SLS 09RS-413 **ORIGINAL**

Regular Session, 2009

SENATE BILL NO. 170

BY SENATOR BROOME

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

HEALTH/ACC INSURANCE. Provides for the adequacy of health care services offered through providers in a network offered in a health benefit plan. (8/15/09)

AN ACT

To enact Subpart A-1 of Part III of Chapter 4 of Title 22 of the Louisiana Revised Statutes of 1950, to be comprised of R.S. 22:1016 through 1020, relative to health benefit plans; to provide for the adequacy of health care services offered through providers in a network offered in a health benefit plan; to provide definitions; to provide with respect to provider agreement requirements and intermediaries; to provide for enforcement provisions; and to provide for related matters.

Be it enacted by the Legislature of Louisiana:

Section 1. Subpart A-1 of Part III of Chapter 4 of Title 22 of the Louisiana Revised Statutes of 1950, comprised of R.S. 22:1016 through 1020,is hereby enacted to read as follows:

SUBPART A-1 NETWORK ADEQUACY

§1016. Purpose and definitions

A. The purpose of this Subpart is to establish standards for the creation and maintenance of networks by health insurance issuers and to assure the adequacy, accessibility and quality of health care services offered under networks of a health benefit plan by establishing requirements for written

agreements between health insurance issuers and participating health care providers regarding the standards, terms and provisions under which the participating provider will provide services to covered persons.

B. As used in this Subpart, the following words and phrases shall have the following meanings ascribed for each, unless the content clearly indicates otherwise:

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

(2) "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 plan, policy, or certificate of insurance.

(3) "Contracted reimbursement rate" means the aggregate maximum amount that a 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 enrollee or insured.

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

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

(6) "Discount billing" means any written or electronic communication issued by a contracted health care provider that appears to attempt to collect from an enrollee or insured an amount in excess of the contracted reimbursement rate for covered services.

(7) "Dual billing" means any written or electronic communication issued by a contracted health care provider that sets forth any amount owed by an enrollee or insured and that is a health insurance issuer liability.

(8) "Emergency medical condition" means the sudden and unexpected

onset of a health condition that requires immediate medical attention, where failure to provide medical attention will result in serious impairment to bodily functions or serious dysfunction of a bodily organ or part, or will otherwise place the person's health in serious jeopardy.

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

(10) "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.

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

(12) "Health care professional" means a physician or other health care practitioner licensed, certified, or registered to perform specified health care services.

(13) "Health care provider" or "provider" means a health care professional or a health care facility or the agent or assignee of such professional or facility.

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

(15) "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, preferred provider organization, a nonprofit hospital

and health services corporation, or any other entity providing a plan of health insurance, health benefits or health services.

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

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

(c) "Health insurance issuer liability" includes the liability pursuant to the health benefit plan or policy provisions between a health insurance issuer and their enrollee or insured for the covered service in the case in which a contracted reimbursement rate has not been established.

(d) "Health insurance insurer liability" includes the amount as determined pursuant to the health benefit plan or policy provisions between the enrollee or insured and the health insurance issuer in the case of out-of-network health care provider rendering covered health care services at a health care facility.

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

(18) "Life threatening illness or condition" means a severe, serious or acute condition for which death is probable.

(19) "Network of providers" or "network" means an entity other than a health insurance issuer that, through contracts with health care providers, provides or arranges for access by groups of enrollees or insureds to health care

services by health care providers who are not otherwise or individually contracted directly with a health insurance issuer.

(20) "Out-of-network health care provider" means a health care provider that is not directly contracted with the health insurance issuer, but who provides covered health care services to an enrollee or insured.

(21) "Participating provider" means a health care 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.

(22) "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.

(23) "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 covered persons.

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

§1017. Heath insurance issuer, general provisions, access plan

A.(1) A health insurance issuer shall maintain a network that is sufficient in numbers and types of health care providers to ensure that all services to covered persons will be accessible without unreasonable delay. Sufficiency shall be determined in accordance with the requirements of this

Section.

