SUBPART J. LOUISIANA HEALTH PLAN

§1201. Legislative findings; purpose; short title

A. Existing law does not establish a health coverage program to provide health insurance to Louisiana domiciliaries who are not otherwise able to obtain health insurance meeting prescribed criteria.

B. Uninsurable Louisianians, left to face the cost of major medical care without health coverage, must look to publicly funded programs in the event of severe illness or injury, thereby placing a burden on the resources of the state.

C. Insurance is a business which affects the public interest and which has been subject to regulation in the public interest in this state since 1855; Louisiana's interest in the regulation of insurance is effectuated by the provisions of the Louisiana Insurance Code, R.S. 22:1 et seq., and in other statutes of this state, and is affirmed in the McCarran-Ferguson Act, 15 U.S.C. §1011 et seq.

D. It is the purpose and intent of the legislature to establish a mechanism to insure the availability of health and accident insurance coverage to those citizens of this state who, because of health conditions, cannot secure such coverage.

E. Federal law authorizes the state, subject to federal review and approval, to utilize the Louisiana Health Plan to ensure the availability of comprehensive health coverage to those citizens of this state who lose their group health care coverage and are guaranteed access to continuing coverage. Under this authority, the state can provide the plan with the ability to utilize alternate funding sources to reduce rates, provided rates do not fall below one hundred twenty-five percent of the standard market average for similar coverage. Under this authority, the financial solvency of the plan for federally defined eligible individuals is guaranteed by fees assessed for plan costs in excess of premiums applicable to participating insurers. It is the purpose and intent of the legislature to establish a mechanism which meets the federal requirements for access to comprehensive health insurance for federally defined eligible individuals and provides options for receipt of alternate funding to improve the affordability of coverage as allowed by federal law.

F. This Subpart shall be known and may be cited as the "Louisiana Health Plan Act".

G. It is the purpose and intent of the legislature to establish a mechanism to increase the availability of health insurance coverage to small businesses that because of the cost of health insurance are not able to offer such coverage to their employees.

H. The Louisiana Health Plan was created to provide health care coverage for individuals to whom comprehensive health care coverage is not available in the individual health insurance market because of preexisting health conditions. As of January 1, 2014, federal law provides that health insurance carriers in the individual market cannot reject applicants for health insurance coverage based upon the presence of preexisting health conditions or exclude health care coverage for preexisting conditions.

Acts 1990, No. 131, §1, eff. Sept. 1, 1990; Acts 1997, No. 1154, §1, eff. Jan. 1, 1998; Acts 1999, No. 163, §1; Acts 1999, No. 294, §1; Acts 2003, No. 528, §1, eff. June 24, 2003; Acts 2004, No. 493, §2, eff. June 25, 2004; Acts 2008, No. 21, §1; Redesignated from R.S. 22:231 by Acts 2008, No. 415, §1, eff. Jan. 1, 2009; Acts 2013, No. 325, §1, eff. June 17, 2013.

NOTE: See Acts 1990, No. 131, §§2 and 3.

NOTE: Former R.S. 22:1201 redesignated as R.S. 22:1621 by Acts 2008, No. 415, §1, eff. Jan. 1, 2009.

§1202. Definitions

As used in this Subpart:

(1) "Ambulatory surgical center" means an establishment in this state as defined in and licensed under the provisions of R.S. 40:2131 et seq., as may be from time to time amended.

(2) "Benefits plan" means the coverages offered by the plan to eligible persons as defined by R.S. 22:1207.

(3) "Board" means the board of directors of the plan.

(4) "Church plan" has the meaning given such term under Section 3(33) of the Employee Retirement Income Security Act of 1974.

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

(6) "Creditable coverage" means, with respect to an individual, coverage to the individual as defined by R.S. 22:1061(4).

(7) "Department" means the Department of Insurance.

(8) "Dependent" means a resident spouse or resident unmarried child under the age of twenty-one years, a child who is a student under the age of twenty-four years and who is financially dependent upon the parent, or a child of any age who is disabled and dependent upon the parent.

(9) "Family group insurance" means health and accident insurance as defined in R.S. 22:1000(A)(2)(a).

(10) "Federally defined eligible individual" means an individual as defined by R.S. 22:1073(B).

(11) "Government plan" has the meaning given such term under R.S. 22:1061(5)(g).

(12) "Group health benefit plan" means an employee welfare benefit plan as defined by R.S. 22:1061(1).

(13) "Health and accident insurance" means hospital and medical expense incurred policies, nonprofit service plan corporation contracts, and coverages provided by health maintenance organizations, individual practices, associations, the Office of Group Benefits, and other similar entities and self-insurers. The term "health and accident insurance" does not include short term, accident only, hospital indemnity, credit insurance, automobile and homeowner's medical-payment coverage, workers' compensation medical benefit coverage, Medicare, Medicaid, federal governmental benefit plans, supplemental health insurance, limited benefit health insurance, or coverage issued as a supplement to liability insurance.

(14) "Health care provider" means a person licensed by this state to provide health care or professional services under the provisions of Title 37 of the Louisiana Revised Statutes of 1950 or any professional corporation, as a health care provider, authorized to form under the provisions of Title 12 of the Louisiana Revised Statutes of 1950 or such a person licensed by the appropriate laws of another state.

(15) "Health maintenance organization" means an organization as defined in R.S. 22:242(7).

(16) "Hospital" means any facility as defined in R.S. 40:2102 established for the care and treatment of the sick and injured.

(17) "Insurance arrangement" means any plan, program, contract, or any other arrangement under which one or more natural or juridical persons provide to their employees or participants, whether directly or indirectly, health care services or benefits other than through an insurer. The term shall also include any "self-insurer" as defined herein.

(18) "Insured" means any natural person domiciled in this state, other than a member of the plan, who is eligible to receive benefits from any insurer or insurance arrangement as defined in this Section.

(19) "Insurer" means any insurance company or other entity authorized to transact and transacting health and accident insurance business in this state. Notwithstanding any contrary provisions of R.S. 22:242(7) or any other law, regulation, or definition contained in this Title, a health maintenance organization shall be deemed an insurer for the purposes of this Subpart. The term "insurer" shall not include any insurance company whose products are marketed on the home service distribution method and which issues a majority of these policies on a weekly or monthly basis.

(20) "Medical care" means amounts paid for as defined in R.S. 22:1061(1)(b).

(21) "Medicaid" means coverage provided under the state plan for Title XIX of the Social Security Act, 42 USC 1396 et seq., as amended.

(22) "Medicare" means coverage under both Parts A and B of Title XVIII of the Social Security Act, 42 U.S.C. 1395 et seq., as amended.

(23) "Member" means a person covered by the plan.

(24) "Plan" means the Louisiana Health Plan as created in R.S. 22:1203.

(25) "Plan of operation" means the plan of operation of the plan, including articles, bylaws, and operating rules, adopted by the board pursuant to R.S. 22:1205.

(26) "Private pay patient" means a natural person who is not covered by any policy or plan of insurance or by a

self-insurer or whose charges for injury or illness are not compensable by his employer or other insurer or insurance arrangement.

(27) "Public program" means any public assistance program which provides funding for health care services rendered by a health care provider that is directly subsidized by the federal government.

(28) "Self-insurer" means a natural or juridical person which provides health care services or reimbursement for all or any part of the costs of health care for its employees or participants in this state other than through an insurer.

