Regular Session, 2014

HOUSE BILL NO. 506

BY REPRESENTATIVE GREENE

INSURANCE/HEALTH: Provides with respect to notice requirements for qualified health plan issuers on the health insurance exchange

AN ACT

To enact R.S. 22:1964(l)(i) and Subpart O of Part III of Chapter 4 of Title 22 of the Louisiana Revised Statutes of 1950, to be comprised of R.S. 22:1260.31 through 1260.38, relative to health insurance; to provide for certain notice requirements which must be satisfied by health insurance issuers offering plans on the exchange; to provide definitions; to provide for recoupment deadlines; to provide for injunctive relief and penalties; to provide for rules and regulations; to provide for severability; and to provide for related matters.

Be it enacted by the Legislature of Louisiana:

Section 1. R.S. 22:1964(1)(i) and Subpart O of Part III of Chapter 4 of Title 22 of the Louisiana Revised Statutes of 1950, comprised of R.S. 22:1260.31 through 1260.38, are hereby enacted to read as follows:

§1964. Methods, acts, and practices which are defined as unfair or deceptive

The following are declared to be unfair methods of competition and unfair or deceptive acts or practices in the business of insurance:

(1) Misrepresentations and false advertising of insurance policies. Making, issuing, circulating, or causing to be made, issued, or circulated any estimate, illustration, circular or statement, sales presentation, omission, or comparison that does any of the following:

* * *

(i) Violation of any provision of the Physician and Provider Notification of Patients in Health Insurance Exchange Grace Period Act, R.S. 22:1260.31 et seq.

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SUBPART O. PHYSICIAN AND PROVIDER NOTIFICATION OF PATIENTS IN HEALTH INSURANCE EXCHANGE GRACE PERIOD ACT

§1260.31. Short title

This Subpart shall be known and may be cited as the "Physician and Provider Notification of Patients in Health Insurance Exchange Grace Period Act".

§1260.32. Definitions

As used in this Subpart, the following words shall have the following meanings, unless the context clearly indicates otherwise:

(1) "Enrollee" means a qualified individual or qualified employee enrolled in a qualified health plan or other health insurance plan. An enrollee is generally a person eligible for services covered by a specific health insurance plan in the exchange.

(2) "Grace period" is a period that applies to recipients of advance payments of the premium tax credit allowed for certain individuals to purchase health insurance coverage on the exchange. The grace period provides three consecutive months of eligibility for health care services to an enrollee when that enrollee has paid a premium at least one full month during the benefit year. The grace period begins when the enrollee fails to pay the premium for a particular month.

(3) "Health insurance exchange" or "exchange" means a governmental agency or nonprofit entity that meets the applicable standards of the Patient Protection and Affordable Care Act and makes qualified health plans available to qualified individuals and qualified employers.

(4) "Qualified health plan" means a health insurance plan that has in effect a certification that the qualified health plan meets applicable state or federal standards required for participation in a health insurance exchange. These may

include minimum standards for essential health benefits, deductibles, copayments, out-of-pocket maximum amounts, and other requirements.

(5) "Qualified health plan issuer" means a health insurance issuer that offers a qualified health plan in accordance with a certification from an exchange.

§1260.33. Notice requirements

A. Timing of notice to physician or provider of grace period status.

(1) When a physician or other health care provider or his representative requests information regarding an enrollee from a qualified health plan issuer about eligibility, coverage, or health plan benefits, or the status of a claim or claims for services provided, or if the physician or health care provider or his designee reports a claim in a remittance advice, and the request or service is for a date within the second or third month of a grace period, the qualified health plan issuer shall clearly identify that the applicable enrollee is in the grace period and provide additional information as required by this Subpart.

(2) The qualified health plan issuer shall provide the notice through the same medium through which the physician or other health care provider or his representative sought the information from the qualified health plan issuer pursuant to Paragraph (1) of this Subsection or by the method in which he normally receives claim remittance advice information.

(3) The information provided about the enrollee's grace period status shall be binding on the qualified health plan pursuant to this Subpart.

B. Specific notice requirements.

(1) If the qualified health plan issuer informs the physician or other health care provider or his representative that the enrollee is eligible for services but not that the enrollee is in the grace period, the determination shall be binding on the qualified health plan issuer and he shall pay the claims for services rendered.

(2) The binding determination shall preclude the qualified health plan issuer from seeking to recoup payment from the physician or other health care provider.

(3) If the qualified health plan issuer informs the physician or other health care provider that the enrollee is in a grace period, he shall then provide further notification pursuant to Subsection C of this Section.

C. Contents of notice. The notice to the physician or other health care provider shall include but not be limited to the following:

(1) Purpose of the notice.

(2) The full legal name of the enrollee and any unique identifying numbers.

(3) The name of the qualified health plan.

(4) The unique health plan identifier of the qualified health plan.

(5) The name of the qualified health plan issuer.

(6) The specific date upon which the grace period for the enrollee began and the specific date upon which the grace period will expire.

