ENROLLED

Regular Session, 2010

HOUSE BILL NO. 464

BY REPRESENTATIVE KLECKLEY

AN ACT

To amend and reenact R.S. 22:272(E)(2), 971, 972(A), 973, 974, 975(A)(introductory paragraph) and (1) through (8) and (10) through (13), (B)(introductory paragraph) and (1) through (7), 976(B), 977(B), 978(A)(2) and (B), 980(B), 983, 984(A) and (B), 985, 986(A)(1) and (3)(introductory paragraph) and (B), 987, 988(I)(1)(introductory paragraph), 989, 990(B)(introductory paragraph) and (1), 992, 993, 995(C), 999(E)(2), 1000(A)(introductory paragraph), (2)(a), and (3)(c), (B), and (D), 1002, 1003(A)(1), 1004(A), 1006(C) and (E)(5), 1009(A)(7), 1015, 1023(A)(9)(b)(introductory paragraph) and (i), (B)(4)(a)(introductory paragraph) and (i), and (F)(2)(introductory paragraph) and (a), 1024(A) and (D), 1025(B), 1026(A)(4) and (B), 1027(B), 1028(A)(4), (F), and (G), 1029(D), 1030(D), 1031(B), (C), and (D), 1032(C), 1034(B)(3) and (D)(1), 1035(D), 1037(A), (B), and (C)(3)(introductory paragraph), 1038(C)(1), (E), and (F), 1040(B) and (E), 1043(A)(3)(b), 1044(A)(4), 1046(F), 1049(I), 1050(H)(3), 1061(1)(a), (3), (4)(j), and (5)(e)(i), (f), and (u)(introductory paragraph) and (ii)(bb), 1062(A)(1) and (D)(3), 1066(A)(2)(c) and (B)(introductory paragraph), 1072(D)(introductory paragraph), 1077(B) and (C)(introductory paragraph) and (1), 1095(D), and 1821(F)(3), all relative to technical recodification of certain provisions of the Insurance Code relative to health and accident insurance, including correction of citations, updates of terms and language, reorganization of provisions, elimination of obsolete or ineffective provisions, harmonizing of inconsistent provisions, and standardizing of

language exempting limited benefit policies or contracts from health insurance mandates; and to provide for related matters.

Be it enacted by the Legislature of Louisiana:

Section 1. R.S. 22:272(E)(2), 971, 972(A), 973, 974, 975(A)(introductory paragraph) and (1) through (8) and (10) through (13), (B)(introductory paragraph) and (1) through (7), 976(B), 977(B), 978(A)(2) and (B), 980(B), 983, 984(A) and (B), 985, 986(A)(1) and (3)(introductory paragraph) and (B), 987, 988(I)(1)(introductory paragraph), 989, 990(B)(introductory paragraph) and (1), 992, 993, 995(C), 999(E)(2), 1000(A)(introductory paragraph), 2(a), and (3)(c), (B), and (D), 1002, 1003(A)(1), 1004(A), 1006(C) and (E)(5), 1009(A)(7), 1015, 1023(A)(9)(b)(introductory paragraph) and (i), (B)(4)(a)(introductory paragraph) and (i), and (F)(2)(introductory paragraph) and (a), 1024(A) and (D), 1025(B), 1026(A)(4) and (B), 1027(B), 1028(A)(4), (F), and (G), 1029(D), 1030(D), 1031(B), (C), and (D), 1032(C), 1034(B)(3) and (D)(1), 1035(D), 1037(A), (B), and (C)(3)(introductory paragraph), 1038(C)(1), (E), and (F), 1040(B) and (E), 1043(A)(3)(b), 1044(A)(4), 1046(F), 1049(I), 1050(H)(3), 1061(1)(a), (3), (4)(j), and (5)(e)(i), (f), and (u)(introductory paragraph) and (ii)(bb), 1062(A)(1) and (D)(3), 1066(A)(2)(c) and (B)(introductory paragraph), 1072(D)(introductory paragraph), 1077(B) and (C)(introductory paragraph) and (1), 1095(D), and 1821(F)(3) are hereby amended and reenacted to read as follows:

§272. Notice required for certain prepaid charge rate increases, cancellation or nonrenewal of service agreements; other requirements

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E.

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(2) The provisions of this Subsection shall not apply to ~~individually underwritten~~ limited benefit ~~and supplemental~~ health insurance policies~~.~~ or contracts.

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§971. Patient's Bill of Rights

It is hereby declared by the Legislature of Louisiana that access to health care for the citizens of this state is a ~~necessary~~ priority ~~and necessary~~ to promote well-being and strong state protections. The state has an obligation to ensure that every

person enrolled in a health plan enjoys basic rights as a patient. Comprehensive care should guarantee patients greater access to information and ~~necessary~~ care including access to needed specialists and emergency rooms, guarantee a fair appeals process when health plans deny care, expand choice, protect the doctor-patient relationship, and hold managed care organizations accountable for decisions that ~~end up harming~~ harm patients. Because many states have passed patient protection laws that are appropriate to their ~~state, there shall be a mechanism by which the state shall review such laws and determine the practicality of implementing such measures in the Louisiana Legislature. The~~ states, the Department of Insurance shall establish and maintain an information collection program to track and evaluate state and federal legislation to provide for a uniform patient bill of rights. The department shall compile the data on an annual basis and submit a written report to the Senate Committee on Insurance and the House Committee on Insurance of ongoing efforts to adopt or enact a uniform patient's bill of rights.

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

A. No policy of health and accident insurance shall be delivered or issued for delivery in this state, nor shall any endorsement, rider, or application which becomes a part of any such policy be used in connection therewith until a copy of the form and of the premium rates and of the classifications of risks pertaining thereto have been filed with the commissioner of insurance; nor shall any such policy, endorsement, rider, or application be ~~so~~ used until the expiration of thirty days after the form has been filed unless the commissioner of insurance ~~shall sooner give~~ gives his written approval prior thereto. The commissioner of insurance shall notify in writing the insurer which has filed any such form if it does not comply with the provisions of this Subpart, specifying the reasons for his opinion; and it shall thereafter be unlawful for such insurer to issue such form in this state. An aggrieved party affected by the commissioner's decision, act, or order may demand a hearing in accordance with Chapter 12 of this Title, R.S. 22:2191 et seq.

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§973. Form of policy

No ~~such~~ health and accident policy or contract shall be delivered or issued for delivery on risks in this state unless~~:~~ all of the following conditions are met:

(1) The entire money and other consideration therefor are expressed ~~therein;~~ ~~and~~ in the policy or contract.

(2) The time at which the insurance takes effect and terminates is expressed ~~therein; and~~ in the policy or contract.

(3) It purports to insure only one person except as ~~hereinafter~~ specifically provided in this Subpart~~; and~~.

(4) Every printed portion of the text matter of the policy and of any endorsements or attached papers is printed in type the size of which shall be uniform and the face of which shall be not less than ten-point. ~~(the~~ The"text" shall include all printed matter except the name and address of the insurer, name or title of the policy, captions and sub-captions, and form numbers~~); and~~.

(5) The exceptions and reductions of indemnity are clearly set forth in the policy or contract and are printed, at the insurer's option, either with the benefit to which they apply or under an appropriate caption, such as~~;~~ "Exceptions" or "Exceptions and Reductions"~~; and~~.

