United HealthCare Agreement
June 3, 2004

1. Introductory Letter:

- Please note that this agreement will replace all other agreements with United.
- The letter references "sample schedules of allowables." According to the North Carolina disclosure law (H1066, attached), the sample fees should include at least the top 30 most commonly billed fees, with the remainder upon request. Since many physicians have been unable to obtain more than 25 fees from United for several years, it may be difficult to verify that there has been no change in the reimbursement levels without obtaining a complete list of current fees. We also understand that some contracts were mailed without fee lists.
- If you are currently participating with United, it appears that signing of the new agreement will automatically enroll you as a participating physician in the Medicare product.
- Non-participating physicians must sign the amendment to the agreement in order to participate in the Medicare product.
- It is unclear what will occur if you do not return the new agreement by July 15, 2004. This is obviously not sufficient time to negotiate fees, correct fees that are not accurately reported or to negotiate the terms of the contract.
- Please note that physicians have repeatedly reported that they are not paid if they do not "notify" United of inpatient stays. Thus, it is not completely accurate to say that United will pay for the care so long as it is a covered benefit. All notification procedures must be followed.

2. Introduction

- We do not believe this section has any legal effect.
- Most of these provisions are required by case law, i.e. physicians have an obligation to discuss treatment options with patients regardless of payment.
- Despite the extensive list of issues that physicians are encouraged to discuss, there is no "permission" for physicians making disparaging remarks about United or its health plans.
- As the language reflects, benefit language including limitations take precedence over medical necessity or other considerations.
- When you call the number listed under Next Steps you are directed to the United website.

3. Physician Contract

- Since the language re: affiliates and products is vague, there is nothing to prohibit United from selling this network to another health plan, or from offering a non-insurance product (such as a "discount card") wherein your

discounts will be offered to people even if there is no underlying insurance product.

- This sentence doesn't make sense: "This agreement applies to you and the services you provide in all of your practice arrangements and for all of your tax identification numbers, except if your services are covered under an agreement between us and a medical group that you are part of."
- The credentialing plan needs to be in accordance with the North Carolina Uniform Credentialing Law and associated regulations.
- Please note the notification requirement.
- Within one year--physician must conduct business entirely on an electronic basis. It is unclear whether this refers to claims, or to all transactions (HIPAA transactions include Health Care Claims and Information, Encounter Information, Referral Certification and Authorization, Coordination of Benefits, Health Care Claim Status (Payment and Remittance Advice), Health Plan Enrollment and Disenrollment, Health Plan Eligibility.) This will be defined by United, and may require acquisition of new software in physician's offices.
- Claims must supply "all applicable information." This should be defined under HIPAA, but appears open-ended in this agreement. There is no provision for limiting requests for medical records.
- The list of reasons under which physician's cannot bill patients include "based on our reimbursement policies and methodologies." Thus United will control whether you can bill a patient. There are no provisions re: what type of notification is required to the patient that the service may not be covered (frequently payors require this in writing). This may be discussed in the policies and procedures (and may include onerous written requirements).
- Please note that United has not committed to CMS coding conventions when describing fee schedule updates. HB 1066 in North Carolina requires that physician offices are notified of fee schedule changes.
- Refund demands apparently will be made within one year in the absence of fraud, this is an improvement in their current refund policies.
- Does the timing requirement at the top of page four mean that there will be a gap in participation for currently participating physicians?
- We are opposed to amendment processes that do not require the affirmative signature of the physician. Similarly, termination should be within 30 days without cause and should not be tied to an anniversary date.
- We believe arbitration requirements to be extremely detrimental to physicians because they preclude the possibility of filing a lawsuit if all arbitration procedures are not followed. Similarly, agreeing waiving a trial by jury is a prior restraint on constitutional rights.
- The phrase "we do not" seems misplaced or incomplete.
- United is not guaranteeing payment by self insured employers or other "non-affiliated" entities. Thus, they can "sell" the network and not be responsible for payment.
- Apparently, the MAMSI contracts will be retained.

