

## Managed Care Regulation

Every year, the North Carolina Medical Society (NCMS) works diligently to eliminate unfair business practices by managed care companies. Over the past several sessions of the General Assembly, the NCMS has successfully led legislative efforts to:

- Require health plans to process health claims in a 30-day period
- Establish a managed care 'Patient's Bill of Rights'
- Require health plans to use a standardized form when credentialing physicians
- Require the Department of Insurance to create a uniform provider credentialing application form
- Limit the time a health plan can recoup alleged overpayment to two years
- Require health plans to use a standard insurance card

In addition to legislative efforts, the NCMS has been involved in several lawsuits against managed care companies in order to change their unfair and unlawful business practices. These suits involve Aetna, Blue Cross Blue Shield, Cigna, HealthNet Inc. Humana, and, most recently United Healthcare.

### 2009 Legislative Action

#### Health Plan Fair Contracting

In 2008, the NC Medical Group Managers Association (NCMGMA), working together with the NCMS, developed a proposal to address a number of perennial problems physicians face when contracting with health plans. Many of these problems persist because of the imbalance in bargaining power between medical groups and health plans. Health plans have significant, and ever-increasing, market concentration, placing doctors in a bargaining position that affords little leverage to negotiate contract provisions that are fair. SB 877 – Health Plan Provider Contracts/Transparency - incorporated all of the major provisions developed by the NCMGMA and NCMS. The bill drew stiff opposition from the health plans. In response, medical specialty groups and health care interests formed a coalition to push for passage of SB 877. The final bill, while leaving many of the original provisions for future consideration, addresses several key issues related to contracts between health plans and physician offices. The focus of the final version, which takes effect on January 1, 2010, is to prevent health plans from unilaterally amending physician contracts that affect the fee schedule. To this end, the bill's key 31 provisions include: (1) the health plan must allow the physician to designate a "notice contact", i.e., the name or title and address of persons to receive amendments and other notices from the health plan, (2) requiring that physician receive proposed amendments at least 60 days in advance of the effective date with the health care provider having 60 days to object to the proposed amendment, in which case the amendment will take effect, (3) the health plan must provide the physician with copies of policies and procedures, and (4) a statement that if policies and

procedures conflict with health plan contracts, including contract fee schedules, the contract language will prevail.

### **Provider Credentialing**

Although insurers are required to credential physicians and other providers within 60 days, if the credentialing application has not been acted on within that time period there is little recourse. HB 1297 – Provider Credentials/Insurer Contracts – revised the Uniform Provider Credentialing Statute to require the issuance of temporary credentials if there has been no action, thereby permitting the providers to be reimbursed for patient care, with certain exceptions if the physician has a serious impediment to his/her eventual credentialing. This law goes into effect January 1, 2010.

### **Recovery of Overpayment by Insurers**

In 2008 insurers were limited to refund demands made not more than two years from the date of the original claims payment, unless there was a reasonable belief of fraud. House Bill 1485 – Insurance/Health Care Provider Relationship - extends the notification of overpayment recovery from 30 to 90 days, and requires detailed documentation of the overpayment including the patient name and identification number, the service date, the payment amount, and an explanation of the proposed revised payment amount. Detailed documentation is not required if there is documented evidence of fraud or other intentional misconduct by the health care provider or health care facility or its agents. The insurer is required to offer an internal appeal process which shall stay the offsetting of past claims to future claims payments. This bill passed the House and was referred to Senate Committee on Commerce, Small Business, and Entrepreneurship and can be considered during the 2010 Session.