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DIRECTIVE NUMBER 147

REQUIREMENTS FOR DISCONTINUANCE OF HEALTH INSURANCE PRODUCTS

TO: ALL HEALTH INSURANCE ISSUERS OFFERING HEALTH INSURANCE IN
THE INDIVIDUAL, LARGE AND SMALL GROUP MARKETS IN LOUISIANA

PURPOSE

The purpose of this directive is to revise Directive 147 issued January 26, 2001. Prior revisions incorporated the amendments of Act 127 of the 1999 Louisiana Legislature. Act 127 requires health insurance issuers to furnish the Commissioner of Insurance with copies of notices and specimen copies of all affected insurance products prior to either discontinuing a product or discontinuing the offer of all health insurance coverage in the individual, large or small group markets of this state. Act 127 also prohibits non-renewal of any policy or contract in these markets prior to the end of the last period of coverage as stated in such policy or contract. The latest revision is to clarify that Section B herein applies only when an insurer elects to discontinue offering both new coverage *and* renewal of existing coverage in this state.

It has come to my attention that health insurance issuers have failed to provide or improperly delayed provision of adequate notice prior to discontinuation of health insurance products in the individual, small or large group markets of Louisiana. It has also come to my attention that some health insurance issuers are not complying with the requirements for non-renewal of such discontinued coverage, in accordance with LSA-R.S. 22:250.1 through R.S. 22:250.16. I hereby direct every health insurance issuer conducting business in this state to immediately assure full compliance with the following statutory obligations.

The purpose of this Directive, as revised, is to establish and enforce uniform notice requirements with respect to a health insurance issuer electing to discontinue offering a particular type or all individual and/or group health insurance coverage in Louisiana. The provisions of LSA-R.S. 22:250.7 and 22:250.13 set forth the requirements that are applicable to health insurance issuers who are discontinuing some or all types of health insurance products marketed in this state.

A. REQUIREMENTS FOR THE DISCONTINUANCE OF A PARTICULAR TYPE OF GROUP OR INDIVIDUAL HEALTH INSURANCE COVERAGE

LSA-R.S. 22:250.7(C)(1) and 250.13(C)(1) allow health insurance issuers to discontinue offering a particular type of group health insurance coverage offered in the small or large group market or a type of individual health insurance coverage respectively, when the following requirements are met.

- To make an election to discontinue offering a particular type of health insurance coverage, any or all remaining types of health insurance coverage currently being offered by the issuer must be available and offered to each individual or plan sponsor. Excepted benefits, as defined under LSA-R.S. 22:250.1(3), are not a type of health insurance coverage that can be offered to meet the statutory requirements. If no other type of health insurance coverage is available to an individual or plan sponsor, the health insurance issuer shall follow the requirements to discontinue offering all health insurance coverage being marketed in the state, as set forth in Section B of this directive.
- In exercising the option to discontinue coverage of a type of individual or group health insurance, the health insurance issuer shall act uniformly without regard to the claims experience of those individuals and sponsors or any health status-related factor relating to any covered individuals, participants or beneficiaries covered or new participants or beneficiaries who may become eligible for such coverage.
- Prior to providing notices to covered plan sponsors and individuals, the issuer shall submit to the Commissioner of Insurance the following information:
 - 1) Copies of all proposed notices.
 - 2) A specimen copy of the insurance product to be discontinued and evidence of Departmental approval of the related policy forms.
 - 3) Specimen copies of the products to be offered and dates of Departmental approval of the related policy forms.
- The issuer shall provide notice to each covered individual or plan sponsor provided coverage of the type being discontinued in the affected markets at least 90-days prior to the date of discontinuation of such coverage.

NON-RENEWAL

Any individual or plan sponsor whose health coverage is not subject to annual renewal or renegotiation until after the minimum 90-day notice period must continue in force until the date upon which the contracted period of coverage ends. To assure that the full 90-day notice period is provided, health insurance issuers must extend coverage where necessary, and nonrenew only after requisite notice has been provided.

Existing contracts of insurance can only be nonrenewed upon the expiration of the stated period of coverage, as provided for under LSA-R.S. 250.7(B) and 250.13(B). The Department asserts that existing blocks of business in a product discontinuation situation can only be discontinued by non-renewing coverage as its specific term expires.

NOTICE REQUIREMENTS FOR DISCONTINUANCE OF A PARTICULAR TYPE OF HEALTH INSURANCE COVERAGE

The issuer shall provide notice to each individual, participant and beneficiary covered under the health insurance coverage being discontinued. Such notice shall be provided at least 90-days prior to the date of non-renewal. LSA-R.S. 22:250.7(C)(1)(a) and R.S. 22:250.13(C)(2)(a).

- For each small or large employer plan sponsor provided coverage and for each individual provided coverage, the issuer shall include the following in the notice:
 - 1) The type of coverage being discontinued; and
 - 2) The option to purchase any of the products currently being offered in such market pursuant to LSA-R.S. 22:250.6.
- The 90-day period following notification of discontinuance does not begin until a complete and accurate disclosure of all remaining types of group health insurance coverage available to the small or large employer or individual has been provided.

