DIGEST

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Thibaut HB No. 592

Abstract: Enacts the Network Adequacy Act to provide standards for the creation and maintenance of networks by health insurance issuers assuring the adequacy, accessibility, and quality of health care services offered to covered persons under its health benefit plans.

Proposed law enacts the Network Adequacy Act, as follows:

(1) Requires a health insurance issuer (issuer) providing a health benefit plan (plan) to maintain a network that is sufficient in numbers and types of health care providers (providers) to ensure that all health care services to covered persons will be accessible without unreasonable delay or cost. If such a network is insufficient, requires the issuer to ensure that covered persons obtains covered health care services at no greater cost. Also requires the issuer to ensure reasonable proximity of participating providers to the primary residences of covered persons and to monitor the ability of its providers to furnish all contracted health care services.

(2) In order to meet the network adequacy requirements of proposed law, requires an issuer to either: (a) submit proof of accreditation from the National Committee for Quality Assurance (NCQA) or from URAC (American Accreditation HealthCare Commission, Inc.) , including an affidavit of compliance with proposed law, to the commissioner of insurance; or (b) submit all required filings required by proposed law to the commissioner of insurance in order for him to conduct a review for the purposes of ascertaining network adequacy.

(3) Requires an issuer, beginning January 1, 2014, to annually file an access plan with the commissioner, portions of which may be deemed proprietary or trade secret information, pursuant to the Public Records Law, or protected health information, pursuant to the Insurance Code. Absent such information, requires issuers to make such plans available under certain conditions. Provides that such a plan shall be subject to approval by the commissioner and updated upon material change, including withdrawal of a hospital from the issuer's network. Specifies numerous components of the access plan, including the issuer's efforts to address the needs of covered persons with diverse cultural and ethnic backgrounds or with physical and mental disabilities, as well as the issuer's plan providing for continuity of care in the event of contract termination.

(4) Specifically provides that a covered person who has been diagnosed with or is being

treated for a life-threatening, terminal, incapacitating, or debilitating condition or illness shall have the right to request covered health care services from a nonparticipating provider which is located in or outside this state if either such provider agrees to the network contractual rate of the covered person's issuer or to any other settlement or negotiated rate between the issuer. Requires that the issuer provide such coverage.

(5) Provides that whenever it is medically necessary to refer a covered person to a nonparticipating provider, it shall be ensured that no greater out-of- pocket expenses be incurred by the covered person, unless such utilization is a willful choice.

(6) Requires that each contract between an issuer and a provider set forth a hold harmless provision for covered persons with respect to nonpayment by the issuer, its insolvency, or breach of the agreement. Provides that it shall also set forth that in the event of the issuer's cessation of operation, services will be continued through the period for which a premium has been paid or until discharge from an inpatient facility, whichever time is greater. Specifies that these contract provisions be construed in favor of the covered person and supercede any contrary oral or written agreement between a provider and covered person.

(7) Requires an issuer to develop selection standards for participating primary and specialized providers that do not exclude certain providers because of their geographic location or the population they treat. Requires that an issuer make its selection standards available to the commissioner.

(8) Requires an issuer to make certain information available to providers and requires that the contract between them include certain components, such as requiring admitting privileges at least one participating hospital.

(9) Requires additional numerous provisions in contracts between issuers and providers, including not prohibiting a provider from discussing treatment options with covered persons irrespective of the issuer's position on such options or from advocating on behalf of covered persons within the issuer's utilization review, grievance process, or external review procedure. Also requires that all patients of a primary care professional be notified when his contract is terminated. Additionally provides that a contract or agreement between an issuer and a provider shall not contain definitions or other provisions that conflict with those of proposed law.

(10) Defines an "intermediary" as a person authorized to negotiate and execute provider contracts with issuers on behalf of providers or on behalf of a network. Specifies that a contract between an intermediary and an issuer satisfy all requirements of proposed law and that providers with whom they contract also comply with such requirements. Disallows an issuer's statutory responsibility to monitor the offering of covered health care services from being delegated or assigned to the intermediary. Otherwise provides with respect to the relationship among intermediaries, issuers, and providers.

(11) Requires that, beginning January 1, 2014, a health insurance issuer file with the commissioner sample contract forms proposed for use with its participating providers and intermediaries. Requires submission of material changes to a contract and provides that if the commissioner takes no action within 60 days after such submission, the change is deemed approved.

(12) Provides that the execution of a contract or agreement by an issuer shall not relieve it of its liability to any person with whom it has contracted for the provision of services, nor of its responsibility for compliance with the law or applicable regulations. Requires that all contracts or agreements be in writing and subject to review.

(13) Provides that if the commissioner determines that an issuer has not contracted with enough participating providers to ensure that covered persons have accessible health care services in a geographic area, that an issuer's access plan does not ensure reasonable access to covered health care services, or that an issuer has entered into a contract that does not comply with proposed law, he may institute a corrective action plan that shall be followed by the issuer within 30 days of notice or use any of his other enforcement powers to obtain the issuer's compliance with proposed law. Provides that the commissioner shall not act to arbitrate, mediate, or settle disputes regarding a decision not to include a provider in a health benefit plan or a provider network if the issuer has an adequate network as determined by the commissioner pursuant to proposed law.

(14) Authorizes the commissioner to promulgate rules and regulations, to issue orders requiring such health insurance issuer to cease and desist from such act or omission which violates proposed law, or to refuse to renew, suspend, or revoke the certificate of authority of an issuer violating proposed law. In lieu of suspension or revocation of a license, authorizes the commissioner to levy a fine not to exceed $1,000 for each violation per health insurance issuer, up to $100,000 for all violations in a calendar year per issuer, after a proper hearing. Also authorizes the commissioner to take other administrative actions, including imposing fines and penalties.

Effective upon signature of governor or lapse of time for gubernatorial action.

(Amends R.S. 44:4.1(B)(11); Adds R.S. 22:1019.1-1019.7)