SENATE COMMITTEE AMENDMENTS

2022 Regular Session

Amendments proposed by Senate Committee on Insurance to Original Senate Bill No. 90 by Senator Robert Mills

1 AMENDMENT NO. 1

2 On page 1, line 2, after "To" delete the remainder of the line and insert in lieu thereof the
3 following"

4 "amend and reenact R.S. 22:1019.2(A), (B)(5), the introductory paragraph of R.S.
5 22:1019.2(C), and R.S. 22:1019.2(D), and to enact R.S. 22:1019.2(F), relative to
6 network adequacy for health benefit plans; to provide"

7 AMENDMENT NO. 2

8 On page 1, line 6, after "Section 1." delete the remainder of the line and insert in lieu thereof
9 the following:

10 "R.S. 22:1019.2(A), (B)(5), the introductory paragraph of R.S. 22:1019.2(C), and
11 R.S. 22:1019.2(D) are hereby amended and reenacted and R.S. 22:1019.2(F) is
12 hereby enacted to read as follows:"

13 AMENDMENT NO. 3

14 On page 1, between lines 7 and 8, insert the following:

15 "A. A health insurance issuer providing a health benefit plan shall maintain
16 a network that is sufficient in numbers and types of health care providers to ensure
17 that all health care services to covered persons will be accessible without
18 unreasonable delay. In the case of emergency services and any ancillary emergency
19 health care services, covered persons shall have access twenty-four hours per day,
20 seven days per week. Sufficiency shall be determined in accordance with the
21 requirements of this Subpart. In determining sufficiency criteria, ~~such~~ **the** criteria
22 shall include but not be limited to ratios of health care providers to covered persons
23 by specialty, ratios of primary care providers to covered persons, geographic
24 accessibility, waiting times for appointments with participating providers, hours of
25 operation, and volume of technological and specialty services available to serve the
26 needs of covered persons requiring technologically advanced or specialty care.
27 B.(1) * * *
28 (5)~~(a)~~ Beginning January 1, 2014, ~~except as otherwise provided in~~
29 ~~Subparagraph (b) of this Paragraph,~~ a health insurance issuer shall annually file with
30 the commissioner, an access plan meeting the requirements of this Subpart for each
31 of the health benefit plans that the health insurance issuer offers in this state. Any
32 existing, new, or initial filing of policy forms by a health insurance issuer shall
33 include the network of providers, if any, to be used in connection with the policy
34 forms. If benefits under a health insurance policy do not rely on a network of
35 providers, the health insurance issuer shall state ~~such~~ **this** fact in the policy form
36 filing. The health insurance issuer may request the commissioner to ~~deem~~ **consider**
37 sections of the access plan to contain proprietary or trade secret information that
38 shall not be made public in accordance with the Public Records Law, R.S. 44:1 et
39 seq., or to contain protected health information that shall not be made public in
40 accordance with R.S. 22:42.1. If the commissioner concurs with the request, those
41 sections of the access plan shall not be subject to the Public Records Law or shall not
42 be made public in accordance with R.S. 22:42.1 as applicable. The health insurance
43 issuer shall make the access plans, absent any such proprietary or trade secret
44 information and protected health information, available and readily accessible on its
45 business premises and shall provide ~~such~~ **the** plans to any interested party upon
46 request, subject to the provisions of the Public Records Law and R.S. 22:42.1.

This set of amendment(s) was prepared by Tom Tyler.

~~(b) In lieu of meeting the filing requirements of Subparagraph (a) of this Paragraph, a health insurance issuer shall, beginning January 1, 2014, except as otherwise provided in Subparagraph (c) of this Paragraph, submit proof of accreditation from the National Committee for Quality Assurance (NCQA) or American Accreditation Healthcare Commission, Inc./URAC to the commissioner, including an affidavit and sufficient proof demonstrating its accreditation for compliance with the network adequacy requirements of this Subpart. The affidavit shall include sufficient information to notify the commissioner of the health insurance issuer's accreditation and shall include a certification that the health insurance issuer's network of providers includes health care providers that specialize in mental health and substance abuse services and providers that are essential community providers. The affidavit shall also certify that the health insurance issuer complies with the provider directory requirement contained in Paragraph (4) of this Subsection. The commissioner may, at any time, recognize accreditation by any other nationally recognized organization or entity that accredits health insurance issuers; however, such entity's accreditation process shall be equal to or have comparative standards for review and accreditation of network adequacy.~~

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

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

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

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

* * *

D. A health insurance issuer ~~not submitting proof of accreditation~~ shall file any proposed material changes to the access plan with the commissioner prior to implementation of any such changes. The removal or withdrawal of any hospital or multi-specialty clinic 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 Subpart. Changes shall be ~~deemed~~ **considered** approved by the commissioner after sixty days unless specifically disapproved in writing by the commissioner prior to expiration of ~~such~~ **the** sixty days."

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