OGB SafeNet Plan Proposal

- **Health reimbursement account of $500 or less**
- **Plan member can use to pay physicians, prescriptions drugs, lab, x-ray, or other approved experiences**
- **At least one network with 100 percent coverage for inpatient and outpatient services up to an annual and/or lifetime maximum**
- **Annual maximum at or below $50,000**

Survey of State Employees
Without OGB Health Insurance
Fall 2001

Please note: This survey is to be completed only by state employees who do **not** participate in one of the health plans of the Office of Group Benefits (OGB), formerly known as the State Employees Group Benefits Program.

1. Do you have health insurance coverage of any kind? 77.9% Yes 22.1%No

2. Are you enrolled in any of the following? (Please check)
   1.1% Medicare 1.8% Medicaid .4% LACHIPS
   3.9% CHAMPUS 25.7 Blank
   67.1% Private insurance (Please name)_____

3. Is the coverage checked in number 2 through: 14.6% yourself
   58.6% your spouse? 26.8% blank

4. Why have you chosen not to participate in OGB?
   49.6% cost
   2.1% insufficient benefits
   .4% not enough providers
   11.8% health insurance is provided through your spouse
   35.7% other_____
   .4% blank

5. How much would you be willing and/ or able to pay every month for health benefits?

   46.1 $0-$50
   20.7 $51-$100
   7.9% Blank
   20.7% $101-$200
   4.6% More than $200

6. What Hospital do you and your family use?_____

7. How many people are there in your family at home or at school?

   0=6, 1=23, 2=86, 3=48, 4=76, 5=30, 6=6, 7=4, 11=1

8. On average, how many times a year do you or your family seek medical treatment? 21.1% 1-2 29.3% 3-4 16.1% 5-6 10% 7-8 22.1% more
   1.4% blank

   Thank you for completing this survey. Please return it to your agency human resources office.

Office of Group Benefits ***Press Release***

FOR IMMEDIATE RELEASE
Contact: Sharon Runyan
225-925-7982

OGB SafeNet Program to Serve Uninsured

Special Pre-Proposal Conference to be Held

The Louisiana Office of Group Benefits (OGB) is developing a program to address the growing problem of Louisiana state workers without health insurance.

OGB is hosting a pre-proposal conference for potential health care provider networks to outline methods and options for this program, called *SafeNet*. The conference will be held Tuesday, November 4, 2003, at 10 a.m. in the 2nd floor OGB Board Room, 5825 Florida Boulevard in Baton Rouge.

A recent U.S. Census Bureau study estimates that 44 million Americans and 18.6 percent of Louisianans have no health insurance. Even more surprising is that many of these uninsured are employed.

A study by the Commonwealth Fund reported nationwide says that a third of the workers without health insurance in the United States are employed by large companies.

"This dovetails with legislation -- Act 528 -- passed in our state developing a program to provide health insurance to state employees who are currently uninsured," according to A. Kip Wall, OGB's chief executive officer.

"SafeNet will offer health benefits to those eligible for OGB, but who have not had health coverage for at least a year," says Mr. Wall.

OGB has issued a notice of intent to contract to conduct a pilot program in Baton Rouge and the surrounding parishes to evaluate the feasibility of offering SafeNet or a comparable health plan to eligible individuals on a statewide basis.

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ENROLLED

Regular Session, 2003

ACT No. 528

HOUSE BILL NO. 1989

BY REPRESENTATIVES HEBERT, DEWITT, BAYLOR, ERDEY, FRUGE, MORRISH, GARY SMITH, TOWNSEND, AND TUCKER AND SENATOR CRAVINS

AN ACT

To enact R.S. 22:231(H) and 236(10) and Chapter 8 of Title 22 of the Louisiana Revised Statutes of 1950, to be comprised of R.S. 22:3101 through 3112, relative to minimal benefit hospital and medical policies; to create the Louisiana Safety Net Health Insurance Program; to provide for the Louisiana Health Plan; to provide for eligibility; to provide for participation; to provide for employers; to provide for administration and oversight; to provide for the Office of Group Benefits; to provide for coverage and benefits; to provide for policy forms and requirements; and to provide for related matters.

