Regular Session, 2012

HOUSE BILL NO. 921

BY REPRESENTATIVE JOHNSON

INSURANCE/HEALTH: Provides for the adequacy of health care services offered through providers in a health benefit plan's network

AN ACT

To amend and reenact R.S. 44:4.1(B)(10) and to enact Subpart A-1 of Part III of Chapter 4 of Title 22 of the Louisiana Revised Statutes of 1950, to be comprised of R.S. 22:1019.1 through 1019.7, relative to network adequacy for health benefit plans; to provide with respect to standards for the creation and maintenance of networks by health insurance issuers assuring the adequacy, accessibility, and quality of health care services offered to covered persons under a health benefit plan; to provide for definitions; to provide with respect to the Public Records Law; to provide for regulation and enforcement, including penalties; and to provide for related matters.

Be it enacted by the Legislature of Louisiana:

Section 1. Subpart A-1 of Part III of Chapter 4 of Title 22 of the Louisiana Revised Statutes of 1950, comprised of R.S. 22:1019.1 through 1019.7, is hereby enacted to read as follows:

SUBPART A-1. NETWORK ADEQUACY ACT

§1019.1. Short title; purpose, scope, and definitions

A. This Subpart shall be known and may be cited as the "Network Adequacy Act".

B. The purpose and intent of this Subpart is to establish standards for the creation and maintenance of networks by health insurance issuers and to assure the adequacy, accessibility, and quality of health care services offered to covered

persons under a health benefit plan by establishing requirements for written agreements between health insurance issuers offering health benefit plans and participating providers regarding the standards, terms, and provisions under which the participating provider will provide services to covered persons.

C. This Subpart shall apply to all health insurance issuers that offer health benefit plans.

D. As used in this Subpart:

(1) "Base health care facility" means a facility or institution providing health care services, including but not limited to a hospital or other licensed inpatient center, ambulatory surgical or treatment center, skilled nursing facility, inpatient hospice facility, residential treatment center, diagnostic, laboratory, or imaging center, or rehabilitation or other therapeutic health setting that has entered into a contract or agreement with a facility-based physician. Pursuant to such contract or agreement, the facility-based physician agrees to provide required health care services to those covered persons presenting at such facility, within the scope of the physician's respective specialty.

(2) "Commissioner" means the commissioner of insurance of this state.

(3) "Contracted reimbursement rate" means the aggregate maximum amount that a participating or contracted health care provider has agreed to accept from all sources for payment of covered health care services under the health insurance coverage applicable to the covered person.

(4) "Covered health care services" means services, items, supplies, or drugs used for the diagnosis, prevention, treatment, cure, or relief of a health condition, illness, injury, or disease that are either covered and payable under the terms of health insurance coverage or required by law to be covered.

(5) "Covered person" means a policyholder, subscriber, enrollee, insured, or other individual participating in a health benefit plan.

(6) "Discount billing" means any written or electronic communication issued by a participating provider that appears to attempt to collect from a covered person

an amount in excess of the contracted reimbursement rate for covered health care services.

(7) "Dual billing" means any written or electronic communication issued by a participating provider that sets forth any amount owed by a covered person and that is a health insurance issuer liability.

(8) "Emergency medical condition" means a medical condition manifesting itself by symptoms of sufficient severity, including severe pain, such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect that the absence of immediate medical attention would result in serious impairment to bodily functions, serious dysfunction of a bodily organ or part, or would place the person's health or, with respect to a pregnant woman, the health of the woman or her unborn child, in serious jeopardy.

(9) "Emergency services" means health care items and services furnished or required to evaluate and treat an emergency medical condition.

(10) "Facility-based physician" means a physician licensed to practice medicine who is required by the base health care facility to provide services in a base health care facility, including an anesthesiologist, hospitalist, intensivist, neonatologist, pathologist, radiologist, emergency room physician, or other on-call physician who is required by the base health care facility to provide covered health care services related to any medical condition.

(11) "Health benefit plan" means a policy, contract, certificate, or agreement entered into, offered, or issued by a health insurance issuer to provide, deliver, arrange for, pay for, or reimburse any of the costs of health care services.

(12) "Health care facility" means an institution providing health care services or a health care setting, including but not limited to hospitals and other licensed inpatient centers, ambulatory surgical or treatment centers, skilled nursing centers, diagnostic, laboratory and imaging centers, and rehabilitation and other therapeutic health settings.

(13) "Health care professional" means a physician or other health care practitioner licensed, certified, or registered to perform specified health care services consistent with state law.

(14) "Health care provider" or "provider" means a health care professional or a health care facility.

(15) "Health care services" means services, items, supplies, or drugs for the diagnosis, prevention, treatment, cure, or relief of a health condition, illness, injury, or disease.

