

SENATE BILL NO. 554

BY SENATOR GARY SMITH

1 AN ACT

2 To amend and reenact R.S. 22:972, Subpart D of Part III of Chapter 4 of Title 22 of the
3 Louisiana Revised Statutes of 1950, comprised of R.S. 22:1091 through 1099,
4 relative to health insurance rate review; to provide for definitions; to provide for rate
5 filings and rate increases; to provide relative to form approval; to provide relative to
6 rating factors, risk pools, and individual market plan and calendar year requirements;
7 to provide with respect to review of proposed rate filings and rate changes; to
8 provide for implementation and enforcement; to provide for the frequency of rate
9 increase limitations; to provide relative to the prohibition of discrimination in rates
10 due to severe disability; and to provide for related matters.

11 Be it enacted by the Legislature of Louisiana:

12 Section 1. R.S. 22:972 and Subpart D of Part III of Chapter 4 of Title 22 of the
13 Louisiana Revised Statutes of 1950, comprised of R.S. 22:1091 through 1099 are hereby
14 amended and reenacted to read as follows:

15 §972. Approval and disapproval of forms; filing of rates

16 A. No policy or subscriber agreement of a health and accident insurance
17 issuer, hereafter including a health maintenance organization, shall be delivered
18 or issued for delivery in this state, nor shall any endorsement, rider, or application
19 which becomes a part of any such policy, which may include a certificate, be used
20 in connection therewith until a copy of the form and of the ~~premium~~ rates and of the
21 classifications of risks pertaining thereto have been filed with the ~~commissioner of~~
22 ~~insurance; nor shall any such~~ department. No policy, subscriber agreement,
23 endorsement, rider, or application, hereinafter referred to as a policy or
24 subscriber agreement, shall be used until the expiration of ~~forty-five~~ sixty days
25 after the form has been filed unless the ~~commissioner of insurance~~ department gives
26 ~~his~~ its written approval prior thereto. ~~The commissioner of insurance shall notify in~~

1 ~~writing the insurer which has filed any such form if it does not comply with the~~
2 ~~provisions of this Subpart, specifying the reasons for his opinion; and it shall~~
3 ~~thereafter be unlawful for such insurer to issue such form in this state.~~ **Written**
4 **notification shall be provided to the health insurance issuer specifying the**
5 **reasons a policy form or subscriber agreement does not comply with the**
6 **provisions of this Subpart. It shall be unlawful for any health insurance issuer**
7 **to issue any form in this state not previously submitted to and approved by the**
8 **department.** An aggrieved party affected by the ~~commissioner's~~ **department's**
9 decision, act, or order **in reference to a policy form or subscriber agreement** may
10 demand a hearing in accordance with Chapter 12 of this Title, R.S. 22:2191 et seq.

11 B. After **providing** twenty days' notice; ~~to the commissioner of~~ **health**
12 insurance **issuer, the department** may withdraw ~~his~~ **its** approval of any such **policy**
13 form **or subscriber agreement** on any of the grounds stated in ~~this Section~~ **R.S.**
14 **22:862.** It shall be unlawful for the ~~insurer~~ **health insurance issuer** to issue such
15 **policy** form or **subscriber agreement or** use it in connection with any policy **or**
16 **subscriber agreement** after the effective date of such withdrawal of approval. An
17 aggrieved party affected by the ~~commissioner's~~ **department's** decision, act, or order
18 **in reference to a policy form or subscriber agreement** may demand a hearing in
19 accordance with Chapter 12 of this Title, R.S. 22:2191 et seq.

20 C. The ~~commissioner of insurance~~ **department** shall not disapprove or
21 withdraw approval of any such policy **form or subscriber agreement** on the ground
22 that its provisions do not comply with R.S. 22:975 or on the ground that it is not
23 printed in uniform type if it shall be shown that the rights of the insured, ~~or the~~
24 beneficiary, **or the subscriber** under the policy **or subscriber agreement** as a whole
25 are not less favorable than the rights provided by R.S. 22:975 and that the provisions
26 or type size used in the policy **or subscriber agreement** are required in the state,
27 district, or territory of the United States in which the ~~insurer~~ **health insurance issuer**
28 is organized, anything in this Subpart to the contrary notwithstanding.

29 **D. All references to rates in this Section shall be controlled by Subpart**
30 **D of this Part, R.S. 22:1091 through 1099.**

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SUBPART D. RATES RATE REVIEW

§1091. Health insurance plans subject to rate ~~limitations~~ review

A. The provisions of ~~R.S. 22:1091 through 1095~~ this Subpart shall apply to any health benefit plan which provides coverage to a small employer except the following: in the small group market or individual market, including any policy or subscriber agreement covering residents of this state. The provisions of this Section shall apply regardless of where such policy or subscriber agreement was issued or issued for delivery in this state and shall include any employer, association, or trustee of a fund established by an employer, association, or trust for multiple associations who shall be deemed the policyholder, covering one or more employees of such employer, one or more members or employees of members of such association or multiple associations, for the benefit of persons other than the employer, the association, or the multiple associations, as well as their officers or trustees. The provisions of this Subpart shall not apply to the following, unless specifically provided for:

(1) An Archer medical savings account that meets all requirements of Section 220 of the Internal Revenue Code of 1986.

