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

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DIGEST

SB 348 Engrossed                                              2022 Regular Session                                              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.