(16) "Health insurance coverage" means benefits consisting of medical care provided or arranged for directly, through insurance or reimbursement, or otherwise, and includes health care services paid for under any health benefit plan.

(17) "Health insurance issuer" means an entity subject to the insurance laws and regulations of this state, or subject to the jurisdiction of the commissioner, that contracts or offers to contract, or enters into an agreement to provide, deliver, arrange for, pay for, or reimburse any of the costs of health care services, including a sickness and accident insurance company, a health maintenance organization, a preferred provider organization, a nonprofit hospital and health service corporation, or any other entity providing a health benefit plan, a plan of health insurance, health benefits, or health care services.

(18) (a) "Health insurance issuer liability" means the contractual liability of a health insurance issuer for covered health care services pursuant to the health benefit plan or policy provisions between the covered person and the health insurance issuer.

(b) In the case of a participating provider, "health insurance issuer liability" is the contracted reimbursement rate reduced by the patient responsibility, which includes in-network coinsurance, copayments, deductibles, or any other amounts identified by the health insurance issuer on an explanation of benefits as an amount for which the covered person is liable for the covered health care service.

(c) In the case in which a contracted reimbursement rate has not been established, "health insurance issuer liability" is the liability pursuant to the health benefit plan or policy provision between a health insurance issuer and the covered person for the covered health care service.

(d) In the case of nonparticipating facility-based physicians providing covered health care services at a base health care facility, "health insurance issuer liability" is the amount as determined pursuant to the health benefit plan or policy provisions between the covered person and the health insurance issuer.

(19) "Intermediary" means a person authorized to negotiate and execute provider contracts with health insurance issuers on behalf of health care providers or on behalf of a network.

(20) "Life-threatening illness or condition" shall mean a severe, serious, or acute condition for which death is probable.

(21) "Network of providers" or "network" means an entity other than a health insurance issuer that, through contracts or agreements with health care providers, provides or arranges for access by groups of covered persons to health care services by health care providers who are not otherwise or individually contracted directly with a health insurance issuer.

(22) "Nonparticipating provider" or "noncontracted health care provider" means a health care provider that has not entered into a contract or agreement with a health insurance issuer or network of providers for the provision of covered health care services.

(23) "Participating provider" or "contracted health care provider" means a health care provider who, under a contract or agreement with the health insurance issuer or with its contractor or subcontractor, has agreed to provide health care services to covered persons with an expectation of receiving full payment, other than in-network coinsurance, copayments, or deductibles, directly or indirectly from the health insurance issuer.

(24) "Person" means an individual, a corporation, a partnership, an association, a joint venture, a joint stock company, a trust, an unincorporated organization, any similar entity, or any combination of the foregoing.

(25) "Primary care professional" means a participating health care professional designated by the health insurance issuer to supervise, coordinate, or provide initial care or continuing care to covered persons, and who may be required by the health insurance issuer to initiate a referral for specialty care and maintain supervision of health care services rendered to covered persons.

(26) "Terminal, incapacitating or debilitating condition or illness" means any aggressive malignancy, chronic end state cardiovascular or cerebral vascular disease, diabetes and its long-term associated complications, pregnancy, acquired immunodeficiency syndrome (AIDS), human immunodeficiency virus (HIV), or any other disease, illness, or condition which a physician diagnoses as terminal, incapacitating, or debilitating.

§1019.2. Network adequacy

A. A health insurance issuer providing a health benefit plan shall maintain a network that is sufficient in numbers and types of health care providers to ensure that all health care services to covered persons will be accessible without unreasonable delay or cost. In the case of emergency services and any ancillary healthcare services, covered persons shall have access twenty-four hours per day, seven days per week. Sufficiency shall be determined in accordance with the requirements of this Subpart and may be established by reference to any reasonable criteria used by the health insurance issuer, including but not limited to provider/covered person ratios by specialty, primary care provider/covered person ratios, geographic accessibility, waiting times for appointments with participating providers, hours of operation, and volume of technological and specialty services available to serve the needs of covered persons requiring technologically advanced or specialty care.

(1) In any case when the health insurance issuer has an insufficient number or type of participating providers to provide a covered health care service, the health insurance issuer shall ensure that the covered person obtains the covered health care service at no greater cost to the covered person than if the health care service were obtained from participating providers or shall make other arrangements acceptable to the commissioner.

(2) The health insurance issuer shall establish and maintain adequate arrangements to ensure reasonable proximity of participating providers to the primary residence of covered persons. In determining whether a health insurance issuer has complied with this Paragraph, the commissioner shall give due consideration to the relative availability of health care providers in the service area under consideration.

(3) A health insurance issuer shall monitor, on an ongoing basis, the ability, clinical capacity, financial capability, and legal authority of its participating providers to furnish all contracted health care services to covered persons.

