

2020 Regular Session

SENATE BILL NO. 231

BY SENATOR TALBOT

INSURANCE POLICIES. Provides with respect to the Louisiana Health Plan. gov sig

1 AN ACT

2 To amend and reenact R.S. 22:1203, 1205, and 1215.1, to enact R.S. 22:1209, 1210, 1216,
3 and 1217, and to repeal R.S. 22:1205(7), relative to the Louisiana Health Plan; to
4 provide relative to coverage for preexisting conditions; to provide for assessment of
5 service charges; to provide for fees; to provide for policy provisions and penalties;
6 to provide relative to health insurance rejections; and to provide for related matters.

7 Be it enacted by the Legislature of Louisiana:

8 Section 1. R.S. 22:1203, 1205, and 1215.1, are hereby amended and reenacted and
9 R.S. 22:1209, 1210, 1216, and 1217 are hereby enacted to read as follows:

10 §1203. Creation of the plan

11 * * *

12 **E.(1) Upon a finding that federal and state law no longer prohibits**
13 **carriers in the individual market from rejecting applicants for health insurance**
14 **coverage based on the presence of preexisting health conditions or excluding**
15 **healthcare coverage for preexisting conditions, the commissioner may submit**
16 **written notification to the Joint Legislative Committee on the Budget and the**
17 **House and Senate committees on insurance of his intention to reactivate the**

1 Louisiana Health Plan. The notice shall include the commissioner's reasoning
2 for finding reactivation necessary and the proposed date for the plan to restart
3 operations.

4 (2) Unless one of the committees notified by the commissioner convenes
5 and votes to reject the commissioner's proposal to reactivate the Louisiana
6 Health Plan no later than thirty days after the written notice is received, the
7 board provided for in R.S. 22:1205 shall reconvene and submit a new plan of
8 operation to the commissioner for approval within ninety days of the date the
9 written notice was submitted.

10 * * *

11 §1205. Plan of operation

12 * * *

13 C. In its plan of operation the board shall:

14 * * *

15 (8) The cessation plan approved and in effect on January 1, 2020, shall
16 continue in effect until and unless the commissioner notifies the board in writing
17 of his intent to exercise his authority under this Paragraph to reestablish the
18 Louisiana Health Plan.

19 (9) Upon approval of the plan of operation provided for in R.S.
20 22:1203(E)(2), the board shall resume operations as provided for in that plan.

21 * * *

22 §1209. Service charges

23 A.(1) Each patient who is not a private pay patient, is not covered by
24 Medicare or any other public program, is not covered by the Office of Group
25 Benefits program, and is not covered by an insolvent insurer who is admitted
26 to a hospital for treatment, other than psychiatric care or alcohol or substance
27 abuse, shall be assessed a service charge in the amount provided in Subsection
28 G of this Section for each day or portion thereof during which the patient is
29 confined in that facility.

1 **(2) Each hospital in which a patient is confined shall calculate the total**
2 **service charge due for that patient's period of confinement and shall include the**
3 **total service charge in the bill for services rendered to the patient. The**
4 **individual patient may be obligated to pay the service charge assessed in the**
5 **event that an insurance arrangement pays for any medical charges or benefits**
6 **but fails to pay the service charge assessed pursuant to this Section. The service**
7 **charge shall be collected as provided for in the plan of operation of the plan**
8 **established pursuant to R.S. 22:1205.**

9 **(3) For purposes of this Section, "hospital" shall not include any hospital**
10 **operated by the state or any hospital created or operated by the Department of**
11 **Veterans Affairs or other agency of the United States of America or any facility**
12 **operated solely to provide psychiatric care or treatment of alcohol or substance**
13 **abuse or both.**

14 **B. Each patient who is not a private pay patient, is not covered by**
15 **Medicare or any other public program directly subsidized by the federal**
16 **government, is not covered by the Office of Group Benefits program, and is not**
17 **covered by an insolvent insurer who is admitted to an ambulatory surgical**
18 **center or to a hospital for outpatient ambulatory surgical care shall be assessed**
19 **a service charge of one dollar for each admission to that facility. The service**
20 **charge shall be included in the bill for services or supplies or both rendered to**
21 **the patient by the ambulatory surgical center or hospital.**

22 **C.(1) Each hospital and ambulatory surgical center shall bill for and**
23 **collect the service charges assessed pursuant to this Section from monies**
24 **remitted to it in payment thereof in accordance with R.S. 22:1216, if authorized**
25 **by the plan of operation under R.S. 22:1205. In the event that no payment is**
26 **made by or on behalf of the patient for services rendered, the healthcare**
27 **provider shall be liable for the remittance of only those fees collected. Each**
28 **hospital and ambulatory surgical center shall remit to the plan for each**
29 **reporting period, as established in the plan of operation, the total amount of**

1 service charges collected during that reporting period in accordance with the
2 reporting and remittance procedures established by the plan pursuant to R.S.
3 22:1205.

