SLS 201ES-7 **ORIGINAL**

2020 First Extraordinary Session

SENATE BILL NO. 8

BY SENATOR TALBOT

INSURANCE CLAIMS. Establishes an independent dispute resolution process for certain health benefit claims. (Item #37)

AN ACT

To enact R.S. 22:1828 and Subpart E of Part II of Chapter 6 of Title 22 of the Louisiana Revised Statutes of 1950, to be comprised of R.S. 22:1885.1 through 1885.8, relative to health insurance; to provide for assignment of benefits; to provide for definitions; to provide for an independent process for the resolution of payment disputes between health insurance issuers and certain health care providers; to provide for applicability; to provide for criteria to be used by an independent dispute resolution entity; to provide for rulemaking; and to provide for related matters.

Be it enacted by the Legislature of Louisiana:

Section 1. R.S. 22:1828 and Subpart E of Part II of Chapter 6 of Title 22 of the Louisiana Revised Statutes of 1950, comprised of R.S. 22:1885.1 through 1885.8, are hereby enacted to read as follows:

§1828. Assignment of benefits

A. For purposes of this Section:

(1) "Health care provider" means:

(a) A physician or other health care practitioner licensed, certified, or registered to perform specified health care services consistent with state law

who provides services in accordance with the provisions of the insurance contract, policy, subscriber agreement, certificate of coverage, or other evidence of health insurance coverage.

(b) A facility or institution providing health care services, including but not limited to a hospital or other licensed inpatient center; an ambulatory, surgical, or treatment center; a skilled nursing facility; an inpatient hospice facility; a residential treatment center; a diagnostic, laboratory, or imaging center; or a rehabilitation or other therapeutic health setting.

(2) "Health insurance coverage" means benefits consisting of medical care provided or arranged for directly through insurance, reimbursement, or otherwise, and including items and services paid for as medical care under any hospital or medical service policy or certificate, hospital or medical service plan contract, preferred provider organization agreement, or health maintenance organization contract offered by a health insurance issuer.

(3) "Health insurance issuer" means any entity that offers health insurance coverage through a policy or certificate of insurance subject to state law that regulates the business of insurance. For purposes of this Section, a "health insurance issuer" includes a health maintenance organization as defined and licensed pursuant to Subpart I of Part I of Chapter 2 of this Title, nonfederal government plans subject to the provisions of Subpart B of this Part, and the Office of Group Benefits.

B.(1) Notwithstanding any other provision of law to the contrary, an insured, beneficiary, subscriber, or enrollee shall have the right to assign in writing any benefits payable under health insurance coverage, including any legal or contractual rights flowing from the coverage, to a health care provider who files claims with a health insurance issuer for medical services provided to the insured, beneficiary, subscriber, or enrollee. A health insurance issuer shall recognize an assignment of benefits to a health care provider by an insured, beneficiary, subscriber, or enrollee and shall not include any language or

provisions prohibiting an assignment in any form, contract, policy, subscriber agreement, certificate of coverage, or other evidence of health insurance coverage.

(2) Any payment made only to the insured, beneficiary, subscriber, or enrollee rather than the health care provider after assignment of benefits has been made as provided for in Paragraph (1) of this Subsection shall be considered unpaid.

(3) An insurance contract, policy, subscriber agreement, certificate of coverage, or other evidence of health insurance coverage shall not prohibit, and claims forms shall provide an option for, the payment of benefits directly to a health care provider who provides medical services in accordance with the provisions of the insurance contract, policy, subscriber agreement, certificate of coverage, or other evidence of health insurance coverage for care provided.

(4) The department shall develop and make available on the department's website a standard form that shall be accepted by any health insurance issuer and that may be executed by an insured to effectuate an assignment of benefits to a health care provider.

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SUBPART E. NO SURPRISES IN HEALTH INSURANCE COVERAGE ACT

§1885.1. Title

This Subpart shall be known and may be cited as the "No Surprises in Health Insurance Act of 2020".

§1885.2. Definitions

For the purposes of this Subpart:

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

(2) "Department" means the Louisiana Department of Insurance.

