

1 periods in accordance with other provisions of this Title.

2 **§1124. Annual and lifetime limits prohibited**

3 A health insurance policy or contract issued or issued for delivery in this
4 state after the effective date of this Subpart shall not provide any of the
5 following:

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

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

11 **§1125. Coverage for dependent children**

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

20 **§1126. Rate setting**

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

27 **§1127. Open enrollment**

28 A health insurance policy or contract issued or issued for delivery in this
29 state after the effective date of this Subpart may restrict enrollment in

1 individual health plans to open enrollment periods and special enrollment
2 periods to the extent not inconsistent with applicable federal law. The
3 commissioner may adopt rules establishing minimum open enrollment dates
4 and minimum criteria for special enrollment periods for all individual health
5 plans offered in this state.

6 §1128. Comprehensive health coverage

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

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

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

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

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

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

28 (1) Ambulatory patient services.

29 (2) Emergency services.

1 **(3) Hospitalization.**

2 **(4) Maternity and newborn care.**

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

5 **(6) Prescription drugs.**

6 **(7) Rehabilitative and habilitative services and devices.**

7 **(8) Laboratory services.**

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

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

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

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

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

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

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

26 **(5) Provide that a qualified health plan shall not be treated as providing**
27 **coverage for the essential health benefits package described in Subsection B of**
28 **this Section unless the plan complies with the provisions of the Patient**
29 **Protection and Affordable Care Act, Public Law 111-148, relative to coverage**

1 and payment for emergency department services.

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

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

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

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

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

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

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

24 E. The commissioner shall establish annual limitations on cost sharing
25 and deductibles that are substantially similar to the limitations for health plans
26 subject to the federal Patient Protection and Affordable Care Act as of
27 January 1, 2019. The commissioner may increase the annual limitation as
28 needed to reflect any premium adjustment percentage. For purposes of this
29 Subsection, "premium adjustment percentage" means the percentage, if any,

1 by which the average per capita premium for health insurance coverage in the
2 United States for the preceding calendar year, as estimated by the commissioner
3 no later than October first of the preceding calendar year, exceeds the average
4 per capita premium for 2019.

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

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

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

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

22 §1129. Conflict of laws

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

26 §1130. Applicability

27 A. The provisions of this Subpart shall only be effective or enforceable
28 in the event that the tax credit authorized in Section 1401 of the Patient
29 Protection and Affordable Care Act of 2010, Public Law 111-148, as amended

1 by the Healthcare and Education Reconciliation Act of 2010, Public Law
2 111-152, and codified in Section 16B of the Internal Revenue Code, is held to be
3 valid by a court of competent jurisdiction or is otherwise enforceable at law, or
4 unless adequate appropriations are timely made by the federal or state
5 government in an amount that is calculated in a similar manner as the tax credit
6 in Section 1401 of the Patient Protection and Affordable Care Act.

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

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

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

14 **SUBPART F-1. LOUISIANA GUARANTEED BENEFITS POOL**

15 **§1131. Short title**

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

18 **§1132. Definitions**

19 As used in this Subpart, the following definitions apply:

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

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

22 **§1133. Louisiana Guaranteed Benefits Pool; establishment**

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

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

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

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

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

7 **§1134. Operation of program**

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

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

12 **§1135. Actuarial analysis**

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

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

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

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

23 **§1136. Program parameters**

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

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

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

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

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

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

9 **(4) The percentage of the premiums paid to health insurance issuers for**
10 **health insurance coverage by eligible individuals that shall be collected and**
11 **deposited to the credit and available for the use of the program.**

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

16 **§1137. Approval by legislature**

17 **A. The commissioner shall submit the actuarial analysis required by R.S.**
18 **22:1135 to the Joint Legislative Committee on the Budget.**

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

23 **§1138. Enrollment or participation limitation**

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

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

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

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

12 Section 3. This Act shall become effective upon signature by the governor or, if not
13 signed by the governor, upon expiration of the time for bills to become law without signature
14 by the governor, as provided by Article III, Section 18 of the Constitution of Louisiana. If
15 vetoed by the governor and subsequently approved by the legislature, this Act shall become
16 effective on the day following such approval.

