RULE
Department of Insurance
Office of the Commissioner

Regulation 116—Stop-Loss or Excess Policies of Insurance
(LAC 37:XIII.Chapter 169)

The Department of Insurance, pursuant to the authority of the Louisiana Insurance Code, R.S. 22:1 et seq., and in accordance with the Administrative Procedure Act, R.S. 49:950 et seq., has promulgated Regulation 116, Stop-Loss or Excess Policies of Insurance. This regulation has been in order to codify the types of stop-loss or excess policies that can be used by employers sponsoring group health plans and in order to codify the requirements for disclosures under R.S. 22:883. This Rule is hereby adopted on the day of promulgation.

Title 37
INSURANCE
Part XIII. Regulations
Chapter 169. Regulation 116—Stop-Loss or Excess Policies of Insurance

§16901. Purpose

AUTHORITY NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, in accordance with R.S. 22:2 and 22:883.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 46:698 (May 2020).

§16903. Applicability and Scope
A. This regulation shall apply to employers that sponsor group health plans.

AUTHORITY NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, in accordance with R.S. 22:2 and 22:883.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 46:698 (May 2020).

§16905. Definitions

Group Health Plan—an employee welfare benefit plan as defined in Section 3(1) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1002(1)) to the extent that the plan provides medical care as defined in this regulation and including items and services paid for as medical care for employees or their dependents, as defined under the terms of the plan, directly or through insurance, reimbursement, or otherwise, or only to a multiple employer welfare arrangement that is a self-insurer and does not include those multiple employer welfare arrangements that meet the definition in 29 U.S.C. 1002(40).

Medical Care—amounts paid for the diagnosis, cure, mitigation, treatment, or prevention of disease, or amounts paid for the purpose of affecting any stricture or function of the body; transportation primarily for and essential to such medical care; and amounts paid for insurance covering such medical care, as defined in R.S. 22:1061(1)(b).

Paid Contract Basis—allows claims incurred under a “group health plan” during the contract period of a stop-loss or excess policy to be paid during the policy’s twelve-month contract period.

Run-In Contract Basis—allows for reimbursement of claims incurred under a group health plan during a stated period prior to the effective date of the twelve-month contract period of a stop-loss or excess policy and paid during the twelve-month contract period.

Run-Out Contract Basis—allows for reimbursement of claims incurred under a group health plan during the stated twelve-month contract period and paid within a stated period extending at least 90 days after expiration of the twelve-month contract period.

Self-Insurance Plan—any contract, plan, trust, arrangement, or other agreement which is established or maintained to offer or provide health care services, indemnification, or payment for health care services, or health and accident benefits to employees of two or more employers, but which is not fully insured. Any such contract, plan, trust, arrangement, or agreement shall be deemed fully insured only if said services, indemnification, payment, or benefits are guaranteed under a contract or policy of health insurance issued by an insurer authorized to transact business in this state. The term self-insurance plan shall not include any arrangement or trust formed under Subpart J of Part I of Chapter 10 of Title 23 of the Louisiana Revised Statutes of 1950 (R.S. 23:1191 et seq.), single employer plans, plans exempt from the state insurance laws under the provisions of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1001 et seq.), except as provided in R.S. 22:463, the Office of Group Benefits, plans of political subdivisions, health maintenance organizations regulated under the Health Management Organization Act, R.S. 22:241 et seq., plans regulated under R.S. 33:1342, 1343, 1346, or 1349, and plans otherwise regulated as insured plans under this Title. A plan of a fraternal benefit society or a labor organization shall not be considered a self-insurance plan for the purposes of this Subpart to the extent that such plan provides health and accident benefits to its members and any of their dependents that are supplemental to those of an employer-provided plan.


Self-Insurer—any entity that makes, provides, or issues a self-insurance plan and is licensed by the LDI.

Stop-Loss or Excess Policy/Policies—insurance covering the losses of an insured above a specific amount or a self-insurer for losses over a stated amount.