(2) A health savings account that meets all requirements of Section 223 of the Internal Revenue Code of 1986.

(3) Excepted benefit or limited benefits as defined in this Title.

B. ~~Notwithstanding any law to the contrary, the following terms shall be defined as follows~~ As used in this Subpart, the following terms shall have the meanings ascribed to them in this Section:

(1) "Actuarial certification" means a written statement by a member of the American Academy of Actuaries ~~that a small employer carrier is in compliance with the provisions of R.S. 22:1092~~ that a health insurance issuer is in compliance with the provisions of this Subpart, based upon the person's actuary's examination, including a review of the appropriate records and of the actuarial assumptions and methods utilized by the carrier health insurance issuer in

1 establishing ~~premium~~ rates for applicable health benefit plans.

2 ~~(2) "Base premium rate" means, for each class of business as to a rating~~
3 ~~period, the lowest premium rate charged or which could have been charged under a~~
4 ~~rating system for that class of business, by the small employer carrier to small~~
5 ~~employers with similar case characteristics for health benefit plans with the same or~~
6 ~~similar coverage.~~

7 ~~(3) "Carrier" means an insurance company, including a health maintenance~~
8 ~~organization as defined and licensed to engage in the business of insurance under~~
9 ~~Subpart I of Part I of Chapter 2 of this Title, which is licensed or authorized to issue~~
10 ~~individual, group, or family group health insurance coverage for delivery in this~~
11 ~~state.~~

12 ~~(4) "Case characteristics" mean demographic or other relevant characteristics~~
13 ~~of a small employer, as determined by a small employer carrier, which are~~
14 ~~considered by the carrier in the determination of premium rates for the small~~
15 ~~employer. Claim experience, health status and duration of coverage since issue are~~
16 ~~not case characteristics for the purposes of this Section.~~

17 **(2) "Excessive" means the rate charged for the health insurance**
18 **coverage causes the premium or premiums charged for the health insurance**
19 **coverage to be unreasonably high in relation to the benefits provided under the**
20 **particular product. In determining whether the rate is unreasonably high in**
21 **relation to the benefits provided, the department shall consider each of the**
22 **following:**

23 **(a) Whether the rate results in a projected medical loss ratio below the**
24 **federal medical loss ratio standard in the applicable market to which the rate**
25 **applies, after accounting for any adjustments allowable under federal law.**

26 **(b) Whether one or more of the assumptions on which the rate is based**
27 **is not supported by substantial evidence.**

28 **(c) Whether the choice of assumptions or combination of assumptions**
29 **on which the rate is based is unreasonable.**

30 (5) "Class of business" means all or a distinct grouping of small employers

as shown on the records of the small employer carrier.

(a) A distinct grouping may only be established by the small employer carrier on the basis that the applicable health benefit plans:

(i) Are marketed and sold through individuals and organizations which are not participating in the marketing or sale of other distinct groupings of small employers for such small employer carrier;

(ii) Have been acquired from another small employer carrier as a distinct grouping of plans; or

(iii) Are provided through an association with membership of not less than twenty-five small employers which has been formed for purposes other than obtaining insurance.

(b) A small employer carrier may establish no more than two additional groupings under each of the items in Subparagraph (a) of Paragraph (5) of this Subsection on the basis of underwriting criteria which are expected to produce substantial variation in the health care costs.

(c) The commissioner may approve the establishment of additional distinct groupings upon application to the commissioner and a finding by the commissioner that such action would enhance the efficiency and fairness of the small employer insurance marketplace.

(3) "Federal review threshold" means any rate increase that results in a ten percent or greater rate increase, or such other threshold as required by federal law or regulation or any rate that, when combined with all rate increases and decreases during the previous twelve-month period, would result in an aggregate ten percent or greater rate increase. For reporting purposes, the federal threshold shall mean any rate increase above zero percent or such other threshold as required by federal law or regulation.

(4) "Grandfathered health plan coverage" has the same meaning as that in 45 C.F.R. 147.140 or other subsequently adopted federal law, rule, regulation, directive, or guidance.

