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

DIGEST

SB 193 Original 2016 Regular Session Long

Present law requires a health insurance issuer providing a health benefit plan, excluding excepted benefits policies, to maintain a network that is sufficient in numbers and types of health care providers to ensure that all health care services to covered persons will be accessible without unreasonable delay. Provides for numerous definitions, including defining a health insurance issuer as 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 health care 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.

Proposed law retains present law requirements.

Present law places various requirements upon issuers, including the following:

(1) Maintenance of a network of providers that includes providers that specialize in mental health and substance abuse services, facility-based physicians, and providers that are essential community providers.

(2) Reasonable proximity of its providers to the primary residences of covered persons.

(3) Monitoring of the ability, clinical capacity, and legal authority of its providers to furnish all contracted health care services.

(4) Maintenance of a directory of its network of providers on the Internet.

Proposed law retains present law requirements.

Present law provides that in order to meet the network adequacy requirements an issuer shall, beginning Jan. 1, 2014, either: (a) submit proof of accreditation from the National Committee for Quality Assurance (NCQA) or from the American Accreditation Healthcare Commission Inc./URAC, including an affidavit of compliance to the commissioner of insurance; or (b) submit all filings required to the commissioner of insurance in order for him to conduct a review for the purposes of ascertaining network adequacy. Further provides that an issuer who is in the process of applying for accreditation from NCQA or URAC shall be deemed accredited upon submission of

an affidavit to that effect to the commissioner. Specifies that if such accreditation is withdrawn or not subsequently received by such an issuer by July 1, 2015, that issuer shall submit all filings to the commissioner. Also requires such submission if an issuer subsequently loses its NCQA or URAC accreditation. Further requires an issuer submitting proof of accreditation or in the process of applying for 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.

Proposed law retains accreditation by NCQA or URAC in lieu of filing an access plan, and requires such plans to be submitted for review by the department by July 1, 2017. Exempts health insurance issuers with 750 or fewer covered persons from filing an access plan. Permits health insurance issuers that lease, rent, or in some other way utilize networks that are accredited by NCQA or URAC an exemption from filing the access plan.

Present law 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 Title 22. Absent such information, requires issuers to make such plans available under certain conditions. Provides that such a plan shall be subject to written approval by the commissioner, and updated upon material change, for existing plans and prior to offering a new health benefit plan.

Present law requires an issuer to inform the commissioner when the issuer enters a new service or market area and to submit an updated access plan. Specifies numerous components of the access plan.

Proposed law deletes present law access plan requirements and replaces them with the following access plan requirements:

(1) The health insurance issuer's network, including how the use of telemedicine or telehealth or other technology may be used to meet network access standards, if applicable.

(2) The health insurance issuer's procedures for making and authorizing referrals within and outside its network, if applicable.

(3) The health insurance issuer's process for monitoring and assuring on an ongoing basis the sufficiency of the network to meet the health care needs of populations that enroll in network plans.

(4) The factors used by the health insurance issuer to build its provider network, including a description of the network and the criteria used to select tier providers.

(5) The health insurance issuer's efforts to address the needs of covered persons, including but not limited to children and adults, including those with limited English proficiency or

illiteracy, diverse cultural or ethnic backgrounds, physical or mental disabilities, and serious, chronic, or complex medical conditions. This includes the insurance issuer's efforts, when appropriate, to include various types of ECPs in its network.

(6) The health insurance issuer's methods for assessing the health care needs of covered persons and their satisfaction with services.

(7) The health insurance issuer's method of informing covered persons of the plan's covered services and features, including but not limited to:

(a) The plan's grievance and appeals procedures.

(b) Its process for choosing and changing providers.

(c) Its process for updating its provider directories for each of its network plans.

(d) A statement of health care services offered, including those services offered through the preventive care benefit, if applicable.

(e) Its procedures for covering and approving emergency, urgent, and specialty care, if applicable.

(8) The health insurance issuer's system for ensuring the coordination and continuity of care:

(a) For covered persons referred to specialty physicians.

(b) For covered persons using ancillary services, including social services and other community resources, and for ensuring appropriate discharge planning.

(9) The health insurance issuer's process for enabling covered persons to change primary care professionals, if applicable.

(10) The health insurance issuer's proposed plan for providing continuity of care in the event of contract termination between the health insurance issuer and any of its participating providers, or in the event of the health insurance issuer's insolvency or other inability to continue operations including, how covered persons will be notified of the contract termination, or the insolvency or other cessation of operations, and the plan to transition covered persons to other providers in a timely manner.

(11) The health insurance issuer's process for monitoring access to physician specialist services in emergency room care, anesthesiology, radiology, pathology, and laboratory services at their participating hospitals.

(12) Any other information required by the commissioner to determine compliance with the provisions of proposed law.

Present law further requires an issuer not submitting proof of accreditation to file any proposed material changes to the access plan with the commissioner prior to implementation of the changes, including the removal or withdrawal of any hospital or multi-specialty clinic from an issuer's network.

Proposed law retains present law.

Present law provides that filings containing any proposed material changes to an access plan shall include certain specific information.

Proposed law deletes the present law requirement of specificity for amended filings.

Present law 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 present law, he may institute a corrective action plan that shall be followed by the issuer within 30 days of notice or the commissioner may use any of his other enforcement powers to obtain the issuer's compliance.

Present law prohibits the commissioner from acting to arbitrate, mediate, or settle disputes regarding a decision not to include a provider in a plan or a provider network if the issuer has an adequate network as determined by the commissioner.

Proposed law retains present law.

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

Proposed law retains present law.

Effective August 1, 2016.

(Amends R.S. 22:1019.1(D), 1019.2, and 1019.3(A); adds R.S. 22:1019.3(E))