(6) Each such form, including riders and endorsements, shall be identified by a form number in the lower left hand corner of the first page ~~thereof.~~ of the form.

(7)(a) There is prominently printed ~~thereon~~ on or attached, ~~thereto,~~ a notice to the insured that ten days are allowed, from the date of his receipt of the policy, to examine its provisions. ~~and if~~ If such policy was solicited by deceptive advertising or negotiated by deceptive, misleading, or untrue statements of the insurer or any agent ~~in~~ on behalf of the insurer, such policy may be surrendered within said ten-day period. ~~and any~~ Any premium advanced by the insured, upon such surrender, shall be immediately returned to him; ~~provided, that~~ however, the insurer shall have the option of printing or attaching the notice ~~above~~ required by this Subparagraph or a notice of equal prominence which, in the opinion of the commissioner of insurance, is not less favorable to the policyholder~~, and provided further that this~~. This

Paragraph ~~(7)~~ shall not apply to ~~trip-~~travel insurance policies which by their terms are not renewable.

(b) If the policy is delivered by ~~an agent or broker,~~ a producer, a receipt shall be signed by the policyholder acknowledging delivery of the policy. The receipt shall include the policy number and the date the delivery was completed. All delivery receipts required by this Subparagraph shall be retained by the insurer, ~~its agent,~~ or ~~the broker~~ its producer for two consecutive years. The requirement of this Subparagraph shall not apply to any insurer that markets under a home service marketing distribution method and that issues a majority of its policies on a weekly or monthly basis.

(c) If the policy is delivered by mail, it shall be sent by certified mail, return receipt requested, or a certificate of mailing shall be obtained showing the date the policy was mailed to the policyholder. For policy issuances verified by a certificate of mailing, it is presumed that the policy is received by the policyholder ten days from the date of mailing. The receipts and the certificate of mailing described in this Subparagraph shall be retained by the insurer or ~~agent~~ producer for three years. In addition, the insurer or ~~agent~~ producer may utilize commercial carriers or other commercially recognized carriers to deliver the policy to the policyholder; however, the insurer or ~~agent~~ producer shall maintain documentation of actual delivery of such policy for three years. The policy or certificate of insurance may also be delivered electronically to the policyholder or insured in accordance with R.S. 9:2608; however, the insurer and the policyholder or insured shall agree ~~electronically~~ to ~~such~~ electronic delivery, and documentation of ~~such~~ delivery shall be maintained by the insurer for three years.

(8) In any case where the policy is subject to cancellation or renewal at the option of the insurer, there shall be prominently printed on the first page of ~~such~~ the policy a statement ~~so~~ informing the policyholder~~.~~ of such option.

§974. Standard forms

The commissioner of insurance may, ~~from time to time~~ in accordance with the Administrative Procedure Act, R.S. 49:950 et seq., promulgate ~~such~~ rules and

regulations as he deems necessary to establish reasonable minimum standard conditions for basic benefits to be provided by health and accident insurance contracts which are subject to R.S. 22:972, 973, 975-983, 985-990, 992, 993, 999-1014, 1021-1048, 1091-1096, 1111, and 1156, for the purpose of expediting his approval of such contracts pursuant to this Code. No ~~such~~ promulgation shall be inconsistent with standard provisions as required pursuant to R.S. 22:863.

§975. Health and accident policy provisions

A. Required provisions. Each ~~such~~ policy shall contain in substance the following provisions or, at the option of the insurer, provisions which in the opinion of the commissioner of insurance are not less favorable to the policyholder; provided that, except as permitted by R.S. 22:972(C), no time limitation with respect to the filing of notice or proof of loss or within which suit may be brought upon the policy shall differ from the time limitations of the following provisions:

(1) Entire contract: Changes: This policy, including the endorsements and the attached papers, if any, and in case of industrial insurance, the written application, constitutes the entire contract of insurance. No ~~agent~~ producer has authority to change this policy or to waive any of its provisions. No change in this policy shall be valid until approved by an executive officer of the insurer and unless such approval be endorsed ~~hereon~~ on or attached ~~hereto.~~ to the policy.

(2) Reinstatement: If default ~~be~~ is made in the payment of any agreed premium for this policy, the subsequent acceptance of ~~such~~ the defaulted premium by the insurer or by any ~~agent~~ producer authorized by the insurer to accept such premium, shall reinstate the policy~~;~~, ~~but~~ however, the reinstated policy shall cover only loss resulting from accidental injury thereafter sustained or loss due to sickness beginning more than ten days after the date of such acceptance.

(3) Notice of claim: Written notice of claim for injury or for sickness must be given to the insurer within twenty days after the date of the accident causing ~~such~~ an injury or the commencement of the disability from such sickness, except that in case of industrial policies such notice of claim must be given to the insurer within ten days in such cases. In the event of accidental death, immediate notice ~~thereof~~

must be given to the insurer. Such notice given by or on behalf of the insured or the beneficiary to the insurer at ~~(insert~~ the location of such office as the insurer may designate for that purpose~~)~~, or to any authorized agent of the insurer, with information sufficient to identify the insured, shall be deemed notice to the insurer. Failure to give ~~such~~ notice within such time shall not invalidate nor reduce any claim if it was not reasonably possible to give ~~such~~ notice within the time required, provided written notice of claim is given as soon as reasonably possible. ~~(~~In this ~~paragraph~~ Paragraph, the requirement relating to immediate notice of claim in event of accidental death may be omitted at the option of the insurer.~~)~~

(4) Claim forms: The insurer, upon receipt of a notice of claim, will furnish to the claimant ~~such~~ forms as are usually furnished by it for filing proofs of loss. If such forms are not furnished within fifteen days after the giving of ~~such~~ notice, the claimant shall be deemed to have complied with the requirements of this policy as to proof of loss upon submitting, within the time fixed in the policy for filing proofs of loss, affirmative written proof covering the occurrence, the character and the extent of the loss for which claim is made.

(5) ~~Proofs~~ Proof of loss: Affirmative written proof of loss must be furnished to the insurer at its ~~said~~ office in case of claim for loss of time from disability within ninety days after the termination of the period for which the insurer is liable and in case of claim for any other loss within ninety days after the date of such loss. Failure to furnish such proof within the time required shall not invalidate nor reduce any claim if it was not reasonably possible to give proof within such time, provided ~~such~~ proof is furnished as soon as reasonably possible and in no event later than one year from the time proof is otherwise required. Any ~~such~~ policy may also provide, at the insurer's option that written notice or proof of continuance of disability must be furnished not less frequently than each ninety days during the continuance of disability.

(6) Time of payment of claims: ~~Indemnities~~ Indemnity claims payable under this policy for any loss other than loss of time on account of disability will be paid immediately upon receipt of written proof of such loss. Subject to written proof of

loss, accrued ~~indemnities~~ indemnity claims for loss of time on account of disability will be paid (insert period of payment which must not be less frequently than monthly) and any balance remaining unpaid upon the termination of liability will be paid immediately.

