SLS 10RS-680 **ORIGINAL**

Regular Session, 2010

SENATE BILL NO. 153

BY SENATOR ERDEY

HEALTH/ACC INSURANCE. Relative to the high risk health insurance pool. (gov sig)

AN ACT

To amend and reenact R.S. 22:1061(3)(d)(i), 1073(B)(4), 1210(D), (E), and (F), 1213(B) (introductory paragraph), (F)(3), and (G), to enact R.S. 22:1061(4)(k), 1205(C)(6) and (D), and 1213(B)(14), and to repeal R.S. 22:1213(D) and (E)(12), relative to the Louisiana Health Plan; to provide for compliance with federal law for expanded coverage by the plan; to redefine certain terms relative to portability, availability, and renewability of health insurance coverage; to provide with respect to coverage of mental and nervous conditions, including alcohol and substance abuse, by the plan; to provider with respect to initial rates for federally and non-federally defined eligible individuals; to delete the six-month preexisting condition provision for federally defined eligible individuals; and to provide for related matters.

Be it enacted by the Legislature of Louisiana:

Section 1. R.S. 22:1061(3)(d)(i), 1073(B)(4), 1210(D), (E), and (F), 1213(B) (introductory paragraph), (F)(3), and (G) are hereby amended an reenacted and R.S. 22:1061(4)(k), 1205(C)(6) and (D), and 1213(B)(14) are hereby enacted to read as follows:

§1061. Definitions

As used in R.S. 22:984 and 1061 through 1079, the following terms shall

have the following meanings:

* * *

(3) "Excepted benefits" means benefits under one or more of the following:

* * *

(d) Benefits not subject to requirements if offered as a separate insurance policy:

(i) Medicare ~~coverage.~~ **supplemental health insurance as defined under Section 1882(g)(1) of the Social Security Act.**

* * *

(4) "Creditable coverage" means, with respect to an individual, coverage of the individual under any of the following:

* * *

(k) Medical assistance coverage provided under 42 USCA 1397 et seq.

* * *

§1073. Guaranteed availability of individual health insurance coverage to certain individuals with prior group or individual coverage

* * *

B. As used in this Section, the term "eligible individual" means an individual who meets the requirements of Subsection H of this Section or an individual:

* * *

(4) Who**,** ~~elected~~ **if offered the option of continuation of** coverage under a COBRA continuation provision or under a similar state program~~.~~**, elected this coverage.**

* * *

§1205. Plan of operation

* * *

C. In its plan of operation the board shall:

* * *

(6) Provide the details of the calculation of each participating insurer's

assessment.

D. The board, with the approval of the commissioner, may establish, provide for, administer, and contract to provide coverage for a health plan to offer eligible individuals and families the ability to purchase or enroll in a program established under federal law that provides expanded coverage for state high risk pools.

* * *

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

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D.**(1)** Each participating insurer's fee assessment shall be in the 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.

~~E.~~ **(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.**

~~F.~~ **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. Any deferrals approved under a voluntary rehabilitation or supervisory plan shall be limited to four years and require repayment of all deferrals by the end of such 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 such 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.

* * *

§1213. Benefits; availability

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B. ~~The board shall establish reasonable reimbursement amounts for the following services and articles prescribed by a health care provider and determined by the plan to be medically necessary, including but not limited to:~~ **Covered expenses shall be the usual, customary, and reasonable charge, as established by the board, in the locality for the following services and articles when prescribed by a physician and determined by the plan to be medically necessary for the following areas of services:**

* * *

(14) Services for diagnosis and treatment of mental and nervous disorders provided that a covered person may be required to pay up to a fifty percent coinsurance payment, and the plan's payment may not exceed twenty-five thousand dollars. Notwithstanding the previous provision, the department may conduct a periodic actuarial cost analysis to determine whether the plan's maximum payment for outpatient services for diagnosis and treatment of mental and nervous disorders should be adjusted.

* * *

F.

* * *

(3)**(a)** The plan**, with the assistance of the commissioner,** shall determine the standard risk rate by calculating the average individual standard rate charged by the five largest insurers offering coverages in the state comparable to the plan coverage. In the event five insurers do not offer comparable coverage, the standard risk rate shall be established using reasonable actuarial techniques and shall reflect anticipated experience and expenses for such coverage.