(29) "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 not less than one nor more than twenty-five eligible employees. 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.

Acts 1990, No. 131, §1, eff. Sept. 1, 1990; Acts 1991, No. 574, §1, eff. July 16, 1991; Acts 1997, No. 1154, §1, eff. Jan. 1, 1998; Acts 1999, No. 163, §1; Acts 1999, No. 294, §1; Acts 2001, No. 1178, §2, eff. June 29, 2001; Acts 2005, No. 154, §1, eff. June 28, 2005; Acts 2008, No. 21, §1; Redesignated from R.S. 22:232 by Acts 2008, No. 415, §1, eff. Jan. 1, 2009.

NOTE: Former R.S. 22:1202 redesignated as R.S. 22:1622 by Acts 2008, No. 415, §1, eff. Jan. 1, 2009.

§1203. Creation of the plan

A. There is hereby created a nonprofit entity to be known as the "Louisiana Health Plan" whose legal domicile shall be in the parish of East Baton Rouge. The plan shall perform its functions under the plan of operation established and approved pursuant to R.S. 22:1205 and shall exercise its powers through a board of directors established by R.S. 22:1204. For purposes of administration and assessment, the plan shall maintain three accounts:

(1) The state guarantee account for non-federally defined eligible individuals.

(2) The federal guarantee account for federally defined eligible individuals.

(3) The small employer insurance risk account for small businesses that employ at least one but not more than twenty-five employees.

B.(1) The plan is not and may not be deemed a department, unit, agency, instrumentality, commission, or board of the state for any purpose. All debts, claims, obligations, and liabilities of the plan, whenever incurred, shall be the debts, claims, obligations, and liabilities of the plan only and not the state, its agencies, instrumentalities, officers, or employees. The debts, claims, obligations, and liabilities of the plan may not be considered to be a debt of the state or a pledge of its credit.

(2) Notwithstanding the provisions of Paragraph (1) of this Subsection, and except as provided in Paragraphs (3) and (4) of this Subsection, the plan shall be subject to the provisions of R.S. 44: et seq. and R.S. 42:4.1 et seq., and may be considered as if it were a public body for the purposes of this Section.

(3) The plan may hold an executive session pursuant to R.S. 42:16 for discussion of one or more of the following, and R.S. 44:1 et seq. shall not apply to any documents as enumerated in R.S. 44:1(A)(2) which relate to one or more of the following:

(a) Names of patients provided to or maintained by the plan, or the administering insurer selected under the provisions of R.S. 22:1208.

(b) Matters protected by an attorney-client privilege.

(c) Matters with respect to claims or claims files, except documents contained in those files which are otherwise deemed public records.

(d) Prospective litigation against the plan after formal written demand, prospective litigation by the plan after referral to counsel for review, or pending litigation by or against the plan.

(e) Any other matter now provided for or as may be provided for by the legislature.

(f) Discussion by or documents in the custody or control of any committee or subcommittee of the plan, or any member, employee, or agent, or the board of directors or its members, employees, or agents, provided the discussion or documents would otherwise be protected from disclosure by any of the exceptions provided in this Paragraph.

(4) Any specific fee, procedure, or unit of service pricing information contained in any contract or the form of any contract made, between the plan and any provider of health care services, network of providers of health care services, or managed care plan shall be deemed confidential and shall not be divulged by the plan or the board except that payment may be disclosed and become public record in any legislative, administrative, or judicial proceeding or inquiry. Any information related to payments under a contract or the form of any contract for health care services other than specific fee, procedure, or unit of service pricing shall not be subject to the provisions of this Subsection.

C. The plan and the administering insurer shall be subject to audit by the legislative auditor in accordance with the provisions of R.S. 24:513.

D. There shall be no liability on the part of and no cause of action of any nature shall arise or exist against the plan, its agents or employees, its board of directors, or the commissioner or his representatives for any action taken by them in the performance of their powers and duties under Subpart J of Part III of this Chapter.

Acts 1990, No. 131, §1, eff. Sept. 1, 1990; Acts 1997, No. 1154, §1, eff. Jan. 1, 1998; Acts 1999, No. 163, §1; Acts 1999, No. 294, §1; Redesignated from R.S. 22:233 by Acts 2008, No. 415, §1, eff. Jan. 1, 2009; Acts 2012, No. 271, §1.

NOTE: Former R.S. 22:1203 redesignated as R.S. 22:1623 by Acts 2008, No. 415, §1, eff. Jan. 1, 2009.

§1204. Board of directors

A. The board of directors shall be composed of the commissioner of insurance or his designee, who shall serve as an ex officio, nonvoting member of the board, and twelve members to be selected from the groups and in the manner as follows:

(1) A representative of a domestic insurance company which is a member of the Louisiana Insurers Conference, selected by the conference.

(2) A representative of a foreign insurance company doing business in the state of Louisiana which is a member of America's Health Insurance Plans, selected by the association.

(3) A representative of a domestic nonprofit health service and indemnity plan, selected by the commissioner.

(4) A representative of a health maintenance organization domiciled and doing business in the state of Louisiana, selected by the commissioner.

(5) A representative of the Louisiana Hospital Association, selected by the association.

(6) A representative of the Louisiana State Medical Society, selected by the society.

(7) A representative of the Louisiana Association of Life Underwriters, selected by the association.

(8) The chairman of the Senate Committee on Insurance, or his designee, who shall serve as an ex officio, nonvoting member.

(9) The chairman of the House Committee on Insurance, or his designee, who shall serve as an ex officio, nonvoting member.

(10)(a) Three consumer representatives, selected as follows:

(i) One consumer representative of the Louisiana Health Care Campaign, selected by that organization.

(ii) One consumer representative, selected by the commissioner from a list of persons compiled from recommendations made by any interested group, who at the time of selection is a member of or eligible for membership in the plan.

(iii) One representative of the business community, selected by the commissioner from a list of persons compiled by recommendations by any interested group.

(b) The commissioner shall make all diligent efforts to make selections from these three groups that will represent a racial, ethnic, and gender reflection of the state for the board of directors.

(11) Repealed by Acts 2004, No. 368, §2, eff. June 23, 2004.

B. Each member of the board other than the commissioner shall serve a term of three years; provided that initially four members shall serve a term of two years and four members shall serve a term of one year, as determined by the board. Members shall serve without compensation but may be reimbursed from the assets of the plan for expenses incurred by them as members of the board of directors.

C. The board shall elect one of its members to serve as chairman for a one year term and may elect such other officers as the board deems necessary to fulfill its duties under this Subpart, all to serve terms concurrent with that of the chairman.

D. Any vacancy on the board shall be filled for the remaining period of the term in the same manner as the initial appointments were made. The commissioner or the board may fill any vacancy on the board in accordance with the requirements of Subsection A of this Section if the vacancy is not filled within sixty days of its occurrence by the appropriate appointing authority as provided in Subsection A of this Section.

E. The board may make and alter bylaws governing the terms of office of directors, the meetings of the directors, and any other provision not inconsistent with the provisions of this Subpart.

F. The board shall submit a written report of the operation of the plan to the commissioner and to the Senate Committee on Insurance and House Committee on Insurance by April first of each year.

G-J. Repealed by Acts 1997, No. 1154, §3, eff. Jan. 1, 1998.

