SLS 13RS-334 **ENGROSSED**

Regular Session, 2013

SENATE BILL NO. 126

BY SENATOR GARY SMITH

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

HEALTH/ACC INSURANCE. Provides relative to health insurance rate review and approval. (See Act)

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, comprised of R.S. 22:1091 through 1097, and R.S. 44:4.1(B)(11), and to enact R.S. 22:821(B)(34), 1092.1, 1098, and 1099, relative to health insurance rate review and approval; to provide for definitions; to provide for rate filings and rate increases; to provide relative to form approval; to provide relative to rating factors, risk pools, and individual market plan and calendar year requirements; to provide with respect to review and subsequent approval or disapproval of proposed 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 provide for the frequency of rate increase limitations; to provide relative to the prohibition of discrimination in rates due to severe disability; and to provide for related matters.

Be it enacted by the Legislature of Louisiana:

Section 1. R.S. 22:972, 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 1097 are hereby amended and reenacted and R.S. 22:821(B)(34), 1092.1, 1098, and 1099 are hereby enacted

to read as follows:

§821. Fees

* * *

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

* * *

(34) Fee for rate filings for health insurance issuers	
(a) New rate filings	**$100.00**
(b) Rate changes	**$150.00**

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

A. No policy **or subscriber agreement** of **a** health ~~and accident~~ insurance **issuer, hereafter 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**, hereinafter referred to as policy or subscriber agreements, 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** 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 **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~~ **health insurance issuer** is organized, anything in this Subpart to the contrary notwithstanding.

D. All references to rates 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~~ **this Subpart** shall apply to any health benefit plan which provides coverage ~~to a small employer except the following:~~ **in the small group market or individual market including any policy**

or subscriber agreement, covering residents of this state. The provisions of this Section shall apply regardless of where such policy or subscriber agreement was issued or issued for delivery in this state and shall include any employer, association, or a trustee of a fund 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 this Subpart shall not apply to the following, unless specifically provided for:

(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 plan coverage.

B. ~~Notwithstanding any law to the contrary, the following terms shall be defined as follows~~ **As used in this Subpart, the following terms shall have the meanings ascribed to them in this Section**:

(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 the provisions of R.S. 22:1092~~ **that a health insurance issuer is in compliance with the provisions of this Subpart**, based upon the ~~person's~~ **actuary's** examination, including a review of the appropriate records and of the actuarial assumptions and methods utilized by the ~~carrier~~ **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 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.~~

(2) "Excepted benefits" means benefits 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.

(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, noncoordinated 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.

~~(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.~~

(3) "Excessive" means the rate charged for the health insurance coverage causes the premium or premiums charged for the health insurance coverage to be unreasonably high in relation to the benefits provided under the particular product. In determining whether the rate is unreasonably high in relation to the benefits provided, the department shall consider each of the following:

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

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

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

~~(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~~

~~(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.~~

(4) "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, directive, or guidance by the United States Department of Health and Human Services, or any 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. For reporting purposes, the federal threshold shall mean any rate increase above zero percent or such other threshold as required by federal law, regulation, directive, or guidance by the United States Department of Health and Human Services. The reporting

format shall be in a standardized form as prescribed by federal law, regulation, directive, or guidance by the United States Department of Health and Human Services.

(5) "Grandfathered health plan coverage" has the same meaning as that in 45 C.F.R. 147.140 or other subsequently adopted federal law, rule, regulation, directive, or guidance.

(6) "Health benefit plan", "plan", **"benefit",** or "health insurance coverage" means ~~benefits~~ **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, 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.~~ **However, excepted benefits are not included as a "health benefit plan".**

(7) "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.

~~(7)~~ **(8)** "Health savings accounts" are those accounts for medical expenses authorized by 26 U.S.C. 220 et seq.

~~(8)~~ **(9)** "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.

~~(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.~~

~~(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.~~

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

~~(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)~~**(11) "Index rate" means the average rate resulting from the estimated combined claims experience for all Essential Health Benefits, as defined pursuant to section 1302(b) of the Patient Protection and Affordable Care Act, Pub. L. 111-148, of all nongrandfathered health plan coverage within a health insurance issuer's single, state-wide risk pool in the individual market and within a health insurance issuer's single, state-wide risk pool in the small group market, with a separate index rate being calculated for each market. Health insurance issuers may make any market-wide and plan-or product-specific adjustments to an index rate as permitted or as required by federal law, rules, or regulations.**

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

(13) "Individual market" means the market for health insurance coverage offered to individuals other than in connection with a group health plan.

