

Regular Session, 2003

ACT No. 1157

HOUSE BILL NO. 1966

BY REPRESENTATIVES HEBERT, ALARIO, ARNOLD, BAUDOIN, BROOME, BRUCE, CAPELLA, K. CARTER, CRANE, CURTIS, DAMICO, DANIEL, DARTEZ, DIEZ, DOWNER, DOWNS, FANNIN, FARRAR, FRITH, FRUGE, FUTRELL, GALLOT, GLOVER, GUILLORY, HAMMETT, HEATON, HONEY, HUDSON, HUNTER, HUTTER, ILES, L. JACKSON, M. JACKSON, JOHNS, KATZ, KENNARD, LAFLEUR, LANCASTER, LANDRIEU, LEBLANC, LUCAS, MARTINY, MCDONALD, MCVEA, MONTGOMERY, MORRELL, MURRAY, NEVERS, ODINET, PEYCHAUD, PIERRE, PITRE, POWELL, QUEZAIRE, RICHMOND, ROMERO, SCHWEGMANN, SHAW, JACK SMITH, JANE SMITH, SNEED, STRAIN, SWILLING, TOWNSEND, WALKER, WINSTON, WOOTON, WRIGHT, AND SCALISE AND SENATOR SCHEDLER

AN ACT

To enact Part VI-E of Chapter 1 of Title 22 of the Louisiana Revised Statutes of 1950, to be comprised of R.S. 22:250.41 through 250.47, and to repeal R.S. 22:230.3, relative to health insurance coverage; to provide with respect to billing of enrollees and insureds by contracted health care providers and certain noncontracted facility-based health care providers; to provide for notice and disclosure to enrollees and insureds by health insurance issuers and health care facilities relative to identification of noncontracted providers and contract relationships which could result in billing of insureds or enrollees; to provide for penalties and enforcement; to provide with respect to the authority of the commissioner of insurance and the attorney general; and to provide for related matters.

Be it enacted by the Legislature of Louisiana:

Section 1. Part VI-E of Chapter 1 of Title 22 of the Louisiana Revised Statutes of 1950, comprised of R.S. 22:250.41 through 250.47, is hereby enacted to read as follows:

PART VI-E. HEALTH CARE CONSUMER BILLING
AND DISCLOSURE PROTECTION ACT

§250.41. Short title

This Part shall be known and may be cited as the "Health Care
Consumer Billing and Disclosure Protection Act".

§250.42. Definitions

As used in this Part:

(1) "Activity statement" means any written communication from a health care provider that advises an enrollee or insured of covered health care services that have been billed to a health insurance issuer.

(2) "Base health care facility" means a facility or institution providing health care services, including but not limited to a hospital or other licensed inpatient center, ambulatory surgical or treatment center, skilled nursing facility, inpatient hospice facility, residential treatment center, diagnostic, laboratory, or imaging center, or rehabilitation or other therapeutic health setting that has entered into a contract or agreement with a facility-based physician. Pursuant to such contract or agreement, the facility-based physician agrees to provide required health care services to those enrollees or insureds presenting at such facility, within the scope of the physician's respective specialty.

(3) "Bill" means any written or electronic communication that sets forth the amount owed by an enrollee or insured.

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

(5) "Consolidated activity statement and bill" means any written or electronic communication from a health care provider that advises an enrollee or insured of covered health care services that have been billed to a health insurance issuer and which sets forth an amount owed by an enrollee or insured.

(6) "Contracted health care provider" means a health care provider that has entered into a contract or agreement directly with a health insurance issuer or with a health insurance issuer through a network of providers for the provision of covered health care services.

(7) "Contracted reimbursement rate" means the aggregate maximum amount that a contracted health care provider has agreed to accept from all sources for provision of covered health care services under the health insurance coverage applicable to the enrollee or insured.

(8) "Covered health care services" means services, items, supplies, or drugs for the diagnosis, prevention, treatment, cure, or relief of a health condition, illness, injury, or disease that are either covered and payable under the terms of health insurance coverage or required by law to be covered.

(9) "Discount billing" means any written or electronic communication issued by a contracted health care provider that appears to attempt to collect from an enrollee or insured an amount in excess of the contracted reimbursement rate for covered services.

(10) "Dual billing" means any written or electronic communication issued by a contracted health care provider that sets forth any amount owed by an enrollee or insured that is a health insurance issuer liability.

(11) "Enrollee" or "insured" means a person who is enrolled in or insured by a health insurance issuer for health insurance coverage.

(12) "Explanation of benefits" means any written communication clearly identified as issued by the health insurance issuer or its agent that contains information regarding coverage, payment, or other information regarding current status of a claim submitted to the health insurance issuer or its agent.

