SLS 23RS-396 **REENGROSSED**

2023 Regular Session

SENATE BILL NO. 188

BY SENATORS STINE, ABRAHAM, BERNARD, FESI, ROBERT MILLS, MORRIS AND TALBOT AND REPRESENTATIVES ROBERT OWEN AND PRESSLY

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

HEALTH/ACC INSURANCE. Provides for utilization review and approval procedures of claims for healthcare provider services. (gov sig)

AN ACT

To enact R.S. 22:1020.62, relative to health insurance; to provide for utilization review; to provide definitions; to provide for documentation and reports; to require items and services subject to prior authorizations be posted on a health insurance issuer's website; to require applications and enrollment materials include a health insurance issuer's web address for any of its health coverage plans; and to provide for related matters.

Be it enacted by the Legislature of Louisiana:

Section 1. R.S. 22:1020.62 is hereby enacted to read as follows:

§1020.62. Utilization review reports; definitions

A. For purposes of this Section, the following terms shall have the following meanings:

(1) "Health coverage plan" means any hospital, health, or medical expense insurance policy, hospital or medical service contract, employee welfare benefit plan, contract, or other agreement with a health maintenance organization or a preferred provider organization, health and accident insurance policy, or any other insurance contract of this type in this state,

including a group insurance plan or self-insurance plan. "Health coverage plan" does not include a plan providing coverage for excepted benefits defined in R.S. 22:1061, excepted benefit health insurance plans, short-term policies that have a term of less than twelve months or the office of group benefits. Notwithstanding excepted benefits as defined in R.S. 22:1061, a "health coverage plan" subject to the provisions of Part III of this Chapter shall include dental insurance plans.

(2) "Health insurance issuer" means an entity subject to the insurance laws and regulations of this state, or subject to the jurisdiction of the commissioner, that contracts or offers to contract, or enters into an agreement to provide, deliver, arrange for, pay for, or reimburse any of the costs of healthcare services, including a sickness and accident insurance company, a health maintenance organization, a preferred provider organization or any similar entity, or any other entity providing a plan of health insurance or health benefits. Health insurance issuer shall not include the office of group benefits.

(3) "Healthcare provider" or "provider" means a healthcare professional or a healthcare facility or the agent or assignee of the healthcare professional or healthcare facility.

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

(5) "Prior authorization" means a determination by a health insurance issuer, or person contracting with a health insurance issuer that healthcare services ordered by the provider for an individual are medically necessary and appropriate.

B.(1) A health insurance issuer on an annual basis and at a time and in a manner determined by the commissioner, shall submit to the department, a report containing a quarterly breakdown of the following information:

(a) A list of all items and services that require prior authorization.

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

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

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

(e) 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.

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

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

(h) 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.

(i) 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.

(2) The commissioner shall submit an annual written report to the Senate Committee on Insurance and the House Committee on Insurance that includes the information submitted to the department in accordance with Subsection B of this Section.

C.(1) A health insurance issuer shall annually publish on the health insurance issuer's publicly available website a list of all items and services that are subject to a prior authorization request according to each health coverage plan. This list shall be published on the insurer's website prior to open enrollment. If a health insurance issuer changes the list of items and services that are subject to prior authorization, a health insurance issuer shall in a

timely manner, update its website to reflect the changes.

(2) A health insurance issuer shall include a current web address on any application or enrollment materials that are distributed by each health coverage plan.

D. A health insurance issuer shall provide along with contract materials to any healthcare provider or supplier who seeks to participate under a health coverage plan, a list of all items and services that are subject to prior authorization under the health coverage plan, and any policies or procedures used by a health coverage plan for making determinations with regards to a prior authorization request.

Section 2. This Act shall become effective upon signature of 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 the day following such approval.

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

DIGEST

SB 188 Reengrossed 2023 Regular Session Stine

Present law provides requirements for utilization review.

Proposed law retains present law but adds definitions for "health coverage plan", "healthcare provider", "health insurance issuer", "healthcare services", and "prior authorization". Excludes the office of group benefits from definition of "health insurance issuer".

Proposed law requires health insurance issuers to submit an annual report that provides a quarterly breakdown that includes the following:

(1) List of all items and services that require prior authorization.

(2) Percentage of standard prior authorizations that were approved, aggregated for all items and services.

(3) Percentage of standard prior authorizations that were denied, aggregated for all items and services.

(4) Percentage of standard prior authorization that were approved after appeal, aggregated for all items and services.

(5) Percentage of prior authorization requests when the timeframe for review was extended, and the prior authorization requests were approved, aggregated for all items and services.

(6) Percentage of expedited prior authorization requests that were approved, aggregated for all items and services.

(7) Percentage of prior authorization requests that were denied, aggregated for all items and services.

(8) An average and median time that elapsed for all standard prior authorization requests and the time between submitting a standard authorization request, and the time a determination was made by a health insurance issuer, aggregated for all items and services.

(9) The average and median time for an expedited review regarding a prior authorization request and the time between submitting the expedited request and the time a decision was made by a health insurance issuer, aggregated for all items and services.

Proposed law requires the commissioner to submit an annual report that provides information regarding prior authorization practices on or before March 15th to the Senate and House Committees on Insurance.

Proposed law requires a health insurance issuer to annually publish a list of all items and services that are subject to prior authorization and include this information prior to open enrollment on its publicly available website, and to timely update any changes made to prior authorization requests.

Proposed law requires a health insurance issuer to include a web address on any application or enrollment materials that are distributed by a health coverage plan.

Proposed law requires a health insurance issuer to provide contract materials including items and services subject to prior authorization and any policy or procedures used to determine prior authorization to any provider or supplier who seeks to participate under a health coverage plan.

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

(Adds R.S. 22:1020.62)

Summary of Amendments Adopted by Senate

Committee Amendments Proposed by Senate Committee on Insurance to the original bill

1. Removes office of group benefits from the definition of health issuer insurer.

2. Makes technical changes.

Summary of Amendments Adopted by Senate

Senate Floor Amendments to engrossed bill

1. Adds dental insurance plans to the definition of health coverage plan.

2. Makes a technical change.