LOUISIANA DEPARTMENT OF INSURANCE
JAMES J. DONELON
COMMISSIONER

DIRECTIVE 208

TO: ALL HEALTH INSURANCE ISSUERS, HEALTH MAINTENANCE ORGANIZATIONS, THIRD-PARTY ADMINISTRATORS, AND GROUP SELF-INSURERS

FROM: JAMES J. DONELON, COMMISSIONER OF INSURANCE

RE: APPLICABILITY OF THE FEES AUTHORIZED IN LA. R.S. 46:2625; ENFORCEMENT ACTIONS AGAINST ENTITIES FOR VIOLATIONS OF LA. R.S. 46:2625

DATE: MAY 9, 2016

It has come to my attention that various health insurance issuers, health maintenance organizations, group self-insurers (often called "multiple employer welfare arrangements" or "MEWAs"), and third-party administrators (which by law includes pharmacy benefits managers) are substantially out of compliance with provisions of Louisiana law that impose various fees that partially finance the Louisiana Medicaid Program. The purpose of Directive 208 is to confirm applicability of the fees, particularly La. R.S. 46:2625(A)(1)(c), which authorizes a 10 cent per prescription fee on every out-patient prescription filled by a pharmacy in this state and by certain out-of-state pharmacies.

The Medicaid Program is a means-tested entitlement program that finances the delivery of primary and acute medical services, as well as long-term care services. It was established in the Social Security Amendments of 1965 (Public Law 89-97), and represents more than twelve percent (12%) of all mandatory federal spending. Although the administration of the Medicaid Program by each state is optional, every state and the District of Columbia, and the five Territories have elected to administer a Medicaid Program. Due to the large costs in the form of federal mandatory outlays, Congress and the U.S. Department of Health and Human Services exercise a close degree of supervision over the mechanisms by which states, the District of Columbia, and the Territories receive federal matching funds.

Throughout the 1980s, many states and to an extent Louisiana utilized fees on health care providers and health care goods and services to secure federal matching dollars to increase Medicaid spending. However, many states entered into hold-harmless

agreements with health care providers to ensure that providers that were taxed or subject to fees would receive that money back in addition to increased Medicaid expenditures or reimbursement rates. In other words, states implemented a system by which they would create a tax, repay the taxpayer in full, and give that taxpayer a part of the increased revenue that was funded from the federal government through higher reimbursements. These schemes drew the ire of Congress. In 1991, Congress enacted the Medicaid Voluntary Contribution and Provider-Specific Tax Amendments (Public Law 102-234), which prohibits such hold-harmless schemes at the expense of federal tax payers. The act of Congress in 1991 codified a requirement that any provider fee, tax, assessment, or other mandatory payment must be both broad-based (imposed on all providers within the class of providers) and uniform (the same tax, fee, assessment, etc. is imposed on all providers within the class).[1] In addition to other specific requirements, the law expressly prohibits any hold-harmless agreements for the taxes, fees, assessments, etc., and prohibits any such fees from applying only to Medicaid providers or enrollees.

As a result of the Congressional action in 1991, the Louisiana Legislature in 1992 amended the Medicaid financing model used in Louisiana with respect to the fees, taxes, assessments, etc., governed by the Congressional act. The pertinent provisions of the Louisiana statute, codified in Title 46 of the Louisiana Revised Statutes of 1950, reads:

> §2625. Fees on health care providers; disposition of fees
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> A.(1) The Department of Health and Hospitals is hereby authorized to adopt and impose fees for health care services provided by the Medicaid program on every nursing facility, every intermediate care facility for people with developmental disabilities, every pharmacy in the state of Louisiana and certain out-of-state pharmacies, dispensing physicians, and medical transportation providers. The amount of any fee shall not exceed the total cost to the state of providing the health care service subject to such fee. In addition, the amount of the fees imposed under the rules and regulations adopted shall not exceed the following:
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> (a) Ten dollars per occupied bed per day for nursing facilities.
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> (b) Thirty dollars per occupied bed per day for intermediate care facilities for people with developmental disabilities.
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> (c) Ten cents per out-patient prescription.
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> (d) Ten cents per out-patient out-of-state prescription.

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[1] The broad-based and uniform requirements are codified in section 1903(w) of the Social Security Act and have implementing regulations at 42 C.F.R. Part 433.

> (e) Ten cents per out-patient prescription dispensed by dispensing physicians.
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> (f) Seven dollars and fifty cents per medical service trip for medical transportation providers.
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> (2)(a) Any fee authorized by and imposed pursuant to this Section shall be considered an allowable cost for purposes of insurance or other third party reimbursements and shall be included in the establishment of reimbursement rates.

The plain language of La. R.S. 46:2625 does not state that the six fees established therein are applicable only to goods or services provided to Medicaid enrollees. Such an interpretation would expressly violate the provisions of federal law, rendering the financing scheme illegal under federal law when the statute was expressly amended in 1992 in order to comply with federal requirements for Medicaid matching funds. Those federal requirements contain the broad-based and uniform standard.[2] Indeed, the rationale for requiring that all residents of this state shoulder the burden of financing the Louisiana Medicaid Program is the same rationale that led Congress to enact the Medicaid Voluntary Contribution and Provider-Specific Tax Amendments in 1991.