(4) A participating provider shall be prohibited from discount billing, dual billing, attempting to collect from, or collecting from a covered person the health insurance issuer's liability or any amount in excess of the contracted reimbursement rate for covered health care services. A participating provider shall only be allowed to collect applicable in-network copayments, coinsurance, and deductibles from covered persons pursuant to the evidence of coverage and shall provide notice to covered persons of their personal financial obligations for non-covered services prior to the rendering of health care services.

(5) Beginning August 1, 2012, a health insurance issuer shall file with the commissioner, in a manner and form defined by rule of the commissioner, an access plan meeting the requirements of this Subpart for each of the health benefit plans that the health insurance issuer offers in this state. The health insurance issuer may request the commissioner to deem sections of the access plan proprietary or trade secret information that shall not be made public in accordance with the Public

Records Law, R.S. 44:1 et seq., and the restrictions under R.S. 22:42.1. For the purposes of this Subpart, information is proprietary or trade secret as provided by the Public Records Law, La. R.S. 44:1 et seq. and the restrictions under R.S. 22:42.1. The health insurance issuer shall make the access plans, absent proprietary or trade secret information, available and readily accessible on its business premises and shall provide them to any interested party upon request, subject to the provisions of the Public Records Law, R.S. 44:1 et seq., and the restrictions under R.S. 22:42.1.

B. The health insurance issuer shall file an access plan for approval with the commissioner for existing health benefit plans and prior to offering a new health benefit plan. The health insurance issuer shall update an existing access plan whenever it makes any material change to an existing health benefit plan. The access plan shall describe or contain, at minimum, each of the following:

(1) The health insurance issuer's network.

(2) The health insurance issuer's procedure for making referrals within and outside its network.

(3) The health insurance issuer's process for monitoring and assuring on an ongoing basis the sufficiency of the network to meet the health care needs of populations that enroll in health benefit plans.

(4) The health insurance issuer's efforts to address the needs of covered persons with limited English proficiency and illiteracy, with diverse cultural and ethnic backgrounds, and with physical and mental disabilities.

(5) The health insurance issuer's methods for assessing the health care needs of covered persons and their satisfaction with services.

(6) The health insurance issuer's method of informing covered persons of the health benefit plan's services and features, including but not limited to the health benefit plan's utilization review procedure, grievance procedure, external review procedure, process for choosing and changing providers, and procedures for providing and approving emergency services and specialty care.

(7) The health insurance issuer's system for ensuring coordination and continuity of care for covered persons referred to specialty physicians, for covered persons using ancillary health care services, including social services and other community resources, and for ensuring appropriate discharge planning.

(8) The health insurance issuer's process for enabling covered persons to change primary care professionals.

(9) The health insurance issuer's proposed plan for providing continuity of care in the event of contract termination between the health insurance issuer and any of its participating providers, as required in R.S. 22:1005 and 1006, or in the event of the health insurance issuer's insolvency or other inability to continue operations. This description shall explain how covered persons will be notified of contract termination, including but not limited to the effective date of the contract termination, the health insurance issuer's insolvency, or other cessation of operations, and how they will be transferred to other providers in a timely manner.

(10) The method of marketing the health benefit plan.

(11) A geographic map of the area proposed to be served by the health benefit plan by both parish and zip code, including marked locations of participating providers.

(12) The names and addresses of the participating providers with whom the health insurance issuer has entered into agreements or contracts.

(13) The scope of health care services to be provided by the network of providers and the health insurance issuer's methods for assessing the health care needs of covered persons and their satisfaction with services.

(14) The location of participating providers within the service area necessary to accommodate the enrolled population.

(15) The addition of participating providers to meet the covered persons' needs based on increases in the number of covered persons, changes in the participating provider to covered person ratio, changes in medical and health care capabilities, and increased demand for services.

(16) The distance or time that the covered person must travel to access health care facility services, including twenty-four hour emergency department services and participating specialty care provider services.

(17) The policies and procedures to ensure access to covered health care services under each of the following circumstances:

(a) The covered health care service is not available from a participating provider in any case when a covered person has made a good faith effort to utilize participating providers for a covered service and it is determined that the health insurance issuer does not have the appropriate participating providers due to insufficient number, type, or distance, the health insurance issuer shall ensure, by terms contained in the participating provider contract, that the covered person will be provided the covered health care service at no greater cost than if the service had been provided by a participating provider.

(b) The covered person has a medical emergency within the network's service area.

(c) The covered person has a medical emergency outside the network's service area.

(18) Any other information required by the commissioner to determine compliance with the provisions of this Subpart.

C. The health insurance issuer shall file any proposed changes, material or otherwise, to the access plan, participating provider agreements, or participating provider contracts, except for changes to the listing of participating providers, with the commissioner prior to implementation of any changes. The removal or withdrawal of any hospital from a health insurance issuer's network shall constitute a material change and shall be filed with the commissioner in accordance with the provisions of this Subpart. Changes shall be considered approved by the commissioner after sixty days unless specifically disapproved.

