2019 Regular Session

HOUSE BILL NO. 371

BY REPRESENTATIVE TALBOT

Prefiled pursuant to Article III, Section 2(A)(4)(b)(i) of the Constitution of Louisiana.

INSURANCE/HEALTH: Establishes an independent dispute resolution process for certain out-of-network health benefit claims

AN ACT

To enact Chapter 21 of Title 22 of the Louisiana Revised Statutes of 1950, to be comprised of R.S. 22:2481 through 2496, relative to independent dispute resolution for out-of-network health benefit claims; to define key terms; to provide for applicability and scope; to require the commissioner of insurance to establish an independent dispute resolution process for out-of-network claims in certain circumstances; to require notice of fee and billing information to patients; to provide for dispute resolution conducted by the division of administrative law; to provide for the payment of costs; and to provide for related matters.

Be it enacted by the Legislature of Louisiana:

Section 1. Chapter 21 of Title 22 of the Louisiana Revised Statutes of 1950, comprised of R.S. 22:2481 through 2496, is hereby enacted to read as follows:

CHAPTER 21. OUT-OF-NETWORK CLAIM DISPUTE RESOLUTION

PART I. GENERAL PROVISIONS

§2481. Definitions

As used in this Chapter, the following definitions apply:

(1) "Administrator" means an administrator, including a third-party administrator, for a health benefit plan providing coverage pursuant to the provisions of this Title.

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

(3) "Department" means the Department of Insurance.

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

(5) "Emergency care provider" means a physician, healthcare practitioner, facility, or other healthcare provider who provides and bills an enrollee, administrator, or health benefit plan for emergency care.

(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) "Enrollee" means an individual who is eligible to receive benefits through a preferred provider benefit plan or a health benefit plan.

(8) "Facility" means an institution providing healthcare services or a healthcare 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.

(9) "Facility-based provider" means a physician, healthcare practitioner, or other healthcare provider who provides health care or medical services to patients of a facility.

(10) "Healthcare practitioner" means an individual who is licensed to provide healthcare services.

§2482. Applicability

This Chapter shall apply to both of the following:

(1) A preferred provider benefit plan offered by an insurer.

(2) An administrator of a health benefit plan, other than a health maintenance organization plan.

§2483. Reform

This Chapter shall not be construed to prohibit either of the following:

(1) An insurer offering a preferred provider benefit plan or administrator from, at any time, offering a reformed claim settlement.

(2) A facility-based provider or emergency care provider from, at any time, offering a reformed charge for health care or medical services or supplies.

PART II. INDEPENDENT DISPUTE RESOLUTION

§2491. Independent dispute resolution

A. The commissioner shall establish an independent dispute resolution process by which a dispute for an out-of-network health benefit claim shall be referred to the division of administrative law for resolution.

B. The division of administrative law shall use licensed healthcare providers in active practice in the same or similar specialty as the facility-based provider or emergency care provider whose fee for healthcare services is subject to the dispute resolution process of this Chapter. To the extent practicable, the healthcare provider shall be licensed in this state.

§2492. Independent dispute resolution; threshhold; exception

A. An enrollee may request independent dispute resolution pursuant to this Chapter for an out-of-network health benefit claim if both of the following apply:

(1) The amount for which the enrollee is responsible to a facility-based provider or emergency care provider, after copayments, deductibles, and coinsurance, including the amount unpaid by the administrator or insurer, is greater than five hundred dollars.

(2) The health benefit claim is for either of the following:

(a) Emergency care.

(b) A healthcare or medical service or supply provided by a facility-based provider in a facility that is a preferred provider or that has a contract with the administrator.

B. Except as provided by Subsections C and D of this Section, if an enrollee requests independent dispute resolution pursuant to this Chapter, the facility-based provider or emergency care provider, or the provider's representative, and the insurer or the administrator, as appropriate, shall participate in the independent dispute resolution.

C. If requested by the enrollee, except in the case of an emergency, a facility-based provider shall, before providing a healthcare or medical service or supply, provide a complete disclosure to an enrollee that does all of the following:

(1) Explains that the facility-based provider does not have a contract with the enrollee's health benefit plan.

(2) Discloses projected amounts for which the enrollee may be responsible.

(3) Discloses the circumstances in which the enrollee would be responsible for those amounts.

D. A facility-based provider who makes a disclosure pursuant to Subsection C of this Section and obtains the enrollee's written acknowledgment of that disclosure shall not be required to participate in independent dispute resolution for a billed charge pursuant to this Chapter if the amount billed is less than or equal to the maximum amount projected in the disclosure.

