GENERAL ASSEMBLY OF NORTH CAROLINA
1985 SESSION

CHAPTER 735
HOUSE BILL 1037

AN ACT TO ENABLE HOSPITAL, MEDICAL AND DENTAL SERVICE CORPORATIONS, INSURERS AND PERSONS TO ENGAGE IN HEALTH CARE COST CONTAINMENT ACTIVITIES.

The General Assembly of North Carolina enacts:

Section 1. The purpose of this act is to authorize corporations organized pursuant to Chapter 57 of the General Statutes, insurers and persons subject to the provisions of Chapter 58 of the General Statutes and persons arranging for the provisions of health care benefits on a fee for service basis to seek, experiment, and implement innovative means of reducing the costs of health care services to persons who are members of or covered by such plans, policies or certificates. Therefore, the General Assembly declares that innovation in the reimbursement mechanisms for health care services and the implementation of reducing such costs is a public good which advances the general welfare of the citizens of this State.

Sec. 2. G.S. 57-1 is amended by the addition of the following paragraph immediately prior to the final paragraph of the section:

"The term 'preferred provider' as used in this Chapter with respect to contracts, organizations, policies or otherwise means a health care service provider who has agreed to accept, from a corporation organized for the purposes authorized by this Chapter or other applicable law, special reimbursement terms in exchange for providing services to beneficiaries of a plan administered pursuant to this Chapter. Except to the extent prohibited either by G.S. 57-16.1 or by regulations promulgated by the Department of Insurance not inconsistent with this Chapter, the contractual terms and conditions for special reimbursement shall be those which the corporation and preferred provider find to be mutually agreeable."

Sec. 3. Chapter 57 of the General Statutes is amended by adding a new Section 57-16.1 as follows:

"**§ 57-16.1. Preferred provider contracts.–**(a) Notwithstanding any other provisions of law, except the second and third paragraphs of G.S. 58-260, corporations organized for the purposes of this Chapter are authorized to enter into preferred provider contracts in addition to all other contracts authorized by this Chapter, or to enter other cost containment arrangements approved by the Commissioner of Insurance, with persons, entities or organizations for the purpose of reducing the costs of providing health care services. Such preferred provider contracts may be entered into with licensed institutions and practitioners of all types without regard to speciality of services or limitation to a specific type of practice.

(b) The Department of Insurance shall have authority to make rules applicable to corporations offering preferred provider plans, policies, or contracts pursuant to this section. These rules shall be designed to provide for (i) accessibility of preferred provider services to individuals comprising the insured or contracted group, (ii) the adequacy of the number and locations of institutions and practitioners, (iii) the availability of services at reasonable times, and (iv) financial solvency.

(c) The Department of Insurance shall require each corporation developing preferred provider plans, policies or contracts under this section to provide summary data regarding the financial reimbursement offered to providers. Any corporation which proposes to offer preferred provider plans, contracts or policies authorized by this section shall furnish annually to the Department of Insurance the following information:

(1) the name by which the preferred provider plan, policy or contract will be known, and its business address;

(2) the name, address and nature of any separate organization which administers the plan, policy or contract on behalf of the insured; and

(3) the names and addresses of all providers designated by the corporation and the terms of the agreements with these providers.

(d) A person enrolled in a preferred provider plan may obtain covered health care services from a provider not participating in the plan. The preferred provider plan may, however, limit the coverage for health care services obtained from a provider not participating in the plan. Preferred provider policies or contracts offered pursuant to this section shall provide for payment for services rendered by non-participating providers. Such payment may differ from that provided to participating providers in the discretion of the corporation. Non- participating providers may participate in other arrangements with the corporation, but will be subject to reimbursement mechanisms approved by the corporation including, but not limited to, direct payment of health insurance benefits to the subscriber without right of assignment to the provider of health care services.

(e) Upon the initial offering of a preferred provider plan to the public, any potential provider institutions and practitioners shall be allowed the opportunity to submit a proposal for participation in accordance with the terms of the plan. The health care providers shall have at least thirty (30) days to submit a proposal for participation. Subsequent to the initial offering of a preferred provider plan, any provider seeking to submit a proposal may be permitted to do so. The second and third paragraphs of G.S. 58-260 are specifically made applicable to preferred provider plans.

(f) Any provision of a contract between a corporation and a provider restricting the provider's right to enter into preferred provider arrangements with other parties is prohibited. Any such restriction in a preferred provider contract between a corporation and a provider of health care services is null and void and shall not be enforceable; however, the existence of any such unenforceable restriction shall not invalidate any other provision of the preferred provider contract.

