

Regular Session, 2013  
HOUSE BILL NO. 592

# ACT No. 205

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

CODING: Words in ~~struck through~~ type are deletions from existing law; words underscored are additions.

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

