

2022 Regular Session

SENATE BILL NO. 165

BY SENATOR TALBOT

INSURANCE CLAIMS. Provides for internal claims and appeals process and external review procedures for health insurance issuers. (1/1/23)

1 AN ACT

2 To amend and reenact R.S. 22:2436(C)(2)(a), and (D)(2), (D)(3), and (E)(2), and R.S.
3 22:2437(C), to enact R.S. 22:2436(D)(4) and R.S. 22:2439(D) and to repeal R.S.
4 22:2436(E)(3) relative to an internal claims and appeals process and external
5 procedures for health insurance issuers; to provide requirements for certain processes
6 and procedures; and to provide for related matters.

7 Be it enacted by the Legislature of Louisiana:

8 Section 1. R.S. 22:2436(C)(2)(a), and (D)(2), (D)(3), and (E)(2), and R.S. 22:2437(C)
9 are hereby amended and reenacted and R.S. 22:2436(D)(4) and R.S. 22:2439(D) are hereby
10 enacted to read as follows:

11 §2436. Standard external review

12 * * *

13 C.(1) * * *

14 (2) If the request:

15 (a) Is not complete, the health insurance issuer shall inform the covered
16 person and, if applicable, his authorized representative in writing and ~~include~~ **state**
17 **with specificity** in the notice ~~what~~ **the** information or materials ~~are~~ needed to make

1 the request complete.

2 D.(1) * * *

3 (2) **A health insurance issuer shall notify the commissioner in a manner**
 4 **prescribed by the department, if a request is determined not complete pursuant**
 5 **to Subsection C of this Section, and the notice shall state with specificity the**
 6 **information or materials needed to make the request complete. If a form**
 7 **required by a health insurance issuer has not been completed, the health**
 8 **insurance issuer shall include in the notice a copy of the form, and copies of any**
 9 **materials submitted by the covered person or, if applicable, his authorized**
 10 **representative that could reasonably be interpreted as pertaining to the same**
 11 **subject matter or purpose of the form. Any notice or form required to be**
 12 **provided by this Paragraph may be provided electronically on the department's**
 13 **website.**

14 (3) In reaching a decision, the assigned independent review organization shall
 15 not be bound by any decisions or conclusions reached during the health insurance
 16 issuer's internal claims and appeals process as provided pursuant to R.S. 22:2401.

17 ~~(3)~~(4) The commissioner shall include in the notice provided to the covered
 18 person and, if applicable, his authorized representative a statement that the covered
 19 person or his authorized representative may submit in writing to the assigned
 20 independent review organization, within five business days following the date of
 21 receipt of the notice provided pursuant to Subparagraph (1)(b) of this Subsection,
 22 additional information that the independent review organization shall consider when
 23 conducting the external review. The independent review organization shall be
 24 authorized but not required to accept and consider additional information submitted
 25 after five business days.

26 E.(1) * * *

27 (2)(a) ~~Except as provided in Paragraph (3) of this Subsection, failure by the~~
 28 ~~health insurance issuer or its utilization review organization~~ **If a health insurance**
 29 **issuer or its utilization review organization fails** to provide the documents and

1 information within the time frame specified in Paragraph (1) of this Subsection, the
 2 assigned independent review organization may terminate the external review
 3 process and make a decision to reverse the adverse determination or the final
 4 adverse determination. ~~shall not delay the conduct of the external review.~~ This
 5 Paragraph shall not apply if the issuer's failure to provide documents or
 6 information is due to the covered person's failure to provide a signed form
 7 authorizing the insurer to proceed with an external review or to release the
 8 insured's personal health information to the independent review organization
 9 as required by federal law.

10 (b) Within one business day after making the decision under
 11 Subparagraph (a) of this Paragraph, the independent review organization shall
 12 notify the covered person in writing, if applicable, his authorized representative,
 13 the health insurance issuer, and the commissioner.