Acts 1990, No. 131, §1, eff. Sept. 1, 1990; Acts 1991, No. 574, §1, eff. July 16, 1991; Acts 1992, No. 377, §1, eff. June 17, 1992; Acts 1997, No. 1154, §3, eff. Jan. 1, 1998; Acts 1999, No. 163, §1; Acts 2004, No. 368, §§1, 2, eff. June 23, 2004; Acts 2008, No. 21, §1; Redesignated from R.S. 22:234 by Acts 2008, No. 415, §1, eff. Jan. 1, 2009.

NOTE: Former R.S. 22:1204 redesignated as R.S. 22:1624 by Acts 2008, No. 415, §1, eff. Jan. 1, 2009.

§1205. Plan of operation

A. The board shall submit to the commissioner a plan of operation for the plan and any amendments thereto necessary or suitable to assure the fair, reasonable, and equitable administration of the plan. The commissioner shall approve the plan of operation provided such is determined to be suitable to assure the fair, reasonable, and equitable administration of the plan.

B. The plan of operation shall become effective upon approval in writing by the commissioner. If the board fails to submit a suitable plan of operation within ninety days after its appointment or at any time thereafter fails to submit suitable amendments to the plan, the commissioner shall adopt and promulgate such reasonable rules and regulations, in accordance with the Administrative Procedure Act, as are necessary or advisable to effectuate the provisions of this Section. Such rules and regulations shall continue in force until modified by the commissioner or superseded by a plan submitted by the board and approved by the commissioner.

C. In its plan of operation the board shall:

(1) Establish procedures for the handling and accounting of assets and monies of the plan.

(2) Establish procedures for the payment of expenses incurred by an administering insurer in the performance of its services.

(3) Establish procedures for the reporting and remittance of charges assessed under R.S. 22:1209 to provide for claims paid under the benefits plan and for administrative expenses incurred for the operation of the plan.

(4) Develop and implement a program to publicize the existence of the benefits plan, the eligibility requirements, and procedures for enrollment of members, and to maintain public awareness of the benefits plan.

(5) Establish such other procedures for the operation of the plan to effectuate the purposes of this Subpart as the board in its discretion deems necessary and proper.

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

(7) Develop an orderly plan of cessation (dissolution plan).

(a) It is the intent of the legislature by the enactment of this Paragraph to provide for the orderly cessation of the Louisiana Health Plan's operation on December 31, 2013.

(i) The Louisiana Health Plan shall cease enrollment and coverage under the plan by January 1, 2014, as required by federal law.

(ii) No provision contained in this Section shall prohibit the Louisiana Health Plan from ceasing coverage or enrollment in the plan prior to January 1, 2014, if approved by the commissioner, in a superseding plan of operation as provided for in this Section.

(b) After paying health insurance claims for plan coverage, meeting all other obligations of the board set forth by this Section, and taking all reasonable steps, including those set forth by this Section, to timely and efficiently assist in the transition of individuals receiving plan coverage to the individual health insurance market, the board shall cease operating the High Risk Pool.

(c) The board may take all actions it deems necessary to cease enrollment for plan coverage by undertaking the following actions:

(i) Provide at least ninety days notice to current policyholders of plan termination.

(ii) Terminate all existing plan coverage at the end of the calendar day on December 31, 2013, provided that there is a minimum of one individual health insurance company authorized to provide individual health insurance coverage in the state at a rate not to exceed the usual and customary rate as of January 1, 2014. In the absence of any other individual health insurance company authorized to provide individual health insurance coverage in this state, the Louisiana Health Plan shall continue to provide such coverage until there is a minimum of one individual health insurance company authorized to provide individual health insurance coverage in this state on or after January 1, 2014.

(iii) Amend plan policies and provide adequate notice to policyholders, agents of policyholders, and providers that in order for such persons to be reimbursed, a claim for plan services is required to be filed by the earlier of one hundred eighty days after the plan coverage ends on December 31, 2013, or three hundred sixty-five days after the date of service giving rise to the claim.

(d) This Section does not require the board to revise plan benefits to comply with federal law or to maintain plan coverage for any individual after December 31, 2013.

(e) After plan coverage terminates pursuant to this Section, the board shall take reasonable steps to dissolve all significant operation of the plan by December 31, 2015.

(f) Notwithstanding any other provision of this Subsection, in order to facilitate an efficient cessation of operations, the following provisions shall apply:

(i) Until the cessation of Louisiana Health Plan's operations, the board may continue to use existing contractors without the need to issue competitive requests for proposals.

(ii) The board shall remain in effect in accordance with the provisions of R.S. 22:1204. The term of each board member shall be extended until the date the High Risk Pool concludes all business and the commissioner of insurance has certified the cessation of operations in accordance with Subparagraph (j) of this Paragraph.

(g) By August 30, 2013, the board shall submit to the commissioner a plan of operation, to be approved by the commissioner. Such plan of operation shall include a dissolution plan and shall supersede the current plan of operation in order to implement with the action required by this Paragraph. The new plan of operation shall go into effect upon signature by the commissioner.

(h) Billing of service charges pursuant to R.S. 22:1209 shall cease for claims incurred before January 1, 2014. Final service charge fees and reports shall be due and payable on January 31, 2014. Collection of all service charges legally due shall continue until cessation of operations. Nothing herein shall prohibit the auditing of any and all eligible providers, employers, insurance arrangements, or insurers.

(i) Effective December 31, 2013, fees assessed to participating health insurers and insurance arrangements under R.S. 22:1210 shall cease. Billing of the assessment based on participating health insurer premiums from calendar year 2013 shall be made no later than February 10, 2014. Payment of the assessment shall be made by the participating health insurers no later than March 31, 2014. Any participating health insurer that has not paid the assessment for calendar year 2013 by the March 31, 2014, deadline shall be reported to the commissioner for sanctions. Sanctions for refusal to timely pay a required assessment shall include the sanctions enumerated in R.S. 22:13 or 16, at the discretion of the commissioner.

(j) The commissioner shall certify the cessation of operations of each pool under the Louisiana Health Plan. The High Risk Pool and HIPAA Plan may be certified as having completed the cessation of operations separately or together, at the commissioner's discretion. The board may also submit the completed dissolution plan at different times based upon the finality of claim submissions or other factors.

(i) If the board has excess HIPAA funds after the commissioner certifies the cessation of operations of the HIPAA Plan in accordance with the provisions of this Subsection, the excess funds shall be returned to the participating insurer on the same basis upon which each participating insurer was assessed in accordance with the provisions of R.S. 22:1210 during calendar years 2013 and 2014.

(ii) If the board has excess High Risk Pool funds after the commissioner certifies the cessation of operations of the High Risk Pool in accordance with the provisions of this Subparagraph, the High Risk Pool funds shall be returned to the state general fund.

(k)(i) By March 1, 2016, the board or liquidator shall file a report with both the House Committee on Insurance and the Senate Committee on Insurance and the commissioner. Such report shall signify completion of the requirements of this Subsection and shall include an independent auditor's report on the financial statements of the pool. Such report shall be submitted in lieu of the written report of operation of the plan required by R.S. 22:1204(F). The board or liquidator may amend such report at a later date if necessary to complete the cessation of operations of the High Risk Pool.

(ii) Upon a satisfactory review of the board's compliance with the cessation of operations provisions of this Subsection, the commissioner shall certify that the business of the High Risk Pool has concluded in accordance with state law and shall publish the certification on the Department of Insurance website.

