SLS 16RS-199 **ORIGINAL**

2016 Regular Session

SENATE BILL NO. 193

BY SENATOR LONG

HEALTH/ACC INSURANCE. Provides relative to the adequacy of networks utilized by health insurance issuers for the provision of health care services. (8/1/16)

AN ACT

To amend and reenact R.S. 22:1019.1(D), 1019.2, and 1019.3(A) and to enact R.S. 22:1019.3(E), relative to the network adequacy act; to provide definitions; to provide with respect to the adequacy of networks utilized by health insurance issuers for the provision of health care services; to provide with respect to enforcement, penalties, and regulations; and to provide for related matters.

Be it enacted by the Legislature of Louisiana:

Section 1. R.S. 22:1019.1(D), 1019.2, and 1019.3(A) are hereby amended and reenacted and R.S. 22:1019(E) is hereby enacted to read as follows:

§1019.1. Short title; purpose; scope; definitions

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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.~~

~~(2) "Commissioner" means the commissioner of insurance.~~

~~(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 health care services 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) "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.~~

~~(7) "Emergency services" means health care items and services furnished or required to evaluate and treat an emergency medical condition.~~

~~(8) "Essential community providers" means providers that serve predominantly low-income, medically underserved individuals, including those providers defined in Section 340B(a)(4) of the Public Health Service Act and providers described in Section 1927(c)(1)(D)(i)(IV) of the Social Security Act as set forth by Section 221 of Public Law 111-8.~~

~~(9) "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.~~

~~(10) "Health benefit plan" means a policy, contract, certificate, or subscriber 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.~~

~~(11) "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.~~

~~(12) "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.~~

~~(13) "Health care provider" or "provider" means a health care professional or a health care facility.~~

~~(14) "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.~~

~~(15) "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.~~

~~(16) "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 or any similar entity, or any other entity providing a plan of health insurance or health benefits.~~

~~(17) "Network of providers" or "network" means an entity, including 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.~~

~~(18) "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 payment, other than in-network coinsurance, copayments, or deductibles, directly or indirectly from the health insurance issuer.~~

~~(19) "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 thereof.~~

~~(20) "Primary care professional" means a participating health care professional designated by a 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.~~

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

(2) "Covered benefit" or "benefit" means any of those health care services to which a covered person is entitled under the terms of a health benefit plan.

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

(4) "Emergency medical condition" means a physical, mental, or behavioral health condition that manifests itself by acute symptoms of sufficient severity, including severe pain that would lead a prudent layperson, possessing an average knowledge of medicine and health, to reasonably expect, in the absence of immediate medical attention, to result in:

(a) Placing the individual's physical, mental or behavioral health or, with respect to a pregnant woman, the woman's or her unborn child's health in serious jeopardy.

(b) Serious impairment to a bodily function.

(c) Serious impairment of any bodily organ or part.

(d) With respect to a pregnant woman who is having contractions.

(i) That there is inadequate time to effect a safe transfer to another hospital before delivery.

(ii) That transfer to another hospital may pose a threat to the health or safety of the woman or her unborn child.

(5) "Emergency services" means, with respect to an emergency condition:

(a) A medical or mental health screening examination that is within the capability of the emergency department of a hospital, including ancillary services routinely available to the emergency department to evaluate the emergency medical condition.

(b) Any further medical or mental health examination and treatment to the extent they are within the capabilities of the staff and facilities available at the hospital to stabilize the patient.

(6) "Essential community provider" or "ECP" means a provider that:

(a) Serves predominantly low-income, medically underserved individuals, including a health care provider defined in Section 340B(a)(4) of the Public Health Service Act (PHSA).

(b) Is described in Section 1927(c)(1)(D)(i)(IV) of the Social Security Act, as set forth by Section 221 of Pub.L.111-8.

(7) "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, residential treatment centers, urgent care centers, diagnostic,

laboratory and imaging centers, and rehabilitation and other therapeutic health settings.

(8) "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.