(7) Payment of claims: Indemnity for loss of life and any other accrued ~~indemnities~~ indemnity claims unpaid at the insured's death will be paid to the beneficiary, if surviving the insured, and otherwise to the estate of the insured. All other ~~indemnities~~ indemnity claims will be paid to the insured. The policy may, at the insurer's option, provide that if there is no beneficiary, or the beneficiary is the estate of the insured, or the insured or beneficiary is a minor or not competent to give a valid release, the insurer may pay any amount not exceeding one thousand dollars, otherwise payable to the insured or his estate to any relative by blood or connection by marriage of the insured appearing to the insurer to which they may be equitably entitled, ~~thereto,~~ and may make payment of any amount not exceeding one thousand dollars, otherwise payable to the beneficiary to any relative by blood or connection by marriage of such beneficiary appearing to the insurer to which they may be equitably entitled. ~~thereto.~~ The policy may, at the insurer's option, also provide that all or a portion of any indemnities provided by any such policy on account of hospital, nursing, medical, or surgical services may be paid directly to the hospital or person rendering such services; ~~but~~ however, the policy may not require that the services be rendered by a particular hospital or person.

(8) Physical examinations: The insurer shall have the right and opportunity to examine the person of the insured when and as often as it may reasonably require during the pendency of a claim ~~hereunder~~ and to make an autopsy in case of death where it is not forbidden by law.

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(10) Consent of beneficiary: Consent of the beneficiary shall not be ~~requisite to~~ required for the surrender or assignment of this policy, nor ~~to~~ for change of beneficiary, nor ~~to~~ for any other changes in this policy.

(11) Legal action: No legal action ~~at law or in equity~~ shall be brought to recover on this policy prior to the expiration of sixty days after ~~proofs~~ proof of loss ~~have~~ has been filed in accordance with the requirements of this policy. No ~~such~~ legal action shall be brought after the expiration of one year after the time ~~proofs~~ proof of loss ~~are~~ is required to be filed.

(12) Extension of time limitations: If any limitation of this policy with respect to giving notice of claim, furnishing proof of loss, or bringing any action on this policy is less than that permitted by law of the state, district, or territory in which the insured resides at the time this policy is issued, such limitation is ~~hereby~~ extended to agree with the minimum period permitted by such law.

(13) Time ~~Limit on Certain Defenses:~~ limit on certain defenses:

(a)(i) After three years from the date of issue of this policy, no misstatements, except fraudulent misstatements, made by the applicant in the application for such policy shall be used to void the policy or to deny a claim for loss incurred or disability, ~~(~~as defined in the policy~~),~~ commencing after the expiration of such ~~three-year~~ three-year period. ~~The foregoing~~ This policy provision shall not be so construed as to affect any legal requirement for avoidance of a policy or denial of a claim during such initial ~~three year~~ three-year period, nor to limit the application of ~~provisions~~ Paragraphs (B)~~,~~ (1), (2), (3), and (4) of this Section in the event of misstatement with respect to age or occupation or other insurance.

(ii) A policy which the insured has the right to continue in force subject to its terms by the timely payment of premium ~~(1)~~ either until at least age fifty, or, ~~(2)~~ in the case of a policy issued after age forty-four, for at least five years from its date of issue, may contain in lieu of the foregoing the following provision, ~~(~~from which the clause in parentheses may be omitted at the insurer's option~~),~~ under the caption: ~~"INCONTESTABLE":~~ **"INCONTESTABLE**

~~After this policy has been in force for a period of three years during the lifetime of the insured (excluding any period during which the insured is disabled), it shall become incontestable as to the statements contained in the application.~~

After this policy has been in force for a period of three years during the lifetime of the insured, excluding any period during which the insured is disabled, it shall become incontestable as to the statements contained in the application."

(b) No claim for loss incurred or disability, ~~(~~as defined in the policy~~)~~ , commencing after three years from the date of issue of this policy shall be reduced or denied on the ground that a disease or physical condition not excluded from coverage by name or specific description effective on the date of loss had existed prior to the effective date of coverage of this policy.

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B. Other optional provisions ~~(optional)~~. No such policy shall be delivered or issued for delivery containing provisions respecting the matters set forth ~~below~~ in this Subsection unless such provisions are, in substance, in the following forms, or, at the option of the insurer, in forms which in the written opinion of the commissioner of insurance are not less favorable to the policyholder:

(1) Change of occupation: If the insured ~~be injured~~ suffers injury or ~~contract~~ sickness after having changed his occupation to one classified by the insurer as more hazardous than that stated in this policy or while ~~doing~~ performing services for compensation ~~anything pertaining to an~~ in any trade, business, or occupation so classified, the insurer will pay only such portion of the ~~indemnities~~ indemnity provided in this policy as the premium paid would have purchased at the rates and within the limits fixed by the insurer for such more hazardous trade, business, or occupation. In applying this ~~provision,~~ Paragraph, the classification of occupational risk and the premium rates shall be such as have been last filed by the insurer prior to the occurrence of the loss for which the insurer is liable or prior to date of proof of change in occupation with the state official having supervision of insurance in the state where the insured resided at the time this policy was issued; ~~but~~ however, if such filing was not required, then the classification of occupational risk and the premium rates shall be those last made effective by the insurer in such state prior to the occurrence of the loss.

(2) Misstatement of age: If the age of the insured has been misstated, any amount payable or any indemnity accruing under this policy shall be ~~such as the premium paid would have purchased at~~ determined as based on the correct age. If because of a misstatement of age, this policy was issued at an age or was continued or renewed beyond an age at which it would not have been issued, continued, or renewed under the insurer's underwriting rules in effect at the date of issue, the amount payable, ~~hereunder on account~~ because of the loss occurring after such age, shall be limited to a return of the premiums paid thereafter.

(3) Other insurance ~~in~~ with this insurer: An insurer may do either of the following:

(a) If a like policy or policies previously issued by this insurer to the insured ~~be~~ are in force concurrently ~~herewith,~~ with this policy, making the aggregate indemnity for (insert type of coverage) in excess of (insert maximum limit of indemnity), the excess insurance shall be void and all premiums paid for such excess shall be returned to the insured or to his estate.

~~or, in lieu thereof:~~

(b) Insurance effective at any one time on the insured under a like policy or policies in this insurer is limited to one such policy, and the insurer will return to the insured or to his estate all premiums paid for such policies in excess thereof.

(4) Insurance with other insurers: If the insured ~~carry~~ carries with one or more insurers other valid insurance covering the same loss without having given written notice thereof to this insurer prior to the occurrence of loss, the only liability under this policy shall be for such proportion of the ~~indemnities~~ indemnity otherwise provided hereunder as the ~~indemnities~~ indemnity of which the insurer had notice, ~~(include~~ including the ~~indemnities~~ indemnity under this policy~~)~~, bear to the total amount of like ~~indemnities~~ indemnity in all policies covering such loss, and for the return of such portion of the premium paid as shall exceed the pro rata portion for the ~~indemnities~~ indemnity thus determined.

(5) Relation of earnings to insurance: If the total monthly amount of loss of time ~~indemnities~~ indemnity promised in all policies or certificates of accident, health,

or disability insurance upon the insured, whether payable on a weekly or monthly basis, shall exceed the average monthly earnings of the insured at the time disability commenced or for the period of two years immediately preceding a disability for which claim is made, whichever is the greater, the insurer will be liable only for such proportionate amount of the ~~indemnities~~ indemnity specified in the policy as the amount of such monthly earnings of the insured bears to the total amount of monthly ~~indemnities~~ indemnity promised under all such policies or certificates upon the insured at the time of such disability and for the return of such part of the premiums paid during such two years as shall exceed the pro rata amount of the premiums for the ~~indemnities~~ indemnity actually paid hereunder; but this shall not operate to reduce the total monthly amount of ~~indemnities~~ indemnity payable under all such policies or certificates upon the insured below the sum of one hundred dollars or the sum of the monthly ~~indemnities~~ indemnity specified in such policies or certificates, whichever is the lesser.

