2018 Regular Session

HOUSE BILL NO. 369

BY REPRESENTATIVE TALBOT

INSURANCE/HEALTH: Provides for mediation of the settlement of out-of-network health benefit claims involving balance billing

AN ACT

To enact Chapter 19 of Title 22 of the Louisiana Revised Statutes of 1950, to be comprised of R.S. 22:2455.1 through 2455.41, relative to mediation of out-of-network health benefit claims; to define key terms; to provide for applicability and scope; to require rulemaking; to provide for to require mediation of an out-of-network claim in certain circumstances; to require notice of certain information; to provide for mediators and their qualifications; to provide for mediation procedures; to require confidentiality; to provide for unsuccessful mediation; to authorize continued mediation; to provide for a mediation agreement; to provide for bad faith mediation including civil penalties; to provide for the investigation of consumer comlaints; and to provide for related matters.

Be it enacted by the Legislature of Louisiana:

Section 1. Chapter 19 of Title 22 of the Louisiana Revised Statutes of 1950, comprised of R.S. 22:2455.1 through 245.41, is hereby enacted to read as follows:

CHAPTER 19. OUT-OF-NETWORK CLAIM DISPUTE RESOLUTION

PART I. GENERAL PROVISIONS

§2455.1. Definitions

As used in this Chapter, the following definitions apply:

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

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

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

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

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

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

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

(8) "Facility" means an institution providing healthcare services or a healthcare setting, including but not limited to hospitals and other licensed inpatient centers, ambulatory surgical or treatment centers, skilled nursing centers, diagnostic, laboratory and imaging centers, and rehabilitation and other therapeutic health settings.

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

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

(11) "Mediation" means a process in which an impartial mediator facilitates and promotes agreement between the insurer offering a preferred provider benefit plan or the administrator and a facility-based provider or emergency care provider or the provider's representative to settle a health benefit claim of an enrollee.

(12) "Mediator" means an impartial person who is appointed to conduct a mediation pursuant to this Chapter.

(13) "Party" means an enrollee, an insurer offering a preferred provider benefit plan, an administrator, or a facility-based provider or emergency care provider or the provider's representative who participates in a mediation conducted pursuant to this Chapter.

§2455.2. Applicability

This Chapter shall apply to both of the following:

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

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

§2455.3. Rulemaking

The commissioner and the division of administrative law shall adopt rules as necessary to implement their respective powers and duties pursuant to this Chapter.

§2455.4. Remedies not exclusive

The remedies provided by this Chapter are in addition to any other defense, remedy, or procedure provided by law.

§2455.5. Reform

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

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

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

PART II. MANDATORY MEDIATION

§2455.11. Availability of mandatory mediation; exception

A. An enrollee may request mediation of a settlement of an out-of-network health benefit claim if both of the following apply:

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

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

(a) Emergency care.

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

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

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

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

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

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

D. A facility-based provider who makes a disclosure pursuant to Subsection C of this Section and obtains the enrollee's written acknowledgment of that disclosure shall not be required to mediate a billed charge pursuant to this Part if the

amount billed is less than or equal to the maximum amount projected in the disclosure.

§2455.12. Notice and information provided to enrollee

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

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

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

(1) Inform the enrollee about mediation pursuant to this Chapter.

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

§2455.13. Mediator qualifications

A. Except as provided by Subsection B of this Section, to qualify for an appointment as a mediator pursuant to this Chapter a person shall have completed at least forty classroom hours of training in dispute resolution techniques in a course conducted by an alternative dispute resolution organization or other dispute resolution organization approved by the commissioner.

B. A person not qualified pursuant to Subsection A of this Section may be appointed as a mediator on agreement of all of the parties.

C. A person shall not act as mediator for a claim settlement dispute if the person has been employed by, consulted for, or otherwise had a business relationship with an insurer offering the preferred provider benefit plan or a physician, healthcare practitioner, or other healthcare provider during the three years immediately preceding the request for mediation.

§2455.14. Appointment of mediator; fees

A. A mediation shall be conducted by one mediator.

B. The commissioner shall appoint the mediator through a random assignment from a list of qualified mediators maintained by the department.

C. Notwithstanding Subsection B of this Seection, a person other than a mediator appointed by the commissioner may conduct the mediation on agreement of all of the parties and notice to the commissioner.

D. The mediator's fees shall be split evenly and paid by the insurer or administrator and the facility-based provider or emergency care provider.

§2455.15. Request and preliminary procedures for mandatory mediation

A. An enrollee may request mandatory mediation pursuant to this Chapter.

B. A request for mandatory mediation shall be provided to the department on a form prescribed by the commissioner and shall include all of the following:

(1) The name of the enrollee requesting mediation.

