

2020 First Extraordinary Session

SENATE BILL NO. 7

BY SENATOR TALBOT

HEALTH/ACC INSURANCE. Provides relative to surprise billing. (Item #37) (1/1/21)

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AN ACT

To enact Subpart E of Part II of Chapter 6 of Title 22 of the Louisiana Revised Statutes of 1950, to be comprised of R.S. 22:1885.1 through 1885.7, relative to health insurance; to provide for definitions; to provide for an independent process for the resolution of payment disputes between health insurance issuers and certain health care providers; to provide for applicability; to provide for criteria to be used by an independent dispute resolution entity; to provide for rulemaking; to provide for an effective date; and to provide for related matters.

Be it enacted by the Legislature of Louisiana:

Section 1. Subpart E of Part II of Chapter 6 of Title 22 of the Louisiana Revised Statutes of 1950, comprised of R.S. 22:1885.1 through 1885.7, is hereby enacted to read as follows:

SUBPART E. NO SURPRISES IN HEALTH INSURANCE COVERAGE ACT

§1885.1. Title

This Subpart shall be known and may be cited as the "No Surprises in Health Insurance Act of 2020".

§1885.2. Definitions

1 **For the purposes of this Subpart:**

2 **(1) "Commissioner" means the commissioner of insurance.**

3 **(2) "Department" means the Louisiana Department of Insurance.**

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

9 **(a) Placing the health of the person afflicted with the condition in serious**
10 **jeopardy or, in the case of a behavioral condition, placing the health of the**
11 **person or others in serious jeopardy.**

12 **(b) Serious impairment to the person's bodily functions.**

13 **(c) Serious dysfunction of any bodily organ or part of the person.**

14 **(d) Serious disfigurement of the person.**

15 **(e) A condition described in clause (i), (ii), or (iii) of Section 1867(e)(1)(A)**
16 **of the Social Security Act, 42 U.S.C. Section 1395dd.**

17 **(4) "Emergency services" means, with respect to an emergency condition**
18 **that requires a medical screening examination pursuant to Section 1867 of the**
19 **Social Security Act, 42 U.S.C. Section 1395dd, services which are within the**
20 **capability of the emergency department of a hospital, including ancillary**
21 **services routinely available to the emergency department to evaluate the**
22 **emergency medical condition. "Emergency services" also means services which**
23 **are within the capabilities of the staff and facilities available at the hospital, for**
24 **any further medical examination and treatment required pursuant to Section**
25 **1867 of the Social Security Act, 42 U.S.C. Section 1395dd, to stabilize the**
26 **patient.**

27 **(5) "Health insurance coverage" means benefits consisting of medical**
28 **care provided or arranged for directly through insurance, reimbursement, or**
29 **otherwise, and including items and services paid for as medical care under any**

1 hospital or medical service policy or certificate, hospital or medical service plan
2 contract, preferred provider organization agreement, or health maintenance
3 organization contract offered by a health insurance issuer.

4 (6) "Health insurance issuer" means any entity that offers health
5 insurance coverage through a policy or certificate of insurance subject to state
6 law that regulates the business of insurance. For purposes of this Subpart, a
7 "health insurance issuer" includes a health maintenance organization, as
8 defined and licensed pursuant to Subpart I of Part I of Chapter 2 of this Title,
9 nonfederal government plans subject to the provisions of Subpart B of this Part,
10 and the Office of Group Benefits.

11 (7) "Insured" means a patient covered under a health insurance issuer's
12 policy or contract.

13 (8) "Nonparticipating" means not having a contract with a health
14 insurance issuer to provide health care services to an insured.

15 (9) "Participating" means having a contract with a health insurance
16 issuer to provide health care services to an insured.

17 (10) "Patient" means a person who receives health care services,
18 including emergency services, in this state.