(13) "Facility-based physician" means a physician licensed to practice medicine who is required by the base health facility to provide services in a base health care facility as an anesthesiologist, hospitalist, intensivist, neonatologist, pathologist, radiologist, emergency room physician, or other on-call physician who is required by the base health care to provide covered health care services related to an emergency medical condition as defined in R.S. 22:3071(15).

(14) "Health care facility" means a facility or institution providing health care services including but not limited to a hospital or other licensed inpatient center, ambulatory surgical or treatment center, skilled nursing facility, inpatient hospice facility, residential treatment center, diagnostic, laboratory, or imaging center, or rehabilitation or other therapeutic health setting. A health care facility may also be a base health care facility.

(15) "Health care professional" means a physician or other health care practitioner licensed, certified, or registered to perform specified health care services consistent with state law.

(16) "Health care provider" or "provider" means a health care professional or a health care facility or the agent or assignee of such professional or facility.

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

(18) "Health insurance coverage" means benefits consisting of medical care provided or arranged for directly, through insurance or reimbursement, or otherwise, and includes health care services paid for under any plan, policy, or certificate of insurance.

(19) "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 Part, a "health insurance issuer" shall include a health maintenance organization, as defined and licensed pursuant to Part XII of Chapter II of this Title, nonfederal government plans subject to the provisions of Part VI-D of this Chapter, and the Office of Group Benefits.

(20)(a) "Health insurance issuer liability" means the contractual liability of a health insurance issuer for covered health care services pursuant to the plan or policy provisions between the enrollee or insured and the health insurance issuer.

(b) In the case of a contracted health care provider, "health insurance issuer liability" is the contracted reimbursement rate reduced by the patient responsibility, which includes coinsurance, copayments, deductibles, or any other amounts identified by the health insurance issuer on an explanation of benefits as an amount for which the enrollee or insured is liable for the covered service.

(c) In the case in which a contracted reimbursement rate has not been established, "health insurance issuer liability" is the liability

pursuant to the plan or policy provisions between a health insurance issuer and their enrollee or insured for the covered service.

(d) In the case of noncontracted facility-based physicians providing covered health care services at a base health care facility, "health insurance insurer liability" is the amount as determined pursuant to the plan or policy provisions between the enrollee or insured and the health insurance issuer.

(21) "Network of providers" or "network" means an entity other than a health insurance issuer that, through contracts with health care providers, provides or arranges for access by groups of enrollees or insureds to health care services by health care providers who are not otherwise or individually contracted directly with a health insurance issuer.

(22) "Noncontracted health care provider" means a health care provider that has not entered into a contract or agreement with a health insurance issuer or network of providers for the provision of covered health care services.

(23) "Noncovered health care services" means services, items, supplies, or drugs for the diagnosis, prevention, treatment, cure, or relief of a health condition, illness, injury, or disease that are neither covered under the terms of health insurance coverage nor required by law to be covered.

§250.43. Notice requirements

A. Provider notice requirements shall be as follows:

(1)(a) Any activity statement received by an enrollee or insured from a contracted health care provider shall clearly delineate the amount billed to the health insurance issuer for covered health care

services and shall contain the following language conspicuously displayed on the front of such activity statement in at least twelve-point boldface capital letters:

"NOTICE:

THIS IS NOT A BILL. DO NOT PAY. IF IT IS DETERMINED THAT THIS SERVICE OR A PORTION OF THESE SERVICES IS NOT PAYABLE BY YOUR HEALTH PLAN, YOU WILL BE RESPONSIBLE."

(b) A provider may revise or update any activity statement to the enrollee or insured based on the status of the health insurance issuer's liability.

(2) Any bill received by an enrollee or insured from a contracted health care provider shall clearly delineate the amount that is owed by the enrollee or insured, based on the contracted reimbursement rate, and shall contain the following language conspicuously displayed on the front of such bill in at least twelve-point boldface capital letters:

"NOTICE:

THIS IS A BILL. BASED UPON INFORMATION FROM YOUR HEALTH PLAN, YOU OWE THE AMOUNT SHOWN."

(3) Any consolidated activity statement and bill received by an enrollee or insured from a contracted health care provider shall clearly delineate the amount owed by the enrollee or insured and the amount billed to the health insurance issuer. A consolidated activity statement and bill shall comply with Paragraph (2) of this Subsection.

(4) In the event that any overstatement in the amount owed by the enrollee or insured in any bill or in any consolidated activity

statement and bill is based on information received from a health insurance issuer, the contracted health care provider shall not be in violation of this Part.

