2018 Regular Session

HOUSE BILL NO. 875

BY REPRESENTATIVE TALBOT

INSURANCE/HEALTH: Provides relative to health insurance network provider directories

AN ACT

To amend and reenact R.S. 22:1873(B)(4) and 1879(B)(3), to enact Subpart A-2 of Part III of Chapter 4 of the Louisiana Revised Statutes of 1950, to be comprised of R.S. 22:1020.1 through 1020.6, and to repeal R.S. 22:1019.2(B)(4), relative to health insurance network provider directories; to provide for the content of a directory; to require the directory to be electronically searchable and publicly accessible; to require continuous review and updating; to set a time period for updates after certain events; to provide for the reporting of inaccurate information; to provide for investigations for compliance; to authorize an assessment on investigated insurers to pay for the costs of investigations; to provide for penalties; to limit liability; to provide for applicability; to provide for an effective date; and to provide for related matters.

Be it enacted by the Legislature of Louisiana:

Section 1. R.S. 22:1873(B)(4) and 1879(B)(3) are hereby amended and reenacted and Subpart A-2 of Part III of Chapter 4 of the Louisiana Revised Statutes of 1950, comprised of R.S. 22:1020.1 through 1020.6, is hereby enacted to read as follows:

SUBPART A-2. NETWORK PROVIDER DIRECTORY

ACCESSIBILITY AND ACCURACY ACT

§1020.1. Short title; purpose; scope; definitions

A. This Subpart shall be known and may be cited as the "Network Provider Directory Accessibility and Accuracy Act".

B. The purpose and intent of this Subpart is to establish standards for the creation and maintenance by a health insurance issuer of a directory of the issuer's network of healthcare providers and to ensure the accessibility and accuracy of the directory.

C. This Subpart shall apply to all health insurance issuers that offer health benefit plans in this state but shall not include excepted benefits policies as defined in R.S. 22:1061(3).

D. As used in this Subpart:

(1) "Commissioner" means the commissioner of insurance.

(2) "Covered person" means a policyholder, subscriber, enrollee, insured, or other individual participating in a health benefit plan.

(3) "Department" means the Department of Insurance.

(4) "Health benefit plan" means a policy, contract, certificate, or subscriber agreement entered into, offered, or issued by a health insurance issuer to provide, deliver, arrange for, pay for, or reimburse any of the costs of healthcare services.

(5) "Healthcare facility" means an institution providing healthcare services or a healthcare setting, including but not limited to hospitals and other licensed inpatient centers, ambulatory surgical or treatment centers, skilled nursing centers, diagnostic, laboratory, and imaging centers, and rehabilitation and other therapeutic health settings.

(6) "Healthcare professional" means a physician or other healthcare practitioner licensed, certified, or registered to perform specified healthcare services consistent with state law.

(7) "Healthcare provider" or "provider" means a healthcare professional or a healthcare facility.

(8) "Healthcare services" means services, items, supplies, or drugs for the diagnosis, prevention, treatment, cure, or relief of a health condition, illness, injury, or disease.

(9) "Health insurance issuer" means 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 healthcare 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.

(10) "Network of providers" or "network" means an entity, including a health insurance issuer, that, through contracts or agreements with healthcare providers, provides or arranges for access by groups of covered persons to healthcare services by healthcare providers who are not otherwise or individually contracted directly with a health insurance issuer.

§1020.2. Provider directory; content; accessibility

A. A health insurance issuer shall maintain a directory of the issuer's network of providers on the internet.

B. The directory shall include the name, specialty, if any, street address, and telephone number of each healthcare provider and indicate whether the provider is accepting new patients.

C. The directory shall be all of the following:

(1) Electronically searchable by healthcare provider name, specialty, if any, and location.

(2) Publicly accessible without necessity of providing a password, a user name, or personally identifiable information.

§1020.3. Continuous review required

A. A health insurance issuer shall conduct an ongoing review of the issuer's provider directory and correct or update the information as necessary. Except as

provided in Subsections B and C of this Section, corrections and updates, if any, shall be made not less than once every twenty business days.