~~(6)~~**(5)** "Health benefit plan", "plan", **"benefit"**, or "health insurance

1 coverage" means ~~benefits~~ **services** consisting of medical care, provided directly,
2 through insurance or reimbursement, or otherwise, and including items and services
3 paid for as medical care; under any hospital or medical service policy or certificate,
4 hospital or medical service plan contract, preferred provider organization, or health
5 maintenance organization contract offered by a health insurance issuer. ~~However,~~
6 ~~a "health benefit plan" shall not include limited benefit and supplemental health~~
7 ~~insurance; coverage issued as a supplement to liability insurance; workers'~~
8 ~~compensation or similar insurance; or automobile medical-payment insurance.~~
9 **However, excepted benefits as defined in R.S. 22:1061(3)(a) are not included as**
10 **a "health benefit plan".**

11 **(6) "Health insurance issuer" means any entity that offers health**
12 **insurance coverage through a policy, certificate of insurance, or subscriber**
13 **agreement subject to state law that regulates the business of insurance. A**
14 **"health insurance issuer" shall include a health maintenance organization, as**
15 **defined and licensed pursuant to Subpart I of Part I of Chapter 2 of this Title.**

16 (7) "Health savings accounts" are **means** those accounts for medical
17 expenses authorized by 26 USC **U.S.C.** 220 et seq.

18 (8) ~~"High deductible health plan" means a high deductible health plan or~~
19 ~~policy that is qualified to be used in conjunction with a health savings account,~~
20 ~~medical savings account, or other similar program authorized by 26 USC 220 et seq.~~

21 (9) ~~"Index rate" means for each class of business for small employers with~~
22 ~~similar case characteristics the arithmetic average of the applicable base premium~~
23 ~~rate and the corresponding highest premium rate.~~

24 (10) ~~"Medical savings account policy" means a high deductible health plan~~
25 ~~which is qualified to be used in conjunction with a medical savings account as~~
26 ~~provided in 26 USC 220 et seq.~~

27 (11) ~~"New business premium rate" means, for each class of business as to~~
28 ~~a rating period, the premium rate charged or offered by the small employer carrier~~
29 ~~to small employers with similar case characteristics for newly issued health benefits~~
30 ~~plans with the same or similar coverage.~~

1 ~~(12) "Rating period" means the calendar period for which premium rates~~
2 ~~established by a small employer carrier are assumed to be in effect, as determined~~
3 ~~by the small employer carrier.~~

4 "Inadequate" means rates for a particular product are clearly
5 insufficient to sustain projected losses and expenses, or the use of such rates.

6 ~~(13)(9)~~ "Index rate" means the average rate resulting from the
7 estimated combined claims experience for all Essential Health Benefits,
8 pursuant to 42 U.S.C. 18022, Section 1302(b) of the Patient Protection and
9 Affordable Care Act, of all nontransitional and nongrandfathered health plan
10 coverage within a health insurance issuer's single, statewide risk pool in the
11 individual market and within a health insurance issuer's single, statewide risk
12 pool in the small group market, with a separate index rate being calculated for
13 each market. Health insurance issuers may make any market-wide and plan-
14 or product-specific adjustments to an index rate as permitted or as required by
15 federal law, rules, or regulations.

16 (10) "Individual health insurance coverage" or "individual policy"
17 means health insurance coverage offered to individuals in the individual market
18 or through an association.

19 (11) "Individual market" means the market for health insurance
20 coverage offered to individuals other than in connection with a group health
21 plan.

22 (12) "Insured" includes any policyholder, including a dependent,
23 enrollee, subscriber, or member, who is covered through any policy or
24 subscriber agreement offered by a health insurance issuer.

25 (13) "Large group" or "large employer" means, in connection with a
26 group health plan with respect to a calendar year and a plan year, an employer
27 who employed an average of at least fifty-one employees on business days
28 during the preceding calendar year and who employs at least two employees on
29 the first day of the plan year, and beginning on January 1, 2016, an employer
30 who employed an average of at least one hundred one employees on business

1 days during the preceding calendar year and who employs at least two
2 employees on the first day of the plan year.

3 (14) "Large group market" means the health insurance market under
4 which individuals obtain health insurance coverage directly or through any
5 arrangement on behalf of themselves and their dependents through a group
6 health plan maintained by a large employer.

7 (15) "Medical loss ratio" means the ratio of expected incurred benefits
8 to expected earned premium over the time period of coverage, subject to the
9 requirements of federal law, regulation, or rule.

10 (16) "New rate filing" means a rate filing for any particular product
11 which has not been issued or delivered in this state.

12 (17) "Particular product" means a basic insurance policy form,
13 certificate, or subscriber agreement delineating the terms, provisions, and
14 conditions of a specific type of coverage or benefit under a particular type of
15 contract with a discrete set of rating and pricing methodologies that a health
16 insurance issuer offers in the state.

17 (18) "Rate" means the rate initially filed or filed as a result of
18 determination of rates by a health insurance issuer for a particular product.

19 (19) "Rate change" means the rates for any health insurance issuer for
20 a particular product differ from the rates on file with the department, including
21 but not limited to any change in any current rating factor, periodic
22 recalculation of experience, change in rate calculation methodology, change in
23 benefits, or change in the trend or other rating assumptions.

24 (20) "Rate increase" means any increase of the rates for a particular
25 product. When referring to federal review thresholds, "rate increase" includes
26 a premium volume-weighted average increase for all insureds for the aggregate
27 rate changes during the twelve-month period preceding the proposed rate
28 increase effective date.