(2) In the case of emergency services, which includes ancillary services, the network shall provide covered persons with access to health care twenty-four hours per day, seven days per week.

B. If the health insurance issuer has an insufficient number or type of network providers to provide a covered health care service as required in Subsection A of this Section, the health insurance issuer shall ensure that the covered person obtains the covered health care service at no greater cost to the covered person than if the covered health care service were obtained from network providers, or shall make other arrangements acceptable to the commissioner.

C. If an out-of-state or out-of-network health care provider agrees to the network contracted reimbursement rate of the covered person's health insurance issuer or any other settlement or negotiated rate between the health insurance issuer and the health care provider and a covered person has been diagnosed with or is being treated for a life-threatening, terminal, incapacitating or debilitating condition or illness, such covered person shall have the right to request covered health care services from that out-of-state or out-of-network health care provider. The health insurance issuer shall provide coverage for the covered person's health care services rendered by the health care provider under the terms of the agreements between the health insurance issuer and the health care provider.

D. The health insurance issuer shall establish and maintain adequate arrangements to ensure a reasonable geographic proximity of participating providers to the business or personal residence of covered persons. In determining whether a health insurance issuer has complied with the requirements of this Subsection, the commissioner shall give due consideration to the relative availability of health care providers in the service area under consideration.

E. Whenever a covered person is referred by a participating provider who finds it medically necessary to refer the covered person to an out-of-network health care provider, the health insurance issuer shall ensure that the covered person referred shall incur no greater out of pocket liability than had the covered person received health care services from a participating provider. A covered person who willfully chooses to access an out-of-network health care provider for health care services shall pay for the out-of-network health care services pursuant to the policy provisions of the network.

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

G. (1) The health insurance issuer shall develop selection standards for participating primary care professionals and each health care professional specialty. The standards shall be used in determining the selection of health care professionals by the health insurance issuer, its intermediaries and any provider networks with which it contracts. The standards shall meet the health care provider credentialing requirements as provided in R.S. 22:1009. Selection criteria shall not allow a health insurance issuer to avoid high-risk populations by excluding providers because they are located in geographic areas that contain populations or providers presenting a risk of higher than average claims, losses or health services utilization nor exclude providers because they treat or specialize in treating populations presenting a risk of higher average claims, losses or health services utilization.

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

H. A health insurance issuer shall monitor, on an ongoing basis, the ability, clinical capacity, financial capability and legal authority of its

participating providers to furnish all covered health care services to covered persons.

I. A participating provider shall be prohibited from discount billing, dual billing, attempting to collect from, or collecting from an enrollee or insured a health insurance issuer's liability or any amount in excess of the contracted reimbursement rate for covered health care services. A participating provider shall only be allowed to collect applicable copayments or deductibles from covered persons pursuant to the evidence of coverage and shall obtain the covered person's informed consent in writing detailing their personal financial obligations for non-covered services prior to the rendering of health care services.

J. Beginning January 1, 2010, a health insurance issuer shall file with the commissioner, in a manner and form promulgated by the commissioner, an access plan meeting the requirements of this Section for each of the health benefit plans that the health insurance issuer offers in this state. The health insurance issuer may request the commissioner to designate certain sections of the access plan as being proprietary or competitive information that shall not be subject to the public records law. The health insurance issuer shall make the access plans, absent proprietary information, available on its business premises and shall provide a copy of the access plan to any interested party upon request.

(1) For the purposes of this Section, information shall be considered proprietary or competitive in nature if revealing the health insurance issuer's information would cause the health insurance issuer's competitors to obtain valuable business information.

(2) The health insurance issuer shall prepare an access plan and file such plan with the commissioner for approval prior to offering a new health benefit plan.

(3) The health insurance issuer shall file any proposed changes, material or otherwise, to the access plan, participating provider agreements or

participating provider contracts, except for changes to the listing of participating providers, with the commissioner prior to implementation of any changes. The removal or withdrawal of any hospital from a health insurance issuer's network shall constitute a material change and shall be filed with the commissioner in accordance with the provisions of this Subsection. Changes shall be considered approved by the commissioner after thirty days from the date of submission unless specifically disapproved by the commissioner.