(l)(i) Upon certification in accordance with Subparagraph (j) of this Paragraph, the operations of the High Risk Pool are terminated.

(ii) The state attorney general shall defend any legal action that may arise against the plan, the board, or the employees of the plan that is filed after the commissioner's certification of cessation of operations. This defense shall include, when appropriate, a request for dismissal of any such action.

Acts 1990, No. 131, §1, eff. Sept. 1, 1990; Acts 1999, No. 163, §1; Redesignated from R.S. 22:235 by Acts 2008, No. 415, §1, eff. Jan. 1, 2009; Acts 2010, No. 123, §1, eff. June 8, 2010; Acts 2013, No. 325, §1, eff. June 17, 2013.

NOTE: Former R.S. 22:1205 redesignated as R.S. 22:1625 by Acts 2008, No. 415, §1, eff. Jan. 1, 2009.

§1206. Powers and duties of the plan

The plan shall have the general powers and authority granted under the laws of this state to insurance companies licensed to provide health and accident insurance and, in addition thereto, the specific authority to:

(1) Contract with an outside independent actuarial firm to assess the solvency of the plan and for consultation as to the sufficiency and means of the funding of the plan, and the enrollment in and the eligibility, benefits, and rate structure of the benefits plan to ensure the solvency of the plan.

(2) Close enrollment in benefit plans of non-federally defined eligible individuals at any time upon a determination by the outside independent actuarial firm that funds of the plan are insufficient to support the enrollment of additional non-federally defined eligible individuals.

(3) Enter into contracts as are necessary or proper to carry out the provisions and purposes of this Subpart, including the authority to enter into contracts, with the approval of the commissioner, with similar plans or pools of other states for the joint performance of common administrative functions, or with persons or other organizations for the performance of administrative functions.

(4) Enter into contracts for the establishment and maintenance of health care cost containment programs as in the discretion of the board are necessary or proper to establish the most cost-efficient levels of coverage as provided herein.

(5) Sue or be sued, including taking any legal actions necessary or proper for recovery of any monies due the plan under this Subpart.

(6) Take such legal action as necessary to avoid the payment of improper claims against the plan or the coverage provided by or through the plan.

(7) Establish appropriate rates, rate schedules, rate adjustments, expense allowances, agent's referral fees, and claim reserve formulas, and perform or contract for the performance of any other actuarial function appropriate to the operation of the plan, subject to the following limitations:

(a) Rates for federally defined individuals and nonfederally defined individuals. (i) For federally defined individuals, subject to approval by the Department of Insurance, the plan shall determine a standard risk rate for each coverage option offered by considering the premium rates charged by other insurers offering similar health insurance coverage to individuals and family groups, if applicable. The standard risk rate shall be established using reasonable actuarial techniques and shall reflect anticipated experience and expenses for such coverage. Subject to the limits provided in this Paragraph, initial rates for each plan year shall be established to provide fully for the expected costs of claims, including recovery of prior losses, expenses of operation, investment income of claim reserves, and any other cost factors subject to the limitations described herein, provided such rates shall not exceed two hundred percent of rates applicable to individual standard risks. Upon the receipt of governmental appropriations or alternative funding sources, other than assessments under R.S. 22:1210, such as authorized service charges, governmental transfer payments, donations, or grants, the board shall be authorized to reduce rates for the plan year based on established actuarial and underwriting practices. In no event shall rates for plan coverage be less than the greater of one hundred twenty-five percent of rates established as applicable for individual standard risks or rates established for other individuals provided coverage by or through the plan unless such rates would exceed the maximum amount allowed under this Paragraph. In no instance shall the rates discriminate between covered individuals on the basis of health-related factors.

(ii) Rates for nonfederally defined individuals. For nonfederally defined individuals, subject to approval by the Department of Insurance, the plan shall determine a standard risk rate for each coverage option offered by considering the premium rates charged by other insurers offering similar health insurance coverage to individuals and family groups, if applicable. The standard risk rate shall be established using reasonable actuarial techniques and shall reflect anticipated experience and expenses for such coverage. Subject to the limits provided in this Paragraph, initial rates for each plan year shall be established to provide fully for the expected costs of claims, including recovery of prior losses, expenses of operation, investment income of claim reserves, and any other cost factors subject to the limitations of prior losses, expenses of operation, investment income of claim reserves, and any other cost factors subject to the limitations described herein, provided such rates shall not exceed two hundred percent of rates applicable to individual standard risks. Upon the receipt of governmental appropriations or alternative funding sources, such as authorized service charges, governmental transfer payments, donations, or grants, the board shall be authorized to reduce rates for the plan year based on established actuarial and underwriting practices. In no event shall rates for plan coverage be less than one hundred ten percent of rates established as applicable for individual standard risks or rates established for other individuals provided coverage by or through the plan, provided such rates shall not exceed the maximum amount

of two hundred percent of rates applicable to individual standard rates. In no instance shall the rates discriminate between covered individuals on the basis of health-related factors.

(iii) Notwithstanding any other provision of this Subpart to the contrary, for persons eligible under a federal waiver pursuant to R.S. 22:1207(B)(2), the board may authorize a premium subsidy if such a premium subsidy is authorized by the federal waiver. If the board authorizes a premium subsidy, the total amount of the subsidy may not be more than sixty-six percent of the premium otherwise specified by this Subpart. The board may authorize the Louisiana Health Plan to provide for the nonfederal share of such premium subsidy. Nothing herein shall permit rates to be calculated other than as described in this Subpart, or otherwise restrict the board from participating in other components of the federal waiver.

(b) Rates for other individuals. (i) Rates shall not be unreasonable in relation to the coverage provided, the risk experience, and expenses of providing the coverage. Rates and rate schedules may be adjusted for appropriate risk factors such as age and area variation in claim cost and shall take into consideration appropriate risk factors in accordance with established actuarial and underwriting practices. In no instance shall the rates discriminate between covered individuals on the basis of health-related factors.

(ii) Notwithstanding any other provision of this Subpart to the contrary, for persons eligible under a federal waiver pursuant to R.S. 22:1207(D)(2), the board may authorize a premium subsidy if such a premium subsidy is authorized by the federal waiver. If the board authorizes a premium subsidy, the total amount of the subsidy may not be more than sixty-six percent of the premium otherwise specified by this Subpart. The board may authorize the Louisiana Health Plan to provide for the non-federal share of such premium subsidy. Nothing herein shall permit rates to be calculated other than as described in this Subpart, or otherwise restrict the board from participating in other components of the federal waiver.

(c) Policy fees or other compensation, or consideration paid to agents. No agent's fees or other compensation, or consideration shall be payable for coverage offered through the plan unless:

(i) The agent is duly registered and certified by the plan under a plan approved by the commissioner of insurance.

(ii) The agent certifies in writing that to the best of his knowledge the individual is a qualifying individual as defined by R.S. 22:1207 or 1073(B).

(iii) The agent has entered into a participation agreement with the plan which provides for recoupment of amounts paid for certifications found to be erroneous.

(d) Reimbursement of expenses. The board shall be authorized to establish policy fees or other compensation, or consideration for reimbursement of the reasonable expenses of participating agents. The plan shall be authorized to recoup any amounts paid for an agent certification found to be erroneous or improper.

