Regular Session, 2012

HOUSE BILL NO. 908

BY REPRESENTATIVE RITCHIE

INSURANCE/HEALTH: Provides relative to health insurance rate review and approval

AN ACT

To amend and reenact R.S. 22:972, Subpart D of Part III of Chapter 4 of Title 22 of the Louisiana Revised Statutes of 1950, to be comprised of R.S. 22:1091 through 1099, and R.S. 44:4.1(B)(10), and to enact R.S. 22:821(B)(34), relative to health insurance rate review and approval; to provide for definitions; to provide for applicability; to provide relative to form approval; to modify community rating; to provide with respect to review and subsequent approval or disapproval of proposed premium rate filings and rate changes; to provide for fees; to provide for exceptions to the Public Records Law; to provide for implementation and enforcement; to prohibit certain discrimination in rates; to provide for transitional provisions by providing for various effective dates; and to provide for related matters.

Be it enacted by the Legislature of Louisiana:

Section 1. R.S. 22:972 and Subpart D of Part III of Chapter 4 of Title 22 of the Louisiana Revised Statutes of 1950, comprised of R.S. 22:1091 through 1099, are hereby amended and reenacted and R.S. 22:821(B)(34) is hereby enacted to read as follows:

§821. Fees

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B. The following fees and licenses shall be collected in advance by the commissioner of insurance:

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(34) Fee for premium rate filings for health insurance issuers

(a) New premium rate filings . . . . . $ 100.00

(b) Rate changes . . . . . $ 150.00

* * *

§972. Approval and disapproval of forms~~; filing of rates~~

A. No policy or subscriber agreement of a health ~~and accident~~ insurance issuer, including a health maintenance organization, shall be delivered or issued for delivery in this state, nor shall any endorsement, rider, or application which becomes a part of any such policy, which may include a certificate, be used in connection therewith until a copy of the form and of the premium rates and of the classifications of risks pertaining thereto have been filed with the ~~commissioner of insurance; nor shall any such~~ department. No policy, subscriber agreement, endorsement, rider, or application shall be used until the expiration of ~~forty-five~~ sixty days after the form has been filed unless the ~~commissioner of insurance~~ department gives ~~his~~ its written approval prior thereto. ~~The commissioner of insurance shall notify in writing the insurer which has filed any such form if it does not comply with the provisions of this Subpart, specifying the reasons for his opinion; and it shall thereafter be unlawful for such insurer to issue such form in this state.~~ Written notification shall be provided to the health insurance issuer specifying the reasons a policy form or subscriber agreement does not comply with the provisions of this Subpart. It shall be unlawful for any health insurance issuer to issue any form in this state not previously submitted to and approved by the department. An aggrieved party affected by the ~~commissioner's~~ department's decision, act, or order in reference to a policy form or subscriber agreement may demand a hearing in accordance with Chapter 12 of this Title, R.S. 22:2191 et seq.

B. After providing twenty days' notice to the ~~commissioner of~~ health insurance issuer, the department may withdraw ~~his~~ its approval of any such policy form or subscriber agreement or on any of the grounds stated in ~~this Section~~ R.S. 22:862. It shall be unlawful for the ~~insurer~~ health insurance issuer to issue such

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policy form or subscriber agreement or use it in connection with any policy or subscriber agreement after the effective date of such withdrawal of approval. An aggrieved party affected by the ~~commissioner's~~ department's decision, act, or order in reference to a policy form or subscriber agreement may demand a hearing in accordance with Chapter 12 of this Title, R.S. 22:2191 et seq.

C. The ~~commissioner of insurance~~ department shall not disapprove or withdraw approval of any such policy form or subscriber agreement on the ground that its provisions do not comply with R.S. 22:975 or on the ground that it is not printed in uniform type if it shall be shown that the rights of the insured, ~~or~~ the beneficiary, or the subscriber under the policy or subscriber agreement as a whole are not less favorable than the rights provided by R.S. 22:975 and that the provisions or type size used in the policy or subscriber agreement are required in the state, district, or territory of the United States in which the ~~insurer~~ the health insurance issuer is organized, anything in this Subpart to the contrary notwithstanding.

D. All premium rates referenced in this Section are to be controlled by Subpart D of this Part, R.S. 22:1091 through 1099.

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SUBPART D. ~~RATES~~ RATE REVIEW AND APPROVAL

§1091. Health insurance plans subject to rate ~~limitations~~ review and approval

~~A. The provisions of R.S. 22:1091 through 1095 shall apply to any health benefit plan which provides coverage to a small employer except the following:~~

~~(1) An Archer medical savings account that meets all requirements of Section 220 of the Internal Revenue Code of 1986.~~

~~(2) A health savings account that meets all requirements of Section 223 of the Internal Revenue Code of 1986.~~

~~B. Notwithstanding any law to the contrary, the following terms shall be defined as follows:~~

~~(1) "Actuarial certification" means a written statement by a member of the American Academy of Actuaries that a small employer carrier is in compliance with~~

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~~the provisions of R.S. 22:1092, based upon the person's examination, including a review of the appropriate records and of the actuarial assumptions and methods utilized by the carrier in establishing premium rates for applicable health benefit plans.~~

~~(2) "Base premium rate" means, for each class of business as to a rating period, the lowest premium rate charged or which could have been charged under a rating system for that class of business, by the small employer carrier to small employers with similar case characteristics for health benefit plans with the same or similar coverage.~~

~~(3) "Carrier" means an insurance company, including a health maintenance organization as defined and licensed to engage in the business of insurance under Subpart I of Part I of Chapter 2 of this Title, which is licensed or authorized to issue individual, group, or family group health insurance coverage for delivery in this state.~~

~~(4) "Case characteristics" mean demographic or other relevant characteristics of a small employer, as determined by a small employer carrier, which are considered by the carrier in the determination of premium rates for the small employer. Claim experience, health status and duration of coverage since issue are not case characteristics for the purposes of this Section.~~

