3. annual experience data on each risk insured, including but not limited to:

a. written premiums;

b. written premiums at a manual rate;

c. paid losses;

d. outstanding losses;

e. loss adjustment expenses;

f. underwriting expenses;

g. underwriting profits; and

h. profits from contingencies; and

4. a record of all complaints including the date the complaint was made, the name of the complainant, the nature of the complaint and the final resolution.

B. The record required by this section may be kept in electronic or written form and shall be maintained by the insurer for a period of five years from the date of issuance of the insurance policy or renewal policy if a new certification form is required pursuant to §9015.C. Upon request, the insurer shall produce such record for examination by the COI or any person acting on behalf of the COI.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:2, R.S. 22:3, R.S. 22:1211 et seq. and R.S. 22:1301.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 26:502 (March 2000).

§9019. Exempt Policy Forms

A. Commercial risk property and casualty policy forms which would otherwise have to be filed with and approved by the COI are exempt from this requirement if issued to an exempt commercial policyholder. The exemption of the policy form from the requirement that it be filed with and approved by the COI is not to be taken by an insurer to mean that an insurance contract confected by the use of such a policy form, or policy forms, may in any manner be inconsistent with the statutory law of this state or public policy as expressed by the courts of this state.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:2, R.S. 22:3. and R.S. 22:620, and 22:1211 et seq.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 26:502 (March 2000).

§9021. Penalties for Failure to Comply

A. The exemption created by this regulation is a limited one and insurers must strictly comply with the conditions creating the exemption. Failure to comply with the regulation by any person subject to its provisions, after proper notice and a hearing held by the COI, may result in the imposition of such penalties as are authorized by law.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:2, R.S. 22:3, R.S. 22:620; R.S. 22:1211 et seq., R.S. 22:1115 and R.S. 22:1457.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 26:502 (March 2000).

Chapter 91. Regulation 68 Patient Rights under Health Insurance Coverage in Louisiana

§9101. Purpose

A. The purpose of this regulation is to clarify the rights of insureds and requirements for health insurance coverage approved under Title 22 of the Louisiana Revised Statutes of 1950. Title 22 of the Louisiana Revised Statutes of 1950 establishes the statutory requirements that health insurance coverage must meet to be issued for delivery in Louisiana. The statutory requirements also establish the intent of the legislature to afford patients with health insurance coverage, basic rights to access covered benefits without undue delays or denials based on arbitrary determinations of medical necessity. The statutory requirements also establish the legislative intent to prohibit the use of a health insurance coverage requirement or procedure that impinges on the ability of the insured patient to receive appropriate medical advice and/or treatment from a health care provider.

B. To carry out the intent of the legislature and assure full compliance with the provisions of applicable statutory requirements, this regulation sets forth the patient rights under health insurance coverage policies or plans issued for delivery in this state.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:3 and R.S. 22:2014

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 26:324 (February 2000).

§9103. Definitions

Emergency Medical Condition the sudden and, unexpected onset of a health condition that requires immediate medical attention, where failure to provide such medical attention could reasonably be expected to result in death, permanent disability, serious impairment to bodily functions, serious dysfunction of a bodily organ or part, or could place the person's health in serious jeopardy.

Formal Managed Care Plan basic health coverage provided by a Health Maintenance Organization licensed to operate in Louisiana. The term does not include health insurance coverage that does not meet the same quality standards that are applied to Health Maintenance Organizations. The term does not apply to any health insurance coverage or employer benefit plan that advertises or markets coverage as "managed care" but is not required to comply with the statutory consumer protections required of formal managed care plans operated by Health Maintenance Organizations in Louisiana.

Geographic Area a parish.

Health Care Professional a physician duly licensed to practice medicine by the Louisiana State Board of Medical Examiners, or other health care professional duly licensed, certified, or registered as appropriate in Louisiana, or an acute care hospital licensed to provide medical care in this state.

Health Insurance Coverage benefits consisting of medical care, provided directly, through insurance or reimbursement, or otherwise and including items and services paid for as medical care, under any hospital or medical service policy or certificate, hospital or medical service plan contract, preferred provider organization, or health maintenance organization contract. This term shall not mean limited benefit insurance as defined in R.S. 22:6(2)(b)(i) or any short term health insurance exempt from guaranteed renewal by PL 102-191, the Health Insurance Portability and Accountability Act of 1996.