(8) Issue individual and family group policies of insurance in accordance with the requirements of this Subpart.

(9) Appoint appropriate legal, actuarial, and other committees as necessary to provide technical assistance in the operation of the plan, policy and other contract design, and any other function within the authority of the plan.

(10) Repealed by Acts 2004, No. 493, §2, eff. June 25, 2004.

Acts 1990, No. 131, §1, eff. Sept. 1, 1990; Acts 1997, No. 1154, §1, eff. Jan. 1, 1998; Acts 1999, No. 163, §1; Acts 2003, No. 528, §1, eff. June 24, 2003; Acts 2004, No. 493, §2, eff. June 25, 2004; Acts 2005, No. 154, §1, eff. June 28, 2005; Acts 2008, No. 21, §1; Redesignated from R.S. 22:236 by Acts 2008, No. 415, §1, eff. Jan. 1, 2009.

NOTE: Former R.S. 22:1206 redesignated as R.S. 22:1626 by Acts 2008, No. 415, §1, eff. Jan. 1, 2009.

§1207. Eligibility

A. Any natural person who has been domiciled in this state for six consecutive months shall be eligible for coverage as a nonfederally defined individual as provided in this Subpart, except the following:

(1) Any person who, on the effective date of coverage by the plan or at any time thereafter, is eligible for coverage under health and accident insurance offered by an insurer, reinsurer, or insurance arrangement. A person shall be considered eligible for coverage by an insurer or insurance arrangement as described herein if he meets the criteria for eligibility under any group health benefits plan provided by his employer, union, or other organization of which he is a member, whether or not the person actually is covered under such plan.

(2) Any person who is, at the time of application for coverage by the plan, eligible for health benefits under Medicaid or Medicare as defined in R.S. 22:1202.

(3) Any person whose coverage by the plan was terminated for nonpayment of premiums unless twelve months have lapsed since such termination.

(4) Any person on whose behalf the plan has paid out the maximum lifetime benefits under the benefits plan as may be established by the plan.

(5) Inmates of public institutions.

(6) Persons eligible for public programs as defined in R.S. 22:1202.

(7) Persons who are not domiciled in this state.

B.(1) Any federally defined eligible individual who is and continues to be a resident of this state shall be eligible for plan coverage as an individual or family group. Each dependent of a person who is eligible for plan coverage shall also be eligible for plan coverage.

(2) Any person meeting any and all eligibility requirements under any approved federal waiver shall be eligible for plan coverage, provided all other eligibility criteria for plan coverage as a federally defined eligible individual are met.

C. Any person who ceases to meet the eligibility requirements of this Section may be terminated from coverage by the plan at the time of loss of eligibility, but any unearned premium shall be refunded. However, this Subsection shall not apply to any person receiving cancer treatment or cancer therapy or any person with an immune system disorder requiring immunosuppression drug treatment or maintenance not covered by Medicaid or Medicare unless such person is eligible for or has attained Medicare at age sixty-five or older.

D.(1) Nonfederally defined eligible individuals whose health and accident insurance coverage has been involuntarily terminated may apply for coverage under the plan. If such coverage is applied for within sixty-three days after the involuntary termination and if premiums assessed by the plan are paid for the entire coverage period, the effective date of the coverage by the plan shall be the date of termination of the previous coverage.

(2) Any person meeting any and all eligibility requirements under any approved federal waiver shall be eligible for plan coverage, provided all other eligibility criteria for plan coverage as a nonfederally defined eligible individual are met.

E. Any natural person who changes his domicile to this state and who at the time domicile is established in this state is insured by the health insurance plan or similar organization for his former domiciliary state shall be eligible for coverage by the plan if:

(1) The health insurance plan or similar organization of the former domiciliary state provides coverage similar to that offered by the plan.

(2) The health insurance plan or similar organization of the former domiciliary state certifies, on a form acceptable to the plan, that the person seeking coverage by the plan is currently insured in such other state.

(3) The commissioner determines that the law of the former domiciliary state provides similar coverage to Louisianians insured by the plan upon their establishment of domicile in such other state.

F.(1) Notwithstanding the provisions of Paragraph (A)(1) of this Section, upon certification by an independent actuarial firm that funds of the plan are sufficient to support the enrollment of additional persons, the board may authorize the enrollment of additional persons as provided for in this Subsection. Any person whose individual insurance premium rate for comparable coverage exceeds by more than two hundred percent the maximum rate which the plan may be authorized to charge under R.S. 22:1213(F)(3), for persons of comparable age, sex, and geographical location, shall be eligible for coverage as provided in this Subpart.

(2) As used in this Subsection, the term "eligible" shall not include persons whose employer, union, or other organization provides a group health benefits plan through an insurer or insurance arrangement to its employees or members, or their dependents, and such person is eligible for coverage under such group health benefits plan.

(3) Plan coverage for which a person is eligible under this Subsection shall exclude charges or expenses incurred or caused by preexisting conditions, as provided in R.S. 22:1213(G).

(4) The board shall establish policies and procedures to effectuate the provisions of this Subsection, which policies and procedures shall:

(a) Guarantee uninterrupted enrollment of federally defined eligible individuals.

(b) Give preference to the applications for membership of persons who, at the time of application, are uninsured and uninsurable, and satisfy the eligibility requirements of Subsection A of this Section.

(5)(a) It shall constitute an unfair trade practice under the provisions of R.S. 22:1961 et seq., for any insurer, reinsurer, insurance agent or broker, or employer, to refer an individual employee to the plan, or to arrange for an individual employee to apply to the program, for the purpose of separating such employee from a group health benefits plan provided in connection with the employee's employment.

(b) In the event that an individual receives coverage by the plan in contravention of this Subsection, the plan may terminate the coverage of the individual but shall maintain a cause of action against any offender of this Subsection for a total amount not less than double the amount of any or all claims paid on behalf of the individual whenever made, without limitation, plus ten thousand dollars for each incident, and attorney fees, court costs, and interest from date of demand by the plan.

Acts 1990, No. 131, §1, eff. Sept. 1, 1990; Acts 1991, No. 574, §1, eff. July 16, 1991; Acts 1997, No. 1154, §1, eff. Jan. 1, 1998; Acts 1999, No. 163, §1; Acts 2001, No. 65, §1, eff. May 24, 2001; Acts 2004, No. 368, §1, eff. June 23, 2004; Acts 2008, No. 21, §1; Redesignated from R.S. 22:237 by Acts 2008, No. 415, §1, eff. Jan. 1, 2009.

NOTE: Former R.S. 22:1207 redesignated as R.S. 22:1627 by Acts 2008, No. 415, §1, eff. Jan. 1, 2009.

§1208. Administration

A. The board shall select an administrator or administrators, which may consist of an insurer or insurers, a third-party administrator or administrators, medical or pharmaceutical providers, or a combination thereof, through a competitive bidding process to administer the benefits plan of the plan. The board shall evaluate bids submitted based on criteria established by the board which shall include:

(1) The administrator's proven ability to handle individual health and accident insurance.

(2) The efficiency of the administrator's claim payment procedures.

(3) An estimate of total charges for administering the benefits plan.

(4) The administrator's ability to administer the benefits plan in a cost-efficient manner.

B.(1) The commissioner shall appoint the administrator or administrators if the administrator or administrators have not been selected within sixty days of the appointment of the board.