(9) "Health care professional" means a physician or other health care practitioner licensed, accredited or certified to perform specified health care services consistent with their scope of practice under state law.

(10) "Health care provider" or "provider" means a health care professional, a pharmacy, or a facility.

(11) "Health care services" means services for the diagnosis, prevention, treatment, cure, or relief of a physical, mental or behavioral health condition, illness, injury, or disease, including mental health and substance use disorders.

(12) "Health insurance issuer" or "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 health insurance issuer, a health maintenance organization, a hospital and health service corporation, or any other entity providing a plan of health insurance, health benefits, or health care services.

(13) "Limited scope dental plan" means a plan that provides coverage substantially all of which is for treatment of the mouth, including any organ or structure within the mouth, which is provided under a separate policy, certificate, or contract of insurance or is otherwise not an integral part of a group benefit plan.

(14) "Limited scope vision plan" means a plan that provides coverage substantially all of which is for treatment of the eye that is provided under a separate policy, certificate, or contract of insurance or is otherwise not an

integral part of a group benefit plan.

(15) "Network" means the group or groups of participating providers providing services under a network plan.

(16) "Network plan" means a health benefit plan that either requires a covered person to use, or creates incentives, including financial incentives, for a covered person to use health care providers managed, owned, under contract with, or employed by the health insurance issuer.

(17) "Participating provider" means a provider who, under a contract 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 payment, other than coinsurance, copayments, or deductibles, directly or indirectly from the health insurance issuer.

(18) "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.

(19) "Primary care" means health care services for a range of common physical, mental, or behavioral health conditions provided by a physician or non-physician primary care professional.

(20) "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 a covered person, 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 the covered person.

(21)(a) "Specialist" means a physician or non-physician health care professional who:

(i) Focuses on a specific area of physical, mental, or behavioral health or a group of patients.

(ii) Has successfully completed required training and is recognized by the

state in which he or she practices to provide specialty care.

(b) "Specialist" includes a subspecialist who has additional training and recognition above and beyond his or her specialty training.

(22) "Specialty care" means advanced medically necessary care and treatment of specific physical, mental, or behavioral health conditions or those health conditions which may manifest in particular ages or subpopulations, that are provided by a specialist, preferably in coordination with a primary care professional or other health care professional.

(23) "Telemedicine" or "Telehealth" means health care services provided through telecommunications technology by a health care professional who is at a location other than the location of the covered person.

(24) "Tiered network" means a network that identifies and groups some or all types of providers and facilities into specific groups to which different provider reimbursement, covered person cost sharing, or provider access requirements, or any combination thereof, apply for the same services.

(25) "To stabilize" means, with respect to an emergency medical condition, to provide such medical treatment of the condition as may be necessary to assure, within a reasonable medical probability, that no material deterioration of the condition is likely to result from or occur during the transfer of the individual to or from a facility, or, with respect to an emergency birth with no complications resulting in a continued emergency, to deliver the child and the placenta.

(26) "Transfer" means the movement, including the discharge, of an individual outside a hospital's facilities at the direction of any person employed by, or affiliated or associated, directly or indirectly, with the hospital, but does not include the movement of an individual who:

(a) Has been declared dead.

(b) Leaves the facility without the permission of any such person.

§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. In the case of emergency services and any ancillary emergency health care 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. In determining sufficiency criteria, such criteria shall include but not be limited to ratios of health care providers to covered persons by specialty, ratios of primary care providers to covered persons, 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.~~

~~B.(1) Each health insurance issuer shall maintain a network of providers that includes but is not limited to providers that specialize in mental health and substance abuse services, facility-based physicians, and providers that are essential community providers.~~

~~(2) A health insurance issuer shall establish and maintain adequate arrangements to ensure reasonable proximity of participating providers to the primary residences 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 and the geographic composition of the service area. The commissioner may consider a health insurance issuer's adjacent service area networks that may augment health care providers if a health care provider deficiency exists within the service area.~~

