States mail.

"**§ 58-50-272. Contract amendments.**

(a) A health benefit plan or insurer shall send any proposed contract amendment to the notice contact of a health care provider pursuant to G.S. 58-50-271. The proposed amendment shall be dated, labeled "Amendment," signed by the health benefit plan or insurer, and include an effective date for the proposed amendment.

(b) A health care provider receiving a proposed amendment shall be given at least 60 days from the date of receipt to accept the proposed amendment. Acceptance of a proposed amendment shall only be effective upon the health care provider signing the amendment and returning it to the initiating health benefit plan or insurer.

(c) If a health care provider does not accept a proposed amendment within 60 days, then the initiating health benefit plan or insurer shall be entitled to terminate the contract upon 90 days' written notice to the health care provider.

"**§ 58-50-273. Policies and procedures.**

(a) A health benefit plan or insurer shall provide a copy of its policies and procedures to a health care provider concurrently when initiating negotiation of a new or amended contract and annually to all contracted health care providers. Such 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 Web site of the health plan or insurer.

(b) The policies and procedures of a health benefit plan or insurer shall not conflict with or override any term of a contract, including contract fee schedules. In the event of a conflict between a policy or procedure and the language in a contract, the contract language shall prevail.

"**§ 58-50-274. 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 Resource-Based Relative Value Scale, the contract shall identify the specific RVU system, its version, edition, or publication date, and 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 fees shall be identified.

(b) Health benefit plans and insurers shall make available on their Web site a pre-adjudication tool that provides information to providers regarding the manner in which its claim system adjudicates claims for specific Current Procedural Terminology codes or combinations of such codes.

(c) When a health benefit plan or insurer offers a contract to a health care provider, or upon written request by a contracted health care provider, the health benefit plan or insurer shall provide the following information:

(1) A copy of any new or existing contract and its attachments;

(2) Fee schedules, methodologies, and adjudication rules applicable to any new or existing contract;

(3) A list of affiliated payers and rental networks eligible to access a health care provider's negotiated fees under a contract;

(4) A list of delegated entities and affiliated vendors doing business with the health benefit plan or insurer.

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