~~(5) "Class of business" means all or a distinct grouping of small employers as shown on the records of the small employer carrier.~~

~~(a) A distinct grouping may only be established by the small employer carrier on the basis that the applicable health benefit plans:~~

~~(i) Are marketed and sold through individuals and organizations which are not participating in the marketing or sale of other distinct groupings of small employers for such small employer carrier;~~

~~(ii) Have been acquired from another small employer carrier as a distinct grouping of plans; or~~

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~~(iii) Are provided through an association with membership of not less than twenty-five small employers which has been formed for purposes other than obtaining insurance.~~

~~(b) A small employer carrier may establish no more than two additional groupings under each of the items in Subparagraph (a) of Paragraph (5) of this Subsection on the basis of underwriting criteria which are expected to produce substantial variation in the health care costs.~~

~~(c) The commissioner may approve the establishment of additional distinct groupings upon application to the commissioner and a finding by the commissioner that such action would enhance the efficiency and fairness of the small employer insurance marketplace.~~

~~(6) "Health benefit plan", "plan", or "health insurance coverage" means benefits consisting of medical care, provided directly, through insurance or reimbursement, or otherwise and including items and services paid for as medical care, under any hospital or medical service policy or certificate, hospital or medical service plan contract, preferred provider organization, or health maintenance organization contract offered by a health insurance issuer. However, a "health benefit plan" shall not include limited benefit and supplemental health insurance; coverage issued as a supplement to liability insurance; workers' compensation or similar insurance; or automobile medical-payment insurance.~~

~~(7) "Health savings accounts" are those accounts for medical expenses authorized by 26 USC 220 et seq.~~

~~(8) "High deductible health plan" means a high deductible health plan or policy that is qualified to be used in conjunction with a health savings account, medical savings account, or other similar program authorized by 26 USC 220 et seq.~~

~~(9) "Index rate" means for each class of business for small employers with similar case characteristics the arithmetic average of the applicable base premium rate and the corresponding highest premium rate.~~

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~~(10) "Medical savings account policy" means a high deductible health plan which is qualified to be used in conjunction with a medical savings account as provided in 26 USC 220 et seq.~~

~~(11) "New business premium rate" means, for each class of business as to a rating period, the premium rate charged or offered by the small employer carrier to small employers with similar case characteristics for newly issued health benefits plans with the same or similar coverage.~~

~~(12) "Rating period" means the calendar period for which premium rates established by a small employer carrier are assumed to be in effect, as determined by the small employer carrier.~~

~~(13) "Small employer" means any person, firm, corporation, partnership, or association actively engaged in business which, on at least fifty percent of its working days during the preceding year, employed no less than three nor more than thirty-five eligible employees, the majority of whom were employed within this state, and is not formed primarily for purposes of buying health insurance, and in which a bona fide employer-employee relationship exists. In determining the number of eligible employees, companies which are affiliated companies or which are eligible to file a combined tax return for purposes of state taxation shall be considered one employer. An employer group of one shall be considered individual insurance under this Section.~~

~~(14) "Small employer carrier" means any carrier which offers health benefit plans covering the employees of a small employer.~~

~~C. Group and individual high deductible health plans are excluded from the provisions of R.S. 22:1091 through 1095.~~

A. The provisions of this Subpart shall apply to any health benefit plan which provides coverage for a large group, individual, or small group, including any policy or subscriber agreement, covering residents of this state. The provisions shall apply regardless of where such policy or subscriber agreement was issued or delivered and shall include any employer, association, or a trustee of a fund

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established by an employer, association, or trust for multiple associations who shall be deemed the policyholder, covering one or more employees of such employer, one or more members or employees of members of such association or multiple associations, for the benefit of persons other than the employer, the association, or the multiple associations, as well as their officers or trustees. The provisions of R.S. 22:1091 through 1097 shall not apply to the following:

(1) An Archer medical savings account that meets all requirements of Section 220 of the Internal Revenue Code of 1986.

(2) A health savings account that meets all requirements of Section 223 of the Internal Revenue Code of 1986.

(3) Group and individual high deductible health plans.

(4) Excepted benefits.

(5) Grandfathered health plans.

B. Notwithstanding any law to the contrary, for purposes of this Subpart:

(1) "Actuarial certification" means a written statement signed by a member of the American Academy of Actuaries that a health insurance issuer is in compliance with the provisions of this Subpart, based upon the actuary's examination, including a review of the appropriate records and of the actuarial assumptions and methods utilized by the health insurance issuer in establishing premium rates for applicable health benefit plans.

(2) "Base premium rate" means, for each class of business as to a rating period, the lowest premium rate charged or which could have been charged under a rating system for that class of business, by the small employer health insurance issuer to small employers with similar case characteristics for health benefits plans with the same or similar coverage. Coverage and case characteristic variations in the manual shall bear a reasonable relationship to normal expectations based on experience of standard risks. The use of experience alone is not sufficient justification for variations beyond such expectations.

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(3) "Case characteristics" mean demographic or other relevant characteristics of a small employer, as determined by a small employer health insurance issuer, which are considered by the health insurance issuer in the determination of premium rates for the small employer. Claim experience, health status, and duration of coverage since issue are not case characteristics for purposes of this Subpart.

(4) "Class of business" means all or a distinct grouping of small employers as shown on the records of the small employer health insurance issuer.

(a) A distinct grouping may only be established by the small employer health insurance issuer on the basis that the applicable health benefit plans meets at least one of the following criteria:

(i) Are marketed and sold through individuals and organizations which are not participating in the marketing or sale of other distinct groupings of small employers for such small employer health insurance issuer.

(ii) Have been acquired from another small employer health insurance issuer as a distinct grouping of plans.

(iii) Are provided through an association with membership of not less than twenty-five small employers which has been formed for purposes other than obtaining insurance.

(b) A small employer health insurance issuer may establish no more than two additional groupings under each of the items in Subparagraph (B)(4)(a) of this Section on the basis of underwriting criteria which are expected to produce substantial variation in the health care costs.