(g) Any corporation marketing a preferred provider plan to subscribers or contracting parties must provide to the same a written list of the then current participating institutions and practitioners in the geographic area in which it is anticipated that the substantial portion of health care services will be provided prior to

entering into a preferred provider plan contract with the actual or potential subscriber or contracting party.

(h) Publications or advertisements of preferred providers shall not refer to the quality or efficiency of the health care services of non-participating providers."

Sec. 4. Article 27 of Chapter 58 of the General Statutes of North Carolina is amended by adding two new sections to read:

"**§ 58-260.5. Preferred provider; definition.–**The term 'preferred provider' as used in this Chapter with respect to contracts, organizations, policies or otherwise means a person, who has contracted for, or a provider of health care services who has agreed to accept special reimbursement or other terms for health care services from any person; or an insurer subject to the provisions of this Chapter or other applicable law for health care services on a fee for service basis, or in exchange for providing health care services to beneficiaries of a plan administered pursuant to this Chapter. Except where specifically prohibited either by G.S. 58-260.6 or by regulations promulgated by the Department of Insurance, not inconsistent with this Chapter, the contractual terms and conditions for special reimbursements shall be those which the insurer, health care provider and the preferred provider find to be mutually agreeable.

"**§ 58-260.6. Preferred provider contracts.–**(a) Notwithstanding any other provisions of law, except the second and third paragraphs of G.S. 58-260, corporations organized pursuant to this Chapter are authorized to enter into preferred provider contracts in addition to all other contracts authorized by this Chapter, or to enter other cost containment arrangements approved by the Commissioner of Insurance, with persons, entities or organizations for the purpose of reducing the cost of providing health care services. Such preferred provider contracts may be entered into with licensed institutions and practitioners of all types without regard to specialty of services or limitation to a specific type of practice.

(b) The Department of Insurance shall have authority to make rules applicable to persons offering preferred provider plans, policies, or contracts pursuant to this section. These rules shall be designed to provide for (i) accessibility of preferred provider services to individuals comprising the insured or contracted group, (ii) the adequacy of the number and locations of institutions and practitioners, (iii) the availability of services at reasonable times, and (iv) financial solvency.

(c) The Department of Insurance shall require each preferred provider plan to provide summary data regarding the financial reimbursement offered to providers of health care. All such plans shall disclose annually the following information:

(1) the name by which the preferred provider plan policy or arrangement is known, and its business address;

(2) the name, address and nature of any separate organization which administers the plan, policy or arrangement on behalf of the preferred provider; and

(3) the names and addresses of all providers of health care designated by the preferred provider and the terms of the agreements entered into with those providers.

(d) A person enrolled in a preferred provider plan may obtain covered health care services from a provider not participating in the plan. The preferred provider plan may, however, limit the coverage for health care services obtained from a provider not participating in the plan. Preferred provider policies or contracts offered pursuant to this section shall provide for payment for services rendered by non-participating providers. Such payment may differ from that provided to participating providers in the discretion of the corporation. Non- participating providers may participate in other arrangements with the preferred provider, but will be subject to the provider's approved reimbursement mechanisms including, but not limited to, direct payment of health insurance benefits to the subscriber without right of assignment to the provider of health care services.

(e) Upon the initial offering of a preferred provider plan to the public, any potential provider institutions and practitioners shall be allowed the opportunity to submit a proposal for participation in accordance with the terms of the plan. The health care providers shall have at least thirty (30) days to submit a proposal for participation. Subsequent to the initial offering of a preferred provider plan, any provider seeking to submit a proposal may be permitted to do so. Any provider seeking to participate in the plan, whether upon the initial offering or subsequently, may be permitted to do so in the discretion of the preferred provider plan. The second and third paragraphs of G.S. 58-260 are specifically made applicable to preferred provider plans.

(f) Any provision of a contract between a preferred provider plan and a health care provider restricting the health care providers's right to enter into preferred provider arrangements with other parties is prohibited. Any such restriction in a preferred provider contract between a preferred provider plan and a provider of health care services is null and void and shall not be enforceable. The existence of any such unenforceable restriction shall not invalidate any other provision of the preferred provider contract.

(g) A list of the current participating health care providers in the geographic area in which a substantial portion of health care services will be available shall be provided to enrollees and contracting parties.

(h) Publications or advertisements of preferred providers plans or arrangements shall not refer to the quality or efficiency of the services of non-participating providers."

Sec. 5. If any section, term or provision of this act shall be adjudged invalid for any reason, such judgment shall not affect, impair or invalidate any other section, term or provision of this act, but the remaining sections, terms and provisions shall be and remain in full force and effect.

Sec. 6. This act shall become effective October 1, 1985.

In the General Assembly read three times and ratified, this the 12th day of July, 1985.