(6) Unpaid premium: Upon the payment of a claim under this policy, any premium then due and unpaid or covered by any note or written order may be deducted ~~therefrom.~~ from such payment.

(7) Cancellation: The insurer may cancel this policy at any time subject to the provisions of R.S. 22:1012. Such cancellation shall be by written notice, delivered to the insured, or mailed to his last address as shown by the records of the insurer, shall refund the pro rata unearned portion of any premium paid, and shall comply with the provisions of R.S. 22:887(F). Such cancellation shall be without prejudice to any claim for benefits accrued or expenses incurred for services rendered prior to cancellation. Benefits and expenses incurred shall be as defined and limited by the terms of the policy. The insured may likewise cancel this policy on the ~~above~~ terms~~.~~ specified in this Paragraph. Upon cancellation by the insurer, however, the insurer shall only be liable for any claim for benefits accrued, or for expenses incurred for services rendered, subsequent to the cancellation date if the subsequent claim is for an illness or condition which was the basis of any claim prior to cancellation and for which the insurer had notice and if the policy of insurance is

cancelled for reasons other than failure of the policyholder to pay premiums or failure of the insured to maintain eligibility as provided in the policy. Upon the written request of the named insured, the insurer shall provide to the insured in writing the reasons for cancellation of the policy. There shall be no liability on the part of and no cause of action of any nature shall arise against any insurer or its agents, employees, or representatives for any action taken by them to provide the reasons for cancellation as required by this Paragraph.

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§976. Health and accident policy provisions; service charges; penalties

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B. Each service charge for each patient admission <u>specified in R.S. 22:1209</u> shall be paid by the insurer or insurance arrangement in accordance with the plan of operation adopted pursuant to R.S. 22:1205. Failure to pay each service charge for each patient according to this Section shall cause the insurer or insurance arrangement to be liable to the Louisiana Health Plan, the commissioner of insurance, or both, for an amount determined by the board, not to exceed five hundred dollars, plus interest. Any insurer or insurance arrangement found to have failed to comply with this Section as to each service charge for each patient admission <u>specified in R.S. 22:1209</u> on three or more occasions during a six-month period shall be liable for an amount determined by the board, no less than five hundred dollars and not to exceed one thousand five hundred dollars per failure to pay each service charge for each patient admission, together with attorney fees, interest, and court costs. The Louisiana Health Plan, the commissioner, or both, are specifically authorized to conduct audits of insurers or insurance arrangements in order to enforce compliance with this Section.

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§977. Cancellation by insurer and grace period; individual health and accident policies

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B. Whenever an insurer ~~which~~ issues an individual accident and health policy and does not receive a premium payment fifteen days prior to the end of the grace period, the insurer shall mail, by first class mail, a notice to the policyholder. The notice shall state that if the premium has not been paid by the end of the grace period, the policy will lapse as provided by the provisions of the policy. The notice shall also state that the policy will be reinstated with no penalties ~~whatsoever~~ to the insured if the full premium payment is received within the period allowed for reinstatement. Nothing in this Code shall mandate a separate lapse notice for nonpayment of premiums on a policy issued by an insurance company whose products are marketed on the home service distribution method and which issues a majority of these policies on a monthly or weekly basis.

§978. Group, family group, blanket, and association health and accident insurance; notice required for certain premium increase, cancellation, or nonrenewal

A.

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(2) The notice required by Paragraph (1) of this Subsection may be waived for a policy of group, family group, blanket, or association health and accident insurance ~~which~~ that covers one hundred or more persons, provided a provision for such waiver is made part of the policy agreed upon by the insurer and the policyholder.

B. Nothing in this Section shall be construed to grant to the insurer any additional authorization in relation to cancellation, nonrenewal, or other termination of policies and all provisions of this Subpart ~~which~~ that regulate such events shall apply. No policy shall be cancelled, nonrenewed, or otherwise terminated because the insurer failed to meet the notice provisions of this Section.

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§980. Additional sources; required coverage

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B. The provisions of this Section shall not apply to ~~individually underwritten~~ limited benefit ~~and supplemental~~ health insurance policies~~.~~ or contracts.

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§983. Application

A. The falsity of any statement in the application for any policy covered by this Subpart shall not bar the right to recovery ~~thereunder~~ under the policy unless such false statement materially affected either the acceptance of the risk or the hazard assumed by the insurer. The insured shall not be bound by any statement unless made in a written application in the case of domestic industrial insurers, and, in the case of other insurers, unless a copy of such application is attached to or endorsed on the policy~~. as a part thereof.~~

B. No alteration of any written application for any such policy shall be made by any person other than the applicant without his written consent, except that insertions may be made by the insurer, for administrative purposes only, in ~~such~~ a manner as to indicate clearly that such insertions are not to be ascribed to the applicant.

§984. Identification of health benefit plan insurer and sponsor

A. Every health insurer authorized to write health and accident policies of insurance in this state who issues an identification card, member card, insurance coverage card, or other documentation of coverage to any ~~policy holder~~ policyholder or health plan participant shall, in issuing such card or cards, satisfy the requirements of this Section.

B. No health insurer acting as the administrator for a health benefit plan which plan is not fully insured shall issue any identification card, membership card, insurance coverage card, or other documentation of coverage on which the name of the health insurer is prominently displayed on the face of such card or documentation. The name of the health benefit plan's sponsor shall be prominently displayed on the face of such card or documentation with an annotation that the plan's benefits are being administered by the health ~~insurance~~ insurer.

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§985. Notice; waiver

The acknowledgement by any insurer of the receipt of notice given under any policy covered by this Subpart or the furnishing of forms for filing proofs of loss, or the acceptance of such proofs, or the investigation of any claim ~~thereunder~~ shall not operate as a waiver of any of the rights of the insurer in defense of any claim arising under such policy.

§986. Nonapplication to certain policies

A. Nothing in this Subpart shall apply to or affect:

(1) Any policy of worker's compensation insurance or any policy of liability insurance with or without supplementary expense coverage~~. therein.~~

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(3) Life insurance, endowment or annuity contracts, or supplemental contracts ~~supplemental thereto~~ which contain only such provisions relating to accident and health insurance as:

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B. The provisions of R.S. 22:973, 975, 976, 980, 1021, 1022, 1023, and 1156 shall not apply to group or blanket health and accident insurance policies, or to group or blanket policies providing only benefits to cover the cost of legal services and related expenses~~, related thereto,~~ including but not limited to counsel's fees, court costs, investigative fees, and expenses incurred by counsel in the investigation of matters, their preparation for trial, and trial, provided that no such policy shall contain any provision relative to notice or proof of loss, or to the time for paying benefits, or to the time in which suit may be brought upon the policy, which in the opinion of the commissioner of insurance is less favorable to the individuals insured than would be permitted by the standard provisions required for individual health and accident policies, or individual policies to cover legal services, as the case may be.

§987. Penalties

A. Any insurer, or any officer or agent thereof, issuing or delivering any health and accident policy on risks in this state in ~~wilful~~ willful violation of any provision of this Subpart shall be guilty of a misdemeanor and shall, upon conviction

thereof, be fined not more than five hundred dollars or shall be imprisoned for not more than six months, or both, for each offense at the discretion of the court.