B. REQUIREMENTS FOR THE DISCONTINUANCE OF ALL INDIVIDUAL AND/OR GROUP HEALTH INSURANCE COVERAGE

LSA-R.S. 22:250.7(C)(2) and R.S. 22:250.13(C)(2) allow health insurance issuers to discontinue offering new coverage and to nonrenew all health insurance coverage in the individual, small or large group markets, or all markets when the following specific statutory requirements are met:

- All health insurance issued or delivered for issuance in the state in the affected market or markets must be discontinued and non-renewed.
- Prior to providing notices to covered plan sponsors, participants, beneficiaries and individuals, the issuer shall submit written notice to the Commissioner of Insurance of such discontinuation that includes, at a minimum, the following information:
 - 1) Copies of all proposed notices.
 - 2) The market or markets in which the health insurance issuer is discontinuing all coverage in this state.

- 3) A specimen copy of each type of health insurance product to be discontinued along with evidence of Departmental approval of the related policy forms.
- 4) The total number of individuals and/or plan sponsors that will be affected by the election to discontinue offering health insurance coverage.
- 5) The total number of covered lives that will be affected by the election to discontinue offering health insurance coverage.
- 6) A listing that identifies each plan sponsor whose coverage will not be renewed and the date on which coverage shall terminate.
- 7) The name, address, telephone number and such other identifying information as may be needed to contact the issuer by the Commissioner or his representative regarding the discontinuation and plan sponsors affected by the decision.
- 8) Written acknowledgement that the health insurance issuer may not issue any coverage in the affected market or markets of this state during the five-year period beginning on the date the last health insurance coverage is non-renewed.

Health insurance issuers that cease offering new coverage in a particular market are neither required to nor prohibited from nonrenewing existing coverage in that market under the state statutes cited above or the Public Health Service Act found at 42 USC section 2712(c)(2) and 2742(c)(2). To the extent that an issuer continues to renew coverage, the five-year period does not being to run.

NON-RENEWAL

When a health insurance issuer elects to discontinue offering both new and renewal coverage, all health insurance coverage issued or delivered for issuance in this state in the affected market or markets shall be discontinued and shall not be renewed. Any individual and/or plan sponsor whose coverage would have annually renewed or been subject to renegotiation prior to the end of the minimum 180-day notice period shall be extended to assure the individual and/or plan sponsor is provided with such minimum notice period in order to obtain replacement coverage.

Any individual and/or plan sponsor whose coverage is not subject to renewal or renegotiation until after the minimum 180-day notice period shall continue in force until the original termination date or date upon which the contracted period of coverage ends.

Existing contracts of insurance can only be nonrenewed prior to expiration of the stated period of coverage, as provided for under LSA-R.S. 22:250.7(B) and 22:250.13(B). The Department asserts that existing blocks of business in a market exit situation can only be discontinued by non-renewing coverage as its specific term expires.

NOTICE REQUIREMENTS FOR DISCONTINUATION OF ALL NEW AND RENEWAL INDIVIDUAL AND/OR GROUP HEALTH INSURANCE COVERAGE

- The issuer shall provide a written notice to each individual and/or plan sponsor of the health insurer's decision to discontinue offering coverage in the affected market or markets at least 180-days prior to the date of discontinuation of such coverage. LSA-R.S. 22:250.7(C)(2)(a)(i) and R.S. 22:250.13(C)(2)(a)(i).
- The issuer shall provide notice to each insured, participant and beneficiary whose coverage is being discontinued at least 180-days prior to the date of the discontinuation of such individual and/or group coverage.

C. REQUIREMENTS FOR MODIFYING A HEALTH INSURANCE PRODUCT

LSA-R.S. 22:250.7(D) and 22:250.13(D) allow health insurance issuers to modify the health insurance coverage for a product offered to a group health plan in the small or large group market or, for a policy form offered to individuals in the individual market provided that the following requirements are met:

- The health insurance issuer must submit the modified policy forms to the Commissioner of Insurance for review and approval before any changes may be effected. LSA-R.S. 22:620(A)(1)
- The modifications are effected on a uniform basis among all groups or individuals with that product.
- Since the original product issued is being discontinued, the issuer shall provide notice to each individual, plan sponsor, participant and beneficiary covered under the health insurance coverage being discontinued. Such notice shall be provided at least 90-days prior to the date of non-renewal. LSA-R.S. 22:250.7(C)(1)(a) and R.S. 22:250.13(C)(2)(a)

D. COMPLIANCE AND ENFORCEMENT

- Subject to the approval of the Commissioner, a health insurance issuer exercising its option to discontinue health coverage may arrange for the assumption of coverage by another health insurance issuer, thereby protecting the terms and conditions as originally issued.

- The health insurance issuer shall be prohibited from the issuance of any health insurance coverage in the market and state during the five-year period beginning on the date of the discontinuation of the last health insurance coverage not renewed, unless all coverage was assumed by another health insurance issuer. LSA-R.S. 22:250 7(C)(2)(b) and R.S. 22:250.13(C)(2)(b).
- Any health insurance issuer who is found to be in violation of the provisions of this regulation shall be subject to the civil money penalties outlined under LSA-R.S. 22:250.10. In no instance shall a health insurance issuer be authorized to non-renew coverage prior to the end of the negotiated period outlined in the policy, group coverage agreement or any binding letter agreement or contract of insurance where the premium or prepayment amount was established based on a guaranteed rate or rate of increase during the period of coverage.

Please be governed accordingly.

BY: _____


J. ROBERT WOOLEY
ACTING COMMISSIONER OF INSURANCE