Be it enacted by the Legislature of Louisiana:

Section 1. R.S. 22:231(H) and 236(10) and Chapter 8 of Title 22 of the Louisiana Revised Statutes of 1950, comprised of R.S. 22:3101 through 3112, are hereby enacted to read as follows:

§231. Legislative findings; purpose; short title

* * *

H. The legislature has established a mechanism to increase the availability of health insurance to the Office of Group Benefits and to employers in Louisiana with the creation of the Louisiana Safety Net

Health Insurance Program, and has provided for certain duties and obligations to be performed therein by the Louisiana Health Plan as set forth in Chapter 8 of this Title, R.S. 22:3101 et seq.

* * *

§236. Powers and duties of the plan

The plan shall have the general powers and authority granted under the laws of this state to insurance companies licensed to provide health and accident insurance and in addition thereto, the specific authority to:

* * *

(10) Perform the duties and obligations as required by Chapter 8 of this Title, R.S. 22:3101 et seq.

* * *

CHAPTER 8. LOUISIANA SAFETY NET HEALTH INSURANCE PROGRAM

§3101. Creation of the Louisiana Safety Net Health Insurance Program

A. There is hereby established the "Louisiana Safety Net Health Insurance Program". The program shall provide for minimal benefit hospital and medical policies, which may be insured by the Office of Group Benefits for employees eligible therefor, and by participating health insurance issuers for all other employers.

B. This Chapter shall be known and may be cited as the "Louisiana Safety Net Health Insurance Program" and be referred to as the "Louisiana Safety Net" or the "program".

§3102. Eligibility

The following are eligible for the program:

(1) Employees of the state of Louisiana, and political subdivisions thereof, who have not been covered by health insurance for at least one year and are eligible for coverage through the Office of Group Benefits.

(2) Employers who have not offered group health insurance coverage to their employees for at least one year.

(3) Employers who are not eligible under Paragraph (2) of this Section but who employ persons with an annual family income of not more than two hundred percent of the federal poverty level may offer the insurance only to those employees whose family income is not more than two hundred percent of the federal poverty level even if there are employees whose annual family income exceeds two hundred percent of the federal poverty level. For purposes of this Chapter, a family may consist of the employee only, or where applicable, include the spouse and/or dependents of the employee.

§3103. Participation and requirements

A. Health insurance issuers who have not been found to be financially impaired by the commissioner in the two years preceding application may participate in this program.

B. Participating health insurance issuers shall offer minimal benefit hospital and medical insurance policies that allow enrollees or insureds access to at least one network alternative that requires contracted health care providers to accept the amount payable for covered health care services as payment in full for such services. This network shall be specifically established for the minimal benefit hospital and medical policies to be offered pursuant to this Chapter.

Health insurance issuers may contract directly with health care providers or through a network of providers.

C. Participating health insurance issuers shall offer minimal benefit hospital and medical insurance policies under which the enrollees or insureds shall be entitled to contracted reimbursement rates by contracted health care providers for covered health care services, whether paid for by the health insurance issuer, the enrollee, or the insured.

D. Notwithstanding any law to the contrary, minimal benefit hospital and medical policies offered under the program shall be exempt from the provisions of Part VI of Chapter 1 of this Title, R.S. 22:211 et seq., Part VI-C of Chapter 1 of this Title, R.S. 22:250.1 et seq., and all other provisions of this Title, unless otherwise specifically provided herein.

E. Participating health insurance issuers may offer additional insurance products that include but are not limited to:

(1) Group health insurance that utilizes employer and/or employee funded savings, reimbursement, or personal care accounts in conjunction with the applicable deductible provisions.

(2) Employer funded personal care accounts shall not be taxable to the employee and shall be deductible to the employer, in accordance with applicable federal and state taxation laws.