(4) All filings of proposed changes, material or otherwise, to the access plan, participating provider agreements or participating provider contracts as required by this Section shall include, but not be limited to the following:

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

(b) Geographic distance from a network health care facility to each covered person's primary residence.

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

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

(e) Any other information requested by the commissioner.

K. The health insurance issuer shall file an updated list of participating providers with the commissioner which, at a minimum, shall be filed quarterly.

L. Each access plan filed by a health insurance issuer shall describe or contain the following information:

(1) The health insurance issuer's network.

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

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

(4) Written policies and procedures for adding providers to a closed network when openings become available due to attrition or expansion.

(5) 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 grievance procedures, its process for choosing and changing participating providers, and the procedures for providing emergency services including ancillary services by participating providers and approving emergency and specialty care.

(6) The health insurance issuer's system for ensuring the coordination of continuity of care for covered persons referred to specialty health care providers, for covered persons using ancillary services, including social services and other community resources, and for ensuring appropriate discharge planning; the health insurance issuer's proposed plan for providing continuity of care in the event of contract termination between the health insurance issuer and any of its participating providers as required in R.S. 22:1005 or in the event of the health insurance issuer's insolvency or other liability to continue operations. The plan for providing continuity of care as required in this Subparagraph shall contain provisions for the following:

(a) How covered persons will be notified of the contract termination, or the health insurance issuer's insolvency or other cessation of operations, and transferred to other health care providers in a timely manner.

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

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

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

(e) A source for the covered person to contact regarding changes in participating providers.

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

(g) A description of the standards by which the health insurance issuer ensures that the covered health care services to be rendered under the network of providers are reasonably accessible and available to covered persons.

M. The description of the standards used to ensure that providers are reasonably accessible and available to covered persons shall include the following:

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

(2) The number and type of participating providers necessary to meet the health care needs and service demands of the currently enrolled population, as well as the demands of the population expected to be enrolled over the next twelve months, including the following items:

(a) Participating provider to covered person ratio by specialty.

(b) Participating primary care professional to covered person ratio.

(c) Waiting times for appointments with participating providers.

(d) Hours of operation.

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

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

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

(5) The addition of participating providers to meet covered persons' needs based on increases in the number of covered persons, changes in the participating provider to covered person ratio, changes in medical and health

care capabilities, and increased demand for services.

(6) Efforts to address the needs of covered persons with limited English proficiency and illiteracy, with diverse cultural and ethnic backgrounds, and with physical and mental disabilities.

(7) Policies and procedures to ensure access to covered services when:

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

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

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

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

§1018. Provider agreements, requirements

A. The contract or agreement between the health insurance issuer and the participating provider shall contain provisions, which include, but are not limited to, the following items:

(1) Requirements that the participating provider comply with applicable administrative policies and procedures of the health insurance issuer.

(2) Requirements that the participating provider cooperate with and participate in the health insurance issuer credentialing and recredentialing processes pursuant to R.S. 22:1009.

(3) Requirements that the participating provider participate in and cooperate with the policies, processes, utilization review or utilization management program including, but not limited to, certification procedures, concurrent and retrospective evaluations, referral procedures, and reporting of clinical encounter data pursuant to provisions for medical necessity review organizations as provided in R.S. 22:1121 et seq.

(4) Requirements that the participating provider maintain and make medical records available to the health insurance issuer for the purpose of determining, on a concurrent or retrospective basis, the medical necessity and appropriateness of care provided to covered persons, and to make such medical records available to appropriate state and federal authorities and their agents involved in assessing the accessibility and availability of care or investigating covered persons' grievances or complaints and to comply with the applicable state and federal laws related to privacy and confidentiality of medical records.

