2019 Regular Session

HOUSE BILL NO. 237

BY REPRESENTATIVE CHAD BROWN

Prefiled pursuant to Article III, Section 2(A)(4)(b)(i) of the Constitution of Louisiana.

INSURANCE/HEALTH: Prohibits preexisting condition exclusions or other discrimination based on health status

AN ACT

To enact Chapter 21 of Title 22 of the Louisiana Revised Statutes of 1950, to be comprised of R.S. 22:2481 through 2488, relative to prohibitions against discrimination by health insurance issuers based on health status; to require coverage for certain health benefits; to prohibit preexisting condition exclusions; to prohibit discrimination based on health status; to prohibit lifetime or annual limits; to require insurers to accept all applicants; to prohibit excessive waiting periods; to provide for applicability; to provide for an effective date; and to provide for related matters.

Be it enacted by the Legislature of Louisiana:

Section 1. Chapter 21 of Title 22 of the Louisiana Revised Statutes of 1950, comprised of R.S. 22:2481 through 2488, is hereby enacted to read as follows:

CHAPTER 21. PROHIBITIONS AGAINST DISCRIMINATION BY HEALTH INSURANCE ISSUERS BASED ON HEALTH STATUS

§2481. Increased portability through prohibition on preexisting condition exclusions

A group health plan or a health insurance issuer offering group or individual health insurance coverage shall not impose any preexisting condition exclusion with respect to the plan or coverage.

§2482. Guaranteed availability of coverage in the individual and group market

A. Subject to the provisions of Subsections B through D of this Section, each health insurance issuer that offers health insurance coverage in the individual or

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group market in Louisiana shall accept every employer and individual in the state that applies for coverage.

B.(1) A health insurance issuer may restrict enrollment in coverage to open or special enrollment periods pursuant to rules and regulations promulgated by the commissioner of insurance as required by this Subsection.

(2) A health insurance issuer shall establish special enrollment periods for qualifying events as defined in Section 603 of the federal Employee Retirement Income Security Act of 1974.

(3) The commissioner of insurance shall promulgate regulations with respect to enrollment periods pursuant to this Subsection.

C.(1) In the case of a health insurance issuer that offers health insurance coverage in the group or individual market through a network plan, the issuer may do any of the following:

(a) Limit the employers that may apply for coverage to those with eligible individuals who live, work, or reside in the service area for the network plan.

(b) Within the service area of the plan, deny coverage to employers or individuals if the issuer has demonstrated to the commissioner of insurance both of the following:

(i) It will not have the capacity to deliver services adequately to enrollees of any additional groups or any additional individuals because of its obligations to existing group contract holders and enrollees.

(ii) It is applying this Paragraph uniformly to all employers and individuals without regard to the claims experience of those individuals, employers and their employees, and their dependents, or any health status-related factor relating to the individuals, employees, and dependents.

(2) An issuer, upon denying health insurance coverage in any service area in accordance with Subparagraph (1)(b) of this Subsection, shall not offer coverage in the group or individual market within the service area for a period of one hundred eighty days after the date coverage is denied.

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D.(1) A health insurance issuer may deny health insurance coverage in the group or individual market if the issuer has demonstrated, if required, to the commissioner of insurance each of the following:

(a) It does not have the financial reserves necessary to underwrite additional coverage.

(b) It is applying this Paragraph uniformly to all employers and individuals in the group or individual market in the state consistent with applicable state law and without regard to the claims experience of those individuals, employers and their employees, and their dependents, or any health status-related factor relating to the individuals, employees, and dependents.

(2)(a) A health insurance issuer, upon denying health insurance coverage in connection with group health plans in accordance with Paragraph (1) of this Subsection in this state, shall not offer coverage in connection with group health plans in the group or individual market in this state for a period of one hundred eighty days after the date coverage is denied or until the issuer has demonstrated to the commissioner of insurance, that the issuer has sufficient financial reserves to underwrite additional coverage, whichever is later.

(b) The commissioner of insurance may issue reasonable regulations for the application of this Paragraph on a service-area-specific basis.