<u>Appendix 2</u>

- Please note that you are being asked to participate in networks even when there is no financial steering mechanism whatsoever.

<u>Appendix 3</u>

- NCMS has previously complained to the North Carolina Department of Insurance about United's failure to integrate North Carolina regulatory requirements into the main body of the contract. As it now stands, it is impossible to

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2003

SESSION LAW 2003-369
HOUSE BILL 1066

AN ACT TO FACILITATE THE SUBMISSION OF COMPLETE CLAIMS BY PROVIDERS UNDER HEALTH BENEFIT PLANS BY REQUIRING HEALTH BENEFIT PLANS TO DISCLOSE TO CONTRACT PROVIDERS THE PLANS' SCHEDULES OF FEES AND CLAIMS SUBMISSION AND REIMBURSEMENT POLICIES, AND TO PROVIDE NOTICE TO THE PROVIDER PRIOR TO IMPLEMENTING CHANGES TO THE SCHEDULES OR POLICIES.

The General Assembly of North Carolina enacts:

SECTION 1. Article 3 of Chapter 58 of the General Statutes is amended by adding a new section to read:

"**§ 58-3-227. Health p lans fee schedules.**

(a) Definitions. - As used in this section, the following terms mean:

(1) Claim submission policy. - The procedure adopted by an insurer and used by a provider or facility to submit to the insurer claims for services rendered and to seek reimbursement for those services.

(2) Health care facility or facility. - A facility that is licensed under Chapter 131E or Chapter 122C of the General Statutes or is owned or operated by the State of North Carolina in which health care services are provided to patients.

(3) Health care provider or provider.- A n individual who is licensed, certified, or otherwise authorized under Chapter 90 or Chapter 90B of the General Statutes or under the laws of another state to provide health care services in the ordinary course of business or practice of a profession or in an approved education or training program.

(4) Insurer. - An entity that writes a health benefit plan and that is an insurance company subject to this Chapter, a service corporation under Article 65 of this Chapter, a health maintenance organization under Article 67 of this Chapter, or a multiple employer welfare arrangement under Article 49 of this Chapter, except it does not include an entity that writes stand alone dental insurance.

(5) Reimbursement policy. - Information relating to payment of providers and facilities including policies on the following:

a. Claims bundling and other claims editing processes.

b. Recognition or nonrecognition of CPT code modifiers.
c. Downcoding of services or procedures.
d. The definition of global surgery periods.
e. Multiple surgical procedures.
f. Payment based on the relationship of procedure code to diagnosis code.

(6) Schedule of fees. – CPT, HCPCS, ICD-9-CM codes, ASA codes, modifiers, and other applicable codes for the procedures billed for that class of provider.

(b) Purpose. – The purpose of this section is to establish the minimum required provisions for the disclosure and notification of an insurer's schedule of fees, claims submission, and reimbursement policies to health care providers and health care facilities. Nothing in this section shall supercede (i) the schedule of fees, claim submission, and reimbursement policy terms in an insurer's contract with a provider or facility that exceed the minimum requirements of this section nor (ii) any contractual requirement for mutual written consent of changes to reimbursement policies, claims submission policies, or fees. Nothing in this section shall prevent an insurer from requiring that providers and facilities keep confidential, and not disclose to third parties, the information that an insurer must provide under this section.

(c) Disclosure of Fee Schedules. – An insurer shall make available to contracted providers the following information:

(1) The insurer's schedule of fees associated with the top 30 services or procedures most commonly billed by that class of provider, and, upon request, the full schedule of fees for services or procedures billed by that class of provider, in accordance with subdivision (3) of this subsection.
(2) In the case of a contract incorporating multiple classes of providers, the insurer's schedule of fees associated with the top 30 services or procedures most commonly billed for each class of provider, and, upon request, the full schedule of fees for services or procedures billed for each class of provider, in accordance with subdivision (3) of this subsection.
(3) If a provider requests fees for more than 30 services and procedures, the insurer may require the provider to specify the additional requested services and procedures and may limit the provider's access to the additional schedule of fees to those associated with services and procedures performed by or reasonably expected to be performed by the provider. The insurer may also limit the frequency of requests for the additional

codes by each provider, provided that such additional codes will be made available upon request at least annually and at any time there are changes for which notification is required pursuant to subsection (f) of this section.