D. All filings containing any proposed changes, material or otherwise, to the access plan, participating provider agreements, or participating provider contracts as required by this Subpart shall include but not be limited to each of the following:

(1) The listing of health care facilities and the number of hospital beds available for covered persons at each network health care facility.

(2) The geographic distance from a network health care facility to each covered person's primary residence.

(3) For each participating provider, a list of network health care facilities at which the participating provider has privileges to admit covered persons.

(4) A ratio of participating providers to current covered persons.

(5) Any other information requested by the commissioner.

E.(1) A covered person who has been diagnosed with or is being treated for a life-threatening, terminal, incapacitating, or debilitating condition or illness shall have the right to request covered health care services from a nonparticipating health care provider which is located out-of-state or in state if either of the following conditions are met:

(a) Such health care provider agrees to the network contractual rate of the covered person's health insurance issuer.

(b) Such health care provider agrees to any other settlement or negotiated rate with the health insurance issuer.

(2) The health insurance issuer shall provide coverage for the covered person's health care services rendered by the nonparticipating health care provider which is located out-of-state or in state as agreed upon by the health insurance issuer and such health care provider.

F. Whenever a covered person is referred by a participating provider who finds it medically necessary to refer such covered person to a nonparticipating health care provider, the health insurance issuer shall ensure that the covered person referred shall incur no greater out-of-pocket liability than had the covered person received health care services from a participating provider. A covered person who

willfully chooses to access a nonparticipating health care provider for health care services shall be required to pay for such nonparticipating health care services pursuant to the policy provision of the network.

G. The health insurance issuer shall provide sample copies of the participating provider contracts or participating provider agreements utilized by the health insurance issuer to the commissioner. If the terms and conditions in such participating provider contracts or participating provider agreements include significant substantial or material variations, the filing of one complete sample participating provider contract or participating provider agreement together with a description of all variable terms and conditions will satisfy this requirement.

§1019.3. Requirements for health insurance issuers and participating providers

A. A health insurance issuer offering a health benefit plan shall satisfy all the requirements contained in this Subpart.

B. A health insurance issuer shall establish a mechanism by which the participating provider will be notified on an ongoing basis of the specific covered health care services for which the participating provider will be responsible, including any limitations or conditions on services.

C. Every contract or agreement between a health insurance issuer and a participating provider shall set forth a hold harmless provision specifying protection for covered persons in reference to nonpayment by an issuer, insolvency of an issuer, or breach of the agreement. This requirement shall be met by including a provision substantially similar to the following:

"PARTICIPATING PROVIDER AGREES THAT IN NO EVENT, INCLUDING BUT NOT LIMITED TO NONPAYMENT BY THE HEALTH INSURANCE ISSUER OR INTERMEDIARY, INSOLVENCY OF THE HEALTH INSURANCE ISSUER OR INTERMEDIARY, OR BREACH OF THIS AGREEMENT, SHALL THE PARTICIPATING PROVIDER BILL, CHARGE, COLLECT A DEPOSIT FROM, SEEK COMPENSATION, REMUNERATION OR REIMBURSEMENT FROM, OR HAVE ANY RECOURSE AGAINST A COVERED PERSON OR A PERSON (OTHER THAN THE

HEALTH INSURANCE ISSUER OR INTERMEDIARY) ACTING ON BEHALF OF THE COVERED PERSON FOR HEALTH CARE SERVICES PROVIDED PURSUANT TO THIS AGREEMENT. THIS AGREEMENT DOES NOT PROHIBIT THE PARTICIPATING PROVIDER FROM COLLECTING IN-NETWORK COINSURANCE, DEDUCTIBLES OR COPAYMENTS, AS SPECIFICALLY PROVIDED IN THE EVIDENCE OF COVERAGE, OR FEES FOR UNCOVERED SERVICES DELIVERED ON A FEE-FOR-SERVICE BASIS TO COVERED PERSONS. NOR DOES THIS AGREEMENT PROHIBIT A PARTICIPATING PROVIDER (EXCEPT FOR A HEALTH CARE PROFESSIONAL WHO IS EMPLOYED FULL-TIME ON THE STAFF OF A HEALTH INSURANCE ISSUER AND HAS AGREED TO PROVIDE SERVICES EXCLUSIVELY TO THAT HEALTH INSURANCE ISSUER'S COVERED PERSONS AND NO OTHERS) AND A COVERED PERSON FROM AGREEING TO CONTINUE SERVICES SOLELY AT THE EXPENSE OF THE COVERED PERSON, AS LONG AS THE PARTICIPATING PROVIDER HAS OBTAINED THE COVERED PERSON'S INFORMED CONSENT IN WRITING STATING THAT THE HEALTH INSURANCE ISSUER MAY NOT COVER A SPECIFIC SERVICE OR SERVICES. EXCEPT AS PROVIDED HEREIN, THIS AGREEMENT DOES NOT PROHIBIT THE PARTICIPATING PROVIDER FROM PURSUING ANY AVAILABLE LEGAL REMEDY."

