

Regular Session, 2013

HOUSE BILL NO. 592

BY REPRESENTATIVE THIBAUT

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

1 AN ACT

2 To amend and reenact R.S. 44:4.1(B)(11) and to enact Subpart A-1 of Part III of Chapter 4
3 of Title 22 of the Louisiana Revised Statutes of 1950, to be comprised of R.S.
4 22:1019.1 through 1019.3, relative to ensuring the adequacy, accessibility, and
5 quality of health care services offered to covered persons by a health insurance
6 issuer in its health benefit plan networks; to provide for definitions; to provide with
7 respect to standards for the creation and maintenance of health benefit plan networks
8 by health insurance issuers; to provide with respect to the Public Records Law; to
9 provide for regulation and enforcement by the commissioner of insurance, including
10 imposition of fines and penalties; and to provide for related matters.

11 Be it enacted by the Legislature of Louisiana:

12 Section 1. Subpart A-1 of Part III of Chapter 4 of Title 22 of the Louisiana Revised
13 Statutes of 1950, comprised of R.S. 22:1019.1 through 1019.3, is hereby enacted to read as
14 follows:

15 SUBPART A-1. NETWORK ADEQUACY ACT

16 §1019.1. Short title; purpose, scope, and definitions

17 A. This Subpart shall be known and may be cited as the "Network Adequacy
18 Act".

19 B. The purpose and intent of this Subpart is to establish standards for the
20 creation and maintenance of networks by health insurance issuers and to ensure the
21 adequacy, accessibility, and quality of health care services offered to covered
22 persons under a health benefit plan by establishing requirements for written
23 agreements between health insurance issuers offering health benefit plans and

1 participating providers regarding the standards, terms, and provisions under which
2 such participating providers will provide services to covered persons.

3 C. This Subpart shall apply to all health insurance issuers that offer health
4 benefit plans but shall not include excepted benefits policies as defined in R.S.
5 22:1061(3).

6 D. As used in this Subpart:

7 (1) "Base health care facility" means a facility or institution providing health
8 care services, including but not limited to a hospital or other licensed inpatient
9 center, ambulatory surgical or treatment center, skilled nursing facility, inpatient
10 hospice facility, residential treatment center, diagnostic, laboratory, or imaging
11 center, or rehabilitation or other therapeutic health setting that has entered into a
12 contract or agreement with a facility-based physician.

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

14 (3) "Contracted reimbursement rate" means the aggregate maximum amount
15 that a participating or contracted health care provider has agreed to accept from all
16 sources for payment of covered health care services under the health insurance
17 coverage applicable to the covered person.

18 (4) "Covered health care services" means health care services that are either
19 covered and payable under the terms of health insurance coverage or required by law
20 to be covered.

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

23 (6) "Emergency medical condition" means a medical condition manifesting
24 itself by symptoms of sufficient severity, including severe pain, such that a prudent
25 layperson, who possesses an average knowledge of health and medicine, could
26 reasonably expect that the absence of immediate medical attention would result in
27 serious impairment to bodily functions, serious dysfunction of a bodily organ or part,
28 or would place the person's health or, with respect to a pregnant woman, the health
29 of the woman or her unborn child, in serious jeopardy.

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

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

8 (9) "Facility-based physician" means a physician licensed to practice
 9 medicine who is required by the base health care facility to provide services in a base
 10 health care facility, including an anesthesiologist, hospitalist, intensivist,
 11 neonatologist, pathologist, radiologist, emergency room physician, or other on-call
 12 physician, who is required by the base health care facility to provide covered health
 13 care services related to any medical condition.

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

17 (11) "Health care facility" means an institution providing health care services
 18 or a health care setting, including but not limited to hospitals and other licensed
 19 inpatient centers, ambulatory surgical or treatment centers, skilled nursing centers,
 20 diagnostic, laboratory and imaging centers, and rehabilitation and other therapeutic
 21 health settings.