4 (2) Unless permitted by the board, the intentional failure to bill, pay,
5 report, or delineate service charges in accordance with this Section shall cause
6 the hospital or ambulatory surgical center to be liable to the plan for a fine in
7 an amount determined by the board, not to exceed five hundred dollars plus
8 interest per failure. Any hospital or ambulatory surgical center found to have
9 intentionally failed to bill, pay, report, or delineate service charges in
10 accordance with this Section, unless permitted by the board, on three or more
11 occasions during a six-month period shall be liable for a fine in an amount
12 determined by the board, not to exceed one thousand five hundred dollars per
13 failure, together with attorney fees and court costs.

14 (3) The plan or the commissioner or both are specifically authorized to
15 conduct audits of hospitals and ambulatory surgical centers in order to enforce
16 compliance with this Section. Fines levied pursuant to this Section shall be
17 consistent with those levied against insurers pursuant to this Subpart.

18 D. The service charges imposed on hospital and ambulatory surgical
19 center patients by this Section shall be payable by the patient's insurer or
20 insurance arrangement, if any, as applicable, except the charges shall not be
21 payable by an insolvent insurer. In no event shall a hospital or ambulatory
22 surgical center be required to remit to the plan uncollected service charges for
23 any patient who is a private pay patient or for any patient whose insurer or
24 insurance arrangement is not legally required to pay the service charges.

25 E. If monies in the plan at the end of any fiscal year exceed actual losses
26 and administrative expenses of the plan, the excess shall be held at interest and
27 used by the board to offset future losses. As used in this Subsection, "future
28 losses" includes reserves for incurred but not reported claims.

29 F. For the purposes of this Section, "insurance", "insurance

1 arrangement", or "policy of an insurer" includes any policy or plan of
2 insurance or of self-insurance that provides payment, indemnity, or
3 reimbursement for charges resulting from accident, injury, or illness when an
4 employer or insurer is responsible for those charges. The terms "insurance",
5 "insurance arrangement", or "policy of an insurer" shall not include
6 short-term, accident only, fixed indemnity, credit insurance, automobile and
7 homeowner's medical payment coverage, or coverage issued as a supplement to
8 liability insurance.

9 G. The service charge required by this Section shall be an amount set by
10 the commissioner upon approval of the plan provided for in R.S. 22:1203(E)(2)
11 and annually thereafter. The commissioner shall establish the amount of the
12 service charge by rule promulgated in accordance with the Administrative
13 Procedure Act no later than August thirty-first of the calendar year preceding
14 the implementation of the service charge. The charge shall apply only to dates
15 of service falling in the calendar year following promulgation of the rule. In
16 establishing the service charge, the commissioner shall determine the amount
17 necessary to fund the plan provided for in R.S. 22:1203(E)(2) but shall not
18 establish a service charge in excess of three dollars plus an inflation factor of
19 four percent per annum.

20 H. This Section shall not be effective until approval of the plan provided
21 for in R.S. 22:1203(E)(2).

22 §1210. Fees assessed to participating health insurers for plan losses
23 attributable to federally defined eligible individuals

24 A.(1) For the purposes of this Section, "participating insurer" includes
25 any insurer providing health insurance to citizens of this state.

26 (2) For the purposes of this Section, fees assessed to participating
27 insurers shall apply to gross premiums for hospital and medical expense
28 incurred policies, nonprofit service plan corporation contracts, hospital only
29 coverage, medical and surgical expense policies, major medical insurance,

1 coverages provided by health maintenance organizations, individual practices,
2 associations, and every insurance appertaining to any portion of medical
3 expense liability incurred under a group health plan as defined in R.S.
4 22:1061(1)(a), including stop-loss and excess-loss coverage unless the gross
5 premium for the coverage is included under any other type of coverage stated
6 in this Section that is issued for delivery in this state. Fee assessments to
7 participating insurers shall not apply to policies or contracts for provision of
8 short term, accident only, hospital indemnity, credit insurance, automobile and
9 homeowner's medical-payment coverage, workers' compensation medical
10 benefit coverage, Medicare, Medicaid, federal governmental benefit plans,
11 supplemental health insurance, limited benefit health insurance, or coverage
12 issued as a supplement to liability.