29 (21) "Rating period" means the calendar period for which rates
30 established by a health insurance issuer are in effect.

1 (22) "Small **group**" or "**small** employer" means any person, firm,
2 corporation, partnership, **trust**, or association actively engaged in business which,
3 on at least fifty percent of its working days during the preceding year, employed no
4 less than three nor more than thirty-five eligible employees, the majority of whom
5 were employed within this state, and is not formed primarily for purposes of buying
6 health insurance, and in which a bona fide employer-employee relationship exists.
7 In determining the number of eligible employees, companies which are affiliated
8 companies or which are eligible to file a combined tax return for purposes of state
9 taxation shall be considered one employer. An employer group of one shall be
10 considered individual insurance under this Section. **has employed an average of**
11 **at least one but not more than fifty employees on business days during the**
12 **preceding calendar year and who employs at least one employee on the first day**
13 **of the plan year, and beginning on January 1, 2016, an employer who employed**
14 **an average of at least one but not more than one hundred employees on business**
15 **days during the preceding calendar year and who employs at least one employee**
16 **on the first day of the plan year. "Small group" or "small employer" shall**
17 **include coverage sold to small groups or small employers through associations**
18 **or through a blanket policy. For purposes of rate calculation by a health**
19 **insurance issuer, a small employer group consisting of one employee shall be**
20 **rated within a health insurance issuer's individual market risk pool, unless that**
21 **health insurance issuer provides only employer coverage and thus has only a**
22 **small group market risk pool.**

23 (23) "**Unfairly discriminatory**" means rates that result in premium
24 **differences between insureds within similar risk categories that do not**
25 **reasonably correspond to differences in expected costs. When applied to rates**
26 **charged, "unfairly discriminatory" shall refer to any rate charged by small**
27 **group or individual health insurance issuers in violation of R.S. 22:1095.**

28 (24) "**Unjustified**" means a rate for which a health insurance issuer has
29 **provided data or documentation to the department in connection with rates for**
30 **a particular product that is incomplete, inadequate, or otherwise does not**

1 provide a basis upon which the reasonableness of the rate may be determined
2 or is otherwise inadequate insofar as the rate charged is clearly insufficient to
3 sustain projected losses and expenses.

4 (25) "Unreasonable" means any rate that contains a provision or
5 provisions that are any of the following:

6 (a) Excessive.

7 (b) Unfairly discriminatory.

8 (c) Unjustified.

9 (d) Otherwise not in compliance with the provisions of this Title, or with
10 other provisions of law.

11 ~~(14) "Small employer carrier" means any carrier which offers health benefit~~
12 ~~plans covering the employees of a small employer.~~

13 ~~C. Group and individual high deductible health plans are excluded from the~~
14 ~~provisions of R.S. 22:1091 through 1095.~~

15 §1092. Restrictions relating to premium rates; health **Health** insurance **issuers;**
16 **rate filings and rate increases**

17 ~~A. Premium rates for group health benefit plans subject to R.S. 22:1091~~
18 ~~through 1094 shall be subject to the following provisions:~~

19 ~~(1) The index rate for a rating period for any class of business shall not~~
20 ~~exceed the index rate for any other class of business by more than twenty percent.~~

21 ~~(2) For a class of business, the premium rates charged during a rating period~~
22 ~~to any employer with similar case characteristics for the same or similar coverage,~~
23 ~~or the rates which could be charged to such employer under the rating system for that~~
24 ~~class of business, whether new coverage or renewal coverage, shall not vary from the~~
25 ~~index rate by more than thirty-three percent of the index rate.~~

26 ~~(3) The percentage increase in the premium rate charged to a small employer~~
27 ~~for a new rating period may not exceed the sum of the following:~~

28 ~~(a) The percentage change in the new business premium rate measured from~~
29 ~~the first day of the prior rating period to the first day of the new rating period. In the~~
30 ~~case of a class of business for which the small employer carrier is not issuing new~~

1 policies, the carrier shall use the percentage change in the base premium rate.

2 (b) ~~An adjustment, not to exceed twenty percent annually and adjusted pro~~
3 ~~rata for rating periods of less than one year, due to one or a combination of the~~
4 ~~following: claim experience, health status, or duration of coverage of the employees~~
5 ~~or dependents of the small employer as determined from the carrier's rate manual for~~
6 ~~the class of business.~~

7 (c) ~~Any adjustment due to change in coverage or change in the case~~
8 ~~characteristics of the small employer as determined from the carrier's rate manual for~~
9 ~~the class of business.~~

10 B. ~~Nothing in this Section is intended to affect the use by a small employer~~
11 ~~carrier of legitimate rating factors other than claim experience, health status, or~~
12 ~~duration of coverage in the determination of premium rates. Small employer carriers~~
13 ~~shall apply rating factors, including case characteristics, consistently with respect to~~
14 ~~all small employers in a class of business.~~