22 (12) "Health care professional" means a physician or other health care
 23 practitioner licensed, certified, or registered to perform specified health care services
 24 consistent with state law.

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

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

1 (15) "Health insurance coverage" means benefits consisting of medical care
2 provided or arranged for directly, through insurance or reimbursement, or otherwise,
3 and includes health care services paid for under any health benefit plan.

4 (16) "Health insurance issuer" means an entity subject to the insurance laws
5 and regulations of this state, or subject to the jurisdiction of the commissioner, that
6 contracts or offers to contract, or enters into an agreement to provide, deliver,
7 arrange for, pay for, or reimburse any of the costs of health care services, including
8 a sickness and accident insurance company, a health maintenance organization, a
9 preferred provider organization or any similar entity, or any other entity providing
10 a plan of health insurance or health benefits.

11 (17) "Network of providers" or "network" means an entity, including a health
12 insurance issuer, that, through contracts or agreements with health care providers,
13 provides or arranges for access by groups of covered persons to health care services
14 by health care providers who are not otherwise or individually contracted directly
15 with a health insurance issuer.

16 (18) "Participating provider" or "contracted health care provider" means a
17 health care provider who, under a contract or agreement with the health insurance
18 issuer or with its contractor or subcontractor, has agreed to provide health care
19 services to covered persons with an expectation of receiving payment, other than
20 in-network coinsurance, copayments, or deductibles, directly or indirectly from the
21 health insurance issuer.

22 (19) "Person" means an individual, a corporation, a partnership, an
23 association, a joint venture, a joint stock company, a trust, an unincorporated
24 organization, any similar entity, or any combination thereof.

25 (20) "Primary care professional" means a participating health care
26 professional designated by a health insurance issuer to supervise, coordinate, or
27 provide initial care or continuing care to covered persons, and who may be required
28 by the health insurance issuer to initiate a referral for specialty care and maintain
29 supervision of health care services rendered to covered persons.

1 §1019.2. Network adequacy

2 A. A health insurance issuer providing a health benefit plan shall maintain
3 a network that is sufficient in numbers and types of health care providers to ensure
4 that all health care services to covered persons will be accessible without
5 unreasonable delay. In the case of emergency services and any ancillary emergency
6 health care services, covered persons shall have access twenty-four hours per day,
7 seven days per week. Sufficiency shall be determined in accordance with the
8 requirements of this Subpart. In determining sufficiency criteria, such criteria shall
9 include but not be limited to ratios of health care providers to covered persons by
10 specialty, ratios of primary care providers to covered persons, geographic
11 accessibility, waiting times for appointments with participating providers, hours of
12 operation, and volume of technological and specialty services available to serve the
13 needs of covered persons requiring technologically advanced or specialty care.

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

18 (2) A health insurance issuer shall establish and maintain adequate
19 arrangements to ensure reasonable proximity of participating providers to the
20 primary residences of covered persons. In determining whether a health insurance
21 issuer has complied with this Paragraph, the commissioner shall give due
22 consideration to the relative availability of health care providers in the service area
23 under consideration and the geographic composition of the service area. The
24 commissioner may consider a health insurance issuer's adjacent service area
25 networks that may augment health care providers if a health care provider deficiency
26 exists within the service area.

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

1 (4) A health insurance issuer shall maintain a directory of its network of
2 providers on the Internet. The directory of network providers must be furnished in
3 printed form to any covered person upon request. The directory of network
4 providers shall identify all health care providers that are not accepting new referrals
5 of covered persons or are not offering services to covered persons.