(2) The administrator or administrators shall serve for a period of three years, subject to removal for cause.

(3) At least six months prior to the expiration of each three-year period of service by an administrator, the board shall invite all administrators, including the current administering administrator or administrators, to submit bids to serve as an administrator for the succeeding three-year period. Selection of an administrator for the succeeding period shall be made at least three months prior to the end of the current three-year period. Nothing in this Section shall prohibit a competitive bid process prior to the three-year period in the event of termination of an administrator or administrators.

C.(1) The administrator shall perform all eligibility and administrative claims payment functions relating to the plan.

(2) The administrator shall establish a premium billing procedure for collection of premiums from persons insured by the plan. Billings shall be made on a periodic basis as determined by the board.

(3) The administrator shall perform all necessary functions to assure timely payment of benefits to persons insured by the plan, including:

(a) Making available information relating to the proper manner of submitting a claim for benefits to the plan and distributing forms upon which submission shall be made.

(b) Evaluation of the eligibility of each claim for payment by the plan.

(4) The administrator shall submit regular reports to the board regarding the operation of the plan. The frequency, content, and form of the report shall be determined by the board.

(5) Following the close of each calendar year, the administrator and actuarial consultants shall determine net written and earned premiums, the expense of administration, and the paid and incurred losses for the year, and report this information to the board.

(6) The administrator shall be paid as provided in the plan of operation for its expenses incurred in the performance of its services.

Acts 1990, No. 131, §1, eff. Sept. 1, 1990; Acts 1999, No. 163, §1; Acts 2004, No. 368, §1, eff. June 23, 2004; Redesignated from R.S. 22:238 by Acts 2008, No. 415, §1, eff. Jan. 1, 2009.

§1209. Service charges

NOTE: §1209 repealed by Acts 2013, No. 325, §2, eff. Dec. 31, 2014.

A.(1) Each patient, except a private pay patient, one covered by Medicare or any other public program, one who is covered by the State Employees Group Benefit Program, or one covered by an insolvent insurer, admitted to a hospital for treatment other than psychiatric care or alcohol or substance abuse, shall be assessed a service charge of two dollars for each day, or portion thereof, during which the patient is confined as an inpatient in that facility.

(2) Each hospital in which a patient is confined shall calculate the total service charge due for that patient's period of confinement and shall include the total service charge in the bill for services rendered to the patient. The individual patient may be obligated to pay the service charge assessed in the event that an insurance arrangement pays for any medical charges or benefits but fails to pay the service charge assessed pursuant to this Section. The service charge shall be collected as provided for in the plan of operation of the plan as established pursuant to R.S. 22:1205.

(3) For purposes of this Section only, "hospital" shall not include any hospital operated by the state, or any hospital created or operated by the Department of Veterans Affairs or other agency of the United States of America or any facility operated solely to provide psychiatric care or treatment of alcohol or substance abuse, or both.

B. Each patient, except a private pay patient, one covered by Medicare or any other public program which is directly subsidized by the federal government, one who is covered by the State Employees Group Benefit Program, or one covered by an insolvent insurer, admitted to an ambulatory surgical center or to a hospital for outpatient ambulatory surgical care shall be assessed a service charge of one dollar for each admission to that facility. The service charge shall be included in the bill for services or supplies, or both, rendered to the patient by the ambulatory surgical center or hospital.

C.(1) Each hospital and ambulatory surgical center shall bill for and collect the service charges assessed herein from monies remitted to it in payment thereof in accordance with R.S. 22:213.2, if authorized by the plan of operation under R.S. 22:1205. In the event that no payment is made by or on behalf of the patient for services rendered, the health care provider shall be liable only for the remittance of those fees collected. Each hospital and ambulatory surgical center shall remit to the plan for each reporting period, as established in the plan of operation, the total amount of service charges collected during that reporting period in accordance with the reporting and remittance procedures established by the plan pursuant to R.S. 22:1205.

(2) Unless permitted by the board, the intentional failure to bill, pay, report, or delineate as service charges in accordance with this Section shall cause the hospital or ambulatory surgical center to be liable to the plan for an amount determined by the board, not to exceed five hundred dollars, plus interest, per failure. Any hospital or ambulatory surgical center found to have intentionally failed to bill, pay, report, or delineate as service charges according to this Section unless permitted by the board on three or more occasions during a six-month period shall be liable for an amount determined by the board, not to exceed one thousand five hundred dollars per failure, together with attorney fees, and court costs.

(3) The plan or the commissioner, or both, are specifically authorized and empowered to conduct audits of hospitals and ambulatory surgical centers in order to enforce compliance with this Section. Fines levied under this Section shall be consistent with those levied against insurers under this Subpart.

D. The service charges imposed on hospital and ambulatory surgical center patients by this Section shall be payable by the patient's insurer or insurance arrangement, if any, as applicable, except such charges shall not be payable by an insolvent insurer. In no event shall a hospital or ambulatory surgical center be required to remit to the plan uncollected service charges for any patient who is a private pay patient or for any patient whose insurer or insurance arrangement is not legally required to pay the service charge.

E. If monies in the plan at the end of any fiscal year exceed actual losses and administrative expenses of the plan, the excess shall be held at interest and used by the board to offset future losses. As used in this Subsection, "future losses" includes reserves for incurred but not reported claims.

F. For the purposes of this Section, insurance, insurance arrangement, or policy of an insurer also includes any policy or plan of insurance or of self-insurance which provides payment, indemnity, or reimbursement for charges resulting from accident, injury, or illness when an employer or insurer is responsible for those charges. The terms insurance, insurance arrangement, or policy shall not include short-term, accident only, fixed indemnity, credit insurance, automobile and homeowner's medical payment coverage, or coverage issued as a supplement to liability insurance.

Acts 1990, No. 131, §1, eff. Sept. 1, 1990; Acts 1991, No. 768, §1, eff. July 19, 1991; Acts 1993, No. 191, §1; Acts 1997, No. 1154, §1, eff. Jan. 1, 1998; Acts 1999, No. 163, §1; Redesignated from R.S. 22:239 by Acts 2008, No.

415, §1, eff. Jan. 1, 2009; Acts 2013, No. 325, §2, eff. Dec. 31, 2014.

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

NOTE: §1210 repealed by Acts 2013, No. 325, §2, eff. Dec. 31, 2014.

A.(1) For the purposes of this Section, "participating insurer" includes all insurers providing health insurance to citizens of this state.

(2) For the purposes of this Section, fees assessed to participating insurers shall apply to gross premiums for hospital and medical expense incurred policies, nonprofit service plan corporation contracts, hospital only coverage, medical and surgical expense policies, major medical insurance, coverages provided by health maintenance organizations, individual practices, associations, and every insurance appertaining to any portion of medical expense liability incurred under a group health plan, as defined in R.S. 22:1061(1)(a), including stop-loss and excess-loss coverage unless the gross premium for such coverage is included under any other type of coverage stated herein that is issued for delivery in this state. Fee assessments to participating insurers shall not apply to policies or contracts for provision of short term, accident only, hospital indemnity, credit insurance, automobile and homeowner's medical-payment coverage, workers' compensation medical benefit coverage, Medicare, Medicaid, federal governmental benefit plans, supplemental health insurance, limited benefit health insurance, or coverage issued as a supplement to liability.