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

(6) Requirements that a health insurance issuer and participating provider provide at least sixty days written notice to each other before terminating the contract without cause. The health insurance issuer shall make

a good faith effort to provide written notice of a termination within fifteen working days of receipt or issuance of a notice of termination to all covered persons who are patients seen on a regular basis by the participating provider whose contract is terminating, irrespective of whether the termination was for cause or without cause. Where a contract termination involves a primary care professional, all covered persons who are patients of that primary care professional shall be notified. Within five working days of the date that the participating provider either gives or receives notice of termination, the participating provider shall supply the health insurance issuer with a list of those patients of the participating provider that are covered by a health benefit plan of the health insurance issuer.

(7) Requirements for explaining the participating provider's responsibilities for continuation of covered services in the event of contract termination pursuant to R.S. 22:1005, or that such continuation is voluntarily provided by the health insurance issuer.

(8) Requirements of the obligation to provide covered health care services on a twenty-four hour per day, seven day per week basis.

(9) Requirements that a health insurance issuer require a participating provider to make health records available to appropriate state and federal authorities involved in assessing the quality of care or investigating the grievances or complaints of covered persons, and to comply with the applicable state and federal laws related to the confidentiality of medical or health records.

(10) A provision that a participating provider is prohibited pursuant to R.S. 22:1874 et seq., from discount billing, dual billing, attempting to collect from, or collecting from an enrollee or insured a health insurance issuer's liability or any amount in excess of the contracted reimbursement rate for covered health care services. A participating provider shall only be allowed to collect applicable copayments or deductibles from covered persons pursuant to the evidence of coverage and shall obtain the covered person's informed consent

in writing detailing their personal financial obligations for non-covered services prior to the rendering of health care services.

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

(12) A hold harmless provision specifying protection for covered persons in reference to an insolvency of a health insurance issuer. The requirement contained in this Paragraph shall be satisfied by including a provision substantially similar in language to the following:

"Participating provider agrees that in no event, including but not limited to nonpayment by the health insurance issuer or intermediary, insolvency of the health insurance issuer or intermediary, or breach of this agreement, shall the participating provider bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from, or have any recourse against a covered person or a person acting on behalf of the covered person, other than the health insurance issuer or intermediary, for health care services provided pursuant to this agreement. This agreement does not prohibit the participating provider from collecting coinsurance, deductibles or copayments, as specifically provided in the evidence of coverage, or fees for uncovered health care services delivered on a fee-for-service basis to covered persons. Nor does this agreement prohibit a participating provider (except for a health care professional who is employed full-time of the staff of a health insurance issuer and has agreed to provide

health care services exclusively to that health insurance issuer's covered persons and no others) and a covered person from agreeing to continue health care services solely at the expense of the covered person, as long as the participating provider has obtained the covered persons informed consent in writing stating that the health insurance issuer will not cover a specific health care service(s). Except as provided herein, this agreement does not prohibit the participating provider from pursuing any available legal remedy for non-covered health care services."

B. Every contract between a health insurance issuer and a participating provider shall set forth the established mechanism by which the participating provider will be notified on an ongoing basis of the specific covered health care services for which the health care provider will be responsible, including any limitations or conditions on health care services.

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

D. The contract provisions that satisfy the requirements of Subsections B and C of this Section shall be construed in favor of the covered person, shall survive the termination of the contract regardless of the reason for termination, including the insolvency of the health insurance issuer, and shall supersede any oral or written contrary agreement between a participating provider and a covered person or the representative of the covered person if the contrary

agreement is inconsistent with the hold harmless and continuation of covered health care services provisions required by Subsections B and C of this Section.

E. Every contract between a health insurance issuer and a participating provider shall contain a provision that notifies participating providers of the providers' responsibilities with respect to the health insurance issuer's applicable administrative policies and programs, including but not limited to payment terms, utilization review, quality assessment and improvement programs, credentialing, grievance procedures, data reporting requirements, confidentiality requirements and any applicable federal or state programs.

F. Every contract between a health insurance issuer and a participating provider shall contain a provision that does not offer an inducement under the health benefit plan to a participating provider to provide less than medically necessary services to a covered person.

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

H. The rights and responsibilities under a contract between a health insurance issuer and a participating provider shall not be assigned or delegated by the participating provider without the prior written consent of the health insurance issuer.

