LOUISIANA DEPARTMENT OF INSURANCE
JAMES J. DONELON
COMMISSIONER

BULLETIN 2022-08

TO: **ALL HEALTH INSURANCE ISSUERS AND HEALTH MAINTENANCE ORGANIZATIONS**

FROM: **JAMES J. DONELON, COMMISSIONER OF INSURANCE**

RE: **SUBMISSION OF ACCESS PLAN ON JANUARY 1, 2023, PURSUANT TO NETWORK ADEQUACY ACT (LA. R.S. 22:1019.2)**

DATE: **DECEMBER 22, 2022**

The purpose of Bulletin No. 2022-08 is to inform all health insurance issuers and health maintenance organizations (issuers) subject to La. R.S. 22:1019.2 (the Network Adequacy Act) of the submission requirements pursuant to the Network Adequacy Act. Act 589 of the Louisiana Legislative Session of 2022 amended La. R.S. 22:1019.2 to remove an exception to the statutory requirement that issuers submit an access plan to the Commissioner of Insurance (Commissioner) on January 1 of each year. As a result of that amendment, a substantial number of issuers will now have to submit an access plan beginning on January 1, 2023.

The access plan may be submitted in any electronic format commonly used for report submissions to the Louisiana Department of Insurance (LDI), including Adobe PDF, MS Excel spreadsheet, MS Word document, or any other format approved by the LDI. Submissions should be made by electronic mail to liz.butler@ldi.la.gov.

Access plans will be reviewed for completeness under the twelve requirements described in the Network Adequacy Act's minimum plan standards (La. R.S. 22:1019.2(C)):

1) The issuer's network that includes but is not limited to the availability of and access to centers of excellence for transplant and other medically intensive services as well as the availability of critical care services, such as advanced trauma centers and burn units.
2) The issuer's procedure for making referrals within and outside its network.
3) The issuer's process for monitoring and ensuring, on an ongoing basis, the sufficiency of the network to meet the health care needs of populations that enroll in its health benefit plans and general health care provider availability in a given geographic area.

4) The issuer's efforts to address the needs of covered persons with limited English proficiency and illiteracy, with diverse cultural and ethnic backgrounds, or with physical and mental disabilities.
5) The issuer's methods for assessing the health care needs of covered persons and their satisfaction with health care services.
6) The issuer's method of informing covered persons of the health benefit plan's services and features, including but not limited to the health benefit plan's utilization review procedure, grievance procedure, external review procedure, process for choosing and changing health care providers, and procedures for providing and approving emergency services and specialty care. Additional information relating to these processes shall be available upon request and accessible via the issuer's website.
7) The issuer's system for ensuring coordination and continuity of care for covered persons referred to specialty physicians, for covered persons using ancillary health care services, including social services and other community resources, and for ensuring appropriate discharge planning.
8) The issuer's processes for enabling covered persons to change primary care professionals, for medical care referrals, and for ensuring that participating health care providers that require the use of health care facilities have hospital admission privileges.
9) The issuer's proposed plan for providing continuity of care in the event of contract termination between the issuer and any of its participating health care providers, as required by La. R.S. 22:1005, or in the event of the issuer's insolvency or other inability to continue operations. This description shall explain how covered persons will be notified of contract termination, including but not limited to the effective date of the contract termination, the issuer's insolvency, or other cessation of operations, and how such covered persons will be transferred to other health care providers in a timely manner.
10) A geographic map of the area proposed to be served by the health benefit plan by both parish and zip code.
11) The policies and procedures to ensure access to covered health care services under each of the following circumstances:
    a. When the covered health care service is not available from a participating health care provider in any case when a covered person has made a good faith effort to utilize participating providers for a covered service and it is determined that the issuer does not

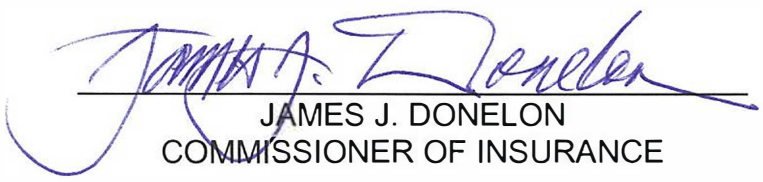
have the appropriate participating health care providers due to insufficient number, type, or distance, the issuer shall ensure, by terms contained in the health benefit plan, that the covered person will be provided the covered health care service.

b. When the covered person has a medical emergency within the network's service area.
c. When the covered person has a medical emergency outside the network's service area.

12) Any other information required by the Commissioner to determine compliance with the provisions of Subpart A-1 of Part III of Chapter 4 of Title 22.

If there are any questions or concerns regarding Bulletin 2022-08, please contact the Deputy Commissioner for the Office of Health, Life, and Annuity at (225) 342-1355 or electronically at public@ldi.la.gov.

Baton Rouge, Louisiana, this 22nd day of December 2022.



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