19 (11) "Surprise bill" means a bill for health care services, other than
20 emergency services, received by any of the following:

21 (a) An insured who receives a bill for services rendered by a
22 nonparticipating physician at a participating hospital or ambulatory surgical
23 center, where a participating physician is unavailable or a nonparticipating
24 physician renders services without the insured's knowledge or the need for
25 unforeseen medical services arises at the time the health care services are
26 rendered; provided, however, that "surprise bill" shall not mean a bill received
27 for health care services when a participating physician is available and the
28 insured has elected to obtain services from a nonparticipating physician.

29 (b) An insured who receives a bill for services rendered by a

1 nonparticipating physician, when the insured was referred by a participating
2 physician to a nonparticipating physician for services without explicit written
3 consent of the insured acknowledging that the participating physician referred
4 the insured to a nonparticipating physician and that the referral may have
5 resulted in costs not covered by the health insurance issuer.

6 (12) "Usual and customary cost" means the eightieth percentile of all
7 charges for the particular health care service performed by a physician in the
8 same or similar specialty and provided in the same geographical area as
9 reported in a benchmarking database maintained by a nonprofit organization
10 specified by the commissioner. The nonprofit organization shall not be affiliated
11 with any health insurance issuer.

12 §1885.3. Dispute resolution process established

13 The department shall establish a dispute resolution process by which a
14 dispute for a bill for emergency services or a surprise bill may be resolved in
15 accordance with the provisions of this Subpart. The department shall have the
16 power to grant and revoke certifications of independent dispute resolution
17 entities to administer the dispute resolution process. The department shall
18 promulgate rules pursuant to the Administrative Procedure Act, establishing
19 standards and procedures for the submission and resolution of payment
20 disputes to an independent dispute resolution entity including but not limited
21 to a process for certifying and selecting independent dispute resolution entities
22 that shall include provisions related to conflicts of interest.

23 §1885.4. Applicability

24 A. The provisions of this Subpart shall not apply to health care services,
25 including emergency services, with physician fees subject to schedules or other
26 monetary limitations under any other law, including but not limited to workers'
27 compensation, Medicaid, or Medicare or to health insurance plans that are
28 subject to the Employee Retirement Income Security Act of 1974, and shall not
29 preempt any such law.

1 **B.(1) With regard to emergency services billed under American Medical**
2 **Association Current Procedural Terminology codes 99281 through 99285,**
3 **99288, 99291 through 99292, 99217 through 99220, 99224 through 99226, and**
4 **99234 through 99236, the dispute resolution process established in this Subpart**
5 **shall not apply when all the following criteria are met:**

6 **(a) The amount billed under a Current Procedural Terminology code**
7 **meets the requirements set forth in Paragraph (3) of this Subsection, after any**
8 **applicable coinsurance, copayment, and deductible.**

9 **(b) The amount billed under a Current Procedural Terminology code**
10 **does not exceed one hundred twenty percent of the usual and customary cost for**
11 **the Current Procedural Terminology code.**

12 **(2) The health insurance issuer shall ensure that an insured shall not**
13 **incur any greater out-of-pocket costs for emergency services billed under a**
14 **Current Procedural Terminology code as set forth in this Subsection than the**
15 **insured would have incurred if the emergency services were provided by a**
16 **participating physician.**

17 **(3) No later than January first each year, the department shall publish**
18 **on a website maintained by the department and provide in writing to each**
19 **health insurance issuer, a threshold dollar amount below which bills for the**
20 **procedural codes identified in this Section shall be exempt from the dispute**
21 **resolution process established in this Subpart. The threshold amount shall equal**
22 **the amount from the prior year, beginning with six hundred fifty dollars,**
23 **adjusted by the average of the annual average inflation rates for the medical**
24 **care commodities and medical care services components of the consumer price**
25 **index for the twelve month period ending September thirtieth of the prior year.**
26 **In no event shall the threshold amount exceed one thousand two hundred**
27 **dollars.**

28 **C.(1) Within three business days of receipt by the department of an**
29 **application submitted by a health insurance issuer or a nonparticipating**

1 physician, the department shall screen the application to determine whether the
2 bill for emergency services or the surprise bill is subject to the provisions of this
3 Subpart.