(c) The commissioner may approve the establishment of additional distinct groupings upon application to him and a finding by him that such action would enhance the efficiency and fairness of the small employer insurance marketplace.

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

(a) Benefits not subject to requirements:

(i) Coverage only for accident, or disability income insurance, or any combination.

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(ii) Coverage issued as a supplement to liability insurance.

(iii) Liability insurance, including general liability insurance and automobile liability insurance.

(iv) Workers' compensation or similar insurance.

(v) Automobile medical payment insurance.

(vi) Credit-only insurance.

(vii) Coverage for on-site medical clinics.

(viii) Other similar insurance coverage, specified in regulations issued by the commissioner pursuant to the Administrative Procedure Act, under which benefits for medical care are secondary or incidental to other insurance benefits.

(b) Benefits not subject to requirements if offered separately:

(i) Limited scope dental or vision benefits.

(ii) Benefits for long-term care, nursing home care, home health care, community-based care, or any combination thereof.

(iii) Such other similar, limited benefits as specified in reasonable regulations issued by the commissioner.

(c) Benefits not subject to requirements if offered as independent, non-coordinated benefits:

(i) Coverage only for a specified disease or illness.

(ii) Hospital indemnity or other fixed indemnity insurance.

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

(i) Medicare supplemental health insurance as defined by Section 1882(g)(1) of the Social Security Act.

(ii) Insurance coverage supplemental to military health benefits.

(iii) Similar supplemental coverage provided under a group health plan.

(6) "Excessive" means the premium charged for the health insurance coverage is considered to be unreasonably high in relation to the benefits provided under the particular product. In determining whether the premium rate is

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unreasonably high in relation to the benefits provided, the department will consider each of the following:

(a) Whether the premium rate results in a projected medical loss ratio below the federal medical loss ratio standard in the applicable market to which the premium rate applies, after accounting for any adjustments allowable under federal law;

(b) Whether one or more of the assumptions on which the premium rate is based is not supported by substantial evidence.

(c) Whether the choice of assumptions or combination of assumptions on which the premium rate is based is unreasonable.

(7) "Federal review threshold" means any rate increase that results in a ten percent or greater rate increase, or such other threshold as required by federal law, regulation, or directive by the United States Department of Health and Human Services, or any premium rate that, when combined with all rate increases and decreases during the previous twelve- month period would result in an aggregate ten percent or greater rate increase.

(8) "Grandfathered health plan" has the same meaning as that in 45 C.F.R. 147.140.

(9) "Health benefit plan", "plan", "benefit", or "health insurance coverage" means services consisting of medical care, provided directly, through insurance or reimbursement, or otherwise, and including items and services paid for as medical care under any hospital or medical service policy or certificate, hospital or medical service plan contract, preferred provider organization, or health maintenance organization contract offered by a health insurance issuer. However, excepted benefits are not included as a "health benefit plan".

(10) "Health insurance issuer" means any entity that offers health insurance coverage through a policy, certificate of insurance, or subscriber agreement subject to state law that regulates the business of insurance. A "health insurance issuer" shall include a health maintenance organization, as defined and licensed pursuant to Subpart I of Part I of Chapter 2 of this Title.

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(11) "Health savings accounts" are those accounts for medical expenses authorized by 26 U.S.C. 220 et seq.

(12) "High deductible health plan" means a high deductible health plan or policy that is qualified to be used in conjunction with a health savings account, medical savings account, or other similar program authorized by 26 U.S.C. 220 et seq.

(13) "Inadequate" means premium rates for a particular product are clearly insufficient to sustain projected losses and expenses, or the use of such premium rates.

(14) "Index rate" means for each class of business for small employers with similar case characteristics the arithmetic average of the applicable base premium rate and the corresponding highest premium rate.

(15) "Individual health insurance coverage" or "individual policy" means health insurance coverage offered to individuals in the individual market or through an association.

(16) "Insured" includes any policyholder, including a dependent, enrollee, subscriber, or member, who is covered through any policy or subscriber agreement offered by a health insurance issuer.

(17) "Large group" or "large employer" means any person, firm, corporation, partnership, or association actively engaged in business which employs more employees than is able to qualify for a small group under this Section.

(18) "Medical loss ratio" means the ratio of expected incurred benefits to expected earned premium over the time period of coverage, subject to the requirements of federal statute, regulation, or rule.

(19) "New business premium rate" means, for each class of business as to a rating period, the premium rate charged or offered by the small employer health insurance issuer to small employers with similar case characteristics for newly issued health benefits plans with the same or similar coverage.

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(20) "New premium rate filing" means any particular product which has not been issued or delivered in this state.

(21) "Particular product" means a basic insurance policy form, certificate, or subscriber agreement delineating the terms, provisions, and conditions of a specific type of coverage or benefit under a particular type of contract with a discrete set of rating and pricing methodologies that a health insurance issuer offers in the state.

(22) "Premium rate" means the rate initially filed or filed as a result of a rate change by a health insurance issuer for a particular product.

(23) "Rate change" means whenever rates for any health insurance issuer for a particular product differ from the rates on file with the department; including any change in any current rating factor, periodic recalculation of experience, change in rate calculation methodology, change in benefits, or change in the trend or other rating assumptions.

(24) "Rate increase" means any increase of the rates for a particular product. When referring to federal review thresholds, a rate increase includes a premium volume–weighted average increase for all insureds for the aggregate rate changes during the twelve-month period preceding the proposed rate increase effective date.

(25) "Rating factors" mean demographic or other relevant characteristics which are considered by the health insurance issuer in the determination of premium rates for a particular product.

(26) "Rating period" means the calendar period for which premium rates established by a health insurance issuer are in effect.

