SLS 23RS-378 **ORIGINAL**

2023 Regular Session

SENATE BILL NO. 164

BY SENATOR CLOUD

Prefiled pursuant to Article III, Section 2(A)(4)(b)(i) of the Constitution of Louisiana.

GROUP BENEFITS PROGRAM. Provides relative to prior authorization for services, procedures, and pharmaceuticals. (gov sig)

AN ACT

To amend and reenact R.S. 42:812(A), relative to the Office of Group Benefits; to provide for requirements for health plans; to provide for prior authorizations; to provide for an annual report; to provide terms, conditions, and procedures; and to provide for related matters.

Be it enacted by the Legislature of Louisiana:

Section 1. R.S. 42:812(A) is hereby amended and reenacted to read as follows:

§812. Transparency in prior authorizations

A. ~~Beginning January 1, 2023:~~

(1) ~~The office shall require every health plan offered through the office to furnish in writing or provide electronically, within one business day of a written or oral request by a healthcare provider, the medical criteria and any other requirements that must be satisfied in order for a particular healthcare service, procedure, or prescription drug to be prior authorized by the health plan.~~ **For every health plan offered through the office, the office shall maintain and publish on a publicly accessible webpage a list of healthcare services, procedures, and pharmaceuticals subject to prior authorization, including step-therapy and fail**

first protocols. The list shall also include the time period allowed for the health plan to render and communicate a decision and the requirements or criteria that shall be satisfied in order for the plan to prior authorize the healthcare service, procedure, or pharmaceutical. A health plan offered through the office shall be prohibited from requiring a prior authorization to be obtained for any health care service, procedure, or pharmaceutical that is not included on the list published and maintained by the office. A health plan that fails to render and communicate a prior authorization decision to the requesting healthcare provider within the timeframe published on the list shall cause the healthcare services, procedures, or pharmaceuticals subject to the request to no longer require prior authorization as a condition of payment of the claim.

(2) Upon the denial of a prior authorization by a health plan offered through the office, the office shall require the health plan to provide with the written notification of the denial either a copy of the applicable law, regulation, policy, procedure, or medical criterion or guideline that was used by the health plan in the determination to deny the prior authorization or instructions on how to access such law, regulation, policy, procedure, or medical criterion or guideline on the website of the health plan that is publicly accessible.

(3)(a) The office shall make aggregate statistics available on an annual basis, delineated by quarter, for each health plan offered through the office regarding prior authorization approvals and denials on its website in a readily accessible format. The chief executive officer shall determine the statistics required in order to comply with this Section in accordance with applicable state and federal privacy laws. The statistics shall include but not be limited to the following:

(i) The percentage of standard prior authorization requests that were approved, aggregated for all items and services.

(ii) The percentage of standard prior authorization requests that were denied, aggregated for all items and services.

(iii) The percentage of standard prior authorization requests that were approved after appeal, aggregated for all items and services.

(iv) The percentage of prior authorization requests when the timeframe for review was extended, and the prior authorization request was approved, aggregated for all items and services.

(v) The percentage of expedited prior authorization requests that were approved, aggregated for all items and services.

(vi) The percentage of expedited prior authorization requests that were denied, aggregated for all items and services.

(vii) The average and median time that elapsed between the submission of a request and a determination by the health insurance issuer, for standard prior authorizations, aggregated for all items and services.

(viii) The average and median time that elapsed between the submission of a request and a decision by the health insurance issuer for expedited prior authorizations, aggregated for all items and services.

(b) The chief executive officer of the office shall submit annually a written report to the Senate Committee on Finance and the House Committee on Appropriations that includes the information required by this Paragraph.

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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 by 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.

The original instrument and the following digest, which constitutes no part of the legislative instrument, were prepared by Michelle Ridge.

DIGEST

SB 164 Original 2023 Regular Session Cloud

Present law provides that the Office of Group Benefits (office) shall require every health plan offered through the office to furnish in writing or provide electronically, within one business day of a written or oral request by a healthcare provider, the medical criteria and

any other requirements that must be satisfied in order for the service, procedure, or drug to be prior authorized by the health plan.

Proposed law removes the requirement that in order to receive information relative to prior authorization requirements for certain services, procedures, or drugs, a healthcare provider must request the information. Proposed law instead requires that the office maintain and publish on a publicly accessible webpage a list of healthcare services, procedures, and pharmaceuticals subject to prior authorization.

Proposed law provides that the list shall also include the time period allowed for the health plan to render and communicate a decision and the requirements or criteria that shall be satisfied in order for the plan to prior authorize the healthcare service, procedure, or pharmaceutical.

Proposed law prohibits a health plan offered through the office from requiring a prior authorization to be obtained for any healthcare service, procedure, or pharmaceutical that is not included on the list published and maintained by the office and provides that a health plan that fails to render and communicate a prior authorization decision to the requesting healthcare provider within the timeframe published on the list shall cause the healthcare services, procedures, or pharmaceuticals subject to the request to no longer require prior authorization as a condition of payment of the claim.

Proposed law requires the office to make aggregate statistics available on an annual basis, delineated by quarter, for each health plan offered through the office regarding prior authorization approvals and denials on its website in a readily accessible format. Authorizes the chief executive officer (CEO) of the office to determine the statistics required in order to comply with proposed law in accordance with applicable state and federal privacy laws. Proposed law provides for an illustrative list of statistics required for compliance.

Proposed law requires the CEO to submit the aggregate statistics annually in a written report to the Senate Committee on Finance and the House Committee on Appropriations.

Effective upon signature of the governor or lapse of time for gubernatorial action.

(Amends R.S. 42:812(A))