(3) Minimal benefit hospital and medical insurance plans to employees of the state of Louisiana, and political subdivisions thereof; to the extent authorized by the Office of Group Benefits.

(4) Such additional insurance products as appropriate.

F. Employers that participate in the program shall:

(1) Pay at least fifty percent of the eligible employee premium cost. This provision shall not apply to the Office of Group Benefits.

(2) Enroll at least fifty percent of eligible employees in the program. This provision shall not apply to the Office of Group Benefits.

§3104. Administration and oversight; Louisiana Health Plan

A. The Louisiana Health Plan, R.S. 22:231 et seq., shall certify that participating health insurance issuers have satisfied the network requirements of this Chapter prior to the issuance of any policies authorized by the program by the participating health insurance issuer.

B. The Louisiana Health Plan is hereby designated as program director and is charged with the following specific responsibilities:

(1) To determine that employer applicants satisfy the eligibility provisions.

(2) To determine that participating health insurance issuers satisfy the network provisions of this Section.

C. The board of directors of the Louisiana Health Plan shall submit a plan of operation to the Committees on Insurance of the Senate and House of Representatives that:

(1) Establish policies and procedures for the determination of program eligibility of employers, as set forth in R.S. 22:3102.

(2) Establish policies and procedures relative to the program network criteria, as set forth in R.S. 22:3103.

(3) Establish fees for the performance of its administrative duties, and the procedure for the collection thereof.

D. The plan of operation shall be approved, in writing, provided such plan of operation meets the criteria set forth above. The plan of operation shall become effective upon approval, as aforesaid. The

Louisiana Health Plan shall provide a semiannual report on its operations. The responsibilities of the Louisiana Health Plan are limited to those set forth in this Section, and it shall not act as a health insurance issuer for the program.

E. The Office of Group Benefits and participating health insurance issuers, respectively, shall be responsible for the administration of the minimal benefit hospital and medical plans or policies, as well as any other insurance products offered pursuant to this program, and shall bear all risk of loss therefor.

F. There shall be no liability on the part of and no cause of action of any nature shall arise or exist against the Louisiana Health Plan, its agents, employees, or its board of directors for any action taken by them in the performance of their powers and duties under this Chapter.

§3105. Producer requirements

A. No producer fees or other compensation, or consideration shall be payable for coverage offered through the plan unless:

(1) The producer is duly licensed by the commissioner and certified by the program under a health insurance issuer.

(2) The producer certifies to the Louisiana Health Plan, in writing, that to the best of his knowledge, the employer is a qualifying employer as required by this Chapter.

(3) The producer has entered into a participation agreement with the health insurance issuer which provides for recoupment of amounts paid for certifications found to be erroneous.

B.(1) To assure faithful performance of his obligations, every producer licensed to sell minimal benefit hospital and medical policies

shall, prior to the issuance of a license, deposit with or for the benefit of the Louisiana Health Plan, financial security which, at all times shall have a value of not less than fifty thousand dollars.

(2) Financial security which may be used as a deposit shall be cash, certificates of deposit purchased from a financial institution licensed to conduct business in the state of Louisiana, bonds of the state of Louisiana or any of its political subdivisions, or bonds of the United States government.

(3) In lieu of the deposit of securities required by this Section, the producer may file with the Louisiana Health Plan a surety bond in the amount required by Paragraph (B)(1) of this Section. The bond shall be authorized by a surety insurer licensed to do business in the state of Louisiana, and shall serve as a substitute for the financial security required above. No such bond shall be canceled or subject to cancellation unless thirty days written notice is given to the Louisiana Health Plan.

(4) If deposit is made in the form of bonds or certificates of deposit, they shall be irrevocably pledged to the Louisiana Health Plan; provided however, that any interest earned on said securities shall be the property of the producer.

(5) Each deposit or surety shall be maintained unimpaired, unencumbered, and pledged to the Louisiana Health Plan until such time as all outstanding policies or agreements have run their full term and expired. It is the intent of this Subsection that the deposit or surety remain fully in force until such time as all of the insurer's obligations to the insured or the enrollee are fulfilled.