Incentive Arrangement any payment or contractual obligation included in a general payment plan, capitation contract, shared risk arrangement, or other agreement between a managed care organization and a health care provider that is tied to utilization of covered benefits.

Managed Care Plan has the same meaning as set forth under R.S. 22:215.18A(3) and (4). This includes health insurance policies and health maintenance organization coverage. The term does not include supplemental insurance or limited benefit coverage for out of pocket expenses that is exempt from being classified as creditable coverage under Part of Part VI-C of Chapter 1 of Title 22 of the Louisiana Revised Statutes of 1950.

Service Area the geographic area or areas of the state served by a managed care plan.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:3 and R.S. 22:2014

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 26:324 (February 2000).

§9105. Applicability and Scope

A. Except as otherwise specifically provided, the requirements of this regulation apply to all health insurance coverage issued for delivery in the state of Louisiana that is otherwise subject to the statutory requirements of Part VI-C of Chapter 1 of Title 22 of the Louisiana Revised Statutes of 1950.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:3 and R.S. 22:2014

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 26:324 (February 2000).

§9107. Patient Rights under Policies or Plans of Health Insurance Coverage

A. Prohibition on the Use of Gag Clauses Applies to HMO Coverage. Patients have a right to talk freely with health care professionals about their health, medical conditions, and any treatment options that are available, including those not covered by their health plan. R.S. 22:215.18(B) prohibits a managed care plan from adopting any requirement that interferes with the ability of a health care professional to communicate with a patient regarding his or her health care. This statutory protection also includes communications regarding treatment options and medical alternatives, or other coverage arrangements. The managed care plan is only allowed to prohibit a health care professional from soliciting alternative coverage arrangements for the purpose of securing financial gain by the health care professional.

B. Prohibition on Incentives to Restrict, Delay or Deny Medically Necessary Care Applies to HMO and Major Medical Insurance Coverage. Patients have a right to receive medically necessary and appropriate services covered under a managed care plan. R.S. 22:215.19 prohibits managed care plans from offering any financial incentives to health care professionals to deny, reduce, limit, or delay specific, medically necessary, and appropriate services.

C. Holding Managed Care Plans Liable for their Actions, Omissions, or Activities Applies to HMO and Major Medical Insurance Coverage. Managed care plans are responsible for their actions, activities or omissions that result in harm to the patient. R.S. 22:215.18(G) prohibits managed care plans from transferring their liability related to activities, actions or omissions of the plan to a health care professional treating the insured. This right does not relieve health care professionals of their responsibilities to appropriately practice within the scope of license, certification, or registration.

D. Guaranteed Direct Access to Obstetricians/ Gynecologists Applies to HMO and Major Medical Insurance Coverage. Women have a right to see an Obstetrician or Gynecologist for routine care. R.S. 22:215.17 requires health insurance coverage to include direct access to these health care professionals without prior authorization. In addition, health insurance coverage is required to include up to two annual routine visits and follow up treatment within 60 days of either visit if a related condition is diagnosed or treated during the visits. This requirement also applies to pregnancy related care if covered by the policy or plan.

E. Requirement for Appropriate Access to Covered Medical Services Applies to HMO Coverage

1. Formal managed care plans operated by health maintenance organizations are required to maintain an adequate number of health care professionals to serve plan participants. Covered services must be provided within a reasonable period of time once ordered or prescribed. R.S. 22:2004, 2005, 2013, 2016, and 2021 establish requirements for HMO plans to document that their networks of primary care physicians and specialists are adequate. HMOs are allowed to use point of service options to expand networks and assure access to plan participants.

2. Other health insurance coverage is only allowed to offer managed care as a coverage option. These plans must offer traditional payment of medical claims based on the terms of the policy for deductibles and co-insurance.