(3) "Emergency condition" means a medical or behavioral condition that manifests itself by acute symptoms of sufficient severity, including severe pain, that a prudent layperson possessing an average knowledge of medicine and

health would reasonably expect the absence of immediate medical attention to result in any of the following:

(a) Placing the health of the person afflicted with the condition in serious jeopardy or, in the case of a behavioral condition, placing the health of the person or others in serious jeopardy.

(b) Serious impairment to the person's bodily functions.

(c) Serious dysfunction of any bodily organ or part of the person.

(d) Serious disfigurement of the person.

(e) A condition described in clause (i), (ii), or (iii) of Section 1867(e)(1)(A) of the Social Security Act, 42 U.S.C. Section 1395dd.

(4) "Emergency services" means, with respect to an emergency condition that requires a medical screening examination pursuant to Section 1867 of the Social Security Act, 42 U.S.C. Section 1395dd, services which are within the capability of the emergency department of a hospital, including ancillary services routinely available to the emergency department to evaluate the emergency medical condition. "Emergency services" also means services which are within the capabilities of the staff and facilities available at the hospital, for any further medical examination and treatment required pursuant to Section 1867 of the Social Security Act, 42 U.S.C. Section 1395dd, to stabilize the patient.

(5) "Health insurance coverage" means benefits consisting of medical care provided or arranged for directly through insurance, reimbursement, or otherwise, and including items and services paid for as medical care under any hospital or medical service policy or certificate, hospital or medical service plan contract, preferred provider organization agreement, or health maintenance organization contract offered by a health insurance issuer.

(6) "Health insurance issuer" means any entity that offers health insurance coverage through a policy or certificate of insurance subject to state law that regulates the business of insurance. For purposes of this Subpart, a

"health insurance issuer" includes a health maintenance organization as defined and licensed pursuant to Subpart I of Part I of Chapter 2 of this Title, nonfederal government plans subject to the provisions of Subpart B of this Part, and the Office of Group Benefits.

(7) "Insured" means a patient covered under a health insurance issuer's policy or contract.

(8) "Nonparticipating" means not having a contract with a health insurance issuer to provide health care services to an insured.

(9) "Participating" means having a contract with a health insurance issuer to provide health care services to an insured.

(10) "Patient" means a person who receives health care services, including emergency services, in this state.

(11) "Surprise bill" means a bill for health care services, other than emergency services, received by any of the following:

(a) An insured who receives a bill for services rendered by a nonparticipating physician at a participating hospital or ambulatory surgical center, where a participating physician is unavailable or a nonparticipating physician renders services without the insured's knowledge or the need for unforeseen medical services arises at the time the health care services are rendered; provided, however, that "surprise bill" shall not mean a bill received for health care services when a participating physician is available and the insured has elected to obtain services from a nonparticipating physician.

(b) An insured who receives a bill for services rendered by a nonparticipating provider, when the insured was referred by a participating physician to a nonparticipating provider for services without explicit written consent of the insured acknowledging that the participating physician referred the insured to a nonparticipating provider and that the referral may have resulted in costs not covered by the health care plan.

(12) "Usual and customary cost" means the eightieth percentile of all

charges for the particular health care service performed by a provider in the same or similar specialty and provided in the same geographical area as reported in a benchmarking database maintained by a nonprofit organization specified by the commissioner. The nonprofit organization shall not be affiliated with any health insurance issuer.

§1885.3. Dispute resolution process established

The department shall establish a dispute resolution process by which a dispute for a bill for emergency services or a surprise bill may be resolved in accordance with the provisions of this Subpart. The department shall have the power to grant and revoke certifications of independent dispute resolution entities to administer the dispute resolution process. The department shall promulgate rules pursuant to the Administrative Procedure Act establishing standards and procedures for the submission and resolution of payment disputes to an independent dispute resolution entity including but not limited to a process for certifying and selecting independent dispute resolution entities that shall include provisions related to conflicts of interest.

§1885.4. Applicability

A. The provisions of this Subpart shall not apply to health care services, including emergency services, with physician fees subject to schedules or other monetary limitations under any other law, including but not limited to workers' compensation, Medicaid, or Medicare or to health insurance plans that are subject to the Employee Retirement Income Security Act of 1974, and shall not preempt any such law.