B. The commissioner of insurance may revoke the license of any foreign or alien insurer, or of the agent thereof, ~~wilfully~~ willfully violating any provision of this Subpart.

§988. Policies, group health and accident; conversion

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I.(1) A converted policy may include a provision under which the insurer may request information, in advance of any premium due date, of any person covered ~~thereunder~~ under the policy as to whether:

* * *

§989. Industrial health and accident insurance

Any insurer authorized to write health and accident insurance in this state shall have power to issue industrial health and accident policies ~~wherein~~ in which the premium is payable weekly. Every such policy must have printed ~~thereon~~ on it the words "Industrial Policy" and must contain in substance those provisions in R.S. 22:975 as may be applicable. Insurers issuing policies under this Section shall be subject to all the other applicable provisions of this Subpart.

§990. Disability loss of income policies

* * *

B. Total disability may be defined in relation to the inability of the person to perform duties but shall not be based solely upon an individual's inability to~~:~~ either:

(1) Perform "any occupation whatsoever", "any occupational duty", or "any and every duty of his occupation"~~; or~~.

* * *

§992. Transportation ticket policy defined

A transportation ticket policy, which may be issued by a health and accident insurer, is any ticket policy sold at stations, ticket offices, or travel bureaus by employees of railroads, steamship lines, ~~air lines~~ airlines, and other common carriers,

or by individuals or employees of persons engaged in selling transportation on such common carriers, having as its dominant feature the protection of the insured from a transportation hazard.

§993. Construction of policy issued in violation of this Subpart

A policy issued in violation of this Subpart shall be held valid but shall be construed as provided herein, and when any provision in such a policy is in conflict with any provisions of this Subpart, the rights, duties, and obligations of the insurer, the policyholder, and the beneficiary shall be governed by the provisions of this Subpart.

* * *

§995. Selection of type of treatment; reimbursement

* * *

C. The provisions of this ~~Subsection~~ Section shall apply to all new policies issued on or after December 1, 1984. Any insurer who on December 1, 1984, has health and accident policies in force shall convert upon the anniversary date of such policies all existing policies to conform to the provisions of Subsection B of this Section. All existing policies shall be converted to conform to the provisions of Subsection B of this Section no later than December 1, 1985.

* * *

§999. Coverage for use of drugs in treatment of cancer

* * *

E.

* * *

(2) The provisions of this Section shall not apply to ~~individually underwritten, guaranteed renewable~~ limited benefit~~, or supplemental~~ health insurance policies or contracts authorized to be issued in the state.

§1000. Group, family group, blanket, and association health and accident insurance

A. Any insurer authorized to write health and accident insurance in this state shall have the power to issue policies described in this Section.

* * *

(2)(a) Except as provided in Subparagraph (b) of this Paragraph, family group health and accident insurance or similar coverage issued by a health maintenance organization is an individual policy covering any one person, with or without any eligible members, including spouse and unmarried children under twenty-one years of age or, in the case of full-time students, unmarried children under the age of twenty-four, and unmarried grandchildren under twenty-one years of age in the legal custody of and residing with the grandparent or, in the case of full-time students, unmarried grandchildren under the age of twenty-four who are in the legal custody of and residing with the grandparent, except that the policy may provide for continuing coverage for any unmarried child or grandchild in the legal custody of and residing with the grandparent who is incapable of self-sustaining employment by reason of mental retardation or physical handicap, who became so incapable prior to attainment of age twenty-one, and any other person dependent upon the policyholder, written under a master policy issued to the head of such family. The policy shall contain a provision that the policy, and the application of the head of the family if attached ~~thereto,~~ to the policy shall constitute the entire contract between the parties.

* * *

(3) Blanket health and accident insurance is any policy covering special groups of persons as enumerated in one of the following Subparagraphs (a) through (g):

* * *

(c) Under a policy issued to a college, school, or other institution of learning or to the head or principal ~~thereof,~~ of that institution who or which shall be deemed the policyholder, covering students or teachers.

* * *

B. The term "employees" as used in this Section shall be deemed to include, for the purposes of insurance ~~hereunder,~~ under this Section as employees of a single employer, the officers, managers, and employees of the employer and of subsidiary or affiliated corporations of a corporation employer, and the individual proprietors,

partners, and employees of individuals and firms of which the business is controlled by the insured employer through stock ownership, contract or otherwise. The term "employer" as used herein may be deemed to include any governmental corporation, unit, agency, or department thereof, or the proper officers, as such, of any unincorporated governmental organization.

* * *

D. Any policy issued under this Section may provide for the readjustment of the rate of premium based on the experience ~~thereunder~~ at the end of the first year or of any subsequent year of insurance, ~~thereunder,~~ and such readjustment may be made retroactive only for such policy year. Any refund under any plan for readjustment of the rate of premium based on the experience under group policies ~~heretofore or hereafter~~ issued, and any dividend paid under such policies may be issued to reduce the employer's share of the cost of the coverage, except that if the aggregate refunds or dividends under such group policy and any other group policy or contract issued to the policyholder exceed the aggregate contributions of the employer toward the cost of the coverages, such excess shall be applied by the policyholder for the sole benefit of insured employees.

* * *

§1002. Coverage of vocational-technical students

A. Children who attend vocational, technical, vocational-technical or trade schools or institutes in Louisiana on a full-time basis shall be considered as full-time students for purposes of coverage by family group health and accident insurance policies issued in this state.

B. The provisions of this ~~section~~ Section shall apply to all policies issued more than ninety days following July 31, 1974. Any insurer who, on July 31, 1974, has health and accident insurance policies in force shall have until July 31, 1975, to convert such existing policies to conform to the provisions of this ~~section.~~ Section.

§1003. Coverage of unmarried students

A.(1) Except as provided in Paragraph (2) of this Subsection, students who are unmarried children who have not yet attained the age of twenty-four and who are

enrolled as full-time students at an accredited college or university, or at a vocational, technical, vocational-technical or trade school or institute, or secondary school, and who are dependent upon the primary insured under any group health and accident or association health and accident insurance policy or health maintenance organization subscriber agreement issued in this state for their support, shall be considered as dependents under the provisions of ~~said~~ such policy.

* * *

§1004. Insurance pending adoption

A. Any unmarried child who is placed in the home of an insured pursuant to an adoption placement agreement executed with an adoption agency licensed in accordance with the Child Care Facility and Child-Placing Agency Licensing ~~Law~~Act, ~~(~~R.S. 46:1401 et seq.~~)~~, or corresponding law of any other state, shall be considered a dependent child of the insured from the date of placement in the home of the insured under the provisions of any individual, group, family group, blanket, or association health and accident insurance policy issued in this state. Coverage available under the policy shall be in accordance with the provisions of the contract of insurance.

* * *

§1006. Health benefit plans; replacement; continuance of benefits

* * *

C. "Health benefit plan" means any hospital or medical policy or group certificate delivered or issued for delivery in this state by an insurer; a nonprofit hospital or medical service organization; a domestic nonprofit mutual association which is engaged exclusively in the ~~furnishing~~ provision of hospital service, medical, or surgical benefits; a health maintenance organization; or a self-insured plan that provides, on an expense-incurred basis, hospital, surgical, or major medical expense insurance, or any combination of these except specified disease, hospital indemnity or other limited, supplemental benefit insurance policies.