B. The health insurance issuer shall update the directory to list a healthcare provider not later than ten business days after the effective date of the provider's credentialing with the health insurance issuer.

C. The health insurance issuer shall update the directory to remove a healthcare provider not later than ten business days after the effective date of the termination of the provider's credentialing with the health insurance issuer.

§1020.4. Reporting of inaccurate information

A. A health insurance issuer shall conspicuously display in the issuer's provider directory an email address, a toll-free telephone number, or another mechanism that is easily accessible to any individual by which the individual may report any inaccuracy in the directory.

B. If the health insurance issuer receives a report from any person that specifically identified directory information may be inaccurate, the issuer shall investigate the report and correct the information, as necessary, in accordance with the following schedule:

(1) Not later than the second business day after the date the report is received if the report concerns the health insurance issuer's representation of the network participation status of a healthcare provider.

(2) Not later than the fifth business day after the date the report is received if the report concerns any other type of information in the directory.

§1020.5. Investigation by the commissioner; assessment; penalties; applicability

A. If, in any thirty-day period, a health insurance issuer receives three or more reports that allege the issuer's directory inaccurately represents a healthcare provider's network participation status and that are confirmed by the issuer's investigation, the health insurance issuer shall immediately report that occurrence to the commissioner.

B. On receipt of a report pursuant to Subsection A of this Section, the commissioner shall investigate the health insurance issuer's compliance with the provisions of this Subpart.

C. The department may collect an assessment in an amount determined by the commissioner from the health insurance issuer at the time of the investigation to cover all expenses attributable directly to the investigation, including but not limited to the salaries and expenses of department employees and all reasonable expenses of the department necessary for the administration of this Subpart.

D. Except as otherwise provided in Subsection F of this Section, the Department of Insurance may promulgate rules and regulations to provide for civil fines payable by a health insurance issuer not to exceed five hundred dollars for each act of violation of the requirements of this Subpart, not to exceed an aggregate fine of fifty thousand dollars. For purposes of this Subsection, "act of violation" is limited to an intentional act or an act of gross negligence.

E.(1) A health insurance issuer shall not be responsible for information that is inaccurately submitted or not submitted by healthcare providers as stated in their contract.

(2) The penalties provided for in this Section shall be the exclusive remedy for any violations and there shall be no independent cause of action by any person based upon a violation or other information reported.

F. The provisions of this Subpart shall apply to the Office of Group Benefits; however, the commissioner of insurance shall not levy an assessment or fine against the Office of Group Benefits. If the commissioner of insurance concludes that the Office of Group Benefits has violated this Subpart, the commissioner of insurance shall notify the commissioner of administration in writing within thirty days of the violation.

§1020.6. Printed form available upon request

The directory of network providers required pursuant to this Subpart shall be furnished in printed form to any covered person upon request.

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§1873. Notice requirements

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B. Health insurance issuer notice requirements shall be as follows:

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(4) A health insurance issuer shall maintain and update ~~its~~ a list of contracted ~~health care~~ healthcare providers ~~on at least an annual basis~~ in accordance with the Network Provider Directory Accessibility and Accuracy Act, R.S. 22:1020.1 et seq., and shall make the current version available to enrollees or insureds on request.

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§1879. Louisiana consumer health care provider network disclosure

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(3) A health insurance issuer shall update its website ~~as soon as possible but not later than thirty days following receipt of any updated information or within thirty days of the effective date of a contract.~~ in accordance with the Network Provider Directory Accessibility and Accuracy Act, R.S. 22:1020.1 et seq.

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Section 2. R.S. 22:1019.2(B)(4) is hereby repealed in its entirety.

Section 3. This Act shall become effective on January 1, 2019.

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)]

HB 875 Reengrossed 2018 Regular Session Talbot

Abstract: Requires the posting and regular updating of a directory of a health insurance issuer's network of providers.

Present law requires a health insurance issuer to maintain a directory of its network of providers on the internet and to identify all healthcare providers that are not accepting new referrals of covered persons or are not offering services to covered persons.

