months. In cases where the log is not complete for the past 24 months, the error rate shall be set by mutual agreement between the audited party and the qualified billing auditor; and when the parties cannot agree, then the historic error rate shall be presumed to be seven percent.

D. The audit log shall contain the amount billed immediately preceding the audit, and net adjustment resulting from the audit, the name, address, and phone number of the audit firm conducting the audit, and the name of the qualified billing auditor who performed the audit. Audits whose results are in dispute and audits ordered by the provider and conducted by its own or contracted audit organization shall not be included in the audit log. The audit log shall be available at all times during regular business hours for inspection by any qualified billing auditor.

E. Audit fees, if needed, are to be paid upon commencement of the on site billing audit. Any payment identified in the audit results that is owed to either party by the other shall be settled by the audit parties within a reasonable period of time-not to exceed 30 days after completion of the audit unless the two parties agree otherwise.

F. Neither the provider nor the qualified billing auditor shall require a billing, or re-billing, or refund request following final audit determination, but all findings shall be netted, and the final result will be due by the relevant party without additional billing.

G. Photocopying and duplication charges shall be paid in accordance with R.S. 40:1299.96.

AUTHORITY NOTE: Promulgated in accordance with Act 664 of the 1993 Regular Legislative Session and R.S. 22:12.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 20:311 (March 1994).

Chapter 31. Regulation 53—Basic Health Insurance Plan Pilot Program

§3101. Purposes

A. The purpose of this regulation is to provide for the implementation of the Louisiana Basic Health Insurance Plan Pilot Program (LA Health); and to provide for related matters.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:11, R.S. 22:2241-2247, and the Administrative Procedure Act, R.S. 49:950 et seq

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 20:1012 (September 1994).

§3103. Applicability and Scope

A. These regulations shall apply to all insurance carriers, health maintenance organizations, employers, health care providers and individuals that apply to cover or to be covered by the Louisiana Basic Health Insurance Pilot Program (LA Health).

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:11, R.S. 22:2241-2247, and the Administrative Procedure Act, R.S. 49:950 et seq

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 20:1012 (September 1994).

§3105. Definitions

A. For purposes of this regulation:

Accidental Injury—bodily injury sustained as the result of an unforeseen event and which is the direct reason for receiving care and treatment (independent of disease, bodily infirmity or any other cause). Such care shall occur while coverage under the pilot is in force. It does not include injuries for which benefits are provided under any workers' compensation, employers' liability, or for which another party is liable under automobile, property and casualty, and other coverage.

Admission—begins the first day an insured becomes a registered hospital inpatient and continues until insured is discharged from the facility.

Adult—an individual who is greater than 24 but less than 65 years of age.

Applicant—an individual who applies for coverage under the LA Health Plan.

Authorized Carrier—the health insurance carrier or health maintenance organization licensed and in compliance with the Louisiana Insurance Code certified by the department to offer the LA Health Plan.

Benefit Payment—the amount the authorized carrier will pay for covered services. See §§3127-3133 of this regulation.

Benefit Period—one year, also referred to as year or calendar year. The benefit period does not begin before the insured's effective date. The benefit period does not continue after the insured's coverage ends.

Clinic—a facility for the diagnosis, care and treatment of outpatients.

Commissioner—the Louisiana Commissioner of Insurance.

Co-Payment—the cost-sharing fee charged to an insured under LA Health as specified in the contract between the authorized carrier for LA Health and the insured.

Department—the Louisiana Department of Insurance.

Dependent—

a. the spouse and all unmarried children under the age of 24;

b. children include natural children, legally adopted children and step-children. Also included are children (or children of a spouse) for whom an insured has legal responsibility resulting from a valid court decree. Foster children that an insured expects to raise to adulthood and that live with an insured in a regular parent-child relationship are considered children;

c. students who are unmarried children who have not yet attained the age of 24 and who are enrolled as fulltime students and who are dependent upon the primary insured;

d. mentally retarded or physically handicapped children remain covered to age 21 at which time they are eligible for their own individual coverage;

e. a child's coverage ends when any of the following occurs:

i. marriage or attaining age 21 (whichever comes first);

ii. termination of an insured's coverage under the LA Health Plan; or

iii. if a child over age 21 no longer qualifies as a full-time student.

Effective Date—the date an applicant becomes eligible for coverage under an authorized carrier for the LA Health Plan.