6 (5)(a) Beginning January 1, 2014, except as otherwise provided in
7 Subparagraph (b) of this Paragraph, a health insurance issuer shall annually file with
8 the commissioner, an access plan meeting the requirements of this Subpart for each
9 of the health benefit plans that the health insurance issuer offers in this state. Any
10 existing, new, or initial filing of policy forms by a health insurance issuer shall
11 include the network of providers, if any, to be used in connection with the policy
12 forms. If benefits under a health insurance policy do not rely on a network of
13 providers, the health insurance issuer shall state such fact in the policy form filing.
14 The health insurance issuer may request the commissioner to deem sections of the
15 access plan to contain proprietary or trade secret information that shall not be made
16 public in accordance with the Public Records Law, R.S. 44:1 et seq., or to contain
17 protected health information that shall not be made public in accordance with R.S.
18 22:42.1. If the commissioner concurs with the request, those sections of the access
19 plan shall not be subject to the Public Records Law or shall not be made public in
20 accordance with R.S. 22:42.1 as applicable. The health insurance issuer shall make
21 the access plans, absent any such proprietary or trade secret information and
22 protected health information, available and readily accessible on its business
23 premises and shall provide such plans to any interested party upon request, subject
24 to the provisions of the Public Records Law and R.S. 22:42.1.

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

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

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

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

27 (e) A health insurance issuer submitting proof of accreditation or an affidavit
28 demonstrating that the issuer is in the process of accreditation shall maintain an
29 access plan at its principal place of business. Such access plan shall be in accordance
30 with the requirements of the accrediting entity.

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

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

16 (2) The health insurance issuer's procedure for making referrals within and
17 outside its network.

18 (3) The health insurance issuer's process for monitoring and ensuring, on an
19 ongoing basis, the sufficiency of the network to meet the health care needs of
20 populations that enroll in its health benefit plans and general provider availability in
21 a given geographic area.

22 (4) The health insurance issuer's efforts to address the needs of covered
23 persons with limited English proficiency and illiteracy, with diverse cultural and
24 ethnic backgrounds, or with physical and mental disabilities.

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

27 (6) The health insurance issuer's method of informing covered persons of the
28 health benefit plan's services and features, including but not limited to the health
29 benefit plan's utilization review procedure, grievance procedure, external review
30 procedure, process for choosing and changing providers, and procedures for

1 providing and approving emergency services and specialty care. Additional
 2 information relating to these processes shall be available upon request and accessible
 3 via the health insurance issuer's website.

4 (7) The health insurance issuer's system for ensuring coordination and
 5 continuity of care for covered persons referred to specialty physicians, for covered
 6 persons using ancillary health care services, including social services and other
 7 community resources, and for ensuring appropriate discharge planning.

8 (8) The health insurance issuer's processes for enabling covered persons to
 9 change primary care professionals, for medical care referrals, and for ensuring that
 10 participating providers that require the use of health care facilities have hospital
 11 admission privileges.

12 (9) The health insurance issuer's proposed plan for providing continuity of
 13 care in the event of contract termination between the health insurance issuer and any
 14 of its participating providers, as required by R.S. 22:1005, or in the event of the
 15 health insurance issuer's insolvency or other inability to continue operations. This
 16 description shall explain how covered persons will be notified of contract
 17 termination, including but not limited to the effective date of the contract
 18 termination, the health insurance issuer's insolvency, or other cessation of operations,
 19 and how such covered persons will be transferred to other providers in a timely
 20 manner.

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

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

25 (a) When the covered health care service is not available from a participating
 26 provider in any case when a covered person has made a good faith effort to utilize
 27 participating providers for a covered service and it is determined that the health
 28 insurance issuer does not have the appropriate participating providers due to
 29 insufficient number, type, or distance, the health insurance issuer shall ensure, by

1 terms contained in the health benefit plan, that the covered person will be provided
2 the covered health care service.

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

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

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

9 D. A health insurance issuer not submitting proof of accreditation shall file
10 any proposed material changes to the access plan with the commissioner prior to
11 implementation of any such changes. The removal or withdrawal of any hospital or
12 multi-specialty clinic from a health insurance issuer's network shall constitute a
13 material change and shall be filed with the commissioner in accordance with the
14 provisions of this Subpart. Changes shall be deemed approved by the commissioner
15 after sixty days unless specifically disapproved in writing by the commissioner prior
16 to expiration of such sixty days.