(27) "Small group" or "small employer" means any person, firm, corporation, partnership, trust or association actively engaged in business which has employed an average of at least one but not more than fifty employees, and beginning on January 1, 2014, at least one but not more than one hundred employees, on business days during the preceding calendar year or plan year and who employs at least one employee on the first day of the plan year. Small group or small

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employer shall include coverage sold to small groups or small employers through associations or through a blanket policy. An employer group of one shall be considered individual insurance under this Subpart.

(28) "Unfairly discriminatory" means premium rates that result in premium differences between insureds within similar risk categories that do not reasonably correspond to differences in expected costs. When applied to premium rates charged, "unfairly discriminatory" shall refer to any premium rate charged by small group or individual health insurance issuers in violation of R.S. 22:1095.

(29) "Unjustified" means a premium rate for which a health insurance issuer has provided data or documentation to the Department in connection with premium rates for a particular product that are incomplete, inadequate, or otherwise do not provide a basis upon which the reasonableness of a premium rate may be determined or is otherwise inadequate insofar as the premium rate charged is clearly insufficient to sustain projected losses and expenses.

(30) "Unreasonable" means any premium rate that contains a provision or provisions that are any of the following:

(a) Excessive.

(b) Unfairly discriminatory.

(c) Unjustified.

(d) Otherwise not in compliance with the provisions of this Title or this Subpart.

§1092. ~~Restrictions relating to premium rates; health insurance~~ Health insurance issuers; premium rate filings and rate increases

~~A. Premium rates for group health benefit plans subject to R.S. 22:1091 through 1094 shall be subject to the following provisions:~~

~~(1) The index rate for a rating period for any class of business shall not exceed the index rate for any other class of business by more than twenty percent.~~

~~(2) For a class of business, the premium rates charged during a rating period to any employer with similar case characteristics for the same or similar coverage,~~

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~~or the rates which could be charged to such employer under the rating system for that class of business, whether new coverage or renewal coverage, shall not vary from the index rate by more than thirty-three percent of the index rate.~~

~~(3) The percentage increase in the premium rate charged to a small employer for a new rating period may not exceed the sum of the following:~~

~~(a) The percentage change in the new business premium rate measured from the first day of the prior rating period to the first day of the new rating period. In the case of a class of business for which the small employer carrier is not issuing new policies, the carrier shall use the percentage change in the base premium rate.~~

~~(b) An adjustment, not to exceed twenty percent annually and adjusted pro rata for rating periods of less than one year, due to one or a combination of the following: claim experience, health status, or duration of coverage of the employees or dependents of the small employer as determined from the carrier's rate manual for the class of business.~~

~~(c) Any adjustment due to change in coverage or change in the case characteristics of the small employer as determined from the carrier's rate manual for the class of business.~~

~~B. Nothing in this Section is intended to affect the use by a small employer carrier of legitimate rating factors other than claim experience, health status, or duration of coverage in the determination of premium rates. Small employer carriers shall apply rating factors, including case characteristics, consistently with respect to all small employers in a class of business.~~

~~C. A small employer carrier shall not involuntarily transfer a small employer into or out of a class of business. A small employer carrier shall not offer to transfer a small employer into or out of a class of business unless such offer is made to transfer all small employers in the class of business without regard to case characteristics, claim experience, health status or duration since issue.~~

A. Proposed premium rate filings. Every health insurance issuer shall file with the department every proposed premium rate to be used in connection with

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particular products. Every such filing shall clearly state the date of the filing, the proposed premium rate, and the effective date of the proposed premium rate. All such filings shall be made electronically or as otherwise instructed by the department. All premium rate filings required by this Section shall be made in accordance with the following:

(1) Premium rate filings shall be made no less than one hundred five days in advance of the proposed effective date unless otherwise waived by the department.

(2) All health insurance issuers assuming, merging, or acquiring blocks of business shall be considered as proposing new premium rates.

B. Contents of proposed premium rate filings.

(1) All premium rate filings shall include each of the following:

(a) An actuarial memorandum, including the actuarial certification, that provides justification for the proposed premium rate and all underlying assumptions.

(b) Sufficient information to support the reasonableness of the premium rate including but not limited to valid company experience, when possible.

(c) For a proposed rate increase, health insurance issuers shall submit each of the following:

(i) A rate increase summary.

(ii) A written description justifying the rate increase.

(d) Any and all relevant information required by the department.

(2) When a premium rate filing made pursuant to this Section is not accompanied by the information upon which the health insurance issuer supports the premium rate filing, and the department does not have sufficient information to determine whether the premium rate filing meets the requirements of this Section, it shall require the health insurance issuer to re-file the information upon which it supports its filing. The time period provided in this Section shall start over and commence as of the date the proper information is furnished to the department.

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C. Compliance with R.S. 22:1095. All proposed premium rate filings shall be reviewed for compliance with R.S. 22:1095. Any proposed premium rate filings which are not in compliance with R.S. 22:1095 shall not be approved.

D. Premium rate filing review. All premium rate filings shall be reviewed by the department to determine whether such filing is unreasonable and compliant with this Subpart.

E. Unreasonableness. Any and all premium rates shall comply with each of the following Paragraphs:

(1) The department shall consider any of the following criteria to determine whether premium rates are unreasonable:

(a) The premium rate is excessive.

(b) The premium rate is unfairly discriminatory.

(c) The premium rate is unjustified.

(d) The premium rate does not otherwise comply with the provisions of this Subpart.

(2) Criteria for unreasonable premium rates. The review of any proposed premium rate may take into consideration the following factors, to the extent applicable, to determine whether the filing under review is unreasonable:

(a) The impact of medical trend changes by major service categories.

(b) The impact of utilization changes by major service categories.

(c) The impact of cost-sharing changes by major service categories.

(d) The impact of benefit changes.

(e) The impact of changes in an insured's risk profile.

(f) The impact of any overestimate or underestimate of medical trend for prior year periods related to the rate increase, if applicable.

(g) The impact of changes in reserve needs.

(h) The impact of changes in administrative costs related to programs that improve health care quality.

(i) The impact of changes in other administrative costs.

