2019 Regular Session

ACT No. 412

ENROLLED

SENATE BILL NO. 173

BY SENATORS MILLS, APPEL, CHABERT, CLAITOR, CORTEZ, ERDEY, FANNIN, GATTI, HENSGENS, HEWITT, JOHNS, LONG, MARTINY AND GARY SMITH

Prefiled pursuant to Article III, Section 2(A)(4)(b)(i) of the Constitution of Louisiana.

AN ACT

To enact R.S. 22:11.1, Subpart F of Part III of Chapter 4 of Title 22 of the Louisiana Revised Statutes of 1950, to be comprised of R.S. 22:1121 through 1130, and Subpart F-1 of Part III of Chapter 4 of Title 22 of the Louisiana Revised Statutes of 1950, to be comprised of R.S. 22:1131 through 1138, relative to health insurance; to provide relative to enrollment, dependent coverage, rate setting, preexisting conditions, annual and lifetime limits, and essential benefits under certain circumstances; to require the commissioner of insurance to establish a risk-sharing program; to provide for the operation, parameters, funding, and legislative approval of the risk-sharing program; to provide for rulemaking; to provide for effectiveness; and to provide for related matters.

Be it enacted by the Legislature of Louisiana:

Section 1. R.S. 22:11.1, Subpart F of Part III of Chapter 4 of Title 22 of the Louisiana Revised Statutes of 1950, comprised of R.S. 22:1121 through 1130, and Subpart F-1 of Part III of Chapter 4 of Title 22 of the Louisiana Revised Statutes of 1950, comprised of R.S. 22:1131 through 1138, are hereby enacted to read as follows:

§11.1. Rules and regulations; essential health benefits package

The commissioner shall promulgate rules pursuant to the Administrative

Procedure Act to define "essential health benefits", to establish annual limitations on cost sharing and deductibles, and to define required levels of coverage. The commissioner shall adopt initial administrative rules before January 1, 2020. Notwithstanding any provision of R.S. 49:953(B) to the contrary, the commissioner may adopt initial administrative rules as required by this Section pursuant to the provisions of R.S. 49:953(B) without a finding that an imminent peril to the public health, safety, or welfare exists.

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SUBPART F. HEALTHCARE COVERAGE FOR LOUISIANA FAMILIES PROTECTION ACT

§1121. Short Title

This Subpart shall be known and may be cited as the "Healthcare Coverage for Louisiana Families Protection Act".

§1122. Effectiveness

If a court of competent jurisdiction rules that the Patient Protection and Affordable Care Act, P.L. 111-148, is unconstitutional and the judgment of that court becomes final and definitive, the attorney general shall give written notification of the final and definitive ruling to the commissioner, the legislature, and the Louisiana State Law Institute. The provisions of this Subpart shall become effective ninety days after receipt by the commissioner of the written notification. However, no provision of this Subpart shall abridge or affect the provisions of insurance policies or contracts already in effect until such policies or contracts are renewed.

§1123. Preexisting condition exclusions prohibited

A health insurance policy or contract issued or issued for delivery in this state after the effective date of this Subpart shall not impose a preexisting condition exclusion. This Section shall not limit an insurer's ability to restrict enrollment in an individual contract to open enrollment and special enrollment periods in accordance with other provisions of this Title.

§1124. Annual and lifetime limits prohibited

A health insurance policy or contract issued or issued for delivery in this state after the effective date of this Subpart shall not do either of the following:

(1) Establish lifetime limits on the dollar value of benefits for any participant or beneficiary.

(2) Establish annual limits on the dollar value of essential benefits, as determined by the commissioner, to the extent not inconsistent with applicable federal law.

§1125. Coverage for dependent children

A health insurance policy or contract issued or issued for delivery in this state after the effective date of this Subpart that offers coverage for a dependent child shall offer dependent coverage, at the option of the policyholder, until the dependent child attains the age of twenty-six. An insurer may require, as a condition of eligibility for coverage in accordance with this Section, that a person seeking coverage for a dependent child provide written documentation on an annual basis that the dependent child satisfies the requirements applicable to dependent children in this Title.

§1126. Rate setting

For all health insurance policies, contracts, or certificates that are executed, delivered, issued for delivery, continued, or renewed in this state after the effective date of this Subpart, the maximum rate differential due to age filed by the carrier as determined by ratio shall be five to one. The limitation does not apply for determining rates for an attained age of less than nineteen years or more than sixty-five years.

§1127. Open enrollment

A health insurance policy or contract issued or issued for delivery in this state after the effective date of this Subpart may restrict enrollment in individual health plans to open enrollment periods and special enrollment periods to the extent not inconsistent with applicable federal law. The commissioner may adopt rules establishing minimum open enrollment dates and minimum criteria for special enrollment periods for all individual health

plans offered in this state.

§1128. Comprehensive health coverage

A. Notwithstanding any other provision of law to the contrary, a health insurance policy or contract issued or issued for delivery in this state thirty days or more after rules promulgated pursuant to Subsection G of this Section become effective shall, at a minimum, provide coverage that incorporates an essential health benefits package consistent with the requirements of this Section.