B. In addition to the powers enumerated in R.S. 22:1206, the plan shall have the authority to assess fees to participating insurers in accordance with the provisions of this Section, and to make advance interim fee assessments as may be reasonable and necessary for the plan's organizational and interim operating expenses. Any such interim fees assessed are to be credited as offsets against any regular fees assessed which become payable following the close of the fiscal year.

C. Following the close of each fiscal year, the administrator shall determine the net premiums, premiums less reasonable administrative expense allowances, the plan expenses of administration, and the incurred losses for the year which are attributable to federally defined eligible individuals. The administrator shall take into account investment income and other appropriate gains and losses which are reasonably attributable to federally defined eligible individuals. Any deficit incurred by the plan shall be identified and recouped as follows:

(1) The board shall identify the source of any deficit related to the provision of coverage to federally defined eligible individuals before assessing any fees authorized under this Section.

(2) The board shall verify the adequacy of any governmental appropriations or alternative funding sources, other than fees assessed under this Subsection, used to reduce rates for the plan year. Where such funds were not sufficient to support the rate reduction provided, that portion of the deficit reasonably related to such funding shortfalls shall be recouped from any subsequent governmental appropriations or alternative funding sources, other than fees assessed under this Section, prior to making any rate reduction for a subsequent plan year. The board shall reasonably act to prevent future deficits related to reducing rates based on receipt of government appropriations or alternate funding sources.

(3) The board shall verify the amount of any deficit reasonably resulting from plan losses not attributable to governmental or alternative funding shortfalls used to reduce rates. Any verified deficit amount attributed to federally defined eligible individuals shall be recouped by fees assessed under this Section to participating insurers.

(4) The board shall provide the commissioner of insurance with a detailed report on any deficit being recouped by fee assessments apportioned under this Section. Such report shall include information on services and utilization patterns which can reasonably be attributed to the deficit as well as analysis and recommendations on cost containment measures which can be taken to minimize future deficits.

(5) The board shall provide the commissioner of insurance with a detailed report on the sources and use of government appropriations and alternate sources of funding used to make rates more affordable. Such report shall include information on the activities of similar plans maintained by other states and recommendations for actions which can be taken to make coverage more affordable for plan members.

D.(1) Each participating insurer's fee assessment shall be in the proportion to gross premiums earned on business in this state for policies or contracts covered under this Section for the most recent calendar year for which information is available.

(2) Each participating insurer's fee assessment shall be determined by the board based on annual statements and other reports deemed to be necessary by the board and filed by the participating insurer with the board. The board may use any reasonable method of estimating the amount of gross premium of a participating insurer if the specific amount is unknown. The plan of operation shall provide the details of the calculation of each participating insurer's assessment which shall require the approval of the commissioner.

E. A participating insurer may petition the commissioner of insurance for deferral of all or part of any fee assessed by the board. If, in the opinion of the commissioner, payment of the fee assessment would endanger the solvency of the participating insurer, the commissioner may defer, in whole or in part, the fee assessment as part of a voluntary rehabilitation or supervisory plan established to prevent the plan's insolvency. Any deferrals approved under a voluntary rehabilitation or supervisory plan shall be limited to four years and require repayment of all deferrals by the end of such period plus legal interest. Until notice of payment in full is received from the board, the insurer shall remain under the voluntary rehabilitation or supervisory plan. In the event a fee assessment against a participating insurer is deferred in whole or in part, the amount by which the fee assessment is deferred may be assessed to the other participating insurers in a manner consistent with the basis for fee assessments set forth in this Section. Collection of such deferrals and legal interest shall be used to offset fee assessments against the other participating insurers in a manner consistent with the basis for fee assessments set forth in this Section.

F. Repealed by Acts 2010, No. 123, §2, eff. June 8, 2010.

Acts 1997, No. 1154, §1, eff. Jan. 1, 1998; Acts 2001, No. 62, §1, eff. May 24, 2001; Acts 2001, No. 1178, §2, eff. June 29, 2001; Acts 2008, No. 21, §1; Redesignated from R.S. 22:239.1 by Acts 2008, No. 415, §1, eff. Jan. 1, 2009; Acts 2010, No. 123, §§1, 2, eff. June 8, 2010; Acts 2013, No. 325, §2, eff. Dec. 31, 2014.

§1211. Powers and duties of the commissioner

A. In addition to the duties and powers enumerated elsewhere in this Subpart, and in other provisions of law, the commissioner shall upon request of the board of directors, and notwithstanding any provision of law to the contrary, provide the plan with a statement of the premiums, in this and other appropriate states, for each participating insurer.

B. The commissioner may suspend or revoke, in accordance and compliance with R.S. 49:961, the certificate of authority to transact insurance in this state of any participating insurer who fails to pay assessed fees when due or fails to comply with the plan of operation. As an alternative, the commissioner may levy a fine on any participating insurer who fails to pay an assessed fee when due. The fine shall not exceed five percent of the unpaid fee assessment per month, but no fine shall be less than one hundred dollars per month.

C. 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.

Acts 1997, No. 1154, §1, eff. Jan. 1, 1998; Acts 1999, No. 163, §1; Redesignated from R.S. 22:239.2 by Acts 2008, No. 415, §1, eff. Jan. 1, 2009; Acts 2009, No. 317, §1.

NOTE: Former R.S. 22:1211 redesignated as R.S. 22:1961 by Acts 2008, No. 415, §1, eff. Jan. 1, 2009.

§1212. Miscellaneous provisions

A. Nothing in this Subpart shall be construed to reduce or offset the liability for unpaid fees assessed to an impaired or insolvent insurer operating a plan with liability for fees assessed under this Subpart.

B. For purposes of carrying out its obligations under this Subpart, the plan shall be deemed to be a creditor of an impaired or insolvent participating insurer to the extent of assets attributable to covered policies reduced by any amounts to which the plan is entitled for unpaid fees assessed. As provided for under R.S. 22:2093, payment of contractual obligations of an impaired or insolvent insurer shall include fees assessed under this Subpart.

C. Any unpaid fees assessed to a participating insurer shall become the liability of any continuing or successor insurer.

Acts 1997, No. 1154, §1, eff. Jan. 1, 1998; Acts 1999, No. 163, §1; Redesignated from R.S. 22:239.3 by Acts 2008, No. 415, §1, eff. Jan. 1, 2009.

NOTE: Former R.S. 22:1212 redesignated as R.S. 22:1962 by Acts 2008, No. 415, §1, eff. Jan. 1, 2009.

§1213. Benefits; availability

A. The plan shall offer comprehensive coverage to every eligible person who is not eligible for Medicare and public programs as defined in this Subpart. Comprehensive coverage offered by the plan shall pay an eligible person's covered expenses, subject to limits on the deductible and coinsurance payments authorized under Paragraph (4) of Subsection E of this Section, up to a maximum lifetime benefit as established by the board of not less than five hundred thousand dollars per covered person, payable up to a maximum of two hundred fifty thousand dollars per covered person per twelve consecutive months of coverage. For federally defined eligible persons, the board shall establish benefits and maximum benefit amounts in accordance with applicable federal law and regulations.

B. Covered expenses shall be the usual, customary, and reasonable charge, as established by the board, in the locality for the following services and articles when prescribed by a physician and determined by the plan to be medically necessary for the following areas of services:

(1) Hospital services.

(2) Professional services for the diagnosis or treatment of injuries, illnesses, or conditions which are rendered by a health care provider or by other licensed professionals at the direction of a health care provider.

