

2022 Regular Session

SENATE BILL NO. 90

BY SENATOR ROBERT MILLS

HEALTH/ACC INSURANCE. Provides relative to network adequacy for health insurer benefit plans. (1/1/23)

1 AN ACT

2 To amend and reenact R.S. 22:1019.2(A), (B)(5), the introductory paragraph of R.S.
3 22:1019.2(C), and R.S. 22:1019.2(D), and to enact R.S. 22:1019.2(F), relative to
4 network adequacy for health benefit plans; to provide for regulations to set standards
5 by which to measure network adequacy; and to provide for related matters.

6 Be it enacted by the Legislature of Louisiana:

7 Section 1. R.S. 22:1019.2(A), (B)(5), the introductory paragraph of R.S.
8 22:1019.2(C), and R.S. 22:1019.2(D) are hereby amended and reenacted and R.S.
9 22:1019.2(F) is hereby enacted to read as follows:

10 §1019.2. Network adequacy

11 A. A health insurance issuer providing a health benefit plan shall maintain
12 a network that is sufficient in numbers and types of health care providers to ensure
13 that all health care services to covered persons will be accessible without
14 unreasonable delay. In the case of emergency services and any ancillary emergency
15 health care services, covered persons shall have access twenty-four hours per day,
16 seven days per week. Sufficiency shall be determined in accordance with the
17 requirements of this Subpart. In determining sufficiency criteria, ~~such~~ the criteria

1 shall include but not be limited to ratios of health care providers to covered persons
 2 by specialty, ratios of primary care providers to covered persons, geographic
 3 accessibility, waiting times for appointments with participating providers, hours of
 4 operation, and volume of technological and specialty services available to serve the
 5 needs of covered persons requiring technologically advanced or specialty care.

6 B.(1) * * *

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

26 ~~(b) In lieu of meeting the filing requirements of Subparagraph (a) of this~~
 27 ~~Paragraph, a health insurance issuer shall, beginning January 1, 2014, except as~~
 28 ~~otherwise provided in Subparagraph (c) of this Paragraph, submit proof of~~
 29 ~~accreditation from the National Committee for Quality Assurance (NCQA) or~~

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

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

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

29 (e) A health insurance issuer submitting proof of accreditation or an affidavit

1 ~~demonstrating that the issuer is in the process of accreditation shall maintain an~~
2 ~~access plan at its principal place of business. Such access plan shall be in accordance~~
3 ~~with the requirements of the accrediting entity.~~

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

16 * * *

17 D. A health insurance issuer ~~not submitting proof of accreditation~~ shall file
18 any proposed material changes to the access plan with the commissioner prior to
19 implementation of any such changes. The removal or withdrawal of any hospital or
20 multi-specialty clinic from a health insurance issuer's network shall constitute a
21 material change and shall be filed with the commissioner in accordance with the
22 provisions of this Subpart. Changes shall be ~~deemed~~ **considered** approved by the
23 commissioner after sixty days unless specifically disapproved in writing by the
24 commissioner prior to expiration of ~~such~~ **the** sixty days.

25 * * *

26 **F. Nothing in this Section shall be interpreted to prohibit the**
27 **commissioner from establishing, by regulation, a set of standards by which to**
28 **measure network adequacy, from specifying periodic reporting to demonstrate**
29 **compliance with those standards, and to engage in a targeted review of the**

1 **adequacy of any insurer's network to meet the needs of the insurer's covered**
 2 **persons. The alternative to annual reporting established in R.S.**
 3 **22:1019.2(B)(5)(b) shall not apply to reporting or review described in this**
 4 **Section.**

5 Section 2. This Act shall become effective January 1, 2023.

The original instrument was prepared by Beth O'Quin. The following digest, which does not constitute a part of the legislative instrument, was prepared by Thomas L. Tyler.

DIGEST

SB 90 Engrossed

2022 Regular Session

Robert Mills

Present law provides for health insurance issuer to file annual access plans with the commissioner for each health benefit plan that the issuer offers in the state. Provides that existing, new, or initial filing of policy forms may include network providers and the issuer is to state whether benefits under the health insurance policy do not rely on a network of providers. Issuer's may request the commissioner to consider sections of the access plan to contain proprietary or trade secret information that shall not be made public under the Public Records Law or to contain protected health information that shall not be made public under the Louisiana Insurance Code. Authorizes the health insurance issuer to make the access plans, absent any proprietary or trade secret information and protected health information, available and readily accessible on its business premises and provide the plans to any interested party upon request.

Proposed law retains these provisions but removes exceptions involving submission of proof of accreditation to the commissioner.

Present law requires a health insurance issuer providing a health insurance plan, not including excepted benefits policies, to maintain a network that is sufficient in numbers and types of health care providers to ensure that all health care services to covered persons is accessible without unreasonable delay. Places various requirements upon issuers, including the requirements to ensure reasonable proximity of participating providers to furnish all contracted health care services, and to maintain a directory of its network of providers.

Proposed law provides that nothing in present law shall be interpreted to prohibit establishing, by regulation, a set of standards to measure network adequacy, from specifying periodic reporting that demonstrates compliance with the standards and engaging in a targeted review of the adequacy of an insurer's network to meet the needs of its covered persons. The alternative to annual reporting in law is not applicable to the reporting or review in proposed law.

Effective January 1, 2023.

(Amends R.S. 22:1019.2(A), (B)(5), (C)(intro para), and R.S. 22:1019.2(D);; adds R.S. 22:1019.2(F))

Summary of Amendments Adopted by Senate

Committee Amendments Proposed by Senate Committee on Insurance to the original bill

1. Adds provisions regarding annual filing of access plans by health insurance issuers.