13 B. In addition to the powers enumerated in R.S. 22:1206, the plan shall
14 have the authority to assess fees to participating insurers in accordance with the
15 provisions of this Section and to make advance interim fee assessments as may
16 be reasonable and necessary for the plan's organizational and interim operating
17 expenses. Any interim fees assessed are to be credited as offsets against any
18 regular fees assessed that become payable following the close of the fiscal year.

19 C. Following the close of each fiscal year, the administrator shall
20 determine the net premiums, premiums less reasonable administrative expense
21 allowances, the plan expenses of administration, and the incurred losses for the
22 year which are attributable to federally defined eligible individuals. The
23 administrator shall take into account investment income and other appropriate
24 gains and losses reasonably attributable to federally defined eligible individuals.
25 Any deficit incurred by the plan shall be identified and recouped as follows:

26 (1) The board shall identify the source of any deficit related to the
27 provision of coverage to federally defined eligible individuals before assessing
28 any fees authorized under this Section.

29 (2) The board shall verify the adequacy of any governmental

1 appropriations or alternative funding sources, other than fees assessed under
2 this Section, used to reduce rates for the plan year. Where such funds were not
3 sufficient to support the rate reduction provided, that portion of the deficit
4 reasonably related to the funding shortfalls shall be recouped from any
5 subsequent governmental appropriations or alternative funding sources, other
6 than fees assessed under this Section, prior to making any rate reduction for a
7 subsequent plan year. The board shall take reasonable action to prevent future
8 deficits related to reducing rates based on receipt of government appropriations
9 or alternate funding sources.

10 (3) The board shall verify the amount of any deficit reasonably resulting
11 from plan losses not attributable to governmental or alternative funding
12 shortfalls used to reduce rates. Any verified deficit amount attributed to
13 federally defined eligible individuals shall be recouped by fees assessed pursuant
14 to this Section to participating insurers.

15 (4) The board shall provide the commissioner of insurance with a
16 detailed report on any deficit being recouped by fee assessments apportioned
17 pursuant to this Section. The report shall include information on services and
18 utilization patterns which can reasonably be attributed to the deficit as well as
19 analysis and recommendations on cost containment measures which can be
20 taken to minimize future deficits.

21 (5) The board shall provide the commissioner of insurance with a
22 detailed report on the sources and use of government appropriations and
23 alternate sources of funding used to make rates more affordable. The report
24 shall include information on the activities of similar plans maintained by other
25 states and recommendations for actions that can be taken to make coverage
26 more affordable for plan members.

27 D.(1) Each participating insurer's fee assessment shall be in proportion
28 to gross premiums earned on business in this state for policies or contracts
29 covered under this Section for the most recent calendar year for which

1 information is available.

2 (2) Each participating insurer's fee assessment shall be determined by
3 the board based on annual statements and other reports deemed to be necessary
4 by the board and filed by the participating insurer with the board. The board
5 may use any reasonable method of estimating the amount of gross premium of
6 a participating insurer if the specific amount is unknown. The plan of operation
7 shall provide the details of the calculation of each participating insurer's
8 assessment which shall require the approval of the commissioner.

9 E. A participating insurer may petition the commissioner of insurance
10 for deferral of all or part of any fee assessed by the board. If, in the opinion of
11 the commissioner, payment of the fee assessment would endanger the solvency
12 of the participating insurer, the commissioner may defer, in whole or in part,
13 the fee assessment as part of a voluntary rehabilitation or supervisory plan
14 established to prevent the plan's insolvency. The duration of any deferral
15 approved under a voluntary rehabilitation or supervisory plan shall be limited
16 to four years. The voluntary rehabilitation or supervisory plan shall require
17 repayment of all deferrals by the end of the period plus legal interest. Until
18 notice of payment in full is received from the board, the insurer shall remain
19 under the voluntary rehabilitation or supervisory plan. In the event a fee
20 assessment against a participating insurer is deferred in whole or in part, the
21 amount by which the fee assessment is deferred may be assessed to the other
22 participating insurers in a manner consistent with the basis for fee assessments
23 set forth in this Section. Collection of deferrals and legal interest shall be used
24 to offset fee assessments against the other participating insurers in a manner
25 consistent with the basis for fee assessments set forth in this Section.

26 F. This Section shall not be effective until approval of the plan provided
27 for in R.S. 22:1203(E)(2).

28 * * *

29 §1215.1. Peremption

1 Dissolution of the operations of the Louisiana Health Plan requires the
2 expeditious determination of its outstanding liabilities. As such, each of the
3 following provisions shall apply:

4 * * *

5 (4) The provisions of this Section shall not apply to any action against
6 the plan, the board, the employees of the plan, or any combination thereof
7 arising out of any obligation, duty, breach, or other activity occurring
8 subsequent to plan activity pursuant to R.S. 22:1205(C)(8).