(5) Any written or electronic notice, publication, or document issued by or on behalf of a health care facility that identifies any health insurance issuer or network of providers with which the health care facility is a contracted health care provider shall state that facility-based physicians providing health care services at the facility may not be contracted health care providers. The facility shall make specific information on contracted or noncontracted physicians available on request from an enrollee or insured.

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

(1) Each health insurance identification card issued by a health insurance issuer shall contain sufficient information to clearly identify the health insurance issuer.

(2) Each policy, certificate of insurance, and health insurance identification card issued by a health insurance issuer shall contain or be accompanied by the following notice to enrollees or insureds:

"NOTICE:

YOUR SHARE OF THE PAYMENT FOR HEALTH CARE SERVICES MAY BE BASED ON THE AGREEMENT BETWEEN YOUR HEALTH PLAN AND YOUR PROVIDER. UNDER CERTAIN CIRCUMSTANCES, THIS AGREEMENT MAY ALLOW YOUR PROVIDER TO BILL YOU FOR AMOUNTS UP TO THE PROVIDER'S REGULAR BILLED CHARGES."

(3) Any written or electronic notice, publication, or document issued by or on behalf of a health insurance issuer or through a network of providers to an enrollee or insured that identifies contracted health care providers shall state that facility-based physicians may not be contracted health care providers. The health insurance issuer shall make specific information on contracted and noncontracted facility-based physicians available on request from an enrollee or insured.

(4) A health insurance issuer shall update its list of contracted health care providers on at least an annual basis and shall make the current version available to enrollees or insureds on request.

(5) In the event that a health insurance issuer determines that any amount due a health care provider is the responsibility of the enrollee or insured, the health insurance issuer shall specifically set forth, in its explanation of benefits, the contracted reimbursement rate and clearly identify the amount due from the enrollee or insured and the reasons therefor. The health insurance issuer shall determine the responsibility of the enrollee or insured based on the contracted reimbursement rate.

(6) To the extent that a health insurance issuer determines that additional information is needed for payment, the health insurance issuer shall notify the health care provider and the enrollee or insured in writing regarding the information needed and identify the party responsible for furnishing such information. In the event that the enrollee or insured is the party responsible for providing such additional information and the enrollee or insured does not provide the requested information to the health insurance issuer within forty-five days from the date of such notification, the health care provider may

bill the enrollee or insured for services at the contracted reimbursement rate when a contract exists.

§250.44. Billing by contracted health care providers

A.(1) A contracted health care provider shall be prohibited from discount billing, dual billing, attempting to collect from, or collecting from an enrollee or insured a health insurance issuer liability or any amount in excess of the contracted reimbursement rate for covered health care services.

(2) No contracted health care provider shall bill, attempt to collect from, or collect from an enrollee or insured any amounts other than those representing coinsurance, copayments, deductibles, noncovered or noncontracted health care services, or other amounts identified by the health insurance issuer on an explanation of benefits as an amount for which the enrollee or insured is liable.

(3) However, in the event that any billing, attempt to collect from, or the collection from an enrollee or insured of any amount other than those representing copayment, deductible, coinsurance, payment for noncovered or noncontracted health care services, or other amounts identified by the health insurance issuer as the liability of the enrollee or insured is based on information received from a health insurance issuer, the contracted health care provider shall not be in violation of this Subsection.

(4) A health insurance issuer contracting with a network of providers is obligated to pay to a contracted health care provider the contracted reimbursement rate of the network identified on the member identification card of the enrollee or insured, pursuant to R.S. 40:2203.1, and established by the contract between the network of

providers and the contracted health care provider. The payor must comply with all provisions of the specific network contract. To the extent that a health insurance issuer does not pay to the health care provider an amount equal to the health insurance issuer liability, the contracted health care provider may collect the difference between the amount paid by the health insurance issuer and the health insurance issuer liability from the enrollee or insured. Any such collection efforts shall not constitute a violation of this Part.

B. No contracted health care provider may maintain any action at law against an enrollee or insured for a health insurance issuer liability or for payment of any amount in excess of the contracted reimbursement rate for such services. In the event of such an action, the prevailing party shall be entitled to recover all costs incurred, including reasonable attorney fees and court costs. However, nothing in this Subsection shall be construed to prohibit a contracted health care provider from maintaining any action at law against an enrollee or insured after a health insurance issuer determines that the health insurance issuer is not liable for the health care services rendered.

§250.45. Billing by noncontracted facility-based physicians providing services in a base health care facility

If a facility-based physician who is a noncontracted health care provider provides health care services in a base health care facility to an enrollee or insured and files a claim with a health insurance issuer for such facility-based services, the health insurance issuer shall provide the facility-based physician with an explanation of benefits as to any payment determination thereof. Nothing contained herein shall supersede the provisions of R.S. 22:2018(D).

