

2022 Regular Session

SENATE BILL NO. 348

BY SENATOR CLOUD

GROUP BENEFITS PROGRAM. Provides for a process for a prior authorization for a particular healthcare service, procedure, or prescription drug. (7/1/22)

1 AN ACT

2 To enact R.S. 42:812, relative to the Office of Group Benefits; to provide for requirements
3 for health plans; to provide for information on denied prior authorizations be
4 transmitted to healthcare providers; to provide for an effective date; and to provide
5 for related matters.

6 Be it enacted by the Legislature of Louisiana:

7 Section 1. R.S. 42:812 is hereby enacted to read as follows:

8 **§812. Transparency in prior authorizations**

9 **A. Beginning January 1, 2023:**

10 **(1) The office shall require every health plan offered through the office**
11 **to furnish in writing, within twenty-four hours of a written or oral request by**
12 **a healthcare provider or covered person, the medical criteria and any other**
13 **requirements that must be satisfied in order for a particular healthcare service,**
14 **procedure, or prescription drug to be prior authorized by the health plan.**

15 **(2) Upon the denial of a prior authorization by a health plan offered**
16 **through the office, the office shall require the health plan to provide with the**
17 **written notification of the denial either a copy of the applicable law, regulation,**

1 **policy, procedure, or medical criterion or guideline that was used by the health**
 2 **plan in the determination to deny the prior authorization or instructions on how**
 3 **to access such law, regulation, policy, procedure, or medical criterion or**
 4 **guideline on the website of the health plan that is publicly accessible.**

5 **B. The office may adopt rules in accordance with the Administrative**
 6 **Procedure Act as are necessary for the implementation of this Section.**

7 Section 2. This Act shall become effective on July 1, 2022; if vetoed by the governor
 8 and subsequently approved by the legislature, this Act shall become effective on the day
 9 following such approval by the legislature or July 1, 2022, whichever is later.

The original instrument and the following digest, which constitutes no part
 of the legislative instrument, were prepared by Martha S. Hess.

DIGEST

SB 348 Engrossed

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Cloud

Proposed law provides that beginning January 1, 2023:

- (1) The office of group benefits shall require every health plan offered through the office to furnish in writing, within 24 hours of a written or oral request by a healthcare provider or covered person, 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.
- (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 a copy of the applicable law, regulation, policy, procedure, or medical criterion or guideline that was used by the health plan to deny the prior authorization or how to access such law, regulation, policy, procedure, or medical criterion or guideline that is publicly accessible.

Proposed law authorizes the office to adopt rules in accordance with the Administrative Procedures Act as necessary for the implementation of proposed law.

Effective July 1, 2022.

(Adds R.S. 42:812)

Summary of Amendments Adopted by Senate

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

1. Removes the provision that created a group benefits appeals subcommittee of the Joint Legislative Committee on the Budget.
2. Removes the provision that authorized the Office of Group Benefits to establish an appeals process for the denial of health benefits.

3. Removes the provision that required the appeals subcommittee of JLCB to review requests of benefits for the provision of health care that were denied but certified by a medical doctor as necessary for the immediate provision of life-saving measures.
4. Authorizes the Office of Group Benefits to require health plans to provide a written response within 24 hours to any request by a healthcare provider or insured the criteria necessary for the prior authorization a particular drug, procedure, or service.
5. Requires health plans offered through Group Benefits to provide a copy of the applicable law, regulation, policy, procedure, or medical criterion or guideline that was used by the plan when prior authorization is denied.