D. In a conspicuous location on a qualified health plan website, the qualified health plan issuer shall include an explanation of his plan of action both during the grace period and upon the exhaustion of the grace period, including options for the provider and the enrollee. This shall include the following:

(1) Whether the qualified health plan issuer will pend any claims of the physician or other health care provider for services that the physician or other health care provider furnishes to the enrollee during the grace period.

(2) A statement indicating that should the qualified health plan issuer indicate that he will pay some or all of the claims for services provided to an enrollee during the grace period, whether and how he will seek to recoup claims payments made to physicians or health care providers for services furnished during the grace period.

§1260.34. Strict compliance required

A qualified health plan issuer shall be obligated to pay for any claims for services rendered during a grace period if he has failed to strictly comply with the provisions of this Subpart.

§1260.35. Deadline for overpayment recoveries

If the qualified health plan issuer seeks to recoup or otherwise recover payments made to the physician or other health care provider for services furnished to an enrollee during the grace period, the qualified health plan issuer shall commence such recovery or recoupment efforts no later than sixty days after the expiration of the grace period. Any attempts to recover payments that are commenced subsequent to this sixty-day period shall be null and void.

§1260.36. Waiver prohibited

The provisions of this Subpart cannot be waived by contract. Any contractual arrangements in conflict with the provisions of this Subpart or that purport to waive any requirements of this Subpart are null and void.

§1260.37. Injunction and penalties

A. Any physician or other health care provider may request a court of appropriate jurisdiction to issue an injunction to enforce any provision of this Subpart.

B. In addition to injunctive relief, violations of this Subpart shall be considered an unfair trade practice and shall be subject to the procedures and penalties as set forth in Part IV of Chapter 7 of Title 22 of the Louisiana Revised Statutes of 1950, R.S. 22:1961 et. seq.

§1260.38. Rules and regulations

The commissioner of insurance shall promulgate all rules and regulations which are necessary and proper to carry out the provisions of this Subpart. All rules and regulations promulgated pursuant to this Subpart shall be in accordance with the Administrative Procedure Act.

Section 2. If any provision of this Act or the application thereof is held invalid, such invalidity shall not affect other provisions or applications of this Act which can be given effect without the invalid provisions or applications, and to this end the provisions of this Act are hereby declared severable. The severability provision of this Section shall be

broadly construed as to give effect to each and every possible provision or application of this Act which is not specifically held invalid, unlawful, or unconstitutional.

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)]

Greene HB No. 506

Abstract: Provides notice requirements and procedures for qualified health plan issuers on the exchange for enrollees in a grace period.

Proposed law provides definitions.

Proposed law requires that when a physician, other health care provider, or his representative requests information from a qualified health plan issuer regarding the eligibility of an enrollee, his coverage, plan benefits, status of a claim, or reports a claim in a remittance advice, and the request is made in the 2nd or 3rd month of a grace period, the qualified health plan issuer shall provide the information and identify that the enrollee is in a grace period.

Proposed law provides that the information regarding the enrollee's grace period status is binding on the qualified health plan.

Proposed law further requires that the information be provided through the same medium the information was sought.

Proposed law provides that if a qualified health plan issuer informs a physician or health care provider than an enrollee is eligible for services but does not inform the provider that the enrollee is in a grace period, then the qualified health plan issuer is responsible for paying the claims and he will be unable to recoup payment from the physician or other health care provider.

Proposed law requires that the notice include:

(1) The purpose of the notice.

(2) The full legal name of the enrollee and any unique identifying numbers.

(3) The name of the qualified health plan.

(4) The unique health plan identifier of the qualified health plan.

(5) The name of the qualified health plan issuer.

(6) The specific date upon which the grace period for the enrollee began and the specific date upon which it will expire.

Proposed law requires the qualified health plan issuer to clearly outline on the qualified health plan website whether he will pay any claims during the grace period as well as a statement which indicates if whether and how he will seek recoupment of payment for the payment of such claims.

Proposed law provides that failure to comply with the requirements of proposed law will result in the mandate of the qualified health issuer to pay for any and all claims for services furnished by the physician or health care provider to an enrollee during a grace period.

Proposed law provides that a qualified health plan issuer has up to 60 days after the expiration of the grace period to seek recoupment of services provided during the grace period.

Proposed law prohibits the waiver of any provisions of proposed law by contract.

Proposed law allows a physician or other health care provider to request an injunction in an appropriate court for the enforcement of proposed law.

Proposed law provides that any violation of proposed law shall be considered an unfair trade practice and shall be subject to the appropriate penalties.

Proposed law allows the commissioner of insurance to promulgate any rules and regulations necessary to carry out the provisions of proposed law.

Present law sets forth a list of practices determined to be unfair methods of competition and unfair or deceptive acts or practices in the business of insurance.

Proposed law adds the violation of proposed law to the prohibited practices set forth in present law.

Proposed law provides for severability of its provisions.

(Adds R.S. 22:1964(l)(i) and 1260.31-1260.38)