9 §1216. Health and accident policy provisions; service charges; penalties

10 A. Any health and accident insurance policy issued under this Subpart
11 or Subpart J of Part III of Chapter 4 of this Title, and any health and accident
12 insurance policy having effect in this state, shall provide coverage without
13 regard to the insured's obligation of deductibles or copayments for the service
14 charges assessed pursuant to R.S. 22:1209. The service charges assessed to a
15 patient pursuant to R.S. 22:1209 shall be mandated benefits of any health and
16 accident insurance coverage issued by any insurer or insurance arrangement,
17 except an insolvent insurer, over and above any insurance policy limits,
18 negotiated per diem, or managed care arrangement.

19 B. Each service charge for each patient admission specified in R.S.
20 22:1209 shall be paid by the insurer or insurance arrangement in accordance
21 with the plan of operation adopted pursuant to R.S. 22:1205. Failure to pay a
22 service charge for each patient pursuant to this Section shall cause the insurer
23 or insurance arrangement to be liable to the Louisiana Health Plan, the
24 commissioner of insurance, or both for a fine in an amount determined by the
25 board, not to exceed five hundred dollars plus interest. Any insurer or
26 insurance arrangement found to have failed to comply with this Section by
27 paying each service charge for each patient admission specified in R.S. 22:1209
28 on three or more occasions during a six-month period shall be liable for a fine
29 in an amount determined by the board, of not less than five hundred dollars and

1 not more than one thousand five hundred dollars per failure to pay each service
 2 charge for each patient admission, together with attorney fees, interest, and
 3 court costs. The Louisiana Health Plan, the commissioner, or both are
 4 specifically authorized to conduct audits of insurers or insurance arrangements
 5 in order to enforce compliance with this Section.

6 C. For the purposes of this Section, "insurance" or "insurance
 7 arrangement" also includes any policy or plan of insurance or of self-insurance
 8 that provides payment, indemnity, or reimbursement for charges resulting from
 9 accident, injury, or illness when an employer, insurer, or tortfeasor is
 10 responsible for those charges.

11 D. For purposes of this Section, "insurance" or "insurance
 12 arrangement" shall not include the Office of Group Benefits program.

13 E. This Section shall not be effective until approval of the plan provided
 14 for in R.S. 22:1203(E)(2).

15 §1217. Health insurance rejections; Louisiana Health Insurance Plan
 16 information

17 A. Each rejection for individual health and accident insurance shall
 18 contain information stating that health insurance may be available through the
 19 Louisiana Health Insurance Plan. Each rejection shall also include the address
 20 and telephone number at which information on the Louisiana Health Insurance
 21 Plan may be obtained. In no event shall the information required by this Section
 22 appear on the rejection in a smaller print than any other required provision of
 23 the rejection. The requirements of this Section may be satisfied by providing a
 24 document separate from the rejection containing the required information in
 25 the required print size. In no event shall this information guarantee placement
 26 in the fund of the Louisiana Health Insurance Plan.

27 B. This Section shall not be effective until approval of the plan provided
 28 for in R.S. 22:1203(E)(2).

29 Section 2. R.S. 22:1205(7) is hereby repealed.

1 Section 3. The commissioner shall inform the Louisiana State Law Institute of the
2 date of the approval of the new plan of operation of the Louisiana Health Plan pursuant to
3 the provisions of this Act.

4 Section 4: This Act shall become effective upon signature by the governor or, if not
5 signed by the governor, upon expiration of the time for bills to become law without signature
6 by the governor, as provided by Article III, Section 18 of the Constitution of Louisiana. If
7 vetoed by the governor and subsequently approved by the legislature, this Act shall become
8 effective on the day following such approval.

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

DIGEST

SB 231 Original 2020 Regular Session Talbot

Present law provides for the dissolution of the Louisiana Health Plan (Plan) on December 31, 2013.

Proposed law establishes a process for reactivating the Plan if necessary due to a change to federal law.

Proposed law provides for the commissioner to submit written notification to the Joint Legislative Committee on the Budget and the House and Senate committees on insurance of his intention to reactivate the Plan.

Proposed law provides for the assessment of a service charge to certain patients for each day or portion thereof during which the patient is confined in a facility.

Proposed law provides for fees assessed to participating health insurers for plan losses attributable to federally defined eligible individuals.

Proposed law provides for health and accident policy provisions, service charges, and penalties.

Proposed law provides for health insurance rejections and the Louisiana Health Insurance Plan High Risk Pool.

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

(Amends R.S. 22:1203, 1205, and 1215.1; adds R.S. 22:1209, 1210, 1216, and 1217)