F. Confidentiality of Medical Records Applies to HMO Coverage

1. Any data or information pertaining to the diagnosis, treatment, or health of any enrollee or potential enrollee obtained from such persons or from any provider by any formal managed care plan shall be held in confidence and shall not be disclosed to any person except:

a. to the extent that it may be necessary to carry out the purposes of operating a formal managed care plan as permitted by law;

b. upon the express consent of the enrollee or potential enrollee;

c. pursuant to statute or court order for the production of evidence or the discovery thereof;

d. in the event of a claim or litigation between such person and the formal managed care plan wherein such data or information is pertinent.

2. A formal managed care plan shall be entitled to claim any statutory privileges against such disclosure which the provider who furnished such information to the formal managed care plan is entitled.

G. Prohibit Unreasonable Denial of Emergency Care Applies to HMO and Major Medical Insurance Coverage

1. Any managed care plan that includes emergency medical services shall provide coverage and shall subsequently pay health care professionals for emergency medical services provided to a covered patient who presents himself/herself with an emergency medical condition.

2. No health insurance plan shall retrospectively deny or reduce payment to health care professionals for emergency medical services of a covered patient even if it is determined that the emergency medical condition initially presented is later identified through screening not to be an actual emergency, except in the following cases:

a. material misrepresentation, fraud, omission, or clerical error;

b. any payment reductions due to applicable co-payments, co-insurance, or deductibles that may be the responsibility of the covered patient;

c. cases in which the covered patient does not meet the emergency medical condition definition, unless the covered patient has been referred to the emergency department by the insured's primary care physician or other agent acting on behalf of the health insurance plan.

H. Appeal/Grievance Procedures for Denials of Coverage Applies to HMO and Major Medical Insurance Coverage

1. Formal managed care plans operated by health maintenance organizations are required to have an administrative appeal or grievance process for patients. R.S. 22:2022 requires these plans to submit their appeal/grievance procedures to the Department of Insurance to verify the process or procedures used are reasonable and meet the intent of the statute.

2. In addition, where any insured patient is denied benefits under a health insurance coverage plan, a request can be made to the Department of Insurance for investigation of the denial. Where the denial is valid, the insured is so notified. Where the denial is erroneous, the health insurance coverage plan is required to institute corrective action and may be subject to fines and penalties if a statutory violation has occurred.

I. Guaranteed Continuation Of Group Insurance Applies To HMO and Major Medical Insurance Coverage

1. R.S. 22:215.13 guarantees Louisiana residents who lose their eligibility for coverage under a group health insurance policy or plan, the right to maintain such coverage in force for up to 12 months. This guaranteed continuation of group health insurance does not include accident only coverage, specific disease coverage, limited benefit coverage for dental, vision care or any benefits provided in addition to the basic hospital, surgical, or major medical benefits of the policy. This means that additional or optional insurance coverage purchased is not guaranteed to be provided during this 12-month continuation period. This continuation of group coverage right is guaranteed for up to one year so long as the following conditions are met:

a. the individual is not eligible for any other group health coverage plan or government sponsored health plan, such as Medicare and Medicaid;

b. the individual timely pays the full monthly premium to keep coverage in force;

c. the individual was not terminated from coverage for fraud or failure to pay any required contribution for the group insurance, and continues to meet the group policy's terms and conditions other than membership in that original group;

d. all dependents covered under the group policy or plan continue to be covered;

e. the group policy has not been terminated or the employer has withdrawn participation in a multiple employer group policy; and

f. the individual continues to reside within the service area of the plan in the event that such group coverage is provided by a Health Maintenance Organization.

2. This right is not automatic and requires the employee or member who is losing coverage to make a written election of continuation on a form furnished by the group policyholder and pay for the first month's coverage prior to the date that coverage is being terminated. Written notification of termination must be provided to the individual in advance to allow election of this right.

3. Special continuation rights are provided to a surviving spouse of an individual who was covered by a group health insurance policy or plan at the time of death and is age 55 or older. Under Louisiana law the surviving spouse is guaranteed the right to continue such group coverage in effect until eligible for any other group coverage. The surviving spouse is also allowed to provide coverage to all dependents that were covered under the deceased spouse's policy or plan at the time of death so long as they remain eligible under the policy.