15 C. ~~A small employer carrier shall not involuntarily transfer a small employer~~
16 ~~into or out of a class of business. A small employer carrier shall not offer to transfer~~
17 ~~a small employer into or out of a class of business unless such offer is made to~~
18 ~~transfer all small employers in the class of business without regard to case~~
19 ~~characteristics, claim experience, health status or duration since issue.~~

20 **A. Every health insurance issuer shall file with the department every**
21 **proposed rate to be used in connection with all of its particular products. Every**
22 **such filing shall clearly state the date of the filing, the proposed rate, and the**
23 **effective date of the proposed rate. All rate filings required by this Subpart**
24 **shall be made in accordance with the following:**

25 **(1) Rate filings shall be made within the time prescribed by the**
26 **department.**

27 **(2) All health insurance issuers assuming, merging, or acquiring blocks**
28 **of business shall be considered as proposing new rates.**

29 **(3) The commissioner may set the date upon which index rates in a**
30 **market are not subject to revision by an issuer.**

1 B. All proposed rate filings shall be filed in the manner and form
2 prescribed by the department.

3 C. When a rate filing made pursuant to this Subpart is not accompanied
4 by the information upon which the health insurance issuer supports the rate
5 filing, with the result that the department does not have sufficient information
6 to determine whether the rate filing meets the requirements of this Subpart, the
7 department may require the health insurance issuer to refile the information
8 upon which it supports its filing. The time period provided in this Section shall
9 begin anew and commence as of the date the proper information is furnished to
10 the department.

11 D. All proposed rate filings may be reviewed for compliance with
12 R.S.22:1095 and with other provisions of law governing rates in the individual
13 market and the small group market. A review of rates made pursuant to this
14 Subpart shall not constitute a determination under the Louisiana
15 Administrative Procedure Act, R.S. 49:950 et seq., nor shall such a review of
16 rates be subject to other administrative or judicial relief.

17 E. Each rate filing shall be reviewed by the department to determine
18 whether such filing is reasonable and compliant with this Subpart.

19 F. The department shall consider the following criteria to determine
20 whether a rate is unreasonable:

21 (1) Whether the rate is excessive.

22 (2) Whether the rate is unfairly discriminatory.

23 (3) Whether the rate is unjustified.

24 (4) Whether the rate does not otherwise comply with the provisions of
25 this Title or with other provisions of law.

26 G. The review of any proposed rate may take into consideration the
27 following nonexhaustive list of factors and any other factors established by
28 federal rule or regulation to the extent applicable, to determine whether the
29 filing under review is unreasonable:

30 (1) The impact of medical trend changes by major service categories.

1 (2) The impact of utilization changes by major service categories.

2 (3) The impact of cost-sharing changes by major service categories.

3 (4) The impact of benefit changes.

4 (5) The impact of changes in an insured's risk profile.

5 (6) The impact of any overestimate or underestimate of medical trend
6 for prior year periods related to the rate increase, if applicable.

7 (7) The impact of changes in reserve needs.

8 (8) The impact of changes in administrative costs related to programs
9 that improve health care quality.

10 (9) The impact of changes in other administrative costs.

11 (10) The impact of changes in applicable taxes or licensing or regulatory
12 fees.

13 (11) Medical loss ratio.

14 (12) The financial performance of the health insurance issuer, including
15 capital and surplus levels.

16 H. Within fifteen days of submission of any proposed rate increase that
17 meets or exceeds the federal review threshold, the department shall publish on
18 its website any documents or forms as required by federal law, rule, or
19 regulation to maintain an effective rate review program. After publication, the
20 public shall have thirty days to submit comments.

21 I. For any rate increase that meets or exceeds the federal review
22 threshold, the department shall post a notice of final determination on its
23 website and undertake any other actions necessary pursuant to Section 2794 of
24 the Public Health Service Act.

25 §1092.1. Grandfathered health coverage; rating practices

26 The rating practices and rating methods and the rating restrictions
27 imposed by law upon grandfathered health coverage in the individual market
28 and small group market that are in effect on the day that this Section takes
29 effect, including the restrictions on rate increases and required notices for such
30 increases, shall remain binding upon such grandfathered health coverage. Such

1 grandfathered coverage is exempt from the provisions of this Subpart, unless
2 specifically provided for otherwise.