§250.46. Correction of credit records

Any contracted health care provider who files, refers, or sends a report to a credit reporting agency for nonpayment by an enrollee or insured of any amount that he is prohibited by R.S. 22:250.44(A) from billing or collecting shall assist in correcting the credit record of the enrollee or insured by providing a letter to the credit reporting agency and to the enrollee or insured. Such letter shall state that such amount is not due from the enrollee or insured to the contracted health care provider. If such letter is not sent within ten days of receipt of written notice from the enrollee or insured, the health insurance issuer, or the commissioner, the contracted health care provider shall be liable for all reasonable costs, including reasonable attorney fees and court costs, incurred by the enrollee or insured with correcting such erroneous credit record.

§250.47. Complaint notice; billing correction and refund; penalty

A.(1) Any enrollee or insured who receives a bill or consolidated activity statement and bill from a contracted health care provider in violation of R.S. 22:250.44(A), or a health insurance issuer acting on behalf of an enrollee or insured, may file a complaint with the Consumer Protection Division of the Department of Justice.

(2) The enrollee or insured, or health insurance issuer acting on behalf of the enrollee or insured, shall provide to the attorney general a copy of the original bill or consolidated activity statement and bill issued pursuant to R.S. 22:250.43 and such additional information that may be requested by the attorney general, documenting an attempt by a contracted health care provider to collect or the collection of any amount from the enrollee or insured that is the liability of the health

insurance issuer or that is in excess of the contracted reimbursement rate. In the event it is determined that billing activity was based on information received from the health insurance issuer, the contracted health care provider shall not be in violation, and the attorney general shall refer the violation to the commissioner.

(3) If the attorney general concludes, based on the information submitted, that a contracted health care provider has attempted to collect, or collected, any amount from the enrollee or insured that is the liability of the health insurance issuer or that is in excess of the contracted reimbursement rate, the attorney general may pursue remedies as provided for in R.S. 51:1401 et seq., beginning with a notice of unfair trade practices.

(4) Any contracted health care provider who has demanded or received payment from an enrollee or insured for any amount which he is prohibited from billing or collecting by R.S. 22:250.44(A) shall correct his billing and refund any such amount paid within forty-five days of service of the notice of unfair trade practices.

(5) The notice of unfair trade practices shall be satisfied by the attorney general within thirty days of receipt of information from the contracted health care provider that shows that any such billing or collection efforts were not in violation of R.S. 22:250.44(A).

(6) In the event that a contracted health care provider fails to comply with a notice of unfair trade practices, the attorney general may proceed in accordance with the Unfair Trade Practices and Consumer Protection Law, R.S. 51:1401 et seq.

B.(1) Any enrollee or insured or contracted health care provider or noncontracted facility-based physicians providing services in a base

health care facility who identifies that a health insurance issuer is in violation of R.S. 22:250.41 through 250.46 shall be entitled to request a cease and desist order from the commissioner of insurance as provided in this Subsection.

(2) The enrollee, insured, contracted health care provider, or noncontracted facility-based physicians providing services in a base health care facility shall provide to the commissioner documentation of such violation.

(3) If the commissioner concludes, based on the information submitted, that a health insurance issuer has violated this Section, the commissioner shall, within sixty days of receipt of such information, issue to such health insurance issuer a written order directing the health insurance issuer to cease and desist such violation.

(4) Any health insurance issuer shall correct such violation within forty-five days of service of the cease and desist order issued by the commissioner.

(5) The cease and desist order shall be rescinded by the commissioner within ten days of receipt of information from the health insurance issuer that it was not in violation.

(6) In the event that a health insurance issuer fails to comply with the cease and desist order issued by the commissioner, the commissioner may subsequently subject the health insurance issuer to a fine of fifty percent of any amount in violation of R.S. 22:250.45 up to a maximum fine of one thousand dollars per claim, or for such violations not related to a reimbursement amount, a fine of one thousand dollars per violation.

C. The commissioner shall not be authorized to issue a cease and desist order or to levy a fine against the Office of Group Benefits. If the commissioner concludes, based on the information submitted, that the Office of Group Benefits has violated this Section, the commissioner shall, within sixty days of receipt of such information, notify the commissioner of administration in writing.

Section 2. R.S. 22:230.3 is hereby repealed in its entirety.

Section 3. This Act shall become effective on January 1, 2004.

SPEAKER OF THE HOUSE OF REPRESENTATIVES

PRESIDENT OF THE SENATE

GOVERNOR OF THE STATE OF LOUISIANA

APPROVED: _____