Hospital—an institution, licensed by the state, which:

a. provides inpatient services and is compensated by or on behalf of its patients;

b. primarily provides medical and surgical facilities to diagnose, treat and care for the injured or sick;

c. has a staff of physicians licensed to practice medicine by the Louisiana State Board of Medical Examiners;

d. provides nursing care by registered nurses or:

NOTE: The term *hospital* does not mean:
1. an extended care facility, nursing home, community based care, or group home;
2. a place of rest;
3. a facility for the aged;
4. a custodial institution whose primary purpose is to furnish food, shelter, training, or unskilled or nonmedical services; or
5. an institution for exceptional or handicapped children. licensed practical nurses on duty 24-hours-a-day.

Insurance Producer or Producer— an individual who is licensed by the commissioner as an insurance producer pursuant to the provisions of R.S. 22:1541-1566.

Insured—an individual domiciled in this state who is eligible to receive benefits from an authorized carrier under the LA Health Plan.

LA Health—the Louisiana Basic Health Insurance Plan Pilot Program.

Louisiana Insurance Code—Title 22 of the Louisiana Revised Statutes of 1950.

Mental and Nervous Disorders—includes (whether organic or nonorganic, whether of biological, nonbiological, genetic, chemical, or nonchemical origin, and irrespective of cause, basis or inducement) mental disorders, mental illnesses, psychiatric illnesses, mental conditions and psychiatric conditions. This includes, but is not limited to, psychoses, neurotic disorders, schizophrenic disorders, affective disorders, personality disorders and psychological or behavioral abnormalities associated with transient or permanent dysfunction of the brain or related neurohormonal systems. This is intended to include disorders, conditions, and illnesses listed in Diagnostic and Statistical Manual of Mental Disorders (DSM-IIIR).

Minor Dependent—a dependent under the age of 24.

Non-Smoker—an individual who has not smoked cigarettes, cigars, pipes or other substances within the past year.

Participating Hospital—a hospital located in Louisiana which has concluded a written agreement with, and in form approved by, an authorized carrier under the LA Health Plan.

Participating Provider—a licensed health care provider who has concluded an agreement with, and in form approved by, an authorized carrier under the LA Health Plan to serve those insured by LA Health.

Pilot Plan—a plan that provides an insured with health insurance under the LA Health program and is governed by R.S. 22:2241-2247 and authorized by the commissioner.

Pilot Program—the program of health insurance which is authorized by R.S. 22:2241-2247.

Provider—includes any discipline licensed by the state of Louisiana to provide and be directly reimbursed for services covered by the LA Health Plan including, but not limited to, the following:

a. doctor of medicine (M.D.) legally entitled to practice medicine and perform surgery by the Louisiana State Board of Medical Examiners;

b. doctor of chiropractic (D.C.) legally entitled to practice chiropractic services;

c. doctor of podiatric medicine (D.P.M.) legally entitled to practice podiatry;

d. all providers shall be licensed by the state of Louisiana.

Semiprivate Room—a hospital room which has 2, 3, or 4 beds.

Service Area—that part of the state of Louisiana in which the authorized carrier is applying to offer or is offering the pilot plan.

Skilled Nursing Care—care required, while recovering from an illness or injury, which is received in a skilled nursing facility. This care requires a level of care or services less than that in a hospital, but more than could be given in the patient's home or in a nursing home not certified as a skilled nursing facility.

Smoker—an individual who has smoked cigarettes, cigars, pipes or other substances within the past year or who is currently smoking cigarettes, cigars, pipes or other substances.

Utilization Review—a function performed by an authorized carrier under the LA Health Plan or an entity selected by the carrier to review and approve whether the services provided, or to be provided, are medically necessary including, but not limited to, whether acute hospitalization, length of stay, outpatient care, or diagnostic services are appropriate.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:11, R.S. 22:2241-2247, and the Administrative Procedure Act,

R.S. 49:950 et seq.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 20:1012 (September 1994), amended LR 49:490 (March 2023).

§3107. Pilot Plan in General

A. An authorized carrier under the LA Health Plan shall deliver coverage for the plan through a fully insured individual health insurance policy or health maintenance organization membership plan. Each authorized carrier shall design the plan to minimize the cost of delivery and administration of the plan and medical services for covered benefits.

B. An authorized carrier may provide coverage to individuals or their dependents or both. However, an authorized carrier may offer coverage for all adults or all children, or the individual's entire family.

C. An authorized carrier may accept partial payment for individuals enrolled under the LA Health Plan from such individual's employers; however, such payment shall not be considered to be part of that employer's group health insurance if the employer offers other health insurance. Furthermore, such payment by an employer shall not change the status of the coverage. It remains an individual policy.