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(j) The impact of changes in applicable taxes or licensing or regulatory fees.

(k) Medical loss ratio.

(l) The financial performance of the health insurance issuer, including capital and surplus levels.

F. Public comment. Within fifteen days of submission of any proposed rate increase which meets or exceeds the federal review threshold, the department shall publish a summary consistent with Items (B)(1)(c)(i) and (ii) of this Section of the rate increase information provided by the health insurance issuer on the department's website. After publication, the public shall have thirty days to submit comments.

G. Disapproval. The department shall disapprove a proposed premium rate filings if it finds the premium rate is unreasonable.

H. Notification of approval or disapproval. The department shall notify the health insurance issuer in writing whether it approves or disapproves a proposed premium rate filing. Such notice shall be in writing and be made within sixty days of the filing. If the department disapproves a proposed premium rate filing, then the written notice shall clearly state the reasons why such proposed premium rate filing was disapproved.

I. For any rate increase that meets or exceeds the federal review threshold, the department shall, upon request by the secretary of the federal Department of Health and Human Services, provide its final determination with respect to unreasonableness to the Centers for Medicare and Medicaid Services in a manner and form prescribed along with a brief explanation of the final determination. The department shall post a notice of the final determination on its website.

J. Implementation of rates. A health insurance issuer may implement a proposed new premium rate filing approved by the department upon approval and proposed rate increases no sooner than forty-five days after the written approval in order for the insured to be notified pursuant to R.S. 22:1093. Any premium rate filing approved by the department shall be implemented within ninety days of notice of approval. Any premium rate not implemented within ninety days of notice of

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approval shall be void and any health insurance issuer seeking to implement the premium rate thereafter shall be required to file a new premium rate filing in compliance with this Section.

K. Request for a hearing. Any aggrieved health insurance issuer may file within thirty days a written request for a hearing with the Nineteenth Judicial District Court for a de novo review.

L. Premium rate filings made by health insurance issuers under this Section shall be subject to the Public Records Law, R.S. 44:1 et seq., and the restrictions on health information under R.S. 22:42.1. The department shall publish for public comment, pursuant to Subsection F of this Section, a summary of the rate increases and written justification of the same, which do not constitute proprietary or trade secret information.

§1093. Disclosure of rating practices and renewability provisions for insureds

~~A. Each carrier shall make reasonable disclosure in solicitation and sales materials provided to small employers of the following:~~

~~(1) The extent to which premium rates for a specific small employer are established or adjusted due to the claim experience, health status or duration of coverage of the employees or dependents of the small employer.~~

~~(2) The provisions concerning the carrier's right to change premium rates and the factors, including case characteristics, which affect changes in premium rates.~~

~~(3) A description of the class of business in which the small employer is or will be included, including the applicable grouping of plans.~~

~~(4) The provisions relating to renewability of coverage.~~

~~B. Each carrier shall provide a reasonable explanation of any rate increase no less than forty-five days prior to the effective date of such increase. Such explanation shall indicate the contributing factors resulting in an increased premium, which may include but not be limited to experience, medical cost, and demographic factors.~~

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A. Each health insurance issuer shall make reasonable disclosure in solicitation and sales materials provided to small employers of each of the following:

(1) The extent to which premium rates for a specific small employer are established or adjusted due to the claim experience, health status, or duration of coverage of the employees or dependents of the small employer.

(2) The provisions concerning the health insurance issuer's right to change premium rates and the factors, including case characteristics, which affect changes in premium rates.

(3) A description of the class of business in which the small employer is or will be included, including the applicable grouping of plans.

(4) The provisions relating to renewability of coverage.

B. Each health insurance issuer shall provide its insureds a written notice of a reasonable explanation of reasonable explanation of any rate increase no less than forty-five days prior to the effective date of such increase. Such explanation shall indicate the contributing factors for the rate increase, which may include the written description justifying the rate increase as required by R.S. 22:1092(B)(1)(c).

§1094. Maintenance of records for the department

A. Each ~~small employer carrier~~ health insurance issuer shall maintain at its principal place of business a complete and detailed description of its rating practices ~~and renewal underwriting description of its rating practices and renewal underwriting practices~~, including information and documentation which demonstrate that its rating methods and practices are based upon commonly accepted actuarial assumptions and are in accordance with sound actuarial principles and the rules and regulations of the department.

B. Each ~~small employer carrier~~ health insurance issuer shall file each March first with the ~~commissioner~~ department an actuarial certification that the ~~carrier~~ health insurance issuer is in compliance with this ~~Section~~ Subpart and that the rating methods of the ~~carrier~~ health insurance issuer are actuarially sound. A copy of such

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certification shall be retained by the ~~carrier~~ health insurance issuer at its principal place of business.

C. A ~~small employer carrier~~ health insurance issuer shall make the information and documentation described in Subsection A of this Section available to the ~~commissioner~~ department for inspection upon request. The information shall be considered proprietary and trade secret information~~, and~~ shall not be subject to disclosure by the ~~commissioner~~ department to persons outside of the department except as agreed to by the ~~carrier~~ health insurance issuer or as ordered by a court of competent jurisdiction~~.~~, and shall not be subject to disclosure under the Public Records Law.