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

~~(4) A health insurance issuer shall maintain a directory of its network of~~

~~providers on the Internet. The directory of network providers must be furnished in printed form to any covered person upon request. The directory of network providers shall identify all health care providers that are not accepting new referrals of covered persons or are not offering services to covered persons.~~

~~(5)(a) Beginning January 1, 2014, except as otherwise provided in Subparagraph (b) of this Paragraph, a health insurance issuer shall annually file with 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. Any existing, new, or initial filing of policy forms by a health insurance issuer shall include the network of providers, if any, to be used in connection with the policy forms. If benefits under a health insurance policy do not rely on a network of providers, the health insurance issuer shall state such fact in the policy form filing. The health insurance issuer may request the commissioner to deem sections of the access plan to contain proprietary or trade secret information that shall not be made public in accordance with the Public Records Law, R.S. 44:1 et seq., or to contain protected health information that shall not be made public in accordance with R.S. 22:42.1. If the commissioner concurs with the request, those sections of the access plan shall not be subject to the Public Records Law or shall not be made public in accordance with R.S. 22:42.1 as applicable. The health insurance issuer shall make the access plans, absent any such proprietary or trade secret information and protected health information, available and readily accessible on its business premises and shall provide such plans to any interested party upon request, subject to the provisions of the Public Records Law and R.S. 22:42.1.~~

~~(b) In lieu of meeting the filing requirements of Subparagraph (a) of this Paragraph, a health insurance issuer shall, beginning January 1, 2014, except as otherwise provided in Subparagraph (c) of this Paragraph, submit proof of accreditation from the National Committee for Quality Assurance (NCQA) or American Accreditation Healthcare Commission, Inc./URAC to the commissioner, including an affidavit and sufficient proof demonstrating its accreditation for~~

~~compliance with the network adequacy requirements of this Subpart. The affidavit shall include sufficient information to notify the commissioner of the health insurance issuer's accreditation and shall include a certification that the health insurance issuer's network of providers includes health care providers that specialize in mental health and substance abuse services and providers that are essential community providers. The affidavit shall also certify that the health insurance issuer complies with the provider directory requirement contained in Paragraph (4) of this Subsection. The commissioner may, at any time, recognize accreditation by any other nationally recognized organization or entity that accredits health insurance issuers; however, such entity's accreditation process shall be equal to or have comparative standards for review and accreditation of network adequacy.~~

~~(c) A health insurance issuer that has submitted an application for accreditation to NCQA or URAC prior to December 31, 2013, but has not yet received such accreditation by January 1, 2014, shall be deemed accredited for the purposes of this Subpart upon submission of an affidavit to the commissioner by January 1, 2014, demonstrating that the issuer is in the process of accreditation. Upon receipt of accreditation, the issuer shall submit proof of such accreditation to the commissioner pursuant to Subparagraph (b) of this Paragraph. However, in the event that the issuer withdraws its application for accreditation or does not receive accreditation prior to July 1, 2015, such issuer shall file an access plan with the commissioner pursuant to Subparagraph (a) of this Paragraph within sixty days of such withdrawal or denial.~~

~~(d) If a health insurance issuer that has submitted proof of accreditation to the commissioner subsequently loses such accreditation, the issuer shall promptly notify the commissioner and file an access plan with him pursuant to Subparagraph (a) of this Paragraph within sixty days of the loss of such accreditation.~~

~~(e) A health insurance issuer submitting proof of accreditation or an affidavit demonstrating that the issuer is in the process of accreditation shall maintain an access plan at its principal place of business. Such access plan shall be in accordance~~

~~with the requirements of the accrediting entity.~~

~~C. A health insurance issuer not submitting proof of accreditation shall file an access plan for written approval from the commissioner for existing health benefit plans and prior to offering a new health benefit plan. Additionally, such a health insurance issuer shall inform the commissioner when the issuer enters a new service or market area and shall submit an updated access plan demonstrating that the issuer's network in the new service or market area is adequate and consistent with this Subpart. Each such access plan, including riders and endorsements, shall be identified by a form number in the lower left hand corner of the first page of the form. Such a health insurance issuer shall update an existing access plan whenever it makes any material change to an existing health benefit plan. Such an access plan shall describe or contain, at a minimum, each of the following:~~