(d) Disclosure of Policies. – An insurer shall make available to contracted providers and facilities a description of the insurer's claim submission and reimbursement policies.

(e) Availability of Information. – Insurers shall notify contracted providers and facilities in writing of the availability of information required or authorized to be provided under this section. An insurer may satisfy this requirement by indicating in the contract with the provider the availability of this information or by providing notice in a manner authorized under subsection (f) of this section for notification of changes.

(f) Notification of Changes. – Insurers shall provide advance notice to providers and facilities of changes to the information that insurers are required to provide under this section. The notice period for a change in the schedule of fees, reimbursement policies, or submission of claims policies shall be the contractual notice period, but in no event shall the notices be given less than 30 days prior to the change. An insurer is not required to provide advance notice of changes to the information required under this section if the change has the effect of increasing fees, expanding health benefit plan coverage, or is made for patient safety considerations, in which case, notification of the changes may be made concurrent with the implementation of the changes. Information and notice of changes may be provided in the medium selected by the insurer, including an electronic medium. However, the insurer must inform the affected contracted provider or facility of the notification method to be used by the insurer and, if the insurer uses an electronic medium to provide notice of changes required under this section, the insurer shall provide clear instructions regarding how the provider or facility may access the information contained in the notice.

(g) Reference Information. – If an insurer references source information that is the basis for a schedule of fees, reimbursement policy, or claim submission policy, and the source information is developed independently of the insurer, the insurer may satisfy the requirements of this section by providing clear instructions regarding how the provider or facility may readily access the source information or by providing for actual access if agreed to in the contract between the insurer and the provider.

(h) Contract Negotiations. – When an insurer offers a contract to a provider, the insurer shall also make available its schedule of fees associated with the top 30 services or procedures most commonly billed by that class of provider. Upon the request of a provider, the insurer shall also make available the full schedule of fees for services or procedures billed by that class of provider or for each class of provider in the case of a contract incorporating multiple classes of providers. If a provider requests fees for more than

services and procedures, the insurer may require the provider to specify the additional requested services and procedures and may limit the provider's access to the additional schedule of fees to those associated with services and procedures performed by or reasonably expected to be performed by the provider.

(i) Exemptions. – Except for the information required to be provided under subsection (c) of this section, this section does not apply to:

(1) Claims processed by an insurer on a claims adjudication system that was implemented prior to January 1, 1982, provided that the insurer (i) verifies with the Commissioner that its claims adjudication system qualified under this subsection, (ii) is implementing a new claims adjudication software system, and (iii) is proceeding in good faith to move all insured claims to the new system as soon as possible and in any event no later than December 31, 2004; or

(2) Information that the insurer verifies with the Commissioner is required to be provided by the terms of a national settlement agreement between the insurer and trade associations representing certain providers, provided that the agreement is approved prior to March 1, 2004, by the court having jurisdiction over the settlement. The exemption provided in this subdivision shall be limited to those terms of the agreement that are required to be implemented no later than December 31, 2004. Nothing in this subdivision shall be construed to relieve the insurer of complying with any terms and deadlines as set out in the agreement."

SECTION 2. On or before the applicable effective dates, each insurer shall provide to the Commissioner of Insurance a written description of the policies and procedures to be used by the insurer to comply with this act.

SECTION 3. Sections 2 and 3 of this act are effective when they become law. Subsection (c) of G.S. 58-3-227, as enacted by Section 1 of this act, becomes effective January 1, 2004, and applies to the earlier of the following: (i) a contract issued, renewed, or modified on or after January 1, 2004; or (ii) any fee schedule request made on or after July 1, 2004. The remainder of this act becomes effective March 1, 2004. Subsection (i) of G.S. 58-3-227 as enacted by Section 1 of this act, expires on January 1, 2005.

In the General Assembly read three times and ratified this the 18th day of July, 2003.