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

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

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

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

23 §1019.3. Enforcement provisions, penalties, and regulations

24 A. If the commissioner determines that a health insurance issuer has not
25 contracted with enough participating providers to ensure that covered persons have
26 accessible health care services in a geographic area, that a health insurance issuer's
27 access plan does not ensure reasonable access to covered health care services, or that
28 a health insurance issuer has entered into a contract that does not comply with this
29 Subpart, the commissioner may do either or both of the following:

1 (1) Institute a corrective action plan that shall be followed by the health
2 insurance issuer within thirty days of notice of noncompliance from the
3 commissioner.

4 (2) Use his other enforcement powers to obtain the health insurance issuer's
5 compliance with this Subpart, including but not limited to disapproval or withdrawal
6 of his approval.

7 B. The commissioner shall not act to arbitrate, mediate, or settle disputes
8 regarding a decision not to include a health care provider in a health benefit plan or
9 in a provider network if the health insurance issuer has an adequate network as
10 determined by the commissioner pursuant to the requirements contained in this
11 Subpart.

12 C. The commissioner may promulgate such rules and regulations as may be
13 necessary or proper to carry out the provisions of this Subpart. Such rules and
14 regulations shall be promulgated and adopted in accordance with the Administrative
15 Procedure Act, R.S. 49:950 et seq.

16 D.(1) The commissioner may issue, and cause to be served upon the health
17 insurance issuer violating this Subpart, an order requiring such health insurance
18 issuer to cease and desist from such act or omission for the whole state or any
19 geographic area.

20 (2) The commissioner may refuse to renew, suspend, or revoke the certificate
21 of authority of any health insurance issuer violating any of the provisions of this
22 Subpart, or in lieu of suspension or revocation of a license duly issued, the
23 commissioner may levy a fine not to exceed one thousand dollars for each violation
24 per health insurance issuer, up to one hundred thousand dollars aggregate for all
25 violations in a calendar year per health insurance issuer, when such violations, in his
26 opinion, after a proper hearing, warrant the refusal, suspension, or revocation of such
27 certificate, or the imposition of a fine. The commissioner of insurance is authorized
28 to withhold fines imposed under this Subpart. Such hearing shall be held in the
29 manner provided in Chapter 12 of this Title, R.S. 22:2191 et seq. Additionally, the

1 commissioner may take any other administrative action, including imposing those
2 finances and penalties enumerated in R.S. 22:18.

3 Section 2. R.S. 44:4.1(B)(11) is hereby amended and reenacted to read as follows:

4 §4.1. Exceptions

5 * * *

6 B. The legislature further recognizes that there exist exceptions, exemptions,
7 and limitations to the laws pertaining to public records throughout the revised
8 statutes and codes of this state. Therefore, the following exceptions, exemptions, and
9 limitations are hereby continued in effect by incorporation into this Chapter by
10 citation:

11 * * *

12 (11) R.S. 22:2, 14, 42.1, 88, 244, 461, 572, 572.1, 574, 618, ~~706~~, 732, 752,
13 771, 1019.2(B)(5)(a), 1203, 1460, 1466, 1546, 1644, 1656, 1723, 1927, 1929, 1983,
14 1984, 2036, 2303

15 * * *

16 Section 3. This Act shall become effective upon signature by the governor or, if not
17 signed by the governor, upon expiration of the time for bills to become law without signature
18 by the governor, as provided by Article III, Section 18 of the Constitution of Louisiana. If
19 vetoed by the governor and subsequently approved by the legislature, this Act shall become
20 effective on the day following such approval.

SPEAKER OF THE HOUSE OF REPRESENTATIVES

PRESIDENT OF THE SENATE

GOVERNOR OF THE STATE OF LOUISIANA

APPROVED: _____