(6) The Louisiana Health Plan may authorize other forms of financial security.

§3106. Form of policy; delivery; cancellation

A. No minimal benefit hospital and medical policy shall be delivered or issued for delivery on risks in this state unless:

(1) The entire money and other consideration therefor are expressed therein.

(2) The time at which the insurance takes effect and terminates is expressed therein.

(3) Every printed portion of the text matter of the policy and of any endorsements or attached papers is printed in type the size of which shall be uniform and the face of which shall be not less than ten point. The "text" shall include all printed matter except the name and address of the insurer, name or title of the policy, captions and subcaptions, and form numbers.

(4) The exceptions and reductions of indemnity are clearly set forth in the policy or contract and are printed, at the insurer's option, either with the benefit to which they apply or under an appropriate caption such as "Exceptions" or "Exceptions and Reductions".

(5) Each such form, including riders and endorsements, shall be identified by a form number in the lower left hand corner of the first page thereof.

(6) There is prominently printed thereon or attached thereto, a notice to the insured that ten days are allowed, from the date of his receipt of the policy, to examine its provisions and if such policy was solicited by deceptive advertising or negotiated by deceptive, misleading, or untrue statements of the insurer or any agent on behalf

of the insurer, such policy may be surrendered within said ten-day period and any premium advanced by the insured, upon such surrender, shall be immediately returned to him; provided, that the insurer shall have the option of printing or attaching the notice above required or a notice of equal prominence which, in the opinion of the commissioner of insurance, is not less favorable to the enrollee or insured.

B. If the policy is delivered by a producer, a receipt shall be signed by the enrollee or insured policyholder acknowledging delivery of the policy. The receipt shall include the policy number and the date the delivery was completed. All delivery receipts required by this Subparagraph shall be retained by the insurer, its producer for two consecutive years. The requirement of this Subsection shall not apply to any insurer that markets under a home service marketing distribution method and that issues a majority of its policies on a weekly or monthly basis.

C.(1) If the policy is delivered by mail, it shall be sent by certified mail, return receipt requested, or a certificate of mailing shall be obtained showing the date the policy was mailed to the enrollee or insured policy owner. For policy issuances verified by a certificate of mailing, it is presumed that the policy is received by the enrollee or insured policy owner ten days from the date of mailing. The receipts and the certificate of mailing described in this Section shall be retained by the insurer or producer for three years.

(2) A health insurance issuer or producer may utilize commercial carriers or other commercially recognized carriers to deliver the policy to the enrollee or the insured; however, the health

insurance issuer or producer shall maintain documentation of actual delivery of such policy for three years.

(3) The policy or certificate of insurance may be delivered electronically to the enrollee or the insured in accordance with R.S. 9:2608; however, the health insurance issuer and the enrollee or insured shall agree to such electronic delivery, and the documentation of such delivery shall be maintained by the insurer for three years.

D. In any case where the policy is subject to cancellation at the option of the insurer, there shall be prominently printed on the first page of such policy a statement so informing the insured or enrollee policyholder.

§3107. File and use of policy forms

Health insurance issuers shall file with the commissioner minimal benefit hospital and medical plans delivered or issued for delivery in this state. Such forms shall be considered approved, unless notified by the commissioner of insurance within thirty days from the filing thereof. The commissioner shall only be authorized to disapprove such policy forms for the following reasons:

(1) The health insurance issuer is insolvent.

(2) The policy form does not comply with the requirements of R.S. 22:3106 and 3108.

§3108. Minimal benefit hospital and medical policy provisions

A. No minimal benefit hospital and medical policy shall be delivered or issued in this state without the following notice:

"THIS IS A MINIMAL BENEFIT HOSPITAL AND MEDICAL POLICY. THIS IS NOT A COMPREHENSIVE MAJOR MEDICAL POLICY."