* * *

E. Whenever a contract of one carrier replaces a health benefit plan of similar benefits of another carrier:

* * *

(5) Whenever a determination of the prior carrier's benefits is required by the succeeding carrier, at the succeeding carrier's request, the prior carrier shall ~~furnish~~ provide a statement of the benefits available, pertinent information, sufficient to permit verification of the benefit determination, or the determination itself by the succeeding carrier. For purposes of this Paragraph, benefits of the prior plan shall be determined in accordance with all of the definitions, conditions, and covered expense provisions of the prior plan rather than those of the succeeding plan. The benefit determination will be made as if coverage was not replaced by the succeeding carrier.

* * *

§1009. Health care provider credentialing

A. As used in this Section, the following words and phrases shall have the following meanings ascribed for each, unless the context clearly indicates otherwise:

* * *

(7) "Health insurance issuer" or "issuer" means any insurer who offers health insurance coverage through a plan, policy, or certificate of insurance subject to state law that regulates the business of insurance. A "health insurance issuer" or "issuer" shall also include a health maintenance organization, as defined and licensed pursuant to Subpart I of Part I of Chapter 2 of this Title, and shall include the ~~office of group benefits.~~ Office of Group Benefits programs.

* * *

§1015. Exemption of proceeds; health and accident

The proceeds or avails of all contracts of health and accident insurance and of provisions providing benefits on account of the insured's disability which are supplemental to life insurance or annuity contracts ~~heretofore or hereafter~~ effected

shall be exempt from all liability for any debt of the insured, and from any debt of the beneficiary existing at the time the proceeds are made available for his use.

* * *

§1023. Prohibited discrimination; genetic information; disclosure requirements; definitions

A. As used in this Section, the following terms shall have the following meanings:

* * *

(9)

* * *

(b) "Genetic test" shall not mean an analysis of proteins or metabolites that~~:~~ either:

(i) Does not detect genotypes, mutations, or chromosomal changes~~; or~~.

* * *

B.

* * *

(4)(a) No insurer shall request, require, or purchase genetic information~~:~~ either:

(i) Of an individual or family member of an individual for underwriting purposes~~; or~~.

* * *

F.

* * *

(2) Any person who~~:~~ either:

(a) Through a request, the use of persuasion, under threat, or with a promise of reward, willfully induces another to collect, store, or analyze a DNA sample in violation of this Section~~; or~~.

* * *

§1024. Group, family group, blanket, and association health and accident insurance; mandatory coverage

A. Any policy issued under this Section, which in addition to covering the insured also covers members of the insured's immediate family, shall provide coverage for illnesses and injuries of unmarried dependent children of the insured and unmarried grandchildren in the legal custody of the grandparent from the date of birth to the attainment of the limiting age. Such coverage ~~so provided~~ shall include coverage for illness, injury, congenital defects, and premature birth, but need not include routine well baby care.

* * *

D. The provisions of this Section shall not apply to ~~individually underwritten, guaranteed renewable or renewable~~ limited benefit ~~supplemental~~ health insurance policies or contracts authorized to be issued in this state.

§1025. Group, blanket, and association health insurance, treatment for alcoholism and drug abuse

* * *

B. Any insurer who, on October 1, 1982, has group, blanket, or association health insurance policies in force shall convert such existing policies to conform to the provisions of this Section on or before the renewal dates. ~~thereof.~~

§1026. Group, family group, blanket, and association health and accident insurance; cleft lip and cleft palate coverage; mandatory coverage

A. Any hospital, health, or medical expense insurance policy, hospital or medical service contract, employee welfare benefit plan, health and accident insurance policy, or any other insurance contract of this type, including a group insurance plan, and a self-insurance plan that provides medical and surgical benefits which is delivered, issued for delivery or renewed in this state on or after January 1, 1998, shall include coverage for the treatment and correction of cleft lip and cleft palate. Such coverage shall also include benefits for secondary conditions and

treatment attributable to that primary medical condition. Benefits shall include but not be limited to the following:

* * *

(4) Preventive and restorative dentistry to ~~insure~~ ensure good health and adequate dental structures for orthodontic treatment or prosthetic management or therapy.

* * *

B. The provisions of this Section shall not apply to ~~individually underwritten guaranteed renewable or renewable~~ limited benefit ~~supplemental~~ health insurance policies~~, limited benefit policies, or specified disease policies~~ or contracts authorized to be issued in this state.

§1027. Hearing-impaired interpreter expenses

* * *

B. The provisions of this Section shall not apply to ~~individually underwritten~~ limited benefit ~~and supplemental~~ health insurance policies~~.~~ or contracts.

§1028. Early screening and detection requirements; examination; coverage

A.

* * *

(4) This Subsection shall apply to any new policy, contract, program, or health coverage plan issued on or after January l, 1992. Any policy, contract, or health coverage plan in effect prior to January l, 1992, shall convert to conform to the provisions of this Subsection on or before the renewal date ~~thereof~~ but in no event later than January 1, 1993.

* * *

F. Any provision in a health insurance policy, benefit program, or health coverage plan under this Section which is delivered, renewed, issued for delivery, or otherwise contracted for in ~~the~~ this state which is contrary to this Section shall, to the extent of the conflict, be void.

G. The provisions of this Section shall not apply to ~~individually underwritten, guaranteed renewable, or renewable~~ limited benefit ~~supplemental~~

health insurance policies or contracts authorized to be issued in this state.

§1029. Requirement for coverage of colorectal cancer screening

* * *

D. The provisions of this Section shall not apply to ~~individually underwritten, guaranteed renewable~~ limited benefit health insurance policies~~.~~ or contracts.

§1030. Immunizations; coverage

* * *

D. The provisions of this Section shall not apply to ~~individually underwritten~~ limited benefit ~~and supplemental~~ health insurance policies~~.~~ or contracts.

* * *

§1031. Attention deficit/hyperactivity disorder; coverage; diagnosis

* * *

B. The diagnosis and treatment for attention deficit/hyperactivity disorder shall be covered when rendered or prescribed by a physician or other appropriate health care provider licensed in this state and received in any physician's or other appropriate health care provider's office, any licensed hospital, or in any other licensed public or private facility, or portion thereof, including but not limited to clinics and ~~mobil~~ mobile screening units. However, benefits for attention deficit/hyperactivity disorder provided for an initial diagnosis shall not exceed six hundred dollars. Services rendered on an ~~out-patient~~ outpatient basis shall not exceed fifty dollars per visit with a physician or other appropriate health care provider and total benefits shall be limited to ten thousand dollars during a person's lifetime, and shall not exceed twenty-five hundred dollars in any given year. The limitation on benefits payable for attention deficit/hyperactivity disorder shall be minimum levels of coverage and nothing in this Section shall prohibit insurers from offering benefits in excess of the coverage provided for in this Subsection.

C. This Section shall apply to any new policy, contract, program, or plan issued on or after January 1, 1994. Any policy, contract, or plan in effect prior to January 1, 1994, shall convert to conform to the provisions of this Section on or

before the renewal date ~~thereof~~ but in no event later than January 1, 1995.

D. The provisions of this Section shall not apply to ~~individually underwritten~~ limited benefit ~~and supplemental~~ health insurance policies~~.~~ or contracts.

§1032. Osteoporosis; bone mass measurement; mandatory coverage

* * *

C. Nothing in this Section shall apply to ~~individually underwritten~~ limited benefit health insurance policies~~.~~ or contracts.