A number of health insurance issuers, health maintenance organizations, and third-party administrators have asserted that the fees authorized in La. R.S. 46:2625 are only applicable to Medicaid enrollees. That argument contradicts the plain language of the statute, its legislative history, and controlling federal law. Pursuant to La. R.S. 46:2625(A)(2)(a), failure of those entities to follow the requirements of La. R.S. 46:2625 is a violation of Louisiana Law, for which the Commissioner of Insurance has the authority

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[2] The plain language of La. R.S. 46:2625 is without ambiguity regarding the applicability of the fees levied within the section. If skepticism as to the universal applicability of La. R.S. 46:2625(A)(1)(c) remains, the legislative record quashes remaining doubt—in particular, the legislative record of the hearings before the House Committee on Appropriations held on April 27, 1992. In that hearing, it was understood that the 10 cent per prescription fee is "for every prescription dispensed in the state..." *House Bill 1615 by Representative Elias Ackal: Hearing on House Bill 1615 Before the Louisiana House Committee on Appropriations*, April 27, 1992, 1992 Regular Legislative Session of the 65th Louisiana Legislature (Testimony before the Committee by Chris Pilley and Charles Castille, of the Louisiana Department of Health and Hospitals).

We see no reason to engage in legal or constitutional debate regarding whether the fees, as they are designated by the statute, La. R.S. 46:2625, are in fact fees for services or taxes for constitutional purposes.

to issue sanctions under La. R.S. 22:1860.1 and La. R.S. 22:1654, among other provisions.

This question has mainly arisen when issuers, health maintenance organizations, or third-party administrators have refused to reimburse pharmacists for payment of the 10 cent fee on out-patient prescriptions pursuant to La. R.S. 46:2625(A)(1)(c). To avoid further alleged ambiguity and to definitively counter efforts of entities to avoid obligations under law, all issuers, health maintenance organizations, multiple employer welfare arrangements, and third-party administrators should know the following

- **The ten cent provider fee on out-patient prescriptions authorized in La. R.S. 46:2625(A)(1)(c) applies to every out-patient prescription of any kind whatever, without regard for whether that prescription is processed by or for a Medicaid enrollee, by or for an enrollee or covered person of a fully-insured health plan, or by or for a covered person or enrollee of a self-insured plan, which includes multiple employer welfare arrangements and employer-sponsored plans of self-insurance—often called "ERISA" plans.**

- **The terms of La. R.S. 46:2625 are broad enough to capture all plans, whether Medicaid, fully insured plans (sometimes called "commercial plans") or self-insured plans ("ERISA" plans).**[3,4]

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[3] In Louisiana Attorney General Opinion 02-0177, it is clear that the Attorney General's Office has long-shared the same opinion that the fee does not apply only to prescriptions filled for Medicaid enrollees. Additionally, in prior guidance, including Directive 157 issued by the Commissioner of Insurance on August 10, 2001, which directs "all insurers, health maintenance organizations, third party administrators, and self-insurance funds" to comply with La. R.S. 46:2625(A)(2)(a), this agency has continuously maintained that any argument that the fees authorized in La. R.S. 46:2625 are only applicable to Medicaid enrollees is without merit.

[4] With respect to self-insured, single-employer sponsored plans or "ERISA" plans, La. R.S. 46:2625 neither relates to nor makes an impermissible reference to the Employee Retirement Income Security Act of 1974, but rather is a law of broad and general application with only tenuous and remote connections to ERISA plans, and as such, La. R.S. 46:2625 is not preempted by ERISA section 514. See *New York State Conference of Blue Cross and Blue Shield Plans vs. Travelers Insurance Co.*, 514 U.S. 645 (1995), *The District of Columbia vs. The Greater Washington Board of Trade*, 506 U.S. 125 (1992), and *De Buono vs. NYSA-ILA Medical and Clinical Services Fund*, 520 U.S. 806 (1997), in which the Court held that the effects of a tax imposed by the state of New York was not preempted simply because ERISA plans had to absorb increased costs—"Any state tax, or other law, that increases the cost of providing benefits to covered employees will have some effect on the administration of ERISA plans, but that simply cannot mean that every state law with such an effect is pre-empted by the federal statute." 520 U.S. 806, 816.

As such, by the terms of La. R.S. 46:2625(A)(2)(a), all entities which reimburse pharmacies or pharmacists shall include the ten cent out-patient prescription fee in the reimbursement. The failure to do so may result in the highest sanctions permissible by law.

All regulated entities are hereby directed to bring their business practices into compliance with the purpose and intent of Directive 208.

Please be governed accordingly.

Baton Rouge, Louisiana, this 9th day of May 2016.

JAMES J. DONELON
COMMISSIONER OF INSURANCE