D. Every contract or agreement between a health insurance issuer and a participating provider shall set forth that, in the event of a health insurance issuer or intermediary's insolvency or other cessation of operations, covered health care services to covered persons shall continue through the period for which a premium has been paid to the health insurance issuer on behalf of the covered person or until the covered person's discharge from an inpatient facility, whichever time is greater. Covered health care services to covered persons confined in an inpatient facility on the date of insolvency or other cessation of operations shall continue until the covered person's continued confinement in an inpatient facility is no longer medically necessary.

E. The contract or agreement provisions that satisfy the requirements of Subsections C and D of this Section shall be construed in favor of the covered person, shall survive the termination of the contract or agreement regardless of the reason for termination, including the insolvency of the health insurance issuer, and shall supersede any oral or written contrary agreement between a participating provider and a covered person or the representative of the covered person if the contrary agreement is inconsistent with the hold harmless and continuation of covered health care services provisions required by Subsections C and D of this Section.

F. A participating provider shall not collect or attempt to collect from a covered person any money owed to the participating provider by the health insurance issuer.

G.(1) The health insurance issuer shall develop selection standards for participating primary care professionals and each health care professional specialty. The standards shall be used in determining the selection of health care professionals by the health insurance issuer, its intermediaries, and any networks with which it contracts. The standards shall meet the requirements of R.S. 22:1009. Selection criteria shall not be established in a manner that would either:

(a) Allow a health insurance issuer to avoid high-risk populations by excluding providers because they are located in geographic areas that contain populations or providers presenting a risk of higher than average claims, losses, or health care services utilization.

(b) Exclude providers because they treat or specialize in treating populations presenting a risk of higher than average claims, losses, or health services utilization.

(2) Subparagraphs (1)(a) and (b) of this Subsection shall not be construed to prohibit a health insurance issuer from declining to select a provider who fails to meet the other legitimate selection criteria of the health insurance issuer developed in compliance with this Subpart.

(3) The provisions of this Subpart shall not require a health insurance issuer, its intermediaries, or the networks with which they contract, to employ specific providers or types of providers that may meet their selection criteria, or to contract with or retain more providers or types of providers than are necessary to maintain an adequate network.

H. A health insurance issuer shall make its selection standards for participating providers available for review by the commissioner.

I.(1) A health insurance issuer shall notify participating providers of the participating providers' responsibilities with respect to the health insurance issuer's applicable administrative policies and programs, including but not limited to payment terms, utilization review, quality assessment and improvement programs, credentialing, grievance procedures, external review procedures, data reporting requirements, confidentiality requirements, and any applicable federal or state programs.

(2) The contract or agreement between the health insurance issuer and the participating provider shall also contain provisions which include but are not limited to each of the following items:

(a) Requirements that participating providers have admitting privileges in at least one hospital with which the health insurance issuer has a written provider contract or agreement. The health insurance issuer shall be notified immediately of any changes in privileges at any health care facility, hospital, or other admitting facility. Reasonable exceptions may be made for participating providers who, because of the type of clinical specialty, or location or type of practice, do not customarily have admitting privileges.

(b) Prohibition of participating providers pursuant to R.S. 22:1874 et seq., from discount billing, dual billing, attempting to collect from, or collecting from a covered person a health insurance issuer's liability or any amount in excess of the contracted reimbursement rate for covered health care services. A participating provider shall only be allowed to collect applicable in-network copayments,

coinsurance, or deductibles from covered persons pursuant to the evidence of coverage and shall obtain the covered person's informed consent in writing detailing their personal financial obligations for non-covered services prior to the rendering of health care services.

(c) Requirements that a participating provider refer all covered health care services for a covered person to a health care provider that is participating in the health insurance issuer's network when there is a participating provider available in that network. If the participating provider refers a covered person for health care service to a nonparticipating health care provider when a participating provider is available, the referring participating provider shall be liable for any cost incurred by the covered person that is not reimbursed by the health insurance issuer to that nonparticipating provider. No covered person shall be liable for the unreimbursed cost incurred and shall be held harmless for the unreimbursed cost incurred pursuant to this Subsection.

J. Every contract or agreement between a health insurance issuer and a participating provider shall prohibit an offer of an inducement under the health benefit plan to a participating provider to provide less than medically necessary services to a covered person.

K. Every contract or agreement between a health insurance issuer and a participating provider shall not prohibit a participating provider from discussing treatment options with covered persons irrespective of the health insurance issuer's position on the treatment options, or from advocating on behalf of covered persons within the utilization review, grievance process, or external review procedure established by the health insurance issuer or a person contracting with the health insurance issuer.