§2493. Notice and information provided to enrollee

A. A bill sent to an enrollee by a facility-based provider or emergency care provider or an explanation of benefits sent to an enrollee by an insurer or administrator for an out-of-network health benefit claim eligible for independent dispute resolution pursuant to this Chapter shall contain, in not less than ten-point boldface type, a conspicuous, plain-language explanation of the independent dispute resolution process available pursuant to this Chapter, including information on how

to request dispute resolution and a statement that is substantially similar to the following:

"You may be able to reduce some of your out-of-pocket costs for an out-of-network medical or healthcare claim that is eligible for independent dispute resolution by contacting the Department of Insurance at (website) and (phone number)."

B. If an enrollee contacts an insurer, administrator, facility-based provider, or emergency care provider about a bill that may be eligible for independent dispute resolution pursuant to this Chapter, the insurer, administrator, facility-based provider, or emergency care provider shall do both of the following:

(1) Inform the enrollee about independent dispute resolution pursuant to this Chapter.

(2) Provide the enrollee with the Department of Insurance's toll-free telephone number and internet website address.

§2494. Request for independent dispute resolution; preliminary procedures

A.(1) An enrollee requesting independent dispute resolution shall make the request to the department on a form prescribed by the commissioner and shall include all of the following:

(a) The name of the enrollee requesting independent dispute resolution.

(b) A brief description of the claim to be resolved.

(c) Contact information, including a telephone number, for the requesting enrollee and the enrollee's counsel, if the enrollee retains counsel.

(d) The name of the facility-based provider or emergency care provider and name of the insurer or administrator.

(e) Any other information the commissioner may require by rule.

(2) Within five days of receipt of a request for independent dispute resolution, the department shall provide the division of administrative law with a copy of the request for independent dispute resolution and shall notify the

facility-based provider or emergency care provider and insurer or administrator of the request.

(3) An enrollee may withdraw the request for independent dispute resolution at any time before a determination is made by the division of administrative law judge.

B. On receipt of notice from the department that an enrollee has made a request for independent dispute resolution that meets the requirements of this Chapter, the facility-based provider or emergency care provider shall not pursue any collection effort against the enrollee who has requested independent dispute resolution for amounts other than copayments, deductibles, and coinsurance before the earlier of either of the following:

(1) The date the independent dispute resolution is completed.

(2) The date the request for independent dispute resolution is withdrawn.

C.(1) On receipt of notice from the department that an enrollee has made a request for independent dispute resolution that meets the requirements of this Chapter, the insurer or administrator shall immediately pay the facility-based provider or emergency care provider any additional amounts required to provide for a reimbursement amount not less than one hundred percent of the Medicare rate for the healthcare services rendered by the facility-based provider or emergency care provider, except for the enrollee's copayment, coinsurance, or deductible, if any, and shall ensure that the enrollee incurs no greater out-of-pocket costs for the healthcare services than the enrollee would have incurred with an in-network provider.

(2) Payment by an insurer pursuant to this Subsection shall in no circumstance be made directly to a patient, enrollee, or insured.

§2495. Determination of a reasonable fee; criteria; good faith negotiation

A. In determining a reasonable fee for the services rendered, the division of administrative law judge shall select either the insurer's or administrator's payment or the out-of-network facility-based provider's or emergency care provider's fee. The

independent dispute resolution entity shall determine which amount to select based upon the conditions and factors provided for in Subsection B of this Section.

B. In determining the appropriate amount to pay for a healthcare service, the division of administrative law judge shall consider all relevant factors, including but not limited to all of the following:

(1) Whether there is a gross disparity between the fee charged by the facility-based provider or emergency care provider, for services rendered as compared to either of the following:

(a) Fees paid to the facility-based provider or emergency care provider for the same services rendered by the provider to other patients in health benefit plans in which the facility-based provider or emergency care provider is not participating.

(b) Fees paid by the insurer to reimburse similarly qualified facility-based providers or emergency care providers for the same services in the same region who are not participating with the health benefit plan.

(2) The level of training, education, and experience of the facility-based provider or emergency care provider.

(3) The facility-based provider's or emergency care provider's usual charge for comparable services with regard to patients in health benefit plans in which the facility-based provider or emergency care provider 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.

C.(1) If the division of administrative law judge determines, based on the insurer's or administrator's payment and the out-of-network facility-based provider's or emergency care provider's fee, that a settlement between the insurer or administrator and the facility-based provider or emergency care provider is reasonably likely, or that both the insurer's or administrator's payment and the out-of-network facility-based provider's or emergency care provider's fee represent

unreasonable extremes, then the administrative law judge may direct both parties to attempt a good faith negotiation for settlement.