Terminal Liability—group health plan that provides an extra ninety days of protection upon termination of the Run-out contract period.

AUTHORITY NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, in accordance with R.S. 22:2 and 22:883.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 46:698 (May 2020).

§16907. Eligible Claims
A. Stop-loss or excess policies are required to contain a provision that eligible claims incurred under the group health plan during the initial contract period shall be covered, provided that proof of payment of the eligible claims by the group health plan is furnished to the stop-loss or excess insurer within ninety days after the expiration of
the stop-loss or excess policy or any later period that is
depository in the contract or stop-loss or excess policy.

AUTHORITY NOTE: Promulgated by the Department of
Insurance, Office of the Commissioner, in accordance with R.S.

HISTORICAL NOTE: Promulgated by the Department of

§16909. Available Claims Incurred and Paid Contract
Bases
A. The following claims incurred and paid contract bases
are available to suit the needs of diverse employers
sponsoring group health plans:
1. paid as defined in Section 16903;
2. run-in as defined in Section 16903;
3. run-out as defined in Section 16903;
4. terminal liability as defined in Section 16903.

AUTHORITY NOTE: Promulgated by the Department of
Insurance, Office of the Commissioner, in accordance with R.S.

HISTORICAL NOTE: Promulgated by the Department of

§16911 Policy Form Requirements
A. Stop loss or excess policy forms intended to cover the
losses of a group health plan must include the following
requirements.
1. Eligible claims incurred under the group health plan
during the initial contract period will be covered, as long as the
“group health plan” submits to the stop loss or excess
insurer proof of payment of the eligible claim within 90 days
after the expiration of the policy, or within any longer period
that is provided in the contract or policy.
2. All applications for stop-loss or excess coverage
must include the option to purchase a policy providing
coverage on a run-out contract basis. A run-out contract
basis extends the claims paid period for at least 90 days
beyond expiration of the twelve-month contract term, the
period within which claims incurred during the contract term
must be submitted and paid.
3. All applications for stop-loss or excess insurance
coverage that include the option to purchase a policy providing
coverage restricted to claims both incurred and paid during the contract term must contain a form for
acceptance or rejection of the ninety-day extension for
claims to be submitted and paid, i.e., run-out coverage. To
reject such offer, the applicant and the writing producer must both sign and date the
application or a supplemental application containing a
disclosure such as the following.

a. “It is hereby agreed and understood that the stop-
loss [excess] insurance contract selected does not provide
reimbursement to the plan sponsor for any expenses incurred
under the “group health plan” prior to the beginning of the
contract period for stop-loss [excess] insurance or for any
expenses paid after expiration of the contract period. Only
eligible expenses that are both incurred under the group
health plan and paid by the group health plan within the
twelve-month contract period for stop-loss [excess]
insurance are reimbursable under the contract selected.”

4. All applications for stop-loss or excess insurance
including options to purchase a policy providing coverage
on a run-in or a paid contract basis must contain a form for
acceptance or rejection. To reject such offer, the applicant
and the writing producer must both sign and date the

A. Stop loss or excess insurers shall exercise due
diligence in ascertaining the legitimacy or authority of the
underlying group health plan before issuing coverage. This
shall include but not be limited to ensuring that the
underlying plan is not a self-insured multiple employer
welfare arrangement pursuant to 29 U.S.C. §1002(40),
unless the underlying plan is authorized to do business in this
state as a self-insurer and meets the requirements of R.S.
22:452.

AUTHORITY NOTE: Promulgated by the Department of
Insurance, Office of the Commissioner, in accordance with R.S.

HISTORICAL NOTE: Promulgated by the Department of

§16913. Reinsurance/Health Insurance
A. Stop-loss or excess insurance shall not be equivalent
to reinsurance, nor shall it be referred to as a contract or
policy of health insurance under R.S. 22:452(1)(a).