D. Employers who agree to make partial payment for individuals enrolled under the LA Health Plan may be authorized by the enrolled employee to deduct insurance premiums for the plan. Such a payroll deduction shall not be construed to alter the plan's status as an individual insurance policy.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:11, R.S. 22:2241-2247, and the Administrative Procedure Act, R.S. 49:950 et seq.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 20:1012 (September 1994).

§3109. Pilot Plan Authorized Carrier

A. An authorized carrier shall be responsible for the operation of the LA Health Plan for which it has been certified to operate.

B. An authorized carrier shall be authorized to participate in the LA Health Plan by entering into a pilot plan agreement with the commissioner. The agreement shall incorporate the application procedure for health and accident insurance policy forms and shall not be authorized until such policy forms have been approved. Such approval shall include any revisions to the application which are agreed upon by the commissioner and the authorized carrier.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:11, R.S. 22:2241-2247, and the Administrative Procedure Act, R.S. 49:950 et seq..

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 20:1012 (September 1994).

§3111. Application Process

A. An applicant to become an authorized carrier shall apply for authorization to operate a LA Health Plan by submitting an application to the commissioner. The applicant shall provide at least the following information:

1. the name of the carrier and a description of its role in funding, insuring, and operating the pilot plan;

2. a full description of how the pilot plan will operate, including plan benefits, coverage limitations, premiums, provider networks, managed care provisions, and administrative procedures of the plan;

3. a listing of participating providers by service category and geographic service area;

4. a draft of all materials describing the LA Health Plan that are intended for distribution to insured members;

5. a description of the financial and organizational resources supporting the pilot plan.

B. Applications submitted to the commissioner's office will, furthermore, be judged on their ability to attain the intent of the LA Health Plan according to the following criteria:

1. their ability to guarantee issue of the LA Health Plan to the eligible population;

2. their ability to provide the LA Health Plan as a community rated product;

3. their ability to provide the LA Health Plan at premium amounts which are significantly lower than premium amounts for standard market policies of health and accident insurance;

4. their ability to implement cost containment features;

5. the degree to which their plan of benefits under the LA Health Plan emphasizes primary health care services designed to prevent the need for more expensive health care services; and

6. variance beneficial to the eligible LA Health population from the minimum standards established for the LA Health Plan's benefits outlined in §§3127-3133 of this regulation.

C. Applications may be submitted to the commissioner's office on or after the effective date of this regulation. Applications received before the effective date shall be subject to any revisions required by changes in this regulation. Applications received in the commissioner's office after 90 days of the effective date of this regulation will not be considered.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:11, R.S. 22:2241-2247, and the Administrative Procedure Act, R.S. 49:950 et seq.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 20:1012 (September 1994).

§3113. Authorization of Pilot Plan

A. The commissioner shall have sole discretion regarding the authorization of carriers under the LA Health Plan. Applications will be evaluated by the commissioner in order of their receipt. The commissioner shall have sole discretion in determining if an application is complete. Within 30 days of receiving a complete application, but in

no event prior to the effective date of this regulation, the commissioner shall provide a written notice of findings to the applying carrier. That notice shall:

1. specify approval or rejection of the application and the grounds for that decision; or

2. specify additional information which is needed to clarify the application and a deadline for submitting that information. Within 30 days of receiving timely additional information, the commissioner shall provide a written notice of findings as described in §3113.A.1. If the additional information is not provided by the deadline, the application shall be rejected.

B. In evaluating and authorizing carriers under the LA Health Plan, the commissioner may consider, but not be limited to, the following criteria:

1. the extent to which the plan helps the pilot program achieve a diversity of participants and plan designs;

2. the potential of the plan to fulfill the objectives of the pilot;

3. the financial and organizational resources of the carrier;

4. the ability of the plan to meet the evaluation criteria described in §3117 of this regulation;

5. the resources available within the department to regulate the pilot program.

C. The LA Health Plan shall not be issued or delivered to an applicant for the plan until a copy of the form is filed and approved by the commissioner. The commissioner shall review these forms in accordance with the Louisiana Insurance Code.

D. Each authorized carrier in the pilot plan shall file with the commissioner the rates, rating plans, and rating systems that will be applicable to the LA Health Plan.

E. The commissioner, in accordance with the Louisiana Insurance Code, may make, or cause to be made, an examination of the books and records of the authorized carrier of the LA Health Plan as the commissioner deems necessary to ensure compliance with these regulations and the pilot plan agreement.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:11, R.S. 22:2241-2247, and the Administrative Procedure Act, R.S. 49:950 et seq.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 20:1012 (September 1994), amended LR 49:492 (March 2023).

