Prior law provided for approval and disapproval of health and accident insurance forms and policies by the commissioner of insurance.

New law retains prior law and increases the time for the use of forms from 45 days to 60 days after filing. Requires written notification to be provided to the health insurance issuer specifying the reasons a policy form or subscriber agreement does not comply with new law. Provides that it shall be unlawful for any health insurance issuer to issue any form not previously submitted to and approved by the department.

Prior law provided rate limitations for health benefit plans for small employers and individuals. Provided for rating factors and sets allowable percentages of annual increases. Required each small group and individual health and accident insurer to make reasonable disclosure of rates to small employers and provides required content of each disclosure. Provided that when a rate increase occurs, the insurer shall provide a reasonable explanation of the increase. Also required each insurer to maintain records of its rating practices and to certify to the commissioner that it is in compliance with the rating requirements. Prohibited health and accident insurers from increasing their premiums except as provided in prior law. Excluded group and individual high deductible health plans from the rate limitations and requirements.

New law makes rate review requirements applicable to health benefit plans which provide coverage in the small group and individual markets. Requires each health benefit plan to file a copy of its rates with all insurance policy forms. Authorizes the commissioner to review rates; specifies that such review shall not constitute a determination under prior law, the APA, and shall not be subject to other administrative or judicial relief. Provides for risk pools. Limits variations on health insurance premiums to variations based on whether the insured is an individual or member of a family group, the age of the insured, geographic region, and whether the insured uses tobacco products. Prohibits insurers from using the health status of the insured in the calculation of rates. Lists and identifies those benefits not subject to the requirements. Additionally, subjects HMOs and any entity that offers health insurance coverage through a policy, certificate, or subscriber agreement to proposed rating law. Requires rate filings with the department, made under certain time lines, and containing required information in prescribed, standardized formats. Requires any such filings containing rate increases beyond a specific threshold to be summarized and for public comment on the department's website.

New law exempts limited benefits plans from new law rating restrictions.

New law requires the rating practices and rating methods, and the rating restrictions imposed by law upon grandfathered health coverage in the individual market and small group market that exist when new law takes effect, including the restrictions on rate increases and required notices for such increases, to remain binding upon such grandfathered health coverage.

Prior law allowed health insurers to create and maintain separate risk pools through closed blocks of business or classes of business. New law prohibits the maintenance of separate risk pools. Requires all health insurance issuers to maintain a single, state-wide risk pool in each of the following markets: small group, individual, and student health plans.

New law provides that the commissioner may issue penalties or cease and desist orders if he determines that any health insurance issuer is not in compliance with the rate review provisions. Provides monetary penalties for violations of cease and desist orders. Authorizes the commissioner to revoke, suspend, or nonrenew a certificate of authority of any health insurance issuer for noncompliance. Permits any aggrieved health insurance issuer the opportunity to seek judicial review of certain decisions by the commissioner.

New law, beginning January 1, 2016, requires all nongrandfathered coverage in the individual market to be offered on a calendar year basis. Provides for purposes of new enrollment effective on any date other than January 1st, the first policy year following such enrollment may comprise a prorated policy year, ending on December 31st. Any exceptions or modifications to the calendar year requirement by federal law or rule shall also apply to health insurance issuers under new law.

New law gives the commissioner authority to grant transitional relief from new law.

Prior law prohibited unfair discrimination in rates or failure to provide life, life annuity, or disability coverage because of severe disability or sickle cell trait.

New law retains prior law and makes technical changes.

Effective upon signature of the governor (June 18, 2014).

(Amends R.S. 22:972 and 1091-1097; add R.S. 22:1098-1099)