

## RÉSUMÉ DIGEST

ACT 81 (SB 165)

2022 Regular Session

Talbot

Prior law required a health insurance issuer to notify a covered person and the commissioner of insurance that a request is eligible for external review.

New law retains prior 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 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. Provides that the notice or form may be provided on the department's website.

New law provides that if a health insurance issuer or its utilization review organization (URO) fails to provide documents and information within a certain timeframe, an independent review organization (IRO) cannot delay the external review. New law deletes the prohibition against an IRO delaying 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.

New law provides that when the commissioner receives the name of the IRO, a health insurance issuer or its URO is required to provide all necessary documents and information considered for making the adverse determination or final adverse determination to the IRO by electronic delivery, telephone, facsimile, or by any other expeditious method.

New law retains prior law and adds that 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. Provides exceptions if the covered person fails to provide signed forms authorizing the issuer to release personal information.

Prior law made 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. New law retains prior law, but prohibits a health insurance issuer from denying coverage of services that were subject of review, if it determined that the covered person was ineligible for coverage due to nonpayment of premiums or for suspected fraud or material misrepresentation of fact.

Effective January 1, 2023.

(Amends R.S. 22:2436(C)(2)(a), (D)(2), (D)(3), (E)(2) and 2437(C); adds R.S. 22:2436(D)(4) and 2439(D); repeals R.S. 22:2436(E)(3))