§3115. Revocation of an Authorized Carrier's Authority

A. The commissioner may revoke the authority of an authorized carrier at any time if, in the judgement of the commissioner, one or more of the following, or similar, conditions exist:

1. the authorized carrier's plan does not comply with R.S. 22:2241-2247 or the Louisiana Insurance Code;

2. an authorized carrier becomes subject to suspension or revocation of its certificate or authority under the Louisiana Insurance Code;

3. the authorized carrier's plan is deficient regarding timeliness, accuracy, customer service, or other administrative practices;

4. the authorized carrier's plan does not meet the evaluation requirements or reporting requirements described in §3117 of this regulation;

5. a breach of the plan of the authorized carrier agreement occurs;

6. the successful operation of the plan of the authorized carrier is jeopardized by a weakness in the financial or operational status of the authorized carrier.

B. The commissioner shall provide written notice to the authorized carrier in advance of any revocation.

C. In providing notice, the commissioner shall specify the concerns at issue and shall request a written statement for the authorized carrier, to be provided within 15 days of the date of notice, describing how they propose to remedy the concerns.

D. Upon completion of review of the proposed remedy, the commissioner shall provide a written response which:

1. approves the remedy; or

2. requests additional information; or

3. provides notice of the proposed revocation of the carrier's authority to participate in the pilot plan.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:11, R.S. 22:2241-2247, and the Administrative Procedure Act, R.S. 49:950 et seq.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 20:1012 (September 1994), amended LR 49:492 (March 2023).

§3117. Evaluation and Reporting Requirements

A. Each plan shall be evaluated by the commissioner on its ability to enhance the delivery and improve the cost effectiveness of medical services for the insured. This evaluation shall compare the results of the plan's coverage. The criteria and methodology for this evaluation shall be determined by the commissioner, with prior advice of the authorized carrier. An authorized carrier shall agree to participate in the evaluation process as a condition of operating under the LA Health Plan.

B. An authorized carrier shall provide the following reports to the commissioner:

1. a written overview of plan results for each six months of plan operations. The report shall outline the operating results of the plan, including significant issues which arose and the responding actions taken by the plan and shall specify the number of insured and a demographic breakdown of those enrolled, the premiums collected, and utilization reports. The report shall be compiled after each six-month period of plan operation and shall be mailed to the commissioner by the twentieth day of the subsequent month;

2. all reports required in accordance with §3117.A.

C. Nothing in this rule shall be construed to limit the commissioner's authority to require information from an

authorized carrier as necessary to monitor the carrier's compliance with the requirements of the LA Health Plan.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:11, R.S. 22:2241-2247, and the Administrative Procedure Act, R.S. 49:950 et seq

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 20:1012 (September 1994).

§3119. Premium Taxes

A. Premium taxes required under R.S. 22:842 shall be imposed on an authorized carrier.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:11, R.S. 22:2241-2247, and the Administrative Procedure Act, R.S. 49:950 et seq.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 20:1012 (September 1994), amended LR 49:492 (March 2023).

§3121. Guaranty Association

A. All applicable assessments for the Louisiana Life and Health Insurance Guaranty Association shall be imposed on an authorized carrier in accordance with R.S. 22:2081-2099.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:11, R.S. 22:2241-2247, and the Administrative Procedure Act, R.S. 49:950 et seq.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 20:1012 (September 1994), amended LR 49:492 (March 2023).

§3123. Health Insurance Producers

A. For purposes of serving a LA Health Plan policy or soliciting prospective insureds for such a policy, insurance producers licensed for the line of accident and health or sickness shall be deemed to be servicing and soliciting within the scope of their license, pursuant to R.S. 22:1541-1547 and 22:255 of the Louisiana Insurance Code.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:11, R.S. 22:2241-2247, and the Administrative Procedure Act, R.S. 49:950 et seq.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 20:1012 (September 1994), amended LR 49:492 (March 2023).

§3125. Eligibility

A. Eligibility for coverage and the effective date for an insured shall be determined by the authorized carrier after an applicant has returned the application for coverage to the authorized carrier and has been approved by said carrier. Eligibility for the LA Health Plan is limited to Louisiana residents with income levels below 250 percent of the federal poverty level. Individuals with major medical accident and health insurance coverage, individuals who are eligible for coverage under the Medicaid or Medicare programs, and those who have voluntarily canceled their accident and health insurance coverage during the last six months are not eligible under the LA Health Plan. The only exception to this requirement is for those individual eligible who are without coverage because their coverage furnished in accordance with R.S. 22:1046, group health continuation coverage, has expired; or for those individual eligibles with significantly reduced coverage through benefit riders or limitations.