(2) A brief description of the claim to be mediated.

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

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

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

C. On receipt of a request for mediation, the department shall notify the facility-based provider or emergency care provider and insurer or administrator of the request.

D. In an effort to settle the claim before mediation, all parties shall participate in an informal settlement teleconference not later than the thirtieth day after the date on which the enrollee submits a request for mediation pursuant to this Section.

E. A dispute to be mediated pursuant to this Chapter that does not settle as a result of a teleconference conducted pursuant to Subsection D of this Section shall be conducted in the parish in which the healthcare or medical services were rendered.

F.(1) The enrollee may elect to participate in the mediation.

(2) A mediation shall not proceed without the consent of the enrollee.

(3) An enrollee may withdraw the request for mediation at any time before the mediation.

G. Notwithstanding the provisions of Subsection F of this Section, mediation may proceed without the participation of the enrollee or the enrollee's representative if the enrollee or representative is not present in person or through teleconference.

§2455.16. Conduct of mediation; confidentiality

A. A mediator shall not impose the mediator's judgment on a party about an issue that is a subject of the mediation.

B. A mediation session shall be under the control of the mediator.

C. Except as provided by this Chapter, the mediator shall hold in strict confidence all information provided to the mediator by a party and all communications of the mediator with a party.

D. A party shall have an opportunity during the mediation to speak and state the party's position.

E. Except on the agreement of all of the participating parties, a mediation shall not last more than four hours.

F. Except at the request of an enrollee, a mediation shall be held not later than one-hundred-eighty days after the date of the request for mediation.

G. On receipt of notice from the department that an enrollee has made a request for mediation that meets the requirements of this Chapter, the facility-based

provider or emergency care provider shall not pursue any collection effort against the enrollee who has requested mediation for amounts other than copayments, deductibles, and coinsurance before the earlier of either of the following:

(1) The date the mediation is completed.

(2) The date the request to mediate is withdrawn.

H.(1) A healthcare or medical service or supply provided by a facility-based provider or emergency care provider shall not be summarily disallowed.

(2) This Subsection shall not require an insurer or administrator to pay for an uncovered service or supply.

I. A mediator shall not testify in a proceeding, other than a proceeding to enforce this Chapter, related to the mediation agreement.

§2455.17. Matters considered in mediation; agreed resolution

A. In a mediation pursuant to this Chapter, the parties shall do both of the following:

(1) Evaluate both of the following:

(a) Whether the amount charged by the facility-based provider or emergency care provider for the healthcare or medical service or supply is excessive.

(b) Whether the amount paid by the insurer or administrator represents the usual and customary rate for the healthcare or medical service or supply or is unreasonably low.

(2) As a result of the amounts provided for in Paragraph (1) of this Subsection, determine the amount, after copayments, deductibles, and coinsurance are applied, for which an enrollee is responsible to the facility-based provider or emergency care provider.

B. The facility-based provider or emergency care provider may present information regarding the amount charged for the healthcare or medical service or supply. The insurer or administrator may present information regarding the amount paid by the insurer or administrator.

C. Nothing in this Chapter shall prohibit mediation of more than one claim between the parties during a mediation.

D. The goal of the mediation shall be to reach an agreement among the enrollee, the facility-based provider or emergency care provider, and the insurer or administrator, as applicable, as to the amount paid by the insurer or administrator to the facility-based provider or emergency care provider, the amount charged by the facility-based provider or emergency care provider, and the amount paid to the facility-based provider or emergency care provider by the enrollee.

§2455.18. No agreed resolution

A. The mediator of an unsuccessful mediation pursuant to this Chapter shall report the outcome of the mediation to the department.

B.(1) The commissioner shall enter an order of referral of a matter reported pursuant to Subsection A of this Section to the division of administrative law.

(2) Each party shall pay the party's proportionate share of the costs for the hearing conducted by the division of administrative law.

C. A hearing conducted by the division of administrative law shall not be deemed relevant or material to any other balance bill dispute and shall have no precedential value.

§2455.19. Continuation of mediation

After a referral is made pursuant to R.S. 22:2455.18, the facility-based provider or emergency care provider and the insurer or administrator may elect to continue the mediation to further determine their responsibilities. Continuation of mediation pursuant to this Section shall not affect the amount of the billed charge to the enrollee.

§2455.20. Mediation agreement

The mediator shall prepare a confidential mediation agreement and order that states both of the following:

(1) The total amount for which the enrollee will be responsible to the facility-based provider or emergency care provider, after copayments, deductibles, and coinsurance.