B. As used in this Section, "essential health benefits package" means coverage that:

(1) Provides for the essential health benefits defined by the commissioner pursuant to Subsection C of this Section.

(2) Limits cost sharing for coverage in accordance with Subsection E of this Section.

(3) Provides for levels of coverage in accordance with Subsection F of this Section.

C. The commissioner shall ensure that the scope of the essential health benefits package required pursuant to this Section is substantially similar to that of the essential health benefits required for a health plan subject to the federal Patient Protection and Affordable Care Act as of January 1, 2019. The commissioner shall define the essential health benefits required for a health plan, provided the definition includes at a minimum the following general categories and the items and services covered within the categories:

(1) Ambulatory patient services.

(2) Emergency services.

(3) Hospitalization.

(4) Maternity and newborn care.

(5) Mental health and substance use disorder services, including behavioral health treatment.

(6) Prescription drugs.

(7) Rehabilitative and habilitative services and devices.

(8) Laboratory services.

(9) Preventive and wellness services and chronic disease management.

(10) Pediatric services, including oral and vision care.

D. In defining essential health benefits for purposes of this Section, the commissioner shall do the following:

(1) Ensure that the essential health benefits reflect an appropriate balance among the categories enumerated in Subsection C of this Section, so that benefits are not unduly weighted toward any category.

(2) Ensure that coverage decisions, determination of reimbursement rates, establishment of incentive programs, and designation of benefits are effected in ways that do not discriminate against individuals because of age, disability, or life expectancy.

(3) Take into account the healthcare needs of diverse segments of the population, including women, children, persons with disabilities, and other groups.

(4) Ensure that health benefits established as essential are not subject to denial to an individual, against the individual's wishes, on the basis of the individual's age or life expectancy or of the individual's present or predicted disability, degree of medical dependency, or quality of life.

(5) Provide that a qualified health plan shall not be treated as providing coverage for the essential health benefits package described in Subsection B of this Section unless the plan complies with the provisions of the Patient Protection and Affordable Care Act, P. L. 111-148, relative to coverage and payment for emergency department services.

(6) Provide that if a plan is offered through an exchange, another health plan offered through that exchange shall not fail to be treated as a qualified health plan solely because the plan does not offer coverage of benefits offered through the stand-alone plan that are otherwise required under Paragraph (C)(10) of this Section.

(7) Annually review the essential health benefits package under Subsection B of this Section and submit a report to the legislature that contains the following:

(a) An assessment of whether enrollees are facing any difficulty accessing needed services for reasons of coverage or cost.

(b) An assessment of whether the essential health benefits package needs to be modified or updated to account for changes in medical evidence or scientific advancement.

(c) Information on how the essential health benefits package will be modified to address any gaps in access or changes in the evidence base.

(d) An assessment of the potential of additional or expanded benefits to increase costs and the interactions between the addition or expansion of benefits and reductions in existing benefits to meet actuarial limitations.

(8) Periodically update the essential health benefits package under Subsection B of this Section to address any gaps in access to coverage or changes in the evidence base the commissioner identifies in the review conducted under Paragraph (7) of this Subsection.

E. The commissioner shall establish annual limitations on cost sharing and deductibles that are substantially similar to the limitations for health plans subject to the federal Patient Protection and Affordable Care Act as of January 1, 2019. The commissioner may increase the annual limitation as needed to reflect any premium adjustment percentage. For purposes of this Subsection, "premium adjustment percentage" means the percentage, if any, by which the average per capita premium for health insurance coverage in the United States for the preceding calendar year, as estimated by the commissioner no later than October first of the preceding calendar year, exceeds the average per capita premium for 2019.

F. The commissioner shall define levels of coverage that are substantially similar to the levels of coverage required for health plans subject to the federal Patient Protection and Affordable Care Act as of January 1, 2019.

G. The commissioner shall promulgate rules pursuant to the Administrative Procedure Act to define "essential health benefits" pursuant to Subsection C of this Section, to establish annual limitations on cost sharing and deductibles pursuant to Subsection E of this Section, and to define required levels of coverage pursuant to Subsection F of this Section.

H. Within thirty days of the effective date of rules promulgated that define essential health benefits as required pursuant to Subsection G of this Section or within thirty days after promulgating rules adopting any changes to the definition of essential health benefits, the commissioner shall submit a report summarizing the definition of essential health benefits to the House and Senate committees on insurance.

I. This Section shall not be construed to prohibit a health plan from providing benefits in excess of the essential health benefits described in this Section.

§1129. Conflict of laws

In case of any conflict between the provisions of this Subpart and any other provision of law, the provisions of this Subpart shall control unless application of this Subpart results in a reduction in coverage for any insured.