(14) "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.

(15) "Large group market" means the health insurance market under which individuals obtain health insurance coverage directly or through any arrangement on behalf of themselves and their dependents through a group health plan maintained by a large employer.

(16) "Large group" or "large employer" means, in connection with a group health plan with respect to a calendar year and a plan year, an employer who employed an average of at least fifty-one employees on business days during the preceding calendar year and who employs at least two employees on the first day of the plan year, and beginning on January 1, 2014, an average of at least one hundred one employees on business days during the preceding calendar year and who employs at least two employees on the first day of the plan year.

(17) "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.

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

(19) "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.

(20) "Rate" means the rate initially filed or filed as a result of determination of rates by a health insurance issuer for a particular product.

(21) "Rate change" means whenever rates for any health insurance issuer for a particular product differ from the rates on file with the department,

including but not limited to 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.

(22) "Rate Filing Justification" means the document filed by a health insurance issuer with the department for all rate filings required under this Subpart. The contents of the Rate Filing Justification document and forms shall be governed and established by 45 C.F.R. 154.200 et seq., or through subsequent federal law, rule, regulation, directive, or guidance issued by the United States Department of Health and Human Services.

(23) "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.

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

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

but not more than one hundred employees, on business days during the preceding calendar year and who employs at least one employee on the first day of the plan year. "Small group or small employer" shall include coverage sold to small groups or small employers through associations or through a blanket policy. For purposes of rate calculation by a health insurance issuer, a small employer group consisting of one employee shall be rated within a health insurance issuer's individual market risk pool, unless that health insurance issuer only provides employer coverage and thus only has a small group market risk pool.

(26) "Unfairly discriminatory" means 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 rates charged, "unfairly discriminatory" shall refer to any rate charged by small group or individual health insurance issuers in violation of R.S. 22:1095.

(27) "Unified Rate Review Template" means the document filed by a health insurance issuer with the department for all rate filings required under this Subpart. The contents of the Unified Rate Review Template document and forms shall be governed and established by 45 C.F.R. 154.200 et seq., or through subsequent federal law, rule, regulation, directive, or guidance issued by the United States Department of Health and Human Services.

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

(29) "Unreasonable" means any 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.

~~(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.~~

§1092. ~~Restrictions relating to premium rates; health~~ **Health** insurance **issuers; 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, 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. Every health insurance issuer shall file with the department every proposed rate to be used in connection with all of its particular products. Every such filing shall clearly state the date of the filing, the proposed rate, and the effective date of the proposed rate. All filings for rate increases pursuant to the federal review threshold and reporting threshold shall be in accordance with any and all federal requirements. All rate filings required by this Subpart shall be made in accordance with the following:

(1) 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 rates.

B. All proposed rate filings shall include:

(1) A completed Unified Rate Review Template, a Rate Filing Justification, and all rating tables used by the health insurance issuer in the formation of the proposed rates.

(2) Any other information, documents, or data requested by the department or by the United States Department of Health and Human Services.

C. When a rate filing made pursuant to this Subpart is not accompanied by the information upon which the health insurance issuer supports the rate filing, with the result that the department does not have sufficient information to determine whether the rate filing meets the requirements of this Subpart, the department may require the health insurance issuer to refile the information upon which it supports its filing. The time period provided in this Section shall begin anew and commence as of the date the proper information is furnished to the department.

D. All proposed rate filings shall be reviewed for compliance with R.S. 22:1095. Any proposed rate filings that are not in compliance with R.S. 22:1095 shall not be approved.

E. All rate filings shall be reviewed by the department to determine whether such filing is reasonable and compliant with this Subpart.

F. The department shall consider the following criteria to determine whether rates are unreasonable:

(1) The rate is excessive.

(2) The rate is unfairly discriminatory.

(3) The rate is unjustified.

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

G. The review of any proposed rate may take into consideration the following nonexhaustive list of factors and any other factors established by rule, regulation, directive, or guidance by the United States Department of Health and Human Services, to the extent applicable, to determine whether the filing under review is unreasonable:

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

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

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

(4) The impact of benefit changes.