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

J. A health insurance issuer shall establish a mechanism by which the

participating providers may determine in a timely manner whether or not a person is covered by the health insurance issuer.

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

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

§1019. Intermediaries

A. Intermediaries and participating providers with whom they contract shall comply with all the applicable requirements of R.S. 22:1018.

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

C. A health insurance issuer may approve or disapprove participation status of a subcontracted participating provider in its own or a network of providers for the purpose of delivering covered health care services to the health insurance issuer's covered persons.

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

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

F. If applicable, an intermediary shall maintain the books, records, financial information and documentation of health care services provided to

covered persons at its principal place of business in the state and preserve them for ten years in a manner that facilitates regulatory review pursuant to the provisions of this Title.

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

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

§1020. Enforcement provisions

A. If the commissioner determines that a health insurance issuer has not contracted with enough participating providers to ensure that covered persons have accessible health care services in a geographic area, or 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 the provisions of this Section, the commissioner may institute a corrective action that shall be followed by the health insurance issuer, or may use any of the commissioner's other enforcement powers to obtain the health insurance issuer's compliance with the provisions of this Section.

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

C. The commissioner may promulgate reasonable regulations to

implement the provisions of this Section in accordance with the Louisiana Administrative Procedures Act.

D. The commissioner may refuse to renew, or may suspend, or revoke the certificate of authority of any insurer violating any of the provisions of this Subpart, or in lieu of suspension or revocation of a license duly issued, the commissioner may levy a fine not to exceed one thousand dollars for each violation per insurer, up to one hundred thousand dollars aggregate for all violations in a calendar year per insurer, when such violations, in his opinion, after a proper hearing, warrant the refusal, suspension, or revocation of such certificate, or the imposition of a fine. Such hearing shall be held in the manner provided in Chapter 12 of this Title. The commissioner may also take any administrative action including fines and penalties as provided in R.S. 22:1969.

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

DIGEST

Proposed law requires a health insurance issuer to maintain a network that is sufficient in numbers and types of health care providers to ensure that all services to covered persons will be accessible without unreasonable delay. Requires access to emergency services 24 hours per day, 7 days a week.

Proposed law stipulates that where the issuer has an insufficient number or type of providers, the issuer must ensure that the covered person obtains the covered health care service at no greater cost than if the covered health care service is obtained from network providers, or make other arrangements acceptable to the commissioner of insurance.

Proposed law requires that when an out-of-state or out-of-network health care provider agrees to the network contracted reimbursement rate of the covered person's health insurance issuer and a covered person has been diagnosed with or is being treated for a life-threatening, terminal illness, such covered person shall have the right to request covered health care services from that out-of-state or out-of-network provider.

Proposed law necessitates a health insurance issuer to establish and maintain adequate arrangements to ensure a reasonable geographic proximity of participating providers to the business or personal residence of covered persons. Requires the commissioner of insurance to give consideration to the relative availability of health care providers in the service area when determining compliance.

Proposed law requires that when a covered person is referred by a participating provider who finds it medically necessary to refer such covered person to an out-of-network health care provider, the health insurance issuer shall ensure that the covered person incur no greater out of pocket liability than if the covered person received services from a participating provider. Requires a covered person who chooses to access an out-of-network provider to pay for services pursuant to the policy provision of the network.

Proposed law calls for health insurance issuers to make its selection standards for participating providers available for review by the commissioner. Requires issuers' selection standards for participating providers be developed for primary care professionals and each health care professional specialty in accordance with present law.

Proposed law prohibits selection criteria to be established in a manner that would allow a health insurance issuer to avoid high-risk populations or that would exclude providers that treat or specialize in treating populations presenting a risk of higher average claims, losses or health services utilization.

Proposed law does not require a health insurance issuer to employ specific providers or types of providers that may meet their selection criteria, or to contract with or retain more providers or types of providers than are necessary to maintain an adequate network.

