2018 Regular Session

HOUSE BILL NO. 556

BY REPRESENTATIVE TALBOT

## INSURANCE/HEALTH: Provides relative to out-of-network balance billing

1	AN ACT
2	To amend and reenact R.S. 22:1875 and 1880(B)(1) and (D) and to enact R.S. 22:1880.1,
3	relative to out-of-network balance billing; to define key terms; to provide for
4	reimbursement rates; to prohibit balance billing for emergency services; to require
5	balance billing disclosures; to provide for mediation; and to provide for related
6	matters.
7	Be it enacted by the Legislature of Louisiana:
8	Section 1. R.S. 22:1875 and 1880(B)(1) and (D) are hereby amended and reenacted
9	and R.S. 22:1880.1 is hereby enacted to read as follows:
10	§1875. Billing by noncontracted facility-based physicians providers providing
11	services in a base health care healthcare facility
12	If a facility-based physician who is a noncontracted health care provider
13	provides health care services in a base health care facility to an enrollee or insured
14	and files a claim with a health insurance issuer for such facility-based services, the
15	health insurance issuer shall provide the facility-based physician with an explanation
16	of benefits as to any payment determination thereof. Nothing contained in this
17	Subpart shall supercede the provisions of R.S. 22:263(D).
18	A. For purposes of this Section, "facility-based provider" means a provider
19	who provides healthcare services to patients who are in an in-patient or ambulatory
20	facility, including services such as pathology, anesthesiology, emergency room care,

CODING: Words in struck through type are deletions from existing law; words <u>underscored</u> are additions.

1	radiology, or other services provided in an in-patient or ambulatory facility setting.
2	These healthcare services are typically arranged by the facility by contract or
3	agreement with the facility-based provider as part of the facility's general business
4	operations, and a covered person or the covered person's health benefit plan
5	generally does not specifically select or have a choice of providers from which to
6	receive the services within the facility.
7	B.(1) A health insurance issuer shall remit a reasonable reimbursement for
8	covered healthcare services provided by a noncontracted facility-based provider
9	within a contracted healthcare facility.
10	(2) In the absence of an agreed to reimbursement amount between the
11	facility-based noncontracted healthcare provider and the health insurance issuer,
12	reimbursement determined using the benchmark calculation of Subsection C of this
13	Section shall be presumed to be a reasonable reimbursement amount.
14	(3) Nothing in this Section shall be construed to require a health insurance
15	issuer to make any direct payment to a healthcare provider.
16	(4) Noncontracted facility-based providers who object to any payment made
17	pursuant to this Subsection may request a mediation of the settlement of the claim
18	pursuant to R.S. 22:1880.1.
19	C. The benchmark amount shall be calculated as the lesser of the following:
20	(1) One hundred percent of the current Medicare payment rate for the same
21	or similar services in the same or similar geographic area.
22	(2) The healthcare provider's actual charges.
23	(3) The median rate paid for services rendered by a contracted provider for
24	the same or similar services in the same or similar geographic area.
25	D. Payment of a reasonable reimbursement amount either individually or
26	collectively by the health insurance issuer and the covered person shall have the
27	effect of prohibiting the provider from collecting any additional amount for the
28	healthcare services rendered.

1	E. For out-of-network emergency services, the noncontracted facility-based
2	provider shall include a statement, in accordance with R.S. 22:1880(D)(2), on any
3	billing notice sent to the covered person for services provided informing the covered
4	person that he or she is responsible for paying their applicable in-network cost
5	sharing amount, but has no legal obligation to pay the remaining balance.
6	F. Noncontracted facility-based providers who do not provide a covered
7	person with a payment responsibility notice, pursuant to R.S. 22:1880, shall not
8	balance bill the covered person.
9	G. Nothing in this Section shall be construed to preclude a covered person
10	from agreeing to accept and pay the bill received from the noncontracted
11	facility-based provider.
12	H. A healthcare facility shall require through the facility's contracts with
13	healthcare providers that do not participate in a health insurance issuer's provider
14	network that the noncontracted providers comply with the requirements of this
15	Section.
16	I. The provisions of this Section shall not be construed to preclude a health
17	insurance issuer and an out-of-network facility-based provider from agreeing to a
18	separate payment arrangement.
19	* * *
20	§1880. Balance billing disclosure
21	* * *
22	B.(1) Health insurance issuer disclosure requirements. Each health
23	insurance issuer shall provide the following balance billing disclosure notice:
24	"NOTICE
25	HEALTH CARE SERVICES MAY BE PROVIDED TO YOU AT A
26	NETWORK HEALTH CARE FACILITY BY FACILITY-BASED
27	PHYSICIANS PROVIDERS WHO ARE NOT IN YOUR HEALTH PLAN.
28	YOU MAY BE RESPONSIBLE FOR PAYMENT OF ALL OR PART OF
29	THE FEES FOR THOSE OUT-OF-NETWORK SERVICES, IN ADDITION

