DIGEST

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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.