B. Eligible adults may choose to purchase coverage only for themselves or all their children, or the entire family.

C. Unmarried eligible dependent children are eligible for coverage to age 21. Those children who are full-time students (after high school) in an institution of higher learning may remain covered to age 24. Such children shall be dependents under federal income tax laws.

D. A newborn child or an adopted child is covered, subject to §3125.E, from the moment of birth or date of assumption of legal responsibility to age 21, unless married before age 21, in the case of a family enrolled. The child's coverage is no different than that of the primary insured adult. An additional premium payment is required.

E. A newborn child or an adopted child of an enrolled individual is automatically covered for 31 days only in the case of an individual enrolled. In order for a newborn child or an adopted child to receive coverage past the thirty-first day, the enrolled individual shall complete an application form and pay the necessary premium for plan coverage.

F. If an eligible individual does not apply for coverage under the plan for himself or any eligible dependent, then application may be made later. If such individual is approved for coverage, the effective date of coverage will be the next month following approval of the application and payment of the necessary coverage.

G. Insureds may reduce the number of individuals covered at any time by submitting a change of coverage form. Such changes become effective on the due date of the LA Health Plan contract.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:11, R.S. 22:2241-2247, and the Administrative Procedure Act, R.S. 49:950 et seq.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 20:1012 (September 1994), amended LR 49:492 (March 2023).

§3127. Benefits

A. The LA Health Plan is a basic health insurance plan providing primary and preventive health care services. Health care services are to be furnished by participating hospitals, clinics, and health care providers who have agreed to provide services under the LA Health Plan. An authorized carrier shall supply insured individuals under the LA Health Plan with a list of participating providers.

B. No requirement of the Louisiana Insurance Code relating to minimum required policy benefits, other than the minimum standards contained in this regulation or in R.S. 22:2241-2247, shall apply to the LA Health Plan, its insureds, or the authorized carrier.

C. The benefits provided by the LA Health Plan are payable for services provided by a participating provider only. LA Health Plan insureds shall receive care from a participating provider. No coverage is provided with any other providers. Insureds shall pay in full for care they receive if the provider they utilize is not a participating provider.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:11, R.S. 22:2241-2247, and the Administrative Procedure Act, R.S. 49:950 et seq.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 20:1012 (September 1994), amended LR 49:493 (March 2023).

§3129. Hospital Services

A. The LA Health Plan provides for the following minimum or their actuarial equivalent inpatient hospital services:

1. 15 days of hospital inpatient care (hospital/medical) per calendar year. A $50 per day co-payment is required;

2. surgical procedures and related expenses are covered up to a maximum of $5,000 per insured per calendar year. A $50 per surgical procedure co-payment is required;

3. the LA Health Plan will pay for covered expenses incurred for services in a participating hospital for the following services based on the limitations above;

a. daily room, board, and general nursing care at the semiprivate rate charged by the participating hospital;

b. confinement in an intensive care or coronary care unit with such payment being in lieu of expenses covered under §3129.A.3.a;

c. services and supplies furnished by the participating hospital which are necessary for inpatient medical care and treatment, including diagnostic x-ray and lab services;

4. maternity care;

5. newborn nursery care from the moment of birth;

6. medical care and treatment by a participating provider while confined as an inpatient in a hospital;

7. radiological services by a licensed radiologist while confined as an inpatient in a hospital;

8. radiation therapy.

B. The LA Health Plan provides for the following minimum or their actuarial equivalent outpatient hospital services:

1. the LA Health Plan shall pay covered expenses incurred for outpatient diagnostic services for pre-admission tests, diagnostic X-ray and laboratory services at a participating facility. The outpatient benefit is limited to $1,000 per insured per calendar year;

2. payment of outpatient hospital services is prohibited on the date of admission or during an admitted stay in a hospital as an inpatient.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:11, R.S. 22:2241-2247, and the Administrative Procedure Act, R.S. 49:950 et seq

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 20:1012 (September 1994).