B.(1) With regard to emergency services billed under American Medical Association Current Procedural Terminology codes 99281 through 99285, 99288, 99291 through 99292, 99217 through 99220, 99224 through 99226, and 99234 through 99236, the dispute resolution process established in this Subpart shall not apply when all the following criteria are met:

(a) The amount billed under a Current Procedural Terminology code

meets the requirements set forth in Paragraph (3) of this Subsection, after any applicable coinsurance, copayment, and deductible.

(b) The amount billed under a Current Procedural Terminology code does not exceed one hundred twenty percent of the usual and customary cost for the Current Procedural Terminology code.

(2) The health care plan shall ensure that an insured shall not incur any greater out-of-pocket costs for emergency services billed under a Current Procedural Terminology code as set forth in this Subsection than the insured would have incurred if the emergency services were provided by a participating physician.

(3) No later than January first each year, the department shall publish on a website maintained by the department and provide in writing to each health care plan, a threshold dollar amount below which bills for the procedural codes identified in this Section shall be exempt from the dispute resolution process established in this Subpart. The threshold amount shall equal the amount from the prior year, beginning with six hundred fifty dollars, adjusted by the average of the annual average inflation rates for the medical care commodities and medical care services components of the consumer price index for the twelve-month period ending September thirtieth of the prior year. In no event shall the threshold amount exceed one thousand two hundred dollars.

C.(1) Within three business days of receipt by the department of an application submitted by a health care plan, a nonparticipating physician, or an insured who has not executed an assignment of benefits, the department shall screen the application to determine whether the bill for emergency services or the surprise bill is subject to the provisions of this Subpart.

(2) If the department determines the provisions of this Subpart do not apply to the bill for emergency services or the surprise bill, the application shall be rejected and returned to the party who submitted the application.

(3) If the department determines that the provisions of the Subpart

apply to the bill for emergency services or the surprise bill, the department shall select an independent dispute resolution entity to resolve the dispute and forward the application to the independent dispute resolution entity within three business days of making the determination.

§1885.5. Dispute resolution for emergency services and surprise bills

A.(1) When a health insurance issuer receives a bill for emergency services or a surprise bill with an assignment of benefits from a nonparticipating physician, the health insurance issuer shall:

(a) Pay the nonparticipating physician the billed amount or attempt to negotiate reimbursement with the nonparticipating physician or nonparticipating referred health care provider. If the health care plan's attempts to negotiate reimbursement for the health care services provided by the nonparticipating physician do not result in a resolution of the payment dispute, the health care plan shall pay the nonparticipating physician an amount the health care plan determines is reasonable for the health care services rendered, less the insured's copayment, coinsurance, or deductible. The payment shall be made in accordance with the timeframes established in Subpart B of Part II of this Chapter.

(b) Provide notice to the nonparticipating physician of the process for initiating the independent dispute resolution process.

(c) Ensure that the insured shall incur no greater out-of-pocket costs for the emergency services than the insured would have incurred with a participating physician pursuant to the insured's health insurance coverage.

(2) A nonparticipating physician or a health insurance issuer may submit an application to the department to request resolution of a dispute regarding a fee or payment for emergency services or a surprise bill by an independent dispute resolution entity; provided, however, the health insurance issuer shall not submit the dispute unless it has complied with the requirements of Paragraph (1) of this Subsection.

(3) The independent dispute resolution entity shall make a determination within thirty days of the receipt of the dispute for review. In determining a reasonable fee for the services rendered, an independent dispute resolution entity shall select either the health care plan's payment or the nonparticipating physician's fee. The independent dispute resolution entity shall determine which amount to select based upon the conditions and factors provided in R.S. 22:1885.7. If an independent dispute resolution entity determines, based on the health insurance issuer's payment and the nonparticipating physician's fee, that a settlement between the health insurance issuer and nonparticipating physician is reasonably likely, or that both the health insurance issuer's payment and the nonparticipating physician's fee represent unreasonable extremes, then the independent dispute resolution entity may direct both parties to attempt a good faith negotiation for settlement. The health insurance issuer and nonparticipating physician may be granted up to ten business days for this negotiation. This ten-day period shall run concurrently with the thirty-day period for dispute resolution.

(4) The determination of an independent dispute resolution entity shall be binding on the health insurance issuer, physician, and patient and shall be admissible in any court proceeding between the health insurance issuer, physician, or patient or in any administrative proceeding between this state and the physician.