Proposed law requires a health insurance issuer to maintain a directory of its network of providers on the internet that includes the name, specialty, if any, street address, and telephone number of each healthcare provider and indicates whether the provider is accepting new patients.

Proposed law requires the directory to be both electronically searchable by name, specialty, and location and publicly accessible without necessity of providing a password, a user name, or personally identifiable information.

Proposed law requires the health insurance issuer to conduct an ongoing review of the directory and correct or update the information as necessary not less than once every 20 business days. Proposed law further requires the health insurance issuer to update the directory not later than 10 business days after either of the following:

(1) The effective date of a provider's credentialing with the health insurance issuer to list the provider.

(2) The effective date of termination of a provider's credentialing with the health insurance issuer to remove the provider.

Proposed law requires the directory to contain a conspicuously displayed email address, toll-free telephone number, or other mechanism that is easily accessible to which any individual may report any inaccuracy in the directory.

Proposed law requires an issuer who receives a report that specifically identified directory information may be inaccurate to investigate the report and make any necessary corrections not later than the second business day after the date the report is received if the report concerns the representation of the network participation status of the provider or the fifth business day after the date the report is received if the report concerns any other type of information in the directory.

Proposed law requires a health insurance issuer who receives three or more reports in any 30-day period that allege the issuer's directory inaccurately represents a provider's network participation status and are confirmed by the issuer's investigation to immediately report that occurrence to the commissioner of insurance.

Proposed law requires the commissioner to investigate the health insurance issuer's compliance with proposed law.

Proposed law authorizes the Dept. of Insurance to collect an assessment in an amount determined by the commissioner from the health insurance issuer at the time of the investigation to cover all expenses attributable directly to the investigation, including the

salaries and expenses of department employees and all reasonable expenses of the department necessary for the administration of proposed law.

Proposed law authorizes the Dept. of Insurance to promulgate rules and regulations to provide for civil fines payable by a health insurance issuer not to exceed $500 for each intentional act or act of gross negligence in violation of proposed law, not to exceed an aggregate fine of $50,000.

Proposed law provides that a health insurance issuer shall not be responsible for information that is inaccurately submitted or not submitted by healthcare providers as stated in their contract.

Proposed law provides that the penalties established in proposed law are the exclusive remedy for any violations and prohibits an independent cause of action by any person based upon a violation or other information reported.

Proposed law applies to the Office of Group Benefits; however, the commissioner of insurance shall notify the commissioner of administration in writing within 30 days of a violation in lieu of levying an assessment or fine against the Office of Group Benefits.

Present law requires the directory of network providers to be furnished in printed form to any covered person upon request.

Proposed law retains present law.

Effective Jan. 1, 2019.

(Amends R.S. 22:1873(B)(4) and 1879(B)(3); Adds R.S. 22:1020.1-1020.6; Repeals R.S. 22:1019.2(B)(4))

Summary of Amendments Adopted by House

The Committee Amendments Proposed by House Committee on Insurance to the original bill:

1. Change the time period for correcting or updating information as necessary pursuant to the ongoing review of the directory from not less than once every five business days to not less than once every 15 business days.

2. Require a directory to be updated not later than 10 business days after the effective date of a provider's credentialing with the health insurance issuer.

3. Require a directory to be updated not later than 10 business days after the termination of a provider's credentialing with the health insurance issuer.

4. Authorize a fine of up to $500 for each violation.

5. Limit a health insurance issuer's responsibility when the issuer receives inaccurate information or no information at all from a provider.

6. Provide that the penalties in proposed law are the exclusive remedies and prohibit an independent cause of action based upon a violation of proposed law.

7. Provide for applicability to the Office of Group Benefits.

8. Make technical changes.

The House Floor Amendments to the engrossed bill:

1. Extend the time period for correcting or updating information as necessary pursuant to the ongoing review of the directory from not less than once every15 business days to not less than once every 20 business days.

2. Authorize health insurance issuers to offer any mechanism for reporting inaccuracies that is easily accessible to any individual.

3. Make technical changes.