3 §1093. Disclosure of rating practices and renewability provisions for insureds

4 A. Each ~~carrier~~ health insurance issuer shall make reasonable disclosure
5 in solicitation and sales materials provided to ~~small employers~~ insureds of the
6 following:

7 ~~(1) The extent to which premium rates for a specific small employer are~~
8 ~~established or adjusted due to the claim experience, health status or duration of~~
9 ~~coverage of the employees or dependents of the small employer.~~

10 ~~(2) The provisions concerning the carrier's right to change premium rates and~~
11 ~~the factors, including case characteristics, which affect changes in premium rates.~~

12 ~~(3) A description of the class of business in which the small employer is or~~
13 ~~will be included, including the applicable grouping of plans.~~

14 ~~(4) The provisions relating to renewability of coverage.~~

15 B. Each ~~carrier~~ health insurance issuer shall provide its insureds with a
16 written notice and reasonable explanation and justification, including the
17 contributing factors for the rate increase, of for any rate increase no less than
18 forty-five days prior to the effective date of such increase. ~~Such explanation shall~~
19 ~~indicate the contributing factors resulting in an increased premium, which may~~
20 ~~include but not be limited to experience, medical cost, and demographic factors.~~

21 §1094. Maintenance of records for the department

22 A. Each ~~small employer carrier~~ health insurance issuer shall maintain at
23 its principal place of business a complete and detailed description of its rating
24 practices ~~and renewal underwriting description of its rating practices and renewal~~
25 ~~underwriting practices~~, including information and documentation which demonstrate
26 that its rating methods and practices are based upon commonly accepted actuarial
27 assumptions and are in accordance with sound actuarial principles and the rules and
28 regulations of the department.

29 B. Each ~~small employer carrier~~ health insurance issuer shall file each
30 March first once per calendar year with the ~~commissioner~~ department an actuarial

1 certification that the ~~carrier~~ **health insurance issuer** is in compliance with this
2 Section **Subpart** and that the rating methods of the ~~carrier~~ **health insurance issuer**
3 are actuarially sound. A copy of such certification shall be retained by the ~~carrier~~
4 **health insurance issuer** at its principal place of business.

5 C. A ~~small employer carrier~~ **health insurance issuer** shall make the
6 information and documentation described in Subsection A of this Section available
7 to the ~~commissioner upon request~~. The information shall be considered proprietary
8 and trade secret information and shall not be subject to disclosure by the
9 commissioner to persons outside of the department except as agreed to by the carrier
10 or as ordered by a court of competent jurisdiction **department for inspection**.

11 §1095. ~~Modified community rating; health insurance premiums; compliance with~~
12 ~~rules and regulations~~ **Rating factors; risk pools; individual market**
13 **plan and calendar year requirement**

14 A. ~~Each small group and individual health and accident insurer shall~~
15 ~~maintain at its principal place of business a complete and detailed description of its~~
16 ~~rating practices and a renewal underwriting description of its rating practices and~~
17 ~~renewal underwriting practices, including information and documentation which~~
18 ~~demonstrate that its rating methods and practices are in full and complete compliance~~
19 ~~with the rules and regulations promulgated by the Department of Insurance for a~~
20 ~~modified community rating system for health insurance premiums.~~

21 B.(1) ~~The Department of Insurance shall promulgate regulations no later than~~
22 ~~January 1, 1994, that provide criteria for the community rating of premiums for any~~
23 ~~hospital, health, or medical expense insurance policy, hospital or medical service~~
24 ~~contract, health and accident policy or plan, or any other insurance contract of this~~
25 ~~type, that is small group or individually written.~~

26 (2)(a) ~~The regulations shall place limitations upon the following~~
27 ~~classification factors used by any insurer or group in the rating of individuals and~~
28 ~~their dependents for premiums:~~

29 (i) ~~Medical underwriting and screening.~~

30 (ii) ~~Experience and health history rating.~~

1 ~~(iii) Tier rating.~~

2 ~~(iv) Durational rating.~~

3 ~~(b) The premiums charged shall not deviate according to the classification~~
4 ~~factors in Subparagraph (a) of this Paragraph by more than plus or minus thirty-three~~
5 ~~percent for individual health insurance policies or subscriber agreements. In no event~~
6 ~~shall the increase in premiums for a small employer group policy vary from the~~
7 ~~index rate by plus or minus thirty-three percent.~~

8 ~~(3) The following classification factors may be used by any small group or~~
9 ~~individual insurance carrier in the rating of individuals and their dependents for~~
10 ~~premiums:~~

11 ~~(a) Age.~~

12 ~~(b) Gender.~~

13 ~~(c) Industry.~~

14 ~~(d) Geographic area.~~

15 ~~(e) Family composition.~~

16 ~~(f) Group size.~~

17 ~~(g) Tobacco usage.~~

18 ~~(h) Plan of benefits.~~

19 ~~(i) Other factors approved by the Department of Insurance.~~

20 ~~C. Any small group and individual insurance carrier that varies rates by~~
21 ~~health status, claims experience, duration, or any other factor in conflict with the~~
22 ~~regulations promulgated by the Department of Insurance shall establish a phase-out~~
23 ~~rate adjustment as of the first renewal date on or after January 1, 2002, for each~~
24 ~~entity insured by the carrier in order to come into compliance with this Section~~
25 ~~pursuant to the regulations promulgated by the Department of Insurance.~~

26 ~~D. The provisions of this Section shall not apply to limited benefit health~~
27 ~~insurance policies or contracts.~~

28 **A. Health insurance issuers may vary premiums from the plan-adjusted**
29 **index rate in the individual or small group market due only to one or more of**
30 **the following factors:**

1 (1) The number of persons such product or coverage covers, whether an
2 individual or family.

