SLS 19RS-429 **ORIGINAL**

2019 Regular Session

SENATE BILL NO. 173

BY SENATOR MILLS

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

HEALTH CARE. Provides for the Healthcare Coverage for Louisiana Families Protection Act. (gov sig)

AN ACT

To enact R.S. 22:11.1 and Subpart F of Part III of Chapter 4 of Title 22 of the Louisiana Revised Statutes of 1950, to be comprised of R.S. 22:1121 through 1129, relative to health insurance; to provide relative to enrollment, dependent coverage, rate setting, preexisting conditions, annual and lifetime limits, and essential benefits under certain circumstances; to provide for rulemaking; to provide for effectiveness; and to provide for related matters.

Be it enacted by the Legislature of Louisiana:

Section 1. R.S. 22:11.1 and Subpart F of Part III of Chapter 4 of Title 22 of the Louisiana Revised Statutes of 1950, comprised of R.S. 22:1121 through 1129, are hereby enacted to read as follows:

§11.1. Rules and regulations; essential health benefits package

The commissioner shall promulgate rules pursuant to the Administrative Procedure Act to define "essential health benefits", to establish annual limitations on cost sharing and deductibles, and to define required levels of coverage. The commissioner shall adopt initial administrative rules before January 1, 2020. Notwithstanding any provision of R.S. 49:953(B) to the

contrary, the commissioner may adopt initial administrative rules as required by this Section pursuant to the provisions of R.S. 49:953(B) without a finding that an imminent peril to the public health, safety, or welfare exists.

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SUBPART F. HEALTHCARE COVERAGE FOR LOUISIANA FAMILIES PROTECTION ACT

§1121. Short Title

This Subpart shall be known and may be cited as the "Healthcare Coverage for Louisiana Families Protection Act".

§1122. Effectiveness

If a court of competent jurisdiction rules that the Patient Protection and Affordable Care Act, P.L. 111-148, is unconstitutional and the judgment of that court becomes final and definitive, the attorney general shall give written notification of the final and definitive ruling to the commissioner, the legislature, and the Louisiana State Law Institute. The provisions of this Subpart shall become effective ten days after receipt by the commissioner of the written notification.

§1123. Preexisting condition exclusions prohibited

A health insurance policy or contract issued or issued for delivery in this state after the effective date of this Subpart shall not impose a preexisting condition exclusion. This Section shall not limit an insurer's ability to restrict enrollment in an individual contract to open enrollment and special enrollment periods in accordance with other provisions of this Title.

§1124. Annual and lifetime limits prohibited

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

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

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

§1125. Coverage for dependent children

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

§1126. Rate setting

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

§1127. Open enrollment

A health insurance policy or contract issued or issued for delivery in this state after the effective date of this Subpart may restrict enrollment in individual health plans to open enrollment periods and special enrollment periods to the extent not inconsistent with applicable federal law. The commissioner may adopt rules establishing minimum open enrollment dates and minimum criteria for special enrollment periods for all individual health plans offered in this state.

§1128. Comprehensive health coverage

A. Notwithstanding any other provision of law to the contrary, a health

insurance policy or contract issued or issued for delivery in this state thirty days or more after rules promulgated pursuant to Subsection G of this Section become effective shall, at a minimum, provide coverage that incorporates an essential health benefits package consistent with the requirements of this Section.

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

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

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

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

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

(1) Ambulatory patient services.

(2) Emergency services.

(3) Hospitalization.

(4) Maternity and newborn care.

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

(6) Prescription drugs.

(7) Rehabilitative and habilitative services and devices.

(8) Laboratory services.

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

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

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

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

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

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

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

(5) Provide that a qualified health plan shall not be treated as providing coverage for the essential health benefits package described in Subsection B of this Section unless the plan provides the following:

(a) Coverage for emergency department services will be provided without imposing any requirement under the plan for prior authorization of services or any limitation on coverage where the provider of services does not have a contractual relationship with the plan for the providing of services that is more restrictive than the requirements or limitations that apply to emergency department services received from providers who do have such a contractual relationship with the plan.

(b) If emergency department services are provided out of network, the

cost sharing requirement, expressed as a copayment amount or coinsurance rate, is the same as the requirement that would apply if the services were provided in network.

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

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

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

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

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

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

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

E. The commissioner shall establish annual limitations on cost sharing and deductibles that are substantially similar to the limitations for health plans subject to the federal Patient Protection and Affordable Care Act as of January 1, 2019. The commissioner may increase the annual limitation as

needed to reflect any premium adjustment percentage. For purposes of this Subsection, "premium adjustment percentage" means the percentage, if any, by which the average per capita premium for health insurance coverage in the United States for the preceding calendar year, as estimated by the commissioner no later than October first of the preceding calendar year, exceeds the average per capita premium for 2019.

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

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

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

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

§1129. Conflict of laws

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

Section 2. This Act shall become effective upon signature by the governor or, if not signed by the governor, upon expiration of the time for bills to become law without signature

by the governor, as provided by Article III, Section 18 of the Constitution of Louisiana. If vetoed by the governor and subsequently approved by the legislature, this Act shall become effective on the day following such approval.

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

DIGEST

SB 173 Original 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 ten 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 before January 1, 2020. 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 10 days after the attorney general notifies the commissioner that the ACA has been ruled unconstitutional.

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.

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

(Adds R.S. 22:11.1 and 1121-1129)