[La. Rev. Stat. Ann. § 22:1007.]

§ 22:1007. Requirements of provider contracts; communications: Health and Accident Insurance; Standards and Contract Requirements in General

A. As used in this Section, the following definitions shall apply:

(1) "Enrollee", "prospective enrollee", or "patient" means an individual, his spouse, and any dependent, if any, who is enrolled in a health maintenance organization or is a member or is applying to become a member of a health care benefit policy, plan, or package, either furnished to him through his employment as part of his compensation or entitlement furnished by a publicly funded program or purchased through his own financial resources.

(2) "Health care services" means any services rendered by providers which include, but are not limited to medical and surgical care; social work, psychological, optometric, optic, chiropractic, podiatric, nursing, and pharmaceutical services; health education, rehabilitative, and home health services; physical therapy; inpatient and outpatient hospital services; dietary and nutritional services; laboratory and ambulance services; and any other services for the purpose of preventing, alleviating, curing, or healing human illness, injury, or physical disability. Health care services also means dental care, limited to oral and maxillofacial surgery as performed by board-certified oral and maxillofacial surgeons and also include an annual PAP test for cervical cancer and minimum mammography examination as defined in R.S. 22:1028.

(3) "Managed care organization" means a licensed insurance company, hospital or medical benefit plan or program, health maintenance organization, integrated health care delivery system, an employer or employee organization, or a managed care contractor which operates a managed care plan. A managed care organization may include but is not limited to a preferred provider organization, health maintenance organization, exclusive provider organization, independent practice association, clinic without walls, management services organization, managed care services organization, physician hospital organization, and hospital physician organization.

(4) "Managed care plan" means a plan operated by a managed care entity which provides for the financing and delivery of health care and treatment services to individuals enrolled in such plan through its own employed health care providers or contracting with selected specific providers that conform to explicit selection, standards, or both. A managed care plan also customarily has a formal organizational structure for continual quality assurance, a certified utilization review program, dispute resolution, and financial incentives for individual enrollees to use the plan's participating providers and procedures.

(5) "Participating provider", "provider", or "health care provider" means a state-licensed, certified, or state-registered provider of health care services, treatment, or supplies, including but not limited to those entities defined in R.S. 40:1231.1(A), that have entered into a contract or agreement with a managed care entity to provide such services, treatment, or supplies to an individual enrollee or a patient.

(6) "Rural hospital" means either:

(a) A hospital with sixty or fewer beds located in either:
(i) A parish with a population of less than fifty thousand according to the most recent federal decennial census.
(ii) A municipality with a population of less than twenty thousand according to most recent federal decennial census.

(b) A hospital classified as a sole community hospital pursuant to 42 CFR 412.92.

(7) "Subscriber" means the person who is responsible for payment to a managed care organization or managed care entity or whose employment or other status, except for family dependence, is the basis for eligibility for enrollment in the managed care organization or managed care entity.

B. In a contract with a health care provider, a managed care organization shall not include provisions that interfere with the ability of a health care provider to communicate with a patient regarding his or her health care, including but not limited to communications regarding treatment options and medical alternatives, or other coverage arrangements. Notwithstanding the provisions of this Section, a managed care organization may include a contract provision that provides that a health care provider shall not solicit for alternative coverage arrangements for the primary purpose of securing financial gain.

C. No managed care organization shall refuse to contract, renew, cancel, restrict, or otherwise terminate a contract with a health care provider solely on the basis of a medical communication. No managed care organization shall refuse to refer patients to or allow others to refer patients to the health care provider, refuse to compensate the health care provider for covered services, or take other retaliatory action against the health care provider. As used in this Subsection "medical communication" shall mean information regarding the mental or physical health care needs or the treatment of a patient.

D. No communication regarding treatment options shall be represented or construed to expand or revise the scope of benefits or covered services under a managed care plan or insurance contract.

E. No managed care organization or managed care entity shall by contract, written policy, or written procedure prohibit or restrict any provider from filing a complaint, making a report, or commenting to an appropriate governmental body regarding the policies or practices of such managed care organization or managed care entity which may negatively impact upon the quality of, or access to, patient care.

F. No managed care organization or managed care entity shall by contract, written policy, or written procedure prohibit or restrict any health care provider from advocating to the managed care organization or managed care entity on behalf of the enrollee or subscriber for approval or coverage of a particular course of treatment or for the provision of health care services.

G. No contract or agreement between a managed care organization or managed care entity and a health care provider shall contain any clause purporting to transfer to the health care provider by indemnification or

otherwise any liability relating to activities, actions, or omissions of the managed care organization or managed care entity.

H. Notwithstanding any other provision of law to the contrary, no managed care organization shall limit the right of a rural hospital to receive payment for covered health care services as long as a claim for payment of such services is submitted within one year after the date on which the rural hospital provided the services.

I. Notwithstanding any provision of law to the contrary, any contract or agreement between a managed care organization and a health care provider shall include provisions that establish the reimbursement of a health care provider in an instance in which the managed care organization requests or requires substitution of a medication for an enrollee and the provider has executed the requested or required substitution. The provisions of this Section shall not apply to generic substitution or step therapy programs utilized by the managed care organization or its delegated entity that promote generic drugs as a first-line therapy.

J.(1) A managed care organization that offers coverage for healthcare services through one or more managed care plans shall not require a provider, as a condition of participation or continuation in the provider network of one or more health benefit plans of the managed care organization, to serve in the provider network of all or additional health benefit plans of the managed care organization. A managed care organization is prohibited from terminating a provider agreement based on the provider's refusal to serve in its network for such additional plans.

(2) Nothing in this Subsection shall prohibit a managed care organization from enabling its affiliated members from other states to obtain healthcare service benefits while traveling or living in the managed care organization's service area including extending the provisions of the provider contract to provide for such services.

K. Any contract provision, written policy, or written procedure in violation of this Section shall be deemed to be unenforceable and null and void.