(b) Standard risk rates for federally defined ~~eligibles~~ **eligible individuals** shall comply with all applicable federal laws and regulations. Initial rates for plan coverage ~~provided to nonfederally~~ **for federally** defined eligible individuals shall not be less than one hundred ~~fifty~~ **twenty-five** percent of rates established as applicable for individual standard risks~~;~~**.** ~~or the minimum monthly rates as provided for herein, whichever is greater. Subsequent rates provided to nonfederally defined eligible individuals shall be established to provide fully for the expected costs of claims, including recovery of prior losses, expenses of operation, investment income of claim reserves, and any other cost factors subject to the limitations described herein. In no event shall plan rates exceed two hundred percent of rates applicable to individual standard risks.~~ In no event shall **plan** rates ~~be lower than one hundred ten percent~~ **exceed two hundred percent** of rates applicable to individual standard risks.

* * *

G. Plan coverage provided to non-federally defined eligible individuals shall exclude charges or expenses incurred for or caused by preexisting conditions as allowed under R.S. 22:1073(A)(1)(b)~~.~~**, except that no preexisting condition exclusion shall be applied to a federally defined eligible individual.**

* * *

Section 2. R.S. 22:1213(D) and (E)(12) are hereby repealed in their entirety.

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.

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

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Proposed law redefines certain terms for purposes of present law relative to assuring portability, availability, and renewability of health insurance coverage, administered in part by the La. Health Plan, as follows:

(1) Deletes Medicare coverage benefits from the definition of those"excepted benefits" not subject to requirements if offered as a separate insurance policy and adds Medicare supplemental health insurance benefits as defined by the federal Social Security Act.

(2) Includes under the definition of "creditable coverage" certain medical assistance coverage provided under federal law.

(3) Changes the definition of "eligible individual" from an individual who elected COBRA continuation or a similar state program to an individual who, if offered the option of continuation of COBRA coverage or a similar state program, elected this coverage.

Proposed law Requires the board of directors of the plan to provide the details of the calculation of each participating insurer's assessment in its plan of operation which is submitted to the commissioner of insurance for his approval. Further authorizes the board, with the approval of the commissioner, to establish, provide for, administer, and contract to provide coverage for a health plan to offer eligible individuals and families the ability to purchase or enroll in a program established under federal law that provides expanded coverage for state high risk pools.

Present law requires the board to establish reasonable reimbursement amounts for health care services and providers determined by the plan to be medically necessary, including but not limited to a list of services specified.

Proposed law instead provides that covered expenses shall be the usual, customary, and reasonable charge, as established by the board, in the locality for the following services when prescribed by a physician and determined by the plan to be medically necessary for the following areas of services specified.

Present law excludes mental and nervous coverage, including alcohol and substance abuse, from these services.

Proposed law eliminates this mental and nervous and alcohol and substance abuse coverage exclusion. However, adds that for the services for diagnosis and treatment of mental and nervous disorders, a covered person may be required to pay up to a 50% coinsurance payment and the plan's payment may not exceed $25,000. Further authorizes the Department of Insurance to conduct a periodic actuarial cost analysis to determine whether the plan's maximum payment for outpatient services for diagnosis and treatment of mental and nervous disorders should be adjusted.

Present law provides that if the amount charged for services provided by or at the direction of a health care provider exceed the amount payable for covered expenses by the plan, the health care provider may seek amounts payable for covered expenses from the member as allowed under applicable contracts or state and federal laws and regulations.

Proposed law deletes present law.

Present law states that the plan determines the standard risk rate by calculating the average individual standard rate for the five largest insurers offering coverage in the state comparable to the plan coverage.

Proposed law adds that the plan shall make this determination with the assistance of the commissioner.

Present law states that there are standard rates for federally defined eligibles.

Proposed law clarifies that such rates are for federally defined eligible individuals. Additionally provides that initial rates for such individuals shall not be less than 125% and not more than 200% of standard risk rates applicable to individuals.

Present law provides that initial rates for plan coverage provided to nonfederally defined eligible individuals shall not be less than 150% of rates established as applicable for individual standard risks, or the minimum monthly rates as provided for in present law, whichever is greater. Further requires that subsequent rates provided to such individuals shall be established to provide fully for the expected costs of claims, including recovery of prior losses, expenses of operation, investment income of claim reserves, and any other cost factors subject to the limitations described in present law. Specifies that in no event shall plan rates exceed 200% of rates applicable to individual standard risks or shall rates be lower than 110% of rates applicable to individual standard risks.

Proposed law deletes present law.

Present law allows a six-month pre-existing condition provision to be applied to non-federally qualified individuals.

Proposed law provides no pre-existing condition for federally defined eligible individuals; otherwise retains present law.

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

(Amends R.S. 22:1061(3)(d)(i), 1073(B)(4), 1210(D), (E), and (F), 1213(B) (intro. para.), (F)(3), and (G); adds R.S. 22:1061(4)(k), 1205(C)(6) and (D), and 1213(B)(14); repeals R.S. 22:1213(D) and (E)(12))