§3131. Emergency Room Benefits

A. The LA Health Plan provides for the following emergency room benefits:

1. outpatient health care received in the emergency room of a participating hospital is covered, limited to a maximum of $1,500 per insured per calendar year. This benefit is subject to an $85 co-payment per visit;

2. the co-payment of $85 per visit shall be waived if such a visit is followed by an admission to the participating hospital for the care of the illness or injury for which the person was treated in the emergency room.

B. An insured receiving emergency room care resulting from an illness or injury outside the service area of the authorized carrier shall have benefits of 50 percent of those for services received at a participating hospital.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:11, R.S. 22:2241-2247, and the Administrative Procedure Act, R.S. 49:950 et seq

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 20:1012 (September 1994).

§3133. Provider Services

A. The LA Health Plan provides for the following minimum, or their actuarial equivalent, primary health care provider services.

1. The LA Health Plan will provide for health care provider services, with such care including the general treatment of illness and diagnostic studies used to diagnose the cause of an illness.

2. All care received by a LA Health insured shall be related to the cause or symptom of the insured's illness or injury. Payment will not be made for care and treatment which is not deemed medically necessary.

3. Participating provider office visits are subject to a $10 per visit co-payment. Covered services in the participating provider's office include:

a. laboratory and x-ray services;

b. immunizations for children under age 19;

c. prenatal care visits. Only one co-payment for all visits shall be charged if the participating provider bills in one lump sum;

d. an annual physical exam.

4. Fees for X-ray and laboratory tests made on an outpatient basis for diagnosis or treatment of an illness are covered when ordered by a participating provider. This benefit has a $1,000 calendar year maximum and is subject to the insured paying either $5 co-payment or a maximum of 10 percent of the charge up to a maximum of $1,100 per calendar year. The authorized carrier shall specify which option is to be taken in applying to participate in the LA Health Plan.

5. Surgical and related expenses are covered under the LA Health Plan up to a maximum of $5,000 per insured per calendar year. A $50 per surgical procedure co-payment is required.

6. Maternity care is a covered service subject to the following co-payment requirements:

a. normal vaginal delivery—$50 co-payment;

b. Cesarean delivery—$100 co-payment;

c. if hospitalization follows delivery, the $50 per day inpatient co-payment shall apply.

B. Outpatient mental health care services provided by a provider licensed to diagnose and treat mental and nervous disorders are covered when provided by a participating provider up to a maximum of $1,000 per calendar year with a $10 per visit co-payment.

C. Benefits for the following services are paid subject to the benefits listed in the regulation:

1. use of a participating hospital operating and treatment rooms and equipment;

2. diagnostic X-rays, laboratory procedures and medical diagnostic procedures used to determine the cause of an illness when performed within 14 days prior to participating hospital admission.

D. Benefits shall be provided for mammograms. A $5 per screening co-payment is required when performed by a participating provider and performed with the following frequency:

1. once as a base line mammogram for any female between 35 and 40 years of age;

2. once every two years for any female between 40 and 50 years of age;

3. once every year for any female age 50 or above; and

4. when recommended by a participating provider for a female at risk. Female at risk means a female:

a. who has a personal history of breast cancer;

b. who has a personal history of biopsy proven benign breast disease;

c. whose grandmother, mother, sister, or daughter has had breast cancer; or

d. who has not given birth prior to age 30.

E. Benefits are provided for one pap smear examination per year when performed upon recommendation of a participating provider. A $5 per examination co-payment is required.

F. Benefits are provided for annual prostate antigen tests for covered males who are 45 years of age or older; or covered males who are 40 years of age or older, if ordered by a participating provider. A $5 per test co-payment is required.

G. Benefits are provided for colon cancer screening when ordered by a participating provider. A $5 per screening co-payment is required.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:11, R.S. 22:2241-2247, and the Administrative Procedure Act, R.S. 49:950 et seq

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 20:1012 (September 1994).

§3135. Limitations

A. Pre-Existing Conditions

1. Until coverage for an insured enrolled in the LA Health Plan has been in force for 12 consecutive months, benefits for services to be paid to an authorized carrier shall not be available for any illness, injury, or other condition for which:

a. the existence of symptoms which would cause an ordinarily prudent person to seek diagnosis, care, or treatment, or a condition for which medical advice or treatment was recommended by or received from a provider of health care services within six months preceding the effective date of coverage of an individual insured.

2. Maternity benefits are available to an insured only if the date of conception occurred after the effective date of coverage under the LA Health Plan.

3. No coverage is available to inpatient hospital admissions which begin before an insured's effective date.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:11, R.S. 22:2241-2247, and the Administrative Procedure Act, R.S. 49:950 et seq

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 20:1012 (September 1994).