1	TO APPLICABLE AMOUNTS DUE FOR CO-PAYMENTS,
2	COINSURANCE, DEDUCTIBLES, AND NON-COVERED SERVICES.
3	SPECIFIC INFORMATION ABOUT IN-NETWORK AND OUT-OF-
4	NETWORK FACILITY-BASED <del>PHYSICIANS</del> <u>PROVIDERS</u> CAN BE
5	FOUND AT THE WEBSITE ADDRESS OF YOUR HEALTH PLAN OR
6	BY CALLING THE CUSTOMER SERVICE TELEPHONE NUMBER OF
7	YOUR HEALTH PLAN".
8	* * *
9	D. Facility-based physicians providers disclosure requirements. Whenever
10	a facility-based <del>physicians</del> provider bills a patient who has health insurance coverage
11	issued by a health insurance issuer that does not have a contract with the facility-
12	based physician, the facility-based physicians provider shall send a bill that includes
13	all of the following items:
14	(1) When the bill is for nonemergency services:
15	(1) (a) An itemized listing of the services and supplies provided by the
16	facility-based physicians provider along with the dates such the services and supplies
17	were provided.
18	(2) (b) The amount that is owed by the enrollee or insured and the following
19	language conspicuously displayed on the front of such the bill:
20	"NOTICE: THIS IS A BILL. BASED UPON INFORMATION FROM
21	YOUR HEALTH PLAN, YOU OWE THE AMOUNT SHOWN
22	AT THIS TIME, YOU ARE RESPONSIBLE FOR PAYING YOUR
23	APPLICABLE COST-SHARING OBLIGATION, INCLUDING
24	COPAYMENT, COINSURANCE, OR DEDUCTIBLE AMOUNT, JUST AS
25	YOU WOULD BE IF THE PROVIDER IS WITHIN YOUR HEALTH
26	PLAN'S NETWORK. WITH REGARD TO THE REMAINING BALANCE,
27	YOU HAVE TWO CHOICES: 1) YOU MAY CHOOSE TO PAY THE
28	BALANCE OF THE BILL OR 2) IF THE DIFFERENCE IN THE BILLED
29	CHARGE AND THE PLAN'S ALLOWABLE AMOUNT IS MORE THAN

Page 4 of 7

1	FIVE HUNDRED DOLLARS, YOU MAY SEND THE BILL TO YOUR
2	HEALTH PLAN FOR PROCESSING PURSUANT TO THE HEALTH
3	INSURER'S NONCONTRACTED FACILITY-BASED PROVIDER
4	BILLING PROCESS OR THE PROVIDER MEDIATION PROCESS
5	<u>REQUIRED BY R.S. 22:1880.1</u> ".
6	(3) (c) A telephone number to call to discuss the statement.
7	(2) When the bill is for emergency services:
8	(a) An itemized listing of the services and supplies provided by the
9	facility-based provider along with the dates such services and supplies were
10	provided.
11	(b) The amount that is owed by the enrollee or insured and the following
12	language conspicuously displayed on the front of such bill:
13	"NOTICE: THIS IS A BILL. BASED UPON INFORMATION FROM
14	YOUR HEALTH PLAN, YOU OWE THE AMOUNT SHOWN, WHICH IS
15	YOUR APPLICABLE IN-NETWORK COST SHARING AMOUNT. YOU
16	HAVE NO LEGAL OBLIGATION TO PAY THE REMAINING
17	BALANCE ABOVE YOUR APPLICABLE IN-NETWORK COST
18	SHARING AMOUNT".
19	(c) A telephone number to call to discuss the statement.
20	* * *
21	<u>§1880.1</u> Balance billing; provider mediation
22	A.(1) Health insurance issuers shall establish a provider mediation process
23	for payment of noncontracted facility-based provider bills for providers objecting to
24	the application of the established payment rate provided for in R.S. 22:1875.
25	(2) The provider mediation process shall be established in accordance with
26	one of the following recognized mediation standards:
27	(a) The Uniform Mediation Act.
28	(b) Mediation.org, a division of the American Arbitration Association.
29	(c) The Association for Conflict Resolution.

1	(d) The American Bar Association Dispute Resolution Section.
2	(3) Following completion of the provider mediation process, the cost of $(3)$
3	mediation shall be split evenly and paid by the health insurance issuer and the
4	noncontracted facility-based provider.
5	(4) A provider mediation process shall not be used when the health insurance
6	issuer and the noncontracted facility-based provider agree to a separate payment
7	arrangement or when the covered person agrees to accept and pay the noncontracted
8	facility-based provider's charges for the out-of-network services.
9	(5) A health insurance issuer shall maintain records on all requests for
10	mediation and completed mediations pursuant to this Subsection during a calendar
11	year and, upon request, submit a report to the commissioner in the format specified
12	by the commissioner.
13	B. The rights and remedies provided pursuant to this Section to covered
14	persons shall be in addition to and shall not preempt any other rights and remedies
15	available to covered persons pursuant to state or federal law.
16	C. The provisions of this Section shall not apply to a facility that has made
17	arrangements with facility-based providers employed by the facility or with whom
18	the facility has contracts which prevent balance bills from being sent to persons
19	covered by the same health benefit plans with which the facility contracts.

## DIGEST

The digest printed below was prepared by House Legislative Services. It constitutes no part of the legislative instrument. The keyword, one-liner, abstract, and digest do not constitute part of the law or proof or indicia of legislative intent. [R.S. 1:13(B) and 24:177(E)]

HB 556 Original	2018 Regular Session	Talbot

Abstract: Provides for a reimbursement rate for out-of-network claims and requires health insurers to establish a mediation process for the settlement of claims.

<u>Present law</u> requires a health insurance issuer, if a facility-based physician who is a noncontracted provider provides healthcare services in a base healthcare facility to a covered person and files a claim with the health insurance issuer for the facility-based services, to provide the facility-based physician with an explanation of benefits as to any payment determination.

Proposed law repeals present law.

<u>Proposed law</u> establishes a reasonable reimbursement rate for a noncontracted facility-based provider providing healthcare services in a base healthcare facility and provides that payment of a reasonable reimbursement amount either individually or collectively by the health insurance issuer and the covered person has the effect of prohibiting the provider from collecting any additional amount for the healthcare services rendered.

<u>Proposed law</u> requires health insurance issuers to implement a provider mediation process for payment of noncontracted facility-based provider bills for providers objecting to the application of the established payment rate and sets forth minimum requirements for the mediation process.

(Amends R.S. 22:1875, 1880(B)(1) and (D); Adds R.S. 22:1880.1)