Proposed law requires a health insurance issuer to monitor the ability, clinical capacity, financial capability and legal authority of its participating providers to furnish all covered health care services to covered persons.

Proposed law prohibits a participating provider from discount billing, dual billing, attempting to collect from, or collecting from an enrollee or insured an issuer's liability or any amount in excess of the contracted rate for covered services. Restricts a participating provider to collect applicable copayments and deductibles from covered persons pursuant to the evidence of coverage. Requires acquisition of written informed consent detailing the personal financial obligations for non-covered services prior to rendering health care services.

Proposed law provides for the filing of an access plan for each of the health benefit plans that the health insurance issuer offers in the state with the commissioner starting on January 1, 2010. Allows the commissioner to deem sections of the access plan as proprietary or competitive and not to be made public. Requires the issuer to make access plans available on its business premises upon request. Requires changes to an access plan be filed with the commissioner prior to their implementation. Requires filing an updated list of participating providers with the commissioner at least quarterly.

Proposed law requires the access plan to describe or contain at least the issuer's networks, the procedures for making referrals within and outside its network, the process for monitoring and assuring the sufficiency of the network to meet the health care needs of populations that enroll in the health plans, the written policies for adding providers to a closed network as well as the issuer's method of informing covered persons of the health benefit plan's services and features.

Proposed law calls for the access plan to also include the issuer's system for ensuring the coordination of continuity of care for covered persons referred to specialty health care providers, for covered persons using ancillary services, including social services and other community resources and for ensuring appropriate discharge planning. Requires the access plan to detail the issuer's proposed plan for providing continuity of care in the event of contract termination between the issuer and any of its participating providers as required in present law or in the event of the issuer's insolvency or other liability to continue operations. Requires a description of the standards by which the health insurance issuer ensures that the covered health care services to be rendered under the network of providers are reasonably accessible and available.

Proposed law calls for standards to address such issues as the scope of health care services to be provided by the network of providers and the issuer's methods for accessing the health care needs of covered persons and their satisfaction with services as well as the number and type of participating providers necessary to meet the health care needs and service demands of the currently enrolled population and the demands of the population expected to be enrolled over the next twelve months. Requires that these standards address the location of

participating providers within the service area necessary to accommodate the enrolled population, the distance or time that the covered person must travel to access health care services, the addition of participating providers to meet needs based on increases in the number of covered persons, and efforts to address the needs of covered persons with limited English proficiency.

Proposed law requires the issuer to provide sample copies of the participating provider contracts or agreements utilized by the issuer. Allows the filing of one complete sample contract or agreement together with a description of all variable terms and conditions.

Proposed law provides that provider agreements include a provision requiring the provider to comply with applicable administrative policies and procedures of the issuer, a provision requiring the participating provider to cooperate with issuer credentialing and recredentialing processes defined in present law, and a provision requiring the provider to participate and cooperate with the policies and processes involved in utilizations management. Requires provider agreements to also include a provision that the provider maintain and make medical records available to the issuer for the purpose of determining the medical necessity and appropriateness of care and to make such medical records available to appropriate state and federal authorities.

Proposed law requires provider agreements to include a provision mandating that all participating providers to have admitting privileges in at least one hospital with which the issuer has a written provider contract as well as a provision requiring that an issuer provide at least 60 days written notice to each other before terminating the contract without cause. The issuer must make a good faith effort to provide written notice of a termination within 15 days of notice of termination to all covered persons who are patients seen on a regular basis whose contract is terminating. Where a contract termination involves a primary care professional, all covered patients must be notified.

Proposed law requires a provider agreement to include an explanation of the provider's responsibilities for continuation of covered services in the event of contract termination as well as a provision regarding any obligation to provide covered health care services on a 24/7 basis. Requires a provision that an issuer require a participating provider to make health records available to appropriate state and federal authorities involved in assessing the quality of care and compliance with applicable state and federal laws related to confidentiality of medical or health records. Requires that a provider only be allowed to collect applicable copayments and deductibles from covered persons pursuant to the evidence of coverage and to obtain the covered person's informed written consent detailing their personal financial obligations for non-covered services prior to rendering health care services.