~~(1) The health insurance issuer's network which includes but is not limited to the availability of and access to centers of excellence for transplant and other medically intensive services as well as the availability of critical care services, such as advanced trauma centers and burn units.~~

~~(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 ensuring, on an ongoing basis, the sufficiency of the network to meet the health care needs of populations that enroll in its health benefit plans and general provider availability in a given geographic area.~~

~~(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, or 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. Additional information relating to these processes shall be available upon request and accessible via the health insurance issuer's website.~~

~~(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 processes for enabling covered persons to change primary care professionals, for medical care referrals, and for ensuring that participating providers that require the use of health care facilities have hospital admission privileges.~~

~~(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 by R.S. 22:1005, 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 such covered persons will be transferred to other providers in a timely manner.~~

~~(10) A geographic map of the area proposed to be served by the health benefit plan by both parish and zip code.~~

~~(11) The policies and procedures to ensure access to covered health care services under each of the following circumstances:~~

~~(a) When 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 health benefit plan, that the covered person will be provided the covered health care service.~~

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

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

~~(12) Any other information required by the commissioner to determine compliance with the provisions of this Subpart.~~

~~D. A health insurance issuer not submitting proof of accreditation shall file any proposed material changes to the access plan with the commissioner prior to implementation of any such changes. The removal or withdrawal of any hospital or multi-specialty clinic 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 deemed approved by the commissioner after sixty days unless specifically disapproved in writing by the commissioner prior to expiration of such sixty days.~~

~~E. All filings containing any proposed material changes to an access plan as required by this Subpart shall include but not be limited to each of the following:~~

~~(1) A listing of health care facilities and the number of hospital beds at each network health care facility.~~

~~(2) The ratio of participating providers to current covered persons.~~

~~(3) Any other information requested by the commissioner.~~

A.(1) A health insurance issuer providing a network plan shall maintain a network that is sufficient in numbers and appropriate types of providers, including those that serve predominantly low-income, medically underserved individuals, to assure that all covered services to covered persons, including children and adults, will be accessible without unreasonable travel or delay.

(2) Covered persons shall have access to emergency services twenty-four hours per day, seven days per week.

B. The commissioner shall determine sufficiency in accordance with the requirements of this Section, and may establish sufficiency by reference to any reasonable criteria, which may include but shall not be limited to:

(1) Provider-covered person ratios by specialty.

(2) Primary care professional covered person ratios.

(3) Geographic accessibility of providers.

(4) Geographic variation and population dispersion.

(5) Waiting times for an appointment with participating providers.

(6) Hours of operation.

(7) The ability of the network to meet the needs of covered persons, which may include low-income persons, children and adults with serious, chronic or complex health conditions or physical or mental disabilities or persons with limited English proficiency.

(8) Other health care service delivery system options, such as telemedicine or telehealth, mobile clinics, centers of excellence, and other ways of delivering care.

(9) The volume of technological and specialty care services available to serve the needs of covered persons requiring technologically advanced or specialty care services.

(10) The extent to which participating physicians are authorized to admit patients to participating hospitals.

(11) The extent to which participating providers are accepting new patients.

(12) The regionalization of specialty care, which may require some children and adults to cross state lines for care.

(13) The extent to which hospital-based providers are participating providers.

C.(1) A health insurance issuer shall have a process to assure that a covered person obtains a covered benefit at an in-network level of benefits, including an in-network level of cost sharing, from a nonparticipating provider, or shall make other arrangements acceptable to the commissioner when:

(a) The health insurance issuer has a sufficient network, but does not have a type of participating provider available to provide the covered benefit to the covered person or does not have a participating provider available to provide the covered benefit to the covered person without unreasonable travel or delay.