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

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

(7) The impact of changes in reserve needs.

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

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

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

(11) Medical loss ratio.

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

H. Within fifteen days of submission of any proposed rate increase which meets or exceeds the federal review threshold, the department shall publish on its website Parts I, II, and III, of each Rate Filing Justification, except the portions which are deemed proprietary information by the commissioner, or any other documents or forms as otherwise required by federal law, rule, or regulation to maintain an effective rate review program. After publication, the public shall have thirty days to submit comments.

I. The commissioner shall disapprove a proposed rate filing if he finds the rate is unreasonable. The department shall notify the health insurance issuer in writing whether it approves or disapproves a proposed rate filing. Such notice shall be given in writing and be made within sixty days of the filing. If the department disapproves a proposed rate filing, then the written notice shall clearly state the reasons why such proposed rate filing was disapproved.

J. For any rate increase that meets or exceeds the federal review threshold, the department shall, upon request by the United States 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.

K. A health insurance issuer may implement a proposed new 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 rate filing approved by the department shall be implemented within ninety days of notice of approval. Any rate or rates not implemented within ninety days of notice of approval shall be void and any health insurance issuer seeking to implement the rate or rates thereafter shall be required to file a new rate filing in compliance with this Part.

L. Any aggrieved health insurance issuer may file a petition seeking a de novo judicial review within thirty days with the Nineteenth Judicial District Court.

M. 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 a summary of the rate increases and written justification of the same, which do not constitute proprietary or trade secret information.

§1092.1. Grandfathered health coverage; rating practices; loss of status

A. The rating practices and rating methods, and the rating restrictions imposed by law upon grandfathered health coverage in the individual market and small group market that are extant on the day that this Section takes effect, including the restrictions on rate increases and required notices for such increases, shall remain binding upon such grandfathered health coverage. Such grandfathered coverage is exempt from the provisions of this Subpart, unless specifically provided for otherwise.

B. Any grandfathered health plan that violates the provisions of this Section with respect to the rating restrictions imposed by law and that were in effect on the day this Section takes effect, shall be deemed to have surrendered grandfathered status for the purposes of this Title. The loss of grandfathered status under this Section shall not result from de minimis violations, but from a pattern or practice of violations. The surrender of grandfathered status under this Section shall be determined by the commissioner and shall be based upon an actuarial determination. Any health insurance issuer that offers grandfathered health coverage that is surrendered pursuant to this Section may petition for a de novo review of a determination by the commissioner that such grandfathered status has been surrendered pursuant to this Section in the Nineteenth Judicial District Court.

C. The loss of grandfathered status pursuant to this Section does not interfere, interrupt, or terminate a grandfathered health plan's grandfathered status under federal law unless specifically provided for by federal law. A grandfathered health plan that surrenders its status pursuant to this Section shall be subject to the provisions of this Part, except that no grandfathered health plan that retains its grandfathered status under federal law shall be subject to the single risk pool requirement of this Subpart.

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

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

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

(2) The provisions concerning the ~~carrier's~~ **health insurance issuer's** right to ~~change premium~~ **vary** rates ~~and the~~ **from the index rate through allowable**

factors~~, including case characteristics,~~ **and allowable adjustments** which affect changes in ~~premium~~ rates **and the provisions concerning the health insurance issuer's right to vary premiums in accordance with R.S. 22:1095**.

~~(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)~~ **(3)** The provisions relating to renewability of coverage.

B. Each ~~carrier~~ **health insurance issuer** shall provide **its insureds with** a **written notice, and** reasonable explanation **and justification**, **including the contributing factors for the rate increase,** ~~of~~ **for** 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.~~

§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 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. ~~Modified community rating; health insurance premiums; compliance with rules and regulations~~**Rating factors; risk pools; individual market plan and calendar year requirement**

~~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.~~

~~(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.~~

A. Health insurance issuers may vary premiums with respect to a particular insured's health benefit plan, whether new or upon renewal, in the individual or small group market only based on one or more of the following factors:

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

(2) Geographic rating area, as established in accordance with this

Section.

(3) Age, except that such variation shall be no more than three-to-one for adults.

(4) Tobacco use as defined in 45 C.F.R. 147.102 or any subsequent federal law, rule, regulation, directive, or guidance issued by the United States Department of Health and Human Services, except that such rate shall not vary by more than one- and one-half-to-one.