L. Every contract or agreement between a health insurance issuer and a participating provider shall contain a provision that requires a health insurance issuer to require a participating provider to make health records available and readily accessible to appropriate state and federal authorities involved in assessing the

quality of care or investigating the grievances or complaints of covered persons, and to comply with the applicable state and federal laws related to the confidentiality of medical or health records.

M. When a contract or agreement termination involves a primary care professional, all covered persons who are patients of that primary care professional shall be notified. Every contract or agreement between a health insurance issuer and a participating provider shall contain a provision in which the participating provider and health insurance issuer shall provide at least sixty days written notice to each other before terminating the contract or agreement without cause. Within five working days of the date that the participating provider either gives or receives notice of termination, the participating provider shall supply the health insurance issuer with a list of those patients of the participating provider that are covered by a health benefit plan of the health insurance issuer. The health insurance issuer shall make a good faith effort to provide written notice of a termination within fifteen working days of receipt or issuance of a notice of termination to all covered persons who are patients seen on a regular basis by the participating provider whose contract or agreement is terminating, irrespective of whether the termination was for cause or without cause.

N. Every contract or agreement between a health insurance issuer and a participating provider shall contain a provision explaining the participating provider's responsibilities for continuation of covered services in the event of contract or agreement termination pursuant to R.S. 22:1005, or that such continuation is voluntarily provided by the health insurance issuer.

O. Every contract or agreement between a health insurance issuer and a participating provider shall provide that the rights and responsibilities under a contract or agreement between a health insurance issuer and a participating provider shall not be assigned or delegated by the participating provider without the prior written consent of the health insurance issuer.

P. A health insurance issuer may notify the participating providers of their obligations, if any, to collect applicable in-network coinsurance, copayments, or deductibles from covered persons pursuant to the evidence of coverage, or of the participating providers' obligations, if any, to notify covered persons of their personal financial obligations for non-covered services.

Q. A health insurance issuer shall not penalize a participating provider because the participating provider, in good faith, reports to state or federal authorities any act or practice by the health insurance issuer that jeopardizes patient health or welfare.

R. A health insurance issuer shall establish a mechanism by which the participating providers may determine in a timely manner whether or not a person is covered by the health insurance issuer.

S. A health insurance issuer shall establish procedures for resolution of administrative, payment, or other disputes between participating providers and the health insurance issuer.

T. A contract or agreement between a health insurance issuer and a participating provider shall not contain definitions or other provisions that conflict with the definitions or provisions contained in the health benefit plan or this Subpart.

§1019.4. Intermediaries

A. A contract or agreement between a health insurance issuer and an intermediary shall satisfy all the requirements contained in this Subpart.

B. Intermediaries and participating providers with whom they contract shall comply with all the applicable requirements of this Subpart.

C. A health insurance issuer's statutory responsibility to monitor the offering of covered health care services to covered persons shall not be delegated or assigned to the intermediary.

D. A health insurance issuer shall have the right to approve or disapprove the participation status of a subcontracted participating provider in its own network, or

in a contracted network, for the purpose of delivering covered health care services to the health insurance issuer's covered persons.

E. A health insurance issuer shall maintain copies of all intermediary health care subcontracts at its principal place of business in the state, or ensure that it has access to all intermediary subcontracts, including the right to make copies to facilitate regulatory review, upon twenty days prior written notice from the health insurance issuer.

F. If applicable, an intermediary shall transmit utilization documents and claims paid documentation to the health insurance issuer. The health insurance issuer shall monitor the timeliness and appropriateness of payments made to participating providers and health care services received by covered persons.

G. If applicable, an intermediary shall maintain the books, records, financial information, and documentation of services provided to covered persons at its principal place of business in the state and preserve them for six years in a manner that facilitates regulatory review.

H. An intermediary shall allow the commissioner access to the intermediary's books, records, financial information, and any documentation of services provided to covered persons, as necessary to determine compliance with this Subpart.

I. A health insurance issuer shall have the right, in the event of the intermediary's insolvency, to require the assignment to the health insurance issuer of the provisions of a participating provider's contract or agreement addressing the participating provider's obligations to furnish covered services.

§1019.5. Filing requirements and state administration

A. Beginning August 1, 2012, a health insurance issuer, as part of its access plan, shall file with the commissioner sample contract forms proposed for use with its participating providers and intermediaries.

B. A health insurance issuer shall submit material changes to a contract or agreement that would affect a provision required by this Subpart or implementing regulations to the commissioner for approval sixty days prior to use. Changes in

provider payment rates, coinsurance, copayments, or deductibles, or other plan health care service modifications are not considered material changes for the purpose of this Subsection.