(b) The health insurance issuer has an insufficient number or type of participating providers available to provide the covered benefit to the covered person without unreasonable travel or delay.

(2) The health insurance issuer shall specify and inform covered persons of the process a covered person may use to request access to obtain a covered benefit from a nonparticipating provider as provided in Paragraph (C)(1) when:

(a) The covered person is diagnosed with a condition or disease that requires specialized health care services or medical services.

(b) The health insurance issuer:

(i) Does not have a participating provider of the required specialty with the professional training and expertise to treat or provide health care services for the condition or disease.

(ii) Cannot provide reasonable access to a participating provider with the required specialty with the professional training and expertise to treat or provide health care services for the condition or disease without unreasonable travel or delay.

(3) The health insurance issuer shall treat the health care services the covered person receives from a nonparticipating provider pursuant to Paragraph (C)(2) as if the services were provided by a participating provider,

including counting the covered person's cost sharing for such services toward the maximum out-of-pocket limit applicable to services obtained from participating providers under the health benefit plan.

(4) The process described in Paragraphs (1) and (2) of this Subsection shall ensure that requests to obtain a covered benefit from a nonparticipating provider are addressed in a timely fashion appropriate to the covered person's condition.

(5) The health insurance issuer shall have a system in place that documents all requests to obtain a covered benefit from a nonparticipating provider under this Subsection and shall provide this information to the commissioner upon request.

(6) The process established in this Subsection is not intended to be used by health insurance issuers as a substitute for establishing and maintaining a sufficient provider network in accordance with the provisions of this Subpart nor is it intended to be used by covered persons to circumvent the use of covered benefits available through a health insurance issuer's network delivery system options.

(7) Nothing in this Section prevents a covered person from exercising the rights and remedies available under applicable state or federal law relating to internal and external claims grievance and appeals processes.

D.(1) A health insurance issuer shall establish and maintain adequate arrangements to ensure covered persons have reasonable access to participating providers located near their home or business addresses. In determining whether the health insurance issuer has complied with this requirement the commissioner shall give due consideration to the relative availability of health care providers with the requisite expertise and training in the service area under consideration.

(2) A health insurance issuer shall monitor, on an ongoing basis, the ability, clinical capacity, and legal authority of its participating providers to

furnish all contracted covered benefits to covered persons.

E.(1) Beginning July 1, 2017, a health insurance issuer shall file with the commissioner for review prior to or at the time it files a newly offered network, in a manner and form prescribed by the commissioner, an access plan meeting the requirements of this Subpart.

(2)(a) The health insurance issuer may request the commissioner to deem sections of the access plan as proprietary information that shall not be made public.

(b) For the purposes of this Subsection, information is proprietary if revealing the information would cause the health insurance issuer's competitors to obtain valuable business information.

(3) The health insurance issuer shall prepare an access plan prior to offering a new network plan, and shall notify the commissioner of any material change to any existing network plan within forty-five business days after the change occurs. A material change is a change in inclusion of a major health system or a significant number of providers that causes the network to be significantly different from that which the covered person initially purchased. The health insurance issuer shall include in the notice to the commissioner a reasonable time frame within which it will submit an update to an existing access plan to the commissioner for review.

F. The access plan shall describe or contain at a minimum the following:

(1) The health insurance issuer's network, including how the use of telemedicine or telehealth or other technology may be used to meet network access standards, if applicable.

(2) The health insurance issuer's procedures for making and authorizing referrals within and outside its network, if applicable.

(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 network plans.

(4) The factors used by the health insurance issuer to build its provider network, including a description of the network and the criteria used to select tier providers.

(5) The health insurance issuer's efforts to address the needs of covered persons, including but not limited to children and adults, including those with limited English proficiency or illiteracy, diverse cultural or ethnic backgrounds, physical or mental disabilities, and serious, chronic, or complex medical conditions. This includes the insurance issuer's efforts, when appropriate, to include various types of ECPs in its network.