B. Each minimal benefit hospital and medical policy shall contain in substance the following provisions or, at the option of the insurer, provisions which in the opinion of the commissioner are not less favorable to the policyholder; provided that, except as permitted by R.S. 22:211(C), no time limitation with respect to the filing of notice or proof of loss or within which suit may be brought upon the policy shall differ from the time limitations of the following provisions:

(1) Entire contract: Changes: This policy, including the endorsements and the attached papers, if any, constitutes the entire contract of insurance. No agent has authority to change this policy or to waive any of its provisions. No change in this policy shall be valid until approved by an executive officer of the insurer and unless such approval be endorsed hereon or attached hereto.

(2) Acceptable claim forms shall be the HCFA 1500 and UB 92. All claims are subject to the provisions of R.S. 22:250.32 through R.S. 22:250.34.

(3) Cancellation: The insurer may cancel this policy at any time subject to the provisions of R.S. 22:228 and R.S. 22:636(F). Such cancellation shall be by written notice, delivered to the insured, or mailed to his last address as shown by the records of the insurer, shall refund the pro rata unearned portion of any premium paid, and shall comply with the provisions of R.S. 22:636(F). Such cancellation shall be without prejudice to any claim for benefits accrued or expenses incurred for services rendered prior to cancellation. Benefits and expenses incurred shall be as defined and limited by the terms of the policy. The insured may likewise cancel this policy on the above terms. Upon cancellation by the insurer, however, the insurer shall only be

liable for any claim for benefits accrued, or for expenses incurred for services rendered, subsequent to the cancellation date if the subsequent claim is for an illness or condition which was the basis of any claim prior to cancellation and for which the insurer had notice and if the policy of insurance is canceled for reasons other than failure of the policyholder to pay premiums or failure of the insured to maintain eligibility as provided in the policy. Upon the written request of the named insured, the insurer shall provide to the insured in writing the reasons for cancellation of the policy. There shall be no liability on the part of and no cause of action of any nature shall arise against any insurer or its agents, employees, or representatives for any action taken by them to provide the reasons for cancellation as required by this Paragraph.

§3109. Construction of policy

A policy issued in violation of this Chapter shall be held valid and shall be construed as provided herein. When any provision in such a policy is in conflict with any provisions of this Chapter, the rights, duties, and obligations of the health insurance issuer, the enrollee and the insured shall be governed by the provisions of this Chapter.

§3110. Statutory construction; relationship to other laws

Except as otherwise provided in this Chapter, provisions of the insurance law and provisions of this Title shall not be applicable to minimal benefit hospital and medical policies, unless as provided in this Chapter.

§3111. Scope and limitation

A. It is not the purpose of this Chapter to alter or diminish any right, privilege, or authority granted to any health insurance issuer to

write hospital insurance under any other Chapter, Part, or Section of this Title.

B. All health insurance insurers operating pursuant to a license as required by this Chapter shall be exempt from the applicability of all other insurance laws of this state, except the Unfair Trade Practices provisions of Part XXVI of Chapter 1 of this Title provided intent is established that the health insurance issuer is committing or performing with such frequency such practices as to indicate a general business practice, any financial solvency enumerated in this Chapter, or where such laws are specifically incorporated herein by reference.

§3112. Definitions

As used in this Chapter:

(1) "Commissioner" means the commissioner of insurance.

(2) "Contracted health care provider" means a health care provider that has entered into a contract or agreement directly with a health insurance issuer or through a network of providers for the provision of covered health care services.

(3) "Contracted reimbursement rate" means the aggregate maximum amount that a contracted health care provider has agreed to accept from all sources for provision of covered health care services under the health insurance coverage applicable to the enrollee or insured.

(4) "Covered health care services" means services, items, supplies, or drugs for the diagnosis, prevention, treatment, cure, or relief of a health condition, illness, injury, or disease that are either covered and payable under the terms of the health insurance coverage.

