DIGEST

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Thibaut HB No. 592

Abstract: Enacts the Network Adequacy Act to provide standards for the creation and maintenance of networks by health insurance issuers assuring the adequacy, accessibility, and quality of health care services offered to covered persons under its health benefit plans.

Proposed law enacts the Network Adequacy Act, as follows:

(1) Requires a health insurance issuer (issuer) providing a health benefit plan (plan), not including 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. Places various requirements upon issuers, including the requirements to ensure reasonable proximity of participating providers to the primary residences of covered persons, to monitor the ability of its providers to furnish all contracted health care services, and to maintain a directory of its network of providers on the Internet.

(2) In order to meet the network adequacy requirements of proposed law, requires an issuer, beginning January 1, 2014, to either: (a) submit proof of accreditation from the National Committee for Quality Assurance (NCQA) or from URAC (American Accreditation HealthCare Commission, Inc.), including an affidavit of compliance with proposed law, to the commissioner of insurance; or (b) submit all required filings required by proposed law to the commissioner of insurance in order for him to conduct a review for the purposes of ascertaining network adequacy.

(3) 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 approval by the commissioner and updated upon material change. Specifies numerous components of the access plan, including the issuer's efforts to address the needs of covered persons with diverse cultural and ethnic backgrounds or with physical and mental disabilities, as well as the issuer's plan providing for continuity of care in the event of contract termination.

(4) Requires an issuer submitting proof of 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. Also provides for provisional accreditation status for such issuers until December 31, 2014.

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

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

Effective upon signature of governor or lapse of time for gubernatorial action.

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

Summary of Amendments Adopted by House

Committee Amendments Proposed by House Committee on Insurance to the original bill.

1. Deletes requirement that an issuer ensure that covered persons obtain covered health care services at no greater cost if its network is insufficient.

2. Exempts excepted benefits policies from proposed law.

3. Allows provisional accreditation status for issuers until December 31, 2014. Also adds requirement that an issuer submitting proof of accreditation maintain an access plan in accordance with the requirements of the accrediting entity.

4. Clarifies that access plan filings and components specified in proposed law apply only to issuers not submitting proof of accreditation. Deletes certain required components related to participating providers.

5. Deletes numerous required provisions in contracts between issuers and providers, including a requirement for a hold harmless provision for covered persons with respect to nonpayment by the issuer, its insolvency, or breach of the agreement, as well as a required provision prohibiting against balance billing by a provider.

6. Deletes requirement that an issuer develop selection standards for participating primary and specialized providers.

7. Deletes all provisions and requirements relative to intermediaries of issuers.

8. Deletes requirement that, beginning January 1, 2014, an issuer file with the commissioner sample contract forms proposed for use with its participating providers and intermediaries, as well as any material changes to a contract.

9. Deletes language prohibiting the commissioner of insurance from arbitrating mediating, or settling disputes among issuers, intermediaries, and provider networks arising by reason of a health care provider contract or agreement.

10. Deletes language providing that the execution of a contract or agreement by an issuer shall not relieve it of its liability to any person with whom it has contracted for the provision of services, nor of its responsibility for compliance with law or applicable regulations. Also deletes requirement that all contracts or agreements be in writing and subject to review by the commissioner.

Committee Amendments Proposed by House Committee on House and Governmental Affairs to the engrossed bill.

1. Adds language specifying the commissioner of insurance's authority to decide that certain sections of an access plan not be disclosed.

2. Instead of providing that information relative to a health insurance issuer's services and features should be available upon request and on the issuer's website, provides that such information shall be available.

3. Makes various technical changes.