§3137. Exclusions

A. There is no benefit provided for the following:

1. any treatment or care not received from a participating hospital or participating provider;

2. private duty nursing;

3. prescription drugs (outpatient) or over-the-counter medicines. However, outpatient prescriptions may be covered by an additional rider to the LA Health Plan;

4. inpatient treatment or counseling for mental and nervous disorders;

5. care for any condition or injury recognized as a compensable loss through any workers' compensation, occupational disease, or similar law;

6. any disease or injury resulting from a war, declared or not, or resulting from any military duty;

7. any item, service, supply, or care not specifically listed as a benefit under the LA Health Plan;

8. care given by a medical department or clinic run by an insured's employer;

9. hospitalization and related services or care rendered if primarily for diagnostic studies;

10. care of corns, bunions (except capsular or related surgery), callouses, nails of the feet (except surgical removal), flat feet, fallen arches, weak feet, chronic foot strain or symptomatic complaints related to the feet;

11. admission or continued hospital stay for care not medically required on an inpatient basis;

12. skilled nursing care;

13. eyeglasses, contact lenses, hearing aids, hearing devices, or cochlear implants, and related examinations and services;

14. charges for convenience items during a hospital admission;

15. custodial care, rest cures, or travel expenses, even if recommended for health reasons by a physician;

16. care, supplies, or equipment not medically necessary for the treatment of injury or illness;

17. cosmetic or reconstructive surgery except to restore function of any body area which has been altered by disease, trauma, congenital/developmental anomalies, or previous therapeutic processes;

18. care prescribed and supervised by other than a participating provider;

19. dental care and treatment by a dentists or a health care provider, including dental surgery, dental appliances, dental prostheses such as crowns, bridges, or dentures; implants, orthodontic care, operative restoration of teeth (fillings); dental extractions (except impacted teeth); endontic care; apicoectomies, treatment of dental caries, gingivitis, or periodontal surgery, vestibuloplasties, alveoloplasties, dental procedures involving teeth and their bone or tissue supporting structures; frenulectomy; temporomandibular joint syndrome (TMJ), including related appliances; or other dental procedures. Except for the following treatments which shall be reimbursable at the levels specified in §3133 of this regulation:

a. to correct traumatic injuries which occur while the insured is covered under the LA Health Plan; or

b. to correct congenital defects of a child born under and who remains covered under the LA Health Plan; or

c. for the extraction of impacted teeth after the required waiting period has been met;

20. surgical or medical care for obesity, weight reduction, or dietary control;

21. surgical or medical treatment to modify the sex of an individual or services related to the treatment for impotence or other sexual dysfunctions or inadequacies;

22. professional ambulance service;

23. hair transplants, hair pieces, wigs, wig maintenance, or prescriptions or medications related to hair growth;

24. advice or consultation given by any form of telecommunication;

25. services and supplies which are experimental or investigational in nature;

26. charges for failure to keep a scheduled visit or charges for completion of claim forms; charges for physician or hospital standby services; charges for holiday or overtime rates;

27. outpatient speech, occupational, cardiac rehabilitation, or physical therapy;

28. outpatient use of durable medical equipment;

29. radial keratotomy; and surgery, services, or supplies for the surgical correction of nearsightedness and/or astigmatism;

30. services related to or performed in conjunction with artificial insemination, in vitro fertilization or infertility;

31. biofeedback, recreational, or educational therapy, or other forms of self-care or self-help training and any related diagnostic testing;

32. services for conditions related to austic disease of childhood, hyperkinetic syndromes, learning disabilities, behavioral problems, or mental retardation;

33. charges for treatment of a physical injury resulting from suicide or a suicide attempt, sane or insane;

34. intentionally self-inflicted injury;

35. injuries received while committing a crime.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:11, R.S. 22:2241-2247, and the Administrative Procedure Act, R.S. 49:950 et seq

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 20:1012 (September 1994).

§3139. Outpatient Prescription Rider

A. An authorized carrier may offer as rider to the LA Health Plan coverage for outpatient prescription drugs that includes a minimal co-payment.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:11, R.S. 22:2241-2247, and the Administrative Procedure Act, R.S. 49:950 et seq

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 20:1012 (September 1994).