J. Guaranteed Renewal of Health Insurance Coverage Applies to HMO and Major Medical Insurance Coverage

1. Under Louisiana law, once health insurance coverage has been purchased, the insurer cannot cancel the coverage unless one of the following conditions exists:

a. failure to pay premiums or contributions in accordance with the terms of the policy;

b. failure to comply with a material plan provision relating to employer contribution or group participation rules;

c. performance of an act or practice that constitutes fraud or the intentional misrepresentation of a material fact under the terms of coverage;

d. the policyholder no longer resides, lives, or works in the service area in the event the coverage is provided under a formal managed care plan operated by a Health Maintenance Organization;

e. the policyholder's coverage is purchased through a bona-fide association plan and the policyholder is no longer eligible to participate in such association;

f. the insurance company is no longer offering the type of coverage purchased and offers to replace the policy with any other type of similar coverage being marketed within 90 days of renewal; or

g. the insurance company is leaving the market and will no longer be selling any group and/or individual health insurance products in Louisiana for a period of at least five years. In such instances the insurer must give each policyholder 180 days advance notice in writing before the policy is terminated. All termination notices must be filed and approved by the Department of Insurance prior to issuance.

K. Limits on Preexisting Medical Condition Exclusions from Coverage Applies To HMO and Major Medical Insurance Coverage. Under Louisiana law, a health insurance plan is allowed to exclude medical conditions from coverage for a limited period of time. All policies now being sold are prohibited from excluding coverage for preexisting medical conditions for more than 12 months. Regardless of the type of coverage (group or individual), health plans are not allowed to apply an exclusion of coverage based on a preexisting medical condition for more than 12 months.

1. Group Coverage. The medical conditions that can be excluded from coverage are limited to those that were diagnosed or treated during the six month period prior to the day coverage begins under the policy. Any condition that was not being treated during the prior six months cannot be excluded from coverage.

2. Individual Coverage. The medical conditions that can be excluded from coverage are limited to those that were diagnosed, treated or reasonably should have been treated during the 12 month period prior to the day coverage begins under the policy. Any condition that was not diagnosed, treated, or reasonably should have been treated during the prior 12 months cannot be excluded from coverage.

L. Guaranteed Portability Protections Applies to HMO and Major Medical Insurance Coverage

1. Individuals who are moving their health coverage from one employment situation to another or from one group plan to another are guaranteed the following rights provided they have enrolled in the new plan within 63 days of termination from the prior plan:

a. if the new plan imposes a 12-month preexisting exclusionary period, the individual must be given one month's credit for each month of continuous coverage under the prior plan. If the individual had 12 or more months of continuous coverage under the prior plan, the preexisting exclusionary period has been satisfied. If the individual had six months of continuous coverage under the prior plan, the preexisting exclusionary period is reduced by six months;

b. if the new employer imposes an exclusionary or waiting period for employees before coverage can begin, such periods do not count as a break in coverage for applying portability rights;

c. during any exclusionary or waiting period, no premiums can be charged to the individual;

d. during any exclusionary or waiting period the individual may maintain their prior coverage if eligible under state continuation of coverage rights, federal COBRA rights, or through purchase of an individual policy;

e. individuals, who had at least 18 months of prior coverage under a group plan, have exhausted or are not eligible for state continuation rights or COBRA rights, are guaranteed access to individual health insurance coverage through the Louisiana Health Insurance Association.

2. Any Louisiana resident who has individual health insurance coverage is guaranteed credit for prior individual coverage when replacing coverage if the insurance plan is applying the prior insurance policy's lifetime benefit usage against the replacement policy. Residents can waive credit for prior coverage to avoid any reduction in the lifetime benefit limit of the replacement coverage. However, state law no longer allows the sale of any policy of insurance that excludes coverage in excess of 18 months.

M. Prohibiting Discrimination against Individuals Based on Health Status Applies to HMO and Major Medical Insurance Coverage

1. State and federal law prohibit any group health coverage plan from discriminating against individuals based on their health status. This means that an individual's medical status cannot be used to determine eligibility to join a group health plan with certain exceptions. Plans are specifically prohibited from adopting any rules for eligibility or continued eligibility based on any of the following health status related factors:

a. health status;

b. medical condition, including both physical and mental illness;

c. claims experience;

d. receipt of health care;

e. medical history;

f. genetic information;

g. evidence of insurability, including conditions arising out of acts of domestic violence; and

h. disability.