B. Every health insurance issuer in this state shall maintain a single, separate, and distinct risk pool for the individual market and a single, separate, and distinct risk pool for the small group market. Health insurance issuers of student health plans shall maintain a single, separate, and distinct risk pool for student health plans.

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 must be attributed, to the extent they are used, to each member to which those factors apply, and may only do so as permitted by federal law, rule, regulation, directive, or guidance by the United States Department of Health and Human Services.

D. With respect to health insurance coverage in the individual market, on January 1, 2015, every health insurance policy in the individual market must be based upon a calendar year with coverage commencing on January first of each year. Any exceptions or modifications of any kind to the calendar year requirement through rule, regulation, directive, or guidance by the United States Department of Health and Human Services shall also apply to health insurance issuers under this Section.

E. The department shall determine the geographic rating area or areas in this state by rule, regulation, bulletin, or any mechanism made available by the United States Department of Health and Human Services.

F. Any rate proposed to be used by a health insurance issuer shall be

submitted and controlled by this Subpart.

§1096. ~~Health and accident insurers; rate increases~~ **Regulations; anti-preemption provision**

~~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.~~

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

B. If at any time a provision of this Part is in conflict with federal law or regulations promulgated pursuant to federal law, such a provision shall be preempted only to the extent necessary to avoid direct conflict with federal law or regulations. The commissioner shall subsequently administer and enforce the provisions of this Part in a manner that conforms to federal law or regulations, and if necessary to preserve the department's regulatory authority or if necessary to effectively enforce the provisions of this Part, the commissioner may promulgate rules or regulations to that effect, and may issue directives or bulletins on a provisional basis before such rules or regulations take effect. Such provisional basis for the issuance of directives or bulletins

under this Section shall not exceed a period of one year.

§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.~~

~~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.~~

A. Whenever the commissioner has reason to believe that any health insurance issuer is not in compliance with any of 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 health insurance issuer. Upon such notice, the commissioner may, in addition to the penalties in Subsection C of this Section, issue and cause to be served upon such health insurance issuer an order requiring the health insurance issuer to cease and desist from any violation.

B. 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 to any one or more of the following at the commissioner's discretion:

(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 for any six-month period.

(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. As a penalty for violating this Subpart, the commissioner may refuse to renew, or may 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., except as otherwise provided by this Subpart. 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 following rate increase limitations shall apply to all health benefit plans, limited benefits, and excepted benefits:

(1) Health insurance issuers of limited benefits and excepted benefits policies shall not increase rates during the initial twelve months of coverage, and may not do so more than once in any six-month period following the initial twelve-month period.

(2) Health insurance issuers shall not increase rates for policies or plans in the individual market during the plan year. Rate increases for policies or plans in the individual market may only occur upon renewal or upon commencement of the policy or plan year.

(3) Rates for policies or plans in the small group market shall not increase during the initial twelve months of coverage unless such increases were previously filed, reviewed, and approved in conformity with this Subpart at the commencement of the policy or plan, and are implemented on a quarterly basis.

(4) With respect to the limitation on rate increases in the small group market, if health insurance issuers are permitted by federal law or regulations to increase rates without including such increases in the initial filing of the Uniform Rate Review Template and the Rate Filing Justification, such rate increases shall be permitted for health insurance issuers in the small group market in this state, but only to the extent allowed by such federal law or regulations. Any such allowable rate increases under this Section must be

submitted to the department for review and approval pursuant to the provisions of this Subpart.

B. No health insurance issuer issuing policies or subscriber agreements shall increase its 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. 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 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 any developmental disability, including but not limited to autism, cerebral palsy, epilepsy, mental retardation, and other neurological impairments.

C. No insurance company 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 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. 44:4.1(B)(11) 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 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:

* * *

(11) 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 3. The provisions of R.S. 22: 821(B)(34), as amended by Section 1 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 4. The provisions of R.S. 22: 972, 1091 through 1097, and R.S. 44:4.1, all as amended by Section 1 of this Act, and R.S. 22:1098 and 1099 as enacted in Section 1 of this Act, shall become effective on January 1, 2014.

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

DIGEST

Gary Smith (SB 126)

Proposed law requires the commissioner of insurance to collect a $100 fee for new rate filings for insurance issuers and $150 for rate changes.