(2) Any agreement reached by the parties pursuant to R.S. 22:2455.19.

§2455.21. Report of mediator

The mediator shall report to the commissioner both of the following:

(1) The names of the parties to the mediation.

(2) Whether the parties reached an agreement or the mediator made a referral pursuant to R.S. 22:2455.18.

PART III. BAD FAITH MEDIATION

§2455.31. Bad faith

A. The failure of a party to do any of the following shall constitute bad faith mediation for purposes of this Chapter:

(1) Participate in the mediation.

(2) Provide information the mediator believes is necessary to facilitate an agreement.

(3) Designate a representative participating in the mediation with full authority to enter into any mediated agreement.

B. Failure to reach an agreement shall not be conclusive proof of bad faith mediation.

§2455.32. Penalties

A. Bad faith mediation, by a party other than the enrollee, shall be grounds for imposition of an administrative penalty by the commissioner.

B. Except for good cause shown, on a report of a mediator and appropriate proof of bad faith mediation, the commissioner may impose an administrative penalty.

PART IV. COMPLAINTS AND CONSUMER PROTECTION

§2455.41. Consumer protection; rules

A. The commissioner shall adopt rules regulating the investigation and review of a complaint filed that relates to the settlement of an out-of-network health benefit claim subject to the provisions of this Chapter. The rules adopted pursuant to this Section shall do all of the following:

(1) Distinguish among complaints for out-of-network coverage or payment and give priority to investigating allegations of delayed healthcare or medical care.

(2) Develop a form for filing a complaint and establish an outreach effort to inform enrollees of the availability of the claims dispute resolution process pursuant to this Chapter.

(3) Ensure that a complaint is not dismissed without appropriate consideration.

(4) Ensure that enrollees are informed of the availability of mandatory mediation.

(5) Require the administrator to include a notice of the claims dispute resolution process available pursuant to this Chapter with the explanation of benefits sent to an enrollee.

B.(1) The department shall maintain information on each complaint filed that concerns a claim or mediation subject to the provisions of this Chapter.

(2) The department shall maintain information related to a claim that is the basis of an enrollee complaint, including all of the following:

(a) The type of services that gave rise to the dispute.

(b) The type and specialty, if any, of the facility-based provider or emergency care provider who provided the out-of-network service.

(c) The parish and metropolitan area in which the healthcare or medical service or supply was provided.

(d) Whether the healthcare or medical service or supply was for emergency care.

(e) Any other information about either of the following, as required by the commissioner:

(i) The insurer or administrator.

(ii) The facility-based provider or emergency care provider.

C. The information collected and maintained by the department pursuant to Paragraph (B)(2) of this Section shall be public information subject to the provisions of the Public Records Act and shall not include personally identifiable information or healthcare or medical information.

D. A facility-based provider or emergency care provider who fails to provide a disclosure required by R.S. 22:2455.11 or 2455.12 shall not be subject to discipline by any regulatory agency for that failure and a cause of action shall not be created by a failure to disclose as required by R.S. 22:2455.11 or 2455.12.

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DIGEST

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

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HB 369 Original 2018 Regular Session Talbot

**Abstract:** Provides for mediation of the settlement of out-of-network health benefit claims involving balance billing in an amount over $500.

Proposed law defines "administrator", "emergency care", "emergency care provider", "emergency medical condition", "enrollee", "facility", "facility-based provider", "healthcare practitioner", "mediation", "mediator", and "party".

Proposed law authorizes an enrollee to request mediation of a settlement of an out-of-network health benefit claim if both of the following apply:

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

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

Proposed law provides that a facility-based provider who makes a disclosure of projected out-of-network costs to an enrollee prior to service and obtains the enrollee's written acknowledgment of that disclosure shall not be required to mediate a billed charge if the amount billed is less than or equal to the maximum amount projected in the disclosure.

Proposed law provides for the qualifications and appointment of a mediator.

Proposed law sets forth the procedures for the mediation and provides that the goal of the mediation is to reach an agreement among the enrollee, the facility-based provider or emergency care provider, and the insurer or administrator, as applicable, as to the amount paid by the insurer or administrator to the facility-based provider or emergency care provider, the amount charged by the facility-based provider or emergency care provider, and the amount paid to the facility-based provider or emergency care provider by the enrollee.

Proposed law requires the commissioner of insurance to enter an order of referral of an unsuccessful mediation to the division of administrative law.

Proposed law provides for bad faith mediation including civil penalties imposed by the commissioner.

Proposed law requires the commissioner to investigate complaints related to the settlement of an out-of-network claim.

(Adds R.S. 22:2455.1-2455.41)