* * *

§1034. Health insurance coverage for diabetes

* * *

B.

* * *

(3) The diabetes self-management training provided in Paragraphs (1) and (2) of this Subsection shall be provided by a health care professional within his ~~or her~~ scope of practice after having demonstrated expertise in diabetes care and treatment and after having completed an educational program required by his ~~or her~~ licensing board when that program is in compliance with the National Standards for Diabetes Self-Management Education Program as developed by the American Diabetes Association.

* * *

D.(1) The provisions of the Section shall not apply to ~~individually underwritten, guaranteed renewable or renewable~~ limited benefit ~~supplemental~~ health insurance policies or contracts authorized to be issued in this state.

* * *

§1035. Inherited metabolic diseases; coverage for food products

* * *

D. The provisions of this Section shall not apply to ~~individually underwritten, guaranteed renewable~~ limited benefit ~~or~~ and short-term health insurance policies~~.~~ or contracts.

* * *

§1037. Health insurance coverage for activities performed by a registered nurse first assistant

A. Any hospital, health, or medical expense insurance policy, hospital or medical service contract, employee welfare benefit plan, health maintenance organization subscriber agreement, health and accident insurance policy, or any other insurance contract of this type, including a group insurance plan and a self-insurance plan that provides medical and surgical benefits which are delivered, issued for delivery, or renewed in this state on or after January 1, 2004, shall not deny coverage of perioperative services rendered by a registered nurse first assistant if the insurer covers the same such first assistant perioperative services when they are rendered by an advanced practice nurse, a physician assistant, or a physician other than the operating surgeon. Payments to ~~RNFAs~~ registered nurse first assistants for such services shall be subject to the same credentialing and contracting requirements that apply to other health care providers paid for such services.

B. The provisions of this Section shall not apply to ~~individually underwritten, guaranteed renewable~~ limited benefit health insurance policies or contracts authorized to be issued in this state. Additionally, the provisions of this Section shall not be construed to prohibit or prevent a health insurer or health maintenance organization from conducting a utilization review pertaining to coverage of the services of a registered nurse first assistant.

C. As used in this Section:

* * *

(3) "Registered nurse first assistant" ~~or "RNFA"~~ means a person who has met all of the following requirements:

* * *

§1038. Hearing aid coverage for minor child

* * *

C.(1) Notwithstanding the provisions of ~~Act No. 1115 which originated as House Bill No. 1606 of the 2003 Regular Session of the Louisiana Legislature~~ R.S. 22:1047 to the contrary, an entity subject to this Section shall provide coverage for

hearing aids for a child under the age of eighteen who is covered under a policy or contract of insurance if the hearing aids are fitted and dispensed by a licensed audiologist or licensed hearing aid specialist following medical clearance by a physician licensed to practice medicine and an audiological evaluation medically appropriate to the age of the child.

* * *

E. The provisions of this Section shall apply to any new policy, contract, program, or plan issued by an entity subject to the provisions of this Section on or after January 1, 2004. Any such policy, contract, program, or plan in effect prior to January 1, 2004, shall convert to the provisions of this Section on or before the renewal date ~~thereof~~ but in no event later than January 1, 2005. Any policy affected by the provisions of this Section shall apply to an insured or participant under such policy, contract, program, or plan whether or not the hearing impairment is a pre-existing condition of the insured or participant.

F. The provisions of this Section shall not apply to ~~individually underwritten, guaranteed renewable~~ limited benefit health insurance policies~~.~~ or contracts.

* * *

§1040. Coverage for dental procedures; anesthesia and hospitalization

* * *

B. An insurer under this Section may require prior authorization for hospitalization for dental care procedures in the same manner that prior authorization is required for hospitalization for other covered medical conditions. For a patient to satisfy the criteria of Subsection A~~,~~ of this Section, a dentist shall consider the Indications for General Anesthesia, as published in the reference manual of the American Academy of Pediatric Dentistry, as utilization standards for determining whether performing dental procedures necessary to treat the particular condition or conditions of the patient under general anesthesia constitutes appropriate treatment.

* * *

E. The provisions of this Section shall not apply to ~~individually underwritten, guaranteed renewable or renewable limited benefit supplemental health insurance~~

~~policies, or~~ limited benefit health insurance policies or contracts authorized to be issued in this state.

* * *

§1043. Severe mental illness and other mental disorders; policy provisions; minimum requirements; group, blanket, and association policies

A.

* * *

(3)

* * *

(b) The provisions of this Section shall not apply to ~~individually underwritten~~ health insurance ~~plans;~~ individual policies or contracts; ~~short term, limited duration health insurance policies; and individually underwritten~~ limited benefit ~~and supplemental~~ health insurance policies~~.~~ or contracts; and short term health insurance policies or contracts.

* * *

§1044. Health coverage; participants in clinical trials

A. As used in this Section, the following terms and phrases shall have the following meanings unless the context clearly indicates otherwise:

* * *

(4) "Health insurance issuer" means an insurance company, including a health maintenance organization as defined and licensed pursuant to Subpart I of Part I of Chapter 2 of this Title, unless preempted as an employee benefit plan under the Employee Retirement Income Security Act of 1974. For purposes of this Section and Subpart B of Part II of Chapter 6 of this Title, a "health insurance issuer" shall include the ~~State Employees~~ Office of Group Benefits ~~Program.~~ programs.

* * *

§1046. Group health insurance continuation

* * *

F. An employee or member electing continuation shall pay to the group policyholder or his employer, in advance, the amount of contribution required by the

policyholder or employer, but not more than the full group rate for the insurance applicable to the employee or member under the group policy on the due date of each payment. The employee or member shall not be required to pay the amount of the contribution less often than monthly. In order to be eligible for continuation of coverage, the employee or member shall make a written election of continuation, on a form ~~furnished~~ provided by the group policyholder, and pay the first contribution, in advance, to the policyholder or employer on or before the date on which the employee's or member's insurance would otherwise terminate. Such form shall be as prescribed in this Section.

* * *

§1049. Requirement for coverage of prosthetic devices and prosthetic services

* * *

I. The provisions of this Section shall not apply to ~~individually underwritten, guaranteed renewable~~ limited benefit health insurance policies~~.~~ or contracts.

§1050. Requirement for coverage of diagnosis and treatment of autism spectrum disorders in individuals less than seventeen years of age

* * *

H. The provisions of this Section shall not apply to:

* * *

(3) ~~Individually underwritten, guaranteed renewable limited~~ Limited benefit health insurance policies~~.~~ or contracts.

* * *

§1061. Definitions

As used in R.S. 22:984 and 1061 through 1079, the following terms shall have the following meanings:

(1)(a) "Group health plan" means an employee welfare benefit plan ~~(~~as defined in Section 3(1) of the Employee Retirement Income Security Act of 1974~~)~~ to the extent that the plan provides medical care, as defined in Subparagraph (b)~~,~~ of this Paragraph and including items and services paid for as medical care to

employees or their dependents, as defined under the terms of the plan, directly or through insurance, reimbursement, or otherwise.

* * *

(3) "Excepted benefits" means benefits under one or more of the following:

(a) Benefits not subject to requirements~~.~~:

(i) Coverage only for accident, or disability income insurance, or any combination. ~~thereof.~~

(ii) Coverage issued as a supplement to liability insurance.