(2) The insurer or administrator and the out-of-network facility-based provider or emergency care provider may be granted up to ten business days for this negotiation, which shall run concurrently with the period for dispute resolution prescribed by the commissioner.

D. The determination of the administrative law judge shall be binding on the insurer or administrator, facility-based provider or emergency care provider, and enrollee, and shall be admissible in any court proceeding between the insurer or administrator, facility-based provider or emergency care provider, or enrollee, or in any administrative proceeding between this state and the facility-based provider or emergency care provider.

§2496. Payment of costs

A. The commissioner shall promulgate a fee schedule for payment of the costs of the independent dispute resolution process established pursuant to this Chapter.

B.(1) For disputes involving an enrollee, when the division of administrative law judge determines the health benefit plan's payment is reasonable, payment for the dispute resolution process shall be the responsibility of the out-of-network facility-based provider or emergency care provider.

(2) When the division of administrative law judge determines the out-of-network the facility-based provider's or emergency care provider's fee is reasonable, payment for the dispute resolution process shall be the responsibility of the health benefit plan.

(3) When a good faith negotiation directed by the division of administrative law judge pursuant to R.S. 22:2496 results in a settlement between the health benefit plan and out-of-network facility-based provider or emergency care provider, the health benefit plan and the out-of-network provider shall evenly divide and share the prorated cost for the dispute resolution process.

DIGEST

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

HB 371 Original 2019 Regular Session Talbot

Abstract: Establishes an independent dispute resolution process for out-of-network health benefit claims in certain circumstances.

Proposed law defines "administrator", "commissioner", "department", "emergency care", "emergency care provider", "emergency medical condition", "enrollee", "facility", "facility-based provider", and "healthcare practitioner".

Proposed law applies to a preferred provider benefit plan offered by an insurer or an administrator of a health benefit plan, other than a health maintenance organization plan.

Proposed law requires the commissioner of insurance to establish an independent dispute resolution process by which a dispute for an out-of-network health benefit claim shall be referred to the division of administrative law for resolution if both of the following apply:

(1) The amount for which the enrollee is responsible to a facility-based provider or emergency care provider, after copayments, deductibles, and coinsurance, including the amount unpaid by the administrator or insurer, is greater than $500.

(2) The health benefit claim is for either emergency care or a healthcare or medical service or supply provided by a facility-based provider in a facility that is a preferred provider or that has a contract with the administrator.

Proposed law exempts a facility-based provider who makes a disclosure of projected out-of-network costs to an enrollee prior to service and obtains the enrollee's written acknowledgment of that disclosure from participating in independent dispute resolution for a billed charge if the amount billed is less than or equal to the maximum amount projected in the disclosure.

Proposed law requires notice of the available independent dispute resolution process to be provided to an enrollee by a healthcare provider or an insurer or administrator for an out-of-network health benefit claim eligible for independent dispute resolution.

Proposed law requires the commissioner of insurance, within five days of receipt of a request for independent dispute resolution, to provide the division of administrative law with a copy of the request and to notify the facility-based provider or emergency care provider and insurer or administrator of the request.

Proposed law prohibits the facility-based provider or emergency care provider, on receipt of notice from the department that an enrollee has made a request for independent dispute resolution, from pursuing any collection effort against the enrollee who has requested independent dispute resolution for amounts other than copayments, deductibles, and coinsurance before the earlier of either the date the independent dispute resolution is completed or the date the request for independent dispute resolution is withdrawn.

Proposed law requires the insurer or administrator to immediately pay the facility-based provider or emergency care provider any additional amounts required to provide for a reimbursement amount not less than 100% of the Medicare rate for the healthcare services rendered by the facility-based provider or emergency care provider, except for the enrollee's copayment, coinsurance, or deductible, if any, and to ensure that the enrollee incurs no

greater out-of-pocket costs for the healthcare services than the enrollee would have incurred with an in-network provider.

Proposed law sets forth the criteria for determining a reasonable fee for the services rendered and requires the division of administrative law judge to select either the insurer's or administrator's payment or the out-of-network facility-based provider's or emergency care provider's fee.

Proposed law authorizes the administrative law judge, if a settlement between the insurer or administrator and the facility-based provider or emergency care provider is reasonably likely, or both the insurer's or administrator's payment and the out-of-network facility-based provider's or emergency care provider's fee represent unreasonable extremes, to direct both parties to attempt a good faith negotiation for settlement.

Proposed law provides for the payment of the costs of the independent dispute resolution.

(Adds R.S. 22:2481-2496)