(3) Services of a licensed skilled nursing facility for up to a maximum of one hundred twenty days per twelve consecutive months of coverage, unless extended for additional days under any cost containment program implemented by the board pursuant to Subsection H of this Section.

(4) Services of a home health agency up to a maximum of two hundred seventy services per twelve consecutive months of coverage, unless increased under any cost containment program implemented by the board pursuant to Subsection H of this Section.

(5) Use of radium or other radioactive materials.

(6) Oxygen.

(7) Anesthetics.

(8) Prostheses other than dental.

(9) Rental of durable medical equipment, other than eyeglasses and hearing aids, for which there is no personal use in the absence of the conditions for which it is prescribed.

(10) Diagnostic X-rays and laboratory tests.

(11) Oral surgery for excision of partially or completely unerupted, impacted teeth or the gums and tissues of the mouth when not performed in connection with the extraction or repair of other teeth.

(12) Services of a physical therapist.

(13) Transportation provided by a licensed ambulance service to the nearest facility qualified to treat the condition.

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

C. The board shall establish reasonable reimbursement amounts for any services covered under the benefits plans which are not included in Subsection B of this Section.

D. Covered expenses shall not include the following, except as mandated by applicable federal law for federally defined eligible individuals:

(1) Any charge for treatment for cosmetic purposes other than surgery for the repair or treatment of an injury or a congenital bodily defect to restore normal bodily functions.

(2) Care which is primarily for custodial purposes.

(3) Any charge for confinement in a private room to the extent surcharge is in excess of the institution's charge for its most common semiprivate room, unless a private room is prescribed as medically necessary by a physician.

(4) That part of any charge for services rendered or articles prescribed by a physician, dentist, or other health care provider which exceeds the reasonable reimbursement amounts established in Subsections B and C of this Section or for any charge not medically necessary.

(5) Any charge for services or articles the provision of which is not within the scope of authorized practice of the institution or individual providing the services or articles.

(6) Any expense incurred prior to the effective date of coverage by the plan for the person on whose behalf the expense is incurred.

(7) Dental care except as provided in Subsection B of this Section.

(8) Eyeglasses and hearing aids.

(9) Illness or injury due to acts of war.

(10) Services of blood donors and any fee for failure to replace the first three pints of blood provided to an eligible person each policy year.

(11) Personal supplies or personal services provided by a hospital or nursing home, or any other nonmedical or nonprescribed supply or service.

E.(1) Premiums charged for coverages issued by the plan may not be unreasonable in relation to the benefits provided, the risk experience, and the reasonable expenses of providing the coverage.

(2) Separate schedules of premium rates based on age, sex, and geographical location may apply for individual risks. Separate schedules of premium rates for federally defined eligible individuals may be based on age, sex, and geographical location, in accordance with applicable federal laws and regulations.

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

(b) Standard risk rates for federally defined eligible individuals shall comply with all applicable federal laws and regulations. Initial rates for plan coverage for federally defined eligible individuals shall not be less than one hundred twenty-five percent of rates established as applicable for individual standard risks. In no event shall plan rates exceed two hundred percent of rates applicable to the individual standard risks.

(c) Initial rates for plan coverage provided to nonfederally defined eligible individuals shall not be less than one hundred fifty percent of rates established as applicable for individual standard risks, or the minimum monthly rates as provided for herein, whichever is greater. Subsequent rates provided to nonfederally defined eligible individuals shall be established to provide fully for the expected costs of claims, including recovery of prior losses, expenses of operation, investment income of claim reserves, and any other cost factors subject to the limitations described herein. In no event shall plan rates exceed two hundred percent of rates applicable to individual standard risks. In no event shall rates be lower than one hundred ten percent of rates applicable to individual standard risks.

(4) The plan coverage defined in this Section shall provide benefits, deductibles, coinsurance, and copayments to be established by the board. In addition, the board may establish optional benefits, deductibles, coinsurance, and copayments.

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

G.(1) Notwithstanding any other law to the contrary, the coverage provided by the plan shall be considered excess coverage, and benefits otherwise payable under plan coverage shall be reduced by all hospital and medical expense benefits paid or payable under any workers' compensation coverage, automobile medical payment, or liability insurance whether provided on the basis of fault or nonfault, and by any hospital or medical benefits paid or payable by any insurer or insurance arrangement or any hospital or medical benefits paid or payable under or provided pursuant to any state or federal law or program.

(2) The plan shall have a cause of action against an eligible person for the recovery of the amount of benefits paid by it which are not covered expenses. Benefits due from the plan may be reduced or refused as a set-off against any amount recoverable under this Paragraph.

H. The benefits plan offered pursuant to this Section shall include such managed care provisions as the board deems necessary and proper for:

(1) Compliance with applicable federal laws and regulations regarding choices of benefit coverage for federally defined eligible individuals.

(2) Containment of costs, including precertification and concurrent or continued stay review of hospital admissions, mandatory outpatient surgical procedures, preadmission testing, or any other provisions determined by the board to be cost effective and consistent with the purposes of this Subpart.

I. Except as otherwise provided in this Subpart and in R.S. 22:976, this Section shall establish the exclusive means for determining the benefits required to be offered by the plan, notwithstanding any mandatory benefits or required policy provisions in this Title to the contrary.

Acts 1990, No. 131, §1, eff. Sept. 1, 1990; Acts 1992, No. 283, §1, eff. June 11, 1992; Acts 1992, No. 955, §1, eff. July 9, 1992; Acts 1997, No. 1154, §1, eff. Jan. 1, 1998; Acts 1999, No. 163, §1; Acts 2004, No. 368, §1, eff. June 23, 2004; Acts 2008, No. 21, §1; Redesignated from R.S. 22:240 by Acts 2008, No. 415, §1, eff. Jan. 1, 2009; Acts 2010, No. 123, §1, eff. June 8, 2010.

NOTE: Former R.S. 22:1213 redesignated as R.S. 22:1963 by Acts 2008, No. 415, §1, eff. Jan. 1, 2009.

§1214. Mandated benefits

Service charges assessed to any patient pursuant to R.S. 22:1209 shall be a mandated benefit of any insurance policy, insurance certificate, insurance arrangement or self-insurance which provides coverage to such patient, except that such charges shall not be payable by any insurer which is insolvent.

Acts 1990, No. 131, §1, eff. Sept. 1, 1990; Redesignated from R.S. 22:241 by Acts 2008, No. 415, §1, eff. Jan. 1, 2009.

NOTE: Former R.S. 22:1214 redesignated as R.S. 22:1964 by Acts 2008, No. 415, §1, eff. Jan. 1, 2009.

§1215. Exemptions; relation to other laws

A. The plan established pursuant to this Subpart shall be exempt from any and all state and local taxes.

B. The plan and any administrator selected by the board to administer the benefits plan shall be exempt from the provisions of R.S. 22:1821.

Acts 1990, No. 131, §1, eff. Sept. 1, 1990; Acts 1999, No. 163, §1; Acts 2008, No. 21, §1; Redesignated from R.S. 22:242 by Acts 2008, No. 415, §1, eff. Jan. 1, 2009.

NOTE: Former R.S. 22:1215 redesignated as R.S. 22:1967 by Acts 2008, No. 415, §1, eff. Jan. 1, 2009.