(iii) Liability insurance, including general liability insurance and automobile liability insurance.

(iv) Workers' compensation or similar insurance.

(v) Automobile medical payment insurance.

(vi) Credit-only insurance.

(vii) Coverage for on-site medical clinics.

(viii) Other similar insurance coverage, specified in regulations issued by the commissioner of insurance under the Administrative Procedure Act, under which benefits for medical care are secondary or incidental to other insurance benefits.

(b) Benefits not subject to requirements if offered separately~~.~~:

(i) Limited scope dental or vision benefits.

(ii) Benefits for long-term care, nursing home care, home health care, community-based care, or any combination thereof.

(iii) Such other similar, limited benefits as ~~are~~ specified in reasonable regulations issued by the commissioner of insurance.

(c) Benefits not subject to requirements if offered as independent, ~~noncoordinated~~ non-coordinated benefits~~.~~:

(i) Coverage only for a specified disease or illness.

(ii) Hospital indemnity or other fixed indemnity insurance.

(d) Benefits not subject to requirements if offered as a separate insurance policy:

(i) Medicare coverage.

(ii) Insurance coverage supplemental to military health benefits.

(iii) Similar supplemental coverage provided under a group health plan.

(4) "Creditable coverage" means, with respect to an individual, coverage of the individual under any of the following:

* * *

(j)(i) A health benefit plan provided to members of the Peace Corps.

(ii) Such term does not include coverage consisting solely of coverage of excepted benefits, as defined in Paragraph (3) of this Section.

(5) Other definitions are:

* * *

(e)(i) "Employer" means any person acting directly as an employer, or indirectly in the interest of an employer, in relation to an employee benefit plan~~;~~, and includes a group or association of employers acting for an employer in such capacity.

* * *

(f) "Church plan" means a plan established and maintained for its employees or their beneficiaries by a church, ~~or by a~~ convention, or association of churches. A plan established and maintained for its employees or their beneficiaries by a church, ~~or by a~~ convention, or association of churches includes a plan maintained by an organization, whether a civil law corporation or otherwise, the principal purpose or function of which is the administration or funding of a plan or program for the provision of retirement benefits or welfare benefits, or both, for the employees of a church, ~~or a~~ convention, or association of churches, if such organization is controlled by or associated with a church, ~~or a~~ convention, or association of churches. The term "church plan" does not include a plan which is established and maintained primarily for the benefit of employees or their beneficiaries of such church, ~~or~~ convention, or association of churches who are employed in connection with one or more unrelated trades or businesses.

* * *

(u) "Affiliated service group" means a group consisting of a service organization, ~~(~~hereinafter in this Paragraph referred to as the "first organization"~~)~~,

and one or more of the following:

* * *

(ii) Any other organization if:

* * *

(bb) Ten percent or more of the interests in such organization is held by persons who are highly compensated employees of the first organization or an organization described in Item (i)~~.~~ of this Subparagraph.

* * *

§1062. Increased portability through limitation on preexisting condition exclusions

A. Limitation on preexisting condition exclusion period; crediting for periods of previous coverage. Subject to the provisions of Subsection D of this Section, a group health plan, and a health insurance issuer offering group health insurance coverage, may, with respect to a participant or beneficiary, impose a preexisting condition exclusion only if:

(1) Such exclusion relates to a condition, whether physical or mental, regardless of the cause of the condition, for which medical advice, diagnosis, care, or treatment was recommended or received within the ~~six month~~ six-month period ending on the enrollment date.

* * *

D.

* * *

(3) To the extent that medical care under a group health plan consists of group health insurance coverage, the plan is deemed to have satisfied the certification requirement under Paragraphs (1) and (2) of this ~~section~~ Subsection if the health insurance issuer offering the coverage provides for such certification in accordance therewith.

* * *

§1066. Parity in the application of certain limits to mental health benefits

A.

* * *

(2) In the case of a group health plan, or health insurance coverage offered in connection with such a plan, that provides both medical and surgical benefits and mental health benefits:

* * *

(c) In the case of a plan or coverage that is not described in Subparagraph (a) or (b) of this Paragraph that includes no or different annual limits on different categories of medical and surgical benefits, the plan shall comply with all applicable federal regulations under which Subparagraph (b) of this Paragraph is applied to such plan or coverage with respect to mental health benefits by substituting for the applicable annual limit an average annual limit that is computed taking into account the weighted average of the annual limits applicable to such categories.

B. Except as provided in Subsection A~~,~~ of this Section, nothing in this Section shall be construed to do the any of the following:

* * *

§1072. Individual health insurance coverage portability and limitation on preexisting condition exclusions; newborn coverage; coordination of benefits

* * *

D. Any hospital, health, or medical expense insurance policy, hospital or medical service contract, employee welfare benefit plan, health and accident insurance policy, or any other insurance contract of this type, or a self-insurance plan, which is delivered, issued for delivery, or renewed in this state shall not deny, exclude, or limit benefits for a covered individual for losses due to a preexisting condition incurred more than twelve months following the effective date of the covered person's coverage unless an exclusion of coverage is established pursuant to Subsection C of this Section. The provisions of this Section shall not apply to limited benefit ~~and supplemental~~ health insurance policies ~~nor to~~ and short-term ~~major medical~~ policies or contracts of a duration of six months or less. Any policy,

contract, or plan subject to the provisions of this Section shall not contain a definition of a preexisting condition more restrictive than the following:

* * *

§1077. Required coverage for reconstructive surgery following mastectomies

* * *

B. A group health plan, a health insurance insurer providing health insurance coverage in connection with a group health plan, or health insurance coverage offered by a health insurance insurer in the individual market shall provide notice to each participant and beneficiary under such plan regarding the coverage required by this Section in accordance with regulations adopted by the department. This notice shall be in writing and prominently positioned in any literature or correspondence made available or distributed by the plan or issuer and shall be transmitted~~:~~ in one of the following ways, whichever is earlier:

(1) In the next mailing made by the plan or insurer to the participant or beneficiary~~;~~.

(2) As part of any yearly informational packet sent to the participant or beneficiary~~; or~~.

(3) Not later than January 1, 2000~~;~~. ~~whichever is earlier.~~

C. A group health plan, a health insurance insurer offering group health insurance coverage in connection with a group health plan, or health insurance coverage offered by a health insurance insurer in the individual market may not~~:~~ do either of the following:

(1) Deny to a patient eligibility, or continued eligibility, to enroll or to renew coverage under the terms of the plan, solely for the purpose of avoiding the requirements of this Section~~; or~~.

* * *

§1095. Modified community rating; health insurance premiums; compliance with rules and regulations

* * *

D. The provisions of this Section shall not apply to ~~individually underwritten~~

limited benefit ~~and supplemental~~ health insurance policies~~.~~ or contracts.

* * *

§1821. Payment of claims; health and accident policies; prospective review; penalties; self-insurers; telemedicine reimbursement by insurers

* * *

F.

* * *

(3) The provisions of this Subsection shall not apply to ~~individually underwritten~~ limited benefit ~~and supplemental~~ health insurance policies or contracts authorized to be issued in the state.

Section 2. This Act shall become effective on January 1, 2011.

SPEAKER OF THE HOUSE OF REPRESENTATIVES

PRESIDENT OF THE SENATE

GOVERNOR OF THE STATE OF LOUISIANA

APPROVED: _____