Proposed law requires a provision in a provider agreement that requires a provider to refer all covered services to a provider in the issuer's network when there is a health care provider available in that network. If the provider refers a covered service to an out-of-network provider when a participating provider is available, the referring provider shall be liable for any costs incurred by the covered person that are not reimbursed by the issuer to that out-of-network provider. Also requires a hold harmless provision specifying protection for covered persons in reference to an insolvency.

Proposed law requires that every contract between an issuer and a provider to set forth the established mechanism by which the participating provider will be notified on an ongoing basis of the specific covered health care services for which the provider will be responsible.

Proposed law requires that every contract between an issuer and a provider set forth that in the event of an issuer or intermediary insolvency or their cessation of operations, services to covered persons will continue through the period for which a premium has been paid to the issuer on behalf of the covered person or until the covered person's discharge from an inpatient facility, whichever is greater.

Proposed law requires every contract between an issuer and provider to contain a provision that notifies providers of the providers' responsibilities with respect to the issuer's administrative policies and programs including payment terms, utilization review, quality assessment and improvement programs. Requires that every contract also include a provision that does not offer an inducement under the health benefit plan to a participating provider to provide less than medically necessary services.

Proposed law provides that every contract between an issuer and provider contain a provision that does not prohibit a participating provider from discussing treatment options with covered persons regardless of the issuer's position on the treatment options.

Proposed law prohibits the rights and responsibilities under a contract between an issuer and provider from being assigned or delegated by the provider without prior written consent of the issuer. Prohibits an issuer from penalizing a provider who, in good faith, reports to state or federal authorities any act or practice by the issuer that jeopardizes patient health or welfare.

Proposed law requires an issuer to establish a mechanism by which the providers may determine in a timely manner whether or not a person is covered by the issuer. Requires an issuer to establish procedures for resolution of administrative, payment or other disputes between providers and issuers. Restricts a contract between an issuer and provider from containing provisions or definitions that conflict with the managed care plan or proposed law.

Proposed law prohibits an issuer from assigning its statutory responsibility to monitor the offering of covered services to covered persons to an intermediary. Allows an issuer to approve or disapprove participation status of a subcontracted provider in its own or a network of providers in or to deliver covered services to the issuer's covered persons.

Proposed law allows an intermediary to transmit utilization documents and claims paid documentation to the issuer. Requires the issuer to monitor the timeliness and appropriateness of payments made to providers and services received by covered persons. Requires the intermediary to maintain the books, records, financial information and documentation of services provided to covered persons at its principal place of business in the state and preserve them for ten years.

Proposed law requires the intermediary to allow the commissioner access to the intermediary's books, records, financial information and any documentation of services provided in order to determine compliance with proposed law. Authorizes an issuer, in the event of the intermediary's insolvency, to require the assignment to the issuer of the provisions of a provider's contract addressing the provider's obligations to furnish covered services.

Proposed law authorizes the commissioner to institute a corrective action that shall be followed by the health issuer when the commissioner determines that an issuer has not contracted with enough participating providers to ensure accessible health care services in a geographic area. Allows the commissioner to use any of his enforcement powers to obtain compliance with all provisions of proposed law.

Proposed law prohibits the commissioner from acting as arbitrator or mediator regarding a decision not to include a provider in a health benefit plan or in a network of providers, as long as the health issuer has an adequate network. Prohibits the commissioner from settling a dispute regarding any dispute between an issuer, its intermediaries or a network of providers arising by reason of a contract termination.

Proposed law authorizes the commissioner to promulgate reasonable regulations to implement the provisions of proposed law subject to the Louisiana Administrative Procedure Act.

Proposed law authorizes the commissioner to refuse to renew, or may suspend or revoke the certificate of authority of any insurer violating any provisions of proposed law. Authorizes the commissioner to levy a fine not to exceed $100,000 for each violation in lieu of suspension or revocation of a license duly issued.

Effective August 15, 2009.

(Adds R.S. 22:1016-1020)