4 (2) If the department determines the provisions of this Subpart do not
5 apply to the bill for emergency services or the surprise bill, the application shall
6 be rejected and returned to the party who submitted the application.

7 (3) If the department determines that the provisions of the Subpart
8 apply to the bill for emergency services or the surprise bill, the department shall
9 select an independent dispute resolution entity to resolve the dispute and
10 forward the application to the independent dispute resolution entity within
11 three business days of making the determination.

12 §1885.5. Dispute resolution for emergency services and surprise bills

13 A. When a health insurance issuer receives a bill for emergency services
14 or a surprise bill from a nonparticipating physician, the health insurance issuer
15 shall:

16 (1) Directly pay the nonparticipating physician the billed amount or
17 attempt to negotiate reimbursement with the nonparticipating physician or
18 nonparticipating referred health care provider. If the health insurance issuer's
19 attempts to negotiate reimbursement for the health care services provided by
20 the nonparticipating physician do not result in a resolution of the payment
21 dispute, the health insurance issuer shall directly pay the nonparticipating
22 physician an amount the health insurance issuer determines is reasonable for
23 the health care services rendered, less the insured's copayment, coinsurance, or
24 deductible. The payment shall be made in accordance with the timeframes
25 established in Subpart B of Part II of this Chapter.

26 (2) Provide notice to the nonparticipating physician of the process for
27 initiating the independent dispute resolution process.

28 (3) Ensure that the insured shall incur no greater out-of-pocket costs for
29 the emergency services than the insured would have incurred with a

1 participating physician pursuant to the insured's health insurance coverage.

2 B. A nonparticipating physician or a health insurance issuer may submit
3 an application to the department to request resolution of a dispute regarding a
4 fee or payment for emergency services or a surprise bill by an independent
5 dispute resolution entity; provided, however, the health insurance issuer shall
6 not submit the dispute unless it has complied with the requirements of
7 Paragraph (1) of this Subsection.

8 C. The independent dispute resolution entity shall make a determination
9 within thirty days of the receipt of the dispute for review. In determining a
10 reasonable fee for the services rendered, an independent dispute resolution
11 entity shall select either the health insurance issuer's payment or the
12 nonparticipating physician's fee. The independent dispute resolution entity shall
13 determine which amount to select based upon the conditions and factors
14 provided in R.S. 22:1885.6. If an independent dispute resolution entity
15 determines, based on the health insurance issuer's payment and the
16 nonparticipating physician's fee, that a settlement between the health insurance
17 issuer and nonparticipating physician is reasonably likely, or that both the
18 health insurance issuer's payment and the nonparticipating physician's fee
19 represent unreasonable extremes, then the independent dispute resolution entity
20 may direct both parties to attempt a good faith negotiation for settlement. The
21 health insurance issuer and nonparticipating physician may be granted up to
22 ten business days for this negotiation. This ten-day period shall run
23 concurrently with the thirty-day period for dispute resolution.

24 D. The determination of an independent dispute resolution entity shall
25 be binding on the health insurance issuer, physician, and patient and shall be
26 admissible in any court proceeding between the health insurance issuer,
27 physician, or patient or in any administrative proceeding between this state and
28 the physician.

29 E. If the independent dispute resolution entity issues a determination in

1 favor of the nonparticipating physician, the health insurance issuer shall pay the
2 nonparticipating physician any additional amount owed within thirty days of
3 the date of the determination.

4 F. The nonparticipating physician shall not bill the insured except for
5 any applicable copayment, coinsurance, or deductible.

6 §1885.6. Criteria for determining a reasonable fee

7 In determining the appropriate amount to be paid for a health care
8 service, an independent dispute resolution entity shall consider all relevant
9 factors, including:

10 (1) Whether there is a gross disparity between the fee charged by the
11 physician for services rendered as compared to:

12 (a) Fees paid to the involved physician for the same services rendered
13 by the physician to other patients in health insurance issuers in which the
14 physician is not participating.

