HOUSE COMMITTEE AMENDMENTS

2020 First Extraordinary Session

Amendments proposed by House Committee on Insurance to Original House Bill No. 61 by Representative Frieman

AMENDMENT NO. 1

On page 1, line 2, delete "R.S. 22:1872(24)," and insert "R.S. 22:1872(24) and 1875.1 through 1875.4,"

AMENDMENT NO. 2

On page 1, at the end of line 4, insert "provide for payment of claims by health insurance issuers; to provide for a certain benchmarking database; to provide for arbitration and processes thereof; to provide for rulemaking authority; to provide for reporting; to provide for an effective date; to"

AMENDMENT NO. 3

On page 1, line 7, delete "R.S. 1872(24) is" and insert "R.S. 22:1872(24) and 1875.1 through 1875.4 are"

AMENDMENT NO. 4

On page 2, line 5, delete "B. The" and insert "B.(1) For any claim of one thousand five hundred dollars or less, the"

AMENDMENT NO. 5

On page 2, between lines 10 and 11, insert:

"(2)(a) For any claim of more than one thousand five hundred dollars, the facility-based physician providing services at a contracted healthcare facility shall submit a written claim to the health insurance issuer within sixty days of the date of service.

(b) Within fifteen days of receipt of the claim, the health insurance issuer shall notify the physician of both of the following:

(i) The median amount the health insurance issuer has negotiated with participating physicians for the covered services rendered, as full payment to the physician. This amount includes any amounts the enrollee or insured owes as cost sharing pursuant to Subsection C of this Section.

(ii) One-half of the median amount the health insurance issuer has negotiated with participating physicians for the covered services rendered, as partial payment to the physician and the physician's right to pursue arbitration pursuant to R.S. 22:1875.2. This amount shall include any amounts the enrollee or insured owes as cost sharing pursuant to Subsection C of this Section.

(c) The health insurance issuer's notice to the physician may be made on the explanation of benefits provided pursuant to Subsection A of this Section or by a separate written document.

(3) Within fifteen days of receipt of the notice described in Subparagraph (2)(c) of this Subsection, the physician shall provide written notification to the health insurance issuer that he agrees to accept either full or partial payment. The issuer

shall pay the physician the full or partial payment amount within thirty days of the issuer's receipt of notice from the physician. The physician shall only bill the enrollee or insured any cost sharing amount pursuant to Subsection C of this Section and shall not surprise bill the insured or enrollee.

(4) A physician who receives payment pursuant to Paragraph (1) of this Subsection or full payment pursuant to Item (2)(b)(i) of this Subsection shall not seek arbitration. A physician accepting partial payment pursuant to Item (2)(b)(ii) of this Subsection may request arbitration in accordance with R.S. 22:1875.2 by filing a written notice with the Department of Insurance within sixty days of receipt of the partial payment from the health insurance issuer. The physician shall not surprise bill an enrollee or insured.

(5) A facility-based physician who does not submit his claim to the health insurance issuer within sixty days as required by Subparagraph (2)(a) of this Subsection shall accept as full payment the median amount the health insurance issuer has negotiated with participating physicians for the covered services and shall not engage in surprise billing or seek arbitration."

AMENDMENT NO. 6

On page 2, after line 18, insert the following:

"E. The requirements of this Section and R.S. 22:1875.1, 1875.2, 1875.3, and 1875.4 applicable to noncontracted, facility-based physicians shall also apply to any allied health care provider providing services under the supervision and direction of the noncontracted facility-based physician.

§1875.1. Benchmarking database

A. The Department of Insurance shall select an organization to maintain a benchmarking database pursuant to the provisions of this Section. The organization shall not do either of the following:

(1) Be affiliated with a health insurance issuer or administrator or any health care provider or health care provider organization.

(2) Have any other conflict of interest.

B. The benchmarking database shall contain information necessary to calculate for health care services and supplies in each parish of the state with respect to the following:

(1) The eightieth percentile of billed charges by all physicians practicing in the parish.

(2) The fiftieth percentile of rates paid to contracted physicians by health insurance issuers doing business in the state.

C. The Department of Insurance may adopt rules governing the submission of information for establishing and maintaining the database.

§1875.2. Request for arbitration; selection of arbitrator; rulemaking authority

A.(1) The Department of Insurance shall establish an arbitration process by which a dispute regarding an eligible claim for services by a noncontracted facility-based physician providing services at a contracted facility is resolved. The department has the power to grant and revoke certification of arbitrators to administer the arbitration process. The department shall promulgate rules pursuant

to the Administrative Procedure Act, R.S. 49:951 et seq., that establish standards and procedures for the submission and resolution of payment disputes to an arbitrator including but not limited to a process for certifying and selecting the arbitrator and a prohibition of conflicts of interest that would adversely impact the arbitrator's impartiality in rendering a decision.

(2) A conflict of interest includes but is not limited to all of the following with respect to an arbitrator or his close family member:

(a) Current or recent ownership of or employment by any health insurance issuer or administrator.

(b) Current or recent employment by any physician or ownership of a provider's healthcare practice.