§1095. Restrictions relating to premium rates; ~~Modified~~ modified community rating; health insurance premiums; ~~compliance with rules and regulations~~ rating factors

~~A. Each small group and individual health and accident insurer shall maintain at its principal place of business a complete and detailed description of its rating practices and a renewal underwriting description of its rating practices and renewal underwriting practices, including information and documentation which demonstrate that its rating methods and practices are in full and complete compliance with the rules and regulations promulgated by the Department of Insurance for a modified community rating system for health insurance premiums.~~

~~B.(1) The Department of Insurance shall promulgate regulations no later than January 1, 1994, that provide criteria for the community rating of premiums for any hospital, health, or medical expense insurance policy, hospital or medical service contract, health and accident policy or plan, or any other insurance contract of this type, that is small group or individually written.~~

~~(2)(a) The regulations shall place limitations upon the following classification factors used by any insurer or group in the rating of individuals and their dependents for premiums:~~

~~(i) Medical underwriting and screening.~~

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~~(ii) Experience and health history rating.~~

~~(iii) Tier rating.~~

~~(iv) Durational rating.~~

~~(b) The premiums charged shall not deviate according to the classification factors in Subparagraph (a) of this Paragraph by more than plus or minus thirty-three percent for individual health insurance policies or subscriber agreements. In no event shall the increase in premiums for a small employer group policy vary from the index rate by plus or minus thirty-three percent.~~

~~(3) The following classification factors may be used by any small group or individual insurance carrier in the rating of individuals and their dependents for premiums:~~

~~(a) Age.~~

~~(b) Gender.~~

~~(c) Industry.~~

~~(d) Geographic area.~~

~~(e) Family composition.~~

~~(f) Group size.~~

~~(g) Tobacco usage.~~

~~(h) Plan of benefits.~~

~~(i) Other factors approved by the Department of Insurance.~~

~~C. Any small group and individual insurance carrier that varies rates by health status, claims experience, duration, or any other factor in conflict with the regulations promulgated by the Department of Insurance shall establish a phase-out rate adjustment as of the first renewal date on or after January 1, 2002, for each entity insured by the carrier in order to come into compliance with this Section pursuant to the regulations promulgated by the Department of Insurance.~~

~~D. The provisions of this Section shall not apply to limited benefit health insurance policies or contracts.~~

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A. Premium rates for health benefit plans in the small group market shall be subject to the following provisions:

(1) The index rate for a rating period for any class of business shall not exceed the index rate for any other class of business by more than twenty percent.

(2) For a class of business, the premium rates charged during a rating period to any employer with similar case characteristics for the same or similar coverage, or the premium rates which could be charged to such employer under the rating system for that class of business, whether new coverage or renewal coverage, shall not vary from the index rate by more than thirty-three percent of the index rate.

(3) The percentage increase in the premium rate charged to a small employer for a new rating period may not exceed the sum of the following:

(a) The percentage change in the new business premium rate measured from the first day of the prior rating period to the first day of the new rating period. In the case of a class of business for which the small employer health insurance issuer is not issuing new policies, the health insurance issuer shall use the percentage change in the base premium rate.

(b) An adjustment, not to exceed twenty percent annually and adjusted pro rata for rating periods of less than one year, due to one or a combination of the following: claim experience, health status, or duration of coverage of the employees or dependents of the small employer as determined from the health insurance issuer's rate manual for the class of business.

(c) Any adjustment due to change in coverage or change in the case characteristics of the small employer as determined from the health insurance issuer's rate manual for the class of business.

B. Nothing in this Section is intended to affect the use by a small employer health insurance issuer of legitimate rating factors other than claim experience, health status, or duration of coverage in the determination of premium rates. Small employer health insurance issuers shall apply rating factors, including case characteristics, consistently with respect to all small employers in a class of business.

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C. A small employer health insurance issuer shall not voluntarily transfer a small employer into or out of a class of business. A small employer health insurance issuer shall not offer to transfer a small employer into or out of a class of business unless such offer is made to transfer all small employers in the class of business without regard to case characteristics, claim experience, health status or duration since issue.

D.(1) Health insurance issuers in the small group and individual markets shall adhere to regulations promulgated by the department which place limitations on the use of the following classification factors used in the rating of individuals and their dependents for premiums:

(i) Medical underwriting and screening.

(ii) Experience and health history rating.

(iii) Tier rating.

(iv) Durational rating.

(2) The premiums charged shall not deviate according to the classification factors in Subparagraph (1) of this Subsection by more than plus or minus thirty-three percent for particular products in the individual market. In no event shall the increase in premium rates for a small employer group policy vary from the index rate by plus or minus thirty-three percent.

(3) The following classification factors may be used by any small group or individual health insurance issuer in the rating of individuals and their dependents for premium rates:

(a) Age.

(b) Gender.

(c) Industry.

(d) Geographic area.

(e) Family composition.

(f) Group size.

(g) Tobacco usage.

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(h) Plan of benefits.

(i) Other factors approved by the department.

§1096. ~~Health and accident insurers; rate increases~~ Regulations

~~Health and accident insurers shall not increase their premium rates during the initial twelve months of coverage and not more than once in any six-month period following the initial twelve-month period, for any policy, rider, or amendment issued in or for residents of the state, no matter the date of commencement or renewal of the insurance coverage except that no health insurance issuer or health maintenance organization issuing group or individual policies or subscriber agreements shall increase its premium rates or reduce the covered benefits under the policy or subscriber agreement after the commencement of the minimum one-hundred-eighty-day period described in R.S. 22:1068(C)(2)(a)(i) or 1074(C)(2)(a)(i). This Section does not affect increases in the premium amount due to the addition of a newly covered person or a change in age or geographic location of an individual insured or policyholder or an increase in the policy benefit level.~~

The commissioner may promulgate such rules and regulations as may be necessary and proper to carry out the provisions of this Subpart. Such rules and regulations shall be promulgated and adopted in accordance with the Administrative Procedure Act.