15 (b) In the case of a dispute involving a health insurance issuer, fees paid
16 by the health insurance issuer to reimburse similarly qualified physicians for
17 the same services in the same region who are not participating with the health
18 insurance issuer.

19 (2) The level of training, education, and experience of the physician.

20 (3) The physician's usual charge for comparable services with regard to
21 patients in health insurance issuers in which the physician is not participating.

22 (4) The circumstances and complexity of the particular case, including
23 time and place of the service delivery.

24 (5) Individual patient characteristics.

25 (6) The usual and customary cost of the service.

26 (7)(a) The fiftieth percentile of rates for the service or supply paid to
27 participating providers in the same or similar specialty and provided in the
28 same geographical area as reported in a benchmarking database maintained by
29 a nonprofit organization specified by the commissioner.

1 **(b) The nonprofit organization specified by the commissioner pursuant**
 2 **to this Paragraph shall not be affiliated with any health insurance issuer.**

3 **(8) The history of network contracting between the parties.**

4 **(9) The historical data for the amounts provided for in Paragraphs (6)**
 5 **and (7) of this Section.**

6 **§1885.7. Payment for independent dispute resolution entity**

7 **When the independent dispute resolution entity determines the health**
 8 **insurance issuer's payment is reasonable, payment for the dispute resolution**
 9 **process shall be the responsibility of the nonparticipating physician. When the**
 10 **independent dispute resolution entity determines the nonparticipating**
 11 **physician's fee is reasonable, payment for the dispute resolution process shall**
 12 **be the responsibility of the health insurance issuer. When a good faith**
 13 **negotiation directed by the independent dispute resolution entity pursuant to**
 14 **this Subpart results in a settlement between the health insurance issuer and**
 15 **nonparticipating physician, the health insurance issuer and the nonparticipating**
 16 **physician shall evenly divide and share the prorated cost for the dispute**
 17 **resolution process.**

18 Section 2. This Act shall become effective on January 1, 2021.

The original instrument was prepared by Cheryl Cooper. The following digest, which does not constitute a part of the legislative instrument, was prepared by Brandi Cannon.

DIGEST

SB 7 Engrossed

2020 First Extraordinary Session

Talbot

Proposed law establishes a dispute resolution process by which a dispute for a bill for emergency services or a surprise bill may be resolved. Authorizes the Department of Insurance the power to grant certifications of independent dispute resolution entities to conduct the dispute resolution process.

Proposed law excludes health care services, including emergency services, where physician fees are subject to schedules or other monetary limitations under any other law, including, but not limited to, workers' compensation, Medicaid, Medicare, or to health insurance plans that are subject to the Employee Retirement Income Security Act of 1974 from the provisions of the proposed law.

Proposed law excludes from the provisions of the proposed law certain emergency services billed under the American Medical Association Current Procedural Terminology codes 99281 through 99285, 99288, 99291 through 99292, 99217 through 99220, 99224 through

99226, and 99234 through 99236, when all the following criteria are met:

- (1) The amount billed for any Current Procedural Terminology code is less than a threshold amount that shall equal the amount from the prior year, beginning with \$650, adjusted by the average of the annual average inflation rates for the medical care commodities and medical care services components of the consumer price index. In no event shall the threshold amount exceed \$1,200.
- (2) The amount billed for the Current Procedural Terminology code does not exceed 120% of the usual and customary cost for that Current Procedural Terminology code.

Proposed law provides that when a health insurance issuer receives a bill for emergency services or a surprise bill from a nonparticipating physician, the health insurance issuer shall:

- (1) Directly pay the nonparticipating physician the billed amount or attempt to negotiate reimbursement with the nonparticipating physician. If the health insurance issuer's attempts to negotiate reimbursement for the health care services provided by the nonparticipating physician do not result in a resolution of the payment dispute, the health insurance issuer shall pay the nonparticipating physician an amount the health insurance issuer determines is reasonable for the health care services rendered, less the insured's copayment, coinsurance, or deductible.
- (2) Provide notice to the nonparticipating physician describing how to initiate the independent dispute resolution process.
- (3) Ensure that the insured shall incur no greater out-of-pocket costs for the emergency services than the insured would have incurred with a participating physician pursuant to the insured's health insurance coverage.