(5) If the independent dispute resolution entity issues a determination in favor of the nonparticipating physician, the health insurance issuer shall pay the nonparticipating physician any additional amount owed within thirty days of the date of the determination.

B.(1) An insured who does not assign benefits in accordance with Subsection A of this Section and who receives a surprise bill may submit an application to the department to request resolution of the dispute regarding a fee or payment for a surprise bill by an independent dispute resolution entity.

The independent dispute resolution entity shall make a determination pursuant to the provisions of this Subpart.

(2) The independent dispute resolution entity shall determine a reasonable fee for the services rendered based upon the conditions and factors provided in R.S. 22:1885.7.

(3) The independent dispute resolution entity shall make a determination within thirty days of receipt of the dispute for review.

(4) A patient or insured who does not assign benefits in accordance with Subsection A of this Section shall not be required to pay the physician's fee to be eligible to submit the dispute for review to the independent dispute resolution entity.

(5) The determination of an independent dispute resolution entity shall be binding on the patient, physician, and health insurance issuer and shall be admissible in any court proceeding between the patient or insured, physician, or health care plan or in any administrative proceeding between this state and the physician.

§1885.6. Assignment of benefits for surprise bills for insureds

When an insured assigns benefits for a surprise bill in writing to a nonparticipating physician who knows the assigner is insured under health insurance coverage, the nonparticipating physician shall not bill the insured except for any applicable copayment, coinsurance, or deductible that would be owed if the insured utilized a participating physician.

§1885.7. Criteria for determining a reasonable fee

In determining the appropriate amount to be paid for a health care service, an independent dispute resolution entity shall consider all relevant factors, including:

(1) Whether there is a gross disparity between the fee charged by the physician for services rendered as compared to:

(a) Fees paid to the involved physician for the same services rendered

by the physician to other patients in health care plans in which the physician is not participating.

(b) In the case of a dispute involving a health care plan, fees paid by the health care plan to reimburse similarly qualified physicians for the same services in the same region who are not participating with the health care plan.

(2) The level of training, education, and experience of the physician.

(3) The physician's usual charge for comparable services with regard to patients in health care plans in which the physician is not participating.

(4) The circumstances and complexity of the particular case, including time and place of the service delivery.

(5) Individual patient characteristics.

(6) The usual and customary cost of the service.

§1885.8. Payment for independent dispute resolution entity

When the independent dispute resolution entity determines the health insurance issuer's payment is reasonable, payment for the dispute resolution process shall be the responsibility of the nonparticipating physician. When the independent dispute resolution entity determines the nonparticipating physician's fee is reasonable, payment for the dispute resolution process shall be the responsibility of the health insurance issuer. When a good faith negotiation directed by the independent dispute resolution entity pursuant to this Subpart results in a settlement between the health insurance issuer and nonparticipating physician, the health insurance issuer and the nonparticipating physician shall evenly divide and share the prorated cost for the dispute resolution process.

The original instrument and the following digest, which constitutes no part of the legislative instrument, were prepared by Cheryl Cooper.

DIGEST

SB 8 Original 2020 First Extraordinary Session Talbot

Proposed law provides that an insured shall have the right to assign, in writing, any benefits payable under health insurance coverage, including any legal or contractual rights flowing from such coverage, to a health care provider who files claims with a health insurance issuer

for medical services provided to the insured, beneficiary, subscriber, or enrollee.

Proposed law requires that a health insurance issuer recognize any such assignment of benefits to a health care provider and shall not include any language or provisions prohibiting any such assignment in any form, contract, policy, subscriber agreement, certificate of coverage, or other evidence of health insurance coverage.

Proposed law provides that an insurance contract or other evidence of health insurance coverage shall not prohibit, and claims forms shall provide an option for the payment of benefits directly to a licensed hospital, licensed ambulance provider, physician, dentist, or other health care provider who provided the medical services in accordance with the provisions the insurance contract for care provided.

Proposed law establishes a dispute resolution process by which a dispute for a bill for emergency services or a surprise bill may be resolved. Grants the Louisiana Department of Insurance the power to grant certifications of independent dispute resolution entities to conduct the dispute resolution process.