(5) "Enrollee" or "insured" means a person, including a spouse or dependent, who is enrolled in or insured by a health insurance issuer for health insurance coverage. A dependent includes unmarried children under twenty-one years of age or, in the case of full-time students, unmarried children under the age of twenty-four, and unmarried grandchildren under twenty-one years of age in the legal custody of and residing with the grandparent or, in the case of full-time students, unmarried grandchildren under the age of twenty-four who are in the legal custody of and residing with the grandparent, except that the policy may provide for continuing coverage for any unmarried child or grandchild in the legal custody of and residing with the grandparent who is incapable of self-sustaining employment by reason of mental retardation or physical handicap, who became so incapable prior to attainment of age twenty-one, and any other person dependent upon the employee.

(6) "Health care facility" means a facility or institution providing health care services including but not limited to a hospital or other licensed inpatient center, ambulatory surgical or treatment center, skilled nursing facility, inpatient hospice facility, residential treatment center, diagnostic, laboratory, or imaging center, or rehabilitation or other therapeutic health setting. A health care facility may also be a base health care facility.

(7) "Health care professional" means a physician or other health care practitioner licensed, certified, or registered to perform specified health care services consistent with state law.

(8) "Health care provider" or "provider" means a health care professional or a health care facility or the agent or assignee of such professional or facility.

(9) "Health care services" means services, items, supplies, or drugs for the diagnosis, prevention, treatment, cure, or relief of a health condition, illness, injury, or disease.

(10) "Health insurance coverage" means benefits consisting of medical care provided or arranged for directly, through insurance or reimbursement, or otherwise, and includes health care services paid for under any plan, policy, or certificate of insurance.

(11) "Health insurance issuer" means any entity that offers health insurance coverage through a policy or certificate of insurance subject to state law that regulates the business of insurance. For purposes of this Chapter, a "health insurance issuer" shall include a health maintenance organization, as defined and licensed pursuant to Part XII of Chapter 2 of this Title, and nonfederal government plans subject to the provisions of Part VI-D of Chapter 1 of this Title, including the Office of Group Benefits.

(12) "Minimal benefit hospital and medical policy" means a policy that provides a fixed payment or benefit, not to exceed the cost of the covered health service.

(13) "Network of providers" or "network" means an entity other than a health insurance issuer that, through contracts with health care providers, provides or arranges for access by groups of enrollees or insureds to health care services by health care providers who are not otherwise or individually contracted directly with a health insurance issuer.

Section 2. This Act shall become effective upon signature by the governor or, if not signed by the governor, upon expiration of the time for bills to become law without signature by the governor, as provided in Article III, Section 18 of the Constitution of Louisiana. If vetoed by the governor and subsequently approved by the legislature, this Act shall become effective on the day following such approval.

_____

SPEAKER OF THE HOUSE OF REPRESENTATIVES

_____

PRESIDENT OF THE SENATE

_____

GOVERNOR OF THE STATE OF LOUISIANA

APPROVED: _____

State of Louisiana Office of Group Benefits
SafeNet Program
November 4, 2003

The SafeNet Program is designed to offer health care benefits to approximately 9,000 limited-income state employees who have not elected coverage under any of the current state health care options. At this preliminary point, we cannot estimate how many of these 9,000 workers would choose to participate.

We believe these employees do not have coverage from any other source. We also believe these employees currently receive care through the state public hospital and clinic system. This includes physician services, inpatient and outpatient diagnostic and therapeutic services, and some limited outpatient prescription drugs. Some of these state employees may also be receiving health care through emergency rooms of community hospitals. In order to be eligible for the SafeNet Program, the employees must have had no health care coverage for at least the past twelve months.

Our objective is to create a viable and inexpensive benefits program that could be offered to these employees so that all state employees can have access to some level of health care coverage. Our goal is to keep the state's cost at $100 or less per employee per month. In addition, we strongly feel that it would be worthwhile to incorporate an employee contribution into the program. This would help create a perception of value to the employees and would facilitate eligibility administration.

The SafeNet Program is currently in its conceptual phase. We have prepared this discussion to help further the program design. This discussion should be considered as preliminary – reliable cost estimates will be developed as the program gains structure.