§1097. ~~Discrimination in rates or failure to provide coverage because of severe disability or sickle cell trait prohibited~~ Enforcement

~~A. No insurance company shall charge unfair discriminatory premiums, policy fees or rates for, or refuse to provide any policy or contract of life insurance, life annuity, or policy containing disability coverage for a person solely because the applicant therefor has a severe disability, unless the rate differential is based on sound actuarial principles or is related to actual experience. No insurance company shall unfairly discriminate in the payments of dividends, other benefits payable under a policy, or in any of the terms and conditions of such policy or contract solely because the owner of the policy or contract has a severe disability.~~

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~~B. "Severe disability", as used in this Section, means any disease of, or injury to, the spinal cord resulting in permanent and total disability, amputation of any extremity that requires prosthesis, permanent visual acuity of twenty/two hundred or worse in the better eye with the best correction, or a peripheral field so contracted that the widest diameter of such field subtends an angular distance no greater than twenty degrees, total deafness, inability to hear a normal conversation or use a telephone without the aid of an assistive device, or persons who have developmental disabilities, including but not limited to autism, cerebral palsy, epilepsy, mental retardation, and other neurological impairments.~~

~~C. Nothing in this Section shall be construed as requiring an insurance company to provide insurance coverage against a severe disability which the applicant or policyholder has already sustained.~~

~~D. No insurance company shall charge unfair discriminatory premiums, policy fees or rates for, or refuse to provide any policy or contract of life insurance, life annuity, or policy containing disability coverage for a person solely because the applicant therefor has sickle cell trait. No insurance company shall unfairly discriminate in the payments of dividends, other benefits payable under a policy, or in any of the terms and conditions of such policy or contract solely because the insured of the policy of contract has sickle cell trait. Nothing in this Subsection shall prohibit waiting periods, pre-existing conditions, or dreaded disease rider exclusions, or any combination thereof, if they do not unfairly discriminate.~~

§1097. Enforcement

A. Whenever the commissioner has reason to believe that any health insurance issuer is not in full compliance with the provisions of R.S. 22:1091 et seq., excluding disapproval by the commissioner as provided in R.S. 22:1092(C) and (G), he shall notify such person. Upon such notice, the commissioner may, in addition to the penalties in Subsection C of this Section, issue and cause to be served an order requiring the health insurance issuer to cease and desist from any violation.

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B. Penalties for violation of a cease and desist order. Any health insurance issuer who violates a cease and desist order issued by the commissioner pursuant to this Subpart while such order is in effect shall be subject at the discretion of the commissioner to any one or more of the following:

(1) A monetary penalty of not more than twenty-five thousand dollars for each and every act or violation and every day the health insurance issuer is not in compliance with the cease and desist order, not to exceed an aggregate of two hundred fifty thousand dollars.

(2) Suspension or revocation of the health insurance issuer's certificate of authority to operate in this state.

(3) Injunctive relief from the district court of the district in which the violation may have occurred or in the Nineteenth Judicial District Court.

C. Penalties for violation of this Subpart. As a penalty for violating this Subpart, the commissioner may refuse to renew, suspend, or revoke the certificate of authority of any health insurance issuer, or in lieu of suspension or revocation of a certificate of authority, the commissioner may levy a monetary penalty of not more than one thousand dollars for each and every act or violation, not to exceed an aggregate of two hundred fifty thousand dollars.

D. An aggrieved party affected by the commissioner's decision, act, or order may demand a hearing in accordance with Chapter 12 of this Title, R.S. 22:2191 et seq. If a health insurance issuer has demanded a timely hearing, the penalty, fine, or order by the commissioner shall not be imposed until such time as the Division of Administrative Law makes a finding that the penalty, fine, or order is warranted in a hearing, held in the manner provided in Chapter 12 of this Title.

§1098. Frequency of rate increase limitations

A. The provisions of this Section shall apply to all health benefit plans, limited benefits, and excepted benefits. Health insurance issuers shall not increase their premium rates during the initial twelve months of coverage and not more than once in any six month period following the initial twelve-month period, for any

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policy, subscriber agreement, rider, or amendment issued in or for residents of the state, no matter the date of commencement or renewal of the health insurance coverage.

B. No health insurance issuer issuing policies or subscriber agreements shall increase its premium rates or reduce the covered benefits under the policy or subscriber agreement after the commencement of the minimum one- hundred -eighty day-period following the notice of the discontinuation of offering all health insurance coverage as described in R.S. 22:1068(C)(2)(a)(i) or 1074(C)(2)(a)(i).

C. This Section shall not affect increases in the premium amount due to any change due to compliance with the addition of a newly covered person or policy benefit level, or such changes necessary to comply with R.S. 22:1095 or other federal or state law, regulation, or rule.

§1099. Discrimination in rates or failure to provide coverage because of severe disability or sickle cell trait prohibited

A. No insurance company shall charge unfair discriminatory premiums, policy fees or rates for, or refuse to provide any policy or contract of life insurance, life annuity, or policy containing disability coverage for a person solely because the applicant therefor has a severe disability, unless the rate differential is based on sound actuarial principles or is related to actual experience. However, health insurance issuers subject to this Subpart et seq. may not, regardless of actuarial principles or actual experience, unfairly discriminate in violation of this Subpart or federal law. No insurance company shall unfairly discriminate in the payments of dividends, other benefits payable under a policy, or in any of the terms and conditions of such policy or contract solely because the owner of the policy or contract has a severe disability.

B. "Severe disability", as used in this Section, means any disease of or injury to the spinal cord resulting in permanent and total disability, amputation of any extremity that requires prosthesis, permanent visual acuity of twenty/two hundred or worse in the better eye with the best correction, or a peripheral field so contracted

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that the widest diameter of such field subtends an angular distance no greater than twenty degrees, total deafness, inability to hear a normal conversation or use a telephone without the aid of an assistive device, or persons who have developmental disabilities, including but not limited to autism, cerebral palsy, epilepsy, mental retardation, and other neurological impairments.

C. Nothing in this Section shall be construed as requiring an insurance company to provide insurance coverage against a severe disability which the applicant or policyholder has already sustained.

D. No insurance company, including health insurance issuers subject to this Subpart, shall charge unfair discriminatory premiums, policy fees, or rates for, or refuse to provide any policy, subscriber agreement, or contract of life insurance, life annuity, or policy containing disability coverage for a person solely because the applicant therefor has sickle cell trait. No insurance company, including health insurance issuers subject to this Subpart, shall unfairly discriminate in the payments of dividends, other benefits payable under a policy, or in any of the terms and conditions of such policy or contract solely because the insured of the policy of contract has sickle cell trait. Nothing in this Subsection shall prohibit waiting periods, pre-existing conditions, or dreaded disease rider exclusions, or any combination thereof, as may be permitted by federal law.

