SLS 22RS-244 **ORIGINAL**

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)

AN ACT

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

Be it enacted by the Legislature of Louisiana:

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

§2436. Standard external review

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C.(1) * * *

(2) If the request:

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

Coding: Words which are ~~struck through~~ are deletions from existing law; words in **boldface type and underscored** are additions.

the request complete.

D.(1) * * *

(2) **A health insurance issuer shall notify the commissioner in a manner prescribed by the department, if a request is determined not complete pursuant to Subsection C of this Section, and the notice shall state with specificity the information or materials needed to make the request complete. If a form required by a health insurance issuer has not been completed, the health insurance issuer shall include in the notice a copy of the form, and copies of any materials submitted by the covered person or, if applicable, his authorized representative that could reasonably be interpreted as pertaining to the same subject matter or purpose of the form.**

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

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

E.(1) * * *

(2)**(a)** ~~Except as provided in Paragraph (3) of this Subsection, failure by the health insurance issuer or its utilization review organization~~ **If a health insurance issuer or its utilization review organization fails** to provide the documents and information within the time frame specified in Paragraph (1) of this Subsection**, the assigned independent review organization may terminate the external review**

process and make a decision to reverse the adverse determination or the final adverse determination. ~~shall not delay the conduct of the external review.~~

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

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§2437. Expedited external review

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

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

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§2439. Binding nature of external review decision

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D. A health insurance issuer shall not deny coverage of a claim regarding an external review decision rendered in favor of coverage based on any reason that was subject to an external review had the reason been raised prior to the request for external review.

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 and the following digest, which constitutes no part of the legislative instrument, were prepared by Beth O'Quin.

DIGEST

SB 165 Original 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.

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.

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 a claim regarding an external review decision rendered in favor of coverage for any reason that is subjected to an external review had the reason been raised prior to the request for external review.

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))