§2483. Guaranteed renewability of coverage

A. Except as provided in Subsection B of this Section, if a health insurance issuer offers health insurance coverage in the individual or group market, the issuer shall renew or continue in force the coverage at the option of the plan sponsor or the individual, as applicable.

B. A health insurance issuer may nonrenew or discontinue health insurance coverage offered in connection with a health insurance coverage offered in the group or individual market based only on one or more of the following:

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(1) The plan sponsor, or individual, as applicable, has failed to pay premiums or contributions in accordance with the terms of the health insurance coverage or the issuer has not received timely premium payments.

(2) The plan sponsor, or individual, as applicable, has performed an act or practice that constitutes fraud or made an intentional misrepresentation of material fact under the terms of the coverage.

(3) In the case of a group health plan, the plan sponsor has failed to comply with a material plan provision relating to employer contribution or group participation rules, pursuant to applicable state law.

(4) The issuer is ceasing to offer coverage in the market in accordance with Subsection C of this Section and applicable state law.

(5) In the case of a health insurance issuer that offers health insurance coverage in the market through a network plan, there is no longer any enrollee in connection with the plan who lives, resides, or works in the service area of the issuer or in the area for which the issuer is authorized to do business and, in the case of the small group market, the issuer would deny enrollment with respect to the plan pursuant to R.S. 22:2482(C)(1)(a).

(6) In the case of health insurance coverage that is made available in the small or large group market only through one or more bona fide associations, the membership of an employer in the association, on the basis of which the coverage is provided, ceases but only if the coverage is terminated pursuant to this Paragraph uniformly without regard to any health status-related factor relating to any covered individual.

C.(1) If an issuer decides to discontinue offering a particular type of group or individual health insurance coverage, the coverage may be discontinued by the issuer in accordance with applicable state law in that market only if all of the following conditions are met:

(a) The issuer provides notice to each plan sponsor or individual, as applicable, provided coverage of this type in the market, and participants and

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beneficiaries covered under the coverage, of the discontinuation at least ninety days prior to the date of the discontinuation of the coverage.

(b) The issuer offers to each plan sponsor or individual, as applicable, provided coverage of this type in the market, the option to purchase all or, in the case of the large group market, any other health insurance coverage currently being offered by the issuer to a group health plan or individual health insurance coverage in the market.

(c) In exercising the option to discontinue coverage of this type and in offering the option of coverage pursuant to Subparagraph (b) of this Paragraph, the issuer acts uniformly without regard to the claims experience of those sponsors or individuals, as applicable, or any health status-related factor relating to any participants or beneficiaries covered or new participants or beneficiaries who may become eligible for coverage.

(d) Prior to providing the notice required by Subparagraph (a) of this Paragraph, the issuer files the notice and the insurance product being discontinued with the commissioner of insurance.

(2)(a) If a health insurance issuer elects to discontinue offering all health insurance coverage in the individual or group market, or all markets, in Louisiana, health insurance coverage may be discontinued by the issuer only in accordance with applicable state law and if all of the following conditions are met:

(i) The issuer provides notice to the commissioner of insurance and to each plan sponsor or individual, as applicable, and participants and beneficiaries covered under the coverage, of the discontinuation at least one hundred eighty days prior to the date of the discontinuation of the coverage.

(ii) All health insurance issued or delivered for issuance in Louisiana in the market or markets are discontinued and coverage under the health insurance coverage in the market or markets is not renewed.

(iii) Prior to providing the notice required by Item (i) of this Subparagraph, the issuer files with the commissioner of insurance the notice and the insurance

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product being discontinued for certification that the notice is in compliance with this Section. Notice shall not be issued to the insureds or enrollees until the expiration of twenty days after the notice and insurance product being discontinued have been filed unless the commissioner of insurance gives his written approval prior to that time.

(b) In the case of a discontinuation pursuant to Subparagraph (a) of this Paragraph in a market, the issuer shall not issue any health insurance coverage in the market and state during the five-year period beginning on the date of the discontinuation of the last health insurance coverage not renewed.

D. At the time of coverage renewal, a health insurance issuer may modify the health insurance coverage for a product offered to a group health plan in the small or large group market if, for coverage that is available in the market other than only through one or more bona fide associations, the modification is consistent with state law and effective on a uniform basis among group health plans with that product.