3 (2) Geographic rating area, as established in accordance with this
4 Section.

5 (3) Age, except that such variation shall be no more than three-to-one
6 for adults.

7 (4) Tobacco use as defined in 45 C.F.R. 147.102 or any subsequent
8 federal law, except that such rate shall not vary by more than one- and one-half-
9 to-one.

10 B. Every health insurance issuer in this state shall maintain a single,
11 separate, and distinct risk pool for the individual market and a single, separate,
12 and distinct risk pool for the small group market. Health insurance issuers of
13 student health plans shall maintain a single, separate, and distinct risk pool for
14 student health plans.

15 C. To the extent that they are applied to coverage issued to members
16 within a family under a small group plan, the ratings variations permitted
17 under Paragraphs (A)(3) and (4) of this Section shall be attributed to each
18 member to whom those factors apply and the factors may be applied only as
19 permitted by federal law.

20 D. Consistent with the single risk pool requirement, as of January 1,
21 2015, all nongrandfathered coverage in the individual market shall be offered
22 on a calendar year basis. For purposes of new enrollment effective on any date
23 other than January first, the first policy year following such enrollment may
24 comprise a prorated policy year, ending on December thirty-first. Any
25 exceptions or modifications to the calendar year requirement by federal law or
26 rule shall also apply to health insurance issuers under this Section.

27 E. The department shall determine the geographic rating area or areas
28 in this state by rule, regulation, bulletin, or any other mechanism made
29 available by law.

30 F. Any rate proposed to be used by a health insurance issuer shall be

1 submitted and controlled by this Subpart. However, the commissioner shall
2 have the authority to grant transitional relief from the provisions of this
3 Subpart.

4 §1096. ~~Health and accident insurers; rate increases~~ Regulations; preemption

5 ~~Health and accident insurers shall not increase their premium rates during the~~
6 ~~initial twelve months of coverage and not more than once in any six-month period~~
7 ~~following the initial twelve-month period, for any policy, rider, or amendment issued~~
8 ~~in or for residents of the state, no matter the date of commencement or renewal of the~~
9 ~~insurance coverage except that no health insurance issuer or health maintenance~~
10 ~~organization issuing group or individual policies or subscriber agreements shall~~
11 ~~increase its premium rates or reduce the covered benefits under the policy or~~
12 ~~subscriber agreement after the commencement of the minimum one-hundred-eighty-~~
13 ~~day period described in R.S. 22:1068(C)(2)(a)(i) or 1074(C)(2)(a)(i). This Section~~
14 ~~does not affect increases in the premium amount due to the addition of a newly~~
15 ~~covered person or a change in age or geographic location of an individual insured or~~
16 ~~policyholder or an increase in the policy benefit level.~~

17 A. The commissioner may promulgate such rules and regulations as may
18 be necessary and proper to carry out the provisions of this Subpart and Section
19 2794 of the Public Health Service Act. Such rules and regulations shall be
20 promulgated and adopted in accordance with the Administrative Procedure
21 Act.

22 B. If at any time a provision of this Subpart is in conflict with federal
23 law or with regulations promulgated pursuant to federal law, such provision
24 shall be preempted only to the extent necessary to avoid direct conflict with
25 federal law or regulations. The commissioner shall subsequently administer
26 and enforce the provisions of this Subpart in a manner that conforms to federal
27 law or regulations. If necessary to preserve the department's regulatory
28 authority or if necessary to effectively enforce the provisions of this Subpart, the
29 commissioner may promulgate rules or regulations to that effect and may issue
30 directives or bulletins on a provisional basis before such rules or regulations

take effect. Such provisional basis for the issuance of directives or bulletins under this Section shall not exceed a period of one year.

§1097. Discrimination in rates or failure to provide coverage because of severe disability or sickle cell trait prohibited

A. No insurance company shall charge unfair discriminatory premiums, policy fees, or rates for, or refuse to provide any policy or contract of life insurance, life annuity, or policy containing disability coverage for a person solely because the applicant therefor has a severe disability, unless the rate differential is based on sound actuarial principles or is related to actual experience. No insurance company shall unfairly discriminate in the payments of dividends, other benefits payable under a policy, or in any of the terms and conditions of such policy or contract solely because the owner of the policy or contract has a severe disability.

B. As used in this Section, "Severe ~~severe~~ disability", ~~as used in this Section~~, means any disease of, or injury to, the spinal cord resulting in permanent and total disability, amputation of any extremity that requires prosthesis, permanent visual acuity of twenty/two hundred or worse in the better eye with the best correction, ~~or~~ a peripheral field so contracted that the widest diameter of such field subtends an angular distance no greater than twenty degrees, total deafness, inability to hear a normal conversation or use a telephone without the aid of an assistive device, ~~or persons who have any developmental disabilities~~ disability, including but not limited to autism, cerebral palsy, epilepsy, mental retardation, and other neurological impairments.