2. A plan's rules for eligibility to enroll under a plan also include rules defining any applicable waiting periods for such enrollment. This means that the plan may only apply exclusionary or waiting period uniformly based on date of hire for all eligible employees. No exclusionary or waiting periods are allowed after coverage begins and premiums are being collected from the insured.

N. Prohibition on Use of Prenatal and Genetic Tests by Health Insurance Plans Applies to HMO and Major Medical Insurance Coverage. State law prohibits health insurance plans from requiring any individual to take genetic tests or prenatal tests prior to being offered coverage. Plans are also prohibited from requesting release of any genetic or prenatal test results or using such information in the determination of benefits or rates for an insured.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:3 and R.S. 22:2014.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 26:325 (February 2000).

§9109. Patient Responsibilities

A. Under Louisiana law, formal managed care plans operated by health maintenance organizations are held to a higher standard than other health insurance coverage plans that include managed care options. All materials provided by a health insurance coverage plan should be carefully reviewed prior to making a purchasing decision. Managed care requirements under each health insurance coverage plan may vary significantly. For this reason, all patient requirements should be carefully reviewed to assure there is no misunderstanding regarding how medical coverage will be provided.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:3 and R.S. 22:2014.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 26:327 (February 2000).

Chapter 99. Regulation 76 Privacy of Consumer

Subchapter A. General Provisions

§9901. Authority

A. This regulation is adopted pursuant to R.S. 22:2 which charges the commissioner of insurance with the duty to enforce and administer all of the provisions of the Insurance Code, the purpose of which is to regulate the business of insurance in all of its phases in the public interest. Sections 501(b) and 505(a)(6) of the Gramm-Leach-Bliley Act specifically designate the Department of Insurance as the agency to establish the appropriate standards covering any person engaged in providing insurance under state law. R.S. 22:3 grants the commissioner of insurance authority to promulgate rules and regulations as are necessary for the implementation of the provisions of Title 22. R.S. 22:3052 specifically refers to the protection of the interests of insurance policyholders in this state with respect to financial institution insurance sales, and R.S. 22:3054 grants the commissioner of insurance authority to promulgate rules and regulations as may be necessary to effectuate the provisions of Chapter 6 Financial Institution Sales in Title 22.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:2, 22:3, 22:3052, 22:3054, and Gramm-Leach-Bliley Act, Public Law 106-102–Nov. 12, 1999).

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner; LR 27:548 (April 2001).

§9903. Purpose

A. The purpose of this regulation is to govern the treatment of nonpublic personal financial information about individuals by all licensees of the state insurance department. This regulation:

1. requires a licensee to provide notice to individuals about its privacy policies and practices;

2. describes the conditions under which a licensee may disclose nonpublic personal financial information about individuals to affiliates and nonaffiliated third parties; and

3. provides methods for individuals to prevent a licensee from disclosing that information.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:2, 22:3, 22:3052, 22:3054, and Gramm-Leach-Bliley Act, Public Law 106-102–Nov. 12, 1999).

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner; LR 27:548 (April 2001).

§9905. Scope and Applicability

A. This regulation applies to:

1. nonpublic personal financial information about individuals who obtain or are claimants or beneficiaries of products or services primarily for personal, family or household purposes from licensees. This regulation does not apply to information about companies or about individuals who obtain products or services for business, commercial or agricultural purposes; and

B. Compliance. A licensee domiciled in this state that is in compliance with this regulation in a state that has not enacted laws or regulations that meet the requirements of Title V of the Gramm-Leach-Bliley Act (PL 102-106) may nonetheless be deemed to be in compliance with Title V of the Gramm-Leach-Bliley Act in such other state.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:2, 22:3, 22:3052, 22:3054 and Gramm-Leach-Bliley Act, Public Law 106-102–Nov. 12, 1999).

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner; LR 27:548 (April 2001).