Section 2. R.S. 22:1093(A) and 1095, both as amended by Section 1 of this Act, are hereby enacted to read as follows:

§1093. Disclosure of rating practices and renewability provisions for insureds

A. Each health insurance issuer shall make reasonable disclosure in solicitation and sales materials provided to insureds of the following:

(1) The extent to which premium rates are established or adjusted due to claim experience.

(2) The provisions concerning the health insurance issuer's right to change premium rates and the rating factors, which affect changes in premium rates.

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(3) The provisions relating to renewability of coverage.

* * *

§1095. Rating factors

A. Health insurance issuers shall vary premium rates, whether new or upon renewal, with respect to a particular product for individuals or in a small group only by one or more of the following:

(1) Whether such product or coverage covers an individual or family.

(2) Rating area, as established in accordance with Subsection D of this Section.

(3) Age, except that such premium rate shall not vary by more than three to one for adults.

(4) Tobacco use, except that such rate shall not vary by more than one and one half to one.

B. No premium rate shall vary with respect to a particular product or coverage involved by any other factor not listed in Subsection A of this Section.

C. With respect to coverage issued to members within a family under a small group plan, the rating variations permitted under Paragraphs (A)(3) and (4) of this Section shall be applied based on the portion of the premium that is attributable to each family member covered under the plan or coverage.

D. The department shall determine by rule or regulation the geographic area or areas to be used for the state of Louisiana.

E. Any premium rate proposed to be used by a health insurance issuer shall be submitted and controlled by this Subpart.

Section 3. R.S. 44:4.1(B)(10) is hereby amended and reenacted to read as follows:

§4.1. Exceptions

* * *

B. The legislature further recognizes that there exist exceptions, exemptions, and limitations to the laws pertaining to public records throughout the revised

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statutes and codes of this state. Therefore, the following exceptions, exemptions, and limitations are hereby continued in effect by incorporation into this Chapter by citation:

* * *

(10) R.S. 22:2, 14, 42.1, 88, 244, 461, 572, 572.1, 574, 618, 706, 732, 752, 771, 1092, 1094,1203, 1460, 1466, 1546, 1644, 1656, 1723, 1927, 1929, 1983, 1984, 2036, 2303

* * *

Section 4. The provisions of R.S. 22:1091(B)(2), (3), (4), (14), and (19), 1093(A) and 1095, all as amended by Section 1 of this Act, shall be effective until January 1, 2014.

Section 5. The provisions of this Section and Sections 1, 3, 4, and 6 of 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.

Section 6. The provisions of Section 2 of this Act shall become effective on January 1, 2014.

DIGEST

The digest printed below was prepared by House Legislative Services. It constitutes no part of the legislative instrument. The keyword, one-liner, abstract, and digest do not constitute part of the law or proof or indicia of legislative intent. [R.S. 1:13(B) and 24:177(E)]

Ritchie HB No. 908

Abstract: Provides for review and approval of rates of health insurance issuers, including health maintenance organizations (HMOs) and brings present law relative to such review into compliance with the federal Patient Protection and Affordable Care Act (PPACA).

Proposed law provides for health insurance rate review and approval as follows:

(1) Present law provides for the approval and disapproval of health and accident insurance forms and policies by the commissioner of insurance.

Proposed law increases the time for use of forms from 45 days to 60 days after filing.

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(2) Present law provides rate limitations for health benefit plans for small employers and individuals. Provides for rating factors and sets allowable percentages of annual increases. Requires each small group and individual health and accident insurer to make reasonable disclosure of rates to small employers and provides required content of each disclosure. Further provides that when a rate increase occurs, the insurer shall provide a reasonable explanation of any increase. Also requires each insurer to maintain records of its rating practices and to certify to the commissioner that it is in compliance with the rating requirements. Prohibits health and accident insurers from increasing their premiums except as provided in present law. Excludes group and individual high deductible health plans from the rate limitations and requirements.

Proposed law makes rate review and approval requirements applicable to health benefit plans which provide coverage to large groups in addition to individual and small group entities. Provides that certain rating restrictions shall become effective January 1, 2014, and phases in certain criteria and factors relating to rates and rate increases. Provides for fees for proposed premium rate filings and rates changes. Lists and identifies those benefits not subject to the requirements. Additionally includes HMOs and any entity that offers health insurance coverage through a policy, certificate of insurance, or subscriber agreement subject to state law that regulates the business of insurance, which includes small groups, large groups, and individuals. Requires premium rate filings with the department, made under certain time lines, subject to certain fees, and containing certain information. Specifies that premium rate filings shall be reviewed by the department for compliance. Lists certain criteria and factors to be used to determine if the premium rates are unreasonable. Requires publication of any proposed rate increase which meets or exceeds the federal review threshold to allow for public comment. Makes certain information submitted to the department exempt from the Public Records Law.

(3) Provides that if the commissioner determines that any health insurance issuer is not in compliance with the rate review provisions, he may issue penalties or issue cease and desist orders. Sets monetary penalties violation of cease and desist orders. Also authorizes the commissioner to revoke, suspend, or fail to renew authority of any health insurance issuer to conduct business in this state for noncompliance. Gives any aggrieved health insurance issuer the opportunity to seek a judicial hearing to review the department's decisions on these matters.

(4) Present law prohibits unfair discrimination in rates or failure to provide life, life annuity, or disability coverage because of severe disability or sickle cell trait.

Proposed law retains this prohibition and additionally prohibits such unfair discrimination by health insurance issuers.

Effective upon signature of the governor or lapse of time for gubernatorial action; however, certain provisions expire or become effective January 1, 2014.

(Amends R.S. 22:972 and 1091-1099 and R.S. 44:4.1(B)(10); Adds R.S. 22:821(B)(34))

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