C. If the commissioner takes no action within sixty days after submission of a material change by a health insurance issuer to a contract or agreement, the change is deemed approved.

D. The health insurance issuer shall maintain participating provider and intermediary contracts or agreements at its principal place of business in the state, or the health insurance issuer shall have access and availability to all contracts or agreements and provide copies to facilitate regulatory review upon twenty days prior written notice from the commissioner.

§1019.6. Contracting

A. The execution of a contract or agreement by a health insurance issuer shall not relieve the health insurance issuer of its liability to any person with whom it has contracted for the provision of services, nor of its responsibility for compliance with the law or applicable regulations.

B. All contracts or agreements shall be in writing and subject to review.

C. All contracts or agreements shall comply with applicable requirements of the law and applicable regulations.

§1019.7. Enforcement provisions, penalties, and regulations

A. If the commissioner determines that a health insurance issuer has not contracted with enough participating providers to ensure that covered persons have accessible health care services in a geographic area, that a health insurance issuer's access plan does not ensure reasonable access to covered health care services, or that a health insurance issuer has entered into a contract that does not comply with this Subpart, the commissioner may do either or both of the following:

(1) Institute a corrective action plan that shall be followed by the health insurance issuer within thirty days of notice from the commissioner.

(2) Use any of the commissioner's other enforcement powers to obtain the health insurance issuer's compliance with this Subpart.

B. The commissioner shall not act to arbitrate, mediate, or settle disputes regarding a decision not to include a health care provider in a health benefit plan or in a provider network if the health insurance issuer has an adequate network as determined by the commissioner pursuant to the requirements contained in this Subpart. The commissioner shall not act to arbitrate, mediate, or settle disputes regarding any other dispute between a health insurance issuer, its intermediaries, or a provider network arising under or by reason of a health care provider contract or agreement or its termination.

C. The commissioner may promulgate such rules and regulations as may be necessary or proper to carry out the provisions of this Subpart. Such rules and regulations shall be promulgated and adopted in accordance with the Administrative Procedure Act, R.S. 49:950 et seq.

D. (1) The commissioner may issue, and cause to be served upon the health insurance issuer violating this Subpart, an order requiring such health insurance issuer to cease and desist from such act or omission which violates this Subpart.

(2) The commissioner may refuse to renew, suspend, or revoke the certificate of authority of any health insurance issuer violating any of the provisions of this Subpart, or in lieu of suspension or revocation of a license duly issued, the commissioner may levy a fine not to exceed one thousand dollars for each violation per health insurance issuer, up to one hundred thousand dollars aggregate for all violations in a calendar year per health insurance issuer, when such violations, in his opinion, after a proper hearing, warrant the refusal, suspension, or revocation of such certificate, or the imposition of a fine. The commissioner of insurance is authorized to withhold fines imposed under this Subpart. Such hearing shall be held in the manner provided in Chapter 12 of Title 22, R.S. 22:2191 et seq. Additionally, the commissioner may take any administrative action including imposing fines and penalties as enumerated in R.S. 22:18.

Section 2. R.S. 44:4.1(B)(10) is hereby amended and reenacted to read as follows:

§4.1. Exceptions

* * *

B. The legislature further recognizes that there exist exceptions, exemptions, and limitations to the laws pertaining to public records throughout the revised statutes and codes of this state. Therefore, the following exceptions, exemptions, and limitations are hereby continued in effect by incorporation into this Chapter by citation:

* * *

(10) R.S. 22:2, 14, 42.1, 88, 244, 461, 572, 572.1, 574, 618, 706, 732, 752, 771, 1019.2(A)(5),1203, 1460, 1466, 1546, 1644, 1656, 1723, 1927, 1929, 1983, 1984, 2036, 2303

Section 3. This Act shall become effective on August 1, 2012.

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)]

Johnson HB No. 921

Abstract: Provides for standards for the creation and maintenance of networks by health insurance issuers assuring the adequacy, accessibility, and quality of health care services offered to covered persons under a health benefit plan.

Proposed law provides for network adequacy as follows:

(1) Requires a health insurance issuer (issuer) providing a health benefit plan to maintain a network that is sufficient in numbers and types of health care providers (providers) to ensure that all health care services to covered persons will be accessible without unreasonable delay or cost. If it is insufficient, requires the issuer to ensure that the covered person obtains covered health care services at no greater cost. Also requires the issuer to ensure reasonable proximity of participating providers to the primary residence of covered persons and to monitor the ability of its providers to furnish all contracted health care services.

(2) Prohibits a provider from billing or collecting any amount in excess of the contracted reimbursement rate and allows only collection of applicable in-network copayments, coinsurance, and deductibles. Also requires a provider to notify covered persons of their financial obligation for noncovered services prior to their being rendered.