Proposed law excludes health care services, including emergency services, where physician fees are subject to schedules or other monetary limitations under any other law, including but not limited to workers' compensation, Medicaid, Medicare, or to health insurance plans that are subject to the Employee Retirement Income Security Act of 1974 from the provisions of the proposed law.

Proposed law excludes from the provisions of the proposed law certain emergency services billed under the American Medical Association Current Procedural Terminology codes 99281 through 99285, 99288, 99291 through 99292, 99217 through 99220, 99224 through 99226, and 99234 through 99236, when all the following criteria are met:

(1) The amount billed for any Current Procedural Terminology code is less than a threshold amount that shall equal the amount from the prior year, beginning with $650, adjusted by the average of the annual average inflation rates for the medical care commodities and medical care services components of the consumer price index. In no event shall the threshold amount exceed $1,200.

(2) The amount billed for the Current Procedural Terminology code does not exceed 120% of the usual and customary cost for that Current Procedural Terminology code.

Proposed law provides that when a health insurance issuer receives a bill for emergency services or a surprise bill with an assignment of benefits from a nonparticipating physician, the health insurance issuer shall:

(1) Pay the nonparticipating physician the billed amount or attempt to negotiate reimbursement with the nonparticipating physician. If the health care plan's attempts to negotiate reimbursement for the health care services provided by the nonparticipating physician do not result in a resolution of the payment dispute, the health care plan shall pay the nonparticipating physician an amount the health care plan determines is reasonable for the health care services rendered, less the insured's copayment, coinsurance, or deductible.

(2) Provide notice to the nonparticipating physician describing how to initiate the independent dispute resolution process.

(3) Ensure that the insured shall incur no greater out-of-pocket costs for the emergency services than the insured would have incurred with a participating physician pursuant to the insured's health insurance coverage.

Proposed law provides that in determining a reasonable fee for the services rendered, an

independent dispute resolution entity shall select either the health care plan's payment or the nonparticipating physician's fee. The independent dispute resolution entity shall determine which amount to select based upon the conditions and factors set forth in proposed law. Requires the determinations to be made within 30 days.

Proposed law provides that if the independent dispute resolution entity issues a determination in favor of the nonparticipating physician, the health insurance issuer shall pay the nonparticipating physician any additional amount owed within thirty days from the date of the determination.

Proposed law provides that if an insured who does not assign benefits receives a surprise bill, the insured may submit an application to the department to request resolution of the dispute regarding a fee or payment for a surprise bill by an independent dispute resolution entity. The independent dispute resolution entity shall make a determination pursuant to the provisions of proposed law within 30 days.

Proposed law provides that the determination of an independent dispute resolution entity shall be binding on the health insurance issuer, physician and patient, and shall be admissible in any court proceeding between the health insurance issuer, physician or patient, or in any administrative proceeding between this state and the physician.

Proposed law provides that when an insured assigns benefits for a surprise bill in writing to a nonparticipating physician that knows the insured is insured under health insurance coverage, the nonparticipating physician shall not bill the insured except for any applicable copayment, coinsurance, or deductible that would be owed if the insured utilized a participating physician.

Proposed law provides that in determining the appropriate amount to be paid for a health care service, an independent dispute resolution entity shall consider all relevant factors, including:

(1) Whether there is a gross disparity between the fee charged by the physician for services rendered as compared to:

(a) Fees paid to the involved physician for the same services rendered by the physician to other patients in health care plans in which the physician is not participating.

(b) In the case of a dispute involving a health care plan, fees paid by the health care plan to reimburse similarly qualified physicians for the same services in the same region who are not participating with the health care plan.

(2) The level of training, education, and experience of the physician.

(3) The physician's usual charge for comparable services with regard to patients in health care plans in which the physician is not participating.

(4) The circumstances and complexity of the particular case, including time and place of the service.

(5) Individual patient characteristics.

(6) The usual and customary cost of the service.

Proposed law provides that the nonprevailing party is required to pay the costs of the independent dispute resolution entity. Further provides that when a good faith negotiation directed by the independent dispute resolution entity results in a settlement between the health insurance issuer and nonparticipating physician, the health insurance issuer and the nonparticipating physician shall evenly divide and share the prorated cost for the dispute resolution entity.

(Adds R.S. 22:1828 and 1885.1-1885.8)