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

(7) The health insurance issuer's method of informing covered persons of the plan's covered services and features, including but not limited to:

(a) The plan's grievance and appeals procedures.

(b) Its process for choosing and changing providers.

(c) Its process for updating its provider directories for each of its network plans.

(d) A statement of health care services offered, including those services offered through the preventive care benefit, if applicable.

(e) Its procedures for covering and approving emergency, urgent, and specialty care, if applicable.

(8) The health insurance issuer's system for ensuring the coordination and continuity of care:

(a) For covered persons referred to specialty physicians.

(b) For covered persons using ancillary services, including social services and other community resources, and for ensuring appropriate discharge planning.

(9) The health insurance issuer's process for enabling covered persons to change primary care professionals, if applicable.

(10) 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, or in the event of the health insurance issuer's insolvency or other inability to continue operations. The description shall explain how covered persons will be notified of the contract termination, or the health insurance issuer's insolvency or other cessation of operations, and the plan to transition covered persons to other providers in a timely manner.

(11) The health insurance issuer's process for monitoring access to physician specialist services in emergency room care, anesthesiology, radiology, pathology and laboratory services at their participating hospitals.

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

F. A health insurance issuer shall not be required to file an access plan with the commissioner pursuant to this Subpart if the health insurance issuer:

(1) Is accredited by the National Committee for Quality Assurance (NCQA) or American Accreditation Healthcare Commission, Inc./URAC.

(2) Leases or in some other manner utilizes networks accredited by the National Committee for Quality Assurance (NCQA) or American Accreditation Healthcare Commission, Inc./URAC.

(3) Insures or provides for health care services for seven hundred fifty or fewer covered persons in a market in this state.

§1019.3. Enforcement provisions; penalties; regulations**; other requirements**

A. If the commissioner determines that a health insurance issuer **that is required to file an access plan** 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:

* * *

E. Every health insurance issuer shall maintain an electronically available and current and accurate provider directory for each of its network plans, and shall make such directory available to covered persons in printed format upon request.

The original instrument and the following digest, which constitutes no part of the legislative instrument, were prepared by Cheryl Cooper.

DIGEST

SB 193 Original 2016 Regular Session Long

Present law requires a health insurance issuer providing a health benefit plan, excluding excepted benefits policies, to 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. Provides for numerous definitions, including defining a health insurance issuer as 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 or any similar entity, or any other entity providing a plan of health insurance or health benefits.

Proposed law retains present law requirements.

Present law places various requirements upon issuers, including the following:

(1) Maintenance of a network of providers that includes providers that specialize in mental health and substance abuse services, facility-based physicians, and providers that are essential community providers.

(2) Reasonable proximity of its providers to the primary residences of covered persons.

(3) Monitoring of the ability, clinical capacity, and legal authority of its providers to furnish all contracted health care services.

(4) Maintenance of a directory of its network of providers on the Internet.

Proposed law retains present law requirements.

Present law provides that in order to meet the network adequacy requirements an issuer shall, beginning Jan. 1, 2014, either: (a) submit proof of accreditation from the National Committee for Quality Assurance (NCQA) or from the American Accreditation Healthcare Commission Inc./URAC, including an affidavit of compliance to the commissioner of insurance; or (b) submit all filings required to the commissioner of insurance in order for him to conduct a review for the purposes of ascertaining network adequacy. Further provides that an issuer who is in the process of applying for accreditation from NCQA or URAC shall be deemed accredited upon submission of an affidavit to that effect to the commissioner. Specifies that if such accreditation is withdrawn or not subsequently received by such an issuer by July 1, 2015, that issuer shall submit all filings to the commissioner. Also requires

such submission if an issuer subsequently loses its NCQA or URAC accreditation. Further requires an issuer submitting proof of accreditation or in the process of applying for accreditation to maintain an access plan at its principal place of business. Specifies that such plan shall be in accordance with the requirements of the accrediting entity.