E. For the purposes of this Section, with respect to health insurance coverage that is made available by a health insurance issuer in the small or large group market to employers only through one or more associations and is provided to an employer member of the association, "plan sponsor" shall include the employer.

§2484. Prohibiting discrimination against individual participants and beneficiaries based on health status

A. A group health plan and a health insurance issuer offering group or individual health insurance coverage shall not establish rules for eligibility, including continued eligibility, of any individual to enroll under the terms of the plan based on any of the following health status-related factors in relation to the individual or a dependent of the individual:

(1) Health status.

(2) Medical condition, including both physical and mental illnesses.

(3) Claims experience.

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(4) Receipt of health care.

(5) Medical history.

(6) Genetic information.

(7) Evidence of insurability, including conditions arising out of acts of domestic violence.

(8) Disability.

(9) Any other health status-related factor determined appropriate by the commissioner of insurance.

B.(1) A group health plan, and a health insurance issuer offering individual or group health insurance coverage in connection with a group health plan, shall not require any individual, as a condition of enrollment or continued enrollment under the plan, to pay a premium or contribution which is greater than the premium or contribution for a similarly situated individual enrolled in the plan on the basis of any health status-related factor in relation to the individual or to an individual enrolled under the plan as a dependent of the individual.

(2) Nothing in Paragraph (1) of this Subsection shall be construed to do any of the following:

(a) Restrict the amount that an employer or individual may be charged for coverage under a group health plan or individual health coverage.

(b) Prevent a group health plan, and a health insurance issuer offering group health insurance coverage, from establishing premium discounts or rebates or modifying otherwise applicable copayments or deductibles in return for adherence to programs of health promotion and disease prevention.

§2485. Comprehensive health insurance coverage; coverage for essential health benefits

A health insurance issuer that offers health insurance coverage in the individual or small group market shall ensure that the coverage includes all of the following essential health benefits:

(1) Ambulatory patient services.

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(2) Emergency services.

(3) Hospitalization.

(4) Maternity and newborn care.

(5) Mental health and substance use disorder services, including behavioral health treatment.

(6) Prescription drugs.

(7) Rehabilitative and habilitative services and devices.

(8) Laboratory services.

(9) Preventive and wellness services and chronic disease management.

(10) Pediatric services including oral and vision care.

§2486. Prohibition on excessive waiting periods

A group health plan and a health insurance issuer offering group or individual health insurance coverage shall not apply to any waiting period that exceeds ninety days.

§2487. Prohibition on lifetime or annual limits; exceptions

A.(1) A group health plan and a health insurance issuer offering group or individual health insurance coverage in Louisiana shall not establish either of the following:

(a) Lifetime limits on the dollar value of benefits for any participant or beneficiary.

(b) Except as provided in Paragraph (2) of this Subsection, annual limits on the dollar value of benefits for any participant or beneficiary.

(2)(a) With respect to plan years beginning prior to January 1, 2014, a group health plan and a health insurance issuer offering group or individual health insurance coverage shall only establish a restricted annual limit on the dollar value of benefits for any participant or beneficiary with respect to the scope of benefits that are essential health benefits pursuant to R.S. 22:2485.

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(b) The commissioner of insurance shall promulgate regulations to define the term "restricted annual limit" for purposes of this Subsection and shall ensure that access to needed services is made available with a minimal impact on premiums.

C. Subsection A of this Section shall not be construed to prevent a group health plan or health insurance coverage from placing annual or lifetime per beneficiary limits on specific covered benefits that are not essential health benefits pursuant to R.S. 22:2485, to the extent that the limits are otherwise permitted by federal or state law.

§2488. Applicability; exemptions; conflict of laws

A.(1) This Chapter shall not apply to any grandfathered health plan coverage.

(2) For the purposes of this Chapter, "grandfathered health plan coverage" has the same meaning as that term in 45 C.F.R. 147.140 or other subsequently adopted federal law, rule, regulation, directive, or guidance.