(3) Requires an issuer, beginning August 1, 2012, to file an access plan with the commissioner, portions of which may be deemed proprietary or trade secret information, pursuant to the Public Records Law, or protected health information, pursuant to the Insurance Code. Absent such information, requires issuers to make such plans available under certain conditions. Provides that such a plan shall be subject to approval by the commissioner and updated upon material change, including withdrawal of a hospital from the issuer's network. Specifies numerous components of the access plan, including its efforts to address the needs of covered person with diverse cultural and ethnic backgrounds and with physical and mental disabilities, as well as its plan providing for continuity of care in the event of contract termination.

(4) Specifically provides that a covered person who has been diagnosed with or is being treated for a life-threatening, terminal, incapacitating, or debilitating condition or illness shall have the right to request covered health care services from a nonparticipating provider which is located out-of-state or in state if either such provider agrees to the network contractual rate of the covered person's issuer or to any other settlement or negotiated rate between the issuer. Requires that the issuer provide such coverage.

(5) Provides that whenever it is medically necessary to refer a covered person to a nonparticipating provider, it shall be ensured that no greater out-of- pocket expenses be incurred by the covered person, unless such utilization is a willful choice.

(6) Requires that each contract between an issuer and a provider set forth a hold harmless provision for covered persons in reference to nonpayment by the issuer, insolvency, or breach of the agreement. Provides that it shall also set forth that in the event of the issuer's cessation of operation, services will be continued through the period for which a premium has been paid or until discharge from an inpatient facility, which time is greater. Specifies that these contract provisions be construed in favor of the covered person and supercede any contrary oral or written agreement between a provider and covered person.

(7) Requires an issuer to develop selection standards for participating primary and specialized providers that do not exclude certain providers because of their geographic location or the population they treat. Requires that an issuer make its selection standards available to the commissioner.

(8) Requires an issuer to make certain information available to providers and requires that the contract between them include certain components, such as requiring admitting privileges at least one participating hospital, prohibiting discount billing, dual billing, or collecting any amount in excess of the contracted reimbursement rate for covered services, and requiring referral to participating provider when one is in the network.

(9) Requires additional numerous provisions in contracts between issuers and providers, including not prohibiting a provider from discussing treatment options with covered persons irrespective of the issuer's position on such options or from advocating on behalf of covered persons within the issuer's utilization review, grievance process, or external review procedure. Also requires that all patients of a primary care professional be notified when his contract is terminated. Additionally provides that a contract or agreement between an issuer and a provider shall not contain definitions or other provisions that conflict with those of <u>proposed law</u>.

(10) Defines an "intermediary" as a person authorized to negotiate and execute provider contracts with issuers on behalf of providers or on behalf of a network. Specifies that a contract between an intermediary and an issuer satisfy all requirements of <u>proposed law</u> and that providers with whom they contract also comply with such

requirements. Disallows an issuer's statutory responsibility to monitor the offering of covered health care services from being delegated or assigned to the intermediary. Otherwise provides with respect to the relationship among intermediaries, issuers, and providers.

(11) Requires that, beginning August 1, 2012, a health insurance issuer file with the commissioner sample contract forms proposed for use with its participating providers and intermediaries. Requires submission of material changes to a contract and provides that if the commissioner takes no action within 60 days after such submission, the change is deemed approved.

(12) Provides that the execution of a contract or agreement by an issuer shall not relieve it of its liability to any person with whom it has contracted for the provision of services, nor of its responsibility for compliance with the law or applicable regulations. Requires that all contracts or agreements be in writing and subject to review.

(13) Provides that if the commissioner determines that an issuer has not contracted with enough participating providers to ensure that covered persons have accessible health care services in a geographic area, that an issuer's access plan does not ensure reasonable access to covered health care services, or that an issuer has entered into a contract that does not comply with proposed law, he may institute a corrective action plan that shall be followed by the issuer within 30 days of notice and/or use any of his other enforcement powers to obtain the issuer's compliance with proposed law. Provides that the commissioner shall not act to arbitrate, mediate, or settle disputes regarding a decision not to include a provider in a health benefit plan or a provider network if the issuer has an adequate network as determined by the commissioner pursuant to proposed law.

(14) Authorizes the commissioner to promulgate rules and regulations, to issue orders requiring such health insurance issuer to cease and desist from such act or omission which violates proposed law, or to refuse to renew, suspend, or revoke the certificate of authority of an issuer violating proposed law. In lieu of suspension or revocation of a license, authorizes the commissioner to levy a fine not to exceed $1,000 for each violation per health insurance issuer, up to $100,000 for all violations in a calendar year per issuer, after a proper hearing. Also authorizes the commissioner to take any administrative action, including imposing fines and penalties.

Effective August 1, 2012.

(Amends R.S. 44:4.1(B)(10); Adds R.S. 22:1019.1 - 1019.7)