SLS 20RS-352 **ENGROSSED**

2020 Regular Session

SENATE BILL NO. 231

BY SENATOR TALBOT

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

AN ACT

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

Be it enacted by the Legislature of Louisiana:

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

§1203. Creation of the plan

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E.(1) Upon a finding that federal and state law no longer prohibits carriers in the individual market from rejecting applicants for health insurance coverage based on the presence of preexisting health conditions or excluding healthcare coverage for preexisting conditions, the commissioner may 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

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

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

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§1205. Plan of operation

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C. In its plan of operation the board shall:

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

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

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§1209. Service charges

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

A.(1) For the purposes of this Section, "participating insurer" includes any insurer providing insurance, as defined by R.S. 22:1209(F), to citizens of this state.

(2)(a) For the purposes of this Section, fees assessed to participating insurers shall apply to gross premiums for hospital and medical expense incurred policies, nonprofit service plan corporation contracts, hospital only

coverage, medical and surgical expense policies, major medical insurance, coverages provided by health maintenance organizations, individual practices, associations, and every insurance appertaining to any portion of medical expense liability incurred under a group health plan as defined in R.S. 22:1061(1)(a), including stop-loss and excess-loss coverage unless the gross premium for the coverage is included under any other type of coverage stated in this Section that is issued for delivery in this state.

(b) The fees assessed to participating insurers shall also apply to the same or similar services as provided for in Subparagraph (a) of this Paragraph when the services are administered by a third-party administrator on behalf of a plan that is not fully insured by a health insurance issuer, health maintenance organization, or group self-insurer. For the purposes of third-party administrators, "major medical insurance" shall not include the provision of pharmacy benefits by a third-party administrator or by a health insurance issuer or health maintenance organization when the pharmacy benefits provisions do not include comprehensive coverage.

(c) Fee assessments to participating insurers shall not apply to policies or contracts for provision of short-term, accident only, hospital indemnity, credit insurance, automobile and homeowner's medical-payment coverage, workers' compensation medical benefit coverage, Medicare, Medicaid, federal governmental benefit plans, supplemental health insurance, limited benefit health insurance, or coverage issued as a supplement to liability.

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

C. Following the close of each fiscal year, the administrator shall

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

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

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

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

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

taken to minimize future deficits.

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

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

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

E. A participating insurer may petition the commissioner of insurance for deferral of all or part of any fee assessed by the board. If, in the opinion of the commissioner, payment of the fee assessment would endanger the solvency of the participating insurer, the commissioner may defer, in whole or in part, the fee assessment as part of a voluntary rehabilitation or supervisory plan established to prevent the plan's insolvency. The duration of any deferral approved under a voluntary rehabilitation or supervisory plan shall be limited to four years. The voluntary rehabilitation or supervisory plan shall require repayment of all deferrals by the end of the period plus legal interest. Until notice of payment in full is received from the board, the insurer shall remain under the voluntary rehabilitation or supervisory plan. In the event a fee

assessment against a participating insurer is deferred in whole or in part, the amount by which the fee assessment is deferred may be assessed to the other participating insurers in a manner consistent with the basis for fee assessments set forth in this Section. Collection of deferrals and legal interest shall be used to offset fee assessments against the other participating insurers in a manner consistent with the basis for fee assessments set forth in this Section.

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

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§1215.1. Peremption

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

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

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

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

B. Each service charge for each patient admission specified in R.S.

22:1209 shall be paid by the insurer or insurance arrangement in accordance with the plan of operation adopted pursuant to R.S. 22:1205. Failure to pay a service charge for each patient pursuant to this Section shall cause the insurer or insurance arrangement to be liable to the Louisiana Health Plan, the commissioner of insurance, or both for a fine in an amount determined by the board, not to exceed five hundred dollars plus interest. Any insurer or insurance arrangement found to have failed to comply with this Section by paying each service charge for each patient admission specified in R.S. 22:1209 on three or more occasions during a six-month period shall be liable for a fine in an amount determined by the board, of not less than five hundred dollars and not more than one thousand five hundred dollars per failure to pay each service charge for each patient admission, together with attorney fees, interest, and court costs. The Louisiana Health Plan, the commissioner, or both are specifically authorized to conduct audits of insurers or insurance arrangements in order to enforce compliance with this Section.

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

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

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

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

A. Each rejection for individual health and accident insurance shall contain information stating that health insurance may be available through the Louisiana Health Insurance Plan. Each rejection shall also include the address

and telephone number at which information on the Louisiana Health Insurance Plan may be obtained. In no event shall the information required by this Section appear on the rejection in a smaller print than any other required provision of the rejection. The requirements of this Section may be satisfied by providing a document separate from the rejection containing the required information in the required print size. In no event shall this information guarantee placement in the fund of the Louisiana Health Insurance Plan.

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

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

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

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

The original instrument was prepared by Cheryl B. Cooper. The following digest, which does not constitute a part of the legislative instrument, was prepared by Brandi Cannon.

DIGEST

SB 231 Engrossed 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; repeals R.S. 22:1205(7))

Summary of Amendments Adopted by Senate

Committee Amendments Proposed by Senate Committee on Insurance to the original bill

1. Provide that the fees assessed to participating insurers also apply to the same or similar services administered by a third-party administrator on behalf of a plan that is not fully insured.