~~C. Nothing in this Section shall be construed as requiring an insurance company to provide insurance coverage against a severe disability which the applicant or policyholder has already sustained.~~

D. No insurance company shall charge unfair discriminatory premiums, policy fees, or rates for, or refuse to provide any policy, **subscriber agreement**, or contract of life insurance, life annuity, or policy containing disability coverage for a person solely because the applicant therefor has sickle cell trait. No insurance company shall unfairly discriminate in the payments of dividends, other benefits

1 payable under a policy, or in any of the terms and conditions of such policy or
2 contract solely because the insured of the policy ~~of~~ **or** contract has sickle cell trait.
3 Nothing in this Subsection shall prohibit waiting periods, pre-existing conditions, or
4 dreaded disease rider exclusions, or any combination thereof, if they do not unfairly
5 discriminate **as may be permitted by federal law.**

6 **§1098. Frequency of rate increase; limitations**

7 **A. The following rate increase limitations shall apply to all health**
8 **benefit plans, limited benefits, and excepted benefits:**

9 **(1) Health insurance issuers of limited benefits and excepted benefits**
10 **policies shall not increase rates during the initial twelve months of coverage,**
11 **and may not do so more than once in any six-month period following the initial**
12 **twelve-month period.**

13 **(2) Health insurance issuers shall not increase rates for policies or plans**
14 **in the individual market during the plan year. Rate increases for policies or**
15 **plans in the individual market may occur only upon renewal or upon**
16 **commencement of the policy or plan year.**

17 **(3) Rates for policies or plans in the small group market shall not**
18 **increase during the initial twelve months of coverage.**

19 **B. No health insurance issuer issuing policies or subscriber agreements**
20 **shall increase its rates or reduce the covered benefits under the policy or**
21 **subscriber agreement after the commencement of the minimum one-hundred-**
22 **eighty-day period following the notice of the discontinuation of offering all**
23 **health insurance coverage as described in R.S. 22:1068(C)(2)(a)(i) or**
24 **1074(C)(2)(a)(i).**

25 **C. This Section shall not affect increases in the premium amount due to**
26 **any change required for compliance with the addition of a newly covered person**
27 **or policy benefit level, or such changes necessary to comply with R.S. 22:1095**
28 **or other state or federal law, regulation, or rule.**

29 **§1099. Enforcement**

30 **A. Whenever the commissioner has reason to believe that any health**

1 insurance issuer is not in compliance with any of the provisions of this Subpart,
2 he shall notify such health insurance issuer. Upon such notice, the
3 commissioner may, in addition to the penalties in Subsection C of this Section,
4 issue and cause to be served upon such health insurance issuer an order
5 requiring the health insurance issuer to cease and desist from any violation.

6 B. Any health insurance issuer who violates a cease and desist order
7 issued by the commissioner pursuant to this Subpart while such order is in
8 effect shall be subject to one or more of the following at the commissioner's
9 discretion:

10 (1) A monetary penalty of not more than twenty-five thousand dollars
11 for each act or violation and every day the health insurance issuer is not in
12 compliance with the cease and desist order, not to exceed an aggregate of two
13 hundred fifty thousand dollars for any six-month period.

14 (2) Suspension or revocation of the health insurance issuer's certificate
15 of authority to operate in this state.

16 (3) Injunctive relief from the district court of the district in which the
17 violation may have occurred or in the Nineteenth Judicial District Court.

18 C. As a penalty for violating this Subpart, the commissioner may refuse
19 to renew, or may suspend or revoke the certificate of authority of any health
20 insurance issuer, or in lieu of suspension or revocation of a certificate of
21 authority, the commissioner may levy a monetary penalty of not more than one
22 thousand dollars for each act or violation, not to exceed an aggregate of two
23 hundred fifty thousand dollars.

24 D. An aggrieved party affected by the commissioner's decision, act, or
25 order may demand a hearing in accordance with Chapter 12 of this Title, R.S.
26 22:2191 et seq., except as otherwise provided by this Subpart. If a health
27 insurance issuer has demanded a timely hearing, the penalty, fine, or order by
28 the commissioner shall not be imposed until such time as the division of
29 administrative law makes a finding that the penalty, fine, or order is warranted
30 in a hearing held in the manner provided in Chapter 12 of this Title.

1 Section 2. The provisions of this Act shall become effective upon signature by the
2 governor or, if not signed by the governor, upon expiration of the time for bills to become
3 law without signature by the governor, as provided by Article III, Section 18 of the
4 Constitution of Louisiana. If vetoed by the governor and subsequently approved by the
5 legislature, this Act shall become effective on the day following such approval.

PRESIDENT OF THE SENATE

SPEAKER OF THE HOUSE OF REPRESENTATIVES

GOVERNOR OF THE STATE OF LOUISIANA

APPROVED: _____