§1130. Applicability

A. The provisions of this Subpart shall be effective or enforceable only in the event that the tax credit authorized in Section 1401 of the Patient Protection and Affordable Care Act of 2010, P. L. 111-148, as amended by the Healthcare and Education Reconciliation Act of 2010, P. L. 111-152, and codified in Section 16B of the Internal Revenue Code, is held to be valid by a court of competent jurisdiction or is otherwise enforceable at law, or unless adequate appropriations are timely made by the federal or state government in an amount that is calculated in a similar manner as the tax credit in Section 1401 of the Patient Protection and Affordable Care Act.

B. The provisions of this Subpart shall not apply to grandfathered coverage as defined in R.S. 22:1091(B)(4).

C. The provisions of this Subpart shall not apply to health benefit plans in the large groups as defined in R.S. 22:1091(B)(13) or to the large group market as defined in R.S. 22:1091(B)(14).

D. The provisions of this Subpart shall not apply to limited or excepted benefits policies as defined in this Title.

SUBPART F-1. LOUISIANA GUARANTEED BENEFITS POOL

§1131. Short title

This Subpart shall be known and may be cited as the "Louisiana Guaranteed Benefits Pool Act".

§1132. Definitions

As used in this Subpart, the following definitions apply:

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

(2) "Program" means the Louisiana Guaranteed Benefits Pool.

§1133. Louisiana Guaranteed Benefits Pool; establishment

A. The commissioner shall establish the Louisiana Guaranteed Benefits Pool which shall be a risk-sharing program to provide payment to health insurance issuers for claims for healthcare services provided to eligible individuals with expected high healthcare costs for the purpose of lowering premiums for health insurance coverage offered in the individual market.

B. In establishing the program, the commissioner shall do all of the following:

(1) Examine Louisiana's historical experience with the Louisiana Health Plan high risk pool, R.S. 22:1201 et seq.

(2) Consult with healthcare consumers, health insurance issuers, and other interested stakeholders.

(3) Take into consideration high-cost health conditions and other health trends that generate a high cost.

§1134. Operation of program

A. The commissioner shall establish the Louisiana Guaranteed Benefits Pool with a framework and operation similar to other state best practices.

B. The program may be administered by either the commissioner or by an independent nonprofit organization.

§1135. Actuarial analysis

In establishing the program, the commissioner shall commission an actuarial analysis to do all of the following:

(1) Inform the development and parameters of the program.

(2) Evaluate how funds that may currently be utilized to pay the Health Insurance Provider Fee (HIPF) or may be recovered pursuant to litigation related to the HIPF may be used to contribute to the funding of the guaranteed benefits pool.

(3) Estimate the necessary funding required to reach the premium reduction goals of the program, taking into consideration all of the above-listed sources.

§1136. Program parameters

In establishing the program, the commissioner shall provide for all of the following:

(1) The criteria for individuals to be eligible for participation in the program.

(2) The development and use of health status statements with respect to eligible individuals.

(3) The standards for qualification, including but not limited to all of the following:

(a) The identification of health conditions that automatically qualify individuals as eligible individuals at the time of application for health insurance coverage.

(b) A process pursuant to which health insurance issuers may voluntarily qualify individuals who do not automatically qualify as eligible individuals at the time of application for coverage.

(4) The percentage of the premiums paid to health insurance issuers for health insurance coverage by eligible individuals that shall be collected and

deposited to the credit and available for the use of the program.

(5) The threshold dollar amount of claims for eligible individuals after which the program will provide payments to health insurance issuers and the proportion of the claims above the threshold dollar amount that the program will pay.

§1137. Approval by legislature

A. The commissioner shall submit the actuarial analysis required by R.S. 22:1135 to the Joint Legislative Committee on the Budget.

B. The Joint Legislative Committee on the Budget shall meet to review and approve the actuarial analysis, the details of the program as determined by the commissioner, and any required funding. The committee may also take any other action with respect to the program deemed necessary by the committee.

§1138. Enrollment or participation limitation

The commissioner shall not enroll an individual or permit any individual to participate as an eligible individual in the program unless the commissioner has received written notification from the attorney general of a final and definitive ruling by a court of competent jurisdiction that the federal Patient Protection and Affordable Care Act, P.L. 111-148, is unconstitutional pursuant to R.S. 22:1122.

Section 2.(A) The commissioner of insurance shall take all such actions as are necessary to commission the actuarial analysis required by R.S. 22:1135, as enacted by Section 1 of this Act, before August 1, 2019.

(B) The commissioner of insurance shall submit the actuarial analysis as required by R.S. 22:1137, as enacted by Section 1 of this Act, and shall submit a report containing a detailed description of the proposed Louisiana Guaranteed Benefits Pool program to the Joint Legislative Committee on the Budget on or before March 1, 2020.

(C) Upon receipt of the actuarial analysis and report, the Joint Legislative Committee on the Budget shall meet at the next available opportunity to review and approve the actuarial analysis, the details of the program as determined by the commissioner, and any required funding pursuant to R.S. 22:1137, as enacted by Section 1 of this Act.

Section 3. 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.

PRESIDENT OF THE SENATE

SPEAKER OF THE HOUSE OF REPRESENTATIVES

GOVERNOR OF THE STATE OF LOUISIANA

APPROVED: _____