The original instrument was prepared by LG Sullivan. The following digest,
which does not constitute a part of the legislative instrument, was prepared
by Christine Arbo Peck.

| | | |
|------------------|----------------------|-------|
| | DIGEST | |
| SB 173 Engrossed | 2019 Regular Session | Mills |

Proposed law, which takes effect only after certain delays following a final and definitive judgment ruling the Patient Protection and Affordable Care Act, P.L. 111-148, (ACA) unconstitutional, requires every health insurance policy or contract issued or issued for delivery in this state to adhere to certain standards. Provides for open enrollment, rate setting, and coverage for dependent children who are under the age of 26. Prohibits preexisting condition exclusions and annual and lifetime limits.

Proposed law requires the attorney general to notify the commissioner, the legislature, and the Louisiana State Law Institute if a judgment ruling the ACA unconstitutional becomes final and definitive. Provides that the provisions of proposed law take effect ninety days after receipt by the commissioner of the notification.

Proposed law requires that health insurance policies cover "essential health benefits". Charges the commissioner with defining the essential health benefits that are required. Specifies that the definition shall include certain categories; among these are ambulatory patient services, emergency services, hospitalization, maternity and newborn care and pediatric services, mental health services, prescription drugs, and wellness services. Provides a framework for monitoring, assessing, and updating the definition of essential health

benefits package.

Proposed law requires the commissioner to promulgate rules pursuant to the Administrative Procedure Act for purposes of implementing proposed law. Requires initial administrative rules to be adopted ninety days after final judgment of a court of competent jurisdiction on the constitutionality of ACA. Authorizes the commissioner to issue emergency rules without finding an emergency exists.

Proposed law applies to any health insurance policy or contract issued or issued for delivery in this state beginning ninety days after the attorney general notifies the commissioner that the ACA has been ruled unconstitutional. Proposed law does not abridge or affect the provisions of insurance policies or contracts already in effect until the policies or contracts are renewed.

Proposed law provides that in case of any conflict between the provisions of proposed law and any other provision of law, the provisions of proposed law shall control unless application of proposed law results in a reduction in coverage for any insured.

Proposed law provides that applicability of proposed law shall occur only if the current federal tax credit is held to be valid by a court of competent jurisdiction or is otherwise enforceable at law, or unless adequate appropriations are timely made by the federal or state government in an amount that is calculated in the same manner as the tax credit in Section 1401 of the Patient Protection and Affordable Care Act.

Proposed law provides that it shall not apply to grandfathered coverage, health benefit plans in the large groups or to the large group market, or to limited or excepted benefits policies as defined in present law.

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

Proposed law establishes program operations and parameters, actuarial analysis, approval of the program by the Joint Legislative Committee on the Budget, and enrollment or participation limitations.

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

(Adds R.S. 22:11.1 and 1121-1138)

Summary of Amendments Adopted by Senate

Committee Amendments Proposed by Senate Committee on Health and Welfare to the original bill

1. Changes Louisiana Department of Insurance rulemaking deadline from January 1, 2020, to ninety days after final judgment of a court of competent jurisdiction on the constitutionality of ACA.
2. Changes effective date from ten to ninety days after receipt by the commissioner of the written notification of the court's ruling in ACA.
3. Provides that proposed law does not abridge or affect the provisions of insurance policies or contracts already in effect until the policies or contracts are renewed.

4. Changes the ratio for rate setting from three to one to five to one.
5. Clarifies that the emergency department services provisions shall comply with those established in ACA for coverage and payment of services.
6. Provides that applicability of proposed law shall occur only if the current federal tax credit is held to be valid by a court of competent jurisdiction or is otherwise enforceable at law, or unless adequate appropriations are timely made by the federal or state government in an amount that is calculated in the same manner as the tax credit in Section 1401 of the Patient Protection and Affordable Care Act.
7. Proposed law provides that it shall not apply to grandfathered coverage, health benefit plans in the large groups or to the large group market, or to limited or excepted benefits policies as defined in present law.
8. Provides for an assessment by the commissioner of insurance on nationwide individual insurance market cost stabilization programs and a report to the Legislature with findings and recommendations by March 1, 2020.
9. Establishes the "Louisiana Guaranteed Benefits Pool" to be administered by the commissioner of insurance which shall be a risk-sharing program to provide payment to health insurance issuers for claims for healthcare services provided to eligible individuals with expected high healthcare costs for the purpose of lowering premiums for health insurance coverage offered in the individual market.