§3141. Premium Maximums, Method for Calculating

A. Premiums charged for the LA Health pilot plans shall be based on the average standard rate charged by the five largest health and accident insurers offering individual coverage in the state, as identified by the Louisiana Health Insurance Association's annual survey in accordance to R.S. 22:1213.E.3. Annual survey results may be obtained from the department. For the purpose of calculating the maximum premiums as established in §3141.B of this regulation, insurers shall use the premiums identified in the Louisiana Health Insurance Association's Plan "A" and shall use the strict average of male and female rates.

B. Premium rates shall be community rated within each service area, but may vary according to an enrolled individual's status, (i.e., adult or minor dependent and smoker or nonsmoker), as established in §3141.B.1-3 of this regulation.

1. Adult individual rates shall be based on a per unit basis. Each individual's premium rate enrolled in the plan shall be no more than 60 percent of the strict average of the

average individual standard rate charges for adults as identified in §3141.A of this regulation.

2. For the purpose of establishing the premium rate for minor dependents, there shall be one rate regardless of the number of minor dependents enrolled under each plan policy. The premium rate for minor dependents shall be no more than 60 percent of the average individual standard charged for children as identified in §3141.A of this regulation.

3. Rates may vary according to an individual's status as either a smoker or nonsmoker. For those individuals enrolled in the plan as a smoker, premium rates identified in §3141 shall be based on the average individual standard rate charged for smokers as identified in §3141. For those individuals enrolled in the plan as a nonsmoker, premium rates identified in §3141 shall be based on the average individual standard rate charge for nonsmokers as identified in §3141.A of this regulation.

4. Where a sliding scale is utilized for setting an individual or family's premium payment amount (including any contribution which may be made by an employer), the maximum payment amount for the highest income level cannot exceed the upper limits established under §3141.B.1-3 of this regulation.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:11, R.S. 22:2241-2247, and the Administrative Procedure Act, R.S. 49:950 et seq.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 20:1012 (September 1994), amended LR 49:493 (March 2023).

§3143. Payment of Benefits

A. An insured under the LA Health Plan is entitled to benefits for covered services as specified in this regulation and in the contract between an authorized carrier and the insured.

B. Benefits will be provided only if covered services are prescribed by or performed by or under the direct supervision of a participating provider.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:11, R.S. 22:2241-2247, and the Administrative Procedure Act, R.S. 49:950 et seq.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 20:1012 (September 1994), amended LR 49:493 (March 2023).

§3145. General Provisions

A. All premium payments for coverage are due in advance. Monthly premium payments are for a complete month of coverage. There are no refunds and any cancellations will be effective on the first day of the month for which a premium has not been paid.

B. Any insured under the LA Health Plan may be considered for reinstatement within six months of termination, no matter what the reason prior coverage was terminated.

C. If coverage is terminated due to lack of payments, the insured may reapply for coverage within 90 days and pay any premiums still due.

D. An insured under the LA Health Plan may renew coverage by payment of the necessary premiums to the authorized carrier by the due date.

E. An authorized carrier may change the amount of monthly premium for the LA Health Plan in compliance with the Louisiana Insurance Code. Payment by the insured of the new rate is sufficient to indicate acceptance of the new rate.

F. The LA Health Plan shall be governed by the laws and regulations of the state of Louisiana and specifically those of the LA Health Plan.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:11, R.S. 22:2241-2247, and the Administrative Procedure Act, R.S. 49:950 et seq.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 20:1012 (September 1994), amended LR 49:493 (March 2023).

§3147. Termination of Coverage

A. An insured's spouse who would otherwise lose coverage due to a divorce or death is automatically eligible for coverage in his or her name.

B. Coverage for any child terminates the last day of the month during which such child is no longer eligible for coverage under the LA Health Plan.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:11, R.S. 22:2241-2247, and the Administrative Procedure Act, R.S. 49:950 et seq

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 20:1012 (September 1994).

Chapter 33. Regulation 55—Life Insurance Illustrations

§3301. Purpose

A. The purpose of this regulation is to provide rules for life insurance policy illustrations that will protect consumers and foster consumer education. The regulation provides illustration formats, prescribes standards to be followed when illustrations are used, and specifies the disclosures that are required in connection with illustrations for policies not excluded herein. The goals of this regulation are to ensure that illustrations do not mislead purchasers of life insurance and to make illustrations more understandable. Insurers will, as far as possible, eliminate the use of footnotes and caveats and define terms used in the illustration in language that would be understood by a typical person within the segment of the public to which the illustration is directed.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:3.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 22:984 (October 1996).

§3303. Applicability and Scope

A. This regulation applies to all group and individual life insurance policies and certificates except:

1. variable life insurance;

2. individual and group annuity contracts;

3. credit life insurance; or