Proposed law provides that the nonparticipating physician shall not bill the insured except for any applicable copayment, coinsurance, or deductible.

Proposed law provides that in determining a reasonable fee for the services rendered, an independent dispute resolution entity shall select either the health insurance issuer's payment or the nonparticipating physician's fee. The independent dispute resolution entity shall determine which amount to select based upon the conditions and factors set forth in proposed law. Requires the determinations to be made within 30 days.

Proposed law provides that if the independent dispute resolution entity issues a determination in favor of the nonparticipating physician, the health insurance issuer shall pay the nonparticipating physician any additional amount owed within thirty days from the date of the determination.

Proposed law provides that if an insured who does not assign benefits receives a surprise bill, the insured may submit an application to the department to request resolution of the dispute regarding a fee or payment for a surprise bill by an independent dispute resolution entity. The independent dispute resolution entity shall make a determination pursuant to the provisions of proposed law within 30 days.

Proposed law provides that the determination of an independent dispute resolution entity shall be binding on the health insurance issuer, physician and patient, and shall be admissible in any court proceeding between the health insurance issuer, physician or patient, or in any administrative proceeding between this state and the physician.

Proposed law provides that when an insured assigns benefits for a surprise bill in writing to a nonparticipating physician that knows the insured is insured under health insurance coverage, the nonparticipating physician shall not bill the insured except for any applicable copayment, coinsurance, or deductible that would be owed if the insured utilized a

participating physician.

Proposed law provides that in determining the appropriate amount to be paid for a health care service, an independent dispute resolution entity shall consider all relevant factors, including:

- (1) Whether there is a gross disparity between the fee charged by the physician for services rendered as compared to:
 - (a) Fees paid to the involved physician for the same services rendered by the physician to other patients in health insurance in which the physician is not participating.
 - (b) In the case of a dispute involving a health insurance issuer, fees paid by the health insurance issuer to reimburse similarly qualified physicians for the same services in the same region who are not participating with the health insurance issuer.
- (2) The level of training, education, and experience of the physician.
- (3) The physician's usual charge for comparable services with regard to patients in health insurance in which the physician is not participating.
- (4) The circumstances and complexity of the particular case, including time and place of the service.
- (5) Individual patient characteristics.
- (6) The usual and customary cost of the service, including historical data amounts.
- (7) The 50th percentile of rates, including historical data, for the service or supply paid to participating providers in the same or similar specialty and provided in the same geographical area as reported in a benchmarking database maintained by a nonprofit organization specified by the commissioner.
- (8) The history of network contracting between the parties.

Proposed law provides that the nonprevailing party is required to pay the costs of the independent dispute resolution entity. Further provides that when a good faith negotiation directed by the independent dispute resolution entity results in a settlement between the health insurance issuer and nonparticipating physician, the health insurance issuer and the nonparticipating physician shall evenly divide and share the prorated cost for dispute resolution entity.

Proposed law is effective January 1, 2021.

(Adds R.S. 22:1885.1-1885.7)

Summary of Amendments Adopted by Senate

Committee Amendments Proposed by Senate Committee on Insurance to the original bill

1. Changes references in proposed law from provider to physician.
2. Changes references in proposed law from health care plan to health insurance issuer.

3. Removes proposed law relative to assignment of benefits.
4. Specifies that a health insurance issuer must directly pay a nonparticipating physician.
5. Prohibits a nonparticipating physician from billing the insured except for any applicable copayment, coinsurance, or deductible.
6. Allows the independent dispute resolution entity to consider the 50th percentile of rates, including the historical data of the rates, for the service paid to participating providers in the same or similar specialty and provided in the same geographical area, the history of network contracting between the parties, and the historical data for the usual and customary cost of the service.
7. Makes proposed law effective Jan. 1, 2021.
8. Makes technical changes.