**Thibaut (HB 592)** **Act No. 205**

New law enacts the Network Adequacy Act, as follows:

(1) Requires a health insurance issuer (issuer) providing a health benefit plan (plan), excluding excepted benefits policies, 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. Provides for numerous definitions, including defining a "health insurance issuer" as an entity subject to the insurance laws and regulations of this state, or subject to the jurisdiction of the commissioner, that contracts or offers to contract, or enters into an agreement to provide, deliver, arrange for, pay for, or reimburse any of the costs of health care services, including a sickness and accident insurance company, a health maintenance organization, a preferred provider organization or any similar entity, or any other entity providing a plan of health insurance or health benefits.

(2) Places various requirements upon issuers, including the following:

(a) Maintenance of a network of providers that includes providers that specialize in mental health and substance abuse services, facility-based physicians, and providers that are essential community providers.

(b) Reasonable proximity of its providers to the primary residences of covered persons.

(c) Monitoring of the ability, clinical capacity, and legal authority of its providers to furnish all contracted health care services.

(d) Maintenance of a directory of its network of providers on the Internet.

(3) In order to meet the network adequacy requirements of new law, requires an issuer, beginning Jan. 1, 2014, to either: (a) submit proof of accreditation from the National Committee for Quality Assurance (NCQA) or from the American Accreditation HealthCare Commission, Inc./URAC, including an affidavit of compliance with new law, to the commissioner of insurance; or (b) submit all filings required by new law to the commissioner of insurance in order for him to conduct a review for the purposes of ascertaining network adequacy, specified in (4) below. Further provides that an issuer who is in the process of applying for accreditation from NCQA or URAC shall be deemed accredited upon submission of an affidavit to that effect to the commissioner. Specifies that if such accreditation is withdrawn or not subsequently received by such an issuer by July 1, 2015, that issuer shall submit all filings specified by (4) below to the commissioner. Also requires such submission if an issuer subsequently loses its NCQA or URAC accreditation. Further requires an issuer submitting proof of accreditation or in the process of applying for accreditation to maintain an access plan at its principal place of business. Specifies that such plan shall be in accordance with the requirements of the accrediting entity.

(4) Requires an issuer not submitting proof of accreditation 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 written approval by the commissioner, and updated upon material change, for existing plans and prior to offering a new health benefit plan. Also requires an issuer to inform the commissioner when the issuer enters a new service or market area and to submit an updated access plan. Specifies numerous components of the access plan, including:

(a) The issuer's network which includes the availability of and access to centers of excellence for transplant and other medically intensive services as well as the availability of critical care services, such as advanced trauma centers and burn units.

(b) The issuer's procedure for making referrals within and outside its network.

(c) The issuer's process for monitoring and ensuring, on an ongoing basis, the sufficiency of the network to meet the health care needs of populations that enroll in its plans and general provider availability in a given geographic area.

(d) The issuer's efforts to address the needs of covered persons with limited English proficiency and illiteracy, with diverse cultural and ethnic backgrounds, or with physical and mental disabilities.

(e) The health insurance issuer's methods for assessing the health care needs of covered persons and their satisfaction with services.

(f) The issuer's method of informing covered persons of the plan's services and features, including the plan's utilization review procedure, grievance procedure, external review procedure, process for choosing and changing providers, and procedures for providing and approving emergency services and specialty care. Also requires that additional information relating to these processes be available upon request and accessible via the issuer's website.

(g) The issuer's system for ensuring coordination and continuity of care for covered persons referred to specialty physicians, for covered persons using ancillary health care services, including social services and other community resources, and for ensuring appropriate discharge planning.

(h) The issuer's processes for enabling covered persons to change primary care professionals, for medical care referrals, and for ensuring that participating providers that require the use of health care facilities have hospital admission privileges.

(i) The issuer's proposed plan for providing continuity of care in the event of contract termination between the issuer and any of its participating providers or in the event of the issuer's insolvency or other inability to continue operations.

(j) A geographic map of the area proposed to be served by the plan by both parish and zip code.

(k) The policies and procedures to ensure access to covered health care services when the covered health care service is not available from a participating provider in any case when a covered person has made a good faith effort to utilize participating providers for a covered service and it is determined that the issuer does not have the appropriate participating providers due to insufficient number, type, or distance. Requires the issuer to ensure, by terms contained in the plan, that the covered person will be provided the covered health care service.

(l) The policies and procedures to ensure access to covered health care services when the covered person either has a medical emergency within the network's service area or a medical emergency outside the network's service area.

(5) Further requires that an issuer not submitting proof of accreditation file any proposed material changes to the access plan with the commissioner prior to implementation of any such changes, including the removal or withdrawal of any hospital or multi-specialty clinic from an issuer's network.

(6) Provides that filings containing any proposed material changes to an access plan shall include: a listing of health care facilities and the number of hospital beds at each network health care facility; the ratio of participating providers to current covered persons; and any other information requested by the commissioner.

(7) 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 new 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 new law. Prohibits the commissioner from acting to arbitrate, mediate, or settle disputes regarding a decision not to include a provider in a plan or a provider network if the issuer has an adequate network as determined by the commissioner pursuant to new law.

(8) Authorizes the commissioner to promulgate rules and regulations, to issue orders requiring issuers to cease and desist from an act or omission which violates new law, or to refuse to renew, suspend, or revoke the certificate of authority of an issuer violating new 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.

Prior law provided for exemptions, exceptions and limitations to public records law.

Adds new law pertaining to network adequacy to the public records law exceptions.

Effective upon signature of the governor (June 10, 2013).

(Amends R.S. 44:4.1(B)(11); Adds R.S. 22:1019.1-1019.3)