14 * * *

15 §2437. Expedited external review

16 * * *

17 C.(1) Upon receipt of the notice from the commissioner of the name of the
 18 independent review organization assigned to conduct the expedited external review
 19 pursuant to Paragraph (B)(4) of this Section, the health insurance issuer or its
 20 designee utilization review organization shall provide or transmit all necessary
 21 documents and information considered in making the adverse determination or final
 22 adverse determination to the assigned independent review organization
 23 electronically, by telephone or facsimile, or by any other available expeditious
 24 method.

25 (2) Any information required by Subparagraph (1) of this Paragraph
 26 and not received from a health insurance issuer as expeditiously as is necessary
 27 for consideration in reaching a decision required in Paragraph E of this Section,
 28 shall be presumed to include the information that is the most favorable to a
 29 covered person in reaching a decision required in Paragraph E of this Section.

* * *

§2439. Binding nature of external review decision

* * *

D. For any decision by an independent review organization in favor of the covered person, a health insurance issuer may only subsequently deny coverage of the services that were the subject of review, if it is determined that the covered person was ineligible for coverage due to nonpayment of premiums or for suspected fraud or material misrepresentation of fact.

Section 2. R.S. 22:2436(E)(3) is hereby repealed.

Section 3. This Act shall become effective on January 1, 2023.

The original instrument was prepared by Beth O'Quin. The following digest, which does not constitute a part of the legislative instrument, was prepared by Cheryl Serrett.

DIGEST

SB 165 Reengrossed

2022 Regular Session

Talbot

Present law provides a health insurance issuer must notify a covered person and the commissioner of insurance that a request is eligible for external review.

Proposed law retains present law but requires a health insurance issuer to notify the commissioner with specificity the information or materials needed to make the request complete. Provides that if a health insurance issuer needs a form to make the request complete, the health insurance issuer is to provide within its notification a copy of the form, and provide copies of all materials submitted by a covered person, or if applicable, his authorized representative that could reasonably be interpreted as pertaining to the subject matter or purpose of the form. Provides that the notice or form may be provided on the department's website.

Present law provides that if a health insurance issuer or its utilization review organization fails to provide documents and information within a certain timeframe, an independent review organization (IRO) cannot delay the external review.

Proposed law removes provisions that an IRO cannot delay an external review but authorizes an IRO to terminate an external review and make a decision to reverse an adverse determination or a final adverse termination.

Present law provides when the commissioner receives the name of the IRO, a health insurance issuer or its utilization review organization (URO) to provide all necessary documents and information the health insurance issuer or its URO considered for making the adverse determination or final adverse determination, and send the documents and information by either electronic delivery, telephone, facsimile, or by other expeditious method.

Proposed law retains present law and adds if an IRO has not received information from the health insurance issuer expeditiously to reach a determination, the IRO is to presume the information submitted is most favorable to a covered person when an IRO reaches a decision

as provided in law. Provides exceptions if the covered person fails to provide signed forms authorizing the issuer to release personal information.

Present law makes all external review decisions binding on the health insurance issuer and the covered person except to the extent that either has other remedies available under applicable federal or state law.

Proposed law retains present law but prohibits a health insurance issuer from denying coverage of services that were subject of review, if it determined that the covered person was ineligible for coverage due to nonpayment of premiums or for suspected fraud or material misrepresentation of fact.

Effective January 1, 2023.

(Amends R.S. 22:2436(C)(2)(a), (D)(2), (D)(3), (E)(2) and R.S. 22:2437(C); adds R.S. 22:2436(D)(4) and R.S. 22:2439(D); repeals R.S. 22:2436(E)(3))

Summary of Amendments Adopted by Senate

Senate Floor Amendments to engrossed bill

1. Provides for electronic posting of notice or forms.
2. Provides exceptions relative to issuers' failure to timely provide documentation if the covered person fails to provide signed authorization.
3. Provides for exceptions to binding nature of external reviews.