Proposed law retains accreditation by NCQA or URAC in lieu of filing an access plan, and requires such plans to be submitted for review by the department by July 1, 2017. Exempts health insurance issuers with 750 or fewer covered persons from filing an access plan. Permits health insurance issuers that lease, rent, or in some other way utilize networks that are accredited by NCQA or URAC an exemption from filing the access plan.

Present law requires an issuer not submitting proof of accreditation to annually 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 Title 22. Absent such information, requires issuers to make such plans available under certain conditions. Provides that such a plan shall be subject to written approval by the commissioner, and updated upon material change, for existing plans and prior to offering a new health benefit plan.

Present law requires an issuer to inform the commissioner when the issuer enters a new service or market area and to submit an updated access plan. Specifies numerous components of the access plan.

Proposed law deletes present law access plan requirements and replaces them with the following access plan requirements:

(1) The health insurance issuer's network, including how the use of telemedicine or telehealth or other technology may be used to meet network access standards, if applicable.

(2) The health insurance issuer's procedures for making and authorizing referrals within and outside its network, if applicable.

(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 network plans.

(4) The factors used by the health insurance issuer to build its provider network, including a description of the network and the criteria used to select tier providers.

(5) The health insurance issuer's efforts to address the needs of covered persons, including but not limited to children and adults, including those with limited English proficiency or illiteracy, diverse cultural or ethnic backgrounds, physical or mental disabilities, and serious, chronic, or complex medical conditions. This includes the insurance issuer's efforts, when appropriate, to include various types of ECPs in its network.

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

(7) The health insurance issuer's method of informing covered persons of the plan's covered services and features, including but not limited to:

(a) The plan's grievance and appeals procedures.

(b) Its process for choosing and changing providers.

(c) Its process for updating its provider directories for each of its network plans.

(d) A statement of health care services offered, including those services offered through the preventive care benefit, if applicable.

(e) Its procedures for covering and approving emergency, urgent, and specialty care, if applicable.

(8) The health insurance issuer's system for ensuring the coordination and continuity of care:

(a) For covered persons referred to specialty physicians.

(b) For covered persons using ancillary services, including social services and other community resources, and for ensuring appropriate discharge planning.

(9) The health insurance issuer's process for enabling covered persons to change primary care professionals, if applicable.

(10) 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, or in the event of the health insurance issuer's insolvency or other inability to continue operations including, how covered persons will be notified of the contract termination, or the insolvency or other cessation of operations, and the plan to transition covered persons to other providers in a timely manner.

(11) The health insurance issuer's process for monitoring access to physician specialist services in emergency room care, anesthesiology, radiology, pathology, and laboratory services at their participating hospitals.

(12) Any other information required by the commissioner to determine compliance with the provisions of proposed law.

Present law further requires an issuer not submitting proof of accreditation to file any proposed material changes to the access plan with the commissioner prior to implementation of the changes, including the removal or withdrawal of any hospital or multi-specialty clinic from an issuer's network.

Proposed law retains present law.

Present law provides that filings containing any proposed material changes to an access plan shall include certain specific information.

Proposed law deletes the present law requirement of specificity for amended filings.

Present law 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 present law, he may institute a corrective action plan that shall be followed by the issuer within 30 days of notice or the commissioner may use any of his other enforcement powers to obtain the issuer's compliance.

Present law prohibits the commissioner from acting to arbitrate, mediate, or settle disputes regarding a decision not to include a provider in a plan or a provider network if the issuer has an adequate network as determined by the commissioner.

Proposed law retains present law.

Present law authorizes the commissioner to promulgate rules and regulations, to issue orders requiring issuers to cease and desist from an act or omission which violates law, or to refuse to renew, suspend, or revoke the certificate of authority of an issuer violating present 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 other administrative actions, including imposing fines and penalties.

Proposed law retains present law.

Effective August 1, 2016.

(Amends R.S. 22:1019.1(D), 1019.2, and 1019.3(A); adds R.S. 22:1019.3(E))