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

Proposed law retains present law and increases the time for the use of forms from 45 days to 60 days after filing. Requires written notification to be provided to the health insurance issuer specifying the reasons a policy form or subscriber agreement does not comply with the provisions of proposed law. Provides that it shall be unlawful for any health insurance issuer to issue any form not previously submitted to and approved by the department.

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. Provides that when a rate increase occurs, the insurer shall provide a reasonable explanation of the 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 in the small group and individual markets. Requires each health benefit plan to file a copy of its rates with all insurance policy forms. Provides that the commissioner shall review rates and may only disapprove proposed rate increases that meet the statutory definition of unreasonable in proposed law. Provides that certain rating restrictions shall become effective on January 1, 2014, including limiting variations on health insurance premiums to variations based on whether the insured is an individual or member of a family group, on the age of the insured, by geographic region, and whether the insured uses tobacco products. Prohibits insurers from using the health status of the insured in the calculation of rates. Provides for fees for proposed rate filings and rate changes. Lists and identifies those benefits not subject to the requirements. Additionally, subjects HMOs and any entity that offers health insurance coverage through a policy, certificate, or subscriber agreement to proposed rating law. Requires rate filings with the department, made under certain time lines, subject to certain filing fees, and containing required information in prescribed, standardized formats. Requires that any such filings that contain rate increases beyond a specific threshold must be published for public comment. Exempts

certain information submitted in required filings from the Public Records Law.

Proposed law requires the rating practices and rating methods, and the rating restrictions imposed by law upon grandfathered health coverage in the individual market and small group market that exist when proposed law takes effect, including the restrictions on rate increases and required notices for such increases, to remain binding upon such grandfathered health coverage. Provides that any grandfathered health plan that violates the provisions of proposed law with respect to the rating restrictions shall be deemed to have surrendered grandfathered status. Requires the surrender of grandfathered status determined by the commissioner to be based upon an actuarial determination. Allows any health insurance issuer that offers grandfathered health coverage that is surrendered to petition for a de novo review in the Nineteenth Judicial District Court. Provides that the loss of grandfathered status pursuant to proposed law does not interfere, interrupt, or terminate a grandfathered health plan's grandfathered status under federal law unless specifically provided for by federal law.

Present law allows health insurers to create and maintain separate risk pools through closed blocks of business or classes of business.

Proposed law prohibits the maintenance of separate risk pools. Requires all health insurance issuers to maintain a single, state-wide risk pool in each of the following markets: small group, individual, and student health plans.

Proposed law 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 cease-and-desist orders. Provides monetary penalties for violations of cease-and-desist orders. Authorizes the commissioner to revoke, suspend, or nonrenew a certificate of authority of any health insurance issuer for noncompliance. Permits any aggrieved health insurance issuer the opportunity to seek a judicial review of certain decisions by the commissioner.

Proposed law requires that on January 1, 2015, every individual health insurance policy or plan year must be for a period of one year, and must commence on January 1, 2015. Prohibits any rate increases in the individual market during the course of the policy or plan year. Requires health insurance issuers to file an actuarial certification that such issuers use actuarially sound methods and are in compliance with applicable laws.

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 present law and prohibits such unfair discrimination by health insurance issuers.

Fee schedules for rate filings effective upon signature of the governor or lapse of time for gubernatorial action. All other provisions become effective on January 1, 2014.

(Amends R.S. 22:972, 1091 through 1097 and R.S. 44:4.1(B)(11); adds R.S. 22:821(B)(34), 1092.1,1098, and 1099)

Summary of Amendments Adopted by Senate

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

1. Removes the large group market from the provisions of rate review and approval in proposed law.

2. Requires the rating practices and rating methods, and the rating restrictions imposed by law upon grandfathered health coverage in the individual market and small group market, including the restrictions on rate increases and required notices for such increases, to remain binding upon such grandfathered health coverage. Requires any grandfathered health plan that violates the rating restrictions to be deemed to have surrendered grandfathered status. Requires the surrender of grandfathered status determined by the commissioner to be based upon an actuarial determination. Allows any health insurance issuer that offers grandfathered health coverage that is surrendered to petition for a de novo review in the Nineteenth Judicial District Court. Provides that the loss of grandfathered status does not interfere, interrupt, or terminate a health plan's grandfathered status under federal law unless specifically provided for by federal law.

3. Makes technical changes.