B. The provisions of this Chapter shall not apply to limited benefit health insurance policies or contracts, as defined by R.S. 22:47.

C. In the event of a conflict between any provision of this Chapter and any other provision of this Title, including but not limited to R.S. 22:1062, 1063, 1067, and 1072 , with respect to any health plan subject to the provisions of this Chapter, the provisions of this Chapter shall supersede and control.

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

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DIGEST

The digest printed below was prepared by House Legislative Services. It constitutes no part of the legislative instrument. The keyword, one-liner, abstract, and digest do not constitute part of the law or proof or indicia of legislative intent. [R.S. 1:13(B) and 24:177(E)]

HB 237 Original 2019 Regular Session Chad Brown

Abstract: Prohibits discrimination by health insurance issuers in the individual market and small and large group market based on health status.

Proposed law prohibits a group health plan or a health insurance issuer offering group or individual health insurance coverage from imposing any preexisting condition exclusion with respect to the plan or coverage.

Proposed law requires each health insurance issuer that offers health insurance coverage in the individual or group market in La. to accept every employer and individual in the state that applies for coverage, except that an issuer may restrict enrollment in coverage to open or special enrollment periods pursuant to rules and regulations promulgated by the commissioner of insurance.

Proposed law authorizes a health insurance issuer that offers health insurance coverage in the group or individual market through a network plan to do any of the following:

(1) Limit the employers that may apply for coverage to those with eligible individuals who live, work, or reside in the service area for the network plan.

(2) Within the service area of the plan, deny coverage to employers or individuals if the issuer has demonstrated to the commissioner of insurance that it will not have the capacity to deliver services adequately and is applying proposed law uniformly to all employers and individuals.

Proposed law requires a health insurance issuer offering health insurance coverage in the individual or group market to renew or continue in force the coverage at the option of the plan sponsor or the individual, as applicable, except that the issuer may nonrenew or discontinue health insurance coverage based only on a failure to pay premiums or contributions, an act or practice that constitutes fraud or an intentional misrepresentation of material fact under the terms of the coverage, or the issuer is ceasing to offer coverage in the market.

Proposed law prohibits a group health plan and a health insurance issuer offering group or individual health insurance coverage from establishing rules for eligibility, including continued eligibility, of any individual to enroll under the terms of the plan based on any of the following health status-related factors in relation to the individual or a dependent of the individual:

(1) Health status.

(2) Medical condition, including both physical and mental illnesses.

(3) Claims experience.

(4) Receipt of health care.

(5) Medical history.

(6) Genetic information.

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(7) Evidence of insurability, including conditions arising out of acts of domestic violence.

(8) Disability.

(9) Any other health status-related factor determined appropriate by the commissioner of insurance.

Proposed law requires a health insurance issuer that offers health insurance coverage in the individual or small group market to ensure that the coverage includes all of the following essential health benefits:

(1) Ambulatory patient services.

(2) Emergency services.

(3) Hospitalization.

(4) Maternity and newborn care.

(5) Mental health and substance use disorder services, including behavioral health treatment.

(6) Prescription drugs.

(7) Rehabilitative and habilitative services and devices.

(8) Laboratory services.

(9) Preventive and wellness services and chronic disease management.

(10) Pediatric services including oral and vision care.

Proposed law prohibits a group health plan and a health insurance issuer offering group or individual health insurance coverage from applying any waiting period that exceeds 90 days.

Proposed law prohibits a group health plan and a health insurance issuer offering group or individual health insurance coverage in La. from establishing either of the following:

(1) Lifetime limits on the dollar value of benefits for any participant or beneficiary.

(2) Annual limits on the dollar value of benefits for any participant or beneficiary, except with respect to plan years beginning prior to Jan. 1, 2014, an issuer shall only establish a restricted annual limit on the dollar value of benefits for any participant or beneficiary with respect to the scope of benefits that are essential health benefits.

Proposed law does not apply to any grandfathered health plan coverage or limited benefit health insurance policies or contracts.

In the event of a conflict between proposed law and any other provision of the La. Insurance Code, the provisions of proposed law shall supersede and control.

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

(Adds R.S. 22:2481-2488)

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