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)