AUTHORITY NOTE: Promulgated by the Department of
Insurance, Office of the Commissioner, in accordance with R.S.

HISTORICAL NOTE: Promulgated by the Department of

§16915. Due Diligence
A. Stop loss or excess insurers shall exercise due
diligence in ascertaining the legitimacy or authority of the
underlying group health plan before issuing coverage. This
shall include but not be limited to ensuring that the
underlying plan is not a self-insured multiple employer
welfare arrangement pursuant to 29 U.S.C. §1002(40),

a. “It is hereby agreed and understood that the stop-
loss [excess] insurance contract selected does not provide
reimbursement to the plan sponsor for any expenses incurred
under the “group health plan” prior to the beginning of the
contract period for stop-loss [excess] insurance or for any
expenses paid after expiration of the contract period. Only
eligible expenses that are both incurred under the group
health plan and paid by the group health plan within the
twelve-month contract period for stop-loss [excess]
insurance are reimbursable under the contract selected.”

b. All applications for stop-loss or excess insurance
including options to purchase a policy providing coverage
on a run-in or a paid contract basis must contain a form for
acceptance or rejection. To reject such offer, the applicant
and the writing producer must both sign and date the

4. The stop-loss or excess insurer shall provide
coverage with rates not subject to adjustment by the stop-
loss or excess insurer during the first 12 months of coverage,
unless:
there is a change in the benefits provided under the group health plan; and/or
b. enrollment under the group health plan changes by at least 10 percent.

5. A stop loss or excess insurer must submit its proposed stop-loss or excess policy to the Commissioner of the Department of Insurance for review at least 30 days prior to the proposed self-insurance plan’s effective date and at least 30 days prior to any subsequent renewal date.

A. Upon receipt of a petition for rulemaking form, the executive director shall forward the petition to the agency designee. The agency designee shall review the petition and determine if it is complete. If the petition is complete, the executive director shall forward the petition to the agency designee. The agency designee shall review the petition for completeness pursuant to the requirements listed in LAC 55:IX.501. The agency designee shall determine whether the petition contains the following basic information organized and captioned:

1. The petitioner’s name and address;
2. The specific rulemaking agency to be petitioned within the Department of Public Safety as listed on the form;
3. A brief description of the facts or justification supporting the petitioner's request for the adoption of a rule or the amending of a rule that has already been adopted;
4. Suggested specific language or language setting forth the substance of the proposed rule or rule change that is being requested, which may be attached to, or in addition to, the petition for rulemaking form;
5. A copy of each and every document upon which the petitioner bases the petitioner’s request for a rule or a citation of the information and where it can be easily obtained for review by the rulemaking agency;
6. The petitioner’s signature and date of signature.

B. Within 60 days of receipt of the petition, the executive director or the agency designee shall either:
1. Initiate rulemaking procedures to adopt a new rule, or to amend an existing rule; or
2. Notify the petitioner in writing of the denial to proceed with rulemaking, stating the reason(s) therefore.

C. Whenever the executive director or the agency designee determines that a public hearing should be held prior to the adoption of any rule or rule change, a notice of the meeting date, time and place will be published in the Louisiana Register.

§503. Consideration of a Rulemaking Petition
A. Upon receipt of a petition for rulemaking form, the executive director shall forward the petition to the agency designee. The agency designee shall review the petition for completeness pursuant to the requirements listed in LAC 55:IX.501. If the petition is found to be complete, the agency designee shall consider the petition.

B. Within 60 days of receipt of the petition, the executive director or the agency designee shall either:
1. Initiate rulemaking procedures to adopt a new rule, or to amend an existing rule; or
2. Notify the petitioner in writing of the denial to proceed with rulemaking, stating the reason(s) therefore.

C. Whenever the executive director or the agency designee determines that a public hearing should be held prior to the adoption of any rule or rule change, a notice of the meeting date, time and place will be published in the Louisiana Register.