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DIGEST

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SB No. 153

Proposed law redefines certain terms for purposes of present law relative to assuring portability, availability, and renewability of health insurance coverage, administered in part by the La. Health Plan, as follows:

- (1) Deletes Medicare coverage benefits from the definition of those "excepted benefits" not subject to requirements if offered as a separate insurance policy and adds Medicare supplemental health insurance benefits as defined by the federal Social Security Act.
- (2) Includes under the definition of "creditable coverage" certain medical assistance coverage provided under federal law.
- (3) Changes the definition of "eligible individual" from an individual who elected COBRA continuation or a similar state program to an individual who, if offered the option of continuation of COBRA coverage or a similar state program, elected this coverage.

Proposed law requires the board of directors of the plan to provide the details of the calculation of each participating insurer's assessment in its plan of operation which is submitted to the commissioner of insurance for his approval.

Present law requires the board to establish reasonable reimbursement amounts for health care services and providers determined by the plan to be medically necessary, including but not limited to a list of services specified.

Proposed law provides that covered expenses include the usual, customary, and reasonable charge, as established by the board, in the locality for services specified in present law when prescribed by a physician and determined by the plan to be medically necessary for the areas of services specified.

Present law excludes from covered expenses, unless mandated by federal law for federally defined eligible individuals, any charge for the diagnosis and treatment of mental and nervous disorders, including alcohol and substance abuse. Proposed law removes this specific exclusion.

Proposed law provides that covered expenses includes services for diagnosis and treatment of mental and nervous disorders, but provides that the covered person may be required to pay up to a 50% coinsurance payment and that the plan's payment may not exceed \$25,000. Authorizes the Department of Insurance to 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.

Present law provides that if the amount charged for services provided by or at the direction of a health care provider exceed the amount payable for covered expenses by the plan, the health care provider may seek amounts payable for covered expenses from the member as allowed under applicable contracts or state and federal laws and regulations. Proposed law deletes these provisions.

Present law requires that the plan determine the standard risk rate by calculating the average individual standard rate for the five largest insurers offering coverage in the state comparable to the plan coverage. Proposed law provides that his determination be made with the assistance of the commissioner of insurance.

Present law provides that standard risk rates for federally defined eligibles comply with federal law and regulations. Proposed law retains this provision but provides that initial rates for plan coverage for such individuals not be less than 125% and not more than 200% of standard risk rates applicable to individuals.

Present law provides that initial rates for plan coverage provided to non-federally defined eligible individuals shall not be less than 150% of rates established as applicable for individual standard risks, or the minimum monthly rates as provided for in present law, whichever is greater. Requires that subsequent rates provided to such 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 in present law. Specifies that in no event shall plan rates exceed 200% of rates applicable to individual standard risks or shall rates be lower than 110% of rates applicable to individual standard risks. Proposed law retains these provisions.

Present law allows a six-month pre-existing condition provision to be applied to non-federally qualified individuals. Proposed law retains these provisions but provides that no pre-existing condition be applied to federally defined eligible individuals.

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

(Amends R.S. 22:1061(3)(d)(i), 1073(B)(4), 1210(D), (E), and (F), 1213; Adds R.S. 22:1061(4)(k), 1205(C)(6) and 1213(B)(14))

#### Summary of Amendments Adopted by Senate

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

1. Reinstates provisions regarding the initial rates for non-federally defined eligible individuals.

#### Summary of Amendments Adopted by House

##### Committee Amendments Proposed by House Committee on Insurance to the engrossed bill.

1. Makes a technical change.
2. Removes authority for the board of the Louisiana Health Plan to offer eligible individuals and families the ability to purchase or enroll in a program established under federal law that provides expanded coverage for state high risk pools.