(c) Engagement as a licensed healthcare practitioner or provider.

B. A request for arbitration by a noncontracted, facility-based physician eligible to seek arbitration shall be provided in writing to the Department of Insurance no later than sixty days after the physician's receipt of payment pursuant to R.S. 22:1875(B)(1) or partial payment from the health insurance issuer. Any request received after such time shall be rejected as untimely and the amount received by the physician from the health insurance issuer shall be deemed to have satisfied the health insurance issuer's obligation in full.

C.(1) Within three days of the Department of Insurance's receipt of an application for arbitration, the department shall screen the application to determine if it is eligible for arbitration.

(2) If the department determines that the application is ineligible for arbitration, the department shall reject the application and return it to the physician.

(3) If the department determines that the application is eligible for arbitration, the department shall select an arbitrator to settle the dispute and forward the application to the arbitrator within three days of the selecting the arbitrator.

(4) In selecting the arbitrator, the department shall give preference to an arbitrator who is knowledgeable and experienced in applicable principles of contract and insurance law and the healthcare industry generally.

§1875.3. Arbitration process

A. Within three days of the arbitrator's appointment, the arbitrator shall provide written notice of the date of arbitration to the parties. Only the physician requesting arbitration and the health insurance issuer, or their respective representatives, shall receive notice and participate in the proceeding.

B. In an effort to reach a resolution prior to arbitration, the physician and the health insurance issuer, or their respective representatives, shall participate in an informal settlement teleconference no later than thirty days after receipt of the arbitrator's notice of appointment. The arbitrator shall not participate in the teleconference. Upon completion of the teleconference, each party shall notify the other party of its final offer which may be different from previous amounts billed by the physician or paid by the issuer. If the parties come to a mutual agreement, they shall provide written notification to the arbitrator of completion of the arbitration process.

C. Upon notice of completion of the teleconference without reaching an agreement, the arbitrator shall set a date for submission of all information to be

considered by the arbitrator. This date may be extended by mutual agreement of the parties. Information submitted by the parties to the arbitrator is confidential and not subject to disclosure. The parties shall not engage in any discovery.

D. A noncontracted, facility-based physician submitting multiple claims to arbitration in one proceeding shall be limited as follows:

(1) The total amount in controversy for multiple claims in one proceeding shall not exceed five thousand dollars.

(2) The claims shall be limited to claims by the same out-of-network physician and shall not be combined with claims by any other physician, including physicians from the same practice or group.

E. The arbitrator is limited to making a determination of a reasonable amount for the physician's rendered services and which party's final offer is closest to that reasonable amount. In making these determinations, the arbitrator shall consider all of the following:

(1) Fees charged by the physician for the same services when participating or not participating in any health insurance issuers' networks.

(2) Fees paid by health insurance issuers for similar services provided in the same geographic area to participating and nonparticipating physicians.

(3) The circumstances and complexity of the particular case, including the time and place of the services.

(4) Individual patient characteristics.

(5) Benchmark database information in accordance with R.S. 22:1875.1 and any historical data pertaining to the data.

(6) The history of network contracting between the parties and the number and percentage of physicians of the same or similar specialty that contract with the health insurance issuer.

(7) Amounts paid for the same or similar services under government programs.

F. No later than sixty days from the Department of Insurance's selection of the arbitrator, the arbitrator shall provide the parties with a written decision of his determination. The decision shall include a determination of whether the final offer by the physician or by the issuer pursuant to Subsection B of this Section is closest to the reasonable amount for the services or supplies determined by the arbitrator. The amount closest to the reasonable amount shall be the binding award amount.

G. If the arbitrator's decision requires any additional payment by the health insurance issuer, such amount shall be paid to the physician by the health insurance issuer within thirty days of the arbitrator's final decision.

H. The parties of the arbitration shall equally split the costs of the arbitration.

§1875.4. Department of Insurance

The Department of Insurance shall promulgate and adopt rules that establish a fee schedule for arbitrators, including a minimum and maximum range for payment. A fee for arbitration shall not exceed one thousand five hundred dollars. The Department of Insurance may adjust the amounts paid under the fee schedule

annually. Such adjustment may include an increase of the one thousand five hundred dollar fee maximum by no more than ten percent per year.

Section 2. Except R.S. 22:1875.2(A) and 1875.4 as enacted by Section 1 of this Act, the provisions of this Act shall become effective on January 1, 2022.

Section 3. The provisions of R.S. 22:1875.2(A) and 1875.4 as enacted by Section 1 of this Act shall become effective on August 1, 2020. The Department of Insurance shall promulgate and adopt all rules in compliance with this Act on or before July 1, 2021.

Section 4. The Department of Insurance shall review the notice provisions of R.S. 22:1871 through 1873, R.S. 22:1880, and any other notice requirements under the law regarding surprise and balance billing to determine if those requirements remain necessary based on the provisions of this Act. The Department of Insurance shall make recommendations to repeal any such notices made unnecessary by this Act and shall submit a written report of its recommendations to the House Committee on Insurance and the Senate Committee on Insurance on or before February 1, 2021."